



RESIDENT PRESIDENT'S MESSAGE

Health Care in America: Prescribing Power

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Prescription drugs have taken somewhat of a back seat in the year-long debate over health care reform. Despite significant attention in the decade prior (with the introduction of Medicare Part D), prescription drugs have not been as central to the debate over reform, which instead has focused more on health insurance, access to care and cost.

This is due in part to the fact that the pharmaceutical industry is on board with the president's reforms. That is not to say that pharma will not be significantly impacted by the 2010 bill. They have agreed to contribute \$85 billion in the form of industry fees and lower prices on drugs for government subsidized programs. By most expert assessments, the pharmaceutical industry is considered a big winner in the new legislation. Despite the hefty bill they agreed to pay, the money is a down-payment to the government in exchange for millions of newly insured consumers.

America and Americans spend roughly \$220 billion annually on prescription drugs. According to the Kaiser Family Foundation, this makes up only about 10% of total health care costs (compared to 31% for hospital reimbursement and 21% for physician services).¹ However, prescription drug costs represent the fastest growing component of overall health care costs (spending has increased at double digit rates since 1990 when costs totaled roughly \$40 billion).²

The landscape of prescription drug costs and payments changed significantly in 2003 with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act which went in to effect in 2006. Signed in to law by a republican president, it was then the largest expansion of government in decades. The plan helped reign in the out of pocket costs assumed by many seniors, but was, and still is, controversial because of provisions that prevent the government from negotiating the cost of drugs with pharmaceutical companies and the so-called "donut hole."³ The "donut hole" is a gap in coverage where the senior must pay all out of pocket expenses if their costs go above a certain level up until a point that coverage kicks in again. President Obama has vowed to end the "donut hole,"³ and the health reform bill of 2010 incrementally fulfills that pledge.

Despite its shortcomings, Medicare Part D was a major shift in prescription drug cost and payment trends and has delighted the AARP and many seniors. Prior to 2006, private insurance paid for roughly half of all prescription drugs, and individuals paid approximately 25% of the costs. Since the implementation of Medicare Part D, the government has kicked in 40% of total costs lowering the burden on private insurance and individuals.

In 1990, individuals paid for over half of all costs of prescription drugs. Over the last twenty years, that share has steadily declined.¹

The question central to this issue is why prescription drugs cost so much. Advocates of the pharmaceutical industry frequently cite the high cost of research and development. While the cost of producing the actual pills patients purchase may be pennies apiece, the cost to develop that first pill is in the million to billion dollar range. And, while the United States accounts for about 5% of the total world population, it accounts for 36% of total pharmaceutical research and development.⁴ Further, expensive drugs sold on the market pay for failed products and future endeavors. Only 11% of drugs actually make it to the market.⁵

Industry advocates also cite a number of sources who argue expensive prescription drugs actually save the country money in the long run. For example, medication compliance may save a patient with heart failure from a costly hospitalization. One study noted that, in particular, medications for AIDS, cancer, coronary artery disease, Alzheimer's disease and psychiatric disorders can prevent the expense of frequent hospitalization.⁴

These arguments from pro-pharma groups are countered by equally compelling arguments from a number of watch-dog groups who cite data that suggest the cost of prescription drugs is a serious issue in the U.S. Drugs are significantly more expensive in the United States compared to virtually every other country in the world, and the U.S. Customs Department estimates that 10 million people bring medications across the border from Canada in order to save money.⁶ Over the last decade, online purchase of foreign manufactured drugs has become a burgeoning industry that is poorly regulated.

An interesting statistic frequently cited is the fact that more money is spent on advertising than research and development (R&D). A study of the U.S. Pharmaceutical Industry from 2004 found that 25% of all expenses were on advertising and promotions versus 13.4% on R&D.⁷ The Center for Public Integrity reported that the industry also spent \$850 million from 1998 to 2006 on lobbying of elected officials, making the pharmaceutical industry among the most well-funded lobby.⁸

Agree or disagree with pharma, the industry is a large and ever-growing part of the U.S. health system. They play an important role in our every day practice and will certainly be shaped by the changes that are now forthcoming.

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RESIDENT EDITOR'S LETTER

An Argument in Favor of Mandatory Medical School Rotations in EM

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Recently, the University of Minnesota backtracked from a long standing tradition and made their emergency medicine rotation optional for medical students. This change was made to save costs for the University, as mandatory rotations are expensive to run. Emergency medicine is a newer field in the house of medicine, and mandatory rotations in medical school are the exception and not the

rule, but as one of the early pioneers in the field, it is disappointing that the University of Minnesota made this change.

Before emergency medicine existed, people with acute cholecystitis, dissecting aneurysm, ectopic pregnancy and meningitis presented to the hospital or clinic and were seen by internal medicine, ob/gyn and surgery residents. Often, these encounters were unsupervised, and the dangers to patient care that such situations presented lead to the development of our specialty. Just because this care was dangerous does not mean that it was not educationally useful, however. This was how physicians in training learned the spectrum of disease presentation and the initial approach to diagnostics when starting a work-up de novo.

With the establishment of emergency medicine residency programs, this vital educational opportunity was changed. It is true that, to this day, a diverse array of other specialties recognize the benefits of seeing patients in the emergency department and send their

residents to learn from our faculty and department. Others, however, have completely abdicated the role of primary diagnostician of acute disease and see patients only when the disease process has been determined to lie within their increasingly narrow specialty. It is for this reason that emergency medicine exposure in medical school is such a vital component of the making of the modern physician.

In medical school, students typically deal only with the management of already diagnosed disease. That management can be incredibly complex, but it is almost never related to the initial diagnosis. It is often only in the emergency department that undifferentiated abdominal pain turns into the post-op day two laparoscopic cholecystectomy patient a surgery clerk is rounding on. Emergency medicine is the ideal capstone to a medical education as it allows a young clinician to synthesize all these things that they have learned in the course of three or more years and finally apply those skills to the diagnosis and acute management of disease.

Most medical students will go into a field other than emergency medicine. Those who are interested will always have the elective option open to them. It is true that a mandatory rotation would likely sway some who otherwise would have headed in another direction. The real loss, however, will be to all those interns and residents who have never had the chance to primarily diagnose across the wide spectrum of pathologic disease. They will always be scared when someone inevitably asks, "Is there a doctor in the house?"

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References:

1. Prescription Drug Trends Fact Sheet - September 2008 Update. Rep. no. 3057-07. The Henry J. Kaiser Family Foundation, 9 Nov. 2008. Web. 22 Mar 2010. <http://www.kff.org/rxdrugs/upload/3057_07.pdf>.
2. Prescription Drug Trends Fact Sheet - May 2007 Update. Rep. no. 3057-06. The Henry J. Kaiser Family Foundation, May 2007. Web. 22 Mar 2010. <http://www.kff.org/rxdrugs/upload/3057_06.pdf>.
3. Medicare Part D 2008 Data Spotlight: The Coverage Gap. Rep. no. 7707. The Henry J. Kaiser Family Foundation, 6 Nov. 2007. Web. 22 Mar 2010. <<http://www.kff.org/medicare/upload/7707.pdf>>.
4. Smith, Charles G and James O'Donnell. The Process of New Drug Discovery and Development, Second Edition. New York: Informa Healthcare, 2006, p. 422.
5. Kola, Ismail and John Landis. Can the Pharmaceutical Industry Reduce Attrition Rates? Nature Reviews Drug Discovery 3(2004): 711-6.
6. Flaherty, Mary P, and Gilbert M Gaul. "Millions of Americans Look Outside U.S. For Drugs. Washington Post, 23 Oct. 2003.
7. Big Pharma Spends More On Advertising Than Research And Development, Study Finds. ScienceDaily. ScienceDaily LLC, 7 Jan. 2008. Web. 22 Mar. 2010. <<http://www.sciencedaily.com/releases/2008/01/080105140107.htm>>.
8. Dilanian, Ken. "Senators Who Weakened Drug Bill Got Millions From Industry." USA Today. 10 May 2007.