AN AMERICAN SICKNESS, Review by David G. Schwartz, M.D., Part II

Regarding the pharmaceutical industry's role, it is common knowledge that pharmaceutical industry's main goal is to maximize profits and shareholder value, regardless of how much it could improve health care. See my article on Dr. Peter GØtzshe's book, Deadly Medicine and Organized Crime.

Companies can extend their patents on brand name drugs by making minor changes to the drug that have very little significance to the patient or doctor. They make deals with generic companies not to bring their products in the market for a number of years. The prices of generics have gone up tremendously because there are few competitors, and those few keep the prices up. New drug companies don't want to bother selling a cheaper form, because it is much more lucrative in such a tight market to keep the price up or to sell something else with a bigger profit margin. It takes several generic companies to result in enough competition to significantly affect prices. We now have a near monopoly situation, with too few generic companies. They prefer to merge rather than compete, and the Justice Department is lax in enforcing antitrust laws.

New drugs are patented just because they are better than placebo, no better than current drugs in use. Studies rarely show "head-to-head" comparisons. So we have more and more patented expensive drugs marketed to doctors with free samples, to get patients started on them, and these new ones are essentially no better than the generics already available. Patients and pharmacies are not allowed to import from other countries, where the cost of the same drug may be a fraction of what is sold here. On the other hand, many of the U.S. companies have plants in Asia that are much less carefully supervised by the FDA, yet these drugs made there are sold here at high prices, as if made in the U.S.A.

Medical devices are another area of price gouging. Hip implants sometimes have a long line of intermediaries that add a markup before they get installed, and then the hospital adds 100 to 300 % on top of it all. A handful of huge device manufacturers dominate the market, making it essentially an oligopoly, an even narrower market than what the pharmaceutical companies have. There is far less scrutiny of new devices before approval than there is for drugs. The medical device industry has a large lobby, spends millions, and gives thousands to each senator that is voting on issues about the device industry. The total cost of a joint replacement in another country is often a fraction of the cost here.

Other areas of graft include fees for pathology, ambulance services, physical therapy, laboratory tests, MRI's, etc. Examples are unnecessary tests and procedures, etc., tacked on "under the radar," not understood by unwary patients. These all add extra costs to patients, insurance subscribers, and taxpayers.

Billing and coding are areas where there are no standards or fixed prices for particular tests or procedures, and in which the fees of the billing and coding consultants add to the inflated costs. Codes are manipulated to get around regulations to make procedures more costly.

Research focuses mostly on opportunities for marketing expensive treatments, much less on inexpensive treatments that could be cures. Rule # 2: A lifetime of treatment is preferable to a cure. Dr. Frederick Banting discovered insulin in the 1920's and licensed the patent for only a dollar, as "a gift to humanity." That kind of generosity in medicine is mostly a thing of the past.

Many of the philanthropic foundations have become more interested in raising money than curing disease, and some have teamed up with venture capital firms to aid the start up of new diabetes companies, for example. If foundations fund research to improve existing medical devices for companies that could afford to do the research themselves, what's the point? Well, the foundations share in the profits of the companies. The AMA (American Medical Association) now has support from only 25% of doctors in the country and is supported by a Corporate Round Table, whose top members are from the pharmaceutical and healthcare industry. The AMA spends over $23 million per year on lobbying, ranking 3rd in 2015 behind the Chamber of Commerce and the National Association of Realtors.

Regarding the fiduciary structures of hospitals and technology, huge conglomerates buy up small hospitals that are not doing well financially but are serving mostly lower income patients. Then they restructure them to make more money, charging patients higher prices. They end up closing departments that are not making "enough" money, such as O.B, hospice, clinics for the poor, etc. Regional consolidation of hospitals doesn't really bring about operational efficiencies; it's more about control, pricing, contracts, etc. Some specialists can no longer give infusions in their offices because the hospitals "deals" with insurance companies require that the infusions be done in "hospitals." These facilities pretend to be hospitals and charge a facility fee, making the cost for the infusion 3 times more than if done in the specialist's office.

Electronic medical records (EMR's) were originally advocated to make information transfer easier for patients and hospitals, but the two major software giants of EMR's are not inclined to make it easy for their systems to talk to each other, (similar to what Apple and Microsoft do). The author states that EMR's in this country "have evolved to put business before patients." She states, "The government invested heavily in EMR's as a tool to enable good patient care, with the idea that they would allow the sharing of medical records between a patient's physicians. But competing health systems have little financial incentive to share. Instead, they have frequently become tools for conglomerates to protect market share or dominate the market."

The Affordable Care Act has been undermined in many ways by doctors, hospitals, and insurers who followed only the letter of the law, gaming the system whenever possible. Free preventive care turned out not to be free, when many of the follow-up tests, treatments, room rental, and anesthesiologist's fees were tacked on. Insurance companies changed their networks to result in a larger number of subscribers and a smaller number of providers. Adult children under 26 staying on their parents' plans, living in another state, were outside the network. The co-op insurance companies, often

small, without the hefty bargaining power of the big commercial insurers, failed because Congress failed to come through with the promised subsidies.

The author then outlines possible specific public and private actions to take regarding this morass. Here are some of the public policy proposals:

1. Fee schedules and national price negotiations. In several other industrialized countries the governments set caps for some basic medicines and hospital services. They still have hundreds of private insurers.
2. Single payer. Some countries have one government insurance payer with privately owned hospitals and provider offices. Some other countries nationalize the whole system, including doctors and hospitals.
3. Transparence and competition. One example is Singapore. Hospital care is in 4 tiers. The highest is most costly, and patients choose and pay for their options. The lowest tier has beds in wards and assigned doctors. Most hospitals are publicly owned, but private hospitals are available to those who choose to pay more. Government limits purchase of expensive machines. Singapore ranks 6th in the World Health Organization's performance, while the U.S.A. ranks 37th.
4. Public regulations that could help would be using antitrust law to break up huge conglomerates. Revoke the tax-exempt status of companies that do not live up to the requirements. Require all-inclusive rates for procedures. No extra bills. Price disclosure of the usually hidden hospital "Chargemaster." An industry-wide standard for billing and collection.
5. Allow importation of prescription drugs. Give pharmacists prescribing power for certain drugs. Reform the patent process for drug and device approval. Negotiate national prices. Put ceilings on prices. Promote transparency and consider cost-effectiveness in every stage of the approval process.

Insurance Regulations:

1. The network provider contract must be in force for the same period of time as the health insurance policy.
2. If a procedure is listed as covered, than all associated tests and ancillary services should also be covered
3. Provider directories should be kept up to date.
4. A patient should pay only in-network fees.
5. Directories of providers should have meaningful descriptions, not "not in network for that procedure," or "in-network but not available."
6. Statements should define annual "out of pocket" maximums.

Medical organizations and charities should ally with patients, not with Pharma.

In my assessment, these public measures are not likely to be made unless patients and subscribers get to actively demanding that their representatives make these changes. There is too much money from very powerful corporations that do not have patients in their best interest, basically having control of Congress, including both political parties. It would take a huge voter activism to overcome the heavy obstructions to these reforms.

Even after reforms were put in place, the strong, persistent drive to undermine, manipulate, and circumvent any new regulations by the corporations is relentless, and would require constant vigilance and exposure by the press and by voter activists.

Then regardless of whether or not public action occurs, here are some things patients can do:

Doctor bills account for 20-20% of the 3 trillion healthcare dollars spent in this country. First priority is to choose a provider.

Ask the office manager:

1. Is the practice owned by a hospital or surgery center, and are there facility fees?
2. Will you refer me only to other providers in my insurance network, or explain why if you can't?
3. Will blood tests or X-Ray's be done in an in-network lab?
4. Will there be charges for phone advice and filling out forms, or an annual practice fee?
5. If I'm hospitalized, will you be seeing me? Who covers on weekends?

Questions in the office:

1. How much will this test or procedure cost?
2. How will it change my treatment?
3. What tests are you ordering and why?
4. Are there cheaper, equally good, alternatives?
5. Where will this test be performed?
6. Who else will be involved with the treatment? In my network? Will there be a separate bill?

Hospital bills comprise 50-50% of the $3 trillion.

Before you ever need a hospital, vet your potential hospitals in Yelp, US. News & World Report's Best Hospitals rankings, Leapfrog Group's grades on safety, Medicare's online Hospital Compare, and download your hospital's IRS Form 990, especially for "non-profits."

In the hospital:

1. If you are assigned to a private room when you didn't request it, say so.
2. In admitting documents, signing financial responsibility forms, write in "as long as providers are in my insurance network."
3. Ask if you are being admitted, or held in observation status? Under the latter, it would cost you more, and you could not qualify for a rehabilitation center on discharge. Ask why?
4. Ask the identity of every unfamiliar person who appears at your bedside, what she or he is doing, and who sent him or her?
5. If the hospital tries to send you home with equipment you don't need, refuse it.

Have a friend or family member to stay with you to be an advocate, if you are too weak or otherwise unable to be your own advocate. Take notes on everything.

Hospital bills:

1. If you receive an outrageous bill, don't wait, negotiate. Make an offer.
2. When a bill arrives in the mail, request a complete itemization.
3. Check the bill against notes you took in the hospital.
4. Protest bills in writing, to create a record, and send a copy to the consumer protection bureau, the state insurance commissioner, and to a reporter at a local newspaper.
5. Appendix A gives several price calculators, to assess a fair price, the Healthcare Bluebook, etc. Appendix E has templates for letters of protest. Argue against out-of-network bills for treatment about which you were not informed or were not asked for your consent.

In choosing an insurance plan, be sure to check on premiums, deductibles, co-payments, annual out of pocket maximum, the network, HMO's, non-profit companies, etc.

Regarding prescription drugs, shop around. Appendix A has pricing resources. Consider imports, although technically illegal. PharmacyChecker.com helps to check overseas mail order pharmacies in English speaking countries to see that they are not fakes.

Regarding charities and medical organizations, use Charity Navigator. Review their IRS 990's.

In the Epilogue, the author reminisces about the fall of empires, the fate of all great societies that fall into decadence after about 200 years. Wealth and power, selfishness, love of money, and loss of a sense of duty has brought American healthcare to that stage already. Medicine's lofty reputation ushered in by unselfish noble pioneers like Frederick Banting, discoverer of insulin, and Jonas Salk, inventor of the first polio vaccine, has now been squandered in just the last quarter century. This book advocates a return to affordable, evidence-based, patient-centered care.

There are many doctors, nurses, pharmacists, and others who are "working their hearts out" and want to deliver patient-centered, evidence-based care at a reasonable price, and patients need to rise up and help to make that possible. The author ends the book by saying, "When the medical industry presents us with a false choice of your money or your life, it's time for all of us to take a stand for the latter."

This book is a valuable resource for anyone who wants better healthcare for self and others. The appendices have loads of information. For anyone who wants to actively move the country to better responsibility it is great to read this whole book. The author's statements are backed up with hundreds of references.

From my perspective, there are other things people can do regarding expensive tests and treatments. If paying out of pocket is necessary, sometimes making an offer on the spot to provide immediate payment may cut the cost to less than half. Especially some religious groups in certain areas who never use insurance are able to get deep discounts for payment at the time of service.

Another option is medical tourism. It would be good to have passports up to date. I have known people who have gone to Mexico, Costa Rica, Thailand, etc., have received good excellent care, for medical and dental procedures, and have saved enough money to more than pay for plane fares. I have known patients who have recovered from cancer with care in Hope 4 Cancer (clinic in Cancun, hospital in Tiajuana), for treatments that would be illegal in this country. I call them medical refugees. I have known people who have gone to the Bumrungrad International Hospital in Bangkok for surgery, with excellent care. It has accreditation from the International Joint Commission. This is not meant to endorse any of these services specifically, but to provide evidence that there are resources out of the country that have excellent, low cost care. Some have gone to Canada, Germany, and others. It is advisable to vet any foreign health care services carefully, with verification, preferably from several sources, and with references.

All this discussion is mostly about a medical care system that is needed when people are sick, but let's not forget that the treatments themselves are primarily drugs, devices, and surgery, which basically treat symptoms, and not the primary causes, and the chronic illness just gets worse. If we don't address poverty, homelessness, poor education, toxic chemicals in our food, water, and air, etc., and if we don't put resources into prevention, health education, nutrition, lifestyle, etc, and if we don't utilize safer and often more effective treatments such as chiropractic, acupuncture, herbal and nutritional medicine, no matter what structure the system takes, the costs will continue to rise to unsustainable levels, and people will continue to get sicker, with shorter life-spans. See my articles in the archives about books such as The Disease Delusion, Farmacology, Healthy At Home, Radical Remission, and Fortify Your Life.

The Union of Concerned Scientists recently estimated that if every person just ate one more serving of vegetables per day, we would save 30,000 lives and $5 billion each year in this country. We need to support school gardens, because when children raise vegetables, they eat them.

People in general have to be basically committed to good health, for themselves and others, or all the structural changes and regulations of medical care that we advocate and are put in place may fail, if people and corporations keep trying to "game the system" for selfish interests. If people generally believe in selfishness, greed, and unregulated capitalism and don't really care that the corporations are mostly in charge of what the government does, then our society will fall into more ruin, economically, politically, morally, and spiritually, and the structural changes we make will likely be reversed under pressure from the corporations. In order for a healthcare system to work for the benefit of all, then the people must be committed to the well being of all. The U.S. Constitution says, "to promote the general welfare," is a major responsibility of government. If "we

the people," are the government, then we are responsible for seeing that all people have the opportunity for obtaining good health care. Pardon the cliché, but "United we stand, divided we fall." We can fix this broken system if we have the collective will to do it.