Health Beat

Health Care Bloggers Raise some Provocative Questions

by Maggie Mahar | June 4, 2011

On the *Heath Affairs'* blog, Chris Fleming hosts the most recent edition of *Health* ***Wonk Review***--a rich round-up of some of the best health care posts of the past two weeks. Below, I've tried to highlight provocative work by bloggers who may not be well-known to HealthBeat readers, as well as posts about topics that we have been discussing here. Inevitably, I have left out some excellent entries. You'll find Fleming's full report here http://healthaffairs.org/blog/2011/05/26/health-wonk-review-memorial-day-edition/

Alzheimer's: Laura Newman recently spent three days "listening to expert neurologists, demographers, caregivers, and policy people talk about Alzheimer's," Flelming reports, and she has a host of interesting and informed questions about all aspects of the disease and how reporters and bloggers can most usefully write about it. She details her thoughts in a post on her blog, Patient POV.

Here are just a few of her observations and questions: "Clinical trials for years have been negative and clinical trial enrollment is poor. Can it be improved? Should I promote enrollment in clinical trials? What might a patient gain from participating in a clinical trial? What about informed consent? How do patients with Alzheimer's disease give informed consent?

What about labeling patients with mild cognitive impairment or Alzheimer's? Is mild cognitive impairment an entity that is meaningful, or should it be discarded? Some speakers at the Alzheimer's disease forum were skeptical about the classification, which is not used in many parts of the world. Will mini-screens being in primary care offices become popular because experts and advocacy groups say that they will reduce stigma and work effectively? Under what conditions, could Alzheimer's disease be overdiagnosed? [This, I think, is a terribly important question.--mm] Remember, older people are on many medicines, they can have electrolyte problems, hearing problems, and other conditions that could impact on diagnosis."

She adds: I am intrigued that some countries have national plans for Alzheimer's and I hope to write about them. Perhaps they will be instructive for the US.

I noticed that in another post Patient POV.Newman offered a short list of acclaimed books, films, and innovative projects on Alzheimer's disease, dementia, and memory loss. Here are a few:

David Shenk. *The Forgetting: Alzheimer's: Portrait of an Epidemic.* If you read one book on Alzheimer's, this is an excellent choice. Shenk is an excellent journalist and storyteller. Also available on PBS as a film in English and Spanish.

Hilda Goldblatt Gorenstein. Hilgos Foundation. *I Remember Better When I Paint.* 2009 documentary that shows how creative arts may help Alzheimer's patients re-engage in life, through painting, visiting art museums, and performing music. Available on DVD. Youtube trailer for film.

Nancy L. Mace, Peter V. Rabins. *The 36-Hour Day: A Family Guide to Caring for People Who Have Alzheimer Disease, Related Dementias, and Memory Loss.* (A Johns Hopkins Press Health Book) now in its 5th Edition. Many consider this the best caregiver's guide.

You'll find the full list here http://www.patientpov.org/books/acclaimed-books-films-and-projects-about-alzheimer%e2%80%99s-disease-other-dementias-and-memory-loss.

Co-Pays: One Reason Poorer Patients Don't Get the Cancer Care They Need: At HealthBlawg, David Harlow talks about a new study showing that 1 in 10 cancer patients don't take their meds. This trend is correlated with the transition from chemo via IV to meds that can be taken at home, in pill form. David suggests that the real issue is the differential approach to cost sharing; he argues that third-party payers should belly up and pay for cancer meds so that patients have low or no deductibles and copays, thereby saving the patients and the payers the readmissions and treatments required as a result of non-adherence to medication regimens.

Hyping Robots: Meanwhile, Well-Insured Cancer Patients May Be Over-Treated: At the HealthNewsReview Blog, Gary Switzer offers a trifecta of reports on prostate cancer treatment:

- a study questioning the benefit of radical prostatectomy surgery in low-risk, early-stage cancer. (This was the first randomized trial in the U.S. comparing radical prostatectomy to "watchful waiting.")
- another study that concludes that the prostate surgery rate is rising because of the use of robotic surgery;
- and a third study that suggests that hospital websites hype robotic surgery, ignore risks, and are often influenced by manufacturers.

Does the "Right" to HealthCare Threaten to Turn Doctors Into 'Slaves'?: The Doctor Liberty blog employs a libertarian perspective to analyze Senator Rand Paul's recent comments that making health care a "right" enslaves doctors. The post looks at why some libertarians might agree with Paul, but also why other libertarians might be uncomfortable with the Kentucky Republican's remarks.

Insurers Not Swimming in Profits: "Profits" and "profit margins" are two different things, despite what you might gather from reading the mainstream media, writes Hank Stern on Insure Blog. Hank faults the media for emphasizing that the nation's major health insurers are entering a third year of record profits, while ignoring the fact that the insurance industry's 4.4 percent profit margin is one of the lowest margins for any health industry sector.

This is very true. When you read that a company reaped tens of millions in profits, you need to put the number in context. The number only means that this is a large corporation: a big company could have 8-digit profits and those profits might still represent only 2 percent of sales.

This means that the company was able to keep only 2 percent of the dollars that came in. Such a thin profit margin would suggest that the company is in danger: one bad season, and it could find itself unable to pay its bills. For insurers, a 4.4 percent profit margin isn't disastrous, but it does mean that they are not great investments.

If you want to know where the money is in the healthcare sector, look at profit margins in the pharmaceutical industry and the medical device industry. Some "non-profit" hospitals also show margins nicely above 4 percent -- along with enormous endowments. These tend to be the brand-name hospitals that over-charge insurers -- simply because they can.

That said, I'm glad that the ACA insists that insurers pay out a certain percentage of premiums in the form of reimbursements for medical care. If they don't meet the target, they must give rebates to customers. **This is why Aetna is now slashing premiums in Connecticut. I suspect that this is just the beginning of a decline in premiums that we'll see in many areas, thinks to the ACA.**

On the Ground, Reform Moves Ahead, As Planned: "It may look like chaos, but it's all going according to plan, says Jonathan Halvorson writing at The Health Care Blog. Fleming explains: "With some acknowledged artistic license, that's how he assesses the post-Affordable Care Act health reform landscape. Only a year after the ACA, there is widespread acknowledgement of the need for new steps to control health care spending and to limit the growth of Medicare and Medicaid. . .. Jonathan sees this as in line with the staged strategy for deep reform developed in Massachusetts: Enact universal coverage first, then use the resulting sense of crisis to control costs in ways that would have been politically impossible before. He points out that we have a little time to tackle spending before the major ACA costs begin in 2014"

As I recently pointed out on HealthBeat, Medicare has already begun to break the inflation curve: growth in Medicare spending has slowed remarkably. This could be because physicians are becoming more aware of the need to think twice when prescribing tests, treatments and hospitalizations.

Meanwhile, Fleming notes, "much of the action under the Affordable Care Act takes place in the states. At the Colorado Health Insurance Insider, Louise Norris reviews the recent legislative session in Colorado. . . . During the session Colorado legislature passed a bill setting up the broad framework for a health insurance exchange, while defeating two other health-related bills at opposite ends of the political spectrum." One of those bills was attractive to progressives, Louise acknowledges, but at least Colorado is moving ahead, setting up the Exchanges. Legislators there understand that reform is going to happen.

Choosing the Right IT Vendor/Consultant and the Right e-Rx technology: : As meaningful use becomes a reality with e-prescribing, purchasers must be careful about what data they trust to help them choose the right vendor with the right e-Rx technology, Jonena Relth says on Healthcare Talent Transformation. Jonena argues that the healthcare profession is not policing the so called "experts" publishing studies that are totally out of the realm of scientific relevance.

Relth is blunt: She's upset about the "the absolute dribble being published about healthcare IT these days! Everyone is trying to stake their spot in the experts' arena on every aspect of EMR and the surrounding technology."

She points to a study by the Center for Studying Health System Change of 24 physician medical-group practices which found "Clunky data-management tools and the juice not being worth the squeeze in obtaining information were cited as the two main barriers to the use of electronic prescribing systems. The research, funded by the Agency for Healthcare Research and Quality, found that physicians in most of the survey group's medical practices had access to patient formulary information, but just slightly more than half could access patient medication histories using their e-prescribing systems."

Relth cautions: "we must all be diligent in the data we trust to help us choose the right vendor with the right e-Rx technology. Remember that the ONC requires as a condition of certification for meaningful use that EHR technology be capable of generating and transmitting electronic prescriptions. However, the certification does not require that EHR technology also be capable of performing electronic prior authorization. This will be a huge issue when interoperability is considered.

The ACA: Part of the Answer to the Medicare 'Crisis": At Managed Care Matters, Joe Paduda observes that "the current pessimism about Medicare's financial future is overdone. " He points out Medicare's hospital insurance fund is not going to run out of money in 2024. According to the Medicare Trustees' recent report: "in 2024 it will be able to cover 90% of its costs . . . However even that overstates the problem," he adds "as it is highly likely the Independent Payment Advisory Commission's (IPAC's) provisions will kick in to reduce costs well before then." [his emphases."]

Under the Affordable Care Act (ACA) if the growth of Medicare spending exceeds GDP growth by a certain amount in a given year, IPAC is charged with coming up with proposals to rein in Medicare inflation -- without rationing care, reducing benefits or shifting costs to Medicare recipients. IPAC's recommendations become law unless Congress can find equal savings--again without rationing or shifting the burden to beneficiaries.

"This is not to say Medicare's cost problems are nonexistent," Paduda writes, "far from it. We absolutely have to get costs under control. The ACA is part of the answer; increasing revenues and reducing expenditures are two other parts of the solution. Of course, we can eliminate the need to increase revenues if Medicare starts negotiating drug prices and Congress eliminates some of the dumber provisions of the Medicare Modernization Act."

Projections About Future Medicare Costs are Guesses On The Incidental Economist, Don Taylor presents an interview with Charles Blauhous, one of two public trustees for Medicare and Social Security. Blauhous explains that because so many variables are involved, any projections of health care spending can, at best, "show the broad parameters of where are heading under current law . . . , but long-term health-care cost projections are inexact to say the least." This is another reason to take panicked projections of Medicare costs (which tend to suggest that the only answer is to give up our commitment to seniors) with more than a grain of salt.

Racial Disparities: Glenn Laffel offers a post on Pizaazz that likens the fight against racial disparities in health care to the Hundred Years War. In 1999,the Federal Government called attention to racial disparities in health care, the IOM issued a call for action. Twelve years later, we have something to show for the effort, Laffel reports. "Steep declines in the prevalence of cigarette smoking among African Americans have narrowed the gap in lung cancer death rates between them and whites, .. . The 3-decade rise in obesity rates, steepest among minorities, has leveled off.

"Nevertheless, racial disparities persist across the widest possible range of health services and disease states in our country. The overall death rate from cancer is 24% *higher* for African-Americans than white people. The racial gap in colorectal cancer mortality has *widened* since the 1980s. African Americans with diabetes experienced *declines* in recommended foot, eye, and blood glucose testing between 2002-2007."

The problem is extraordinarily complicated Laffel observes.. "Hundreds of factors contribute to racial disparities in health care." Some of them are "culturally-driven lifestyle choices"--and we are dealing with a great many different cultures. Our tendency to lump people from any country once considered part of the Spanish empire as "Hispanic," is not helpful. Each group has a unique culture. Meanwhile, we are just beginning to tease out seemingly small differences that can have a huge impact on health: "Just this week for example, scientists showed that African Americans suffering strokes tend to call friends first–not 911–a behavior that delays onset of lifesaving treatment."

I would add that many African-Americans call friends first because they do not entirely trust our health care system. They want a friend at their side. The majority of our physicians are white, and this creates a cultural barrier that can make it difficult for them understand their patients. This does not mean that, over time, a white doctor cannot come to understand a different culture. He can. But it would be much easier to overcome many racial disparities in health care if we made a greater effort to ensure that medical school classes came much closer to reflecting the diversity of the population as a whole. The good news is that the Affordable Care Act does just that by funding scholarships and loan forgiveness for students willing to practice "where no one else will go." Research shows that students from inner city ghettos and poor rural areas are much more likely to want to practice in an area that reminds them of the place where they first decided to become a doctor. Many of them are minorities.

Poverty, Public Health and the Private Sector: At Improving Population Health, David Kindig stresses the important health effects of upstream social and economic factors such as income and education. "Interventions in these areas are often assumed to be the purview of the public and non-profit sectors, but for-profit activity in economic development and job creation are just as important as anti-poverty public policies and programs such as the Earned Income Tax Credit," David writes. He adds that improving community health is a complex enterprise that requires broad collaboration and robust private sector support and financing that goes beyond job creation to upstream investments in education, particularly for early childhood.

Why should the private sector become involved in fighting poverty by investing in early childhood development among the poor? Kindig makes the pragmatic argument: "the health and

economic competitiveness of our nation over the next 50-100 years is at stake. Surely investing in maternal and early childhood health should be a priority."

"I applaud the growing numbers of employers promoting employee wellness and fitness and rewarding healthy behavior choices," he writes. "But the healthy choice is not often easy to make, particularly among lower SES populations. We need to cultivate business sector buy-in to the notion of shared responsibility for education; strategic investments now will pay off in the form of a healthy and productive workforce in years to come.

"In a 2010 MATCH essay, *the head of the National Business Coalition on Health said it this way: "a compelling business case can and should be made for business leaders to look beyond the worksite to the communities where their organizations do business and their employees reside. Business leaders must understand that an employer can do everything right to influence the health and productivity of its workforce at the worksite, but if that same workforce lives in unhealthy communities, employer investments can be seriously compromised."*

Heath Savings Accounts Let Everyman Become a Health Care Expert: A Virtue or a Vice? *Fleming points to John Goodman's* eponymous blog, John Goodman where he discusses a new RAND study finding that people with Health Savings Account plans consume less care than people with conventional insurance and have lower health care costs.

HSA holders cut back on such 'useful care' as mammograms, screenings for cervical and colorectal cancer **and even childhood vaccinations**, Goodman acknowledges, but surprisingly, he finds this a virtue rather than a vice. We could spend our entire incomes entirely on "useful" health care, he points out; to preserve money for housing, clothing, and other things, it is far better for individuals to determine what 'useful' care is worth the price, as opposed to having government make the determination for us."

Here, I cannot help but ask: "What happens when your child contracts a serious disease because another parent- (who thought she could discern the difference between necessary and unnecessary care) decided not to have her child immunized? As a result, her child becomes a carrier and your child falls ill. Childhood diseases such as measles can be fatal. This is the danger of thinking individually rather than collectively.

As Goodman himself acknowledges, another famous Rand study shows that when health care "consumers" have high deductibles (which go hand in hand with health savings accounts") they were as likely to cut back on useful health services as they were to cut back on unnecessary care. Virtually no one needs to die of cervical cancer. When they do, we all wind up paying for the cost of their care. This is why, in other countries, (where cervical cancer is non-existent) the screening is free.