Why It’s Risky To Pay For A Proprietary Health IT System

Edmund Billings, M.D.

“No aspect of health IT entails as much uncertainty as the magnitude of its potential benefits.”

A few years into the Meaningful Use program, it seems this quote from a 2008 Congressional Budget Office report entitled “Evidence on the Costs and Benefits of Health Information Technology“ may have been written with the assistance of a crystal ball.

Fast forward to 2013.

“Just from reading a week’s worth of news, it’s obvious that we don’t really know whether healthcare IT is better or worse off than before [Meaningful Use incentives],” popular blogger and health IT observer Mr. HIStalk wrote earlier this year.

So, perhaps RAND was hypnotized by Cerner funding when they created their rosy prognosis (hearken back, if you will, to 2005 and the projected $81 billion in annual healthcare savings). Maybe they were just plain wrong and the most recent RAND report stands as a tacit mea culpa.

Either way, we’re left with hypotheses that, while not incontrovertible, are gaining traction:

Health IT benefits will manifest gradually over an extended timeframe.
Those benefits will not quickly morph into reduced costs, if they ever do.
Because of 1 and 2, investing in a hugely expensive electronic health record system is potentially risky.

How risky? Without question, massive health IT expense and the predominant proprietary IT model are threats to a hospital or health system’s financial viability, to its solvency.

We’re seeing some examples even now.

Michigan’s Henry Ford Health System recently reported a 15 percent decrease in net income as a result of uncompensated care and $36 million spent on a proprietary EHR system. According to health system CEO Nancy Schlichting, “We knew that 2012 and 2013 would not be easy years for the system because of the Epic costs.”

The Boston Globe reported that fully one-third of Massachusetts’ hospitals are on or

over the financial edge. Profit margins for the state's acute care hospitals have fallen to an average of 2.1 percent as a result of government regulation and reduced revenue from the continuing economic malaise. Health IT is certainly not the only culprit, but if EHR systems can't pay for themselves, they are making a bad financial situation worse for some hospitals.

While it may seem that the financial problem created by expensive, proprietary health IT is simple and straightforward—health IT expenses push the budget into the red, doctors see fewer patients, revenue falls, and creditors come calling—healthcare economics are unique and apparently beamed from some other dimension where up is down and black is white, so linear explanations don't really hold.

As Steven Brill's article in Time magazine (subscription required) on healthcare costs makes clear, there is no underlying logic to hospital fees and billing practices. The chargemaster rules and answers to no one, which enables some supposedly non-profit hospitals and health systems to earn profit margins of 20 to 30 percent, sometimes more.

This scenario cannot continue for a host of reasons that culminate in only one that truly matters: Healthcare costs regularly destroy the financial lives of individual Americans and threaten to swamp the entire economy. The chargemaster can't continue to print money for an expensive EHR when the healthcare fabric is starting to weaken at the seams.

"The ROI-rationale for the widespread adoption of health IT in the U.S. is a macro, national one. It's a public health calculation that's been mired in commercial/private health arithmetic," wrote health economist and management consultant Jane Sarasohn-Kahn in 2008. "The denominator of these wrong-headed ROI calculations has been wrong-chosen: it's been the individual physician practice, or the hospital, or the single health plan. The denominator is the public's health."

Not much has changed since 2008 in how we view the potential ROI from health IT. Indeed, the public health argument for health IT is currently the most viable argument for continuing down the same path, which is just fine from a federal government perspective. But individual hospitals and health systems don't often make macroeconomic or macro-public health decisions. They decide what's best for that hospital / health system.

Which makes it perhaps unwise to pay $80, $150 or even $700 million dollars for a proprietary model EHR unless you think you can continue to extract 200, 300 and 400 percent margins from informationally unarmed patients and an increasingly less powerful insurance industry.

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