

The quest for value in health care: A place for consumers

Executive summary

Paying attention to the consumer and providing high-quality experiences in health care are rising business imperatives.

Three key disruptors are driving health care providers, health plans, and life sciences companies to provide better quality and value to consumers:

1. Emergence of choice-oriented insurance
2. Employer risk-sharing and enhancements to support consumer choice
3. Improved accessibility to quality ratings and price information

The Deloitteⁱ Center for Health Solutions' surveysⁱⁱ of health care consumers reveal that consumers do not believe the U.S. health care system is providing value today nor is it meeting their needs. Consumers also worry about future health care affordability. As they increasingly gain access to price and quality information and begin to exercise active choice, consumers are likely to bring to health care the expectations and habits they have from shopping in the retail or travel industries. As this happens, health care industry stakeholders will no longer be able to avoid consumers' desire to make decisions based on the value they perceive they are getting from health care.

Key takeaways

The following insights from this study can guide organizations in designing strategies to 'win the consumer':

- Offer a better customer experience, more choice of products (such as health plan options), smarter personalized technologies and greater transparency and accessibility of price and quality information.
- Provide tools that assist consumers in finding affordable products and improving messaging around the benefits/security of insurance.
- Offer websites to allow consumers to search for quality and price information. Even though consumers are not using these much yet, they express interest, especially if timing and technologies are right.
- Think about the consumer of the future. Millennials and Gen X generations show more interest in using interactive technologies, and are more likely than older generations to negotiate pricing of care.



ⁱ As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.

ⁱⁱ Conducted annually since 2008, the Deloitte Center for Health Solutions surveys a nationally representative sample of more than 4,000 adults per year about their interest in and ability to operate in a consumer health care market.

Background

The Affordable Care Act (ACA), structural industry changes, and employer reactions to growing health care costs are creating conditions and disruptors that are likely to accelerate the emergence of a consumer-centric health care system. As the industry shifts from volume- to value-based and organizes to deliver quality patient outcomes, stakeholders are likely to move to a consumer-centric focus and become value-oriented organizations.

The key disruptors influencing the need to provide value in health care include:

A larger role for value in health care
 The concept of value in health care is impacting the greater health care system. As the health care system shifts to embrace value, health care organizations are challenged to improve cost, quality, and outcomes by reorganizing care, shifting to new reimbursement models, integrating service delivery, coordinating care processes, and reporting/learning from outcomes.



Disruptor 1 Emergence of choice-oriented insurance markets	Roll-out of health insurance exchanges (HIX)	Over the next 10 years, coverage mandates and the roll-out of HIXs will result in considerable growth in the individual insurance market. ¹ HIXs will allow a large pool of consumers to directly compare and purchase their insurance coverage. When selecting coverage, consumers will make choices and trade-offs among plans based on premiums, cost-sharing, and provider networks. Another type of marketplace, private health insurance exchanges, are run by non-government or private sector companies and are designed to help consumers find plans specific to their budget, health care needs, and preferred doctor networks.
	Growing eligible population for Medicare Advantage and Medicaid	Both the Medicare and Medicaid programs offer beneficiaries the option to receive benefits through private health plans – with most having a variety of plans from which to choose.* As program enrollment grows, the number of consumers in a choice-based market will also grow. Medicare enrollment is projected to grow from 47.7 million in 2010 to 64.3 million in 2020, and many of those new beneficiaries are likely to choose a Medicare Advantage plan.** Medicaid, where the use of managed care plans is also growing, is anticipated to have an additional seven million that qualify by the end of 2014 and 11 million by 2020. ² <small>* In 2009, half of all Medicare beneficiaries had at least 41 plan choices – including Health Maintenance Organizations (HMOs), Provider Sponsored Organizations (PSOs), local Preferred Provider Organizations (PPOs), regional PPOs, Private Fee-For-Service Plans (PFFS), Medical Savings Accounts (MSAs), and Special Needs Plans (SNPs).³</small> <small>** The percentage of Medicare enrollees choosing private plans has been increasing over the past decade. Since 2004, the number of Medicare beneficiaries enrolled in private plans has almost tripled, from 5.3 million to 14.4 million in 2013.⁴</small>

Disruptor

2

Employer risk-sharing and enhancements to support consumer choice

Increased cost-sharing	<p>In an effort to manage or reduce their health care costs, employers have been increasing cost-sharing with employees and anticipate that they will continue to do so.* The average deductible in employer-sponsored plans nearly doubled during the past 10 years (from \$2,412 in 2003 to \$4,565 in 2013), and while the overall average insurance premium grew by 80 percent, the worker's share grew by 89 percent over the same time period.⁵</p> <p>* Two in five U.S. employers (38 percent) providing health care benefits consider that increasing employee financial responsibility (such as increasing premium contributions) and introducing defined contribution approaches (29 percent) will have a high impact on managing or reducing a company's health care costs.⁶</p>
Incentives to improve employee health	<p>A growing number of employers offer incentives such as cash or cash equivalents (premium reductions, lottery competitions, and merchandise) to encourage participation in programs and health plans that lower costs (e.g., worksite wellness programs). In 2013, 37 percent of large employers (2500+ employees) reported using rewards and penalties to encourage improvements in employee (and dependent) health status in 2013.⁷</p>
Reference-based pricing	<p>Health plans increasingly are using reference-based pricing to make consumers decide whether they are willing to pay higher prices to go to providers that charge more than a pre-set amount for services. In reference-based pricing, insurers set a maximum payment amount based on an assessment of the relative cost and quality of competing providers in a local market. If a consumer elects to go to a provider who charges more than the set amount, they pay the difference out-of-pocket. This type of benefit structure makes cost and quality information more transparent, allowing consumers to make their own cost, quality, and service trade-offs.</p>
Increasing enrollment in high-deductible health plans (HDHP)	<p>As part of Consumer-Driven Health Care (CDHC), HDHPs* give consumers a larger role in decision-making than other health plans. Because HDHP enrollees must pay out-of-pocket for most medical expenses (aside from preventive care) until a deductible is reached, these plans impact consumers' medical decision-making through cost awareness and increased responsibility.</p> <p>In 2013, 40 percent of large employers (200+ employees) offered HDHPs.⁸ And more insured individuals have been choosing HDHPs as their health plan over the past five years: during the first quarter of 2013, 32 percent of the insured population under age 65 was enrolled in a HDHP, up from 19 percent in 2008.⁹</p> <p>In addition, employers are beginning to offer employees tools to comparison shop for value as a part of either a health savings account or high deductible plans.</p> <p>*Note: The U.S. Department of Health and Human Services defines a high-deductible health plan as one with deductibles of \$1,250 for self-only coverage and \$2,500 for family coverage in 2013.</p>

<p>Disruptor</p> <p>3</p> <p>Improved accessibility to quality ratings and price information</p>	<p>ACA requirements of HIX: transparency and “navigators”</p>	<p>Recognizing the potential complexity of making choices among health plans on HIXs, the ACA included two elements to assist consumers in navigating their expanding choices. 1) HIXs are required to display information on health plan value, including quality ratings and costs. 2) “Navigators” were created and funded to support consumers as they select their health plan. Navigators are expected to distribute fair and impartial information about health plan options.</p>
	<p>Improved accessibility to quality and safety ratings for hospitals and health plans</p>	<p>In addition to public reporting sites such as the federally run Hospital Compare, several organizations, such as Healthgrades.com and Consumer Reports, have developed websites and apps that collate quality and safety data and make this accessible to consumers in a user-friendly way. Medicare Advantage also has a Five-Star quality rating system,* which was developed to make health plan service and quality more transparent.</p> <p>* The Medicare Star quality rating system measures the performance of health plans in more than 50 areas, which are then grouped into five categories:</p> <ol style="list-style-type: none"> 1. Screenings, tests, and vaccines 2. Managing chronic conditions 3. Plan responsiveness and care 4. Members complaints, problems getting services, and choosing to leave the plan 5. Customer service

As consumers increasingly bear more costs and face more opportunities to choose their health care coverage and care, they will need to evaluate options and consider value trade-offs. In response, the health care industry is organizing to support consumer choice. One of the biggest challenges will be educating consumers about the factors to consider and the potential choices they could make to help them move beyond the prevailing viewpoint that “higher prices ... [are] a proxy for quality.”¹⁰ Public reporting of clear, understandable, and comparable price, quality, and service information eventually may help to raise consumer awareness about the price of care and impact their utilization choices. For industry stakeholders, however, the trends and disruptors suggest this: Consumers will play an increasing role in health care decision-making and are likely to consider concepts of value in that process.

Focusing on the consumer and on delivering value – through price, quality, and a superior customer service experience – may be essential to future success in the health care market. A clear understanding of consumers’ unmet needs and perceptions of value could be a key business differentiator. This report offers insights on three important areas in a consumer-focused quest for value: consumers’ perceptions of value and unmet needs in the U.S. health care system; their anxieties about affordability; and what consumers value in their health care experience.

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Room for improvement: views on U.S. health care system value and unmet needs

Consumers think the U.S. health care system is expensive, wasteful, and does not always provide value for the money spent. These are sentiments reported over the past five years in the Deloitte Survey of U.S. Health Care Consumers. These perceptions of waste and lack of value may be contributing to dissatisfaction with the system; in 2012, 62 percent of consumers believed that 50 percent or more of the dollars spent on health care were wasted, and 72 percent gave the U.S. health care system an unfavorable grade (a grade of “C”, “D”, or “F” on an A through F scale) on value.

Consumers think the nation’s growing health care costs are unreasonable. In their mind, costs are driven by a myriad of factors: hospital and drug expenses, fraudulent activity, and insurance company administrative costs are considered major contributors.¹¹ Consumers are not inclined to blame one sector of health care (such as hospitals or health insurance) more than another; rather, they believe that each sector has some responsibility for the increase in overall health care system costs.

Yet, in 2013, only half of consumers said that their behavior has a “major influence” on increasing health care costs. Employers and physicians have different opinions: 58 percent of employers and 82 percent of physicians believe that consumer behavior has a “major influence” on costs.

Clearly, consumers would like the health care system to improve performance and provide better value. In particular, consumers think that:¹²

- **Health care providers** can improve overall system performance with more emphasis on prevention and health promotion (85 percent of consumers), greater use of health information technology (HIT) (84 percent), and greater price transparency (79 percent).
- **Health insurers** can improve overall system performance by offering more customized plans (82 percent of consumers) and incentives for wellness programs (80 percent).
- **Employers** can impact overall system performance by offering health insurance to all employees (86 percent of consumers) more choices (84 percent), and more programs and incentives to address prevention and health maintenance (84 percent).

Close to half of consumers believe the health care system underperforms on delivering value

When graded on delivering value, the system receives a “D” or an “F” from almost half of respondents. Consumer sentiment that the health care system provides “poor value” for money rose from 44 percent in 2012 to 48 percent in 2013.

Value in the U.S. health care system

Using a typical report card scale with grades of A, B, C, D, and F, how would you grade the U.S. health care system with respect to getting the best value for money spent on health care?

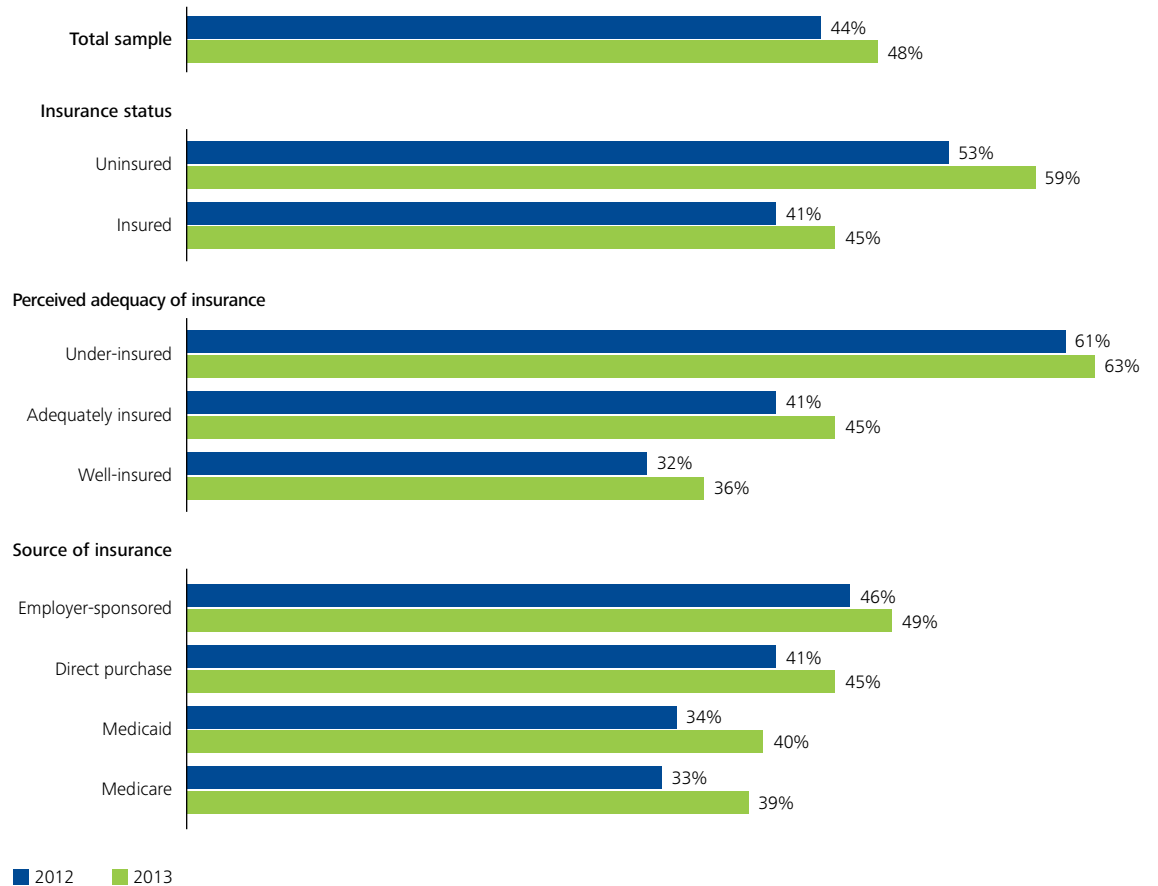


Chart shows percentage who gave a grade of “D” or “F” on a scale of “A” to “F” where “A” is excellent and “F” is failing

Source: Deloitte Center for Health Solutions: 2012-2013 Surveys of U.S. Health Care Consumers

Some consumers find the health system does not meet their needs

One in four consumers believes that the system is not meeting their needs or the needs of their families. This sentiment appears to be increasing (21 percent in 2012 vs 24 percent in 2013).

Meeting the health care needs of individuals and their families

Using a typical report card scale with grades of A, B, C, D, and F, how would you grade the U.S. health care system with respect to meeting the health care needs of you and your family?



2012: 21%

2013: 24%

Chart shows percentage who gave a grade of "D" or "F" on a scale of "A" to "F" where "A" is excellent and "F" is failing

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

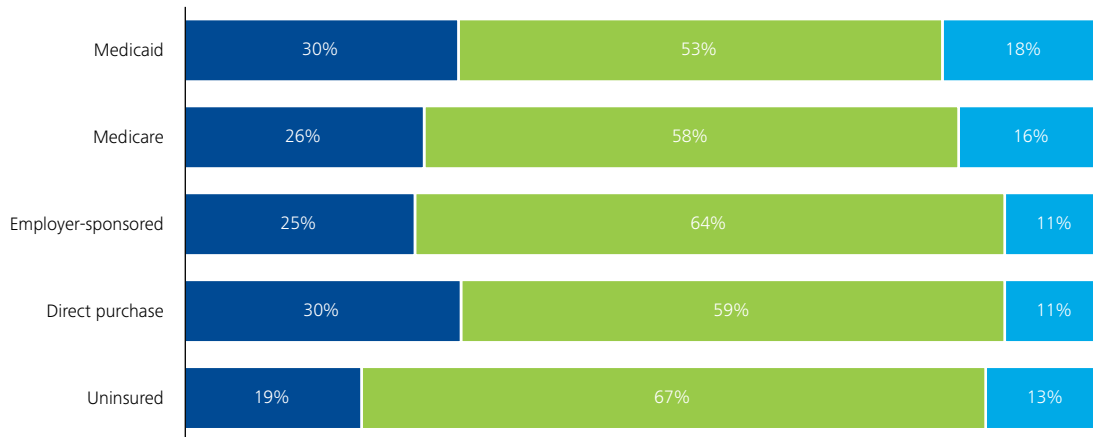
Almost 70 percent of adults think that health care costs are unreasonable

Irrespective of age or insurance status, consumers consider health care costs to be unreasonable. One in four consumers believes that health care costs are reasonable.

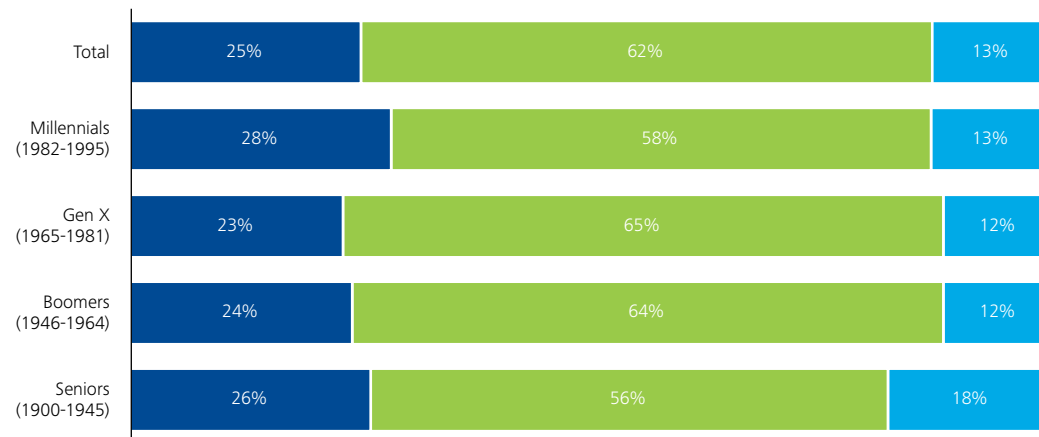
Views on the costs of the U.S. health care system

The total costs of the health care system have increased by more than four percent per year for the last three years. Does that increase seem reasonable or unreasonable to you?

Views held by insurance source



Views held by generation



Reasonable Unreasonable Not sure

Note: Data are rounded and may not sum to 100 percent

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

More “skin in the game”: uncertainty and anxiety around costs and the impact on health care decisions

Consumers are anxious about the affordability of health care. Even consumers with insurance say they have difficulty paying and are concerned that future health care costs might impair their financial security. National health expenditure data indicates that out-of-pocket spending grew from 3.5 percent to 3.8 percent from 2011 to 2012, mainly due to increased cost-sharing.¹³ Many consumers say they experience difficulty covering their medical expenses, and even more express concern about their ability to cover future health care costs. Many consumers have responded by delaying or skipping care.¹⁴

As more financial responsibility is placed onto consumers, how will they react? The answer is as yet unknown. However, several examples in which consumers have more “skin in the game” suggest that, as they are more exposed to cost, they make decisions that are cost-conscious. A 2012 study found that consumers were more likely to apply cost information to their care decisions when they had a strong financial incentive or high exposure to out-of-pocket costs.¹⁵ And when enrolled in plans that have higher deductibles (i.e., health savings accounts and HDHPs), consumers exhibited more price sensitivity and attention to the products and services for which they were paying.¹⁶ Decreased medication adherence, for instance, was also associated with increased cost-sharing.^{17,18,19} Also, lowering co-payments on highly valued prescription drugs resulted in improved clinical outcomes and reduced overall medical expenditures.²⁰ It will be essential for organizations in the health care industry to consider the potential impact of increased out-of-pocket expenses on consumers as they concurrently strive to maintain consumer loyalty and keep costs down.



Out-of-pocket spending is increasing, particularly for Gen X and Boomer generations

Nearly half of all respondents in the Deloitte Center for Health Solutions 2013 Survey of U.S. Health Care Consumers reported increased out-of-pocket health care spending in the previous year – up slightly from 43 percent in 2010 and 42 percent in 2011. This spending is highest among those who directly purchased insurance, enrollees in employer plans, and the middle generations (Gen X [born 1965-1981] and Boomers [born 1946-1964]).

Out-of-pocket spending by generation

In the last 12 months, did your household's out-of-pocket spending on health care increase, decrease, or stay about the same?

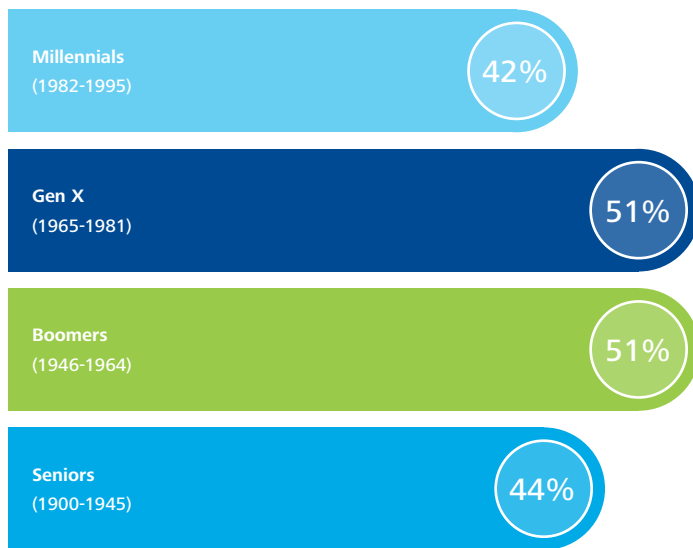


Chart shows percentage who answered "increased"

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

**Even with insurance,
some experience difficulty
paying medical expenses**

Nearly two in five respondents say they experienced difficulty paying for out-of-pocket health care expenses in the previous year, as did slightly more than half of adults without insurance. The presence of health insurance did not assist some, with almost a quarter of those with health insurance reporting difficulty meeting medical expenses.

Difficulty paying out-of-pocket health care expenses

In the last 12 months, did your household have any financial difficulty paying for out-of-pocket health care expenses?

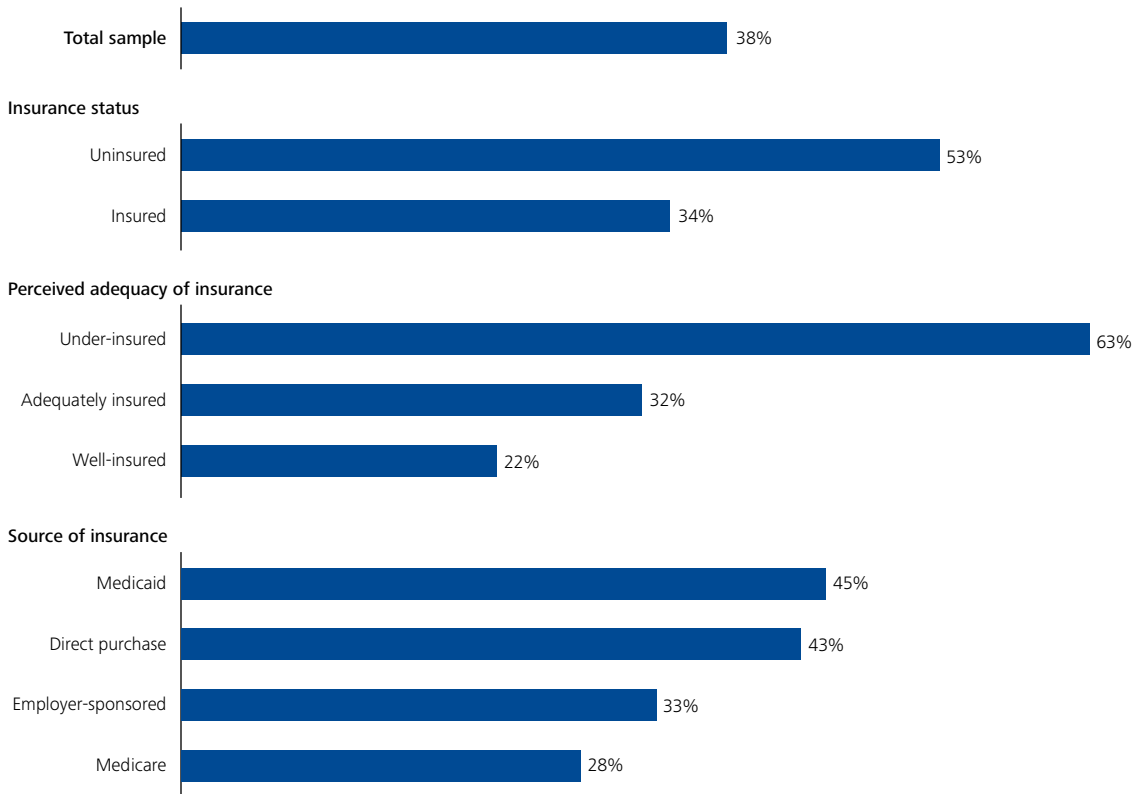


Chart shows percentage of the total sample and each subgroup who reported “yes”

Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

Perceived adequacy of insurance coverage and optimism about handling future health care costs are aligned

One in three consumers feels unprepared financially to deal with health care costs; one in five feels prepared.

Those who consider themselves to be “under-insured” are the least likely to feel financially prepared to deal with future health care costs.

Preparedness for future health care costs

To what extent do you feel your household is financially prepared to handle future health care costs?

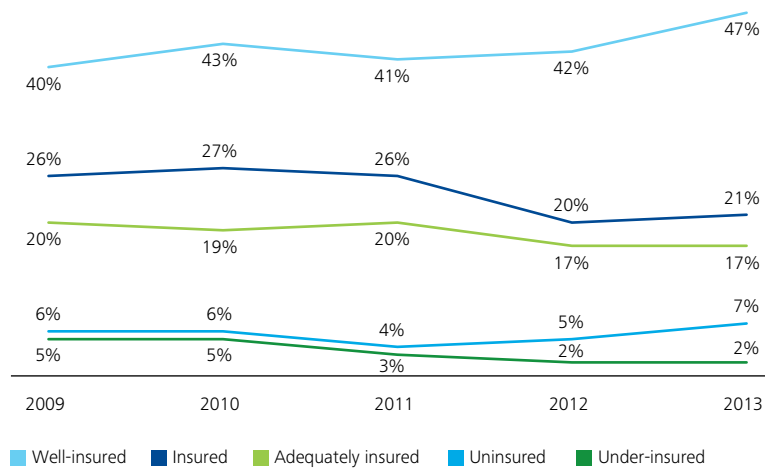


Chart shows percentage of each subgroup who reported feeling financially prepared (gave a rating of 8, 9, or 10 on a 10-point scale where 1=not at all prepared and 10=completely prepared)

Source: Deloitte Center for Health Solutions: 2009-2013 Surveys of U.S. Health Care Consumers



1 in 5 consumers feels prepared* for future health care costs

*where “prepared” is a rating of 8, 9, or 10 on a 10-point scale where 1=not at all prepared and 10=completely prepared

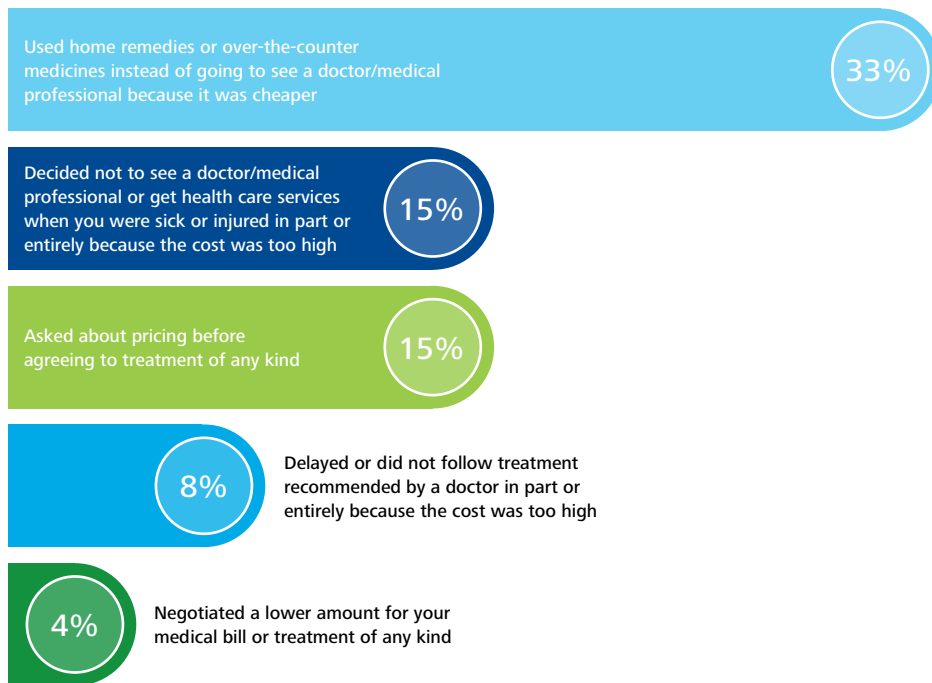
Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

One in three consumers self-rations to manage health care costs

Consumers have shown willingness to skip care and/or use over-the-counter products to avoid the cost of visits to doctors' offices and hospitals. Fifteen percent report they asked about price before agreeing to treatment.

Cost-driven behaviors

Which of the following, if any, have you done in the last 12 months?



Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

The “value” equation: understanding and demonstrating value to consumers

Increasing exposure to the costs of care, emergence of choice-oriented markets, and access to better information: each of these may lead consumers to more actively consider what “value” in health care spending means to them. Therefore, understanding the consumer value equation – a combination of price and quality attributes (both customer experience and clinical quality) – could be a key differentiator for health care organizations.

Customer service and convenience are components of the health care value equation. In focus groups, consumers defined “quality care” as providers that take their time during an appointment; are easily accessible and convenient; exhibit a good bedside manner; and demonstrate knowledge and technical proficiency.²¹ In Deloitte’s Surveys of U.S. Health Care Consumers, two out of three respondents point to service or quality issues when asked the reason behind a dissatisfying hospital experience. As consumers begin to have even more choices in health care, providing a superior customer experience may become increasingly important.

The other part of the equation, price, is slowly becoming more transparent and available for consumers to consider. But, barriers to understanding the cost of care are numerous. Price variations, negotiated rates, fragmented billing, few trusted information sources, and reporting of measures that are not relevant to consumers make health care cost information difficult to obtain and understand. In addition, for many consumers, high-quality care equates to higher price.^{22,23} The message that “more isn’t always better” has not yet resonated, despite research that shows higher health care costs do not necessarily lead to higher-quality health care.^{24,25,26}

Currently, both health plans and employers are pursuing strategies to raise consumer awareness of costs and move them towards choosing higher-value health options. Tactics such as reference-based pricing, value-based insurance, and behavioral incentives encourage consumers to select high-value providers and services.



Securing cost and quality information is one of the first steps. Few consumers say they currently research pricing and quality information, yet many report they are interested in using this information in the future to make health care decisions. For consumers to use quality and cost information, it needs to be relevant, readable, and easy to understand.²⁷ Also, as the shift to more choice-based markets occurs, consumers will have a stronger imperative to comparison shop for health care and, thus, use both cost and quality information.

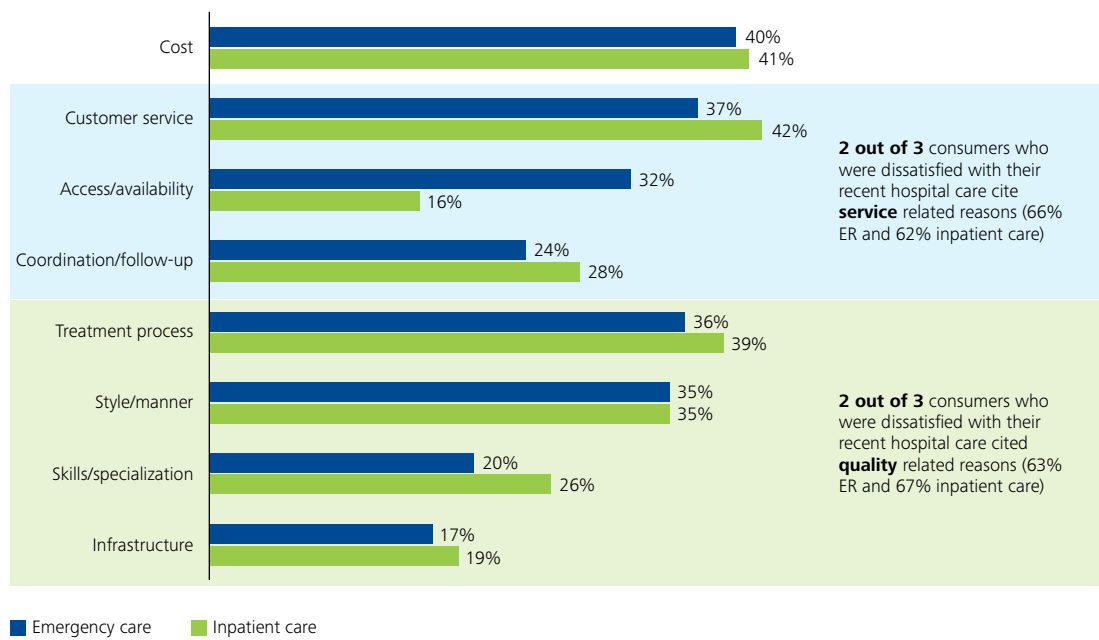
While a portion of each generational group is actively engaged in decisions about their health, the youngest generations appear to be especially inclined to take a more active role. Millennials (born 1982-1995) are the most likely to report seeking cost and quality information, as well as asking about and negotiating pricing with providers in the search for value. As these younger generations age and more frequently engage with the health care system (either for themselves or as caregivers for others), they are likely to come together to form a core customer segment for the health care industry.

Consumers value customer service and style/bedside manner as part of the overall health care experience

Customer service and style/manner of health care professionals rank as some of the top reasons for consumer dissatisfaction with recent hospital visits.

Key drivers of dissatisfaction* in health care service

Why are you less than completely satisfied with your most recent experience of care received in an emergency room or inpatient care setting?



*Chart shows those who had recently been hospitalized and were dissatisfied with their experience. Of those recently hospitalized with emergency care, 45% were dissatisfied. Of those recently hospitalized with inpatient care, 33% were dissatisfied.

Source: Deloitte Center for Health Solutions: 2012 Survey of U.S. Health Care Consumers

Future use of quality and price information is likely, despite low current utilization

Although consumers say they would like ready access to online information about quality of care and prices, few report actually seeking such information. In Deloitte’s 2012 Survey of U.S. Health Care Consumers, 13 percent looked online for quality data and 12 percent for price information – and yet, around half say they would use websites that offer quality/satisfaction rankings (52 percent) or physician price comparisons (44 percent).

Utilization and likelihood of use of quality ratings and price information

In the last 12 months, have you looked online for any of the following types of information either for yourself or a family member?



How likely would you be to use websites that offer the following?



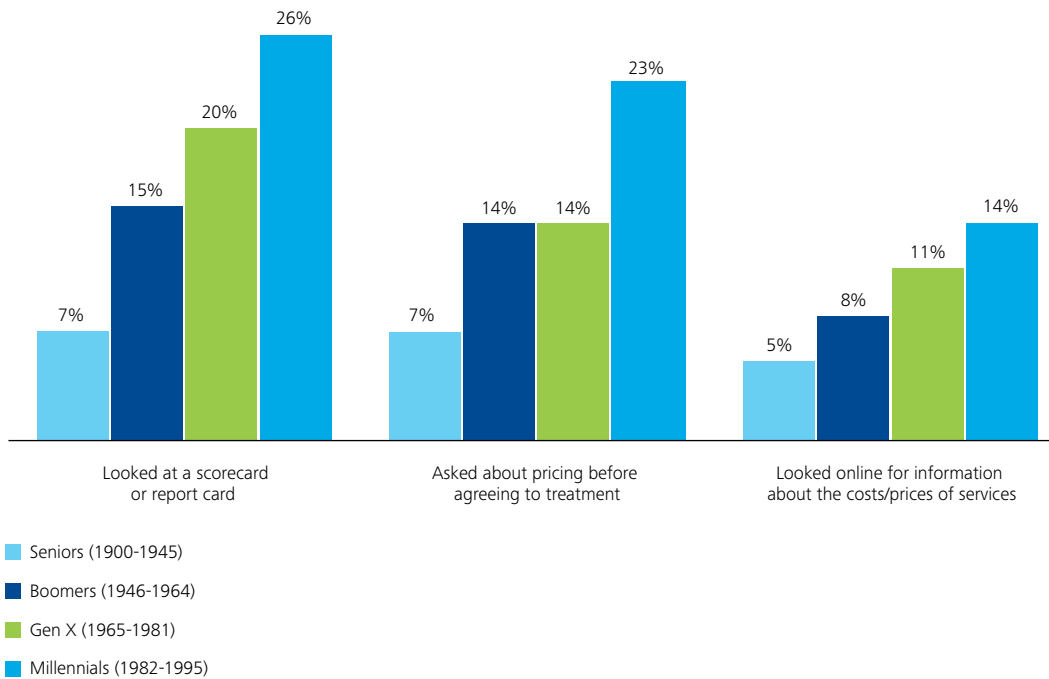
Source: Deloitte Center for Health Solutions: 2012 Survey of U.S. Health Care Consumers

Younger generations actively seek information about quality and price of care

Millennials are more likely than other generations to ask about pricing before agreeing to receive treatment, view quality scorecards, and look online for price information. The trend of higher engagement is true of Gen X respondents, as well.

Looking for value: asking about pricing, searching for quality

Which of the following, if any, have you done in the last 12 months?



Source: Deloitte Center for Health Solutions: 2013 Survey of U.S. Health Care Consumers

Final thoughts

Health care industry stakeholders may seek to become value-based, consumer-centric entities as the system shifts from a focus on volume to value and organizes around delivering quality patient outcomes.

Meanwhile, as consumers assume a greater share of health care costs and experience increased opportunities to engage in choice-based markets, value may become a driving force shaping their perceptions, decision-making, and the long-term relationships they form with providers and other stakeholders. Value, for consumers, extends beyond price to include the quality of their service experience, interpersonal interactions, and the availability of transparent information and tools that facilitate effective navigation within the health care system.

As health care organizations seek to “win the consumer” they should keep in mind the following strategic insights:

- From the viewpoint of the consumer, stakeholders can improve system value and performance by offering a better customer experience, more product choices (such as health plan options), smarter personalized technologies, and greater transparency and accessibility of price and quality information.
- In their personal touch points with the health care system, consumers consider value to extend beyond price to include convenience and customer care.
- The time is fast approaching when consumers will habitually seek price and quality information before making a health care purchase decision. Despite the low number of consumers that report looking up quality and price ratings, many consumers indicate interest in using quality and price ratings for health plans and providers. Perhaps this will occur when the timing and technologies are right and when they are more incentivized to use ratings.

- Younger generations show interest in using interactive technologies, sourcing comparative information, and being more engaged in purchase or utilization decisions. As interactions with the health care system increase for this group (either for themselves or as caregivers for others), they could become the “customer of the future.”

Each encounter that a consumer has with the health care system will need to “count” as competition increases for loyal customers served by new care and coverage models in a more retail-oriented market. Similarly, every service instance, interaction, or touch point should be considered through a personalized and consumer-centric lens. This approach will most likely become increasingly important as hospitals, health plans, life sciences companies, and medical groups seek to differentiate themselves. In time, an informed consumer, equipped with sophisticated information and tools, will hold the system accountable for improved value and high-quality care.

Stakeholders take note – do not leave the consumer out of the equation.

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Stakeholder considerations

Providers:

- Develop consumer engagement strategies by moving into the online, social media, and mobile health space. Maintain focus on security, privacy, and risk management, while also considering the four dimensions of effective mobile health: people, payment, places, and purpose.
- Use a consumer-based approach to understand what patients want and develop the capabilities to serve them as customers. A patient's experience is broader than just the clinical aspects of care; it includes the quality and value of all interactions – direct and indirect, clinical and non-clinical – spanning the duration of the patient/provider relationship.²⁷
- Evaluate each patient touch point in a health care setting for its customer service appeal. Revisit patient access, care planning, and revenue cycle management services for potential improvements.
- Take advantage of data collected in patient or customer satisfaction surveys. Analyze the customer experience through the lens of satisfaction. Seek to improve the customer experience by establishing comparative benchmarks, best practices, and continuous improvement.
- Share transparent data about the efficiency, effectiveness, outcomes, costs, and other elements of health care delivery and financing in teachable moments. For consumers to effectively engage with the health care system, data must be understandable, relevant to their particular circumstances, and easily accessible via online tools and social media.

Health plans:

- As they move into an increasingly retail-focused market with consumers as the purchaser or key decision maker, health plans need to build meaningful connections at each touch point.
 - Focus on the customer experience and continue improving tools that allow consumers to shop for, compare, and select health plans, hospitals, and doctors efficiently and effectively. According to a Deloitte survey of health plans, customer

segmentation analytics, experience, and mobility are the “table stakes” of the future. While few health plans possess these leading capabilities today, 90 percent or more will have them by 2017.²⁸

- Further develop resources and structures to provide advice and information for consumers to help them navigate the system and better manage/coordinate health.
- Understand consumers' behaviors, needs, attitudes, beliefs, and motivations.
- Use a thorough understanding of the consumer's purchase process and preferences (shopping vs. purchase, where they go, who influences them, etc.) to inform channel strategy and design.
- Use consumer insight to deliver a value-based customer experience from purchase to service through renewal.
- Establish brand loyalty with plan enrollees by providing consistent, excellent service once a consumer has signed up for a plan.
- Develop strategies to work with providers in their networks to improve consumer experience.

Life sciences companies:

- When moving towards becoming a trusted partner with consumers, emphasize strategies that focus on communication channels; consumer relationship management; the use of social channels to communicate – especially with younger consumers; and the use of data analytics to identify customer preferences. Companies should be mindful of maintaining compliance in each of the above interactions.
- Understand how global stakeholders (governments, health plans, providers, patients) define and determine “value” and “value-based competition” and how various global health systems approach the creation of value.
- Understand that a shift to competing on value will change market dynamics as to how products are identified, selected, and delivered. Utilization decisions may be made on a basis that goes beyond just clinical grounds.



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Appendix

Methodology for Deloitte's 2013 Survey of U.S. Health Care Consumers

A nationally representative sample of 4,065 American adults, aged 18 and older, responded to an online survey between February 20, 2013 and March 5, 2013. The national sample aligns with the U.S. census with respect to age, gender, race/ethnicity, income, and insurance status. The margin of error is +/- 1.6% at the .95 level of confidence.

	U.S.
Sample size	4,065
Millennials (born 1982-1995)	24%
Gen X (born 1965-1981)	28%
Boomers (born 1946-1964)	33%
Seniors (born 1900-1945)	14%
Male	49%
Female	51%
Uninsured (no health insurance)	17%
Insured (any health insurance)	83%
Employer-based insurance	57% of insured
Individually-purchased insurance	7% of insured
Medicare	22% of insured
Medicaid	11% of insured
Other/Don't Know	3% of insured
Have 1+ chronic conditions	51%

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