American Journal of Law & Medicine, 36 (2010): 288 - 294

Foreword: Following the Money

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Follow the money is a versatile phrase; the term can be used as an exhortation, designate a pathway, or denote a lifestyle choice. When it comes to health care, following the money is at least part of the *sine qua non* for anyone seeking to understand how this complex sector of the US economy has arrived at its present sorry state. It's not hard to conclude that a country which allocates 13.7% of its GDP to health care,[1] yet ranks down at #37 on the World Health Organization's listing of global health systems,[2] has not been spending its money wisely. Things may get a whole lot better - or a whole lot worse - now that Congress has enacted the Patient Protection and Affordable Care Act of 2010[3], but in any event things will most definitely be different. The essays in this Symposium all contribute to an understanding of how different they could turn out to be.

Popular wisdom has it that the term *follow the money* originated with Deep Throat in the Watergate Era – at least Hal Holbrook uttered those words when playing the character in the film version of *All the President's Men*. But as Professor David Hyman notes in his article for this issue,[4] the phrase appears nowhere in any of Bob Woodward and Carl Bernstein's Watergate writings, nor does it show up in Woodward's interview notes for his meetings with his clandestine source. The movie's screenwriter has finally concluded that he probably thrust those words into Deep Throat's mouth all on his own.[5]

This symposium contains articles by an impressive group of health law scholars, extremely knowledgeable about health care economics and financing. They need quote no Deep Throats about the way the US and other health sectors actually function, for they have been doing their own hard work researching, writing and teaching about health care delivery for many decades. Thus they have unique authority to analyze and comment upon the

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[1] The World Health Report 2000 – Health Systems: Improving Performance, 105 (2000); *available at* http://www.who.int/whr/2000/en/whr00_en.pdf.

[2] *Id.* at 155.

[3] Pub. L. 111-148, 124 Stat. 199 (2010), [hereinafter "the 2010 Act"] (as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152, 124 Stat. 1029 (2010).

[4] David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else,* 36 Am. J.L.& Med. 370,388 (2010).

[5] William Safire, *Follow the Proffering Duck,* NY Times Mag., Aug. 3, 1997.

role of money in health sector, and each of them has put his or her own special spin on the topic. The great pleasure for me in writing this Foreword has been to see how each one of them has taken up the topic of money and run with it, in ways both predictable and unexpected. And just for fun, I've tried to figure out whether each of these talented scholars has approached the subject as the potential pathway, exhortation or lifestyle choice with which I framed this essay.

Professor Robin Wilson's meticulously-documented contribution to this symposium, *The Death of Jesse Gelsinger: New Evidence of the Influence of Money and Prestige in Human Research*, is at first easy to pigeonhole as a straightforward response to an exhortation to follow the money. Her article draws upon reams of evidence, accumulated for a high-profile lawsuit, that never really saw the light of day because the case settled so quickly. She did indeed follow the significant sums of money a biotech company poured into the financing of a Phase I gene therapy clinical trial at the University of Pennsylvania, all the way through Penn's organizational chart and procedures, and her comprehensive account constitutes legal investigative reporting and analysis at its very best.

Professor Wilson dug deeply into the circumstances surrounding Jesse Gelsinger's highly-publicized 1999 death during the clinical trial, where both the principal investigator and the sponsoring institution had substantial financial investment in the technology at issue. Her persistence in ferreting out and exposing the financial and other facts of this tragic case, and the conflicts they engendered that may have affected Jesse's fate, has provided the research community and the rest of the world an invaluable reminder that conflicts of interest will always breed suspicion about ulterior motives. But perhaps more importantly, her work spotlights the cozy research relationships between industry and academe – lifestyle choices, in the framing terminology of this Foreword – that can compromise both the process and the product of scientific investigation.

Professor Tim Jost continues the conflict of interest theme affecting pharmaceutical industry-medical professional relationships in his crisp, no-nonsense analysis and prescription for reform entitled *Oversight of Marketing Relationships Between Physicians and the Drug and Device Industry: A Comparative Study*. Professor Jost's work could be categorized in the framing terminology as another response to an exhortation to follow the money, for he focuses on "[b]iases resulting from industry-physician [financial] relationships [that] may result in bad research, patient injury, and high health care costs."[6] He acknowledges the positive attributes of "close working relationships between industry and physicians,"[7] but he also catalogues the conflicts and distortions those close relationships (lifestyle choices, as it were) inevitably engender when money is involved - particularly when it comes to marketing pharmaceutical products. Pharmaceutical largesse directed to physicians is (or at least has been until recently) legendary, ranging from industry funding of medical education (including lavish travel and entertainment), to consulting fees, gifts, free meals and pharmaceutical

[6] Timothy Stoltzfus Jost, *Oversight of Marketing Relationships Between Physicians and the Drug and Device Industry: A Comparative Study,* 36 Am. J.L. & Med. 326, 327 (2010).

[7] *Id.* at 328.

https://doi.org/10.1177/009885881003600201 Published online by Cambridge University Press

samples.[8] One of his statistics alone demonstrates the magnitude of the problem: "In 2004 . . . pharmaceutical companies . . . spent . . . $61,000 [on marketing their products] for every physician in the United States."[9]

After presenting a succinct primer on the way drug and device markets function, Professor Jost looks at the way other countries regulate industry/professional relationships, comparing those efforts with our own. He shows that all these countries have concern about the propensity of pharmaceutical money to undermine physician decision-making, that all employ some combination of direct governmental regulation, professional self- regulation, and the criminal law to combat abuse, but that these methods are far from uniform – or uniformly enforced. He concludes by advocating a flat-out prohibition on drug and device companies "giving *any* gifts to professionals who have the authority to prescribe or order their products."[10] Furthermore, he would replace the medical education funding shortfalls that would result from implementing his recommendations by taxing the pharmaceutical industry and re-directing the money generated thereby to governmental or not-profit agencies charged with "disseminat[ing] . . . to doctors accurate, evidence-based and unbiased information on drugs and devices."[11] He writes a provocative prescription indeed, and one that would turn a long-standing industry/professional lifestyle upside down. But it's a prescription worth serious consideration, given mounting evidence of treatment decision-making distorted by financial bias.

Professor Joan Krause's thoughtful essay, *Following the Money in Health Care Fraud: Reflections on a Modern Day Yellow Brick Road*, is a further contribution to this symposium that might be thought to fall easily into the category of a response to exhortation. Instead, however, Professor Krause's frank and informed observations about the shortcomings of the pathway we've already taken to combat health care fraud provide good reason to re-think our current enforcement route. She shows us that the volume of actual US health care fraud is virtually impossible to calculate using current methods, that "real" fraud (i.e. that committed by determined fraudsters) can be incredibly difficult to detect, and that the sheer volume of (sometimes inconsistent) regulation on the subject is enough to make providers despair. Focusing on the perspectives of three players, those inclined to commit fraud, prosecutors, and policymakers, she explains why health care attracts fraud ("that's where the money is"[12]), and comments on the perverse financial incentives embedded in legislation that make perpetrating fraud relatively easy, and that skew prosecutorial decisions as well.

All is not gloom and doom, however, and Professor Krause sees a ray of hope in the administrative Health Care Fraud Prevention & Enforcement

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[8] *See, e.g.*, Shirley S. Wang, *Psychiatric Group to Unveil Guidelines to Curb Conflicts*, June 11, 2010 WALL ST J., June 11, 2010.

[9] Jost, *supra* note 6, at 331.

[10] *Id.* at 340.

[11] *Id.* at 341.

[12] Joan H. Krause, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J.L. & MED. 342, 344 (2010) (citing Pamela H. Bucy, *Crimes by Health Care Providers*, 1996 U. ILL. L. REV. 589, 589 (internal quotation and citation omitted)).

Action Team (HEAT), put together by Attorney General Eric Holder and HHS Secretary Kathleen Sebelius in mid-2009, and expanded upon by Congress in The 2010 Act. Patterned on the successful Medicare Strike Force program, "HEAT is designed to utilize state-of-the-art technology to analyze electronic claims data for patterns that might indicate fraud, in as close to real time as possible. . . ."[13] The point is to prevent fraud by identifying improper billing practices before any claims are paid, thus obviating the need to prosecute violators after they already have their hands on the money. Clearly more reform is needed before our fraud and abuse laws can be deemed efficient and effective, but Professor Krause's article is convincing on the point that we need to move to a preventive approach rather than continuing to rely on expensive and often random after-the-fact enforcement.

Professor David Hyman's trenchant commentary, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else,* takes a different tack. Professor Hyman takes for granted that economic incentives affect medical decision-making - that money sends seductive messages to doctors, just as it does to everybody else. His response to an exhortation to follow the money is to aver that the incentives embedded in our health care payment system are basically out-of-whack, and he cites chapter and verse about "[e]ncounter-based, quality-insensitive fee-for-service compensation"[14] to prove it. In essence, he believes that "unless and until we alter the core incentives created by our existing payment system, we will get more of what we've already got – a dysfunctional non-system that delivers uncoordinated care of widely varying quality at a high cost."[15] Professor Hyman, who is both a lawyer and a physician himself, has never been known for beating around the bush.

Professor Hyman also points an accusing finger at inappropriate levels of payment by our public and private payors, and at the tax subsidies which induce the over-consumption of health insurance by US patients. Noting that these subsidies are "the source of considerable horizontal and vertical inequity and allocative inefficiency,"[16] he sees them as part of the mis-placed incentives that undermine the existence of a logical and consistent health care delivery system in this country. When it comes to federal health reform, the best he can muster is that some of the House and Senate initiatives (and presumably the provisions in the legislation ultimately enacted) were "promising but significantly underpowered."[17] He characterizes the Massachusetts health reforms, on which the federal statute was partially modeled, as a "dessert first, spinach later, we hope"[18] approach, and there is truth to that characterization. But the hard work of re-aligning incentives at the state level is showing signs of life,[19] and perhaps some re-aligned day Professor Hyman may conclude that

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[13] *Id.* at 368.
[14] Hyman, *supra* note 4, at 372.
[15] *Id.* at 371.
[16] *Id.* at 379.
[17] *Id.* at 380.
[18] *Id.* at 384.
[19] Massachusetts Division of Health Care Financing and Policy Health Care Cost Trends 2010 Final Report (2010) *available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/final_report_docs/health_care_cost_trends_2010_final_report.pdf; Christine E. Eibner, et al., Rand Corporation,

https://doi.org/10.1177/009885881003600201 Published online by Cambridge University Press

the Massachusetts reforms - and with luck the federal ones as well - are not *all* pie in the sky.

Professor Peter Jacobson and Soniya Keskar Mathur's article, *Health Law 2010: It's Not* All *About the Money,* provides a fitting counterpoint to Professor Hyman's money-as-dominant-incentive point of view. While acknowledging that identifying "who controls the money" tells you a great deal about the way health systems operate, Professor Jacobson and Ms Mathur remind us that non-monetary factors matter to the way these systems function too. They explore where the pathways, as it were, of these other factors (primarily fiduciary duties and non-financial conflicts of interest) lead, then turn their attention to the perverse inducements created by many current regulatory regimes. Here they join forces with Professor Hyman to decry regulatory incentives that impede sensible - and sensitive – delivery of effective and efficient health care services.

The authors' exploration of fiduciary incentives focuses on the duties of obedience and loyalty, owed by directors of both for-profit and not-for-profit health care institutions, which temper the siren call of generating the healthiest bottom line possible. They ask us to accept that health care is not "just another commodity,"[20] and that social justice concerns have an important part to play in health care delivery. In essence they maintain that mission is the *raison d'etre* for the care-giving enterprise, and cite directors' fiduciary obligations to patients to buttress that assertion. They also point to the role played by non-financial conflicts of interest in medicine, particularly involving conscience clauses, treatment decisions and end-of-life decisions, to underscore that it's not *only* about the money in delivering health care.

Professor Eleanor Kinney continues the exploration of margin versus mission with her provocatively-titled and ambitious commentary, *For Profit Enterprise in Health Care: Can It Contribute to Health Reform?* Professor Kinney's article "analyzes the characteristics and behavior of the major players in the healthcare sector . . . and assesses what characteristics and behavior might be undesirable in a publically-subsidized sector of the national economy."[21] Her piece first sets forth a wealth of historical information and intriguing statistical data as background for the health insurance crisis she and many others believe precipitated the 2010 reforms. She then turns her attention to for-profit health care, which dominates in three (physicians, health insurers, and pharmaceutical, medical device and medical supply companies) of the four major player groups she identifies as crucial to health sector functioning. Only one-quarter of the fourth player group, hospitals, takes the for-profit form, but Professor Kinney correctly observes that just because not-for-profits don't distribute the excess of their revenues over expenses to shareholders doesn't mean that they don't enjoy impressive financial gains.

Controlling Health Care Spending in Massachusetts: An Analysis of Options, (2009), *available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

[20] Peter D. Jacobson & Soniya Keskar Mathur, *Health Law 2010: It's Not All About the Money*, 36 Am. J.L. & Med. 389,391 (2010).

[21] Eleanor D. Kinney, *For Profit Enterprise in Health Care: Can it Contribute to Health Reform?*, Am. J.L. & Med. 405, 406 (2010).

Professor Kinney then pinpoints what she sees as undesirable profit-maximizing practices, "highly detrimental to patients,"[22] in each of these four groups. Presumably few people would defend physicians who order unnecessary services, non-transparent and uncharitable hospital practices, aggressive insurer underwriting and post-claims underwriting, or unfair drug and device pricing, but her article places a bulls-eye on all of their backs as targets for reform. The final section of the article outlines steps that could be taken to ameliorate these destructive practices fostered by for-profit motivations, control costs, and avoid turning our publicly-subsidized health sector into a "cash cow"[23] for entrepreneurial providers who compete unfairly. Tackling the for-profit US health care that constitutes the health sector's "lifestyle of choice," in my framing terminology, might seem akin to tilting at windmills. By raising the issue directly, however, Professor Kinney opens the dialogue and puts some deeply worrying practices - and their destructive consequences - onto the table for debate.

Professor Wendy Mariner tackles the nettlesome health "insurance" controversies associated with health reform head-on as well in her lucid and instructive piece, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance.* She identifies the basic disagreement that all but torpedoed the 2010 reforms as one between those who see health insurance as an underwriting mechanism, with its risk-spreading roots in indemnity insurance, and those who believe it should function primarily as a financing vehicle, in the manner of Western European social insurance systems. She further illuminates the dispute by tracing the rise (and recent fall) of indemnity health insurance in the US, and by showing that European social insurance systems treat health insurance as serving a public (rather than a private) function, including paying for preventive services designed to improve health in addition to traditional medical expenses incurred as a result of illness.

Professor Mariner's important contribution here is to point out that the health insurance reforms envisioned by the Patient Protection and Accountable Care Act[24] contemplate a hybrid form of insurance that "uniquely combines elements of risk spreading insurance and service payment commitments."[25] In other words, she seeks to make explicit that the reforms were designed in part to eliminate the industry practice of cherry-picking low-risk subscribers – to follow a new pathway, if you will. The reforms envision the insurance industry using its actuarial proficiency to calculate costs rather than to underwrite risks in the traditional manner. Once that is accomplished, insurers can then proceed "to finance socially beneficial services by spreading the cost of care."[26] That would indeed be a new way of following the money.

Finally, Professor Guy Seidman's absorbing account of the Israeli health system's recent evolution toward the private sector, *Is a Flat-Line a Good*

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[22] *Id.* at 424.
[23] *Id.* at 435.
[24] The 2010 Act, *supra n*ote 3.
[25] Wendy K. Mariner, *Health Reform: What's Insurance Got to do with it? Recognizing Health Insurance as a Separate Species of Insurance,* 36 AM. J L. & MED. 436, 450. (2010).
[26] *Id.*

https://doi.org/10.1177/009885881003600201 Published online by Cambridge University Press

Thing? On the Privatization of Israel's Health Care System, gives this collection of essays an international bent and a great deal to think about. His cleverly-titled essay provides a pathway to illustrate what can happen when the (government) money for funding universally available health care is no longer considered sufficient – i.e., when there is not much money to follow.

The Israeli situation seems paradoxical at first: how has the country managed to keep quality up and health care costs stable at approximately 7.7% of GDP for more than a decade, while that percentage has been rising in the rest of the world? Professor Seidman's first answer is deceptively simple: the Israeli economy has fared relatively well over that decade, so although total health care costs have increased, they have not outpaced the country's steady rise in GDP. On a more sobering note, however, he asserts that the government has chronically underfunded the "healthcare services basket," producing "a sharp, continuous rise in the share of private individuals in financing the national healthcare expenditure."[27] Since not everyone can afford to shoulder the full burden of these excluded costs, many Israelis simply forego care they would otherwise get, and these social costs fall disproportionately heavily on two relatively impoverished groups: Arab-Israelis and ultra-orthodox Jews. Although the Israeli Supreme Court has been asked to intervene on behalf of those asserting rights to state-funded healthcare services, thus far the Court has declined to second-guess the government's health policy choices. This leaves Israel with a shrinking health care basket of publicly-funded services, and a steadily increasing share of health care costs borne by private individuals. As always with alleged miracles, there's a complicated story behind the story of the Israeli flat-line – one that Americans might do well to heed as they contemplate reform.

CONCLUSION

Thinking about these thoroughly interesting and challenging articles has been catnip for me – some of the essays have taken me down fascinating pathways my ordinary money-tracing route has not previously kept under surveillance, and all of them have enriched my understanding of our complex, fascinating, and sometimes frustrating and disheartening US health sector. I'm deeply grateful - and honored - that such a distinguished group of my wonderful health law colleagues accepted the Journal's invitation to contribute these stimulating articles to the symposium. I look forward to following their future work – along with the money – in the years to come.

[27] Guy I. Seidman, *Is a Flat-Line a Good Thing? On the Privatization of Israel's Healthcare System,* 36 Am. J.L. & Med. 452,467 (2010).

https://doi.org/10.1177/009885881003600201 Published online by Cambridge University Press