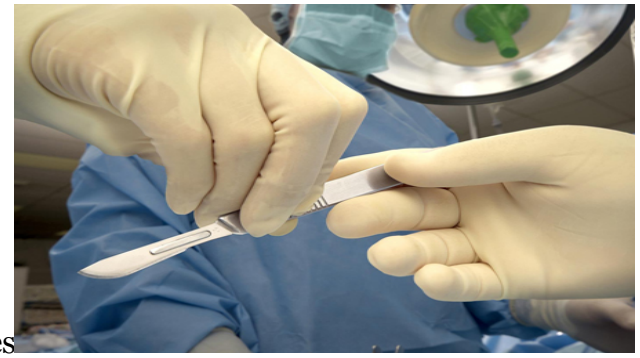
The Economist

America's hospital industry

Taking a scalpel to costs

Hospital operators brace themselves for health-care reform

Jul 16th 2009 | NEW YORK | From the print edition



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EARLIER this month America's hospital bosses gathered in Washington, DC, with vice-president Joseph Biden. To the amazement of many, they vowed to accept a cut of $155 billion in their expected revenues over the next decade as part of a grand bargain on health-care reform. How can they justify giving away such a vast sum? There are several explanations, not all of them altruistic. Taken together, they show that the industry's leaders are bracing themselves for a period of upheaval.

For hospitals, the positive thing about health-care reform is that it is going to be good for business. It will be welcome news to an industry that is hardly in rude health. Despite two decades of consolidation, hospitals' finances remain anaemic; over a quarter of them regularly post negative operating margins. The recession is making things worse. Moody's, a credit-rating agency, notes that many patients are putting off non-essential treatments.

So any reforms that promise a flood of new demand for health services should be welcome. Rich Umbdenstock, the head of the American Hospital Association (AHA) and one of the bosses who shared the stage with Mr Biden, acknowledges that extending health insurance to most of America's nearly 50m uninsured will benefit his industry in the long term. Those unfortunates still turn up at emergency rooms and often do not pay their bills.

The government gives hospitals some money to compensate them for this, but the AHA says it does not cover the full cost, which it put at $34 billion in 2007 (around 5% of hospitals' annual revenues), up from $3.9 billion in 1980. Paul Mango of McKinsey, a consultancy, estimates that the hospitals recover only 10-12% of this cost. But he says the problem would be greatly reduced under a system of universal health-insurance which included subsidies for the indigent, as the proposed health reforms envisage. Herbert Pardes, chief executive of New York-Presbyterian, a research hospital, says the large numbers of underinsured patients,

who frequently fail to pay their bills in full, cost hospitals still more.

The huge sums the hospitals stand to gain from reducing such losses make even $155 billion over ten years look like a reasonable amount of money to sacrifice to secure such a bonanza. But there are less virtuous reasons why the hospitals offered such a generous-sounding deal. As Mr Umbdenstock notes, it was less painful than the $225 billion or more in cuts that Barack Obama had been pressing for earlier in the year. This is a tacit acknowledgment that hospital chiefs were seeking to avert the one thing that strikes fear into their hearts: the spread of price controls.

Because of the creeping expansion of Medicare and Medicaid, the publicly funded health-care schemes for the elderly and the poor, the government already pays over half the bills at the average American hospital. But the political left is clamouring for a government-run insurance plan, to compete with private ones, as part of any reform effort. The problem, argues Toby Cosgrove, chief executive of the Cleveland Clinic, a hospital group, is that the existing public schemes routinely underpay hospitals for care. Some economists question that claim. Even so, it is probably right to suggest, as Dr Cosgrove does, that any public insurance plan based on Medicare's pricing would squeeze hospitals hard and, as a result, require private insurers to cross-subsidise the bill.

In addition to a determination to head off any moves towards greater government control over prices, another even less noble reason for offering the price cut was a desire to thwart a proposed change to the tax status of non-profit hospitals, which make up most of the national total of 5,700 or so. On the ground that they provide charitable care, many religious and community hospitals have been granted an exemption allowing them to issue tax-free bonds, avoid taxes on property and income, and so on. But investigations by the Internal Revenue Service and others have revealed that many in fact provide very little charitable care, while paying enormous salaries or going on acquisition sprees.

On this proposal, the industry may carry the day. Although the tax break is hard to defend, closing the loophole would lead to many small, weak hospitals shutting down—something voters would be unlikely to tolerate. Even those hospitals that survived might spark a backlash. Dr Pardes argues that abolishing the tax advantages would mean higher running costs that would inevitably be passed through to those patients who have private insurance.

The other great fear of hospital bosses is being forced to accept greater competition. Although the industry is fragmented, Jon Scholl of the Boston Consulting Group points out that because pricing is done at city or regional level, there are “local pockets of power.” Alain Enthoven, an economist at Stanford University's business school who helped inspire the “managed health care” movement of the 1990s, promoted an approach that succeeded in squeezing costs at the time, but ultimately failed as patients rebelled against the restrictions it placed on their choice of doctors and treatments. Mr Enthoven argues that the consolidation

that followed managed care has resulted in too little competition. “Antitrust action in the hospital field has been woefully weak,” he says.

There are some innovative competitors emerging to challenge hospitals. Paul Keckley of Deloitte, a consultancy, estimates that there are over 1,000 retail health clinics operating today at Wal-Mart stores, Walgreens pharmacies and other convenient locations, and their numbers are expected to multiply in the next few years. Some of these cheap and cheerful outfits are staffed by nurse practitioners (who are much cheaper than doctors), which incenses doctors and hospital bosses.

The nascent boom in medical tourism could also disrupt the hospital business, even if every hip-replacement patient does not actually go to India to get it done. Mr Keckley points out that in several parts of the country the mere introduction of insurance plans offering cheap surgery abroad has forced local hospitals to respond by slashing their prices—something unheard of in this industry.

Mr Enthoven argues that if reforms are done properly, they would “force hospitals to get organised to compete and get more efficient.” Alas, the omens are not good. One of the explicit concessions wrung by the hospital bosses from the White House was a promise to crack down on clinics owned by doctors. These outfits are guilty of anti-competitive self-dealing, since the doctor has a financial motive to refer cases to his own firm, but what hospital bosses were really concerned about was that such clinics are competing hard with them, and siphoning off the most profitable patients.

As this back-room deal illustrates, the strongest motives behind the hospitals' ostensibly generous price cut were self-serving ones: to reduce competition, not boost it, and to head off any increase in government influence over their prices. As health-care reform forges ahead, reformers are desperate to find cost savings and the hospital industry is a juicy target. So its bosses felt they had to cut a deal. As Julius Hobson of Bryan Cave, a veteran health lobbyist, puts it: “If you're not at the table, then you're on the menu.”

From the print edition: Business