

RIGHT PLACE, RIGHT TIME

MARKETPLACE PERSPECTIVES ON PROVIDING HEALTH
INFORMATION TO VULNERABLE POPULATIONS



RIGHT PLACE, RIGHT TIME

MARKETPLACE PERSPECTIVES ON PROVIDING HEALTH INFORMATION TO VULNERABLE POPULATIONS

Health information can play a vital role in helping people manage their own health and make optimal use of their healthcare resources. It can help consumers understand what their insurance covers, how to access care, how to select a provider based on quality and value, and how much treatment will cost. It can teach consumers when to seek care, what kind, and where, as well as guide them in managing chronic diseases. The right information, used well, can enhance the efficiency and effectiveness of the entire healthcare system.

But as information becomes an increasingly important part of healthcare, there is reason to fear that vulnerable populations – especially the low-income, the uninsured, non-English speakers, and their caregivers – are being left behind. This has significant repercussions, for reasons both ethical and practical. On the one hand, a healthcare system that uses healthcare information as an indispensable tool cannot be

fair and equitable if the information needs of vulnerable consumers are not met. On the other, in the kind of healthcare system the nation seems to be moving toward – one based on quality and transparency – it is impossible to improve overall quality and control costs without engaging vulnerable populations. They have the potential to ensure the success of a healthcare strategy or to disrupt it.

To assess how well the market is serving the needs of vulnerable populations, to understand how various healthcare stakeholders see their own role in developing and providing information, and to identify areas for improvement, Oliver Wyman and Altarum Institute, with support from the Robert Wood Johnson Foundation, are partnering on an extensive multidisciplinary study of consumer-facing health information. (See “Vulnerable Consumers and Health Information.”) In this paper we will address the businesses and institutions that provide it.

VULNERABLE CONSUMERS AND HEALTH INFORMATION

To investigate the health information needs of vulnerable consumers, Altarum Institute conducted semi-structured interviews and focus groups with sixty-five vulnerable healthcare consumers (including low-income people, caregivers, and Spanish speakers), in addition to interviews with middle-income patients and Medicare retirees for comparison. The interviews took place in the spring of 2016. In brief, the findings include:

Vulnerable individuals are different from more stable populations in many critical ways. Their health literacy and general reading levels are low. Many have problems processing materials written in English. They value simple, jargon-free health information. Though these individuals want to be proactive about their healthcare, they are often overwhelmed with the challenges of just getting by in everyday life.

Vulnerable consumers don’t trust the healthcare system. They question the motives of all stakeholders from the government, to the insurance companies, to the clinicians themselves. Many believe that their concerns will be dismissed, that they receive substandard care, and that physicians are highly motivated to choose treatments based on financial incentives rather than patient needs. This culture of fear is reinforced by personal and family members’ experiences of being disrespected and mistreated.

Caregivers are highly engaged and hungry for information. They report tapping into any information and technology they can get their hands on. Caregivers can be easily reached with minimal effort and thus are an easy entry point to the dissemination of health information.

[Learn more about Altarum Institute’s consumer research here.](#)

Between March 1 and June 10, 2016, we interviewed 94 senior leaders at health systems, government agencies, insurance companies, health information companies, and other organizations. (For a complete breakdown, see “Stakeholder Interviews.”) For the purpose of the interviews, we defined consumer-facing health information as any print or digital content or tools intended to influence individuals’ health-related actions. We focused on three use cases: (1) helping already-enrolled members of a health plan understand their benefits; (2) assisting consumers in receiving care – anything from selecting the site of service to selecting a clinician to understanding that clinician’s orders or care plan; and (3) helping them manage health and wellness between care visits, including managing a chronic disease or other long-term medical condition. We specifically excluded information designed to help consumers select coverage and pay for care.

In our interviews, we attempted to learn:

- What individual organizations are currently doing to provide health information, what obstacles they have faced, and what results they have achieved.
- How well the market understands the health information needs of vulnerable populations.
- Whether these needs are being considered as new resources are developed.
- How stakeholders envision the future and how their organizations will need to prepare themselves.

In the following pages, we report on what we heard, looking first at the current state of health information from the perspective of individual stakeholder groups and then at three key insights we heard from across the spectrum of stakeholders. (Note: perspectives from financial investors are forthcoming.)

STAKEHOLDER INTERVIEWS



GOVERNMENT AGENCIES
8 organizational leaders



EMPLOYERS
13 organizational leaders



PROVIDERS
26 organizational leaders



HEALTH INFORMATION COMPANIES
22 organizational leaders



HEALTH PLANS
15 organizational leaders



OTHER SOCIAL AND CHARITABLE ORGANIZATIONS
5 organizational leaders



FINANCIAL INVESTORS
5 organizational leaders

THE CURRENT STATE OF HEALTH INFORMATION

As one might predict, different stakeholder groups offered very different perspectives on health information. All believed it was important, but saw very different roles for themselves in providing it.



GOVERNMENT AGENCIES

The only kind of information offered by the government agencies we spoke to (state Medicaid agencies thus far) relates to Medicaid eligibility and enrollment, which we do not directly address in our study. The agencies we spoke to did not see their role as directly providing health information to Medicaid beneficiaries (or their caregivers). Instead, they said their job is to create the right policy and reimbursement/incentive environment to encourage member health plans, as well as the providers with whom they partner, to invest and innovate. In their view, an agency should focus on long-term goals and allow health plans and providers, who are managing the day-to-day costs of healthcare, to choose where and how to invest.

While this makes sense in terms of mission, it overlooks the fact that Medicaid agencies possess valuable data that could assist consumers in making better choices. To that end, we talked to one state agency that is currently considering how to leverage its claims data to generate cost and quality information on specific clinicians, offering it to health plans, referring clinicians, and eventually Medicaid beneficiaries and other consumers.



HEALTH PLANS

The multi-line and single-line health plans we spoke with generally reported providing health information across all the use cases we were concerned

with – understanding benefits, receiving care, and managing health and wellness – because they saw it as contributing to achieving better cost and quality outcomes, fulfilling regulatory and accreditation requirements, or improving the consumer experience. All reported providing information on basic insurance concepts such as how insurance works, services covered and not covered, and consumer responsibilities and costs. They also offered resources such as triage tools (nurse hotlines, for example) and price comparison tools, or at least estimates for the most commonly received procedures or treatments.

Lastly, they also offered health and wellness guides and disease and care management resources to help consumers engage in healthy behavior and better manage their conditions. Very little caregiver-specific information was provided, though several stakeholders saw caregivers as important secondary, if not primary, consumers of some health information, particularly disease and care management resources.

A few of the multi-line plans we spoke to reported customizing or tailoring their health information offerings and efforts by line of business, such as ACA/Individual and Medicaid, while the majority provided the same information across all lines. All offered some pieces of information in multiple languages, most often in Spanish.

Most single-line Medicaid plans tended to tailor their information for their consumers' unique needs and really emphasized the need for community-level engagement. Among other things, these plans offer multiple communication channels (face-to-face, text, phone, web, patient portals). They provided non-English speakers access to translated materials and 24/7 translation services (some via bilingual staff and others via third-party services). These plans are using community health workers to ensure that their members understand their coverage and select appropriate sites of care. Some have started to help their members deal with non-clinical health needs as well, providing information and resources to help resolve, for example, issues with housing and nutrition, thereby allowing these consumers to spend less time worrying about daily necessities and more time on their health.



CASE STUDY #1: BUILDING A HEALTHY COMMUNITY

As part of its population health strategy, one health system focused on improving the environment of its highly diverse community. Starting with needs assessments and community visioning, the system brought community members together to find ways to make the community healthier. The conversation went far beyond talk of clinics and classes – and so did the results. To address unemployment, the health system created a mechanism to fund small businesses willing to relocate to the area around its hospital. It engaged in discussions of how its facilities could better meet community needs. This led to one hospital parking lot being converted to a grocery store that serves both vulnerable individuals and other community members.

The system's multi-ethnic population led it to translate all health information materials into multiple languages and to partner with organizations representing various segments of the community for outreach and cultural relevance. Several initiatives integrated communications with treatment. One program remotely monitored patients in danger of relapse and texted or phoned them if warning signs were detected. Another partnered with a diabetes management company to provide real-time support for Hispanic patients with type 2 diabetes.



PROVIDERS

The healthcare providers we spoke to overwhelmingly focused on health information related to accessing care and managing health and wellness between care visits. These types of information are seen as improving healthcare outcomes and quality. This was especially true for doctors and hospitals working under fee-for-value contracts.

All providers emphasized the key role clinicians play in delivering a wide variety of health information to consumers, but acknowledged that it is ad-hoc and situational, and frequently depends on the patient-clinician relationship, specific medical needs, and physician availability. Some have started to use the web to provide cost and quality information on select procedures, but they described it as a work-in-progress that currently lacks the ability to customize information based on consumers' specific insurance coverage.

For higher-risk patients or those who had undergone complex procedures, most providers offered self-care information in print or on the web, supplemented by face-to-face or telephonic care coordination services. Again, very little caregiver-specific information is provided, but most stakeholders viewed caregivers as important consumers of the previously mentioned sources.

Most providers stated that they provide care for all populations, including vulnerable populations, as part of their social mission as faith-based and/or non-profit organizations. All of these providers emphasized that they take a "population view", not an insurance view or method-of-payment view; and they do not view vulnerable consumers as a separate category of patient.

So while the information resources described above are available to all patient populations, providers admit that they have taken only limited steps to optimize these resources for vulnerable populations by providing translations, creating content on mobile-friendly platforms, or building in cultural awareness. A handful of forward-looking providers are specifically supporting their vulnerable populations by partnering with community resources to address food and housing issues as well as access to care. Some mentioned working with food banks to distribute food boxes containing healthy food items to those in need, while others noted joining local non-profit organizations in setting up mobile health clinics in underserved areas to better reach vulnerable individuals.



CASE STUDY #2: BEING AN EMPLOYER OF CHOICE

A large retailer wants to become an employer of choice by helping employees save money and become healthier. Health information is a major part of its strategy, but the company believes it needs to go further. “We are saying information alone is not enough,” one executive told us. “Information tied to access to resources – that is how information is going to be helpful.”

The company leverages its managers’ strong relationships with their teams by having managers lead discussions on health and well-being. With its retail mindset, the company segments and sub-segments its employee population, targeting them with appropriate health messages. (For example, 18- to 25-year-old males hear less about flexible spending accounts and more about the cost of using the emergency department as a primary care provider.)

The company also makes use of its own products and services to address issues with access and cost. It offers employees discounts on fruits, vegetables, and athletic equipment to address cost barriers to making healthy decisions. It also provides transportation support to address physical access barriers.



EMPLOYERS

When asked why they provided health information, most self-insured employers cited a combination of decreasing medical costs, maintaining a healthier workforce, and attracting and retaining talent. They wanted employees to make better decisions about receiving care and managing health and wellness, and they felt that information on managing benefits should be the plan administrator’s role, not theirs.

Intentionally or unintentionally, employer-provided information (with the exception of events like health and wellness fairs) tends to be available only to enrollees in the company’s health plan. Vulnerable employees (and for purposes of our research, an employee without insurance is vulnerable by definition) are mostly excluded. However, since lower income employees, especially those working part-time, can cycle in and out of commercial insurance, Medicaid, and insurance altogether, information made available to enrollees is still insightful because of its potential to create life-long information-seeking habits that transcend insurance status.

Most employers offered price transparency tools. They provide health and wellness guides (for example, brochures on the importance of diet and exercise) to encourage healthy lifestyles. Caregiver-specific information and tools were not offered by the employer stakeholders we spoke to. Within the workplace, some employers have encouraged team discussions around health-related topics and have provided in-person resources to assist employees in dealing with health issues such as finding access to care and finding specialists for specific conditions. Employers also have the ability to change benefit design to encourage the use of health information (or penalize the failure to use it). Some, for example, are implementing reference pricing for pharmacy and imaging.

The most progressive employers are focusing on improving the health of their entire employee population, which takes into account both enrolled and unenrolled employee populations. These employers are creating clinics or other forms of on-site access to healthcare and are addressing non-clinical health needs, such as access to healthier food and resources for regular exercise.



CASE STUDY #3: TAILORING SERVICES FOR VULNERABLE POPULATIONS

Though most health information companies focus on health plans, providers, and commercial populations, at least one has committed to serving vulnerable consumers and has actively tailored its solutions to better suit their needs.

Funded with foundation grants, the company crafted its content at fourth- and fifth-grade reading levels while also creating easy-to-follow video tutorials. Understanding that vulnerable populations often face day-to-day economic difficulties, it has adapted information to be more sensitive to economic insecurity, neighborhood safety, and food access. The company has also developed a comprehensive Spanish version of its product.

Such efforts have led to great success in terms of health outcomes and engagement levels among vulnerable members. According to an executive at the company: “In that large group about 500 have been in the program for over a year and have a 4.2 percent sustained weight loss. In terms of engagement it’s in line with our general population” – and welcome evidence that it is possible to serve vulnerable consumers and serve them effectively.



HEALTH INFORMATION COMPANIES

The health information companies we spoke to provided content and delivery means (such as apps) for all three use cases. Some specialize in a specific use case, such as price transparency or medical second opinion, while others focus on population segments, such as people with diabetes or those with high utilization. Most of these companies viewed their primary market as the commercial insurance market – either self-insured employers or insurance companies – because these customers can afford to pay for such services and offer information companies a proven business model.

These companies do not deliberately target vulnerable populations, but because many products focus on high-cost claimants, their end users do include or touch some vulnerable consumers, particularly caregivers. Health information companies serving Medicaid plans (and increasingly commercial plans with ACA/individual market business) have developed community-level engagement programs and tactics – for example, going to a patient’s home or workplace to deliver health information or encourage a visit to a primary care provider.

Very little is directed at the uninsured, though at least one transparency tool on the market is free and in principle could be used by an uninsured person. While some companies have translated materials for non-English speakers, such efforts were not common, and little has been done to address cultural relevance. Looking forward, some health information companies believe they could adapt their products for vulnerable populations. Very few have made plans to create such products, however, because they do not currently believe health plans, at-risk providers, or employers are willing to pay for them.



OTHER SOCIAL AND CHARITABLE
ORGANIZATIONS – FOOD BANKS AND
SOCIAL SERVICE ORGANIZATIONS – SURROUNDING
VULNERABLE POPULATIONS

The social organizations we spoke with did not directly supply information aligned to our use cases of interest. But they believed the information and resources they do provide – including support in obtaining food, shelter, and other daily necessities – indirectly address health and healthcare needs. Furthermore, these organizations recognize that they have important engagement points with vulnerable consumers. They are starting to think through, and in a few instances develop investment cases for, how to use their touch points with vulnerable individuals to deliver health and healthcare services, including health information.

THESE ORGANIZATIONS
RECOGNIZE THEY
HAVE IMPORTANT
ENGAGEMENT POINTS
WITH VULNERABLE
CONSUMERS.

KEY INSIGHTS ACROSS STAKEHOLDER GROUPS

In the course of our interviews, three key themes emerged:

1. Stakeholders recognize that the health information they currently provide does not adequately enable consumers, vulnerable or otherwise, to make informed healthcare decisions; but their response to the issue depends on – and is potentially limited by – broader organizational priorities.

There was a strong consensus across stakeholder groups that all health information had to be more accessible, understandable, and actionable. Many recognized that for this to happen – especially for vulnerable populations – any print or digital content relating to, for example, insurance benefits, price comparison guides, and health and wellness guides, must be tailored for specific audience needs. (For example, adjusting language to accommodate users who read at a low-literacy level.) But they were unclear on the exact “recipe” they needed to follow and where to start. Finally, stakeholders recognized that information resources are useless if consumers do not know they exist. Most actively publicize their health information through traditional channels such as benefit handbooks, employee intranets, and patient portals, but they are aware that they need to do more.

STAKEHOLDERS
RECOGNIZED THAT
INFORMATION
RESOURCES ARE USELESS
IF CONSUMERS DO NOT
KNOW THEY EXIST.

Caregiver-specific information content and tools are a mostly unexplored area, with most stakeholders acknowledging caregivers’ importance, but not able to quantify the market need or size.

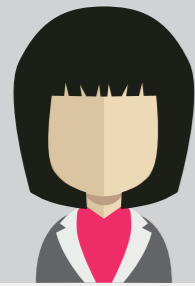
Organizations varied widely in both how they prioritized making health information more effective and the resources they devoted to it.

In part, the variation was related to each stakeholder group’s original motives for offering health information. For example, when an employer provides information on selecting a healthcare provider, the goal is to get employees to visit higher-quality, lower-cost sites of care in order to reduce costs and improve outcomes. When a provider offers the same kind of information – for example, information related to its quality metrics or lower cost – the goal is more likely to encourage consumers to use its network. (See “Stakeholders Have Differing Motivations and Paths to Providing Health Information.”)

Employers, health plans, and providers are especially focused on health information related to receiving care and managing health and wellness because it can lead to cost and quality improvements for the system. This can lead to multiple stakeholders providing information on the same health need or topic to consumers, potentially confusing the consumer as to which they should seek out and listen to, and certainly duplicating stakeholder efforts and resources.

The ultimate decision to provide any health information came down to each organizations’ strategic imperatives – the “North Stars” that drive investment priorities. The health plans we talked to, for example, had imperatives that ranged from growing membership to reducing medical costs. For providers, the list went from adopting a population health strategy to improving consumer experience and satisfaction.

Certain strategic imperatives – such as surviving the highly turbulent beginnings of the ACA market by reducing medical loss ratios – caused some stakeholders to halt their investments in consumer-facing health information. Other imperatives – such as adopting a population health model or reengineering consumer experience – caused organizations to launch new health information initiatives and to create new information-oriented positions such as care navigators and care coordinators. Caregiver-specific information was mostly described as a second- or third-order effect of one of these other initiatives, for example, a population health objective leads to improved chronic condition self-management tools which in turn lead to caregiver-specific supporting information.



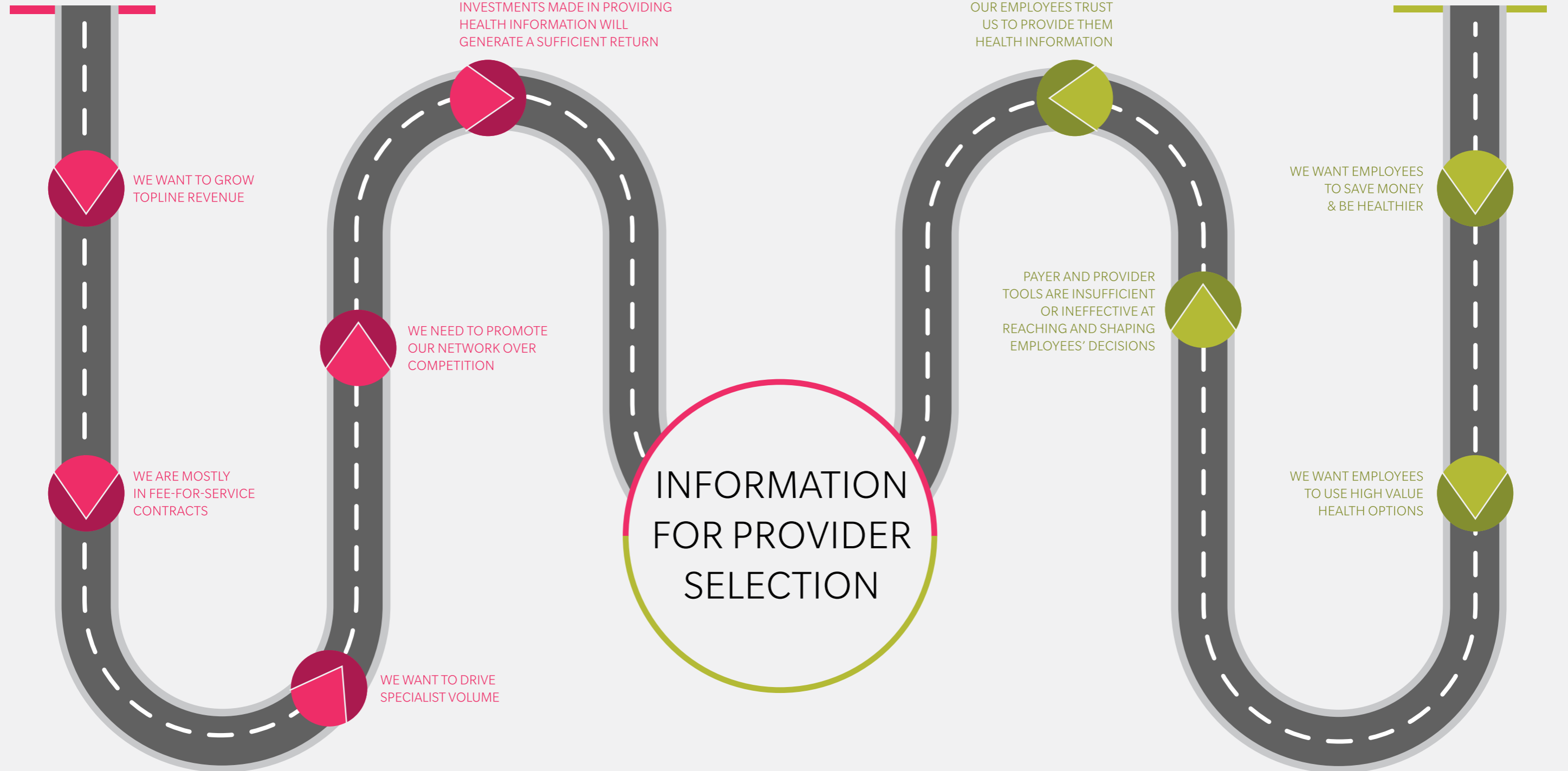
STAKEHOLDERS HAVE DIFFERING MOTIVATIONS AND PATHS TO PROVIDING HEALTH INFORMATION

Stakeholders arrive at prioritizing the same health information in very different ways. What follows is an illustrative comparison of the logic leading two stakeholder groups to prioritize and provide the same information.



PROVIDER

EMPLOYER



Tellingly, no organization saw providing health information as a strategic imperative. It was not that health information was viewed as unimportant. Rather, it is that it was seen in terms of how it contributed to other imperatives. As an executive at one health plan said, “We don’t have a bucket we call health information. I’d say there is a thread throughout the entire journey that is about knowing what they need to know with time relevance.”


In other words, many of the stakeholders we spoke to are focusing on improving existing health information offerings to enable informed consumer decision making – especially by adding care coordinators, navigators, social workers, and telehealth (which improves access to health information and helps with triage). But they are doing so because it is a necessary element of larger strategic imperatives.

2. No one yet has “cracked the nut” on providing health information to vulnerable populations, and stakeholders identified numerous barriers to progress, including industry-wide issues, organizational limitations, and the ongoing challenge of consumer engagement.

The senior decision makers we spoke to told us that they see barriers to providing effective health information at every level of the healthcare system. And they are frustrated at the need to confront not only their own organizations’ difficulties, but also system-wide issues over which they have little influence. There was pervasive concern over the intractable challenges of getting consumers, particularly vulnerable consumers, to engage with health information.

Their list of challenges includes:

Regulation. At the system-wide level, many stakeholders felt that innovation was being blocked by regulations such as HIPAA, along with administrative and bureaucratic requirements that make them less able (and less willing) to develop new health information assets. Some Medicaid plans singled out the regulated Medicaid benefit design, which does not permit tools such as cost sharing to incentivize members to select lower-cost care. Given the regulation, they questioned whether it made sense for them to invest at all in resources to help Medicaid consumers select an appropriate site of care.



ORGANIZATIONS
RECOGNIZE
PROVIDING HEALTH
INFORMATION IS
IMPORTANT, BUT ROI IS
DIFFICULT TO MEASURE.

Reimbursement. Most providers operate under fee-for-service contracts; they are not paid to provide health information or educate consumers about general health and management of chronic conditions. This absence of payment was also a concern to health information companies, whose leaders said they needed more financial incentives – or at least a clearer economic model – before they could develop products for vulnerable populations.

Data exchange and information systems.

In their efforts to better understand consumers and provide better services to them, several stakeholders expressed frustration at the lack of collaboration around consumer-oriented data. Health plans have vast amounts of their members’ health data while providers have numerous insights into the clinical history and current needs, as well as preferences of their patients. However, such consumer information is often not shared with, for example, health information companies that would find such insights invaluable in developing better consumer-facing solutions. In addition, the information technology platforms at many organizations are still basically business-to-business oriented and transactional (e.g., paying of claims) and are not adequately configured or scalable to handle the increased loads that come with consumer-facing technology services.

Return on investment. While organizations may recognize that providing health information is important, they find it difficult to prioritize, largely because ROI is difficult to measure. Commonly available metrics such as web traffic and call volume are suggestive but lack the detail companies need to justify significant investments. One health plan executive lamented, “I’m a business guy. I’m charged with running a P&L, I’m charged with balancing membership and financial sustainability. That was the problem. I couldn’t measure it. I couldn’t make it pay back, because I couldn’t track it all.”

Engagement. Stakeholders cited a host of challenges in effectively engaging vulnerable consumers. It can be difficult simply to reach them, because many lack stable physical addresses, e-mail addresses, or phone numbers. Some stakeholders were concerned that many vulnerable populations can have an unfavorable view of the healthcare system, leading them to avoid care until it is absolutely necessary. Others said the same was considered true of some non-English speaking groups that have cultural tendencies of avoiding care, instead preferring home remedies. Still others believed vulnerable populations simply have never learned how to navigate the healthcare system. Lastly other stakeholder believed daily necessities such as food, shelter, electricity, and gas are more pressing concerns than health. These factors also restrict individuals’ ability to act on health information provided – a consumer who has been taught to eat well may still lack the money and opportunity to buy healthy food. The overwhelmingly majority of these insights were based on anecdotal or secondary data – very few have done direct primary research.

3. If current trends continue, health plans and providers will drive any improvement of health information for vulnerable individuals, while government agencies, health information companies, and social organizations will play supporting roles.

Those stakeholders ultimately responsible for “paying the bill” feel they are primarily responsible for designing and implementing an improved health information end-state. Here’s how one provider executive put it: “I think

information historically comes from whoever’s at risk. If it’s now a [fee-for-value] environment, then information comes from both the provider side and the plan side, because both are at risk. It’s really health plans and organizations that are at risk for a certain population that are or should be communicating to those folks, because it’s in the organization’s best interest and it’s in the patient’s best interest.”

Each stakeholder group has perceived advantages in leading improvement efforts: Most of the health plans we spoke to thought they had the best integrated view of consumers’ health data and, therefore, needs; while many providers thought they have better and more influential relationships with consumers that can drive greater consumer engagement. Together, they do potentially have significant consumer understanding and influence points.

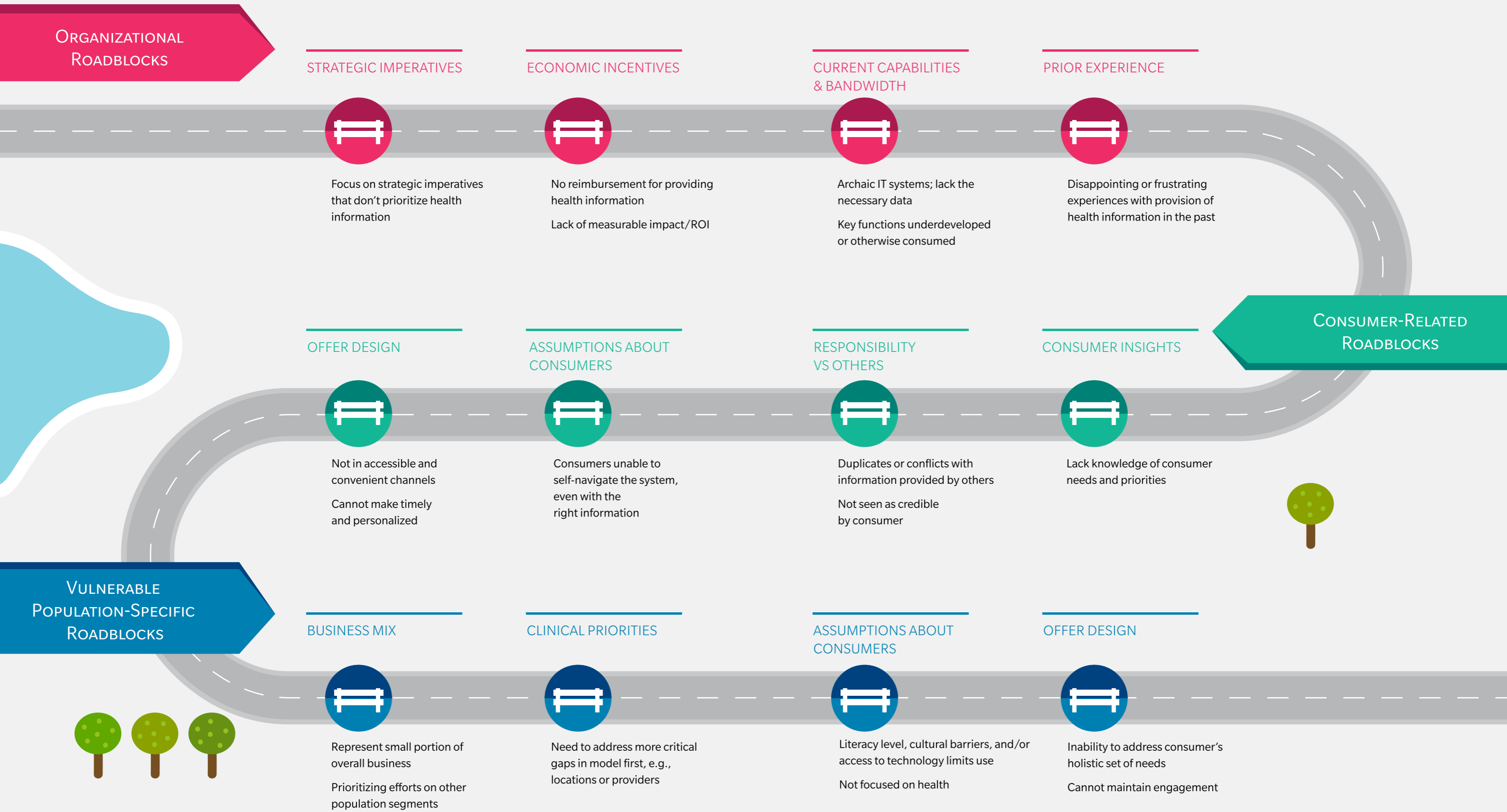
Furthermore, some health plan and provider stakeholders talked about being a primary customer for health information companies, giving them the leverage to shape the products and services that will be offered in the future. This, however, requires health plans and providers to gain sufficient knowledge of vulnerable consumer needs, which hopefully this study will help address in the coming months.

While government agencies, health information companies, and social organizations are also important in the health information space, they see themselves as playing supporting roles in driving improvements. Government agencies, which again see themselves as mostly responsible for creating incentive structures for plans and providers, have implemented measures such as steering members to high-performing health plans and disseminating performance bonuses to organizations that prioritize outcomes. Health information companies will cater to the demands of plans and providers in developing solutions going forward given the existing business model. Social organizations – such as food banks and charitable foundations – see health information as tangential to their organizational missions but will support healthcare players in addressing non-clinical health needs – such as lack of food and shelter – that might prevent consumers from focusing on health information and their overall well-being.



ROADBLOCKS TO DELIVERING HEALTH INFORMATION TO VULNERABLE POPULATIONS

Most marketplace stakeholders recognize the importance of health information, but there are many obstacles that get in the way of delivering it to vulnerable populations.



LOOKING FORWARD

Despite the many challenges that organizations face in providing effective health information to vulnerable populations, we heard encouraging news in our interviews: Most stakeholders across the U.S. healthcare system recognize its importance; many understand in general terms how health information needs to change to serve these populations' needs (though more specific tactics and plans are needed); many have a reasonable vision of who needs to do what going forward; a few are laying the groundwork for improvement efforts down the road and another few are already taking action.

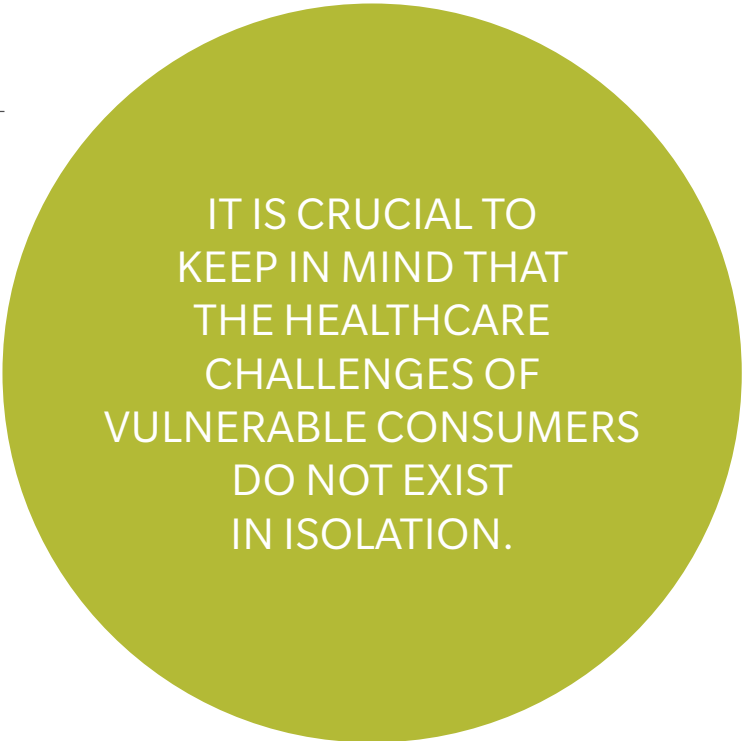
But what will it take to accelerate the pace of change?

Certainly, the aforementioned issues around regulations, data connectivity, returns on investments, and consumer engagement need to be addressed. These are issues greater than one organization or even group of organizations in one healthcare sector – multi-sector collaboration and cooperation will be required. Incentives also remain a key issue in a healthcare system that has only partially transitioned toward fee-for-value models. We know, for instance, that information companies could be developing new tools if they believed they would be paid for them. And providers and health plans would be willing to pay for them if it was clearly worth their while. A gradual fuller adoption of value-based care will break the logjam, but a near-term accelerant would be welcome.

Finally, it is also crucial to keep in mind that the healthcare challenges of vulnerable consumers do not exist in isolation. They are inextricably tied to issues of poverty, social isolation, language, and culture. To attempt to deal with one of these issues without considering the others is a recipe for failure. This is not to say that collectively these issues are insurmountable, but rather that some organizations

may be better served helping to address these non-health, but health-determining issues before turning to health itself.

We continue to be hopeful. Taken as a whole, our interviews indicate that increased provision of more effective health information for vulnerable populations is a strong possibility in the near future. The biggest uncertainty is the timeframe or rate of change, which depends in part on each organization's other competing priorities. The healthcare ecosystem's challenge is to make health information rise to the top. We hope these efforts to better understand stakeholders' current thinking and uncover key obstacles and roadblocks will aid the search for ways and means of driving positive change and progress.



IT IS CRUCIAL TO
KEEP IN MIND THAT
THE HEALTHCARE
CHALLENGES OF
VULNERABLE CONSUMERS
DO NOT EXIST
IN ISOLATION.

AMERICAS

+1 212 541 8100

EMEA

+44 20 7333 8333

ASIA PACIFIC

+65 6510 9700

ABOUT OLIVER WYMAN

Oliver Wyman is a global leader in management consulting. With offices in 50+ cities across 26 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm's 3,000 professionals help clients optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE: MMC], a global team of professional services companies offering clients advice and solutions in the areas of risk, strategy, and human capital. With 52,000 employees worldwide and annual revenue exceeding \$10 billion, Marsh & McLennan Companies is also the parent company of Marsh, a global leader in insurance broking and risk management; Guy Carpenter, a global leader in risk and reinsurance intermediary services; and Mercer, a global leader in human resource consulting and related services.

Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions.

Oliver Wyman launched the Health Innovation Center (OWHIC) in 2011 dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today's and tomorrow's challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas.

For the latest on the business of transforming healthcare, visit Oliver Wyman Health digital platform at health.oliverwyman.com.

For more information, visit www.oliverwyman.com.

Follow Oliver Wyman on Twitter @OliverWyman.

AUTHORS

GRAEGAR SMITH

Principal

graegar.smith@oliverwyman.com

HELEN LEIS

Partner

helen.leis@oliverwyman.com

With special thanks to Joseph Hsu and Gary Zhu.

Copyright © 2016 Oliver Wyman

All rights reserved. This report may not be reproduced or redistributed, in whole or in part, without the written permission of Oliver Wyman and Oliver Wyman accepts no liability whatsoever for the actions of third parties in this respect.

The information and opinions in this report were prepared by Oliver Wyman. This report is not investment advice and should not be relied on for such advice or as a substitute for consultation with professional accountants, tax, legal or financial advisors. Oliver Wyman has made every effort to use reliable, up-to-date and comprehensive information and analysis, but all information is provided without warranty of any kind, express or implied. Oliver Wyman disclaims any responsibility to update the information or conclusions in this report. Oliver Wyman accepts no liability for any loss arising from any action taken or refrained from as a result of information contained in this report or any reports or sources of information referred to herein, or for any consequential, special or similar damages even if advised of the possibility of such damages. The report is not an offer to buy or sell securities or a solicitation of an offer to buy or sell securities. This report may not be sold without the written consent of Oliver Wyman.