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CUTTING REIMBURSEMENT DOESN'T IMPROVE HEALTH CARE OR REDUCE ITS COST

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As a serious student of economics, Dr. David Brailer no doubt learned very early on that in a market system every transaction entered into freely and knowledgeably either results in economic gain for everyone involved or is not completed. The estimated gain for private insurers and Medicare (not to mention Medicaid and employers who shoulder the cost of health care insurance) from the implementation of his medical internet initiative ranges from a conservative \$120 billion per year to a staggering \$600 billion (*Business Week*, October 31, 2005). However, if the medical internet produces no gain for providers, Brailer's scheme fails Economics 101. Unless, of course, it is forcibly imposed on them.

Leaving aside the issue as to who pays for the estimated \$150 billion startup costs, providers face the higher costs of operating and maintaining the system without any balancing financial return thereby further eroding the gain required to provide health care. In addition, who decides what's best for patients? What norm is most important in deciding what's best -- safety, effectiveness, or costs? How does the medical internet system differentiate patients who faithfully follow a program of care from those who depart from that program, and how is that behavior versus the quality of the care linked to patient outcome? Taking at face value the statement in the *BW* article that "the economist in Brailer came to see medicine as driven by incentives that bred complacency, if not greed," is Brailer saying that the gain for many providers is *excessive and should be reduced and that he can build a system that rewards the competent and caring provider and penalizes the complacent and greedy ones, and that protects patient privacy without independently examining patients directly?*

The private insurer and the employer see the cost first hand and know how that cost bears directly on their gain but do not accept any direct responsibility for safety or effectiveness. For years, they have been vigorously (some would say ruthlessly) driving down reimbursement below the charges billed by providers, reducing gain and thereby undermining Brailer's premise that savings can be achieved throughout the health care system by reducing excessive gain. Medicare and Medicaid administrators also see the cost first hand and know that cutting reimbursement to the wealthy few who provide health care is politically easier than forcing the many who are less prosperous to contribute more to Medicare or pay higher taxes to support Medicaid. The result is that access to care has become more restricted as more and more physician providers, aware that their financial viability is threatened by a system wherein reimbursement does not cover the cost of

providing service, refuse Medicare and Medicaid patients who then turn to the much more expensive hospital emergency room for primary care because hospitals are not free to refuse service.

Total quality management is successful in making more and better goods and services available to the public at more affordable prices not by eroding the gain to the producer but by cutting the cost of production, and allowing the price to fall as the cost of production falls thereby preserving the gain necessary for the producer to continue operations. TQM is a positive-sum strategy. In Brailer's medical internet proposal, the cost of providing health care is cut by forcing providers to accept less for their service and thereby eroding the gain -- judged at the start to be excessive -- that is necessary for them to continue providing that service. The medical internet is a zero-sum strategy.

From the perspective of economic theory, Brailer is not proposing more competition to make health care safer, cheaper, and more effective but more monopsonistic-like wherein a single buyer -- the payment provider -- dictates price driven by the greater gain for that provider to be gotten from lower reimbursement. At bare minimum, Brailer has to demonstrate that his scheme improves reimbursement and collection rates for physicians who otherwise are being forced out of practice or required to work even longer hours to produce the gain necessary to keep them engaged in providing service. With reimbursements shrinking and collection rates eroding, how does introducing Brailer's medical internet which adds more cost to the private practice of medicine help motivate the physician to supply the information required when the overall system at best promises to reward the caring and competent and punish the complacent and greedy and at worst may punish the caring and competent who are honest and play by the rules and reward the complacent and greedy who are clever and devious enough to manipulate the system for personal advantage. Who then monitors the data streaming into the medical internet to assure that the information reported is accurate and complete, and who pays for quality control of the data that are critical to the system?

Quite apart from the financial side of the proposed medical internet, what will it do to physicians on the cutting edge of patient treatment? Will it encourage or dampen new treatment modalities that offer promise of successfully treating patients who heretofore have not been treated effectively with the state-of-the-art modalities? In what way is the information that would become accessible to the physician via the medical internet any better than the articles published in peer-reviewed medical journals already available in large numbers of medical libraries that for decades have been the mainstay of continuing education and professional development? The present system with links already established to the internet, coupled with the good search engines, e-journals, and backed up with experienced medical librarians provides ready and inexpensive access to the current knowledge base in virtually every specialized field in medicine.

Information systems do not save human lives. Nor do they improve the quality of care or cut the cost of that care. What every practicing physician knows is that it is experienced, competent, committed, caring providers, at times taking risks in the treatment of a patient who is not responsive to the standard treatment modalities, who are capable of achieving

those results. The reason is simple: health care is not about things that can be controlled and standardized in a manufacturing process. Rather health care reduces most fundamentally to human beings who are unique persons, in part mysteries even to themselves, who must be respected first before they can be treated and who when treated may not respond in ways that are as statistically predictable as the results from using techniques devised by Deming for achieving zero defects in manufacturing.

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