

CONSUMERISM IN THE CONNECTICUT HEALTH CARE MARKET

INTRODUCTION

Health care consumerism gained momentum in Connecticut during the 1990s, as a growing number of people began to demand a greater role in making their health care decisions.¹ The establishment of a competitive hospital market in 1994 and the subsequent spread of managed care altered the traditional doctor-patient relationship; as a result, more and more patients have become discerning health care consumers. They are better informed as they obtain health care information from a number of sources including the Internet. They are aware of the latest drugs and therapies and have higher expectations regarding the quality and effectiveness of care. The new health care consumers also generally want convenient, quicker care. Most importantly, they are willing to act to have their expectations met. Thus, consumer behavior and expectations are beginning to affect the health care system. In this competitive market, hospitals are responding to consumer demands by broadening the services they offer, and enhancing the convenience of care by relocating facilities in the suburbs and providing more care on an outpatient basis. They are also providing consumers with more health care information and often involving them in decisions about their care.²

THE EVOLUTION OF CONSUMERISM IN CONNECTICUT

In comparison with other goods and services, consumers are more limited when making choices about their health care. They are constrained by their level of health care insurance coverage and by the decisions of their physicians and health plan administrators. Consumers

may have limited medical knowledge and information about the quality of area providers. Fundamentally, the necessity, urgency and availability of medical treatment will also limit people's health care choices.

Despite these inherent limitations on consumer choice, health care consumerism did gain much momentum in Connecticut during the 1990s. Increasing numbers of patients shed the passivity of the traditional doctor-patient relationship in favor of a more active role in their health care. Although payers have had the strongest influence over the health care system since its deregulation in 1994, consumer demand has also become an important force. The conjunction of a number of factors was responsible for fostering the development of consumerism.

The Creation of a Competitive Health Care Market

Prior to the mid-1990s, Connecticut did not have a competitive hospital market because the state extensively regulated the industry, particularly its acute care hospitals, until hospital Fiscal Year (FY) 1995.³ From FY 1974 until FY 1994, the State Commission on Hospitals and Health Care reviewed and approved all financial operations of health care facilities including rate schedules, capital budgets, gross and net operating revenue, and net expenses. Concerned with the rising health care costs of the early 1990s, however, the Connecticut General Assembly decided to create a competitive health care market by reducing the state's regulatory role. In P.A. 94-9, the Legislature terminated the state's authority to set hospital rates and on the revenue side removed any restrictions on discount rates and payment arrangements that managed care payers negotiate with hospitals. In July 1994, it abolished the

Commission on Hospitals and Health Care and replaced it with the Office of Health Care Access (OHCA) (P.A. 94-3).⁴

In the new competitive health care market, providers were compelled to compete for revenue and market share. While they sought to attract the large payers such as managed care companies, they also had to increasingly appeal to consumers.

Changes in the Delivery of Health Care

The FY 1994 deregulation of the hospital market created an atmosphere more conducive for managed care; by FY 2000 over 1.4 million state residents were enrolled in these plans.⁵ Managed care

affected the relationship between health care providers and patients. Patients realized that physician gatekeepers, utilization reviews, and practice protocols were primarily designed to hold down costs. Nationally, there has been a reduction in the average time that physicians spend with their patients.⁶ This change

has been referred to as the “corporatization of health care.” Hospitals also have been shifting patient volume from expensive inpatient care to less costly, more convenient outpatient services. From FY 1993 to FY 1999, inpatient volume fell by 5% while outpatient visits increased by 23%.⁷ Delays in treatment caused by waiting for insurance approval, denial of certain types of care, and paperwork affected public perceptions of the quality of care. National clinical studies suggest that staff reductions, particularly in nursing, diminish the quality of care.⁸

Declining confidence in the quality of the health care system, increasing co-pay-

ments, and the changing relationship between patients and their physicians were incentives for people to take greater control of their health care. Medical care has also become more fragmented as patients receive treatment from an array of specialists and health care professionals. Patients and their families have had to adapt to this fragmentation by becoming “case managers.” Increasingly, they must coordinate care among the many physicians from whom they are receiving treatment. They must frequently take the lead in alerting caregivers to medical conditions, allergies, and medications that they are already taking.

Medical Advances

Over the last fifteen years, there have been tremendous medical breakthroughs.⁹ In the U.S., new technologies and therapies diffuse quickly and medical care is technology-intensive. The general public learns about these advances through advertising, media coverage, and health care websites. As a result, their expectations regarding the effectiveness and quality of care are heightened. More consumers have been responding to this information by asking their health care physicians and providers for these cutting-edge technologies and therapies.¹¹ Hospital services are likewise affected by consumer demand because some of them are performed at the hospital and much of the flow of hospital patients is controlled by physicians; 43% in FY 1999.¹²

Connecticut hospitals have a sophisticated array of medical services that include the most advanced technologies.¹³ While these technologies have been largely beneficial to consumer health, they increase the cost of care. This causes friction between insurers who wish to hold down costs through utilization reviews or the prescription of generic drugs, and con-

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sumers who want the newest or most advanced care. Rising insurance co-payments and fixed-dollar employer health care contributions are increasingly shifting more of the cost to health care consumers, particularly when they choose expensive therapies.¹⁴

Direct-to-Consumer Advertising

With the development of a more competitive health care market during the 1990s, providers for the first time began to aggressively market their goods and services directly to consumers. Traditionally, manufacturers of such health care goods as pharmaceuticals had almost exclusively focused their marketing to physicians. In the mid-1990s, the federal government loosened restrictions upon medical advertising; in addition to their traditional marketing to physicians, the health care industry then began to make greater use of direct-to-consumer (DTC) advertising. This strategy has succeeded as it has stimulated consumer demand for new drug therapies.

In the forefront of DTC marketing, pharmaceutical companies primarily utilized television ads and Internet web sites to inform consumers about new products, to build brand awareness, and to highlight specific diseases or health problems. Aggregate DTC spending for the pharmaceutical industry, which was just \$47 million in 1990, reached \$595 million in 1995 and topped \$1.48 billion in 1998.¹⁵ As DTC marketing expanded consumer choice, particularly with pharmaceuticals, it naturally eroded physicians' role as intermediary between patients and drug companies.

Consumer advertising had a powerful effect as pharmaceutical spending experienced the greatest growth in the health care field in the late 1990s, reaching over \$90 billion in U.S. sales.¹⁶ During

that time, the number of patients treated with drug therapies grew by nearly 30% as in just one year, 1998 to 1999, the average number of prescriptions written per physician jumped by almost 10%.¹⁷ In the six years from 1993 through 1998, pharmaceuticals grew from 6% to 8% of total U.S. health spending.¹⁸ Advertising spurred consumer demand as the ten most heavily advertised drugs accounted for more than 20% of the growth in pharmaceutical spending from 1993 to 1998. Following the introduction of Merck's advertising campaign for Propecia, physicians experienced a

79% increase in the number of patient visits for male pattern hair loss.¹⁹ A Scott-Levin poll found that over half of all physicians had been asked by their patients to prescribe advertised drugs and many felt compelled to honor these requests. For example, 86% of all patients who asked for Claritin received it as did 93% of those who wanted Pravachol. Although this consumer behavior reflects basic market demand, new drugs and cutting-edge therapies have contributed to an escalation of the cost of care.²⁰ Consumer demand for new drugs has created conflict with managed care companies who initially had offered quite generous drug benefits.²¹ By 1995, consumers paid out of pocket for nearly one-half of all pharmaceutical costs.

The increased demand for brand drugs suggests DTC advertising has affected the behavior of health care consumers. Polling has confirmed that the majority of consumers have a positive attitude toward DTC advertising as they think that it provides them with information on new treatments.²³ Associate FDA Commissioner

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William Hubbard reasoned that DTC ads provide people with information that can facilitate and improve communication between patients and their physicians.²⁴ This ultimately empowers consumers and allows them to make better decisions

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about their health care. Initial evidence also shows that patients who participate in decision-making regarding their treatment are more likely to adhere to it.

Critics of DTC advertising, such as pharmacologist Dr. Brian Strom, argue that due to advertising,

physicians are increasingly prescribing new drugs over older, better-tested, and often less expensive ones, frequently without a compelling medical reason.²⁶ He is uneasy about the potential for adverse effects from the stronger drugs that are now being produced. Dr. Strom and other physicians are also concerned about the public's ability to understand and weigh the risks of these newer drugs. Furthermore, studies by *Consumer Reports* and physicians have found from one-third to 40% of all ads overstate the effectiveness of their products while understating their potential risks.

Increased Health Care Information

Information is critical to people's ability to make health care decisions that genuinely reflect their interests and values. In a 1998 review of 30 controlled studies, the Agency for Health Care Policy and Research (AHCPR—now the Agency for Healthcare Research Quality—AHRQ) with the Research Triangle Institute, found that, in fact, most people would like to have more information to make their health care decisions.²⁶ In particular, they would like to have more information

about quality of care because it is so important in selecting health plans and providers. Initial controlled studies have found that patients really want to be able to make choices regarding their health care and those who had more information became more involved in decision-making about their treatment. Better-informed, active patients were more likely to adhere to their treatment regimens; they were also more likely to opt for non-surgical therapies.²⁷

The information revolution associated with the development of the World Wide Web has had a significant effect upon the amount of health care information that is available to consumers. Based upon a recent poll, Harris and Associates estimated that 98 million Americans use the Internet to find health-related information.²⁸ An Associated Press/University of Connecticut survey found that Connecticut residents picked the Internet as the most reliable source of health care information.²⁹ In 2000, there are over 25,000 websites devoted to issues of health and fitness; search engines can return hundreds of thousands of related pages to medical queries.³⁰ At free reference sites like "VirtualHospital," "Hyperdoc," "WebMD," and "MedicineNet," people can search exhaustive databases for medical information. At "healthgrades.com," consumers can examine information on the quality of over 5,000 hospitals, 17,000 nursing homes, 8,000 home health agencies, 400 health plans, and most physicians across the country. Universities and non-profit health foundations such as the American Cancer Society, the American Heart Association, the American Diabetes Association, and the Arthritis National Research Foundation have their own informative websites. There are also a number of commercial sites operated by manufacturers of health care products.

In addition to providing health care information, these sites advertise products and many allow consumers to directly purchase merchandise. While the information that consumers gain on the Internet can empower them to participate in their health care decisions, there is no content validation for the websites. The National Council for Reliable Health Information and the federal government have warned that some of the available information is even dangerous.³¹

The print and electronic media have also responded to the growing public demand for health care information. Diet and fitness books frequently dominate bestseller lists. Most newspapers have a health section. In the electronic media, there are many health and fitness television programs, news broadcasts usually include a health report, and an increasing number of advertisements are from the providers of health care goods and services.

A number of independent organizations, alliances, and associations are focused upon the issue of health care quality and consumer information. The American Association of Retired Persons (AARP), with 30 million members, is the best known and most powerful of these organizations. Through its magazine *Modern Maturity*, mass mailings, its chapters, and its website, the AARP provides information to older health care consumers. Among the most prominent national health care consumer alliances are the Coalition for Quality Patient Care, the American Health Quality Association, and the Health Care Quality Alliance. Government also supplies health care information to the consumer. In Connecticut, the Departments of Public Health, Mental Health and Addiction Services, Mental Retardation, Social Services, and the Office of Health Care Access all provide the state's citizens with

health care information. For example, the Department of Public Health's website furnishes information on a variety of health topics including HIV and Lyme Disease; the Department of Social Services' site includes information on the various Medicaid programs including eligibility standards and how to obtain benefits. The Office of Health Care Access has a toll free number to assist consumers with problems they may have had with health care provider billing.

At the federal level, the Health Care Financing Administration (HCFA) oversees the Medicare and Medicaid programs and is responsible for the quality of these programs. HCFA supplies programmatic information to Medicare and Medicaid recipients through toll-free numbers, its website, mass mailings, and through its regional offices. The Centers for Disease Control and Prevention website provides medical information, public health news, as well as safety and health tips.³² The federal government also funds two of the best health-related search engines, "healthfinder.com" and "chid.nih.gov." The Agency for Healthcare Research and Quality produces the Consumer Assessment of Health Plans (CAHPS), a software program that has annually provided information to over 90 million people. AHRQ also produces additional quality evaluation computer programs that are utilized by health professionals, employers, and other purchasers of health plans.³³



The Growth of Alternative Medicine

Alternative medicine/holistic health care is itself a catch-all term for a broad array of practices such as naturopathy, homeopathy, massage therapy, acupuncture, aromatherapy and energy therapy. In the late 1960s and early 1970s, Americans largely identified health practices such as vegetarianism,

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yoga, herbal remedies, natural foods, meditation, and acupuncture with the counterculture. Thirty years later, the *Journal of the American Medical Association (JAMA)* reported that four out of every ten Americans used alternative therapies.³⁴ They also spent an estimated \$27 billion for alternative medicinal products, services, books, cassettes, instructional videos, and classes. JAMA's national surveys, first conducted in 1990 and repeated in 1997, found a 47% increase in visits to alternative healers, particularly for chronic health problems such as backaches, arthritis, and headaches. Therapies with the largest increases included herbal and folk remedies, massage, megavitamins, and homeopathy. Two separate independent surveys found that 30% of all Internet health searches are for alternative medicine.³⁵ Most people who utilize alternative therapies also consult conventional medical doctors, but less than 40% of them tell their physicians that they use alternative therapies.³⁶ The medical community is beginning to test alternative therapies and has found some to have beneficial medicinal effects.³⁷ Some hospitals have begun to incorporate alternative therapies into their array of services or service referrals.

The public's perception of alternative medicine has changed radically over the last few decades. This change may be due to the effectiveness of certain alternative therapies as well as to the limitations of

modern clinical medicine. According to Dr. David Eisenberg of the Harvard Medical School, four major factors in the growth of alternative medicine are:³⁸

1. The realization that conventional biomedicine cannot solve all of America's health problems
2. The growing acceptance of a holistic concept of health, i.e., that health is more than just the absence of disease
3. The growing public sentiment and research that alternative medicine is often more economical, less invasive and harmful, and, for some conditions, more effective than conventional medicine
4. The growing number of informed health care consumers who want to be treated as a person and not as a diagnosis by their physicians

Summary of Consumerism

Health care consumerism gained momentum in Connecticut in the mid-1990s as part of the new competitive market. Reacting to the "corporatization of health care" that was associated with managed care, consumers have increasingly become more active in making their health care decisions and more vocal in demanding quality care. Due to the information revolution, consumers are increasingly knowledgeable about health care and recent medical breakthroughs have raised their expectations regarding the effectiveness and quality of care. Health care consumers also want convenient care delivered quickly. Raised expectations, greater knowledge, and increased co-payments have also catalyzed changes in consumer behavior. In the fragmented health care system, more and more patients and their families must act as their own case managers. Health care providers report that patients and their families are asking

more questions and demanding specific therapies and drugs.³⁹ They are also reporting an increase in the number of people who are “self-medicating,” that is, treating themselves.⁴⁰ This can be dangerous given the absence of content standards for health websites. Surveys show that nearly one-half of all people have gone outside of the medical establishment and used alternative medicine, particularly for chronic illnesses.

Hospitals Respond to Health Care Consumerism

In a competitive market, hospitals must attract consumers and contend for market share. Hospitals now not only compete with each other, but with independent ambulatory care and diagnostic centers, and physician offices that offer services that were once primarily restricted to hospitals, such as surgery. Hospitals have responded to consumerism and other market forces by expanding the range of services they offer to include ambulatory care, primary and preventative health, home health care, nursing facilities, and, in some cases, even alternative therapies. To make these services more conveniently accessible, hospitals have constructed or acquired suburban outpatient centers and health facilities. Hospitals also provide consumers with health information through websites, bulletins and pamphlets, and outreach and other educational programs. Hospitals have broadened their services beyond acute care in order to increase their share of the health care market and in response to consumer and physician demands. Most of them have also entered into agreements with other hospitals to coordinate care in one or more service areas.⁴¹ Through these means, hospitals are trying to offer services to consumers that cover the full “continuum of care,” from pre-natal services to hospice. From FY 1994 through FY 1998, the Office of

Health Care Access approved 226 Certificates of Need (CONs) with capital expenditures of over \$809 million as hospitals made capital investments to improve their competitiveness.⁴² One-quarter of these CONs authorized new services as hospitals sought to increase their share of the health care market beyond acute care. Twenty-two percent of all CONs approved the purchase of imaging and major medical equipment as hospitals tried to improve their competitive position against independent ambulatory care and diagnostic facilities. A further 11% of the CONs authorized the renovation or construction of new facilities as many hospitals constructed ambulatory care centers, assisted living and nursing homes, and improved their physical plants. While facility renovations are often cyclical in nature, several hospitals made changes primarily to improve the atmosphere of their buildings. During this period, one-half of the acute care hospitals also upgraded or replaced their management information systems. Advanced information systems are necessary to facilitate the development of integrated health systems because they can provide multiple health service professionals with clinical information about patients as they receive care at many different points within the integrated health system.

At least two-thirds (20) of Connecticut hospitals have expanded their range of services to include primary and preventative health and one-half (16) of them have freestanding clinics that offer ambulatory care and diagnostic services such as MRIs. Many hospitals have placed these facilities in suburban locations. By placing family health centers, wellness

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clinics, imaging centers, and ambulatory care facilities in suburban locations, hospitals are trying to more effectively compete with independent freestanding health care facilities that have proliferated since the deregulation of Connecticut's health care market. From FY 1994 to FY 1998, five hospitals received state authorization to open student health clinics.

As the population ages and an increasing proportion of inpatients are being discharged to skilled nursing and long-term care facilities, one-third (13) of all hospitals have constructed or acquired convalescent homes, nursing and long-term care facilities, and assisted living institutions. With shorter inpatient stays, home health care services have become an important part of health care; at least 18 hospitals offer these services.

Hospitals have added a variety of other services. At least 15 of the 31 acute care hospitals operate physical therapy or rehabilitation clinics. The state boasts six invasive cardiology centers and four Level 1 Trauma Centers. During the late 1990s, a number of hospitals expanded their behavioral health services. Ambulatory detoxification and outpatient substance abuse treatment services were added by four hospitals. Two hospitals have even established their own bloodless medicine and surgery programs in response to the growing number of people who, because of their religious convictions or their health concerns, do not wish to receive blood transfusions. Hospitals offer community wellness pro-

grams that include services such as free blood pressure, glucose, and cholesterol screenings; support groups for cancer survivors, the bereaved, diabetics, and stroke victims; and health and fitness programs.

Hospitals provide an abundance of health care information to the consumer. Connecticut hospitals have taken advantage of the Internet. Over 80% of hospitals have their own websites that furnish people with information about their services, educational and outreach programs, and medical and fitness issues. Some of these sites even allow visitors to submit medical questions and receive electronic answers. Most hospitals publish newsletters that provide health and fitness information to consumers. They maintain "Patient Information Resource Rooms" or small medical libraries that allow patients and their families to gather health care information. Hospitals also provide community health programs that include seminars and classes on numerous health topics such as managing diabetes, wound care and pain management, coping with cancer, and child-care. Many offer fitness and nutrition programs for children, seniors, and those with health problems including cardiac and stroke patients. Hospitals also reach out to consumers through health fairs; some have educational vans and buses that deliver wellness and preventative health care information to the community.

CONCLUSION

During the 1990s, patients become increasingly better informed, developed higher expectations regarding the convenience and quality of care, and became more active in trying to have these expectations met. As a result, they increasingly demanded more of a voice in decisions that affected their health care. Although health care consumerism has only recently gained momentum in Connecticut, it is a force that providers have had to respond to over the last decade. As it continues to gain momentum, consumerism could become one of the most important factors shaping the state's health care system.⁴³

Consumerism developed in the 1990s as the result of the combination of a number of factors. The first of these factors was the deregulation of the hospital industry in 1994 and the creation of a competitive market. Next were changes in the delivery of care, particularly the replacement of the traditional doctor-patient relationship with managed care, and the associated development of the primary physician as a gatekeeper. Individual patients have had to act as the coordinators of their care in an increasingly fragmented health care system. Third, the financial difficulties of hospitals and managed care pressures to limit costs led to staff and service reductions; this affected consumers' perceptions of the quality of care. Fourth, increased co-payments created a financial incentive for people to play a more significant role in their health care decisions. Fifth, consumer demand for health care information has dramatically expanded and, in response, the amount of medical information that is now accessible to the layperson has grown. One out of every two persons will draw information from among the 25,000 health sites on the

World Wide Web. Finally, the combination of advances in medical technology and therapies and direct-to-consumer advertising has stimulated consumer demand for cutting-edge treatment. Medical breakthroughs have also raised the public's expectations regarding the quality, convenience, and effectiveness of care.

As a result of these developments, there are increasing numbers of people now acting as discerning consumers of health care services. A negative aspect of this trend is that there are no content validation standards for information available on the World Wide Web, and more people are prescribing therapies for themselves based upon the information they find, which may not be correct. However, consumerism has put the focus in health care back upon the patient at a time when managed care and the competitive health care market have concentrated upon finances. Providers have responded by:

- ◆ Supplying more health care information to consumers;
- ◆ Increasing the amount of outpatient care;
- ◆ Locating ambulatory and preventive care centers in more convenient suburban locations;
- ◆ Responding to patient demands for new drugs and the most advanced therapies; and
- ◆ Advertising to consumers.

While health care providers have begun to respond to consumerism, the substantial growth in the number of people using alternative medicine reflects in part their dissatisfaction with traditional medicine as well as their desire for their providers to treat them as a whole person. People

choose alternative therapies because they are holistic and patient-centered. The added element of paying for such care gives consumers more control over their treatment. The issue of consumer choice in an era of managed care is difficult to resolve. The question remains: Can providers such as hospitals meet consumer expectations of quality and convenience as financial pressures intensify, thus constricting their flexibility to respond to a changing health care market?

RECOMMENDATIONS OF THE HOSPITAL STUDY FOCUS GROUP ON CONSUMERISM

In the summer of 2000, the Office of Health Care Access sponsored a focus group that discussed health care consumerism. Members included representatives of

hospitals, health care consumer advocacy groups, physicians, and government. They offered the following recommendations:

- ◆ The government should develop outcomes measurement standards so that the quality of care can be assessed.
- ◆ Providers should implement consumer quality initiatives (CQI) and establish practice guidelines.
- ◆ The government should disseminate health care information to consumers, particularly on the cost and quality of available health care.
- ◆ There is a need for survey analysis of Connecticut residents' attitudes about the quality and convenience of their health care.

NOTES

¹“Health care consumerism” refers to patients (as well care-givers who make health care decisions for others) who are informed about their medical conditions, have high expectations about the quality and convenience of care, and make discriminating choices in order to have these expectations met.

²State of Connecticut Office of Health Care Access Hospital Study Focus Group on Consumerism, Summer 2000.

³Hospital fiscal year runs from October 1st through September 30th.

⁴OHCA inherited responsibility for the CON process, auditing the hospitals' financial results, maintaining an inpatient database, and carrying out health care research and planning. While OHCA does not determine hospital rates, it does establish net revenue limits for acute care hospitals and gross revenue limits for specialty hospitals. These limits are based upon budget requests filed by the hospitals.

⁵State of Connecticut Department of Insurance.

⁶Bodenheimer, T. The American Health Care System: The Movement for Improved Quality in Health Care, *The New England Journal of Medicine*, 340(1) (January 1999) 488 – 492.

⁷State of Connecticut Office of Health Care Access Inpatient Database and Hospital Financial Reporting System.

⁸From FY 1993 to FY 1998, the number of full-time equivalents declined by 8% (CT Office of Health Care Access Hospital Budget Reporting System). A recent report by the California Nursing Association summarized extensive contemporary studies of nursing and safe staffing practices that suggested the link between staff levels and the quality of patient care—Nursing Practice Alert, November 1, 1999.

⁹Bodenheimer, op cit.

¹⁰Iglehart, John. The American Health Care System: Expenditures. *The New England Journal of Medicine* 340(1) (January 1999) 70 – 76.

¹¹Iglehart, op cit.; <http://scottlewin.com>, news release 4/19/00; Hospital Study Focus Group on Consumerism, 2000.

¹²State of Connecticut Office of Health Care Access Inpatient Database.

¹³State of Connecticut Office of Policy Management. Health Care Discussion Group Report to Governor Lowell P. Weicker, 1994.

¹⁴Iglehart, op. cit. & Kuttner, R. The American Health Care System—Employer Sponsored Health Care Coverage. *The New England Journal of Medicine*; 340(1) January 1999, 248–252

¹⁵Gelles, J. Critics Warn Ads for Prescription Drugs are Flawed. *Philadelphia Inquirer* 8/18/97; & <http://www.scottlevin.com>, news release 4/16/00.

¹⁶There were other factors besides DTC advertising that contributed to the dramatic growth of pharmaceutical spending in the 1990s. The first one was the spread of managed care plans as most of them offered generous drug coverage (Levit, et. al., Health Spending in 1998: Signals of Change, <http://www.projhope>, 2000). The second factor was the continued successful marketing to physicians, which pharmaceutical companies spent \$6 billion on in 1999 (<http://www.scottlevin.com>, news release 4/19/00). The third cause in the recent growth of pharmaceutical spending was the FDA's decision to streamline its drug testing process which reduced the average time from submission to approval from two years to just under one (Levit, et. al. 2000). As a result, drug companies can more quickly introduce new products to the public.

¹⁷<http://www.scottlevin.com>, news release 4/19/00.

¹⁸Levit, op. cit.

¹⁹<http://www.scottlevin.com>, news release 4/19/00.

²⁰Bodenheimer, op. cit.

²¹Levit, et. al. op. cit; Iglehart, op. cit.

²²Kuttner, R. The American Health Care System – Health Insurance. *The New England Journal of Medicine*. 340(1) January 1999, 163 – 168.

²³<http://www.scottlevin.com>, news release 4/19/00.

²⁴Gelles, op. cit.

²⁵Managed care organizations (MCOs) have criticized DTC advertising for raising the cost of health care (<http://www.scottlevin.com>, news release 4/19/00). MCOs prefer that their enrollees use generic drugs, but advertising generates consumer pressure upon them to cover brand name ones. Rising pharmaceutical costs were a significant factor in the increased cost of insurance benefits (Levit, et. al, 2000). As a result during the 1990s, the prescription drug share of private insurer premiums doubled and from 1995 to 1998 the cost of the average premium increased by nearly 20%.

²⁶That study, like ones by the AHRQ with the Lewin Group, the AHRQ with the Kaiser Family Foundation, and the Princeton Survey Research Associates, and one by the American Health Quality Association (AHQA) argued that the health care industry needs to develop better standards for assessing the quality of care along with new means for providing information to health care consumers and providers alike (AHRQ/Kaiser Family Foundation/Princeton Survey Research Associates study, <http://www.ahrq.gov>, 1996 & AHRQ/Lewin Group study, <http://www.ahrq.gov>, 1999 & <http://www.ahqa.org>, 1997).

²⁷Polling by the AHRQ revealed that in choosing a health plan, selecting a specialist, or picking a hospital, the majority of people rely upon the judgments of family, friends, and their physicians. They also found that familiarity weighs heavily in people's health care decisions as three-quarters of those surveyed would prefer a familiar physician or hospital over ones that might be more highly rated by independent organizations. The AHRQ poll found that part of the reason that many people are not using quality assessments by independent organizations is that they are not familiar with this information. While four-fifths of all respondents believed that independent quality assessments could be very useful in making their health care decisions, only two-fifths claimed to have seen quality comparisons within the prior year. Furthermore, only one-third of those who had seen a comparison used this information in making their health care decisions. It is important to note that the AHRQ poll was conducted in 1996 at a time when the Internet was just becoming a significant source of health care information.

Dr. Mark Hochhauser, contributing editor to *Managed Healthcare*, argued that the complexity of quality assessments discourages the average person from understanding and utilizing them. Examining HMO report cards, he found that they are filled with hard to interpret statistics and graphs, and their texts are very complex because they contain so many obscure and ambiguous insurance and health care terms (Hochhauser, March & May 1998).

²⁸*Connecticut Post*. Health tips draw users to Internet, August 20, 2000, G5.

²⁹*Connecticut Post*. Public approves highly of state health-care quality: poll, July 2000, A8.

³⁰Guttman, M. The Web Makes House Calls. USA Weekend. June 2 – 4, 2000, 6 – 8.

³¹Guttman, op. cit.

³²Guttman, op. cit.

³³AHRQ Profile, <http://www.ahrq.gov>, 2000. The National Committee for Quality Assurance (NCQA) was founded by HMOs in 1979 and has become the most respected source for quality assessments of HMOs. Half of all HMO's are accredited by the NCQA, which collects information from them on 50 measures of quality, the Health Plan Employer Data and Information Set—HEDIS (Bodenheimer, 1999). This data is used to rate the individual HMOs and about 45% of them allow the NCQA to publicly report its findings. Like the AHRQ software, employers, health care consultants, and health plans are the major consumers of the NCQA quality assessments. In addition, eleven states either mandate NCQA accreditation for state employee health plans, use HEDIS to evaluate their Medicaid managed care plans, or, like Connecticut, permit NCQA accreditation to satisfy external quality review requirements (<http://www.ncqa.org>, 2000).

³⁴Eisenber, et. al. Trends in Alternative Medicine in the United States, 1990 – 1997. *Journal of the American Medical Association*, 280(18), 1998, 1569 – 1575.

³⁵www.intel.ie/intel/e-health, 2000.

³⁶Eisenberg, et. al. op. cit.

³⁷The medical community has adopted the value of a high fiber, low fat diet rich in vegetables (Naturopathy, http://health.yahoo.com/health/alternative_medicine, 2000). Through their clinical research, Medical Doctors such as Adele Davis and Linus Pauling proved the value of certain vitamins as well as the effect of nutrition upon health. Recently, antioxidant vitamins, such as vitamin E, and certain herbs, like St. John's Wort, have begun to earn acceptance among mainstream physicians. Clinical studies have shown the effectiveness of Chinese herbs in treating irritable bowel syndrome, Saw Palmetto extracts for benign prostatic hyperplasia, and yoga for carpal tunnel syndrome (Bensoussan, et. al., 1998, Wilt, et. al., 1998, & Garfinkel, et. al., 1998). In clinical trials, mega-dose vitamins and food supplements have failed to show any positive effects. National Institute of Health tests in 1997 provided evidence of acupuncture's effectiveness in relieving dental surgery pain, and reducing the nausea and vomiting that is associated with pregnancy, chemotherapy, and anesthesia (Acupuncture, http://health.yahoo.com/health/alternative_medicine, 2000).

³⁸Eisenberg, op. cit.

³⁹<http://www.scottlevin.com>, news release 4/19/00.

⁴⁰State of Connecticut Office of Health Care Access Hospital Study Focus Group on Consumerism, 2000.

⁴¹Some affiliation agreements between hospitals were designed to create "integrated health systems," that is health care institutions with a common parent corporation, common planning, and integrated information systems (Shortell, et. al. 1996). Integrated health systems offer a broader scope of services than acute care to a more geographically diverse population. In Connecticut, four systems have emerged and a fifth has recently begun to establish itself.

⁴²The Certificate of Need Program (CON) is a mandatory examination by OHCA of all health care facilities' proposed acquisitions or divestments of significant medical equipment or services. The CON process was designed to reduce the duplication and fragmentation of health care services while assuring the broadest access to these services. State of Connecticut Office of Health Care Access Hospital Financial Reporting System.

⁴³State of Connecticut Office of Health Care Access Hospital Study Focus Group on Consumerism, 2000.