THE GARDEN OF WEEDEN: THE *REAL* ROOT CAUSE OF THE HEALTHCARE CRISIS

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As politicians in Washington and pundits on television continue to debate the merits and demerits of healthcare alternatives, skyrocketing costs continue to cripple individuals and businesses alike. Expenditures for health "care" represent approximately 17% of the gross national product – far exceeding the majority of other first world countries, many of whom have healthcare systems equivalent, if not superior to our own.

Debate in Congress, and the deluge of press surrounding it has focused primarily on the wisdom of The Affordable Care Act (aka "Obamacare"), "The Skinny Repeal," "Repeal and Replace" or one hundred other acronyms. Regardless if one agrees with the Democratic or the Republican approach to the premium crisis, an objective analysis demands we step back from this debate and ask whether *either* approach provides an adequate – or even less than adequate – solution to the problem.

The issue is not simply buyer side costs for healthcare coverage. The cancer lies much deeper than that. Simply providing dollars to pay for proffered services does not alleviate the cellular issue, a metastasis embedded in the deepest tissues of the US "medico-industrial complex".

Healthcare is extremely expensive, scientifically advanced, innovative, life saving and these features all come with a significant price tag. Competing interests exist, and derive their livelihood from a healthcare system composed of physicians, hospitals, pharmaceutical develops, medical device manufacturers, insurers, and others. There is no question that these are all businesses with stakes of their own intrinsically woven into the threads of the system.

Physicians undergo years of intensive training, continuing education, malpractice liability, orbital malpractice insurance costs, and high office and equipment expenses. They are obliged to charge and receive a return on their investment and commitment.

Pharmaceutical companies and medical device manufacturers spend hundreds of millions of dollars on research and development (aka "R & D"), and are likewise entrenched on their own ROI (return on investment.)

Yet, the financial incentives that fuel the engines of these entities remains at odds with the outcome of providing excellent care at a sustainable cost. In 1988, California Congressman Pete Stark introduced the "Ethics in Patient Referrals Act" focused on physician self-referrals, which became law as part of the Omnibus Budget Reconciliation Act of 1990. The law prohibited physicians from referring patients to a "Designated Health Service" (including, but not limited to, radiology facilities, radiation therapy

centers, outpatient prescription drug dispensaries, clinical laboratories and others) in which the physician, or a family member, held a financial interest.

This was designed to limit so-called "self-referral," defined as, "the practice of a physician ordering testing or procedures on a patient and in an effort to receive direct financial compensation for performance of these interventions."

Why is it that in-office pharmacy services are no longer available? The answer is simply that physicians had too large an incentive to prescribe drugs that they themselves were proffering – in addition to the fact that the drugs dispensed were simply those that were carried by the physician's office (possibly with pharmaceutical company incentives), and were not necessarily the most effective drugs from a cost or therapeutic perspective.

With regard to medical imaging, it has been shown in numerous peer-reviewed studies that utilizing in-office imaging services for which the radiologist him/herself are reimbursed, utilize such services between four and seven times more often than those physicians who refer patients to independent diagnostic testing facilities.

Unfortunately, exceptions to the Stark Law exist and a large loophole known as in the know as the "in-office ancillary services exemption," does permit a physician to order diagnostic imaging tests if the imaging equipment is located in the physician's office.

Such practices of physician self-referral also extend to many other areas of medical practice.

The recent case of a Florida dermatologist who referred and billed patients for radiation therapy for skin cancer to his own radiation center, despite the fact that the patients did not even have the disease, resulted in Medicare charges into the millions. (http://www.palmbeachpost.com/news/crime--law/palm-beach-doctor-agrees-pay-18m-settle-medicare-suit/i9UkrbaaP9Bbz2h261yA3K/)

The rate of spinal surgery has risen steadily in the United States and constitutes the most expensive Medicare expenditure in the realm of orthopedics. Rates of spinal surgery in the United States are higher than in any other country, and continue to spiral rapidly. Just in the decade between 1992 and 2003 the rate of such surgeries doubled with no end to the upward trend in sight. Surgeons evaluating patients in personal injury cases where disc surgery charges can run as high of $100,000 have little disincentive to offer such services when the cost is borne by someone else.

Physicians have also been cited for practicing "defensive medicine" and rightfully so. Costs for defending a medical malpractice case are often in the many tens of thousands, with damages often rising into seven figures. Legal fees, expert witness costs, court costs and rising malpractice insurance premiums contribute to the burden.

On evening television we sees a steady stream of advertisements from major pharma advising viewers to contact their physician about adopting their miracle cures. Increased utilization translates into increased profits. Many viewers/patients have no real concept of alternative therapies, relative costs, or efficacy, yet consumer driven demand fuels a substantial utilization and cost to an already overtaxed healthcare system.

Predatory pricing by pharmaceutical companies is also a significant contributor. It is well documented that pharmaceutical costs in the US far exceed costs for the exact same medications in other developed countries. A particularly striking example is that of "Acthar" an ACTH hormone extracted from the pituitary glands of pigs and byproduct of the meatpacking industry available since the 1950's. QuestCor™ bought the rights to this drug in 2001 for $100,000, then, after establishing a monopoly on the product raised the price from $50 per vial to nearly $28,000. (This is not a typo.)

Finally, a cottage industry has been created around ways to maximize the arcane coding system used by hospitals in an effort to maximize reimbursements for procedures, services, and materials. While there is nothing inherently wrong with using a mutually agreed to categorization to track billings, there are many opportunities for gaming the system and increasing expenses and costs that are, at times, egregious. The New York Times has reported on this issue in the past ["Those Indecipherable Medical Bills," March 2017]. When an aspirin is billed at $25 at a mainstream hospital, the act is both compensatory and wrong. [http://www.healthcarefinancenews.com/blog/why-aspirin-taken-hospital-can-cost-upwards-25]

Insurance is to medical care what weeds are to a garden. If you just cut off the top of the weed it will quickly grow back. Likewise, current legislative initiatives to pay for services which themselves are out of control, does not burrow to the root of the issue.

Medical costs have skyrocketed in part because there are significant financial incentives to provide the most services possible, not necessarily the optimal. Until there is a coherent attempt to control the etiology of the expenses themselves, payment reform will only temporize the problem. Solutions such as transitioning to a single payer system or more rigorous use of evidence based medicine may help to alleviate the situation. In the meantime, the issue facing the American people is not only having the insurance to pay for healthcare, but the driving forces in the health care system itself.