

Similar Health Challenges Exist Across the Globe

Aging populations are putting a strain on health care systems in nearly every industrialized country.

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WASHINGTON — The globalization of health care is creating challenges for health care systems worldwide. Though the systems themselves may be very different in terms of financing and administration, the problems they must address—aging populations, increasing chronic disease, shrinking budgets, extreme mobility of both patients and health care professionals—are very similar.

Health care analysts, administrators, and providers compared notes on these challenges at the fourth annual World Health Care Congress, sponsored by the Wall Street Journal and CNBC.

“Despite the fact that health care may be organized and financed very differently in different countries, and there may be cultural differences, there are ... a lot of common themes, and shared objectives for high-performing health care systems, innovation, and sustainability,” said Robin Osborn, director of the International Pro-

gram in Health Policy and Practice at the Commonwealth Fund.

Simon Stevens, who served as a health care advisor in U.K. Prime Minister Tony Blair’s cabinet, said the United States is not alone in confronting a major health care crisis. Single-payer national health systems of the sort found in the United Kingdom and all over Europe make the dynamics a bit different, but they certainly do not avert the crises.

“Despite differences in financing mechanisms, the challenges are similar across all industrialized nations. Tobacco, bad diet, lack of exercise are driving the conditions that result in the greatest consumption of health care resources, and tensions are erupting across [health care] systems due to changes in financing. The U.S. is not the only country debating these issues. The challenges are the same regardless of how you choose to finance the health care,” said Mr. Stevens, now the CEO of UnitedHealth Group’s Ovations, a health plan for individuals over age 50.

Aging populations are the juggernauts

straining health care systems in nearly all industrialized countries. Over the next 30 years, the dependency ratio, an expression of the number of elderly nonworking dependents versus younger working people, “will grow rapidly in the U.S., Western Europe, Japan, and China. And this will radically change how health care is financed,” Mr. Stevens said.

He added that while American corporate leaders have been screaming the loudest, the issues around employer-funded health care are not uniquely American.

In a number of European countries, private corporations are footing the bill for significant chunks of health care spending. “In the U.K., 52% of spending is private sector spending, despite the fact that the delivery systems are government funded.”

Across the globe, health care is increasingly a transnational endeavor, with immigration, relocation, medical travel, and multinational business blurring borders. The establishment of the European Economic Community, the paragon of economic boundary breaking, has created an interesting health care quandary, said Mr. Stevens.

“In the earlier days of the [European Union], many had hopes that the confederation would lead to harmonization of health care benefits. Not so. Per capita spending on health care in Eastern and Western Europe is fourfold different. Western Europe spends way more. It is implausible to have a set of uniform benefits that are acceptable in Germany but unaffordable in Slovakia.”

Migration also has an impact. Whether for employment opportunity or in pursuit of leisure, more people are living outside their countries of origin, and this makes for some peculiar health care dilemmas.

Mr. Stevens noted that in many parts of the world, national borders are blurred. “In California, for example, we know there are 8 million Hispanics living in border counties. Many have dependents across the border in Mexico. How do we handle that? Can we mandate that dependents of U.S. employees only be treated in clinics in Mexico?”

At the other end of the socioeconomic spectrum, there are thousands of retired U.S. citizens living in Mexico, Costa Rica, Panama, and other Central American countries. They’re eligible for Medicare, but unable to get coverage for medical services or drugs they obtain where they live. “Does this mean these people must fly back to the U.S. every time they need medical care?”

Physicians, nurses, and other medical personnel also have become highly mobile, often moving far from their countries of origin to countries of perceived opportunity.

Citing only one example, Mr. Stevens said there are more Filipino nurses, born and trained in the Philippines, working in the United States than there are in the Philippines. In the European Union, there are significant migratory flows of health care professionals from east to west.

This can result in shortages of qualified professionals in many countries, hindering the growth and development of their medical systems.

Ironically, it is the influx of international patients seeking lower-cost health care that will be an important driver for the development of hospitals and the retaining of health professionals in nations such as Thailand, India, Hungary, and many Latin American countries.

Health plan administrators are struggling to figure out ways to do business without borders. The challenges are daunting, said UnitedHealth Group’s Ori Karev. Speaking specifically of coverage for Americans obtaining care outside the United States, he noted, “There are a lot of complicated issues involved in this: transportation issues, authorization issues, tax issues in terms of the ways in which the IRS will treat medical travel expenses.”

As countries such as India, Thailand, China, Brazil, and others become more affluent, their health care spending will increase, as will the number of risk-sharing plans. UnitedHealth Group is already a major health insurance player in India, with an employer-funded plan now covering 300,000 members via a large provider network. ■

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CLINICAL PHARMACOLOGY:

Topical corticosteroids share anti-inflammatory, antipruritic and vasoconstrictive actions.

The mechanism of anti-inflammatory activity of the topical corticosteroids is unclear. Various laboratory methods, including vasoconstrictor assays, are used to compare and predict potencies and/or clinical efficacies of the topical corticosteroids. There is some evidence to suggest that a recognizable correlation exists between vasoconstrictor potency and therapeutic efficacy in man.

Pharmacokinetics: The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings.

Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings substantially increase the percutaneous absorption of topical corticosteroids. Thus, occlusive dressings may be a valuable therapeutic adjunct for treatment of resistant dermatoses. (See **DOSE AND ADMINISTRATION**).

Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma proteins in varying degrees. Corticosteroids are metabolized primarily in the liver and are then excreted by the kidneys. Some of the topical corticosteroids and their metabolites are also excreted into the bile.

INDICATIONS AND USAGE:

Topical corticosteroids are indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

CONTRAINDICATIONS:

Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

PRECAUTIONS:

General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing’s syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Therefore, patients receiving a large dose of a potent topical steroid applied to a large surface area or under an occlusive dressing should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests. If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid.

Recovery of HPA axis function is generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids.

Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. (See **PRECAUTIONS—Pediatric Use**).

If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted.

In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Information for the Patient: Patients using topical corticosteroids should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive unless directed by the physician.
4. Patients should report any signs of local adverse reactions especially under occlusive dressing.
5. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

Laboratory Tests: The following tests may be helpful in evaluating the HPA axis suppression:
 Urinary free cortisol test
 ACTH stimulation test

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.

Studies to determine mutagenicity with prednisolone and hydrocortisone have revealed negative results.

Pregnancy Category C: Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.

Pediatric Use: Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and Cushing’s syndrome than mature patients because of a larger skin surface area/body weight ratio.

Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing’s syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation,

delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilledema.

Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS:

The following local adverse reactions are reported infrequently with topical corticosteroids, but may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence:

- Burning
- Itching
- Irritation
- Dryness
- Folliculitis
- Hypertrichosis
- Aceform eruptions
- Hypopigmentation
- Perioral dermatitis
- Allergic contact dermatitis
- Maceration of the skin
- Secondary infection
- Skin atrophy
- Striae
- Miliaria

OVERDOSAGE:

Topically applied corticosteroids can be absorbed in sufficient amounts to produce systemic effects (see **PRECAUTIONS**).

DOSE AND ADMINISTRATION:

Apply Cloderm (clocortolone pivalate) Cream 0.1% sparingly to the affected areas three times a day and rub in gently.

Occlusive dressings may be used for the management of psoriasis or recalcitrant conditions.

If an infection develops, the use of occlusive dressings should be discontinued and appropriate antimicrobial therapy instituted.

HOW SUPPLIED:

Cloderm (clocortolone pivalate) Cream 0.1% is supplied in 15 gram, 45 gram and 90 gram tubes.

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