

**FIX THIS/HEALTH CARE** February 23, 2012, 5:00 PM EST

## The Massachusetts Lesson on Fixing Health Care

Affordable health care is available to nearly all residents of the state, while cost increases have been slowing down

By [Dr. Ralph de la Torre](#)

Affordable health care for all U.S. residents is well within our reach. You'd never know this by listening to the polarizing debates among Presidential candidates. In March, the rhetoric will get harsher as the U.S. Supreme Court hears oral arguments on whether it's legal to make all Americans purchase health insurance, a pillar of President Barack Obama's Affordable Care Act. We'll also have the spectacle of several Presidential candidates repudiating the health care overhaul Mitt Romney himself promoted as governor of Massachusetts. Those reforms, in many ways, were the model for the national law that's on the firing line.

Bombarded by facts and fictions about Obamacare, many Americans may not realize that the experiment in Massachusetts is very much on track. More than 98% of state residents now have health coverage—the nation's highest level. The Massachusetts companies out in front of this transformation have been able to provide quality care to a diverse population while holding down costs. This has big implications for how the health-care crisis can be solved at a national level.

First, to clarify: Massachusetts hasn't solved the riddle of rising costs. Total health-related spending has risen sharply since 2006, when the state enacted laws requiring all residents to obtain coverage. Fortunately, there has been significant progress in the past year, with the pace of cost increases slowing down in some areas.

Our company, Steward Health Care System, operates 10 hospitals in Massachusetts. We serve more than 1 million patients, most of whom receive care in the communities where they live or work. We're now in the process of linking all our facilities to let patients, nurses, primary care doctors, and specialists see exactly the same information when they call up electronic medical records. This helps us coordinate patient care, eliminate redundant tests, and reduce errors—all of which lower costs.

Creating this community-based model required resources. Steward committed \$400 million to capital improvements at our hospitals, including IT systems. These steps are now on track to produce hundreds of millions of dollars in savings over the next three years. Patients enjoy a higher level of care and ultimately will also benefit from lower insurance premiums. The insurance plan Steward currently offers to more than 17,000 employees and their families is priced substantially below competing products. In January, in a partnership with Tufts Health Plan, we rolled out a similar offering for small businesses that's about 20% less expensive than other plans in the state.

### **NOW IN VIEW: 100% COVERAGE**

This is a long way of saying that the most cherished ideal—for me, personally, and for Steward—is now plainly in view: delivering affordable health care to 100% of residents in our reach.

At a hospital level, some components of total medical costs aren't amenable to change. Labor makes up about 60 percent of the pie and doesn't go away. As much as 30 percent goes to drug treatments and devices, with the remainder consumed by other fixed costs. This breakdown probably stays steady—but that doesn't mean there's no way to “bend the cost curve,” as people in the industry say.

Let's start with the small, more obvious places. In an integrated medical system, you reap economies of scale by consolidating back-office functions (IT, legal) and other such steps. You may also be able to bring economies of scale in clinical operations such as cardiology—merging duplicative activities into one structure. More important are savings based on standard quality management methods: If 10 hospitals are running 10 different routines in high-tech examination rooms known as catheter labs, it's almost impossible to spot recurring errors. Get all 10 labs working from the same checklists and you'll have a much better chance of fixing flawed practices that lead to misdiagnoses and higher medical costs.

Changes at the hospital level are important, but don't expect savings of more than about 6 percent. At the macro level, the key is a credo we call right-siting. If a patient seeking specialized attention at an expensive academic research center can be treated just as effectively at a hospital near his or her home or office, why send that patient to a premium center? If treatment is available at the doctor's office, this may be even safer, cheaper, and more efficient. And if care can be delivered at the patient's home, even better. Each step down to the next rung I have just described yields cost savings of about 20 percent.

### **RIGHT-SITING: EFFICIENT AND FAIR**

Right-siting also has an important, equalizing impact on the insurance premiums patients pay. In Boston, the same medical procedure may be reimbursed at a higher rate when performed at an

academic research medical center, compared with reimbursements at local hospitals. In effect, this means poor patients, who generally choose to stay local, subsidize the wealthy ones who hop in their cars and drive downtown. At Steward, care is contained in the community hospitals, unless the patient's condition requires specialized attention at an academic research center.

There is one caveat to right-siting. This approach only works if you have rigorous systems to monitor medical outcomes and ensure the quality of care. The method cannot be executed without standard processes, a robust IT infrastructure, and a culture that ensures patients get focused attention from all the staff. Success also depends on the availability of skilled primary-care doctors, who are tasked with making decisions on the location of care. We have more than doubled the number of primary care physicians in the last 1 1/2 years.

Today we're geared up to think of reform in terms of insurance reimbursement rates. In fact, rates will have little to do with the future cost of health care. The real problem is utilization by a huge swath of aging baby boomers demanding more attention. Because most doctors are currently paid under the fee-for-service model—which rewards the volume of care—elderly patients moving from doctors' offices to hospitals to clinics are tested and retested, dosed with medications and re-dosed, all without proper tracking or coordination.

This mode of payment has to change. We have replaced the fee-for-service model with an approach known as global payments—also called a risk-capitated model. In a nutshell, payers (insurers and employers) give physicians and their staff a fixed sum of money each year to manage the health of their patients. If this in-network medical team exceeds its budget for the patient, the doctors must pay the difference. If the team keeps the patients healthy and has money left over, profit is pocketed. To make sure nobody cuts corners or skimps on necessary care, medical teams receive bonuses pegged to meeting meticulous quality goals. At Steward, 90 percent of patients not covered by Medicare or Medicaid are treated under the global-payment model.

## **GUIDELINES ON DRUGS AND TESTS**

The next step is for physicians to set medical guidelines describing what tests and interventions are suitable for different patients. The rules must be grounded in solid research on comparative effectiveness. I concede that the body of medical data we depend on today needs work. What's more, getting groups of geographically and culturally different physicians to agree on standards can be difficult. But at Steward, we have succeeded in developing a variety of guidelines built on consensus among experts in our network. We've come a long way in slashing duplicative testing. In some cases, we have shown patients evidence that expensive new drugs or surgeries they think they want will not lead to the outcomes they desire.

Some commentators seem tempted to blame America's cost woes on patients who demand unnecessary, counterproductive tests or treatments. But how can we blame patients who are besieged with messages from shiny new cardiology centers and neurosurgery units? Is it the hospitals that have steered us astray? Or medical specialists? In truth, each piece of the care chain is linked to every other. The lock and key to this chain of woe is a revenue-based medical system that is already out of date. Forward-thinking health-care systems across the United States are starting to apply some of the same principles described above: creating value through quality incentives, global payments, IT-driven integration, and care in local communities.

While a revenue-based model hinges on increasing the volume of patients and procedures, a cost-based model draws strength from the opposite. For some hospitals—especially academic research institutions priced at the top of the food chain—this transition will bring painful adjustments. Yet the shift from a revenue-based, drive-the-top-line culture to a cost-based paradigm is inexorable. In the integrated, community-based health-care networks of the future, hospitals, doctors, nurses, and patients will all have access to the same high-quality information. We are all working off the same playbook. Under the new rules, it is wellness and disease prevention, not volume of care, that must come first.

*Dr. Ralph de la Torre is the chairman and chief executive officer of [Steward Health Care System](#), New England's largest community health-care operation.*