FIGHTING TO HELP LOWER COSTS: MAKING A FINANCIAL CASE FOR CHIROPRACTIC

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INTRODUCTION

Recent announcements say healthcare insurance costs in 2002 are skyrocketing again. According to the *Miami Herald*, employers' insurance costs rose 10.5 percent last year—the first double-digit increase in a decade, according to the employment policy foundation. The analysis, based on data collected on 7,300 businesses by the Bureau of Labor Statistics, shows that employers paid an average of \$4,891 for health insurance per covered employee last year. If such increases continue, companies will be paying \$7,200 per employee by 2006 (1).

According to a similar article released by the Associated Press, "Study Says HMO Rates Set to Rise" (2), HMO rates for next year will surge more than 20 percent, an unexpectedly high figure that sets the stage for a third year of double-digit increases in overall health-care premiums. As companies begin negotiations for 2003 contracts, rates are rising an average of 22 percent but as much as 94 percent, according to the survey released by Hewitt Associates from information from nearly 140 companies with a total of more than 1 million employees.

Hewitt had been expecting HMO rates to increase about 14 percent for 2003. HMO premiums for 2002 rose an average of 15.3 percent. Several factors are driving up costs for the HMOs and other types of plans, including the high price of prescription drugs and new medical technologies. Moreover, health plans are adding new computers and software programs to comply with federal medical privacy regulations which go into effect next year.

To offset some of the increases, companies are shifting more costs to employees. The survey found that the number of companies charging \$15 for a doctor visit more than doubled to 24 percent in 2002. Meanwhile, the number of employers offering a \$10 visit dropped to 58 percent in 2002 from 64 percent in 2001.

Patients also are paying more for their medicines. In 2001, 52 percent of companies surveyed offered a \$5

copay for generic drugs. That dropped to 46 percent in 2002. Meanwhile, the number of companies with a \$10 copay for generic drugs increased to 40 percent in 2002 from 27 percent in 2001. The number of firms with a \$20 copay for branded drugs increased to 26 percent in 2002 from 12 percent in 2001.

Another study by PriceWaterhouseCoopers shows that overall healthcare costs rose 13.7 percent in 2001 (3). That survey, prepared for the American Association of Health Plans, showed that the reasons for the increase were spread over several areas:

- 22 percent from drugs, medical devices and other medical advances;
- 18 percent from provider expenses;
- 18 percent from general inflation;
- 15 percent from increased demand;
- 15 percent from government regulations;
- 7 percent from the impact of lawsuits, including rising malpractice insurance; and
- 5 percent from fraud and abuse.

A new study from The Hartford Financial Services Group released at the Risk and Insurance Management Society annual meeting in New Orleans found that prescription drug use accounts for nearly half of the rise in workers' comp medical costs (4). It had been thought that the increase in comp medical expenditures was solely due to provider costs of expensive new procedures but that was not found to be the case. In the late 1980s and the early 1990s—the last time the workers' comp industry faced rapidly rising medical bills—pharmacy expenditures accounted for just 3% to 4% of total medical costs. Now pharmacy accounts for 10% of total medical cost and this is increasing at a rate of 30% per year.

DISCUSSION

Along with the escalating rise in diagnostic tests and surgical procedures is the rise in pharmaceutical costs. Not only are all medical services rising dramatically, health analysts might also question the appropriateness of many of these services as well as their escalating costs when spine experts such as BE Finneson, PhD, states that 50–90% of the 300,000 disc surgeries done each year for ruptured discs are unnecessary and ineffective (5).

It's bewildering that the press and governmental health-care regulators are overlooking a large reason for this huge increase in medical costs—the epidemic of back pain and the explosion of unnecessary and costly back surgeries. This silent epidemic has certainly not gotten the attention it deserves compared to other epidemics like heart disease and cancer because it's not fatal, but its reach is just as significant. Consider these facts about back pain:

- 80–90% of all adults will suffer with acute low-back pain (LBP) sometime in their life,
- LPB is the leading workers' compensation injury,
- LPB is the leading cause of disability for people under the age of 45,
- LBP is the second-leading cause of visits to doctors' offices,
- LBP is the third-leading cause for hospital admissions,
- LPB the second-leading cause of surgery other than heart surgeries (6).

Not only is this tsunami of 300,000 back surgeries annually overlooked as one large way to save money, it is escalating at incredible rates, only adding to the huge expense that some experts believe approaches \$75 to \$100 billion annually in the US alone (6). Just as the avalanche of tonsillectomies, hysterectomies, and Caesarean sections were finally considered an overkill years ago, the same can be said today of spinal surgeries. Indeed, back pain is big business in American health-care, and it is breaking the back of taxpayers and policyholders who eventually pay for these expensive and often unnecessary and ineffective surgeries. Fortunately, there is a valid alternative to this wasteful situation.

Coming to the rescue of this epidemic of back pain are the chiropractors who have long believed they can help save billions if they were more mainstream in hospitals, group health insurance and workers' compensation programs, and now many researchers from around the world during the last decade have come to the same conclusion. Studies in the US (6), UK (7), Canada (8), Denmark (9), to name a few, have all concluded the same—back surgeries are out and spinal manipulative therapy is in as the best approach to the vast majority of LBP problems. According to Canadian researcher, Pran Manga, PhD, medical economist, "There is overwhelming body of evidence indicating that chiropractic management of LBP is more cost-effective than medical management" (8).

The US Public Health Service authorized a study completed in 1994 by the Agency for Health Care Policy and

Research (AHCPR) that has been regarded as the most extensive study ever done on the epidemic of low-back pain, and it was just as emphatic as the Canadian study about the therapeutic superiority of spinal manipulative therapy (SMT) for LBP, citing it as a "proven method" and recommending SMT as a first-line approach over prescription drugs, physical therapy and surgery.

The most shocking conclusion in this federal guideline by the AHCPR panel focused on unnecessary back surgery. This expert panel found back surgeries to be costly, based on misleading tests, and were generally ineffective.

"Even having a lot of back pain does not by itself mean you need surgery. Surgery has been found to be helpful in only 1 in 100 cases of low back problems. In some people, surgery can even cause more problems. This is especially true if your only symptom is back pain" (6).

It also stated that other treatments like traction, ultrasound, injections into the back, massage, acupuncture, TENS, biofeedback, and back corsets "may give relief for a short time, none have been found to speed recovery or keep acute back problems from returning." And they found them to be very expensive for the amount of short-term relief they provided (6).

Needless to add, this silent epidemic is only getting worse as people become more deconditioned and sedentary in their lifestyles. OSHA now recognizes musculo-skeletal disorders (MSDs) as the leading cause of repetitive stress injuries (RSI), namely LBP, neck pain and carpal tunnel syndrome (wrist pain), which account for 60% of all workplace illnesses with claims costing employers some \$100 billion annually (10).

And experts now admit that routine medical treatments like physical therapeutics, drugs and surgery have proven ineffective, and chiropractors think they know why—back pain has to do with mechanical joint problems primarily. Basically, chiropractors state that you don't slip disks or pull muscles, the standard medical explanations, as much as you slip joints. They point out that there are 137 joints in the human spinal column, and 8 small carpal bones in the wrist alone. Whenever these joints become misaligned from trauma, compression from prolonged sitting or standing, vibration, bad working or sleeping postures, or overuse from repetitive stress, problems arise such as pain, stiffness, swelling, or nerve compression leading to numbness, tingling or worse, the inevitable aches, pains and inflammation begin.

A recent study on neck pain, which strikes 10 to 15% of the general population daily, causing stiffness, headaches, brachialgia, dizziness, was done in the Netherlands and compared manual therapy, physical therapy exercises, and medical analgesics. At 7 weeks, the success rates were 68% for manual therapy, 50% for physical therapy, and only 36% for medications, leading the researchers to state, "In daily practice, manual therapy is a favorable treatment option for patients with neck pain compared with physical therapy or continued care by a general practitioner" (11).

Many medical researchers now agree with this chiropractic supposition. According to JL Shaw, MD and orthopedic researcher, "Joint dysfunctions are the major cause of LBP as well as the primary factor causing disk space degeneration and ultimate herniation of disc material" (12). In this light, chiropractors claim that disk problems are secondary to the underlying joint misalignment; hence, manipulation to restore normal alignment and function has proven effective. In fact, a medical journal survey found that chiropractic patients enjoy a 3-time better patient satisfaction ratio over medical patients, and a Gallup poll found that 90% of chiropractic patients polled stated that chiropractic was therapeutically helpful (13).

THE ESCALATING BACK SURGERY NUMBERS

Although spinal manipulative therapy has become the preferred method for the vast majority of back and neck problems, the 1980's saw a dramatic increase in the rate of spine surgery. Estimates suggest that while the population grew only 23% during the decade, the number of spine surgeries increased 137%. Lumbar surgeries increased from 148,000 to 250,000 per year, while cervical spine surgeries increased from 41,000 to 76,000 per year (14). This vast increase in spine surgeries despite the growing opinion by experts that surgery is unnecessary in the majority of cases begs the question: Have Americans inherited weak backs, or American surgeons are rather eager to operate due to the huge fees from back surgery? In fact, the former seems to be the answer.

This trend of increasing numbers of back surgeries has not abated despite the evidence that SMT is preferable in this epidemic of back pain. From 1979–81 to 1988–90, the rate of hospitalizations with cervical spine surgery increased over 45%, with the rates for cervical fusion surgery increasing more than 70%. The rate of hospitalizations with lumbar spine surgery increased over 33%, with the rate for lumbar fusion surgery increasing more than 60%, the rate for lumbar disc

surgery increasing 40% among males and 21% among females, and the rate for lumbar exploration/decompression surgery increasing more than 65% in each sex. Obviously from 1979–1990, rates of hospitalizations with cervical and lumbar spine surgery increased markedly among both sexes and for different categories of spine surgery (14).

The National Center for Health Statistics analyzed the data from all hospital discharges to see if it could be determined why such a large increase had occurred. The increase seemed to be related to only 2 factors. The first was a 24% per capita increase in the number of spine surgeons. The other was the increased use of MRI despite the opinion of the AHCPR panel that only 1 in 200 patients needed these expensive scans. The author of this study suggests that the increased imaging of spine patients brought about by the ease and safety of MRI has led to an increased incidence of false positive diagnoses. In other words, because they can see some abnormality, the surgeons mistakenly tell patients it must be the problem. But recent MRI studies have concluded just the opposite and say that disc degeneration and herniation are commonplace and a natural part of the aging process, like finding grey hair, and fixing it with surgery is a waste (15–16).

As Dr. Richard Deyo, a leading spine researcher, concludes in his report on low back pain in the *NEJM*:

"There are wide variations in care, a fact that suggests there is professional uncertainty about the optimal approach. In addition, there is evidence of excessive imaging and surgery for low back pain in the United States, and many experts believe the problem has been 'overmedicalized'" (17).

Not only are the rates of lumbar fusion procedures increasing rapidly, particularly for lumbar spinal stenosis in older patients, but fusion rates appear to vary markedly among individual surgeons, among small and large geographic regions in the nation, and between the United States and England according to researchers (18). These variations are considerably more dramatic than variations in rates of lumbar discectomy.

"Fusion for spinal stenosis with spondylolisthesis is, as expected, associated with higher costs and complication rates than is decompressive surgery for this indication without fusion. Fusion rates are increasing rapidly and show dramatic geographic variations, suggesting differences in opinion within the surgical community regarding the appropriate indications for lumbar fusion. Studies are needed to determine whether the frequency, costs, and complications of lumbar fusion are justified by clinical benefits." (18)

Due to the expense from escalating medical costs for injured workers, the Washington State Department of Labor and Industries (L&I), which pays for most workers' compensation costs in the state, established guidelines for elective lumbar fusion as part of its inpatient utilization review program. The guidelines were tied to reimbursement, and showed appreciable drops once oversight was implemented. After November 1988, when the guidelines went into effect, the state fusion rate declined 33%. The data suggest that the lumbar fusion surgery criteria and reimbursement standards implemented in 1988 contributed to a decline in rates of performing that procedure (19).

THE SLIPPED DISK: A "FALSE POSITIVE" DIAGNOSIS

The reason why many experts deem back surgeries ineffective and unnecessary rests with the new evidence that shows disk abnormalities are not the primary cause of back pain. Unbeknownst to most patients with low-back pain, the standard medical diagnosis of a disk abnormality, the diagnostic standard for spinal surgery for decades, has now been disproved and criticized by many spine researchers.

Dr. Richard Deyo criticizes the over-reliance on imaging for "misleading . . . incidental findings" of disk abnormalities.

"Early or frequent use of these tests [Computed tomography (CT scans) and MRI] is discouraged, however, because disk and other abnormalities are common among asymptomatic adults. Degenerated, bulging, and herniated disks are frequently incidental findings, even among patients with low back pain, and may be misleading (20)."

The US federal guideline on acute low-back pain also recognizes the "irrelevant findings" of disk abnormalities on MRI exams as the cause of low-back pain:

"Degenerative discs, bulging disk and even herniated discs are part of the aging process for the spine and may be irrelevant findings: they are seen on imaging tests of the lumbar spine in a significant percentage of subjects with no history of low back problems. Therefore, abnormal imaging findings seen in a patient with acute low back problems may or may not be related to that individual's symptoms. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compression, rarely benefit from a surgical consultation (6).

Other international spine researchers state the same conclusion that disk abnormalities are not the primary problem.

- According to WH Kirkaldy-Willis, MD and David Cassidy, DC, discs are involved in fewer than 10% of back pain cases (21).
- According to Nikolai Bogduk, MD, PhD, disks are involved in fewer than 5% of these cases (22).
- According to V. Mooney, MD, disks problems account for less than 1% of these cases (23).
- According to Dr. Scott Boden, orthopedist/researcher, "the disc might not be the cause of pain. And if so, fixing it is a waste" (15).

This points out the single-most prevalent cause of misdiagnosis in low-back pain problems—that is, the use of costly MRI images to show disk abnormalities to convince patients that some sort of disk problem is the cause of their pain. In fact, as Dr. Deyo, the U.S. guideline, and other researchers have repeatedly shown, disk abnormalities are not the cause of most back pain, often appear in perfectly pain-free patients, and continue as the largest segment of "false positives" in the diagnosis of most back pain problems.

As Dr. Deyo mentioned, "Detecting a herniated disk on an imaging test therefore proves only one thing conclusively: the patient has a herniated disk" (17). He concludes that 97% of back pain is "mechanical" in nature, and disk abnormalities account for only 1% of back problems. Concerning herniated intervertebral disks, Dr. Deyo believes, "In the absence of the cauda equina syndrome or progressive neurologic deficit, patients with suspected disk herniation should be treated non-surgically for at least a month" (17).

With this plethora of evidence in mind, is it little wonder a 1994 British study on low-back pain concluded, "Traditional medical treatment has failed to halt this epidemic and may have contributed to it. There is a clear need to reconsider our whole approach to the management of low back pain and disability" (7)? According to Dr. Pran Manga, Ph.D. and medical economist, he came to a similar conclusion when he stated, "On the evidence, particularly the most scientifically valid clinical studies, spinal manipulation applied by chiropractors is shown to be more effective than alternative (medical) treatments for low back pain" (8).

THE FAILURE OF BACK SURGERY

Not only have researchers concluded there are many "outdated ideas" about the cause and treatment of back pain, research has repeatedly shown the poor results from back surgery.

A recent study by Dr. E. Berger published in *Surgical Neurology* emphatically showed the high rates of perma-

nent disability from spinal fusions. One thousand workers' compensation patients who had undergone lumbar spinal surgery were divided into two groups; one group consisted of 600 patients with a single operation and was evaluated on average 51 months after surgery. The second group consisted of 400 with multiple operations and was evaluated 38 months postoperatively. The results of this study were stunning, to say the least. 71% of the single-operation group had not returned to work more than 4 years after the operation, and 95% of the multiple-operations had not returned to work. In none of these cases was there a neurological deficit that precluded gainful employment—the failure to return to work being blamed on chronic postoperative pain (24).

Not only are many lumbar fusions unsuccessful, other research has shown the success rates for all types of spinal surgery were also questionable as to the cost-effectiveness. In patients with disc herniation only, good results were observed in 53%, moderate in 19%, and bad in 28%. In the group of patients with diagnoses other than disc herniation, the success rate of the operation was 38% good, 28% moderate, and 41% bad (25).

Researchers have noted this epidemic of failed back surgery with very poignant comments. Dr. Gordon Waddell mentions that the high disability rate is actually enhanced by medical methods:

"Sadly, we must conclude that much low back disability is iatrogenic (doctor-caused) . . . It [back surgery] has been accused of leaving more tragic human wreckage in its wake than any other operation in history . . . There is now considerable evidence that manipulation can be an effective method of providing symptomatic relief for some patients with acute LBP" (26).

The AHCPR guideline also mentions the low success rate of back surgery and fusion in particular.

"Moreover, surgery increases the chance of future procedures with higher complication rates" (6).

"There appears to be no good evidence from controlled trails that spinal fusion alone is effective for treatment of any type of acute low back problems in the absence of spinal fracture or dislocations . . . Moreover, there is no good evidence that patients who undergo fusion will return to their prior functional level" (6).

Noted medical author, Dr. Ruth Jackson, formerly chief of orthopedic surgery and instructor at Baylor University College of Medicine in Dallas, who wrote the mainstay of textbooks on neck problems, summarized the true indications for fusion: "When, then, should fusion be done? Certain fracture-dislocations with marked instability may need fusion. Marked ligamentous instability with spinal cord irritation, or if there is danger of cord involvement, may indicate the necessity for

fusion . . . Surgery should be avoided unless there are absolute and definite indications for it, otherwise the results from operative procedures will be disappointing and the symptoms may be worse than they were before surgery was done" (27).

Another study conducted in 1994 by Drs. D. C. Cherkin, R. A. Deyo, J. D. Loeser, T. Bush, and G. Waddell compared international rates of back surgeries and found the startling fact that American surgeons are unusually excessive.

"The rate of back surgery in the United States was at least 40% higher than any other country and was more than five-times those in England and Scotland. Back surgery rates increased almost linearly with the per capita supply of orthopedic and neurosurgeons in that country" (28).

Given the poor outcomes that can follow surgery, the high cost of the surgery itself, and the need to control health-care costs as a national priority, a strong need exists for better clarification of which patients should have spine surgery. It is perhaps just as wise to question which patients need spine surgery at all when the high failure rates are acknowledged and a safer and more cost-effective method like chiropractic care exist.

Other issues of prevention of spinal problems and maintenance care have not been addressed by the medical model, which is astounding considering up to 90% of all adults will suffer sometime from an acute low-back attack, while millions more children and adults suffer from idiopathic scoliosis—the abnormal curvature of the spine. Chiropractors contend this silent epidemic stems from the historical medical boycott and institutional exclusion of chiropractic care throughout the health-care delivery system, much of which is still covertly happening today. This is equivalent, if you will, to a boycott of dentistry that would lead to massive amounts of dental problems and crooked teeth.

Not only has the medical boycott of chiropractic care resulted in this epidemic of spinal problems, undoubtedly adding to the overall costs, it also led to a successful antitrust trial filed by the plaintiff chiropractors against the AMA, AHA, et al. in the northern district of Illinois federal court for the illegal boycott of chiropractors in public hospitals (29). Considering the high fees associated with spinal surgery and hospitalization, few administrators and medical staffs want the services of chiropractors on staff that would benefit patient outcomes as well as lessen expenses. Ironically, in most American for-profit hospitals, the better, cheaper services are not popular because they may take money out of medical pockets.

POTENTIAL SAVINGS USING CHIROPRACTIC CARE

While these scientific studies were sweet music to chiropractors, much of it has fallen on deaf ears in the medical world, especially the workers' compensation companies and among hospitals, for the very reasons touted. Basically, chiropractic care is too cheap to suit these for-profit insurance companies that work on a "cost-plus" basis where the more they pay out, the more they can charge in premiums. Obviously in this light, decreasing costs lowers their profit margins; so ironically, workers' compensation prefers the more expensive methods regardless of their ineffectiveness.

The same type of situation occurs in hospitals that prefer surgical cases that bring in much more than the average \$800 chiropractic case. For example, the costs for surgical procedures alone ranged from \$3,042 for a discectomy to \$6,243 for a spinal fusion, and hospitalization for a fusion ranges from \$6,796 to \$12,481 depending upon complications (30). And for many patients, failed back surgery syndrome adds to the cost when patients receive multiple surgeries, as noted in the Berger study.

Obviously, chiropractors are being snubbed in the present for-profit system since they pose a financial threat to the MDs, PTs, hospitals, attorneys, and health insurance companies that all profit from these expensive and ineffective back surgeries. It's a conspiracy that the public is unaware of and which adds greatly to the escalating cost of group health and workers' comp insurances. In fact, this might be considered fraud in that it extracts money from consumers under false pretenses.

As an example of the possible savings by using DCs as primary physicians skilled in conservative care, one innovative IPA company in Highland Park, Illinois, Alternative Medical Inc., that uses chiropractors as primary care physicians in the greater Chicago area, found huge reduction in costs for self-insured companies.

For example, AMI's statistics found:

- 1) 80% reduction in hospital costs within 21 months;
- 2) 85% reduction in out-patient procedures and surgeries;
- 3) 56% reduction in pharmaceuticals;
- 4) For patient satisfaction surveys, AMI achieved a 100% vs. a 60% for BCBS;
- 5) For "thousands and thousands of member months" no back or neck surgeries have been performed on

their patient population to date according to the president of AMI, Mr. Jim Zeckman. (Zeckman J, personal communication).

More evidence from studies done in North America and Australia by health economists have shown a potential of 20–60% savings in total costs inclusive of health care (e.g., office visits, pharmaceuticals, hospitalization, surgery, diagnostic testing, referral to allied health-care providers) and disability (time off work) is possible with chiropractic rather than medical treatment of low back pain (31).

According to a recent report on Florida's workers compensation program, the executive summary concluded:

"Current economic pressure within our nation's health care delivery system has prompted renewed consideration of the value of expanded roles and access to chiropractic care to enhance the overall success and cost-effectiveness of our nation's health care delivery system. Recent studies and events continue to demonstrate that expanded access to chiropractic care has had a positive impact on patient outcomes and cost-effectiveness of treatment in a variety of health care settings including occupational medicine, health maintenance organizations, the US military, and the Medicare system (Muse & Associates).

"Implications for the Florida workers' compensation system are obvious. Low back pain is responsible for half of workers' compensation costs (Mootz, Franklin, & Stoner, 1999). Past research clearly demonstrates the success and cost-effectiveness (inclusive of all direct costs) of chiropractic care compared to other common medical treatments for low back pain. Similar effectiveness and cost savings appear to occur with chiropractic treatment of numerous other work-related musculoskeletal conditions as well. Therefore, the State of Florida should consider current policy restricting accesses of workers' compensation claimants to chiropractic care and take full advantage of this promising cost containment opportunity" (32).

While the chiropractic profession has cleared many major hurdles in its road to acceptance, the lack of full integration into the mainstream health-care delivery system may be more a battle of political and economic warfare than research findings. The medical cartel of doctors, hospitals and insurance companies have no desire to see this \$100 billion dollar industry collapse from the inclusion of chiropractors, and they will continue to ignore the facts until they are forced to by legislation.

Another futile example to lower health-care costs is seen in an effort by the Governor of Georgia who has empanelled an Advisory Commission on Workers' Compensation in order to determine ways to lower the escalating costs of workers' comp costs that have deterred some companies from moving their business to the Peach State. This Commission is mainly comprised

of MDs, attorneys, hospital administrators, and insurance executives whose goal is to “lower costs and improve patient outcomes in a controlled environment.”

In 1999, the State Workers’ Compensation Board in Atlanta revealed it paid over \$28 million for nearly 3,000 back injuries that equate to just under \$10,000 per case. Of these 3,000 cases, chiropractors took care of only 81 cases at an average cost of less than \$1000 per case (1). Even though chiropractors are covered under the state and federal workers’ comp programs, patients are routinely discouraged to use spinal manipulation in lieu of surgery so that the insurance companies can maintain their huge cash flow from inflated premiums.

The AHCPR panel also found that 5% of low back patients accounts for 60% of the costs, principally these victims of unnecessary and ineffective back surgery. Factoring in the permanent disability costs for patients of failed back surgery syndrome, there’s a large possibility that SMT could save workers’ comp programs millions of dollars.

For example, in 1999, the WC program in Georgia incurred 119,039 lost workdays with the average case having 58 lost workdays at an average cost of a case at \$7,723. Physician’s benefits totaled over \$66 million while chiropractic benefits were only \$413,079; physical therapists were paid over \$13 million. In fact, the WC program paid more for burials (\$641,045) than for chiropractic. If chiropractic care could save just 50% of these cases that would save millions of dollars for the overall WC program.

Despite a detailed explanation of the cost-savings of chiropractic care for the epidemic of LBP, the Commission appeared disinterested in a total inclusion of chiropractors as the initial provider as recommended by the AHCPR and Manga reports. Ironically, some critics of the Commission believe appointing these members were equivalent to having the foxes guarding the hen-house. In other words, the very people profiting from the present expensive workers’ comp program are the same folks on the Commission aimed at lowering these costs. To no one’s surprise, the Commission notified the Georgia Chiropractic Association that it would not accept the chiropractic recommendation despite the federal guideline to use DCs as a first avenue in this epidemic of LBP. Is it little wonder that the chiropractic profession believes their pleas have fallen on deaf ears?

Fortunately, not all health-care delivery systems seek the most expensive treatments, and that includes our

military health services. Former President Clinton signed legislation for incorporating chiropractic as a permanent part of military health care. The law, which is part of the huge National Defense Authorization Act for fiscal year 2001, requires that full implementation of the chiropractic benefit be phased in over a 5-year period throughout the 3 military services.

This legislation came after a 3-year trial period on 13 bases using chiropractors. The final analysis of this demonstration concluded chiropractic care would save the Military Health Services \$28 million in medical costs and 199,000 in lost workdays. Back injuries presently constitute 30% of the military’s hospitalization and 20% of their disabled.

Another self-insured health-care system in Ontario, Canada, sought the most effective method to treat the epidemic of back pain and authorized 2 studies known as the Manga Reports that cited the benefits of using chiropractic care. Pran Manga, Ph.D, medical economist, and Doug Angus, Director of Masters Program in Health Administration at the University of Ottawa, concluded in their report on back pain in the Canadian medical system that the exclusion of chiropractic services from mainstream medical services has caused increase costs to taxpayers and patients alike.

“Chiropractic care is a cost-effective alternative to the management of neuromusculoskeletal conditions by other professions. It is also safer and increasingly accepted by the public, as reflected in the growing use and high patient retention rates. There is much and repeated evidence that patients prefer chiropractic care over other forms of care for the more common musculoskeletal conditions . . . The integration of chiropractic care into the health care system should serve to reduce health care costs, improve accessibility to needed care, and improve health outcomes.” (33)

Furthermore, they discuss the concept of “distributive justice” as a factor in improving health care:

“We would argue that the principle of distributive justice, and a parallel principle of equality of opportunity, require that the government implement all cost-effective substitutions; failure to do so results in unfairness to the taxpayers and unfairness to certain health care professions . . . The monopolization of the health care services turf is also inequitable from yet another perspective. It denies some professions equal opportunity to earn income commensurate with their ability . . . Curiously, the professions that have and still suffer the adverse effects of the inefficient use of our health manpower have not used this argument forcefully enough to encourage and urge the desired reforms. They should” (33).

And when chiropractors have argued this point of the lack of an open competitive marketplace in health-care to reduce costs, it generally falls on deaf ears of those

medical bureaucrats who are unconcerned about saving taxpayers' money or allowing competition on a level playing field for chiropractors. Indeed, this unfair economic situation has not gone unnoticed by many health-care experts.

Considering back procedures are the third-leading reason for hospital admissions and the average "surgical back" costs \$13,990 compared to \$800 for an average chiropractic case, and that the annual costs of back problems in the US alone range up to \$75 to \$100 billion, this is a huge money-maker that the medical cartel has no interest in having it decline with spinal manipulative therapy (SMT) or any other alternative method (34). Competition may be good for the rest of the American economy, but apparently not in the medical world.

IT'S ALL ABOUT MONEY

P. Joseph Lisa, in his book, *The Assault on Medical Freedom*, declares, "Regrettably, restraint of trade, unfair trade practices, anti-competitive activity, and conspiracy to eliminate the competition have been hallmarks of American medicine. It has been this way from its conception and blatantly continues to this day" (35).

Indeed, did the *Wilk v. AMA* antitrust case (29) liberate hospitals from the medical society's boycott of chiropractors? Did the RAND investigation (36) of low-back pain (LBP) and its acknowledgement of spinal manipulative therapy (SMT) as an appropriate and superior method change the nature of LBP management in the medical field? (Apparently not, since approximately 60% of patients seek medical care for their neck and back pain compared to only 23% who seek chiropractic care (37).) Has the AHCPR guideline (6) on LBP emancipated insurance programs to allow payment for SMT as a "proven method"? Have Dr. Pran Manga's reports (8) urging chiropractic gatekeepers for all LBP cases been implemented anywhere? The answer to all these questions is a resounding "no."

Obviously evidence-based criteria sounds good in principle, but in practice it's another story. Indeed, it's all about money and market control, not evidence-based "best practices" or using the best technology to solve health problems.

"New technologies are bursting onto the marketplace according to the free-market principles of Adam Smith. But they are not being paid for according to free market principles. Instead, they are reimbursed by compensation regulations set by doctors and insurance companies to maximize their profits and to keep out cheaper, more

effective alternative therapies. They are set without regard to public health and healthcare policy concerns,"

according to Dr. James Carter, in his book, *Racketeering in Medicine* (38).

What's the answer to these huge problems of the medical cartel? Interjecting free market enterprise to allow pluralistic competition to prevail, thus offering better services at lower prices. Realistically, only when actually mandated by legislative enactment will we see an open marketplace in health-care, which is unlikely considering the enormous political and monetary influence of the AMA.

On the other hand, is a single-payer system the solution like those in Canada and the Scandinavian countries? Since the US is the only major country that still has a for-profit healthcare system, converting to a single-payer system will be like pulling teeth without Novocain. The Clinton Health Care Reform Act in 1994, while flawed, was scuttled by the medical/drug cartel and insurance companies that like things just the way they are. This cartel has too much money and too much influence among people in high places for reforms to take place quickly. And the last thing the AMA wants is a pluralistic marketplace with open competition for health-care dollars. Indeed, a closed market under their sole control suits their interests best, as it would with any monopoly.

This for-profit, cost-plus incentive is the leading economic reason why the better mousetrap concept is being ignored in health care. Research futurists, such as Dr. Clem Bezold of the Institute for Alternative Futures, deem this incentive as a "perverse motivation" (39). This cost-plus motivation is one reason why private health insurance and workers' compensation insurance are so expensive—there is no real incentive on the insurers' parts to decrease costs, as in a self-insured situation. Simply put: higher gross cash flow = higher percentage take. Indeed, the better mousetrap of chiropractic and other alternative care would lower their gross revenues, something any good capitalist has no interest in achieving!

"National health insurance will probably come to the United States after a major change in the political climate—the kind of change that often accompanies a war, a depression, or large-scale unrest. Until then, the chief effect of the new plans will be to make young and healthy workers better off at the expense of their older, sicker colleagues," so says Victor R. Fuchs, PhD, of Stanford University in his article, "What's Ahead for Health Insurance in the United States" (40)?

Perhaps the major change that Dr. Fuchs suggests will not be a war or depression, but when health care insur-

ance costs exceed that of home mortgages. Indeed, if we can expect to pay over \$7,000 in 2006, what will it be in 2010? And unlike home mortgages that eventually end, health insurance only ends upon death.

CONCLUSION

Only in the medical world is a better mousetrap frowned upon when it comes from a competitor. If chiropractic care were fully integrated into the present medically dominated healthcare delivery system, costs would drop as would profits for hospitals, insurance companies and medical providers. Is there little wonder why the medical establishment opposes the inclusion of chiropractic care? It's all about money nowadays, and the introduction of chiropractic care into most for-profit hospitals might bankrupt them since back surgeries are so profitable. The real issue no longer has anything to do with clinical or cost-effectiveness since the research has shown the superiority of manipulation over surgery, but it now is simply a matter of turf warfare for economic gain.

Chiropractic's dilemma has changed over the past 100 years since its inception in 1895. For the first half of the 20th century, chiropractic's main dilemma was to legislate its right to practice without incrimination from the medical profession. In the second half of the 20th century, chiropractic fought for inclusion into the health insurance system and Medicare. For the past 20 years, chiropractic has sought to legitimize itself with research studies in order to broaden its acceptance in the scientific community, which it has done.

Presently in the 21st century, the chiropractic profession finds itself facing new dilemmas, such as establishing evidence-based protocols, upgrading its education requirements, and expanding its political influence to expand its market share. The evidence is now clear that chiropractic care for the epidemic of musculoskeletal disorders is the most clinical and cost-effective method for the majority of these cases.

But the most important question remains: Will the for-profit health-care programs be interested in the best mousetrap to lower costs? Presently, outside of self-insured, non-profit programs, the answer appears negative because there's just too much money at stake. Rather than patient-driven, best practices, or cost-driven, the present American health-care system is profit-driven, and chiropractic care is just too inexpensive to appeal to these capitalists.

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