expert voices

Issue 9
October 2005

NIHCM FOUNDATION

ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

Engaging Consumers in Quality Issues

While the road to engaging consumers is steep, it is fairly well marked.

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The saying "What you don't know can't hurt you" clearly does not apply to the problems consumers face in getting high quality health care. Yet, consumers have been slow to use comparative performance reports to help them make health care choices. About 19% of consumers said they saw and used quality information in their decisions in 2004, up from 12% in 2000.[1] It's surprising that people have little interest in information that could help them avoid injury and death.

The answer to this apparent enigma can be found in three inter-related areas:

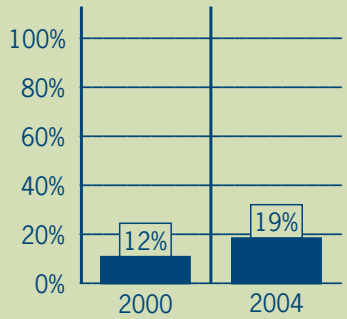
- The invisibility of the quality gap;
- Consumer concepts of quality; and
- Challenges faced in making choices using comparative performance information.

The Invisibility of the Quality Gap

While health care policy analysts, researchers and industry leaders are quite aware of the major quality problems, safety hazards and wide variations in practice patterns documented in recent years, consumers are largely unaware of these quality problems. In fact, most people believe that the technical quality of care is high and that it is uniformly high across providers and hospitals. In a recent survey of consumers, 60% of respondents thought there were no differences among hospitals in terms of safety or quality.[2] This is not surprising, as one of the most ubiquitous public messages about health care over the last several decades is that "the U.S. has the highest quality health care in the world."

Consumers, however, are aware of differences in terms of interpersonal aspects of care. They know, from their own experiences, that there are real differences among providers in how well they communicate, listen and are responsive and respectful.[3] Thus, if one believes that technical quality is uniformly high, and that real differences are in the interpersonal aspects of care, then the need to pay attention to quality reports is minimal.

FIGURE 1: Percent who used quality information in choice



SOURCE: Kaiser Family Foundation, 2004.

How Consumers Define Quality

While research shows that consumers care about the quality of medical care, they define it differently than experts and industry leaders.[1] When asked "what is quality of care?" consumers most often mention: access, cost, having a choice of doctors, doctors who spend enough time and doctor qualifications. This is consistent with the idea that technical quality does not vary, and what does are the interpersonal aspects of care.

Thus, when consumers talk about quality, they are talking about somewhat different concepts than those described in quality reports. Because of these differences, the messages that report sponsors send about health care quality may be missing the mark with consumers.

This is not to say that consumers can't understand quality; it simply means that we have failed to bring them into the discussions where quality is defined and where quality deficits are delineated. Bringing consumers into the discussion would help to appropriately broaden the concepts of quality among both consumers and industry leaders. In fact, studies show that when consumers are exposed to broader definitions of quality such as effectiveness and safety, they change their views to include these areas of quality as important to them. Studies have shown that by providing consumers with a brief framework for understanding quality (e.g., a modified IOM framework, including measures of effective, safe, and patient centered care), the range of quality indicators they value are broadened.[3,4]

Challenges Consumers Face in Using Comparative Reports to Inform Choices

While it may look easy, using performance reports to make a choice is not. Report designers usually operate on the assumption that people pick and choose which quality indicators are important and relevant to them. Thus, they offer several different quality indicators in a report, believing that this is appropriate and helpful. The reality, however, is that giving people lots of information can be counter productive.[5-7] Studies have found that:

- As the number of factors to consider increases, people's ability to use that information to inform their choices decreases.
- Consumers often do not understand the meaning or import of many of the indicators

included in comparative reports, and thus do not know how to make trade-offs or differentially weight factors.

• Processing lots of information and making trade-offs among quality indicators involves difficult cognitive tasks.[6]

When faced with these kinds of complexities, a common strategy is to simply take a shortcut by ignoring most of the information and making a decision based on one or two factors that are well understood. These shortcuts are effective in reducing the burden involved in making choices, however, they often result in undermining the decision-maker's own self-interest. That is, because the task of using performance reports is difficult and burdensome, consumers are less likely to actually use the data to inform their choices.

Consumers must have a relatively high level of motivation and skill to use comparative quality reports to inform their choices. Yet they lack this motivation primarily because the quality gaps are not visible to them and they are unaware that they may be at risk of choosing a poor quality provider.

Policy Solutions

Engaging consumers requires addressing barriers. Consumers need to understand that they put themselves at risk when they select a provider without knowing about its performance. Making this concrete and specific drives home the point. For example, a key message on a report could read: "**If you choose the poorest quality hospital in your community for your surgery, you will have a three times greater chance of having a complication than if you have your surgery at the best quality hospital.**" This simple message makes three critical points clear:

• There is risk, and the magnitude of that risk is significant,

• There is variability in quality among hospitals and

• A consequential choice must be made.

However, even after consumers understand the risks, we must still reduce the burden to use the information. This means making the reports more comprehensible and easier to use. For example, by using familiar terms and doing some of the difficult cognitive work for them (e.g. summarizing and interpreting information), reports can be made more useable and more likely to be used. Figure 2 shows an example of a report that is designed to make it easy for consumers to apply the information in choice. Because the hospitals in the example are ordered by performance (best to worst), it is easy to quickly identify good and bad options.

Adopting standardized formats — ones that had been tested and proven effective in helping consumers use the information — would also improve the quality of public reports. Current formats, if tested at all, are typically tested for consumer comprehension and preferences. However, consumer preferences and data display formats that actually help consumers integrate and weight the information in choice are two very different things. If the ultimate goal is to influence choices, then formats that have been tested and proven to support choice are essential. Since this type of testing requires skill and resources, it is wasteful to repeat this testing for every report. By adopting a standard format for reporting, report sponsors can use the tested formats rather than having to create their own.

A standardized report format could also include a standard framework of quality categories. This framework could include such overarching categories as: (1) effectiveness, (2) safety and (3) patient centeredness. If all reports used these categories for reporting, consumers would come to understand that these areas are critical components of quality and eventually demand to see quality information in all three domains.

Ironically, the characteristics of reports that help consumers the most (e.g. ordering by performance) are also the ones that providers most often resist. The strategy of making the quality gap more visible to consumers is also problematic. Even though purchasers want their constituent consumers to be aware of quality differences, they do not want to have to be the messenger of this news. Providers are not interested in spreading the message either. While we widely agree that the system would improve if consumers made choices based on quality, few seem willing to take on the responsibility of educating the public about quality gaps.

The road to engaging consumers in the quality issue, while steep and rocky, is fairly clearly marked. The question is whether there is sufficient will to make the trek.

FIGURE 2 : Example hospital performance report

Community Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital A	⊕	⊕	⊕	○	⊕
Hospital B	⊕	⊕	⊕	⊕	○
Hospital C	⊕	⊕	⊕	○	○
Hospital D	⊕	⊕	⊕	○	○
Hospital E	⊕	⊕	⊕	○	○
Hospital F	⊕	⊕	⊕	○	○
Hospital G	⊕	⊕	⊕	⊕	⊖
Hospital H	⊕	⊕	○	○	—
Hospital I	⊕	⊕	⊕	○	⊖
Hospital J	⊕	⊕	⊕	⊖	○
Hospital K	○	⊕	⊕	○	—
Hospital L	⊕	○	○	○	—

⊕ Fewer mistakes, complications and deaths than expected
○ Average number of mistakes, complications and deaths
⊖ More mistakes, complications and deaths than expected

Adapted from QualityCounts™, a service of the Employer Health Care Alliance. http://www.qualitycounts.org/report_interactive.htm

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