CHRONIC AILMENTS

The hard ECONOMICS of health care make a difficult backdrop for IT vendors.

BY MARK WILLIAMS

IT'S A NO-BRAINER that the Internet has the potential to bring enormous cost savings to America's physicians, hospitals, insurers, pharmacies, labs, and patients by clearing up the immense paper morass that currently links them. But the tech companies that imagined they'd get wealthy selling the industry on the Net are being stymied by the peculiar economics of the health care market, which is rife with problems that won't be transformed with a wave of an Internet wand. Here are some of the obstacles that face companies targeting the health care industry.

A market that isn't a market. At least, not anything resembling anybody's definition of a free market. The Health Care Financing Administration (HCFA), a federal agency within the U.S. Department of Health and Human Services, oversees Medicare and Medicaid for more than 74 million Americans and the State Children's Health Insurance Program for 10 million uninsured children. It spends more than $360 billion annually on these programs alone. In total, the government is responsible for almost half of all health care spending. And of course health care is heavily regulated, including prices for Medicare and Medicaid reimbursement.

A flawed economic model. To a large degree, providers—doctors and hospitals—don't determine their own prices. The HMOs/insurers primarily decide on prices, and not in response to what the final consumers—patients—will pay, but according to what employers will spend. Meanwhile, the majority of health care consumers tend to be insensitive to price, as they're not paying directly for each item or service they receive.

A strapped hospital system. In 1997, while hospitals were seeing higher use of their services and rising costs for prescription drugs, the Balanced Budget Act of 1997 (BBA) cut approximately $116 billion from projected Medicare spending for 1998 through 2002. More than $50 billion of these reductions would be borne by U.S. hospitals. The BBA also cut $10 billion from Medicaid hospital payments. In 1999, $17 billion of the BBA's Medicare reductions were restored, but these were just a fraction of the cuts. Struggling hospitals cut staff as their first line of defense.

Safety-net hospitals, of course, depend on public subsidies. Even more remarkably, these hospitals aren't just vital sources of care for the indigent and uninsured in their local communities, but also important providers of specialty services to both privately insured and Medicare patients, according to the American Hospital Association's Annual Survey of Hospitals for 1991 and 1995. Compared with other urban hospitals, safety-net hospitals are nearly five times as likely to provide burn care, four times as likely to provide pediatric intensive care, and more than twice as likely to provide neonatal intensive care. They're more likely than other urban hospitals to

offer HIV/AIDS services, crisis prevention, and psychiatric emergency care. Many of these services are high-cost and/or unprofitable. If safety-net hospitals closed in some areas, other hospitals might be reluctant or financially unable to broaden the scope of their care. In short, the whole edifice of the profitable health care industry rests, to some extent, on the backs of the nonprofit hospitals.

An industry that is inherently local. Health care markets differ from one another based on their populations, methods of health care delivery, penetration of managed care entities, proliferation of self-funded plans, and the reactions of providers to managed care trends. Medicare payments to HMOs vary from county to county. With so many scattered and conflicting systems, economies of scale are elusive. Of course, the Internet is supposed to be the perfect low-cost means of connecting the various industry constituents. But selling software and services to each of this country's 5,000 hospitals, 40,000 nursing and assisted-living homes, hundreds of thousands of physician practices, and hundreds of health plans is a slow, incremental process, further complicated by thousands of (often incompatible) software and paper-based systems that IT vendors must help their customers move to the Internet.

An industry at odds with itself. At press time, an HMO trade group had just announced that insurance coverage will be canceled for more than 700,000 Medicare beneficiaries in selected counties in various states, with industry representatives citing rising drug costs and saying that the federal government has underpaid and over-regulated HMOs. Overall, HMOs have already dropped approximately 734,000 Medicare beneficiaries in the last two years. All the Internet services in the world will not resolve such conflicts, which spring from fundamental contradictions in America's present health care model.

Stakeholders with unreasonable expectations. Americans want patients to be treated and drugs to be affordable. We do not want doctors given incentives to perform as many surgeries as they can schedule. At the same time, we don't want government-funded medical programs to affect our taxes. One result of such conflicting objectives was the BBA. Medicare costs were soaring, but Medicare beneficiaries were voters. So the politicians slashed providers' budgets, presuming Americans would be too amnesiac to connect the dots when higher premiums came, and Medicare beneficiaries were struck from HMO rolls. It appears that the politicians made the correct presumption, given historical evidence, which brings us to the the central problem confronting e-health companies.

A long history of cure-alls that have failed. HMOs, of course, were designed to stem rising health care costs and impose some sort of consistency in treatment, based on

industry "best practices." In the '80s, in fact, many hospitals and other providers lobbied for regulation to be abandoned for some vaguely specified notion of "the market" as a cure-all, and the Reagan administration happily complied. Various assessments exist of how managed care's introduction affected health care, but it's reasonable to assume that HMOs' rules determining which patients got what treatment under what circumstances increased the industry's administrative complexity by at least 25 percent. Market forces can do many things, but blindly wishing for them to create profits in scenarios where there may be no opportunity for profit—as with some Medicare beneficiaries and rural clinics—is a self-defeating exercise. Today, Blue Cross and Blue Shield of Massachusetts employs as many people to administer coverage for about 2.5 million New Englanders than are employed in all of Canada to administer single-payer coverage for 27 million Canadians, according to the American Hospital Association.

Which is not to say that market forces can't increase efficiency in the health care system. After all, the Canadian system isn't socialized medicine (unlike that of the United Kingdom, where doctors and nurses are employed by the government). In one significant sense, Canada's health care system more nearly approaches a free market than the American model: Canadian physicians negotiate their own fees with the government. In the United States, HMOs and intermediary organizations have introduced themselves into the equation by telling providers what they'll receive.

The United States has definitely not found the right model for using market forces in health care. Rather, this country has consistently chosen short-term fixes that appease various factions and heighten the whole health care system's inefficiencies. Which leads to two conclusions:

1. We can afford stopgaps for now. But the HCFA projects that total spending for health care is projected to increase to $2.2 trillion in 2008, while rising as a share of gross domestic product from 13.6 percent to 16.2 percent. Thereafter, as the Internet gives the public increasing access to treatment information not provided by physicians or insurers, and as demand rises for the increasing number of revolutionary treatments that will result from the Human Genome Project, the health care industry's inefficiencies and inequities will only become increasingly apparent.

2. The Internet is too potent not to be of enormous benefit overall in health care. Yet tech companies should be wary of promoting themselves as cure-alls. Based on the evidence, the U.S. health care industry has consistently turned companies touted as the solution into part of the problem.

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