

How Patients Think about Their Health Care

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Reducing costs, improving quality, and increasing value are among the most pressing needs in health care today (Bauchner and Fontanarosa 2016; Obama 2016). Strategies such as value-based insurance design, patient-centered care, and shared decisionmaking seek to reduce costs and improve quality by linking provider payments to quality of care or by giving patients a say in their experience of care (CMS 2015, 2017; Epstein et al. 2010).¹ Despite this emphasis on quality for patients, relatively little is known about how patients themselves assess their health care, or what factors they consider in assessing their care. Current evidence suggests that health care experts and medical professionals often think of health care quality in terms of technical measures, but patients often associate quality with the “soft skills” of their providers (AP-NORC 2014; Lynn, McKethan, and Jha 2015; Quincy 2014, 2016). Consumer surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), usually focus on specific aspects of the patient experience in one type of setting or circumstance (e.g., hospital, clinic, Medicare, Medicaid, or commercial health insurance plan) to identify areas for improvement. In this brief, we explore patients’ overall assessments of their own health care along different dimensions as well as the factors underlying those assessments.

What We Did

This brief draws on data from the September 2016 Health Reform Monitoring Survey (HRMS).² All adults in the sample were randomly assigned to one of three groups, and each group was asked a different version of a question about the health care they had received over the past 12 months. The three versions were variations on a question from CAHPS,³ and assignment was randomized to test whether respondents’ health care ratings differed significantly with respect to different concepts of health care value. The groups were asked to rate on a scale of 0 to 10, where 0 represented the worst care possible and 10 represented the best care possible,

1. their health care in the past 12 months;
2. the quality of their health care in the past 12 months; or
3. how well their health care met their health needs in the past 12 months.

All respondents were then asked the same follow-up question about the most important factor they considered when they rated their health care:

1. care setting: the doctor’s offices, clinics, and hospitals where they received health care;
2. care providers: the doctors and other health care providers who cared for them; or
3. care received: the health care services, tests, and treatments that they received.

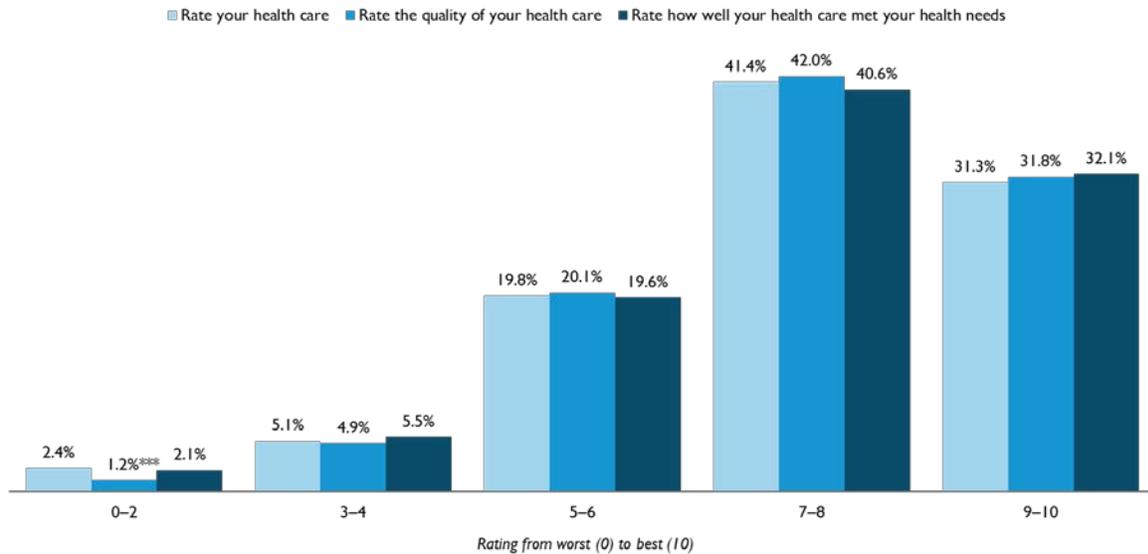
Participants were also given the option to write in a response. We examine patients’ ratings of their health care and the factors underlying those ratings. The sample in this analysis is limited to

7,233 adults who received health care in the past 12 months.⁴ Like all survey data, these are self-reported assessments and do not necessarily reflect clinical outcomes or appropriate care delivery.

What We Found

Most adults gave high ratings of their health care; more than 30 percent rated their health care a 9 or 10, where 10 is the best care possible.

Figure 1. Nonelderly Adults' Ratings of Their Health Care in Response to Three Versions of a Survey Question



Source: Health Reform Monitoring Survey, quarter 3 2016.

Notes: Sample is limited to adults who received care in the past 12 months.

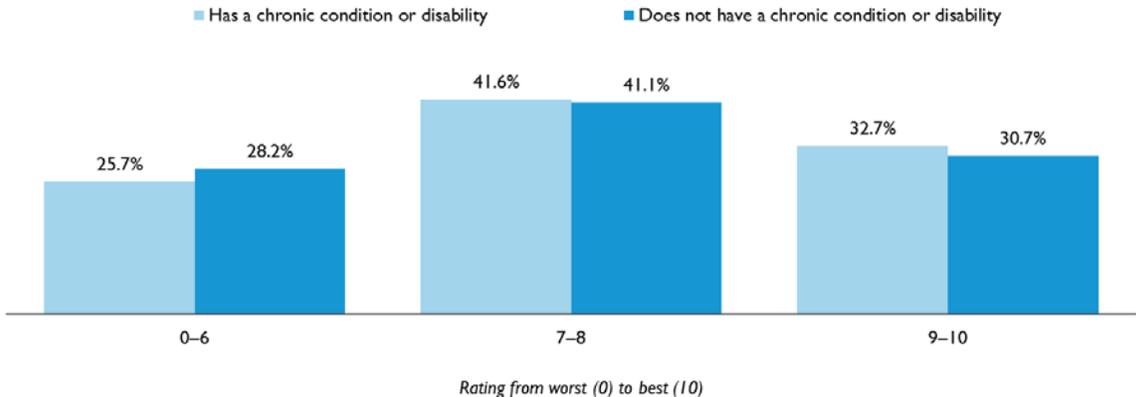
*** Estimate differs significantly from estimate for "rate your health care" at the 0.10/0.05/0.01 level, using two-tailed tests.

Nonelderly adults tended to rate their health care favorably no matter what version of the question they received (figure 1). Across all three versions of the health care question, the median response category was a rating of 7–8 on the 0 to 10 scale, with more than 30 percent of respondents rating their health care a 9 or 10. Another 20 percent of respondents gave ratings in the middle of the scale, at 5 or 6. Relatively few adults (less than 10 percent) gave ratings from 0 to 4. Adults who gave ratings below the median category of 7–8 tended to be younger, Hispanic or nonwhite, and lower-income, as shown in Bart and Long (2017).

Ratings across the three versions of the health care rating question remained similar when comparing adults with and without health problems, adults at different income levels, and adults of different racial/ethnic backgrounds (data not shown). As a result, we focus on the overall rating of health care that combines the three versions of the question for the rest of this brief.

Ratings of health care were similar across adults with and without health problems, but higher-income adults were more likely than low-income adults, and white, non-Hispanic adults were more likely than adults of other racial/ethnic backgrounds to give high ratings.

Figure 2. Comparison of Nonelderly Adults' Ratings of Their Health Care, by Chronic Condition or Disability Status

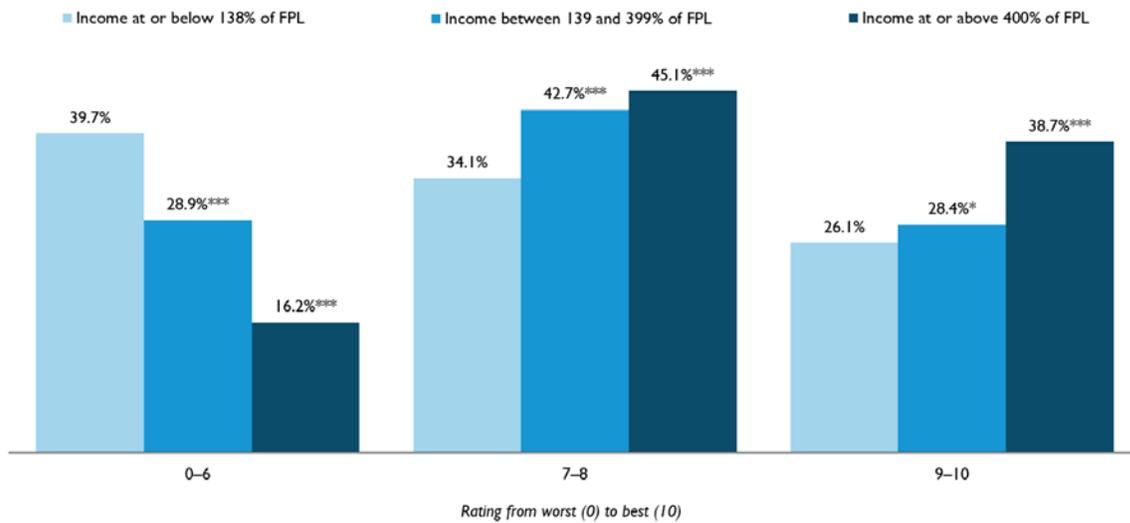


Source: Health Reform Monitoring Survey, quarter 3 2016.

Notes: Sample is limited to adults who received care in the past 12 months. We found no significant differences in estimates between the two population subgroups at the 0.10 level, using two-tailed tests.

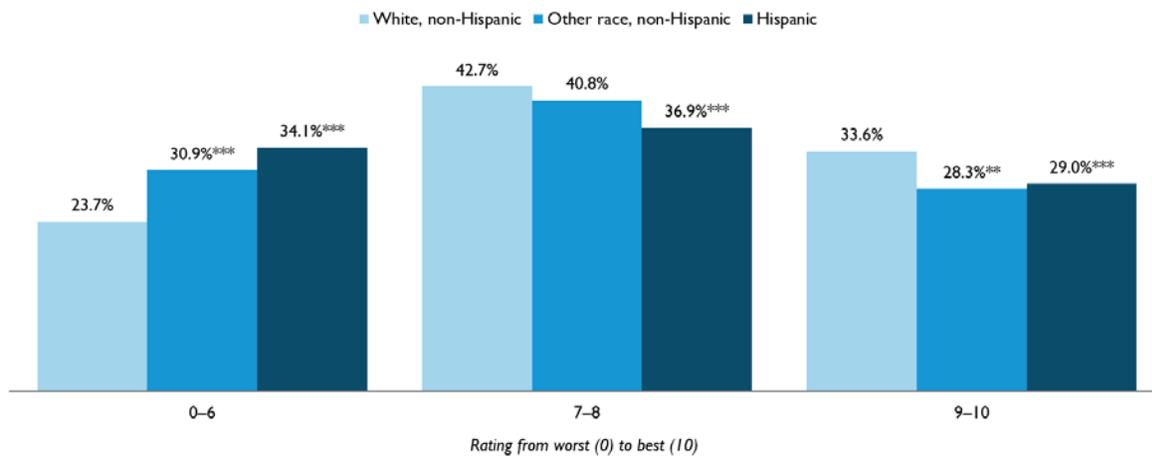
Adults with and without a chronic condition or disability did not differ significantly in how they rated their health care (figure 2). Consistent with the overall population, the median response category among adults with and without health problems was a rating of 7–8; roughly 30 percent of each group rated their health care a 9 or 10. By contrast, ratings of health care differed significantly across family income groups and across racial and ethnic groups, although the median rating remained high. High-income adults were more likely than lower-income adults to report ratings of 9 or 10 (figure 3), and white, non-Hispanic adults were more likely than other non-Hispanic adults or Hispanic adults to report ratings of 9 or 10 (figure 4).

Figure 3. Comparison of Nonelderly Adults' Ratings of Their Health Care, by Family Income



Source: Health Reform Monitoring Survey, quarter 3 2016.
 Notes: FPL = federal poverty level. Sample is limited to adults who received care in the past 12 months.
 /**/ Estimate differs significantly from estimate for adults with family income at or below 138% of FPL at the 0.10/0.05/0.01 level, using two-tailed tests.

Figure 4. Comparison of Nonelderly Adults' Ratings of Their Health Care, by Race/Ethnicity

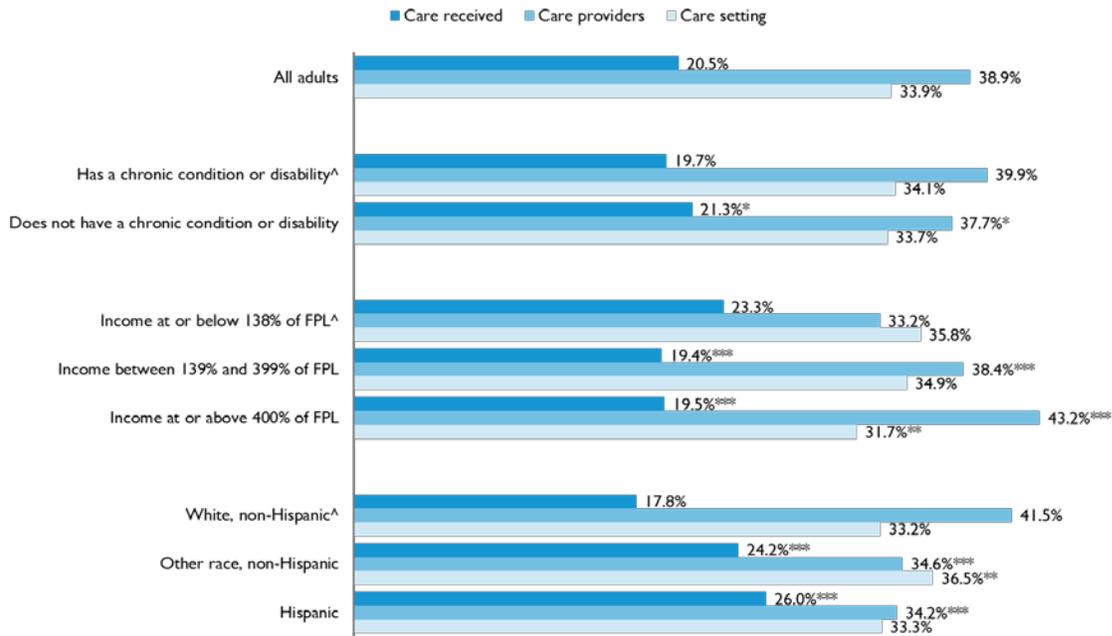


Source: Health Reform Monitoring Survey, quarter 3 2016.
 Notes: Sample is limited to adults who received care in the past 12 months.
 /**/ Estimate differs significantly from estimate for white, non-Hispanic adults at the 0.10/0.05/0.01 level, using two-tailed tests.

Most adults named either care providers or care setting as the most important factor in rating their health care.

Care providers were most often reported as the most important factor in the health care rating; 38.9 percent of adults considered this most important, compared with 33.9 percent who considered care setting most important (figure 5). Only about one in five adults said the care they received was the most important factor in rating their health care.⁵

Figure 5. Comparison of Factor Deemed Most Important in Nonelderly Adults' Ratings of Their Health Care



Source: Health Reform Monitoring Survey, quarter 3 2016.
 Notes: FPL = federal poverty level. Sample is limited to adults who received care in the past 12 months. The figure does not include people who reported other factors as most important (roughly 6 percent of the sample) or those who did not report any factor as most important (roughly 1 percent of the sample).
 //*/*/* Estimate differs significantly from the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

The factors considered most important in rating health care varied across population subgroups. Notably, higher-income adults and white, non-Hispanic adults were more likely than other adults to report care providers as the most important factor, and low-income adults and racial/ethnic minorities were more likely to report the care received.

What It Means

Overall, adults rate their health care favorably, with less than one in ten adults giving a rating below 5 on a 0 to 10 scale. Relatively high ratings were reported across the overall population and across population subgroups, although higher-income adults were more likely to give high ratings (9 or 10) than low-income adults, and white, non-Hispanic adults were more likely to give high ratings than adults of other racial/ethnic backgrounds. Adults consistently gave favorable ratings, whether they were asked to rate their health care, the quality of their health care, or how well their health care met their health needs.

Most adults (over 70 percent) considered either their care setting or their care providers to be the most important factor in the rating of their health care; roughly 20 percent said the care they received was the most important factor. This highlights a disconnect between medical professionals' and patients' perceptions of care quality. Patients consider the patient-provider setting and relationship to be the most important aspects; however, current evidence suggests that health care experts and medical professionals often consider the care provided most important in assessing quality. With an increasing focus on reforms that reward quality of care and approach care with a more patient-centered perspective, it is important to recognize that care setting and the patient-provider relationship are critical to patients' own assessment of their health care.

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About the Series

This brief is part of a series drawing on the HRMS, a survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

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Sharon K. Long is a senior fellow and Lea Bart is a research assistant with the Urban Institute's Health Policy Center. The authors thank Genevieve Kenney and Stephen Zuckerman for their comments on an earlier draft.

Notes

¹ Mark McClellan, Frank McStay, and Robert Saunders, “The Roadmap to Physician Payment Reform: What It Will Take for All Clinicians to Succeed under MACRA,” *Health Affairs Blog*, August 30, 2016, <http://healthaffairs.org/blog/2016/08/30/the-roadmap-to-physician-payment-reform-what-it-will-take-for-all-clinicians-to-succeed-under-macra/>; “Shared Decision-Making,” Agency for Healthcare Research and Quality, last

updated March 2016, accessed July 5, 2017, <https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html>.

² The data collection period for the September 2016 round of the HRMS extended into October and November for a small share of the sample.

³ The three question versions are variations on the following question from CAHPS: “Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?” (AHRQ 2012).

⁴ Twenty-six respondents (less than 1 percent of the sample) had received care in the past 12 months but did not rate their health care; they were excluded from the analysis.

⁵ Roughly 6 percent of adults in the sample provided write-in responses to this question. Most write-in responses mentioned either problems with their insurance plans or high costs as the most important factor in rating their health care.