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Perceptions of the healthcare system among stakeholders

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Abstract

The U.S. healthcare system is rife with complexities and is consistently a source of political debate. One's interaction with the system may directly impact the understanding of the system. The objective of this research is to examine the perceptions of the United States healthcare system from the viewpoint of healthcare providers, insurers, and consumers. Using a grounded theory approach, theoretical sampling was used to explore similarities and differences between the three groups of actors in the healthcare system. Data were collected through interviews with thirty-one participants using a semi-structured interview schedule. Themes of cost, access, and inefficiency emerged from the data. The theme of cost included the ability to pay, innovative care delivery, and relation to access. Access included the need for guidance, geographical proximity to healthcare, and socioeconomic status. The theme of inefficiency included how insurance dictates care, and the unwieldy system. Similarities among groups were the high cost of care, ability to pay, and complexity. Differences discovered were the insurers' dual role as professional and consumer, providers' informal access to care, and differing views on who is to blame for the high cost of healthcare. This research unveils perspectives of three stakeholders of actors in the healthcare system, providing a foundation for further research to better understand these perspectives in improving equity and access in healthcare.

Keywords

Qualitative methods, perceptions of healthcare, health policy, grounded theory, patient experience

Introduction

Perceptions of the healthcare system are sought by healthcare providers to effectively deliver care, by health insurers to efficiently compensate for care, and by policymakers to ensure concepts of quality and access are adequately defined.[1,2] With a growing volume of the working population employed in healthcare,[3] it is necessary to determine the commonalities and differences in perceptions of healthcare system from those providing healthcare, insuring care, and receiving care.

Qualitative research has examined perspectives of consumers, providers, and/or insurers (i.e., those who work for insurance companies).[4-10] While several studies have examined ~~studied~~ facilitating and inhibiting factors to accessing care,[4-6] one focused on general perceptions of the healthcare system. Within this population of consumers, the subjects' age and place of dwelling affected their perceptions of the Israeli healthcare system.[7] Other studies have compared findings across more than one of these groups. Two studies have compared the perceptions of providers and insurers.[8,9] In examining facilitating and inhibiting factors of hypertensive care in Nigeria, similar system wide issues were identified by both groups.[8] In an

analysis of a U.S. state-wide grant program for care coordination of patients with depression, providers, insurers, and administrators valued coordination of care along with workforce training and cost containment.[9] The only known qualitative study comparing all three groups of consumers, providers, and insurers was an analysis of the perceptions of user fees in the Hungarian health system. While the authors chose to include policy makers in the group with insurers, several categories under the theme of healthcare utilization were identified as common across all three groups.[10]

While these studies represent important advances to understanding the perceptions of healthcare from various actors, no single research study examines system-wide issues from the perspective of consumers, providers, and insurers. The aim of this study was to examine the perceptions of the U.S. healthcare system from the viewpoint of healthcare providers, insurers, and consumers. We define "healthcare system" as the ecosystem in which patients, providers, and insurers interact to receive, provide, and facilitate healthcare services. This study serves to inform researchers, practitioners, and policymakers on the perceptions of the healthcare system among three groups.

Methods

This paper used a grounded theory approach to explore the similarities and differences among three groups of stakeholders. This approach focuses on theoretical sampling and emerging categories.[11-13] The use of theoretical sampling allowed concepts to be explored and developed throughout the data collection process. The emphasis on emerging categories comes from the use of a constructivist approach to grounded theory, where the unique context of the subject's responses shape and clarify the resulting themes and categories.[11]

This study was conducted with thirty-one participants including nine healthcare providers, eight insurers, and fourteen consumers. Providers were defined as those delivering care in the health setting. Insurers were subjects who worked for public or private insurance companies. Consumers were those who were unemployed or employed outside of the health and insurance settings. Participants included males and females from different countries of origin with education levels ranging from high school to graduate degrees, and who carried different types of health insurance (Table 1). (As data collection progressed, we included perspectives of research participants originating from and/or living in different

Table 1. Demographic Characteristics

Profile	Participants (n)
Gender	
Female	16
Male	15
Role in Healthcare	
Insurer	8
Provider	9
Consumer	14
Country of Origin*	
United States	18
Foreign-born	13
Level of Education	
High school	3
Some college	2
College	5
Graduate degree	19
Unknown	2

* The countries of foreign-born subjects include China, Germany, Iran, Canada, Mexico, Pakistan, South Korea, Sudan, and Taiwan

countries. This variety enriched our data as participants with experience in other healthcare systems contributed striking observations of that of the U.S.) The specific roles in healthcare and countries of origin varied widely among the participants, and as such this study is not intended to

be comprehensive of all roles in healthcare or of the countries represented.

Ethical approval was received from Institutional Review Board at Saint Louis University prior to participant recruitment. Individuals were sent a letter of invitation via e-mail to participate in the study with informed, verbal consent received by each individual who agreed to participate. Participants were recruited through convenience and snowball sampling based on the principle of theoretical sampling unique to a grounded theory approach. Convenience sampling included friends, colleagues, and family members who were willing to participate and fit within one of the three categories. Snowball sampling included these initial participants providing names of friends or colleagues whom they deemed to be willing participants and who were considered by the authors to fill the subject groups. The combination of sampling methods and researchers from one institution likely led to a majority of the subjects being highly educated (Table 1). Subjects were categorized using a stratified and quasi-variational maximization sampling method.

Data were collected using semi-structured interviews that generally followed a schedule of questions pertaining to the healthcare system and to health insurance (see Appendix). The group of insurers were also asked about health insurance companies and their role in the healthcare system. The interviewer asked subsequent questions to allow for elaboration or clarification on a specific piece of data. This contextual aspect of grounded theory speaks to the unique perspective of healthcare that cannot be captured by a standardized interview schedule.[11]

Interviews were recorded on digital recorders and performed in person, over the web, or by phone. Three sets of interview schedules were prepared for healthcare providers, insurers, and healthcare consumers. The interview questions were open-ended and were designed to capture attitudes about the healthcare system in the U.S., compared to other countries when the interviewers were foreign-born, and personal experiences with the healthcare system in the U.S. Participants were encouraged to add anything else to the interview they felt was relevant. Interviews were conducted in English, Chinese, Spanish, and German by native-speaker interviewers. All non-English interviews were translated to English by the interviewer. Notes and memos were taken following each interview to provide additional observations made during the interview. Following interviews, each interview was transcribed verbatim by the interviewer.

Data were analyzed and categorized using the constant comparative method during open, axial, and selective coding.[12] Open coding was conducted by thorough, iterative readings of the interviews, line-by-line analysis,

and conceptual ordering of the data into discrete concepts based on their properties and dimensions by the interviewer. In axial coding, these concepts were further developed and clustered through interpreted relationships and categories. When applicable, in vivo coding was used to represent the data more accurately. Finally, through selective coding, these concepts were integrated around core categories to form and refine the theoretical framework. Themes were then derived out of core categories.

A consensus was reached at the formation of the categories and of the themes among the authors. Agreement was also reached on the commonalities and discrepancies among the three groups of participants. When the data were examined for similarities and differences among the three groups of participants, context was considered by the authors to understand the intent of the participants.[11]

Results

Positive and Negative Attributes of the U.S. Healthcare System

Across all groups of participants, eight categories emerged that are organized under three major themes: cost, access, and inefficiency (Figure 1).
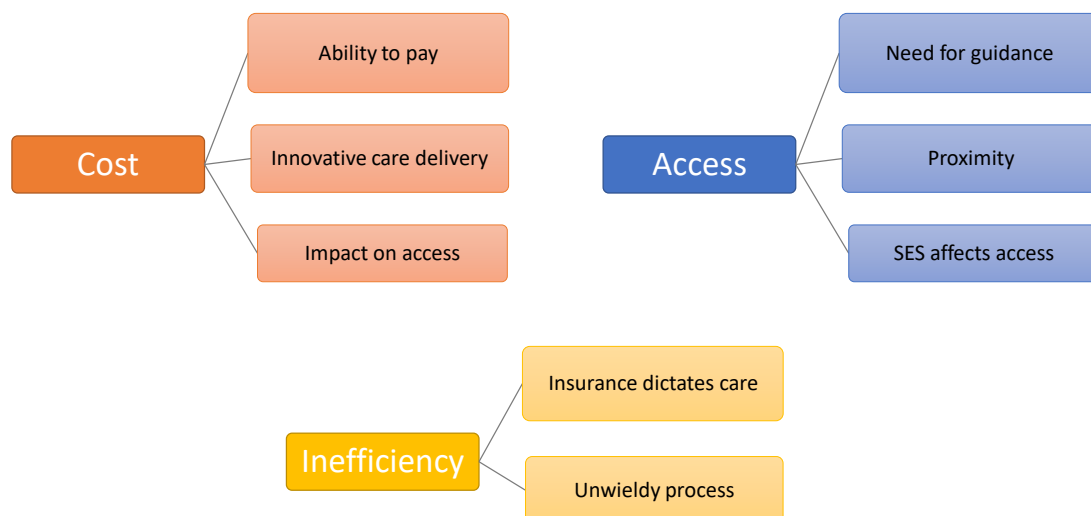
Cost

The theme of cost included three categories: ability to pay, innovative care delivery, and relation to access (Figure 1).

The consumer's ability to pay relates to the affordability of care. An insurer said the following of private insurance:

So many people have these huge deductibles that, that's the only way they, that's the only thing they have available to them, but yet they don't have those, that savings, to cover something, a three-thousand-dollar deductible, a three-thousand-dollar hospital bill. And then, you know, once you hit the deductible, you're still having to pay either, sometimes thirty percent, more often than not twenty percent, or sometimes ten percent.

One factor contributing to cost is the introduction of innovative models of care delivery. In an industry that relies on the private market for much of the funding and delivery of healthcare services, new delivery methods and services come at an expense, ultimately, to the consumer. These methods can be positive according to one insurer, with "telemedicine where you can interface with a doctor over FaceTime or WebEx or Skype. And you don't have to go to the doctor's office." Strides like these can improve healthcare by lowering the cost of delivery. Another insurer mentioned, "I think also our upside is advances in medicine that we're making whether it is on the pharmaceutical side or the (durable medical equipment) side or research side. I do think we are moving in the right direction." Insurers have found innovative ways to provide coverage, thus reducing cost. As a private insurer said, "I was just in a meeting among benefits council meeting and uh we meet monthly, and we saved…by having a certain amount of people leave our plan because their spouses had

Figure 1. Three Themes and Associated Categories

coverage at their place of employment…We saved about one million dollars in claims."

The last category relates to how cost affects access. A healthcare provider stated, "With Medicaid…if you're not happy with the services you're provided you're kind of stuck. You don't have a lot of options unless you want to pay out-of-pocket or do a sliding scale fee. So, um, it's nice for them that they have now limited, little to no cost for their services but it's a negative because if they don't like what they are getting they're kind of out of luck." With little to no option available for a specific provider, the choices are limited due to one's ability to pay. Even those who subscribe to what some perceive as good insurance can experience less access to care if a procedure is not covered or a provider is out of network. If the cost of the procedure exceeds the ability of the patient to pay, then the patient's only option may be to forgo the surgery. In this case, the access to treatment options is now lowered based on the cost. The categories of ability to pay, innovative models of care, and access are closely intertwined in their relation to cost.

Access
The theme of access includes three categories: need for guidance, geographical proximity, and the impact of socioeconomic status (SES). The complexity of the healthcare system can limit the beneficiary's knowledge of the options available in choosing the best health insurance policy. For example, a consumer who recently enrolled in Medicare said, "Because it's just…it's complicated and there are a lot of options and you really, you almost need a, a mentor to get you through (laughs), you know, to get you where you want to be." A healthcare provider with private insurance noted, "Things should be easier for people to see a doctor. Like, we should be able to see a doctor whenever we need it. We don't have to check, you know, if this is in network or if this is out of network when an emergency happens."

Yet, some Medicare beneficiaries have realized the simplicity compared to other insurance providers and relate this to the programs and resources in place to help beneficiaries understand the network. A Medicare beneficiary said the following:

> Well, I have Medicare and I'm very satisfied with it, and the reasons for that are that it's…in my opinion, it's been pretty simple to uh, go through the process of getting what was right for me. Now I did go to…there's information that's put out by, by the Medicare administration online. And in Columbus they held, there have been…presentations where you can learn more about you know Medicare, particularly as you're just getting of

age, so that, so that you can kind of know if you're in the right direction.

Access can be limited by the geographical proximity of the consumer to the provider. Some participants indicated that both rural and some urban environments have limited access to primary care, such as the physical location of the consumer to the provider, transportation, or the means to be seen in a timely manner.

The SES of the individual can determine access to healthcare. In the eyes of a healthcare provider, "I used to do medical social work once upon a time and I worked in the hospitals. And at that time, if a person didn't have any insurance basically what the hospital did then is they would barely stabilize them and they'll either transfer them to another hospital, or they'll kick them out the door. And so, there's this huge gap for people that don't have any insurance." This implies that because of the lack of resources or, presumably, the social status, the patient would not receive access to the care that was available. This lack of access is felt from the side of the consumer, as well. One consumer stated, "Well I was lucky to be covered under my father's job's benefits until the age of 26. After turning 26, I lost all of those benefits. And it was my dad has a job, so I had good benefits at the time, and healthcare was working for me great then. But, all of a sudden, now that I have no insurance because I, I work for a contractor, so I'm uninsured because I'm, I'm unable to pay you know money for going to doctors. So, I just patch myself up and keep on working."

This determinant of healthcare is felt across other classes, including those with private insurance benefits. A consumer with private insurance benefits said, "If you can afford it, you can have access to [quality care]. If you do not have those resources, you will not have that access. Or you will have that access at the price of future servitude to your own debt."

Admittedly, there is a close relationship between the category of access that exists under cost and the category of SES that exists under access. In the theme of cost, the cost of insurance and of the provision of services can impact one's ability to access healthcare. The focus is primarily on the financial impact of the services provided and how it affects the patient monetarily. Comparatively, the category of SES here includes not only one's income, but also the social class, race, ethnicity, and perceived ability to pay.

This category is distinct from the theme of cost and its impact on access. Under the theme of cost, the cost of insurance and of the provision of services can impact one's ability to access healthcare. It focuses primarily on the financial impact of the services provided and how it affects the patient monetarily. Comparatively, the theme of

access includes a category of SES, which considers not only one's income, but also the social class, race, ethnicity, and perceived ability to pay [14]. While these two categories of different themes are not mutually exclusive, it is to be noted they have unique connotations.

Inefficiency

The theme of inefficiency includes two categories: insurance dictates care, and the system is unwieldy. The perception that insurance determines where and what care one receives can be summarized by a healthcare provider recalling a recent episode (as a privately insured consumer) with a spouse:

> So…last year there was one night that my husband, he had severe stomachache and then we were like, oh my god, what should we do? … And then if I were in Taiwan, the first thing I would do is just drive him to emer, ER, and then we would see a doctor. But then last year, when that happened, the first thing we did was just to check up our policy plan and see, oh my god, if our plan covers ER, if our plan covers this hospital, stuff like that, so I'm just like so frustrated about that because I feel like he should get the care that he needed as soon as possible, rather than spending time to see where we can go and if we go to that ER.

Another healthcare provider finds the patient frequently receives care as determined by the insurance company rather than by the provider. "Unfortunately, sometimes, patients plan of care can be affected by their insurance either less frequent visits when they need more visits, or the opposite way where visits are over-utilized because they have good healthcare."

In describing the unwieldy process of the healthcare system, the subjects pointed to the care itself, the insurance system, and sometimes both. In describing the cumbersome nature of care delivery, an uninsured consumer said, "Well a negative aspect I've seen when I go to the emergency room, um, it will take forever, um, for me to see a doctor. [...] It's just the process, uh, it takes forever sometimes." A research assistant with private insurance notices that "you go to the primary physician, then they refer you to a doctor again. If you want to see a primary care physician, it takes a week or two. Again, you need to make an appoint (with a) doctor with specialty and that takes a month or two."

Similarities among the Three Stakeholders

Several similarities among healthcare providers, insurers, and consumers arose. First, all groups acknowledged that the cost of healthcare and the ability to pay were key concepts within healthcare. Many consumers expressed the high cost of healthcare as a negative aspect, and that

healthcare should be more affordable. For example, one stated that "…I think it's too expensive and also it seems… well when it comes to medicine, it is very good but it doesn't seem equal because the people, the people that work not all of them have access to the healthcare system especially when they have a certain salary." Similarly, providers acknowledged that in order to thoroughly access healthcare, consumers must be able to afford the costs and/or budget strategically. According to one, "…without those plans [Medicaid/Medicare] some of these individuals would not have been able to get the procedure needed or afford the medication to help cure an illness or at least reduce the symptoms that may be getting into the way of their everyday normal functioning." This shared acknowledgement of the high cost of care led members of each group to describe ways in which healthcare is a human right. In this context, one healthcare provider expressed a desire for universal healthcare. "Healthcare is a right like education is a right. We educate everyone in this country, why do we not provide healthcare for everybody in this country?"

Another shared theme among all groups was the complexity of the healthcare process. Consumers typically described this complexity in terms of understanding billing, knowing how to access care, and general knowledge about their coverage. One consumer laughed when mentioning the need for a "mentor" to navigate the system. Providers and insurers also face issues with navigating a complex system both on behalf of their patients and for themselves as providers. A social worker described the willingness of her hospital to expedite the discharge of patients with little to no insurance coverage. Healthcare providers described this complexity specifically in terms of managing changing plans and insurance rules and regulations. One provider detailed, "…one of the challenges is they're always changing, and they're different with each health insurance company. And every health insurance company, different among the plans. So being able to stay on top of each insurances' unique characteristics and requests…" Insurers also face unique complexities as illustrated by one, "…You know, the hoops they make you jump through, the way that the billing, you know, something's billed in a wrong code, so it gets denied. So, you have to spend six hours with not only the insurance company, but then the provider who billed."

Despite the challenges, another shared theme was the perception of high quality of care in the U.S. All groups expressed that despite shared complaints about the high cost of healthcare in the U.S., a positive was the high level of care provided if accessed. A healthcare provider shared, "…we do have one of the leading medical research, um, pharmaceuticals in the world, you can come to this country, and if you have health insurance and have wherewithal, you can have an astounding number of procedures, or um just be in an incredible position to get

all of the top-notch research you possibly can and, um, care."

Differences among the Stakeholders

Despite these commonalities, several distinctions among the groups also emerged. One such dynamic was notable among the insurers group involving their dual role as both insurer and health insurance consumer. As expressed by one insurer, "...there's two different sides...there's my broker consultant side and then there's my individual who has a family, who needs health insurance side." Another expressed a similar conflict stating, "I wish healthcare and healthcare systems weren't so driven by insurance companies or pharmaceuticals. A lot of the […] decisions we make within the hospital that affect the community on how we can provide care stems from what insurance is within network..." This respondent further described, "...a lot of it has to do with numbers and who can make the most money […] and so I think a lot of times when we talk about the culture of healthcare, we lose that human element."

Another distinction was observed among the providers who expressed possessing more advantageous access to healthcare by proximity to other physicians. For example, a provider stated, "…because I am constantly around doctors, I am fortunate enough to just have a colleague or a friend look at my symptoms and then I am able to go out and secure remedies that may help." This leads to a more privileged double role for providers accessing the system. Similar to insurers, they have two vantage points; however, providers can use this access to either self-treat or seek the assistance of colleagues.

One final difference involves where blame is placed for high costs. While these perspectives are not necessarily in opposition, there is variance in how they are expressed. An insurer said, "…because health insurance is so expensive, um, for-profit corporations are putting the cost more and more on the employee." However, from one consumer's perspective, providers are more responsible stating "…but you look at the providers and they are going to go where they can make the most money." This addresses the struggle to identify the source of the problem in the high cost of healthcare and the varying attributions that the different stakeholder groups make regarding these costs.

Discussion

The results showed three major themes emerged from the data: cost, access, and inefficiency. These findings are consistent with Andersen's behavioral model of health services, highlighting contextual and individual factors that affect access. Specifically, our data emphasize the importance of the enabling characteristics of financing and organization in this model.[15]

The elevated cost of healthcare in the U.S.—16.9% of GDP, compared to an average of 8.8% among the 37 countries in the Organisation for Economic Co-operation and Development[16]—is not new[17] and has been reported as a barrier to access.[18] This rising cost leads to inequalities in access and outcomes among Americans,[19] leading several authors to promote universal coverage of healthcare.[19,20]

The theme of access echoes the findings of Brems et al.[21] as a barrier to care. While our study did not distinguish urban versus rural settings, these authors identified service access as more problematic in rural settings that is affected by limited resources and providers having to travel to remote communities by a variety of modes of transportation.[21] In a study of barriers to access among immigrants, Sangaramoorthy and Guavara used in depth interviewing of healthcare providers as well as immigrant consumers. Their grounded theory approach to data analysis resulted in emerging themes that occasionally differed in perspective between the two groups.[22]

The inefficiency described in this study refers to the complexity of the system, similar to Andersen's contextual enabling characteristics of the organization.[15] This study expounded on this concept further by identifying the ability of third-party payers to dictate care. Through provider networks and utilization management, care is frequently regulated to varying degrees by the insurance provider.

Commonalities among the three groups of respondents were the topics of elevated cost and the high quality of healthcare. While the groups shared the view of complexity, the respondents varied based on how they participated in the system. Consumers focused on the confusing organization of choosing providers and insurances; whereas providers spoke to the obstacles in getting care approved and reimbursed.

Relative to the three themes, a difference among the groups is in where to lay blame for the elevated cost. Healthcare spending per capita in the U.S. is approximately twice the OECD median despite providing fewer resources,[23,24] with administrative costs being a likely contributer.[25] This characteristic was noted in among the providers in our data, but not shared by the consumers. Further research should explore the difference of responsibility for cost.

Other key differences found in this study are the dual role that providers and insurers play in healthcare. While they are receiving care as consumers, they also have firsthand knowledge of what occurs behind the curtain that lay people may not appreciate. Also, providers have a different form of access to healthcare. They may treat themselves with simple, conservative means, thus giving

them easier access. Similarly, the network of providers can lead to collaboration by seeking advice from their colleagues. The result of any of these scenarios can impact the healthcare system by affecting the workload of providers. Further research should examine the impact of this dual role in relation to the quality of care being delivered.

Limitations and Conclusion

This study used a grounded theory approach following the coding format set by Corbin and Strauss,[12] often seen either as a blend between post-positivism and constructivism[26] or leaning more towards objectivity[11]. A methodology more aligned with a constructivist approach[11] would include a deeper dive into certain data to know experiences of participants. In exploring the category of proximity in the theme access, for example, a more constructivist approach would allow the researcher to search for "tacit meanings about values, benefits, and ideologies."[26] This may include more probing questions about this theme, perhaps in subsequent interviews.

While our study used a novel sample to identify of perceptions of the healthcare system, we used a convenience sample comprised of primarily highly educated individuals in urban settings. Research in this area would benefit from reaching consumers from a variety of demographics, SES and settings,[21] as the representation of subjects with no insurance or less comprehensive plans is larger than our sampling.

The literature involving the perspective of the health insurers is limited. While we have attempted to bring them into the conversation, expanding the sample of insurers from various levels of leadership and responsibility may provide additional insights that our current sample did not allow.

Although the importance of patient satisfaction and other healthcare outcomes is well documented, no known research has evaluated the perceptions of healthcare by consumers, providers, and insurers. With 14% of the total employment in the U.S. being in the healthcare occupation,[27] research that studies the perceptions of the healthcare system should consider how stakeholders interact with the healthcare system, either directly or indirectly. The differences in perspectives among populations could provide more understanding of achieving equity and equality in healthcare.

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Appendix – Interview Schedule

About Health-Care system

1. What are positive and negative aspects of health-care system of this country?

2. Tell me a story when you felt that the health-care system of this country worked well.

3. Tell me a story when you felt that the health-care system of this country needed to change. (follow-up with a question; how do you think the system should be changed?)

4. If a person is an immigrant, add the following question; How do you compare the health-care system of this country with the one in your country?

About Health Insurance

1. How are you satisfied with your health insurance policy?

2. What are the positive and negative aspects of your health insurance policy?

    a) What type of health insurance do you have (from the workplace, from the government, including Medicaid, Medicare, Military-related, etc.)
    b) May I ask the premium, deductible amount, and out of pocket?

3. If a person does not have a health insurance, ask why he/she does not have one.

4. If a person is a health care provider, ask "what are major challenges in terms of health insurance policy as a health care provide?"

5. What is your opinion about national health insurance that other advanced countries have, such as Canada, France, Germany, England, Italy, and Japan.