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GUEST EDITORIAL

What do economists have to do with health? Reflections from a person-centered approach

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Introduction

In economic theory, healthcare is regarded as an example of "market failure", given the absence of price competition, a circumstance that does not allow the basic conditions for demand and supply to be reached and justifies the consideration of health economics as an autonomous area of research [1].

Among the factors that distinguish health economics from related disciplines is the factor of extensive government intervention, which acts as third party payer. Also, the presence of uncertainty, related both to demand and supply, and asymmetric information that determines, as will be explained, a principal-agent relationship between patient and physician, together with barriers to entry and other externalities, are additional factors which merit careful examination [2]. Indeed, these characteristics combine to determine a peculiar situation: at the *macro* level, expenditure for health is mostly funded by the public sector, so that its extent often depends on available resources and on the priorities set out by the government. At the *micro* level, patients, who need healthcare, cannot be considered as common consumers - their demand is not formulated individually, but guided mainly by physicians according to the information they can provide.

Physicians respond to the payers for healthcare expenditure and are supposed to establish a "principal-agent relationship" with patients, selecting the therapies necessary for the patient and taking into account the typical information/knowledge asymmetry gap. Perfect agency relationships rarely exist in practice, due to the principal's uncertainty as well as to the agent's preferences that are often not clearly defined. Moreover, the physician may convince patients to increase their use of medical care, therefore inducing demand.

The relationship between physicians and patients has been examined in other disciplines (e.g., psychology, sociology and philosophy), besides health economics. In light of this multidisciplinary approach in the literature, the notion of "patient empowerment", that has clinical, psychological and sociological characteristics, has been viewed as complementary to the physician-patient relationship. As a function of patient empowerment, the patient gains an increased centrality within the consultation, so that no therapeutic approaches can be implemented without his/her cooperation and consent. Developments in the physician-patient relationship over the last fifty years have seen an increased cooperation between the two, establishing the core foundation for person-centered care. Currently, the questions about *why* this new perspective has been developed and *how* it can be implemented, are at the centre of a debate that implies a re-designing of the priorities for healthcare [3]. Given the multidisciplinarity associated with these issues, economists' point of view will be addressed here, specifically in terms of the evolution from patient empowerment, through patient-centered healthcare, to person-centered health and social care [3,4], outlining what has been achieved to date with the aim of providing a better assistance to patients and those who care for them.

The “revolution” of patient-centered care

The trend towards an increased patient empowerment has paved the way for re-designing patient care and assistance. New priorities have been identified and the same patient has gradually become the protagonist of his/her personal therapeutic path.

A formal definition of patient empowerment has been provided by WHO [5], describing it as a process through which “*patients understand their role, are given the knowledge and skills by their health-care provider to perform a task in an environment that recognizes community and cultural differences and encourages patient participation*”.

A number of components have been identified as fundamental to the process of patient empowerment. There is the *understanding*, by the patient of his/her role. The patient cannot own the physician’s knowledge and skills and is not typically aware of the therapies that may be medically indicated. This being said, the patient may acquire, through his/her personal experience and health literacy, sufficient *knowledge and skills* to be able to engage with the healthcare provider. Moreover, patient empowerment can be reinforced in the presence of a *facilitating environment*.

The reasons for patient involvement are based on the recognition of the legal autonomy of the person, deriving from moral, political, social and economic imperatives. Indeed, it is recognized that the person lives his/her situation and that he/she knows well every aspect of the condition experienced and may have the ability to participate with the doctor to define his/her own care. For sure, that is why the person wishes to govern, as far as is possible, the process of care [6]. Research on this topic has received adequate attention only in recent years, given that patient participation has long been considered a “non-priority” for therapeutic efficacy, despite the fact that the centrality of the citizen and of the patient is widely affirmed, not only for its ethical implications, but also for the outcome [7].

There are three principal justifications to ‘do’ PCH as Miles and Asbridge describe [3]: (a) an ethical/professional justification, (b) a scientific/evidence based justification and (c) an economic justification. In addition, there are various other dimensions of the patient-centered approach. Operationally, patient-centered communication includes ensuring privacy and comfort, setting an agenda, establishing the patient’s understanding of the situation and identifying clues to the patient’s personal story, facilitating the patient’s expression of concerns and using emotion-handling responses [8]. Furthermore, many authors have called for a greater cultural awareness when teaching patient-centered care and communication skills, highlighting how important this is for clinicians to cultivate attitudes such as curiosity and attentiveness in order to explore patients’ needs and to provide ‘hands on’ patient-centered care in operational practice [9,10].

The concept of patient-centered care emerged in the early 50s, although it became relevant for healthcare research policy only in the late 1990’s. Over the last 20 years, the term ‘patient-centered’ has become widely synonymous with high-quality care in the Western healthcare world. However, despite recognition of the concept, there is considerable ambiguity concerning the precise meaning of patient-centeredness in clinical practice [11] and research settings [12,13]. Patient-centered care implies individualized patient care based on patient-specific information, rather than focusing exclusively on the disease. This creates a comprehensive healthcare approach, where the physician is called to respond to the patient’s needs and preferences, his/her illness experience [14,15] and the psychosocial context, so to enable a shared decision-making [16].

Operationally, a patient-centered model may consist of approaches to primary care aimed at enabling improvements, including assignment of patients to a physician responsible for directing the whole process of care and the adoption and the use of health information technology [17,18]. However, the evidence regarding the model’s impacts on patient experience, cultural differences and, at a *macro* level, the resources needed and the level of expenditure, remains mixed.[1]

With reference to patient-centered care, a further step is taken with the person-centered care approach. Person-centered care, as an innovative approach to the planning, evaluation and delivery of healthcare in every environment/context, is grounded within a partnership between providers, patients and families, conferring mutual benefits, and based on the following principles. First, there is respect for the *dignity* of the patient, who is first and foremost a person. Providers, listen to and respect the values, beliefs, choices and culture of the patient, who takes an active role in care planning in the light of his/her experience. Second, *information* exchanged between health professionals and patients must be shared in a positive and useful manner so that the patient is able to guarantee his/her participation in care and decision-making. Third, from an organizational point of view, this *cooperation* ensures patients’ and family members’ involvement in institutional choices and in the improvement of services. Together with the principles enunciated as the foundation of person-centered healthcare, the International Alliance of Patients’ Organizations [21] also reiterates related principles based on respect, needs, preferences and values,

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[1] Reports on single case studies can be mentioned: the work by David *et al*. [19] uses data on 152,093 patients over 6 years (370,764 patient-years in total) covered by a private insurer in southeastern Pennsylvania. These patients were treated in 104 different practices. The authors find that the implementation of measures based on patients’ interests affects performance, suggesting that generally-unobserved features of primary care reorganization may influence patients’ outcomes. Lamiani *et al*. [20] carry out a comparison between Italy and USA, focusing on the cultural differences in the approach to the patient. Exploring the patient’s illness experience and handling the patient’s emotions were the two elements identified as core components of patient-centered care by both the US and Italian groups. The cultural differences were outlined by looking at the findings of the research. Respecting the patient’s autonomy was recognised as a component of patient-centered care only by the US group, while the Italian group demonstrated a more implicitly paternalistic approach.

autonomy and independence, choice and patient empowerment, involvement in health policies, access and support and information.

Patient-centered care and person-centered care

In general terms, patient-centered care has developed into person-centered care and analyses are now required to investigate each of the basic requirements that underline its ethical, moral and economic values. Here, the shared aspects of patient-centered care and person-centered care can be briefly summarized as follows: Patient information and involvement of the patient in the process of care; Respect for patient preferences; Dignity; Access to care; Continuity of care. All these elements are the goals towards which healthcare should be directed. Recently, each of these concepts has received increasing attention and the literature contributions, not only medical, but also economic, have been augmented. Each of these aspects can be examined in detail.

Information and patient involvement

Beginning with patient empowerment and as part of the implementation of patient-centered care, attention has shifted towards the individual patient and the assistance he/she needs and requires. Person-centered care reinforces the role and the autonomy of the individual with appropriate and individually tailored care provided in a wider context. In this context, person-focused care specifically focuses on the whole person. Tools to assess person-centered care are available and deserve a more widespread use in primary care [22]. Patient empowerment now becomes full patient engagement.

From this perspective, the analyses carried out by the research centre EngageMinds Hub at the Catholic University of The Sacred Heart in Milan, Italy, on a sample of 1,389 chronically ill patients in Italy [23], shows how patients less involved in the treatment process have a 10 times higher risk of relapse and/or worsening of illness when compared to patients with a high level of engagement. In addition, patients with low levels of engagement report anxious-depressive symptoms in 9 cases out of 10. Treating these patients would require, on average, a greater level of resource allocation.

Respecting patient preferences

Treatment decisions can have important implications (emotional and, often, financial), not only for patients, but also for their relatives. Respecting patient preferences implies the undertaking of shared and informal decisions. An informed decision is one where a reasonable choice is made by a rational individual using relevant information about the advantages and disadvantages of all the possible courses of action, in accordance with his/her beliefs [24]. Shared decision-making occurs when the physician and the patient share all stages of the decision-making process simultaneously. In the purest form, both the physician and the patient reveal treatment preferences and both agree on a basis to proceed [25,26].

Dignity

Dignity is a difficult concept to define and has a strong association with respect. A Europe-wide study of dignity and older people outlined how it is rather easier to describe and provide examples of indignity, that is, the opposite of dignity [27,28]. The evaluation of the perceived dignity requires the joint evaluation of the clinical conditions, functional state and cognitive abilities, as well as the social, economic and environmental conditions [29,30].

Dignity therapy has been developed to reduce suffering and to guarantee a positive impact on the end-of-life phase. At the moment it has been rewarded as the only proposal for a systematic, operative method [31], but the advantages in terms of quality of life that could be achieved with a minimum expenditure of resources appear unquestionable.

Access to care

Access to care has, instead, shown much greater economic implications. Improving patients' access to care is more than just a public health imperative, it should be an economic one, too [32]. Access improvements significantly increase consumer satisfaction. Yet evidence suggests that within many health systems, access is reducing, not increasing. In an analysis carried out for the US, average wait times for new patients to access primary care and specialist appointments have risen by about 30% since 2014 [33].

Waiting times are often investigated in questionnaires aimed at evaluating the quality of care, such as in the EORTC, developed for oncology patients [34,35]. From this perspective, the design of care pathways that respond to the needs of patients, rather than provider perspectives, should also be well considered. In Italy, this was the case, for example, for the adoption of PDTA (*Percorsi Diagnostico-Terapeutici Assistenziali* - Diagnostic-Therapeutical Assistance Paths) pathways for chronic diseases. PDTAs, also known as "critical pathways", "care pathways", "integrated care pathways", "case management plans", "clinical pathways" or "care maps" and which are employed to plan a patient-centered care program and systematically follow the patient through the care process.

PDTAs are used all over the world. However, despite their widespread use, there are still many uncertainties, both in terms of the terminology and regarding the modalities according to which they are defined and developed. With reference to their impact, different analyses on the effects of PDTAs have described a wide variety of outcomes [36].[2]

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[2] Another organizational innovation, based on attention and care for the patient, consists in the implementation of a network. The size of the network is constituted by the number of subjects that compound the network (with the problem, likely to arise, of defining the "borders" of the network itself: for example, who is supposed to stay within the network? Who is outside the

Continuity of care

Continuity of care is concerned with the quality of care over time. There are two important perspectives in this regard. Traditionally, continuity of care is seen from the patient's experience as a 'continuous caring relationship' with an identified healthcare professional [38]. Continuity in the experience of care relates conceptually to patients' satisfaction with both the interpersonal aspects of care and the coordination of that care. In contrast, continuity in the delivery of care cannot be evaluated solely through patients' experiences and is related to important aspects of services such as 'case-management' and 'multidisciplinary team working'. From a provider perspective, the focus is on new models of service delivery and improved patient outcomes.

A full consideration of continuity of care should, therefore, cover both of these distinct perspectives, exploring how these come together to enhance the patient- (and person-) centeredness of care [39].

There is a consensus that continuity of care can improve the quality of patient care and a concomitant belief that continuity of care and care coordination can be cost-effective [40]. Care coordination also implies adhering to guidelines. Guidelines can be helpful to physicians since they predispose them to concentrate on the management of specific diseases in a specific way. In fact, many diseases are syndromes, that is, common manifestations of diverse processes set in motion by interacting influences on health [41], that can be fully understood through a global and person-centered approach.[3] From this perspective, guidelines provide physicians with a comprehensive approach to the patient's conditions.

Some health plans in the US and, particularly, the National Health System in the United Kingdom, under the Quality and Outcomes Framework, have introduced payment systems that reward physicians for adhering to guidelines in the care of their patients. Although payment for performance is, in theory, a worthy approach to encourage adherence to processes of care, several aspects of its application are problematic in terms of attention to people's problems [43]. Here, we must be mindful of the care purpose of quality measures:

> "Quality measures should identify excellent comprehensive care. They must recognize successful management of multiple complex chronic conditions, meeting the counseling and communication needs of patients, and providing continuity of care and other attributes of comprehensive care. All measures must sustain and enhance appropriate patient care and the physician-patient relationship" [44].

More attention to the concept of person-centered care over time, as well as efforts to measure it, may provide a new dimension to efforts to improve care. In this context, person-oriented questions are of immediate relevance. An example of a person-oriented question might be: "*Does your physician know you very well as a person, rather than as someone with a medical problem?*" There is no doubt that patterns of communication make a difference, but the extent to which good communication in individual visits is a sufficient strategy to provide the person focus and "continuous healing" that good primary care requires is still unknown [45].

Economic implications

The benefits that may be obtained from a healthcare scheme based on the centrality of the person are evident both at the clinical level, where it is possible to detect an improvement in the patient's wellbeing and quality of life, and at the economic level, where resource savings are associated with the planning of an adequate assistance. The integration of clinical data and indexes with psychosocial information would allow us to detect, prevent and monitor both current and potential conditions of discomfort and suffering, both for the patient and for the family, in order to optimize and personalize the treatments and assistance [46,47]. In this way, the worsening of clinical situations at risk could be prevented, the monitoring of the psychophysical conditions would improve, and the resources employed, together with assistance provided, could be distributed more efficiently and accurately, with a consequent saving also in economic terms, time and stress for operators.

To improve the quality of care, incentives are being developed for patient-centered care performance in healthcare settings. Measures of patient-centered care may enable accrediting agencies and other organizations to determine the extent to which physicians provide such care and integrate these measures into reward or incentive programs. In the US, for example, the California Pay for Performance Program has changed the way physicians are paid by targeting new performance measurements [48,49]. With quality measures including assessments of patient-centeredness, it is incumbent upon physicians and managed care practices to incorporate methods and tools to enhance the involvement of patients.

Patient-centered care reduces the risk of malpractice lawsuits. Indeed, the Physician Insurers Association of America found that 35% of malpractice claims reported that "failure to communicate with or instruct the patient" was the principal or secondary reason for the claims. Hence, communication saves time and decreases the risk of litigation [50,51]. Overall, when physicians practise patient-centered medicine, the risk factors predisposing to

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network?). The density of a network is the overall level of connectivity: the greater the number of relationships between pairs of subjects belonging to a network, the greater the density of the network itself. However, a higher density might not correspond to a greater effectiveness of the network: a study on health networks for the treatment of mental illness in three different US cities has shown that higher levels of effectiveness are associated with lower levels of density [37].

[3] An example is given by the Chronic Fatigue Syndrome, still not clearly clinically defined: for the variety of symptoms and their personal as well as economic burden, a person-centered approach may guarantee the appropriate management of these patients [42]. This consideration was stressed at the Fourth Annual Conference of the European Society for Person Centered Healthcare, London, October 2017.

malpractice suits are reduced [52]: as an effect, there is the reduction in liability exposure and the increase in economic benefits [53]. Furthermore, patient-centered care increases patient loyalty: more than twenty years ago, the Miles Institute of Health Care Communication found 25% of patients leave a doctor because of poor communication and not being sufficiently involved in decision-making [54]. Hence, nowadays the challenge lies in strengthening patient- and person-centered care through *macro* level policy measures and *micro* level incentives at organizational and systems level.

Conclusions

This *Guest Editorial* has presented some reflections on the opportunity to shape patient assistance *via* person-centered healthcare models. The stages through which an evolution from patient empowerment to patient-centered care, to the development of assistance modalities that see the need for an all-encompassing consideration of the 'patient as a person', have been described. Surely, the highlighting of the economic advantages and the savings of resources with the simultaneous improvement of the quality of life and wellbeing for the patient, that are linked to these solutions, may call the attention of the policymakers, together with the promotion of these goals [3]. Undoubtedly, further research into the utility of person-centered care is of fundamental importance.

Conflicts of interest

The author declares no conflicts of interest.

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