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The Myth of Consumer Choice: What Will Take Its Place?

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LEARNING OBJECTIVES

- Put into historical perspective several current strategies to improve quality, safety and cost-effectiveness
- Differentiate among market-based strategies and their mechanisms of operation
- Apply lessons of the past to development of future strategies

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WHAT IS THE "CONSUMER CHOICE" MODEL OF HOW TO IMPROVE THE QUALITY AND REDUCE THE COST OF HEALTH CARE… AND WHY DOESN'T IT WORK?

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Consumer Choice Model

- Patients use publicly-available quality, safety and cost information to make decisions about where to seek care.
- High-quality, safe, low-cost physicians and hospitals prosper, others lose patients.
- The result is better provider performance overall and better health through improved care.

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SHIBBOLETH:

an old opinion or principle

that is still considered essential

by some members of a group

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Patient Information

Trace publicly-available patient information (on hospital quality) to:

- HCFA's *Medicare Hospital Mortality Information* (1985)
- Pennsylvania's Health Care Cost Containment Council (PHC4) reports (1986)
- New York State Department of Health's Cardiac Surgery Reporting System (first made public after a 1990 New York *Newsday* Freedom of Information Act lawsuit)

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Consumer Choice Model

BUT: Even with increasing amounts of publicly-available information on provider performance, consumer choice has not "moved the market" for three reasons:

- Asymmetry of knowledge
- Patients have limited choices
- Patients are uncomfortable challenging their providers

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Asymmetry of Knowledge

- The asymmetry of knowledge between patient and physician cannot be surmounted by "report cards".
  - Your physician always will know more about your diagnosis and treatment options than you do. Therefore, "informed" decision-making is limited.

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Patients have Limited Choices

- Patients have few instances when they can make choices
    - Early releases of public information about provider quality focused on hospitals, but patients seldom have a choice of where to be hospitalized (except for childbirth, which is not an illness) – this was the "looking for lost keys under the lamp post" phenomenon.

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Patients Uncomfortable Challenging Providers

- Few patients feel comfortable challenging someone they entrust with their wellbeing
    - Trust is important in the physician-patient relationship. Patients are anxious, fearful, in pain, etc. - not in a position to assert their prerogatives or to "bargain." Will patients assume a buyer vs. seller negotiating position with their physician over price, quality, etc.?

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What market strategies have supplanted the consumer choice model – what *is* "moving the market"?

- Not much new under the sun, but…
- A recent history of purchaser and payer strategies to improve quality and safety while reducing costs

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Can Purchasers and Payers Be More Effective Than Consumers?

- The most important contribution to our use of competitive markets to increase quality and control costs is **managed competition,** a competitive/regulatory strategy.
    - *Laissez faire* competition is not enough to harness the benefits of competition – the market must be structured with specific rules to overcome attempts by insurers to avoid price competition.

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Managed Competition

- Refined and promoted in the 1970s by Alain Enthoven
  - Chaired Stanford's Committee on Human Resources and used the university's health care benefit offerings as a laboratory
  - Worked with the Bay Area Business Group on Health (now the Pacific Business Group on Health) to promulgate managed competition among large California employers, including state government (CalPERS)

Managed Competition (cont.)

- Managed competition is based on large purchasers offering a selection of health plans with guaranteed access, no exclusions, and community rating.
  - Purchasing cooperatives for smaller groups
  - Encourage organized provider systems
  - Principles of managed competition in the 2010 PPACA (e.g., guaranteed access, fixed-dollar subsidies to ensure price-elastic demand, insurance exchanges).

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Value-Based Purchasing (V-BP)

Value-based purchasing (V-BP) of health care benefits is an employer purchasing strategy that includes many principles from managed competition (e.g., performance measurement, selective contracting)

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Pay-for-Performance (P4P)

- Pay-for-performance (P4P) is a logical outgrowth of managed competition - a "downstream" result of V-BP's pressure on health plans and of having more and better quality/cost metrics.
  - Health plans hold hospitals and physician networks financially responsible for their quality and cost performance.

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Who Can Improve Care?

In all of these strategies it is important to remember that the only people who can ***improve*** care are the physicians, nurses, et al. who ***provide*** care.

All the other actors in this drama are attempting to modify the behavior of a well-defined group of professionals who diagnose and treat patients.

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Consumer Behavior

At the heart of these strategies, whether national reforms such as managed competition or individual buyer vs. seller strategies such as V-BP or P4P, are assumptions about patients' use of information to make choices of high-quality, low-cost hospitals and physicians.

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Assumptions About Consumer Behavior

- These assumptions run counter to observed behavior. After two decades of increasing information on quality, safety and cost, patients still make choices based on other information
- Public transparency is vital, however, for regulatory affairs, policymaking and oversight (government, press, professions)

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The Influence of Public Reporting

- The most significant effect of public reporting on the relative performance of hospitals and physicians has been the "shaming" of poor performers, causing them to examine their performance and improve both patient outcomes and their public image.
  - P4P now reinforces this with financial penalties (the opportunity costs of foregone performance bonuses)

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Raising the Floor

- Should we concentrate on "raising the floor" – making sure all providers are higher quality so choice doesn't have as many consequences for whether patients get evidence-based care?
  - This would emphasize providers, purchasers, plans and policy makers as audiences for information on provider quality, safety and cost-effectiveness.

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Barriers to Use of Information

- Substantial literature on continuing barriers to patient use of quality information
- Conventional wisdom regarding patient engagement/activation

VS.

Our increasing understanding of how people make choices: can we expect rational decisions?

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Consumer Decision Making

- Desire for transparency is predicated, in part, on the assumption that patients are rational decision-makers who need only accurate information to make logical decisions.

We know this is not the case.

  - Biases and heuristics (rules of thumb) have enormous influence over the process by which people make decisions, and can result in decisions that are not in their best interest.

(Tversky, Kahneman, Thaler)

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Consumer Decisions About Risk

- People don't understand risk (of illness, of financial loss, etc.) and don't make logical decisions where risk is involved.
- Should not make assumptions about patient decision making based on how they make other decisions.

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"Bars" Become "Floors"

The "Lake Wobegon" Effect: what once was a challenging "bar" for providers to reach is now a "floor" that doesn't differentiate (e.g., board certification, Joint Commission accreditation).

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"Bars" Become "Floors" (cont.)

When was the last time you were treated in a hospital that wasn't accredited (by JC, DNV, AOA)?

When was the last time you saw a physician who was not board certified?

- 94% of US hospitals are accredited.
- More than 8 out of 10 US physicians are board certified. This is no guarantee of excellence.

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Examples of Poor Care are Frequent

- Patients receive recommended ambulatory care about 55% of the time.
- Only 14% of Joint Commission accredited hospitals that report core performance measures achieved "top performance in key quality measures" (95% performance on 22 quality measures).

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WE NEED TO THINK CRITICALLY
ABOUT PATIENTS' USE OF INFORMATION
ABOUT THE COST AND QUALITY OF HEALTH CARE.

WHAT IS ITS TRUE VALUE AND BEST APPLICATION
FOR PATIENTS?

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Final Thoughts:
The Politics of Consumer Information

If health care reform depends on market mechanisms, we must accept that transactions between payers and providers, and between plans and providers, are adversarial, buyer/seller relationships.

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Final Thoughts: The Politics of Consumer Information

- Organizations that inform patients' or purchasers' decisions should be fair and transparent, but can't "represent" the provider community at the same time they purport to serve patients.
  - *E.g.*, imagine how meek and ineffectual *Consumer Reports'* annual automobile ratings would be if Consumers Union had created a "stakeholder steering committee" that included auto manufacturers and car dealers.

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Final Thoughts: New Media

New media constitute a huge strategic question for health policy makers. The younger generation refuses to pay for content, and often settles for content that isn't research-based rather than pay for content.

Will there be a market in the future for research-based consumer ratings in healthcare?

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Final Thoughts: Social Media

Will **social media be a source of user-generated content**? In that case, standardization (templates) for collection of personal experience information "over the (electronic) back fence" would be an important methodological contribution.

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Final Thoughts: Social Media (cont.)

- Pregnancy, pre-natal care, childbirth and well-baby care might be the first area of intersection for health care and social media.
  - Facebook has over 40 million US women users in their child-bearing years (15-44). Potential health issues: contraception, STDs, fertility, pregnancy, maternity, other gynecologic, pediatric.
  - Prenatal care, delivery and pediatrics are services where patients really exercise choice.

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Final Thoughts: Social Media (cont.)

One important influence of social media (list serves, community forums, blogs, Facebook, etc.) is that quality measures will not be delivered alone – they won't necessarily be the centerpiece of the communications vehicle, but only one component.

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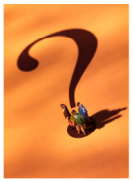
Thank you very much!



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