Public Health Views... and News

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In this issue:

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An Opinion on Health Care Reform and Public Health in Michigan - 2009

Congress and the President are bent on enacting national health care reform this year. Again, the will of the people may be thwarted by special interests. The powerful insurance lobby has already assumed a major role in "planning sessions" in Washington and around the country. The Michigan State Medical Society has co-sponsored a conference on health reform along with BCBS of Michigan. Public health has not spoken up as a united front or demanded a seat at the table. Universal insurance plan activists have attempted to get representation on congressional panels only to be jailed for their efforts.

Insurance companies are not interested in national budgeting or "public" insurance options for obvious self-preserving reasons. Studies have shown, however, that runaway costs can be feasibly controlled only by those methods. The recent promises by insurance leaders to cut trillions of dollars from health care cost sound good, but actual plans for this are not forthcoming. This rhetoric is likely a delaying tactic to keep government at bay and maintain the status quo. Insurance firms have a great financial stake in the huge health care sector and have tremendous lobbying power. One should not forget that the goal of health insurance companies is to prevent losses (i.e. payment for medical care) and to make substantial profit for stock holders.

The majority of the population (including physicians) supports a public national insurance plan. The government has a legitimate interest in health insurance because of its large investment in health care (Medicare, VA, government employee health and Medicaid). Also, the public health risk of un-insurance (spread of undetected contagious disease) and the social disruption from bankruptcy due to illness are concerns. Spiraling health benefit costs are a drag on the economy.

Contrary to the standard rhetoric, a national health insurance plan would not restrict access to physicians or interfere with a doctor's decision making authority. Government health insurance would not be "socialized medicine". Ironically, control of medical practice is now in the hands of insurance executives. "Big insurance" not "big government" is the wedge between patient and physician and is the agent actually "peering into Harry and Louise's medicine cabinet". The private insurance market disarray has resulted in billing nightmares for providers. Doctors and their patients are often left bewildered and unaware of coverage restrictions. The working poor with medical problems are victims, generally left without any affordable insurance option.

Private insurance companies shy away from coverage of preventive care. Health promotion and disease prevention techniques are crucial for long term wellness, but are omitted from coverage because the benefits don't accrue on short-term balance sheets. Scientific input from public health and physician groups would be a feature of a national health insurance plan assuring coverage for recommended preventive treatments. Physicians should be in charge of medical decisions and be less fettered by insurance company bureaucrats. When restored this authority, physicians do well at providing cost effective care.

National health insurance could provide a Medicare-like insurance card for all citizens, collecting premiums from individuals based on income and from employers based on payroll. A negotiated fee schedule for physicians and annual allotments for hospitals and nursing facilities could be part of health care budgeting. None of the piecemeal health reform plans so far come close to the savings of a national insurance plan. At a time of economic meltdown with business failures due to high benefit costs, a health reform plan that controlled these costs would be welcome. A bold move in this area is now politically possible and would help strengthen the economy in the long run. It would be good social policy favored by most legislators' constituents.

Michigan could take the lead if Washington gets bogged down in philosophical bickering and worries about the next election cycle. What better way to prime the business pump than eliminating large and expanding health benefit obligations. GM and Ford might again be able to compete globally and operate independently. Entrepreneurs could manage the risks of new startups in Michigan with a state health insurance plan for their employees. Our state's commitment to public health could again be the envy of the nation. Michigan could pull itself out of the depths of economic depression with this forward thinking health insurance plan. Our citizens would be amply rewarded and tax dollars well spent.

H1N1 Vaccine Development

Swiss drug giant Novartis AG says it has already produced an initial 10-liter batch of vaccine against the Novel H1N1 pandemic influenza strain.

The vaccine is available for early testing and possibly some clinical trials weeks ahead of expectations. The announcement came the same day the World Health Organization (WHO) declared that the outbreak of the novel H1N1 strain qualifies as a pandemic -- with sustained community transmission in at least two regions of the world.

The WHO has been in close contact with vaccine makers and believes that production of next fall's seasonal flu vaccine will be finished soon, leaving "full capacity" available for production of vaccine against the pandemic strain.

The speed of the Novartis vaccine development was made possible by the use of a cell-based manufacturing system, rather than the traditional method that uses chicken eggs to grow the vaccine, the company said. The company's vaccine production facility in Marburg, Germany could produce up to a millions of doses a week.

The cell-based vaccine was based on the wild-type virus, not the seed strain distributed by the CDC in early May. But the company said it is close to making a vaccine based on the seed strain as well.

The company said it hopes to start clinical trials in July with a vaccine made from the seed strain and expects to have it licensed by the fall.

Cell-based vaccine production has been predicted to abbreviate the time needed to produce new vaccines.

It usually takes between three and six months to make a flu vaccine, "so this timeline is very fast," commented Frank James, M.D., of the University of Washington in Seattle.

The use of the cell-based method is also significant because it avoids the difficulty that some flu strains -- notably the highly pathogenic avian H5N1 strain -- are deadly to chicken embryos, he added.

Novartis is suggesting that their vaccine will be used with their proprietary adjuvant MF59, which has been licensed in Europe for several years but is not approved in the U.S.

Dr. James said a vaccine against a novel strain of the flu would usually need two doses several weeks apart.

"With a potent adjuvant this might not be needed," he said, "and that would significantly decrease the time and complexity of the vaccination process."

One possible hurdle, Dr. Schaffner said, is the FDA's response to the use of MF59. "How will FDA handle an adjuvanted H1N1 vaccine? So far, no clear answer has appeared," he said.

The adjuvant could be quickly used in Europe and in resource-poor countries, according to Gregory Poland, M.D., of the Mayo Clinic in Rochester, Minn.

In the U.S., though, it will probably have to go through clinical trials, he said, "Unless an emergency use authorization is granted."

Dr. Poland's concern was echoed by Donald Henderson, M.D., of the University of Pittsburgh Medical Center.

"The use of an adjuvant has much to recommend it," he said, "but the U.S., to date, has steadfastly refused to license any adjuvant other than aluminum hydroxide."

"I'm afraid that they will demand testing of a very large number of people over an extended period of time -- no matter what data have been produced in Europe," he said.

Technology and Health

Technology will empower patients in new ways during 2009. Patients have more access to health information than ever through laptops, handheld computers, and Internet-enabled cell phones. The increase of patient to-patient interactions over social networking platforms, often referred to as Health 2.0, is creating a significant buzz among consumers and companies.

Websites such as patientslikeme.com and americanwell.com are changing how healthcare is navigated and experienced by consumers. Patientslikeme.com is a networking website that allows patients to share information about and experiences with diseases with other individuals.

Americanwell.com has the goal of providing access to healthcare services in the home through technology such as web communications and digital telephony.

Biotech companies are looking toward harvesting the collective knowledge within such platforms to improve their product development, enhance innovation, and target their advertising. And in 2009, the Centers for Medicare and Medicaid Services (CMS) will add more patient consultations to the list of reimbursable tele-health services.

CMS is also pushing technology for prescriptions. Starting in 2009, health care providers who used qualified e-prescribing systems can earn incentive payments of up to 2%.22 Private health plans are also encouraging the move to e-prescriptions. Blue Cross and Blue Shield of Massachusetts announced that it will offer doctors bonus payments for using e-prescription systems starting in 2011.

Electronic health records (EHR) and electronic medical records (EMR) are becoming more commonplace, thanks to large investments by key players. Microsoft Corp. offers HealthVault, and last year, Google launched Google Health.

Both products allow users to manage their personal health records and other information online.

The above information comes from The Price Waterhouse Coopers report from the Health Research Institute, which identifies nine significant issues that will impact the health industry in 2009. The report also addresses the implications of these issues for businesses and the health industry-at-large.

New Cancer Research

A team of researchers has found an association between breast cancer survival and two proteins that, when present in the blood in high levels, are indicators of inflammation. Using data from the Health, Eating, Activity and Lifestyle (HEAL) study sponsored by the National Cancer Institute, the researchers found that breast cancer patients with elevated levels of C-reactive protein (CRP) and serum amyloid A (SAA) were approximately two to three times more likely to die sooner or have

their cancer return than those patients who had lower levels of these proteins, regardless of the patient's age, tumor stage, race, body mass index, or history of previous cardiovascular issues. The results of this study are published online in the Journal of Clinical Oncology.

Inflammation is an immune response. It is part of the body's natural defense against harmful elements, such as pathogens, damaged cells, or other irritants, and helps facilitate the healing process.

CRP and SAA accumulate in the blood in response to inflammation. CRP is produced by the liver, as well as by fat cells, and has several immune-related functions. SAA, which is also secreted by the liver, is involved in both the transport of cholesterol from the liver to the bile, and the recruitment of immune cells to sites of inflammation. Both proteins are found in higher concentrations in the blood of people with low-grade chronic inflammation. Chronic inflammation is believed to contribute to the development and spread of breast cancer, and breast cancer survivors with chronic inflammation may be at a higher risk of recurrence. Elevated CRP is also linked to increased risk of heart disease.

This study joins an increasing body of research indentifying CRP and SAA as indicators of reduced survival from cancer. Previous studies have shown an association between elevated levels of CRP and poor survival outcomes in metastatic prostate cancer, as well as gastroesophageal, colorectal, inoperable non-small-cell lung, and pancreatic cancers. In other studies, a similar association was shown for SAA and gastric cancer and renal cell carcinoma. Although research has indicated that inflammation may play a role in the progression of cancer, the exact mechanism by which this happens has been unclear.

For this study, 1,183 women with early-stage breast cancer were recruited from three cancer centers, including the Fred Hutchinson Cancer Research Center in Seattle, the University of New Mexico, Albuquerque, and the University of Southern California, Los Angeles. Participants completed a lifestyle questionnaire when they joined the study and the researchers collected blood samples (which were analyzed for CRP and SAA levels) and height and weight measurements at a subsequent visit two years later (approximately 2.5 years after their initial diagnosis). The women will be followed for a total of 10 years.

This is the first large, population-based study to look at the relationship between breast cancer survivorship and biomarkers of inflammation that were measured after treatment. Because the biomarkers were measured approximately 31 months after diagnosis, enough time had passed so that the researchers could accurately assess the effect of chronic inflammation, as opposed to acute inflammation that may have been a result of the breast cancer treatments each patient received.

The researchers examined the relationships between the inflammation biomarkers and both overall survival and disease-free survival. Overall survival was defined as the amount of time from the follow-up appointment until the patient died (from any cause) or the study period ended. Disease-free survival was defined as the amount of time from the follow-up appointment until the patient's breast cancer returned, another, new cancer was diagnosed, the patient died, or the study period ended. The researchers found that elevated levels of both SAA and CRP were associated (statistically significant) with reduced overall survival. Women with high levels of SAA were three times as likely to die sooner, and women with high levels of CRP were two times as likely to die sooner. They found similar, but weaker, associations with disease-free survival, in that women with high levels of SAA were two times as likely to die of have their cancer return, and women with high levels of CRP were more than 1.5 times as likely to die or have their cancer return. This suggests that SAA and CRP may be more closely related to overall survival than disease-free survival. More research is needed to get a better understanding of these associations and other potential mediating factors, in order to create more precise risk estimates.

Inflammation has been associated with several modifiable risk factors, such as obesity, low physical activity, and cardiovascular disease, all of which can affect a cancer survivor's prognosis.

Office Closing

Note: As of August 1, 2009, the Sturgis Office of the Branch-Hillsdale-St. Joseph Community Health Agency will be closing permanently. Clients can access services in our Three Rivers and Coldwater Sites. We apologize for any inconvenience this may cause to our clients, their families or our community partners.