Pharmacy Benefit News

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Specialty Spotlight

Pharmacists Want Supreme Court to Hear Religious Objections Case

National and state pharmacy associations want the U.S. Supreme Court to take a case about a Washington state regulation that says pharmacies cannot refuse to fill certain prescriptions because of religious beliefs.

Source: Schencker, L. (2016, February 8). Pharmacy associations ask Supreme Court to take religious objections case. Retrieved February 23, 2016, fromhttp://www.modernhealthcare.com/article/20160208/NEWS/160209870?utm_source=modernhealthcare

Comment:
The question of whether health care professionals have an ethical responsibility to treat a patient regardless of their own personal beliefs has already been adjudicated by physicians and nurses. The responsibilities of physicians to treat criminals arguably goes back to the so-called “Mudd Rule”. This rule is attributed to Dr. Samuel Mudd who went to jail because he treated John Wilkes Booth for his broken leg after he assassinated Abraham Lincoln, the 16th President of the United States. The idea is that the health care professional is obligated to treat the patient regardless of the circumstances and their own personal beliefs. The rule has been extended and expanded over the years, even to our own times, when the State of Florida was sued for “illegally depriving needy kids of healthcare”.

Interestingly, at a time when pharmacists have achieved provider status in some states and are seeking this status nationally, the pharmacy profession has not adjudicated the pharmacist responsibility similar to a Mudd Rule. The Supreme Court will decide whether to address this issue legally, but what of the profession and its’ concept of ethical responsibility? Pharmacy has clearly not adjudicated this issue, but it must to provide a foundation for professional practice.

I have tried to be impartial in my comments in this Pharmacy Benefit News, but this issue bears further reflection. I categorically object to individuals who call themselves professionals and then apply personal religious, political, sexual, or other personal beliefs to the treatment of patients. Even health care benefits, that are covered under Title I of the Social Security Act, must also adhere to the prohibitions on bias as articulated in the Constitution and the Bill of Rights. The obvious concern is that one person’s bias is not applicable to everyone. In a larger sense, professionals may sympathize, empathize, or disagree with their patient’s beliefs or actions, but they don’t have a responsibility to act

on their personal beliefs. If we fall into the personal bias reasoning model then history tells us the consequences. These consequences are not acceptable.

Find out more

The Law of Large Numbers and The Affordable Care Act (ACA) - Commentary

This is grist for politicians and those who oppose the ACA. The problem is that large insurers that participate in the exchanges lose money when offering different benefits to small samples of patients who are heavily weighted with sick vs. healthy patients. The benefit models require large participation to spread the risk, and therefore increase cost, to all beneficiaries. The result is higher premiums which younger, healthier individuals find unacceptable.

However, despite business, political and other contentious interests, there is a mathematical principle at work that bears discussion. The "Law of Large Numbers" is the basis for spreading risk over a large population. It is also the basis for individual health insurance models based on tax relief (e.g., "Blues" models) versus group health that can spread risk (aka adverse selection) over heterogeneous populations.

The Law of Large Numbers is one of several mathematical theorems that, simply put, expresses the idea that larger sample sizes appear to mimic the whole population. The challenge is that the ACA mandates individual care that inherently violates the law of large numbers, while trying to spread the risk across a large population. There is essentially no ability in the current insurance models offered through the exchanges to provide an ROI for absence of disease. Yet, the benefits are priced for care of disease and the cost of prevention. Hence, insurers provide models that are unacceptable or unaffordable to the healthy, young population.

Therefore, benefits offered to individuals must be structured to address those with chronic disease/conditions as well as those without current disease. The current ACA models do not contain all options to address the population without disease at an affordable cost. Health care savings accounts may provide one option for addressing the affordability option for healthy individuals that provide low premiums that are acceptable and affordable.

The solution to the problem requires more inventive benefit

New Report Calls for Increased Focus on Diagnostic Errors

"A new report released by the National Academy of Medicine (formerly the Institute of Medicine or IOM) outlines how health care stakeholders can more quickly identify, resolve and reduce the incidence of diagnostic errors and improve patient safety. Improving Diagnosis in Health Care reveals that most people will experience at least one diagnostic error in their lifetime, whether an incorrect diagnosis or a diagnosis that's delayed. These errors, according to the report, contribute to approximately 10 percent of patient deaths and between 6 percent and 17 percent of hospital adverse events.

Diagnostic errors are also the largest category of paid medical malpractice claims and are almost twice as likely to have resulted in a patient death compared with other claims, according to the report. The report identifies eight recommendations to improve diagnosis, including how patients and health professionals can better communicate, as well as how diagnostic errors can serve as the catalyst for delivering safer care, both of which align with AHRQ's core mission."

Source: New Report Calls for Increased Focus on Diagnostic Errors. (n.d.). Retrieved February 23, 2016, from http://www.ahrq.gov/news/newsletters/e-newsletter/487.html

Comment:
This report places a target on the back of physicians and their diagnostic processes. However, as medicine moves to team models for ACOs and Medical Homes, diagnoses are not wholly the province of physicians. The recommendations identified above place a clear target on inter-professional communication and better communication with the patient to identify new symptoms and gaps in histories.

Of particular concern is drug-induced disease which is the first option for new symptomatology in elderly patients. Pharmacists are well positioned to identify drug-induced disease in individuals. In a larger sense, conditions are often identified through histories and leading questions to elicit problems or causes that the patient may not associate with disease. The bottom line is that the identification and correction of errors is

options in order to ensure that the Law of Large Numbers does not mandate financial loss for insurers.

Source: Mathews, A. W. (2016, February 1). Aetna Reports Surge in Profit and a Dark Spot on Results. Retrieved February 23, 2016, fromhttp://www.wsj.com/articles/aetna-profit-rises-38-1454326988

everyone's problem and require a team to correct.

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