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Listening to Consumers: Values-Focused Health Benefits and Education

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- ***Importance of education in consumer-directed health plans:*** Greater education of workers about health care and health insurance is widely viewed as critical to the success of consumer-directed health plans, since these rapidly growing health benefit plans typically require far greater responsibility and impose more direct costs on individual health plan participants.
- ***How can employers educate their workers about health coverage? Is there a payback?*** Since the vast majority of Americans who have health coverage obtain it through their (or a family member's) employer, and with health benefits on track to become the single-largest expense of any employee benefit, the issue of education is important both to the sponsors and the beneficiaries of health insurance coverage. Among the key questions facing employers: What *kind* of education will work? And is there a payback for trying to educate workers about health coverage and care?
- ***"Top-down" efforts to control costs haven't worked for long in the past.*** Trying to "activate consumerism" by promoting consumer-directed health plans seems little different from past managed care attempts to stem out-of-control health costs by changing consumer behavior. But past (and current) "top down" approaches, structured without a better understanding of what consumers need to know and what they value, are likely to be ineffective over time. There is no research consensus that consumer-driven health benefits alone will contain health care costs.
- ***Importance of consumer values:*** As marketers have known for years, consumers' values are the powerful motivators in the psychology of decision making. They involve people's perceptions about what constitutes life quality, reflect deeply held cultural and personal meanings, vary in importance from person to person, and they can appear to others as irrational and vague.
- ***The need for values-focused education and wellness outreach:*** In order to inspire consumers to choose healthy lifestyles and make cost-effective care decisions, they need help resisting some entrenched unhealthful dimensions of American culture and education that takes their psycho-social and income-security concerns into account. But consumers have little or no input into the "consumerism" discussed among policymakers and employers today, and few are receiving health education that addresses their psycho-social and income-security concerns.
- ***"Consumerism" in health care risks failure by ignoring consumer values.*** Should health education initiatives prove ineffective, the "consumer-driven health movement" could well be doomed, especially if it relies upon fully educated health consumers taking self-initiated actions. The perceived ineffectiveness of education in 401(k) plans resulted in legislation to add "defaults" to these plans so that they no longer relied upon positive employee action. In the health arena, the default approach is exactly what the consumer-driven health model seeks to move away from.

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Introduction

At a recent daylong meeting of health benefits researchers, vendors, and professionals, every presentation ended with a recommendation for greater education so that the rapidly growing consumer-directed health coverage models can become effective for both employers and workers. This is crucial, since consumer-directed plans typically require far greater responsibility and impose more direct costs on individual health plan participants, compared with the typical "comprehensive" type of plan, where neither health care costs nor quality are readily apparent.

But what *kind* of education is the question? And is there a payback for employers that take on the difficult task of trying to educate their workers about health coverage and care? Since the vast majority of Americans who have health coverage obtain it through their (or a family member's) employer, and with health benefits on track to become the single-largest expense of any employee benefit, the issue of education is important both to the sponsors and the beneficiaries of health insurance coverage.

The purpose of this *Issue Brief* is to (1) briefly review past efforts by employers to curb rising costs in health benefit coverage and care, (2) help shed light on consumer values and how (and why) consumers make the health-related decisions they do, and (3) describe and discuss values-based, patient-centered approaches being taken in some hospital and other health care settings, and (4) present the case for values-focused employee education in health benefits and care.

Consumer values can provide essential insights into consumer thinking about health-related behaviors and financial decision-making. They also can provide a blueprint for health care businesses and policymakers working to make the U.S. health care system more responsive to consumers. Should health education initiatives prove ineffective, the "consumer-driven health movement" could well be doomed, especially if it relies upon fully educated health consumers taking self-initiated actions. The perceived ineffectiveness of education in 401(k) plans resulted in legislation to add "defaults" to these plans so that they no longer relied upon positive employee action.[1] In the health arena, the default approach is exactly what the consumer-driven health model seeks to move away from.

Background

Employers, clearly, are in a quandary: Steadily rising costs are making it increasingly difficult for them to provide affordable health benefits for workers and their families. Yet health benefits are necessary to attract and retain talent and to keep their work forces healthy and productive (Fronstin, 2007b). U.S. Census Bureau data report that 46.5 million Americans lacked coverage in 2006 (or almost 18 percent of the nonelderly population), primarily because of the erosion of employment-based insurance (Fronstin, 2007a).

Workers, too, are in a quandary. Their ability to handle higher payments is limited. Helman and Fronstin (2007) found that, among individuals experiencing increasing health care costs, 30 percent decreased retirement savings, 52 percent decreased other savings, 29 percent had difficulty paying for basic necessities, and 36 percent had difficulty paying other bills. Some workers are "taking their chances" by opting out of employment-based health plans (Holahan 2003, Fronstin, 2007a). Others are reducing needed care or are scrambling to find ways to skimp on routine living expenses to afford the increased costs (Helman and Fronstin, 2007; Fronstin and Collins, 2006).

Some business leaders and policymakers hold high hopes that "consumerism" in health care will stem rising health costs for both employers and workers. Although health care consumerism is not dependent upon any particular health benefit plan design, consumer-*driven* or consumer-*directed* health benefit plans (CDHPs) are the most common form of plan design that many sponsors of employment-based plans are betting will "activate" consumerism in health care.

"Activation" of consumers is often mentioned in the literature, but originally this term had little to do with money or cost-consciousness. The term is borrowed from health policy literature on "patient activation and engagement," meaning to "wake up" consumers so they feel free, if not eager, to speak up and participate in their own care (Groopman, 2007). This report combines these meanings in the term *activate* to mean: Wake up consumers so they can participate freely in their own care and become more cost-conscious as well.

Distinguishing Value from Values in Health Benefits and Care

Value is a term with many meanings. In the health business and policy literatures, value most often refers to the monetary worth or market price of health benefits and medical care. This provides an operational or quantifiable definition of value, which is useful as a measure of utility, cost containment, and/or profitability (Higgins, 2006).

Value as used in value-based insurance design refers to the relative usefulness and *merits* of high-value and low-value medical interventions and treatments in light of the financial costs of various clinical services and protocols. Some value-based insurance design perspectives also try to take a "clinically sensitive" approach to health benefits (Fendrick and Chernew, 2007).

Values in social psychology is a dynamic, less quantifiable concept having a strong motivational component as well as cognitive, affective, and behavioral components (Rokeach, 1968). Values are formed and reinforced by families, peer groups, teachers and other authority figures, organizations, and the media. They can arouse emotions, for or against them, and when values are shared by many others, common appraisals build value standards across societal boundaries about desirable goals and the instrumental behaviors needed to attain them (Keeney, 1992; Rokeach, 1973, 1978).

Certain desirable health standards (e.g., avoid illness, lose weight) often are at odds with the behaviors necessary to attain such goals (e.g., stop smoking, exercise regularly). Such conflicts of health goals and the behaviors to achieve them also raise perplexing questions for public health officials and medical care providers who hope to implement behavior change for at-risk consumers. Policymakers and health benefit designers, however, must also tackle these and other difficult questions as they consider how consumerism and CDHPs will be accepted across U.S. populations:

- Can health benefits be designed that inspire workers to voluntarily improve health behaviors and use health care more cost effectively?
- Are activated consumers the nation's best hope for achieving quality care and cost savings?
- Will employers be willing (and able) to create educational approaches that can help workers fund health care needs and save for retirement too?
- Will employers be willing (and able) to provide tools and resources so that workers and their families can make informed decisions regarding health care use?

This report is written against a backdrop of a U.S. employment-based health benefit system that is in a state of flux, and calls by politicians and others for national health care reform. Not only is health care high on the nation's political agenda, new research is surfacing that unfavorably compares the higher costs and lower health outcomes of the U.S. system with those of other Western nations' health care systems (AARP, 2007; Commonwealth Fund, 2007).

Why should plan sponsors or policymakers pay attention to consumer values? Because intensive studies of consumer values can provide essential insights into consumer thinking about health-related behaviors and financial decision-making. They can also provide a blueprint for health care businesses and policymakers working to make the U.S. health care system more responsive to consumers.

Top-Down Efforts to Control Health Spending

Since the early 1980s, employers have implemented various strategies to slow rapid health care inflation. Under scrutiny, variations in hospital and physician practice styles revealed that care at times was "over-prescribed and overused," needlessly expensive, and in some instances not beneficial for patients. Overuse of care became the target for cost containment policies, and employers looked to "managed care" strategies to counter them.

Managed care, especially health maintenance organizations (HMOs), was initially cost effective and service intensive, but it also disrupted the time-honored doctor-patient relationship. Control of patient care shifted from physicians to business managers whose priority, in their mission to stem rising health care costs, was to ascertain (and approve or, especially, deny) medical necessity and appropriateness of care for patients.

Although costs moderated for a few years, over the longer term the managed care experiment failed; it did so, in part, because it violated the personal and social values of American consumers—for autonomy and control of their own health care, among other things.

With the decline of managed care, health spending during recent years is rising faster than the economy as a whole and faster than workers' earnings (Kaiser Family Foundation, 2006). Costs for insurance administrative overhead and pharmaceutical spending have increased more rapidly than spending on other health care services (Commonwealth Fund, 2007). These and other increased costs are being passed on to employers in the form of higher premiums for health coverage and to consumers in the form of higher expenses for health care services.

The Future? Consumerism and Consumer-Directed Plans

To counter rising costs, the nation's health benefit designers and health service organizations have been seeking ways to motivate consumers to adopt healthier lifestyles, become more cost conscious, and exercise restraint in their use of health services. Many health benefit vendors and employment-based sponsors hope that carefully crafted health benefit design holds the potential for influencing workers' personal health habits and the manner in which they use and pay for health care. For the most part, they are relying on cost-sharing strategies to reduce consumer health spending. Others regard "consumerism" as key to motivating consumers to restrict their own care:

> To control health care costs, someone must choose between health care and other uses of money. The value of most health care is experienced subjectively, as is the value of other goods and services. No one is in a better position to make these subjective trade-offs than patients themselves (Goodman, 2006).

Few would dispute the importance of consumers' active involvement in their own health care to achieve affordability as well as quality and safety. There is abundant evidence that, in addition to access, information, and care coordination, individuals *want* to be involved—more or less—in the medical decisions affecting them (Picker, 1996).

Consumers, however, have little or no input into the "consumerism" discussed among policymakers and employers today. Nor are many consumers receiving health education that takes both their psycho-social and income-security concerns into account.

Consumer-Driven Health Plans

CDHPs are examples of using plan design to engage individuals in their health care. They are benefit plans with generally higher deductibles that are usually combined with one of two types of tax-preferred accounts: health savings accounts (HSAs) or health reimbursement arrangements (HRAs). Those who have CDHPs are expected to pay out-of-pocket costs from personal funds on an after-tax basis or from HRAs and HSAs on a tax-preferred basis (Fronstin and Collins, 2006).

According to a survey of 316 employers released on November 15, 2006, by Deloitte Center for Health Solutions, 77 percent said they expected CDHPs to change consumer purchasing patterns by making them aware of the true cost of health care. Tommy G. Thompson, chairman of Deloitte, predicted that business would reduce health spending by making consumers "smarter shoppers for health care" (Human Resources, 2005).

Physician groups generally support the concept of consumerism in health care because they think it helps to restore at least some of the traditional doctor-patient relationship. There are also a number of administrative advantages to CDHPs: Third party administrative interference may be less than that of managed care, and some CDHPs may not require referrals. But concerns and unknowns remain: Despite efforts to offer more "patient-centered care," physicians often do not have the information systems they need to help consumers make informed choices (Buntin et al., 2006). It is unclear how health providers will respond to "activated" consumers who want to compare prices and quality, and who may question or second-guess their prescribed medical care. And providers remain concerned about increased uncompensated care under CDHPs, as they are under the comprehensive health insurance model.

One concern expressed by physicians is that giving people control over their health care dollars through their CDHPs could limit *needed* care. They are not so sure that money saved on the healthy—the main beneficiaries of the new models—will offset costs of care for those with serious illnesses and chronic disease. There is good reason for this concern: A growing body of evidence demonstrates that, in response to increased cost sharing, consumers decrease the use of life-saving interventions (e.g., immunizations, cancer screening, essential prescription drug use) and may experience worse—and more expensive—eventual health outcomes as a result (Fendrick and Chernew, 2007).

However, wellness programs, and other incentives aimed at engaging consumers in maintaining their health, could boost participation in, and improve the success of, CDHPs. Making nurse coaches available to enrollees, integrating self-management incentives, and providing financial allowances for preventive care are some types of innovations recently introduced or planned by large employers (Tu and Ginsburg, 2007). In addition, there are efforts to couple CDHPs with tools to help consumers make better choices about the health care they use.

New sources of information such as provider quality, personalized Web sites, suggested questions to ask when choosing providers, and other decision-support tools are being provided for plan enrollees, and there are indications that the information is being used by some plan enrollees. But many others still feel that they lack sufficient information, especially in the area of health costs (Buntin et al., 2006). And even when information is provided, research has shown that large numbers of Americans have difficulty understanding health information, which could affect their ability to obtain quality care (Buntin et al., 2006; Vitt et al., 2002).

Déjà Vu All Over Again?

A close review of current goals for activating health care consumerism and adopting CDHPs seems little different from managed care objectives held by sponsors of employment-based health benefits and policymakers 25 years ago. Stripped down, they strive to:

- Improve health care outcomes by creating structures that control inappropriate health care use and treatment costs, and
- Raise consumer awareness that poor health care choices and misuse, abuse, or underuse of health care inevitably contributes to the overall cost of care for everyone.

Nor have HMOs, preferred provider organizations (PPOs), health utilization review, and gate-keeping strategies disappeared. In comprehensive health coverage, and after the high deductible is reached in CDHPs, experience with the health care system for many consumers remains essentially unchanged, even as parallel discussions gather momentum about health literacy, health decision making, "partnering" between patients and providers, greater transparency in pricing, and increased health care choice among treatment alternatives.

What *is* different about CDHPs is consumer control over the use and investment of tax-deductible contributions into an HSA when an accompanying account exists. Pre-tax dollars can be invested in various financial vehicles, accumulate earnings, and be withdrawn, all on a tax-exempt basis as long as they are used to cover qualified medical expenses (Park and Greenstein, 2006). Another difference is how and where benefit plan sponsors hope eventually to extract cost savings. Rather than overtly attempting to change the behavior of *both* the providers of care (doctors and hospitals) and those receiving care (consumers), the focus of CDHPs and consumerism is almost exclusively on changing the health behaviors of consumers (Cohn, 2007) as the strategy for implementing change in the greater health care system.

What Consumers Think About CDHPs

Employment-based health coverage is the employment benefit most valued by workers and their families (Salisbury and Ostuw, 2000), and most believe that the primary function of employer-sponsored health insurance is to pay for *needed* health care. Contrary to this expectation, they have seen health plan coverage, eligibility provisions, and exclusions increasingly designed to constrain health care payments to providers.

Despite the attention given to CDHPs by plan sponsors and policymakers, worker acceptance has met with less-than-anticipated success to date. In 2002, health benefits planners predicted that CDHPs would go mainstream and represent at least 50 percent of health coverage and care by 2007 (Gabel, Lo Sasso, and

Rice, 2002). But workers are not signing up in large numbers. In 2005, only 10 percent of privately insured nonelderly adults were enrolled in a plan with a high deductible; about 10 percent of them had an HRA or HSA. One-fifth of employers offering health insurance offered a high-deductible plan, and about 4 percent offered such a plan with an HRA or HSA option. A 2006 survey of these plans, however, found that enrollment had more than tripled since early 2005, reaching 3.2 million, and predictions for future growth in the HSA market include a recent forecast that the market will expand to 15 to 30 million enrollees over the next five to 10 years (Bunting et al., 2006).

According to the 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, only 8 percent of the privately insured population ages 21–64, or fewer than 10 million individuals, were enrolled in CDHPs in 2006 or in plans with deductibles high enough to meet the threshold that would qualify them to make tax-preferred contributions to a health savings account (Fronstin and Collins, 2006).

Other findings of the EBRI/Commonwealth Fund survey:

- Adults enrolled in CDHPs are in better health than those in more comprehensive health plans.
- CDHPs enrollees are more likely to be single, white, college graduates, younger (although the age effects are not strong), and to work in small firms than those with comprehensive health plans.
- CDHPs enrollees are less satisfied with their health plan than those with comprehensive coverage.
- Individuals enrolled in CDHPs are more likely than those with comprehensive care to report that they delayed or avoided needed care because of cost.
- CDHP enrollees were less likely than those in more comprehensive plans to report that they received information on the costs and quality of providers.

The EBRI/Commonwealth Fund findings did show that people in consumer-driven and high-deductible plans are somewhat more cost conscious than those in comprehensive plans. However, CDHP enrollees were also more likely to avoid or delay needed health care because of costs than those having more comprehensive health coverage (Fronstin and Collins, 2006).

Can CDHPs Inspire Workers to Voluntarily Lower Costs for Employers?

There is no consensus among health benefits planners and policymakers that consumer-driven health benefits will help contain health care costs (e.g., Nichols, 2002). Harvard Business School professor Regina Herzlinger (2007), a health care consumerism advocate (but not a proponent of CDHPs *per se*) insists that a planned, market-driven, system of "consumer-directed health care, in which the people who use the health system and who pay for all of it" is the preferred path to national health care reform.

High-deductible insurance products have never been very popular. Take-up rates have historically been low and could remain low. CDHPs could have an adverse impact on older and/or sicker consumers while rewarding the healthy. Studies have found that increased cost sharing leads to decreased health care use. Early research from the RAND Health Insurance Experiment found that people enrolling in cost-sharing health plans were significantly less likely to see a doctor for services. Low-income individuals in poor health, who were subject to cost sharing vs. those who were not, experienced poorer health outcomes, including the risk of dying for those with heart disease risk factors (Hoffman and Tolbert, 2006; Crane and Tollen, 2002).

As for activating consumers to choose healthy lifestyles, make cost-effective care decisions (and thus reduce the nation's soaring rates of health spending), it is useful to factor into such predictions some entrenched dimensions of American culture that adversely affect the population's health today (Majoras, 2006):

- Few city planners and developers provide sidewalks and bike paths.
- Schools have severely cut their physical education classes.
- Home entertainment systems and video games encourage indoor recreation and sedentary life at home.
- Computer-bound jobs and careers are increasing.
- When both parents work outside the home, no time remains for the preparation of nutritious meals.

- Restaurants and fast-food chains serve ever-larger portion sizes, and the food and beverage industries offer good-tasting and convenient foods that are far too high in calories and fat.
- Schools offer fast food and soda as meal choices, in partnership with the companies that produce them.

In the United States, more than 60 million adults are obese, and the trend among children is even more disturbing. Nine million American children between the ages of 6 and 19 are obese today, as the percentage of overweight children has tripled since 1980. One prediction is that by 2010, nearly half of the children in North American will be overweight (Majoras, 2006), which is expected to lead to greater health consequences and higher costs.

Further, scientists warn that massive quantities of toxic agents are still polluting the environment, despite amelioration of most of the visible environmental problems of the 1950s and 1960s.[2] This includes chemicals that are known to be rodent and human carcinogens and neuro-, immuno-, or developmental toxins. Whether current levels of exposure to these agents are contributing to the high or increasing incidence of cancer, Parkinson's, and Alzheimer's disease, asthma, autism, learning disabilities, diabetes, or other complex disorders is a matter of considerable concern (Olden, 2002).

In addition, there is considerable statistical evidence of a variety of serious or growing health problems in the national population, which are likely to be major sources of increased morbidity and mortality in the years ahead.[3]

Some argue that the rise in health care costs is due not to wasteful consumption by consumers but to an increase in treated disease prevalence and innovations in medical care (Thorpe, 2005). Cutler and McClellan, (2001) have analyzed whether technological advances have been worth the costs for treating various illnesses. In four of the five conditions they analyzed—heart attacks, low-birthweight infants, depression, and cataracts—the estimated benefit of technological change is much greater than the costs. In the fifth condition they studied, breast cancer, costs and benefits were about the same (Cutler and McClellan, 2001). Others, Kenneth Olden (2002) among them, insist that disease prevention has proven to be the most effective means of reducing the nation's health care costs:

> This past century saw tremendous increases in health and longevity because of water sanitation, vaccinations, refrigeration, and regulation of food safety. The new century will see further improvements as we identify and implement national prevention strategies based on knowledge of gene-environment interactions (Olden, 2002).

Motivated consumers who make informed health care decisions and lifestyle choices that reduce their need for medical care could very well enjoy improved health and see personal health expenses decline. But improved health outcomes and sustainable cost savings *across the U.S. population* may require a social movement built upon shared consumer values that are consonant with political, business, and community-based interests. Without this synchronicity, and fundamental changes in national health behaviors, it seems unlikely that business alone can generate health cost containment over the long term, no matter what types of health care plans are created and made available to workers and their families.

The Social Psychology of Values and Consumer Health Decisions

Individuals hold beliefs and attitudes about the way things are and make judgments about the way things should be according to what they value. Their assessments of available choices, their decisions, and their ultimate actions—consciously or unconsciously—are values-driven (e.g., Hitlin, 2003; Keeney, 1992; Rokeach, 1968, 1973, and 1979). When individuals are functioning at peak level, valuing is a reflective and creative process of inner and outer dialogue during which they are sometimes capable of transcending even entrenched habits and behaviors in favor of standards that embody real wisdom (Smith, 1991).

It is this kind of consumer competence that renders decision making deliberative and consciously proactive. This state of consumerism is required for activated consumers to seek quality care and, in time, perhaps, achieve cost savings as well. But it is inner-directed and must come from consumers themselves, and while it may be *informed* by facts, it will not be *dictated* by facts (Smith 1991).[4]

Values are the powerful motivators at work in the psychology of decision making. They can transcend the importance of financial concerns and sometimes even health itself. They involve people's perceptions about what constitutes life quality, reflect deeply held cultural and personal meanings, vary in importance from person to person, and they can appear to others as irrational and vague.

Health as a Value

In U.S. culture, health is both a value and a means to some other valued end—looking good, being fit, feeling well, living without physical pain or other impediment. When health status is taken for granted or neglected entirely, it can be argued that health is neither a valued means nor a valued end. Even when health is an important value, according to decision theorist Ralph Keeney (1992), few people could—or would want to—devote their life to maintaining a state of perfect health.[5] Health itself is less valued in the American population than may be presumed (Gochman, 1997). Findings from studies indicate that many consumers are more concerned about their appearance than about their health (e.g., Cockerham, Kunz, and Lueschen, 1988; Jones and Leary, 1994).

In the decision science literature, *value* is a measure of the attractiveness of each possible outcome. Yet when consumers face health care decisions, they may be required to make uncertain and often risky assessments under difficult physical and emotional stress and time constraints. This can place high cognitive demands on already-compromised individuals who might have limited attention and working memory resources in complex environments (Pierce and Hicks, 2001).

Valuing Health in Decision-Making

Everyday decisions often have health or physical safety implications. However, there is a class of deliberative decision-making that addresses health in the context of quality of life, including lifestyle choices and the financial decisions that tie into health coverage, preventive care, and medical services (Keeney, 1992). These are values-based decisions, and when individuals consciously adopt health-improving behaviors, seek jobs that provide health benefits, schedule routine check-ups, plan disease management or long-term care strategies, they may be demonstrating, as noted by Professor Ralph Keeney (1992), that health is an important means to another valued end.

Their underlying valued motives may involve financial goals, identity issues, social connectedness, physical comfort, autonomy and control, security, safety, and other standards that impact and shape everyone's life experiences.[6] While the relative importance of each value domain varies, human values drive everyone's major life choices consciously or unconsciously (Keeney, 1992; Rokeach, 1973, 1978). They are especially present in situations involving health and illness.

As one might expect, a number of studies link spiritual values—measured by church attendance—with physical health outcomes (Larson, Swyers, and McCullough, 1998). For example:

- Frankel and Hewitt (1994) report better perceptions of health and less need for medical services for those who attend religious services.
- Idler and Kasl (1992, 1997) show that spiritually active elders in nursing home settings have greater functional ability than those who do not share spiritual values.

Some decision researchers are concluding that deliberative, calculated decisions are the exception and that most behavior is relatively automatic (Loewenstein, 2001). This paradox leads us to plant the seeds of an approach that recognizes both the automatic character of decision-making and the notion that health care decisions—with help—can become more deliberative.

{PRIVATE }Domains of Life{tc \l 4 "Domains of Life"}

A large literature within the social sciences concerns people's subjective well-being. Studies examine satisfactions with various aspects of life—work, marriage, friendships, health, finances, and other areas—in order to determine the general well-being of groups and populations within and across cultures and nations. While all individuals do not conform to a single pattern of concerns, certain areas of life affect everyone, and life experiences contribute in an additive way to satisfaction with "life-as-a-whole."[7]

Values can be grouped into domains that consist of (1) inner, (2) physical, (3) social and (4) financial (material) concerns. Any unresolved decision problem creates more or less tension (dissonance) within each value domain, depending on its importance to the decision maker. When facing health-related decisions, consumers consider their choices—consciously or unconsciously—by "feeling" their way through each of the following life domains:

- ***Inner Values*** are the psychological or spiritual (and moral) standards that individuals set for themselves. They involve identity (concepts of self) and the drives for achievement, safety and security, and autonomy and control. In health-related experiences, these values are usually paramount.
- ***Physical Values*** are motivating factors in how people care for themselves and their environment, whether and to what extent they seek comfort or expedience in their person and in their surroundings, and how they fare when confronted with physical limitations and pain.
- ***Social Values*** are inherent in people's intimate and family relationships, in friendships and collegial connections, and in any social group where one feels that he or she **"**belongs.**"** Social values extend outward to include cultural and political affiliations and even to the greater society itself.
- ***Financial (Material) Values*** operate as overarching questions: 1) *Sufficiency*—Do I have enough? 2) *Sustainability*—How long will my money, assets, or resources last? and 3) *Appropriateness*—is this/the expenditure appropriate?

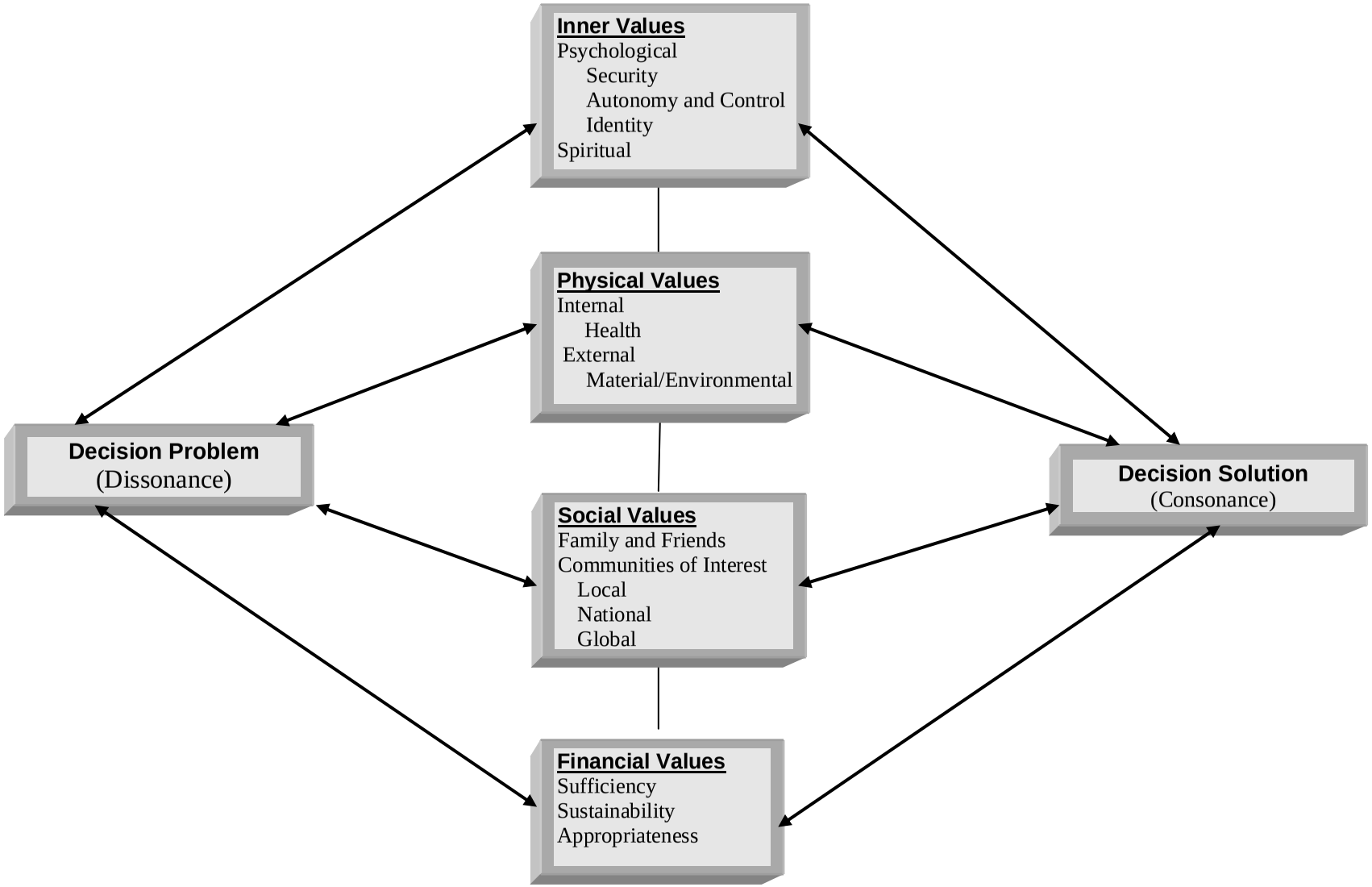
A decision problem by its nature causes discomfort until it is satisfactorily resolved. When individuals feel comfortable (consonant) on all value dimensions, they will make a decision. Until this equilibrium state is reached, however, they will experience discomfort that can vary from mild to severe. The decision may be postponed, or aborted altogether in favor of doing nothing. This internal process varies along the following dimensions as shown in Figure 1.

Values are subjective and connected to emotion. Identity and other inner issues are psychological and symbolic representations of what people desire and/or strive to become. Physical values concern what constitutes "physical comfort" for particular individuals. Social values consist of feelings and perceptions about intimate and social relationships. And financial values can have little relationship to actual income resources or bank balances.

Perhaps the best understanding of the subjective nature of consumer decision-making is the body of research that supports commercial advertising and marketing (e.g., Dittmar, 1992; Pham, 1998; Ray, 1997; Stern, 1991; and Witkowski, 1991).[8] What marketers understand is that people's decision processes, at best, are only partially objective. Competing psychological, physical, social, and material values, all of which are subjective, also are at work in consumer decision areas. Unless a person is highly motivated to value a healthy lifestyle and use health care judiciously, other more valued options may take priority. An underlying social value—surprising a hospitalized diabetic with a forbidden sugary treat, for example—can override cautions against this unwise behavior and its potentially harmful consequences. There are many reasons for such values clashes, resistance to change, and/or imprudent consumer decisions:

1. Some consumers perceive the health care system as adversarial and unfair. They feel rebellious, helpless to change, and/or fearful about this aspect of their life, so they avoid or ignore proactive health behavior altogether.
2. Many workers have long valued employer-based health coverage. They misunderstand the perceived unwillingness of otherwise profitable employers to provide comprehensive health benefits and to advocate for them.
3. Consumers are bombarded by product images, offers, and advertising, including advertising for prescription drugs and medical devices and services. They identify with actors on TV screens, and they often *want* the medications, devices, and services they are being offered, regardless of whether they may actually *need* them.
4. Some consumers lack any *desire* to master the level of health literacy and knowledge needed to understand the costs and rules of health coverage today. They seriously dislike tackling complex details of any kind and instead prefer to engage in other activities and interests that they do like.

Figure 1
Life Values and Consumer Decision Model



Source: Adapted from *LifeValues Decision Model* (Vitt, 2002, 2004)

5. Consumers traditionally have sought providers that will suggest (or direct) a therapy to remedy their problem and return them to a healthy state. Some are surprised (and unprepared) to participate in selecting their own treatment or therapy (Pierce and Hicks, 2001).

When consumers do express values in health-related situations, health professionals often disregard them as unrelated to the medical approach required to treat illness (Kahana and Kahana, 2001). Brennan (1995) suggests that a health care provider's appraisal of what he or she would want under similar circumstances may be substituted for a patient's value or perspective. Eisenberg and Kleinman (1981) described "healing ceremonies" that, even when effective, were dismissed as "no substitute for antibiotics or surgery."

Some health literature is more positively inclined toward the consideration of consumer values. Hyland and Crocker (1995) argue that improvement in health outcomes depends not just on biological improvement but also on psychosocial factors. When asked about values and preferences, however, people often are unprepared to think about these personal issues and unclear about how their values might influence a treatment or other decision (Peirce and Hicks, 2001). Yet, to influence consumers to change health behaviors, employers or care providers must help consumers activate their values, to have them accessible in their efforts to change old behaviors, and to match new behaviors to their own value standards.[9]

Listening to Consumers

Prior research has been designed to encourage consumers to express values, opinions, and feelings as a foundational method for creating more effective consumer education (Morrison, 2000; Vitt et al., 2002; Weaver, 2001). To discover and more deeply probe links between consumers' values and their experiences of health, health care, and health-related decision-making, the Valeo Initiative sponsored a pilot study, *The Living Dialogue on Health and Care* during 2001–2002.[10] Initially an effort of the Veteran's Health Administration and the Center for Health Care Improvement, the Valeo Initiative was subsequently expanded to include representation from the health care delivery, policy, information technology, and education sectors. The research was conceptualized and designed as a vehicle to help consumers think more constructively about health and health care. The researchers sought to describe and to explain health and health care experiences through the voices of consumers.

Participants were primarily white (86.6 percent), female (72.6 percent), educated (68.8 percent were college graduates), had a regular doctor (89 percent), and some form of health coverage. Nearly 80 percent reported regularly using home remedies when ill. They defined "what health means to me" in terms of:

Inner Values

- Having a positive attitude (79.3 percent).
- Taking charge of personal life (77.7 percent).
- Spiritual connectedness (46.3 percent).

Physical Values

- Not feeling sick (86 percent).
- Being involved in exercise or physical activity (38.8 percent).
- Being in control of diet and nutrition (19 percent).

Social Values

- Enjoying family and friends (78.5 percent).

Financial Values

- Having money to pay for care (19.9 percent).

Not surprisingly, financial values were not mentioned as often as other life values. Most consumers typically become acquainted superficially with health costs and coverage when they first learn about (and choose) their employment-sponsored health plan. In most cases, they will continue their health education only when a health crisis requires them to come to terms with their coverage and care, or when bills mount, or both.

Consumers hold unconscious motives and awareness about their well-being, and they are seldom detached about their own (or a loved one's) health status or need for care. Moreover, they differ from one

another, and even a single individual often behaves in a seemingly inconsistent fashion across situations and over time (Loewenstein, 2001). This lack of consistency observed in risk taking and decision making poses a challenge to health care designers with a mission to change or affect consumer behaviors.

Some hospitals, communities, and health care provider networks are listening to consumers in an effort to create programs that help them make improved health care choices. Similarly, some enlightened employers are linking benefit plans to wellness programs and other initiatives that empower consumers. Such efforts may pay dividends for their sponsors, and not just in improved health behaviors and lowered health costs—the factors that in all likelihood have motivated these initiatives. Powerlessness itself has been linked to poor health and is a significant health risk factor. Conversely, research has shown that opportunities to experience power and control in one's life contribute to health and wellness (Bergsma, 2004).

A Focus on Values-Based Patient-Centered Care

Care provider networks—particularly those that are community-based—are on a mission of their own to meet the health care needs of the nation's aging population. By redesigning internal regimens and promoting respectful approaches and educational tools that empower consumers, they are seeking to improve care, reduce costs, and satisfy patients. Across the nation, hospitals and care providers are holding community retreats, discussing options in town-hall meetings, and listening to emotionally charged consumer accounts in an effort to improve their approaches to care. As a result, many are implementing services under patient-centered perspectives to achieve their goal of "personalized, efficient, effective, and maximally positive patient outcomes at appropriate costs" (e.g., Lehigh Valley Hospital and Health Network, 2007).

The following *Patient Centered Care Framework* indicates the dimensions that are being targeted for improvement of patient care experiences:

1. Respect for patient's values, preferences, and expressed needs;
2. Coordination of care and integration of services within an institutional setting;
3. Communication between patient and providers, dissemination of accurate, timely and appropriate information, and education about the long-term implications of disease and illness;
4. Physical care, comfort, and the alleviation of pain;
5. Emotional support and alleviation of fears and anxiety;
6. Involvement of family and friends;
7. Transition and continuity from one locus of care to another;
8. Access to care.

Health services organizations that are adopting such health care guidelines hold no illusions that the financial returns on their investments of time, money, and consumer education efforts will be immediate. Rather, their vision of improved quality and care is of an evolving organizational culture that will focus on consumer needs and values over projected periods of 10 years or more. By redirecting efforts toward consumer-centered services, these health networks are fully expecting to meet the public's increasing need for health care and have a competitive advantage over other less consumer-friendly organizations. These networks also are expecting to invest in capital improvements, and believe their facilities and services will give them increased strength that ultimately will help them survive unforeseen business or financial circumstances.

Values-Focused Employment-Based Health Benefits

Health benefits are not "health services" as in provider networks, but "financial products" that are packaged and offered in a variety of arrangements. The *purchasers* of health benefit models are plan sponsors (employers, unions, government)—not consumers—and health benefits are structured under constraints determined as much or more by market forces as by consumer preferences. To be sure, many of the newer health benefits models are less structured and provide more choices—features that are preferred by many consumers. But they also require more engagement by workers in their own health coverage selection and in the health and personal financial outcomes they experience as a result.

This structured change means that more workers will be required to choose and manage the health care and financial details of their health benefits, as they increasingly are managing their self-directed retirement benefits. It also means that education about the finances of health coverage and care is needed in the same way that work place financial advice and education are needed to help workers save and invest for their future retirement income security.

Even the best employment-based health benefits package cannot produce behavioral change by itself. Benefits designers *can* help workers and their families become more activated health care consumers by discerning two overarching issues: (1) the importance of health care within people's perceptions of their entire life situation and (2) their need to be included in the employment-based health benefits conversation. In fact, a concerted effort between employers and workers can be considered a "heath-related call to social action" (Kolbe, 1988).

Cost shifting to workers *requires* that employers redefine their relationship with workers and become partners in health benefits and care management. Simply put, employers need workers and their families to become better consumers of health care—to take better care of themselves. Workers require better communication and improved decision support from employers. They need help with shopping for coverage and care, incentives for preventive care, wellness programs, and health literacy education within the context of general work-place financial education.

Values-Based Consumer Education in Health Benefits and Care

Prior research has demonstrated that synergistic programs (e.g., educating consumers simultaneously to be health conscious and to avoid unnecessary personal costs) work well when they are designed to tap into consumer values and motivations (Kolbe, 1988). Many participants in "best practices" employer-sponsored programs express gratitude to employers for teaching them the basics of financial management, including health financial planning. Unfortunately, health benefits and health care were found to be least well-covered (or least well-understood by workers) in work-place settings; yet no other subject could be more important to their future general well-being (Vitt et al., 2000; Vitt et al., 2005).

Having adequate health coverage is a basic requirement for financial and personal security for families and individuals today. But consumers also need in-depth, values-guided education about health care and health finances if they are to navigate the other financial aspects of their lives successfully.[11]

The mobilization of the public and private sectors to increase personal financial competence is creating a sense of increased self-efficacy for those few who are exposed to targeted values-based education. Many consumers, however, are unprepared for having even more financial responsibility shifted to them through the emerging models of health benefits and care. Moreover, they have few tools to navigate the complexities of a health care market that doesn't act like any consumer market with which they are familiar (Vitt et al., 2002).

Health care and coverage literacy are also essential if consumers are expected to assume the sort of responsibility being rapidly planned for them. Plan sponsors and care providers (aided by public policy initiatives) need to help consumers prepare for the knowledge levels and financial realities that await them by providing values-focused education at language and cultural levels that are appropriate (Vitt et al., 2000).[12]

What Is Health *Coverage* Literacy?

Health *care* literacy is the ability to obtain, process, and understand health information and the services needed to make appropriate decisions and follow instructions for treatment. Health *coverage* literacy is the ability to understand, manage, communicate clearly (and appeal) the health insurance reimbursement rules applicable to necessary care. It includes the ability to compare plan coverage with care alternatives to balance optimal quality with affordability.

Research has shown, however, that consumers often do *not* address health care in their budgeting or other financial planning. Many consumers do not know what type of health plan they are currently enrolled in, or the quality of health care to expect under the type of plan they have chosen. In addition, consumers are not knowledgeable about health benefits in general and health care costs in particular. They expect and accept not understanding health-related information, and they ignore what they don't understand (Vitt et al., 2002).

Consumer Financial Benefits Education

Activated health care consumers must be able to choose health coverage wisely and incorporate health care into saving goals, life events, and retirement planning. Otherwise, they are likely to be unprepared for possible financial upheaval in their lives if they remain unaware of, or indifferent to, the need for health care financial planning. They must be able to foresee and plan for the financial losses that can follow an injury or serious illness.

Unlike personal financial education, which is perceived as a means to a valued end—a better job, a home of one's own, a new business, retirement—health care financial issues are not positively correlated with rewards in the perceptions of consumers. In fact, they are often associated with personal and financial loss, hardship, and even bankruptcy (Warren, 2000). And if consumers do get caught in the financial quagmire that often follows a health-related calamity, the nation's bankruptcy system recently has become tougher (and more costly) for them to approach for a fresh start.[13]

The Conflation of Retirement Savings With Health Care Finances

The emergence of activated consumers in health care holds the promise—but not yet the reality—of a consumer-driven marketplace. Before consumers can successfully take on the responsibility for their own health coverage and care, however, they must be provided with the necessary financial and health literacy tools to help them address broader responsibilities and become knowledgeable savers, managers, consumers, and citizens. Health care does not exist in a vacuum for consumers; instead it is a complex and confusing aspect of daily financial reality, which employers and policymakers expect them to maneuver successfully.

The public and private sectors together during the past decade have mobilized to encourage consumer financial literacy at every life stage. Government, educators, businesses, trade associations, community groups, and coalitions representing all societal groups have created or supported financial literacy educational initiatives, campaigns, and public service announcements that encourage consumers to become more knowledgeable and make financially self-enhancing choices and decisions (Vitt et al., 2005). But consumers need the same targeted help with *health care* that they require in *personal finance* education.

The goal of financial educators and their sponsors is to encourage consumers to accept responsibility for their own well-being and future economic security, most notably retirement. The extent and importance of consumers' need for financial self-sufficiency illuminates very broad and complex issues of credit and debt, budgeting, saving and investment, asset accumulation, and managing shifting work-place values. To this should be added the health-related costs of sudden or chronic illness, disability, and normal aging (Vitt, 2003).

Summary and Discussion

Values-focused financial education that includes health coverage and care can help consumers adopt healthier behaviors, increase their access to coverage, enhance their ability to participate actively in patient-centered care, and raise their levels of understanding about health-related finances. Consumers are not knowledgeable about the varying costs of health care. They are not aware of the real cost of medication and services for which they make a "co-payment," nor do they think of countering a physician's determination that an MRI is needed with a suggestion that a lower-cost CT scan would save their insurance company (or themselves) money.

Consumers believe they have little standing in a health care world that has always been structured as "top down." They have not been taught to speak up to health care providers, to be partners in their own health coverage and care. Nor do they know what to expect in connection with the *finances* of health benefits or health care. This chasm needs to be bridged if the emerging health care system is to be successful, but doing so will require health benefits planners and health care providers to develop a much better understanding of what it is that consumers value and expect from their health care system.

When Americans know what is expected of them, and when they are given the tools and the opportunity to become successful at whatever they undertake, they accept—and even seek—responsibility. But having to assume more responsibility for selecting and paying higher health costs on top of self-directed retirement

models is catching many consumers by surprise. Moreover, the steady rise of health care costs over the longer term is widely perceived as out of their *power to control.*

The starting point is to change the dynamics that exist between the combined business interests that package and sell health benefits, employers, and their workers. While U.S. workers are increasingly expected to navigate their coverage "rules" and to judge the costs and economic value of the care they are being provided, the challenge they face is enormous. They must learn to:

- Prevent health problems by raising and living up to new personal health standards in a commercial marketplace they are expected—at the same time—*to resist.*
- Communicate more effectively with health professionals.
- Understand what evidenced-based medicine is and how to demand it.
- Help coordinate their own care in order to recognize and prevent medical errors.
- Comply with treatment protocols, yet recognize and complain when they do not work.

The challenge for business is no less daunting. The future of employment-based health care lies in innovation in prevention and the delivery of *high-value* coverage, care, and consumer financial education. Based on this review of current trends and the educational challenges that exist for employers, the following recommendations may be a useful guide for health benefit designers and business decision-makers that want consumers to adapt and the emerging health care system to succeed:

- Build a collaborative network comprised of stakeholders across businesses, government, labor unions, health professionals, researchers, and others committed to products and services that help consumers become knowledgeable and active health care purchasers.
- Create state-of-the-art health education and train-the-trainer programs in health care finances, and encourage top-down employer support for work-place wellness programs and effective disease management strategies.
- Convince workers that they matter in decisions affecting their own well-being and health care.
- Maintain a basic respect for people and understand the values that drive individuals' health-affecting decisions and behavior.
- Provide aggressive help to those who cannot help themselves.

The success of an employment-based health care system that is realigned with the personal values of consumers depends increasingly upon spearheading work-place awareness of the issues; heightened sensitivity to the personal and financial chaos awaiting anyone who is not knowledgeable about combined health care and retirement issues in later life; and broadened educational offerings and other tools based on researched links between what consumers value and what employers want them to know and value.

The stakes are high. As Keeney (1992) notes, even the desirability of pure objectivity in health care or detachment as an ideal for financial reasons is highly questionable: "A health care system dominated by Dr. Strangelove and like-minded cost accountants may become devoid of acts of affection, conscience, compassion and humanity."

Consumer values can provide essential insights into consumer thinking about health-related behaviors and financial decision-making. They also can provide a blueprint for health care businesses and policymakers working to make the U.S. health care system more responsive to consumers. Should health education initiatives prove ineffective, the "consumer-driven health movement" could well be doomed, especially if it relies upon fully educated health consumers taking self-initiated actions. The perceived ineffectiveness of education in 401(k) plans resulted in legislation to add "defaults" to these plans so that they no longer relied upon positive employee action. In the health arena, the default approach is exactly what the consumer-driven health model seeks to move away from.

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Endnotes

[1] See DiCenzo (2007).

[2] Testimony by Kenneth Olden, then-director of the National Institute of Environmental Health Sciences, National Institutes of Health, before the Senate Subcommittee on Public Health, Committee on Health, Education, Labor, and Pensions, March 6, 2002.

[3] These include:

- About 22 percent of Americans age 18 and older suffer from mental disorders that interfere with their productivity and can lead to disability and death (AHRQ, 2002).
- There are 20.8 million children and adults in the United States., or 7 percent of the population, who have diabetes. While an estimated 14.6 million have been diagnosed, 6.2 million people (or nearly one-third) are unaware that they have the disease (CDC, 2005).
- In 2004, an estimated 6.2 million children younger than age 18 had asthma, of which 4 million suffered from an asthma attack or episode in 2004 (NCHS, 2004).
- In 2007, the Centers for Disease Control reported that 1 in every 150 children is diagnosed with autism.
- Overall, 62 percent of adults 18 years of age and over never engage in any periods of vigorous leisure-time physical activity lasting 10 minutes or more per week (NCHS, 2006).
- Arthritis and other rheumatic conditions affect approximately 46 million adults in the United States, resulting in substantial disability and costs of $128 billion annually (CDC, 2006).
- In 2005, 49 percent of adults 18 years of age and over were current regular drinkers and 21 percent of adults 18 years of age and over were current cigarette smokers (NCHS, 2006).
- Up to 25 percent of women have experienced domestic violence in their lifetime, resulting in immediate injury and/or long-term chronic medical conditions such as depression (AHRQ, 2002).
- In 2005, one state—Pennsylvania—reported 19,154 cases of hospital-acquired infections, generating 400,000 additional patient days in the hospital and $3.5 billion in charges (Sack, 2007).

[4] While it is important to provide benefits and other health information, having the facts—even those that relate directly to one's personal situation—can be surprisingly insufficient to change behavior. Some individuals find health behaviors impossible to change, even when told that not altering a life habit may be a matter of life and death (Deutschman, 2005).

Most benefits vendors, health professionals, and educators rely on disciplined, analytical thinking and training to influence behavioral change. As health researchers discovered over many years, *cognitive* studies designed to change human values had limited effect on the habituated behaviors they were hoping to change (Smith, 2002). Often, the research or educational approach assumes that consumers *know what they want and will make self-interested decisions based on the evidence.*

The challenge for health and financial educators and others hoping to promote self-enhancing health behaviors is nothing less than helping people make transparent their underlying worldview, and in the process, possibly changing that worldview. For lasting behavioral change to happen, people need to experience change at deeper levels while coming to understand their behavior in relation to self and society. They must bring into their awareness embedded values, which are formed not only in psychological but also in social and cultural contexts. The process involves

tapping into "soft" or inner dimensions where perceptions, feelings, and emotions shaped people's values formations in the first place (Kotter, 2003).

[5] "Health is very important, but…if I had perfect health and yet did not contribute to my strategic objectives, I would be exactly the same as a healthy tree. This clarified my thinking and I realized that health is a means to me." (Keeney, 1992.)

[6] Deliberative personal valuing and health care decision-making is also linked in the literature to end-of-life treatment decisions (Abood and Conway, 1992; Howard et al., 2000; Karel, 2000; Kelly et al., 1996; Smith and Wallston, 1992). Even elders with cognitive impairments that limit other decision-making abilities have been able to express deeply held values (Karel, 2000). Other research finds that consumers apply health care decisions inconsistently (Irwin and Baron, 2001); they make different value decisions in public vs. private contexts (Pauly, 2001); and they behave unpredictably when values, such as available care and cost, conflict (Irwin and Baron, 2001).

[7] Different life domains contribute unequally under varying conditions to general well-being, and the kind, quality, and measures of domain evaluations that optimally explain well-being have been the subject of much research. General well-being is also influenced by demographic characteristics of individuals within study populations (e.g., George et al., 1985; Vermunt, et al., 1989) and by people's financial status (George, 1992; Vitt 1993). Life domains are especially useful to organize, guide, and analyze research about human values that affect health-related beliefs, attitudes, decisions, and, ultimately, their actions or inaction (Karel, 2000).

[8] Market researchers have long known that consumer values inform the process of purchase decisions. Companies invest heavily in research that examines consumers' lifestyle patterns, spending habits, and their purchases of services and products. Results are aggregated and used to target segmented markets with savvy advertising that taps right into what consumers at various ages and life stages are known to value.

[9] "Values are like the hub of a wheel and behaviors are like the spokes. Just as all spokes originate from a hub, behaviors originate from values" (Beller, Weiss, and Palter, 2005).

[10] One hundred and fifty-three people participated in workshops held in 10 geographic locations: Jackson, MS; Maui, HI; Braddock, PA; LaTrobe, PA; South Bend, In; Cleveland, OH; Philadelphia, PA; Tampa, FL; Ava, MO; and London, UK. Data about care experiences and health-related decisions were collected during paired interviews.

[11] Like the education now in progress in some hospital settings and other provider networks, employers could help to sow the seeds of "an epidemic of health" (Tom Munnecke, 1999) by offering values-based employer-sponsored health education in conjunction with a health benefits plan that:

- Taps into what consumers value.
- Is bottom-up as well as top-down.
- Is clear and respectful.
- Is motivating and empowering.
- Rewards both its sponsors and consumers.

[12] See *Personal Finance and the Rush to Competence: Financial Literacy Education in the United States*, available at http://isfs.org for a discussion of the seven dimensions of effective personal financial literacy education programs.

[13] For long-term cancer patients, even those who have health care coverage, the inadequacy of health care coverage without additional financial resources to fall back on is well known (Houts et al.,1984; Nielsen and Mayer, 2000): "The best health insurance policy in the world doesn't pay all the expenses associated with a fight with cancer!" (Nielsen and Mayer, 2000).

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