Market Conduct Ethics: Policy Disclosure

This course was written in 2009.

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The Issue

Brokers have several legal and ethical disclosure responsibilities when they present a policy.

First, they must honestly explain policy terms. Second, they cannot leave out important information. Third, they must honestly quote the price.

But do they also have a fourth ethical requirement – to disclose policy implications, such as likely medical outcomes and medical risks? Should the broker provide clients with data about treatment practices and medical outcomes?

The knowledgeable broker knows that we sometimes overuse our medical system. Above a certain level of care, however,

> There is just no evidence that doing more helps. At best you do the same, and in some cases you actually do worse [due to infections, errors, patient fatigue, etc] [1]

Indeed, researchers have discovered that patients in some regions regularly receive excessive and unnecessary care – and have higher mortality rates! The reason:

> The additional medicine patients are getting in the high-cost regions is leading to harm. [2]

Should the broker – the 'benefits advisor' - provide warnings to clients? Does the broker have an ethical responsibility to educate clients?

What ethical disclosure responsibilities does the broker have?

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[1] Jonathan Skinner, John E. Wennberg, How Much is Enough", NBER Working Paper 6513, 1998

[2] Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

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Preface:
Education, Not Advocacy

This is an education course, not an advocacy exercise. Our goal: to stimulate broker's thinking. We hope this course will help you consider your own ethical standards.

We outline in this course a very activist ethical position based on our interpretation of traditional sales ethics. Many of these come from the Judeo-Christian tradition that permeates western civilization. Living according to these standards is generally synonymous in our society with living ethically.

Examples of such traditional ethical standards in the non-business arena include injunctions against killing, stealing, adultery and incest. We will focus, in this course, on the traditional business ethical standards relating to *unequal product knowledge between the seller and the buyer*.

Not all brokers will agree with our analysis. Some will think that our interpretation of traditional ethics is flawed. Others will argue that these are 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.

Note: We have inserted Key Idea Text Boxes – like this – throughout this course. These highlight the main ideas. We encourage students to review these boxes prior to taking the exam.

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Introduction: Summary of the Problem

Key Idea: Excessive and unnecessary medical care poses risks to your clients.

Here are two examples:

First, unnecessary prostate surgery. A 2009 study of prostate cancer screening found that PSA tests identified approximately 48 times as many benign tumors as cancerous. In other words, only about 1 of 49 men who had prostate treatment actually suffered from life threatening prostate cancer.[3]

But all the men, including those who had unnecessary surgery, risked incontinence and impotence, both byproducts of the surgery. Indeed one study indicated that the majority of men were impotent and still wearing adult diapers a year after their prostatectomy. [4]

Key Idea: Only about 2% of men receiving prostate treatment actually had prostate cancer. Yet all risked incontinence and impotence – frequent byproducts of prostate treatment. This is an example of excess or unnecessary treatment.

Second, the case of negative appendectomies. Appendicitis is common but sometimes difficult to diagnose. Research shows that about 15% of our 250,000 annual appendectomies are inappropriate; the patients don't actually have appendicitis. In other words, surgeons removed a healthy organ (a 'negative appendectomy') in response to abdominal pain. [5]

[3] Stephen Smith, Benefits of Screening Questioned, Boston Globe 3/19/09

[4] Shannon Brownlee, Overtreated, Bloomsbury Press 2008, page 202

[5] ibid, page 151

In women of reproductive age, some 25% of appendectomies are negative. Other conditions, including burst ovarian cysts, intestinal blockages, constipation or menstrual cramps can appear as a swollen appendix.

The concerns: first, unnecessary surgery puts patients at risk. Remember some medical risk data. The Institute of Medicine estimates that 1.5 million patients are annually sickened, injured or killed due to medication errors and that hospital patients average 1 medication error for every day that they stay in the hospital. [6] Plus infection risks, surgical risks, unnecessary organ removal, etc.

Second, negative appendectomies do not address the patient's underlying problem. So even after the surgery, physicians need to determine the source of the patient's pain. The negative appendectomy accomplished nothing.

Key Idea: Up to 25% of appendectomies are 'negative' – meaning physicians removed a healthy appendix. The surgery did not solve the patient's underlying medical problems, but did subject the patient to medical risk.

What ethical, advisory role does the broker have here?

Does the broker have an educational, advisory role toward his / her clients in these cases? If so, what is it?

Demand for Health Services: Americans want all the medical care available. 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.

[6] Institute of Medicine, Preventing Medical Errors, 2007

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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.

Key Idea: Americans want all the medical care available. We strongly resist restrictions imposed by carriers. The lack of restrictions does not always benefit patients.

One result: today's insurance policies allow easier, even unfettered (in the case of many PPO or POS type plans) 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?

Who advises people NOT to receive medical care? In our healthcare financing system, physicians are paid to treat. They have a financial incentive to intervene, for they generally do not get paid unless they do something to the patient. Many studies have shown that surgeons tend to recommend surgery - far more than non-surgeons do – and sometimes more than patients need.

Key Idea: No one in our healthcare system is paid to advise consumers against getting medical care. By contrast, physicians who get paid fee-for-service for treating patients have an economic interest in providing as much care as possible. Who balances against their economic interests?

Should this advisory role become the broker's responsibility?

(We are not ascribing any base motives to doctors. We simply note the economic incentives.)

Some possible results: 48 out of 49 'inappropriate' prostate treatments, or 15% - 25% negative appendectomies. The providers earned money; the patients did not get healthier - but did risk complications.

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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 have a certain set of economic incentives. We do not pay anyone to oppose the provider's point of view.

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

That leaves the broker. Should the broker advise clients of potential risks of easy availability of medical care? How much should the broker inform clients about systemic abuses? In sum…

What ethical disclosure responsibilities does the broker have to protect his/her client from unnecessary / excess treatments and the related potential medical harm?

Key Idea: This course will explore the ethical disclosure responsibilities of professional health insurance brokers. In particular, we will discuss the ethical responsibilities brokers have to protect their clients against excessive or unnecessary care.

We will base our ethical position on traditional Judeo-Christian ethical teachings, particularly the story of Abraham's first commercial purchase, found in Genesis.

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Chapter 1:
Overview of Disclosure Ethics

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.[7] **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.

Second, business ethics 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.

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

Key Idea: Traditionally, business ethics fall into two different areas.

The **first type** has an immediacy or personal effect, such as lying to induce a customer to purchase the wrong product.

The **second type** concerns social responsibilities, such as protecting scare resources for the good of society. This course will discuss the first type primarily.

This course will deal primarily with the first type of ethical business considerations – the direct contact situations – though we will make some social responsibility types of ethical observations also.

Unequal Knowledge about our Healthcare System

Key Idea: This course will focus on the ethical issues raised by unequal knowledge about the healthcare system between brokers and their clients.

What does 'unequal knowledge about the healthcare system' mean?

Brokers typically know a great deal more about our healthcare system than do their clients. Among the areas of broker expertise:

- Underwriting guidelines
- Provider cost data (at least rough and crude measures)
- Outcome data (again, rough and crude measures)
- Treatment complication data (assuming a well informed broker)

Key Idea: Brokers typically know much more about our healthcare system than their clients do. Brokers, for example, read industry journals and understand underwriting practices. Their clients, typically, do not.

We will explore the broker's ethical responsibilities to share all available information with their clients.

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In developing our overall position on the ethics of disclosure, we will rely primarily on traditional Judeo-Christian ethics. These have served as the moral and ethical foundation of western civilization for thousands of years.

Virtually all the great historical ethicists and philosophers had a deep understanding of these ethical traditions. These permeate our shared views of right and wrong, morals and ethics, and have done so for a very long time.

Some Judeo – Christian Business Ethical Positions on Disclosure: Abraham's first purchase

In the first commercial transaction in the Bible, Abraham laid down the 'full disclosure' commercial principle.[8]

Some Biblical scholars suggest that this business principle is of overwhelming importance, and that is why it is found so early in the text.

The story of Abraham purchasing a burial plot for his wife Sarah is instructive from our ethical viewpoint. The haggling over land takes five 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';
> **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'.

[8] 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*

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(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.

Key Idea: The story of Abraham's burial plot purchase shows that the seller has an ethical responsibility to educate the buyer about the product. Abraham was a foreigner, needing advice about local burial procedures and options, which plot to purchase, etc. The seller provided that education.

The fundamental ethical message: sellers who educate buyers are ethical. This begins the ethical tradition of full disclosure.

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

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The lesson about this transaction? That 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.

Key Idea: The principle of 'let the buyer beware' is unethical for two reasons. First, the buyer rarely has as much product information as the seller.

Second, even if the buyer has the information, he/she generally lacks the context in which to understand the information.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc, 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. The simple reason: the seller deals in this market – for this product – far more frequently than does the typical buyer.

This was clearly the case for Abraham, whose expertise did not include detailed knowledge of local burial plots. It's also the case in our industry, where the health insurance broker regularly reads industry information

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provided by carriers and regulators, for example, while the buyer only purchases health insurance one time per year.

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.

Key Idea: Today's broker is much like Abraham's burial plot seller – and, according to Biblical injunctions still relevant today, responsible to educate the client.

Thus 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.

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Key Idea: Traditional ethical standards obligate the seller to understand the product completely. Sales may be cancelled due to product defects even if the seller was ignorant of the flaw.

'I didn't know the policy contained that' is not an ethical defense. Our ethical question: are policy implications part of the policy content?

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. [9] 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'***, exactly the opposite of 'seller selfishness'. [10]

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 may occur.

Key Idea: Traditional ethical standards go even further, requiring the seller to 'do his fellow a favor' and highlight problems that may occur. This means the broker should advise clients about policy implications, not just details.

The broker's ethically defenseless position has now become both 'I didn't know the policy contained that – **or implied that**.'

Why would ethicists place such a burden on sellers?

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

[10] Ibid.

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There appears some thinking that these burdens ultimately work to the advantage of the seller. If all sellers act ethically as described above, then it becomes very easy to sell products to buyers. The reason: buyers would have a very high degree of confidence in the seller's representations.

Business Ethics = Business Efficiency

Key Idea: Traditional ethics equate business ethics with business efficiency. Its ethical standards are really instructions for successful businesspeople.

This approach follows directly from the two fundamental ethical dictates of Judeo-Christian religions described above: 'Do unto others as you would have them do unto you' and 'Love thy neighbor as yourself'.

Effectively, this means sellers should put their long term financial interests ahead of short term profit goals and give clients excellent advice.

If everyone followed these traditional ethical standards, in other words, we would have a very well functioning business economy.

Ethical sellers would not have to prove their honesty or credibility. They could concentrate, instead, on selling products. This is very efficient: sellers could focus on their income generating activities (i.e. sales) rather than spending time explaining or justifying their personal ethical standards, or establishing personal credibility. They would thus generate higher incomes.

Abraham's burial plot sellers, apparently, had this credibility, as there is no mention of him searching for other plot sellers. He did not shop around for a 'better deal'. He was – apparently – satisfied with his seller's ethical positions and chose to do business with him.

These standards work to the seller's advantage.

Efficiency and Health Insurance Sales

Let's apply this standard to health insurance brokers. If we all ***do our clients a favor*** and warn them about risks of healthcare systemic abuse

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and excess, then we may help control healthcare inflation. Some studies, most notably from Dartmouth Medical School researchers, suggest that up to 1/3 of all US healthcare provides no discernable benefits to patients. [11] (We'll return to this point several more times in this course.) By ***doing our clients a favor***, we may serve the interests of our entire economy by reducing healthcare costs.

Key Idea: 'Do your fellow a favor' by, for example, advising clients about systemic abuses, may reduce overall healthcare costs. This addresses considerations under the second type of business ethics – social responsibility – described above.

In short, we do well for our clients and do well for our country by doing our clients a favor. We also, according to the Torah, do well for ourselves as brokers by adhering to this ethical standard.

Whose Interests Should the Broker Protect?

This ethical disclosure standard seems to require brokers to act <u>against</u> physician and hospital financial interests by describing policy implications. Providers, under our fee-for-service financing arrangements, have an economic incentive to treat, and often to overtreat – by Dartmouth Medical School researcher's estimates, up to a third of the time. Brokers, under this standard, have the burden of countering these physician economic incentives.

Seen in this light, the ethical sales practices may set up a conflict in our healthcare economy. Let's look at the gray area, in which a subscriber may or may not need treatment, and discuss the economic incentives facing each party. (Ethical discussions <u>always</u> focus on gray areas, as these are the difficult cases. There's no ethical dilemma in an easy or obvious case.)

Providers – physicians and hospitals – have an economic interest in treating and make the most money by providing the most treatment. The

[11] Dr. Elliott Fisher, Healthcare in America: Is More Better?, Annals of Internal Medicine, February 2003

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lens through which they view the patient may – consciously or unconsciously – include their own financial self interest. 'Patients of this type', they may think, 'often improve with treatment.' When in doubt, our economic system may motivate providers to treat.

Patients with health insurance have little or no *economic* incentive to avoid treatment. They purchased insurance exactly for this situation. They have no (or little, depending on their policy type) out of pocket cost associated with treatment. Even a $500 or $1000 inpatient deductible pales in comparison to a potentially life saving treatment, or to treatment that eliminates a chronic pain.

Key Idea: Many patients are in the gray area between definitely needing treatment and definitely not needing. Providers have an economic incentive to treat in the gray area. Patients with insurance have **no** economic incentive to avoid treatment. This is an uneven playing field and sets up ethical issues for the broker.

Who wins and who loses in the gray area?

In addition, patients who are sick or in pain are often scared and want to trust someone who offers relief. The reassuring physician who counsels 'I have treated many patients like you successfully' provides exactly the advice that the patient wants to hear.

Thus, our systematic incentives may induce unnecessary treatment for patients in the gray area. The providers gain, but the patient doesn't pay.

Who Wins and Who Loses in the Gray Area?

This seems, at first cut, a win-win situation. The provider wins – gets paid. The patient wins – gets better. Even if the patient doesn't improve much, he/she didn't pay much. No harm, no foul.

Except for two problems. **First**, in the US, a great deal of care generates 'no discernable benefit' according to data provided by researchers at Dartmouth Medical School. Our 'win-win' situation, according to the

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Dartmouth folks, becomes 'providers win, patients get nothing' up to about a third of the time.

Those odds might be attractive to patients if medical treatments were risk-free; if we never had treatment complications, then reasonable and rational patients might decide that a 67% chance of improvement is good enough. They might discount the risk of 'no discernable benefit' and agree with their physician's advice to receive treatment.

Unfortunately, however, medical treatments are never risk-free. This is the **second** problem. There are always significant complication risks. Here are two examples. We'll discuss many more in future chapters:

- Medical errors occur, on average, twice per day for every person in Intensive Care; [12]
- Up to 40% of hospital deaths occur in patients who are not hospitalized for end-of-life issues. [13]

Key Idea: Our 'win-win' situation has deteriorated. Providers win – they get paid. Patients may not win – and apparently do not – up to a third of the time.

But the patients accept all the risk.

This is not the business efficiency envisionedby ethics commentators. This is very inefficient and unethical: one group in our society (providers) wins with every transaction while another (patients) loses a significant percent of the time.

The Broker's Education Responsibility

[12] Atul Gawande, The Checklist, The New Yorker, December 10, 2007

[13] Data from Dr. David Pryor, Medical Director of Ascension Health, lecture given 4/7/08 to the Massachusetts Healthcare Council in Waltham, Massachusetts

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What group in our society can counter the providers? Who can give warnings to patients about risk? Who can give unbiased advice to patients about when to trust providers and when not to? Who can act – in ethical terms – like Abraham's burial plot seller?

We will argue in this course that the broker has these responsibilities. This is a wider definition of broker duties than is currently common in our industry. But it is the definition that follows from the evolution of ethical standards in western civilization.

Key Idea - the core of our argument: The knowledgeable, well educated, professional broker understands both provider financial incentives and patient risks of medical care far better than his/her clients.

The broker has an ethical obligation to advise clients about these.

Here are some medical *treatment* risks:

- Medication errors, that occur, on average, once per day for every person hospitalized;[14]
- Medical errors, that occur, on average, twice per day for every person in Intensive Care;[15]
- Death – up to 98,000 people die annually due to medical systemic errors;[16]
- Death – 90,000 people die annually from hospital acquired infections;[17]
- Death – some 126,000 people die annually from failure to observe evidence-based medicine; [18]

[14] Institute of Medicine, Preventing Medical Errors, op. cit

[15] Atul Gawande, The Checklist, The New Yorker, December 10, 2007

[16] Institute of Medicine, To Err is Human, 1999

[17] Centers for Disease Control and Prevention, 'Morbidity and Mortality Weekly Report 2000';49:149-53

[18] RAND Corporation, First National Report Card on Quality in Health Care in America, page 4.

- Death – up to 40% of hospital deaths occur in patients who are not hospitalized for end-of-life issues; [19]
- Wrong side surgery occurs in 1 out of every 15,000 patients; [20]
- Excess expense – up to 1/3 of US medical care generates 'no discernable benefit'; [21]
- Unnecessary tests and treatments may lead to 30,000 deaths each year; [22]
- 1 in 10 Massachusetts community hospital patients suffered 'serious and avoidable medication mistakes' in the early 2000s, leading to 4 extra days in the hospital. 'Serious errors' included the patient receiving a drug when his / her personal medical files recommended against, or drug doses that exacerbated a medical condition. [23]

Here are some ***treatment variation*** risks:

- Prostate testing vs prostate mortality: Between 1987 – 1997, men in Seattle were 5x more likely to get a PSA test than men in Connecticut, and 5x more likely to undergo prostate removal surgery. But there was almost NO DIFFERENCE in death rates from prostate cancer… except that the Seattle men were SLIGHTLY MORE LIKELY to die of prostate cancer than Connecticut men, perhaps due to the increased rates of treatment.[24] The men in Seattle were also more likely to suffer impotence and incontinence as a result of the unnecessary surgery;

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[19] Data from Dr. David Pryor, Medical Director of Ascension Health, lecture given 4/7/08 to the Massachusetts Healthcare Council in Waltham, Massachusetts

[20] Institute of Medicine, Preventing Medical Errors, 2007

[21] Dr. Eliott Fisher, Healthcare in America: Is More Better?, Annals of Internal Medicine, February 2003

[22] Shannon Brownlee, op cit. page 6

[23] Boston Globe 2/14/08, page A9. This conclusion was drawn largely from a PricewaterhouseCoopers financial analysis of Massachusetts community hospitals

[24] ibid page 201.

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- Who you see is what you'll get. Dr. Richard Deyo, a back expert at the University of Washington, discovered that people with back pain received very different treatments – depending on which medical specialist they visited. Rheumatologists tended to give blood tests – to look for rare immunologist disorders. Neurologists looked for nerve damage. Surgeons ordered MRIs and CT scans to check on bones and soft tissues. In other words, **specialists treated according to their expertise, more than according to patient need**; [25]

- Conclusions from the Back Pain Patient Outcomes Assessment Team: 'There is no evidence that spinal fusion is superior to other surgical procedures for common degenerative spine conditions. Patients who undergo spinal fusion have more complications, longer hospital stays and higher hospital charges than do patients undergoing other types of back surgery.' These conclusions were published by the Back Pain Patient Outcomes Assessment Team in 1994. Yet the rate of fusion surgeries tripled between 1997 and 2007. One possible reason - it's quite lucrative; [26]

- Surgical rates vary geographically. Gall bladder removal rates vary up to 270% comparing 1 US region to another; hip replacement rates vary up to 450%, intensive care hospitalization rates during the last 6 months of life vary 880%. Doctors in Santa Barbara are 5x more likely to recommend back surgery than doctors in Bronx, New York; [27]

- Medicare beneficiaries in Fort Myers Florida were twice as likely to have back surgery (6.9 surgeries per 100K beneficiaries) than Medicare beneficiaries living 3 hours away in Miami (3.2 surgeries per 100K beneficiaries). There was no evidence of epidemiological

[25] Shannon Brownlee, Newtered, Washington Monthly, October 2007

[26] www.ahrq.gov/CLINIC/medtep/backpain.htm . The rate data from ibid

[27] See Dartmouth Atlas of Healthcare

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> differences – people with bad backs don't flock to Fort Myers, which people with strong backs go to Miami. The question: between 1992 – 2001, did Fort Myers perform 4800 unnecessary back surgeries, at a cost of $2 billion – and put these people at increased risk for complications? [28]

We could go on and on. But this list provides an indication of the magnitude of medical risks. Clearly, these risks are worth taking for people who absolutely need medical care.

But these risks are excessive for folks who don't need care – those who undergo unnecessary treatments.

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

Such a description would include a discussion of copayments and deductibles, pre-existing condition 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 the our ethical requirement.

Key Idea: Describing the insurance policy in detail does not satisfy the 'do your fellow a favor' ethical requirements.

The broker also has an ethical responsibility to describe policy implications and healthcare systemic problems that may harm the customer.

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?**

[28] Washington Post, When Geography Influences Treatment Options, July 24, 2005, page A12

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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 one type of health insurance policy – say, a PPO - leads to unnecessary care more often than another type – say an HMO? The answer: 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.

Different Types of Health Insurance Policies May Lead to Different Types of Treatment

Some policies promote excess treatment implicitly, by offering large provider networks and allowing easy access to specialists and easy referrals. This can feed into the provider's economic incentive to treat. Other policies are more restrictive in terms of network size, ease of access and ease of referrals.

How much of this information should the broker tell the client? When – if ever – should the broker advise a client against policies with large provider networks and few referral restrictions?

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Key Idea: Health insurance policies with larger networks and fewer restrictions implicitly induce more unnecessary care and may ultimately cause more patient harm than more restrictive policies.

The broker is not 'ignorant of this flaw' and has an ethical obligation to 'do the fellow a favor' by explaining this to clients. This follows directly from the development of our traditional ethical standards.

Brokers should advise clients about risks of unnecessary care from certain types of health insurance policies.

Conventional wisdom says this is not the broker's responsibility - that medical decisions should be made between the doctor and patient. The broker's traditional role is limited to providing healthcare financing - insurance coverage - and then stepping back. Brokers should have no role in medical decisions: the broker is not a trained medical professional, does not know the current medical technologies, does not know which surgeons are good and which poor, etc. The broker's role should be limited to selling insurance policies honestly.

Conventional wisdom may be wrong. The broker may have an ethical responsibility to 'do his fellow a favor'. Here's why:

Our fee-for-service healthcare finance system pays medical providers based on the number of treatments they perform, not on the quality or applicability of those treatments. Physicians and hospitals have an economic incentive to provide as much treatment as possible, not as little. The more tests and procedures they perform, the more they will get paid.

Our healthcare financing system does not have any counterweight to the provider's incentives to provide excess medical care. Physicians can too easily use their knowledge and prestige – at a time when the patient is sick or frightened – for their own financial gain.

The patient rarely wants less care – after all, he / she has purchased insurance that pays all, or almost all, medical costs. It is too easy for the

patient to acquiesce to the physician's advice ---- advice that serves the financial interests of the physician. (Of course physicians also provide good medical care. That is given. But ethical discussions take place at the boundaries, not the center, of normal activities.)

Excess and unnecessary treatments can cause harm. We touched on some indicators of this, above.

The broker has an ethical responsibility to advise clients about these risks.

Conclusion

Traditional ethical standards suggest that a knowledgeable broker is not 'ignorant of the flaw' of overtreatment and has an affirmative ethical responsibility to 'do the fellow a favor' and advise against the risks of overtreatment.

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Hypothetical Case Study

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A broker offers two family plans to a client.

Policy A is a PPO type plan costing $1400 per month. It has no copayments or deductibles for tests or hospitalizations, and has no in-network referral restrictions. The network is virtually all hospitals and physicians in the area.

Policy B is an HMO type plan costing $1250 per month. It also has no copayments or deductibles for tests or hospitalizations in network, but has stringent referral requirements. Its network is about 60% of the hospitals and physicians in the area. It has a high out-of-network deductible.

How should the ethical broker advise the client?

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Let's assume that the client prefers the PPO type plan's wider network and lack of referral restrictions.

The **unethical broker** would advise Plan A, using the following reasoning:

> This plan is very good. It covers all state mandated services with no copays or deductibles and has a network including virtually all providers in the state.
>
> Plan B has a smaller network and has significant referral restrictions. It poses risks to you, as you might not be able to see your specialist of choice or get admitted to your hospital of choice.
>
> The $150 monthly savings from Plan B is not worth the risk.

Why this is unethical: This broker takes the 'let the buyer beware' attitude and leaves the client to make difficult and complicated decisions without any help.

The unethical broker equates network size and lack of referral restrictions with quality. As we have suggested above, these are faulty assumptions. Limiting referral restrictions does not necessarily improve mortality rates or the quality of medical care.

The client purchasing Plan A opens himself to inducements for overtreatment.

This broker is not 'ignorant of the flaw' of excess treatment - yet does not tell the client. This alone is grounds to cancel the sale, according to the Torah.

The broker also does not live up to the ethical dictates of the Torah to 'do the fellow a favor.'

The **more ethical broker** would advise differently:

> Plan A is good, but poses risks to you. Studies have shown that people in these types of plans get more medical care than they need.

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Their health outcomes are no better than people in Plan B, but are sometimes worse due to treatment complications from unnecessary care.

I can show you some of this data.

Plan B is also good. It gets your Primary Care Physician involved in all aspects of your care, so reduces the risks of poor communication among your providers.

Though Plan B only contracts with 60% of our providers, we have no indication that the other 40% are any better; we have virtually no outcome data by provider. We have, therefore, no reason to suggest that you pay a higher premium to access more providers of the same quality.

Your risk with Plan B: that the carrier will deny referrals for its own financial gain and that your care will suffer as a result.

The ethical broker would then discuss Plan B's referral processes and referral decision making.

This broker helps the client understand how our healthcare system functions and the trade-offs. In particular, this broker advises on risks of both overtreatment (due to no gate-keeper) and undertreatment (due to carrier referral restrictions).

The client of the ethical broker can make a more informed decision on which policy to purchase.

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What do you think? Should brokers warn clients about the risks of overtreatment?

If you were a client, what would you want your broker to advise you?

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Chapter 2:
The Problem of Excess Medical Care: An Overview

Americans currently spend between $500 and $700 billion dollars annually on medical care that does nothing to improve our health.[29] This is money spent on unnecessary tests, unnecessary treatments, excess treatments, excess use of intensive care units, and similar. It is money that does not improve patient health or extend patient longevity.

Key Idea: We annually spend between about $500 - $700 billion on medical care that does not improve our health. This care does, however, subject us to medical risks.

These unnecessary medical interventions are certainly expensive and wasteful – but that's a different ethical issue from our focus in this course. Here we are more concerned about the negative medical effects of excess care and the root causes of all this unnecessary treatment. We want to discover the ethical role the broker should play.

Let's let Atul Gawande, a surgeon and professor at Harvard Medical School and the Harvard School of Public Health, guide us through the landscape. Gawande is the author of two excellent books on healthcare, *Complications* (2002) and *Better* (2007), as well as numerous articles in the New Yorker.

Gawande suggests that about 97% of hospital admissions turn out positively…meaning that about 3% of hospital admissions result in complications, with infections accounting for about half of the total. [30]

Key Idea: For every 100 unnecessary hospital admissions, 3 people will be unnecessarily harmed.

[29] Shannon Brownlee, op cit, page 5

[30] Atul Gawande interviewed by Charlie Rose on PBS, April 2, 2009

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How many people are harmed? In 2006, we had 120 million ER visits [31] and 35 million inpatient discharges. [32] Researchers estimate that up to 1/3 of medical care is unnecessary – provides no benefit. (See below, page 37) That's up to 11 million annual unnecessary hospitalizations. Gawande's 3% complication estimate suggests that up to 350,000 of us are harmed by these unnecessary inpatient visits annually. (I did not apply the estimates to ER visits. The resulting number is too frightening.)

Here's a brief summary of how excess treatments actually harm us:

- Radiological tests sometimes identify conditions that would never have bothered the patient had they never been found. 'There is a vast ocean of potentially diagnosed, but clinically meaningless cancers' according to Dr. James Talcott, Director of Outcomes Research at Massachusetts General Hospital. 'The more you [test] the more of those meaningless cancers you're going to find' and potentially treat unnecessarily. [33]

  Doctors annually perform an estimated 2 million biopsies on healthy women's breasts and male prostate glands as a result of 'false positives' (incorrect radiological readings that show cancer when it does not actually exist). In addition, some 500 women with no symptoms of cancer annually undergo unnecessary abdominal surgery due to false positives. These tests are stressful, painful and may lead to complications…in Gawande's estimate about 3% of the time.

- Back surgery is overused as the treatment of choice for people in pain, even in the absence of conclusive evidence that surgery works. Surgery sometimes makes the pain worse.

[31] National Health Statistics Report, Number 7, August 6, 2008

[32] 2009 US Statistical Abstract, Table 169

[33] Boston Globe, 'Scares Grow as Cancer Screening Rises' September 30, 2007, page A1, A20

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Medicare's 2001 back surgery rate per 1000 beneficiaries was 6.9 in Fort Myers Florida but only 3.2 in Miami, and 2.3 back surgeries at Dartmouth-Hitchcock Hospital in New Hampshire. According to Chuck Krivenko, medical director at Lee Memorial Health Systems in Fort Myers – apparently a big fan of back surgeries - 'if the only tool you have is a hammer, then everything looks like a nail'. But Dartmouth-Hitchcock orthopedists disagree: 'What we have found is that patients tend to make good decisions when presented with good information'. [34]

It's worth noting that back surgeries are very profitable for hospitals. In 2001, according to a study by the American Academy of Orthopedic Surgeons, spine surgery accounted for more than half of all profits from orthopedic hospital procedures, but only 21% of the volume. Lee Memorial's Medicare reimbursements for spine surgeries grew by 50% from 1998 – 2003.

Surgeons and hospitals apparently have an economic incentive to operate. **Who objectively advises patients of these provider inducements**…and that surgery is not always the best approach? Who tells patients about the apparent overuse of back surgery in Fort Myers? **Who advises them of their <u>geographic</u> risk?**

- Patients sometimes contract lethal infections while in the hospital for unnecessary or elective surgeries. In 2000, the Centers for Disease Control estimated that up to 90,000 people die annually from hospital acquired, preventable infections. How many died of preventable infections due to <u>unnecessary</u> hospitalizations…a third?;

- Up to another 98,000 Americans die annually from medical system errors, such as poor coordination among providers, according to the Institute of Medicine's 1999 study 'To Err is Human. Again how many suffered medical systemic errors due to <u>unnecessary</u> hospitalizations?;

[34] Washington Post, 'When Geography Influences Treatment Options' July 24, 2005, page A12

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- Some 1.5 million Americans are 'sickened, injured or killed' annually due to medication errors, according to the Institute of Medicine's 2006 study 'Preventing Medical Errors'. In another report, the Institute estimates that patients receive, on average, 1 medication error per day that they stay in the hospital. A different study found that patients in intensive care receive, on average 2 errors per day. How many suffer these problems unnecessarily, due to unnecessary treatments or hospitalizations?

Medical Treatment Complications Present the Smaller Ethical Problem

Gawande's 3% medical complication estimate – 350,000 of us annually - though, is just the tip of the 'healthcare systemic harm' iceberg. He limited his analysis to medical treatments where something actually went wrong.

He did not discuss unnecessary treatments that do no patient good - but may cause harm. He does not discuss poor handoffs between hospitals and rehab facilities - that may lead to poor outcomes. He does not discuss poor preventive care - often a stimulus to excessive surgeries.

Key Idea: The 3% hospital error rate is only the tip of the iceberg. It is the smaller of our 2 ethical problems. It does not, for example, include the number of people readmitted within 30 days – approximately 18% of hospital discharges, often due to poor follow up.

Let's review the data on poor handoffs from the acute care hospital to rehab to highlight an issue.

We Have Very High Hospital Readmission Rates in the US

Unfortunately in this country, we are quite poor at these handoffs. Here is post 2000 Medicare 30 day readmission data:

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Some 30-day Medicare Hospital Readmission Rates [35]

NJ: 18% readmission
NY: 18% readmission
MA: 19% readmission
LA: 24% readmission
CA: 18.5% readmission
MD: 20.5% readmission

On average in these 6 states, about 20% of Medicare patients were readmitted to the hospital within 30 days of discharge. The main reason for readmissions: poor post-discharge patient follow up. Too many patients failed to see their doctors as instructed on their discharge paperwork; too many failed to take their medications as indicated; and too many failed to follow the other discharge instructions.

Contrast this with data from the Maimonides Medical Center's Heart Failure Readmission Rates below. The Maimonides people decided to try to reduce readmissions by more actively following patients post-discharge. They cut their readmission rate by more than half:

Maimonides Medical Center Heart Failure Readmission Rates

1998: 21% readmitted
1999: 18%
2000: 7%
2001: 8%
2002: 3%
2003: 8%
2004: 8%
2005: 6%
Source: Schoen, op.cit.

The contrast between these slides shows the difference between what we actually do in American healthcare today, and what we could do.

[35] Source: 'Aiming High: Toward a High Performance, Value Based Health System' Cathy Schoen, Commonwealth Fund, lecture at Massachusetts Health Council, 4/7/08. The Medicare readmission rates listed here were estimated from various of Schoen's slides.

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Why the high readmission rates in this country? Because our healthcare system suffers from fragmented care – far more than healthcare systems in other advanced countries. Health Affairs reported in October of 2008 on a comparative study of 7500 chronic patients in the US, Australia, Canada, Germany, UK, Netherlands and New Zealand. Some results: [36]

- 1/3 of US patients encountered 'poorly coordinated care' – higher than any other country;
- 1/3 of US patients reported medical errors, about double that of the Netherlands;
- More US patients complained about 'inefficient, unsafe, wasteful and poorly coordinated care' than did patients in other countries.

As a result we develop (far more than other countries) post-discharge medical problems that require rehospitalization. That puts us at risk for all the problems outlined above: 10% suffering 'serious and avoidable medication mistakes', etc.

That's one way that Gawande underestimates the impact of medical complications. Perhaps only 3% of hospitalizations go badly – but if we keep readmitting the same patients unnecessarily, each person's risk of complications increases with each readmission.

Under Use of Preventive Medicine

Here's a second way Gawande underestimates the extent of our excess hospital treatments – our under-reliance on prevention. In short, we fail in this country to treat certain types of medical problems early enough in the disease cycle. As a result, we intervene with sicker patients later in the disease.

One effect: **our medical protocols and standard operating procedures are more aggressive than other countries.** There may be a provider financial incentive issue here also.

[36] Health Affairs online 11/13/08

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Key Idea: We underuse preventive medicine. As a result, we hospitalize later in the disease cycle, and intervene more aggressively, than do many other countries. These hospitalizations may not result in complications – but may harm patients.

One example: an excess of foot amputations in this country compared to other countries. Many could have been prevented by better care earlier in the disease cycle.

Let's look at lower limb amputation data as a case study example.

In the US, we amputate about 100,000 feet annually, due primarily to diabetes. Below, we contrast this rate with other countries that present with approximately the same rate of diabetes in their population: [37]

Key Idea: We amputate feet approximately twice as frequently than many Western European countries.

An International Comparison of Lower Extremity Amputations
US counties compared to similar regions in other countries

US rate per 100K population

Average US male amputation rate: 24
Average US female rate: 15
Lowest studied US county rate, females: 10
Bergin County, NJ
Lowest studied US county rate, males: 14
Morris County, NJ
Highest studied US county rate, females: 20
Bucks County, PA
Highest studied US county rate, males: 35
Montgomery County, PA

Other countries per 100K pop

Average int'l male amputation rate: 14
Average international female rate: 7
Lowest studied female rate: Madrid 0.5, Leicester England, 4
Lowest studied male rate: Madrid 4, Leicester England 7

[37] Renzi, et al, An International Comparison of Lower Extremity Amputation Rates, Annals of Vascular Surgery 2006

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Key Idea: In the US, we treat problems via amputation, for example, far more frequently than in other countries. Stated differently, we prevent fewer foot amputations than do many other countries. As a result, our treatment protocols may be more aggressive. The patient in Spain who would receive therapy, might in the US receive an amputation.

Might Financial Incentives Affect Advice?

Let's remember the financial incentives at work here. The hospital can bill about $100 per hour of physical therapy or per podiatric visit. This is not particularly profitable and may even be unprofitable depending on various overhead factors.

Alternatively, the hospital can bill perhaps $40,000 per amputation – financially, much more attractive. Unscrupulous providers might put their financial interests ahead of the patient's interests.

Imagine the situation where a US patient receives an (unnecessary) foot amputation…and then picks up a serious infection in the process! Potentially more billing by the hospital – but such harm to the patient.

Relying solely on your surgeon's advice, then, might lead to an unnecessary amputation. Our underlying broker ethical question, of course: where else can the patient get relevant information?

Key Idea: Providers may have financial incentives to overtreat, as, for example, by amputating rather than providing podiatric therapy.

The broker has an ethical obligation, according to the Torah, to advise clients of this.

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The Bigger Problem: Medical Care That Does No Good

Large as it is, this type of medical complication – where the patient gets infected or has some surgical complication during treatment - represents only a small portion of our national problem of medical risk and excess. Assuming Gawande is right --- apparently a reasonable assumption as he's a highly regarded medical commentator --- it represents only a small broker disclosure / ethical issue. It is, by far, the easier of the two medical excess problems to analyze ethically, and the easier to advise.

When brokers 'do the fellow a favor' as recommended by the Torah, we should advise clients that our healthcare treatments do sometimes go badly. We as brokers should tell our clients that about 3% of medical treatments result in complications that require additional and unexpected care. This is a fairly simple ethical case.

The far more complicated case – and the far larger problem of excess treatment – is the second type of healthcare excess problem. That is the problem of unnecessary treatment.

How Much Care Does No Good?

How large is this problem? Dr. Elliot Fisher, a researcher at Dartmouth Medical School – and also highly regarded in the medical community – summarizes this problem:

> Our research suggests that up to about a third of medical care is devoted to services that do not provide any detectable benefit. [38]

Key Idea: Up to about 1/3 of US medical care does not provide any detectable benefit…but may cause patient harm.

Who tells your clients about this?

[38] Eliott S. Fisher, 'Healthcare in America: Is More Better?' Annals of Internal Medicine, 2003

Fisher and his colleagues at Dartmouth reviewed Medicare data from the 1980s and 90s on treatment frequencies and death rates to establish this estimate.

Interestingly, the Dartmouth researchers confirmed what many in the medical profession already knew: that the availability of hospitals, beds and specialists led to an excess of medical care.

Roemer's Law and Its Effects on Treatment Excess

This interaction – between hospital bed availability and treatment excess – had been noticed initially in the 1950s by a medical economist named Milton Roemer, developer of 'Roemer's Law'. This 'law' states that the number of hospital admissions is the result of bed availability – not of underlying disease epidemology. Roemer claimed that 'the supply of hospital beds in a community or state is the major determinant of the hospital utilization rate'. [39]

Roemer concluded this by studying a town in update New York in the 1950s (he doesn't tell us which town). In 1957, this town had 1 general hospital with 139 beds and an average daily census of 108 --- meaning that the hospital had excess capacity. In 1958, the hospital moved to a new facility with 197 beds, and utilization increased to 137 daily --- an increase of 26%.

Roemer claimed that there were no other changes in the community --- no population increase, no new industry, no increase in diseases. His only explanation: physicians respond to the increased availability of beds by admitting more patients.

Let's apply Roemer's Law and Dr. Fisher's research to our national medical situation. Between 1960 – 1980, we doubled the number of medical school places and expanded the number of hospital beds. From 1980 – 2000, the number of US physicians increased 4x faster than our population and we gained more hospital beds.

[39] Milton Roemer 'Bed Supply and Hospital Utilization: A Natural Experiment' Hospitals 35 (1961) page 36

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Boosting the number of physicians and beds led to more procedures. Why?

(1) As we expanded the number of physicians, we also expanded the availability of health insurance, through employers, Medicare and Medicaid. This shielded the majority of Americans from the costs of medical treatment;

(2) Medicine is a 'super good' where the patient's desire to live pain free or feel better is continuous and robust. This creates a virtually unlimited demand for medical services ---- that appear virtually free to patients; [40]

(3) Physicians generally bill the insurance carrier 'fee-for-service'. They only get paid when they do something – see a patient or perform a test or procedure. They thus have an economic incentive to provide more treatment, not less;

(4) Many medical conditions were complex, difficult to diagnose and treat, and lacking specific treatment guidelines. How often should a physician see patient in pain, suffering from a chronic condition or desiring to feel better? Once a month? Once a quarter? Semi-annually?
The answer, according to John Wennberg, another of the Dartmouth researchers:

'The doctor will sort it out based on how sick an individual patient is and how many opening he has in his schedule. Specialists tend to fill their appointment books to capacity.' [41]

[40] This discussion comes from Robert Galvin and Suzanne Delbanco 'Between a Rock and a Hard Place: Understanding the Employer Mind Set' Health Affairs, Nov/Dec 2006

[41] This discussion comes from Maggie Mahar, Money Driven Medicine, 2006, page 172, including Wennberg's quote.

Key Idea: Increasing the number of physicians, hospital beds and the availability of health insurance leads to an increase in medical treatments, often unrelated to any underlying disease issues.

Insurance policies that allow virtually unfettered access to medical care exacerbate, rather than mitigate, these problems.

Three Effects of Unnecessary Care

First, regions of our country with more physicians have more medical procedures and higher medical costs. Among the most famous comparisons, Medicare recipients in Minneapolis cost about half as much as Medicare recipients in Miami --- without any indication of underlying health differences. (These people are all over 65 years old. There's no indication that sick people move to Miami, but healthy beneficiaries remain in Minneapolis.)

Researchers found that Medicare beneficiaries living in high spending areas were no healthier, no less disabled and had no lower mortality rates than people living in low spending areas. [42] At best, more care accomplishes nothing positive. But this gets worse.

Second, surprisingly, beneficiaries in high spending areas were more likely to be undertreated than beneficiaries in low spending areas. This is, perhaps, a direct effect of having too many specialists and not enough generalists in high spending regions. Dartmouth researchers found, for example, that only 75% of heart attack patients in high spending areas had hospital discharge orders to take baby aspirin – the single most effect drug for reducing patient's risks of having a second heart attack.

By contrast, heart attack patients discharged from hospitals in low spending regions received baby aspirin orders 83% of the time. [43]

[42] Fisher, op. cit.

[43] ibid.

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Only 48% of patients in high spending regions received flu vaccinations, while 60% in low spending regions did.

Where did the excess spending go? The Dartmouth researchers discovered that

> Differences in spending were explained almost entirely by greater frequency of physician visits, more frequent use of specialist consultations, more frequent tests and minor procedures, and greater use of the hospital and intensive care units…
>
> We found no evidence to suggest that the pattern of practice observed in higher-spending regions led to improved survival, slower decline in functional status or improved satisfaction with care. [44]

Dartmouth's conclusion: hospitals that spent more were simultaneously overtreating patients (with specialists unnecessarily) and undertreating patients (with primary care) and generating no patient improvements.

But sometimes generating negative results.

Negative results? This is the **third** problem of excess treatment. Fisher and his Dartmouth colleagues found that patients who went to the most expensive hospitals had a 2 – 6% increased chance of dying, compared to patients who visited less expensive facilities. The reason:

> The most reasonable explanation for the higher mortality rate is that the additional medicine patients are getting in the high-cost regions is leading to harm. [45]

The specific findings:

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[44] Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

[45] Fisher, quoted in Brownlee, op cit, page 50

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- An increase in medical spending per person was associated with a small increase in the risk for death;
- For every 10% increase in medical spending, the relative risk for death over 5 years increased;
- In none of the groups examined was a higher expenditure rate per capita associated with a statistically significantly lower mortality rate.

Note that Fisher and his team 'bent over backwards' to ensure that their cohorts of patients were equally sick. The generally accepted analysis of Fisher's study: there was no consistent medical difference among patients at the different hospitals. [46]

Key Idea: Above a certain level, more medical interventions do not improve patient functional status or longevity. But unnecessary care correlates with increased mortality rates – perhaps due to patient fatigue or medical complications.

The broker should advise clients of these risks.

What have we learned from all these Dartmouth – and other – studies? That regions with fewer specialists in relation to the population – and more primary care physicians – have better overall health. Fisher, in his major 2003 studies found both less undertreatment and lower mortality rates in hospital regions where there are more primary care physicians and fewer specialists. [47]

[46] Brownlee, op. cit, page 320, note 50.

[47] Ibid, page 67

Key Idea: Regions with fewer specialists and more primary care physicians in relation to the population have better overall health.

The availability of outstanding hospitals and specialists does not translate into better patient health. Indeed more hospitalizations, more specialist visits and more healthcare spending may actually lead to poorer patient health and higher mortality rates!

This is the big overtreatment problem. Remember how Dr. Gawande, above, noted that 97% of hospital treatments turn out well, so only about 3% are subject to error or mistreatment. As we suggested, that is the smaller overtreatment problem.

Key Idea: The larger overtreatment problem is inappropriateness. Our excess supply of specialists may do their jobs perfectly --- but the patient may suffer. Not due to error --- but due to lack of a properly working Primary Care function. Patients may receive outstanding technical service --- but not be advised to take aspirin. They may receive outstanding acute care --- but suffer from poor post-hospital-release follow up.

Each medical intervention may go well – i.e. not have complications – but the regional mortality rates may increase! The ethical broker should advise clients of these types of healthcare system flaws.

Armed with this knowledge, the broker faces two ethical dilemmas. First, how much should he / she educate clients about these systemic problems? Second, should he / she steer clients toward insurance policies that reduce access to specialists?

We'll address those questions shortly. We'll also address the current consumer demands for easier access to a wider provider network when purchasing health insurance policies.

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But first, let's understand why our healthcare system promotes unnecessary – often harmful – care.

Why our healthcare system promotes excessive and unnecessary care

Key Idea: There is, unfortunately, a simple reason why hospitals and physicians provide excessive and unnecessary care: they get paid more!

According to Shannon Brownlee, author of **Overtreated**:

> The most powerful reason doctors and hospitals overtreat is that most of them are paid for how much care they deliver, not how well they care for their patients. They get paid more for doing more.[48]

The provider's financial interests may cloud his / her judgement, especially when patients present in the gray area - between needing medical interventions and not. See Roemer's Law, above, page 37.

Compounding this incentive problem is the 'provider orientation' problem. We touched on this problem above in our discussion of Dr. Deyo's insight about how different specialists address back pain problems.

Surgeons tend to recommend surgery, therapists tend to recommend therapy and psychiatrists recommend medications. Medicine today, according to Harvard's Gawande, is too complex for any physician to understand completely. Doctors specialize and view patients through their own education / orientation lens.

Interestingly, Gawande points out, we currently have over 11,000 different kinds of operations and over 6,000 different kinds of drugs. No one can keep current on all of this.[49]

[48] Brownlee, op cit, page 8

[49] Gawande, op cit.

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Physicians, like any of us, tend to stay within their comfort zones. Surgeons understand surgery, so are comfortable recommending it --- even if they are unfamiliar with potentially more useful alternative treatments. Other physicians recommend treatments that they understand and feel comfortable with.

Some Examples of Treatment Variation

Some physician groups overtreat - while others undertreat or mistreat - the same patients. Here are some examples from Vermont, with data collected by John Wennberg of Dartmouth Medical School and his research teams over the past 30 years:

Key Idea: Treatment variation – where different physicians treat patients with similar health problems very differently – is a huge problem. Our healthcare system does not inform patients of this. The broker should.

- In Middlebury, 7% of the children under age 16 had their tonsils removed, but in Morrisville, nearly 70% did. There were very few significant, if any, demographic or epidemiological differences between Middlebury and Morrisville;
- One Vermont region had 20 hysterectomies performed for every 10,000 people, while another region had 60, again with no evidence of epidemiological differences ;
- Hemmorrhoid removal ranged from 2 per 10,000 to 10 per 10,000 people in various towns, apparently unrelated to underlying diseases;
- Appendectomies and mastectomies varied threefold across the state;
- Vericose vein surgeries varied fourfold.

Twenty percent of the kids in Waterbury, Vermont had their tonsils removed by age 15, but in next door Stowe, some 70% did. Why? These towns were socioeconomically similar. Town water systems were apparently similar. Researchers could find no significant demographic or epidemiological differences. What caused these huge treatment variations?

The answer: kids in Waterbury went to one pediatrician group, while kids in Stowe went to another. Perhaps the Stowe pediatricians were more aggressive. Perhaps they believed in the efficacy of tonsillectomies more than the Waterbury physicians. Or perhaps in the gray area, they unconsciously followed their own economic interests too closely.

The other discrepancies noted above seem to have the same cause – physician orientation – rather than any underlying disease differences.

Physicians Sometimes Use Treatments That Don't Work

Physicians, perhaps like all of us, get comfortable with one treatment protocol, believe in its utility and then ignore contrary evidence…sometimes to the detriment of their patients. Here's a description of the problem from Dr. Sherwin Nuland of Yale Medical School:

> Better watch out or the pendulum swing of medical dogma will bash your head in. It swings back and forth far more often than most people realize and with greater velocity. Thirty years ago patients with inflammation of … the colon were routinely treated with a diet low in roughage. There was no uncertainty about this course of action…and yet, a few years later, medical opinion reversed: decreased roughage was found not to be a panacea but a cause of the disease. This new medical discovery was announced in the same assuredness and supported by just as much evidence as had been used for precisely the opposite viewpoint. [50]

Some physicians became comfortable treating colon inflammation with low roughage diets…just like the Stowe pediatricians apparently became comfortable removing tonsils. Sometimes the wrong treatment – leading to patient harm.

Similar situations occurred in many treatment protocols:

[50] Sherwin B. Nuland, 'Medical Fad: Brain, Midwives and Leeches' New York Times, June 25, 1995, section 4, page 16.

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- Hormone replacement in post-menopausal women,
- Bone marrow transplantation in women with breast cancer,
- Stent placement for patients after heart attacks,
- Tonsillectomies
- Hysterectomies
- Frontal lobotomies
- Radical mastectomies
- Arthroscopic knee surgery for arthritis,
- X-ray screening for lung cancer,
- Proton pump inhibitors for ulcers,
- High dose chemotherapy for breast cancer patients…to name just a few.[51]

Key Idea: Why do physicians persist in recommending inappropriate treatments? One reason is economic. A second relates to the quality of our medical outcome data.

Our Lack of Quality Outcome Data

Our fee-for-service healthcare financing system is notoriously poor at generating outcome data. We have fewer follow-up studies than we should. Perhaps this is due to our billing system: providers get paid based on inputs – procedures performed – rather than on outcomes. Data showing that they generate poor outcomes may harm them economically. This may lead to a reluctance to engage in outcome studies.

Perhaps as a result, doctors are less scientific than we would like to believe. Here's Shannon Brownlee, author of *Overtreated*, articulating the problem:

[51] This list comes from Boston Globe, January 1, 2008 op ed piece by H. Gilbert Welch and Steven Woloshin and from Shannon Brownlee, op cit, page 27

> Much of what doctors were doing was based more on hunches than good research. There were gaping holes in medical knowledge even when it came to something as seemingly mundane as a tonsillectomy. [52]

And here's Harvard Business School Professor Michael Porter on the same issue:

> Physicians generally lack information on results, or their efficiency in achieving results, that is essential for knowing if they are doing their job well…most physicians lack any objective evidence of whether their results are average, above average or below average. [53]

Here's our provider situation: medicine is too complicated for anyone to understand all diseases and treatments. Physicians specialize and get comfortable treating patients in certain ways. They become reluctant to change their treatment protocols. Change might require an admission that they were wrong in their previous treatments – hard to do. Change might also require them to learn new treatments and techniques – hard to do. And change might negatively impact on their pocketbooks – unattractive.

Key Idea: Medicine is too complicated for any physician to understand everything. They specialize and get comfortable with certain types of treatment. Lacking high quality outcome data, they often resist change – sometimes to the detriment of their patients.

So they overtreat – or treat inappropriately - as in some of the examples above.

A patient might receive excellent care or, in Gawande's words, be part of the 97% success rate. No hospital infection, no post surgery complications, successful rehab. But it might be the wrong care – stent insertion that

[52] Brownlee, op cit, page 27

[53] Porter and Teisberg, Redefining Health Care, page 54

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accomplishes nothing. (We'll provide that data in the next chapter.) That's the real overtreatment problem we face.

What should the broker do? How should he / she advise clients? When should the broker intervene? How best can the broker 'do his fellow a favor'?

Or should the broker simply say 'not my responsibility' – the Biblical injunctions don't apply to me?

Key Idea: An ethical health insurance broker can help clients think through the various systemic issues discussed above. One way to proceed: Advise your clients how to access good healthcare systemic information.

Let's ponder the broker's position as we turn to a discussion of coronary treatments provided in hospital 'Centers of Excellence'.

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Chapter 3:
How Excess Treatments Can Harm Patients: Coronary Problems at Centers of Excellence

Do Hospital Financial Interests Always Coincide with Patient Health Interests?

> 'I sometimes just shake my head at the American system, where the financial intent is almost cleverly designed to create mischief. For administrators, it creates a conflict of interest when they're trying to deliver the numbers at the same time that doctors are saying the hospital is doing too much cardiac surgery.' Princeton Health Economics Professor Uwe Reinhardt [54]

Hospitals need to earn money – to expand, to pay investors, to attract top talent, to keep current with technologies, and for many other reasons. In our fee-for-service financing system, hospitals are financially induced to invest in the most profitable procedures; like all income generating enterprises, they seek the best margins. And they invest to gain the greatest return on investment --- that's called capitalism.

Key Idea: Some hospital services are more profitable than others. Cardiology is generally profitable; emergency medicine generally not.

Hospitals know that, based on Medicare and other insurance payment systems, the following services are most profitable so they invest the most in these: [55]

- Cardiology
- Neurosurgery

[54] Quoted from Kurt Eichenwald 'Operating Profits: Mining Medicare – How One Hospital Benefited from Questionable Surgery' New York Times, August 12, 2003.

[55] This list and subsequent discussion comes from Brownlee, op cit. page 82

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- Orthopedics
- High end imaging (CT scans and MRI)
- Bariatric surgery

Far less profitable – indeed, often unprofitable – services include:

- Psychiatric wards
- Emergency medicine
- Medical wards dealing with chronically ill patients

One study of California emergency rooms indicated that hospitals lost an average of $84 per patient who was seen but not admitted. (That seems a pretty good financial incentive to admit.)

Cardiac surgery is particularly profitable. A 2002 MedPAC study indicated that hospitals made an average profit of $9600 per bypass patient. Heart valve replacements generated about a 60% profit margin. Hospitals earned about $20,000 per angioplasty, about 40% of which was profit. [56]

On the other hand, treating heart attack patients with medication generates about an 11% operating loss per patient. Where would the smart hospital administrator invest?

Key Idea: Some cardiac procedures are more profitable than others. Surgery, for example, is far more profitable than treating heart attack patients with medication. Hospital financial interests may conflict with patient health interests.

Remember that hospitals earn money by treating patients. The more treatment they provide - and the longer the treatment takes - the more money they'll make.

Duke University Medical Center Does It Right – But Loses Money

[56] See Liz Kowalczyk, Small Hospitals Battle for Right to Do Angioplasties, Boston Globe, Feb 13, 2005 and Richard Lange, et al, Use and Overuse of Angiography and Revascularization, New England Journal of Medicine 338, no. 25 (1998) pages 1838-39

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Duke University Medical Center learned this lesson the hard way in 1995. They had implemented an aggressive coronary patient service system to ensure that patients followed all appropriate procedures. Nutritionists checked on patients nutrition programs, nurses verified that patients took the right medications, doctors designed new and improved procedures.

Annual treatment costs per patient declined by almost 40%. As Harvard Business School Professor Regina Herzlinger summarizes:

> Duke's new model achieved these cost reductions by improving participants' health status – hospital admissions and lengths of stay dropped. [57]

The net result? As the number of coronary admissions fell and patients spent less time in the hospital, Duke lost money.

Terry Langbaum, a senior financial officer at Johns Hopkins Medical Center in Baltimore, explains how a hospital views various medical treatments. (Note that cochlear implants were not profitable at the time of this quote due to carrier reimbursement practices, but cancer treatments were):

> Would we want to grow the cochlear implant program? No. Are we going to advertise it? No. But we make money taking care of [cancer patients]. Are we trying to grow those programs? Yes. [58]

So they advertise their wonderful cancer programs.

The hospital investment criteria: servicing its bottom line.

Let's summarize to this point: hospitals and physicians have an economic incentive to treat. They have no economic incentive to avoid treating. So a patient who presents in the gray area, between needing treatment or not,

[57] Regina Herzlinger, Who Killed Healthcare?, McGraw-Hill 2007, page 78

[58] Brownlee, op cit. page 86

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may receive unnecessary care – which may lead to the complications discussed in Chapter 2, above.

Further, the hospital makes more money with certain types of treatments than others - so has an economic incentive to recommend those treatments. Hospitals make more money from angioplasties than from medication treatments, so have an economic incentive to promote the former. Hospital administrators and physicians typically know this.

The patient, meanwhile, doesn't know all this, but trusts his / her physician to work in the patient's best interests. Is this trust always warranted?

Let's consider what happens when the hospital bottom line contradicts patient needs.

Cardiac 'Centers of Excellence' May Not Always Serve Your Clients Best

Cardiac catheterization involves inserting a wire through the patient's femoral artery into the heart. These are often done during a heart attack – on about 800,000 patients annually.

Sometimes catheterization is done electively or preventively – on about 1.2 million of us annually. Cardiologists perform these procedures on patients suffering from shortness of breath, stable angina or similar….or on patients who appear to have plaque built up in their arteries. Cardiologists may perform angioplasties - insertion of a balloon that inflates and crushes plaque against an artery wall. They also sometimes insert stents to keep the artery open.

About 14% of these angioplasty procedures – some 170,000 annually - are 'inappropriate' meaning they should not have been performed. [59] Another 500,000 are of 'questionable value' – not quite inappropriate, but probably

[59] Schneider, et al, Racial Differences in Cardiac Revascularization Rates: Does 'Overuse' Explain Higher Rates among White Patients?, Annals of Internal Medicine, September 4, 2001, Volume 135, Issue 5, pages 328-337

not necessary either. [60] Some 10% of CABG – Coronary Artery Bypass Grafts, more commonly known as bypass surgery – about 40,000 annually - were also 'inappropriate'.

Key Idea: Cardiac catheterizations – angioplasty procedures – are profitable. But some 14% (about 170,000 annually) are 'inappropriate' and another 500,000 are of 'questionable value'. These carry a mortality risk of 1 – 2%, or potentially 13,000 annual deaths from unnecessary or questionable procedures.

These procedures carry a mortality risk, estimated at about 1 – 2% of bypass surgeries…or potentially 13,000 annual deaths due to unnecessary CABG surgeries annually! That's incorporated in Gawande's 3% poor hospital outcome estimate.

Key Idea - The underlying problem: Researchers at the Veteran's Health Administration have discovered that vast majority of these elective cardiac procedures are no more effective at preventing heart attacks than good medical management including lifestyle management and medication. See Brownlee, Overtreated, page 99

Hospitals may follow their financial interests and subject patients to unnecessary risk, without any upside for the patient. This is one aspect of inappropriate treatment discussed above.

The reason: heart attacks are caused when a plaque bursts, forming a clot that blocks blood flow to the heart. Some 75 – 80% of the time the erupting plaque was not obstructing an artery, so would not have been stented (or bypassed). Heart attack patients may have hundreds of these vulnerable plaques – which would, theoretically, require hundreds of angioplasties and stents. That's why cholesterol controlling medications often generate better outcomes. [61]

[60] Brownlee, op cit. page 99

[61] Gina Kolata, New Heart Studies Question the Value of Opening Arteries, New York Times 3/21/04

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Though the rate of these preventive procedures has skyrocketed over the past 15 or so years, our rate of heart attacks has not decreased. A reason, according to Dr. David Hills, an interventional cardiologist in Dallas:

> If you're an invasive cardiologist and Joe Smith, the local internist, is sending you patients, and if you tell them they don't need the procedure, pretty soon Joe Smith doesn't send patients anymore. Sometimes you can talk yourself into doing it even though in your heart of hearts you don't think it's right. [62]

Here's what often happens. The patient has a vague complaint so gets a scan – which indicates a plaque build-up or artery narrowing - and gets referred to a cardiologist. The cardiologist performs the angiogram and, sure enough, confirms the scan findings. Unfortunately, according to Gina Kolata, the well known science reporter for the New York Times

> Since most people who are middle-aged and older have artherosclerosis [plaque build-up], the angiogram will more often than not show a narrowing. Inevitably, the patient gets a stent. [63]

Or, depending on perceived severity or physician disposition, a bypass.

This mirrors Dr Talcott from Massachusetts General Hospital (above, page 30) who claimed 'the more you test, the more you find'.

Patients too often want the highest technology treatments and question cardiologists who defer or refuse to treat. In our society – too often – they simply go elsewhere.

But the general data discussed above hides three significant other patient risks.

The first risk: hospitals performing low volumes of these procedures have higher mortality rates than hospitals performing high volumes. The

[62] ibid

[63] ibid

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American College of Cardiology and American Heart Association, for example recommend that hospitals perform a minimum of 400 angioplasty procedures annually to maintain the highest level of quality. Several studies have shown that patients have more complications at hospitals performing fewer than 200 procedures annually, with mortality rates increasing as volumes decreased. [64]

Similar data indicates that CABG procedures performed at low volume hospitals generates higher mortality rates. Indeed, the Leapfrog Group – odd name for a good research group – recommends a 450 minimum number of CABG procedures annually per hospital to keep mortality rates low.

Many US hospitals do far fewer than Leapfrog's minimum. Some do as few as 1 CABG per week. You can look up some of your local hospitals on the Leapfrog Group website**,** **www.Leapfroggroup.org** . As you do this research, ask yourself how much of this information you should share with your clients. Should you 'do your fellow a favor'? Or just keep quiet and let the doctors advise? What would you want your broker to tell you?

Key Idea – There are at least 3 risks from unnecessary / inappropriate coronary procedures. **Risk #1**: Low volume hospitals have higher mortality rates than high volume hospitals. This is easily accessible information. The broker can 'do your fellow a favor' and advise clients of this.

The second risk: geography. A detailed 1990s study led by Eric Topol of Scripps Clinic in California, indicated that cardiac treatment rates differed by region. [65] Patients were least likely to get angioplasty or CABG in New England or California, but most likely to get these treatments in the central part of our country – Texas, Oklahoma or Louisiana for example. Treatment variations were unrelated to underlying health differences.

[64] See Magid, et al, Relation Between Hospital Primary Angioplasty Volume and Mortality…' JAMA, Vol 284, 2000, pages 3131-3138

[65] This section comes from Brownlee, pages 107 - 109

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But treatments correlated almost perfectly to locations of cardiac catheterization labs --- often called 'Centers of Excellence'. (New England was the only exception to this rule.)

In other words the more catheterization labs available in a region – i.e. the more Centers of Excellence - the more frequently patients underwent invasive cardiac treatments. Cath labs are special facilities designed for invasive heart procedures.

But there is no difference in coronary mortality rates among regions with more cath labs than with fewer! The providers got paid, but the patients took on all the risk.

Key Idea: Risk #2 - Researchers has determined significant regional differences in cardiac surgery rates, with little difference in cardiac mortality rates. Again, easily accessible information for an ethical broker.

The third risk: patients undergo unnecessary procedures and then have a 'pre-existing condition' which may preclude them from obtaining health insurance in the future (depending on state regulations, employment, carrier underwriting guidelines, etc). The 'pre-existing condition' may simply be normal aging. The catheterizations, etc may be among the 14% labelled 'inappropriate' that do nothing to improve the patient's health. The net result for the patient: no better health but a future inability to purchase health insurance.

Key Idea: Risk #3 of unnecessary cardiac surgery - The client may now have a 'pre-existing condition' that will make purchase of health insurance more difficult in the future.

Though these procedures doesn't necessarily help the patient, they certainly benefit the cardiologist and hospital. In 2006, Medicare paid the physician about $1800 to catheterize a patient, plus $800 for the first stent

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insertion and about $200 more for every additional stent. [66] The hospital received additional fees, often a very profitable $20,000. [67]

What's a Center of Excellence?

We have no clinical definition of Center of Excellence. No minimum number of procedures, minimum number of cardiologists, required technologies, minimum mortality rates, etc. We have precious little meaningful outcome data by hospital, by surgical team, by procedure, etc.

So here's what a cardiac 'Center of Excellence' means. A hospital invests in high technology coronary facilities – cath labs – which it calls a 'Center of Excellence' and advertises as state-of-the-art. Perhaps it recruits cardiologists to attract referrals also. These are exploratory facilities, designed to perform preventive procedures if / when they discover dangerous levels of plaque in patients.

But most middle aged patients have artherosclerosis – it's a normal part of aging. So as the Center of Excellence performs more scans and angiographies, it sees more plaque in patients. Then advises more invasive procedures.

Center of Excellence is a marketing, not a clinical term. Hospitals performing low volumes of angioplasties or CABG may advertise themselves as 'Excellent' to attract patients. Why not? It attracts patients.

> Key Idea: A cardiac 'Center of Excellence' may be an excellent income source for the hospital, but not generate excellent results for patients.

Here's what a Center of Excellence is not (generally). A facility that advises and monitors patients on lifestyle changes necessary to reduce their risks of coronary problems and keep them out of the hospital. A facility that uses medication first and invasive cardiac technologies only if medication fails.

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[66] Brownlee, op cit.

[67] Kowalczyk, op. cit.

A facility that integrates lifestyle (diet and exercise) with medication over a long time period to reduce the risks of heart failure. In short, a facility like Duke Medical School in the 1990s that actually reduced the need for coronary care.

Instead of this, 'Center of Excellence' too often means 'Center of Profit' for the hospital. The Center's method of generating profits: failure to prevent heart attacks via diet, exercise or patient lifestyle change – and then use of the most profitable interventions on the patient.

The hospital's financial interest may diverge from the patient's good health interests.

How does the ethical broker approach these issues?

The ethical, informed broker understands three conflicting consumer trends:

First, the trend of consumers to demand easier access to specialists from carriers with wider provider networks;

Second, in the absence of clear, understandable outcome data, the trend for consumers to equate provider name recognition with medical quality (i.e. teaching hospitals affiliated with prominent universities are often perceived as better than community hospitals);

Third, the trend for consumers in PPO or POS types of plans to overuse cardiac services – generally testing services - often to their detriment.

Key Idea: There are 3 consumer trends in America that may harm patients. First, consumers want easier access to specialists. Second, they want access to 'name' hospitals. Third, they get an excess of cardiac tests.

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Let's remember the ethical basis of this course: that the ethical broker is not 'ignorant of the flaw' and should 'do the fellow a favor'. In our case, that means advise clients of the risks associated with these three trends.

Remember the policy sales landscape: consumers look to their physician for medical advice. The physician functions under a set of financial incentives that may run counter to the consumer's best interests. The broker is the only party that can advise consumers how much to trust their physician.

Key Idea: The ethical broker, of course, cannot second guess a doctor. But the ethical broker can do homework for his / her clients and present relevant information.

Brokers can present their clients with the following types of information:

- Number of angioplasties performed by each in-network hospital annually, as reported by the hospital;
- Number of CABG performed by each in-network hospital annually, as reported by the hospital;
- Number of procedures reported by the Leapfrog Group, along with Leapfrog's recommendations for minimum number of procedures annually;
- Rate of 30 day readmissions for cardiac treatments;
- Success rates of angioplasty compared to medication treatments (note: if a hospital cannot provide this data, include it in your report. Shows your clients how responsive the hospital is.)
- Number of cardiac treatments by cardiologist annually

Providing this information to your clients, along with the standard policy terms, restrictions and premium prices, will comply with the Torah's ethical dictates. The reason: you have 'done the fellow a favor'. You have helped your client understand relevant issues about choosing a cardiologist, a hospital and a treatment protocol.

By actively educating our clients about cardiac treatments, procedures and incentives, the ethical broker avoids exploitation through silence.

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The ethical broker educates him / herself about cardiac procedures and treatments and stays up-to-date with treatment trends and data. He / she then provides this data to clients and helps them make informed choices. That's what the Torah recommends.

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Hypothetical Case Study

Note the differences between Unethical, More Ethical and Ethical behavior

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A broker meets with a middle aged accountant to present health insurance options. The accountant has been self employed for years and appears financially quite well off; he lives in a very large house in a highly desirable suburb and mentioned his second home on the beach. He is married with two teen aged children.

During the conversation, the accountant says that he has recently been experiencing some minor chest discomfort – not exactly pain or shortness of breath, but more discomfort than he's had in the past. He also says that he exercises regularly, generally by playing racquetball with friends before work. He doesn't smoke, but is about 25 pounds overweight.

The accountant is not a big fan of HMO restrictions, but he has had the same primary care physician for years and likes her.

The broker offers four policies.

Policy A is a PPO type plan that costs $1600 monthly. This policy covers all routine outpatient tests with no copayment and hospitalizations with no deductible, among other features. It has no specialist referral restrictions in network. The network consists of virtually all hospitals and physicians in the local area. This policy pays a 3% first year commission

Policy B is a PPO type plan that costs $1400 monthly. This policy covers all routine outpatient tests with a $50 copayment, and all necessary

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hospitalizations with a $1000 deductible, among other features. It has no specialist referral restrictions in-network. The network is the same as Policy A. This policy pays a 3% first year commission.

Policy C is an HMO that costs $1300 monthly. This policy covers all routine outpatient tests with no copayment, and all necessary hospitalizations with a $250 deductible. It has specialist referral restrictions, requiring a PCP referral before seeing a specialist. The HMO network consists of about 75% of all local hospitals and physicians. This policy pays a 2.5% first year commission.

Policy D is also an HMO that costs $1200 monthly. This policy covers all routine outpatient tests with no copayment, provided the PCP files the appropriate paperwork. It also covers hospitalizations in network for $100 per day, up to a $500 maximum per hospitalization. Specialist visits require a PCP referral, which are not always approved. This HMO network consists of about 40% of the local hospitals and physicians. This policy pays a 2.25% first year commission.

Which policy should an ethical broker recommend?

First, the ethical broker should ignore the commission. This follows from the 'Do not do unto others as you would not like done to yourself' principle. You would want your broker to work in for your best interests. Don't do to your client as you would not like done to you.

That's the easy ethical question.

The far more difficult ethical question follows from our Biblical discussion of unequal information. There is no 'buyer beware' concept in the Torah, but there is a 'do the fellow a favor' requirement. The Torah recognizes that the broker has access to far more information than does the accountant, and requires that the broker disclose this to his client.

The ***unethical*** broker might say 'Policies A and B offer the widest available network of hospitals and specialists, plus easy access. You probably want this, since you have been experiencing some chest discomfort. We don't know if this is a serious condition or not. But we have many excellent

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cardiologists locally. You can see any of them by purchasing Policies A or B. The other policies place restrictions on specialists.'

This is the unethical position precisely because it contradicts the Torah. The broker puts all decision making responsibility on the accountant, even though the broker knows far more about our healthcare system than the accountant does. The broker takes the 'let the buyer beware' attitude and does not do the fellow a favor.

A ***more ethical*** broker might say 'Policies A and B offer the widest access, but Policies C and D also include many fine hospitals and cardiologists. Let me give you some data on our hospitals so you can make an informed decision.' The broker then does his homework and presents some or all of the following information:

- Background on some local cardiologists;
- Information on number of bypass surgeries performed annually at each hospital, along with quality data from the Leapfrog Group website;
- Basic information on the risks of invasive cardiac treatments.

Here's why this is only more ethical and not completely ethical: the broker still places too much responsibility on the client. This broker leaves the client to negotiate our complex healthcare landscape alone, albeit with some basic information to help guide his journey.

The client is an accountant, not a physician, not medically trained, and likely to misinterpret or misuse the information provided. The broker appears to help the accountant by providing some advice, but falls short of providing the critical, most useful advice. The unethical treatment here follows the old dictate 'a little knowledge is dangerous' for, in this case, the accountant doesn't know what he doesn't know.

By providing some healthcare system data, the broker appeared more knowledgeable and helpful than he really is.

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The ***ethical*** broker might say 'Here is some general healthcare system information. It indicates that you need a good, trusted advisor to help you get the services you need – in other words, a good Primary Care Physician. I would recommend Policies C or D.'

Here's why this is the most ethical position. The broker knows that regions of our country that have the fewest specialists and the most primary care physicians as a percent of the population have the best healthcare outcomes. This broker has read the Dartmouth Medical School research studies.

The broker also knows how tempting it is for patients to bypass their PCP if they can. The PCP may appear an obstacle or impediment to the care that the accountant thinks he wants. The accountant has already said this to the broker.

But the data are pretty clear. The more the patient relies on his PCP, the better the healthcare outcomes. The broker knows this --- he has more knowledge than the client and he shares that knowledge usefully.

Policies A and B allow the patient to ignore the PCP --- perhaps to the patient's detriment. This broker tells the client.

Policies C and D require that the client and PCP work as a team. The likely result: better health for the client. The broker tells this to the client also.

Summary: the most ethical broker in this hypothetical might try prefer to steer the client into the HMO with the most referral restrictions. This is because the most referral restrictions require the most PCP involvement with the patient's treatment. The broker knows that having more PCP involvement generates the best healthcare outcomes.

Thus the most ethical broker uses his/her knowledge of our healthcare system to steer the client toward the policy that offers the best chance for good patient outcomes.

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Do you agree? Should the broker use his / her knowledge about our healthcare system to help the accountant?

If you were the accountant, would you prefer to work with the unethical broker above, the more ethical broker or the ethical broker?

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Chapter 4:
Should Clients Spend More to Include Famous Teaching Hospitals In-Network?

aka What should an ethical broker respond when the client says 'I want treatment at a famous university-affiliated teaching hospital'

Health insurance premiums are outrageously expensive today – and will be even more expensive tomorrow.

One way to reduce premium costs: limited network plans. These often exclude the most famous – and most expensive – teaching hospitals. Clients often perceive access to these as necessary, and perceive policies that reduce access as inferior.

Carriers understand this. Sometimes they offer policies with narrow networks - without access to the famous local teaching hospitals - at a substantial discount. Most Americans, traditionally, have chosen the wider-access policies, even at the higher cost.

> Key Idea: Limited hospital network insurance plans may reduce premiums. But few of us like the limitations. Is this wise? What should an ethical broker advise clients?

Is this always a wise decision? What advice should the broker offer? Does the broker have an ethical responsibility to advise clients one way or the other?

This chapter will look at these types of decisions. We'll first discuss why purchasing health insurance (healthcare) is fundamentally different from purchasing other goods and services. This difference places ethical responsibilities on health insurance brokers that other salespeople – for other products – do not share.

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Key Idea: Healthcare consumers rarely have good outcome data from different hospitals. As a result, they often prefer the 'name' hospitals, generally teaching hospitals. These facilities know this, so price their services accordingly.

Second, we'll look at some special and specific operational issues involving teaching hospitals. We'll look at **technologies available at teaching hospitals** compared to community hospitals to determine which provide better patient outcomes.

We'll then look at **the impact of teaching on patient care** - specifically at the role of residents in treatment. We'll show how the teaching function may actually harm patients.

Third, we'll look at how **the constant upgrading of technology may increase patient mortality**. Teaching hospitals often pride themselves on offering the newest and greatest available technologies. This may not always be a good thing for patients.

Key Idea: Teaching hospitals may differ from community hospitals in 3 ways: (1) technologies available; (2) use of residents; (3) constant upgrading of technology. **These do not always generate the best patient outcomes.** An ethical broker should advise clients accordingly.

Why buying healthcare differs from buying cars

Buying healthcare is fundamentally different from buying other goods and services in our economy ---- cars, tennis racquets or tuna fish, for example.

When we purchase these types of products, we know a great deal about the product's quality. A Lexus vs a Suburu. Solid white tuna vs chunk light. But we don't have this information in healthcare.

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As we go through this discussion, consider the ethical implications for health insurance brokers. As a general rule, people selling other goods and services have a lower ethical bar. The reason: consumers have easier access to information about other goods and services than they do about healthcare.

Thus the Torah's requirement that we 'do our fellow a favor' is far more important in the health insurance field than in other markets.

The role and availability of critical information in healthcare

We typically know a great deal about a car, for example, before we purchase it. We know the color, condition and style --- all pretty obviously --- and can decide if we like them.

We also know various safety and economic indicators about the car. We know – or can very easily learn – the crash test rating, the estimated resale value and operating costs – miles / gallon, manufacturer's warranty, etc.

We can get this information not only about the car we're considering purchasing, but also about other vehicles, so we can chose among cars based on various quality measures.

We – Americans – are used to comparison shopping for goods and services. We do it for almost all goods and services that we purchase.

Key Idea: We cannot comparison shop for healthcare like we shop for other products. We cannot shop for medical quality because we rarely know it. We often use hospital name and university affiliation as a proxy for hospital quality.

We typically don't choose a provider based on comfort or style --- medical services are not promoted based on any type of customer service model developed by other industries. (Would that it was…we might have better healthcare.)

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We typically don't chose a provider based on quality data for this very rarely exists in healthcare. Sample hospital quality questions:

- What is the 30 day readmission rate per surgical team, for each type of operation performed in a specific hospital?
- What is the patient infection rate in competing hospitals … or on various floors of a hospital…or by various procedures?
- What is the mortality rate / failure rate by surgical team, for a specific procedure?

Even when choosing a primary care physician, we rarely shop wisely. Ask yourself about your PCP:

- Is he / she aggressive, perhaps referring unnecessarily to specialists? Or conservative, suggesting we watch and wait before referring? Which approach is 'better' – i.e. generates the best results? Which suits your personality better?
- When referring, does your PCP prefer aggressive specialists who operate as quickly as possible ---- or conservative specialists who understand surgical risks and operate only as a last resort?
- Do the specialists that your PCP recommends test appropriately? Do they overtest, perhaps letting their financial interests (consciously or unconsciously) influence their judgement?
- Does your PCP prescribe medications over the phone, without seeing you? Is this good --- by getting you treatment without an unnecessary trip to the doctor? Or bad, by prescribing medications without seeing you – and perhaps missing something critical?

Most typically, our clients tell brokers that they trust their PCP. When questioned, however [we do this in live lectures] few could answer any of these questions. The reason: the data don't exist.

So in healthcare, we use proxy information for quality – including reputation and name brand. 'University affiliated teaching hospital' sounds more impressive than 'local community hospital'. We apparently believe that the smartest or 'best' physicians have university affiliations. They're more

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current on the literature it would seem, more fluent with cutting edge research and better able to treat our medical problems.

In our insurance brokerage business, we regularly hear from clients who demand access to the famous Boston area teaching hospitals…but virtually never from clients who demand access to a particular local community hospital.

Our client's underlying assumption: the teaching hospitals are better, so will provider better care and better outcomes.

Let's evaluate these assumptions, and then ask what ethical responsibilities the broker has to disclose information to clients.

We'll look at three issues that university affiliated teaching hospitals face and then pose the disclosure / ethical questions to brokers.

Three Unique Issues that Teaching Hospitals Face

Issue 1: Levels of technology available at teaching hospitals may not correlate with better outcomes.

Most healthcare commentators recognize that new surgical techniques and medical treatments are generally introduced at teaching hospitals. The reason: these hospitals have closer / easier access to medical researchers and are in the best position to try experimental types of treatments.

These new and improved treatments often save lives, particularly for patients presenting with rare or difficult to diagnose / treat conditions. But they may not be the best places for routine, preventive or chronic care.

Here's the problem: we lack evidence that teaching hospitals generate better outcomes for routine procedures than do community hospitals. Indeed, teaching hospitals may be more focused on teaching and research than routine procedures, and may not perform the volume of routine treatments necessary to achieve excellence.

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They may be better as back up, for acute cases with unique problems, rather than as facilities for routine care or non-controversial treatments.

The critical variable that affects outcomes is **hospital experience with a particular treatment** – not level of technology available. Studies have shown that hospitals with newer technologies but less experience generate poorer outcomes than hospitals with less robust technologies and more experience.

A case in point: number of Coronary Artery Bypass Graft procedures performed by various hospitals. The Leapfrog Group lists the number of these procedures performed by various hospitals annually. See discussion above.

The information below was downloaded in June 2008 from the Leapfrog Group website. It has not been independently audited and is not comprehensive.

Note in reviewing this information: in my unscientific analysis, I was unable to find any hospitals performing fewer than 100 CABG procedures annually which reported 'better than average' results. 'Better than average' outcomes were generally reported by hospitals performing higher numbers of CABG procedures. [68]

General Hospitals: Annual Coronary Artery Bypass Grafts
Data from leapfroggroup.com, downloaded June 26, 2008.
Data voluntarily provided, not audited and not comprehensive.
Leapfrog's recommended annual minimum: 450 CABG / year

City	Hospital	# Procedures	Outcomes Rank
Tallahassee, FL	Capital Regional Med Center	99	Data Not Yet Available
Inglewood, CA	Centinela Freeman Reg'l	97	Worse than Nat'l Average

[68] As of 2010, the Leapfrog Group does not make this information available in the public / free section of its website, but charges 'a few thousand dollars' (according to the salesperson with whom I spoke) for it. This may impede brokers from offering such high quality, comparative data to their clients.

City	Hospital	# Procedures	Outcomes Rank
McAllen, TX	Rio Grande Regional	96	Not Participated
Aventura, FL	Aventure Hospital	96	Worse than Nat'l Average
Fort Worth, TX	Huguley Memorial	95	Not Participated
Fort Worth, TX	Baylor All Saints Med Ctr	95	Worse than Nat'l Average
Duluth, MN	St Lukes Hospital	95	Worse than Nat'l Average
Evanston, IL	St Francis Hospital	92	Worse than Nat'l Average
North Richland Hills, TX	North Hills Hospital	89	Not Participated
Houston, TX	West Houston Med Ctr	87	Not Participated
Bedford, TX	Harris Methodist HEB	84	Not Participated
Miami, FL	South Miami Hospital	83	Not Participated
Melrose Park, IL	Gottlieb Memorial Hospital	82	Data Not Yet Available
El Paso, TX	Del Sol Medical Center	78	Not Participated
El Paso, TX	Las Palmas Med Center	74	Not Participated
West Hills, CA	West Hills Hospital	70	Not Participated
Bakersfield, CA	Adventist Health	67	Not Participated
Covina, CA	Citrus Valley Med Center	65	Worse than Nat'l Average
Richardson, TX	Richardson Regional Med Ctr	60	Not Participated
Anaheim, CA	Western Medical Center	53	Not Participated
Highland Park, IL	Highland Park Hospital	49	Worse than Nat'l Average
Lynwood, CA	St. Francis Med Center	46	Worse than Nat'l Average
Denver, CO	Rose Medical Center	42	Did Not Report
McKinney, TX	Medical Center of McKinney	42	Not Participated
Baberton, OH	Baberton Citizens Hospital	39	Not Participated
Van Nuys, CA	Valley Presbyterian	35	Not Participated
Melrose Park, IL	Westlake Community Hosp	27	Not Participated
San Antonio, TX	Methodist Specialty	24	Not Participated
Lone Tree, CO	Sky Ridge Medical Center	22	Data Not Yet Available
Chicago, IL	Michael Reese Med Ctr	22	Not Participated

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Note the almost perfect correlation between results and number of CABG procedures performed. Hospitals performing more than about 300 procedures almost uniformly produce 'above average results', while hospitals performing fewer than 100 procedures almost all report 'below average results' or 'results data unavailable'…regardless the technologies available.

Key Idea: patient outcomes are generally more a function of physician / hospital experience with a procedure than of the level of technology available. Hospitals with the same technologies may generate discrepant outcomes, as in the case of Heart Transplant procedures.

A second case in point: mortality rates from heart transplants. Many if not most in the early 2000s took place in teaching hospitals. But mortality rates varied greatly depending on frequency of treatment. Here's the data:

Heart Transplant Mortality Rates [69]

	Number of heart transplants performed annually in each facility surveyed	
	Less than18 transplants annually	More than 50 transplants annually
Total number of facilities surveyed	63	6
Approx total annual # of transplants performed in these facilities	630	425
% of facilities with 1 yr patient survival rate average less than 80%	52%	0%

Experience matters.

But this gets worse. Remember the Duke University Medical Center discussion above. Duke learned that providing good preventive and follow

[69] Porter and Teisberg, Redefining Healthcare, Harvard Business School Press, 2006, page 50. Data from 2001. Some estimates by this course author.

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up care reduced the number of patients and length of patient stays --- and reduced hospital income. Good healthcare for patients was bad financial care for the hospital.

Other university affiliated teaching hospitals may have learned from Duke. What have they learned? There are two potential lessons. First, that good preventive and outpatient care keeps people healthier and out of the hospital. Second, that such care reduces hospital income.

The lesson from Duke may be: follow the traditional hospital business model more closely. Treat sicker patients for longer to improve hospital finances. Invest more in technology - and less in prevention and patient follow up – and make more money.

Which Duke lesson did your local hospital learn? The first - that better care improves patient lives – so it improves care? Or the second - that better care harms hospital cash flow – and invests accordingly?

The ethical broker should check two important variables before advising clients to use famous local hospitals. First, the broker should determine treatment volumes. Start with the Leapfrog Group website and proceed from there.

Second, the broker should determine the level of patient services. Check the average length of patient stays and compare this data to national averages. Also check the rate of hospital readmissions and compare that to national averages.

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The underlying ethical lesson for brokers: You cannot blindly assume that a hospital is better simply because it is affiliated with a famous medical school. Or that it is better simply because it has the most modern and newest technologies. It may be better – but you need to determine this.

You should determine treatment outcomes whenever possible. When impossible, check the treatment volumes for the services your client needs. You should also determine the level of patient services – average length of stay compared to a national norm, for example, and the readmission rate for patients with your client's condition.

(Some people argue that increased readmission levels indicate that teaching hospitals serve sicker patients. This may be true - though objective data is very difficult to obtain. If true, however, it simply makes our point: that teaching hospitals specialize in difficult cases, not routine. It may make much more sense to use community hospitals for routine care.)

There are many other variables to consider before determining that a particular hospital is 'outstanding'. The *Economist*, for example, in its major April 2009 report on Healthcare and Technology, claims that the quality of the hospital's information technology system is critical. The *Economist* argued that a top-notch hospital IT system, combined with specialization and high volumes, can outperform low volume hospitals that have mediocre IT systems but outstanding medical technologies. [70]

Only after doing your homework, can an ethical broker advise patients which local teaching hospitals actually justify their reputations…and justify the higher prices they tend to charge carriers.

Issue 2: Teaching hospitals use interns and residents.

Atul Gawande's brilliant essay 'Education of a Knife' describes the role that residents play in teaching hospitals. [71]

[70] 'Lessons from a Frugal Innovator' Economist, April 18, 2009, page 67

[71] Atul Gawande, Education of a Knife, Complications, Picador, 2002

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Gawande wrote this deeply personal article about his first weeks as a surgical resident. He describes the difficulty the first time he inserted a line into a patient's vena cava – the main blood vessel to the heart. He missed on his first two attempts – fortunately, not collapsing a lung or lacerating a blood vessel – but fumbling around, hurting the patient, and ultimately allowing a more experienced physician fix the problem.

Key Idea: Surgical residents have to learn on someone ---- should it be your client? Residents often make mistakes early in their careers. How can the ethical broker 'do your fellow a favor'?

Gawande continues, and describes his second line insertion – unfortunately, no more successful that his first. This time he missed several times, the patient's chest turned black and blue, and she ended up with a hemotoma --- all from the surgical resident's mistakes.

It took until the third patient for Gawande to insert a line correctly – 'I still have no idea what I did differently that day.' But several weeks later he thought back over the first 100 lines that he inserted:

> I am by no means infallible. Certainly, I have had my fair share of what we prefer to call 'adverse events'. I punctured a patient's lung, for example…

While learning the trade, resident surgeons 'assist' in surgery. Though the attending physician directs the surgery

> To say I just assisted remains a kind of subterfuge. I wasn't merely an extra pair of hands…I was there to practice.

What happens when a resident's need for practice and experience affects surgery? Gawande describes reconnecting a colon during residency.

It turns out that there are two ways to reconnect a colon. You can staple the ends together or sew them. Stapling is swifter and easier

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> But the attending suggested I hand-sew the ends – not because it was better for the patient but because I had done it few times before.

Gawande continues:

> My stitching was…imprecise. [I put] stitches too far apart.

The attending surgeon made him put in extra stitches so the connection would not leak.

Key Idea: Here is the uncomfortable truth about teaching hospitals - they need patients for their residents to practice on. Someone has to be the first vena cava insertion of each surgical resident, or first colon sewing. Someone must be available to be practiced on or else surgical residents would never gain experience.

Should it be your client? 'Do not do unto others as you would not like done to yourself' – would you like to be practiced on by residents?

Certainly the patient's right to the best possible care always supercedes the training needs of young doctors. But we also need to train young surgeons. Having young surgeons practice under the watchful eye of the attending is clearly necessary.

But remember our ethical disclosure question: when should brokers advise their clients to use famous teaching hospitals?

Gawande himself helps answer that question. His then infant son needed cardiac surgery followed by ongoing treatment from a pediatric cardiologist. Gawande knew all the hospital's cardiologists. Which did he choose? He had several options.

One option was the physician who correctly diagnosed his son's condition – the fellow who put in the most time caring for his son, coordinated his son's care, visited his son every day to check up and answer questions. Did Gawande chose this fellow?

No – that was a resident. Instead, Gawande chose the hospital's associate cardiologist in chief. The reason: she had more experience. As he says

> I know this was not fair…But I was not torn about the decision…Given a choice, I will always choose the best care I can for [my child]. How can anybody be expected to do otherwise?

He fell back, perhaps, on the experience of others in his position. One in a similar position was a health policy expert, important in the hospital hierarchy. Gawande one day noticed a picture of a young baby in the expert's office. 'Did you let a resident deliver the baby?' Gawande asked.

> 'No. We didn't even allow residents in the room.'

Hospital data probably shows that residents did not work on the most famous, celebrity patients - though this information is undoubtedly not available to the general public.

Key Idea: think twice about recommending teaching hospitals to your clients for routine work. For hugely complex treatments requiring state of the art technologies? That's a different story. But for routine, non-controversial procedures…

Issue 3: Learning New Technologies

Here's another hidden truth about our healthcare system. Physicians get frighteningly little training in the use of new technologies. New technologies and treatments emerge constantly, and physicians – somehow – are expected to master these.

Let's let Atul Gawande lead us through this discussion also. [72]

'Three quarters of what I do today I never learned in residency' says his father, a urologist. Working alone, miles from others in his specialty, he had

[72] ibid

to learn to put in penile prostheses, to perform microsurgery, to reverse vasectomies, to implant artificial urinary sphincters, to use shock-wave lithotripers, electronhydraulic lithotripters, laser lithotripters and dozens of other techniques and technologies. Only some of these were related to things he had studied in medical school.

Many of today's technologies were not even imaginable when our current crop of surgeons was in medical school.

To learn a new treatment or technology, typically surgeons take a one or two day course offered by the equipment manufacturer. They may participate in or watch an operation. 'See one, do one, teach one' goes the surgical training mantra – so surgeons had better be quick studies.

After observing an operation they go home. Sometimes they watch an educational video. Sometimes they read additional articles. Then – maybe before they're comfortable and feel ready? – they operate on a real person.

Key Idea: The first patient with a new technology incurs risks that later patients do not.

Unquestionably, the first 'guinea pig' faces risks that later patients do not. How much risk?

This question was addressed in the British Medical Journal in 2000, in an article entitled 'Scientific, ethical and logistical considerations in introducing a new operation: a retrospective cohort study from paediatric cardiac surgery'. This article summarized Great Ormond Street Hospital's (London) experience introducing a new surgical technique to repair infant heart defects. [73]

Researchers studied the mortality rates from 325 heart operations using the (older) Senning technique, and 100 operations using a new arterial

[73] Bull, et al 'Scientific, ethical and logistical considerations in introducing a new operation: a retrospective cohort study from paediatric cardiac surgery, British Medical Journal 2000; 320: 1168 – 1173 (29 April). See also Gawande, ibid, pages 27 and 28.

switch technique that offered various longevity benefits. Both procedures were extremely complex.

The operative mortality rate using Senning was about 6%. But the operative mortality rate using the new procedure was 25% for the first hundred patients. In other words, **nineteen additional infants died so surgeons could develop familiarity with the new techniques and procedures!**

Key Idea: Researchers have learned that mortality rates sometimes increase initially when a new technology is introduced. In a British study, 19 infants died so physicians could learn a new procedure, though the mortality rate later declined.

Patients may not know that they should ask about risks posed by new techniques.

The British Medical Journal summarized its findings:

> If early risk alone had been considered, the arterial switch operation (which had a higher early mortality when first introduced) might have been abandoned.

Once surgeons gained familiarity with the new technique, the mortality rate dropped - only 5 infants died during the next 100 operations.

Why change treatments in the first place?

> This study shows that the theoretical rationale based on life expectancy projections used to justify the change from a Senning to a switch policy has been corroborated by the outcomes obtained so far in practice.

Corroborated perhaps for the survivors – but would the 19 additional dead infants (or their families) agree?

How does this relate to teaching hospitals and to the ethical responsibilities brokers have to their clients?

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Brokers, we have argued, have a responsibility to inform their clients of medical risks. Here, clearly, they should inform clients that hospitals that keep current on technologies and treatment techniques pose certain risks – specifically the risks that surgeons will have insufficient practice or familiarity with the new treatment. Some clients may suffer accordingly.

Ethical brokers, however, can mitigate this risk by learning about hospital procedures.

Hospitals purchase new technologies for several reasons. Sometimes they purchase to keep up with their competitors – for marketing and referral reasons. (I once spoke with a noted Boston area surgeon who complained that his hospital had just purchased a new robotic type surgical machine for $1 million. 'It doesn't do a better job than me – but the hospital across town just bought one, so we had to.' I wondered about his learning curve on this new machine.)

This is sometimes called the Medical Arms Race – hospitals purchase the newest available technologies to avoid falling behind in the competitive physician referral business. [74]

Sometimes also hospitals may purchase to keep current with new technological developments.

And sometimes hospitals may actually perform the longevity benefit analysis discussed in the British Medical Journal above.

The ethical broker should learn which purchase criterion their local teaching hospital uses and advise clients accordingly. In the third case above – where the hospital purchased new technologies based on expected longevity gains – a slight increased operating mortality risk may be justified, so long, of course, as the client understands this.

[74] See David Dranove, The Economic Evolution of American Healthcare, Princeton University Press, 2000, pages 46 - 47

The mortality risk increase is clearly NOT justified when a hospital purchases new equipment simply to participate in the Medical Arms Race – i.e. to enhance it's own position in the market.

Key Idea: An increased surgical mortality risk from a new technique may sometimes be justified based on increased expected longevity. The patient should know the risks. An ethical broker can help advise the patient how to get relevant data and information.

Which criterion does your local teaching hospital use? How will you – an ethical broker – obtain the necessary information to advise clients? What will you advise clients who insist on having the local teaching hospital in-network?

Hypothetical Case Study

A broker presents two family plans to a client. Both policies have the same benefits, but differ in network size and price.

Policy A costs $1500 and includes virtually all hospitals and physicians in network.

Policy B costs $1325 but only allows access to the famous local teaching hospitals 'when necessary services are unavailable elsewhere in network'.

We'll compare and contrast an ethical and unethical broker.

The **unethical broker** says

> Policy A allows you to access all our wonderful medical facilities, so in the unfortunate event that you need world class treatment, you can get it easily.
>
> Policy B requires lots more paperwork and delays. When you need the best care, you don't want to wait and complete forms.

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> Policy B poses too many potential risks to you. It's not worth the $175 monthly savings.

This is unethical for four reasons:

First, the broker fails to inform the client of potential risks posed by interns, residents and new technologies at the famous teaching hospital.

Second, the broker fails to explain the teaching hospital's technology purchasing criterion. Does the hospital purchase new technologies primarily to compete in the Medical Arms Race? Or does it perform a rigorous cost benefit analysis to analyze patient mortality risks and longevity gains before purchasing?

Accessing some services at some teaching hospitals may put the patient at unnecessary risk.

Third, the broker does not explain what the expression 'necessary services unavailable elsewhere' means. Depending on the carrier and interpretation, this may be a huge impediment to obtaining life saving treatment. Or it may be a minor, routine bureaucratic issue.

Fourth, the broker uses his / her own values to justify the more expensive policy. A $175 monthly savings to one client may be huge. To another, it may be minor.

The **ethical broker**, by contrast, says

> Policy A allows you easy access to all our local facilities. You can choose (actually, we can choose together with your PCP) which is best for you if and when you need treatment.
>
> Policy B also allows you access to all our local facilities. However, you can only access the local teaching hospitals if you have a rare or particularly complicated condition. Again, I can help you chose the most appropriate hospital.

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> This policy may work out best for you, as the community hospitals are best equipped for routine medical treatments, while the teaching hospital handles unique, difficult and complicated cases best. Since they have different missions, you can use each for its particular strengths.

This broker makes several important ethical points.

First, he / she explains the differences among policies clearly and objectively.

Second, he / she explains the differences among hospitals and how each serves a specific function.

Third, he / she offers to help the client chose which hospital is best when need arises. The broker can, for example, review the Leapfrog Group website and present data on hospital volumes of the relevant procedure. Or, perhaps, the broker can present information on the hospital's technology purchasing criterion to help the client decide if / when to take risks with new treatments.

Fourth, this broker does not substitute his / her values for the client's. This can help the client consider the premium savings vs network size tradeoff more easily.

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Do you agree? What ethical position would you take as a broker?

If you were a client – what ethical position would you want your broker to take toward you?

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Chapter 5

How Should an Ethical Broker Proceed?

British think death is inevitable; Canadians think death is preventable; and Americans think death is optional.[75]

Shannon Brownlee summarizes an underpinning of our overuse of medicine in *Overtreated*: [76]

> Our relentless search for wellness through medicine has created a kind of therapeutic imperative, the urge to treat every complaint, every deviation from the norm, as a medical condition.

If we test or intervene with every new development along our normal aging process, we'll abuse our medical system --- and likely generate more unnecessary and counterproductive care, and perhaps higher mortality rates.

> We've come to believe that if a test can be performed, it should be performed… [almost] regardless of whether the intervention will improve the patient's sense of wellbeing.

Remember Dr. Talcott's observation from page 31, above:

> There is a vast ocean of potentially diagnosed, but clinically meaningless cancers…The more you [test and scan] the more of those meaningless cancers you're going to find [and potentially treat unnecessarily].

Dr. Talcott was the Director of Outcomes Research at Massachusetts General Hospital. He's the fellow who measures the utility of all these tests and scans against patient gains.

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[75] I don't know the origin of this expression. I first heard it from John Kingsdale, Director of the Massachusetts Healthcare Connector, at a speech at the Boston Harvard Club sponsored by the Pioneer Institute of 1/15/09.

[76] Brownlee, op cit, page 206. Same source for the next quote and the French proverb.

Just because a medical test exists doesn't mean we need to embrace it. Or the fact that a treatment is available isn't always a good reason to use it.

Maybe an old French proverb got it right: the physician's job is 'to cure sometimes; to relieve often; to comfort, always.'

The ethical, sensitive broker understands this and helps clients accordingly.

Clearly no broker can keep current on all healthcare literature and advise clients on all healthcare decisions. That's beyond any human's capabilities.

But, as we have argued in this course, the ethical broker has a responsibility to advise clients not only on policy details but also on likely treatment outcomes, and to help clients chose policies that improve chances of treatment successes.

We have outlined some issues in this course. Many, many more exist.

Hopefully, we have pointed brokers in the right direction, both for ethical advising and for their own future research.

But in this concluding chapter we'd like to offer some general advice for how best to ***do your fellow a favor***: [77]

We recommend five types of general advice for ethical brokers. **First**, educate yourself about our healthcare system, so you understand both details about health insurance policies and treatment implications of various policies.

1. Educate yourself about our healthcare system.

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

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The ethical broker has a responsibility to 'do your fellow a favor'. The more you know about our healthcare system, the better you can help 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 Atul Gawande;
Better, by Atul Gawande;
Best Care Anywhere, by Phillip Longman;
Should I Be Tested for Cancer?, by H. Gilbert Welch;
Know Your Chances, by Steven Woloshin, et al

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

Second, help your clients understand the importance and utility of their primary care doctor.

2. Help your clients understand the importance and utility of their primary care doctor. Help them find primary care doctors with whom they can communicate easily.

   The PCP is your client's link to our entire healthcare system. A good PCP will advise your clients in ways appropriate to them: perhaps treating illnesses aggressively for aggressive patients, and conservatively for more conservative folks.

   Too many of us consider specialists the 'really important doctors' who we use for major medical issues, and relegate PCPs to the less important, more minor medical activities like prescription refills and annual physicals.

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Remind your clients to rely on their PCP's advice. The PCP is the medical professional responsible for your 'whole' client, not just for his or her kidneys, heart or blood system. The various Dartmouth Medical School studies showed that the more people rely on their PCP's advice, the better their mortality outcomes.

3. Help your clients ask questions. Help them remember that doctors are guides to medicine, not gods to be believed unquestioningly.

Third - help your clients ask good questions.

Here, for example, are 5 questions they should ask about screening tests such as PSA tests or calcium screening tests that look for buildup in the coronary arteries:

- How good is the evidence that this screening test will reduce my risk of dying?
- Is the test itself dangerous?
- Could the test lead to my being treated unnecessarily?
- Does the treatment I might face have side effects?
- Can I make lifestyle changes – diet, exercise, stress reduction, etc – to reduce the risk of getting the disease?

Sometimes patients are intimidated by specialists; sometimes awed by specialists; or sometimes tongue-tied in front of specialists. Encourage your clients to ask good questions and to enlist the help of their PCP in this process.

Medicine is still a young science, constantly evolving. We often know less than we think we know. Honest physicians will approach your client in this light.

4. Help your clients use the web appropriately. One of the best online resources is the Agency for Healthcare Research and Quality at www.ahrq.gov. The Consumer Health section provides information about a wide range of conditions and treatments.

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Also see the US Preventive Services Task Force on the same website. The USPSTF consists of experts who regularly assess the scientific evidence underlying many medical tests and treatments.

Fourth - help your clients use the web appropriately, not excessively.

These information sources are more conservative than many practicing physicians. Perhaps their information can help your clients formulate questions to ask their medical providers.

5. Remind your clients that physicians and hospitals have an economic incentive to treat, and generally earn the most by providing the most treatment. Help your clients understand that medicine is a business as well as a 'helping profession'.

Fifth - remind your clients that medical providers have certain economic incentives that do not always correlate to your clients' interests. Help your clients maintain a healthy – emphasize healthy – skepticism.

Encourage your clients to ask about alternative treatments – maybe less aggressive or less invasive, maybe from a different kind of specialist, maybe from a different geographic region. Each of these changes can affect your client's treatment and outcome.

Help your clients to have the courage to advocate for themselves and to protect their own interests, for in the end, all healthcare decisions are ultimately their own.

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We have, in the Judeo-Christian ethical tradition, thousands of years of business experience. Hopefully some of the ideas in this course will help today's health insurance brokers continue that ethical tradition.

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