

Malpractice Concerns Eat 10% of Premium Dollars

BY JOYCE FRIEDEN

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WASHINGTON — The costs of malpractice insurance and defensive medicine account for about 10 cents of every dollar spent on health care premiums, several speakers said at a press briefing sponsored by America's Health Insurance Plans.

Medical liability and defensive medicine represented the "lion's share" of cost increases in the physician and outpatient areas, Michael Thompson, principal at the New York office of PricewaterhouseCoopers, said at the briefing.

Litigation and defensive medicine also accounted for about a third of the costs associated with poor-quality health care, said Mr. Thompson, noting that the cost of poor-quality care was spread throughout the health care system.

According to AHIP President Karen Iagnagni, efforts must be made to reduce the amount of poor-quality care being given. "We have a system where 45% of what's being done is not best practice," she said. "No public or private entity could operate at that rate."

Overall, the rate of increase in health care premiums was 8.8% in 2004-2005,

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into how well someone does, not only for the heart but for health in general."

She credits her patients for teaching her that good care for the heart goes well beyond medicine and biomechanics. "I have evolved because of my patients," she said. "I never came out of cardiology training thinking about the heart as an emotional organ. I never really thought about broken heart syndrome until I started talking to patients and they told me about the death of their child, or their arrhythmia began when X amount of stressful things happened. That's where the book came from. The hope for the book is that when you read someone else's story, you'll look at your own life through a different lens. From there, you can start to make change."

Dr. Guarneri, who majored in English literature as an undergraduate at New York University, New York, started collecting patient stories on her personal computer. "It was in spurts, because there would be a moving story from the day, but not every day," she said. "I would go home, think about those things, and then I would write what happened. I would also write my reaction to it: what kind of effect was this having on me personally as a physician."

Dr. Guarneri advises aspiring physician writers to keep a journal. "Start to put your thoughts down, even if it's a little bit every day," she said. "Take what your passion is and write from there. Don't write for anyone else but you. I wrote this [book] for me. I never intended to publish it. I was amazed how Simon & Schuster bought this book in less than a week, because it never occurred to me that a physician had not done anything like this before." ■

By Doug Brunk, San Diego Bureau

down significantly from 13.7% in 2001-2002, noted Jack Rodgers, managing director at PricewaterhouseCoopers. One factor contributing to the slowdown was a decrease in the rate of cost increases for prescription drugs, according to Mr. Thompson. "It's now trending in line with overall premiums," he said.

Part of the reason for that decrease is employers' increasing use of three-tiered or four-tiered drug programs, in which patients pay a larger share for brand-name

drugs, especially if there are generic equivalents. In 2000, only 27% of patients were in drug plans with three or more tiers; in 2004, the figure was 68%, he said.

In addition, cost trends were helped by a drop in the number of state mandates that are being added each year, from 80 in 2000 to less than 40 in 2004, Mr. Thompson said.

Outpatient costs rose significantly last year, Mr. Rodgers said. "Those are the services that are really growing rapidly." The

increase in outpatient services accounted for more than a third of the 8.8% increase in premiums, he noted.

Despite these problems, Mr. Thompson said in an interview that he did not expect premium increases to go higher next year. "We're looking at the same number or maybe a little lower," he predicted. Part of the stabilization will likely be due to consumers having to pay more for their health care costs and becoming more aware of prices as a result, he added. ■

EMERGING CONCEPTS IN ROSACEA MANAGEMENT

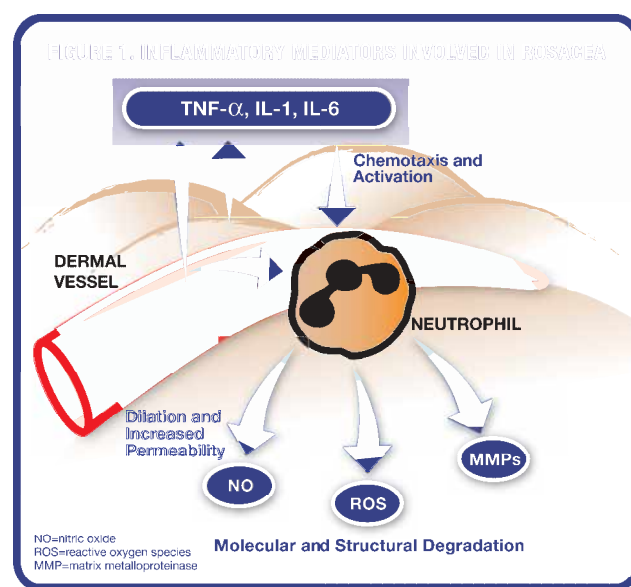
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CAN ORAL THERAPY FOR ROSACEA BE OPTIMIZED FOR ANTI-INFLAMMATORY EFFECT?

Certain oral antibiotics appear to diminish the inflammatory manifestations of rosacea.^{1,2} This effect is most likely due to the intrinsic and surprisingly robust anti-inflammatory properties of these agents.^{1,2} By contrast, the antimicrobial actions with which these drugs are more commonly associated may contribute to bacterial resistance and other use-limiting adverse effects.

ROSACEA IS A CHRONIC INFLAMMATORY DISORDER

While a definitive pathophysiologic mechanism for rosacea has not been established, many theories point to chronic inflammation as the common pathogenic factor.³ The view that rosacea is an inflammatory, rather than an infectious, disorder is supported by histopathologic findings that include follicular and perivascular leukocytic infiltrates^{1,2} and an absence of pathologic microflora.³ This hypothesis is further reinforced by research demonstrating that the antibiotics effective against rosacea suppress a variety of inflammatory mediators thought to play a primary role in rosacea pathogenesis⁴ (Figure 1).



ANTIMICROBIAL ACTIVITY LIMITS THE USE OF ORAL THERAPY

Despite the demonstrated clinical benefit of antibiotics in the treatment of rosacea, many dermatologists are apprehensive about prescribing prolonged courses of oral agents. Of particular concern are the potential for promoting the spread of antimicrobial resistance, alterations of normal microflora that permit the growth of opportunistic organisms (e.g., *Candida albicans*), and various class-based side effects. These drawbacks have largely restricted the use of systemic antibiotics to the periodic treatment of flares, even though the chronic inflammation associated with rosacea calls for the type of effective, long-term anti-inflammatory therapy at which these agents might potentially excel.

ISOLATION OF ANTI-INFLAMMATORY ACTION MAY BE POSSIBLE

It may be possible to modify the pharmacokinetics of systemic antibiotics in a way that isolates their anti-inflammatory properties from their antimicrobial properties. By maintaining plasma concentrations within a defined therapeutic window—high enough for anti-inflammatory effect, yet low enough to avoid antibacterial activity—one might be able to achieve inflammatory, but not microbial, suppression. A novel oral therapy with these characteristics could more precisely target the underlying pathophysiology of rosacea. Theoretically, such an agent could replicate the anti-inflammatory properties of established antibiotics, yet:

- Eliminate the selective pressure that encourages antimicrobial-resistant bacterial strains to emerge
- Leave normal populations of bacterial microflora intact
- Minimize other adverse effects often associated with the administration of oral antibiotics

An agent designed to deliver the beneficial anti-inflammatory actions of systemic antibiotics without the detrimental antimicrobial effects could be a valuable tool for long-term rosacea management.

References:

1. Jansen T, Plewig G. Rosacea: Classification and treatment. *J R Soc Med.* 1997;90(3):144-150.
2. Buechner SA. Rosacea: An update. *Dermatology.* 2005;210(2):100-108.
3. Millikan L. The proposed inflammatory pathophysiology of rosacea: Implications for treatment. *SKINmed.* 2003;2(1):43-47.
4. Attur MG, Dave MN, Mohandas N, et al. Regulation of inflammatory mediators by tetracyclines. In: Nelson M, Hillen W, Greenwald RA, eds. *Tetracyclines in Biology, Chemistry and Medicine.* Basel, Switzerland: Birkhäuser Verlag; 2001:295-310.

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