SMASHING INTO WINDOWS:
The Limits of Consumer Sovereignty in Health Care

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CHOICE I: Shopping for Treatments
THE FLOWERING OF CONSUMERISM

It is an economic idea at its core: as consumers we can engage in rational decision making and wisely choose among services and products. How? By shopping for services and products that give good value (low risk, high quality and low price).

This flowering of consumerism has spread to medicine. We imagine ourselves as model patients – skeptical, aggressive, and self-reliant.

*We will be the “new sick” managing our own illnesses, processing risk and cost information, and partnering with our doctors.*
THE EMPOWERED PATIENT
How to Get the Right Diagnosis
Buy the Cheapest Drugs
Beat Your Insurance Company
And Get the Best Medical Care Every Time
ELIZABETH COHEN
CNN Senior Medical Correspondent

THE PATIENT WILL SEE YOU NOW
The Future of Medicine is in Your Hands
ERIC TOPOL
Author of The Creative Destruction of Medicine
THE PATIENT IS IN CHARGE


“Patients will be increasingly in charge through iPhone and laptop apps, armed with evidence based information about health problems......Information and expertise will be readily available to all, without having to go to the doctor's office, and new technologies will make it possible to "predict and preempt" many major ills — all of which ultimately will contribute to the "emancipation" of consumers.”
I. GOALS OF MEDICAL TRANSPARENCY

A. PROMOTING PATIENT AUTONOMY THROUGH CHOICE

Bioethics begins with patient rights and strong versions of autonomy. 

*Autonomy* is “… the ground of the dignity of human nature and of every rational nature.” Immanuel Kant. Autonomy is grounded in the right and ability to make choices. Surely then the language of consumer sovereignty in health care makes sense—if we allow individuals more and more spheres of decisionmaking, from treatment elections to insurance selections, then we maximize their autonomy in the health care setting at least.

B. IMPROVING MEDICAL DECISIONMAKING

- Monitor errors and mismanagement, inattention, staff foul-ups
- Control costs by detecting wasteful ideas, profitable only to the hospital
- Detect gaming and medical actions based on external financial reasons.
CareFlow maps how people make healthcare decisions.

START
- Senses something may be wrong or possible medical need
- Gathers information
  - Seeks professional help
  - Assessed by doctor and learns diagnosis
  - Decides to seek alternative treatment and advice
  - Seeks to understand disease and treatment
  - Initiates treatment and fills prescription
  - Experiences initial treatment benefits and side effects
  - Refills prescription and is adherent to care protocol
  - Abandons treatment
  - Visits doctor for checkup
  - Condition changes or stabilizes, new conditions emerge

CURED
II. LIMITS ON PATIENT HEALTH CARE CHOICES

A. PROVIDER LIMITS: TREATMENT RISKS

1. Unnecessary Treatments. Medical practice variation and medical uncertainty create barriers to accurate communication of treatment necessity and risk assessment. Providers too often offer care that is not “trustworthy”, i.e., it is of uncertain and therefore questionable value. Many drug therapies and most dietary supplements are wasteful of resources and without proven benefit. Off-label prescribing is often the triumph of hope over evidence.

2. Low Quality Treatments. Americans receive appropriate, evidence-based care when they need it around half the time. All Americans are at risk of receiving poor care— regardless of where they live, how much money they have, or their race, education or health insurance. Tens of thousands of Americans die each year as a result of preventable hospital errors. Legally driven conversations between doctor and patient hardly begin to address the preexisting problems of unnecessary and poor quality treatments offered by providers.

3. Unaffordable Treatments. Patient care is often denied because of high cost. Even beneficial treatments may be too costly for either patient or insurer to pay for.
'Medical Excess'

Here’s a breakdown of what services 26 specialty societies, that participated in the Choosing Wisely campaign, say are overused.

- Procedures and other services: 18%
- Lab tests and pathology: 12%
- Medications: 21%
- Cardiac Testing: 21%
- Radiology: 29%

Source: Dartmouth Institute for Health Policy & Clinical Practice and The New England Journal of Medicine
B. PROVIDER POWER: THWARTING PATIENT DECISIONS

1. **Doctors Direct Patient Decisions.** They may overstate the benefits, overstate their experience with a procedure, or intimidate patients through a range of psychological devices. Hoffman and Del Mar write:

   “Clinicians rarely had accurate expectations of benefits or harms, with inaccuracies in both directions. However, clinicians more often underestimated rather than overestimated harms and overestimated rather than underestimated benefits. Inaccurate perceptions about the benefits and harms of interventions are likely to result in suboptimal clinical management choices.” Tammy C. Hoffman and Chris Del Mar, Clinicians’ Expectations of the Benefits and Harms of Treatments, Screening, and Tests: A Systematic Review, 177 JAMA Intern.Med 407 (March 2017)

2. **Doctors Misuse Consent Forms.** The formality of legal compliance protects providers while obfuscating risks and alternatives, a ritual without teeth.

3. **Doctors Don’t Communicate Well.** Doctors often lack empathy, are poor listeners, are rushed in their clinical encounters, or have distaste for or have unconscious biases against certain classes of patients. And at the same time they believe they are doing well.

4. **Doctors Can Be Bribed to Prescribe Brand Name Drugs and Devices.** A $15 sandwich given by a drug or device manufacturer to a doctor changes prescribing patterns, and the more costly the sandwich, the bigger the change.

5. **Doctors Resist Disclosure of Error Rates and Personal Performance Data.** Disclosure to a patient of a medical error that has resulted in serious harm is considered a bioethical imperative that informs patients about the particular risks that a doctor may pose. Yet full error disclosures are rare.
The Patient-Provider Experience Chasm

- **Has empathetic medical and administrative staff**: 36% of consumers vs. 57% of providers
- **Scheduling appointments is quick and easy**: 36% of consumers vs. 47% of providers
- **Communicates results of tests in timely manner**: 35% of consumers vs. 48% of providers
- **Takes time to understand my opinions and needs**: 34% of consumers vs. 51% of providers
- **Allows me to see the doctor I want, when I want**: 30% of consumers vs. 41% of providers

Breakdown of Visit Time

- Patient Waiting Time: 31 min (74%)
- Visit Time: 11 min (26%)
- Physician Speaking: 3.5 min (8%)
- No One Speaking: 3.5 min (8%)
- Patient Speaking: 4 min (10%)


NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
50% of patients walk out of the physician’s office not knowing what they were told or are supposed to do.
NOW... THIS MEDICATION CAN CAUSE WEIGHT GAIN.

HOW SO?

THE DRUG COMPANY WINES AND DINES ME FOR PRESCRIBING IT.
A $15 hoagie provided by a pharm rep to a primary care doctor changes her prescribing patterns.

Physician Payment Sunshine Act: makes pharma gifts to doctors transparent on a website.
C. HOSPITAL AVOIDANCE OF CONSENT OBLIGATIONS

Hospitals have no legal duty to obtain a patient’s consent to surgery, nor to conduct any kind of inquiry into the quality of the plaintiff’s consent.

Hospitals are supposed to help their independent medical staffs use consent forms, but typically such forms are little more than a ritual, without any real conversation about risks.

These hospital consent forms are treated in many states as presumptively valid consent to the treatment at issue, with the burden on the patient to rebut the presumption.
D. PATIENT LIMITS: BOUNDED RATIONALITY

1. Patients Struggle to Process Medical Information. Average functional health literacy and numeracy in the United States are extremely low. Social class and income level matters in terms of rational decisionmaking. Health information is hard to process even when providers make serious attempts to communicate. Most patients neither understand nor remember information even when well communicated to them.

2. Patients Refuse Treatments Because of Belief Structures. Patients may be anxious about effective treatments for irrational reasons such as fears of the knife or phobic feelings about diseases such as cancer.

3. Disclosure May Not Matter to Patients. Studies suggest that risk information will go unused in any event, since patients rarely change their minds. Patients also tend to make one-reason decisions when considering treatment options for serious ailments, where multiple factors should be considered.

4. Patients as Consumers Can Be Seduced by Powerful Marketing. Vendors of drugs, supplements and medical devices market to circumvent patient rationality. Vendors market to doctors as agents of patients, and sometimes they sell doctors a bill of goods. And direct-to-consumer advertising of drugs can, like sugar, be addictive and dangerous as patients push doctors to prescribe unnecessarily.
People’s tastes can also create excess demand for health care, and Americans have a strong appetite. Cultural norms can encourage a desire for health care. One poll found that 34% of Americans thought that modern medicine could cure almost any illness, compared to only 27% of Canadians and 11% of Germans. These American attitudes are likely to lead to greater trust in and reliance on advanced medical procedures.
OUR PRODUCT COMES IN 27 MODELS WITH OVER 9,000 OPTIONS.

GIVEN MY LIMITED TIME TO STUDY THE OPTIONS, YOU HAVE GUARANTEED THAT I WILL MAKE A SUB-OPTIMAL CHOICE.

THANKS FOR MAKING ME A FAILURE.

WELL, IT’S NOT REALLY “SELLING” IF WE BOTH WIN.
Patients face the problem of bounded rationality. “Health care decisions are, by their nature, choices in which the stakes are high, the potential for regret substantial, and the emotional overlays pervasive…. “Bounded Rationality and the Conceptual Underpinnings of Health Policy: A Rationale and Roadmap for Addressing the Challenges of Choice in Medical Settings” Mark Schlesinger and Brian Elbel (2006)

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<td>Endowment Bias and Sunk Costs Bias</td>
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<td>Framing Bias</td>
<td>Overconfidence Bias</td>
<td>Optimism Bias</td>
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Ps. 22. SYMBOLICAL HEAD ILLUSTRATING THE NATURAL LANGUAGE OF THE FACULTIES.
Patients are ill, and illness makes them vulnerable:  
**Illness disables.** Sick bodies rebel, and the ill are defeated.  
**Illness pains.** The faltering body hurts.  
**Illness exhausts.**  
**Illness erodes control.**  
**Illness enforces dependence.**  
**Illness disorients.** The sick suffer a disturbing, exhausting strangeness  
**Illness baffles.**  
**Illness terrifies.**  
**Illness isolates.** Illness is “always a place where there's no company, where nobody can follow.”

CHOICE?
III. EVOLUTION OF PATIENT DECISIONMAKING:
LEGAL PRESSURES

A. GENERATION 1 (Gen1). Informed Consent and the Doctor-Patient Relationship

The common law mandates that physicians (but not hospitals or institutions generally) obtain their patients’ informed consent. Crude tools are limited by both physician and patient rationality limits. The process has some value: the mandate for physicians to disclose and discuss material risks of a medical treatment, and alternatives to it, are perhaps the most important pieces of information for a patient to consider. Harbeson v. Parke Davis, 746 F.2d 517 (9th Cir.1984).

Gen1 informed consent has clearly advanced the art of giving information to promote patient choices, but suffers from all the limits discussed previously. Informed consent doctrine has moved patients into a more important role as a reasonable patient....but consent has been poorly implemented; it is largely a desultory ritual in hospitals in particular.
Wake him up. We need informed consent for the next part.
B. GENERATION 2 (Gen2) Decision Aids and Preference Sensitive Care

Reinforced by the ACA, this model promises improvements in patient decisional sovereignty. Decision Aids (DAs) are decision support tools that provide patients with detailed and specific information on options and outcomes, help them clarify their values, and guide them through the decision making process.

Key Steps Of Shared Decision Making Based On Decision Aids

1. Decision opportunity identification
   - Opportunity recognized
   - DA matched to opportunity

2. Decision aid use
   - DA distributed
   - Patient uses DA

3. Post-DA conversation
   - Clarify medical information
   - Elicit values and preferences
   - Make shared decision

4. Health care delivery
   - Care consistent with final shared decision
Decision Aids tend to reduce rates of high volume discretionary surgery

Source: O’Connor et al. Decision aids for patients facing health treatment or screening decisions (review). Cochrane Library; 2009 volume 2.
Current Risk of having a heart attack

Risk for 100 people like you who do not medicate for heart problems

- Over 10 years
  - 25 people will have a heart attack
  - 75 people will have no heart attack

Future Risk of having a heart attack

Risk for 100 people like you who do take standard dose statins with aspirin

- Over 10 years
  - 14 people will have a heart attack
  - 75 people will have no heart attack
  - 11 people will be saved from a heart attack by taking medicine

https://statindecisionaid.mayoclinic.org/
C. GENERATION 3 (Gen3). Patient Engagement and Chronic Disease

The goal is to improve information at all levels, from patient understanding to physician access to best evidence information. Patients can benefit from live and computer-based approaches such as patient navigators, medical avatars, video games, and mobile apps. Physician ability to explain medical choices to patients can be enhanced by decision analysis tools such as microrisks. Hospitals may hire Chief Cognitive Officers.

1. Accountable Care Organizations
2. Virtual Forms of Provider-Patient Contact
3. Health Coaches
4. Social Media Platforms
1. Accountable Care Organizations

*Patient engagement* is defined as a concept that combines a patient's knowledge, skills, ability and willingness to manage his own health and care with interventions designed to increase *activation* and promote *positive patient behavior*.
Surveyed ACOs’ Patient Engagement Offerings

- Post-discharge/care coaching: 65%
- Patient portal: 61%
- Patient navigators: 58%
- Notifications/reminders for preventive services: 55%
- Notifications/reminders for gaps in care: 48%
- Wellness coaching: 37%
- Secure messaging: 32%
- Electronic forms to capture patient-generated data: 29%
- Tailored patient-specific educational programs: 27%
- Telehealth (e.g., remote/video consults): 23%
- Remote monitoring: 18%
- Interactive voice response system: 10%

48% of surveyed ACOs cite patient engagement as the most challenging activity to perform.
Patient Engagement Improves Outcomes

Higher patient engagement is associated with numerous improvements across various aspects of health delivery:

- Be readmitted to a hospital w/in 30 days of discharge: 28% less for more activated patients, 13% less for less activated patients.
- Experience a medical error: 36% less for more activated patients, 19% less for less activated patients.
- Suffer a health consequence from poor communication among providers: 49% less for more activated patients, 13% less for less activated patients.

- Diagnostic testing and expenditures
- Referrals
- Elective surgeries
- Adherence to prescribed medical treatments
- Functional status and faster recovery
- Satisfaction
- Well-informed and engaged patients carry out more health-related behavior changes (e.g., exercise, smoking cessation, dietary modification).

1AARP survey of patients over 50 with 2 or more chronic conditions 2Bipartisan Policy Center Health Information Technology Initiative, December 2012 (internal citations omitted)

Cortney Nicolat, Supporting ACO Success with Meaningful Patient Engagement, Becker’s Hospital Review, August 1, 2013
2. Virtual Forms of Provider-Patient Contact

Virtual humans (VHs) improve clinical interviews by increasing patient willingness to disclose information. Automated VHs can help overcome a significant barrier to obtaining truthful patient information.

Gale M. Lucas et al, It’s Only a Computer: Virtual Humans Increase Willingness to Disclose, 37 Computers in Human Behavior 94 (2014)
AVATARS FOR TRAINING, DIAGNOSIS AND COUNSELING

Sherry-Ann Brown, Principles for Developing Patient Avatars in Precision and Systems Medicine, 6 Frontiers in Genetics 1 (Article 365 January 2016)

https://www.youtube.com/watch?v=qL4BXXX1AX4&t=71s
WHO IS PEPPER?

Pepper is a human-shaped robot. He is kindly, endearing and surprising. We have designed Pepper to be a genuine day-to-day companion, whose number one quality is his ability to perceive emotions.

Pepper is the first humanoid robot capable of recognising the principal human emotions and adapting his behaviour to the mood of his interlocutor. To date, more than 140 SoftBank Mobile stores in Japan are using Pepper as a new way of welcoming, informing and amusing their customers. Pepper also recently became the first humanoid robot to be adopted in Japanese homes!

https://www.ald.softbankrobotics.com/en/cool-robots/pepper
SWEDISH CLINICS USE VIRTUAL REALITY TO REDUCE THE STING OF SHOTS

3. Health Coaches

Do You Need Health Coaching?
4. Social Media Platforms

Social Media and Health

- More than 40% of consumers say that information found via social media affects the way they deal with their health.

- 90% of respondents from 18 to 24 years of age said they would trust medical information shared by others on their social media networks (Pew Internet).

- 60% of doctors say SM improves the quality of care delivered to patients.
<table>
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<tr>
<th>Channel</th>
<th>Uses</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Wikipedia</td>
<td>Comprehensive online encyclopedia</td>
<td>Trusted by patients and many physicians</td>
<td>Vulnerable to misinformation, though most content is to a high standard</td>
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<td></td>
<td>Editor-moderated content from user consensus</td>
<td>Comprehensive and free online information source</td>
<td>The combination of trust in Wikipedia and its vulnerability to both mistakes and author bias has caused concern within the academic and medical community</td>
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<td></td>
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<td>Emphasis on self-regulation resulting in higher quality control than other social networks</td>
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<tr>
<td>Twitter</td>
<td>140 character user-generated comments or ‘tweets’</td>
<td>Effective broadcasting platform, high viral possibilities</td>
<td>Character limit makes it difficult to have any depth</td>
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<td></td>
<td>Following other users</td>
<td>Strong for news and live events such as conferences</td>
<td>Hard to generate meaningful engagement</td>
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<td></td>
<td>Sharing links</td>
<td>Small message size is easily digestible</td>
<td>Requires regular updating</td>
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<td></td>
<td>Commenting on personal and corporate accounts</td>
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<td>Very small window for meaningful engagement</td>
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<td>Facebook</td>
<td>Add friends to create a peer network</td>
<td>The largest social network based on numbers of monthly active users</td>
<td>Regulatory adherence is more difficult and varies according to geographic region</td>
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<td></td>
<td>A plethora of services including groups, events, games and personal</td>
<td>The most diverse social network</td>
<td>Small window for meaningful engagement</td>
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<td>messaging</td>
<td>Capable of detailed and engaging interactions</td>
<td>Privacy concerns</td>
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<td></td>
<td>Sharing links</td>
<td>Enhanced word-of-mouth effect from friends’ activity</td>
<td>Very little central content control</td>
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<tr>
<td>YouTube</td>
<td>Sharing video content</td>
<td>Favored by physicians for highly informative, detail-oriented videos</td>
<td>Videos often require a large time investment</td>
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<td></td>
<td>Commenting on videos</td>
<td>Engagement correlates to emotive patient focused content</td>
<td>Capability to share videos within the social network is limited</td>
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<td></td>
<td>Following content creators</td>
<td>Can be linked to other social networks</td>
<td>Filming and editing video to a suitable standard is expensive and requires specialist skills</td>
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TRUSTED VOICES ON SOCIAL MEDIA?

kimkardashian OMG. Have you heard about this? As you guys know my #morningsickness has been pretty bad. I tried changing things about my lifestyle, like my diet, but nothing helped, so I talked to my doctor. He prescribed me #Diclegis, I felt a lot better and most importantly, it’s been studied and there was no increased risk to the baby. I’m so excited and happy with my results that I’m partnering with Duchesnay USA to raise awareness about treating morning sickness. If you have morning sickness, be safe and sure to ask your doctor about the pill with the pregnant woman on it and find out more www.diclegis.com; www.DiclegisImportantSafetyInfo.com

view all 10,983 comments.

imoumaima @youssefchorfi
flawlessfashionstore Idk if shes getting paid for this and do not care. But it is safe for mom & baby. I called my doctor because i couldn’t even keep water down.
Patient health outcomes may improve if patients are fully involved in understanding their treatments and their illness, and in managing their own treatments to a greater extent. We are moving beyond informed consent to a more robust model of “patient engagement”, “shared decisionmaking”, and “activation”.

- **Quality** of care may improve when patients are engaged in their own care.

- **Patient “voice”** may be enhanced if patients are listened to and allowed wider ranges of choices in tough cases.

- **Costs** may be reduced if patients made more informed health care choices, were better able to manage their own conditions, and adopted healthier lifestyles.
CONCLUSION. PROVIDERS NEED TO INCORPORATE SHARED DECISIONMAKING — DECISION AIDS, CONVERSATIONAL PROCESSES, AND SO ON — INTO THEIR RELATIONSHIPS WITH PATIENTS.

Gen1 is obsolete. How does the law promote the new and improved versions of shared decisionmaking?

Medical standards of care, existing legal doctrines, and health care institutional practices will have to change.
After decades of slow acceptance, shared decision-making is becoming a pivotal part of the transition to a value-driven delivery system.

Giving the Patient a Say.

No, Really.

BY LOLA BUTCHER
CHOICE II: Shopping Based on Cost
Irene Papanicolas, Liana Woskie, and Ashish K. Jha, Health Care Spending in the United States and Other High-Income Countries, 319 JAMA 1024 (2018)
Americans Say More Free-Market Competition is Better Way to Provide High Quality, Affordable Health Care

Which is the better way to sustainably provide high quality and affordable health insurance to people? (1) More government management of insurance companies, doctors, and hospitals; OR, (2) More free market competition among insurance companies, doctors, and hospitals

- More Govt Management: 39%
- More Free Market Competition: 55%

CATO INSTITUTE/YOUGOV FEB 22-23 2017
Response options randomized; Don't Know/Refused 6%
I. SHOPPING FOR CARE BASED ON COST.

A. WILL A MARKET BLOSSOM?

To repeat our assumption: as consumers we can engage in rational decision making and wisely choose among services and products.

How? By shopping for services and products that give good value (low risk, high quality and low price).

We are desperate to lower our costs individually and nationally.

Some argue that we should let the market blossom, just as we do with other consumer goods. If we shop wisely, suppliers of health care will respond competitively by dropping costs and improving quality.

”If a consumer is being sold rotten meat, he has the best protection agency available: the market. He simply stops trading at that store and moves to another.”

Milton Friedman
CHOICE has limits in the health care marketplace.

Paul Krugman: “There are, however, no examples of successful health care based on the principles of the free market, for one simple reason: in health care, the free market just doesn't work. And people who say that the market is the answer are flying in the face of both theory and overwhelming evidence.”


For a positive view of patients at least as risk regulators, see Kristin Madison, Patients as Regulators? Patients’ Evolving Influence over Health Care Delivery, 31 J. LEGAL MED. 9, 15 (2010),
## COUNTRY RANKINGS

### Top 2*

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### Health Expenditures/Per Capita, 2011**

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<th>Canada</th>
<th>France</th>
<th>Germany</th>
<th>Netherlands</th>
<th>New Zealand</th>
<th>Norway</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>United Kingdom</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
<td>$5,599</td>
<td>$3,182</td>
<td>$5,669</td>
<td>$3,925</td>
<td>$5,643</td>
<td>$3,405</td>
<td>$8,508</td>
</tr>
</tbody>
</table>

**Notes:** * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

**Source:** Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).
The U.S. Spent $3,205.6 Billion on Health Care in 2015
Where Did It Go?*

- Hospital care: $1,036.1 billion (32.3%)
- Physician services: $502.8 billion (15.7%)
- Other personal health care: $476 billion (14.8%)
- Prescription drugs: $324.6 billion (10.1%)
- Clinical services: $132.1 billion (4.1%)
- Nursing care facilities: $156.8 billion (4.9%)
- Home health care: $88.8 billion (2.8%)
- Government administration: $42.6 billion (1.3%)
- Net cost of health insurance: $210.1 billion (6.6%)
- Investment: $154.7 billion (4.8%)
Where the money goes
Top categories for personal consumption expenditures

Note: Seasonally adjusted annual rate, in billions of dollars, as of 2017 second quarter. Blue bars are services, green bars are nondurable goods, and orange bars are durable goods.

Source: BEA
Growing share of spending
Greatest percentage change in share of spending 1997-2017

Health-care services: 2.5
Prescription drugs: 2.0
Internet access: 1.2
Cell-phone service: 0.9
Money management: 0.6
Rent: 0.4
Owner-occupied housing: 0.3
Higher education: 0.2
Software: 0.2
Banking fees: 0.2

Note: These categories had the largest increase from 1997 to 2017 in relative share of consumer spending. For instance, health-care services accounted for 14.3% of spending in 1997, and 16.9% in 2017.

Source: BEA
A Bigger Bite

Middle-class families’ spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

Percent change in middle-income households’ spending on basic needs (2007 to 2014)

- Health care: 24.8%
  - Food at home: -3.6%
  - Housing: -6.0%
  - Total: -6.3%
  - Transportation: -6.4%
  - Total food: -7.6%
  - Food away from home: -13.4%
  - Clothing: -18.8%

Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department.

THE WALL STREET JOURNAL.
B. CONSUMERISM IN HEALTH CARE IS FORECAST BY INDUSTRY

• "More wired, consumer-oriented and innovative than ever before, the $2.8 trillion US health care industry is undergoing profound transformation," writes PWC.

• "In 2015, the...sector will begin to look and feel like other industries, catering to customers expecting one-click service. A true consumer-driven market is slowly taking shape."

• What does this mean for the practice of medicine? Is it all to the good?
How Consumers Purchase Healthcare

50% GROWTH expected in clinics in the next 5 years

SHOPPABLE PROCEDURES

“I need to have a procedure done, but it’s not urgent. Where do I go?”

• Diagnostic procedures
• Surgical procedures
• Therapeutic procedures

Estimated market size: $700 BILLION

EMERGENT CARE

“I have an injury or illness that must be addressed immediately”

• Low- to mid-acuity urgent care
• Emergency Care

Projected alternative emergent care site revenue, 2020: $40 Billion

ENHANCED MANAGEMENT

“I want a relationship with a provider to manage my ongoing health needs”

• Preventative care
• Lifestyle management
• Chronic disease management

Projected annualized growth rate:* 10%

*vs. 4% for primary care
C. THE LIMITS OF CONSUMER SHOPPING IN HEALTH CARE

Figure 1: Distribution of Total ESI Spending by Shoppable/Non-Shoppable Services, 2011

- Shoppable Outpatient/Physician Services: 34%
- Shoppable Inpatient Facility Knee and Hip Replacements: 1.3%
- Shoppable Inpatient Facility Services: 7%
- Prescription Drugs: 11%
- Non-shoppable Inpatient Facility Services: 14%
- Non-shoppable Outpatient/Physician Services: 33%

Source: HCCI, 2016. Claims data from employer-sponsored insurance (ESI) population younger than age 65 for the year 2011, data weighted to be nationally representative.
CONSUMER CHOICE MEANS THE ABILITY TO SHOP FOR HEALTH CARE GOODS AND SERVICES BASED ON BOTH QUALITY AND PRICE. HOW?

- Vaginal Delivery: 14.0%
- Vaginal hysterectomy (excl. cancer or non-malignant tumor): 12.9%
- Upper spine and neck procedures: 11.9%
- Cesarean delivery: 11.5%
- Appendix removal: 11.3%
- Hip joint replacement: 10.9%
- Pneumonia: 9.6%
- Balloon angioplasty without heart attack: 8.4%
Would You Price Shop for Treatment

**HESITATION:**
- 30% Quality of Care
- 21% Happy w/ current Dr
- 13% Price Not Everything
- 13% Specific situation
- 9% Consumer burden
- 8% Use recommendations

Legend:
- Definitely
- Maybe
- Probably not
- Definitely not
- Depends
People with deductibles over $500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:

<table>
<thead>
<tr>
<th>No deductible</th>
<th>Less than $500</th>
<th>$500 to $1,000</th>
<th>$1,001 to $3,000</th>
<th>More than $3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>48%*</td>
<td>53%*</td>
<td>67%†</td>
<td>67%†</td>
<td>74%†</td>
</tr>
</tbody>
</table>

Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by * are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by * are statistically different from groups indicated by † at the p<.05 level.
Americans are split on whether or not patients should be expected to compare prices before getting care.

Figure 15: Percent who say one of the following statements comes closest to their view:

- Patients should be expected to compare prices across different doctors before getting medical care: 48%
- It is not reasonable to expect patients to compare prices across different doctors before getting medical care: 43%
- Don't know/Refused: 9%

Base: All respondents, N=2,010.

* Indicates “Don’t know” and “refused”
Consumer-based approaches -- price transparency, comparison shopping, retail clinics, and high-deductible health plans featuring health savings accounts -- have severe limits.

Less than 7% of total U.S. healthcare spending in 2011 was paid by consumers for “shoppable” services.

The Health Care Cost Institute concluded that “…the potential gains from the consumer price shopping aspect of price transparency efforts are modest.”

Information is hard to find. A secret-shopper study by the Pioneer Institute found that a price of a standard MRI test for the knee, in a survey of 54 hospitals, could not be found in about 25% of the hospitals.

Patients “can't shop for price, even if they wanted to.”
PATIENTS SHOP FOR HEALTH CARE?

Everyone agrees to help reduce health care costs!

I can't afford that diagnosis. Do you have a cheaper one?
D. Consolidation In Health Care Drives Higher Cost Care

• “Five years after the Affordable Care Act helped set off a health-care merger frenzy, the pace of consolidation is accelerating, transforming the medical marketplace into a land of giants.”*

  – Payors -- Aetna-Humana, Anthem-Cigna
  – Hospitals -- “2015 is on pace to notch the most U.S. hospital deals since 1999, with 71 announced through the end of August”*

  – Jefferson has just merged with Abington Hospital and soon with Aria Health

*WSJ 9/21/2015
CONCENTRATION IN HEALTH CARE MARKETS MAKES THE IDEA OF CONSUMER SHOPPING TO REDUCE PRICES A JOKE.*

Prices in the private sector are out of control. On average, private insurers pay 25 percent more than Medicare for physician services and 30 percent more for hospital care. What’s more, both public and private sector payment rates for doctors in America are far and away the highest in the world, and research suggests that these high rates are among the principal reasons health care is so much more expensive in this country than elsewhere.

*Diane Archer, No Competition: The Price Of A Highly Concentrated Health Care Market, Health Affairs Blog, March 6, 2013.DOI: 10.1377/hblog20130306.028873
Provider Consolidation
LESS COMPETITION AND HIGHER COSTS

Research demonstrates that when hospitals consolidate, either merging with other hospitals or buying up physician practices, health care costs go up. Provider consolidation gives hospitals greater negotiating strength and limits competition, resulting in higher prices for services, higher costs for patients, and no improvement in the quality of care delivered.

Physicians Are Becoming Hospital Employees:

- In 2000, 1 in 20 specialists was a hospital employee...
- Today, 1 in 4 specialists is a hospital employee.

“Last year, a 15-minute visit to a doctor in private practice cost $69...That same visit to a hospital-employed physician cost $124.”
- Orlando Sentinel

Increasing Market Concentration Leads to Higher Prices for Consumers:

Percentage increase in market concentration from 1999-2003.

- WEST: +5.5%
- SOUTHWEST: +6.7%
- MIDWEST: +7.4%
- SOUTH: +9.4%
- EAST: +7%

“Research suggests that hospital consolidation in the 1990s raised prices by at least five percent and likely significantly more. Prices increase 40 percent or more when merging hospitals are closely located.”
- Robert Wood Johnson Foundation
Prices Are Likely Driven by the Different Market Power or Bargaining Power of Different Hospitals, As Hospitals With Greater Market Share Tend to Command Higher Prices

RELATIVE PRICES AND HOSPITAL MARKET SHARE OF TOTAL BLENDDED HOSPITAL PAYMENTS

% OF TOTAL BLENDDED HOSPITAL PAYMENTS

Private payments for an office visit in the United States cost 70 percent more than those abroad, while public payments are 27 percent higher. Prices are largely set by insurers and providers with monopoly power to maximize profits. Big hospital chains and provider groups dominate most local markets and extract extremely high rates from dominant insurers, which are motivated by fear of losing market share if they fail to attract these providers to their networks.

<table>
<thead>
<tr>
<th>Medical Procedure</th>
<th>Average Price in the U.S.</th>
<th>Average Price in Canada</th>
<th>Average Price in Switzerland</th>
<th>Average Price in Spain</th>
<th>Average Price in New Zealand</th>
<th>Average Price in the Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiogram</td>
<td>$914</td>
<td>$35</td>
<td>$655</td>
<td>$7,731</td>
<td>$6</td>
<td>$319</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$1,185</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip replacement</td>
<td>$40,364</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipitor</td>
<td>$124</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.R.I. scan</td>
<td>$1,121</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: 2012 Comparative Price Report by the International Federation of Health Plans. The average prices shown for colonoscopies do not include added fees for sedation by an anesthesiologist, a practice common in the United States, but unusual in the rest of the world. The additional charges can increase the cost significantly.
CAN “SKIN IN THE GAME” HELP IN THE FACE OF MARKET CONCENTRATION AND ITS POWER TO DRIVE PRICES??

WHERE’S YOUR SKIN IN THE GAME?
FAMILY HEALTHCARE COSTS RISING

SOURCE: 2011 MILLIMAN MEDICAL INDEX
CONSUMER-DIRECTED HEALTH PLANS

Employees in high-deductible plans

Percentage of all covered employees enrolled in high-deductible plans

- 2006: 3%
- 2007: 5%
- 2008: 7%
- 2009: 9%
- 2010: 11%
- 2011: 13%
- 2012: 16%
- 2013: 18%
- 2014: 23%
- 2015: 25%
- 2016: 29%

—Mercer’s National Survey of Employer-Sponsored Health Plans
HSA High Deductible Health Plan (HDHP) - 2017 Guidelines

To be considered a HDHP (and to qualify for opening an HSA), the HDHP must meet the following minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2017.

<table>
<thead>
<tr>
<th></th>
<th>Self-only coverage</th>
<th>Family coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum annual deductible</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
<tr>
<td>Maximum annual deductible and other out-of-pocket expenses*</td>
<td>$6,550</td>
<td>$13,100</td>
</tr>
</tbody>
</table>

* This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.
A CONSUMER DREAM COME TRUE—FOR THE TOP 1% (AND LAWYERS!)
Figure 1. Many people have low awareness of insurance terms and processes, and question health plans’ affordability.

- 55% found it hard to know where to look for a plan
- 55% didn’t find and sign up for a health plan the last time they looked
- 66% found it hard to find a plan that covered all of the care they needed
- 70% found it hard to understand all of the fine print and details
- 77% found it hard to find a plan they could afford


Graphic: Deloitte University Press | DUPress.com
HEAVY BURDEN FOR MOST. Lower monthly premiums tradeoff coverage for the payment of much more out-of-pocket before your insurance begins to cover your bills. Individuals are paying an average $2,295 before insurance kicks in and families are ponying up $4,364 on average, according to the Kaiser Family Foundation.

COST-SHIFTING TO EMPLOYEES. EMPLOYERS SHIFT COSTS. That’s a big deal, because more than half of Americans get health insurance through their employer.

HIGH-DEDUCTIBLE PLANS WILL BECOME THE ONLY CHOICE FOR MANY. Within three years, almost 40 percent of companies that offer health insurance may make the move. In 2012, it was just 13 percent.

CARE IS POSTPONED FOR MOST, AS THE HIGH DEDUCTIBLES SINK IN. PATIENTS END UP SICKER AND POORER....OR IN BACKRUPTCY. A 2015 survey found that almost 30% of people with deductibles higher than $ 1,500 for individual coverage avoided medical care—tests, treatments, follow-up-care, and prescription drugs—because they couldn’t afford the out-of-pocket costs. CONSUMERS DO NO MORE PRICE SHOPPING FOR MEDICAL SERVICES THAN THE AVERAGE PERSON, AND FAIL TO USE FREE PREVENTIVE SERVICES.
Where Americans Are Falling Behind on Debt

Lowest state average: Minnesota (17%)

Highest state average: Louisiana (46%)

Highest state averages:
1. Louisiana (46%)
2. Texas (44%)
3. South Carolina (43%)
4. West Virginia (42%)
5. Nevada (41%)

Lowest state averages:
1. Minnesota (17%)
2. South Dakota (18%)
3. North Dakota (19%)
4. Nebraska (20%)
5. New Hampshire (22%)
**THE PATIENT AS SHOPPER IS A POOR STRATEGY**

**KNOWLEDGE ASYMMETRY.** The patient-as-consumer faces a knowledge asymmetry almost impossible to overcome. Americans' general deference to physicians isn't just a cultural trait, it simply reflects the expertise and training regarding diagnoses, possible treatments, and likely outcomes doctors possess and their patients do not. For some cases and for some conditions, the layman can narrow that yawning information gap. But WebMD or no, it can't be eliminated.

**HEALTH AS A NON COMMODITY.** Those who believe that choosing a health care product or service is no different than buying a car, television, or cell phone might feel differently after, say, developing colon cancer.

**PRICES ARE LARGELY INVISIBLE OR COMPLETELY OPAQUE.** Even if the diagnoses, treatments, and cures for heart disease, diabetes, or depression could be purchased in a free market, in the United States the buyer simply doesn't—or can't—know what price he or she will pay. See Stephen Brill, *America’s Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Health Care System* (2015)
CHOICE III: All-payer Systems

If a centralized rate-setter bands every insurer together to negotiate prices, all payer can functionally act like single payer in terms of bringing down costs. All payer reduces hospital and insurer overhead, since billing costs are known in advance. France, Germany, Japan, Switzerland, and The Netherlands — all use all-payer rate setting as the basis for their universal health care systems. These countries have been found to control costs far better than America’s fragmented system.

Either a government agency or a panel of private insurers sets one distinct price for every medical procedure.
Exhibit 7. Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

<table>
<thead>
<tr>
<th>Country</th>
<th>Total hospital and physician costs, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Diagnostic imaging prices, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Price comparison for in-patient pharmaceuticals, 2010 (U.S. set to 100)&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bypass surgery</td>
<td>Appendectomy</td>
<td>MRI</td>
</tr>
<tr>
<td>Australia</td>
<td>$42,130</td>
<td>$5,177</td>
<td>$350</td>
</tr>
<tr>
<td>Canada</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>France</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Germany</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$15,742</td>
<td>$4,995</td>
<td>$461</td>
</tr>
<tr>
<td>New Zealand</td>
<td>$40,368</td>
<td>$6,645</td>
<td>$1,005</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$36,509</td>
<td>$9,845</td>
<td>$138</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>United States</td>
<td>$75,345</td>
<td>$13,910</td>
<td>$1,145</td>
</tr>
</tbody>
</table>

<sup>a</sup> Source: International Federation of Health Plans, 2013 Comparative Price Report.

<sup>b</sup> Numbers show price indices for a basket of in-patient pharmaceuticals in each country; lower numbers indicate lower prices. Source: P. Kanavos, A. Ferrario, S. Vandoros et al., “Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs,” Health Affairs, April 2013 32(4):753–61.
All-payer rate setting -- All the insurers negotiate jointly with all of the health care providers, and set on one specific price for each procedure...

Single-payer health care systems -- Save money in two ways: reducing administrative costs and increasing the bargaining power of health insurers. This is true of all-payer rate setting systems, too.

Whether in the nationalized system of the UK, the single-payer systems of Canada’s provinces, the mandated health savings accounts in Singapore, or the universal coverage regimes dependent on private insurers in France, Germany, Switzerland, and Japan, the solution for cost control and price transparency is the same-- **the government sets the prices for prescription drugs, tests, treatments, hospital stays, and pretty much everything else.**
Health is not a consumer good but a universal right, so access to health services cannot be a privilege.

POPE FRANCIS