What Patients Really Want From Health Care

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In 2012, perhaps the most widely scrutinized sector of the economy in North America will be the health care industry. Politicians, policy analysts, academics, and the public share concerns about the state of health care in both the United States and Canada. However, each of these constituencies has a different perspective.

Most sectors of the economy are characterized by a supply side that focuses on minimizing costs, expanding sales, and maximizing profits and a demand side that considers consumer preferences, incomes, and alternative purchases. Markets use prices to link supply to demand. Health care is very different.1 In the mid-20th century, patients’ aversion to the risk of large health care expenses gave rise to a market for insurance, thereby separating patients from the true costs of care at the point of service delivery. This in turn greatly expanded demand for health care, resulting in cost escalation, which gave rise to government involvement in many ways (eg, tax subsidies, US Medicare, the Canada Health Care Act, and, most recently, the US Affordable Care Act).

Decades after this evolution began, the United States and Canada are struggling to contain the “beast” of health care costs by setting priorities, an important step in policy formation. Politicians, the media, and academics often focus on important issues like cost increases, waste, inefficiency, access, cost-effectiveness, evidence-based medicine, and conflicts of interest.

This Commentary focuses specifically on what people want from health care services and rates these preferences from highest to lowest. The opinions are based on my 30 years of experience, both in performing research in health economics and as a practicing general internist who cares for inpatients, many of whom are elderly and very ill. Because preferences vary in health care, like preferences in every sector, the characterizations described may not apply to all.

What the Public Wants Most

Restoring Health When Ill. Patients want a health care system that responds when care is needed; that is, when they develop signs or symptoms causing pain, disability, or anxiety. What they want most is to be returned to a state of good health, however they define it. In other words, they simply want to be better. Some patients understand the concept of preventive medicine and want the health care sector to provide services such as cancer screening that will prevent illness in the future. However, the majority of patients primarily focus on relieving illness and symptoms rather than disease prevention.

Timeliness. Patients desire access to services in a timely fashion. While many patients procrastinate seeking medical attention, those who do not delay seeking care want it immediately.2

Kindness. Patients want to be treated with kindness, empathy, and respect for their privacy. In the days before health insurance, patients paid for care that consisted primarily of kindness.

Hope and Certainty. Even if patients are in a health state for which cure is exceedingly unlikely, they want to have hope and be offered options that might help. Patients are uncomfortable with uncertainty about diagnoses and prognoses and often request tests to help alleviate those anxieties. As well, patients and their families feel guilty if they do not try to get better. These characteristics make patients and their families highly susceptible to accepting active test and treatment options, even when those options are unlikely to help.3 This occurs especially at times when patients are emotionally vulnerable, such as when death is near. Although many patients prefer not to “know” or “try,” the majority of those who seek health care prefer active strategies. An extra test or two, “just to be sure,” is often preferred to possibly missing something.

Continuity, Choice, and Coordination. Patients want continuity of care and choice. They want to build a relationship with a health care professional or team in whom they have confidence and have that same person or team care for them in each episode of a similar illness. They want the members of their health care team to communicate with each other to coordinate their care.

Private Room. Patients want to be hospitalized in their own room, with their own bathroom and no roommate.4

No Out-of-pocket Costs. Patients want to pay as little as possible from their own pocket at the point of service delivery. They also want to be assured that insurance or third-party coverage is always available to them.

The Best Medicine. Patients want to know that the clinicians delivering their care are highly qualified. Indeed, some seek “the best” physicians. Patients want information about clinician qualifications but they do not want it to be statistical. They prefer testimonials from other patients or clinicians they trust.

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Medications and Surgery. Patients prefer treatments that they perceive will require little effort on their part. Medications and surgical procedures are preferred over clinical strategies that involve behavioral changes (eg, diet or smoking cessation) or exercise regimens.

Second-Level Priorities

Efficiency. What patients mean by efficiency is that their time is not wasted. No one likes to have an appointment with a physician scheduled for 9:00 AM only to be seen at 11:30 AM. Rapid scheduling of tests and reporting of results is also important. However, to most policy analysts, efficiency means something different. To them, efficiency is delivering the most value with the least resources. While the public shares this concern, this kind of efficiency is of lower priority to patients.

Aggregate-Level Statistics. Most patients care little about the average patient; they primarily care about themselves. As such, evidence that does or does not support the use of treatments based on large groups of people is of much less interest to patients than whether those treatments work in their specific case. Again, testimonials trump scientific evidence. This lack of appreciation for evidence-based medicine explains why comparative effectiveness research is an easy target, especially the part funded by tax revenues. However, the lack of rationality does not render these preferences irrelevant. What people want when they are healthy may be very different from what they want when they are sick. In addition, patient preferences before undergoing tests and treatments will clearly be different from how they perceive those choices after the fact, altered by the outcomes they experience.

This description of patients’ preferences does not render efficiency, evidence, and rational thinking in health care unimportant. Technological progress should lead to increased efficiency by developing technologies that both improve health and lower costs. Market distortions clearly interfere in the development of a health care system that offers value, and there are serious challenges ahead. However, policy makers need to truly understand and appreciate what the public really wants when they undertake efforts to reform health care. There may be no answer to what linear programmers call “a set of constraints without a solution.” But failure to consider consumer priorities will certainly lead to failure.

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