Putting a New Face on Managed Care

Consumers need convincing about quality issues.

By Howard P. Greenwald, Robert J. Chen, and Margaret Johnston-Zamora

Growing suspicion among consumers, health professionals, and public officials threatens the future of managed care. Intense competition among plans is also taking a toll. Positioning managed care as a provider of higher quality service than alternative delivery options is one way to help mitigate negative public perceptions and gain an advantage in today's competitive environment.

Managed care has features capable of promoting high quality seldom visible to the consumer. Unlike traditional fee-for-service plans, managed care requires accountability outside the provider-patient relationship. Boards of directors, trustees, consumer representatives, and health professionals exercise oversight, often assisted by utilization review units operating under research-based protocols. The size and internal integration of managed care organizations (MCOs) enable them to collect and analyze data on procedures and outcomes, promoting successive refinement of methods for preventing and treating illness. The data collection capabilities of MCOs make oversight possible by outside agencies such as the National Commission on Quality Assurance (NCQA).

A group known as the Phoenix Gathering—top MCO officials, health policy and marketing experts, and University of Southern California (USC) personnel—decided to focus attention on the female managed care consumer. Reviewing an extensive body of existing studies and conducting focus groups in early 2000, investigators at USC found four service features to be strongly identified with quality: personal relationships with physicians, medical expertise, speed of access, and comprehensiveness of service. As signs of quality, NCQA accreditation was not seen as important, and discount pricing was viewed negatively. Although most consumers used direct interpersonal contacts to help select plans, certain celebrities seemed potentially valuable in future promotion efforts.

EXECUTIVE HIGHLIGHTS

Widespread consumer suspicion about the quality of managed care indicates that marketers still have work to do. Research shows that women identify personal relationships with physicians, medical expertise, speed of access, and comprehensiveness of service as important signs of quality when selecting a managed care plan for their families. Based on existing research findings and new focus group data, this article provides guidelines for promoting an association of quality with managed care, particularly among women.

What Consumers Think

To large segments of the public, managed care has represented a decline in quality as compared with traditional fee-for-service arrangements. According to the Commonwealth Fund Survey of Patient Experiences with Managed Care, many consumers associate managed care with long waiting times for appointments, barriers to care by specialists, poor communication with providers and support personnel, and potential denial of needed services. Other research suggests that many consumers connect managed care with deteriorated relationships with health professionals. Studies indicate that patients in managed care plans are more likely to mistrust their providers than are patients in fee-for-service plans. Observers suggest that managed care creates conflicts of interest between consumers and providers of care.

The female consumer represents a crucial market segment for positioning managed care. Russell Coile reports that women make the majority of health care decisions for both themselves and for their families. (See Additional Reading, page 19.) They spend two out of every three health care dollars. In addition, women age 14 and older visit doctors 25% and are hospitalized 15% more often than men.

Several important studies focusing specifically on female consumers raise challenges for managed care. According to the Commonwealth Fund's Women's Health Survey, women enrolled in HMOs were more likely than fee-for-service patients to report difficulties in obtaining medical care due to lack of coverage in specific areas and inability to get appointments. Women enrolled in HMOs were also less likely to receive preventive health care services than non-HMO enrollees were. Lack of physician time and preventive health counseling were cited as important reasons for not getting needed care. More HMO enrollees than non-enrollees felt they were talked down to by their health care providers and rated the quality of communication as poor or fair.

A 1998 National Partnership for Women and Families survey suggests a widespread perception among women that managed care plans and health care personnel often treat people without proper respect. Respondents also report barriers to health care access, including difficulty obtaining an appointment, short appointment times, and referral delay or denial.

How Consumers Assess Quality

Currently available research provides guidance for selecting strategic marketing options. Research suggests that health care consumers assess quality according to a variety of dimensions:

Technical quality: Outstanding (or at least adequate) physical resources and expertise within an organization or plan

Quality of communication: Clear information provided by the health professional and willingness to take the time required to respond to questions

Stable relationships with chosen provider: Consumer's ability to choose a provider and have timely access to him or her

When assessing health plan options, consumers value the impressions of personal intimates rather than standardized, official-sounding information. They prefer to seek recommendations from their personal physicians, friends, and family members. In fact, a 1996 survey by the Kaiser Family Foundation and the federal government found that only a small number of health care consumers know

Learning From Other Industries

Positioning managed care as a quality service faces the challenge of public skepticism, perhaps more intense among women than other market segments. The features of managed care that are capable of enhancing quality are unfamiliar or invisible to consumers, compounding the challenge. Industries other than health care, however, have met similar challenges by using the methods listed below.

- **Establishing widely recognized performance standards (e.g., gasoline octane ratings)**
- **Comparative quality expressions (e.g., restaurant star ratings)**
- **Factual repositioning of products to emphasize their quality (e.g., "touch and feel of cotton" campaign)**
- **Validation by celebrities, authorities, and objects of personal identification to lend credibility to marketing and public relations messages**

about systems for assessing and reporting health plan quality such as HEDIS.

Market segmentation creates diversity in the indicators individuals will accept as meaningful signs of quality. People of different genders and ages have different health concerns and use different products. Members of different races, ethnic groups, and socioeconomic categories have different expectations regarding relationships with providers.

Current research, then, raises three practical problems for marketing strategy. First, the consumer views managed care with suspicion if not outright hostility. Second, consumers don't appear likely to assess managed care through a single, consistent, or objective set of criteria. Third, they have historically looked to sources other than the media for information about health care.

To help resolve these issues, marketers need to improve understanding of (1) the common factors that large numbers of consumers might accept as indicative of quality in a managed care setting; (2) what objective standards of quality the consumer might find credible; (3) which trade-offs the consumer might be willing to make among quality-related features of health plans; and (4) which agencies or individuals might be effective validators of information about managed care.

Consumer Focus Groups

As noted earlier, women in the United States occupy a position among consumers of health care disproportionate to their numbers in the population. Adult women often select the health plans utilized by their entire families. They monitor and facilitate the health care of their dependent children and elderly spouses and schedule appointments, provide transportation, observe procedures, and give emotional support. Increasingly, they participate in the care of their own or their spouse's elderly parents.

Two focus groups were held in Los Angeles in March 2000 to assess the quality-related opinions and concerns of adult women in managed care plans. The focus groups were conducted in rooms equipped with audio and video recording equipment, and members of the research team observed the groups, which were led by a professional facilitator, from behind a one-way mirror. Both groups were composed of 10 women representing a wide range of age, race, and employment categories. Recruitment took place via random digit dialing and use of a set of screening questions on gender, age, employment status, and race/ethnicity. Quotas were established for age, employment, and race/ethnicity. Males were excluded, as were women under age 18 or age 64 and older.

The facilitator's script covered the following areas:

Plan selection. Each focus group session started with a question about why the participant or her partner had selected the plan to which she belonged.

Conceptions of quality in a health plan. Questions of this nature were first framed in general language, then couched in terms of specific services that focus group members considered most important. Finally, questions were posed as trade-offs among different features of a plan.

Measures of quality. The script inquired about the signs and measures of quality used by, known to, or potentially acceptable among the focus group participants.

Sources of information. We evaluated potential reception of individuals and agencies other than personal acquaintances as sources of information.

Findings

Nearly every focus group member had participated in her family's health plan decision or had made the decision herself. Quality, as defined by training and medical expertise of the staff, was mentioned by few participants. Responses to the question on factors in plan selection tended to focus on convenience of location and scheduling. Several negative factors appear to have played a role, such as bad experience with another plan or lack of an alternative plan offered by the employer. Several participants selected their plan on the basis of low cost.

Participants indicated a variety of criteria for recognizing quality. Attentiveness and responsiveness by physicians was the predominant theme, including such concerns as willingness to communicate, use appropriate tests, and make referrals. Prompt scheduling of appointments and brief waits at the doctor's office also were mentioned frequently. Several participants mentioned specific service offerings, such as chiropractic, health education, and preventive care.

These themes were reinforced in a follow-up question that asked respondents to think of encounters they'd had with their health care provider for specific types of service, to indicate the level of quality of care they received, and to specify good and bad points about the episode. Good points recalled include caring, communication, and making an appropriate referral. Recol-

lected bad points included long waiting time and poor communication.

The next set of questions attempted to determine how consumers might trade off quality according to one dimension vs. cost as well as another dimension of quality. This question was included so answers wouldn't merely reflect utopianism, that is, a desire to have the ideal health plan unconstrained by resource limitations.

One question asked respondents whether they would accept a plan that had health professionals who were qualified, but not expert, in exchange for a 50% reduction in premium. In one group, about half the participants said they would "check out" such a plan. Reflecting a sense of resignation, several group members expressed the feeling that their current plan didn't offer the state of the art, so they would lose nothing by joining a plan offering a 50% cost reduction. No one in the other group seemed strongly attracted to such a plan, though. Participants made comments such as "I feel I deserve the best" and "you get what you pay for."

Other responses suggest that, although focus group participants would value better appointment-scheduling and more communicative physicians, they wouldn't consider trading off medical expertise for these other dimensions of quality.

Participants were asked to indicate the information sources they used for selecting a health plan. This question explicitly excluded information sources such as friends and family and drew a narrow range of responses. Participants mentioned materials made available at work, coworkers, and health professionals such as family doctors.

The next question asked participants whether they would find a disinterested, outside agency that rated health plans useful in making their decisions. This question was asked because many MCOs today obtain certification by the NCQA in the belief that such certification demonstrates quality and is significant to employers and consumers. Responses to this question seemed unenthusiastic. Some participants said it would be valuable, but a few indicated they would have little time or energy to study such ratings.

Finally, the focus group participants were asked about which public figures they might find credible as sources of information about health plan quality. Several figures appeared to enjoy trust in this area, including present and former purveyors of hard news in the media and current or former public officials with reputations for plain dealing. Examples of figures likely to enjoy public trust regarding managed care-related messages were Barbara Walters, C. Everett Koop, Jimmy Carter, and Hillary Clinton. The participants explicitly excluded television personalities and actors, with one individual commenting that "these people say whatever they are paid to say."

Developing a Strategy

Several of the themes summarized here confirm findings from surveys of managed care that are clearly representative of defined populations. Both present focus groups and earlier surveys, for example, suggest that most members of the public aren't primarily concerned with basic medical expertise, which they assume is assured to them. Rather, consumers stress areas such as convenience, an adequate range of services, prompt appointments and referrals, a feeling of being cared for, and a sense that the health plan does not skimp on needed resources such as physician time, tests, and technology. The consumer appears willing to pay for a plan with these qualities.

Both prior research and the focus group findings presented here suggest that consumers are most likely, at present, to respond to messages emphasizing willingness of health professionals to communicate and spend adequate time with them. Indicators of quality visible to consumers include clean, well-run facilities, convenience in getting appointments, and courtesy of health professionals and staff. A marketing strategy corresponding to the consumer's present understanding would emphasize observable features such as convenience, reliability, adequate resource delivery, and caring.

Such a marketing strategy may be effective for individual plans. However, it may be less useful in helping the managed care industry as a whole to reposition itself. This strategy may encounter significant resistance because claims of superior convenience and communication would contradict the impressions of many consumers.

A marketing strategy corresponding solely to indicators of quality currently articulated by consumers, moreover, would ignore the basis for a strong claim of managed care's superiority. Such a claim requires emphasis on accountability of health professionals, treatment according to research-based protocols, and capabilities required for NCQA accreditation. A marketing plan omitting these advantages would undersell the product.

Improving the consumer's knowledge and understanding of these features should be a central focus of efforts by managed care—either the industry as a whole or individual plans—to position itself as the quality service provider. Marketers of goods and services other than managed care have successfully overcome lack of ready visi-

bility of features that make their products desirable. The "touch and feel of cotton" campaign is a familiar example.

It's important to include a factual focus in promotional efforts. References to agencies such as NCQA, however, seem likely to lack appeal to consumers. Focus group respondents didn't express enthusiasm about a neutral rating agency for health care plans. In addition, Americans seem skeptical of experts and disinclined to use information of a detailed and technical nature. The public also seems unaware of established agencies such as NCQA and the potential benefits they can offer consumers.

Using public figures as carriers of messages supporting linkages between managed care and quality appears more promising. The most appropriate public figures are those identifiable with earned media. According to the focus groups, several major public figures enjoy a high level of credibility in validation of messages regarding health care. "Hard news" media figures appear effective as message-carriers, as do individuals known for public-spirited commitment and concern for health. Implementing just a few of these suggestions may help build consumer trust and help managed care companies and plans gain an edge in an intensely competitive universe. ■

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Additional Reading

Coile, R.C., and J. Durham (1999), "Designing Health Systems for Women—America's Number One Health Care Consumers," *Health Trends*, (11), 2-8.

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