

334: EXTERNAL AND INTERNAL INDICATORS – A HAPPY MARRIAGE?

Authors:

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Objective:

This paper analyses the tensions and synergies between two modes of using indicators to improve the quality of health care: generating indicators for public accountability ('external indicators') and using indicators for professional self-development ('internal indicators').

Methods:

The project consists of a detailed literature review of both internally and externally oriented indicator-development projects, and a theoretical analysis. The literature review will draw upon medical journals, medical management journals, and quality in health care journals, from 1995 onward. The theoretical analysis draws on information sciences, technology studies, and the sociology of professions.

Results:

We argue that the business of professional self-development and the aim of public accountability are too often seen as two sides of the same coin when it comes to the development of indicators. Often, for example, those who are working on the development of benchmarking indicators (for the public, for payers) will state that these same indicators will be highly useful for the professionals involved in the care processes being benchmarked. These professionals, after all, can use these indicators for their continuous quality improvement activities. We argue, however, that there are at least two reasons to remain clear about the fact that these indicators are fundamentally different. First of all, in the case of internal indicators, the (sets of) measurements will have to be directly *relevant* for the professionals involved – they should be directly related to potential improvement areas in the care process that they have selected. These indicators will often be highly specific, and thus rather useless for comparison *between* care organisations. On the other hand, more 'generic' indicators are often less relevant for professional self-development, since their relative 'coarse' nature – ideal for making overall comparisons between organisations – yields little opportunities for the (re)design of a specific care process in a specific organisation.

Second, the validity of *external* indicators is crucial. A fair and objective comparison would become impossible if it was not absolutely clear, for example, that the mortality data of the cardiac surgeons in hospital X are comparable to those of hospital Y. The validity of *internal* indicators is a wholly different matter. When aggregated data are given as feed-back to those who were responsible for the generation of those data, much of the interpretation necessary to make sense of these data can be done by the professionals themselves – they can use their practical knowledge of their own practices to *interpret* outliers, differences in mortality, and to separate wheat from chaff when it comes to setting goals for professional self-improvement.

Conclusions:

Because of these two points, it is highly problematic to confuse the two approaches, and to suggest that these indicators are interchangeable as a rule. Whereas external indicators serve a primarily public function, internal indicators should remain indeed internal, because a) the indicators will often not be very relevant to the public, or to payers and b) there where they *might* be relevant, their validity as 'external' indicator is not guaranteed. Underestimating this difference might lead to very counterproductive developments: payers and managers might want to find it 'natural' to get access to sets of internal indicators, for example. This will lead to useless data: because those data are not suitable for this purpose, but also because professionals will start to become strategic in their generation of these data. The biggest danger is that this equation of goals will obstruct the development of internal indicators, and will thwart attempts to stimulate the professional's drive to self-development.