

# Bloomberg Businessweek

## Technology

### How the Experts Would Fix Health Care

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People are living longer. Life-threatening diseases have been eliminated. What were once considered medical miracles are now commonplace procedures. Yet there's a near-universal sense that the U.S. health-care system is a heaving mess, rife with errors and injustices. It's expensive, too. By 2020 related costs will reach an estimated \$4.6 trillion, nearly 20 percent of gross domestic product. So how do we fix health care? That's the question *Bloomberg Businessweek* Chairman Norman Pearlstine put to our esteemed panel: **Dr. Ralph de la Torre**, chairman and chief executive officer of Steward Health Care System; **Dr. Gregory Curfman**, executive editor of the *New England Journal of Medicine*; **Gail Wilensky**, economist and senior fellow at Project HOPE; **Ronald Williams**, former chairman and CEO of Aetna; and **Jonathan Bush**, CEO, president, and chairman of Athenahealth. Their conversation has been condensed and edited.

**Pearlstine: Is it possible, given the culture of the U.S., to change the way we implement health care and impose some things that have worked well overseas?**

**Williams:** In Europe, there's a notion of solidarity. If you're 80 years old and you do not qualify for a hip replacement, it's OK as long as your neighbor does not qualify for a hip replacement. In the U.S., [it's] "I'm going to get mine or you're going to hear from my attorney." We have to have a thoughtful, mature debate recognizing there are limits to the country's resources and care should be delivered based on the physician's judgment.



Fix This/Health Care panelists

**Wilensky:** The horse has left the barn when it comes to using what other countries have done. A lot of what they do is not only to have a [central] budget, where there is a decision by the national government how much should be allocated for the national program of health care, but they have direct controls on all the stuff that costs money. We have a plethora of everything that costs money—specialists, freestanding MRI centers, many freestanding ambulatory centers. That’s going to be very hard to rein in. God help the politician who tries.

**De la Torre:** At this point it’s hard to tell whether the culture created the structure or the structure enabled the culture. But we do have a problem in both. What we’ve done is create a system that has 2,600 physicians intertwined with our 12 community hospitals who completely share risk upside and downside and share quality upside and downside. And so we begin to align incentives to provide the appropriate care.

**Wilensky:** The problem in health care that you don’t have in other industries is that you’re mostly using somebody else’s money. It’s not that you can’t have market-based incentives, but it makes it much more difficult. Even if you have high-deductible plans, anybody who has any serious medical problem, i.e., enters a hospital for any reason, is going to blow through any threshold you set up. Which means you’re either using third-party payment in the private sector or you’re using government parties. And that’s why the notion of trying to have people with aligned incentives is so important.

**Williams:** I do believe this is where the private sector will move much faster than the federal government. We don’t need Congress. We can enter into a relationship with a hospital system, and before I left Aetna we had signed up with 12 different systems to collaborate and share data with the notion that the hospital can do well by moving people down the spectrum of care and improve the quality with reduced costs. The problem we have is in alignment. If a hospital has a CAT scanner, and it can reduce the use of that CAT scanner but not generate enough revenue, it’s a self-defeating activity.

**Bush:** What we’re good at—better than Norway—is we like situations where there are many buyers, many sellers. We love that stuff. We love Groupon ([GRPN](#)). We love to shop for an edge. But in health care we don’t get to. If you look at the claims in AthenaNet—all of these tests and all of these encounters—if the patient could take home \$20, what percentage would they be more than happy to handle over the phone? What percentage would they have happily done not downtown but on Route 9 at the mini-mall? It’s a big percentage.

### **Where can technology help?**

**Curfman:** I think what you’re referring to is health information technology and

whether there is money to be saved by putting electronic medical records in place and transferring medical information among caregivers more efficiently. Some doctors are rather resistant to this.

**Wilensky:** You're not rewarded for doing it.

**De la Torre:** The biggest cost of pulling AthenaNet or any other electronic record into a doctor's office is not the cost of the record. It's an incredible productivity hit to the physicians who are already strained by decreasing reimbursement. All of a sudden in the first six months, they plummet. We see productivity drop 30 percent across the board while we first deploy it.

### **Are there things on the horizon that simplify that process?**

**Bush:** We don't do anything over the Internet. Aetna was a huge early mover—how you got it going, I don't know, Ron—but I'd say literally 25 percent of all of the federal standard transactions that have been created by fabulous committees over the generations are actually doable today electronically. [Yet] none are Internet-based. AthenaNet's been doing very well, so we're growing quickly, and other companies are starting cloud-based medical records. The nice thing about these is we've got everybody—30,000 doctors, 25 million patients—all in one database and we can reconcile. When we build one connection into one of Ralph's laboratories, every doctor in Massachusetts who might want to use that lab can now go in with their accession electronically, see when the test is done, and find out when it gets back.

**Williams:** Technology adoption is not a technology problem—it's a human behavior problem. And part of it will change as the new generation of physicians enters practice. They've grown up with technology. They think paper is strange.

**Curfman:** There's no question that medical information needs to be made electronic. It's going to improve care. I'm very doubtful whether we're going to save a whole lot of money there.

**Wilensky:** Outside of health care, if you come up with a new technology, you don't get any extra brownie points. If it does it better, you're in. If it does it better and it's more expensive, you've got to be able to convince the buyer it's worth the additional cost. In health care we need to understand who exactly benefits and how much they benefit.

**De la Torre:** Our experience has been that health information technologies are probably not useful in 60 percent to 70 percent of patients. The patient who comes to see a doctor once a year doesn't benefit tremendously. The 20 percent to 30 percent who utilize 80 percent of the resources, as Medicare data have shown, those are the people who need a lot of integration. Now, when you're talking \$30,000 to \$40,000 to deploy

an electronic medical record to a physician, another \$15,000 for the IT hookup—those numbers applied to 70 percent of the patients who don't actually benefit is what makes it hard to justify that expenditure. That said, people always tell me, "Isn't part of the problem that all of this expense comes in the last six months of life?" And I say, "No. The real problem is that you never know when the last six months are."

**Bush:** If you knew, you'd go have a scotch.

**Curfman:** The numbers are very clear. Ten percent of the population consumes 63 percent of the total health-care dollars in the country. One percent consumes 20 percent of the health-care dollars. Fifty percent of them consume nothing at all. So this is the issue, and we have to get a better handle on those 10 percent.

### **How much of that could be addressed through prevention?**

**De la Torre:** You have to think of it as a spectrum. It begins with obesity, so you prevent obesity. You prevent obesity [in] a kid, and that prevents diabetes. Then diabetes begets peripheral vascular disease. Peripheral vascular disease and coronary disease beget congestive heart failure. Everyone agrees that investing in the beginning of the spectrum is going to yield tremendous benefit. But because we didn't do that 10 or 15 years ago, we're going to be paying for those ramifications now and we need to make an investment on top of that for the future. So for a while we're going to be double-paying systems.

### **Do we overtest, or does testing actually lead to better diagnosis?**

**Curfman:** The U.S. Preventive Services Task Force recently came out with a D rating for PSA testing for prostate cancer. They don't recommend it for routine screening. And that recommendation has had zero impact. PSA testing continues, and we spend \$3 billion a year only for the tests. But then there are all of the biopsies and the surgery that may follow, the cascade that's initiated by the testing. We're facing another issue just like this using CT scanning for lung cancer screening. We recently published in the *New England Journal* that routine regular CT scanning in smokers can reduce mortality from lung cancer by 20 percent. But how many of these scans do you have to do and at what cost? Uh, you have to do 1,000 scans to prevent one lung cancer death. These scans are quite expensive. Many will bring up false positive results, which brings more expense.

**Wilensky:** But you have to protect the hospitals and the physicians.

### **So health care won't be fixed without tort reform?**

**Wilensky:** Institutions and physicians who follow evidence-based medicine and have patient safety measures in place shouldn't be liable unless they've engaged in criminally negligent behavior.

**Williams:** There needs to be some safe harbor for people who are following clinical guidelines, applying their own clinical judgment, not [doing] cookbook medicine.

**De la Torre:** You don't actually believe that's a solution to health-care reform? The core of the problem is at the foundation. The very way we deliver care in America is flawed. And until we tackle that foundation, we can talk about the fringe of whether we're going to paint the walls white or green or whether we're going to have nice terraces. It doesn't matter. Our foundation is flawed.

### **If we're going to look out a decade from now, what will make health care better than it is today?**

**De la Torre:** We cannot stay in a revenue-driven system. We have to get to a system that tackles the cost side of the equation also. A necessary driver needs to be in place to get America to grapple with changing the way it consumes health care. The U.S. is about to insure everyone with the Affordable Care Act. The best thing about health-care reform as it's currently passed is that it's going to bring America near bankruptcy. It's going to finally force us as a society to act. The bad side is, boy, if we don't act we're in trouble.

**Bush:** I'm bullish. There's a future of cost reduction primarily driven by the fact that we've recessed our economy a little so we're paying more attention to it.

**Wilensky:** Two things for me are reforming the payment system so you change incentives and reorganizing delivery systems so you can better achieve coordination.

**Williams:** We need more and better physician leadership. I think the work that people like Ralph are doing is critical, but you can probably count the institutions on both hands that have the demonstrated level of leadership to produce the type of care we would aspire to in terms of aligning incentives and reengineering the system.

**Curfman:** We have too much health care. Our health-care system needs to be smaller, and we need to be able to make wiser choices about the use of new technologies. And at the same time we have to place much more emphasis and align incentives on preventative health care.

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