What Is Transparency in Health Care and Why Does It Matter?
California State Assembly Committee on Health, February 17, 2009

Mr. Chairman and Members of the Assembly Health Committee, I am Maribeth Shannon, director of the Market and Policy Monitor program, with the California HealthCare Foundation (CHCF). I appreciate the invitation to provide an overview of transparency in health care for the committee.

The Foundation is a non-partisan, independent philanthropy dedicated to improving how health care is delivered and financed in California. We are committed to the application of transparency as an effective tool to inform health care decisions and to encourage quality improvements. In the 11 years since the Foundation began, it has worked to increase the availability of information on health care quality through research, and by being active practitioners: supporting consumer-oriented Web sites on quality. The Foundation provides rating information for long term care (through California Nursing Home Search, or www.CalNHS.org) and on hospital quality (through www.CalHospitalCompare.org). In addition, CHCF works collaboratively with many of the other transparency efforts you will hear about today, through financial and technical support.

Over the years we have learned a lot about what works—the elements of successful efforts—and also identified challenges and opportunities for the future.

There are four areas in particular on which I’d like to focus:

1. Transparency efforts need to have input and buy-in from key audiences;
2. Measurements need to focus on reliability, variability, understandability and accessibility of the data;
3. While we have come a long way, gaps still exist; and
4. Finally, coordination is key.

Three Different Audiences
In our experience, we have found that there are three distinct audiences: providers, health plans and purchasers, and consumers of health care services (patients).

First, providers of health care services: Hospitals, long term care organizations and other providers strive to deliver high quality care, but without comparison information it is hard for them to gauge their own success. Displaying reliable, consistent data for individual providers, and showing how these results compare to state and national peers, helps to focus quality improvement efforts. Administrators, boards of directors, and even financial service organizations, such as bond-rating agencies, pay attention to quality metrics. Quality care is the business they are all in and public disclosure facilitates improvement by focusing attention on deficiencies and providing incentives to be the best.

Health plans and other health care purchasers are a second important audience. These groups need reliable information to determine where to send their employees, or enrolled members, and to
gauge whether the costs are justified given the quality of care delivered.

Finally, health care consumers—patients and family members—need this information to make choices, when choice is available. Though research—even that funded through CHCF—shows limited uptake by consumers, I encourage you to put these numbers in perspective. Our surveys have shown that about one in four Californians are aware that quality information is available online.\(^1\) Fewer (2 to 4 percent) have actually used these Web sites and considered a change in their planned care based on the information they found. But there are about 3.5 million hospital admissions each year in California—or one for every 10 Californians. Those decisions are critical, and people are currently making them with limited information.

However, the real power in transparency is the improvement we know is going on because the information is publicly available. There have been measurable improvements in health care quality in recent years—much of this change can be attributed to the attention that the Institute of Medicine, the media, and these reporting efforts, have placed on the failures of the current health care system.

Looking at a different industry provides an interesting parallel example. In Los Angeles, restaurants now prominently display letter grades—A, B, C—derived from health inspection reports. Published work from researchers at Stanford and the University of Maryland demonstrated a 20 percent drop in the number of people hospitalized with food-borne illnesses following the implementation of the grade cards in January 1998.\(^2\) The drop was attributable to both improvements in quality by restaurant managers and more careful selections by consumers. Few restaurants could survive for long with a “C” rating.

Hospitals are not restaurants, of course, and patients don’t have as many opportunities to make choices, but many of the same principles apply. Before the advent of grading, restaurants were inspected and only 25 percent achieved the score that would have been equivalent to an “A” rating. There were few direct incentives to achieve that level. Consumers could, of course, request access to the reports, but few did. With a rating available—at the point a customer is about to walk in the door—the results of an inspection took on a new and critical weight. Public display engages hospital administrators and their board members in much the same way—hospitals wouldn’t be able to survive long with “C” ratings either.

**Elements of Successful Quality Transparency**

So what do we know about applying the principles of transparency to health care? I’d like to highlight a few best practices that have been identified through the Foundation’s research, and more importantly, through our work with our Web sites.

First, the measures and formulas should be reliable—based on evidence and clearly understood and accepted by those being measured. If one of the primary levers for change is convincing a hospital that its performance is below average, having them clearly understand how the measure was calculated—and what action can be taken to improve—is vitally important.

Second, we have found that it’s essential that the measures selected actually vary. If all of the facilities are doing equally well, or if only a small number are determined to be above expected levels, and a small number below—leaving hundreds of hospitals in the middle—it isn’t very helpful to a consumer trying to differentiate. Focusing on the services with the greatest variation in performance is important for all three audiences.

Third, the information must be displayed in an approachable way. Even the most determined consumer
will get turned away by a wall of words and an impenetrable Web site. Engaging with actual consumers in selecting measures, displaying ratings, and navigating the information, whether displayed in a booklet or electronically, is essential. Having the information available at the time a patient is being asked to make a choice—like those restaurant customers in Los Angeles—is even more important.

**Unique Issues Related to Price Transparency**

Most of what I’ve covered so far has been around transparency in quality. There are two areas related to price transparency worth mentioning briefly.

Where quality is largely independent of what kind of coverage a patient has—though some may debate that—cost is very specific to an individual’s insurance coverage, benefit design, and financial situation. What is important here is to know not the average price but to know “my price.” *Given my unique condition and coverage (or lack of coverage) what will I be expected to pay?* For those lacking insurance, almost more important than price—since any hospitalization is likely to be unaffordable for people in the low- to middle-income range—is access to charity care and discount policy information. Help in understanding how to negotiate a price—or how to comparison shop for discounts—is often of greater use.³

Last year CHCF published two reports on price transparency that go into more depth on this topic. These have been included in the materials provided to the committee.⁴,⁵

A second focus is on cost of a health plan—when a choice is available. Though the Office of the Patient Advocate provides measures on member satisfaction and other metrics of health plan quality, there isn’t much information available comparing costs of different coverage options adjusted for differences in benefit plans. CHCF supported work last year to highlight opportunities for making coverage choices more transparent—particularly for those in the individual coverage market. A report on this work—*Check the Label: Helping Consumers Shop for Individual Health Coverage*—is also included in your packets.⁶

**Gaps**

So, where do we go from here? You will hear from a number of others this afternoon who have been working to advance transparency—through state and private efforts. In spite of these collaborative efforts, however, there remain significant gaps.

One area of particular concern is for those facing serious and sudden illness. We have a lot of information on which medical groups provide the best care for prevalent chronic diseases, yet very little information has been developed to help those diagnosed with breast cancer to choose the best treatment path or provider. Here the problem is lack of reliable data. Very little information is available at the individual doctor level. About 28 percent of consumers were faced with selecting a specialist because of a newly diagnosed condition of their own, or of a family member last year. The vast majority relied exclusively on physician referral. Most people can do more research to select a hotel for an upcoming vacation stay.

Providing reliable information—for consumers to choose, for providers to focus on improvement, and for health plans and purchasers to make sound network selections—is a vital link to a more functional health care system. Though much has been done, large gaps remain and efforts to date have been patchwork. Critical to a successful effort will be keeping all of these audiences for transparency in mind, but most importantly, consumers. Having information—not by individual state agency or private sector effort—but consolidated in a way that a consumer can understand and use will be important to avoid a “Tower of Babel.” Our goals should be to
balance comprehensiveness with usability—for all three audiences.

Thank you for the opportunity to share our perspectives. I will be happy to answer any questions.

ENDNOTES


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