Pre-conference roundtable discussion "Impact of consumerism on outcomes"

By David Roye

We had a series of questions that were posed at the beginning:Do you believe in and or support the shift to consumerism in healthcare?

Will this shift ultimately help improve quality and access?

What are the limitations and or required changes to the broader landscape to maximize the value of consumerism in healthcare?

How do you leverage the shift to consumerism to your system?

There was a general consensus that the healthcare environment is supporting a shift to consumerism particularly in North America but also in Europe. There are heightened expectations for service, quality and access in a more educated and technologically adept population. Consumerism in the form of patient engagement/activation is here and is having impact on clinical care. Consumer satisfaction is being ubiquitously measured and there is more and more recognition that time and efficiency matter to those using our systems. The success of the CityMD model points to that sea change; patients would rather see a doctor in the urgent care center with a requisite few minute wait than to go to their general practitioner (GP), on his schedule and wait an hour. The CityMD service model has led to burgeoning growth in its urban US locations.

Competition has led hospital systems to use the rise of consumerism to mine the activated group with a view to consumer capture. On the American side that competition has led to looking at consumer capture as a goal.

The underlying question is whether or not quality, safety, access and outcomes in general were improved by consumerism. An argument by the single payer system advocates was that if costs were increased by shortening wait times and improving the health care interface for the consumer it did not add value and in fact made allocation of scarce resources more difficult. Proponents argue that process improvements that are inspired as a response to consumer needs can and should improve outcomes. On the other hand consumer preference could drive inefficiency and add costs. The clinician and the insurer want integration/consolidation of care, keeping the consumer on a single platform for continuity and for cost containment – the consumer wants to go where they want to go and there are times when that decision is not price sensitive.

An underlying constituent of consumerism is patient inclusion in planning and decision making. Consumerism is sometimes defined as patient preference and is often regarded in a way that diminishes the meaning of that preference/input. Patient input, opinions and complaints should be considered when we are building systems, changing process or performing clinical research. Who better knows what serves the patient than the patient? That inclusion improves outcomes and increased patient satisfaction.

Furthermore, gaining trust from the consumer via an optimal service experience can be leveraged into trust by a provider in helping consumers seek higher-value care, as illustrated by the CityMD model.

The consumer wants a system that is centered on him/her. The consumer wants patient centered care that is characterized by efficiency, convenience, quality, access. The patient is why the healthcare delivery system exists and our processes must be designed to meet the needs of that patient. The consumer/patient needs to be included in the design of the systems we institute.