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John T. James, Ph.D.

Question: Eleven percent of all prescription drugs are brand-named. What percentage of all spending on prescription drugs goes to pay for these drugs? A) 20% B) 40% C) 60% D) 80 %

Book Review: You Are Worth Your Health – Introducing 360 Degree Living
Carmen Keith, MD

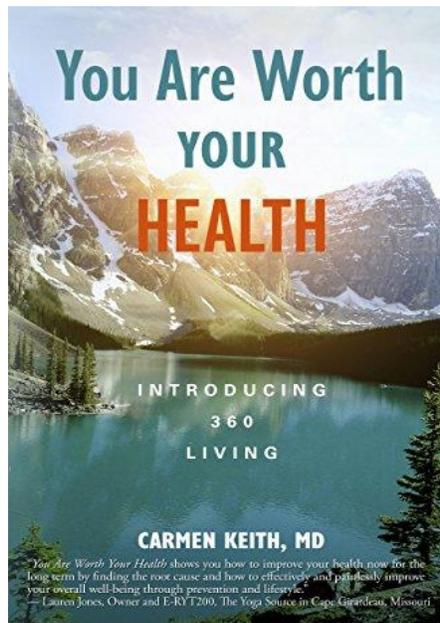
This small book was recommended to me by one of my newsletter readers. Since I am used to thick books, I was surprised when the envelope came and its contents ran to just over 100 large-print, small pages. Could there be much in here?

The author is a practicing physician, now days encouraging her patients on a self-actualized pathway to improved health, rather than the old way of prescribing pills for what may seem to be better health. She describes her stressful journey to success as a physician, only to realize that she is called to keep people healthy rather than offer them “sick care.” She is unrelenting in criticism of the pharmaceutical industry’s influence on the idea that pills will fix just about anything that is wrong with you.

Her points are generally well referenced, although I wanted to know the reference to her 2013 data claiming that the number of per capita prescriptions is 19 prescriptions for people ages 50 to 64, and 27 prescriptions for people ages 65 to 79 (pages 24-25). Frankly, my experience with people and medications does not match these high use rates. Her [source](#) was Statista. I could not verify a primary source.

Dr. Keith does not delve into medical harm beyond overprescribing. She ignores the overuse of devices and invasive procedures when a little physical therapy could solve the problem. She

makes personal observations about the advantages of a gluten-free diet, but does not offer references to the likelihood that this might help a specific person. I hate to give up my occasional pizza without data!



On the good side, Dr. Keith espouses the advantages of stress relief with the 80% solution. She also nicely conveys the idea of leaving a legacy of healthy living to kids and grandkids. She speaks to the importance of a “higher calling” that defines a purpose for which each of us should be living. She cautions against a charge-ahead lifestyle without opportunities to “smell the roses.” If you are looking for an easy read that will encourage you to think seriously about how to improve your health without medications, then this book would be a good start toward that goal. 4 Stars. Amazon, \$15.

Controlling Health Care Costs is Challenging

Three experts address the history of attempts to control health care costs by facilitating consumer choices that favor [less costly care](#). There are many competing factors that have resulted in little participation of consumers in trying to find lower costs for care. One might suppose that the great increase in out-of-pocket costs, which were \$250 in 1980 and are now \$1400, would catalyze consumer shopping. Furthermore, difficulty in paying out-of-pocket costs affects about half of all households. In the first place, calculating out of pocket costs from on-line sources may be challenging because of the foibles of insurance companies. Furthermore, how does one determine quality? Is the provider a reliable Toyota or a used Yugo? Ideally, medical

boards should protect the public from dangerous doctors, but there are many instances where this has not happened (my opinion). Some on-line prices may not be clear on the breadth of coverage for a stated price. High deductible plans lead to lower overall costs, but only because subscribers use less medical care, potentially compromising their health.

There are two approaches that offer some promise. One is reference pricing. By this approach, a suitable price for a given service is determined. The insurance company pays that price, but the consumer pays for anything over that price. There has been some success with this approach. Another approach is by using tiers for providers. If patients choose a provider in a less costly tier, then they pay less out of pocket. In some cases, if the patient makes a really low-cost choice, they may be given part of the savings (rebate). There are problems with these approaches. These center on patients wanting to stay with the same provider, despite the extra costs. Such changes tend to run afoul of the need for continuity of care many patients desire.

Low-Value Care Should Include Cost

One would think that “low-value care” would take into account the cost of care and the gain in outcomes patients want. That is not actually the case. For example, the “Choosing Wisely Campaign” simply identifies procedures that offer little to no gain in outcomes. Some low value care actually causes more harm than good or is simply not effective. Such procedures should be termed “no-value care.” This leads us to the concept of “quality-adjusted life year (QALY)” and the idea that at some point the [cost for gain](#) in this index is not sustainable. In the U.S. this seems to be in the \$100,000 to \$150,000 range per QALY

It seems there is a large database of QALY vs. cost and the worst 50 in this database have an index that ranges from \$2.5 million to \$60 million per QALY. Whew! The author points out that the flexibility of costs compared to clinical effectiveness (outcomes) would make addition of cost to determination of low-value care more responsive to change. For example, the cost of an expensive drug might be lowered to achieve a QALY less than \$100,000. The writer argues that to ignore cost-effectiveness is to ignore the problem of patients paying for procedures that offer little benefit. I might observe that cost-effectiveness is often going

to depend on the specific patient. A young patient cured by a specific drug may gain much more QALY than an elderly patient cured by the same drug.

Drugs Prescribed to Children

Children are among my favorite people, and I never want to see a child harmed because of uninformed prescribing of a medication. Two recent studies provide some insight into how well we protect children from potentially harmful prescription drugs. A MD summarized the findings from a large study of [prescriptions given to children](#) from 1999 to 2014. The good news was that the percentage of children having used a prescription in the past 30 days has dropped during that time from 25% to 22%. One of the major successes was the drop from 8% to 4% in prescriptions of antibiotics. This is likely due to the campaigns to reduce over-prescribing of these drugs when the cause of illness is not a bacterium. Likewise, the prescribing of antihistamines has dropped from 4% to 2%; however, some of this drop may be due to increased availability of this class of drugs without a prescription. The increase in use of blood pressure medications from 0.2% to 0.8% could be due to increased treatment of high blood pressure in adolescents; however, this could be due to increased obesity in this group, which is associated with high blood pressure. The writer opines that additional examination of the data is needed to clarify details about trends in prescribing to children.



In another article two MDs ask for more [real world data](#) when it comes to predicting drug safety in children. The authors note that there are substantial gaps in the knowledge we have about

safety of drugs in children. For example, most trials do not go long enough to assess potential long-term effects on development and growth. The problem is exacerbated because children may move from one insurance plan to another, making integration of the real world data challenging. One solution would be to link databases and medical records to glean real world effects of prescription drugs.

The message here for parents is that any drug prescribed to your child must be thoroughly justified, and you should know how to detect adverse effects should these occur. Long-term, if something unexpected happens that may be due to prescription drugs, then ask your child's pediatrician about your suspicions. You know your child much better than the doctor does.

Value-Based Pricing of Drugs – A Mess

It's no secret that drug prices in general are escalating to the point that many suffer because they cannot afford drugs they may need. Two experts wrote about the variations that pass under the label of [value based](#), but are not really that way. "Value-based" means that a cognizant group (presumably the Institute for Clinical and Economic Review, ICER) has determined that the benefits and size of the user population have been considered in declaring what a given drug should cost. The writers cite an example of a single-use drug for a rare condition that is priced by the maker at \$850,000. It should cost no more than \$426,000 according to ICER. The writers attack the current pricing scheme, which in most cases is "what the market will bear."

What are the permutations of value-based pricing? One is indications-based pricing, which involves pricing according to the indication for which the drug is being used. This is a subset of the value-based approach and has been used by some companies. Another approach is called "outcomes contracting" According to this idea, patients get a refund if a drug fails to work for them. Yet another is "mortgage pricing." This involves the patient's insurance company paying for the drug over time, typically over years. The authors note that patients are more likely to comply with taking a drug if it is affordable. Of course, the drug companies want to get as much for their drug sales as possible. All this seems like "smoke and mirrors" to me.

Let's take a closer look at [specialty drugs](#), which are high-cost prescription medications used to

treat complex, chronic conditions like rheumatoid arthritis, multiple sclerosis, and cancer. These medications often require special handling and administration. Prices for these drugs are higher in the U.S. than in other countries and are increasing rapidly. Typically, insurers demand convincing evidence from a clinician that the patient needs the specialty drug, often asking that cheaper drugs be tried first. For now, drug makers are reluctant to use value-based pricing because this may not lead to more users, which would compensate for the reduced profit when sold at the value-based price. This tension often creates barriers for patients who may need the drug. Physicians want to be relieved of the paperwork necessary to justify a specific drug for their patient. It is a mess in the U.S.

How often do Residents make Medical Errors?

A team of MDs set out to determine if more intense [supervision of residents](#) by attending physicians would reduce medical errors committed by residents. They did not detect a difference, but what was interesting to me was the prevalence of medical errors by doctors. Per 1000 patient days in the hospital, the residents with standard supervision averaged 108 errors, whereas those under enhanced supervision averaged 91 errors. Statistically at the 95% confidence level, the investigators found that these rates were not different. What this shows is that residents make 1 error for every 10 days a patient is in the hospital. Medical errors, were defined as preventable failures in the process of care, consisting of preventable adverse events and near misses. A preventable adverse event was

Made A Mistake? Consider reflective practice of medicine. Ask why this.

defined as medical care that led to patient harm. Roughly 3/4ths of the medical errors involved harm rather than near misses.

This study, while limited in scope, shows that harmful medical errors are not uncommon and that physicians create many of these regardless of the system in which they work.

Patients must be vigilant if they do not want to be a victim of a medical error while hospitalized.

Disease Prevention, Now!

Two MDs asked if the time is right for a paradigm shift in health care to more emphasis on preventive services. They report that in 2015 only 3% of health care dollars were spent on [preventive services](#). I have observed recently that tobacco companies have been forced by the Department of Justice to provide ads on TV that, in sometimes gross ways, express the potential harms of smoking. The prevalence of smoking in American adults is down; excellent! The writers of the article point out the success of a preventive, life-style intervention to keep adults with elevated fasting glucose from progressing to diabetics.

The writers ask what barriers exist to adoption of more preventive services. Insurance companies may not support preventive measures because contracts may be for only a year and the enrollee may change companies. Medicare holds preventive services it pays for to a higher standard

Siri: What have you eaten today that you should not have eaten? Me: A piece of cake and 4 small candy bars. Siri: I am sorry to hear that. Were you stressed over something? Me: No, the cake was getting old, so it needed eating. Siri: Needed? How big was this piece of cake? Me: Well, it covered a medium-sized plate. Siri: I'm going to count that as 3 pieces of cake. I'm disappointed; you must do better tomorrow. Siri: Let's change the subject. When was the last time you took your blood pressure? Me: I can't remember. It was good then, I think. Siri: Please take your blood pressure tomorrow. Siri: I see you have skipped walking for the last 2 days. Your Fit-Bit shows only 3,000 steps. Are you ill? Me: It's too hot to walk. Siri: Will you please walk today – no excuses. I happen to know that the temperature in Houston in the early morning is only 75F. Me: But it has rained a lot. Siri: Excuses, excuses. Have you not heard of umbrellas? Me: I lost mine. Siri: You live in Houston with no umbrella! I'm going to refer you for mental health counseling.

than sick-care. Preventive care must demonstrate cost-effectiveness, whereas sick-care only has to be deemed effective at almost any cost. Providers may not be schooled in how to implement preventive services. Medication adherence by patients is often poor, so preventive interventions that circumvent the need for any medication are valuable. Yet clinicians seem geared to prescribing medications rather than preventive support.

The authors propose web-based approaches to preventive services. This would keep costs down and require less time from clinicians. I could envision something like Siri-health for i-Phones. Siri-health would ask me to report in each evening.

Perspectives on Blood Pressure

The question of meditation (stress reduction), in addition to diet and exercise, was recently addressed by the [American Heart Association](#). It found limited evidence that some forms of meditation may modestly reduce blood pressure. Of course, there are many forms of meditation, and measuring blood pressures with enough accuracy to determine any difference is challenging.

A study published in the *American Journal of Industrial Medicine* found that work in a [noisy environment](#) may raise blood pressure significantly. In addition, cholesterol may be higher and hearing loss more prevalent.

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