Smithville angioplasties would not have been performed on Jonesville residents. I wonder what the cost differences would be.'

Broker B continues:

> *I do not know whether angioplasty is a good treatment protocol or not; I'm not a doctor. I can't give medical advice or opinions. Neither can you.*
>
> *But your employees in Smithville and Jonesville might be interested to see this data. We can present it to them. It may help them discuss their treatment options with their own physicians.*

The Benefits Administrator then pauses and thinks for a couple of minutes. 'Giving us data like this is a good thing. But it may be too specific for many of my employees. They may not need Caesarian or coronary treatment information. But they may need information about other treatments. What can you do for us there?'

Broker B responds:

> *We provide general information about our healthcare system, for example, about 'treatment variation' – like the data I just presented. We explain what it is, why it exists and how your employees can learn more. We use local examples for medical procedures ranging from mastectomies to leg amputations to back surgeries*.
>
> *We want to help your employees become sophisticated healthcare consumers. We want to provide them with data to discuss with their physicians.*
>
> We *never advise people whether or not to seek treatment.*
>
> *Instead we teach them how our healthcare system works. We try to give them tools to negotiate the system better, and to protect their own interests better.*
>
> *In short, we inform them of systemic problems that they may not have realized exist.*

In the end, the Benefits Administrator considers the two brokers. One who takes the 'let the buyer beware' approach about dealing with our healthcare system. The other who 'does his fellow a favor'. Which will help my employees the most, he wonders.

In the end, the Benefits Administrator chooses…..*Well, who would you choose?*

**If the Broker 'let's the buyer beware', then who will 'do his clients a favor'?**

In the 1990s, carriers restricted access to medical care as part of their cost containment programs. Patients needed referrals – which were not always accepted by the carrier. Carriers limited access to expensive specialists, limited the number of physician visits / condition, or limited the types of medications covered.

The American public perceived this as an attempt to improve carriers' financial positions rather than to improve patient outcomes – and objected to these inappropriate restrictions.

One result: today's insurance policies allow easier, even unfettered (in the case of many PPO or POS type plans – the 'generous insurance plans' described by Mr. Rosof in our Preface) access to the hospital or specialist of choice. Post-2000, many carriers have acquiesced to consumer demands for easier access to care. Today many insured Americans can get access to all the medical care available.

Is this always a good thing? Not necessarily, suggests Mr. Rosof in our Introduction.

**Purchasing medical services is different from purchasing most other services: The Impact of Trust**

John Wennberg, from Dartmouth, addresses the underlying issue here. Purchasing medical services, he suggests, is vastly different from purchasing goods and services in most markets. 'The doctor-patient relationship is different,' he suggests 'because of the asymmetry of information.'

The consumer – your client "Does not know what he or she truly needs; it is the physician who knows the nature of the patient's illness and can select the right treatment…[as a result] patients delegate decision making to the seller of the services. [26]

Arnold Relman, Professor Emeritus of the Harvard School of Public Health, echoes Wennberg on the asymmetry of medical information between patient and physician: [27]

> *Patients usually know much less about the diagnosis and treatment of their disease or injury than their doctors do. Furthermore, because of illness or injury they may be in no condition to evaluate their options.*
>
> *As a consequence they cannot independently decide what medical services they want in the same way consumers choose services in the usual market…*

[26] Wennberg, Tracking Medicine, page 23

[27] Arnold Relman, A Second Opinion, 2007, pages 22 - 23

*The penalties for making a mistake in the health care market are usually higher than in others.*

*Patients must therefore trust their physicians to decide what services they need.*

Imagine doing this with your home repair contractor. We might call it 'license to steal' if the homeowner said 'tell me what I need and I'll buy it all.'

But in medicine we accept that the service seller (physician) will identify the problem, design the solution, implement the solution, get paid for his/her efforts and that the patient will agree.

**Various factors may affect advice, consciously or subconsciously**

Dartmouth's Wennberg provides a cautionary note.

*Physician decisions…are strongly influenced by the capacity of the local medical market - the per capita number of…medical specialists, and hospital or ICU beds, for example.* [28]

In other words, physicians in areas with *greater medical services available* are likely to design more expensive and more generous treatment programs than physicians in areas with *fewer medical services available*…for the same patient. And often generating the same outcomes.

(Remember that in the US, no regions have *insufficient* medical resources as, for example, do many foreign countries. This is, in part, due to Medicare's payment system. We do not have significant regional mortality rate differences that researchers attribute to a lack of medical resources. All US regions have at least a sufficient level of medical resources available.)

Here is Wennberg's startling suggestion: treatment protocols vary more based on ***medical supply differences and the regional medical culture*** than based on *patient medical differences*. He suggests that your chance of having surgery can be predicted by the rate of surgery in your region 10 years prior:

*The really fascinating thing to me is to think that what predicts your risk of surgery today in a particular region is what it was ten years ago in the same region.* [29]

[28] Ibid. page 11

[29] Brownlee, op cit, page 41

As a result, a Medicare beneficiary with early stage breast cancer who moves from Springfield, Massachusetts to Hartford, Connecticut – about 20 minutes away – approximately doubles her chance of having a mastectomy.

**An Embarrassing Live Example**

Wennberg and his colleagues at Dartmouth Medical School tested this Treatment Variation idea on physicians practicing in Boston and New Haven. [30]

Their reasoning: the Boston medical landscape is dominated by Harvard Medical School, its affiliated teaching hospitals and its alumni. The New Haven medical landscape is similarly dominated by Yale Medical School. Both are outstanding and prestigious academic medical centers. Both publish widely. Both read each other's research studies.

We would expect both to treat similar patients similarly. Wennberg wanted to explore this idea, and determine if the supply of medical resources affected the physician's judgement.

Here's what Wennberg's team did. First, they counted the number of hospital beds available in the Boston and New Haven areas. They then divided the number of beds by the number of Medicare beneficiaries to get a ratio. (They used Medicare beneficiaries because Medicare provides sufficient data for this research study.)

Boston had 55% more beds per 1000 Medicare beneficiaries than did New Haven. And, just as Roemer had predicted in his Law some 25 years earlier, Boston area Medicare beneficiaries spent about 40% more time in the hospital than did New Haven beneficiaries.

This meant that a patient in Boston had a much higher likelihood of being hospitalized for something that a similar patient in New Haven would not be hospitalized for!

Yet, as Shannon Brownlee, another Dartmouth scholar, summarized the situation:

> *Patients in Boston weren't any sicker than those in New Haven; they were just more likely to be hospitalized – and admitting them more often to Boston hospitals did not appear to improve their outcomes.*

Wennberg's initial publication of this phenomenon was entitled 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?' [31]

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[30] This story comes from Brownlee, Overtreated, pages 111 - 112

[31] Lancet, 1987

He continued his research. He discussed standard admission decisions with physicians in Boston and New Haven. He asked physicians in New Haven if they felt like they were forced to ration care, and they said no. He asked physicians in Boston the same question, and got the same answer. Physicians in both cities felt that they had sufficient medical resources available and hospitalized patients at the right rate.

He then presented his findings to physician groups in Boston and New Haven. But he played a trick***:*** *he reversed the labels on his slides!*

He labeled Boston admission rates 'New Haven' and labeled New Haven as 'Boston'. He then showed Boston area physicians that 'New Haven' doctors (i.e., themselves in reality) were admitting patients 40% more often. And he showed New Haven doctors that 'Boston' physicians were admitting 40% less.

He then asked the Boston group to comment on how New Haven docs practiced medicine. The result, according to Megan McAndrew, editor of The Dartmouth Atlas: The Boston audiences

> *Would come up with all these reasons why those guys down in New Haven were admitting too many patients.*

This group, being highly trained physicians, would explain in detail which admission errors the New Haven docs made – by disease type, etc. Wennberg dutifully wrote everything down.

He then said 'Opps, I mislabeled the slides' showed the *correctly* labeled slides and went through the reasons given for poor admission decisions in New Haven. He discussed item-by-item the treatment differences and hospital admission differences, by patient presentation and disease, for Boston and New Haven.

The lesson here, according to Brownlee:

> *Doctors were blithely, astonishingly unaware that the supply of hospital beds was affecting their clinical decisions. They thought they were putting patients in the hospital entirely on the basis of what would help the patients…*

Not based on any external supply factors.

I have no idea whether Boston admission rates or New Haven admission rates were correct. I only know that they differ. As a consumer, I would like someone to inform me of this discrepancy.

Our ethical question returns: *do you think your clients should be advised of this information? Would* <u>*you*</u> *like to be advised of this if you were a client? If so, how would you know that this information exists? Who, in our healthcare system, would tell you?*

## How Much Consumer Education?

The average doctor's visit only lasts about 8 minutes.[32] During this time, the physician needs to diagnose the patient's problems, describe the treatment options and help the patient make a decision – that's plenty to do in 8 minutes.

The physician doesn't also have time to (a) explain the treatment variation issues, (b) research the likelihood of excess care for a particular medical problem in a specific region, (c) research the treatment tendencies of each hospital in the region for that particular medical problem (see our example of Caesarean deliveries by hospital above) and (d) answer all the patients questions. That's too much information for the poor patient – who may be emotionally upset by the diagnosis in the first place!

Our physician, thus, is unlikely to 'do your clients a favor' during the short office visit…even if the physician understands the treatment variation issues.
.
But even worse, from a patient education point of view, our medical system does not pay anyone to disagree with the physician

By analogy, our legal system requires both a prosecution and defense attorney to question witnesses. That way neither has too much power.

In our medical system, however, patients only get one point of view ---from providers who earn money by providing care. Your doctor plays the equivalent roles of police investigator, prosecutor, defense attorney and judge. This puts enormous advisory power in the hands of one person – and, interestingly, a person who has an economic interest in the patient's decision.

Our system does not pay anyone to oppose the provider's point of view.

Carriers might also play that role – but the managed care experience of the 1990s has turned popular opinion against trusting carriers too much.

Second opinions might fulfill the role, but probably do not. Physicians in the same group practice, hospital or region tend to treat patients with similar protocols, and disagree far less than perhaps they should. This is very well documented in the healthcare literature.

Also, physicians may have informal – perhaps even unconscious – motivations to support each other.

No one, it seems, will do your clients a favor….except you, the broker!

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[32] Estimate from David Cordani, CEO of Cigna at Keynote Lecture, Yale Healthcare Conference 2015

**Review Questions**

Correct answers on next page

1. This course noted 3 effects of and excess supply of medical services and of excessive medical care. Which below is **NOT** an effect of excess supply and care? In other words, which below is **FALSE**?

a. Regions in our country with more physicians have more medical procedures and higher medical costs

b. Patients in high spending regions are more likely to be undertreated with routine care than patients in low spending regions

c. Mortality rates in high spending regions are lower than in low spending regions. In other words, people in high spending regions live longer than people in low spending regions

d. Mortality rates in high spending regions are higher than in low spending regions. In other words, patient's chances of dying increase as medical spending increases

2. Which factor, below, does NOT appear to affect the number of medical specialists in a region?

a. Cost of living

b. Availability of good schools for their children

c. Underlying disease risks

d. Weather

3. How good is the quality of outcome data in our healthcare system?

a. The overall quality is quite good

b. The quality of acute care outcome data is good, but the quality of chronic care outcome data is poor

c. The overall quality is poor

d. The quality of chronic care outcome data is good, but the quality of acute care outcome data is poor

**Review questions**
Correct answers in bold

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   b. Patients in high spending regions are more likely to be undertreated with routine care than patients in low spending regions
   c. **Mortality rates in high spending regions are lower than in low spending regions. In other words, people in high spending regions live longer than people in low spending regions**
   d. Mortality rates in high spending regions are higher than in low spending regions. In other words, patient's chances of dying increase as medical spending increases

2. Which factor, below, does NOT appear to affect the number of medical specialists in a region?
   a. Cost of living
   b. Availability of good schools for their children
   c. **Underlying disease risks**
   d. Weather

3. How good is the quality of outcome data in our healthcare system?
   a. The overall quality is quite good
   b. The quality of acute care outcome data is good, but the quality of chronic care outcome data is poor
   c. **The overall quality is poor**
   d. The quality of chronic care outcome data is good, but the quality of acute care outcome data is poor

## How Should an Ethical Broker Proceed?

In this chapter we'd like to offer some general advice for how best to ***do your fellow a favor***: [33]

1. Educate yourself about our healthcare system.

   The ethical broker has a responsibility to 'do your fellow a favor'. The more you know about our healthcare system, the better you can educate your clients.

   Today's bookstores are full of insightful and useful books about healthcare. Some that we have found particularly useful (also quite engaging and easy to read):

   **Overtreated**, by Shannon Brownlee;
   **Complications**, by Dr. Atul Gawande;
   **Better**, by Dr. Atul Gawande;
   **Best Care Anywhere**, by Phillip Longman;
   **Should I Be Tested for Cancer?**, by Dr. H. Gilbert Welch;
   **Overdiagnosed**, by Dr. H. Gilbert Welch;
   **Know Your Chances**, by Dr. Steven Woloshin, et al
   **Tracking Medicine**, by Dr. John Wennberg

   Here's typical feedback from our students who have read these books: they contain fascinating and very useful information. Ethical brokers use that information in their normal professional work.

2. Help your clients ask questions.

   Patients sometimes are intimidated by specialists; sometimes awed by specialists; or sometimes tongue-tied in front of specialists. The better you educate your clients about the inner workings of our healthcare system, the better they'll be able to ask important questions of their physicians.

3. Give general, but not client specific advice. Do not play the role of doctor or give medical advice. This is illegal unless you are licensed to practice medicine.

Rather than give specific, detailed advice to a client about his / her specific medical condition, we encourage you to offer general education about the workings of our system.

You can, for example, use the Dartmouth Atlas of Healthcare (www.dartmouthatlas.org) to see comparisons between your region / state and other states or national averages.

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[33] Some of this advice comes from the Afterward of Overtreated. See Brownlee, op cit pages 308 - 310

Some other useful websites include the Kaiser Family Foundation site (www.KFF.org) , the Centers for Disease Control site (www.cdc.gov) and the Agency for Healthcare Research and Quality site (www.ahrq.gov) and the Commonwealth Fund (www.commonwealthfund.org) .

These sites provide extensive data about the operation of our healthcare system.

## Conclusion

So far in this this course, we have suggested that ethical brokers educate their clients. An ethical broker adopts the 'do your fellow a favor' standard rather than 'let the buyer beware'.

I would like to extend this idea here and suggest that ***adopting the ethical standard of 'do your fellow a favor' is good customer service.*** The more you treat your clients as you would like them to treat you (were conditions reversed), the more satisfied they will be with your service.

'Customer service' in this regard is much more than answering telephones promptly, responding to emails and processing the myriad of forms that health insurance brokers process. It is also more than generating quotes for health, life, disability and dental coverage.

Customer service begins to mean 'help your customers navigate our healthcare system.' This may be far more important than answering phones promptly.

Imagine how satisfied a client will be with your service when she learns from you about the risk of Caesarian births at local hospitals. Absent that knowledge, she might have had an (unwanted) Caesarian; her lack of information may have reduced her ability to plan and increased her risk of a procedure that she did not want. Armed with information, however, she can make more informed decisions about where and how to deliver her baby.

Alternatively, imagine how pleased a different woman may be to learn that some hospitals perform very low rates of (desired) Caesarian births. She may use your information in discussions with her obstetrician, and alter her choice of delivery hospital as a result.

Imagine how satisfied another client will be when they begin a conversation with their cardiologist armed with data about the relative rates of angioplasty performed in your region compared to the national average.

Now ask yourself the chance that a client who is so satisfied with your services will switch to another broker at the next policy renewal. I suggest that your client retention rates will increase as you embrace the 'do your fellow a favor' ethical standard.

Good ethics is good customer service.

We have an ethical tradition of full disclosure and ‘do your fellow a favor’ extending back to the time of Abraham. I hope that today’s health insurance brokers will embrace this tradition, and practice both good ethical behavior and good customer service as a result.

**Case study: A brief historical view**
**Some health insurance trends since 2000.**
**Did the health insurance industry evolve ethically?**

This section applies the tools introduced previously to evaluate healthcare systemic evolution since 2000. Consider, as you read it, the implications for your own professional behavior.

- How has your behavior changed over the past decade or so?
- Are you acting today as ethically as you did years ago?
- How does your own ethical position change as the overall industry changes?

This section will describe two major industry activities post-2000s: the introduction of Consumer Driven Healthcare aimed at controlling costs and of HEDIS quality measures aimed at improving quality. These are not the only programs developed. Rather, they are examples of the *types* of programs implemented by carriers over the past decade. As you read this, consider whether the insurance industry acted ethically (in our terms) or not. Did it *let the buyer beware* or *do your fellow a favor*? What responsibilities does this place on the broker's shoulders?

**Our starting point: the 2004 NCQA report**

The National Council on Quality Assurance, a managed care industry association, published the following in its 2004 Annual Report, clearly identifying the need to improve the quality of our nation's medical care. I choose 2004 because it was the first year after the introduction of Health Savings Accounts in the Medicare Modernization Act of 2003 and because the 2004 NCQA report so eloquently framed these issues: *The disparity between the care most Americans receive and the care delivered through the nation's best plans results in from 42,000 to 79,000 premature deaths each year……thousands of preventable second heart attacks, kidney failures and other conditions……more than $9 billion in lost productivity and nearly $2 billion in hospital costs could be averted through more consistent delivery of best-practice care……more than 14,000 heart attacks and strokes could be prevented each year through better diabetes management alone.*

This report followed on the groundbreaking 1999 ***To Err is Human*** study by the Institute of Medicine that documented, for example: *preventable medical errors cost the US economy between $17 billion and $29 billion annually plus thousands of preventable annual deaths…These errors include diagnostic, treatment, preventive and systemic*

*problems…The IOM believes that faulty systems, processes and conditions, rather than individual physician mistakes cause these medical errors.* These preventable errors account for up to about 100,000 unnecessary deaths per year.

Both statements describe a poor quality medical care system that includes huge amounts of unnecessary care, expense, preventable injury and death, all of which has a significant financial impact. How did the insurance industry respond to these types of wake-up calls? In part by introducing process metrics like the HEDIS system that I'll describe later, and in part by introducing Health Savings Accounts, a tax codification of the trend toward high deductible health plans, the so-called Consumer Driven Healthcare, aimed at controlling medical care inflation.

**Consumer Driven Healthcare**

Consumer Driven Health Care aims to treat medical care purchasing like all other consumer purchases such as cars and homes. It does this by requiring consumers to spend their own money on medical care, up to some specified annual deductible.

Consumer engagement starts – and generally stops – with deductibles. Few plans include meaningful medical care quality metrics like the Number Needed to Treat or Number Needed for Harm. Few consumers know their Starting Risk of developing various medical problems, or the Modified Risk offered by medications, therapies or tests. Even fewer can understand which medical claims - from medical ads for example - are meaningful and which are not. The industry has, so far at least, failed to teach consumers how to choose high quality medical care over low and avoid unnecessary care altogether.

Lacking this knowledge, consumers spend their money unwisely on medical waste…up to, about, 1/3 of the time…regardless their deductible or the tax treatment thereof. What price-based medical decision making overlooks: better outcomes almost always cost less than poorer ones.

One reason for this: better medical quality leads to fewer missed diagnoses, hospital readmissions, unnecessary tests and unnecessary procedures. This suggests that wiser medical consumers – i.e., those who make the most well-informed medical care quality decisions – are generally the *lowest cost* medical consumers, not the 'penny-wise, pound foolish' folks who shop based on price.

Dissuading people from choosing *quality* care by motivating them to choose *cheaper* care may well take us in the wrong direction. Medical care prices are, of course, important. Pricing information is *most appropriate* for medical commodities like radiologic scans, pharmaceutical products, and routine tests and procedures. In these,

the care quality is either approximately the same - many hospitals use the same type of MRI machine, for example - or unknowable. How can a patient determine the quality of one physical therapist as compared to another? They can generally only determine the friendliness.

Pricing information is *least appropriate* for complex, expensive, highly individualized, potentially life threatening medical interventions. Would an elderly patient suffering from congestive heart failure, decreased kidney function, Parkinson's disease and diabetes - who needs his pacemaker removed and upgraded - choose the least expensive facility? Or an obese, diabetic woman suffering from COPD and lupus choose the least expensive facility for her double mastectomy? I suspect these people would want the *best* facility because the risks are so high. These individualized, non-routine interventions are the ones with the most potential to save money. But they're the ones for which we're least able to get meaningful pricing information.

In general, price is a secondary consideration in medicine, one that wise patients should only consider after they have determined the care quality.

Here's how the wise patient would make an informed medical decision, at least conceptually: First, decide which medical care *treatment* offers the best outcomes for people like you. Spinal fusion surgery or back therapy, for example; mastectomy or watchful waiting. Second, decide which *hospitals and physicians* provide that treatment the best, as measured by outcomes for people like you, Third, if you find two hospitals or physicians that generate the same outcomes for the same treatment, then sure, choose the least expensive.

Of course, medical decisions are often rushed so you can't go through this sequence in detail. Often these data don't exist for your particular medical need so you need to estimate. But the key point remains: *choose high quality, necessary medical care based on outcomes for people like you as a first consideration, and relegate cost issues to a secondary role.* So- called Consumer Driven Healthcare tends to flip this process on its head.

**Consumer Driven Healthcare Defined by Deductibles (largely)**

In common insurance lingo 'consumer driven products' are those with $1000 or more annual deductibles. Each consumer spends that $1000 as best he/she sees fit – for physician visits, medications, tests or therapies. Only after satisfying the deductible does insurance begin to pay. Then, depending on the specific plan design, insurance pays all of the additional medical expenses, or part up to some set amount.

In theory, when people spend their own money they shop more wisely and get better value than they would if they only spent the carrier's money. This is the same theory that underlies other consumer products, ranging from refrigerators to cars to tennis racquets. Unfortunately, the theory fails in healthcare due primarily to the lack of medical *quality* information – the necessary first step to wise medical care decision making. Today we only have some medical *pricing* information. (I'll give examples shortly.)

The lack of quality info makes medical decisions different from, say, car purchasing decisions. The car buyer can compare various cars before deciding which to purchase. Large or small, good gas mileage or poor, lots of luxuries or few, good crash-testing rating or not, high resale value or low, built-in GPS units, etc…and price too, of course! But the medical purchaser generally has very little similar information. How effective is this intervention compared to that? Or this medication compared to that one? Which doctor has the best outcomes for people with my illness? Which hospital? You don't need a medical degree to compare the effectiveness of different medical treatments. You just need the information. But we generally lack it.

For this reason, I suggest that today's so-called Consumer Driven Health Care is really nothing more than cost shifting to sick people. These plans have virtually nothing to do with consumerism. And they can't, since patients have virtually no useful medical care quality information today upon which to make wise medical care decisions.

## Some Examples

To help patients spend their deductibles wisely, insurance carriers, private companies and some states have developed and promoted pricing tools – lists of medical treatment prices from various local providers that, theoretically, help patients shop for the best deal. Some of these models are extremely detailed, showing, for example, what an individual consumer will pay based on his/her deductible payments so far this year, how much your employer will pay, what types of follow up care you may need and what they will cost, etc.

I'll show you some simple examples. To avoid any confidentiality or related issues, I'll use a public pricing site, the New Hampshire state site, nhhealthcost.org. I chose it because it was easy to use. I also used a fictitious Cigna group insurance policy, chosen entirely at random.

This may or may not be representative of medical prices nationally, but it serves to show how different providers charge vastly different amounts for the same medical

services.[34] The first chart shows costs for laparoscopic out-patient hernia repair.

| Facility | Cost |
|---|---|
| Elliot Hospital | $10,237 |
| Wentworth-Douglass Hospital | $15,896 |

We have no meaningful quality information – infection rates, speed of return to normal health, patient satisfaction, 30 day readmission rates, etc. The only so-called quality information available includes the following metrics, partial list, with each hospital given 1 – 5 stars. I can't imagine how these measures or the star averages would help a hernia patient make a wise location decision.

| **Patient Centered Care Metrics** |
|---|
| Overall patient experience |
| Area around room was quiet at night |
| **Timely Care Metrics** |
| Patients with stroke symptoms who received head CT scan upon arrival |
| Recommendation for follow up |
| **Safe Care Metrics** |
| Patients infected with Cdiff while at hospital |

A word about stars and 'average patient experience' at general hospitals. First, there is no 'average patient' in terms of treatment. Some have foot issues, others head. Some have orthopedic issues, others cancer. They go to different departments, see different doctors, have different interventions and follow different protocols. A hospital might be excellent at hematology but weak at nephrology, strong at child psychiatry but weak at interventional radiology, etc. 'Average' has no meaning in this context.

[34] I downloaded these costs in April, 2021

Second, there is no ‘average patient’ in terms of illness severity. Some cancer patients might have their disease under control and receive excellent outpatient care while others need surgery. A given hospital might be much better at treating one level of severity than another.

Third, none of these so-called quality metrics measure outcomes – risk adjusted patient mortality rates, for example. None, in other words, suggest whether or not patients will actually get healthier at one hospital or another.

For these 3 reasons, the quality metrics employed in New Hampshire – again, simply an example of the current state of transparency – have no meaning for our sample hernia patient. They are, in other words, meaningless.

Here’s a second example, again from New Hampshire, but with a different insurance carrier. I choose Anthem this time, again entirely randomly, for colonoscopy with polyp removal.[35]

| **Facility** | **Total Cost** |
|---|---|
| Wentworth Surgery Center | $964 |
| Elliott Hospital | $1,098 |
| St. Joseph Hospital | $1,585 |
| Valley Regional Hospital | $2,003 |
| Mary Hitchcock Memorial Hospital | $3,533 |

Again, no quality information – rates of false positives, misdiagnoses, overdiagnoses etc. No information on number of call backs, unnecessary further investigations, etc. But an impressive price discrepancy. Some patients – presumably – will choose the lower cost provider to save money. Others may choose the *higher* priced treatments, assuming that the most expensive is the best. Still others may choose the one closest to home, regardless the price, especially if they have already satisfied their deductible. And others may follow their doctor’s advice, regardless of price. I’m not sure what all

[35] https://nhhealthcost.nh.gov/costs/medical/result/colonoscopy-with-polyp-removal-outpatient?carrier=2&plan_type=3

this has to do with medical care quality – the ‘up to about a third generating no detectable benefit’ – as we have no reliable, similarly detailed outcome metrics to combine with these prices. I’m also not sure exactly how consumers will change their behavior when faced with this pricing information. But some industry folks are developing ways to address that behavioral issue.

**New plan designs: do you let the buyer beware of details?**

Once prices for lots of procedures – and for bundles of procedures – become available, carriers and brokers can design *reference based pricing* plans. That’s likely the next new thing. Reference based pricing takes the deductible concept a step further: The *deductible* applies to all your medical care. Once you pay it, the care is free for the rest of the year, though some plans may still call for a co-insurance payment up to some specified amount. *Reference based pricing* says the insurer will only pay the lowest price in the region after you satisfy your deductible. The insurance subscriber is responsible for all or part of any excess if he/she chooses a different provider.

The low price provider may change by treatment. In our examples above, Derry was the low price pelvis MRI provider and Concord the low price arthroscopic knee surgery vendor. Whichever provider is the lowest price becomes the ‘reference’ for that treatment. These plans are still very new and we don’t have evidence of their effectiveness. Creative carriers and brokers will almost certainly develop variations on this theme.

Prices serve a variety of supplier goals including profit generation and customer attraction (marketing). I’ll use an automotive analogy to introduce all this and then show how hospitals do the same things.

Here’s the example: An independent auto mechanic advertises oil changes for $19.95. Meanwhile the large dealer up the road charges $34.95. Is the independent better or worse at oil changes? We don’t know. But by charging $19.95 he’s probably trying to attract new customers who will like his work and use his services for brake jobs, tune-ups and other higher priced, more profitable work. In other words, the $19.95 oil change is part of his marketing strategy to get people in the door with the low priced item and then upsell them: ‘You know, your brake pads are pretty thin. I could replace them while I do your oil change.’

Retailers do this all the time: attract new customers with cheap, low margin items and then sell them higher priced expensive stuff.

Two points here: **First:** there are lots of auto repair competitors, so consumers can quite easily research their options. You can’t make too much of an auto repair mistake

as you're normally only spending a few hundred dollars at most. A bad decision probably just means you overspend by a bit. Pretty small risk to the consumer. *Not so true of complex medical issues where poor quality care can literally kill you.*

**Second,** auto repairers are notorious for upselling unnecessary services, at least in the common public perception, so consumers are 'defensive shoppers,' constantly on their guard to avoid getting ripped off. George Castanza articulated this in a 1995 Seinfeld episode, describing his dealings with an auto repair facility: [36] *Well of course they're trying to screw you! What do you think? That's what they do. They can make up anything; nobody knows! "Why, well you need a new Johnson rod in here." Oh, a Johnson rod. Yeah, well better put one of those on!*

Could hospitals do the same thing, upsell patients? Attract them in and then provide lots of additional, perhaps unnecessary but high margin billable services?

**Item:** Emergency room physicians at Carlisle Regional Medical Center in Pennsylvania had targets for how many patients to admit. According to the New York Times investigation, published in November, 2012: [37] *doctors said that hospital administrators created targets for how many patients they should admit. More admissions translated into more dollars for the hospital…one of the physicians recalled getting phone calls in the middle of the night questioning why he had not admitted an older patient whose hospitalization he could easily have justified. "The pressure to admit was so high," he said.*

**Item:** 60 Minutes reported on December 2, 2012 that Health Management Associates, the 4th largest for-profit hospital chain in the country *relentlessly pressured its doctors to admit more and more patients -- regardless of medical need -- in order to increase revenues.* [38] The Emergency Room admission benchmark was 15% in some places, 20% in others and 50% for Medicare enrollees, with hospital administrators emailing ER docs messages like: *Only 14 admits so far!!! Act accordingly… I will be blunt…I have been told to replace you if your [admission] numbers do not improve.*Sounds like upselling to me. ER is a low margin business, like oil changes. Inpatient admissions - far more profitable. Like Johnson rods.

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[36] http://www.imdb.com/title/tt0697702/quotes

[37] Creswell and Abelson, A hospital war reflects a bind for doctors in the US, New York Times, Nov 30, 2012

[38] 60 Minutes, Hospitals: The Cost of Admission, December 2, 2012

Just image the potential impact if hospitals *compete* with each other on advertised prices, but *compensate* their doctors based on admission rates or surgeries performed.

**Item:** On September 12, 2012, Westerly Hospital in Westerly, Rhode Island offered free PSA screening from 5 – 6 PM. [39] 'Free' is the ultimate low cost. Now…why would a hospital give its services away for free? And why PSA screening in September 2012, *four months after the US Preventive Services Task Force recommended* *<u>against</u>* *PSA screening for prostate cancer?*

Dr. Otis Brawley, Chief Scientific and Medical Officer at the American Cancer Society suggested an answer in an interview: [40] We at Emory have figured out that if we screen 1,000 men at the North Lake Mall this coming Saturday, we could bill Medicare and insurance companies for $4.9 million in health care costs [for biopsies, tests, prostatectomies, etc]. But the real money comes later--from the medical care the wife will get in the next three years because Emory cares about her man, and from the money we get when he comes to Emory's emergency room when he gets chest pain because we screened him three years ago. Questioner: You're saying that screening creates long-term customers. So, did Emory Healthcare decide to go ahead with the free PSA screening on Saturday?

> Dr. Brawley: No, we don't screen any more at Emory, once I became head of Cancer Control. It bothered me, though, that my P.R. and money people could tell me how much money we would make off screening, but nobody could tell me if we could save one life. As a matter of fact, we could have estimated how many men we would render impotent...but we didn't. It's a huge ethical issue.

Seems that Westerly Hospital made a different decision.

I'm left to wonder if publishing price lists will still leave as unnecessary about half the Connecticut mastectomies…or perhaps increase the rate of unnecessary mastectomies if radiologists are compensated based on mastectomy rates or a similar metric.

I just don't see how all this pricing information cuts down on our rate of unnecessary care or switches people from low to high quality treatments. I *<u>do</u>* see how this can cut some hospital and treatment costs, but I hesitate to guess whether this means better care or worse. Will hospitals routinely admit more patients in the 'gray area' between definitely needing admission and definitely not to maintain their income…like our ER

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[39] http://www.westerlyhospital.org/hospital-offers-free-psa-screening-on-sept-12/

[40] http://www.whale.to/cancer/psa_screening.html . Brawley reports a similar story in his book How We Do Harm, pages 228 - 9

examples above? Will others do *more* investigations to find *more* microscopic abnormalities that require *more* low quality care, perhaps like Westerly Hospital? Will our overall medical inflation rate actually *rise*? Shopping for medical care based on price requires people to understand what those prices actually mean. I'm not sure many do. I worry about the tyranny of the unintended consequence.

**Are current metrics ethical or not?**

Here are some New Hampshire mammography prices. As you review these, remember Dr. Brawley's comments and ask yourself 'if I ran a high priced hospital, how could I keep my mammography prices high to maintain my income while also maintaining my volume?' I probably wouldn't want to compete on mammography *price* as that could mean foregoing $300 or more per mammogram with a potentially significant negative impact on my bottom line. ($300 per mammogram, 11 mammograms/day, 6 days/week is about a million dollars per year.)

I used that fictitious Anthem policy again here for Outpatient Mammography'.

| Facility | Total Cost |
|---|---|
| Parkland Medical Center | $127 |
| St. Joseph Hospital | $186 |
| Speare Memorial Hospital | $365 |
| Dartmouth-Hitchcock Clinic | $488 |
| Memorial Hospital | $570 |
| Valley Radiology Associates | $797 |

Again, no quality information: no false positive or false negative rates. We only know that prices vary.

How would a hospital compete? How might it expand in the breast cancer market? How might it attract more patients?

One suggestion (I'm sure creative hospital marketing people will come up with dozens more): a hospital might decide to attract mammography patients by advertising an *'over 95% 5-year breast cancer survival rate'*.

That sounds pretty good. People might pay more to use this facility based on the quality it apparently has and the peace of mind it offers. It's a good marketing campaign that might even increase patient volumes while the hospital maintains high prices. But the 95% 5-year survival rate tells nothing about the hospital's breast cancer treatment *quality*; survival rate statistics are spurious, misleading at best and bogus at worst.

Here's why: The 5-year survival clock starts when the breast cancer is diagnosed. Over time, we have diagnosed smaller and smaller abnormalities, earlier and earlier in the breast cancer's life. In fact, between the mid 1990s and mid 2000s, we diagnosed breast cancer about 1 full year earlier, according to the National Cancer Center's SEER data.

> Average age of breast cancer diagnosis mid-1990s: about 62; [41]
> Average age of breast cancer diagnosis 2006: about 61. [42]
>
> Unfortunately, the average age of breast cancer death was the same in 1996 and 2006: 68. [43]

Screening starts the 5-year clock earlier. Screening identifies an abnormality before it becomes symptomatic. It may take a year, 2 years, 5 years or more to become symptomatic, if ever. Identifying an abnormality – breast cancer, for example – by screening *automatically* adds all the pre-symptomatic time to the survival time. This increases 5-year survival rates at even *poor quality* hospitals, because most of the women diagnosed wouldn't die within 5 years anyway.

Diagnosing more women with small, young, hard to detect cancers will increase your 5-year survival rate - by definition - regardless of your medical care quality. You can, thus, improve your 5-year survival rates (or 10 or 20 year rates) by diagnosing cancer earlier but without treating it better or without extending the woman's life at all. Women may still die at the same age, but just live longer with the (earlier) cancer diagnosis. This is apparently the case in the US, or diagnosing cancer no earlier, but providing better cancer treatment and extending the woman's life through better care, or both. Knowing only the 5-year survival rate doesn't tell us which of these 3 situations occurred. That's why 5-year (or 10 year, or any number of year) survival rates may not tell us *anything at*

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[41] Glockler, Cancer survival and incidence, The Oncologist, December 2003

[42] National Cancer Inst, SEER Stat Fact Sheet: Breast downloaded Oct 2012

[43] The 1996 estimate comes from Saenz, Trends in Breast Cancer Mortality, Population Reference Bureau, December 2009; the 2006 from SEER Stat Fact Sheet, ibid.

*all* about the hospital's cancer treatment quality. But a hospital that advertises these to an unsophisticated public may make lots of money! *Caveat emptor.* [44]

More insidiously, using 5-year survival rates may put marketing pressure on hospitals and carriers to widen our definition of 'cancer' beyond utility and label more women as having cancer; it's a way to create more patients. *This actually happens!* Studies suggest, for example, about 25% of breast cancer diagnoses are for DCIS – ductal carcinoma in situ – an abnormal collection of cells in the milk duct. [45] It's a low grade tumor, something between normal breast tissue and breast cancer, not really what we think of as life threatening breast cancer. Some cancer specialists including Dr. Brawley of the American Cancer Society want to remove 'carcinoma' from the name – i.e. not call it cancer at all - out of concern **'**that we are scaring a whole host of people that have ductal carcinoma in situ who make rash decisions because it's called 'carcinoma'–decisions that they wouldn't make if it was more adequately described for what it truly is.'

An expert panel of the National Institutes of Health agrees, recommending that the word 'carcinoma' be deleted from this diagnosis. [46]

But hospitals, presumably, want to keep the name as-is to advertise their spectacular 5-year survival statistics and attract patients. Indeed, as our radiologic equipment detects smaller and smaller abnormalities, maybe some of these will be called a new type of 'cancer' under pressure from hospital marketers and lobbyists. A hospital, knowing all this, can advertise its (potentially non-existent) high quality medical care and charge high prices to unsuspecting patients. *Prices tell us nothing about quality*…or lack thereof.

Consider delivery prices at two hospitals. Hospital A costs $4000 for a normal, vaginal delivery and $8000 for a C-section. Hospital B costs $4500 for the vaginal and $8500 for the C-section. Both have similar delivery volumes and first class NICUs. Hospital A is obviously cheaper and is, perhaps, the reference hospital in a reference based pricing system.

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[44] Latin for Let the Buyer Beware. Fine advice if the buyer has the relevant tools to beware with!

[45] This discussion comes from Gary Schwitzer's discussion of January 14, 2010, Why don't journalists pay more attention to DCIS? On HealthNewsReview.org [http://www.healthnewsreview.org/2010/01/why-dont-journalists-pay-more-attention-to-dcis/](http://www.healthnewsreview.org/2010/01/why-dont-journalists-pay-more-attention-to-dcis/)

[46] Kolata, 'Cancer' or 'Weird Cells': Which Sounds Deadlier? New York Times, November 21, 2011

But Hospital A performs 48% of its deliveries by C-section, while Hospital B only performs 21%. The same woman would have a 27% increased likelihood of delivering by C-section at Hospital A.

Here's the correct way to calculate the average delivery costs at both hospitals (go ahead and try):

> * Cost of vaginal delivery times the % of vaginal deliveries *plus*
> * Cost of C-section times the % of C-sections *plus*
> * Number of extra days in the hospital for C-sections times the cost/day *plus*
> * The infant and maternal readmission rate for C-sections times the cost per day times the % of deliveries by C-section *plus*
> * The infant and maternal readmission rate for vaginal deliveries times the cost per day times the % of vaginal deliveries *plus* etc.

That's why I suggest that shopping for medical services based on price is far more difficult than it initially appears, and the effort may not bear any fruit at the end anyway.

This time, consider two breast cancer prevention drugs. [47] (I have no idea why I use so many breast cancer examples – perhaps because there's so much breast cancer data around and examples abound.) Drug A – $20 copayment – reduces the number of breast cancers by only about 21 per 1000 women. It seems to fall into our 'low quality' care definition….1000 women need to take it for 21 to benefit. That's only about a 2% effectiveness rate and 98% of women who take Drug A don't receive any benefit from it.

But women who take the alternative, Drug T – with a $50 copayment – have 50% fewer breast cancers than women who don't. This seems to fit our 'high quality' care definition much better. Cutting my chance of having breast cancer in half seems like a terrific deal for only $30 more/month, tax deductible in my Health Savings Account or Flexible Spending Account. A 50% reduction in breast cancer risk is a bargain at any price.

Here's the catch: they're the same drug**,** Tamoxifen. Taken prophylactically, it cuts women's risk of developing breast cancer by about 50%, from about 43 to 22 per thousand. Sophisticated marketers can induce different kinds of consumer behavior by presenting medical information in different ways – a 50% cancer reduction is much more powerful than a 21 case reduction per 1000 women. The wise, *sophisticated* consumer will buy the $20 copayment drug and still enjoy the 50% breast cancer risk

[47] These examples are apparently true, from a lecture by Dr. Gilbert Welch, The Two Most Misleading Numbers in Medicine, Feb, 2012, viewed on You Tube. I made up the copayment amounts arbitrarily.

reduction….while the *unsophisticated* one may spend an unnecessary $360 per year, presumably for many years.

Again, simply having medical pricing information tells you nothing at all about quality. But you need medical care quality information to make wise consumption decisions. In short, the extent to which Consumer Driven Healthcare focuses on medical prices is the extent to which it fails to help people make medical decisions based on care *quality*. But as we've seen, decisions made on care quality tend to save money – in addition to helping patients get the best care, which is obviously the goal in the first place.

Of course, pricing information along with medical care quality information can be very useful to patients. Unfortunately, we have, today, little useful quality information.

**Process guidelines as quality information**
**Would an ethical broker *do his fellow a favor* and explain all this… or *let the buyer beware* and ignore it?**

The health insurance industry responded to the Institute of Medicine's *To Err is Human* report and the NCQA studies showing big treatment quality differences among hospitals and physicians by developing new sets of *process guidelines*. These are like manuals designed to improve clinical practice. The National Committee for Quality Assurance (NCQA) in particular developed the HEDIS guidelines – the Healthcare Effectiveness Data and Information Set - basically instructions for how to provide high quality medical care to various types of patients. Today, according to the NCQA website, the HEDIS tools are used by more than 90 percent of America's health plans to measure performance of their contracted hospitals and physicians. Because so many plans collect HEDIS data, and because the measures are so specifically defined, the NCQA claims that HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. [48]

The NCQA, for example, publishes lists of carrier rankings based on their contracted hospital and physician HEDIS scores. (I should point out that HEDIS is but one of a handful of measures. Another commonly used metric is CAHPS, the Consumer Assessment of Healthcare Providers and Systems, which also measures process compliance and has the same fundamental flaws as HEDIS, which I'll describe below.) Note that HEDIS measures *inputs*, not *outcomes*. Inputs are what the doctor does to the

[48] http://www.ncqa.org/HEDISQualityMeasurement.aspx

patient; outcomes are how the patient actually did. HEDIS assumes that similar inputs lead to similar outcomes. Here are some of the 2013 HEDIS measures.[49]

| Measure | Commercial Patients | Medicaid Patients | Medicare Patients |
|---|---|---|---|
| Assistance with smoking cessation | x | x | x |
| Flu shots for adults over 50 | x | | x |
| Annual monitoring for patients on persistent medications | x | x | x |

Others, perhaps less compelling:

| Measure | For Commercial Patients | Medicaid Patients | Medicare Patients |
|---|---|---|---|
| Breast cancer screening | x | x | x |
| Cervical cancer screening | x | x | |
| Colorectal cancer screening | x | | x |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | x | x | x |

One specific concern: breast cancer screening with mammography is controversial, to say the least. The US Preventive Services Task Force only gives this a B recommendation, not A, concluding that 'there is a moderate certainty that the net benefit is moderate' Not exactly a ringing endorsement. The USPSTF recommends *biennial*, not *annual* mammograms due to the risk of false positives and breast cancer overdiagnosis, in women 50 – 75. They make no recommendation about mammograms for women 75 and older, saying *the USPSTF concludes that the current evidence is*

[49] http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2013/List_of_HEDIS_2013_Measures_7.2.12.pdf

*insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.* [50]

The Preventive Services Task Force actually *disagrees* with HEDIS about spirometry testing for COPD, recommending *against* screening adults for COPD using spirometry. HEDIS says 'do it to increase your scores'; the USPSTF advises against saying 'the incremental benefits are judged to be no greater than small' and 'fair evidence indicates that spirometry can lead to substantial overdiagnosis of COPD.' [51]

I certainly can't tell you whether spirometry testing is a good or bad thing and apparently, neither can the medical community. But doing it is necessary to get a good HEDIS score.

The fundamental point here: getting a high HEDIS score may not indicate medical care excellence. It may only indicate that your doctor checked the relatively easy-to-check boxes on one particular table of relatively easy-to-measure physician activities.

Michael Porter, Harvard Business School's great strategy professor, explains this problem much more lucidly: [52] Much more relevant is information about providers' actual experience levels, the treatments they use…and, most importantly, the results they achieve. Porter's concern – and yours, if you want good medical care – is that process compliance in medicine doesn't always translate to outcome similarities. *Process compliance* means physicians treat similar patients similarly; *Outcome metrics* tell us how well patients actually did. In medicine *similar medical processes can lead to different patient outcomes.* (Sorry if this is difficult to grasp, but it's really important to understand.)

A classic example of the difference between process compliance and patient outcomes comes from Atul Gawande's study of cystic fibrosis.[53] All CF treatments at all 117 specialized CF treatment centers across the country use exactly the same protocols for treating CF patients.

All CF physicians have the same specialized training. According to the theory underlying HEDIS, all CF patients should therefore enjoy about the same outcomes – lung function and longevity, for example. Unfortunately, patient outcomes vary

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[50] http://www.uspreventiveservicestaskforce.org/uspstf09/breastcancer/brcanrs.htm

[51] http://www.uspreventiveservicestaskforce.org/uspstf08/copd/copdrs.htm

[52] Porter and Teisberg, Redefining Healthcare, page 54

[53] Gawande, The Bell Curve in Gawande, Better

significantly by CF treatment center, with some consistently *over*performing and others consistently *under*performing the norm.

Gawande graphed this as a classic bell curve of outcomes. Interestingly, Gawande learned that at least one facility regularly outperformed the norm, year after year. HEDIS type process metrics assume that this doesn't happen. How can 117 facilities following exactly the same treatment protocols generate a bell curve of patient outcomes? Here's Porter again: *There are simply too many dimensions of process to track and too much heterogeneity among patients. Focusing on just a few visible process steps creates a checklist that providers can address, but oversimplifies the problem*. [54] In fact, we may use for our checklists only the *easiest to measure* processes not the *most important*. I suspect that's what HEDIS and similar checklists do.

**Some other problems**

**First,** the HEDIS type checklists, as any process oriented checklists, become institutionalized, bureaucratized and resistant to change. The new medical information that constantly becomes available – the latest mammogram studies, for example – may not make it onto the HEDIS lists.

Or may make it after a lengthy time delay, during which even newer, potentially critically important data, becomes available. Process oriented checklists are often, if not always, at least somewhat out of date.

Yet physicians are often reluctant to deviate from the approved checklist. Their hospital administrators may sanction them for this.

**Second,** the designers of HEDIS type lists may become susceptible to industry lobbying. We have numerous examples in the medical care industry where experts who write regulations and who make recommendations are paid by pharmaceuticals or other suppliers to recommend their products. A classic example is the 2003 Adult Treatment Panel III, which lowered the definition of dangerous total cholesterol to 200. Eight of the 9 panelists had financial ties to pharmaceutical companies, most to companies that manufactured cholesterol-lowering drugs. [55] One wonders how the designers of HEDIS style lists might be equally affected.

**The information your clients really want**
**The crux of *do your fellow a favor***

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[54] Porter, op cit, page 87

[55] http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04_disclose.htm

How will this treatment affect me? Will I get better? Will I be harmed? We call these outcome measures and the insurance industry is remarkably poor at providing these. Outcome measures describe how well patients actually do.

What percent of lung function do patients at a particular cystic fibrosis facility actually have? What is the average life expectancy at each CF facility? How many heart bypass patients need readmission to Hospital C within 30 days of discharge, and how many to Hospital D? How many TURP or hip replacement patients? Do patients having carpal tunnel surgery from Surgeon G return to work more quickly or less than patients of Surgeon H? And, even more basically, how many heart bypass surgeries, kidney removals, rotator cuff surgeries or hip replacements does a given hospital perform each year?

We have evidence that higher rates of a specific surgery by a specific medical team generate better outcomes, suggesting that the *quantity* of surgeries performed by a surgical team is a reasonable indicator of medical *quality*….but we often can't get the quantity information. HEDIS style lists don't provide it.

Porter gives this depressing summary:

> In only a few isolated disease areas - notably cardiac surgery, organ transplants, cystic fibrosis and kidney dialysis - is broad-based results information available, and, most physicians lack any objective evidence of whether their results are average, above average, or below average.[56]

Fairly astonishing, don't you think? This industry sector costs about $3.5 trillion per year and represents about 18% of the American gross domestic product. But we lack data indicating which medical professionals are the best, which are average and which are the worst.

In other words, most patients have no idea how good their physicians and hospitals are. Remember that half are below average, because, by definition, 'average' means that patient outcomes from half of all surgeons and at half of all hospitals are above it and *half are below*. Here's Porter's take on this: *it is human nature for most people to believe that they are above average, which cannot be true*, [57] meaning you can't just ask your doctor if he/she is above average because there's no data to support the answer. Perhaps as a result of this mind-boggling lack of care quality information, the definition of a 'good' health plan is one that offers easy access to a wide range of

[56] Porter, op cit, page 55

[57] Porter, ibid

physicians and the ‘best’ offers *really* easy access. This may be because of our poor outcome data. You want to try one doctor but, since you really don’t know if he/she is any good, you want the option to change.

Interestingly, we compare country healthcare systems on cost, longevity and infant mortality, but we compare carriers on provider network size, access ease and HEDIS scores. In doing so, we forget Kenneth Thorpe’s comments about ‘excess mortality’ and Elliott Fisher’s findings that easier access and more medical spending leads to slightly higher mortality rates, slightly poorer outcomes.

To escape these problems, people sometimes look at so-called consumer oriented physician rating services or social networking websites. A lot of these exist, all with about equally mediocre quality information.

HealthGrades, for example, claims that more than 200 million consumers use it to research and select a doctor or hospital and that it’s America’s most comprehensive source of information on hospitals and doctors. [58] Atul Gawande once looked up his own HealthGrades report card: *They don’t tell you that much. You will learn, for instance, that I am certified in my specialty, have no criminal convictions, have not been fired from any hospital, have not had my license suspended or revoked, and have not been disciplined for misconduct….it sets the bar a tad low, doesn’t it?* [59]

I looked up my own PCP and learned the following: 79% of patients would recommend him, He’s ‘very good’ at scheduling appointments, at office environment and at office friendliness, Most patients report that he listens well, helps patients understand their condition, spends enough time with patients and that they trust him. I suspect my auto mechanic would get the same write-up, word-for-word.

Surely there’s something about medical competence and patient outcomes that’s relevant here!

Here’s what I didn’t learn, for example:

- Does he generally refer to aggressive specialists who operate as soon as possible on patients, or to more conservative ones who prefer to watch and wait?
- What percent of the orthopedic patients he refers for surgery need to be readmitted within 30 days of hospital discharge?

[58] http://www.healthgrades.com/about

[59] Better, page 207

- What percent of cardiac? Urologic? Other?
- What percent of his female patients have mastectomies?
- What's the average age of death of his patients with breast cancer? With prostate cancer?
- What percent of his male patients over age 65 have prostatectomies?
- What percent of his Medicare patients have leg amputations?
- What percent of his patients maintain their Body Mass Index within a couple of points through their 50s and 60s? Develop diabetes? Keep their blood pressure low-to-moderate? Have heart attacks? Maintain a full range of physical functioning and exercise regularly?
- What tests does he perform at annual physical? How open is he to discussing specific tests?
- And lots more similar info. Now that's some really useful information on which to base a physician choice decision. Too bad it's all unavailable.

The health insurance industry now requires that people spend their own money on medical care, perhaps $1000 or more annually, before insurance kicks in. We call this Consumer Directed Health Care. To aid consumers in this spending process, carriers publish medical care price lists from various providers. That helps them identify the least cost providers. The industry has developed metrics based almost entirely on medical process compliance to show consumers the 'quality' of various doctors and hospitals, though virtually none of those metrics include any outcome measures.

Neither the prices now available, nor process metrics like HEDIS, mean very much about medical outcomes. The insurance industry has failed to address the 'up to about a third of medical spending generates no detectible benefit' problem. Prices and process metrics fail to tell us which treatments are effective, which low quality, which unnecessary and which may do more harm than good.

Nor does the industry tell us which physicians are higher quality – above average in Porter's terms – or below. Which generate excellent patient outcomes and which mediocre.

In fact, the insurance industry doesn't even help patients determine which questions to ask. Does 'appointment scheduling efficiency' mean anything at all about patient care or outcomes? Should I spend my deductible on someone having a good HEDIS score…or

someone who says the system is nonsense and, as a result, has a poor score but perhaps quite healthy patients?

Let's conclude. If the insurance industry that developed Consumer Driven Healthcare and HEDIS type process metrics actually provides any useful patient education and decision support, then one of three things would happen:

> * *American healthcare spending would decrease relative to healthcare spending in other countries since our outcomes are not superior to theirs.* That has not happened. The trend is getting worse;
>
> * *American outcomes, as measured by longevity and other factors (infant mortality for example) would improve relative to other countries since our spending exceeds theirs.* That also has not happened over the past decade.
>
> * *Healthcare systemic harms would decrease relative to the harm caused by a lack of access / lack of insurance, since consumers would spend their healthcare money more wisely.* That also has not happened. Remember the mortality rates for uninsured Americans vs. insured folks who die from medical error that we presented at the beginning of this chapter. Our health insurance industry – part of what Harvard Medical School Professor Emeritus Arnold Relman once referred to as the medical-industrial complex – has failed to help patients differentiate high cost, low quality medical care from the opposite. Today's patient may have a vague idea of his/her medical care costs but absolutely no idea the quality.

**Consumerism, Disclosure and Broker Responsibilities**

I would summarize our post-2000 insurance industry evolution as *placing more responsibility on consumers without providing information or tools to help them discharge that responsibility.*

We know, from extensive research, that health outcomes improve when patients are engaged in their own care and that people are eager to play a strong role in their own health care *when given the right tools.*[60] But post-2000, the industry failed to provide those tools.

It acted, in our terms, unethically. It *let the buyer beware* without *doing your fellow a favor.*

Who, in our medical care landscape, can help consumers acquire the 'right tools'?

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[60] Patients Charting the Course, US Institute of Medicine, 2011

I submit that a key candidate is the health insurance broker: Doctors are too busy to teach ‘tools’ while they diagnose, prescribe and treat. Carriers, for the reasons explained above, have basically dropped the ‘right tools’ ball, and hospitals, also for some reasons discussed above, tend to operate out of economic self interest and would be poor candidates to play this educational role.

Brokers, on the other hand, are the professionals who design benefits program at most companies and who communicate it to employees. They, I would argue, have the ethical responsibility to provide required ‘tools’ to their clients.

I hope this course helps brokers understand and accept that ethical responsibility.

## Part II: Ethical Considerations in Product Sales

This section reviews some standard business ethical principles and then applies them to Consumer Driven products.

- What special ethical issues do these products raise?
- Do most brokers acknowledge these issues?
- Do most brokers act ethically when presenting these products?

Ask yourself how your own behavior changes when you introduce high deductible products from low … and if you act ethically in both situations.

The first section of Part II reviews some basic ethical issues introduced in Part 1.

### Some Business Ethical Standards

**The Traditional View of Business Ethics:** 'Do unto others as you would have them do unto you' and 'Love thy neighbor as yourself' are two fundamental ethical dictates of Judeo-Christian religions. We – Americans coming from Judeo-Christian traditions and teaching – believe that we have responsibilities to treat others as we would want them to treat us.

Ethical business considerations fall into two separate categories.[61] **First,** business ethics regulates conduct in direct contact situations, such as with employees, clients or suppliers. These commonly fall into standard categories including employee relations, honest representation and truth in advertising.

These types of ethical issues have an immediacy or personal effect: lying to a customer may induce that person to buy the wrong product. Shading the truth may persuade a client to purchase a policy that benefits the broker inappropriately. In both cases, the only party harmed is the party in direct contact with the unethical broker.

This type of ethical behavior – 'direct contact situations' - will be the focus of this course.

The **second** type of business ethical considerations involves social responsibility. These ethical issues consider how much all of us must take responsibility for society as a whole. Ethical social behavior, for example, includes protecting our natural resources, caring for the poor and providing equal educational opportunities to all. This course will not discuss these types of issues. Hopefully a future course will.

### We Use Traditional Judeo – Christian Business Ethical Positions in This Course

[61] This discussion comes from www.besr.org/DCPage.aspx?PageID=199

We base our discussion on Biblical ethical standards. We present in this course a very activist ethical position based on our interpretation of Biblical sales ethics - specifically the story of Abraham's purchase of a burial plot for his wife.

In basing this course on that Biblical story, we note that it is the first commercial transaction discussed in the Bible. Some Biblical scholars suggest that this placement indicates that the lesson of this story is of primary or overwhelming importance for businesspeople. Were some other lesson more important, they suggest, then *it* would have been placed first and not the full disclosure principle.

Though we base our discussion on Biblical ethical principles, we do not advocate any particular religion - or religion at all, for that matter. We base this course on the Bible because it has served as the ethical basis of western civilization for thousands of years. Living according to Biblical teachings is generally synonymous in our society with living ethically.

Not all brokers will agree with our analysis. Some will think that our interpretation of Abraham's purchase is flawed. Others will argue that the Bible is not relevant to today's health insurance market. Still others will argue that we set an unrealistically high ethical standard for health insurance brokers. Regardless of whether you agree with our activist position or not, we hope that you will consider the ethical issues discussed in this course, and that you will be a better broker as a result.

**The First Ethical Principle in the Bible Comes From Abraham's Purchase of a Burial Plot for His Wife**

In the first commercial transaction in the Bible, Abraham laid down the 'full disclosure' commercial principle.[62] His purchase from the land seller consists of 5 different steps:

> **Step 1:** Abraham explains what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot;
>
> **Step 2:** The sellers offer 'the choicest of our burial places';
>
> **Step 3:** Abraham considers this (perhaps even goes on a guided tour of choice burial places) then asks for 'the cave of Machpelah…which is at the end of [the sellers] field', and offers to pay 'full price';
>
> **Step 4:** The sellers confirm that they have exactly what Abraham wants 'the field and cave that is in it';

[62] This genesis of this discussion comes from www.torah.org Business Ethics: The Challenge of Wealth, *Parchas Chayei Sarah, Parchas Metzora, Parshas Shoftim* and *Responsa-Vayigash*

**Step 5:** The buyer and seller ultimately agree on the land and price and transact the purchase in public 'in the presence of the sons of Heth, before all who went in at the gate of his city'.

Note the similarity with health insurance policy sales:

**Step 1:** the Buyer explains what he/she needs in vague terms – a policy to cover my family's medical needs, perhaps with some specific issues in mind;

**Step 2:** the Broker says 'we have many quality plans available' and explains them;

**Step 3:** the Buyer considers several options, then stipulates what he/she wants;

**Step 4:** the Broker confirms that a specified policy contains the desired benefits;

**Step 5:** the Buyer enrolls by signing a contract.

It was clear from Abraham's negotiations that he had the opportunity to view the land and cave prior to purchasing. The seller had helped him learn about the land, pointing out the choicest burial place. Indeed, the seller may even have warranted the land: 'none of us will withhold from you his burial place', thereby confirming that this was, in fact, burial property.

The seller apparently understood that Abraham – 'a foreigner and a visitor' – did not know all details about local burial plots. The seller therefore helped Abraham learn everything that he needed to know so he could make a wise, informed purchase. There was no ambiguity about the land, the location or the use. No confusion about exactly what Abraham bought…because the seller provided such a thorough and detailed education.

### 'Let the Buyer Beware' is Unethical

The lesson about this transaction? Traditional ethical standards do not contain any concept of 'let the buyer beware'. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc. This was clearly not true for Abraham, the 'foreigner and visitor'. The seller could have taken advantage of his lack of knowledge to swindle him – but did not. The seller educated the buyer. This is the ethical business lesson from this story.

‘Let the buyer beware’ also assumes that all parties have equal abilities to understand the information available. In Abraham’s case, he was only able to understand the intricacies of burial plots after being educated by the seller.

- Is this concept still valid today?
- Can ‘let the buyer beware’ serve as a valid basis for commercial transactions?

The answer is no. Traditional ethics remain valid today - for two main reasons.

**First,** sellers and buyers rarely have exactly the same information. The seller generally knows his / her products far better than the buyer because the seller deals in this market – for this product – far more frequently than does the typical buyer.

- For example, a broker selling Consumer Driven policies has had feedback from many clients about how they used these policies.
- Or, lacking feedback from clients, the broker attends seminars sponsored by carriers or others involved in the field.

This gives the broker the opportunity to learn from others about their experiences and to ask questions to better serve his/her own clients. In short, the broker learns how well CDHC policies work and how satisfied purchasers are with them. The broker can provide his/her clients with independent information about how well these policies work…or how well they satisfy consumers.

The Biblical Abraham clearly lacked such independent information about burial plot qualities. Abraham’s expertise did not include detailed knowledge of local burial plots….just like the health insurance purchaser often lacks detailed knowledge about networks, tiers, Rx copayments, etc. Abraham relied on the burial plot sellers’ expertise to guide him…just like many policy purchasers rely on their brokers.

**Second,** in the real world, sellers can understand their product information far better than the buyer can. This is primarily because the health insurance broker has studied healthcare issues in far greater depth than the typical buyer. Even if the buyer has access to information, he / she often lacks the background and context in which to place that information. Again, this is similar to Abraham’s situation. He was a merchant, with expertise in his own arena – not in burial plots. He was not in a strong position to understand burial plot issues without additional education.

Our clients are similar to Abraham. They are accountants, schoolteachers, fishermen or others, with expertise in their own fields, not healthcare. Lacking the broker’s healthcare

education and background, they are less able to understand healthcare details and issues than the broker.

For these two reasons – that the broker has *better access* to product information and a *better ability to understand that information* – today's health insurance salesperson has an ethical responsibility to educate the client. Just like Abraham's burial plot seller.

### Do Your Fellow A Favor

Traditional ethical standards build on this concept and go even further. Many ethical commentaries contain injunctions that forbid the seller from hiding product flaws, and even from creating a false impression.

This is covered in traditional ethical concepts of 'faulty sale'. According to this doctrine, the seller is obligated to make full disclosure of any defect in the goods or services sold. One ethical commentator suggests that 'even where the seller was ignorant of the flaw, the sale may be cancelled' as the buyer cannot be forced to accept a discount as compensation for the defect. [63]

Thus, the broker who claims 'I didn't know that the policy contained that' has no ethical defense: traditional ethical standards make the seller responsible to understand fully all the implications of each health insurance policy. Over time, traditional business ethics evolved and introduced the higher standard. This became known as '***do your fellow a favor'*** standard, exactly the opposite of 'seller selfishness'. [64] Now the seller has an even greater ethical burden. Not only must he / she educate the buyer and make full disclosure, but the seller must ***do his fellow a favor*** and highlight problems with the health insurance policy that <u>*may*</u> occur.

### Is it enough simply to describe the health insurance policy in detail?

Such a description would include a discussion of copayments and deductibles, exclusions if any, available providers, prescription drug coverage, price etc and then show alternative products and describe them. Though this may satisfy some customers, it does not satisfy our ethical requirement.

### How Much Should Brokers Disclose?

The question posed by ethicists above in the discussion of ***do the fellow a favor*** remains: How much should a seller disclose about a product to a customer?

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[63] Rabbi Dr. Meir Tamari in ibid. Responsa-Vayigash

[64] Ibid.

Let's review the doctrine of 'faulty sale' discussed above. That's the doctrine requiring full disclosure of any defect in the goods or services sold, and a cancellation of the sale due to product defects *even if the seller was ignorant of the flaw at the time of sale*.

It is unclear exactly *how much* information Abraham's burial plot seller provided. He apparently provided a great deal, and probably all that was necessary in that circumstance.

But we get into a gray area when applying these lessons to more complicated transactions like health insurance policy sales.

- Is it a 'product defect', for example, if someone buys a high deductible health insurance plan but does not get any advice about how to spend the deductible?
- Is it a product defect is someone who buys a high deductible plan asks a broker how to locate better quality medical care, but does not get a satisfactory answer?
- Is it a product defect if a broker presents wellness programs as a mechanism to cut costs and utilization, but such a program does not achieve these objectives over a 3 – 5 year period?
- Is it a product defect if a broker portrays price transparency as a mechanism to cut costs but over a 3 – 5 year period the program does not achieve these objectives?
- Is it a product defect if a broker simply shows costs for 2 networks without indicating how to determine care quality in either?

We don't know. Ethicists seem vague on the issue of 'how much information must the seller provide'. That's why they expanded the discussion to include *do the fellow a favor.* Now we have the ethical tools to address this question.

### He Who Does Not 'Do His Fellow a Favor' is Not of the Sons of Abraham [65]

Dr. Tamari puts the Biblical ethical position like this:

> Sanctity is achieved … by doing or sharing with others, irrespective of the utility or reciprocity... We force one to act contrary to the selfishness of Sodom. [66]

### Translating These Ethical Standards to Policy and Product Sales

[65] Dr. Meir Tamari, Parshas Shoftim http://www.torah.org/learning/business-ethics/shoftim.html

[66] Ibid.

The broker who simply describes the health insurance policy by defining the terms and conditions appears to act ‘selfishly’. Here’s why: The broker knows that his/her clients don’t have easy access to various critical bits of information. For example, brokers often hear clients complain that they don’t know how best to spend their discretionary medical monies.[67]

In healthcare language, this means clients often have difficulty differentiating expensive, high quality medical care from inexpensive, low quality. Should the client spend deductible money on everything his/her doctor recommends? How does a client decide? What tools are available? How can a broker ‘do your fellow a favor’?

Or, absent should the ethical broker simply describe policy details, then ‘let the client beware’?

[67] At least, that’s what some brokers report to me. GF

**Review Questions**

Correct answers on next page

1. This course evaluated several ethical principles. Which below is ***unethical***?

   a. Love your neighbor as yourself
   b. Do to others as you would have them do to you
   c. Do your fellow a favor
   d. Let the buyer beware

2. This course described ethical considerations that arise from having *unequal information* about the way our healthcare system works. What does this mean?

   a. Brokers generally know much more about select networks, deductibles, tiered products, Rx formularies and similar than do most consumers because brokers attend industry educational functions, read industry journals and take CE classes
   b. Consumers generally know far more about the US healthcare system than do brokers because consumers read headlines in the popular press and watch TV
   c. Both brokers and consumers know virtually exactly the same amount about health insurance and our healthcare system
   d. As a general rule, senior governmental officials have the greatest understanding of our healthcare system, far better than most brokers or consumers, so, by the ethical constructs developed in this course, they should make all healthcare decisions

3. What is the fundamental ethical principle from the Biblical story about Abraham's purchase of a burial plot for his wife?

   a. That the seller has a responsibility to educate the buyer about the product
   b. That the buyer has a responsibility to educate the seller about the product
   c. That the buyer has a responsibility to articulate exactly what he/she wants to buy, essentially to develop a detailed specification for the seller to understand, and the buyer's failure to do this does not place any ethical burden on the seller
   d. That the notion of 'let the buyer beware' is ethical and founded in the Bible

4. Where does the concept of 'do your fellow a favor' come from?

   a. It was developed when ethicists determined that 'let the buyer beware' was unethical
   b. It was introduced in early Biblical stories, but was dropped over time in favor of 'let the buyer beware'

c. ‘Do your fellow a favor’ is part of an early business development program begun by King Herod that was later adopted by Greek and Roman philosophers
d. ‘Do your fellow a favor’ was developed by International Harvester to sell tractors during the depression in the 1930s. IH suggested that farmers ‘do your fellow a favor’ by lending tractors during peak harvest times. IH set up a credit / leasing schedule that proved enormously profitable to them. It was adopted by business ethicists in the 1950s as an example of ethical business practices.

5. What does the ethical concept of ‘full disclosure’ mean?

a. That the seller has an ethical obligation to disclose everything he/she knows about the product *or the implications of the product*, to the buyer
b. That the seller should disclose any and all financial relationships that he/she has with the product supplier *and/or with the buyer*
c. That the consumer should disclose any and all financial relationships that he/she has with the product supplier
d. That both the seller and the buyer should sign a ‘full disclosure’ document that covers both from potential fraud *and non-disclosure* accusations

6. What is the primary ethical standard derived from the Judeo-Christian tradition?

a. Let the buyer beware
b.The customer is always right
c. A penny saved is a penny earned, so brokers should always emphasize the lowest cost products
d. Treat others as you would have them treat you.

7. When is the practice of ‘let the buyer beware’ ethical?

a. It is never ethical
b. When both the buyer and seller have the same educational background
c. When the seller knows more about the product than does the buyer
d. When a third party can officiate at the sale

8. How often do product sellers and buyers have the same information about the product?

a. Very rarely
b. About 89% of the time
c. Close to 91% of the time
d. Always

**Review Questions**

Correct answers in bold

1. This course evaluated several ethical principles. Which below is ***unethical***?

    a. Love your neighbor as yourself
    b. Do to others as you would have them do to you
    c. Do your fellow a favor
    d. **Let the buyer beware**

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**Case Study: Some Ethical Issues in Consumer Education**

Consider these estimates of healthcare system waste:

- From Aetna and Cigna in their 2013 Annual Reports: the US healthcare system annually wastes $765 billion on unnecessary care. That's care that doesn't benefit patients because it's unnecessary.

  Note for comparative purposes, that $765 billion is about twice Iran's total GDP, and about half of Russia's in 2013. It's a huge amount of money representing a huge amount of medical care.

- From the Dartmouth Atlas of Healthcare: about 1/3 of all medical spending is wasted on unnecessary care but Dartmouth researchers consider this an 'underestimate given the potential savings even in low cost regions'.[68]

- About $3000 per policy funds this waste. That estimate comes from the two factors above.

- Many other research organizations have arrived at roughly the same conclusions.

Now remember that deductibles rise over time, with typical deductibles today running $1000 - $3000 annually. This suggests that the average consumer is likely to waste 1/3 of his/her out of pocket deductible on unnecessary care, an increasingly large amount.

Some brokers (in my experience) either wring their hands or shrug their shoulders, suggesting that 'these are big problems that someone should address', but implying that they, acting as the benefits advisor / professional do not have responsibility here. 'The government should do something about this' they seem to say, or carriers should, or hospitals should or some unnamed other group should.

But the Biblical commentators above, writing about Abraham's burial plot seller's responsibilities, suggest that the broker him/herself needs to take some responsibility here. The broker cannot, according to this ethical position, simply 'let the buyer beware' and waste deducible money. Brokers who know about these problems but do not educate buyers about how to spend their deductibles act unethically.

**One way to act ethically in this situation**

[68] Quote from the Dartmouth Atlas website

An ethical broker, on the other hand, can acknowledge some responsibility to help clients avoid wasting deductible money. They can follow a simple two-step program here.

First, tell clients about the size, magnitude and implications of the healthcare waste problem.

Second, give clients some simple tools to address the problem. One tool that holds great promise is called a Checklist of Key Questions to Ask Your Doctor.

Checklists – good ones, at least – can guide your clients through discussions with their doctors so they get all the information they need to make wise medical care decisions. Patients who ask the right questions are far more likely to make wise decisions.

We have found two simple questions help patients identify and avoid some unnecessary care.

- Out of 100 people like me, how many benefit from this medical intervention? And
- Out of 100 people like me, how many are harmed by it?

These two questions can help patients determine how well a medical intervention works and their likelihood of being harmed by it.

**Background for brokers i**
**Phrasing**

An ethical broker teaches clients to ask ‘out of 100’ to get a number for the answer. ’26’ means more than ‘some’ or ‘this is a very good medication’.

Once armed with this information, the patient can decide if the medication, test or intervention works well enough for them. Some people may decide that 26 people benefitting out of 100 is a good result while others think it’s too low. We call this a ‘well informed decision’ and research suggests that people who make well informed decisions are more likely to avoid unnecessary medical care.

‘people like me’ asks if the intervention has been studied on an appropriate population. A medication can impact a teen aged male athlete quite differently from an 80 year old female obese diabetic smoker, for example.

‘benefit’ is the purpose of the medical intervention in the first place. If you want to avoid a heart attack, for example, ‘benefit’ means ‘avoid a heart attack’. Benefit does not necessarily mean ‘lower your cholesterol’ because the correlation between having lower cholesterol and avoiding a heart attack is relatively weak.

An ethical broker might choose to address the huge healthcare waste problem by teaching clients about it and providing this kind of tool to help clients address it.

**Background for brokers ii**
**Ways to educate clients ethically**

Some brokers reading the brief discussion above might say 'this is such a simple question that I don't want to embarrass myself or my clients by introducing it. Everyone knows this. It's just common sense'.

That's a standard problem with checklists. The most effective ones are the most banal and obvious.

Consider this historical example from the medical community – how a simple, banal and obvious check list reduced central line infection rates at Johns Hopkins Hospital. [69] We'll examine the problem and checklist solution in the medical community first then apply the lessons to the health insurance community.

Central lines either add or remove fluids from patients. Examples include catheters, bile drains and dialysis lines. Some 80,000 of these get infected annually, causing patient harms and increasing treatment costs.

A critical care specialist at Johns Hopkins Hospital named Peter Pronovost studied this problem and determined that physicians used different processes when inserting central lines: some covered the entire patient with sterile drapes, for example, while others didn't. Pronovost figured that performing this simple, routine and elementary intervention in different ways might explain some of the infection problem. He developed a simple checklist for physicians to use when inserting lines. Here's the list that doctors should follow, according to Pronovost:

1. Wash your hands
2. Clean the patient's skin with chlorhexidine antiseptic
3. Put sterile drapes over the entire patient
4. Wear sterile mask, hat, gown and gloves
5. Put a sterile dressing over the insertion site once the line is in

The Johns Hopkins physicians immediately objected (just like broker clients will, and for the same reasons). These steps, they said, are obvious common sense. We've done

[69] This example comes from Atul Gawande's article, The Checklist, New Yorker, Dec 10, 2007.

these for years. We were trained in medical school about proper line insertion. Our clinical internships and residency programs reinforced that education. Following this check list is beneath us and insulting. (This was perhaps particularly poignant at Johns Hopkins Hospital, one of the best in the world according to many. The physicians graduated from Harvard, Yale, Stanford and similar top ranked colleges and medical schools. Most had years of experience and were highly esteemed within their profession.)

And do we really need to cover the patient's legs when inserting a line into his/her chest?

In addition, the doctors said, 'we're busy saving lives. Following this checklist will take time away from our lifesaving work.' (I can only imagine the vitriol behind those objections).

And the hospital administration initially opposed Pronovost's checklist idea. They wanted to reduce the administrative costs and the burden on physicians, not add to it.

All this created a problem for Pronovost. How could he convince both the physician staff and hospital administrators that they needed his checklists and that integrating his lists into their normal activities would both improve patient outcomes and decrease hospital costs?

He solved his problem quite creatively. He asked the nurses in his ICU to observe doctors when they inserted lines into patients and to note how frequently they followed all these steps. Astonishingly, he learned that in about a third of patients, physicians skipped at least one step.

Armed with this information, Pronovost convinced the hospital administration to adopt his list. The hospital administration gave nurses permission to stop physicians *during the line insertion process* when the physician missed a step. Nurses were empowered to implement his checklists.

Pronovot watched what happened:

Over the first year, the 10-day line infection rate fell from 11% of patients to 0%. Only 2 infections occurred during the next 15 months. Pronovost and his team estimated that this one, simple checklist prevented 43 infections and 8 deaths and saved Johns Hopkins Hospital $2 million in costs.

Note that there are about 5000 hospitals in the US. If each hospital generated the same results as Pronovost found at Johns Hopkins, the US healthcare system would save about 40,000 lives annually and $10 billion. Pretty impressive!

Pronovost then expanded his checklist approach to include patients on mechanical ventilators, patients being observed for pain and other medical interventions. He learned that checklists provided two main benefits to doctors:

1. First, they helped with memory recall especially the mundane matters that people sometimes overlook when they're focused on more dramatic activities.
2. Second, they make explicit the minimum steps necessary for success in a complex process.

Checklists, according to Dr. Atul Gawande of Harvard Medical School and the Brigham Hospital, ultimately established a higher standard of performance among physicians.

In other words, these simple – almost overly simplistic and even insulting – lists of steps in a complex procedure could have a huge impact on lives and medical costs.

Could the same thing happen with for patients?

**Ethical Applications of This Approach**

Let's apply the lessons from Johns Hopkins to typical clients with high deductible plans. These people want to ensure that they get good medical care and avoid wasting money on unnecessary care. Here's a simple 5 question check list that any patient can use with virtually any medical condition.

Question #1: Out of 100 people like me, how many benefit from this medical intervention?

This question focuses both the patient and physician on likely outcomes. It helps both parties try to understand the likelihood of benefit.

- Ask 'out of 100' to get a number as your answer. That helps the patient far more than learning that 'some', 'many' or 'a few' people benefit, since 'some', 'many' and 'a few' mean different things to different people.

  If 12 people benefit per 100 who have an intervention, is this 'many' or 'few'? The answer is that different people will define 'few' and 'many' differently. 12 is 'many' for some people and 'few' for others. That's why getting a number for your answer is helpful.

- Ask about 'people like me' because medical effects differ in young men and elderly women, or even sometimes in middle aged men and women.

- ‘Benefit’ is the reason you seek medical care in the first place. If you want to avoid a heart attack, ask ‘out of 100 people like me, how many avoid a heart attack?’. If you want to avoid a hip fracture, ask ‘out of 100 people like me, how many avoid a hip fracture?’

We have anecdotal information about the impact of this question on patients. As one middle aged gentleman reported (not a direct quote but you’ll get the idea):

> I had been brought up to accept physician advice, not to question it. But I heard this question in a lecture and kept it in the back of my mind ‘just in case’.
>
> Sometime later, my daughter developed a medical problem and I took her to the doctor. He recommended a treatment. I plucked up my courage and asked ‘out of 100 patients like her, how many benefit from this treatment?’
>
> The doctor answered my question with a pretty good estimate (and a few caveats), then went on to say ‘I have 1700 patients in my practice and only 4 have ever asked me how well care works. You’re one of the 4. Congratulations.’
>
> He then introduced me to some of his colleagues and other patients as a ‘star’ patient who asked the right questions of the doctor.
>
> I will always ask this question of every medical recommendation. It’s obviously the right one to ask.

Question #2: Out of 100 people like me, how many are harmed by it?

> This obviously helps patients compare treatment benefits to harms.
>
> Appropriate answers to this question include ‘17’ and ‘31’.
>
> Inappropriate answers include ‘very few’ and ‘it’s a tried and proven treatment’.
>
> Be sure to ask about specific harms, since medical interventions can have several, only some of which interest you. Aspirin, for example, often harms peoples stomachs so many doctors mention this when prescribing aspirin to patients. It doesn’t affect my stomach though, so when my doctor starts talking about this particular harm from aspirin, I cut him off since I’m not interested. (This is somewhat similar to the restaurant waiter who likes to describe the specials in great detail. I often interrupt – as politely as possible – when he/she starts describing a dish that I don’t care for. Why waste his/her time, and mine, learning about something that doesn’t concern me?)