Health Insurance Broker Ethics 1

Mass CE course #C60661, 9 ethics credits

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Health Ins Broker Ethics I
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Introduction

This course considers the ethical standards related to health insurance policy sales and disclosure.

We know that health insurance brokers have an ethical obligation to disclose several things:

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

But does the broker's ethical responsibility end with these three obligations? Should an ethical broker disclose additional information? Specifically, do health insurance brokers have a disclosure responsibility to educate their clients about the workings of our healthcare system, or should the broker 'let the buyer beware' of them?

Let's remember that the ultimate product we sell is healthcare. Insurance is simply (simply?) the means of financing healthcare services. We know that our clients will ultimately purchase healthcare services – examinations, surgeries, medical treatments and the like. Our products facilitate access to, and use of, these services: health insurance is not an 'end' product in and of itself. The 'end' product is good health.

This raises a key question: **can brokers differentiate health *insurance* from health *care***? In other words, can brokers reasonably claim that their jobs involve *only* making financial resources available to clients for medical care, but not the end-use for which clients use this money?

In this text, we will suggest that they cannot reasonably make this claim.

Instead, we will suggest that healthcare financing (insurance) is inextricably tied into medical care. The 'benefits advisor' should, in other words, advise on the benefits that clients will access. The 'ethical benefits advisor' will help clients understand the likely impact of using various services.

We'll discuss this at great length, shortly. But in this Preface, let's look at a warning issued by Bernard Rosof, Chairman of Huntington Hospital in New York: [1]

> 'Often people with generous insurance plans can run up large bills and face life-threatening complications from unnecessary care. Those problems include back surgeries that result in wound infections when physical therapy might have been a more effective treatment.'

[1] Washington Post, September 29, 2009, Connolly. Italics added. Many other commentators have made similar suggestions.

Rosof suggests several things here.

- First, that people with 'generous insurance plans' may receive different care from people with less generous plans.
- Second, that some of the different care is 'unnecessary'.
- Third, that this 'unnecessary care' can lead to harm.
- Fourth, that this happens 'often'.

Does Rosof – the Chairman of a hospital - mean that patients with certain types of health insurance actually receive unnecessary and harmful care *as a function of their health insurance*? Might some types of health insurance actually result in more patient harm than other types? Could you, as a broker, unintentionally cause some harm to your clients?

Rosof's quote raises a number of ethical questions for brokers.

- How should they respond when faced with evidence that their policies (i.e. the products that they sell) may lead to patient problems and harms?
- Should they simply 'let the buyer beware'?
- Or should brokers live up to a higher ethical standard?

The knowledgeable broker knows that we sometimes *overuse* our medical system. Researchers like Professor Jonathan Skinner of Dartmouth Medical School who have studied this phenomenon suggest that above a certain level of care:

> *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] [2]

This is apparently the thrust of Mr. Rosof's comments.

We want our clients to receive the right care – not too little or too much. Too much care, or *overtreatment*, may lead to poorer patient results. Indeed, some Dartmouth Medical School researchers, among others, have discovered that mortality rates go ***up*** as patients receive more and more medical care. Dr. Elliott Fisher, a Dartmouth Medical School researcher and Director of the Dartmouth Institute for Health Policy and Clinical Practice, did an exhaustive study of medical spending patterns and discovered that hospitals that *spent the most* and *did the most* for patients had a 2 – 6% *higher* mortality rate [3] concluding

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

[3] Elliott Fisher, et. al. The Implications of Regional Variations in Medicare Spending, Annals of Internal Medicine, 2003, several articles. See Shannon Brownlee, Overtreated, page 50 for a summary of relative mortality risks.

> The additional medicine patients are getting in the high-cost regions is leading to harm. [4]

More care led to more patient risks from error, infection and fatigue without any compensating medical advantages.

Here's our potential patient cycle: patients with 'generous insurance plans' (Mr. Rosof's words) may receive unnecessary care. That care, according to Dr. Fisher, corresponds to higher mortality rates. How should an ethical broker react to this kind of information? What should he/she do with this information? What ethical disclosure standard should he / she adopt?

New Health Insurance Plans and the Medicare Modernization Act of 2003

make broker ethical disclosure even more important

Two trends over the past 10 years highlight the need for brokers to disclose likely medical impacts ethically.

First, deductibles have increased dramatically. In the early 2000s, a 'high deductible' plan might include an annual $250 deductible. In 2016, many (most?) plans include a $1000 annual deductible with some exceeding $2000. This places an increased economic burden on clients who want to avoid wasting their own money on unnecessary care.

In the past brokers might have considered the 'unnecessary care' problem a minor issue. Yes, they may have thought, some excessive care may be unnecessary but other so-called excessive care might prove useful to patients. No individual actually paid for it since virtually all plans included first dollar coverage and the harms from excessive care were not widely known or understood.

Today's high deductibles, though, create an economic cost to patients. Each *unnecessary* MRI can waste several hundred dollars, money more usefully spent in other ways. This makes the broker more responsible for helping clients identify and avoid unnecessary care today than ever previously.

Second, more companies try self funding, with some carriers offering self funded or partially self funded plans to groups as small as 50. In self funded arrangements, each wasted dollar of medical care comes directly from the company's bottom line.

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

These two trends have fundamentally changed the broker's responsibilities. Not only must the broker assemble an appropriate benefits package for each client and keep clients in compliance with state and federal regulations, but brokers today must try to control healthcare spending. Among the ways to do this: teach people how to identify and avoid unnecessary medical care.

Disclaimer

We discuss various medical procedures, treatment protocols and outcomes in this course. We do so as insurance brokers and educators, not as physicians or medically trained professionals. We at *HealthInsuranceCE, LLC* are not medically trained or licensed and provide no medical advice herein. You should always consult your own physicians about medical care. You should not interpret anything contained in this course as medical advice, and you should not rely on anything contained in this course as a basis for medical decision making.

Education Differs from Advocacy and Advice

This is an education course. We do not advocate any particular ethical position. Nor do we advocate any particular approach to medicine.

Rather, our goal is to stimulate broker's thinking about these issues. We will present data, ethical dilemmas and alternative solutions. We hope this course will help you consider your own ethical standards, for in the end, you must make your own decisions about ethical behavior.

We will base our ethical positions on standards that have existed for hundreds (thousands?) of years. We will trace the origins of these standards and comment on their applicability to today's health insurance brokers. Why do we take this approach?

Most ethicists – the people who discuss ethical behavior - have a strong background in historical ethical thought, often as articulated in traditional Judeo-Christian positions. Many of these positions have become codified in our laws and insurance regulations.

Our regulatory injunctions against theft, for example, may be seen as directly descending from Judeo-Christian ethical positions. While some of the ethical positions discussed in this course are based on traditional Judeo-Christian ideas, we do not advocate any particular religion or even religion itself. Rather, we use these traditional ideas because they have served as the ethical basis of western civilization for thousands of years. Living according to Judeo-Christian teachings is generally synonymous in our society with living ethically.

We aim, in this course, to stimulate your thinking about ethical issues, rather than to direct brokers to act in any specific way. We offer ethical positions not dogmatically, but rather as a teaching guide.

Review Questions

Correct answers on next page

1. What ethical advisory role do brokers have according to this course?
    a. They should explain policy terms only
    b. They should quote prices only
    c. They should answer specific client questions only
    d. They should explain policy terms, quote prices, answer client questions and educate clients about the workings of our healthcare system

2. What is the ultimate product that health insurance brokers sell, according to this course?
    a. Healthcare
    b. HMOs
    c. Deductibles
    d. Health savings accounts

3. What function does *insurance* play in our healthcare system?
    a. Insurance is a mechanism of financing healthcare
    b. Insurance covers deductibles and copayments
    c. Insurance applies to employed children up to age 26
    d. Insurance identifies appropriate medical treatments

4. What is one potential risk of having a generous health insurance plan, according to Bernard Rosof, Chairman of Huntington Hospital in New York?
    a. People with generous insurance plans can run up large bills and face life-threatening complications from unnecessary care, including back surgeries that result in wound infections when physical therapy might have been a more effective treatment
    b. Generous health insurance plans are far more expensive than less generous plans, which can create stress for people paying the premiums
    c. Generous health insurance plans generate greater profits for insurance carriers, which they use to fund lobbying and political activities that ultimately work against the policy holder's interests
    d. People with generous health insurance plans may disregard healthy lifestyle advice and turn to medical care instead when they get sick

Correct answers in bold

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Part 1:
Disclosure Ethics

Introduction to the Problem

Some information that an ethical broker should disclose

Here are some examples. Note when reading these that we take no position on whether or not the benefits outweigh the risks or vice versa. We simply provide data here and pose questions about the broker's ethical responsibilities to inform his/her clients.

First, an overview. A massive 2013 study and important 2015 book concluded that 40% of established medical practices are 'ineffective or harmful'. [5] This study wasn't published in some unknown or disrespected journal, by unknown researchers. Instead it was published in the Mayo Clinic Proceedings, a highly respected medical publication, written by lead author Dr. Vinay Prasad, a Senior Fellow at the National Cancer Institute and National Institutes of Health, and reviewed in the New York Times.[6]

Prasad and his team reviewed every article written in the New England Journal of Medicine between 2001 and 2010 and found 363 that examined an established medical practice. 146 of them, about 40%, were found to be ineffective or harmful when put to a rigorous comparative test, 38% were beneficial and 22% unknown. Examples include:

- Prolonged antibiotics for patients with persistent symptoms and history of Lyme disease
    - No benefit found in, 2 randomized, placebo-controlled, dble blind studies
- Low calcium diet for patients with history of kidney stones vs. diet low in animal protein and salt (but normal calcium)
    - After 5 yrs, low calcium group had double rate of kidney stones
- Intensively lowering blood sugar in Type 2 diabetics to reduce cardiovascular events
    - Low blood sugar group (A1c < 7%) sustained for 3.5 yrs increased mortality without fewer cardiovascular events compared to more permissive goal
- And about 140 more

Dr. Prasad summarized his findings this way in a You Tube video attached to the Mayo article:

> Patients who are embarking on procedures, screening tests or diagnostic tests should really try to ascertain whether or not those tests are based on good evidence. Of all those things we're doing that lack good evidence, probably about half of them are incorrect.

[5] Prasad, A Decade of Reversal, Mayo Clinic Proceedings, August 2013 and Ending Medical Reversal written with Adam Cifu

[6] Bakalar, Medical Procedures May Be Useless or Worse, NY Times, July 26, 2013

The fundamental problem, he said to the New York Times, edited for space here: Medical procedures

> ‘all sound good if you talk about the mechanisms. You have cholesterol-clogged arteries, it makes sense that if you open them up it will help. But when that was studied, it didn’t improve survival.”
>
> Patients, like to talk about mechanisms. “They tend to gravitate toward the nuts and bolts — what does it do, how does it work? But the real question is: Does it work? What evidence is there that it does what you say it does? What trials show that it actually works? You shouldn’t ask how does it work, but whether it works at all.”

Our ethical dilemma starts here.

- Who discloses this type of information – that about half of all medical treatments are ineffective or harmful – to your clients?
- Should brokers ‘let their clients beware’ and assume that physicians and other medical professionals will provide the necessary information?

We’ll address that question in detail later in this course. For now, though, a very brief answer: **No – leaving all medical education to physicians has been conclusively proven ineffective.** See Mr Rosof’s comments above, along with Dr. Fisher’s.

Relying on doctors to educate patients has generated a waste factor in American healthcare of up to about 30% of all spending. Brokers – responsible to employers for both assembling benefit programs and helping control costs – cannot leave all medical education to physicians and the internet.

Of course, since brokers are not licensed medical professionals, they can only provide a specific type of consumer education. We’ll articulate that below. But the message so far – from Mr. Rosof, Dr. Fisher and Dr. Prasad: leaving medical education exclusively to physicians has been proven to raise costs, raise risks and generate sub-optimal outcomes. The broker has, at minimum, an ethical responsibility to disclose this fact to clients.

Second, some specifics. Various highly respected medical organizations publish lists of ‘Things Providers and Patients Should Question’ on ChoosingWisely. (All brokers should be aware of ChoosingWisely, our opinion.) Among things to question, per this initiative:

Stress tests on asymptomatic patients. The American College of Cardiology states bluntly on ChoosingWisely ‘

- Don’t perform stress cardiac imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
- Don’t perform annual stress cardiac as part of routine follow-up in asymptomatic patients.
- This practice may lead to unnecessary invasive procedures without any proven impact on patients’ outcomes.
- Stress tests on insured patients costs about $200 - $400 per test – often an unnecessary expense that can lead to unnecessary procedures (according to the College of Cardiology)
- Our ethical question: who tells this to your clients?

Allergy tests. The American Academy of Allergy, Asthma and Immunology, consisting of 6500 members in 60 countries, developed this statement for ChoosingWisely

- Don’t perform indiscriminant battery of immunoglobulin tests in evaluation of allergy…Appropriate diagnosis is based on the patient’s clinical history
- Random allergy testing usually doesn’t help, can lead to unnecessary lifestyle changes…give up foods, such as wheat, soy, eggs, or milk, end up with nutritional problems
- Who advises patients to ask their physicians about these risks?

Back MRIs. The American Academy of Family Physicians, representing 105,000 physicians, bluntly states on ChoosingWisely

- Don’t do imaging for low back pain within the first six weeks unless red flags are present
- …Imaging of the lower spine before six weeks does not improve outcomes but does increase costs
- Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected.

But the American Academy of Family Physicians isn’t alone in questioning the utility of back MRIs when someone feels back pain. Here’s the North American Spine Society, 7500 members from orthopedic surgery, neurosurgery, radiology and physical therapy, also on ChoosingWisely

- Don’t have advanced imaging (e.g., MRI) of the spine within the first six weeks for non-specific acute low back pain in the absence of red flags.
- In the absence of red flags, advanced imaging within the first six weeks has not been found to improve outcomes, but does increase costs.
- Red flags include, but are not limited to: trauma history, unintentional weight loss, immunosuppression, history of cancer, intravenous drug use, steroid use, osteoporosis, age > 50, focal neurologic deficit and progression of symptoms.

- Again, who tells this to your clients?

The American College of Physicians representing 126,000 physicians agrees with this official statement on ChoosingWisely

- Don't obtain imaging studies in patients with non-specific low back pain.
- In patients with back pain that cannot be attributed to a specific disease or spinal abnormality following a history and physical examination (e.g., non-specific low back pain), imaging with plain radiography, computed tomography (CT) scan, or magnetic resonance imaging (MRI) does not improve patient outcomes.

And the American Society of Anesthesiologists – Pain Medicine, comprised of 50,000 members who advocate for patients who need anesthesia or pain medicine, goes even further

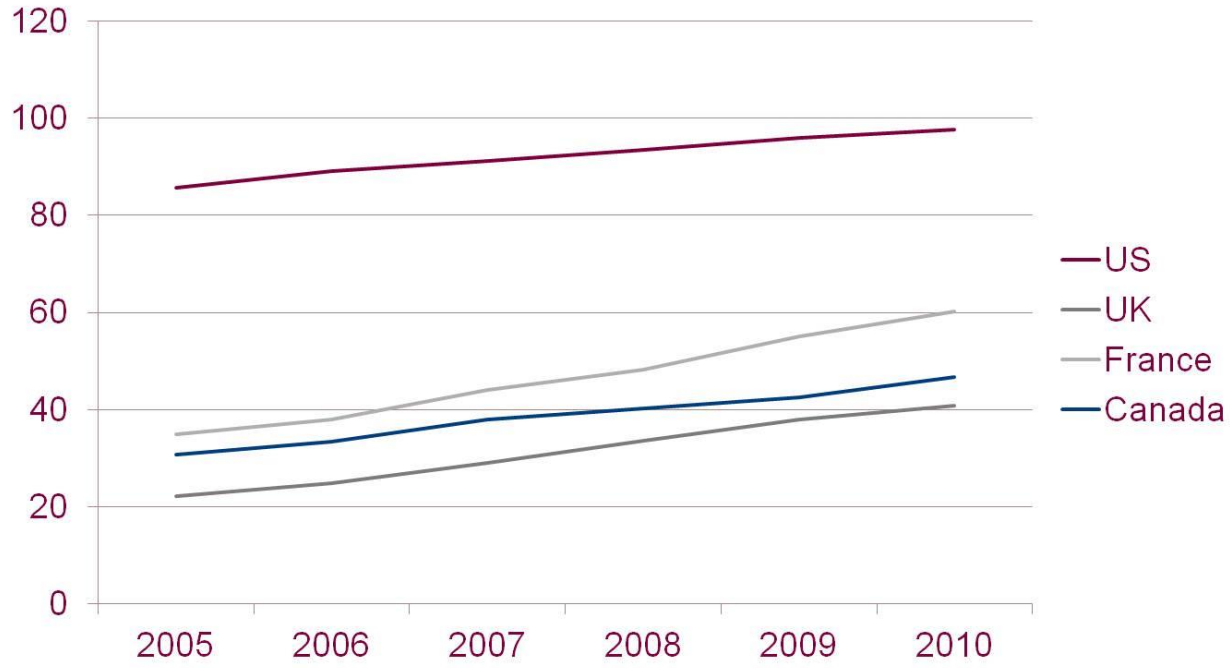
- Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications.
- Imaging for low back pain in the first six weeks after pain begins should be avoided in the absence of specific clinical indications (e.g., history of cancer with potential metastases, known aortic aneurysm, progressive neurologic deficit, etc.).
- Most low back pain does not need imaging and *doing so may reveal incidental findings that divert attention and increase the risk of having unhelpful surgery.*

Why do we make such a big point about back imaging and list so many medical societies that recommend against having such a test when you first feel the pain? Because our national rate of MRIs has increased from about 56 per thousand people in 2000 to 98 per 1000 people in 2010. [7] Clearly the medical community has not educated patients about the risks of unnecessary MRIs.

Here's the excess-MRI issue on a broader scale, comparing the number of MRI's per 1000 Americans to the number per 1000 British, French or Canadians.

[7] OECD data

MRI Exams per Thousand Population, OECD data



Some MRIs are clearly useful. Based on the evidence from other countries that are demographically and socio-economically like us, having about 50 scans per thousand of population seems about right. That's about what other advanced countries – with slightly better infant mortality and longevity data – have. We currently do about double that. British, French and Canadian life expectancies slightly exceed ours and their infant mortality rates slightly trump ours. The relative lack of MRIs has not, apparently, harmed their national statistics.

Here's a very rough estimate of the economic costs of those additional or unnecessary MRIs: $30 billion annually.

> The calculation: MRIs cost about $2000 each, according to New Choice Health, a website that compares medical care prices. [8]
>
> That's $2000 for each of the 50 unnecessary MRIs per thousand of us…and there are about 310 million of us!

Remember the key point here: the medical community is unable to cut the rate of apparently unnecessary MRIs on its own. This excess harms our employer clients who pay for the unnecessary utilization as well as employees who may actually be harmed

[8] http://www.newchoicehealth.com/MRI-Cost

by the excessive scans. Our customers pay – either individually through their deductible or self funded companies by spending their own money unnecessarily.

Should brokers ‘let the buyer beware?’

Ethical brokers, from our point of view, should tell their clients about their risks of receiving excessive, unnecessary and potentially harmful medical care.

Ethical brokers should make resources like ChoosingWisely available to their clients.

Ethical brokers should inform their clients that the medical community has questions about the utility of certain medical practices.

And ethical brokers should help their clients learn the key questions to ask their physicians to avoid medical harms.

We’ll discuss the origins of these ethical standards next.

A comparison of two ethical standards

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

Some Judeo – Christian Business Ethical Positions on Disclosure

Let's start with the first commercial transaction in the Torah or Old Testament, in which Abraham laid down the 'full disclosure' commercial principle.[9]

Many commentators think that this ethical principle is of fundamental importance, given its prominent position in the Bible. They argue that if some other principle was more important, then ***it*** would have appeared first.

The story of Abraham purchasing a burial plot for his wife Sarah – who died while on an out-of-town business trip with her husband - shows the importance of full disclosure by the product seller to the product buyer. The haggling over land takes five steps in Genesis 23: 3 - 20:

> **Step 1:** Abraham explains to the local people what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot and indeed, doesn't know the local burial plot details or issues;
> **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'.

Note the similarity to 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, or a policy to cover all our full time employees;
> **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;

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

Step 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.

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 message here: 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

The lesson about this transaction: in traditional Judeo-Christian ethics there is no concept of 'let the buyer beware'. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc. This was clearly not true for Abraham, the 'foreigner and visitor'. The seller could have taken advantage of his lack of knowledge to swindle him, but did not. The seller educated the buyer. This is the ethical business lesson of Genesis 23: 3 – 20.

'Let the Buyer Beware' Assumes that All Parties have Equal Abilities to Understand the Information Available

In the Biblical case, Abraham 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 Judeo-Christian ethics remain valid today, for two main reasons.

Reason 1: Sellers and Buyers Rarely have Exactly the Same Information

The seller generally knows his / her products far better than the buyer, as was the case of Abraham's burial plot seller or an insurance broker. The seller deals in this market, for this product, far more frequently than does the typical buyer so understands it better.

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

Reason 2: 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 very good *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.

In fact, Abraham might not even know which questions to ask the burial plot seller. He needed guidance from a trusted source here.

Our clients are similar to Abraham. They are accountants, schoolteachers or fishermen 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.

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 ethics goes even further. *Parshas Shoftim*, a commentary on ethical principles, stipulates that 'He who does not ***do his fellow a favor***, is not of the sons of Abraham' for 'we force one to act contrary to the selfishness of Sodom'.

This places an even greater ethical burden on the seller. 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 healthcare system that may occur.

Why would traditional Judeo-Christian ethics place such a burden on sellers?

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 because buyers would have a very high degree of confidence in the seller's representations.

Translating These Ideas to Product Sales and Business

One way that many of us would like to be treated: we would like people with expertise to share their expertise with us. Let's look at a simple example of 'treating others as you would want them to treat you' – an interaction with a car mechanic.

When I have a question about my car, I ask my local mechanic – i.e. my car expert.

I seek his advice because he has had years of experience working with cars. He has an expertise that I do not share. He can differentiate serious from minor problems and advise me if and when to get my car fixed. A good mechanic answers my questions when I ask them. He treats me as he would want to be treated were conditions reversed.

But here's a slightly more complicated case: when my mechanic changes my oil and notices a problem with my car, I expect him to inform me. My local mechanic recently told me, for example, that – since I was coming up on 100,000 miles - I should schedule a tune-up and install new brake pads. I appreciated his advice: he treated me well, which means 'he did unto me as I hope I would do unto him' were conditions reversed.

I would be very unhappy with a mechanic who told me after a serious accident 'Yes, I noticed that your brake pads were worn out, but I decided not to tell you'. Here the expert did not share his expertise. I thought that he would 'do unto me as I would do unto him' were conditions reversed and he let me down.

An ethical expert shares his/her expertise with clients. An unethical expert does not. Note some issues with this lack of disclosure:

1. Since he did not tell me that there *was* a problem with my car, I assumed that there was, in fact, *no* problem;

2. The underlying issue here is definitional. I define a good mechanic as one who looks out for my interest. Part of his job is to be my 'car advisor' and offer advice about how best to maintain my car.

He, apparently, defines his job much more narrowly, simply as fixing things that I ask him to fix, but no more.

3. His definition of ‘good mechanic’ puts an enormous burden on me. I must ask after every oil change for example, a number of specific questions about my car’s operation. Are the brake pads good? Is the air filter working properly? Does the head gasket leak? Are the brake rotors in good condition? Are the tires balanced?

Unless I ask, he will not disclose.

4. My interest in developing a long term relationship with this mechanic is very weak. I don’t trust him to look out for my interests. I worry that I may fail to ask the right questions and have an avoidable accident as a result.

5. As a result, I will probably switch to a different mechanic. After all, they just fix cars. They all use the same parts. They all – more or less – repair things that have broken.

I will switch because I define ‘good mechanic’ as someone who looks out for my interest, who helps me be proactive in maintaining my car and who fixes things that brake.

The fundamental issue between me and my mechanic: I want him to share his expertise with me, in addition to fixing my car. I want him to do me a favor, not let me beware!

Case Study
Insurance Broker Ethical vs. Non Ethical Behavior

Several years ago I had a poignant interaction with an insurance professional over this *information disclosure issue*. The situation:

I had considered changing a liability insurance policy (written by an out-of-town agent) so got a quote from my long-term local P & C agent. He informed me by phone that he had a better policy at a lower price than my current plan. He summarized some key points and said he could bind it on my verbal approval. I trusted him, so agreed.

He also suggested that I cancel my existing policy, which I also did.

After a detailed policy review (a week or two later) I decided that the new policy was not as comprehensive as the previous one. I re-activated the old policy with the out-of-town agent, and informed my long-term local agent by email that I wanted to terminate the new one.

He never cancelled my new policy. Instead, several months later, he told me that neither I nor the other broker had submitted the cancellation request on the correct form. (It then took numerous phone calls and significant upset to correct the problem.)

Note the different definitions at work here. My local agent defined his job as getting quotes, processing bills and filing the correct forms. He took the 'let the buyer beware' approach, apparently thinking that the burden of looking out for my interests fell on me or on others. He would sell me the policies that I requested, and nothing more.

I defined his job as 'looking out for my interests', or 'doing to me as I would do for him were roles reversed' - which included informing me that I needed to file a specific form to achieve my cancellation goal. I had no way of knowing which form to file absent his input; he had specific expertise and product knowledge that he failed to share with me. He 'let the buyer beware' to an upsetting end.

This destroyed my ability to trust his advice. What other information, I wondered, would he also leave out? What avoidable harms might I endure? What unnecessary problems would I face? In short, why should I pay him to advise me when he takes the 'let the buyer beware' approach?

Needless to say, he fairly quickly lost my home and auto insurance accounts!

Unequal Knowledge about Health Insurance

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)

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.

Is a health insurance broker like the car mechanic above who has specialized knowledge? Is he like the P & C broker who failed to share his expertise with me? What disclosure responsibilities does a health insurance broker have?

We suggest adopting the ‘do your fellow a favor’ ethical position, based on the Judeo-Christian roots described above. This has served as the moral and ethical foundation of western civilization for thousands of years.

Business Ethics = Business Efficiency

Ethical Practices = Good Customer Service

Traditional ethics equates business ethics with business efficiency. The 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 like done to yourself’ and ‘Love thy neighbor as yourself’.

Effectively, this means sellers should give clients excellent advice about the products they are selling.

In doing this, traditional ethics advises us to educate our clients as we would like them to educate us, were conditions reversed.

If everyone followed these ethical principles, in other words, we would have a very well functioning business economy. The principles can be seen as a manual for how to prosper in business. We’ll read its various ethical teachings in this light.

Ethical sellers – i.e. those who follow these traditional principles - 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.

Ethical practices, as we have discussed above, also equal good customer service. Would you prefer to purchase something from a seller who 'lets the buyer beware?' Or would you prefer that the seller 'do you a favor?'

Abraham apparently preferred the latter. His burial plot sellers were, apparently, credible, 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 the quality of education they offered, so chose to do business with him.

My car mechanic – the one who advises me that my brake pads are thin or that I need a tune up at 100,000 miles – also takes this ethical position. He 'does his fellow a favor' by advising of problems that may occur, so I can fix them promptly. When I find a mechanic like this – who looks out for my interest – I stay with him.

Not so for my long ago local P & C agent. He did not share the mechanic's business approach. He chose to offer the minimum client education and not to inform me of the specific policy cancellation process. He ended up operating his business less one client.

As with burial plot sellers, car mechanics and P & C agents, so with health insurance brokers. Brokers who 'do their fellow a favor' act ethically; those who 'let the buyer beware' do not.

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 all the ethical dictates discussed above: Simply describing the insurance policy in detail does not satisfy the traditional ethical dictates discussed above.

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 in Parchas Shoftim above, in the discussion of ***do the fellow a favor*** remains: ***How much*** **should a seller disclose about a product to a customer?**

It is unclear from Genesis 23 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 the lessons of Genesis to more complicated transactions, like health insurance policy sales.

How Should the Broker Educate the Buyer?

Clearly a broker should not give medical advice. That's outside the realm of his / her licensed authority.

Rather, we suggest that health insurance brokers have an educational responsibility to offer clients information indicating that, for example, there is a disagreement over the use of back MRIs in the medical community: The ethical broker can advise clients that educational resources exist.

The ethical broker's goal in educating the client: help the client become an informed consumer of medical services. The ethical broker becomes a resource for his/her clients.

Some Samples

Just as a public library makes information on a wide range of subjects available to the general public, so the ethical broker can make information on medical care available to clients.

We have tried this is out in our live classes. One telling example: we distribute information on the rates of Caesarian births by local hospital.

I often start the discussion by asking 'How do you decide which hospital to use for child delivery?' Most women respond that they use the hospital recommended by their obstetrician.

'When do you choose an obstetrician?' I then ask. Answers range from 'I use my gyn for obstetrics, and I've known my gyn for years', to 'I use the obstetrician recommended by my friends, relatives or primary care physician.' In any case, women report that they generally have an obstetrician on board quite early in their pregnancy.

I then present data on the various rates of Caesarian births in different local hospitals. Here's a partial list of Massachusetts hospitals published in 2010: [10]

Hospital Name	Rate of Caesarian Births

[10] Massachusetts Births 2008, Massachusetts Department of Public Health, Bureau of Health Information, Statistics, Research and Evaluation, Division of Research and Epidemiology, March 2010

Holy Family, Methuen	47%
Melrose-Wakefield	46%
South Shore	44%
Metro West	42%
Signature	41%
Holyoke	22%
Tobey	19%
North Adams Regional	18%
Heywood	16%

The next comment that typically arises in live classes: there must be medical differences among the patients in those hospitals. For example, women at high risk will use Holy Family more frequently than Heywood.

But wait, I caution. You said that you use the hospital where your obstetrician has admitting privileges. You choose your obstetrician before you had any delivery complication issues (generally). Now you've changed your story!

In fact, the analysis of these treatment rate differences *does not* indicate that women presented with such different medical needs. Rather, according to Dr. Lauren Smith, medical director of the Massachusetts Department of Public Health, the reason for the rate differences include:

> A complex array of factors….including how they organize the staffing of their labor and delivery units, what are the resources that might be available. [11]

Patient need differences played a minor role and *did not explain the vast differences in Caesarian rates.*

Indeed, Smith, the Massachusetts DPH Medical Director, went on to say that in a similar analysis performed from 2004 – 2006 – *where hospitals were divided into three groups based on the complexity of obstetrical care they provided* – the caesarean rates varied widely within the groups.

The New Hampshire insurance department looked into similar C-section rate disparities among New Hampshire hospitals and concluded, in the official report

> There are no obvious reasons that explain why c-sections are higher at one NH hospital vs. another … [and] … there does not appear to be a relationship between c-section rates and health status. [12]

[11] Boston Globe, 6/7/10

[12] A Commercial Insurance Study of Vaginal and Cesearean Section Rates at New Hampshire Hospitals, State of New Hampshire Insurance Department, April 1, 2011

Or, stated more bluntly in a 2013 Harvard School of Public Health study

> the same woman would have a different chance of undergoing a c-section based on the hospital she chooses [13]

Might physicians at some hospitals perform the procedures with which they are the most comfortable and ignore patient presentations that suggest a different treatment is more appropriate?

One hospital might overperform a treatment with which it feels comfortable, while another might underperform one with which it feels uncomfortable. Hospitals might staff up and organize their resources around a particular treatment and then gain a comfort level with it – just as Dr. Smith of the Mass DPH suggests.

Why might a hospital organize itself to perform more or fewer Caesarians? A number of factors may impact on this decision, including financial incentives, religious or philosophical orientations or entrenched hospital bureaucratic interests. Patient need differences, according to the analysis by the Mass DPH, play a relatively minor role in all this.

Brokers learning this information in our live classes – especially the pregnant ones – are generally quite astonished. I often ask 'do you think your clients would like to know this?' The typical answer: Yes, of course.

In our ethical terms, these brokers would like to treat their clients as they would like to be treated. They verbalize – though not in so many words – a desire to 'do their fellow a favor'.

[13] Pregnant women's likelihood of cesarean delivery in Massachusetts linked to choice of hospitals, Harvard School of Public Health News, March 19, 2013

Review Questions

Correct answers on next page

1. What does ‘unequal knowledge between sellers and buyers’ mean?
    a. Sales people generally know far more about their product than do consumers, because sales people have specialized education or training in that product, which consumers generally do not have
    b. Consumers are generally smarter and more worldly than sales people because they shop for many different kinds of products while the sales person specializes in only one or a few products
    c. Consumers have access to much more information (on the internet, for example) than they used to, so today they generally have equal – not unequal – product knowledge today
    d. Consumers can comparison shop widely, so generally know more about a specific product than does the sales person

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

3. What does ‘let the buyer beware’ mean?
    a. That the buyer should beware that the seller is probably lying when he/she represents something
    b. That the buyer should beware that the seller is probably taping the transaction to protect him/her self in the event of a fraud accusation
    c. That the buyer should beware that the product probably contains hidden defects that the seller is not under any legal or ethical obligation to disclose
    d. That they buyer must do his/her own product research because the seller feels him/her self under no ethical obligation to disclose product details

4. What does ‘let the buyer beware’ assume?
    a. That the buyer understands that the seller is probably lying when he/she represents something
    b. That all parties to the transaction have equal abilities to understand the product information available
    c. That buyers have a certain minimum level of intelligence
    d. That sellers have less than a certain minimum level of intelligence

5. Is ‘let the buyer beware’ an ethical or unethical standard?
    a. This is an ethical standard
    b. This is not an ethical standard. In fact, it is unethical
    c. It is only an ethical standard for service type products like health insurance
    d. It is generally an ethical standard but is inappropriate for service type products like health insurance

6. What does ‘do your fellow a favor’ mean?
    a. That buyers should help sellers whenever possible
    b. That sellers should try to put themselves in the buyer’s position, and should educate buyers as they would like to be educated themselves if they were the buyer
    c. That sellers should embrace ‘the selfishness of Sodom’ thus creating a more competitive market
    d. That buyers should embrace ‘the selfishness of Sodom’ thus putting more demands on the seller

7. Is ‘do your fellow a favor’ an ethical standard?
    a. No
    b. Yes
    c. Only when the buyer figures that the ‘favor’ is worth less than the product in question
    d. Only when the buyer figures that the ‘favor’ is worth more than the product in question

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Correct answers in bold

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Some Ethical Advice Issues
The problem of treatment variation

Geographic treatment variation means that the *same* patient, with the *same* medical condition, might receive *different* care in *different* geographical regions.

In other words, a retiree living in Fort Myers, Florida and experiencing lower back pain, for example, is about twice as likely to have back surgery as the same person living in Miami.[14]

Or a person suffering from angina might be 70% more likely to have angioplasty in Elyria, Ohio, than the same person living in Akron – about 50 miles away. [15]

Or a person living in Florence, South Carolina with a chronic medical condition may be about 50% more likely to be hospitalized than the same person, with the same medical condition, in nearby Charleston, SC. [16]

How can this be?

Treatment Variation and the Broker's Ethical Advisory Role

Below, we'll explain why treatment variations exist. But first, we seek to make two key points to brokers:

1. No region of the US suffers from a lack of medical resources, though in some rural areas people need to travel longer to receive care than do urban dwellers.

   This suggests that treatment intensity above the minimum may be unnecessary and wasteful, potentially causing more harm than patient benefit.

2. No entity in the US healthcare distribution system has a specific responsibility to inform patients of this situation. Indeed, many healthcare providers are either ignorant of this or have financial incentives (fee for service) to provide more care.

Note how the broker shares long-term financial interests with the employer-client. The client may switch carriers and change provider networks while staying with the same broker.

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[14] http://www.dartmouthatlas.org/data/table.aspx?ind=74&tf=6&ch=35&loc=143,221&loct=3&fmt=99

[15] http://www.dartmouthatlas.org/data/table.aspx?ind=80&tf=6&ch=35&loc=54,94,112,119,132,332,358&loct=3&fmt=105

[16] http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=24

As such, the broker wants his/her clients to receive the best medical care, at the best possible price, over the long term.

The broker may have an ethical reason ('do your fellow a favor') and a financial reason (remember how Judeo-Christian teachings equate business ethics with business efficiency) to advise patients about the risks of treatment variation.

Why Variations Exist

Perhaps the key source of geographic treatment variation data is the Dartmouth Atlas of Healthcare, which uses Medicare data to determine the amounts of medical care received in different regions of the US. The Atlas describes and documents the vast variations in medical care available to patients in the US. You can access this information at www.DartmouthAtlas.org.

One reason for variations in medical treatment between regions is the supply of medical resources – i.e. hospital beds per capita, radiological equipment per capita, specialists per capita, etc.

Here's how the Dartmouth Atlas describes this situation: [17]

> Regional variation in capacity reveals the irrational distribution of valuable and expensive health care resources. Capacity represents the capital investments and labor that permit the delivery of medical services.
>
> Two types of capacity determine the majority of health care costs.
>
> The first is hospital capacity, including the number of general and intensive care beds, imaging devices, and procedure suites like operating rooms and cardiac catheterization labs.
>
> Health care labor is the second and related component of capacity, and includes the physicians, nurses, allied health professionals and administrative staff who work in hospitals and physician practices.
>
> Unfortunately, the distribution of capacity fails to reflect the regional need for health care, either for beds or for physicians and hospital staff.

[17] http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=24 . Emphasis added.

> Even after controlling for differences in age and sex, some regions had more than twice the number of beds per capita than other regions.
>
> More beds means that patients are more likely to receive their care during a hospital admission, with greater costs, and a higher likelihood of hospital-acquired infections and medical errors.
>
> Higher physician supply offers little benefit in population health or in patients' satisfaction with access to care and with the care received.
>
> In other words, as the supply of hospital beds increases, the number of patients admitted also increases…but outcomes, as measured by mortality rates, speed at which patients return to functional status or patient satisfaction with medical care do not improve.

In fact, the mortality rates go *up* as patients receive more medical care, not down!

Here's Elliott Fisher of Dartmouth Medical School, describing how regional spending rates vary, along with mortality rates:

> For every 10% increase in spending [comparing one US region to another], relative risk of death in 5 years increased.[18]

The reason, again: above a certain amount of care (say, the US regional minimum), additional medical care increases risks of error, infection or patient fatigue with no concomitant benefit increases.

Note that Fisher and the other Dartmouth studies work primarily with Medicare data, as that's the most comprehensive US healthcare data source available.

Why might regions with more hospital beds and physicians per capita of the population provide more medical care?

Roemer's Law

Researchers have studied the impact of bed supply on hospitalization rates since the 1950s, at least. The pioneer of this research, Dr. Milton Roemer, first studied the impact of expanding the bed supply in a study of an upstate New York town in 1957 – 8.[19]

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[18] Fisher, Implications of Regional Variations in Medicare Spending Part 2, 2003

[19] Milton Roemer, Bed Supply and Hospital Utilization: A Natural Experiment, Hospitals, 35 (1961)

Here's what Roemer found: in 1957 this town (Roemer doesn't name it, so unfortunately, we can't verify his data) had one general hospital with 139 beds. The average daily occupancy was 108 (78%) suggesting some excess bed capacity.

The hospital was apparently satisfying the medical needs of this community reasonably well. Roemer based this conclusion on his reading of the local newspapers, which reported few, if any, stories about inadequate hospital resources.

In 1959, the town opened a new general hospital with 197 beds. Roemer doesn't explain why, but notes that there was no population change, no new industries moving to town and no major disease epidemics. Apparently the town took advantage of some financing available to build a new hospital and close the old one.

Almost overnight, the hospital occupancy grew to 137 – a 26% increase!

Roemer suggested that physicians responded to this increased bed supply by hospitalizing patients in 1959 that they would not have hospitalized in 1958.

His conclusion: 'the supply of hospital beds in a community or state is the major determinant of the hospital utilization.' The amount of treatment variation due to bed supply: about 26%.

Roemer's Law – that a hospital bed built is a hospital bed occupied – suggests that the availability of excess hospital beds may account for 26% of all US healthcare spending.

Other Studies Reinforce Roemer's Conclusion

Fisher, in his major 2003 studies, concluded that

> Up to a third of medical care is devoted to services that do not provide any detectable benefit.

He studied the distribution of medical resources by region, and compared patient treatment patterns and mortality rates. His studies have not been refuted. Indeed, other researchers have found the same expenditure patterns.

Here, for example, is a comparison of Medicare spending in El Paso and McAllen, Texas, using 2006 data: [20]

> Average Medicare spending/capita, McAllen: $14,900
> Average Medicare spending/capita, El Paso: $7,500

McAllen Medicare beneficiaries had, compared to El Paso:

[20] Atul Gawande, Cost Connundrum, New Yorker, September 2009

50% more specialist visits
20% more abdominal ultrasounds
30% more bone density tests
60% more stress tests with echocardiography
2/3 times more pacemakers, cardiac bypass operations and coronary artery stents

Yet the McAllen demography appeared virtually identical to the El Paso demography, with no significant mortality or longevity differences:

	McAllen	El Paso
Average household income	$40K	$36K
Poverty rate	27%	27%
% Hispanic	80%	77%

Why do McAllen Medicare recipients get more medical care than El Paso folks? The answers appear to include (a) regional treatment norms and (b) the availability of medical specialists.

Would Your Clients Like to Know This?

The number of specialists varies significantly by region, even if the population demographics do not

Here, for example, is the distribution of physicians in 'high spending regions' vs 'low spending regions' (spending levels calculated on a per capita basis) per 1000 Medicare beneficiaries in 2003: [21]

	High Spending Region	Low Spending Region
	Rates per 1000 Medicare beneficiaries	
Specialists	78	57
Sub Specialists	44	27
Surgeons	56	44
GPs / Family practitioners	27	36

High spending regions have more specialists per capita and fewer primary care physicians. They enjoy (enjoy?) higher medical costs.

But researchers who have studied the medical outcomes suggest that this additional spending generates no better medical outcomes. Here's Fisher again, from his same studies:

[21] Maggie Mahar, Money Driven Healthcare, page 170

> we found no evidence that the pattern of practice observed in higher spending regions led to improved survival, slower decline in functional status or improved satisfaction with care.

Thus the type of medical care received by people in the higher spending regions – defined as having more beds and more specialists – does not impact positively on patients.

As a region gets more hospital beds and more medical specialists, the medical costs increase. But patient outcomes do not improve.

Two other researchers from Dartmouth, Katherine Baicker and Amitabh Chandra, arrived at an even stronger conclusion:

> Researchers have found that underlying population risk (i.e. disease factors) does not seem to drive the presence of specialists and that outcomes are not improved by increased access to these specialists. [22]

Specialists don't set up their shops based on the disease epidemiology in a region – i.e. based on patient demand for their services. They set up their shops in regions where the local medical culture indicates that patients will access their services.

For patients, having easy access to a greater number of specialists does not generate better outcomes. Yet – often – this is exactly what your clients want in a health insurance policy: easy access to a wide range of specialists.

Kenneth Thorpe of the Rollins School of Public Health at Emory University takes this one step further. He suggests that having access to more specialists means that patients will use more specialists and that this process may lead to *unnecessarily high mortality rates*. Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services from 1993 to 1995. His research shows that

> A typical Medicare beneficiary sees two primary care physicians and five specialists working in four different practices…who rarely coordinate the care they deliver. Because of this structural deficiency, patients with chronic illnesses receive only 56% of clinically recommended medical care. That gap in care may explain a nontrivial portion of morbidity and excess mortality. [23]

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[22] Baicker and Chandra 'Medical Spending, the Physician Workforce and Beneficiaries Quality of Care' Health Affairs, April 7, 2004

[23] Thorpe, et al, Chronic Conditions Account for Rise in Medicare Spending from 1987 – 2006, Health Affairs Web First, April 2010

'Excess mortality' is a death rate higher than the underlying demographics would predict.

Why does access to more specialists lead to this 'excess mortality'? We'll turn to the final researchers in this section, Peter Muennig and Sherry Glied, both of the Mailman School of Public Health at Columbia University. Muennig and Glied asked 'What Changes in Survival Rates Tell Us About US Health Care' and conclude that:

> Unregulated fee-for-service reimbursement and an emphasis on specialty care may contribute to high US health spending, while leading to unneeded procedures and fragmentation of care…Fragmentation of care leads to poor communication between providers sometimes conflicting instructions for patients, and higher rates of medical errors. [24]

Here's our summary:

> 1. As we provide a higher supply of hospital beds and specialists, we generate higher utilization (Roemer's Law);
>
> 2. This does not improve outcomes or generate higher patient satisfaction with care (Fisher);
>
> 3. Indeed, specialist location decisions are not a function of patient need or the epidemiologic demand for specialist services (Baicker);
>
> 4. But the availability of excess beds and specialists leads to systemic fragmentation and excess mortality (Thorpe);
>
> 5. The reason for excess mortality is poor communication between and among the excess supply of specialists (Muennig).

Should You Inform Your Clients?
How Would an Ethical Broker Behave?

Armed with this type of information, an ethical broker would inform his/her clients (a) that treatment variations exist and (b) some ways the client can protect him/herself from receiving excessive and unnecessary care that may pose unnecessary risks and generate unnecessary costs.

One way for the client to protect him/herself: access information from the Dartmouth Atlas, Medicare or other sources to determine if he/she is *likely* to receive unnecessary care.

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[24] Muennig and Glied, What Changes in Survival Rates Tell US About US Health Care, Health Affairs, November 2010, page 2105

Your client can then discuss this with his/her physician(s). The client and physician can, together, review the available data and then discuss appropriate treatment strategies.

Alternatively, of course, you can let your client beware…

Case Study

If you were a customer, would you want your broker to advise you of this?

We have, so far in this course, made two fundamental points.

First, that traditional business ethics requires brokers to 'do their fellow a favor', which, in the health insurance brokerage arena, means to advise their clients about various systemic risks;

Second, we've discussed one of those systemic risks: regional treatment variation or the chance that people will receive excessive and unnecessary care in certain regions, and have higher medical risks as a result.

In this Chapter, we will look at three types of medical care to see the role that local treatment orientations play. You can find the same situation in all other states.

Do you think your clients would like to know this?

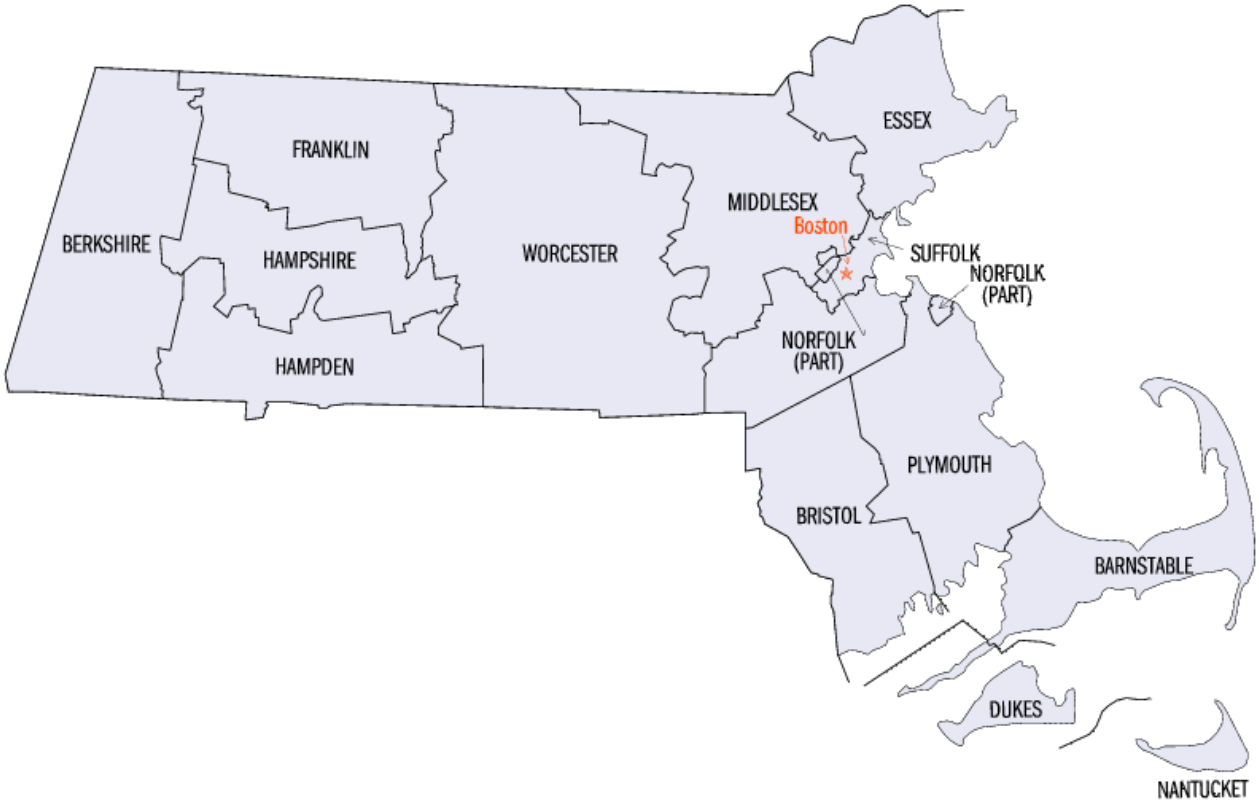
Some Geographic Background

(This information is specific to Massachusetts. The methodology, however, applies to all states.)

Massachusetts is broadly divided into 5 hospital referral regions by the Dartmouth Atlas of Healthcare.

Dartmouth defines hospital referral regions as 'regional health care markets for tertiary medical care that generally require the services of a major referral center.'

Among the 5 Massachusetts hospital referral regions, 2 use out-of-state hospitals for tertiary care: extreme western Massachusetts uses the Albany, New York hospitals, and extreme southern Massachusetts uses Providence, Rhode Island hospitals. These two regions contain relatively small populations. As such, and for simplicity here, we will focus on the 3 most heavily populated regions in Massachusetts: the Boston area, the Worcester area and the Springfield area.



The **Boston area** is generally defined by patients living in, or east of, Middlesex and Norfolk counties. This population tends to use the downtown Boston teaching hospitals – Massachusetts General Hospital, the Brigham and Women's Hospital and the Beth Israel Hospital – for major tertiary care.

The **Worcester area** is generally defined by patients living in Worcester county. This population tends to use the University of Massachusetts Medical Center in Worcester for major tertiary care.

The **Springfield area** (Springfield is in Hampden County) is generally defined by patients living in Franklin, Hampshire, Hampden and Berkshire counties. This population tends to use the Springfield hospitals for major tertiary care.

We'll evaluate the treatment tendencies of each region for three common acute procedures: mastectomies, leg amputations and coronary angioplasty.

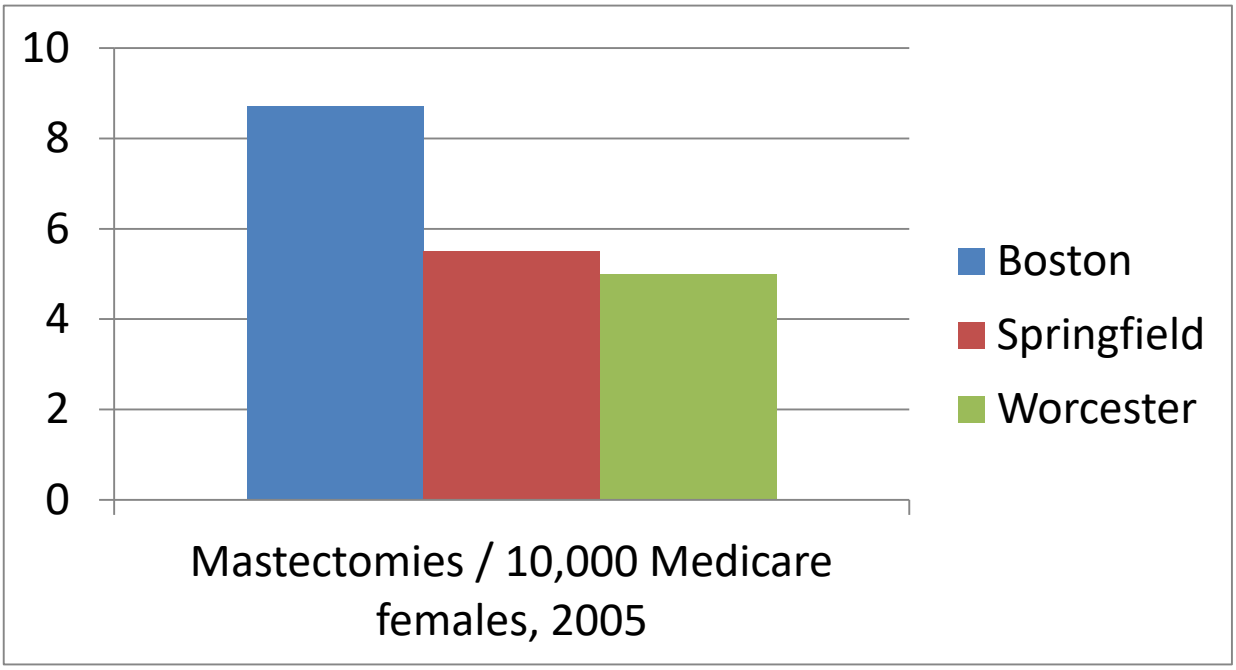
Mastectomies

Dartmouth's raw data indicate the following rates for mastectomies in these three Massachusetts hospital referral regions:

Boston area --- 8.7 per 10,000 female Medicare beneficiaries
Springfield area – 5.5 per 10,000
Worcester area – 5.0 per 10,000

Here's a graph showing the differences.

Regional Treatment Tendencies:
Mastectomies
Source: Dartmouth Atlas. Data downloaded Feb 2011



(If you're seeing this in black and white, Boston is the left bar, Springfield is the center bar and Worcester is the right bar.)

This chart shows that Boston area female Medicare beneficiaries have about a 60% greater likelihood of having a mastectomy than Springfield women, and about a 74% greater likelihood of having a mastectomy than Worcester women.

This, claim many, is not particularly surprising. The Boston area hospitals include several Harvard Medical School affiliated teaching hospitals and the world famous Dana Farber Cancer Hospital. It is not unreasonable to think that women living only an hour or two away and suffering from breast cancer would visit one or more of these highly respected hospitals for care.

Or that the very sickest women, in general, will travel to Boston for care.

Thus, they claim, the Boston area data might pick up sick women living in the Worcester or Springfield areas also, thus skewing this graph. Maybe…

There are two alternative theories that fail to stand up to critical analysis:

- Some people might suggest that there is 60 – 70% more breast cancer in the Boston female population, due, perhaps, to environmental factors. No data support this proposition. [25]

- Others might suggest that the sample size is too small to generate any statistically significant conclusions. This doesn't stand up as the historical data indicate that these proportional variation trends have existed over a very large population for many years.

The only other potential explanation suggests that Boston area oncologists operate on the same population (from an epidemiologic perspective) more frequently than do Worcester or Springfield area oncologists.

Which analysis is correct? Do women at risk for mastectomies travel from Worcester and Springfield to Boston for care? Or do Boston area oncologists perform mastectomies on patients who would not have this treatment in Worcester and Springfield?

We'll test both theories by reviewing the leg amputation data and the coronary artery stent data. If we find that the Boston area physicians perform these procedures more frequently than Worcester or Springfield physicians, then we can hypothesize that sick patients travel to Boston for treatment.

*But **if Worcester or Springfield physicians perform more leg amputations or insert more stents, then we will suspect that local medical treatment preferences are more important.*** (No one in the Massachusetts medical or medical research community argues that massive numbers of patients travel from Boston to Springfield for tertiary medical care. Also, my casual perusal of the local media over the past 20 years suggests that there are no stories in the local press indicating this trend either.)

Leg Amputations

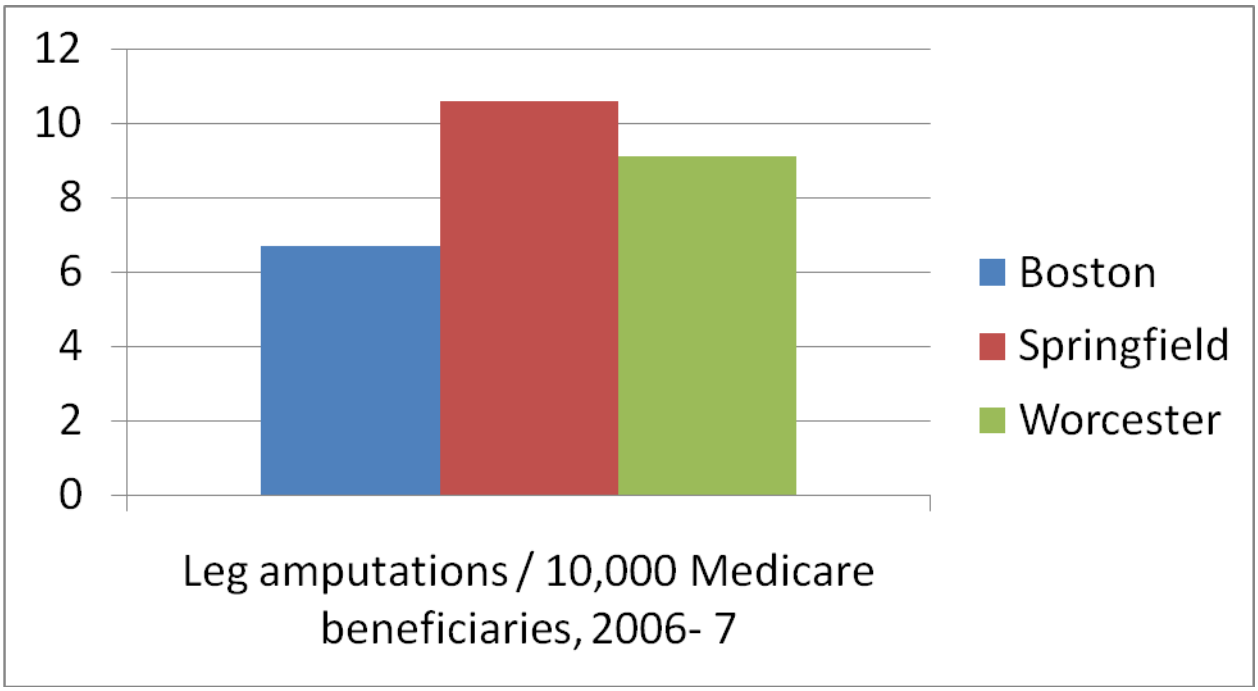
Dartmouth's raw data indicate the following rates for leg amputations in these three Massachusetts hospital referral regions:

[25] There is some data to indicate that more rigorous cancer screening identifies more cancer in some regions than in others, but not that there is a significant regional difference in cancer incidence rates. Also, some data indicate that a specific environmental contaminant may affect cancer rates in a very small region, but not in regions as geographically diverse as the three we are considering here.

Boston area --- 6.7 per 10,000 Medicare beneficiaries
Springfield area – 10.6 per 10,000
Worcester area – 9.1 per 10,000

Now Boston has the lowest rate of treatment and Springfield the highest.

Regional Treatment Tendencies:
Leg Amputations
Source: Dartmouth Atlas. Data downloaded Feb 2011



If you're seeing this in black and white, Boston is the left bar, Springfield the center bar and Worcester the right bar.

These data show that Springfield area Medicare beneficiaries have about a 60% greater likelihood of having a leg amputated than Boston area beneficiaries.

How can this be?

No one in Greater Boston seriously suggests that Boston area Medicare beneficiaries at risk for leg amputation travel to Springfield for medical care – at least, not in the numbers required to skew these data.

Indeed, those who believed that Medicare females suffering from breast cancer travel from Springfield to Boston, must now believe that Boston folks go to Springfield for

orthopedic or vascular treatments. This simply doesn't make sense. Where would a women suffering from breast cancer *and* at risk of a leg amputation go for treatment?

There are virtually no stories in the local press suggesting this migration of people needing leg amputations to Springfield.

It's beginning to look like the treatment variation argument will prevail.

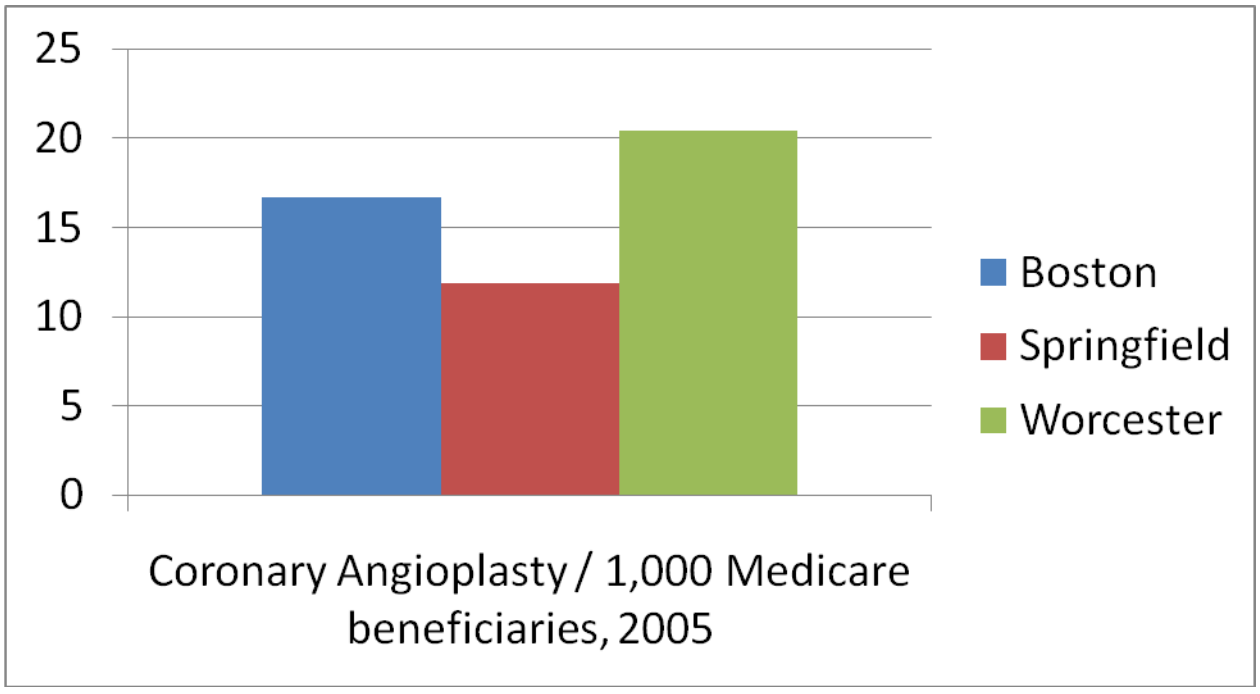
Inpatient Coronary Angiography

Dartmouth's raw data indicate the following rates for inpatient coronary angiography in these three Massachusetts hospital referral regions:

Boston area --- 16.7 per 1,000 Medicare beneficiaries
Springfield area – 11.9 per 1,000
Worcester area – 20.4 per 1,000

Now Worcester has the highest rate and Springfield the lowest.

Regional Treatment Tendencies:
Inpatient Coronary Angiography
Source: Dartmouth Atlas. Data downloaded Feb 2011



Again, if you're seeing this in black and white, Boston is on the left, Springfield in the center and Worcester on the right.

These data show that Worcester area Medicare beneficiaries have about a 70% greater likelihood of having a coronary artery stent inserted than Springfield area beneficiaries, and a 22% greater likelihood than Boston area beneficiaries.

Again, there is no evidence of significant underlying population medical differences (remember, all Medical beneficiaries are 65+, and no one suggested that those with coronary conditions move to Worcester, while those with poor leg circulation move to Springfield).

Rather, these three charts suggest quite strongly that the impact of local treatment preferences is quite strong.

Jack Wennberg, the founder of Dartmouth Institute for Health Policy and Clinical Practice, ties all this treatment variation information together. He suggests that treatment protocols vary more based on ***medical supply differences and the regional medical culture*** than based on *patient medical differences*. He suggests that your chance of having surgery can be predicted by the rate of surgery in your region 10 years prior:

> *The really fascinating thing to me is to think that what predicts your risk of surgery today in a particular region is what it was ten years ago in the same region.* [26]

The reason: physicians in a region develop 'medical cultures' that get transmitted to new doctors entering the area. Young docs learn from more senior partners in their practice. Career advancement may mean accepting the senior's approach. After all, what senior partner wants a junior partner who very often disagrees with him?

It seems, from the data presented in this Chapter, that Wennberg is right. Your chances of having a particular medical procedure may vary up to 70% by region in Massachusetts for any one of these three procedures: mastectomy, leg amputation and coronary artery stent insertion.

Extending This Analysis to Other States

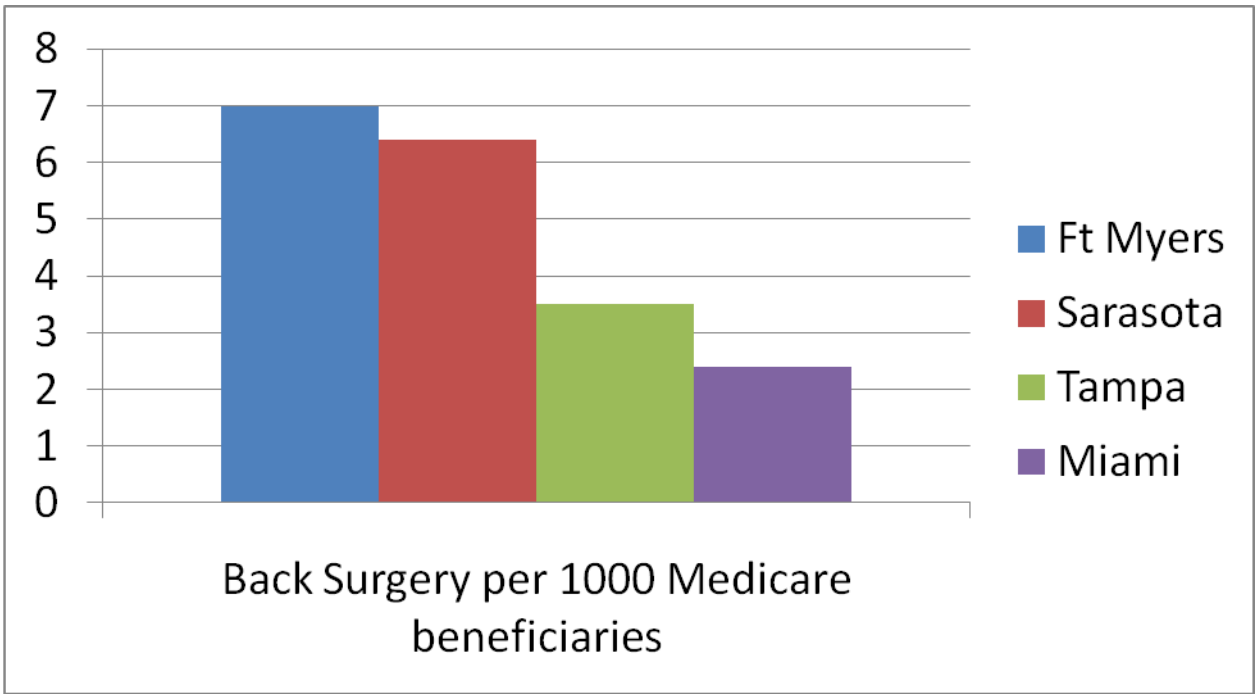
Brokers interested in learning about the treatment variation risks in their own state may visit the Dartmouth Atlas website and do their own research.

Here are some of the (astonishing) things they will find:

[26] Brownlee, op cit, page 41

In Florida, rates of inpatient back surgery vary almost by a factor of 3 by Hospital Referral Region

Back Surgery Rates, Florida
Data from Dartmouth Atlas, downloaded Feb 2011



These bars are ordered, from left to right, Ft. Myers, Sarasota, Tampa and Miami.

The Medicare populations in these 4 cities are quite similar. Interestingly, Sarasota is about an hour drive from Tampa and Ft Myers. Yet the treatment protocols vary quite significantly.

Why Do These Rate Discrepancies Exist?

The Washington Post ran a series of articles in July, 2005 to celebrate the 50th anniversary of Medicare. One article in the series, *When Geography Influences Care Options*, addressed the issue of treatment variation. [27]

Among the Post's findings:

- The rate of back surgery over the previous 10 years had increased by more than half;

[27] Gaul, When Geography Influences Treatment Options, Washington Post, July 24, 2005

- There is no clear-cut science for treating back pain. ‘Some doctors favor surgery, while others recommend exercise, rehabilitation and other conservative approaches’;
- Had Fort Myers's surgeons operated at the more conservative Miami rate, ‘there would have been 4,800 fewer back surgeries from 1992 to 2001 and Medicare would have saved millions of dollars.’

How many millions might Medicare have saved? About 200! That’s 4800 surgeries at an average cost of $40,000, or $192 million.

"It's highly improbable that Medicare retirees living in Fort Myers prefer back surgery two times as often as residents of Miami," according to James Weinstein, chairman of the Department of Orthopedic Surgery at Dartmouth Medical School. Weinstein has tracked variations in the number of spine surgeries in South Florida for a decade.

Rather than understanding this phenomenon as a function of patient demand, researchers look for ‘surgical signatures’ of physicians. Some back specialists prefer surgery while others prefer medication and therapy. Lacking clear outcome data, the patient is likely to receive the type of care preferred by the specialist.

Unfortunately, clinical preferences are sometimes influenced by economics. The Post notes that back surgery can be very profitable. In 2001, spine surgery accounted for more than half of all profits from orthopedic procedures in hospitals but only 21 percent of the volume, according to a study done for the American Academy of Orthopedic Surgeons.

One hospital chain located in Fort Myers saw its Medicare payments for back surgeries grow by 50% over the previous 5 years.

Are Miami Medicare beneficiaries underserved by back specialists? Do they get an insufficient number of back surgeries? Are they harmed as a result of having fewer back surgeries, per capital, than Fort Myers beneficiaries? There’s no evidence to support any of this.

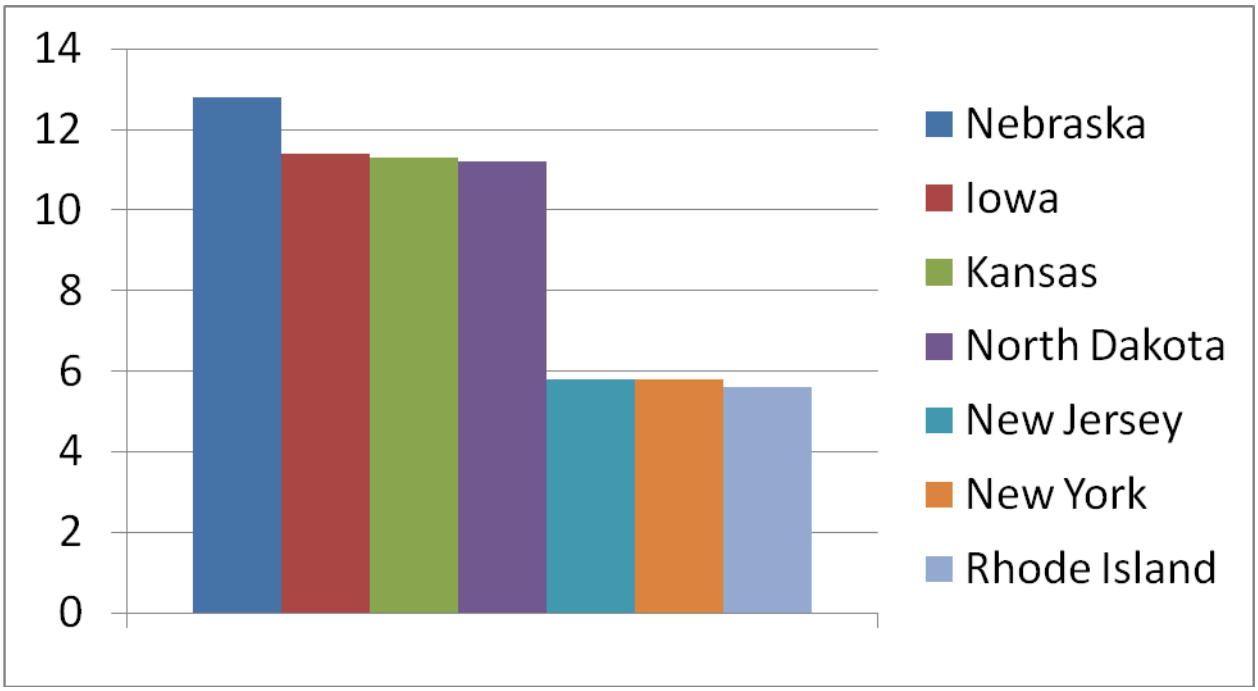
Instead, Fort Myers Medicare beneficiaries seem to get more back surgeries than necessary, pay more than necessary and possibly put themselves at greater risk of error or infection than their Miami compatriots.

Our underlying ethical question: ***do you think your clients would like to know this?***

****

Mid-Western states have 2+ times more inpatient knee surgeries than some other parts of the country

Inpatient Knee Replacement
Data from Dartmouth Atlas, downloaded Feb 2011



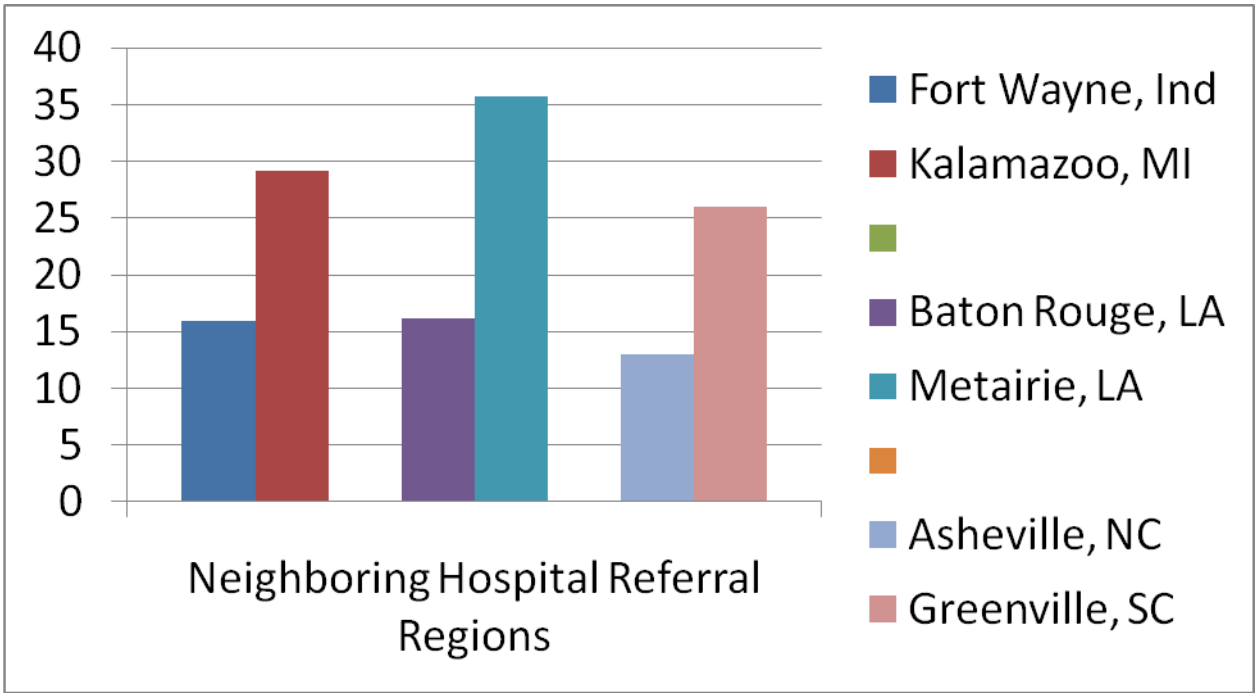
Left to right: Nebraska, Iowa, Kansas, North Dakota, New Jersey, New York and Rhode Island.

Again, it appears that the specialist preferences and local medical norms best describes this data. There are no data to suggest that New Jersey, New York or Rhode Island perform too few knee replacements on their Medicare beneficiaries.

Of course, there's an alternative theory: less healthy mid-western retirees stay in Nebraska, Iowa and Kansas, while healthier retirees move to…New Jersey, New York and Rhode Island? Sorry, doesn't pass the laugh test.

Rates of Coronary Artery Bypass Graft exhibit huge discrepancies in next door Hospital Referral Regions

Coronary Angiography
Rates Per 1,000 Medicare Beneficiaries
Data from Dartmouth Atlas, downloaded Feb 2011



Left to right, if you're seeing this is black and white: Fort Wayne and Kalamazoo, Baton Rouge and Metairie, Asheville and Greenville.

These pairs of Hospital Referral Regions border each other:

> Fort Wayne, Indiana borders the Kalamazoo, Michigan region,
> Baton Rouge, Louisiana borders the Metairie, Louisiana region, and
> Asheville, North Carolina borders the Greenville, South Carolina region.

Again, no one claims that Fort Wayne, Baton Rouge or Asheville are underserved by cardiologists. Nor that their populations are sicker than Kalamazoo, Metairie or Greenville.

Rather, it appears that local medical treatment preferences define these variations.

The Ethical Broker's Role

Your clients may find this type of information interesting or useful when considering medical care. Some may prefer more aggressive care – a mastectomy, for example, rather than watching and waiting.

Others may prefer more conservative care – watching and waiting, for example, rather than a mastectomy.

In any case, they may appreciate learning about the treatment tendencies in their area. This may well give them something useful to discuss with their physicians.

Our underlying point here: **most patients do not know that these treatment variations exist.** The broker who ‘does his fellow a favor’ may help people avoid inappropriate care.

The broker who ‘let’s the buyer beware’ may not be protecting his/her client as well.

Remember also that no regions in the US suffer from insufficient medical care, or widespread *undertreatment* of patients. The data presented here may suggest that some regions, rather, *overtreat* patients by providing excessive or unnecessary care.

The broker may have a role in client education and data distribution. By helping to educate the client about systemic risks, the broker may help the client have a more detailed and fruitful discussion with his/her physician.

Brokers who ‘do their fellow a favor’ may aid in this process.

Brokers who ‘let the buyer beware’ probably do not.

Review Questions

Correct answers next page

1. Which factor, below, strongly influences physician decisions according to John Wennberg of Dartmouth Medical School?

a. The reputation of the nearest medical school
b. The capacity or supply of the local medical market, including the per capita number of specialists, hospital beds or ICU beds
c. The educational background of other physicians in the region
d. The quality of the local hospitals

2. Complete this sentence: According to Dartmouth's Wennberg, treatment protocols vary more based on _____ than on _____.

a. local epidemiological differences *than on* local medical differences
b. medical supply differences and the regional medical culture *than on* patient medical differences
c. patient medical differences *than on* insurance reimbursement differences
d. insurance reimbursement differences *than on* medical supply differences

3. According to John Wennberg, what predicts your risk of surgery?

a. Your genetic background
b. The rate of surgery in your geographic area 10 years ago
c. Your job or occupation
d. The type of health insurance you have

4. What is Roemer's Law?

a. Brokers who 'let the buyer beware' generate smaller commissions than brokers who 'do their fellow a favor'
b. Brokers who 'do their fellow a favor' generate smaller commissions than brokers who 'let the buyer beware'
c. The more medical services available in a community, the lower the mortality rate in that community
d. A hospital bed built is a hospital bed occupied

5. Our legal system requires 3 different functions to interact: a prosecuting attorney, a defense attorney and a judge. The judge decides 'truth' after hearing from both prosecution and defense. (OK, sometimes juries decide also). In our legal system no one party has all the power. But our medical system determines 'truth' very differently. What, in our medical system, is 'truth'? Who determines truth? How do they determine it?

a. Insurance carriers determine 'truth' i.e. the correct diagnosis, after reviewing medical diagnoses from specialists
b. Hospital administrators determine 'truth' i.e. what the patient needs, after hearing from various physicians who have examined the patient

c. The physician chosen by the patient determines ‘truth’, i.e. the correct medical diagnosis and appropriate treatment, after examining the patient
d. Medicare administrators determine ‘truth’ i.e. the correct treatment plan after receiving appropriate paperwork from physicians and hospitals

6. Our legal system requires 3 different functions to interact: a prosecuting attorney, a defense attorney and a judge. The judge decides ‘truth’ after hearing from both prosecution and defense attorneys who are paid to disagree. (OK, sometimes juries decide also). The prosecuting and defense attorneys are paid to disagree with each other over questions of fact, and the interpretation of facts. Who, in our healthcare system, is paid to disagree with the diagnosing physician?

a. The hospital administrators
b. Insurance carriers
c. No one
d. Medicare administrators

7. About what percent of our medical care generates ‘no discernible benefit’ according to researchers at Dartmouth Medical School?

a. 1%
b. 1.5%
c. 30%
d. 97.5%

8. What does treatment variation mean?

a. That there are many different ways to perform the same medical treatment
b. That some patients respond to the same medical treatment very differently
c. That the same patient might receive different treatments for the same medical problem in different parts of the country
d. That different medical treatments cost very different amounts of money

Review Questions

Correct answers in bold

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Case study: A Discussion with a Benefits Administrator

A Benefits Administrator for a large company puts the company's benefits out to bid. Two brokers respond. Both offer similar plans at similar prices. Both are experienced. Both are professional. Both offer all the standard services – 401(k) administration, FSA administration, wellness programs, etc.

The Benefits Administrator tries to find some reason to choose one broker over the other. Since they appear to be mirror images of each other, he has little to choose. So he asks both brokers 'why should I choose you?'

Broker A talks about experience: 20 years in the business, a good customer service reputation, intimate knowledge of carriers and plenty of references. Broker A talks about his commitment to clients and interest in helping clients. He even offers to meet with the Benefits Administrator quarterly to provide policy and regulatory updates.

Certainly, thinks the Benefits Administrator, Broker A is fine. There's nothing wrong with him.

Then Broker B comes along. This broker also has years of experience, a good customer service reputation, good relations with the various local insurance carriers and plenty of references. This broker also offers to meet quarterly to discuss policy and regulatory updates. (Both brokers, it seems, value face time with the Benefits Administrator.)

But in addition to all these services, Broker B makes a surprising statement:

> *My company has a clear business standard that defines our relationship with clients. The ethical standard that we embrace is called 'Do Your Fellow A Favor'. I've studied business ethics and decided that I want my company and my employees to live up to this standard.*
>
> *Many of my competitors use a different ethical standard. They 'let the buyer beware.'*

Intrigued, the Benefits Administrator asks Broker B to continue.

> *I won't save you any premium money in the short term as compared to Broker A. He's a fine broker who is perfectly capable of running rates and showing alternative policies.*
>
> *I won't show you any plans that he doesn't. And I offer all the same services as he does.*

But in addition to offering everything that he offers, under my 'do your fellow a favor' standard, I'll also educate your employees about how to use our healthcare system.

I'll tell them things about the healthcare system that they probably won't learn from their doctors but that may help them interact with their doctors. I'll help them become wiser consumers of medical care.

The Benefits Administrator was starting to yawn as Broker B continued:

Better educated consumers, who shop more wisely, use medical resources more efficiently. In the long run, this may save you money….maybe quite a bit.

The Benefits Administrator suddenly perked up:

You'll save us money? Explain. Give me an example.

Broker B then summarizes:

We know, for example, that the rate of Caesarian births varies among hospitals in this state almost 3 to 1. The infant mortality rates and maternal mortality rates, though, are about the same among all in-state hospitals. [28]

Researchers have not identified any significant health differences among women delivering at the various hospitals. Instead, they found that the main causes for this Caesarian birth rate variation are hospital staffing and organizational differences, not patient epidemiological differences.

This means that the same woman will more likely have a Caesarian at some hospitals than at others. Her choice of hospital may have an impact on her likelihood of having a Caesarian delivery.

'I didn't know that' exclaims the Benefits Administrator. Broker B continues:

I have no opinion about whether Caesarian births are better or worse than natural births. But some of your employees might. They may find this information useful when planning their delivery.

At the very least, it may give them something to talk with their obstetrician about.

[28] This discussion uses real data from Massachusetts hospitals. See Boston Globe, Why Caesarian Birth Rates Differ at Area Hospitals, 6/7/2010, Cooney

‘So,’ suggests the Benefits Administrator, ‘having this information available may reduce my employee’s rate of unintended Caesarian deliveries. That could affect our Experience Modifier and save us some premium money in the future. Interesting.’

Broker B continues:

> *Here’s another example of what we discuss with employees. It’s an analysis of the rate of angioplasty procedures performed in Smithville and Jonesville, the two largest cities near here.*[29]
>
> *People in Smithville have about 3x the rate of angioplasties as people in Jonesville, and about 4x the national average. Researchers have not discovered any major epidemiological differences among people in the two towns.*

The Benefits Administrator: ‘Why are there such stark differences?’

Broker B:

> *I don’t know for sure, but it seems that the physicians in Smithville favor angioplasties in cases where the physicians in Jonesville would not. The researchers seem to suggest that the Smithville physicians use angioplasty more aggressively than the Jonesville physicians.*

Benefits Administrator: Why is that?

Broker B:

> *Again I don’t know for sure, but it seems that studies of the usefulness of angioplasty present a confusing picture. Some studies show that angioplasty is a useful and necessary procedure that helps a great number of people. Other studies indicate that it is useful in only a much smaller number of circumstances.*
>
> *Some physician groups embrace this treatment protocol and use it widely; others seem to shy away from it.*

‘Interesting,’ comments the Benefits Administrator. ‘That seems to suggest that our employees living in Smithville will have higher rates of this procedure than our employees living in Jonesville. Let me check my claims data and get back to you.’

The Administrator, who has a remarkably good computer system, immediately compares claims data and, sure enough, notes this discrepancy. ‘I wonder how many

[29] I have changed the town names, but use actual data as presented in the New York Times, Heart Procedures is Off the Charts, 8/18/2006

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

Broker B continues:

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

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

Broker B responds:

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

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

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

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

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

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

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

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

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

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

The consumer – your client:

> Does not know what he or she truly needs; it is the physician who knows the nature of the patient's illness and can select the right treatment…[as a result] patients delegate decision making to the seller of the services. [30]

Arnold Relman, Professor Emeritus of the Harvard School of Public Health, echoes Wennberg on the asymmetry of medical information between patient and physician: [31]

> *Patients usually know much less about the diagnosis and treatment of their disease or injury than their doctors do. Furthermore, because of illness or injury they may be in no condition to evaluate their options.*

[30] Wennberg, Tracking Medicine, page 23

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

As a consequence they cannot independently decide what medical services they want in the same way consumers choose services in the usual market…

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

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

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

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

Various factors may affect advice, consciously or subconsciously

Dartmouth's Wennberg provides a cautionary note.

Physician decisions…are strongly influenced by the capacity of the local medical market - the per capita number of…medical specialists, and hospital or ICU beds, for example. [32]

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

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

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

The really fascinating thing to me is to think that what predicts your risk of surgery today in a particular region is what it was ten years ago in the same region. [33]

[32] Ibid. page 11

[33] Brownlee, op cit, page 41

As a result, a Medicare beneficiary moving from Tampa Florida to Fort Myers Florida – about 2 hours away - increases his/her chance of receiving back surgery by 60%. [34]

Or residents of Elyria, Ohio are about 3 times more likely to have an angioplasty procedure than are residents of Cleveland, about 20 miles away. [35]

An Embarrassing Live Example

Wennberg and his colleagues at Dartmouth Medical School tested this Treatment Variation idea on physicians practicing in Boston and New Haven. [36]

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

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

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

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

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

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

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[34] Ibid.

[35] Heart Procedure is Off the Charts, NY Times, 8/18/2006

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

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

Wennberg's initial publication of this phenomenon was entitled 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?' [37]

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

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

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

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

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

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

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

The lesson here, according to Brownlee:

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

[37] Lancet, 1987

Not based on any external supply factors.

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

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

How Much Consumer Education?

The average doctor's visit only lasts about 8 minutes. [38] During this time, the physician needs to diagnose the patient's problems, describe the treatment options and help the patient make a decision – that's plenty to do in 8 minutes.

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

Our physician, thus, is unlikely to 'do your clients a favor' during the short office visit…even if the physician understands the treatment variation issues.

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But even worse, from a patient education point of view, our medical system does not pay anyone to disagree with the physician

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

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

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

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

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

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

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

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

Review Questions

Correct answers on next page

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

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

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

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

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

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

a. Cost of living

b. Availability of good schools for their children

c. Underlying disease risks

d. Weather

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

a. The overall quality is quite good

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

c. The overall quality is poor

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

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Correct answers in bold

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How Should an Ethical Broker Proceed?

In this concluding chapter we'd like to offer some general advice for how best to ***do your fellow a favor***: [39]

1. Educate yourself about our healthcare system.

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

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

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

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

2. Help your clients ask questions.

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

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

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

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

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

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

Another very useful website is www.TheMedicalGuide.net that teaches consumers how to avoid unnecessary medical care.

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

Conclusion

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

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

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

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

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

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

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

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

Good ethics is good customer service.

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

Case study: some health insurance trends since 2000. Did the health insurance industry evolve ethically?

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

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

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

Our starting point: the 2004 NCQA report

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

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

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

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

Consumer Driven Healthcare

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

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

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

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

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

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

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

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

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

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

Consumer Driven Healthcare Defined by Deductibles (largely)

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

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

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

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

Some Examples

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

I'll show you some simple examples. To avoid any confidentiality or related issues, I'll use a public pricing site, the New Hampshire state site, nhhealthcost.org. I chose it because it was easy to use. It may or may not be representative of medical prices nationally, but it serves to show how different providers charge vastly different amounts for the same medical services.[40] The first chart shows sample total costs (deductible +

[40] I downloaded all this information on December 6, 2012, posing as an Anthem subscriber with HMO coverage. Anthem was one of the carrier options and HMO one of the plan options. I chose both at random.

insurance payment) for arthroscopic knee surgery. Note the huge price difference among providers: [41]

Facility	**Total Cost**
Concord Ambulatory Surgery Center	$3,431
Franklin Regional Hospital	$5,118
Cheshire Medical Center	$6,644
Parkland Medical Center	$7,717
Weeks Medical Center	$9,873

We have no quality information – infection rates, speed of return to normal health, patient satisfaction, 30 day readmission rates, etc. Nor do we know for which patients this is necessary surgery and for which unnecessary. But we know that prices for this procedure range from $3431 to $9873. Radiology prices also vary hugely. Here are sample prices for a pelvis MRI, same subscriber, downloaded the same day:

Facility	**Total Cost**
Derry Imaging Center	$1,486
St Joseph Hospital	$2,574
Exeter Hospital	$2,758
Speare Memorial Hospital	$3,381
Monadnock Community Hospital	$3,868

41 http://www.nhhealthcost.org/insuredWizardUserInput.aspx?procedure=2&procedureName=Arthroscopic+Knee+Surgery+(outpatient)

Again, no quality information – rates of false positives, misdiagnoses, overdiagnoses etc. No information on number of call backs, unnecessary further investigations, etc. And no indication of the number of *unnecessary* pelvic MRIs performed. But an impressive price discrepancy. Some patients – presumably – will choose the lower cost provider to save money. Others may choose the *higher* priced treatments, assuming that the most expensive is the best. Still others may choose the one closest to home, regardless the price, especially if they have already satisfied their deductible. And others may follow their doctor's advice, regardless of price. I'm not sure what all this has to do with medical care quality – the 'up to about a third generating no detectable benefit' – as we have no reliable, similarly detailed outcome metrics to combine with these prices. I'm also not sure exactly how consumers will change their behavior when faced with this pricing information. But some industry folks are developing ways to address that behavioral issue.

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

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

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

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

Here's the example: An independent auto mechanic advertises oil changes for $19.95. Meanwhile the large dealer up the road charges $34.95. Is the independent better or worse at oil changes? We don't know. But by charging $19.95 he's probably trying to attract new customers who will like his work and use his services for brake jobs, tune-ups and other higher priced, more profitable work. In other words, the $19.95 oil change

is part of his marketing strategy to get people in the door with the low priced item and then upsell them: 'You know, your brake pads are pretty thin. I could replace them while I do your oil change.'

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

Two points here: **First:** there are lots of auto repair competitors, so consumers can quite easily research their options. You can't make too much of an auto repair mistake as you're normally only spending a few hundred dollars at most. A bad decision probably just means you overspend by a bit. Pretty small risk to the consumer. *Not so true of complex medical issues where poor quality care can literally kill you.*

Second, auto repairers are notorious for upselling unnecessary services, at least in the common public perception, so consumers are 'defensive shoppers,' constantly on their guard to avoid getting ripped off. George Castanza articulated this in a 1995 Seinfeld episode, describing his dealings with an auto repair facility: [42] *Well of course they're trying to screw you! What do you think? That's what they do. They can make up anything; nobody knows! "Why, well you need a new Johnson rod in here." Oh, a Johnson rod. Yeah, well better put one of those on!*

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

Item: Emergency room physicians at Carlisle Regional Medical Center in Pennsylvania had targets for how many patients to admit. According to the New York Times investigation, published in November, 2012: [43] *doctors said that hospital administrators created targets for how many patients they should admit. More admissions translated into more dollars for the hospital…one of the physicians recalled getting phone calls in the middle of the night questioning why he had not admitted an older patient whose hospitalization he could easily have justified. "The pressure to admit was so high," he said.*

Item: 60 Minutes reported on December 2, 2012 that Health Management Associates, the 4th largest for-profit hospital chain in the country *relentlessly pressured its doctors to admit more and more patients -- regardless of medical need -- in order to increase*

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

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

revenues. [44] The Emergency Room admission benchmark was 15% in some places, 20% in others and 50% for Medicare enrollees, with hospital administrators emailing ER docs messages like: *Only 14 admits so far!!! Act accordingly… I will be blunt…I have been told to replace you if your [admission] numbers do not improve.* Sounds like upselling to me. ER is a low margin business, like oil changes. Inpatient admissions - far more profitable. Like Johnson rods.

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

Item: On September 12, 2012, Westerly Hospital in Westerly, Rhode Island offered free PSA screening from 5 – 6 PM. [45] 'Free' is the ultimate low cost. Now…why would a hospital give its services away for free? And why PSA screening in September 2012, *four months after the US Preventive Services Task Force recommended <u>against</u> PSA screening for prostate cancer?*

Dr. Otis Brawley, Chief Scientific and Medical Officer at the American Cancer Society suggested an answer in an interview: [46] We at Emory have figured out that if we screen 1,000 men at the North Lake Mall this coming Saturday, we could bill Medicare and insurance companies for $4.9 million in health care costs [for biopsies, tests, prostatectomies, etc]. But the real money comes later--from the medical care the wife will get in the next three years because Emory cares about her man, and from the money we get when he comes to Emory's emergency room when he gets chest pain because we screened him three years ago. Questioner: You're saying that screening creates long-term customers. So, did Emory Healthcare decide to go ahead with the free PSA screening on Saturday?

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

Seems that Westerly Hospital made a different decision.

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[44] 60 Minutes, Hospitals: The Cost of Admission, December 2, 2012

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

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

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

I just don't see how all this pricing information cuts down on our rate of unnecessary care or switches people from low to high quality treatments. I *do* see how this can cut some hospital and treatment costs, but I hesitate to guess whether this means better care or worse. Will hospitals routinely admit more patients in the 'gray area' between definitely needing admission and definitely not to maintain their income…like our ER examples above? Will others do *more* investigations to find *more* microscopic abnormalities that require *more* low quality care, perhaps like Westerly Hospital? Will our overall medical inflation rate actually *rise*? Shopping for medical care based on price requires people to understand what those prices actually mean. I'm not sure many do. I worry about the tyranny of the unintended consequence.

Are current metrics ethical or not?

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

Facility	Total Cost
St Joseph Hospital	$273
Woman's Life Imaging	$291
Elliott Hospital	$313
Cottage Hospital	$371
Memorial Hospital	$555
Androscoggin Hospital	$673

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

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

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

> Average age of breast cancer diagnosis mid-1990s: about 62; [47]
> Average age of breast cancer diagnosis 2006: about 61. [48]
>
> Unfortunately, the average age of breast cancer death was the same in 1996 and 2006: 68. [49]

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

Diagnosing more women with small, young, hard to detect cancers will increase your 5 year survival rate - by definition - regardless of your medical care quality. You can, thus, improve your 5 year survival rates (or 10 or 20 year rates) by diagnosing cancer earlier but without treating it better or without extending the woman's life at all. Women may still die at the same age, but just live longer with the (earlier) cancer diagnosis. This is apparently the case in the US, or diagnosing cancer no earlier, but providing better cancer treatment and extending the woman's life through better care, or both. Knowing

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

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

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

only the 5 year survival rate doesn't tell us which of these 3 situations occurred. That's why 5 year (or 10 year, or any number of year) survival rates may not tell us *anything at all* about the hospital's cancer treatment quality. But a hospital that advertises these to an unsophisticated public may make lots of money! *Caveat emptor.* [50]

More insidiously, using 5 year survival rates may put marketing pressure on hospitals and carriers to widen our definition of 'cancer' beyond utility and label more women as having cancer; it's a way to create more patients. *This actually happens!* Today, for example, about 25% of breast cancer diagnoses are for DCIS – ductal carcinoma in situ – an abnormal collection of cells in the milk duct. [51] It's a low grade tumor, something between normal breast tissue and breast cancer, not really what we think of as life threatening breast cancer. Some cancer specialists including Dr. Brawley of the American Cancer Society want to remove 'carcinoma' from the name – i.e. not call it cancer at all - out of concern **'**that we are scaring a whole host of people that have ductal carcinoma in situ who make rash decisions because it's called 'carcinoma'– decisions that they wouldn't make if it was more adequately described for what it truly is.'

An expert panel of the National Institutes of Health agrees, recommending that the word 'carcinoma' be deleted from this diagnosis. [52]

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

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

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

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

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

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

Here's the correct way to calculate the average delivery costs at both hospitals (go ahead and try): Cost of vaginal delivery times the % of vaginal deliveries *plus* Cost of C-section times the % of C-sections *plus* Number of extra days in the hospital for C-sections times the cost/day *plus* the infant and maternal readmission rate for C-sections times the cost per day times the % of deliveries by C-section *plus* the infant and maternal readmission rate for vaginal deliveries times the cost per day times the % of vaginal deliveries *plus* etc.

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

This time, consider two breast cancer prevention drugs. [53] (I have no idea why I use so many breast cancer examples – perhaps because there's so much breast cancer data around and examples abound.) Drug A – $20 copayment – reduces the number of breast cancers by only about 21 per 1000 women. It seems to fall into our 'low quality' care definition….1000 women need to take it for 21 to benefit. That's only about a 2% effectiveness rate and 98% of women who take Drug A don't receive any benefit from it.

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

Here's the catch: they're the same drug**,** Tamoxifen. Taken prophylactically, it cuts women's risk of developing breast cancer by about 50%, from about 43 to 22 per thousand. Sophisticated marketers can induce different kinds of consumer behavior by presenting medical information in different ways – a 50% cancer reduction is much more powerful than a 21 case reduction per 1000 women. The wise, *sophisticated* consumer will buy the $20 copayment drug and still enjoy the 50% breast cancer risk reduction….while the *unsophisticated* one may spend an unnecessary $360 per year, presumably for many years.

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

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

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

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

The health insurance industry responded to the Institute of Medicine's *To Err is Human* report and the NCQA studies showing big treatment quality differences among hospitals and physicians by developing new sets of *process guidelines*. These are like manuals designed to improve clinical practice. The National Committee for Quality Assurance (NCQA) in particular developed the HEDIS guidelines – the Healthcare Effectiveness Data and Information Set - basically instructions for how to provide high quality medical care to various types of patients. Today, according to the NCQA website, the HEDIS tools are used by more than 90 percent of America's health plans to measure performance of their contracted hospitals and physicians. Because so many plans collect HEDIS data, and because the measures are so specifically defined, the NCQA claims that HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. [54]

The NCQA, for example, publishes lists of carrier rankings based on their contracted hospital and physician HEDIS scores. (I should point out that HEDIS is but one of a handful of measures. Another commonly used metric is CAHPS, the Consumer Assessment of Healthcare Providers and Systems, which also measures process compliance and has the same fundamental flaws as HEDIS, which I'll describe below.) Note that HEDIS measures *inputs*, not *outcomes*. Inputs are what the doctor does to the patient; outcomes are how the patient actually did. HEDIS assumes that similar inputs lead to similar outcomes. Here are some of the 2013 HEDIS measures.[55]

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

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

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

Others, perhaps less compelling:

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

One specific concern: breast cancer screening with mammography is controversial, to say the least. The US Preventive Services Task Force only gives this a B recommendation, not A, concluding that 'there is a moderate certainty that the net benefit is moderate' Not exactly a ringing endorsement. The USPSTF recommends *biennial*, not *annual* mammograms due to the risk of false positives and breast cancer overdiagnosis, in women 50 – 75. They make no recommendation about mammograms for women 75 and older, saying *the USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.* [56]

The Preventive Services Task Force actually *disagrees* with HEDIS about spirometry testing for COPD, recommending *against* screening adults for COPD using spirometry.

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

HEDIS says ‘do it to increase your scores’; the USPSTF advises against saying ‘the incremental benefits are judged to be no greater than small’ and ‘fair evidence indicates that spirometry can lead to substantial overdiagnosis of COPD.’ [57]

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

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

Michael Porter, Harvard Business School’s great strategy professor, explains this problem much more lucidly: [58] Much more relevant is information about providers’ actual experience levels, the treatments they use…and, most importantly, the results they achieve. Porter’s concern – and yours, if you want good medical care – is that process compliance in medicine doesn’t always translate to outcome similarities. *Process compliance* means physicians treat similar patients similarly; *Outcome metrics* tell us how well patients actually did. In medicine *similar medical processes can lead to different patient outcomes.* (Sorry if this is difficult to grasp, but it’s really important to understand.)

A classic example of the difference between process compliance and patient outcomes comes from Atul Gawande’s study of cystic fibrosis.[59] All CF treatments at all 117 specialized CF treatment centers across the country use exactly the same protocols for treating CF patients.

All CF physicians have the same specialized training. According to the theory underlying HEDIS, all CF patients should therefore enjoy about the same outcomes – lung function and longevity, for example. Unfortunately, patient outcomes vary significantly by CF treatment center, with some consistently *over*performing and others consistently *under*performing the norm.

Gawande graphed this as a classic bell curve of outcomes. Interestingly, Gawande learned that at least one facility regularly outperformed the norm, year after year. HEDIS type process metrics assume that this doesn’t happen. How can 117 facilities following

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

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

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

exactly the same treatment protocols generate a bell curve of patient outcomes? Here's Porter again: *There are simply too many dimensions of process to track and too much heterogeneity among patients. Focusing on just a few visible process steps creates a checklist that providers can address, but oversimplifies the problem*. [60] In fact, we may use for our checklists only the *easiest to measure* processes not the *most important*. I suspect that's what HEDIS and similar checklists do.

Some other problems

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

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

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

Second, the designers of HEDIS type lists may become susceptible to industry lobbying. We have numerous examples in the medical care industry where experts who write regulations and who make recommendations are paid by pharmaceuticals or other suppliers to recommend their products. A classic example is the 2003 Adult Treatment Panel III, which lowered the definition of dangerous total cholesterol to 200. Eight of the 9 panelists had financial ties to pharmaceutical companies, most to companies that manufactured cholesterol-lowering drugs. [61] One wonders how the designers of HEDIS style lists might be equally affected.

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

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

What percent of lung function do patients at a particular cystic fibrosis facility actually have? What is the average life expectancy at each CF facility? How many heart bypass

[60] Porter, op cit, page 87

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

patients need readmission to Hospital C within 30 days of discharge, and how many to Hospital D? How many TURP or hip replacement patients? Do patients having carpal tunnel surgery from Surgeon G return to work more quickly or less than patients of Surgeon H? And, even more basically, how many heart bypass surgeries, kidney removals, rotator cuff surgeries or hip replacements does a given hospital perform each year?

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

Porter gives this depressing summary:

> In only a few isolated disease areas - notably cardiac surgery, organ transplants, cystic fibrosis and kidney dialysis - is broad-based results information available, and, most physicians lack any objective evidence of whether their results are average, above average, or below average.[62]

Fairly astonishing, don't you think? This industry sector costs about $2.7 trillion per year and represents about 16% of the American gross domestic product. But we lack data indicating which medical professionals are the best, which are average and which are the worst.

In other words, most patients have no idea how good their physicians and hospitals are. Remember that half are below average, because, by definition, 'average' means that patient outcomes from half of all surgeons and at half of all hospitals are above it and *half are below*. Here's Porter's take on this: *it is human nature for most people to believe that they are above average, which cannot be true*, [63] meaning you can't just ask your doctor if he/she is above average because there's no data to support the answer. Perhaps as a result of this mind-boggling lack of care quality information, the definition of a 'good' health plan is one that offers easy access to a wide range of physicians and the 'best' offers *really* easy access. This may be because of our poor outcome data. You want to try one doctor but, since you really don't know if he/she is any good, you want the option to change.

Interestingly, we compare country healthcare systems on cost, longevity and infant mortality, but we compare carriers on provider network size, access ease and HEDIS

[62] Porter, op cit, page 55

[63] Porter, ibid

scores. In doing so, we forget Kenneth Thorpe's comments about 'excess mortality' and Elliott Fisher's findings that easier access and more medical spending leads to slightly higher mortality rates, slightly poorer outcomes.

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

HealthGrades, for example, claims that more than 200 million consumers use it to research and select a doctor or hospital and that it's America's most comprehensive source of information on hospitals and doctors. [64] Atul Gawande once looked up his own HealthGrades report card: *They don't tell you that much. You will learn, for instance, that I am certified in my specialty, have no criminal convictions, have not been fired from any hospital, have not had my license suspended or revoked, and have not been disciplined for misconduct….it sets the bar a tad low, doesn't it?* [65]

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

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

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

- Does he generally refer to aggressive specialists who operate as soon as possible on patients, or to more conservative ones who prefer to watch and wait?
- What percent of the orthopedic patients he refers for surgery need to be readmitted within 30 days of hospital discharge?
- What percent of cardiac? Urologic? Other?
- What percent of his female patients have mastectomies?
- What's the average age of death of his patients with breast cancer? With prostate cancer?

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

[65] Better, page 207

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

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

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

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

In fact, the insurance industry doesn't even help patients determine which questions to ask. Does 'appointment scheduling efficiency' mean anything at all about patient care or outcomes? Should I spend my deductible on someone having a good HEDIS score…or someone who says the system is nonsense and, as a result, has a poor score but perhaps quite healthy patients?

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

American healthcare spending would decrease relative to healthcare spending in other countries since our outcomes are not superior to theirs. That has not happened. The trend is getting worse;

American outcomes, as measured by longevity and other factors (infant mortality for example) would improve relative to other countries since our spending exceeds theirs. That also has not happened over the past decade.

Healthcare systemic harms would decrease relative to the harm caused by a lack of access / lack of insurance, since consumers would spend their healthcare money more wisely. That also has not happened. Remember the mortality rates for uninsured Americans vs. insured folks who die from medical error that we presented at the beginning of this chapter. Our health insurance industry – part of what Harvard Medical School Professor Emeritus Arnold Relman once referred to as the medical-industrial complex – has failed to help patients differentiate high cost, low quality medical care from the opposite. Today's patient may have a vague idea of his/her medical care costs but absolutely no idea the quality.

Consumerism, Disclosure and Broker Responsibilities

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

We know, from extensive research, that health outcomes improve when patients are engaged in their own care and that people are eager to play a strong role in their own health care *when given the right tools.*[66] But post-2000, the industry failed to provide those tools.

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

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

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

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

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

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

Part II: Ethical Considerations in Product Sales

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

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

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

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

Some Business Ethical Standards

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

Ethical business considerations fall into two separate categories.[67] **First,** business ethics regulates conduct in direct contact situations, such as with employees, clients or suppliers. These commonly fall into standard categories including employee relations, honest representation and truth in advertising.

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

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

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

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

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

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

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

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

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

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

In the first commercial transaction in the Bible, Abraham laid down the 'full disclosure' commercial principle.[68] His purchase from the land seller consists of 5 different steps:

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

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

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

Note the similarity with health insurance policy sales:

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

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

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

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

Step 5: the Buyer enrolls by signing a contract.

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

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

'Let the Buyer Beware' is Unethical

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

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

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

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

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

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

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

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

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

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

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

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

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

Do Your Fellow A Favor

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

This is covered in traditional ethical concepts of 'faulty sale'. According to this doctrine, the seller is obligated to make full disclosure of any defect in the goods or services sold. One ethical commentator suggests that 'even where the seller was ignorant of the flaw, the sale may be cancelled' as the buyer cannot be forced to accept a discount as compensation for the defect. [69]

Thus, the broker who claims 'I didn't know that the policy contained that' has no ethical defense: traditional ethical standards make the seller responsible to understand fully all the implications of each health insurance policy. Over time, traditional business ethics evolved and introduced the higher standard. This became known as '***do your fellow a favor'*** standard, exactly the opposite of 'seller selfishness'. [70] 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.

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

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

How Much Should Brokers Disclose?

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

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

[70] Ibid.

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

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

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

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

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

He Who Does Not 'Do His Fellow a Favor' is Not of the Sons of Abraham [71]

Dr. Tamari puts the Biblical ethical position like this:

> Sanctity is achieved … by doing or sharing with others, irrespective of the utility or reciprocity... We force one to act contrary to the selfishness of Sodom. [72]

Translating These Ethical Standards to Policy and Product Sales

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

[72] Ibid.

The broker who simply describes the health insurance policy by defining the terms and conditions appears to act ‘selfishly’. Here’s why: The broker knows that his/her clients don’t have easy access to various critical bits of information. For example, brokers often hear clients complain that they don’t know how best to spend their discretionary medical monies.[73]

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

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

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

Review Questions

Correct answers on next page

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Review Questions

Correct answers in bold

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Case Study: Some Ethical Issues in Consumer Education

Consider these estimates of healthcare system waste:

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

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

- From the Dartmouth Atlas of Healthcare: about 1/3 of all medical spending is wasted on unnecessary care but Dartmouth researchers consider this an 'underestimate given the potential savings even in low cost regions'.[74]

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

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

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

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

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

One way to act ethically in this situation

[74] Quote from the Dartmouth Atlas website

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

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

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

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

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

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

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

Background for brokers i
Phrasing

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

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

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

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

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

Background for brokers ii
Ways to educate clients ethically

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

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

Consider this example from the medical community – how a simple, banal and obvious check list reduced central line infection rates at Johns Hopkins Hospital. [75] We'll examine the problem and checklist solution in the medical community first then apply the lessons to the health insurance community.

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

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

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

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

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

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

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

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

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

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

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

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

Pronovot watched what happened:

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

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

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

1. First, they helped with memory recall especially the mundane matters that people sometimes overlook when they're focused on more dramatic activities.

2. Second, they make explicit the minimum steps necessary for success in a complex process.

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

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

Could the same thing happen with for patients?

Ethical Applications of This Approach

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

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

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

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

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

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

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

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

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

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

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

Note about the phrasing of these and the other questions in our checklist. The wording matters, just as the process that Peter Pronovost introduced at Johns Hopkins Hospital mattered.

- Pronovost didn't say 'use sterile equipment'. He said 'wear sterile mask, hat, gown and gloves.' That's potentially quite different.
- Patients should ask the questions exactly as phrased here. Other formats and wording, like 'is this a good treatment?' or 'would you have this treatment yourself?' can generate quite different answers and lead in quite different directions.

Question 3: Would most doctors make the same treatment recommendation or might some doctors recommend something different?

This is the second opinion question and again, wording matters. We want to help patients develop good working relationships with their doctors, not destroy them; we strongly and actively support strengthening the doctor-patient relationship.

This question doesn't question your doctor's competence but it recognizes that different doctors can approach the same medical problem quite differently.

It also recognizes that physicians within the same practice, hospital or region tend to treat similar patients similarly.

Asking 'can I have a second opinion?' can easily generate a referral to the specialist down the hall, who agrees with your doctor's first opinion all the time. But asking for an opinion from a doctor who is likely to disagree with your initial opinion can expose you to a much richer range of options and may have a huge impact on your ultimate medical decision.

Studies show that second opinions can alter the patient's treatment decision up to about 1/3 of the time.

The ethical broker understands this and teaches patients the right / best way to ask.

Question 4: How many patients like me do you treat annually?

Extensive research shows that the best predictor of likely medical outcomes from surgery is the number of patients treated annually by the surgeon. [76] In fact, physician experience trumps every other indicator of likely patient outcomes including

- Technology
- Medical school affiliation and
- Hospital reputation

Research shows the same relationship for hospitals: the more knee replacements performed annually in a specific hospital, the better the outcomes for knee replacement patients at that hospital.

Experience is not, however, a perfect predictor. Sometimes a high volume surgeon may still get a poor patient outcome and sometimes a low volume surgeon may generate an excellent outcome for a specific patient. But on average, most of the time and in general, the higher the volume of patients like you that a hospital or surgeon treats annually, the better the outcomes for those patients.

One caveat to note: researchers have identified some threshold numbers for surgical procedures. These act as indicators of likely quality. The Leapfroggroup, for example, suggests that hospitals achieve optimal results at 500 coronary artery bypass graft procedures annually.

- Hospitals performing fewer than 500 CABG annually generate poorer patient outcomes
- Hospitals performing 700 or 1000 annually do not generate results better than hospitals performing 500
- 500 is the threshold for optimal outcomes from this procedure.

Leapfrog publishes hospital thresholds for other procedures, including abdominal aortic aneurysm repair (30 annually) and carotid endarterectomies (100 annually) among others.[77]

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[76] See for example, Paul Ruggieri's book **The Cost of Cutting** which summarizes many studies and John Birkmeyer, former director of clinical services at Dartmouth Hitchcock Medical Center, **High Volume Surgeon, Better Chance of Patient Survival** and **Surgeon Volume and Operative Mortality in the United States.** Many similar studies exist.

[77] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360105/

Question 5: How much does it cost?

This is the standard price question that a wise consumer would ask about any product or service. Price is especially important for people with high deductible plans and certain kinds of other policies, including reference based plans and some types of self insured policies.

But be sure to ask the pricing question only after you have asked the first 4 questions. Otherwise you risk getting ineffective or poor quality inexpensive care, while more effective and higher quality care might cost just a little more.

Summary of this ethical application

Ethical brokers would introduce a simple checklist like this to their clients. It complies with the various ethical standards we discussed earlier in this text:

- It does not ‘let the buyer beware’ of potential harms of receiving unnecessary, wasteful or poor quality care
- It ‘does your fellow a favor’ by identifying problems that your clients may face and providing assistance to your clients in dealing with those problems
- It addresses the ‘faulty sale’ issue by identifying a potential product defect in a typical health insurance policy – i.e. coverage for interventions that don’t work – by providing tools to customers who face this issue.

Unethical brokers would fail to introduce such a checklist. They would ‘let the buyer beware’ and suffer harms – both financial and potentially medical – from a product defect.

Review Questions

Correct answers on next page

1. About how much waste / unnecessary medical care is there in the US today?

    a. Up to about 1/3 of all spending is wasted on unnecessary medical care
    b. Most researchers estimate that less than 1% of all medical spending is wasted
    c. Cutting edge research suggests that about 150% of all spending is wasted
    d. Between about $100,000 and $150,000 annually

2. Why would an ethical broker introduce checklists of key questions for patients to ask their doctors?

    a. To help clients remember the most important questions to ask their doctors. This is particularly critical in medical care situations because patients can become emotionally upset during physician meetings and forget to ask one or more key questions
    b. To compete with doctors for patient / client respect
    c. To undermine client trust of their doctor. This follows the currently out-of-favor ethical guideline that ‘blind trust is only for the blind’ both physically and intellectually
    d. To promote alternative medical interventions which generally cost much less. Brokers know that the lower the per client expenditure, the higher the annual bonus from each insurance carrier.

3. The average health insurance policy (average of individual, couple and family plans) costs about $10,000 per year. About how much of that is wasted on unnecessary medical care?

    a. About $11,000
    b. About $10,000
    c. Less than about $96
    d. Up to about $3300

4. What is one reason brokers might not want to introduce checklists of key questions to ask your doctor?

    a. It’s too much work and brokers are inherently lazy
    b. The questions are so simple and obvious that it’s almost insulting to the clients
    c. Insurance carriers might become upset
    d. The medical community might become upset

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Case study: Selling ancillary products ethically

Today's benefits brokers sell many products besides simply health insurance. They typically sell dental insurance, disability insurance, long term care insurance and other types of insurance to satisfy their clients' needs.

They also often sell non-insurance products ranging from payroll services to discounted gym memberships to onsite nutritional programs to wellness programs.

This case study discusses some ethical issues arising from sale of these ancillary products and specifically to wellness programs.

Wellness programs aim to reduce medical spending by helping employees become healthier. These programs typically start from the premise that 70% or so of medical spending is driven by 5 factors: [78]

- Poor diet
- Inactivity
- Tobacco use
- Stress and
- Alcohol and drug use

Wellness programs generally seem to start with a Health Risk Appraisal (HRA), a set of questions designed to determine how healthy an employee actually is. Based on the information in the HRA, wellness vendors then supply various services targeted at appropriate employees. These include nutrition coaching, exercise coaching, stress counseling, substance counseling and tobacco cessation programs and maybe a few others. The goal, of course, is to get employees healthy, as defined by the needs identified in the HRA.

Wellness programs define health by numbers: your BMI, cholesterol levels, blood pressure levels etc. Program goals generally focus on getting your own number to match some ideal number, a BMI between 20 and 25 for example, or your blood pressure below 140/90. The assumption is that people with appropriate numbers cost

[78] This information comes from Total Care Wellness by the ESI Group. http://www.totalcarewellness.com/tcw-general-wellness-ad?leadsource=Web%20Paid&gclid=CJf5s_Cd6scCFcQUHwodwxQOCg I found them by googling 'corporate wellness programs'. They seem like a typical wellness vendor so I'll use their definitions and orientation as typical of wellness programs. I have no other relationship with them.

less medically than people with abnormal numbers so the closer the Wellness Program can get employees numbers to the norm, the more money they'll save.

'We have the program and tools to bring people's numbers into the normal / healthy range' seems the typical wellness sales presentation, which will benefit the corporate client by reducing medical costs and improving employee productivity. All of which is great if it actually works…

Sales Ethics
Case study

Let's now consider Bob, a broker who sells The World's Greatest Corporate Wellness Program (TWGCWP) to several of his clients. Bob researched corporate wellness programs and selected TWGCWP as the best; he doesn't sell products that he doesn't believe in. (That's one of his own ethical standards.) Bob's an outstanding salesman partly because of his personality and partly because of his belief that TWGCWP is the best on the market and will benefit his clients. He's passionate about wellness and passionate about TWGCWP's program.

Bob earn commissions from TWGCWP for each sale, which generates a sizeable percentage of this annual income. Many of Bob's customers seem happy and some even invite him to participate in the wellness programs along with their employees for free.

Bob is middle aged, getting paunchy around his belly and exercising less than he did earlier in life. He decides to do something about this and hires a personal trainer / nutritionist. He and his trainer work out 3x each week together. The trainer prescribes a strict nutritional program for Bob. Over the first year, Bob loses 25 pounds, increases his lean muscle mass, stops taking various medications and feels better than he has in years.

Bob opted not to participate in the program offered at any of his clients. Instead he pays his trainer $65/hour for 5 hours/ week, totaling about $15,000 per year.

Is Bob acting ethically here? He sells a program to his clients as 'the best available', collects commissions from TWGCWP but doesn't participate. He chooses a different program for himself.

Bob appears to violate the first rule of ethics 'do unto others as you would have them do unto you' and 'love your neighbor as yourself'. He sells a product to his clients ('it's good enough for them') but uses a different product himself. He happily takes his client's money for a product that he would not use himself.

How Bob could act more ethically

Bob has a couple of ethically easy-to-do activities.

First, he could participate in a wellness program at one of his accounts. This ‘eat what you cook’ approach would demonstrate his belief in the product and satisfy the ‘do unto others as you would have them do unto you’ standard. It’s an easy ethical call.

People who use the products they sell always avoid the suspicion of duplicitous behavior - that they’re acting unethically by selling one product while using a different one. Using the products that you sell is always a good idea.

But this approach may make Bob feel uncomfortable, like he’s favoring one account over another. Such participation might have a negative impact on his business, especially if one of the ‘not favored’ accounts learns of this and shifts their business from Bob to a different broker.

Would Account A become upset with Bob because he participated in the wellness program offered by Account B? Probably not. But a business risk nonetheless.

Second, Bob could contract with TWGCWP directly perhaps. This way he would eat what he cooks but not have the risks of favoring one account over another. This is also an easy ethical solution.

But TWGCWP may not contract with individuals (directly with Bob, for example) or with agencies as small as his (assuming he works for a small agency). Bob may not have this option available to him.

So Bob’s ethical problem remains. He could act ethically by participating in the wellness program offered by one of his accounts and face a very slight risk of another account finding out and becoming upset. On the face of things, this would be the most ethical way to proceed.

Or he could hire his own personal trainer and appear to act unethically, not to eat what he cooks, and argue that the risk described above actually exceeds the benefits of participation in TWGCWP’s program.

Or is something else going on here?

Some additional background
‘Just the facts’ but they’re ethically unsavory

Bob may not believe the benefit claims of TWGCWP. Yes, they may offer a nice sounding nutritional program but no, that program may not actually improve people's health and reduce their medical costs.

And yes, they may offer a nice sounding exercise program or stress reduction program but no, these may not improve health or reduce costs.

Bob may hire his own personal trainer because he wants results, not sound bites or excuses from TWGCWP. He may have done his research and decided that corporate wellness programs really don't work. Yes, he can make money selling these programs to unsuspecting clients but no, he can't sell these programs and still act ethically.

He may have simply decided to forego acting ethically and make some money from commissions!

Why might corporate wellness programs not actually work? Let's look first at nutrition programs and consider the underlying economics here. We'll start with the federal government's corn subsidy.

Our domestic corn productivity grew dramatically, from about 72 bushels per acre in 1970 to 155 bushels in 2013 with the acreage up slightly over time. [79] This expansion is stimulated, many suggest, by the $5 billion in annual corn production subsidies.

Our total corn production grew from 2010 to 2014 by about 11%, to 14 billion bushels. [80]

About 55% of this corn becomes animal feed and 5% sweetener, sometimes called high fructose corn sweetener, sometimes corn sweetener, sometimes corn sugar and even sometimes just 'sugar'.

Corn, as Michael Pollan has eloquently written, is

> what feeds the steer that becomes the steak. Corn feeds the chicken and the pig, the turkey and the lamb, the catfish and the tilapia and, increasingly, even the salmon, a carnivore by nature that the fish farmers are reengineering to tolerate corn. The eggs are made of corn. The milk and cheese and yogurt, which once came from dairy cows that grazed on grass, now typically come from Holsteins that spend their working lives indoors tethered to machines, eating corn.

[79] cornandsoybeandigest.com, Sept 2013 USDA Crop Production summary

[80] Projection by Kansas State University, May 15, 2014

> To wash down your chicken nuggets with any soft drink in the supermarket is to have some corn with your corn…after water, corn syrup is the principle ingredient. Grab a beer for your beverage and you'd still be drinking corn in the form of alcohol-fermented glucose refined from corn.
>
> Corn is in the coffee whitener and Cheez Whiz, the frozen yogurt and TV dinner, the canned fruit and ketchup and candies, the soups and snacks and cake mixes, the frosting and gravy and frozen waffles, the syrups and hot sauces, the mayonnaise and mustard, the hot dogs and bologna, the margarine and shortening, the salad dressing and relishes and even the vitamins. [81]

Each American, on average, consumes over half a ton of food that uses corn as an ingredient. Here's the breakdown: [82]

- Total average annual food consumption average: 1994 lbs / person consisting of
    - 630 lbs of milk, yogurt, cheese, ice cream (corn based as cow feed)
    - 415 lbs of vegetables, mainly potatoes and corn
    - 264 lbs of meat and poultry [83] (corn based as animal feed)
    - 197 lbs of grains
    - 273 lbs of fruit, mainly water weight
    - 141 lbs of sweetener, including 42 lbs of corn syrup
    - 85 lbs of fat, butter & oil (fat & butter from corn + corn oil)

"When you look at the isotope ratios," in American's hair and skin according to Todd Dawson, a Berkeley biologist who's done this sort of research, "we North Americans look like corn chips with legs." [84]

One result of the corn subsidies / cheap and easy availability of corn for livestock feed, is that we eat about 40% more meat, on average per person per year, than western

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[81] Michael Pollan, The Omnivores Dilemma, page 18

[82] From National Public Radio's report on food consumption by correspondent Allison Aubrey, December 31, 2011

[83] Estimate from Chartbins.com

[84] Paraphrased from Pollan, Ominvores Dilemma, page 18

Europeans [85] - about ¾ pound of meat per person per day. That's about 2.5 times the government recommendation of 1/3 pound of meat *and beans*. [86]

The US government actually recommends against eating that much meat. Here are recommendations from the US Department of Agriculture's Dietary Guidelines for Americans: [87]

Food Groups to Encourage

- Fruit
- Vegetables
- Whole Grains

Food Groups Discouraged in Large Quantities

- Meat
- Sugar

Note the advice / subsidy discrepancy. We encourage but don't subsidize fruit and vegetables. We subsidize but don't encourage meat and sugar. Money in the form of subsidies, seems to speak louder than words in the form of recommendations.

What an ethical broker needs to know this before selling a nutritional program

I did some detective work in 2010 and 2012 at my local Shaw's grocery store in Easton, Massachusetts. Shaw's is a typical mid-market American supermarket with some 135 stores throughout New England. It's not upscale like Whole Foods nor a budget operation like PriceRite. Shaw's prices are roughly comparable to other large chain grocery stores I've visited in my travels.

In both 2010 and 2012, I determined prices per calorie of various foods by dividing the package cost by number of servings, then by calories per serving. For fruits and vegetables, I found average calories per piece or per pound online then determined the

[85] The raw data comes from Chartbins.com. France, Italy, Germany, Britain and Switzerland average about 187 pounds of meat per person per year. We consume about 264.

[86] See the USDA Dietary Guidelines for Americans, 2005 edition.

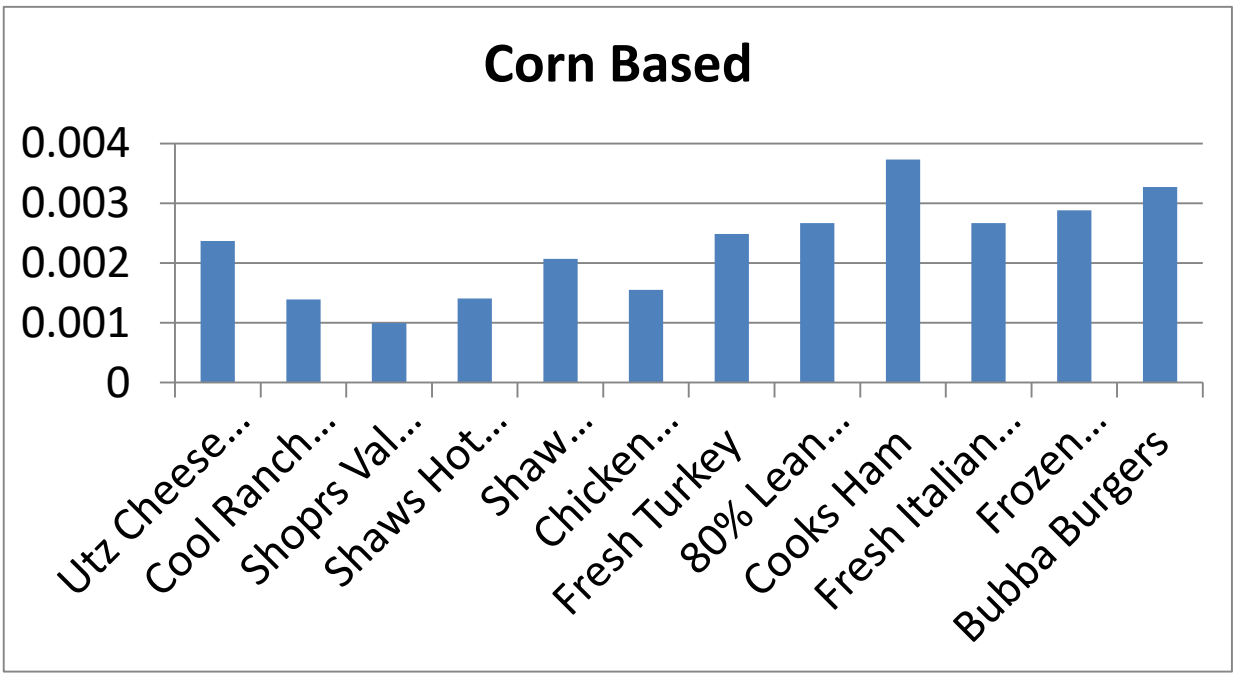
[87] I refer specifically to the 2005 recommendations because they're so clearly stated. Recommendations from other years say pretty much the same things.

price per piece or pound at Shaw's. (I'm not sure the local branch manager was pleased with my detective work but, as I recall, I forgot to ask permission.)

The graphs I plotted for food costs/calorie were very similar both years. I'll reproduce the October 21, 2012 results below.

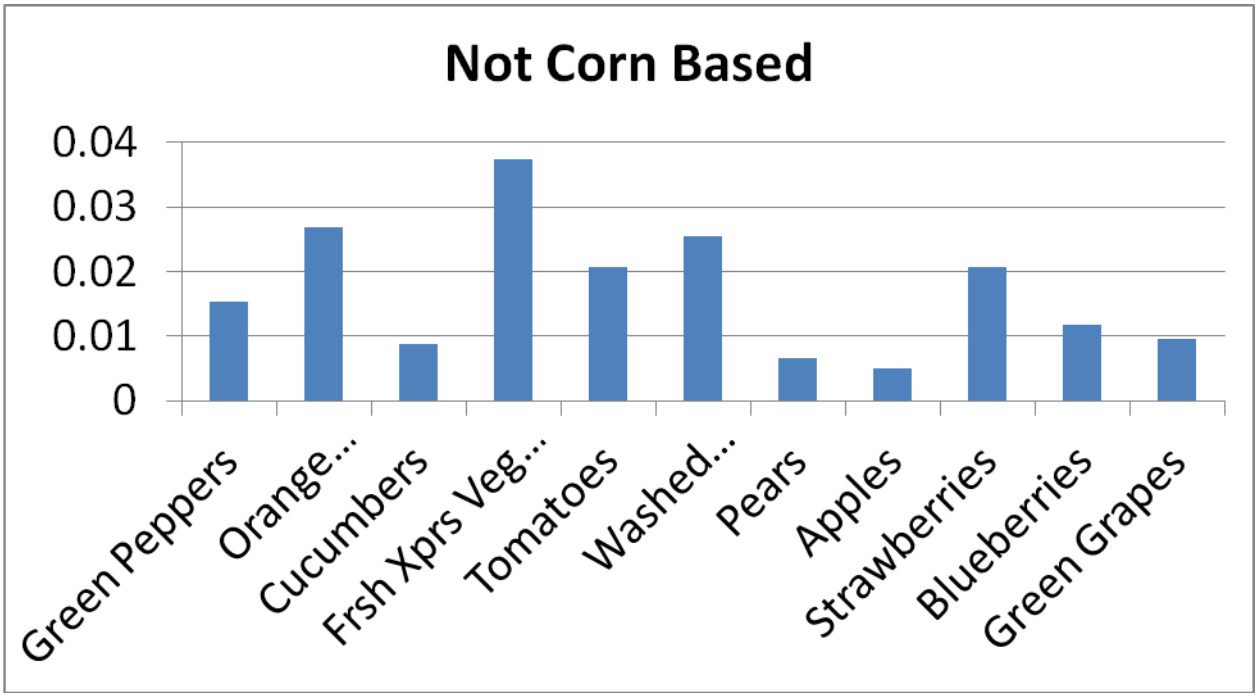
My goal in all this: determine how much it costs to purchase 2700 calories of corn-based products and compare that to 2700 calories of non-corn based. I wanted to see the impact of the corn subsidy on actual daily, monthly and annual food costs for an average American.

The first chart shows the cost/calorie of corn based foods like cheese doodles, Shoppers Value Corn Chips, Shaw's brand hot dogs and chicken legs, 80% lean ground beef, fresh Italian sausages and frozen meatballs.



As you can see, these foods cost about 2 tenths of 1 cent per calorie.

The second chart shows costs of some non-corn based foods like green and orange peppers, Fresh Express salad bags, washed green beans, tomatoes and apples – the foods encouraged by the US Department of Agriculture.



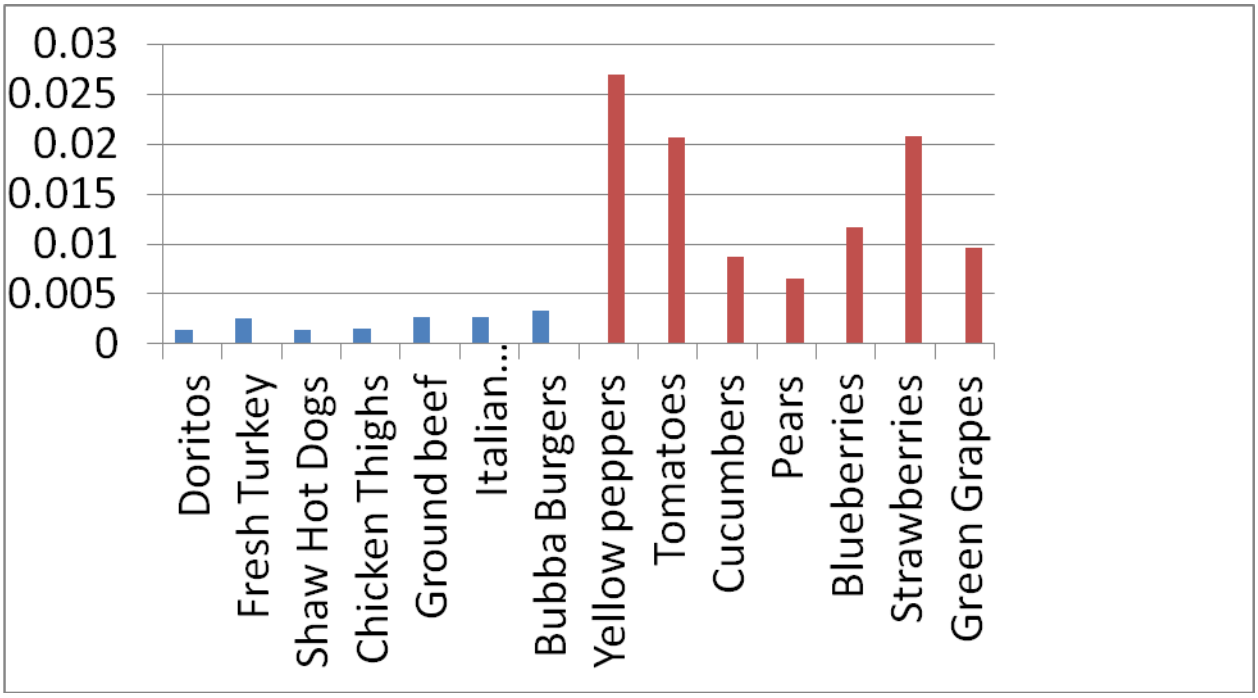
These foods average about 1 cent per calorie.

Let's assume you're a cash-strapped, low income person, trying to feed your family. You need to purchase 2700 calories of food per day to satisfy them, so when you buy the non-corn based 'healthier' foods, you choose the cheapest like apples and pears, costing about half a cent per calorie. Orange peppers, Fresh Express salad bags and strawberries become luxuries.

The difference between the *average* cost of corn-based foods and the *lowest* cost non-corn based is about 1/3 of a cent. (I'm intentionally underpricing the healthier foods to minimize the food cost differences people face; I want to understate the case here, not overstate it.)

Multiply that 1/3 of a cent times 2700 calories and you'll see that the cost of eating better runs about $9/person/day. That's not the cost of *eating*, but of eating *better*. People who eat orange peppers, bags of salad, tomatoes and strawberries see a bigger cost difference.

Here's a comparison chart showing corn based (subsidized through the corn subsidy) foods on the left in blue, and non-corn based / non-subsidized on the right in red.



At the $9 per day premium for eating better, our average American needs to spend $3000 annually to eat better.

The average household of 2.5 people spends about $7500 annually and a family of 4 about $12,000.

Remember, again, that's not the cost of *eating* but of *eating better* due to the corn subsidy, centrality of corn in our food production system and lack of subsidies for many fruits and vegetables.

Let's correlate this to saturated fat and cholesterol, both discouraged by the US Department of Agriculture's Dietary Guidelines:

- All animal based foods – low cost these days, thanks in part to the corn subsidy - contain fat and cholesterol
- Cheese consumption – high in fat and cholesterol – has tripled since the 1970s.

  Perhaps as a result, Americans combine cheese and meat far more frequently than do people in other countries. See the popularity of Philly Cheese Steak sandwiches, cheese burgers, ham and cheese sandwiches and Egg McMuffins (a delicious combination of corn based eggs, ham and cheese).

> One BBC TV show, Top Gear, aired an amusing Q & A (sorry, I don't remember which episode. I normally watch it late at night) asking How to be an American: 'wear cowboy boots and put cheese on everything'. I guess that's how we're perceived internationally. Perhaps with good reason.

- No plants contain animal fat or cholesterol. This led Deepek Chopra and 3 other academic physicians to write in the Wall Street Journal [88]

  > *The disease that accounts for more premature deaths and costs Americans more than any other illness is almost completely preventable simply by changing diet and lifestyle.*

But changing diet and lifestyle may be cost prohibitive for a large section of our population. Indeed, the Economist analyzed American food prices and concluded

> Americans, increasingly, cannot afford to eat a balanced diet [because] … Over the last four years, the price of the healthiest foods has increased at around twice the rate of energy-dense junk food. [89]

Let's switch now from discussing the 55% of corn that becomes animal feed to the 5% that becomes sweetener.

High Fructose Corn Sweetener and other corn byproducts
Only unethical brokers would ignore this information when presenting products to their clients

As our corn productivity increased in the 1980s and 90s, corn byproducts replaced sugar in breads, cereals, yogurts, soups, lunch meats and other products since corn was so cheap.

- HFCS consumption 1970s was about 26 pounds per person per year
- HFCS consumption 2000: 85 pounds per person [90]

Corn subsidies leading to less expensive corn sweeteners saved Coke and Pepsi about $100 million annually over the past 20 years according to studies from Tufts University

[88] Chopra et al, Alternative Medicine is Mainstream, Wall Street Journal, January 9, 2009

[89] *Economist* 7/9/11, If you build it, they may not come

[90] USDA agricultural fact book

researchers. [91] Soda consumption has doubled since the 1970s to about 50 gallons per person per year. [92]

Michael Pollan summarized this nicely in the New York Times: [93]

> Nearly 10% of all the calories Americans consume now come from corn sweeteners; the figure is 20% for many children [because sweeteners are in *everything*]…
>
> Sweetness became so cheap that soft drink makers, rather than lower their prices, super-sized their serving portions and marketing budgets.
>
> It's probably no coincidence that the wholesale switch to corn sweeteners in the 1980s marked the beginning of the epidemic of obesity and Type 2 diabetes in this country.

Implications for the ethical broker who considers offering wellness programs

Many corporations and agencies have introduced wellness programs, attempting to educate people to eat better with inducements for lowering their cholesterol, blood pressure, blood sugar and the like. The apparent theory: people make bad food consumption decisions because they don't know better. Wellness programs typically provide both nutritional education and a financial incentive to change behavior.

We have some academic evidence about the impact of education on food consumption. A study published in the Archives of Internal Medicine in 2010 compared soda consumption among groups that received advice about the nutritional impacts of drinking soda *without* any financial inducement to change behavior, to a group that received similar advice *with* a financial incentive to change. The result:

- Those receiving advice *without* an economic incentive had no decrease in soda consumption
- Those receiving advice *with* an economic incentive did have a soda consumption decrease. [94]

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[91] Harvie and Wise, Sweetening the Pot: Implicit subsidies to corn sweeteners and the US obesity epidemic, http://www.ase.tufts.edu/gdae/Pubs/rp/PB09-01SweeteningPotFeb09.pdf

[92] Duffrey, Food Price and Diet, Archives of Internal Medicine, March 2010

[93] Pollan, When a crop becomes king, NY Times, July 19, 2002

We can estimate the required incentive size by comparing costs for unhealthy / high calorie / high fat / high cholesterol food to costs of healthier choices. As we've already seen, the difference is about $3000 per person per year. I suggest that wellness programs need to incent people at least this much to generate the desired behavioral change….but probably more.

- Healthier foods aren't as convenient as KFC or a Big Mac. Consider convenience – ease of access and preparation - when you calculate the appropriate wellness incentive. (I, for example, hate cutting fruits and vegetables. I sometimes go without simply because I find cutting so unpleasant.)

- Healthier foods don't taste as good, especially to someone habituated to high sugar, high salt, high fat foods. You'll probably need an additional incentive to get people to change their taste preferences.

  New York Times reporter Michael Moss explored this idea in some detail in his 2014 book 'Salt, Sugar, Fat'. He writes that the giant food companies aim for the taste 'bliss point' – a combination of sugar, salt and fat – that satisfies people's taste buds and gets them to want more, to keep eating as in the famous potato chip ad 'Bet you can't eat one'. The critical factor, Moss explains, is that you generally need *all three* tastes – salt, sugar and fat - to reach bliss: having only 1 of the 3 doesn't work.

  Foods outside that bliss point - fruits and vegetables for example – are less tasty and satisfying for most people. Moss presents tons of research to back his analysis, including detailed discussions with food scientists working for the largest food production companies.

  That's why I suggest you need additional financial incentives to get people to eat foods outside the bliss point.

My guess, somewhat educated but really only a guess: corporations would need to budget around $4000 per person per year (i.e. $16,000 for a family of 4) to effectuate real dietary change. Compare this to a 2013 wellness average of about $450 per employee, not per member of the employee's family. [95] Way short.

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[94] Duffrey, op cit

[95] Ladika, Well, Well: Employers Tie Health Care Financial Incentives to Specific Outcomes, Workforce Magazine, September 29, 2012

That's the wellness bind. The amount *necessary* to generate behavioral change far exceeds the amount *available* for the task.

These are, of course, averages. High income employees would probably need less of a financial incentive; low income folks probably more. (I'll address the issue of income disparity and effects on disease rates later in this chapter.)

We're starting in a $3000+ hole per person. Those private sector wellness programs may not offer much help despite their noble attempts to create systemic value.

Let's continue but change gears. Diet is only part of the 'diet and exercise' behavior change program. Let's discuss the exercise bit next.

Exercise
The rest of what an ethical wellness salesperson needs to understand

Americans don't exercise enough. We know that from many studies, including compliance with the 2008 Physical Activity Guidelines quoted at the beginning of this chapter.

Why don't Americans exercise enough? We all know that exercise is good for us. We all want to exercise more. I've never heard anyone say they want to exercise less (well, maybe a few landscapers). But too few of us do.

I'd like to focus on 3 reasons we exercise too little: the home interest deduction, our relatively low federal gas taxes and single acre zoning, and suggest that they explain much about our lack of daily exercise. People, I would argue, respond rationally to economic incentives.

American population densities are much lower than European or Canadian. This allows Europeans and Canadians to develop more sophisticated and efficient urban public transportation systems. An exercise impact of this, according to Alain Desroches of the Public Health Agency of Canada in a personal email:

> The denser, mixed use development in Canada makes average trip distances only half as long as in America, so more walkable than the longer trips Americans make. Canada also has higher transit user rates per capita accounting for more walking between trips.

This was at least partly due to these country's reactions to oil price hikes in the 1970s. Most Western European countries dramatically shifted their urban transportation policies in the 1970s to curb car travel and promote public transportation and walking

according to John Pucher, writing in Transportation Policy magazine. [96] They walk to work, shopping and social events; we drive.

Our suburban physical environment, dominated by single family houses, exacerbates this problem. Over time, Americans have purchased bigger and bigger houses, generally on larger and larger lot sizes.

- In 1970 the average new house contained about 1400 square feet of living space
- In 2012 new houses averaged almost 2600 square feet

'The home mortgage interest deduction subsidizes Americans to buy bigger homes…**Americans, even poor Americans, have *almost twice as much living space* as the average resident of France or Germany'** claims Harvard economics professor Edward Glaser. [97] Our government tax policy incents us to place these homes on larger lots by making local property taxes deductible on our annual Federal income tax. Local property tax deductibility acts as a subsidy to buy larger lots: the bigger the lot, the higher the property tax deduction.

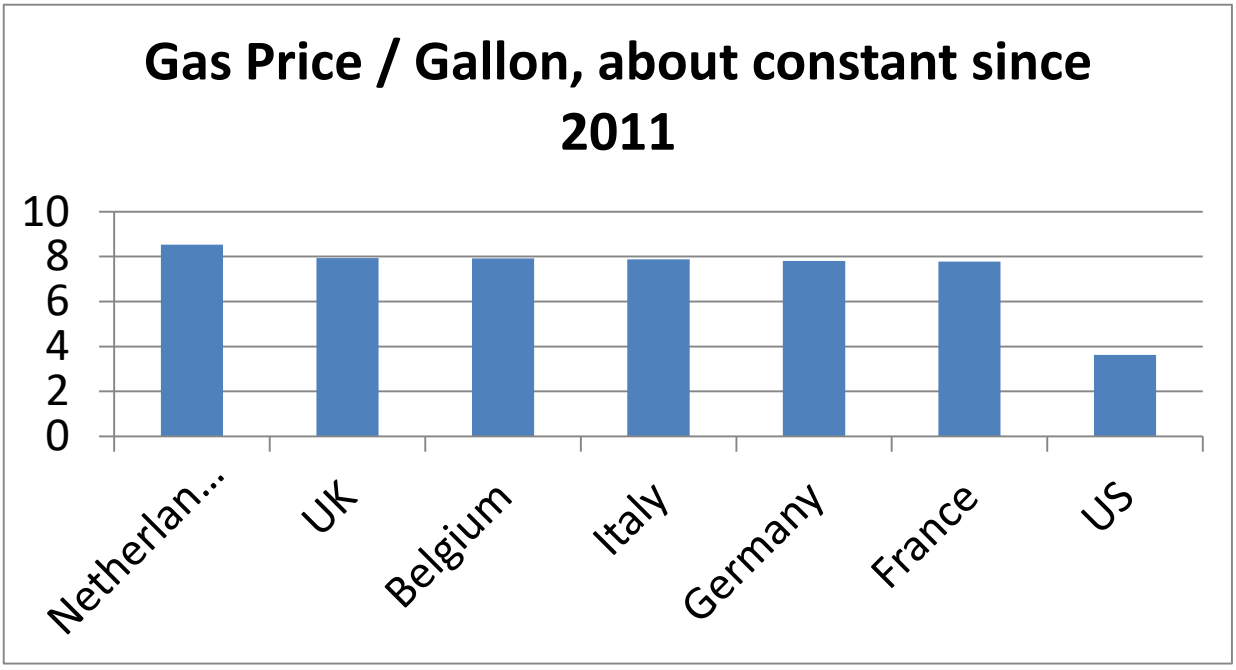
Commuting from these larger homes on larger lots requires a car. Consider the person who passes 100 dwelling units while going from home to work:

- Pass 100 homes on single acre lots = go 100 linear acres (about **4 miles** if square acres). Too far to walk. And too difficult to locate a public transportation hub nearby.
- Pass 100 homes in cluster = perhaps 5 linear acres (about **1/5 of a mile**). Easily walkable and, with high population density, much easier to locate a public transportation hub nearby.

As gas prices rose over time, our government responded by keeping gas prices low through below-world-market gas taxes. Consider this chart comparing prices per gallon of gas in various countries in February 2011:

[96] Pucher, Why Canadians cycle more than Americans, Transportation Policy, 2006 http://vtpi.org/pucher_canbike.pdf

[97] Boston, Globe 5/7/10, page A19



Americans paid about $3.75 per gallon compared to western Europeans who paid about $8. (Though prices have fluctuated since, the relative ratios remain roughly constant.)

Exercise summary

The three government subsidies – behavior incentives, if you will - significantly impact American's daily exercise:

- Home mortgages are income tax deductible, incenting people to buy bigger houses
- Property taxes are income tax deductible, incenting people to buy bigger lots
- Gas taxes are below the world market, incenting people to drive, not walk or take public transportation

Let's do a quick calculation to assess the impact:

- Assume someone walks 5 minutes from their home to and from the local public transportation stop to get to work, total 10 minutes daily, at the *home end* of each journey
- Then assume he/she also walks 5 minutes from public transportation to work each day, total 10 minutes daily at the *work end* of each journey

- The 5 day commute to and from work on public transportation accounts for 100 minutes per week of walking

- Now assume 5 more journeys per week, to shopping (because of the local availability of stores) and socializing (restaurants, cafes, bars and walks to and from public transportation) = 100 more minutes of walking per week for a grand total of 200 minutes or about 166 hours of walking exercise per year that typical suburban Americans don't get.

At 3 miles per hour – a comfortable walking pace – our typical European or Canadian walks about 500 miles more annually than a typical American, burning perhaps an extra 50,000 calories per year.

Compare this exercise pattern --- about 200 minutes of public transportation related walking per week – with the 2008 Physical Activity Guidelines for Americans. Among the statements in the Summary: [98]

> *Most health benefits occur with at least 150 minutes a week of moderate intensity physical activity, such as brisk walking.*

The physical environment in western Europe and Canada helps residents meet this standard; the physical environment in the US mitigates against it. That, in and of itself, can explain some of the obesity rate differences between us and them.

Implications for the ethical broker
hidden costs to the client / range of wellness incentives required

We've already discussed the cost difference between eating healthier and less healthy food and implications for wellness program incentives. I suggested that incentives in the $4000 range, per person per year, would probably be necessary to generate the desired food consumption behavior change, though that's a guess on my part: the actual number may be lower *or higher*.

Now let's add an exercise incentive.

Americans walk, according to the analysis above, about 166 hours/year less then Europeans and Canadians due to the differences in land use and availability of public transportation. How much do we need to incentivize people so they spend 166 hours of their leisure time walking?

Consider these factors:

[98] http://www.health.gov/paguidelines/guidelines/summary.aspx

- People generally value their leisure time at about 1/3 of their hourly income, or at least that's the rule of thumb I learned at Harvard so many years ago.
- The 2014 hourly wage, as reported by the US Bureau of Labor Statistics, was $24.63. [99] Let's estimate about 1/3 of that or $10/hour for budgeting purposes.

The conclusion: Wellness programs would need to pay about $1600 per person per year to incent people to spend 166 hours of their leisure time in corporation-sponsored exercise endeavors. That's the amount necessary to match our western European and Canadian counterparts.

Of course, some exercise programs burn calories more quickly than walking so an appropriately incented program would offer a range of options, time commitments and payments.

Our wellness program, therefore, would need to budget more than $5000/person/year to generate the desired nutritional and exercise changes. Remember that this may be a low estimate: I only calculated the cost difference between eating poorly and well, and not exercising at all and getting 166 hours/year. I left out any behavior change premium: some people may enjoy their current lifestyles and need some additional payment to get out of that comfort zone. I have no idea how much that might be.

Targeting behavior change

Now for the wrench in the works.

All the analysis above describes 'average' people and 'average' disease rates. But studies indicate a very wide population divergence from 'average' with some groups exhibiting far higher disease rates and others lower. Targeting programs at those with highest risk is more expensive than the 'averages' above, perhaps much more so.

One outstanding group of studies called the Whitehall studies aimed to identify groups at highest risk. Unlike most medical studies, the Whitehall folks didn't focus on *what causes* disease but rather *who gets sick*. Incorporating their information into wellness programs will help managers target interventions.

Some background: 'Whitehall' in Britain is the same as 'Capitol Hill' in the US, the seat of national government power and offices of many national civil servants. The Whitehall studies have tracked disease rates among British bureaucrats since the late-1960s.

[99] http://www.bls.gov/news.release/empsit.t19.htm

Whitehall researchers choose the British civil service as their Petri dish for several reasons:

- British public administrators tended to remain on their jobs for many years, often their entire career. This gave researchers longitudinal information.
- British privacy laws, at least during the initial period of these studies, allowed researchers to identify specific individuals rather than just groups of people. This gave researchers the ability to follow up on specific disease and behavior details at an individual level.
- The British civil service was very hierarchical and status oriented, consisting of several different grades. Oxford and Cambridge graduates entered the service at the highest grades, made the most money and enjoyed the highest status; high school dropouts exactly the opposite.

  Given the status-based nature of hiring and promotions, it was highly unlikely that someone entering the civil service at grade 4 would be promoted to grade 2 or even grade 3: the grade at which you entered was generally the grade from which you retired.

  This gave researchers the ability to track disease rates by income and status.

I'll let Professor Michael Marmot, Director of the Whitehall studies, summarize what they found: [100]

- *Firstly, just looking at heart disease, it was not the case that people in high stress jobs had a higher risk of heart attack, rather it went exactly the other way: people at the bottom of the hierarchy had a higher risk of heart attacks.*
- *Secondly, it was a social gradient. The lower you were in the hierarchy, the higher the risk. So it wasn't top versus bottom, but it was graded.*
- *And, thirdly, the social gradient applied to all the major causes of death.*

Those at the bottom of the hierarchy were 3x more likely to die of heart disease than those at the top.

[100] These quotes come from an interview at UC Berkley in March 2002, http://globetrotter.berkeley.edu/people2/Marmot/marmot-con3.html

Today's corporate benefits advisors and wellness program managers – at least, those who have read this far in this chapter - could have predicted this, largely based on the food cost analysis above. People at the bottom of the hierarchy earned less money so ate a less healthy diet. They had, consequently, higher cholesterol rates, higher blood pressure, were more frequently overweight and consequently less healthy.

Unfortunately that conclusion is wrong! Here's Professor Marmot again

- *we looked at the usual risk factors that one believes that are related to lifestyle -- smoking prime among them, but plasma cholesterol, related in part to fatty diet and an overweight, sedentary lifestyle.*
- *We asked how much of the social gradient in coronary disease could be accounted for by smoking, blood pressure, cholesterol, overweight, and being sedentary.*
- *The answer was somewhere between a quarter and a third, no more.*

After controlling for risk factors like cholesterol and smoking, people in the lowest grades were twice as likely to die of coronary disease as those in the highest grades.

- *The social gradient applied to all the major causes of death -- to cardiovascular disease, to gastrointestinal disease, to renal disease, to stroke, to accidental and violent deaths, to cancers that were not related to smoking as well as cancers that were related to smoking -- all the major causes of death…*
- *2/3 at least of this gradient is unexplained*

Was Whitehall unique? Does it apply to America? Or, stated differently, is Senator Frist right (from the first page of this chapter) when he claims 'health is socio-economic status and disparity'?

The answer is yes to the second two questions above. These patterns exist not only in Britain but also here in the US. Here's the New England Journal of Medicine discussing Class: The Ignored Determinant of the Nation's Health [101]

- Differences in rates of premature death, illness and disability are closely tied to socio-economic status
- Unhealthy behavior and lifestyle *alone* do not explain the poor health of those in lower classes

[101] September 9, 2004

- There is something about lower socioeconomic status *itself* that increases the risk of premature death

Sounds like Whitehall's conclusion.

The International Journal of Cancer considered the impact of socio-economic class on breast cancer survival rates. Their rather startling conclusion [102]

- breast cancer patients of low Socio-Economic Status have a significantly increased risk of dying as a result of breast cancer compared to the risk in patients of high SES.
- Low SES patients were diagnosed at a later stage, had different tumor characteristics and more often received suboptimal treatment.

However…

- Even after adjusting for all these factors, the risk of dying of breast cancer remained 70% higher among patients of low SES than among patients of high SES.

Madeline Drexler of Harvard's School of Public Health summarized the issue here succinctly

> 'an individual's health can't be torn from context and history. We are both social and biological beings…and the social is every bit as real as the biological …' [103]

The 2015 Dietary Guidelines Advisory Committee report echoes this, saying (in typical governmental bureaucratese)

- Health and optimal nutrition and weight management cannot be achieved without a focus on the synergistic linkages and interactions between individuals and their environments [104]

That's the same conclusion Professor Stuart Wolf reached in his study of disease rates and social patterns in very poor but very egalitarian Roseto, Pennsylvania [105]

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[102] Bouchardy et al, Social class is an important and independent prognostic factor of breast cancer mortality, International Journal of Cancer, Vol 119, Issue 5, March 2006

[103] Drexler, The People's Epidemiologists, Harvard Magazine, March 2006

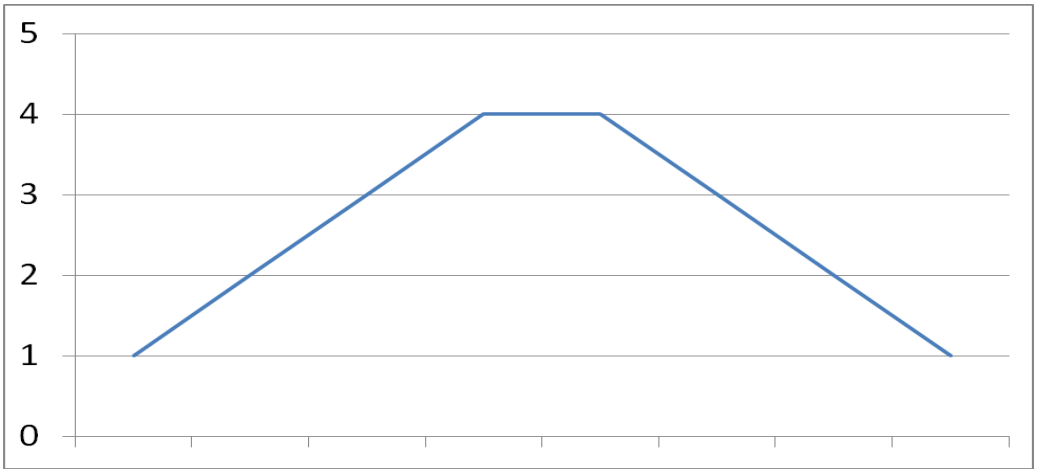
[104] 2015 Dietary Guidelines Advisory Committee report issued February 19, 2015, Part D, Chapter 4

[105] Wolf and Bruhn, The Power of the Clan: Influence of Human Relationships on Heart Disease

the characteristics of a tight-knit community are better predictors of healthy hearts than are low levels of serum cholesterol or tobacco use.

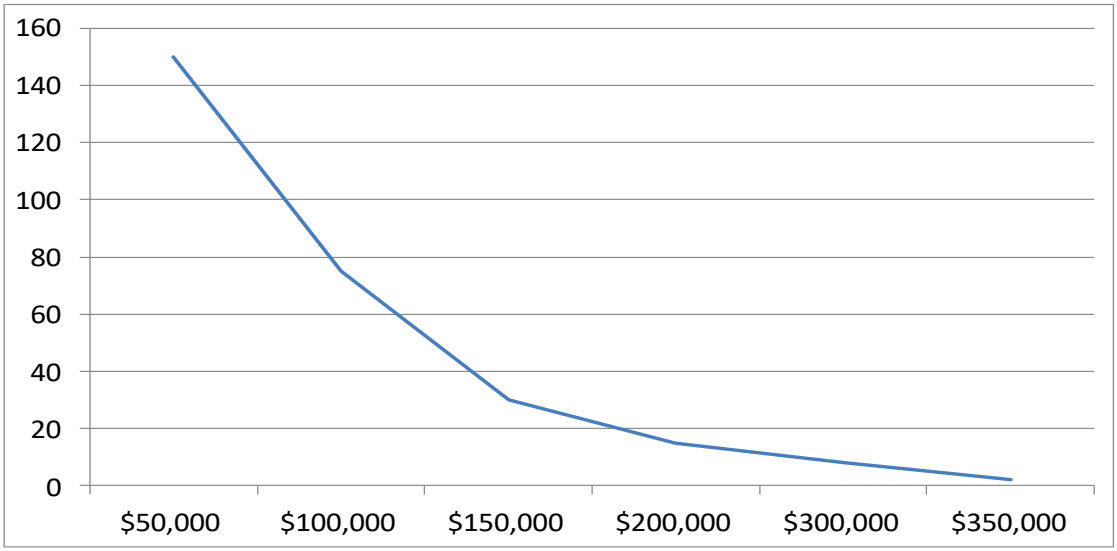
Whitehall and wellness programs

Let's apply this information to a typical corporate wellness program. Screening for cholesterol, blood pressure and other disease indicators assumes a bell curve model.



A few people at the far left have low cholesterol, blood pressure or blood sugar and are unlikely to get sick, while people at the far right have high levels and are therefore at risk. Most people fall in the middle. The appropriate wellness program focus using this model is the group at the far right.

But Whitehall, the New England Journal of Medicine, Madeline Drexler and Stuart Wolf suggest a different disease risk model:



Here, a lot of people earn $50,000 or less per year while a few earn $250,000 or more. Whitehall suggests that disease rates among the $50,000 earners will run about 3x the rate of the $250,000 folks, making the low income folks and equally appropriate wellness program target.

Let's assign some numbers to a hypothetical risk scenario. The company above has 10 employees earning $250,000 or more annually (high income, high status) and 150 employees earning $50,000 or less (low income, low status). For every heart attack in the high income, high status group, how many heart attacks can we expect among the low income people?

Take a second to think this through.

The correct answer is 45. Three times the risk and 15 times the number of people. While it's unlikely that these numbers would play out in a company as small as this, the ratios would likely hold over very large numbers of companies and employees.

Whitehall and the 2015 Dietary Guidelines Advisory Committee report

The 2015 DGAC report specifically acknowledged that low income groups face greater impediments to healthy lifestyle behavior than do others in our society, saying, for example 'household food insecurity hinders the access to healthy diets for millions of Americans'. [106] More than 49 million people in the United States, including nearly 9 million children, live in food insecure households. [107] For these people, the issue is not 'what should I eat' but rather 'will I eat anything at all'. Food access, rather than nutritional quality, becomes a primary concern. As does food price.

Related to this, the Committee found that closer proximity and greater access to convenience stores (as in lower income, inner city food deserts) is associated with significantly greater Body Mass Index scores in the community and/or increased odds of being overweight or obese. [108] Access, not quality, often rules nutrition decision making.

The Committee bluntly stated that

[106] From the Executive Summary of http://www.health.gov/dietaryguidelines/2015-scientific-report/PDFs/Scientific-Report-of-the-2015-Dietary-Guidelines-Advisory-Committee.pdf

[107] Part B of the 2015 DGAC report

[108] DGAC report, Part D, Chapter 4, Question 2

nutrition services *that take into account the social determinants of health are largely unavailable in the U.S. health system* to systematically address nutrition-related health problems, including overweight and obesity, cardiovascular disease, type 2 diabetes, and other health outcomes. [109]

Can employer-based wellness programs address this disparity?

Implications for ethical brokers
Addressing target populations cost much more than vendors admit…
and face much bigger obstacles

We've previously discussed how corporate wellness programs need to budget some $4000 annually per person to affect nutritional behavior change, and $1600 to affect exercise change, totaling over $5000 per person per year if they hope to accomplish their goals.

Now we see that targeting these programs to the most at risk – and medically most expensive - can raise those amounts. The lowest income, lowest status employees are probably the least interested in the program. They worry about doing their jobs, losing their jobs and may even need to rush to a second job just to pay their rent.

- They're probably suspicious of people telling them to eat or behave differently.
- They may face food insecurity issues.
- They probably lack any financial cushion or discretionary income, so the wellness incentive may go to other basic needs like rent, car payments, clothes or children's education rather than their own behavior change.

These people - the corporate medical cost drivers - are the most expensive to reach and impact.

Let's review Bob's ethical situation

Bob may know all these facts about corn subsidies and their impact on food costs, the impact of zoning on exercise rates and the relative disease rates based on income levels. He may have decided not to participate in TWGCWP's programs at any of his clients *because he knows that these programs don't work*.

In fact, he may have decided to act unethically for the sake of a commission!

[109] From the Executive Summary of the 2015 DGAC report, emphasis added

And that's the real ethical dilemma of selling wellness programs. They don't work well, if they work at all. Bob apparently knew this so, when he decided to lose some weight and get back into good physical shape, he hired his own trainer.

This then raises the bigger question: can any broker act ethically and sell corporate wellness programs?

Based on all the information presented above, the answer appears to be no. It is impossible to act ethically and sell wellness programs.

The tragedy in this unethical behavior

Corporations purchase wellness programs from brokers like Bob in their attempt to control medical costs. In doing so, they admit (implicitly or otherwise) that various government programs – the corn subsidy, single acre zoning, etc – lead people in the wrong / unhealthy direction so they need to step in and try to make their own employee population healthier. It's a process that cannot work since no company's financial resources can match the government's.

Yet our healthcare system wastes $700 billion or more annually on unnecessary care: our inefficiently organized *supply* of medical services exacerbates the problems of our unnecessarily high *demand* for those services.

Corporate wellness programs won't ameliorate these trends and, even if they do, probably won't reduce the number of unnecessary medical tests or the false positive rate from those tests.

- Probably won't reduce the number of back MRIs and unnecessary spinal fusion surgeries that result [110]
- Probably won't reduce the number of head CT scans related to sinusitis, advised against by the American College of Emergency Physicians and the American Academy of Pediatricians [111]
- Probably won't reduce the number of pediatric antibiotic prescriptions for ear aches, unnecessary 95% of the time and harmful about 15% [112]

[110] See ChoosingWisely, position statements by the American Academy of Family Physicians and others http://www.choosingwisely.org/doctor-patient-lists/imaging-tests-for-lower-back-pain/ . Some research suggests that people who have back MRIs shortly after they feel back pain are 8x more likely to have back surgery but don't recover faster.

[111] See ChoosingWisely, http://www.choosingwisely.org/?s=ct+scans+sinusitis&submit=

- Probably won't reduce the amount of ineffective medical care like postnatal dexamethasone therapy for lung disease of prematurity, use of laparoscopic mesh for inguinal hernia repair or any of the 144 other ineffective interventions listed in Vinay Prasad's seminal article in the Mayo Clinic Proceedings [113]

- Probably won't reduce geographic treatment variation rates for cancer treatments, orthopedic treatments, cardiovascular treatments and others that alone represent about 1/3 of medical spending, at least according to tons of research published by scholars at the Dartmouth Institute, among other places.

In all these senses, wellness programs fail to deliver the goods in part because they're based on a tragic misunderstanding of economic incentives and in part because they're ill targeted. Even if wellness programs worked well, we would still waste the same $700 + billion annually. Being thinner doesn't lead to making wiser medical treatment choices.

The well informed broker knows all this information. When he or she acts on it, the ethical brokers probably downplay the importance of corporate wellness programs while the unethical brokers may choose commissions over client impacts.

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[112] See Antibiotics for Otitis Media on the NNT website, http://www.thennt.com/nnt/antibiotics-for-otitis-media/

[113] See Prasad et al, A Decade of Reversal, Mayo Clinic Proceedings, August, 2013 http://www.mayoclinicproceedings.org/cms/attachment/2007391767/2029532464/mmc2.pdf

Review Questions
Correct answers on next page

1. About how much more does it cost, per calorie, to eat healthier foods?

a. About $10
b. About 1/3 of a cent
c. About $100
d. About $1000

2. Americans each eat about 2700 calories of food daily. About how much more does a typical family of 4 need to spend in order to eat healthier - rather than less healthy - food *per year*?

a. About $1.96
b. About $12,000
c. About $125
d. About $100

3. The US government encourages us to eat certain foods and discourages us from eating large quantities of other foods. Which food groups does the government subsidize?

a. Both
b. The food groups we are discouraged from eating in large quantities
c. The food groups we are encouraged to eat
d. Neither

4. This text suggested a ball park annual amount of money necessary to incentivize people to change their diets and choose healthier foods rather than less healthy. What is that annual amount of money?

a. $150
b. $4,000
c. $200
d. $100,000

5. What impact do our zoning laws have on the amount of daily exercise most Americans get?

a. Single acre zoning makes our neighborhoods more beautiful and less crowded, thus making evening / after dinner walks more attractive.
b. Single acre zoning generally puts more distance between someone's house

and work, requiring driving to work, rather than walking to a public transportation stop. This lowers the daily amount of walking most Americans do, as compared to Europeans or Canadians.
c. Single acre zoning makes the distance to the nearest gym too long to drive, especially in the winter when it's typically cold and snowy outside
d. There is no relationship between zoning laws and daily exercise

6. This course suggested that the 'average' European or Canadian walks about 166 hours per year more than a similar American. Studies show that people value their free time at about 1/3 of their average hourly wages. The average American wages in 2014 were about $24. Roughly how much would an employer have to pay an employee to incent that employee to walk 166 hours in his or her spare time?

a. $175
b. $1600
c. $150
d. $200,000

7. About what impact will wellness programs have on our rate of ineffective or harmful medical services, like using head CT scans to diagnose sinusitis, or using laparoscopic mesh for inguinal hernia repair?

a. A major impact. Wellness programs will reduce the rate of these and similar ineffective medical services by well over half
b. No impact at all
c. Wellness programs are expected to eliminate all ineffective and unnecessary medical care within 8 – 10 years
d. Recent studies suggest a decrease of 5 – 10% of all ineffective services by 2025.

Review Questions
Correct answers in bold

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Some tools to help brokers act ethically

Let's summarize this course so far:

- Part 1 introduced some basic business ethical standards, specifically that brokers who 'let the buyer beware' act *un*ethically while brokers who 'do your fellow a favor' act ethically.
- Part 2 introduced one specific health insurance problem, that much of our medical spending is wasted on unnecessary services. Part 2 discussed how ethical brokers can teach clients how to use checklists to differentiate necessary from unnecessary medical interventions.
- Part 3 discussed sale of ancillary products, specifically wellness programs. It demonstrated that unethical brokers can sell these programs – and collect commissions – without regard to the fundamental efficiency of these programs. In other words, wellness programs generally do not (even 'cannot') generate the desired outcomes. Unethical brokers ignore this information and continue to sell these programs while ethical brokers 'do their follows a favor' and explain the pitfalls of investing in corporate wellness programs.

In Part 4, we'll expand on our Checklist idea and introduce some targeted checklists for specific medical needs. These are only examples / introductions to consumer education. But they're a way to act ethically in our current high deductible health insurance environment.

Questions an ethical broker would introduce to clients about Screening Tests

Some screening tests are beneficial, others less so. These 4 questions will help you decide which are which.

We'll focus on Event X, a specific medical event like having a heart attack or dying of colon cancer. You can substitute whichever medical event concerns you for Event X. Be sure to include a time period, say 5 or 10 years. Ask '*Out of 100 people like me...*'

1. ...how many will have Event X if they *don`t* have the screening test?
2. ...how many will *still have* Event X if they have the screening test?
3. ...how many *actually benefit* from the test and treatment by avoiding Event X?
4. ...how many are *harmed* by the screening test and related treatment?

We'll explain each question individually below.

Two types of patients and two types of medical tests:

- First, *symptomatic* people can benefit from earlier care (surgery on a smaller tumor for example), *due primarily to education*.

  For example a woman may feel a lump in her breast and visit her doctor; she's learned that breast lumps are potentially serious.

  She'll have a diagnostic test to identify her breast lump. In other words, *symptomatic* people get *diagnostic* tests to identify their medical problems and develop treatment plans.

  Diagnostic tests are scheduled based on medical need.

- Second, *asymptomatic* people may benefit from earlier care *due to primarily to screening tests*.

  Screening tests are scheduled based on your calendar.

  The same woman (as above) may have her annual mammogram every May 15th because she can't feel every microscopic abnormality in her breasts.

  We'll focus, in this section, on asymptomatic people getting screening tests.

The four questions listed above can help you determine how well tests actually work.

Consider, for example, the statement 'breast cancer mortality rates are down over time'.

This does not necessarily mean that mammography *screening* tests work terribly well or account for all the improvement. [114] The breast cancer mortality rate reduction may occur because symptomatic women get earlier – and, over time, better – treatment. When you talk to your doctor about tests, ask whether patient benefits come primarily from screening tests on asymptomatic people or diagnostic tests on symptomatic ones. It's an important distinction.

[114] See, for example, Bleyer, *Effect of Three Decades of Screening Mammography on Breast Cancer Incidence*, New England Journal of Medicine, November 22, 2012 or *Ignoring the Science on Mammograms*, New York Times, November 28, 2012 by Dr. David Newman, and *Vast Study Casts Doubts on Value of Mammograms*, Gina Kolata, New York Times, February 11, 2014

Questions an ethical broker would introduce about screening tests
Out of 100 people like me,
how many will have Event X *without* the screening test?

This question helps you determine which medical risks are big enough to concern you. Not all are.

Some people may decide that a 7 in 100 chance of having an event is too *small* a risk to warrant a screening test.

- Others may think that a 1 in 100 chance is *big* and definitely warrants the test.

No one answer fits everyone. Words like ‘big’ and ‘small’ mean different things to different people so don’t help you decide.

Remember when you ask this question to include a time frame: over 5 years or over 10 years for example, whichever concerns you the most.

Appropriate answers come in this form:

- ‘3 in 100 people like you will have Event X in the next 5 years without a medical intervention’

Inappropriate answers come in this form:

- ‘You’re at risk of having Event X’
- ‘A significant number of people like you are likely to have Event X’
- ‘Enough people like you will have Event X to justify screening’

The downsides of unnecessary screening include overdiagnosis and false positive harms.

A good follow up question: after you learn how many people, out of 100 like you, will have Event X *without* a screening test, ask Out of 100 people like me, how many will *still* have Event X if they have the screening test?

Remember, you can substitute ‘stroke’ or ‘hip fracture’ or ‘develop diabetes’ or many others for ‘Event X’, depending on your own situation.

Questions an ethical broker would introduce about screening tests
Out of 100 people like me,
how many will *still have* Event X *with* the screening test?

This question helps you determine how well the screening test works; it reminds you and your doctor that screening tests aren't perfect.

You may learn, for example that 6 people out of 100 like you will *still have* Event X even if they have the screening test. Knowing how many people still have the event may influence your decision to have the screening test at all.

The answer to this question leads directly to *Out of 100 people like me, how many actually benefit from the test by avoiding Event X?*

Questions an ethical broker would introduce about screening tests
Out of 100 people like me,
how many *actually benefit* from the test by avoiding Event X?

This tells the likely benefit *to you* of a particular screening test.

- Benefit is the difference between the number of people who would have the event *without* screening, and the number who *still* have it, with screening. Include a time period, say over 5 or 10 years.

Remember: you need to know 2 numbers to determine how well a screening test works. You can't tell from just 1 number.

What about 5-year survival rates?

Five year survival rates (or 10 or 20 year for that matter) do not tell you how many lives a screening test saves.

Here's why:

- The 5-year survival clock starts when the abnormality (generally a suspected cancer) is found.
- As our screening technologies improve over time, we identify smaller and smaller abnormalities. Identification starts the 5-year survival clock.

Researchers call this 'lead time bias': lead time is the amount of time between the detection of a disease and its clinical presentation. By identifying smaller abnormalities, we start the clock earlier and automatically extend the lead time, thus always increasing the number of people who 'survive' at least 5 years.

But this doesn't tell us if the screening tests saves any lives; people may still die at the same age only now live longer with a diagnosis. (Or they may actually live longer. You can't tell from only 1 number.)

Beware of relying on 5-year survival statistics. They may mislead you. We have much better ways to measure screening test effectiveness. Ask the questions introduced in this chapter, for example. You'll get more useful information.

Questions an ethical broker would introduce about screening tests
Out of 100 people like me,
how many are harmed by the screening test?

We discussed some key harms previously. To reiterate and summarize:

- False positive results indicate that you have a medical problem when, in fact, you really do not.
- Treatment harms including medication side effects, surgical error or infection.
- Overdiagnosis or the identification and treatment of abnormalities that will never harm you.

False positives and overdiagnosis may lead to unnecessary treatment.

Ask your doctor about all three of these risks.

****

Remember that there are benefits and risks of *testing* and benefits and risks of *not testing*.

Ask yourself if you're more concerned about

Missing a potentially dangerous abnormality until it's too late Many dangerous abnormalities can be successfully treated once they become symptomatic. Unfortunately we don't always know which or how frequently.

Or

Suffering the potential harms of false positives and/or overdiagnosis

You may not be able to have one of these without the other.

Case Study:
Asking these 4 questions about colonoscopies

I'll provide estimates for a **50 year old non-smoking male over 10 years**. Your own numbers may differ based on your age, sex, smoking status and other factors. See the references below.

I listed the answers in two forms: *out of 100* people and *out of 1000* because the incidence and benefits are decimal points on a scale of 100. I hope this clarifies and doesn't confuse the issue.

I choose colonoscopies because the data are fairly easy to get and because this is a generally non-emotional test. No other reasons. I'm neither a fan of, nor opposed to, colonoscopies.

Out of a hundred 50-year old non-smoking men, how many will die of colon cancer over a 10 year period without colon cancer screening? Our answer comes from Risk Charts published in the Journal of the National Cancer Institute: it's about .2 (that's 2/10ths of 1). [115]

> Since people get confused by decimal points, we can also state this risk as 2, 50-year old non-smoking men per thousand will die of colon cancer over 10 years. Two per thousand is the same as .2 per 100. It's also the same as saying that 99.8% of 50-year old non-smoking men will not die of colon cancer over a 10 year period. Which presentation impacts you the most? The colon cancer mortality risk increases as you age. Sixty and 70 year old men face higher risks than do 50-year olds. I've stated *average* risks. You may face higher or lower risks based on family history, diet or other factors. Ask your doctor if you deviate from the norm, and if you deviate, how much and in which direction.

Out of one hundred 50-year old non-smoking men, how many will *still* die of colon cancer over a 10 year period *with* screening? The answer is about .1 (that's 1/10th of a person) or 1 per thousand men screened will still die of colon cancer.

> I base this on two large studies that found about a 50% colon cancer mortality reduction from colon screening exams and associated treatment, one published in the New England Journal of Medicine [116] and the other in the Lancet. [117]

[115] Woloshin et al, Risk Charts, Journal of the National Cancer Institute, June 5, 2002. You can find the same information on the VA Outcomes Group website, http://www.vaoutcomes.org/our_work/risk-charts/

[116] Zauber et al, Colonoscopic Polypectomy and Long-Term Prevention of Colorectal-Cancer Deaths, New England Journal of Medicine, February 23, 2012, easy to read summary in the New York Times, *Report Affirms Live Saving Role of Colonoscopy*, Denise Grady, February 22, 2012

Out of 100 fifty-year old non-smoking men, how many benefit from screening by avoiding dying from colon cancer? This is a simple subtraction from the numbers above. Colonoscopy screening prevents about .1 death in our 100 person reference group of 50 year-old non-smoking men, or 1 death per 1000 non-smoking, 50-year old men over 10 years. The benefit increases with age. Do you see why statements like 'colonoscopy reduces colon cancer mortality by 50%' can be misleading?

Out of 100 fifty-year old non-smoking men, how many are harmed by colonoscopies? Research suggests that between .1 and .2 people per hundred screened suffer colon bleeding or perforation, about the same as the number of 50-year-old non smokers who avoid dying over 10 years.

> The Johns Hopkins Medicine Colorectal Cancer website states, for example: *The examination has an extremely small risk of complications (0.1% to 0.2% risk of bleeding or perforation).*[118]

You can now make an informed decision about colonoscopy.

> You know the benefit per 100 fifty-year old non-smoking men over 10 years is about .1 life saved over 10 years.
>
> You also know the risks, about .15 people harmed by colon perforation or bleeding per 100 people screened.

Do you think the benefits outweigh the risks? If so, at all ages? Patients with this information can now have *informed* discussions and can make *wise* decisions.

A note on phrasing: the Johns Hopkins website calls colonoscopies *'crucial to improve one's chances against colon cancer'* with *'an extremely small risk of complications'*.

But we've shown that the benefits and harms are about *the same* for 50 year old men.

How can the benefits be 'crucial' and risks 'small' *if they're the same number*?

The answer: patients don't ask the right questions!

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[117] Atkin et al, Once-only flexible sigmoidoscopy screening in prevention of colorectal cancer: a multicentre randomised controlled trial, Lancet, April 28, 2010, easy to read summary in Dr. Margaret McCartney's blog http://margaretmccartney.com/2010/04/29/bowel-cancer-screening-and-noise-to-signal-ratio/

[118] http://www.hopkinscoloncancercenter.org/CMS/CMS_Page.aspx?CurrentUDV=59&CMS_Page_ID=33CD25B0-CCC6-4F55-A226-3C202E67D0B1, downloaded 1/24/14

The psychology of reciprocals:
Our final word on reporting benefits and risks

Remember reciprocals from high school? Most people forgot…unfortunately. Learning that .2 in 100 men will die of colon cancer is the same as learning that 99.8 in 100 –--- that's 99.8% --- will *not* die.

- Some people respond to learning that '.2 in 100 will die' by thinking 'I might be one.'
- Others respond to learning that '99.8% will not die' by thinking they'll be fine.
- Different medical treatment actions follow from these different reactions.

How do *you* respond to alternate presentations of the same risks?

Try to remember, whenever you hear medical risks and treatment impacts, to consider the reciprocal. It may affect your treatment choices.

Questions an ethical broker would introduce to clients about Medications

Here are four useful medication questions that act as a checklist:

1. What is the Number Needed to Treat for this medication?
2. What is the Number Needed for Harm for this medication?
3. When do I stop taking this medication?
4. Are there any long term studies about the effects of this medication?

Questions an ethical broker would introduce about medications
What is the Number Needed to Treat?

The Number Needed to Treat (NNT) tells how many people need to take a medication for 1 person to benefit. The NNT tell you *how well* a medication actually works. Doctors learn about NNTs in medical school so will understand this question.

- An NNT of 75 means that 1 in 75 people who takes it, actually benefits from it; 74 do not.
- The lower the Number Needed to Treat, the more effective the medication.

Researchers calculate the Number Needed to Treat from a *comparative study*.

That compares a group of people that *received* the medication to a similar group that *did not*.

Researchers identify how many more people benefited in the medication group then calculate how many people needed to take the medication for 1 to benefit.

Good NNT studies are very specific, identifying benefits, personal characteristics (age, disease history, etc) and a specific time period.

Two NNT examples
for illustration purposes only

I choose these examples because the data are relatively easy to find. See the references below. I'm neither a fan of, not opposed to Vitamin D supplements or statin medications.

Vitamin D supplements for elderly, institutionalized adults to prevent hip fractures have an NNT of about 36. [119]

That means 35 out of 36 people who took Vitamin D supplements did not benefit over a 3 - 5 year period by avoiding bone fractures. You learn that from a comparative study.

Most of these people didn't benefit because they were not going to have a bone fracture during this time period anyway, so the medication did not help them.

A few may not have benefited because they *still* had bone fractures.

But all 36 spent money on the medicine and exposed themselves to Vitamin D harms. (We'll discuss harms in the Number Needed for Harm section below.)

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Statins to prevent a first heart attack or stroke in people *with* risk factors but *without* known heart disease have an NNT of between 70 and 250 over 4 years. [120]

Again, most people weren't going to have a heart attack during this time period anyway and a few still had heart attacks despite taking the statins. Unfortunately, we don't know in advance which people fall into which category.

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[119] This calculation comes from www.TheNNT.com

[120] This NNT estimate comes from Bloomberg BusinessWeek, Do Cholesterol Drugs Do Any Good, January 16, 2008

Hundreds of NNT calculations exist. Ask your doctor about them. Follow up with *What is the Number Needed for Harm?*

Questions an ethical broker would introduce about medications
What is the Number Needed for Harm?

The Number Needed for Harm (NNH) tells how many people need to take a medication for 1 person to be *harmed*.

It's exactly the opposite of the Number Needed to Treat

- An NNH of 75 means 1 in 75 who take the medicine is harmed by it; 74 are not harmed.
- The higher the Number Needed for Harm, the safer the medicine.

Let's see the Number Needed for Harm in our Vitamin D and statin examples from the previous page.

First, the Vitamin D example. TheNNT.com website estimates the Number Needed for Harm from kidney stones or renal insufficiency from Vitamin D supplements: 36, *the same as the Number Needed to Treat!*

> In other words, for every person who benefits from Vitamin D supplements by avoiding a hip fracture, another suffers kidney harm.

The wise patient, along with his or her physician, can now make an informed decision: am I more concerned about suffering a hip fracture or suffering renal harm? Or equally concerned? Different people can reasonably answer those questions differently.

Second, the statin example. Studies show that the Number Needed for Harm for causing diabetes among people who took statins for 4 years is 255. [121]

> The *well informed* patient now understands that for about every 2 heart attacks prevented, 1 person develops diabetes. The *wise* patient discusses this information with his or her doctor and decides together with his/her doc how to proceed.

[121] Sattar, Statins and the Risk of Incident Diabetes, The Lancet, Feb 27, 2010. There are other statin risks also, but I wanted to keep this example simple. For an easy-to-read summary of statin risks, see Dr. Barbara H. Roberts, The Truth About Statins, Chapter 3. Roberts lists many risks but only provides NNH calculations for some, including rhabdomyolysis.

Learning the Number Needed to Treat and Number Needed for Harm allows you to compare medication benefits and harms. They're extremely powerful tools.

Additional comments about NNTs and NNHs

Once you learn a medication's Number Needed to Treat, you need to decide if that number satisfies *you*.

Different people make different decisions about the same numbers.

Dr. Nortin Hadler of the University of North Carolina Medical School, for example, suggests that public insurance like Medicare only cover services with NNTs up to 20 for 'hard outcomes' like death, stroke, heart attacks, renal failures, etc, and only cover NNTs up to 5 for 'soft outcomes' like feeling better or enjoying less depression. [122]

- An NNT of 5 means that 80% of people taking the medicine do not benefit from it. Do you understand why? (Only 1 in 5 benefits. 4 in 5 do not. That's 80%.)

Where do you draw your line? Different people make difference decisions. That's a topic to discuss with your doctor.

****

Final thought: Dr. David Newman suggests that knowing the Numbers Needed to Treat and Harm is *basic literacy for patients and doctors*. [123]

- Absent NNT and NNH information – or a similar metric – you simply can't make wise, well informed medication decisions.

- Do you agree with Dr. Newman?

I previously offered an alternative metric, the 'out of 100 people like me' series of questions. Now you have 2 options.

Use whichever you find most appealing when you consider medications, treatments and preventive services.

But use one of them.

And always discuss your research and concerns with your doctor.

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[122] Dr. Nortin Hadler, Worried Sick, page 223

[123] Dr. David Newman, Hippocrates' Shadow, page 217

Questions an ethical broker would introduce about medications
When do I stop taking this medication?

Medication guidelines – especially for preventive meds – typically detail when to *start* taking the drug, but not as often when to *stop* taking it. Your underlying medical condition may change over time due to diet, exercise, stress levels, other medications, aging, environmental conditions or behavioral changes. Two potential ways to phrase this question:

- When do I stop taking this medication? **Or**
- How will I know if my condition has changed sufficiently to stop needing this medication?

Feel free to ask about any medication that does not have a clear end point.

You can follow up with *'Are there any long term studies about the effects of this medication?'*

Questions an ethical broker would introduce about medications
Are there any long term studies about this medication?

Some medications may have been tested for 1 year, say, but be prescribed for longer.

What are the 8, 15 or 20 year effects, both positive and negative?

You and your doctor may need to estimate, since the exact data may be unavailable. Beware of taking a drug for the rest of your life - maybe 30 or 40 years - if it's only been tested for 1 or 2. We simply may not know the long term effects, both positive and negative.

Conclusion

Ethical brokers who ‘do their fellow a favor’ can help their subscribers enjoy better healthcare outcomes at lower costs than brokers who ‘let the buyer beware’.

We have shown in this course, some ways to act ethically. They’re not always obvious or easy. In fact, ethical behavior often actually runs counter to standard operative procedures in many agencies.

But we hope the reader now has a greater appreciation for the benefits of ethical behavior both to the client and to the broker. In the long run, both benefit from ethical broker behavior.