Panel: Hope Is Slim for Long-Term Care Reform

BY KEITH HAGLUND

WASHINGTON — Long-term care is "the big missing piece in health care reform" Leonard Burman, Ph.D., said during a panel discussion hosted by the Urban Institute.

While Dr. Burman, codirector of the Tax Policy Center, and his fellow panelists said that long-term care should be included in the health reform discussion, home- and nursing-home care are probably too complex for Congress to tackle this year.

"The system of providing long-term care is just broken," said Dr. Burman. He and several panelists said the system is unsustainable because it bankrupts individuals and, without reform, will eventually do the same for Medicaid and the state and federal governments.

The Urban Institute and the Brookings Institution, which cosponsor the Tax Policy Center, assembled the panel of experts to discuss long-term care issues as Congress began working on health reform bills.

Although the ongoing health care debate is a "wonderful opportunity" to look for solutions to long-term care, that probably won't happen, said Howard Gleckman, a senior research associate at the Urban Institute. In fact, he predicted, "health care won't be resolved this year," with many issues to be left on the table even if legislation passes. For action on long-term care, Congress is "waiting for Obama," said Mr. Gleckman, but the president "has frankly said nothing about this."

Long-term care "makes Congress nervous," said Bob Rosenblatt, of the National Academy of Social Insurance, because the government costs involved already are enormous and lawmakers don't know how much higher those costs might go in various reform scenarios.

Anne Tumlinson, a vice president and long-term care expert at the consulting company Avalere Health, said that she sees a "silver lining" in long-term care's exclusion from reform so far: The ability to focus more closely on long-term care reform later.

"We have to get [overall health reform] out of the way," she said. "The way we design health reform could have major implications for the way we design long-term care reform."

For instance, if a government-run public plan alternative to private health insurance emerges from the process this year, long-term care's mix of coverage by private insurance and Medicaid—or some other government program—could be fundamentally affected, said Ms. Tumlinson.

William Galston, Ph.D., of the Brookings Institution, pointed out that, ironically, long-term care seems to be "a classic insurable event," with catastrophic costs incurred by a minority within a large population. Yet, he and Richard Johnson, Ph.D., of the Urban Institute ticked off reasons long-term care insurance has been "intractable" including the fact that people don't want to confront the notion of becoming old and frail, care is expensive wherever it's provided, and insurers are doing a poor job of creating and selling long-term care policies. ■

Health Disparities Support Need for Larger Reform

BY MARY ELLEN SCHNEIDER

Racial and ethnic minorities have higher rates of disease and reduced access to health care compared with the general population, according to a new report from the Department of Health and Human Services.

African Americans, for example, suffer from chronic diseases such as diabetes at nearly twice the rate of whites. About 15% of African Americans, 14% of Hispanics, and 18% of American Indians have type 2 diabetes, compared with 8% of whites, according to the report.

Racial and ethnic minorities and low income individuals also have reduced access to health care. For example, the report found that Hispanics are only half as likely as whites to have a usual source of medical care. Racial and ethnic minorities were also less likely to lack health insurance.

These disparities highlight the need for larger health reform that invests in prevention and wellness and ensures access to affordable health care, the report concluded. HHS Secretary Kathleen Sebelius repeated that message during a roundtable discussion at the White House in June.

"Certainly the kind of disparities we've seen too often in the health care system are disproportionately represented by low income Americans and minority Americans," she said. "Health reform is key to helping to address these challenges."

But new health reform legislation will be only one part of the administration's push to reduce health disparities.

The roundtable event included representatives from various minority and public health groups who cautioned the administration that health coverage alone does not equal meaningful access. Other critical elements that are needed to help improve the equity of health care include a greater investment in prevention, more data collection to identify disparities, and access to more culturally competent care, the representatives said. ■

POLICY & PRACTICE

Vermont Bans Most Pharma Gifts

Vermont Gov. Jim Douglas (R) has signed into law a bill that prohibits manufacturers of drugs, medical devices, and biologics from providing free gifts, including meals and travel, to physicians and other health care providers. The toughest of its kind in the nation, the legislation also requires disclosure of any allowed gifts or payments, regardless of their value. Under the stronger law, manufacturers can give physicians only gifts such as samples intended for patients, "reasonable quantities" of medical device evaluation or demonstration units, and copies of peer-reviewed articles. They still can provide scholarships or other support for medical students, residents, and fellows to attend educational events held by professional associations.

More Flu Preparation Needed

Federal and state governments need to do more to prepare for possible pandemic flu, the Government Accountability Office (GAO) said after reviewing the H1N1 flu outbreak. The office acknowledged pandemic planning throughout government but said that more efforts are needed to improve disease surveillance and detection, address issues of coordination between various governmental entities, and improve capacity for patient care in the event of a pandemic. The GAO warned that the H1N1 virus could return next fall or winter in a more virulent form. Meanwhile, a Robert Wood Johnson Foundation report on the recent H1N1 outbreak concluded that health officials reacted effectively but urged improvements in the ability of providers to manage a massive influx of patients.

Minorities, Docs Miscommunicate

Black, Hispanic, and Asian patients are more likely than white patients to report problems communicating with their physicians, the Agency for Healthcare Research and Quality said. The AHRQ found that 13% of black and Asian patients, and 12% of Hispanic patients, said they had trouble communicating with their doctors in 2005, compared with 9% of whites. Roughly twice as many poor people as high-income people, regardless of their race or ethnicity, reported communication problems with their physician.

Bankruptcies, Illness Linked

Medical problems contributed to nearly two-thirds of all bankruptcies in the United States in 2007, according to a study in the American Journal of Medicine. Based on court-record reviews and interviews of more than 2,300 bankruptcy filers in 2007, the study found that 62% of filers cited medical debts and income lost to illness as reasons for seeking bankruptcy. Of these "medically bankrupt families," 9 out of 10 said they had medical debts over $5,000, and the rest met criteria for medical bankruptcy because they had lost significant income because of illness or mortgaged a home to pay medical bills. Out-of-pocket medical costs averaged $17,943 for all medically bankrupt families, including the three-quarters of families that had insurance at the outset of their problems. Most medical debtors were well educated, owned homes, and had middle-class occupations, the study found.

Medical Homes, Clinics Urged

A series of innovations, including patient-centered medical homes and retail clinics staffed by nurse practitioners and physician assistants, would help transform the primary care system into one that is higher in quality and more effective, according to a report from the Massachusetts-based New England Healthcare Institute. The report noted that "the promise of a high-quality primary care system has remained largely unfulfilled" but said the current crisis in primary care offers an opportunity for change. In addition to urging adoption of the medical home model and retail clinics, the institute recommended such changes as shared medical appointments, open-access scheduling, more worksite wellness programs, and primary care home visits. The report said that improvements in health information technology could free physicians to spend more time with patients.

ED Overcrowding Continues

The emergency department wait time to see a physician for emergent patients—those who should be seen in 1-14 minutes—averaged 37 minutes in 2006. Half of such patients waited longer than recommended, the GAO said in a report. In addition, patients who should have been seen immediately waited an average of 28 minutes, and about three-fourths had to wait to be seen. Hospitals performed better with urgent cases: Those patients, who should be seen in 15-60 minutes, waited an average of 50 minutes, and only about 20% waited longer than recommended, the report said. Lack of inpatient beds continues to be the main driver of ED overcrowding. ED boarding of patients who are waiting for an inpatient bed continues to be a problem, the GAO noted. The American College of Emergency Physicians warned that overcrowding and wait times will only grow worse as the general population ages. "People age 65 and older represent the fastest growing segment of the population and the group whose visits to the emergency department are increasing the fastest," Dr. Nicholas Jouriles, ACEP president, said in a statement.

—Jane Anderson