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CounTinG
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The Science of Dreams, Disorders and Disease
I have to find a new doctor.

Last month, my primary care physician wrote me a letter. He said he was leaving private practice. He’s an outstanding physician—a doctor’s doctor whom I’ve known since he was a medical student. His reason for closing up shop? The sheer frustration of getting paid by private insurance companies.

When a physician of his stature and skills departs private practice for a reason like that, it is an indictment of our health care system—that is, if we had a health care system. We all know the U.S. has great physicians and the world’s best medical technology. But the best health care system? Not in the least. Our crazy patchwork quilt is an accident of history and one that we need to fix. It fails us in so many ways, from its gross inefficiencies to the fact that it has left 47 million Americans without health insurance.

The evidence of our ailing health care system is pretty clear: Despite spending twice as much (more than $7,100 per capita) as the rest of the industrialized countries, we have poor health outcomes. Our life expectancy is below many other industrialized countries’ and perhaps more significantly our life expectancy has improved less than that of nearly all industrialized countries in the last 20 years. On some health status indicators the U.S. is near the top, on many near the middle and on some near the bottom. Not very good value for the extra money we spend. Where does the money go? Some of it is lost to inefficiency. We all know you get 10 pieces of mail for every procedure or hospital visit and almost certain confusion about what you’re supposed to pay. In addition, our fee-for-service model encourages utilization of resources, especially expensive technology. Lastly, systems that emphasize primary care have lower costs and better outcomes than those that don’t, but we have created incentives that push physicians away from primary care and into increasing specialization.

We have inherited a system that doesn’t work and desperately needs to be fixed.

Every system is perfectly designed to obtain the results it produces. Ours produces poor outcomes, inadequate access and great inefficiency.

This was the challenge that President Barack Obama vowed to address. Six months ago, his administration’s leadership on health care looked like our best chance in a generation for genuine reform. However, the political compromises that have been made thus far make it clear this historic opportunity will probably increase the number of Americans with insurance coverage but not reduce growth in costs.

To put things in perspective, let’s look back on another historic opportunity that our government did embrace. Almost half a century ago, our government committed to improving the health and economic welfare of older people in the U.S. by creating Medicare. And Medicare has been a tremendous success. Before it was instituted, 29 percent of those 65 and older lived in poverty. After Medicare, that proportion fell to about 10 percent because it provided health insurance coverage to all Americans over age 65. Since then, the health status of older people has improved markedly. Even its critics admit that Medicare’s administrative costs are a fraction of those of private insurers.

Medicare is not perfect, of course. Despite its warts, however, Medicare has been a success and a huge benefit to our older population. Now, we need to take that kind of step for the rest of Americans.

As I write this, I am not sure what the outcome of health care reform efforts will be. The sausage will go through the grinder, and we’ll get, in my view, a suboptimal solution. Far from wallowing in disappointment, however, I’m moving on and so should our country. President Obama’s reforms can serve as the foundation for the more comprehensive fix that’s needed. Call it Reform 2.0.

If we want true health care reform, we need a single-payer system. In this system, the government would act as administrator, paying for all patient visits, prescription drugs, medical procedures, and so on. Instead of thousands of different insurance companies, HMOs and others with all of their separate forms and billing contacts, doctors, hospitals and others would deal with a single administrator—eliminating waste in our system. At a large hospital, this would dramatically reduce overhead costs, allowing hundreds of people to be retrained so that their talents could be directed to ways that would have greater societal benefit than paper shuffling.

Those of you shaking your heads and saying it can’t be done should know that it has been done—repeatedly. Korea in the 1980s and Taiwan in the 1990s, for example, revamped their health care systems. They have multiple insurers but only follow the same rules. Korea’s and Taiwan’s leadership (including many of our alumni) scrutinized health care programs around the world and chose a system that works best. It is not socialized medicine. The hospitals and providers do not work for the government, they work for private organizations. They just don’t have to deal with the time-sapping, unnecessary administrative burdens of our inefficient system.

Every system is perfectly designed to obtain the results it produces. Ours produces poor outcomes, inadequate access and great inefficiency. It places tremendous burden on both providers and payers and drives great doctors like mine to other careers. As hard as it is, we must completely reform our system. Otherwise we risk bequeathing to the next generation the same problems we struggle with today.
Navigating Ethical Quandaries in the Field

What is the right way to treat people? When Maria Merritt, an assistant professor in International Health and core faculty at the Johns Hopkins Berman Institute of Bioethics, digs into data from her studies, that question guides her.

More specifically, she asks of the data, What is the right way to treat the people who participate in community-based public health field trials in low-income settings?

“There’s little, if any, established guidance,” says Merritt, PhD. “If investigators want to do the right thing, they have to figure it out on their own.”

Most of the bioethics work so far applies to the researcher-participant relationship in relatively well-funded clinical settings. Bioethicists provide plenty of guidance on issues such as informed consent and genetic testing. But in a field trial in Bangladesh, for example, the ethical questions that arise look different.

One such question is that of parallel treating. If study workers in a maternal health field trial encounter participants who suffer from injury or malnutrition, should they treat the participants for their co-morbidities? Parallel treatment, or ancillary care, stirs up further quandaries: How much is enough? Could the treatment jeopardize the study? The questions go beyond ancillary care, as well. Study teams sometimes have opportunities to provide benefits for the community at large—chlorinating a well, for example—and have to make decisions about how much to do.

To answer these questions, Merritt and her colleagues Holly Taylor, also a core faculty member at the Berman Institute, and Luke Mullany, assistant professor in International Health, have a project under way.

The team has amassed a body of qualitative data from Bangladesh, Nepal and India. The data consist of feedback from seasoned investigators and senior field directors collected during interviews: The participants relay challenges they’ve experienced in the field and their responses to the problems. Merritt and her colleagues are looking for the common threads.

“You need to know what these experienced practitioners see, what stands out,” says Merritt.

While there are broad ethical guidelines in place for international trials, Merritt would like to focus on operational guidelines for the particular ethical challenges presented by low-resource, low-tech communities, where the study is not taking place in a clinical facility. Her hope is that these guidelines would lead investigators to explore things such as the study site’s local health care infrastructure, existing programs that could do parallel treatment, the population’s burden of disease, and options for referral and collaboration.

“Investigators navigate intuitively through these situations,” says Merritt. “I’d like to connect and document the data we have, which encompasses best practices.”

In part, Merritt’s endeavors will be supported by the Greenwall Foundation, which named her this year’s recipient of the Greenwall Faculty Scholars Program in Bioethics career development award. The award is intended to support early career research among young bioethicists.

—Christine Grillo

Maria Merritt wants to guide researchers on ethical challenges they face while carrying out projects in low-resource settings.

Chad Boult, MD, MPH, MBA, director, Roger C. Lipitz Center for Integrated Health Care, and the Eugene and Mildred Lipitz Professor in Health Care Policy, Health Policy and Management (HPM), has been awarded a Health and Aging Policy Fellowship, funded by The Atlantic Philanthropies. (See page 38.) He also will receive the 2009 Medical Economics Award for Innovation in Practice Improvement co-sponsored by the Society of Teachers of Family Medicine, the American Academy of Family Physicians, and Medical Economics magazine.

Diane Griffin, MD, PhD, Alfred and Jill Sommer Professor and Chair in Molecular Microbiology and Immunology, was named the recipient of the 2009 Pioneer in Neurovirology Award by the International Society for Neurovirology.

Bernard Guyer, MD, MPH, Zanvyl Krieger Professor of Children’s Health, in the Department of Population, Family and Reproductive Health, received the David Rall Medal from the Institute of Medicine for outstanding service as chair of the Board on Children, Youth and Families. He also was named the 2009 recipient of the Lifetime Achievement Award by the Coalition for Excellence in MCH Epidemiology.

Thomas Hartung, MD, PhD, the Doerenkamp-Zbinden Professor and Chair for Evidence-Based Toxicology, is the 2009 recipient of the Russell and Burch Award, offered by the Humane Society of the United States.
Rafael Irizarry, PhD, professor, Biostatistics, was named the 2009 Presidents’ Award recipient by the Committee of Presidents of Statistical Societies (COPSS) and was named a fellow of the American Statistical Association. The Presidents’ Award honors early career contributions and is offered jointly by the five major statistical societies comprising COPSS. Irizarry also was recognized by ScienceWatch as one of the world’s most cited researchers of the last decade.

Hee-Soon Juon, PhD, associate professor, Health Behavior and Society (HBS), served as organizing committee co-chair of the second biennial Global Breast Cancer Conference (GBCC) 2009 in Seoul, Korea, in October. Debra Roter, DrPH ’77, MPH ’75, professor, HBS, and Janice Bowie, PhD ’97, MPH, associate professor, HBS, served as members of the GBCC International Steering Committee and were invited speakers.

The Board on Children, Youth and Families of the National Research Council and Institute of Medicine, chaired by Robert Lawrence, MD, the Center for a Livable Future Professor, Environmental Health Sciences, was named the recipient of the Society for Adolescent Medicine’s 2010 Hilary Millar Award for Innovative Approaches to Adolescent Health Care, to be awarded in the spring. Lawrence was also chosen by his colleagues to receive the 2009 Sedgwick Memorial Medal for Distinguished Service in Public Health, on behalf of APHA.

Silvia Martins, MD, PhD, assistant scientist, Mental Health, was elected a member of the American Psychopathological Association and of the Epidemiology Section of the World Psychiatric Association. Martins recently became associate editor of BMC Public Health.

Jean B. Nacheza, MD, MPH ’99, associate scientist, International Health, was recently appointed an Honorary Professor in the Department of Medicine, Faculty of Health Sciences, University of Cape Town in South Africa.

Myaing Myaing Nyunt, MD, PhD, assistant professor, International Health, received a Faculty Development Award from the PhRMA Foundation.

David Peters, MD, DrPH ’93, associate professor, International Health, was elected the director of the Health Systems Program in the Department.

Jason Rasgon, PhD, assistant professor, MMI, was named a 2009 Innovator of the Year by The Daily Record (Maryland).

George Rebok, PhD, professor, Mental Health, has been selected to be the 2009 Gary Andrews Visiting Fellow for the Australian Association of Gerontology.

Noel Rose, MD, PhD, professor, MMI, was awarded the Nicolaus Copernicus Medal by the Polish Academy of Sciences. The award is the Academy’s highest honor.

David Sack, MD, professor, and Alain Labrique, PhD ’07, MHS ’99, assistant professor, both of International Health, received a Technology Transfer SEED Award.

Daniel Scharfstein, ScD, professor, Biostatistics, was named a fellow of the American Statistical Association.

Keerti Shah, MD, DrPH, professor, MMI, was recognized by ScienceWatch as one of the world’s most cited researchers of the last decade.

Donald Steinwachs, PhD, professor, HPM, received the 2009 Carl Taube Award from Mental Health America for his numerous contributions to the field of mental health services research.

Donna Strobino, PhD, professor, PFRH, received the 2009 Excellence in Teaching Award from the Coalition for Excellence in MCH Epidemiology.

A paper co-authored by Elizabeth Stuart, PhD, assistant professor, Mental Health and Biostatistics, was named a 2009 “New Hot Paper” in the field of economics and business by ScienceWatch.

Youfa Wang, MD, PhD, associate professor, International Health, was elected chair of the Nutrition Epidemiology Section, American Society for Nutrition (ASN), and became an adjunct professor at both the School of Public Health, Peking University, and the School of Medicine, Xi’an Jiaotong University.

Keith West Jr., DrPH, MPH, professor, International Health, was elected the director of the Department’s Human Nutrition Program.

David Celentano Named New Chair of Epidemiology

David Celentano, ScD ’77, MHS ’75, has been appointed chair of the Bloomberg School’s Department of Epidemiology. A longtime Epidemiology faculty member, Celentano is an internationally recognized scholar in the prevention of HIV and sexually transmitted infections. He is the principal investigator of four NIH–supported studies in Thailand, focusing on interventions that harness peer networks for risk reduction. Celentano is a fellow of the American College of Epidemiology and a member of the American Epidemiological Society. In 2006, he received an honorary doctorate from Chiang Mai University; it was conferred by Her Royal Highness Princess Maha Chakri Sirindhorn. Celentano will be officially installed as the new Epidemiology chair early next year.
The Best Investment

As everyone knows, the University’s Knowledge for the World Campaign wrapped up at the end of last year as a resounding success. The campaign benefited the School in many ways, but the area of greatest need remains: support for students. Although the campaign increased our scholarships (both in number and dollar amounts), our students still need much more support than we can provide. They are, after all, not entering the field for its financial rewards.

This School’s essential mission is to educate the best students to become the best public health leaders. A degree from the oldest and best school of public health in the world does not come cheap. The cost of an education at the Bloomberg School makes it impossible for some to attend unless they receive financial support. To expand our support and make sure that the very best students continue to come to the Bloomberg School, Dean Michael J. Klag has made support for additional scholarships a top fundraising priority.

As someone who was unable to attend my first choice for a university because of finances, I can personally relate to the frustration this causes. Everyone should be able to attain his or her education goals. Existing scholarships at the School have made it possible for us to educate such outstanding students as the Sommer Scholars, Brown Scholars, Johnson & Johnson Scholars, P&G Fellows, De Beers African Scholars and recipients of other programs. Students who have been awarded these scholarships clearly demonstrate academic and research acumen, but they also are acquiring knowledge and skills that will make them leaders in public health. Think of the legacy that a Bloomberg School education will make possible. As these students devote the rest of their careers to public health, imagine the discoveries they will make in the lab, the programs they will lead in the field and the policies they will create in the halls of governments around the world. That is true impact.

That’s what drives those of us who work to raise funds for the School. For us, it is an exciting, challenging time. I like to think that one day we will have scholarship funding available for any student who needs it. It’s an audacious goal to be sure, but one we should all work to achieve.

Imagine the possibilities.

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Letters to the Editor

Better Ways to Keep Howard Healthy?

Since I left JHSPH, in 1971, I have worked in the field of social health insurance in about 40 countries. It is not easy to understand why the U.S. has not been able to achieve equity in access to adequate health care for all. “Keeping Howard Healthy” [Summer 2009] was therefore a pleasant surprise. However, I question why such an important initiative, which could be expanded and replicated, is not based on good practice?

First, why is the coverage offered on an individual basis, and not on a family basis, to avoid adverse selection, and increase the size of the pool? It is fairly simple to work out premiums for all family members. Second, why is coverage limited to a specific income bracket? The near poor and families with incomes of over US$66,000 may not be able to afford unexpected, expensive but necessary surgery. Third, why is there only six primary health care visits per year? Health insurance is not like purchasing a subscription to a planned series of events; the need for health care is usually unpredictable. In all the social health insurance systems I have been involved in, we scrapped such limitations. Fourth, the provision of pro-bono services by specialists is not an adequate basis for expansion and replication. Neither is free care by hospitals. Why not find a way to include these services?

Aviva Ron, ScD ’70, ScM ’68
Netanya, Israel

Andy Barth, Director of Communications for Healthy Howard and Howard County Health Dept., responds: We appreciate the kind words. Dr. Ron would like our efforts at providing care for all to be perfect, and so would we, where we fall short of that standard it is simply due to a lack of funding. Why do we provide six visits to a primary care doctor a year? Since the average American visits his primary care physician 2.3 times a year, we hope and believe six will be adequate. Why rely on pro-bono care in some instances? Because we don’t have resources to pay for all services. Our county and our country have come a long way toward more equitable care this year; we hope constructive critics like Dr. Ron will continue to help us forward.

Proof of Purpose

As a college student myself, I was particularly interested in your article on lowering the drinking age [“Proof,” Summer 2009]. I cannot argue with data, and if studies show that a lower drinking age would only serve to exacerbate a serious problem, then I won’t say it makes sense. However, it is quite apparent that the population is not heeding the laws. I’ve seen many alcohol awareness programs, and they all say the same thing and have the same effect: none. Spending money on helping students find a purpose in their lives, helping them focus their attention, would combat drinking more, as they would be more inclined to pursue tangible goals, rather than party every weekend.

Matt Getz
University of Florida

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