Summary
Patient Experience of health care performance

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Executive Summary

Patient-centred care, a fundamental tenet of quality healthcare, means delivering services which respond to and are sensitive to the needs and wishes of the consumers or patients. Without systematic ways of collecting information about patients’ experience of the health care system, a vital perspective is missing from efforts to improve the quality of care. Submissions to the draft National Primary Health Care Strategy identified that consumer satisfaction, holistic care, equity of access, and obtaining feedback from users are some areas which are appropriate for performance management via indicators.

Mechanisms to measure performance of health care from a patient perspective

Measuring patient satisfaction is neither sensitive nor useful, as there is little evidence of reliability or validity of the tools that measure satisfaction, and almost all individuals are ‘satisfied’ with the care they received, regardless of its quality. Measuring expectations and experiences, the constructs underpinning satisfaction, is more fruitful to inform continuous improvement activities.

Expectations: The Picker Institute in Europe found patients distinguish between what they want as a citizen taxpayer, and what they want as healthcare users. Picker produces a series of survey tools that have become the foundation of many surveys of patient experience worldwide. The Picker tools measure eight dimensions of care that are important to patients: information and education, coordination of care, physical comfort, emotional support, respect for patients’ preferences, involvement of family and friends, continuity and transition, and overall impression of care.

Experience: Patient experience is influenced by human and organisational factors at different levels of care. Information about patient experience can be collected by survey, by narrative methods or through patient feedback processes.

Surveys can be conducted at national, state, group or provider level. Examples include the Commonwealth Fund (international surveys); experiences with PHC in Canada (national level); Consumer Assessment of Healthcare Provider Surveys (CAHPS) in USA (standardised survey at health plan level) and National PCT Survey in UK (provider level). Appropriate sample sizes are needed if national surveys are to be useful for quality improvement at provider level. In Australia, most surveys at provider level take place for accreditation or audit purposes, for the sole use of the provider, and because of privacy cannot be aggregated up to provide information at regional or higher levels.

Narrative methods such as critical incidents, patient journey and tracer methodologies gather information by interviewing patients about a particular health incident in which they used a health service.

These patient experience measures are utilised to improve the quality of the care and services provided to consumers. This is achieved through a variety of drivers, from pay for performance, to accreditation, and clinical service redesign programs. Underpinning many of these drivers is the assumption that free market principles and transparent accountability processes will increase competitiveness amongst providers and organisations in the quality of care domain. The UK is the most advanced country in this respect, with their patient experience measures informing multiple
mechanisms, from annual public service agreements to patient choice websites, pay for performance schemes and provider and fundholder accountability.

Patient feedback systems and other mechanisms for community engagement and participation in planning and implementation at organisation or higher level are necessary, but do not replace systems to collect patient or client experience of the service being delivered on the ground.

**How are the results of patient experience measures used?**

Patient experience measures are intended to supplement rather than replace measures of clinical outcome and other measures of the process, outcomes and costs of safe quality care.

The reasons for studying patient experiences include:

- external accountability of health care providers
- enhancing patient choice
- improving the quality of care and
- measuring the performance of the health care system as a whole.

Patient experience information can be analysed in a variety of formats, for example auditing an organisation against its policies and procedures, auditing an organisation against external accreditation or best practice standards, or identifying incidents or points in the patient journey that have a significant impact on the patient.

When patient experience surveys are used as an auditing tool, ratings of performance are lower than in a traditional audit. The probable explanation is that patient journey methodologies assess if policies and procedures are enacted, as opposed to the traditional audit processes which test whether a policy or procedure exists in an organisation.

Standardised questions and comparison between health care facilities are required to provide information to enhance patient choice.

Patient experience is a component of the UK Quality and Outcomes Framework (QOF), a pay for performance scheme under which general practices receive a proportion of their income according their score on indicators in the QOF. Patient experience points are calculated from the National Primary Care Trust Survey. The results of patient experience questions in the National GP Survey are made available to patients through NHS Choices to assist with choice of provider.

Providing patient feedback or experience information is not sufficient in itself to stimulate quality improvement, without being integrated into a system specifically designed to support the use of this information.

**Information available to and used by patients**

Australian users of primary health care services have little information to guide them in choosing a practice or practitioner. Resources include telephone directors, links through Health/nsite to the patient’s jurisdiction, Divisions of General Practice, AGPAL to identify accredited practices, public libraries, and some specific consumer groups such as Cancer Voices NSW and beyondblue. In contrast, through NHS Choices UK patients have access to information about opening hours of practices, the services provided, names and qualifications of doctors, and clinical achievements of the practice on items of the Quality and Outcomes Framework including patient experience as measured by the GP Survey.
However, the use that patients make of such information is not clear. One UK study found the public do not like league tables comparing the performance of practices, being more interested in information about the context and availability of services. A US study found individuals seeking to change providers or waiting for elective treatments, rated patient experience information more highly than information on practice location and hours, physician characteristics and credentials, advice from other health professionals, and advice from friends. As more information becomes available on the internet, it is important to understand consumers’ access to the internet and skills in using it as part of their help seeking behaviour. It is also necessary to consider consumers’ health and functional literacy when providing health information to optimise its value.

**Application in Australia**

A review of patient experience measures concluded that European countries who wish to introduce similar programmes of measuring quality of care from the patient’s perspective can learn at least three things:

- measure detailed patient experiences instead of overall patient satisfaction
- introduce an integrated system for:
  - internal quality measurement and improvement on the one hand
  - external reporting and accountability on the other hand
- standardise questionnaires and methods.

Submissions to the NHHRC and the NPHCS indicate support for the measurement of patient experience from health consumer representative bodies, safety and quality organisations, multidisciplinary representative bodies, state government health departments and organisations such as the AGPN and Divisions of General Practice.

Existing mechanisms which could be adapted include the 2010 Commonwealth Fund survey and the 2010 Australian Bureau of Statistics Survey. The Australian Commission in Quality and Safety in Health Care is considering including questions in each of these surveys to provide comparison on international and national level. The existing CATI surveys conducted regularly by State and territory jurisdictions could include appropriate questions about patient experience, standardised across the jurisdictions to collect information relevant to COAG agreements and National Partnerships. Existing instruments developed for accreditation of primary care providers at practice or provider level would be relevant for quality improvement at this level.

New options in a reformed health system include establishing patient experience systems to collect and use patient experience information from those high-need patients who voluntarily enrol in primary care entity. The advantage of this would be obtaining information about their experience across a number of providers.

The Australian Charter for Health Care Rights, recently endorsed by COAG, could provide useful standards against which to measure some aspects of patient experience at national level in each of the above options. The domains measured can include, though not be limited to the rights identified in the patient charter.

Experience elsewhere as well as local submissions suggests it is important for an independent organisation to develop and monitor this process.