



Why Healthcare Analytics Still Optimizes the Wrong Things

Dominic Etli*

Purdue Global University, USA

***Corresponding author:** Erela Datuowei, Lehman College, City University of New York, USA,

Email: erela@earlyscholars.org

Editorial

Volume 9 Issue 1

Received Date: February 15, 2026

Published Date: February 18, 2026

DOI: 10.23880/jqhe-16000440

Editorial

A patient leaves clinic with pristine documentation. Every required field is complete. Every quality indicator is technically satisfied. Two months later, that same patient presents with a preventable complication. On paper, the system performed flawlessly. Clinically, it did not.

This disconnect sits at the center of modern healthcare analytics. Quality measurement is now embedded in reimbursement, accreditation, and public reporting. Health systems invest heavily in dashboards, reporting pipelines, and performance infrastructure. Yet much of what we measure remains oriented toward throughput, documentation proxies, and compliance-driven processes rather than toward durable improvements in patient health or meaningful economic value.

Many commonly used quality indicators are process-based and selected primarily for feasibility of extraction and auditability. While process measures can signal activity, their association with meaningful clinical outcomes is inconsistent. Analyses of widely reported hospital quality measures demonstrate weak or variable relationships between performance on these measures and outcomes such as mortality [1]. In effect, healthcare analytics often rewards being busy and well-documented rather than being effective.

The economic implications of this paradigm are substantial. Saraswathula and colleagues describe the significant administrative burden associated with hospital quality measurement and reporting, highlighting the scale of resources required to comply with current reporting frameworks. These efforts consume analyst time, clinician time, and vendor expenditures that could otherwise be directed toward outcome surveillance, prevention programs, or direct patient care [2]. From an economic perspective, this

represents a misallocation of scarce resources toward low-yield measurement activities.

Donabedian’s framework remains conceptually straightforward: structure and process are necessary, but outcomes are the ultimate dimension of quality [3]. Yet contemporary analytic ecosystems frequently stall upstream. Dashboards proliferate with counts, percentages, and compliance indicators, while longitudinal patient trajectories, functional status, and complication patterns remain underdeveloped or siloed.

Recent commentary has underscored that outcome measurement remains underdeveloped in the United States not because of conceptual disagreement, but because policy and payment systems do not consistently require transparency or alignment around standardized outcome measures [4]. As long as incentives prioritize auditability and reporting uniformity over health improvement, analytic portfolios will continue to favor process proxies.

Emerging work in person-centered outcome measurement offers a viable alternative. National and international initiatives have advanced standardized outcome sets that prioritize functional status, symptom burden, and quality of life [5,6]. These approaches shift the analytic question from “Was the box checked?” to “Did health improve in a way the patient can perceive?” Clinically, this aligns measurement with therapeutic goals. Economically, it aligns investment with endpoints that reflect true value rather than administrative activity.

Reorienting toward outcome-weighted quality frameworks requires deliberate change.

First, outcome measures must be repositioned as the primary currency of quality. Measurement portfolios should



be anchored in sustained health status, functional capacity, complication reduction, and disease control. Process measures retain supporting value, but only insofar as they demonstrably contribute to outcome improvement.

Second, analytic infrastructure must be designed for longitudinal outcome capture rather than episodic reporting. This requires interoperable data models, standardized outcome definitions, and architectures that allow outcome data to be reused across surveillance, quality improvement, and predictive modeling. In occupational and preventive health surveillance, this shift already demonstrates practical value. Predictive models that identify elevated injury or illness risk before events occur enable targeted intervention, reduced downstream cost, and measurable harm prevention. These capabilities are not feasible in environments built solely around retrospective documentation.

Third, incentive structures must be recalibrated to reward health improvement rather than documentation performance. Payment and accountability models should preferentially recognize sustained outcome gains, complication avoidance, and population risk reduction. When organizations are rewarded for keeping people healthy rather than proving they followed a process, analytic priorities change accordingly.

Clinically, this transition supports individualized care, prevention, and longitudinal management. Economically, it redirects investment toward activities that reduce future utilization rather than simply documenting present utilization. Value-based care cannot be achieved through volume-based analytics.

Healthcare does not lack data. It lacks disciplined prioritization of which data deserve to drive decisions. Continuing to optimize volume and compliance while labeling the result “value” is increasingly untenable. If quality measurement is to justify its economic and human cost, it must move decisively away from counting activity and toward demonstrating health. Work that moves this field from measuring activity to demonstrating health deserves a platform, and the Journal of Quality in Health Care & Economics intends to provide one.

References

1. Werner RM, Bradlow ET (2006) Relationship between Medicare’s Hospital Compare performance measures and mortality rates. *JAMA* 296(22): 2694-2702.
2. Saraswathula A, Venkatesh AK, Jha AK (2023) Administrative burden of quality measurement and reporting in US hospitals. *JAMA* 330(6): 527-529.
3. Donabedian A (1988) The quality of care: How can it be assessed? *JAMA* 260(12): 1743-1748.
4. Lee TH, Porter ME (2024) Overhauling quality measurement in the US: measure what matters. *Am J Manag Care* 30(2): 70-72.
5. Porter ME, Larsson S, Lee TH (2016) Standardizing patient outcomes measurement. *N Engl J Med* 374(6): 504-506.
6. National Committee for Quality Assurance (2024) Person-centered outcome measures. NCQA.