AN AMERICAN SICKNESS by Elizabeth Rosenthal, M.D.
Book Review and Comments by David G. Schwartz, M.D. July 20, 2 017, Part I

Dr. Rosenthal, a reporter and senior writer at The New York Times for 22 years and editor in chief of Kaiser Health News, investigates thoroughly the dangerous, expensive, and dysfunctional American healthcare system. She presents possible solutions, actions that can be taken by patients, and possible public policy changes, much more sweeping than the Affordable Care Act or anything that Congress is considering or may have passed by the time this article is aired.

Health Care is considered a basic human need by most countries, along with water, food, sewage disposal, and fire and police protection. Please indulge me with the following ridiculous metaphor or parable to illustrate the severity and complexity of the current crisis:

Suppose you lived in a country where most houses have faulty electrical wiring, and fire departments are privatized and can charge as much as the "market" would bear, to come to your house to try to put out a fire. You may not know how competent each fire service is, only how well trained they were in the entrepreneurial and business model. Ratings for quality of service are available for the newness and appearance of the high tech equipment and how good the fire trucks look, and the quality of sound of the sirens. The is no rating available for the effectiveness of the service to respond promptly and to get the fire out as soon as possible, or the probability that the damage to your house done by the fire service would be greater than the fire. There are only 2 or 3 very expensive statewide fire company conglomerates that serve your area, with very little competition among them. You have no way in advance to know for any of them what the total cost could be, which could leave you bankrupt.

You could be billed separately for part of the cost of a new piece of expensive equipment, the amount of water used, the driver's fee, the fire fighter's fees, etc. None of this information is available to you in advance, yet you are allowed to choose which fire service you want based on "free market" principles. Many of these bills are not itemized even when they come to you, and before you can find out, with many phone calls and letters, they are already sending you to collections.

Fire services could provide "preventive" services which could mean remodeling and redesigning certain parts of the house considered "fire hazards," but the work done on your house could also end up increasing the fire risk. All this is without you having adequate information for evaluating the service

The ownership of fire companies is increasingly taken over by large for profit corporations headquartered in other parts of the country, owned by equity firms and venture capital, increasingly tied to Wall Street. These large firms pressure subsidiary fire services to pay more attention to competence in the business model and to increasing profit margins, more than on fire-fighting proficiency and fire safety. Some companies are "non-profit," but you wouldn't know it by the size of the corporate buildings with

marble entrances and enormous CEO salaries, and the priority is to maximize income over quality of service.

If you don't have fire service insurance, the fire fighters may not come to your house. The fire protection insurance companies likewise are owned by huge for-profit corporations, which base their premiums largely on how much administrative and marketing costs are and how high they dare go before losing subscribers. The premiums continue to rise as mergers result in fewer, larger insurance companies. The reliability of the insurance to pay out what it says it will is not certain, and it is exceedingly complex to determine how much of the service it will cover, under what conditions, and which fire services in your area (or out of your area) are certified to bill for insurance payout. If they are certified, you won't know which of the costs of the several itemized bills for the services will be covered, and what portion of each bill. You can't determine in advance these factors, and even after the fact, you can't know what is going to be covered until the hassle between the insurance company and the fire service will be settled, and you finally know what portion is yours to pay. The insurance has no incentive to promote fire safety measures, because subscribers and policies keep changing, and besides, the whole industry derives so much income from fires.

All other countries but yours have publicly owned, taxpayer funded, fire departments in each area, some with volunteer fire fighters. Preventive services have incentive to reduce future costs to the system. The services are free to the homeowners. Some people emigrate from here to those countries as "fire service" refugees.

When you propose publicly funded fire service, you are told that it is not realistic, there is not the political will to pass such a measure because there is public opposition to "socialized" fire protection. Furthermore, the politicians receive huge funds from the huge conglomerates in the fire service industry and the fire insurance industry. The elimination of private insurance would cause massive job loss. We must allow the "free market" to function because it has "made this country great."

Now, this analogy is not perfect, and the situation unlikely and ludicrous, but the general description eerily coincides with our situation with healthcare. We would not put up with such abuse of the general public by a fire protection industry, profiting from larger numbers of fires. This would be considered a despicable extortion, by holding hostage the serving of such a basic need such as fire protection. (Well, there probably are a few libertarians who would like to see fire protection privatized.) Yet we put up that situation with healthcare.

The author explains in detail this nightmare in the medical care system, with patients as pawns in a manically, addictively monetized system that is running down hill out of control, with patient safety and quality of care getting worse all the time. Dr. Rosenthal examines each system in this illness: insurance, hospitals, physicians, pharmaceuticals, medical devices, tests, ancillary services, contractors, and research, as well as the conglomerate corporate structures that drive this dysfunction. She provides a prescription for healing, with both public and private measures to take back our health care.

She says health care is unaffordable, despite the Affordable Care Act, which, however, made insurance more available. "Faced with disease, we are all potential victims of medical extortion." The system delivers worse health outcomes of any other developed country, all of which spend half per person than we do. The system seems to be a free-for-all situation for businesses involved, but it is not a free market for patients, the consumers. "How do participants in the marketplace make purchasing choices? Prices are often unknowable and unpredictable; there's little robust competition for our business; we have scant information on quality to guide our decisions; and very often we lack power ourselves even to choose."

She lays out the economic rules of the dysfunctional medical market:

1. More treatment is always better.
2. A lifetime of treatment is preferable to a cure.
3. Amenities and marketing matter more than good care.
4. As technologies age, prices can rise rather than fall.
5. There is no free choice. Patients are stuck. And they're stuck buying American.
6. More competitors vying for business doesn't mean better prices; it can drive prices up, not down.
7. Economies of scale don't translate to lower prices. With their market power, big providers can simply demand more.
8. There is no such thing as a fixed price for a procedure or test. And the uninsured pay the highest prices of all. There are no standards for billing. There's money to be made in billing for anything and everything.
9. Prices will rise to whatever the market will bear.

Part I of this article covers the author's description of what the insurance industry, hospitals, and doctors have done to create this problem. Part II is about the pharmaceutical and medical device industries, research, philanthropic foundations, business conglomerates, the Affordable Care Act, and possible solutions to the problem.

When medicine was not such a big business, insurance plans were mainly for covering time off work due to illness. That was how employers started sponsoring health insurance. Then in the early 20th century when medical care involved more technology, with general anesthesia, surgery, and intensive care, hospitalization became a lot more expensive, and catastrophic insurance became available.

Blue Cross and Blue Shield was a highly trusted and respected non-profit charitable institution. It accepted everyone who signed up, covering all 50 states, and all were charged the same rates no matter how sick or old. That came much closer to the possibility of universal coverage than anything ever since. (My perspective)

Then when the medical system became so large, and so much more money was involved, the "robber barons" (my words) decided to "go where the money is," as in the comment by Willie Sutton, the famous bank robber. The for-profit insurance companies came in and ruined a perfectly good system that was affordable and available to all. In

my opinion, all profit making health insurance should have been prohibited, and all nonprofit companies should have had to follow the same rules and principles as the "Blues" did. This system could be implemented now, with federal subsidies. The profit making companies "cherry-picked" mainly young and healthy people, charging higher rates to the old and the sick, to make large profits. This left Blue cross/Blue Shield to cover only the sickest patients. The Blues hemorrhaged money, and could no longer survive as a charitable institution. So they were allowed to join the for-profit game in 1994. This was the final "nail in the coffin" for noble-minded, affordable health insurance.

In 1994 before the Blues went for-profit, 95% of premiums was spent on medical care. Now the average ratio is around 80%. The Affordable Care Act requires that 80-85 % be spent on patient care. So to continue high returns for investors, the companies just raised the premiums over all, so that the 15-20% they could keep for administration, lobbying, and profits, came from a larger "pie" from generally costlier premiums. In contrast, Medicare uses 2% of its funding for administration, and 98% for patient care. How's that for an "inefficient" socialized medicine bureaucracy, I ask?

Next, the author takes on the hospitals. When the insurance business grew, so did the hospitals. With patients then not caring so much about costs, since insurance was paying, (not much patients could do about it anyway, except refuse some aspects of care) the hospitals started charging more. They devised ingenious ways to bill for more services and changed the way doctors practiced medicine, which in turn changed the types of drugs and devices that were manufactured. "The money chase was on. No one was protecting the patient."

The cost of hospital services grew faster than other parts of the "healthcare" system. From 1997 to 2012, it grew 149%. In 2013 average daily hospital stay was $4,300, ten times the cost in Spain. The hospital raised prices not because the cost of their care increased so much, but <u>just because they could.</u>

Most hospitals are nonprofit, but that doesn't make them charities. They have to do some token charity care to qualify, but that pales in comparison to the billions in revenue and assets, millions in annual CEO compensation, and marble lobbies. 10-15% of revenue goes to billing, collection, insurance claims, and pre-approval, jobs that don't exist in Europe. They get Wall Street to finance new wings. In the words of a finance executive, "We have so much surplus capacity, which should lead to falling prices. But instead we get the opposite. It's a market failure, but it follows certain logic. This is not a healthcare system, it's an industry, and at every point there's a way to make money."

Mergers of hospitals to form huge conglomerates give the company enormous negotiating power with insurance, so they can get by with obscenely high prices for services that can vary by more than a factor of 10. For example, an infusion of Remicade given every 6 weeks could cost $19,000 per session. Prescribed by the same doctor, for the same patient, given at a different (upscale) branch of the same hospital system, it was billed at $132,791.04 for the 3rd infusion. The first infusion was billed at $98,575.98, and

it kept rising each time. The insurance paid $73,931.98 for it. NYU was such a huge client that the insurance company, Emblem Health, did not want to risk losing it, so they "sucked it up." ("Deal making", my comment.) The actual wholesale price of the drug was $1,200 (in 2013).

Refer to Rule #7- Economies of scale don't translate to lower prices. With their market power, big providers can simply demand more. As for the upscale branch that provided T.V., Internet, bottled water, and snacks, after the "patient navigator" met him at the front desk and walked him to the cubicle, refer to Rule #3 – Amenities and marketing matter more than good care.

The administration of hospitals started changing in the 1980's into more financially driven operations and less about health care. The head nurse used to fiercely protect the patients on her ward, regardless of financials. Now the title "head nurse" began to morph into "clinical nurse-manager," attuned to the business of medicine. The top position on the medical staff used to be Physician in Chief and Surgeon in Chief, focusing on the quality of the practice of medicine at the hospital. The CMO, the Chief Medical Officer, now became the physician whose primary allegiance was to use his professional influence to make the way the doctors on the hospital staff practice medicine in a way that was most profitable to the hospital. (Now I wonder whether the overabundance of unwarranted stents placed in coronary arteries is not just due to cardiologists' disagreements with the guidelines, or greed, but because of pressure by hospital administration to do more procedures.)

A 1974 federal law required hospitals to get approval and to provide a "certificate of need" before building new facilities or investing in new technology, the purpose being to avoid increased costs from overbuilding and duplication of services. Then in 1987, the law was rescinded, and hospitals could buy or build whatever they wanted. Medical purchases became an "investment," and the "arms race" between hospitals began. Hospitals hired consultants like Deloitte and Touche to increase revenue by manipulating how they bill. Many hospitals were administratively and financially restructured "as if they were steel mills or chicken processing plants." Hospitals learned to uncouple or un-bundle services and to charge separately for each item, such as operating room, medications, bandages, etc., and each item could be enormously increased. Deloitte is ranked #1 by revenues in healthcare consulting, fueled by more than 17% annual growth in the healthcare sector.

The hospitals established productivity bonuses for doctors, to motivate them, just like bond traders, to up-code (to code a task as a higher level of service or complexity than it really was), and to order unnecessary tests. Then, the up-coding also allowed the hospital to charge more for the "facility fee," an extra charge for use of rooms and equipment. The high cost of the facility fee then in turn encouraged the use of the hospital for more minor procedures that were previously done in doctor's offices.

Hospitals began closing departments that usually lost money as "loss leaders," such as outpatient clinics in poor neighborhoods, dialysis, drug treatment centers, labor and

delivery, and put more into infusion centers (for expensive cancer chemotherapy), stroke centers (expensive scans), cardiac care (coronary stents), etc, and began promoting new machines like proton beam therapy (with no long term benefit over tradition radiation therapy), bariatric surgery, etc. Rule #1 – More treatment is always better. Default to the most expensive option.

And now, for the doctors: For the first half of the 20th century, doctors generally followed Hippocrates' "Precepts" that "the doctor should be kindhearted and do his best to accommodate fees to the patient's circumstances." Then with the growth of employer sponsored insurance and Medicare, doctors could charge much higher fees, and Medicare paid 95% of them. The 1980's were the golden Age of physician reimbursement. The higher fees by all physicians established a higher "usual and customary fee" established by insurance. Rule #6- More competitors vying for business doesn't mean better prices; it can drive prices up, not down.

Medicare assigned the task of deciding what fair value and payment should be, to the AMA (American Medical Association), medicine's most powerful industry group. "Allowing the AMA to determine doctors' payments is like allowing the American Petroleum Institute to decide what BP and Shell and Exxon Mobil can charge us, not just for gas but somehow, for wind and solar as well."

Many doctors opened ambulatory surgery centers and other treatment centers and could charge for "facility fees." Many times patients do not even know that the center their doctor is referring them to is owned by that doctor, the information being hidden in mountains of paperwork, signed just before entering the center.

In hospitals, patients and insurance are billed separately for doctors they never saw, such as radiologists, pathologists, etc., and for consultants that may have walked into the patient's room and said "Hi." Sometimes the patient chooses a hospital within his or her insurance network, but after discharge, gets an enormous bill for a doctor whom the hospital called in for consultation or surgery, but who does not participate in the patients' network.

Some doctors are able to bill for physician extenders such as Physician Assistants, and the doctor is not on the premises. A doctor can have several offices, have a physician extender in each one, and bill for each one of them as if the doctor personally saw all those patients.

"Meanwhile doctors who have not commercialized their practices are today at risk of extinction."

Part II of this article continues next month, as described above, with possible solutions. I think this book is a masterpiece, should be used as template or a textbook for assessing the current healthcare situation and possible solutions.