# What Patients Really Want From Health Care

Allan S. Detsky, MD, PhD

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.

**Author Audio Interview available at www.jama.com.**

**Author Affiliations:** Departments of Health Policy, Management, and Evaluation and Medicine, University of Toronto, and Department of Medicine, Mount Sinai Hospital and University Health Network, Toronto, Ontario, Canada.
**Corresponding Author:** Allan S. Detsky, MD, PhD, Mount Sinai Hospital, 427-600 University Ave, Toronto, ON M5G 1X5, Canada (adetsky@mtsinai.on.ca).



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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 for politicians and interest groups who dislike the results of those efforts because the results may threaten their incomes or access to currently available care.[5]

**Equity.** Although everyone recognizes that health care is a "merit good" (ie, all members of society should have the right to it regardless of income), most patients put equity lower on the priority list than whether they are receiving adequate health care services. Illness, like other stresses, inherently breeds selfishness.

**Conflicts of Interest.** Although most patients would be disappointed to learn that some treatments are recommended partially for the purpose of increasing the income of the prescribing health care professional, most patients do not fundamentally care as long as the service helps make them better without increasing the costs they have to bear.

## Lowest Priority

**Real Cost.** Individual patients have virtually no interest in costs they do not bear. Presenting patients with bills that are sent to insurance companies listing real costs or full charges is meaningless unless the patients face those costs.

**Percent GNP Devoted to Health Care.** The amount of gross national product (GNP) spent on health care is just a number and has absolutely no relevance for individual patients. Similarly, expenditure trends, international comparisons, and government debt mean little to patients.

## Implications for Policy Makers

Policy makers in the United States and Canada have serious concerns about the sustainability of the health care sector, especially the part funded by tax revenues. However, predictions that the health care sector will overwhelm the entire economy are likely overstated.[6] Health care is perhaps society's most valued service. Patients want to know that over time their chances of being restored to good health when ill are continuously improving. As a result, consumers understand that they are going to have to devote more resources to health care. Preferences for immediate care and elimination of uncertainty make excess capacity and waste tolerable to the public. It may be more rational to spend resources on interventions that are of more value, like efforts to combat obesity, but most of the public cares more about treating illness. Changing attitudes about priorities would require a public health strategy, much like the efforts to make smoking or putting children at risk while playing sports socially unacceptable.[7]

Some may say that the consumers' preferences described in this article are irrational and unrealistic; that may be true. In fact, I have spent most of my research career on the issues that are herein described as unimportant to patients (eg, cost-effectiveness and conflict of interest). 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,[1] 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."[1] But failure to consider consumer priorities will certainly lead to failure.

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