It is intuitively obvious that healthcare is best delivered when diagnostic and therapeutic services are provided in a coordinated, comprehensive fashion. This future vision is being realized in prostate cancer, where centers of excellence have formed where physicians of different specialties work together to ensure that patients have access to all appropriate treatment modalities. Men battling prostate cancer – the second leading cause of cancer death in men – now have the option of receiving integrated care at centers with specialized expertise in their disease. That’s why repealing the in-office ancillary services exception would devastate prostate cancer victims receiving intensity-modulated radiation therapy (IMRT) treatments for their disease. But that’s exactly what specialists with historical monopolies on ancillary services – such as radiation oncologists – are asking Congress to do. While asking legislators to preserve their income stream, their self-serving policy fix would only restrict access to care and drive up costs. If Congress is serious about improving patient care while reducing expenditures, we must protect comprehensive cancer care models like those offered by integrated urology groups specializing in prostate cancer treatment.

The efforts of historical monopoly specialists appeared to receive a boost last week when the Government Accountability Office (GAO) released a report showing that the use of IMRT to treat prostate cancer by urology group practices increased at the end of the last decade. But importantly, the GAO did not recommend banning or even limiting so-called self-referral for prostate cancer treatment. Moreover, analysis of the report’s data actually undermines the efforts of the historical monopoly specialists and reveals why there is no health policy advantage to limiting where patients can choose to receive radiation oncology services.

Let’s take a look. While the number of IMRT services performed by urology groups increased after 2007, overall use of IMRT to treat prostate cancer actually decreased over the same period. In fact, the GAO found that “[a]fter 2007, the rapid increase in prostate-cancer related IMRT services performed by self-referring groups coincided with declines in these services within hospital outpatient departments and among non-self-referring groups.” It is clear that increased IMRT use to treat prostate cancer by urology groups simply reflects a shift in where patients chose to access these services.

Expenditures for prostate cancer-related IMRT are declining as well – but not everywhere. After 2007, despite the migration of patients away from hospitals to physicians’ offices, prostate cancer-related IMRT costs in physicians’ offices decreased by $28 million. Simultaneously, although the number of services provided by hospitals declined substantially, hospital prostate IMRT expenditures increased by $8 million. The GAO explains this paradox by stating that, “reimbursement rates for IMRT services have been increasing for services performed in hospital outpatient departments and declining for those performed in physician offices.” It makes no sense to close more affordable treatment sites in favor of more expensive ones.

Shifts in healthcare delivery patterns are inevitable – and healthy – as medicine becomes more integrated, historical monopolies over certain services are eliminated and patients choose to receive their care in specialized treatment centers that are convenient and cost effective. Legislatively restoring healthcare monopolies would not serve the nation’s health outcomes or economic interests. Our focus should be on ensuring access to affordable care that produces the best results – not on where that care is delivered.

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