People have views about their own health care that may or may not differ from their views about the health care system. One of the more consistent, often discussed findings across the entire range of public opinion research on health care is that Americans have serious concerns about the health care system as a whole, but are generally happy with their own health care. Both reflect people’s experiences as well as concerns about the future. Although Americans report barriers to care, problems with communication, coordination among providers, and administrative inefficiencies, the majority—who have health insurance and have a regular doctor or place where they go for care—are mostly happy with what they have, and worry about losing it. People want to know how reforms will affect them now as well as in the future.

Developing a fuller understanding of values, preferences, concerns, and misconceptions about health care is critical for policymakers as they shape legislation and seek support for change from the public. Better understanding of public views could help policymakers avoid potential problems both in designing, describing, and marketing reform proposals. History clearly suggests that reform proposals can be derailed when interest groups are able to leverage evidence of public opposition to or concern about some sensitive issue or aspect of the reforms.

Policy experts and the majority of the American public seem to agree that there are serious problems with the health care system. Many believe that some form of fundamental changes may be needed to ensure access to affordable, high quality care. In the broadest strokes, a “generic” description of the health system reforms that policymakers are debating would include three interrelated components working together to provide integrated care.

- A foundation built on primary care “medical homes” that are responsible for coordinating evidence-based, comprehensive care to patients of all ages. Medical homes are organized on principles of ongoing relationships with patients, shared decision-making, and systematic coordination of care across settings. Medical homes would be pivotal for the systematic application of:

  - Evidence-based care, based on clinical care research (including preventive services, diagnostic procedures, clinical treatments, drugs, devices, therapeutics, and care management protocols) as well as methods and
systems for disseminating this knowledge to providers and consumers and for ensuring that it is integrated into practice; supported by:

- **Electronic health information systems** that facilitate care coordination and provide information needed for quality improvement and accountability as well as for performance-based payment that promotes the effective use of health care.

The focus here is on health care delivery system issues, rather than public views about expanding, or paying for, health insurance coverage. Looking across a wide variety of inputs, including meetings and polls, secondary review of existing poll data reveals remarkable consistency over time with respect to broad views about the health care system and health care in the United States. Together with published scientific literature addressing public perceptions of and values regarding health care, it also provides some direction for policymakers considering the three general components of health system reform.¹

**What Does The Public Say About Reforming Health Care Delivery?**

While the public wants the health care system to serve them better, public views of ongoing efforts to improve the coordination, quality, and effectiveness of health care may offer some notes of caution for policymakers.

**Prevention**

Across all these sources of information, there is widespread support for comprehensive health coverage that includes an emphasis on preventive care, with some reservations.

Data from community meetings and polls shows public support for an emphasis on prevention and “wellness.” People attending community meetings held over the past several years have strongly expressed their support for preventive services and wellness programs, which many think should be part of any basic benefit package. There is also evidence of support for a strong education component in health care, and for the need to begin health education and promote health literacy early, beginning in grade school.

However, when it comes to actually obtaining preventive screenings or engaging in health promotion activities such as weight loss programs, smoking cessation, exercise, and so forth, people’s values and preferences reveal some ambivalence. Surveys have found, for example, relatively high levels of “comfort” with employers offering lower-cost opportunities for health screenings and other programs, but lower comfort levels with programs that send reminders about annual check-ups or screenings, and still less comfort with programs that tie participation in wellness programs to lower insurance premiums. Other surveys have found broad general support for care management programs, health education, wellness programs, individualized coaching, etc., but also that the percent reporting they were “interested” in these programs was far higher than the percent saying they would be willing to pay more to have access to these programs. There appears to be a gap between reported interest in getting assistance in maintaining a healthy lifestyle and actually participating in these programs.

Public support for preventive services or health promotion programs reflects personal values and preferences regarding health behavior in general. This support is related to a widespread belief that better health behaviors can reduce health care costs, and therefore make health coverage more affordable. At one end of a continuum of views about prevention and wellness, there are people who believe, sometimes quite strongly, that better health behaviors could generate enough savings to pay for universal health coverage, without need for any additional reforms in health care organization or financing. Although there appears to be agreement that greater involvement in one’s health care, focusing on prevention, and promoting better health behaviors are good things, there also is evidence of ambivalence about how far the health care system should go in offering incentives to guide personal behaviors. For example, while people participating in community meetings often engage in discussions of linking insurance premiums to better health behaviors, concerns generally lead to relatively low levels of support for such policies.

**Patient-centered, Coordinated Care**

There is also broad, but nuanced, support for patient-centered concepts, including involvement in decision-making and having a system that is easy to navigate.

Public opinion surveys and polls have found clear support for the concepts underlying the emerging construct of “medical homes.” Recent surveys and community discussions indicate that many Americans believe it is important to have one place or one doctor responsible for a person’s primary care and for coordinating that care. There are also data showing support for the notion of doctors and nurses working together in teams as a means of improving patient care, and for doctors to practice in groups rather than on their own, and for new systems and technology to improve care coordination, efficiency, and quality.

But there is, again, a divide between general perceptions and personal experience. A survey conducted in March 2009, for example,
found that a majority (52 percent) of adults said that coordination among health care professionals was “not a problem at all.” This may have reflected relatively infrequent negative experiences with health care coordination. When asked whether, in the past two years, they had experienced a variety of problems, most had not. As a percent of the population, relatively few (in the range of 10-20 percent) reported that they had to redo a test or procedure because the doctor did not have the earlier test results, or had to come back because a health professional did not have their medical information, or had tried unsuccessfully to get two of their doctors to talk to each other. While these rates may be of great concern from a policy perspective, they do not appear to be nearly as salient to people on a day to day basis.

Provider Choice

Although the public sees health care coverage and affordability as more important than having a choice of providers, polls have shown that support for universal health care could be undercut by fears about limits on patients’ choice of providers.

Medical homes are intended to foster strong relationships between primary care doctors and patients. This model gives primary care doctors the lead role in guiding patients into appropriate specialty care providers. Systems that organize access to specialty care or diagnostic tests could look to some like “gatekeeping.” There is some evidence that the public believes that current trends in coverage point to reduced consumer choice of providers over time (without reforms to the current system). But polls have also shown that support for universal health care could be undercut by fears about limits on patients’ choice of providers.

Evidence-based Care

The public believes that the effectiveness of health care can be improved, but how people define good health care varies, and there are serious concerns about how efforts to promote greater effectiveness will affect access to care.

A variety of surveys and polls have shown that people are aware of, and concerned about, the effectiveness of medical care. A variety of polls have found that the public is concerned about both underuse and overuse of medical treatments, procedures, tests, etc. More than one third of those surveyed in March 2009 said they would oppose the establishment of such an organization, while 32 percent said they would still support it. Additional polling indicated underlying concern about who would be making recommendations about which tests and treatments should be covered. While a majority (55 percent) of those surveyed in March 2009 said they would place a great deal or fair amount of trust in a panel of experts from an independent scientific agency, trust levels dropped to 41 percent when the phrase “appointed by the federal government” was added to the description of the entity.

Available evidence suggests that some concept of “best medical treatment” is highly valued by the public. One national survey conducted in 2007 reported, for example, that significantly more respondents agreed with the statement, “Making sure I have access to the best medical treatment is more important to me” (68 percent) than “Lowering health care costs is more impor-
Recent surveys have found that people think that it is important for doctors to use computerized medical records, have electronic access to medical and lab tests, and be able to share information electronically with other doctors in order to improve patient care. Other surveys have found that many agree that using online patient health records would provide major benefits to individuals by helping them manage health care and health services. Relatively few, however, are interested in joining a free online personal health record system. The most common concerns are about privacy and confidentiality—an issue that also threatens support for practitioner/office-based electronic medical records systems. A 2009 survey found that 34 percent of respondents were not at all confident, and another 25 percent were “not too confident” that personal medical records and information stored electronically and accessed online would remain confidential. Further, while most thought that medical records kept electronically that could be shared online would improve quality of care nationally and for their own families, few believed that the electronic systems would lead to reduced health costs. More than one-third thought electronic health information would result in higher costs of care for their families and for the country.12

Public Opinion and Health Care Decisions: What Really Matters?
A primary goal of delivery system reform is to help health providers, consumers, and insurers decide on the best treatment, and align insurance and payment incentives accordingly. Decisions that reflect the best available evidence will result in limits on payment for some treatments. Although the current vision of a high-performing health system presents a new, innovative approach to restructuring health care, it incorporates some key components of what could be termed “good” managed care.

- There is underlying support for improved coordination of care, better communication between patients and providers, less interference in the care process by third-party administrators, and, in the abstract, having an infrastructure that allows everyone to navigate the care they need more easily.

- There is only limited evidence to support the view that people will react positively to any changes that result in, or appear likely to result in, their choices being constrained, even if limits would increase health care quality and effectiveness.

Research on managed care has identified a generic problem with “restrictions on consumer choice.” This label encompasses a complicated set of problems associated with barriers to obtaining the latest diagnostic and therapeutic care, but also to access to providers, specialists, or hospitals. An array of surveys and in-depth research shows that restrictions on choice of physicians, or perceptions that choices are restricted, is associated with lower satisfaction with health care, including levels of trust in health providers. Research also suggests that concerns about “choice” are more closely related to being able to pick, or pick among, providers than to choice of health plans.

Research has shown that consumers place high value on primary care they receive from health plans, including having primary care providers play a key role in identifying medical problems and coordinating referrals. But while consumer satisfaction with primary care providers is generally high, a subset of consumers perceive some care management arrangements as barriers to obtaining the latest diagnostic and therapeutic care, but also to access to providers, specialists, or hospitals. An array of surveys and in-depth research shows that restrictions on choice of physicians, or perceptions that choices are restricted, is associated with lower satisfaction with health care, including levels of trust in health providers. Research also suggests that concerns about “choice” are more closely related to being able to pick, or pick among, providers than to choice of health plans.

Views about specialty care are also affected by people’s own health care needs and circumstances. Survey data examining perceptions of managed care found that people with greater health care needs were less comfortable than healthier enrollees with cost containment strategies that limit choices that could affect their ability to obtain services that are important to them.

Health Information Technology
Health information technology scores highly in public opinion polls, but there is a big gap between general views and particular concerns about health information.

In the abstract, electronic health records and the use of information technology in doctors’ offices have public support.
Investigations into the factors associated with issues of choice, satisfaction, and trust also confirm that concerns about primary care and access to specialty care can differ a great deal among population groups. While differences in populations’ views about health care can be lost in public opinion data, there is enough evidence to suggest that these differences may be important for policymakers. There is clear evidence that people with disabling conditions as well as those in generally poor health—in both managed care and fee-for-service plans such as Medicare—have greater concerns about access to providers and the specialized treatment they need than healthier people. While there is only limited generalizable data at this point, comparative effectiveness research is also likely to be a special concern to people with serious illnesses or disabilities. A consortium of patient and disease advocacy organizations has called for an active role for consumers and patients in all stages of research development, translation, implementation, and oversight of evidence-based health care.

Soon after the passage of the economic stimulus package in early 2009, which included substantial funding for comparative effectiveness research, another group was quickly organized to represent people with disabilities, racial and ethnic communities, and the elderly, among others, to ensure that the research “does not become the basis for denying patients access to the care they need.”

What differences in preferences about interacting with health care providers might mean in terms of public reaction to proposals to restructure health care is, at this point, not yet clear. People who generally trust providers to direct their health care decisions may have fewer problems accepting evidence-based clinical recommendations. People with more resources and education may be receptive to systems that emphasize collaborative decision-making. Or, people who are not comfortable with approaches to health care predicated on involvement in managing one’s health care could be resistant or threatened by reforms, and people with the time, resources, and ability to research their health care might not like the limitations on choice that would accompany more systematic application of evidence-based clinical practice. But one way or another, the health system reforms that the Congress debates could elicit questions or concerns that policymakers will need to address. Some might be:

- What does more care coordination and management mean—to me and my family—compared to how it is now, especially when it comes to making decisions about choice of providers and access to specialty care?
- Who is going to decide what is good, or acceptable health care? What are the roles and responsibilities of consumers, doctors, health plan administrators, employers, health insurance companies, or the government when it comes to decisions about treatment options?
- How will medical homes, insurers, consumers, or others use, and protect, personal health information?

Conclusion

Context is critical in interpreting public opinion data about health care coverage and health care delivery. There are important differences between current proposals and the managed care models that generated some intense backlash from consumers in the 1990s. These include, but are not limited to, the emergence of more credible and accountable systems and information to support assessments of provider quality, shared decision-making, and care management. It is also possible that the public may, given the increasing costs of health care and insecurity of insurance coverage, give less emphasis to concerns about constraints on health care options than in the past.

However, now as a decade ago, reforming health care ultimately comes down to the issue of trust. Reforming health care in the United States does not just imply, but requires constraining consumer and provider choices. So the root question, in terms of public opinion, is how can policymakers craft reforms, and then explain them to the public, in ways that convince enough people that the reforms are in their best interests?

About the Author

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Endnotes

1 The findings presented here are based on reanalysis of data from the Citizens Health Care Working Group, available at govinfo.library.unt.edu/ech. Data from other state and local initiatives designed to elicit community input about health care and health reform options, including meetings held by the Obama Transition Team in late 2008 (Review of Americans Speak on Health Reform, March 2009; www.healthreform.gov) and a review of more than 100 surveys, polls, and reports on quantitative and qualitative analyses of public views of health care, focusing on past three years.

3 The Joint Principles of the Patient Centered Medical Home issued by four national primary care professional associations (AAP, AAFP, ACP, AOA) state, for example, that “the personal care physician is responsible for providing or taking responsibility for appropriately arranging care with other qualified professionals.” The Patient Centered Medical Home, “Joint Principles of the Patient Centered Medical Home,” Patient Centered Primary Care Collaborative, February 2007. Also see www.pcpcc.net/content/joint-principles-patient-centered-medical-home.


13 The powerful effect of managed care “horror stories” was also noted by a variety of authors contributing to the October 1999 Journal of Health Politics, Policy and Law devoted to analysis and commentary on the managed care backlash, including Mark Peterson, Ph.D. (“Introduction: Politics, Misperception, or Apropos”), Gail Wilensky, Ph.D. (“What’s Behind the Public’s Backlash”), and Marsha Gold, Sc.D. (“ISO Quick Fix, Free Lunch, and Share of Pie”).

