MERCOLA
Take Control of Your Health

Health Care — A Monopoly of Monsters

Analysis by Dr. Joseph Mercola ✔ Fact Checked | January 25, 2023

STORY AT-A-GLANCE

- Americans pay twice as much for their health care yet get the worst care of any developed Western nation. And, while other countries guarantee treatment regardless of income, treatment in the U.S. depends on whether you can afford costly health insurance, or have a job that provides it
- Nearly 70% of Americans support a Medicare for all scheme over the current health insurance system and making health care affordable was the second-highest priority of Americans in a 2022 poll. Medicaid will terminate benefits for an estimated 15 million Americans once the public health emergency ends
- One of the reasons why U.S. health care is so exorbitantly expensive is because it's a conglomerate of monopolies. This results in higher costs while discouraging innovation and efficiency optimization
- Strategies that could lower costs and improve care include leveraging economies of scale, offering hospital services seven days a week, and providing at-home health care services
- Another thing that could go a long way toward improving medical outcomes and lowering patient costs is banning drug ads, especially in electronic health record (EHR) systems and patient portals, as such ads drive up costs and result in poor prescribing decisions that put patients at risk

As noted by The Hill's anchor Briahna Joy Gray in the video above, Americans pay twice as much for their health care yet get the worst care of any developed Western nation.

And, while other countries guarantee treatment regardless of income, treatment in the U.S. depends on whether you can afford costly health insurance, or have a job that provides it.

According to polls cited by Gray, nearly 70% of Americans support a Medicare for all scheme over the current health insurance system, and making health care affordable was the second-highest priority of Americans in a 2022 poll.

15 Million Americans Will Soon Lose Medicaid Benefits

Concerns about the cost of health care are likely to increase even further once Medicaid starts terminating benefits for an estimated 15 million Americans, which is expected to begin in April 2023. These were people who qualified for Medicaid and/or the Children's Health Insurance Program (CHIP) coverage during the pandemic emergency.[1] Once the public health emergency (PHE) ends, this coverage will be rescinded.

"Are we really going to go back to letting 68,000 people die each year simply because they're too poor to live?" Gray asks. President Biden campaigned on a public option for health care, but that promise has yet to come to fruition — possibly because he took more money from the health insurance industry than any previous president.

Former President Obama folded when it came to a public option after the industry lobbied hard to prevent it, and while so-called "Obamacare" promised to be an affordable option, health insurance prices and industry profits soared once the Affordable Care Act was enacted.

Since people were financially penalized for not having insurance, insurance companies took advantage and raised prices across the board, even though we were promised that wouldn't happen.

The public option would (allegedly) allow Americans to purchase a government-backed Medicaid-like plan at a competitive price. The idea is that government would not seek to make a profit on the public option in the way private health insurers do.

US Health Care Is a Conglomerate of Monopolies

There are many reasons for why U.S. health care is so exorbitantly expensive, but one of them is because it's a monopoly or, as Dr. Robert Pearl, former CEO of The Permanente Group, describes it, "a conglomerate of monopolies." In a January 16, 2023, Forbes article, he writes:[2]

> *"In any industry, market consolidation limits competition, choice and access to goods and services, all of which drive up prices. But there's another — often overlooked — consequence. Market leaders that grow too powerful become complacent. And, when that happens, innovation dies.*
>
> *Healthcare offers a prime example. De facto monopolies abound in almost every healthcare sector: Hospitals and health systems, drug and device manufacturers, and doctors backed by private equity. The result is that U.S. healthcare has become a conglomerate of monopolies.*
>
> *For two decades, this intense concentration of power has inflicted harm on patients, communities and the health of the nation. For most of the 21st century, medical costs have risen faster than overall inflation, America's life expectancy (and overall health) has stagnated, and the pace of innovation has slowed to a crawl …*
>
> *[M]erged hospitals and powerful health systems have raised the price, lowered the quality and decreased the convenience of American medicine."*

According to Pearl, 40 of our largest health care systems combined own 2,073 different hospitals. That's approximately one-third of all emergency and acute care facilities in the country. The top 10 health care systems combined own one-sixth of all hospitals and have an annual net revenue of $226.7 billion.

While there are all sorts of antitrust and anticompetitive laws on the books, "legal loopholes and intense lobbying continue to spur hospital consolidation," Pearl says. As a result of all this consolidating, hundreds of communities have just one option for

inpatient care. This means there's no competition in terms of pricing, so prices tend to go up, while quality of care often declines since patients can't complain and go elsewhere.

A Better System Is Possible

As noted by Pearl, health care could be far more affordable, and medical outcomes could be improved, if only hospital-system administrators were willing to embrace more innovative care-delivery. For example, they could:[3]

- **Leverage economies of scale —** Size equals cost savings, so when larger hospitals acquire smaller ones, they gain negotiating power. They can also eliminate redundancies. This "could and should result in lower prices for medical care," Pearl says.

  That's not happening, however. Instead, inefficiencies at both hospitals persist. Why? Because "hospital administrators prefer to raise prices … rather than undergo the painstaking process of becoming more efficient." Pearl goes on to give the following example:

  > *"Following M&A [merger and acquisition], health systems continue to schedule orthopedic, cardiac and neurosurgical procedures across multiple low-volume hospitals.*
  >
  > *They'd be better off creating centers of excellence and doing all total joint replacements, heart surgeries and neurosurgical procedures in a single hospital or placing each of the three specialties in a different one.*
  >
  > *Doing so would increase the case volumes for surgeons and operative teams in that specialty, augmenting their experience and expertise — leading to better outcomes for patients."*

- **Offering services seven days a week —** Many hospitals cut back on services on the weekends, as staff prefer to have weekends off. As a result, patients admitted on a

Friday evening or weekend end up spending, on average, one extra day in the hospital because procedures are postponed until Monday. Not only does this result in additional cost for the patient, it also places them at higher risk of hospital-acquired infection and medical errors.

- **Offering at-home services —** During the pandemic, patients were frequently sent home with intravenous medication and monitoring devices when hospitals ran out of beds. A nurse would come check on them if or when needed, and according to Pearl, "Clinical outcomes were equivalent to (and often better than) the current inpatient care and costs were markedly less."

  Hospitals could easily expand on this approach "with readily available technologies," Pearl says. For example, a team of clinicians in a central location could monitor hundreds of patients in their homes, around the clock, using biomonitoring devices and video streaming.

Prescriber Drug Ads Increase Costs and Put Patients at Risk

Another thing that could go a long way toward improving medical outcomes is banning drug ads, especially in electronic health record (EHR) systems. Yes, 15% of electronic health record systems actually feature pharmaceutical marketing to doctors while they're entering your medical data.

> **“Drug ads in electronic health record (EHR) systems and patient portals drive up costs and result in poor prescribing decisions that put patients at risk.”**

Some EHRs are even subsidized by drug company partnerships. While 15% is a minority, it's still considerable when you consider that 80% of doctors have adopted EHRs,[4] with more adopting them each year. As reported by the American Medical Association (AMA):[5]

> *"Research cited in the AMA board report shows that exposure to physician-directed advertising is associated with less effective, lower-quality prescribing decisions and that exposure to pharmaceutical company-provided information leads to higher prescribing frequency and higher costs.*
>
> *In one instance, Practice Fusion, a company Allscripts purchased in 2018, used an ad-supported revenue model. After a federal investigation, Practice Fusion admitted to soliciting and receiving kickbacks from opioid manufacturer Purdue Pharma in exchange for clinical decision support (CDS) alerts promoting unnecessary opioids at the point of prescribing in their EHR system …*
>
> *The Pain CDS in Practice Fusion's EHR displayed alerts more than 230 million times between 2016 and 2019. Those who received the alerts prescribed extended-release opioids at a higher rate than those that didn't.*
>
> *'This activity by Practice Fusion demonstrates how the EHR can present opportunities for stakeholders to abuse the system, inappropriately influence physicians' decisions and put patients at risk,' the board report says."*

A report by CMI Media Group[6] also reveals the power EHR-based ads have to massively increase prescriptions for a given drug. Using its recommended EHR messaging strategy, CMI was able to increase prescriptions of a drug by 388%, while prescriptions for its competitor dropped by 36%.

> *"Further, when the campaign was paused for a month, scripts dropped 13% compared to the previous month. When the campaign resumed, scripts increased 23%,"* CMI Media Group reported.

AMA House of Delegates Opposes EHR Drug Ads

As a result of the AMA board's findings, the AMA House of Delegates, the legislative and policy-making body of the AMA, amended its policy and now opposes direct-to-prescriber drug ads in EHRs, medical reference software and e-prescribing software.

The policy also opposes the preferential placement of brand-name medications in e-prescription search results or listings, and instead encourages e-prescribing and EHR companies to list generic medication names first.

Advertising That Doesn't Look Like It

That said, advertising companies are still looking for novel ways to market their clients drugs through EHRs. For example, CMI Media Group recommends[7] focusing on providing patient instructions instead of "glossy promotional messaging," or sponsoring things like instructions on how brands are coded in the system or drug titration recommendations.

While such information is said to address real needs by doctors and patients, at the end of the day, it's just another strategy meant to increase sales.

Another strategy that many might not realize is pure advertising is the offering of financial assistance and patient education through patient portals. "With approximately 30% of first time prescriptions not being filled, ensuring patients are receptive is incredibly important," CMI Media Group writes.[8]

Drug Ads in Medical Journals Can Compromise Patient Care

Considering the fact that drug ads in EHRs can entice doctors to make lethal drug decisions, in addition to driving up costs by promoting brand name drugs, I believe they should be banned altogether. After all, doctors are already influenced by drug reps and drug ads in medical journals.

In 2016 alone, drug companies spent $637 million on nearly 100,000 pages of print advertisements in medical journals that reach 90% of doctors.[9] For journals, drug ads are a great source of revenue, but that cash flow comes at a price, namely patient care and safety.

As noted in "Pharmaceutical Advertising in Medical Journals; Revisiting a Long-Standing Relationship," an editorial in the Chest Journal:[10]

> *"Advertisements enable pharmaceutical manufacturers … to sway prescribing practices in favor of the product being advertised, regardless of whether it is the most efficacious or cost-effective option for a patient.*
>
> *Although some physicians may not believe that they are influenced by advertising, studies indicate a return on investment between $3 and $5 for every dollar a pharmaceutical company spends on journal advertising."*

One example of how ads can steer doctors in the wrong direction is that of Acthar Gel, a repository corticotropin injection advertised in the Chest Journal in 2016. In March that year, Chest editorial board member Mark Metersky wrote a letter to the editor questioning the evidence supporting its use.

Not only did this formulation of corticotropin cost nearly $34,000 for a 5-milliliter vial, there was no reliable evidence that it was any better than oral corticosteroids that cost pennies per pill — and this despite being on the market for more than 50 years. Metersky also cited evidence showing there were "substantial financial ties between top prescribers of the drug and its manufacturer."

Three other physicians wrote a Chest editorial in support of Metersky's letter, and the manufacturer subsequently withdrew the ad. No doubt they weren't happy about it, seeing how a one-page ad cost about $6,400, which means the ad paid for itself five times over if it resulted in a single prescription.

In a case such as this, what responsibility does the journal have? Should they allow ads for ineffective drugs that cost tens of thousands of dollars more than proven ones? Should medical journals advertise drugs at all?

Half of Drug Ads in Journals Violate Advertising Guidelines

A study[11,12] of 83 drug ads featured in medical journals also found that nearly half of them failed to comply with one or more of the requirements in the U.S. Food and Drug Administration's prescription drug advertising guidelines, which makes this kind of advertising even more questionable. Apparently, drug makers are playing fast and loose with advertising rules when they're marketing to doctors. As noted by the authors:[13]

> *"Few physician-directed print pharmaceutical advertisements adhere to all FDA guidelines; over half fail to quantify serious risks. The FDA could better protect public health by creating new more objective advertisement guidelines requiring transparent presentation of basic safety and efficacy information."*

Without doubt, the American health care system is beyond broken. Sure, it excels when it comes to emergencies, but when it comes to treatment of chronic diseases, which is what gobbles up most of our health care spending, it's completely inept.

Unfortunately, it's about to get even worse. As detailed in "**The Redesign of Our Food System Is a Plot for Control**," President Biden has launched a "Food Is Medicine" program that will allow doctors to prescribe food the way they prescribe drugs.

At the same time, the globalist cabal is redesigning the food system to eliminate natural whole foods such as meat and dairy and replace them with patented synthetics. Once such a system is in place, there's really no hope for health, as doctors will be pushing synthetic drugs AND foods.

To circumvent this, we must focus on building alternative, parallel health care systems that are outside the conventional paradigm. Some medical groups are already doing this, which is great news. On an individual level, you'd be wise to get as healthy as you possibly can now, just to avoid any unnecessary hospital encounters. For my top tips, check out "**The Most Important Topics of Our Time**."

Sources and References

- [1] CHN.org December 15, 2022
- [2, 3] Forbes January 16, 2023
- [4, 6, 7, 8] CMI Media Group February 23, 2021

- [5] AMA June 16, 2021
- [9, 10, 12] Chest Journal January 1, 2018; 153; 1: 9-11
- [11, 13] PLOS One 2011; 6(8): e23336