

Patients Willing to Pay Out-of-Pocket for Procedures that Lead to Earlier Return to Work and Smaller Incisions

Title: Patient Willingness to Pay for Faster Return to Work or Smaller Incisions¹
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SUMMARY OF MANUSCRIPT

For complete manuscript, please visit
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OBJECTIVE

To complete an exploratory study analyzing patient willingness to pay for a hypothetical treatment option that leads to faster return to work after hand surgery or a surgical option with a smaller incision size in the setting of treatment equipoise.

BACKGROUND

- Value-based health care models such as bundled payments can penalize health systems and physicians for excess costs that lead to low-value care.
- Health systems are increasingly incentivized to provide lower cost and higher value care options to patients in scenarios with treatment equipoise, where no one procedure is known to be superior to another.
- Restricting patient choices to preselected high-value options may be one strategy payers use to control costs; however, this approach could potentially neglect patient preferences for the various attributes of care that may be important to them.
- Willingness to pay (e.g., cost share) is an economic concept used to assess the value a patient places on health care interventions and services.

METHODS

- Prospective, IRB-approved study for new patients presenting to a hand surgery clinic.
- Inclusion criteria included patients 18 years of age or older with English fluency and literacy. Exclusion criteria included patients who were unable to give informed consent.
- Paper questionnaires were self-administered and electronically transcribed into a web-based application for research purposes.
- Variables collected included age, sex, and socioeconomic elements; financial distress scores were also captured.
- Additional variables included how much patients were willing to pay out-of-pocket for an earlier return to work or a smaller incision.

- Questionnaires included patient preference scenarios regarding how much they are willing to pay (\$0, up to \$250, \$251-500, \$501-\$1000, \$1001-\$2500, or >\$2500 for a procedure that leads to earlier return to work (3, 7, and 14 days earlier) or one that can be performed through a smaller incision (1, 2, 3, 4 or 5 cm smaller).

RESULTS

- 122 patients completed the survey and were included in the study. Patient ages ranged from 18 to 87 years with a mean age of 50.4. Most patients were white (66.1%), employed (66.1%), and had health insurance (55%). The mean education level was 16.4 years and average financial distress score was 7.0 (1=highest financial distress and 10=financial security).
- 62.4% of patients were willing to pay to return to work 3 days earlier, and that number grew to 73.3% to return 7 days earlier. The percentage of patients willing to pay to return 14 days earlier was not substantially greater (72.3% for 14 days earlier vs. 73.3% for 7 days earlier) (Table 1). Patients who were currently working (vs. non-working) were significantly more willing to pay to return to work 14 days earlier.
- 51.7% of patients were willing to pay for an incision 1 cm smaller, and that number grew to 73.3% for an incision 2 cm smaller (Table 2). Non-white patients were significantly more willing to pay for a treatment that uses a 1 cm smaller incision than white patients.
- Approximately 10% of patients were willing to pay maximum amounts (greater than \$2500) for earlier return to work and smaller incision sizes of any length.

DISCUSSION

- In this study, some patients value a faster return to work or smaller incisions and are willing to cost share for these treatment attributes. Understanding patients' willingness to pay for these elements of care can inform health policy in value-based health care models.
- Patients are likely more concerned with the impact of direct medical costs on their personal life and less interested in lowering the economic burden on payers and society.

CLINICAL HIGHLIGHTS

- Employment status was significantly associated with willingness to pay for return to work. Employed patients may be willing to pay to return to work earlier to avoid indirect costs, including loss of job, as many patients have no paid sick leave. Patients returning to work earlier may result in less overall loss of salary and increased productivity for society. The current value equation (health outcomes/quality per dollar spent) disregards these indirect costs, as well as patient preferences.
- Total cost reduction without considering the needs and values of the patient (patient-centered care) leads to false “savings” and may limit effective care.
- Shared decision-making requires information exchange between the physician and patient to allow them to work collaboratively to reach a medical decision that is aligned with the patient’s values, goals, and preferences.
- Policy makers may need to include not only patient preferences regarding various attributes of care, such as earlier return to work and smaller incision sizes, but also information regarding willingness to pay and cost sharing for an intervention.

TABLE 1. Patient preferences regarding earlier return to work.

Days earlier	Willingness to Pay Out of Pocket		
	Pay	Count	%
3	No	44	37.6
	Yes	73	62.4
7	No	32	26.7
	Yes	88	73.3
14	No	33	27.7
	Yes	86	72.3

REFERENCES

1. Alokozai A, Lindsay SE, Epplier SL, Fox PM, Ladd AL, Kamal RN. Patient willingness to pay for faster return to work or smaller incisions. *HAND*. 2021;16(6):811-817. doi:10.1177/1558944719890039.



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TABLE 2. Patient preferences regarding smaller incision sizes.

Incision size decrease, cm	Willingness to Pay Out of Pocket		
	Pay	Count	%
1	No	56	48.3
	Yes	60	51.7
2	No	32	26.7
	Yes	88	73.3
3	No	33	27.7
	Yes	86	72.3
4	No	32	26.7
	Yes	88	73.3
5	No	33	27.7
	Yes	86	72.3

LIMITATIONS

- The studied cohort of patients was from a suburban academic hand surgery clinic within the United States. Most patients were employed, highly educated, and had low financial distress.
- Patients were not provided a baseline length of starting scar size; therefore, patients had no reference to gauge the degree of improvement of a smaller scar.
- The largest cost-sharing options provided to patients was “greater than \$2500”, which created a ceiling effect for patients who might have been willing to pay significantly more than \$2500 for a faster recovery or smaller incision.
- By asking hypothetical scenarios, patients did not have to make a financial commitment toward these treatment choices.

CONCLUSION

- Patients may be willing to pay out-of-pocket and cost share for procedures that lead to earlier return to work and smaller incisions. When developing and implementing alternative payment models, health systems could offer services for a supplementary out-of-pocket charge.