Helping Consumers Make Good Healthcare Choices

TO THE EDITORS:

The 2006 World Health Organization Report made a compelling case for improving the efficiency of healthcare resource allocation in the United States.[1] In terms of life expectancy, the United States tied with 5 other nations to rank somewhere between 26th and 31st among 192 countries. This relatively lower life expectancy rank of the United States adds some perspective to a healthcare spending level that is slightly greater than ($1.687 trillion vs $1.659 trillion) the rest of the globe on about one twentieth of the population.

The resource allocation inefficiency is the context for the development of consumer-directed health plans (CDHPs). Dr Retchin[2] suggests that there is a limited appetite for CDHPs. The January 2007 periodic census conducted by America's Health Insurance Plans shows a January 2007 enrollment of 4.5 million up from 3.2 million in January 2006, a 40% growth rate.[3] In addition to the growth of CDHPs, the secular market trend is toward the adoption of CDHP features. According to the Kaiser Family Foundation employer survey, 86% of single-coverage preferred provider organization (PPO) plan holders in 2000 had a deductible of less than $499 while in 2006 only 62% had a deductible of less than $499. Twelve percent of single-coverage PPO plan holders had deductibles of $1000 or more in 2006, compared with less than 2% in 2000.

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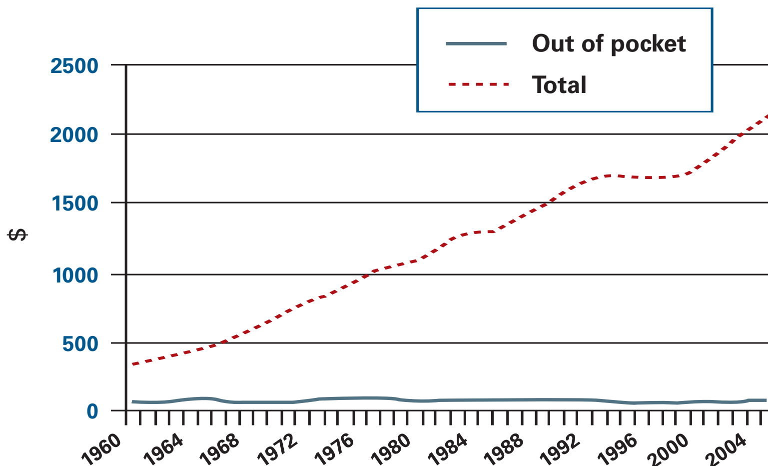
Dr Retchin asks whether consumers will make cogent decisions—a question that is obviously important to the success of CDHPs. Citing the experience of a 1998 study on the public use of coronary bypass surgery mortality rates, Retchin suggests that even when adequate data are available, there is little evidence to suggest that the information would be used to make a decision. Little has been done until recently to energize healthcare consumers toward taking an active role in the healthcare decision-making process. The average real percent change in total per capita hospital spending from 1960 to 2005 was 532%, whereas the average real percent change in per capita out-of-pocket hospital spending was 0% (calculated from the all urban consumers, all-item consumer price index reported by the Bureau of Labor Statistics and National Health Expenditures reported by the Centers for Medicare & Medicaid Services).[4] A consumer in 1998 would have less incentive to research the decision to have coronary artery bypass surgery if someone else is paying all but a very small portion of the bill (**Figure**), a point that supports the case for CDHPs.

Higher out-of-pocket costs have both health advantages and disadvantages. Dr Retchin points out that financial disincentives have been shown to reduce unnecessary use of antibiotics in viral illnesses and prescription drug treatment compliance for those in treatment for hypertension; they have also been shown to decrease use, cost, and mortality among emergency department (ED) users. Hsu et al[5] showed a higher mortality rate at low ED copayment levels in the commercially insured and a reduced mortality rate in the Medicare insured at high ED copayment levels. Wharam et al[6] showed that traditional health plan members

Figure. Real Per Capita Spending for Hospital Services*



*2005 Dollars, CPI All-items.
Source: Reference 4.

who switched to high-deductible plans reduced ED repeat visits for conditions that were not classified as high severity and also reduced hospitalizations from the ED. Selby et al[7] demonstrated similar findings following the introduction of a small copayment in a health maintenance organization. Care must be used in interpreting this information, however, it may suggest that consumers can make cogent healthcare decisions.

Consumers make judgments based on price and quality in every other industry every day, and those industries have seen substantial productivity growth. It is not clear that the market information currently available is the right information or is presented with enough clarity and consistency to provide the decision support that consumers require when purchasing healthcare. While I concede that no one yet knows whether consumers will make cogent healthcare decisions in the face of greater economic incentive and availability of market information, the case in favor of consumer choice may be stronger than some believe.

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TO THE EDITORS:

Dr Retchin[2] suggests that a new workforce of "medical decision makers" be created to assist consumers in navigating medical decision making, especially when choosing facilities and agencies that provide care. This workforce already exists: we are called case managers. Case managers are registered nurses, usually with many years of nursing experience at the bedside, in clinics, and in many other medical settings. Many of us are specialists with vast experience in fields such as oncology, orthopedics, pediatrics, solid organ transplant, catastrophic case management, and

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many other specialties. We guide our patients through the quagmire of agencies and facilities seeking their "business." We also assist our patients in dealing with their insurance issues, such as lack of coverage for services that are most definitely "medically necessary." In fact, many of us actually work for insurance companies and HMO medical groups and assist patients in choosing facilities that are contracted with the insurer, have the ability to treat their particular diseases, and have demonstrated quality and good outcomes.

Nurses have long been advocates for their patients. We care for patients in many settings, both in and out of the hospital. We teach, we advise, we guide, and sometimes we cry with our patients.

Dr Retchin is correct in saying that consumers need assistance when trying to make choices regarding healthcare providers, and fortunately there are experienced, caring, and dedicated nurse professionals out there who are doing just that.

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"Although high-deductible health plans may be a useful method for augmenting consumer interest in value purchasing of healthcare services, I find it curious that Mr Cecil did not mention the distinctively American practice of excessive expenditures on administration."

IN REPLY:

Mr Cecil has correctly pointed out that US per capita healthcare expenditures surpass spending from all other developed countries—by a wide margin. Moreover, although recent trends suggest increases in deductibles and copays, he also notes these are modest and that limited out-of-pocket expenditures contribute to the restraint of consumer interest in healthcare choices. For instance, the average annual deductibles increased from $219 in 1992-1993 to $334 in 2000.[8]

Although high-deductible health plans may be a useful method for augmenting consumer interest in value purchasing of healthcare services, I find it curious that Mr Cecil did not mention the distinctively American practice of excessive expenditures on administration. Administration accounts for 31% of healthcare expenditures in the United States, but less than 17% in Canada.[9] In fact, insurance overhead and employer costs to manage healthcare benefits in the United States have continued to rise inexorably. Although these administrative costs were not a focus of my commentary, it is noteworthy that reductions in these costs would yield significant savings. However, this will require substantive health insurance reform. Hopefully, this will be a focus during the healthcare reform debates that will surely accompany the 2008 presidential race.

Mr Cecil cites Milton Friedman's confidence in the wisdom of consumer preferences as evidence to employ similar strategies for healthcare. Another Nobel laureate, George Akerlof,[10] studied used cars and showed that the seller's superior knowledge of the condition of the car led to an imperfect market—and the inability of consumers to detect "lemons." Somehow, if we are going to lead our patients down the path of selection in the healthcare market, we have to avoid a similar outcome.

Clearly, the information asymmetry inherent in the used car industry is easily trumped by the complexity of healthcare. For instance, Mr Cecil implies that consumer disinterest in selecting a hospital or surgeon for coronary bypass surgery in 1998 was due to the lack of financial consequences. Really? Would a well-informed consumer actually select a cardiothoracic surgeon on the basis of fee structure or hospital charges—and ignore morbidity and mortality data? Since these data are available now, there must be a reason that consumers ignore these data. The real explanation is that consumers have a difficult time interpreting the information. For example, how does a consumer interpret risk adjustors that appropriately control for patient selection differences among surgeons and hospitals? Only data, appropriately supplemented by professional consultation, perhaps with a new cadre of trained medical decision advisers, will allow consumers to make the informed choices that will reflect a true healthcare market.

Ms Goodstein correctly points out that nurse case managers could be potential candidates for a new role as medical decision advisers. In fact, my article discusses that many "…healthcare workforce professionals could be eligible, such as nurses and pharmacists…."[2] However, nurse case managers serve many different roles in healthcare delivery and oversight; at present, most work in hospitals or managed care organizations in either discharge planning, care coordination, or utilization review roles. Although some nurse case managers may be ideally positioned to assume roles as medical decision advisers, most would benefit from a newly structured curriculum to accommodate an evidence-based advisory role as I portrayed it in the article.

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