SABETH AN AMERICAN

AMERICAN SICKNESS

HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK

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upheaval, a shocking investigation into the dangerous, expensive, and dysfunctional American healthcare system, as well as solutions to its myriad problems

In these troubled times, perhaps no institution has unraveled more quickly and completely than American medicine. In only a few decades, the medical system has been overrun by organizations seeking to exploit for profit the trust that vulnerable and sick Americans place in their healthcare. Our politicians have proven themselves either unwilling or unable to rein in the increasingly outrageous costs faced by patients, and market-based solutions seem only to funnel larger and larger sums of our money into the hands of corporations. Impossibly high insurance premiums and inexplicably large bills have become facts of life; fatalism has set in. Very rapidly Americans have been made to accept paying more for less. How did things get so bad so fast?

Breaking down this monolithic business into the individual industries—the hospitals, doctors, insurance companies, and drug manufacturers—that together constitute our healthcare system, Rosenthal exposes the recent evolution of American medicine as never before. How did healthcare, the caring endeavor, become healthcare, the highly profitable industry? Hospital systems, which are managed by business executives, behave like predatory lenders, hounding patients and seizing their homes. Research charities are in bed with big pharmaceutical companies, which surreptitiously profit from the donations made by working people. Patients receive bills in code, from entrepreneurial doctors they never even saw.

The system is in tatters, but we can fight back. Dr. Elisabeth Rosenthal doesn't just explain the symptoms, she diagnoses and treats the disease itself. In clear and practical terms, she spells out exactly how to

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doctors is an essential requirement. Patients will have direct access to their medical data and the system will allow referrals, discharge summaries, data, and prescriptions to be shared securely among all providers.

In the United States, EMRs have evolved to put business before patients. Disjointed and siloed, they have not delivered on their promise. Dr. Joanne Roberts, chief medical officer at Providence Regional Medical Center in Everett, Washington, recently completed a master's degree in health administration. The professor teaching a course on medical information systems began the class with an apology: "On behalf of the informatics industry I just want to say 'I'm sorry.'"

Re: Sutter Health

What Happens to Small Hospitals After Consolidation

When Sutter Health first invited Coast Hospital in Crescent City, California, to come under its umbrella in 1985, it seemed like a perfect union. At that time, Sutter merely offered management assistance, the service it typically performed at affiliated hospitals. Coast remained community owned, serving a lightly populated swath of the far northern reaches of California's redwood forests. According to Dr. Greg Duncan, then a young orthopedic surgeon, "They made sure we had good equipment and were very supportive of the docs. For eighteen years, I was happy."

But in 2009 Sutter Health ended its role of supporting locally owned hospitals and embarked on a statewide merger strategy it called "regionalization." The plan was to transfer ownership of the affiliate hospitals, many of which were the sole providers for hundreds of miles around, to Sutter-controlled regional corporations.

Regionalization led to higher charges: At one point, Blue Cross Blue Shield refused to sign with Sutter, noting that its rates were 60 percent

higher than the statewide average. But it ultimately had to surrender because it could not leave patients stranded in huge areas where Sutter was the only option. By 2013 Sutter hospitals represented seven of the ten most expensive hospitals in California, according to California's Valued Trust, a public employees group focusing on benefits.

At Coast Hospital, prices kept rising. By 2012 an MRI of the knee at Sutter Coast cost $3,383, more than double the rate at the three closest hospitals not owned by Sutter—though none was close enough to provide a practical alternative. In 2013, it was billing patients nearly $6,000 for the first thirty minutes of operating room time under general anesthesia—not including drugs, IVs, sterile supplies, or the fees of the surgeon and anesthesiologist. By 2011 Dr. Duncan "had patients come to [him] after minor surgery with bills in excess of twenty thousand dollars. The financial stress among working families was too profound to ignore."

A negotiating stalemate over rates between Sutter and Anthem Blue Cross, one of the region's big insurers, prompted Anthem to ask physicians like Dr. Duncan to obtain admitting privileges at a non-Sutter hospital. Dr. Duncan started to drive to a hospital in Arcata, about one hundred miles away, to operate on patients who needed more affordable care, although the elderly and poor couldn't make such trips. When Dr. Duncan pointed out to a Sutter executive that commercially insured patients were leaving town to avoid the conglomerate's high charges, the response, he says, was that Sutter said it would consider lowering the charges for elective services to gain back the business, but not for emergencies—since patients in extremis couldn't travel.

In 2011, according to Dr. Duncan, a Sutter Health representative rewrote the hospital's bylaws with more than a thousand changes, which included a clause requiring the board to be "loyal" to Sutter Health. That same year, Sutter drew up a plan to replace the Sutter Coast Hospital

board, then made up largely of locals, with a "community committee" that had no decision-making authority, as had already taken place at Sutter's twenty-three other affiliates under regionalization.

In 2012 Dr. Duncan was elected medical chief of staff by his colleagues and attended board meetings in an ex officio capacity: "It was really an eye-opener. Regionalization is OK if it brings operational efficiencies," he told me. "But an executive even told us there are no efficiencies in this. It's about control, pricing, contracts, profits." (One longtime healthcare executive who was recruited by Sutter but took a job elsewhere told me, "They pay their administrators an enormous amount of money and the appetite for acquisition was enormous.")

In December 2013 Sutter announced that Coast was not financially viable and would be converted into a "critical access hospital"—downsizing from forty-nine to twenty-five beds.

Sutter had already closed Coast's surgical care unit and hospice program, when a directive arrived announcing that the corporation was studying discontinuing obstetrical care as well because it was losing money. "I was truly beside myself," Dr. Duncan said. "We were all shocked. There's no other place around here to have babies." When he divulged the proposal to the medical staff, the board formally censured him at the recommendation of a Sutter Health attorney. Following physician backlash, Sutter Health left OB services in place.

The critical access program was created in 1997, to ensure the survival of small remote hospitals of not more than twenty-five beds. Medicare pays these hospitals more for their services, which are exempt from many of the government insurer's cost-saving measures. They can, for example, bill full hospital rate for "swing beds," for recovering patients who might have been discharged to cheaper rehabilitation facilities in urban centers.

The critical access program was being manipulated for profit, in the opinion of many Sutter Coast staff doctors. Sutter had already used the program to downsize Lakeside, another Sutter hospital in Lakeport, Cali-

fornia, to critical access status, taking advantage of the higher payments. But because of bed shortages at the smaller hospital, emergency transfers from Lakeside increased 300 percent, and patients or their insurers, including Medicare, were left paying massive bills—including charges for air ambulances to fly patients out. The hospital's twenty-five beds were often filled with elective admissions, patients with nonurgent problems, as well as patients who merely needed rehabilitation occupying swing beds.

In 2015 the HHS OIG found that billing for such swing beds at critical access hospitals had risen rapidly, costing Medicare an extra $4.1 billion from 2005 to 2010. Sutter Lakeside's charges to Medicare were the highest of all thirteen hundred hospitals in the program the year after its conversion to critical access status in 2008, 24 percent higher than those of the institution in second place. It was a model that others would follow, as bigger fish ate up smaller fish all over the country.

A Part-Time Emergency Room

New York State assemblyman James Skoufis represents five towns about fifty miles north of New York City in the Hudson Valley. Much of his first term in office had been consumed by preventing attempts to gut some essential services at the community's health provider, Cornwall Hospital, or St. Luke's Cornwall Hospital, as it is now called.

Cornwall Hospital, which opened its doors in 1931, was founded with a grant from a doctor, Ernest Stillman, who explained:

> Some years ago I was asked to see a sick child. As the patient was in dire need of hospital care to save her life, I rushed her in my car to an adjacent hospital. But the hospital would not admit the patient and the child died. That tragedy marks the starting of the Cornwall Hospital.