



CALIFORNIA
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Consumers and Health Care Quality Information: Need, Availability, Utility

The Quality Initiative

Prepared by RAND Health
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Consumers and Health Care Quality Information: Need, Availability, Utility

Prepared for the
CALIFORNIA HEALTHCARE FOUNDATION'S
QUALITY INITIATIVE

By RAND Health

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The **California HealthCare Foundation** (CHCF), a private philanthropy based in Oakland, California, focuses on critical issues confronting a changing health care marketplace by supporting innovative research, developing model programs, and initiating meaningful policy recommendations. Additional copies of this and other publications can be obtained by calling 1-888-430-2423 or visiting us online (www.chcf.org).

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Foreword

In disseminating this report, the Quality Initiative hopes to provide guidance to all those who are engaged in the process of providing health information to consumers, or who are interested in learning more about how consumers make their health care choices.

THE CALIFORNIA HEALTHCARE FOUNDATION'S mission is to expand access to affordable, quality health care for under-served individuals and communities, and to promote fundamental improvements in the health status of the people of California. Accordingly, in 1998 CHCF created the Quality Initiative (QI) to work towards improving the quality of medical care for all Californians through public reporting of comparative performance data and support for accountability and quality improvement efforts.

Why is the quality effort so important? Providers of health services have been historically removed from direct accountability to consumer preferences for a number of reasons. These reasons can be briefly described as (1) *the knowledge gap*—medicine is a highly technical endeavor and impossible for the layperson to adequately evaluate; (2) *the payment gap*—services are usually purchased on behalf of individuals by organizations such as the government or employers; and (3) *the culture gap*—a collectively learned willingness to defer to the authority of medical professionals or to the system itself. The understanding that such accountability cannot be simply taken for granted (as it would in a normal marketplace for goods and services) defines a core challenge for health care: How can the delivery of health services be made accountable to the needs and desires of those who receive and, ultimately, pay for it?

Although purchasing health services will never be as straightforward as purchasing a toaster, the Quality Initiative believes that it is possible to develop valid comparative information about health care and to stimulate consumer demand for and use of this information. Greater use of better information will lead to better health care purchasing decisions, which will in turn, encourage greater accountability on the part of providers.

In order to move in these directions, the Quality Initiative first needed to obtain a detailed view of the present attitudes and opinions of consumers regarding health care. Are consumers concerned about health care? Are they experiencing difficulty in choosing health plans or physicians or deciding upon treatment options? Are there good, available sources of information out there? Who do consumers trust to give them advice about health care?

This survey, the largest of its kind, was conducted by RAND between November 1999 and January 2000 and provided the Quality Initiative with important insight about the answers to these critical questions. The survey sampled over 4,000 Californians, and in addition, allowed a close up view of difficult to reach and traditionally under-served populations: the elderly, the chronically ill, the uninsured, low-income populations, and Hispanics. To the extent more recent national surveys of quality awareness among consumers have tracked movement in public opinion, the public appears to be even more aware of and concerned about quality, perhaps as a result of extensive news media coverage of the Institute of Medicine's findings on medical errors, than when this survey was conducted.

This survey has been of enormous value in helping shape the ongoing grant making and consumer-oriented activities of the Quality Initiative. For example, nearly half of the consumers surveyed felt that they sometimes or never had the right information on which to make choices about insurance plans, providers, and treatment options. QI staff agreed that the existing sources of information were inadequate and were able to identify gaps in the quality information currently available and to support the development of new measures of quality and new measurement initiatives to fill those gaps.

QI grants were made to improve the supply of salient, standardized, and comparative quality of care information. These projects and their intended impacts include:

- ***Patients' Evaluation of Performance in California (PEP-C)***. Some 113 hospitals participated in the first-ever release of California patient experience data on medical, surgical, and maternity care.
- ***CHCF/Consumers Union Guide to Medicare HMOs***. California county-specific data is now available on Medicare+Choice plans.
- ***California Nursing Home Consumer Information System***. The first-ever public report of validated indicators of quality of skilled nursing facilities.
- ***Translation of the Consumer Assessment of Health Plans Survey (CAHPS)***. CAHPS instrument is now available in Spanish, Vietnamese, Chinese, Khmer, and Korean; translations are in use by both Medicaid and SCHIP state agencies.

The survey and the focus groups done in support of this report continue to inform QI's approach to packaging and disseminating information in a way that targets and is sensitive to the needs of those who seem to have the most difficulty locating information. (Focus groups were conducted several months prior to the survey to help design this study. The complete report, *California Consumers Talk about Health Care Quality: Findings from Focus Group Discussions*, can be obtained at www.chcf.org or by calling 1-888-430-2423.)

A key finding of the survey is that consumers tend to trust consumer organizations and family and friends as sources of information about health care quality more than they trust reports by health plans or by government agencies. Accordingly, in 2001 the Quality Initiative commissioned the following projects and partnerships targeted to informing the public:

- Eight consumer/patient groups were funded to carry out quality projects and mobilize their constituencies to address health care quality issues. Through partnerships with patient/consumer groups, employers, unions and other intermediaries, QI is building the trusted resources through which successive waves of quality information will be channeled to stimulate and sustain health care consumerism.
- QI partnered with the Consumers Union to release the first ever county-by-county comparison of Medicare HMO plans.

In disseminating this report, the Quality Initiative hopes to provide guidance to all those who are engaged in the process of providing health information to consumers, or who are interested in learning more about how consumers make their health care choices.

Overview

People over age 55, Spanish- and English-speaking Hispanics, people with less than a high school education, and people who rate their health as fair or poor have a great need for information about health care but face greater than normal barriers to obtaining it.

HEALTH CARE IS BOTH AN IMPORTANT PERSONAL concern and a major consumer purchase. While decisions about purchasing health care are made by government policy-makers, insurance companies, and employers, many of the most important choices are made by individuals for themselves and their family members based on the information they have available to them. But how good is that information? Where does it come from? What information sources do consumers trust? Are there subgroups of the population that have particular needs or wishes for information?

In this report, we describe the needs for health information among California consumers as a group and focus on a few special populations—people over age 55, Spanish- and English-speaking people who describe themselves as Hispanics, people with less than a high school education, and people who rate their health as fair or poor. We selected these groups because we think their need for information about health care is great and their barriers to obtaining information may be greater than the population as a whole. While there is obviously overlap among these groups, throughout this report we call attention to important differences among the groups in order to provide guidance to people with an interest in these under-served populations.

Making Choices

California consumers in this survey perceive health care to be very important and, for most people, it is the issue most likely to be rated as a big concern. However, for people who have many other economic and social pressures in their lives, such as Spanish-speaking Hispanics, health and health care rank below care of family and safety from crime.

While a small majority of people report no difficulty making choices about health care, a quarter report moderate or extreme difficulty. People who are in poor health report the most difficulty making health care choices.

Consumers make their choices about health and health care without the information they need. Only a third have the right kind of information all of the time and 40 percent have it only some of the time or none of the time. The information deficit is greatest for people who have low levels of education, are in fair or poor health, or are Hispanic. This is illustrated in the responses to questions about choosing a doctor. More than a third of people who changed doctors in the two years prior to the survey reported that they found it difficult to find a new one that they liked; over half the people in fair or poor health had difficulty. People are interested in several kinds of information to use in choosing doctors—including how the doctor interacts with patients, how the practice works, and background characteristics of the doctor—but report that they often lack that information. They are less likely to perceive expert ratings of doctors or patient ratings as important.

“It depends; if I had someone ill in my family, I would have to pay more attention to my decision instead of saying, ‘Well more or less I’m just going to choose this one just by chance.’ So if someone were ill, I would be more careful about my choice.”

—Spanish-speaking focus group panelist, Burbank

Information Availability

Information is available with which to compare health plans and HMOs, doctors and medical groups, and hospitals, but most consumers are unaware of it. People who are over age 55 are most likely to report having seen such information. People in fair or poor health and Spanish speakers were least likely to report having seen it. If they do see it, most consumers don’t rate the information as very useful to them. However, Hispanics and people with less education were more likely to say the information was useful to them.

Only 38 percent of consumers reported that they had actively looked for information about health. The groups we focused on (i.e., over age 55, English- or Spanish-speaking Hispanics, lower education, fair or poor health) were less likely to be information seekers than the population as a whole. However, among those who did look for information, more than two thirds reported it was very or somewhat easy to find. Spanish speakers and people in fair or poor health reported the most difficulty finding information.

Information Sources

Consumers reported that they would be most likely to look for health information by consulting personal contacts—friends and relatives, people with the same medical condition, or “insiders” such as nurses or others who work in the health care field. However, more than two thirds said they would be very or somewhat likely to consult sources such as books or pamphlets, information in a doctor’s waiting room, or newspapers or magazines. More than half said they would be very or somewhat likely to consult a Web site. Both English- and Spanish-speaking Hispanics were more likely than the population as a whole to say they would call a toll-free number to speak with someone who was qualified to answer questions about health care.

“So when I had to decide on a health plan, I asked my co-workers, especially since they were already with the company, and they knew what the choices were. That’s how I decided to go with Kaiser originally.”

—Non-college-educated male focus group panelist, Encino

Whether or not they would seek information in the media, exposure is widespread with nearly three quarters of consumers reporting that they watch TV daily and 70 percent listening to radio daily. TV viewing was higher in all of the subgroups we focused on than it was in the population as a whole. While only 35 percent of consumers were daily newspaper readers, 58 percent of the consumers over age 55 were daily readers. Only a quarter of the general population were daily Internet users and that fraction was lower for all the subgroups we examined. For Spanish speakers it was only 3 percent.

There are information sources that consumers trust. Two-thirds or more report trusting their own doctors and organizations that benefit particular diseases, such as the American Cancer Society. Levels of trust are lower for organizations such as the American Medical Association (AMA), the American Association of Retired People (AARP), and for *Consumer Reports* and other national magazines, but 30 to 46 percent of the population report trusting these sources. Web sites are not widely trusted. Not surprisingly, the over-55 group was most trusting of the AARP. Spanish speakers were least trusting of the sources we listed overall, probably because they were less familiar.

People over age 55 have greater health needs than the population as a whole, but are more likely to think they have enough information and are not having difficulty making choices. They rely heavily on their doctors and on family and friends for information, but they also watch TV and read newspapers. They are slightly more likely than others to have seen information comparing health plans and HMOs, doctors, and hospitals, but are no more likely to have found it useful. While a small number use the Internet, most do not.

Traditionally Under-served Populations

Hispanics who speak English are much like the population as a whole, but Spanish speakers are very different. They are facing a variety of concerns in their lives, of which health care is only one. They don’t feel they have the right information for making health care choices, find it difficult to find information, and don’t see the information they do find as being very useful. They don’t trust most traditional sources for health information very much. In addition to talking with family and friends, people with similar conditions, and health insiders, they would be willing to seek information from a toll-free number where they could talk with someone who was well informed.

People with less education have difficulty making health care choices and have more difficulty than the population as a whole finding information that is useful to them. They are the group that is most exposed to television, but do not report having been exposed to information about health plans, doctors, or hospitals. They are least likely to be information seekers of any group we studied.

“I think the people in the public should be told what to look for in a good health care [plan] or a good doctor. A lot of people don’t know what to look for.”

—TANF recipient focus group panelist,
Los Angeles

People who report being in fair or poor health are having difficulty making decisions and are well aware of it. Health is by far their most important concern, and they don’t feel they have the right information for making choices about it. They are less likely than the general population to have seen information, but are more likely to have found it useful if they saw it, perhaps because they needed the information more than others did. As a group, they are less likely to read newspapers or listen to the radio than the general population and more likely to be watching TV. About a third reported having looked for health information for themselves. Only 12 percent were daily Internet users.

In a nutshell, information about health care quality is reaching only a minority of consumers, but most of those who have been exposed to it report that it was at least somewhat useful to them. There are differences among the *exposure*, perceived *usefulness*, and *trust* of information sources. Exposure to TV and radio is widespread, but these are not sources cited as most likely to be used to obtain information about health or as most trusted. The Internet is not yet widely used or trusted. People are the most widely cited sources of information—other patients, family and friends, medical staff, experts, and co-workers. The most trusted sources are consumers’ own doctors, organizations such as the American Cancer Society, and family and friends.

Consumers express interest in a wide range of different kinds of information that would be of interest to them, such as treatment guidelines, expert ratings, and results of consumer surveys, but would likely integrate it into their decision processes along with information they receive from trusted personal sources, such as doctors, friends and family, and other patients.

Recommendations for Providers of Health Care Information

Health is an important concern for consumers, but the case for needing information has yet to be made in the general population. While most don't have the information they would like to have, they are not reporting a lot of difficulty making decisions about health and health care and they are not seeking information. Most are unaware of seeing comparative information, even when it exists. If they do see it, they don't perceive that it's very helpful. Following are some recommendations for providers of health information, based on the results of this survey and on similar research.

1. Build the case for seeking and using information. Consumers need to know how information can help them receive better health care. They need to know what to look for and how to use information effectively in their own lives. For example, healthy people choosing a health plan may need to be shown why it pays to consider how well the plan treats people with chronic conditions.
2. Teach people how to look for information and where to find it, so that when they have a real need and are motivated they have a starting point for their search. Focus on key points when information is needed, so called "teachable moments" such as changing providers or being diagnosed with an illness.
3. Focus on providing information about decisions that consumers are actually making and choices they actually have. Some people have a large range of choices of health plans or physicians and need to sort through them. Others need to know how to obtain basic services and improve the level of care they receive from health care providers. Some people are concerned with general care, while others have specific medical conditions.
4. Provide information in ways that people can understand. Attend to reading levels, language, levels of detail, and overall clarity.
5. People prefer to get information from other people. Even when information is statistical, such as the results of expert ratings or patient surveys, give it a personal touch by having it narrated or written by a specific, identifiable person. People actually want to know things that expert ratings and patient surveys can tell them, but they don't see the statistical information as being as useful to them as personal contacts.
6. People are aware that there is a lot of information and that the quality varies. Working through a trusted organization to provide information is a good way to increase the perceived credibility. While some sources are widely trusted, other are trusted more by some groups than others, so information sources should be tailored to the patient.
7. Consider media habits when designing information campaigns. Newspapers are not widely read in general, but are a good way to reach people who are over age 55. Television reaches everyone, but is especially important for people who are in poor health. Radio also reaches a large fraction of the population. While slightly more than half the people we surveyed say they would look for information on the Internet, most are not regular users and their level of trust for Internet information is low.
8. Although use of the Internet is rapidly increasing among all populations, at the time this survey was conducted, online services were rarely used by the vulnerable subgroups we examined. The Internet may be useful for these groups (the elderly, ill, or who have poor reading or language skills) by informing the friends, family members, and others whom they turn to for advice. Internet access and use rates among vulnerable populations should continue to be monitored, and meanwhile, Web designers should make information easy to print in a readable format.

Findings

In picking a doctor, people felt it was most important to have information about how the doctor interacts (listening and communication) but had difficulty finding that information.

THE INFORMATION IN THIS REPORT IS DRAWN from a statewide survey of 4,089 California residents conducted for the California HealthCare Foundation by RAND, a nonprofit public policy research organization. The weighted sample includes 963 people age 55 and over, 556 Spanish speakers (described themselves as Hispanic and were interviewed in Spanish), 560 English-speaking Hispanics, 580 people with less than a high school education, and 658 people who say they are in fair or poor health. Results are examined first for the general population, and second for the subgroups studied. Provided at the end of this report are descriptions of the survey design and implementation (Appendix A) and the population interviewed (Appendix B).

How Much of a Concern Are Health and Health Care?

To determine the importance of concern about health and health care relative to other common issues, we started the survey by asking: “I’m going to read you a list of things that might be of concern for you right now. Is each of these things a big concern, moderate concern, small concern, or not a concern for you right now?”

About half the people in this survey reported that health and health care were big concerns. As shown in Table 1, health care was the issue reported most frequently as a big concern by California adults, followed by caring for children and other family members. Safety from crime and job and finances were slightly less frequently reported to be big concerns. Air and water quality and retirement planning, followed by quality of schools in the area were less of a concern among the general population.

While the over-55 group is less likely to rate issues as big concerns in general (only about 33 percent do so on average), health and health care stands out as important and is cited as a big concern by 47 percent of the over-55 group. Health and health care were also most frequently cited as big concerns by other special focus populations—people with less than a high school education (55 percent) and by people who reported themselves to be in fair or poor health (63 percent)—in proportions that are higher than for the population as a

Table 1: Respondent Concerns

Issue	Big Concern	Moderate Concern	Small Concern	Not a Concern
Health and health care	50%	25%	9%	16%
Caring for children and other family	47%	18%	9%	27%
Safety from crime	45%	24%	14%	17%
Job and finances	44%	22%	10%	24%
Air and water quality in area	40%	29%	12%	20%
Planning for retirement	39%	24%	9%	28%
Schools in area	30%	20%	10%	40%

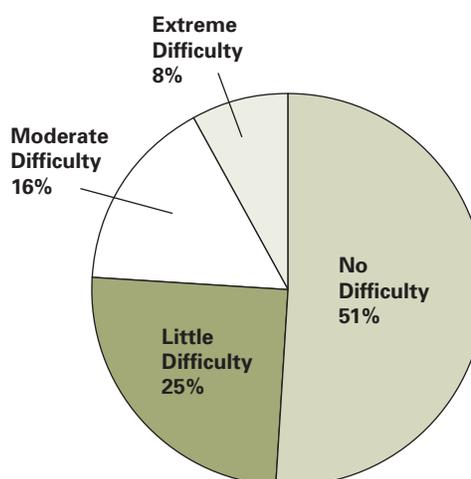
Sample size = 4,089

whole. However, health and health care was not the issue most frequently cited as a big concern by Hispanics. English-speaking Hispanics cited caring for children and other family members most frequently as a big concern (59 percent), followed by health care (55 percent). Spanish-speaking Hispanics were most likely to rate issues as big concerns in general (52 percent on average), possibly reflecting the strains of recent immigration and poorer economic status. They cited safety from crime and caring for children and other family members (both 64 percent) most frequently as big concerns, followed by health care (58 percent). However, while health care may not be the most frequently cited big concern, it is still reported to be a big concern by Hispanics at rates that are higher than for the population as a whole.

How Difficult Is It to Make Health Care Choices?

Everyone was asked how easy or difficult it was to make choices or decisions about health care and medical needs. A slight majority overall reported little or no difficulty. However, as shown in Figure 1, about 25 percent said they had little difficulty and 24 percent had moderate or extreme difficulty making health care choices.

Figure 1: Difficulty Making Health Care Choices



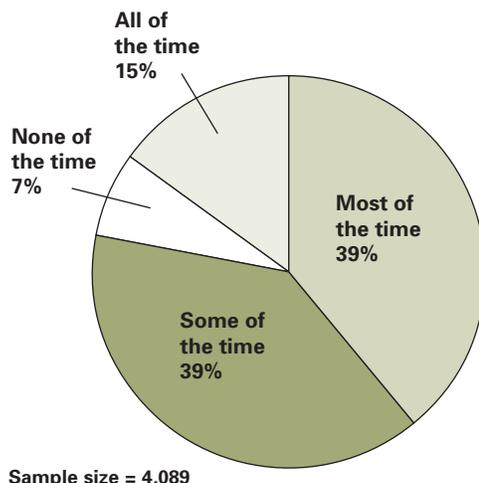
Sample size = 4,089

The proportion reporting difficulty making health care decisions was much greater among those in fair or poor health, with 35 percent reporting moderate or extreme difficulty, and among people with less than a high school education (29 percent). Spanish-speaking Hispanics were also more likely to report more difficulty, with 28 percent reporting moderate or extreme difficulty. English-speaking Hispanics reported difficulty at about the same rate as the population as a whole (25 percent) and people over 55 were less likely to report moderate or extreme difficulty (23 percent).

Do People Have the Right Information for Making Choices?

Most adults need to make choices about health and health care—whether picking insurance plans or providers for adults who are mainly healthy, deciding when to seek treatment, or selecting among treatment options when they are ill. As shown in Figure 2, while a majority reported having enough of the right kind of information for making choices or decisions about health care and medical needs all or most of the time, a large minority (39 percent) said they felt they had the right kind of information only some of the time, and 7 percent felt they never had the right information for making choices.

Figure 2: Have the Right Information for Making Health Care Choices



While 46 percent of the population as a whole felt they sometimes or never had the right information, the information deficit was much higher for people with less than a high school education (54 percent) and for people in fair or poor health (58 percent). The deficit was also large for English-speaking Hispanics (53 percent) and for Spanish-speaking Hispanics (58 percent). Interestingly, people over 55 were slightly less likely than the population as a whole to feel they had an information deficit, only 42 percent.

Do People Have the Right Information When They Select Doctors?

Selecting a physician is a common kind of health care decision. We asked whether survey participants had changed doctors within the past two years. While 38 percent of the overall population had changed doctors (largely due to job or insurance plan changes), the proportions of subgroups who had changed doctors was lower, ranging from a high of 37 percent for English-speaking Hispanics, 35 percent for people age 55 and over, 34 percent for people in fair or poor health, 27 percent for Spanish-speaking Hispanics to 23 percent for people with less than a high school education.

Of those who changed doctors, 36 percent reported finding it difficult to find a new doctor that they liked, including 2 percent who said they did not find one. People in fair or poor health were most likely to report difficulties (55 percent), including 6 percent who did not find a doctor that they liked.

Although most consumers reported that it was easy to find a doctor they were happy with, many respondents reported not having information about the factors they rated as important in choosing a doctor. We asked people who had changed doctors within the past two years how important a list of factors was in choosing a doctor and, for factors rated very important, whether they had that information when they selected their doctors. The results are shown in Table 2.

Looking at the information in another way, we focused on the proportion of people who said a particular type of information was very important to them and who also said they did not have it available for making a choice. In the general population, about 10 to 15 percent reported that they did not have information about something

Table 2: What Are the Important Factors When Picking a Doctor and Is the Information Available at the Time of the Decision?

Factor	Very Important	Somewhat Important	Not Very Important	Not Important	Information Available
Doctor listens to you	87%	9%	2%	3%	45%
Doctor provides all needed info	75%	20%	2%	3%	48%
Doctor experience and training	70%	21%	5%	4%	58%
Wait for an appointment	59%	28%	8%	6%	51%
Malpractice suits or complaints	58%	21%	13%	9%	22%
Ease of working with office staff	54%	33%	8%	5%	39%
Time doctor spends with patients	53%	32%	8%	7%	41%
Language doctor/staff speaks	50%	18%	15%	17%	69%
Hospital doctor uses	49%	29%	12%	9%	86%
Friend/relative recommendation	44%	32%	12%	13%	79%
Rating of doctor by experts	39%	33%	16%	13%	46%
Nurse/staff recommendation	35%	34%	16%	15%	62%
Patient survey results	34%	32%	19%	14%	43%
Transportation to office available	29%	13%	26%	32%	66%
Doctor gender	17%	16%	28%	39%	85%
Doctor race/ethnicity	12%	14%	24%	51%	62%

Sample size is 809 who picked a new doctor in the past two years. Sample size varies between 93 and 703 for the questions on the availability of information.

that was very important to them, including information about how the doctor interacts with patients (listening, providing information, spending time), how the practice works (appointment waits, ease of dealing with staff), and facts about the doctor and the practice (education and training, malpractice claims, languages spoken, hospital privileges, etc.). Fewer people (7 to 8 percent) reported that they thought expert ratings or ratings by patients were an important kind of information that they did not have available. These patterns were similar across the groups, except that Spanish speakers (2 to 3 percent) and people with less than a high school education (6 to 8 percent) were less likely to report missing important information.

“When I see the doctor, I’d like him to think about me as a person first and not think how much it’s costing the plan each time he sees me. The patient is number one, and not thinking about the next patient or how many patients he can see.”

—Spanish-speaking male focus group panelist, Burbank

Are People Aware of the Information Available?

Information about health and health care is available for consumers from a variety of sources. We asked whether respondents had ever seen or heard information that compared doctors and medical groups, hospitals in their area, and health plans or HMOs. As shown in Table 3, less than 40 percent reported that they had seen information comparing health plans or HMOs, doctors or hospitals and but that this was the type of information most frequently encountered.

Table 3: Respondent Has Seen or Heard Comparative Information

Type of Information	Yes
Health Plans or HMOs in your area	39%
Doctors or medical groups in your area	29%
Hospitals in your area	20%

Sample size varies from 4,002 to 4,040

People over age 55 were more likely than the general population to report having seen comparisons of health plans or HMOs (44 percent), doctors or medical groups (29 percent) and hospitals (24 percent). English-speaking Hispanics reported exposure to information at about the same rates as the population as a whole. However, people with less than a high school education, people in fair or poor health and Spanish-speaking Hispanics were much less likely to report being exposed to information. For example, exposure to information on health plans or HMOs was reported by 24 percent of people with less education, 31 percent of people in fair or poor health, and only 21 percent of Spanish-speaking Hispanics. Exposure to information on doctors or medical groups was reported by 21 percent of people with less education, 26 percent

of people in fair or poor health, and only 20 percent of Spanish-speaking Hispanics. Exposure to information on hospitals in the area was reported by 16 percent of people with less education, 19 percent of people in fair or poor health, and only 14 percent of Spanish-speaking Hispanics.

If They Do See Information, How Useful Is It?

We asked people who said they had seen comparative information how useful it was to them for making choices. As shown in Table 4, of those who had seen the information, less than 40 percent thought it was very useful, while most found it somewhat or less than useful.

This was also true for people over age 55. However, the sub-groups we questioned were more satisfied with the information they encountered than the population as a whole. For example only half of the English-speaking Hispanics found the information they encountered to be less than very useful. About half of the Spanish- and English-speaking Hispanics and people with less than a high school education found information on hospitals to be less than very useful. Just over half the English-speaking Hispanics, people with less than a high school education, and people in fair or poor health found information on doctors and medical groups to be less than useful. Only 42 percent of Spanish-speaking Hispanics found the information they saw on doctors and medical groups to be less than very useful.

Table 4: How Useful Was the Health Care Comparison Information?

Type of Information	Very Useful	Somewhat Useful	Not Very Useful	Not Useful
Health plans or HMOs	39%	30%	12%	20%
Hospitals	38%	26%	15%	21%
Doctors or medical groups	37%	29%	12%	23%

Sample size = 788 to 1,517

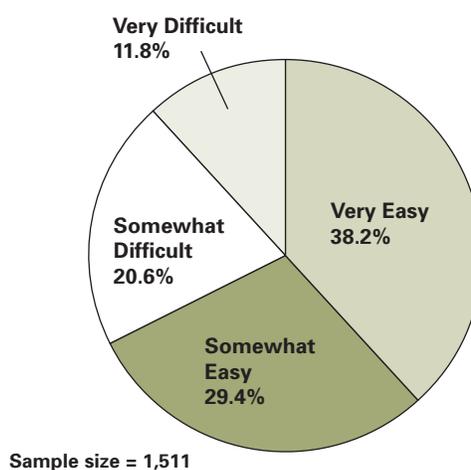
If They Look for Information, How Easy Is It to Find?

In addition to asking about information they had encountered, we also asked about whether respondents had specifically gone out and looked for information about health and health care. Thirty-eight percent reported that they had looked for information about health care to use in making decisions about where to go for health care or about treatment choices for themselves or someone in their families. For all the subgroups we examined, the fraction who said they had looked for information was lower than for the population as a whole. It was highest for English-speaking Hispanics (37 percent) and people over age 55 (35 percent) and lower among people in fair or poor health (34 percent), Spanish-speaking Hispanics (27 percent) and people with less than a high school education (23 percent).

We then asked people who had looked for information how easy it was to find. As shown in Figure 3, of the people who looked for information, about 68 percent found it very or somewhat easy to find information and 32 percent found it very or somewhat difficult.

Two groups, Spanish-speaking Hispanics and people who are in fair or poor health, were much more likely to report that finding information was very or somewhat difficult (44 percent). People who had less than a high school education were more likely to report difficulty finding information (39 percent), as were people who were over age 55 (35 percent).

Figure 3: Ease of Information Seeking



What Information Sources Would People Use?

If there are information gaps, the obvious question is how to reach consumers with the information they need. We asked, “How likely would you be to use each of these ways of getting information about health care and medical needs?”

As shown in Table 5, the most likely sources for information were people who appear to have special knowledge of the medical condition, the local medical scene, or of the specific provider. For example, the most trusted sources are:

- People with the same medical condition
- Family and friends
- Nurses or other people who work for local doctors and hospitals

Talking to a qualified person on a toll-free number, co-workers, and seeking information from a library, church, or community organization were also viewed as likely sources, though less likely than personal contacts.

Books, reports, and pamphlets, independent evaluations or ratings, and information in doctors’ waiting rooms were cited less often as likely sources than personal contacts. Other sources, such as viewing videotapes at home, visiting a Web site, calling a toll-free number for recorded information, TV and radio, or newspapers and magazines were viewed as the least likely means of acquiring information.

There were some similarities and differences by subgroup. While talking to people with the same medical condition, talking with family or friends, and talking with nurses or others who work for local doctors or hospitals were important sources of information for all groups, both Spanish- and English-speaking Hispanics chose calling a toll-free phone number to speak with someone who could answer questions as

a very likely source of information (44 percent of Spanish speakers and 42 percent of English speakers). Spanish-speaking Hispanics also listed reading a book, report, or pamphlet as a very important source (41 percent).

If Information Is Presented in the Media, Who Is Likely to See It?

While consumers indicate that they are more interested in seeking information from personal sources, they have the potential to be exposed to information presented in the media in large numbers, as shown in Table 6. To contrast the media habits among our subgroups, we focused on daily use of each form of media (television, radio, newspaper, and Internet).

While nearly three quarters of the general population watched TV every day, the proportion of daily viewers was higher in each of the subgroups we looked at. Among people over age 55, 86 percent reported daily TV viewing, as did 81 percent of Spanish-speaking Hispanics and people with less than a high school education. Eighty percent of people in fair or poor health watched TV daily.

In comparison with 70 percent of the general population, about 77 percent of English-speaking Hispanics reported listening to the radio every day, although in the other subgroups the proportion of daily listeners was 63 percent or fewer.

Table 5: Likely Information Sources

Source	Very Likely	Somewhat Likely	Not Likely
Talking to people with same medical condition	56%	30%	14%
Talking with family and friends	51%	36%	13%
Talking with nurses or others who work for local doctors or hospitals	48%	37%	16%
Talking to a qualified person who answers a toll-free number	34%	37%	29%
Talking with coworkers	32%	37%	31%
Information from a library/church/community organization	31%	36%	33%
Reading a book, report, or pamphlet	31%	48%	22%
Information in a doctor's waiting room	26%	42%	32%
Independent evaluations or ratings	24%	44%	33%
Newspapers or magazines	22%	48%	31%
TV or radio	20%	42%	38%
Visiting a Web site	19%	31%	50%
Viewing a videotape at home	16%	36%	49%
Calling a toll-free number for health care quality information	14%	27%	59%

Sample size = 4,089

Table 6: Respondent Activities that Expose Them to the Media

Activity	Every Day	Few Times a Week	Once a Week	Less than Once a Week	Never
Watch TV	74%	18%	3%	2%	3%
Listen to the radio	70%	15%	4%	4%	7%
Read a daily newspaper	35%	24%	15%	9%	15%
Use the Internet	26%	16%	7%	7%	45%

Sample size = 4,089

Daily newspaper reading was reported less frequently for most of the subgroups than it was in the population as a whole (35 percent), with the exception of people age 55 and over, 58 percent of whom read the newspaper daily.

Daily Internet use was reported by 26 percent of the general population but by fewer than 20 percent of those over age 55, Hispanics, people in fair or poor health, and people with less than a high school education. English-speaking Hispanics (20 percent) and people over age 55 (16 percent) were most likely to be daily Internet users. People in fair or poor health (12 percent), people with less than a high school education (8 percent), and Spanish-speaking Hispanics (3 percent) were least likely to be daily Internet users. Given the widely documented rise in Internet use among all populations, however, it is likely that these numbers have increased since the study was conducted.

What Information Sources Do Consumers Trust?

For health information to be useful, it not only has to reach consumers, but it should also come from a source that consumers believe is trustworthy. To assess which sources consumers would believe, we asked, “I am going to read you a list of people or organizations that provide information about health care and medical needs. For each one, please tell me if you trust what they said a lot, trust it a little, or not trust it at all?”

As shown in Table 7, most consumers said that they trust their own doctors most of all, followed by voluntary organizations for particular diseases (e.g., American Cancer Society, American Heart and Lung Associations) and family and friends. Consumer Reports is trusted more than most national magazines and all enjoy more trust than

doctors on TV and Web sites. Sources that are identified with individual hospitals or HMOs and drug companies show lower levels of trust, as do government agencies.

For most subgroups, the sources that were trusted most often mirrored the population as a whole. However, family and friends were somewhat less likely to be trusted a lot among groups other than those over age 55, who in turn were more likely to trust the AARP a lot (44 percent) than other groups. Spanish-speaking Hispanics were generally less likely to trust information sources on the list we presented. The only source trusted by over 50 percent of them was the American Cancer Society (57 percent), followed by the American Heart and Lung Associations (47 percent). The AMA was trusted by 44 percent of the English-speaking Hispanics and 39 percent of the people over age 55, but not by more than a third of any other subgroup.

Web sites were not trusted a lot by any sub-group (under 14 percent). There was also very little trust of national magazines such as *Consumer Reports* by Spanish-speaking Hispanics, probably because they are not provided in Spanish.

Table 7: Trusted Information Sources

Source	Trusted A Lot	Trusted A Little	Trusted Not At All
Own doctor	71%	25%	4%
American Cancer Society	67%	28%	5%
American Heart and Lung Associations	65%	30%	5%
Family and friends	53%	40%	7%
American Medical Association	46%	45%	9%
<i>Consumer Reports</i> magazine	43%	44%	13%
California Medical Association	41%	49%	11%
AARP	39%	49%	13%
Employer	34%	47%	18%
California HealthCare Foundation	33%	54%	14%
National magazine (e.g., <i>Newsweek</i>)	30%	54%	17%
Individual hospitals	28%	59%	13%
Government health care regulating agencies	21%	56%	23%
Drug or pharmaceutical companies	20%	55%	25%
Doctors on TV	20%	59%	22%
Individual health insurance plans/HMOs	18%	57%	26%
Internet	13%	55%	32%

Sample size varies from 2,767 to 3,963

Appendix A: Design and Implementation of the Survey

The survey data are based on a Random Digit Dial (RDD) sample survey conducted between November 1999 and January 2000.¹ Adults in California households with telephones were surveyed. The RDD sampling method includes households with both listed and unlisted telephone numbers.² We selected 26,222 telephone numbers after assigning sampling rates to counties to maximize the representation of groups that are of particular interest and that have low incidence in the population. These include those with public insurance or no insurance; African Americans; Asians; Hispanics; and other non-White races, based on 1990 U.S. Census data. This method limited the over-sampling of counties with high rates of the groups of interest to a factor of two, in order to avoid large “design effects” through over-concentration of the sample in a small number of counties.

Data Collection

An interviewer called each of the 26,222 selected telephone numbers in a centralized telephone facility.³ At the beginning of each call, interviewers first verified that they had reached a California household and then selected a random adult to be interviewed. Once they had the person on the phone, the interviewers asked a few questions designed to further screen the respondent. This brief “screener” includes questions about medical insurance coverage, whether the respondent has seen a doctor in the previous 12 months, and the respondent’s race/ethnicity. A computer uses this information to judge the appropriateness of the respondent for the survey and guides the interviewer to proceed with the interview or to end it.

Interviews were attempted seven days a week during the hours of 9 AM to 9 PM. Assignment of numbers to interviewers was controlled by computer, so each number was called on different days of the week and at different times of the day. The interview was conducted in English or Spanish (10 percent of interviews were in Spanish).

Table A1 shows the final status of each of the telephone numbers we attempted to use for this survey. We interviewed 93 percent of the known eligible households; however, the eligibility of 38 percent of the sampled numbers could not be determined with certainty. Of the households with unknown eligibility, 3,176 were numbers that rang but were unanswered after at least 10 calls and 6,701 were households that could not be screened (including answering machines that did not appear to be businesses). If we assume that the numbers that were never answered were ineligible pay phones or other unassigned numbers and apply the proportion of screened households that were determined to be eligible (76 percent who speak English or Spanish and were selected based on sampling algorithm) to the number of households that could not be screened, we estimate the response rate to be about 44 percent.

Table A1: Disposition of Cases in Random Dial Sample

Total Sample	26,222
Known Eligible	4,390
Complete	4,089
Partial or break off	254
Max calls or refusal	47
Known Ineligible	11,955
Language not English or Spanish	943
Not working	5,376
Business	2,901
Call blocked	10
Fax or modem	1,781
Excess sample not selected	624
Other ineligible	320
Unknown Eligibility	9,877
Did not complete screener	9,877

Weighting the Sample

The sampling weight is the inverse of the sampling probability. The sampling probability was constructed from the probability that a phone number was drawn from a given county, from the probability that the respondent was selected based on the screener interview, and the number of phone lines in the household.

The number of phone numbers drawn from each county is computed from a mild over-sampling scheme, which is described as follows: Knowing the population mix at the county level for relevant variables, we over-sampled some counties to yield a minimal overall sample size for some sub-populations: 900 each of White, Black, and Asian; 900 in each of three age categories (18-64, 64-74, greater than 75); 900 below the poverty line; 900 in each of the categories uninsured, Medicare recipients, and Medi-Cal

recipients. It turned out that most of these constraints would have been easily met using a random sample. The design effect introduced in this stage is 1.03, meaning that the loss of efficiency introduced by these constraints (3 percent) is remarkably low.

We then matched the totals by race within area code according to the 1990 census data. In areas of high population density there may be several area codes in a single county. This step ensures that a race sub-population in one area code does not get mixed together with the corresponding race sub-population in another area code. The weights were then trimmed at the 95th percentile and re-normalized. We post-stratified the data to match all six bi-variate tables for gender, race, age, and income according to the Current Population Survey for California.

Statistical Significance

The sample size for this survey was quite large and many of the comparisons that are presented are statistically significant. The significance level varies depending on the sizes of the subsamples being compared and the proportions for the responses. However, for the sake of completeness, data are presented for each subgroups, even if the differences are not statistically significant.

¹ Sample was purchased from Survey Sampling, Inc.

² Over 95 percent of California households have telephones and approximately 65 to 75 percent have unlisted numbers. All of the ten Metropolitan Statistical Areas with the highest prevalence of unlisted numbers are in California (SSI Web site).

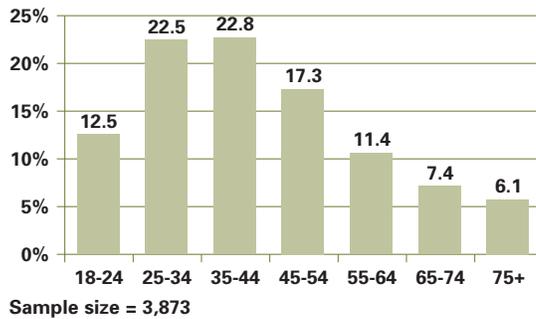
³ Interviewing Services of America, Van Nuys, California.

Appendix B: Overview of the Survey Participants

This section provides an overview of the survey respondents in the analyzed sample, which was weighted as described in Appendix A.

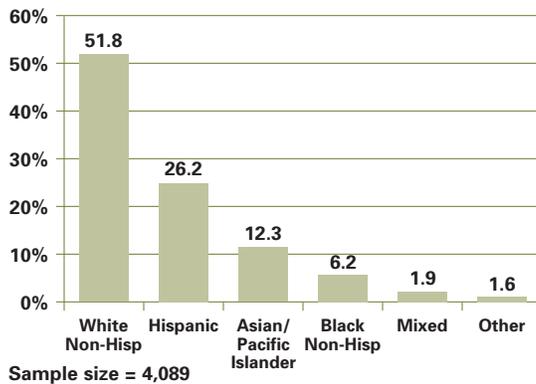
Our sample was 49 percent male and 51 percent female and was distributed across all age groups.

Figure B1: Age Distribution of Survey Respondents



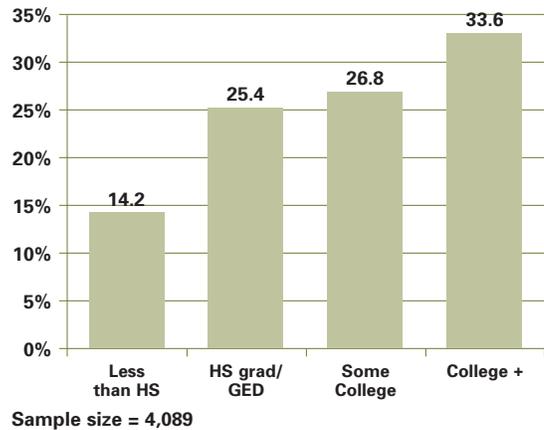
The sample was selected to provide representation across racial and ethnic groups, allowing estimation at the subgroup level.

Figure B2: Race/Ethnicity Distribution of Survey Respondents



The sample includes all education levels, but as is common with telephone surveys tends to include more people who have higher levels of education.

Figure B3: Education Levels of Survey Respondents



We asked about health status by asking: “In general, would you say your health is excellent, very good, good, fair, or poor?” Most respondents reported being in excellent or very good health; however a substantial group was in fair or poor health.

Figure B4: General Health Status of Survey Respondents





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