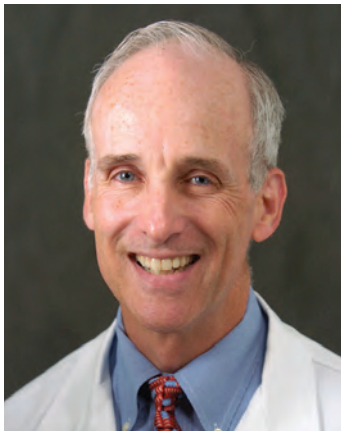
It's health care … but not as we know it

David H Henry, MD, FACP

Welcome to the Journal of Community and Supportive Oncology's August 2016 issue. I doubt our readers are as focused on their work this month as they are during the rest of the year. Other thoughts occupy this last gasp of summer – making vacations to the beach or even abroad take precedence before coming back to school for our children or work for ourselves after Labor Day.



Of course, with the month of July just passed, who could have avoided watching the Republicans in Cleveland and the Democrats in Philadelphia, and all of the drama that ensued. Viewer numbers and political engagement this presidential convention season were apparently higher than for any other in recent memory. The candidates clearly have different styles, and their parties very different agendas, but I could not help noticing that neither party spent much time talking about health care during their respective conventions. It simply boiled down to one party saying it would repeal the Affordable Care Act (without much detail on what would replace it), and the other party proudly claiming responsibility for the law, espite its flaws.

But consider this. In January 2014, National Public Radio reported on something that happened in the state of Oregon.[1] The state wanted to offer insurance to the uninsured as stipulated by the ACA, but had funding for only about half of those who would qualify. How do you decide who gets insurance, and who doesn't? State officials ran a completely randomized lottery system, "awarding" the winners with Medicaid health care insurance. It was, in effect, a randomized controlled trial, with all the ensuing data to mine. The data were analyzed to examine what would happen to emergency department (ED) visits for those who were insured compared with those who were not insured. The authors of the study were surprised to find that there was an increase of some 40% in ED visits for the insured citizens compared with the uninsured.[2] The reason for this is fairly obvious: uninsured patients can go to the ED for health care, but they will be charged and billed for the services, whereas those who are now insured can go to the ED for free, hence the bump in ED visits for that population.

However, the study highlights a significant failing in the ACA. Although the law has increased access to health care for millions of Americans who were previously uninsured, it did not provide a commensurate ready source of available health care providers (physicians, nurse practitioners/physician assistants). So of course this newfound access to health care simply made it possible for patients to frequent the only source of health care available to them … the emergency department.

Was placing additional stress on an already over-used health care resource the best solution? Of course not. ED staff work hard to quickly triage, evaluate, diagnose, and treat patients, but, as we all know, this takes an enormous amount of time and ends up costing a lot more. Where are the health care providers to offer patients timely access to outpatient care? This is a challenge that both political parties need to prioritize when they finally get around to talking health care in this rollercoaster presidential election season.

So as you look to read something to get you back into gear for when you return to your practice and your patients in the fall, I hope you will consider some of the exciting articles in this month's issue. In our regular Community Translations section, we report on the recent approvals of elotuzumab and ixazomib for the treatment of multiple myeloma in previously treated patients (p. 334) and of uridine triacetate as an antidote for 5-fluorouracil or capecitabine overdose and toxicity (p. 332). Three Original Reports examine abnormal vaginal bleeding and contraception counseling in women who are undergoing chemotherapy (p. 337), the effects of intravenous iron treatment on health-related quality of life in patients with iron deficiency (p. 342), and mindfulness-based cancer recovery in survivors recovering from chemotherapy. And finally, we have a comprehensive review of new therapies for gynecologic cancers (p. 367). I hope you enjoy this month's issue.

References

1. Rovner, J. Medicaid expansion boosted emergency room visits in Oregon. http://www.npr.org/sections/health-shots/2014/01/02/259128081/medicaid-expansion-boosted-emergency-room-visits-in-oregon. National Public Radio, Morning Edition. Broadcast January 3, 2014. Accessed August 2, 2016.
2. Taubman SL, Allen HL, Wright BJ, Baicker K, Finkelstein AN. Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. Science. 2014;343(6168):263-268. doi: 10.1126/science.1246183.

JCSO 2016;14(8):331. doi: 10.12788/jcso.0289.