Health Care Issues;  
Costs Reduce Access to Care; 2003

Costs are increasing rapidly for health care.

High costs lead to bad impacts on companies, government budgets, and insurance.

If governments try to control the costs of health care
  • There will be huge pressure on the government to just pay the health bills.
  • But with rising unit costs and more retirements, this trend cannot be sustained.

It is a very difficult situation to handle.
  • But it will be impossible to avoid the problems forever.

It is frustrating because health care can be so good and so needed.

For most economic services, the following applies:
  • The buyers of the service pay for the service.
  • The providers of the service compete on the basis of both the quality of the service and the cost.
  • This usually leads to good quality and reasonable costs. But it is hard to make the health market work like this.

There are many health topics here and 55 pages.

RJ0270

Roy Jenne
Feb 13, 2003
Health Care Issues; Costs Are Killing Access to Care

Roy Jenne
Feb 12, 2003

The costs of health care are again going up very rapidly. This hurts health care users; it is hurting the budgets of companies and it is killing government budgets. The result is that the government cannot pay for other needs and more people go without health insurance.

Suppose that we financed cars the way we finance health care. Then cars would be very expensive.

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Health-Care Cost Explosion
Will Trickles Down to Workers

THE SHARPEST RISE in years in employee health-care costs is spurring employers to make the most significant changes in their workers’ insurance plans since the managed-care revolution took firm hold in the early 1990s.

This wave of bad news, despite the nation’s preoccupation with terrorism and a sluggish economy, is expected to make health care a major political and personal concern in 2003, and a hot campaign issue in 2004. Already, companies are passing along the cost increases by raising premiums, co-payments, and deductibles to a degree not seen in years. Some small employers are eliminating coverage altogether, which is certain to swell the ranks of the uninsured.

While most nonunion workers can do little to stop employers from making drastic changes, many Americans are increasingly going to seek out and employ the few consumer tactics available to them, such as, most notably, buying prescription drugs from Canada, using generics more often, or buying medicines in bulk.

Although some folks can employ such strategies to keep out-of-pocket expenses in check, no amount of collective consumer behavior is likely to stem the sharp rise in health-care spending anytime soon. That, in turn, is certain to increase the still-small ranks of policy makers and politicians who believe it is finally time for some kind of overhaul of the nation’s health-care system.

Employer surveys released in the past week report that the cost to employers of providing health benefits rose about 15% on average this year—more than seven times the rate of inflation. Employer health bills are likely to surge by a similar amount again in 2003, the surveys say. These back-to-back increases are the largest percentage gains since 1989 and 1990. Put simply, health-care inflation, which cooled off in the mid-1990s, is raging anew.

This new round of cost increases is going to be felt by many more people than in the past,” says Barry Shilmeister of Mercer Human Resource Consulting. “More and more, employers are going to be exposed to what their health care really costs.”

Mr. Shilmeister says employers are making changes that will force workers to pay a larger portion of their health bills, or simply cut back on medical services, especially for care not deemed essential or an emergency.

The current cost explosion is more painful than in the past for the simple reason that the percentage jumps are coming on per-patient annual expenses double what they were in 1990. “Employers who have absorbed increases in the past tell us they can’t do it anymore,” says Edward Kaplan, a health-benefits consultant with Segal Co.

Health Care Costs Explode, Again

Medical plan cost per active employee, by plan type:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>2002</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional/Indemnity</td>
<td>$5,642</td>
<td>$4,838</td>
</tr>
<tr>
<td>Preferred Provider Organization</td>
<td>$5,227</td>
<td>$4,544</td>
</tr>
<tr>
<td>Point Of Service plans</td>
<td>$5,219</td>
<td>$4,653</td>
</tr>
<tr>
<td>Health Maintenance Organization</td>
<td>$4,803</td>
<td>$4,167</td>
</tr>
</tbody>
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*Includes dental and other related healthcare costs.

and a backlash against the restrictions by managed-care plans that had been able to keep costs increases under control during much of the 1990s. “No amount of tweaking of company plan designs or passing along of increases are going to make us a dent in medical inflation,” says Paul Ellwood, a veteran health-care reformer. Dr. Ellwood, who leads an ad hoc task force called the Jackson Hole Group, is joining a chorus of policy specialists who believe the time is finally ripe for the implementation of universal coverage in which patients and medical providers have economic incentives to use health care in a radically different way.

But calls for change in the past have failed because of pressure from competing interest groups, as well as a deeply embedded American culture that, understandably, often expects the very best care no matter what the cost. As employers, consumers and government providers begin to feel the full weight of the new cost increases, the time for change may finally be upon us.

Send comments to prescriptions@wsj.com

Dec 12, 2002
Wall Street Journal

Dec 12, 2002

[Image 0x0 to 610x789]
Costs Are Rising Fast in Health Care

By Peter Landers

Health-care costs are rising even faster than feared, according to a survey from Towers Perrin that says the costs of health-benefit plans at big companies will rise an average of 15% in 2003. The consulting firm predicts that the higher costs will impel many companies to consider "consumer-driven" plans that try to lower costs by giving employees more responsibility for their health spending.

The survey is the latest to show rapid inflation in health-care costs even as overall inflation is tame at about 2% a year. Jim Foreman, managing director of the global health practice at Towers Perrin, said the firm had anticipated a rise of about 10% to 12%. He said businesses are searching for ways to cut costs but aren't likely to succeed quickly. "It's really a conundrum," Mr. Foreman said. "Businesses can't charge their customers 15% more."

The survey asked 285 companies how much they have agreed to pay in insurance premiums in 2003. Companies that pay their employees' health expenses directly—under so-called self-insured plans—were asked how much they would have paid for insurance had they bought it. Overall health-benefit costs will rise 15%, according to the survey, but the cost for companies will rise at a slightly slower pace because they are shifting more costs to employees.

For example, employees will bear 22% of the cost for family coverage in 2003, up from 21% this year, the survey said. The average employee at a big company will contribute $250 a month for health care, up from $264 this year. Employees who get coverage only for themselves will contribute 19% of their health-care costs, up from 17%. These employees will pay an average of $48 a month, up from $38, according to the survey.

The higher costs may drive more companies to consider plans under which employees get a lump sum to spend on health care. The Internal Revenue Service ruled this summer that such payments don't constitute income and aren't taxable, giving a crucial government imprimatur to the idea. "Most of our clients have investigated it," Mr. Foreman said. "We'll see if biggest organizations move forward next year.''

Health-Care Reformers Regroup in Jackson Hole

By Laura Landro

JACKSON HOLE, Wyo.—Consumers, empowered by information technologies, could be the new driver of health reform.

That is the radical idea put forth here at a recent meeting of the Jackson Hole Group, a band of health reformers who spearheaded the concept of health-maintenance organizations in 1970 and later stimulated national debate over the Clinton administration's health reform package.

The group went into retreat after that debacle, but founder Paul Ellwood has quietly started to muster his forces again, inspired by the promise of new information technologies to help deliver care and measure its quality. Dr. Ellwood, who last month convened the first meeting of the loose-knit group in six years, will continue to lobby for some form of universal health-care coverage—one of the group's original animating principles.

But in place of its past emphasis on "big-time health policy aimed at politicians, insurers, payers and providers," he says, the group will focus on "advocacy for immediate steps to give patients more power in the health system."

At the center of Mr. Ellwood's ambitious new proposal is a voluntary system of electronic medical records that would be transportable over the Internet, but owned and controlled by individual patients. Instead of "being secreted away in files in innumerable physicians' offices and hospital records rooms," Dr. Ellwood says, each person's lifetime medical history, or "personal health journal"—from blood tests to drug allergies to insurance data—would be compiled in one record. Patients could make it available to any health-care provider.

New technologies would further enable patients to get access to information about treatments based on medical evidence, and tools to help them judge the performance of their doctors and hospitals. For instance, patients would contract for a fee with a physician or medical group, to provide content individually tailored to their needs, from alerts about new medical breakthroughs, to health warnings, reminders, appointment scheduling and referrals. Empower patients, the theory goes, and much of what ails the system can be cured.

The timing of the group's current initiative may work in its favor. The issue of health reform has started to percolate in Washington again, spurred by alarming cost increases.

But the barriers to the Jackson Hole proposal are formidable. Electronic medical records exist but are still available to only a fraction of the U.S. population. There is no easy way for one medical record to share records with another. Hospitals and other providers contend they don't have the money to add electronic patient medical records, given the cuts in Medicare reimbursement. Skeptics at the meeting pointed to privacy issues and whether the swelling ranks of uninsured Americans weren't a more pressing problem.

Still, the idea intrigued those who have witnessed the advantages of technology in health care. And successful models for an electronic medical record already exist at institutions, including Veterans Health Administration and Boston-based Partners' Healthcare Group.

Dr. Ellwood, a pediatrician and neurologist who left the practice of medicine in 1969 to pursue national health reform, advocates the creation of a new Institution for Medical Practice and Technology, or IMPACT, to help communities install transportable, voluntary Personal Health Journals. The Veterans' program in New York is his model.

HHS Inspector Releases Rules On Drug-Marketing Practices

By Chris Adams

WASHINGTON—The federal government, on the lookout for anything that smells of kickbacks or fraud, is cautioning drug makers to mind how they market drugs to doctors.

The Department of Health and Human Services inspector general released guidance spelling out what it sees as acceptable pharmaceutical marketing practices. For starters, drug makers should be wary of offering financial or other incentives to persuade doctors to prescribe their drugs.

Already, major drug companies have updated contracts and made other changes since PhRMA's guidelines became effective July 1. "Companies are more serious about ensuring that the reps comply with the law," said John Benvitiglio, a Washington health-care lawyer.

In the past, drug sales representatives rewarded doctors with meals, bottles of wine, tanks of gas, trips, books, baseball tickets and even Christmas trees for merely listening to short sales pitches. The latest PhRMA guidelines allow only an occasional modest meal accompanying a scientific discussion.

Other practices are encouraged as well. Because many consumers are at this in-between type of universal health-care coverage—one of the group's original animating principles.
WHAT'S AILING COMPANIES: MEDICAL BILLS

With fierce competition ensuring razor-thin margins—and limiting companies' ability to raise prices—execs will continue to seek ways to cut expenses. But one area where costs figure to keep swelling is health-care coverage.

While the Labor Dept. recently reported that overall worker pay and benefits are up only 3.7% from a year ago, unpublished estimates show employer health-benefit costs surged an estimated 11.2%. And that pace is expected to accelerate next year. Management consultant Towers Perrin estimates that health-plan costs for large companies will jump 15% in 2003 (chart). That would boost the average total cost to $9,216 per employee with family coverage. Those spiraling costs can quickly subtract from earnings.

The burden won’t be felt equally across Corporate America, though. "The biggest hit is being taken by companies that have older workers with more heavily unionized contracts," says Standard & Poor's chief economist David A. Wyss. That includes industries such as manufacturers, utilities, and telecom. Ford Motor Co. shells out $2.5 billion for health coverage for 620,000 current and retired employees and dependents. One reason for the hefty bill: While the average company picks up 80% of insurance costs, the auto maker pays 100% of the premium for its hourly workers. And for the most part, Ford's hands will be tied until at least next September when the latest contract with the United Auto Workers comes up for renewal.

What's fueling health-care inflation are new drugs and medical technologies, greater utilization of new technology by doctors, and the consolidation of health-care companies, which have more power to force price hikes. Insurers pass along those cost increases and then some. In response, more employers plan to raise co-payments and deductibles and increase the portion of premiums paid by employees. And they have more leverage to do so— with the unemployment rate up to 5.7% in October, valued workers are less likely to bolt for another job.

Still, companies are being forced to find other ways to combat the rise in health costs. More employers, including Bank of America, are rolling out free voluntary education-and-treatment services for employees and dependents with chronic conditions such as diabetes. Those employees, on average, account for roughly 75% of claims paid out. The upshot is less emergency care and better work attendance, which means companies can "affect the bottom line while also improving the quality of care," says Blaine Bos, a principal at Mercer Human Resource Consulting LLC. Prescription drugs are another area where companies are looking to save. Ford is working with insurers to prescrip the same daily dosage in fewer pills.

Insurers, hospital groups, and makers of high-tech medical gear will continue to be the big winners from the rise in health costs. Boston Scientific Corp., which just introduced a new artery stent, forecasts double-digit sales gains for the "foreseeable future."

Eventually, the economy will pick up enough to alleviate the strain that health care is putting on bottom lines. But until then, businesses mired in slow growth will be under increasing pressure to squeeze out productivity gains and hold down hiring. One way or another, rising costs of health care will continue to be a bitter pill for most employers.

By James Mehring in New York

The explosive increase in medical costs hurts the finances of companies.

- And it hurts nearly all of the workers in the US economy.
- When costs go up, then fewer families have health insurance.
- These high costs rip at workers, government, companies, etc. They are a huge problem.
- There is no valid reason why costs should increase this fast.

Roy Jenne
Jan 2003
Companies Pass The Buck on Benefits

In Weak Economy, Employees Have to Pay More For Health, Retirement Plans; The $50 Co-Pay

By RON LIEBER
And BARBARA MARTINEZ

IF YOU AREN'T healthy, wealthy and wise, the rising costs of employee benefits will hit you squarely in the wallet next year.

Faced with meager profits and a sputtering economic recovery, a growing number of companies are asking workers to take a hit on the two most valuable benefits: health insurance and retirement accounts. Because of higher premiums and co-payments, workers already are paying 27% more for health-care coverage than they were in 2001, according to the Kaiser Family Foundation, a health-care philanthropy in Menlo Park, Calif. Meanwhile, Goodyear is about to suspend its matching contribution to employees' 401(k) plans altogether, joining companies such as Ford Motor and DaimlerChrysler that have already taken similar steps.

In other cases, companies are scaling back benefits that they added in better days. Wal-Mart Stores, the world's biggest retailer, will stop covering employees' visits to chiropractors next year. Acuity Brands, a maker of lighting fixtures and specialty chemicals, will no longer cover in vitro fertilization.

The pared-back benefits underscore how quickly labor priorities have changed for U.S. corporations. In the booming 1990s, their biggest worry was attracting and keeping good workers in a tight labor market. Now, with the economy limping along and unemployment up, corporations are turning their focus to slashing labor costs. Benefits typically represent about 27% of total labor costs, according to U.S. Department of Labor statistics.

The cutbacks are a rude awakening for many American workers. Although small companies often trim benefits in slow times, most big companies have continued to improve their benefit packages until recently. Now the tide may be turning, starting with companies in industries that are under relentless pressure to reduce costs.

Despite the difficulty of switching jobs, employees aren't taking all the proposed cuts quietly. General Electric recently jacked up health-insurance co-payments for workers and certain retirees. Some GE workers were so upset that they gave their union authorization to strike if necessary. Workers at Wal-Mart have declined the company's offer to redirect some of their retirement-plan contributions to pay for health-insurance increases.

The tough benefits picture makes it increasingly important for workers to understand how to maintain the best possible safety net. In the case of health care, employees who have access to flexible-spending accounts can save money by contributing pretax dollars to pay for co-payments and other medical expenses their insurance doesn't cover. On

Please Turn to Page D2, Column 3
Where Are Health Care’s ‘Hondas’?

By Alain C. Enthoven

Since the beginning of this election season, the received wisdom in Washington has been that for Democrats to eke out mid-term gains against a popular president, the focus must be on domestic issues. Many have aimed their campaigns at the economy and education, but the perennial issue of health-care costs still dominates concerns in many markets. Problem is, the high costs and inefficiencies that plague the market won’t change until competition forces old models to be redesigned.

Remember the decline of the American car—that time not long past when Detroit’s gas-guzzlers were best known for being expensive and unreliable? It didn’t last long. Within a few years, a flood of cost-effective imports like Honda and Toyota had sucked up market share and forced America’s auto industry to improve. Why can’t we have Hondas and Toyotas in health care?

One day spent operating within the artificial constraints of the health-care market would drive a company from any other industry to the brink. Most people get their health insurance through company plans, and it is in the structure of these plans that the market has gone awry. The employers of 75% of insured employees do not offer a choice of carrier. Even so-called choices between plans all use mostly the same doctors.

What employers need is competition among alternative delivery systems, each with a carrier partner that shares their commitment to passing on its lower cost to customers. Instead, at the moment, the choices look unappealing. Single source managed care cannot be effective because, to satisfy employees, employers must require such insurance plans to include practically every doctor and hospital in town, leaving insurers no leverage. On the other hand, effective managed care must be selective, including only providers committed to working together to improve quality and reduce cost. Effective managed care must be voluntary for both doctors and patients.

Research and experience show that many people happily choose selective networks, but people who are forced into them are very likely to be dissatisfied. Many employers choose a single source because of administrative costs and concerns about adverse selection. Carriers prefer to have each group to themselves, and offer a lower premium if they can cover the whole group. This may work in the short run, but it isn’t working in the long run.

To reduce administrative costs, employers should create shared health-insurance exchanges that bring together several or many risk-bearing health insurers, and several or many employment groups for the purpose of arranging multiple choice of carrier on the part of individual employees. Administrative costs can be shared, while health care costs need not be.

When will Washington start listening?

The federal government and several states have exchanges for public employees. If private sector employers don’t follow suit, the federal government ought to create incentives for them to do so, such as exemption of participating carriers from state benefit mandates. If this doesn’t happen, nothing will stand in the way of an endless upward spiral in health-insurance premiums.

Most employers that do offer choice of carrier pay the whole premium, or some flat, high percentage, like 60%, denying “Honda” the opportunity to pass the full savings to the employee subscriber. It is very hard for “Honda” to compete on value for money in a market where employers systemically subsidize the competitor to the tune of 60% of the potential cost savings.

Given these market incentives, it would not be surprising to see the “Hondas” wise up and quit positioning themselves as value competitors. The RAND Health Insurance Experiment found in the 1970s and 1980s that the Group Health Cooperative of Puget Sound provided high-quality care for 28% less than the traditional fee-for-service sector in Seattle. But these systems don’t get very far.

In fairness, it hasn’t been an easy road for employers. Many got into earmarking the 100% or 80% of the premium of the plan of the employee’s choice to take advantage of the tax break for employer-paid health care. For others, misguided union demands got them there.

What the “Honda’s” need is for most employers to offer multiple choice and expose employees to full responsibility for premium differences so that the “Honda’s” can enter the market, grow and achieve economies of scale. Employers must create health-insurance exchanges to promote competition on value. Then maybe we’ll finally have a normal market where the “Honda’s” and “Toyotas” can compete for customers.

Mr. Enthoven, professor emeritus at the Graduate School of Business at Stanford, is a director of eBaoX Inc.

Wall et al.

Oct 24, 2002

- Employers need competition among health care delivery systems
- Can the Hondas enter the market?
Health spending rises along with uninsured

By Marsha Austin
Denver Post Business Writer

The number of uninsured residents in Colorado increased in the last decade while health care spending almost doubled, according to a report released Thursday. The Coalition for the Medically Underserved, the organization that produced the report, wants to know why, with so much money being spent on health care, there isn't enough to pay for the working poor who have no insurance. The group's goal is to achieve health insurance coverage for every state resident by 2007.

"Based on such a huge annual expenditure, we should be able to provide basic health care coverage to every Coloradan," said Dr. Gary VanderArk, coalition chairman.

Critics say the coalition's perspective smacks of socialized medicine. They argue that Colorado's increased spending on health care simply means medical care is getting more expensive, not that there's extra money for the uninsured.

Spending by the government, private health plans and individuals rose to $14 billion in 1998 from $7.7 billion in 1990, coalition officials said. Since 1990, the number of uninsured residents has climbed to 700,000 from 516,450.

The doubling in health spending compares with a 29 percent increase in overall consumer prices for metro-area residents for the same time period, according to the Bureau of Labor Statistics.

Among the reasons for rising health costs are an aging population, explosion in prescription drug use and HMOs' failure to keep a lid on health care costs.

One of the critics of the coalition's position is Bill Lindsay, a health care consultant for Denver-based Benefit Management and Design.

"What that speaks of is Big Costs on SC next page"
Health tally lifts red flag

COSTS from Page 1C

Brother,” Lindsay said. “Is someone going to deny that (an auto-accident victim) doesn’t get trauma care because we need more money for maternity programs and child care?”

Colorado’s personal health costs could be a red flag to legislators and taxpayers.

The coalition estimates the state spent $2,440 per person — including Medicare members — on health care in 1998, which is the latest year data are available. Using the coalition’s calculation, the 700,000 uninsured would cost Colorado another $2 billion in 1998 dollars.

The cost could be higher if administrative costs were included, Lindsay said. Or, if many of the uninsured are young and healthy, the cost could be less, he said.

Private health plans spend an average $2,200 per member per year — less than the coalition’s estimate because Medicare patients are excluded.

Despite the report, the coalition, sponsored by the Colorado Medical Society Foundation, is not ready to make any specific recommendations on how to provide health insurance to the underserved, said Chet Seward, coalition program director.

Its members just want to raise awareness about the growing number of Coloradans who can’t get the medical care they need, Seward said. The group is also gathering feedback from residents by hosting town meetings.

“I think it’s great some legislators are going to freak out and say, ‘This is going to cost more money,’” Seward said. “We’re asking, ‘Are there ways we can spend this money more efficiently?’”

The coalition’s report, which will be issued in full this fall, found that the bulk of medical spending goes to hospitals and doctors, which accounted for about two-thirds of Colorado’s medical bills in 1998.

Pharmaceutical drugs made up 7.1 percent of the bill, followed by nursing homes at 6.6 percent.
Why You Can't Buy Insurance

The press corps is playing up new Census Bureau figures showing that the number of Americans without health insurance grew by 1.4 million last year to 41.2 million. That's a story, all right, but we also hope they now focus on one of the main reasons—the federal and state government policies that make insurance so expensive to buy.

We refer to the exploding number of laws mandating that health insurance cover this disease or that medical procedure. This summer the National Association of Manufacturers warned that such mandates could force some employers to drop their health insurance benefits. And the Census study suggests many are doing just that. The proportion of Americans who get health insurance through their job fell for the first time in nearly a decade.

Yet you'd never know this is a problem by reading media coverage of the latest mandate working itself through Congress, the bill sponsored by Senators Pete Domenici and Paul Wellstone requiring more mental-health coverage. They're hailed as moral titans for wanting to strengthen a 1996 law they co-sponsored requiring "parity" in insurance coverage for physical and mental illness.

Now, mental-health insurance in some form makes medical sense. Diseases such as schizophrenia and bipolar disorder have definite, and often treatable, biological causes, and are precisely the sorts of debilitating conditions health insurance would help manage. As psychiatric medicine has advanced, private insurance coverage has moved to include such treatments.

But the current draft of Domenici-Wellstone needs, well, some Prozac of its own. The bill would require that most medium and large businesses insure employees for every one of the conditions listed in the American Psychiatric Association's 941-page Diagnostic and Statistical Manual—conditions that include, for example "social phobia" (irrational fear of embarrassment).

Do you have the urge to travel without a clear plan, often under an assumed identity? Then you may be a reporter, a politician, or you may suffer from a "disorder" that the APA's manual labels "dissociative fugue." This is an invitation to a lifetime of Woody Allen psychotherapy. Refusing to recognize the reality of schizophrenia is a scandal, but so is requiring coverage that will raise costs and price more people out of any kind of health insurance, mental or physical.

There are currently very few such federal health mandates. But over the past four decades state legislatures have passed more than 1,500, requiring that insurers cover everything from infertility treatments to wigs for cancer patients. Together with procedural mandates such as "community rating" (insurers can't price based on differing risk factors such as age) and "guaranteed issue" (you can wait until you're sick to buy insurance), they are largely responsible for the vast disparities in the cost of health insurance among states. A self-employed 30-year-old man in Westchester, New York, would have to spend more than $250 a month to insure himself. If he moved a few miles away to Greenwich, Connecticut, he could do it for about $36.

Mandates hurt those who can least afford it. Large employers that "self-insure" are exempt from state mandates under the 1974 Employee Retirement and Income Security Act. Instead, the burden falls on small business and the self-employed. According to a recent study from PricewaterhouseCoopers, mandates were responsible for 15% of the $67 billion increase in health spending in 2001. And the Health Insurance Association of America estimates that mandates are the reason one in four uninsured Americans lacks coverage.

For years mandates sailed through state legislatures with large majorities since politicians saw them as an easy giveaway to constituents without having to tax and spend. But soaring costs and the increasing number of uninsured are finally starting to have an impact.

Stung by a 25% increase in health-insurance premiums for the state retirement system, California legislators shelved plans earlier this year to require HMO coverage of such things as bone-density screenings and hearing aids; they also created a commission to study the costs and benefits of each proposed mandate. And Maine Governor Angus King vetoed a mental-health mandate for some of those disorders in the APA manual: "We cannot allow the best [comprehensive coverage including full mental health benefits] to become the enemy of the good [any coverage at all]."

The real scandal in American health insurance isn't that some people lack coverage for this or that treatment, but that tens of millions of Americans risk financial ruin because of policies that make basic insurance difficult or impossible to buy.
Conflicting Claims
Doctors, Insurers Brawl Over Software That Shaves Bills

Health Plans Say ClaimCheck Cuts Fraud; Physicians See Giant Blow to Bottom Line

Second Opinion on a Biopsy

The patient walked into the office of gynecologist David E. Rogers in Allen, Texas, complaining of heavy, irregular bleeding. Dr. Rogers followed his usual routine, performing an examination and asking a series of questions about the woman's health and habits. He took a biopsy to check for cancer. The doctor's office then sent her insurer, Cigna Corp., a bill for $250, for both the exam and biopsy.

The payment back from Cigna: just $173 for the biopsy. Cigna's software chopped the $75 office-visit charge out of the bill before sending the doctor his check. Cigna's explanation to Dr. Rogers: The biopsy charge already included the cost of an office visit.

"They call it claims processing," grouses Dr. Rogers, who says such bill cutting by Cigna and others has eaten away some 30% of his income in the past six years. "I call it fraud against doctors."

Such disputes are mushrooming into one of the most vicious battles ever waged between health insurers and physicians. Cigna and hundreds of other health plans have in recent years begun employing arcane software programs that automatically—and unilaterally—slice and dice physicians' bills to what the insurers think is a more appropriate payment. The insurers say the main purpose is to guard against doctors who try to pad their claims. They view the software as an important tool in the effort to keep down soaring U.S. health-care costs, which hit $1.3 trillion in 2000, the latest year for which figures are available.

"Because providers and their staffs often make errors—and some providers file fraudulent claims—it is important to..."
Insurance Rise Closes Parts of Some Hospitals

Continued From Page 1

fallen apart," said Sam Cameron, the chief executive of the Mississippi Hospital Association. "There is a so-called Golden Hour in which a patient with a serious head injury needs to see a specialist like a neurosurgeon, and in some areas of our state that service is no longer available."

In West Virginia, two hospitals closed maternity wards and several hospitals no longer have either neurosurgeons to treat head injuries or orthopedists to mend broken bones, said Steven Summer, the chief executive of the West Virginia Hospital Association.

In New York City, many of the biggest hospitals have kept their insurance prices down by creating their own nonprofit insurance companies. No reductions in service have been reported in the city or elsewhere in the state.

Steven M. Visner, an insurance specialist at Ernst & Young, the consulting firm, said many hospitals had inquired about starting their own insurance companies. But it takes more capital than most of them have, he said, and exposes the institution to greater risk than buying coverage from a commercial carrier.

The New Jersey Hospital Association says insurance costs in the state have nearly doubled in the last year. Gary Carter, the chief executive of the association, said that although most services were being maintained, some New Jersey hospitals say specialists are balking at taking on-call duties in emergency rooms. "But this is just beginning in New Jersey," he said. "We're expecting to see hospitals increasingly cutting back on services."

Insurance costs have also risen sharply in Connecticut, said Ken Roberts, a spokesman for the Connecticut Hospital Association. But he said the association had received no reports of service curtailments.

Around the country, hospitals say they are cutting services because the high cost of their own insurance is overwhelming and because specialists, unwilling to bear the new costs for insuring their practices, are becoming scarce.

Some specialists, for example, have abandoned life-long practices and started anew in states where malpractice insurance prices have yet to escalate. Many obstetricians and surgeons are restricting themselves to low-risk procedures. Still other specialists have become consultants, providing advice but leaving actual treatment to others to avoid medical malpractice insurance altogether.

The costs have become truly staggering. Premiums for doctors have doubled and tripled, in some cases, rising to as high as $200,000 a year for obstetricians in Fort Lauderdale and Miami. But even those prices begin to look mild compared with gargantuan insurance bills for hospitals.

In Philadelphia, for example, the cost of malpractice insurance at Thomas Jefferson University Hospital, which operates several hospitals, doubled this year, to $32 million. As a result, on June 30, Jefferson closed the maternity unit in its Methodist Hospital in South Philadelphia and cut 270 jobs at Thomas Jefferson and at the Jefferson Hospital for Neuroscience.

In June, the Brandywine Hospital closed its trauma center, which served the southwestern suburbs of Philadelphia, and the Paoli Hospital, also near Philadelphia, closed its paramedic unit, said Andrew Wigglesworth, the president of the Delaware Valley Health Care Council.

Many obstetrics units have struggled financially because of growing competition and reduced payments from the federal government and private insurers. That was the fate of the obstetrics unit that closed on Friday at Mercy Hospital in West Philadelphia.

"We had been subsidizing the program because we had the resources," said Gavin Kerr, the chief executive of the Mercy Health System. "But as the malpractice premiums increased, that dramatically shrunk the resources.

"There are other obstetrics programs in the community," Mr. Kerr added, "but you want to have a baby as close to home as you can, in as comfortable a place as you can."

Concern for the safety of mothers grows when maternity wards close. Since early July, when the Atmore Community Hospital in southern Alabama shuttered its ward, women have had to travel 15 miles, to Brewton, Ala., for a hospital with an obstetrics department.

The roots of the crisis are complex. The insurance companies, President Bush and the American Medical Association largely fault the rising cost of awards in malpractice lawsuits. From 1985 to 2000, the average jury award jumped more than 70 percent, to $3.5 million, and a few claims since then have run to more than $40 million, according to Jury Verdict Research in Horsham, Pa.

J. Robert Hunter, the insurance director of the Consumer Federation of America, attributes the soaring premiums to insurance companies' mismanagement. The insurers acknowledge that through most of the last decade they dropped premium prices while battling for more business from doctors and hospitals, depending for profits on financial reserves and returns from booming equity and bond markets. Now, with Wall Street in a slump, the insurers say they must increase prices to survive. Mr. Hunter and other consumer advocates say the price shock is intolerable.

Mr. Bush and the A.M.A. are campaigning for a federal law that would limit claims for pain and suffering to $250,000 in each malpractice case. The medical association is also urging state legislatures to take similar action. Already this year, lawmakers in Pennsylvania and Nevada have imposed lawsuit limits, and Gov. Ronnie Musgrove of Mississippi is expected to call a special session of his state legislature to confer practice insurance costs.

Advocates of reducing the insurers have to pay for mistakes often cite California model. In the 1970's, California ceiling of $250,000 for jury for pain and suffering, and $100,000 for all insurance prices have been there. But Harvey Rosenfield Foundation for Taxpayer and Consumer Rights in Santa Monica says patients have suffered, and the cap on payouts, he says, makes for repress practice victim, making it for them to pursue claims.

Joanne Doroshow, the director of the Center for Ju Democracy, a national c group based in Manhattan, says on the civil courts, threat of high jury award keeps doctors and hospitals at their best.

Though many doctors Doroshow's reasoning often nearly all favor limits awards, some acknowledge pressure to avoid any cl can push our insurin even higher is causing them practices that enhance patien ty.

"We can't control what the companies are charg said Dr. Craig Miller, the chical officer for Baptist Health Pensacola, Fla., which operates a community hospital in re
Now Hospitals Are the Ones Squeezing Insurers

Continued From First Page

threaten its members to a rival hospital down the street.

Now the tables have turned, and more aggressive hospital operators are beating managed-care companies at their own game. "The end result is cost is going up without a clear link to more or higher-quality services being provided," says Peter Lee, president of the Pacific Business Group on Health, a coalition of big West Coast employers.

The turnaround in health care comes at a time when economic forces are leading industry after industry to gravitate toward a few major players. Hospitals are following a pattern set by airlines, telephone companies, cable corporations and banks, all of which are gaining new clout with consumers as they merge into giants.

Higher hospital rates—along with increasing doctors' fees and pharmaceutical costs—mean higher premiums for corporate and individual insurance. Today major carriers, such as Aetna and Cigna Corp., are raising premiums 10% to 20% a year, the largest increases in a decade. That is prompting many employers to require workers to pay more for health coverage. All told, 166 million people have insurance through their jobs. About 39 million Americans lack insurance, according to the 2000 Census.

Most of the newly assertive hospital operators have built local bulk through mergers and acquisitions. In a $1.3 trillion national health care market, with more than 5,000 hospitals, there were about 700 mergers from 1996 to 2000, according to Irving Levin Associates Inc., a New Canaan, Conn., health-care information firm. That is a marked increase from earlier years, industry analysts say.

In Cleveland, two hospital systems now control 68% of all the beds in an area that serves two million people. In Grand Rapids, Mich., one hospital system controls nearly 70% of a market of one million residents.

The Justice Department and Federal Trade Commission tried in the 1980s to prevent such acquisitions, but the big regional insurer refused to accept rate increases, HCA wouldn't provide health-plan treatment for 1.3 million Humana members in Florida. The warning had punch because HCA operated 52 hospitals throughout the state.

Managed-care companies grumble that such threats have become routine preludes to rate negotiations. In Florida, Humana representatives were quoted in local newspapers dismissing HCA's threat as a "negotiating ploy" and calling the rate demands "outrageous." Talk of local hospitals becoming off-limits rules up residents of a region, who then tend to pressure their federal Medicare reimbursements for care of the elderly hospitals nationwide have lost about $76 billion in government money, according to the American Hospital Association, a trade group in Washington, D.C. Many hospitals have compensated by increasing rates for insurers.

Hospital operators also point out that new and more expensive technology has driven up costs. For example: traditional x-ray machines that cost $175,000 are increasingly being replaced by more powerful CT-scan devices that go for $1 million each.

Separately, mounting federal and state regulations, such as those requiring new record-keeping methods to protect patient privacy, are adding billions of dollars of new expenses for hospitals across the country, according to the AHA. Within a hospital, no one knows how much the cost of increasing services is offset by the cost of improved technology.

In all, other hospital heavyweights argue that consolidation has heightened efficiency, which will improve care and, eventually, lead to lower prices. In Richmond, HCA's five hospitals use one centralized automated-pharmacy dispenser. The computerized system, dubbed "Regis Fill Bin," cuts out some human labor costs, HCA says. The system also protects patients by eliminating common human errors in the delivery of prescriptions, the company says.

HCA says it also cuts costs by combining administrative offices for hospitals in a single region and, in some instances, having them share expensive diagnostic equipment.

Some corporations seeking health coverage for their current and former workers complain they haven't detected significant advances in hospital quality. "In the short term, I haven't seen quality improvements that will offset rate increases that are coming from the hospitals," says L.I. Williams, executive director of health care initiatives at General Motors Corp. GM spent $4 billion on health care in 2000.

The federal courts have resoundingly endorsed the hospital industry's argument that consolidation has beneficial effects. Since 1995, federal and state antitrust enforcers have lost all seven cases

Increasing Dominance, Rising Costs

Oligopolies formed by HCA and other major hospital chains have helped pump up health care costs

Market Maker

HCA's market share in six cities, based on admissions and days spent in the hospital

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<thead>
<tr>
<th>City</th>
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<tr>
<td>Richmond, Va.</td>
<td>41%</td>
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<tr>
<td>Austin, Texas</td>
<td>41%</td>
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<td>Las Vegas</td>
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<td>Denver</td>
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<td>Tampa Bay, Fla.</td>
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<td>Houston</td>
<td>22%</td>
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Higher Costs

Spending in U.S. hospitals, in billions

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Increased Spending

All healthcare spending as a percentage of GDP

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Corporate Burden

Amount spent on health benefits, per employee

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Sources: HCA, U.S. government statistics; Mercer Human Resource Consulting

almost as much as its combined income for 1998, 1999 and 2000.

Some nonprofit chains, such as Sutter

health plan to meet the hospital company's health plans, insurers executives maintain.

On the eve of the Florida contract's

Londo

Continued

year, Ecuador's Joshua Chelanga, a bunch of nobodies in the men's division, agreed to support women's virgin Emma Ndiel Nothombi in his debut marathon in his debut in the 42-km. "The next best thing," Mr. Morse with Wimbledon, "the Indy 500."
W

ith the American health-care system steaming flank speed toward the iceberg, tinkering with insurance plans does have the air of rearranging

Deck Chairs. But, hey, some deck chairs are nicer than others. When time comes to pick up the debris and try again, the creators of a new system may be able to salvage good some ideas.

The recently unveiled "consumer-driven health plans" could be worth a second look. About 1 million Americans have switched to this kind of insurance, and many more companies are about to offer it.

These plans differ widely, but here is an example of a good one: The boss puts $600 in your tax-free medical-spending account. This money goes to cover visits to the doctor, prescription drugs and other health-care costs. If you spend more than $600, you pay the next $600.

Should you exhaust both the employer's and your contributions, some sort of traditional insurance coverage kicks in to pick up the rest.

If you spend less than $600, whatever is left stays in the account for the following year. (Say you have $250 left — that plus a fresh infusion of $600 gives you $850 the next year.) Finess of consumer-driven health care note that it gives you, the consumer, complete control over which doctors you see, which treatments you get and which drugs you buy. And because the employer contributions are yours to spend or save for future years, you have an incentive to shop around for the best deals. You will probably question how doctors arrive at their charges and seek out lower-cost generic drugs.

Consumer-driven health plans do have their critics. They worry that for some sick people, the prospect of having to spend hundreds of their own dollars will push them to forgo needed tests or skip treatment altogether.

I'm not very sympathetic to this argument. Americans have no difficulty spending hundreds on auto insurance or cable television. Where is it written that health care must be totally free? In any case, the employee's exposure is limited. The plan takes over in the event of a catastrophic illness.

Yet despite their virtues, consumer-driven plans can only chip away at the iceberg. The health-care system is too big, and any change alters the relationship between the parts. For example, the presence of consumer-driven insurance alongside the usual managed-care options could destroy the latter. The healthy young worker who spends only $300 on medical care in a typical year will make a beeline for the savings plan. Sick colleagues with big medical bills will not, leaving the traditional plans with all the expensive customers.

Consumer-driven plans could serve as a useful model for encouraging everyone to spend medical dollars more wisely. Take Medicare, where costs are exploding. Medigap insurance pays expenses that Medicare doesn't cover. Thus, an elderly American with a Medigap policy can devote five hours a day to visiting doctors and not spend an extra penny of his or her money. Wouldn't it make sense to have a system in which beneficiaries have to dig into their wallets at least a little whenever they use medical services? There is also something wrong with asking American workers to carefully manage their health-care dollars while the U.S. government allows prescription-drug companies to charge them exorbitant prices.

Consider the case of someone taking Lipitor, a popular cholesterol drug. A year's supply of 20-milligram Lipitor tablets could cost $1,000 (almost twice the Canadian price).

Meanwhile, other bad developments are propelling the health-care ship into the ice. The ranks of the uninsured continue to rise. Close to 42 million Americans have no coverage at all. HMOs continue to pull out of the Medicare system, leaving thousands of beneficiaries stranded. And with Medicare payments slashed, many doctors are refusing to take elderly patients at all.

Then there's the cost of employers' health-insurance premiums. They have multiplied 12 times over the last decade. Some companies are dropping insurance altogether. Some are sharply increasing the workers' co-payments and deductibles. Many are cutting back on health benefits for their retirees.

So consumer-driven health insurance plans, if generously constructed, do hold promise for people lucky enough to qualify for them. But these deck chairs can hold up just so long under a system in distress. The way things are going in American health care, the lifeboat could be the next place to look for seating.

Froma Harrop (harrop@projo.com) is an editorial writer and columnist for the Providence (Rhode Island) Journal-Bulletin.
Prescriptions / By Michael Waldholz

Bush’s Coming Medicare Plan Won’t Assuage Critics, Doctors

Long overdue, a proposal to overhaul Medicare is expected later this month from the Bush White House. But many critics argue that the changes being considered won’t make the elderly happy, or calm the clamoring of complaints from the medical profession.

Few dispute that Medicare, enacted in 1965, is an agency that needs some intensive care. Despite its numerous problems, Medicare provides essential coverage of physician and hospital services for some 40 million elderly Americans at a relatively low premium charge of about $705 a year (a $940-a-year deductible and a 20% co-pay for doctor visits typically adds more to the bill). But Uncle Sam’s tab for this benefit is swelling by almost 8% a year, is expected to have risen to more than a quarter-trillion dollars in 2002, and will be almost double that by 2010, gobbling up increasingly huge portions of the nation’s domestic budget.

Pointing to the latest spending data released Tuesday, Tom Scully, who runs the agency that administers the government’s health plans, said, “If ever there was an argument for Medicare and Medicaid reform, this report is it.”

President Bush is likely to argue that the best way to restrain costs while adding new benefits, such as a prescription-drug option, is to offer the elderly a menu of plans from competing private insurance companies. Insurers, the theory goes, will want the increased business, and vie for it by offering a host of goodies not now readily available. Under such a plan, seniors would pay higher premiums and probably have to agree to join some kind of managed-care plan, and in return get a drug benefit, more preventive-care services, and, if they can afford it, maybe even nursing-home insurance. To encourage more people to opt out of the existing plan, the federal government might subsidize premiums for those with lower incomes. Those who don’t want the expanded benefits would be allowed to stay in the current plan.

The logic here, still largely unproved, is that private insurers driven by a profit motive will do a better job than the federal government in containing costs, steering patients to providers who offer discounts to the plans, and encouraging use of less expensive medicines such as generics or brand-name products bought in bulk.

Democrats and consumer advocates are sure to argue that this strategy was tried in the 1990s and failed miserably. Millions of elderly joined private HMOs under a program called Medicare + Choice, mostly to get prescription-drug coverage and doctor visits that cost little or nothing. But as many of the sickest seniors rushed into these plans, and the federal government failed to increase payments to match the rising cost of their care, insurers stopped offering the option, forcing seniors to scramble for new coverage.

Up, Up, and Away
Medicare spending, in billions

<table>
<thead>
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<th>Year</th>
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<td>1970</td>
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Sources: Centers for Medicare and Medicaid Services; Health and Human Services Department

Critics say Washington is trying to use the spending crisis to privatize Medicare, and shift more costs to seniors. A survey by the Medicare Rights Center, a New York group, found that seniors don’t want to join managed-care plans that restrict access to doctors in return for drug coverage. Robert Hayes, president of the group, says it isn’t likely private insurers will want to enroll the truly sick who need the extra benefits the most.

Hospitals and doctors say their idea of reform is for higher payments, not smaller ones. Medicare reduced doctor fees 9% the past two years. As a result, 24% of physicians say they will limit the number of Medicare patients they see, according to the American Medical Association.

Health-care experts, meanwhile, say Medicare reform ought to be part of a larger change in the nation’s approach to health care. In particular, they say, seniors and others would benefit if all Americans were insured, allowing insurers to spread their risk among the healthy as well as the sick. They also argue that folks who are the costliest to insure, such as those with chronic illnesses such as heart disease or diabetics, would benefit from a system that aggressively monitors their health and offers incentives for using preventive-health services.

Another idea that would save money and improve care would be the creation of a national electronic medical-records system that would be easily accessed by any health provider. This approach might help avoid costly medical errors caused when doctors or emergency rooms aren’t aware of a patient’s existing illnesses or treatment regimens.

Most Washington observers believe the Bush administration needs to promote reform to keep Democrats from making political hay of the issue next year. Democrats aren’t likely to give Republicans such a victory. Amid the political wrangling, seniors will likely have to wait at least another year to get the kind of real reform that will save money and improve their care.

Send comments about Medicare to Prescriptions@WSJ.com

Jan 9, 2003
Wall Street Jour
Shot in the Arm

Generic Drugs Find Potent New Formula: Friends in Congress

Political Currents May Carry Their Brand-Name Rivals To Rare Legislative Defeat

Closing Patent-Law Loopholes

By Laurie McGinley
And Chris Adams

WASHINGTON—When it comes to politics, generic-drug makers used to be about as potent as a placebo.

Many lawmakers could afford to ignore them and did. The companies' own lobbyists couldn't agree on what policies to push. Their deeper-pocketed and better-organized brand-name rivals undermined them at every turn, with the help of generous political donations and armies of lobbyists.

But now, thanks to a confluence of politics, economics and scandal, the generic-drug industry appears within reach of a big victory on Capitol Hill. That win would come at the expense of the brand-name drug industry, which is used to getting its way in Washington.

The Senate is poised to vote on legislation that generic-drug makers say would help them speed cheaper drugs to market, benefiting consumers, employers and government health-care programs. The measure would close patent-law loopholes that its supporters say let brand-name drug makers excessively delay the introduction of cheaper generic versions of their drugs.

The brand names say the bill would slow the pace of new-drug development by making it harder for them to recover their hefty research and development costs.

The two sides have been making those arguments for years. But plenty has changed. With control of both the House and Senate at stake, the looming November elections have increased pressure on lawmakers to rein in soaring drug costs.

Fed up with rising medical costs, big employers, such as General Motors Corp., Eastman Kodak Co. and Caterpillar Inc., have joined consumer groups and insurers in pushing for action. At the same time, the recent wave of corporate scandals has increased public mistrust of big business, making it trickier for lawmakers to line up alongside the big brand-name drug manufacturers.

Over the past two years, the generic-drug makers—smaller, often closely held companies—have overhauled their Washington operations. They have consolidated their three often-bickering trade groups into one, the Generic Pharmaceutical Association. As its leader, the GPhA this year hired Kathleen Jaeger, an energetic 38-year-old attorney, pharmacist and Republican. People who know her say she has a flair for making lawmakers understand the nuances of patent law.

The generics industry's fortunes could still sour. Supporters believe that

Please Turn to Page A10, Column 1
The Real Tenet Scandal

At first glance the furor over Tenet Healthcare looks like one more corporate scandal, with a plunging stock price amid revelations that the hospital giant faces both a federal audit and government raids at its hospitals. But look more deeply and what you find is a story of the perils of running a public company in the regulatory maze known as Medicare.

It's a complicated tale, because Medicare is itself so bizarrely complex. But bear with us for the telling, because, as the nearby chart shows, the consequences for Tenet shareholders have been all too real, and dismaying. And the lessons apply to any modern health-care manager who has to operate in the political netherworld of Medicare contracts.

Health-care providers have been gaming Medicare since that federal insurance program evolved into a system of Soviet-style price controls in the 1980s. Medicare pays a fixed amount for a treatment, regardless of costs, and in turn companies search for loopholes in the system's 100,000 pages of regulations to make up the difference. Sooner or later Medicare discovers the "loophole," closes it and the cycle starts all over.

Tenet and many other hospitals found their loophole in what Medicare terms "outlier" payments, a kind of bonus payment to hospitals to cover patients whose care proves to be unusually expensive. Here's how it works:

Every hospital maintains a chargemaster list—a "retail" price list for its procedures and products—which it uses to negotiate fees with managed-care companies. But Medicare also uses the charges in calculating its "outliers." The agency knows that the charges are inflated, so each year it compares a hospital's chargemaster list with the facility's actual cost reports, and then discounts.

If a fictional Tenet hospital charges $100 for pneumonia, but it actually costs the hospital $50 on average to treat pneumonia, Medicare discounts the $100 by $50, since the hospital's cost is $50, and through its price gouging regulations, Medicare is paying the hospital $50.

Tenet's outliers make up nearly a quarter of the company's projected revenue from Medicare this fiscal year, and were $412 million more in 2002 than just two years ago. Medicare has finally caught on, and Mr. Barbarakow has had to admit that fixing the loopholes will "expose Tenet to earnings risk that other companies may not have." No kidding.

Tenet was also slow to disclose information about the first raid, and we've since learned that company insiders sold stock just prior to the outlier revelations. Charges of fraud aside, this is bad corporate governance and explains why so many Tenet holders have hit the road. A separate probe into Tenet doctors accused of

Off a Medicare Cliff

Tenet Healthcare's stock price

Source: Nasdaq

All that being said, Tenet has done a disservice to one group: its shareholders. CEO Jeffrey Barbakow says he was unaware of the increased outlier payments, and that's plausible given his non-hospital background. But the recent, abrupt departures of COO Thomas Mackey, author of the company's aggressive pricing; and CFO David Dennis suggest that someone at Tenet knew. Tenet's earnings growth and rocketing share price were driven by outlier payments that were bound to end sooner or later, yet shareholders weren't let in on the secret.

Tenet is a government bureaucracy that fails years behind on its bills, its calculations are a joke, its audits are a joke, and its controls are a joke. When Tenet raises its prices, the actual cost to the hospital is $50. Medicare, using its old $50 outlier formula, would figure the cost at $150.

None of this is illegal: Tenet has the right to raise its charges and benefit from doing so. Not to mention such practices are fairly common. None of this is good corporate governance. Tenet's share price fell 30% from $50 million in 2001.

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Physicians Revive House Calls, Lured by Medicare Fees

By KELLY GREENE

It's 8 A.M. on a recent Tuesday, and Aaron Hurowitz, an Atlanta internist, pulls his Grand Marquis into Sandra Powell's driveway. Black bag in hand, he's ready for his first appointment.

"I'm so glad you're here," says Ms. Powell, who lives here with her mother, Chestina Sharp, 89 years old, has been in bed since breaking her hip last summer. She watches silently as the doctor rolls down her sock to reveal a purplish sore on her left heel.

After a 30-minute examination, Dr. Hurowitz says he wants to call in a wound specialist to help diagnose the problem with Ms. Sharp's foot. Concerned for the daughter, too, Dr. Hurowitz says he will contact a hospice agency so she can get a break. Back in his car, he calls the family's pharmacist to adjust Ms. Sharp's prescriptions.

"I can make house calls on little pieces of time that aren't important to my office practice," Dr. Hurowitz explains, "and we can keep people out of the emergency room."

He also can bill Medicare $130 for a comprehensive home visit such as this one—roughly $50 more than what he would charge for a comparable office visit. As a result, the 52-year-old family practitioner is thinking about making house calls full-time one day, when he sells his office practice.

At a time when Medicare has cut reimbursements and many medical practices treating elderly patients are in the red, a small but growing number of doctors are reviving the house call to help pay the bills. Nobody knows exactly how many doctors are doing it, but the number of home visits that Medicare paid for shot up almost eight-fold to 1.5 million in 2001 from 196,700 in 1996, according to the Centers for Medicare and Medicaid Services.

"Interest is picking up," says Peter Boling, professor of geriatrics at Virginia Commonwealth University School of Medicine, in Richmond. In pockets from San Diego to Detroit, he says, doctors are making thousands of home visits each month. The national caseload is potentially enormous: At least two million Americans are chronically ill and homebound, Dr. Boling estimates.

Until the 1990s, when advances in medical technology and a boom in hospital construction helped shift treatment almost entirely to the office, nearly half of all doctor-patient contact occurred during home visits. House calls had largely disappeared by 1966, the year the federal government created Medicare, the national health-insurance program covering 40 million elderly and disabled Americans. Reimbursement rates for house calls were set at basement levels and stayed there.

But in the mid-1990s, Dr. Boling and other members of the American Academy of Home Care Physicians, a 700-member group based in Edgewood, Md., began telling regulators that house calls to the elderly were just as complicated and time-consuming as the office visits Medicare was reimbursing more generously. After two years of negotiations, Medicare in 1998 finally raised payments for home visits by as much as 50%.

House-call doctors say home treatment for many elderly patients will cost less over the long term than repeated trips to the emergency room, extended hospital stays or even nursing-home care. Home visits are certainly necessary in cases when the alternative would be no care at all, they say.

Some urban hospitals are adding house-call doctors to their staffs. Knight Steel, a geriatrician and director of Hackensack (N.J.) University Medical Center's Homecare Institute, started a house-call practice on July 1 with two doctors and two
Future Retirees’ Benefits Clouded

One in Five Major Firms May Pare Health Coverage, According to New Survey

By Peter Landers

About one in five large employers is very or somewhat likely to end health benefits for future retirees, according to a new survey. People who have already retired are likely to hold on to their benefits but may bear more of the cost.

The figures come from a survey of 435 companies that have more than 1,000 employees and currently offer health benefits for retirees. It was conducted by the Kaiser Family Foundation, a nonprofit research group, and consulting firm Hewitt Associates. About half of companies with more than 1,000 employees pay for retiree health care, says Kaiser, which isn’t affiliated with Kaiser Permanente, a California health-maintenance organization.

The Kaiser-Hewitt survey says the 435 big companies each paid about $28 million on average to cover retirees’ health care in 2001, and that cost is rising about 16% this year. The rate of increase is slightly faster than the 13.7% increase in costs for active workers reported in an earlier Hewitt survey.

Companies are especially worried about the high costs for retirees under 65 because these people often have heavy medical expenses and aren’t covered by Medicare, the government program for the elderly that kicks in at age 65.

Asked what changes they’re likely to make over the next three years, 6% of the responding companies said they are very likely to terminate benefits for future retirees. An additional 18% said they are somewhat likely to do so.

Frank McArthur, a researcher in Hewitt’s Washington office who was the study’s lead author, said companies that end coverage for future retirees usually do so only for employees under age 35 or 40. “Most people in their 40s or 50s who are counting on these benefits are less likely to experience” a cutoff, he said.

Also, companies that end retiree health benefits often permit retirees to stay in the company health plan provided they pay the full cost. Although people have to pay more in such cases, their costs are lower than if they walked into an insurance broker off the street to buy fresh coverage.

Mr. McArthur said the survey shows that younger employees need to think about how they will cover their health-care costs after retirement, since they can’t assume their company will foot the bill. “Saving for retiree health care has been an overlooked aspect of financial planning,” he said.

Current retirees are in a much safer position unless their company is in bankruptcy or close to it. Only 1% of companies said they are very likely to cut off current retirees, and 4% said it is somewhat likely.

However, retirees are likely to be paying a greater portion of their bill. The survey said 64% of companies are very likely to increase retiree contributions to insurance premiums, and 54% are very likely to increase cost-sharing when retirees get treatment or take prescription drugs.

Coverage for retirees has already been eroding in recent years. According to Mercer Human Resource Consulting, the percentage of employers with more than 500 employees who offer medical coverage for retirees under age 65 fell to 23% in 2001 from 46% in 1993. For retirees 65 and over, the percentage fell to 23% from 40% over the period.

Venture Bets on Wi-Fi in Public Places

By Nick Wingfield

And Shawn Young

In a potentially significant boost for wireless Internet access, AT&T Corp., Intel Corp. and International Business Machines Corp. said they are backing a new venture that plans to deploy a nationwide wireless data network in coffee shops, hotels and other public venues.

The new venture, called Cometa Networks Inc. of San Francisco, will install wireless-access devices in locations throughout the U.S. and operate the network. But the company won’t sell the service directly to users, instead relying on Internet service and telecommunications providers to market to, bill and support customers.

Larry Brilliant, Cometa’s chief executive, said the venture’s goal is to search firm In-Stat/MDR estimates users will snap up about 16 million Wi-Fi devices, which typically plug into laptops and other computers, this year.

It remains to be seen whether a broadly available Wi-Fi network can be a financial success, though. A number of large and small companies are beginning to deploy so-called hot spots where wireless access is available—Deutsche Telekom, Sky Dayton, chief executive of Boingo Wireless Inc., a company that provides wireless access through partners in 950 locations, said a national Wi-Fi network operator is “something I’ve been saying for a long time needs to happen in this space.”

Mr. Dayton said he would like Boingo to enter into a partnership with Cometa, even though the two companies will, in some cases, compete for the same customers. Executives wouldn’t say precisely how much Cometa, previously known by the code-name Project Rainbow, would have to pay to deploy its wireless network. Theodore Schell, a general partner at Apax Partners Inc., a venture-capital firm that’s funding Cometa, said wireless antennas, each capable of serving a range of 100 to 500 feet, will cost about $500 apiece. That suggests a $10 million investment in wireless gear to install about two thousand access points by ’04.

‘We’re talking about deploying a network with tens of thousands of access points’ by ’04.'
Medical funding group calls for clamp-down on hype

David Adam, London

Researchers who talk to the press prematurely about unpublished research could soon face harsher sanctions than the odd disapproving glance from a colleague. Under research misconduct guidelines just released by an association of British medical charities, they could be blacklisted for funding, the head of the association says.

Diana Garnham, chief executive of the London-based Association of Medical Research Charities (AMRC), which issued the guidelines on 17 October, says its members are fed up dealing with the fallout from over-hyped or misleading results. “Scientists don’t do their work in a vacuum,” she says. “There is an audience for whom their work is directly relevant, and they need to bear that in mind.”

The guidelines state simply that researchers should be “especially careful” when discussing incomplete work, and are intended to coax universities and other research institutions into drawing up their own rules. They also point out that the aim of disseminating research “should not be primarily to seek publicity for the researcher, the research institution or the funder.” From January next year, the AMRC says it will recommend that its members fund only researchers at institutions that have published specific standards for sound scientific conduct.

The AMRC counts major research funders such as the Wellcome Trust and Cancer Research UK among its members — but it remains unclear how much impact the new proposals will have. The Wellcome Trust has already issued guidelines of its own, which came into force earlier this month (see Nature 412, 667; 2001).

Robert Terry, a senior policy adviser at the trust, says that the charity is unlikely to act immediately on the new recommendations.

Research on the health risks of the MMR vaccine reached the press before it was finalized.

“They are a useful addition but I don’t think we would go that far,” he says. The existing peer-review process of grant applications can already take into account bad publication practices or the over-promotion of results, Terry claims.

But the AMRC says that more action is needed to deal with what it says are a small but nonetheless significant number of incomplete research findings — such as those concerning a possible link between childhood autism and the combined measles, mumps and rubella (MMR) vaccine — that are promoted by researchers and then heavily reported in the press.

“When scientists want to protect the commercial outcome of their research they stay in control of the timing of its release, so why should this be any different?” says Garnham. “We don’t go as far as saying that their funding should be cut off — but I think some of our charities would be willing to do that.”

Others observers say that it will be hard to hold researchers accountable for premature release of their results, still less for their misinterpretation by the media. “Some sort of quality-control mechanism is needed,” says Bob Ward, a spokesman for the Royal Society, which will shortly announce its own inquiry into the dissemination of research results, “but it’s not a straightforward issue.”
Backlash Is Brewing Among Companies Who Believe Flashy Ads Drive Up Costs

By Thomas M. Burton
Staff Reporter of The Wall Street Journal

General Motors Corp. spent $55 million last year for something totally unrelated to steel, tires—or to cars at all. It was for Prilosec, the expensive little purple pills for heartburn.

The auto company's overall cost of drugs for workers and retirees shot up 14% last year, to $1.3 billion. A prime culprit was direct-to-consumer advertising, say GM executives. And they regard Prilosec, as the No. 1 drug expense at GM, as a case in point: It was heavily advertised for years, is often unnecessary in GM's view and costs 13 times as much as a leading generic.

"Are drug company ads driving up health-care costs? You bet," says Woody Williams, GM executive director of health-care initiatives. "Not everyone with heartburn needs the purple pill."

Direct-to-consumer drug advertising exploded in 1997, when the Food and Drug Administration loosened restrictions, and it has revolutionized drug marketing. The result has been a torrent of ads hawking medicines just like soda, sometimes using celebrities as pitchmen. An ad for Zocor, the cholesterol drug, shows NFL coach Dan Reeves talking to kids and saying: "Taking care of my cholesterol has become an important part of my game plan." And Olympic gold-medalist Dorothy Hamill appears in an ad for Vioxx, while lacing her skates she confides: "Along with all the great memories has come something I thought I'd never experience—the pain of osteoarthritis."

But a backlash is brewing from companies who think drug advertising steers consumers away from cheaper alternatives. Ford Motor Co. recently started a pilot program at one hospital offering a financial incentive to doctors' groups for prescribing more generics. GM launched a "Generics First" campaign early last year promoting generics in e-mails, paycheck stubs and corporate newsletters; the company's pharmacy-benefits provider also drops off free samples of generics at doctors' offices. So far, the efforts have increased the share of generic drugs prescribed to GM employees by 3%, saving some $36 million.

Meantime, a coalition of companies included:

Please Turn to Page B4

Drug Makers Offer Coupons for Fre

But Patients Still Have to Get Their Physician's Approval, And Most Don't Pay for Pils

By Gardner Harris

The Ad Inundation
Spending Takes Off
Total ad spending for prescription medications, in billions

Who Spent

The top advertiser

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Agencies Join in Dru

More than telling American consumers why they need a particular medication, advertising agencies are increasingly working with large pharmaceutical companies in the earliest stages of drug development.

In a potentially controversial practice, agencies are helping drug companies recruit patients for clinical trials and are even conducting medical experiments in agency-owned labs. In the past, such crucial groundwork was solely the purview of the drug makers and took place a decade or more before an agency came into the picture.

"What you're seeing is an emerging convergence of the clinical development and the commercialization of drugs," says Thomas Harrison, chief executive officer of the Diversified Agency Services division of Omnicom Group Inc., the New York parent to BBDO Worldwide, DDB Worldwide and TBWA Worldwide. He adds: "The ultimate goal is to make drug development more efficient."

According to the Pharmaceutical Research and Manufacturers of America, the industry trade group, drug companies invested an estimated $30.3 billion in research and development last year.
[Health Care]

THE OVERTREATED AMERICAN

One of our biggest health-care problems is that there's just too much health care. Cutting down on the excess could save enough to cover everyone who is now uninsured.

BY SHANNON BROWNLEE

Americans enjoy the most sophisticated medical care that money can buy—and one of the most vexing health-care-delivery systems. We spend about $1.2 trillion each year, two to four times per capita what other developed nations spend, yet we can't find a way to provide health insurance for 41 million citizens. After a brief respite in the 1990s when HMOs held down expenses by squeezing profits from doctors and hospitals, medical costs are once again soaring by 10 to 12 percent a year. Yet reforms proposed by Congress and the White House are only nibbling around the edges of the problem.

Such political timidity is understandable, given the experience of would-be reformers of the past. Any attempt to expand coverage for the uninsured while holding down costs inevitably raises fear in the minds of voters that the only way to accomplish these seemingly opposing goals is by restricting access to expensive, life-saving medical treatment. Sure, we feel bad about the 18,000 or so of our fellow citizens who die prematurely each year because they lack health insurance, and about the seniors who are forced to choose between buying food and buying medicine. But Americans want nothing to do with a system like England's, which, for example, is reluctant to provide dialysis to the elderly, and most of us who are now covered by either Medicare or private insurance have little stomach for health-care reform that contains even a whiff of rationing.

Behind this fear lies an implicit assumption that more health care means better health. But what if that assumption is wrong? In fact, what if more medicine can sometimes be bad not just for our pocketbooks but also for our health?

An increasing body of evidence points to precisely that conclusion. "There is a certain level of care that helps you live as long and as well as possible," says John Wennberg, the director of the Center for Evaluative Clinical Sciences at Dartmouth Medical School. "Then there's excess care, which not only doesn't help you live longer but may shorten your life or make it worse. Many Americans are getting excess care." According to the center, 20 to 30 percent of health-care spending goes for procedures, office visits, drugs, hospitalization, and treatments that do absolutely nothing to improve the quality or increase the length of our lives. At the same time, the type of treatment that offers clear benefits is not reaching many Americans, even those who are insured.

That's a sobering thought, but it opens the possibility of a new way to look at the conundrum of health-care reform. Lawmakers, insurers, and the health-care industry might be able to save money if they were to concentrate on improving the quality of medicine rather than on controlling costs. Better health care will of course mean more medicine for some Americans, particularly the uninsured; but for many of us it will mean less medicine.

Support for this idea can be found in The Dartmouth Atlas of Health Care, a compendium of statistics and patterns of medical spending in 306 regions of the country. The atlas is generated by a group of nearly two dozen doctors, epidemiologists, and health-care economists, using data from Medicare, large private insurers, and a variety of other sources. Wennberg is the group's leader and the patron saint of the idea that more medicine does not necessarily mean better health—a view that has not exactly endeared him to the medical establishment over the years. These days, however, his ideas are bolstered by the Institute of Medicine and other independent researchers, and by new results coming from his Dartmouth research team, which is showing precisely how the nation misspends its health-care dollars.

Take the regions surrounding Miami and Minneapolis, which represent the high and low ends, respectively, of Medicare spending. A sixty-five-year-old in Miami will typically account for $50,000 more in Medicare expenses over the rest of his life than a sixty-five-year-old in Minneapolis. During the last six months of life, a period that usually accounts for more than 20 percent of a patient's total Medicare expenditures, a Miamian spends, on average, twice as many days in the hospital as his counterpart in Minneapolis, and is twice as likely to see the inside of an intensive-care unit.

This type of regional variation would make perfect sense if regions where citizens were sickest were the ones that used the most medical services. After all, it's only fair that we
should spend more and do more in places where people need more medical attention. But, as Wennberg and his colleagues Elliott Fisher and Jonathan Skinner point out in a recent paper, “Geography and the Debate Over Medicare Reform,” which appeared online in the journal Health Affairs, rates of underlying illness do not account for the differences in spending among regions. If they did, the region around Provo, Utah, one of the healthiest in the country, would get 14 percent fewer Medicare dollars than the national average, because its citizens are less likely to smoke, drink, or suffer from strokes, heart attacks, and other ailments. Instead it receives seven percent more than the national average. In contrast, elderly people in the region around Richmond, Virginia, tend to be sicker than the average American, and should be receiving 11 percent more—rather than 21 percent less—than the national average. Nor are regional differences explained by variations in the cost of care. Provo doctors are not, for example, charging significantly more for office visits or lumpectomies than doctors in Richmond, and their patients aren’t getting costlier artificial hips.

Rather, much of the variation among regions—about 41 percent of it, by the most recent estimate—is driven by hospital resources and numbers of doctors. In other words, it is the supply of medical services rather than the demand for them that determines the amount of care delivered. Where neonatal intensive-care units are more abundant, more babies spend more days in the NICU. Where there are more MRI machines, people get more diagnostic tests; where there are more specialty practices, people see more specialists. It’s probably safe to assume that many people are gravely ill during the last six months of their lives no matter where they live; but Medicare beneficiaries see, on average, twenty-five specialists in a year in Miami versus two in Mason City, Iowa, largely because Miami is home to a lot more specialists.

It would be one thing if all this lavish medical attention were helping people in high-cost regions like Miami to live longer or better. But that doesn’t appear to be the case. Recent studies are beginning to show that excess spending in high-cost regions does not buy citizens better health. Medicare patients visit doctors more frequently in high-cost regions, to be sure, but they are no more likely than citizens in low-cost regions to receive preventive care such as flu shots or careful monitoring of their diabetes, and they don’t live any longer. In fact, their lives may be slightly shorter.

The most likely explanation for the increased mortality seen in high-cost regions is that elderly people who live there spend more time in hospitals than do citizens in low-cost regions, Wennberg says, and we know that hospitals are risky places. Patients who are hospitalized run the risk of suffering from medical errors or drug interactions, receiving the wrong drug, getting an infection, or being subjected to diagnostic testing that leads to unnecessary treatment.

An obvious way we might cut excess medical care is to change the way we pay hospitals and doctors. “Medicine is the only industry where high quality is reimbursed no better than low quality,” says David Cutler, a health economist at Harvard. “The reason we do all the wasteful stuff is that we pay for what’s done, not what’s accomplished.” Although that’s clearly the case, figuring out the right incentives for health-care providers is by no means easy. Let’s say that Medicare decided to use low-cost regions as a benchmark and told providers in the rest of the country that their compensation would be capped at some level not far above the benchmark. Some doctors in high-cost regions would undoubtedly be encouraged to practice more conservatively, but many others would maintain their incomes by either dropping Medicare patients altogether or giving them even more hysterectomies and CT scans they don’t need (thus compensating for lower fees by simply performing a greater number of procedures).

Even if policymakers come up with the right financial incentives, restructuring compensation will constitute only one small component of the reform that’s needed to turn medicine into an efficient, effective industry. Think of it this way: at 13 to 14 percent of GDP, health care is the nation’s largest single industry, and probably its most complex. Transforming this sprawling behemoth is going to involve a lot more upheaval than, say, the shift that took place in the auto industry when companies adopted the assembly line, or the shake-up that Hollywood and the music industry now face with the advent of Web entertainment.

Step No. 1 toward improving the quality of health care is reducing what the Dartmouth group calls “supply-sensitive” care—the excess procedures, hospital admissions, and doctor visits that are driven by the supply of doctors and hospital resources rather than by need. Organizations such as mant an processing, and not necessarily because, are part of Med Advisory Board. The evidence opens the question of whether they need to be expanded. But doctors in low-cost regions would hold them to practice deeper and spend more time on patients. But the two counties of Los Angeles, on average, have a phone, and are low-technology women, and $40. Instead, the region in low technology, etc., of the Med Fund are there, and there have a different way of thinking. There is a billion, 41 million. That failed was vision and would the view of being effects and the health care industry. The way of what is happening is through the advent of Web entertainment.

Shannon's senior editor frequent
such as the American Medical Association and Kaiser Permanente will need to set standards for more-conservative practices, and for measuring patient outcomes. Benchmarks are also needed to ensure that doctors deliver more “evidence-based” medicine: procedures and practices whose benefits are proven. Three recent studies, conducted by the Institute of Medicine, the Rand Corporation, and the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, report widespread underuse of evidence-based treatment, such as balloon angioplasty to open blocked arteries in heart-attack victims, even among citizens with gold-plated health insurance.

Probably the hardest part of reforming health care will be persuading policymakers and politicians that improving the quality of care can also save money. The Medical Quality Improvement Act, introduced last July by Vermont Senator James Jeffords, is a step in the right direction. It would call on several medical centers around the country to model high-quality medicine that also reins in costs.

But evidence already exists that improving quality can hold down costs. Franklin Health, a company based in Upper Saddle River, New Jersey, manages so-called “complex cases” for private insurers. Complex cases are the sickest of the sick, patients with multiple or terminal illnesses, who are also the most costly to treat. They typically make up only one or two percent of the average patient population while accounting for 30 percent of costs. Franklin employs a battalion of nurses, who make home visits and spend hours on the phone, sometimes every day, to help patients control pain and other symptoms and stay out of the hospital. For this low-tech but intensive service the company charges insurers an average of $6,000 to $8,000 per patient—but it saves them $14,000 to $18,000 per patient in medical bills.

How much money is at stake? If spending in high-cost regions could somehow be brought in line with spending in low-cost regions, Medicare alone could save on the order of 29 percent, or $59 billion a year—enough to keep the Medicare system afloat for an additional ten years, or to fund a generous prescription-drug benefit for seniors. And there's no reason to believe that doctors and hospitals behave any differently toward their non-Medicare patients. That means the system as a whole is wasting about $400 billion a year—more than enough to cover the needs of the 41 million uninsured citizens.

The last attempt at reforming the U.S. health-care system failed in large measure because of fears of rationing. Reform was viewed as an effort to cut costs, not to improve health, and voters believed, rightly or wrongly, that they would end up being denied the benefits of modern medicine. Future efforts at reform are going to have to persuade Americans and their doctors that sometimes less care is better.  


24
The Federal Government has responded to increasing health care costs in part by attempting to limit the reimbursement rates paid by public programs to health care providers. This approach in turn has resulted in the substantial shifting of costs to the private sector described earlier.

- The total cost of health care in the USA has increased very rapidly.
- The pressure on government to spend a lot more on health care is huge.
- When government health spending increases a lot, then:
  - less money for education
  - less money for transportation
  - less money for welfare programs
  - etc
The compensation of employees is wages plus "benefits." The benefits are health plans, retirement plans, payments by the company for social security, etc.

When the benefits increase, then the amount of total compensation that can be paid to the worker has to decrease.
Labor productivity—output per hour of work—may seem an abstract concept, of more interest to analysts than to working men and women. But without productivity growth, higher real wages would lead directly to lower employment.

But America's long-run average productivity growth rate over the century leading up to 1973 was slightly above 2 percent per year; since 1973 it has averaged about 1 percent. At 2-percent growth, productivity doubles in 35 years; at 1-percent growth, doubling takes 70 years.

See chart 1-2. More useful output was produced during each hour of work during 1947-1992, so the real pay (compensation) of workers increased at the same rate.

- Roy Janner
- Jan 2003

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1 Includes medical research and medical facilities construction, not shown separately. 2 Includes other private expenditures, not shown separately. 3 Includes other objects of expenditure, not shown separately.


Big increases in spending

Health and Nutrition 91

U.S. Census Bureau, Statistical Abstract of the United States: 2001
Republicans tend to approach health care policy the way the rest of us do a root canal. So it’s notable, and encouraging, that the GOP is now saying that Medicare reform will be among its top priorities in the new Congress.

The challenge, and it’s a large one, will be to bring that creaking program into the 21st century without breaking the federal fisc. The temptation will be to take the easy route merely of adding a politically popular prescription drug benefit. But down that path lie drug price controls and, eventually, Canadian-style health care. Adding a drug benefit makes sense, but only if it is added as part of reform that introduces market incentives and competition to Medicare.

On its current road, Medicare is what Louisiana Democrat John Breaux calls a “smoking jelly.” Private health insurance now pays for prescription drugs because it has responded to market demand and the changes in medical care. But Medicare, founded in the big-government heyday of 1965, is a command-and-control system that responds mainly to political incentives. Despite price controls on fees and services imposed in the 1980s, Medicare spending is still growing like Topsy and is expected to gobble up about a quarter of all federal revenues by 2030, more than double its current share. A drug benefit would pile on another $500 billion or so every 10 years to that burden.

Meanwhile, the program’s bureaucracy so frustrates doctors that more and more of them refuse to accept new Medicare patients. Not long ago the Mayo Clinic tallied more than 100,000 pages of Medicare rules, regulations and bulletins it had to adhere to. Perfectly innocent doctors and hospitals risk prosecutions every day because of these rules, which can be arbitrarily enforced whenever the next “fraud” crusade hits Congress.

The solution is to change Medicare into a defined-contribution health care model much like the insurance system that covers nine million federal employees and family members. Instead of directly paying for all medical charges, Medicare should pay seniors to help them buy modern medical insurance, including drug coverage, on the private market.

This was the idea behind the Republican reform that passed Congress before Bill Clinton vetoed it in 1995. And it was the essence of the plan proposed by Mr. Clinton’s own bipartisan Medicare commission in 1998 and 1999, before the former President threw it over the side to save himself from impeachment. That commission included Mr. Breaux, as well as new Senate leader Bill Frist and House Ways and Means Chairman Bill Thomas.

One good way to make the transition to such a system would be to simply give seniors some options: remain in traditional fee-for-service Medicare (without a drug benefit), or elect a drug-inclusive HMO or preferred-provider coverage. This would be an improvement and expansion of the Medicare Plus Choice program, which has been a failure only because it is underfunded and overregulated.

Liberal Democrats will bitterly resist these ideas, precisely because they want Medicare to remain a command-and-control system. Their long-term goal is to make American health care into another British or Canadian government-run system. But most seniors only want the certainty of health coverage, and the reforms we are talking about are rarely radical. They’d retain the government as the insurer of senior health insurance, but they would allow the more efficient, more responsive private sector to compete in administering different insurance plans.

Some Republicans, recalling their 1995 disaster, will not want to be this bold. But they should keep in mind that they didn’t then control the White House bully pulpit with its ability to shape the debate. Even at that they were able to persuade the AARP and other lobbies to support reform. More broadly, if Medicare reform isn’t possible even with the huge carrot of drug coverage as a political sweetener, it won’t be reformed in our lifetimes.

Of course reform will take 60 Senate votes, and too many Senate Democrats may be running for President in 2004 to allow a decent compromise this year. The best fallback in that case would be to pass a privately administered benefit only for the low-income seniors who are most in need. Republicans shouldn’t give up the universal drug benefit that is the only carrot for broader reform and that would, by the way, displace private drug benefits that a majority of seniors already have.

We know that some Congressional Republicans would like to get the prescription drug issue off the table in any way possible. But that’s an act of fiscal and medical irresponsibility. President Bush, to his credit, seems to appreciate that Republicans have a historic chance to reform the Medicare entitlement that liberals have let go to seed, delivering drug coverage and saving future taxpayers in the bargain.

Good Riddance to the Luxury Tax

Most Americans celebrated as the ball fell in Times Square New Year’s Eve. But for auto dealers this new year is especially sweet. A new law allows the luxury tax—on cars selling for more than $50,000—to be rolled back, meaning millions of dollars will flow back to car dealerships.

The luxury tax was a big seller for the Clinton administration. It was a cash cow, but it was also a symbol of the administration’s fiscal responsibility. The luxury tax was expected to bring in $6 billion over five years.

But the tax was also a political liability. It was a tax on luxury, and many people found that to be unfair. In the end, the luxury tax was a political blunder, and the administration decided to roll back the tax as part of its budget deal with Republicans.

The luxury tax was an example of how the Clinton administration was willing to accept revenue from any source, no matter how unpopular. The administration was willing to accept revenue from a tax on luxury, even though it was a tax on luxury. The luxury tax was a symbol of the administration’s willingness to accept revenue from any source, no matter how unpopular.
Oregon’s ‘Guinea Pigs’

The only control mechanism would be the board’s ability to coerce providers into accepting lower fees. According to a new study commissioned by the American Association of Health Plans, the Oregon proposal would cost at least $3.5 billion more in its first year than it raised in new taxes. Those new taxes would average $4,000 to $5,900 a year per resident—far more than even gold-plated private coverage.

That explains why even organized labor isn’t buying this plan. “This is the first time I’ve ever spoken against a single-payer system, but if an employer brought this kind of cost shift to the bargaining table we’d be on strike for a long time,” said Ken Allen of the Association of Federal, State, County and Municipal Employees. The AFL-CIO voted 186-64 to oppose the measure.

Even Oregon’s media dislike it. “This is nothing less than a bizarre prescription for financial ruin . . . it would break the state and drive businesses—and health-care providers—out of the state, as fast as they could get away,” editorializes the liberal Oregonian, the state’s leading daily. In short, many Oregonians seem to understand there are better ways to address rising health costs, for example, by repealing (not adding to) state regulations that make insurance more expensive to buy.

Some on the left (for whom Oregon has become a modern Haight-Ashbury), of course, still cling to the fantasy that HillaryCare was defeated in 1994 only because of those brainwashing “Harry and Louise” ads. But on November 5 Oregonians will have a chance to show it was because voters are smart enough to understand the facts. Despite its problems, American health care remains the best in the world. There’s no reason to become “guinea pigs” in a failed experiment other countries have already tried.

By Scott Gottlieb

President Bush’s new initiatives that drug company profits won’t significantly level the playing field for drugmakers. They will, I would argue, accelerate the trend toward lower drug prices.

Right now, generic drugs that a branded drug’s patent has expired for are hitting the market. But the brand-name drug companies haven’t been left out—generic drugmakers will block. Generic drugmakers have a long history of taking on the big pharma companies and winning.

Since the FDA doesn’t consider generic drugs to be the same as branded drugs, the FDA has been able to block generic drugmakers from bringing their products to market. But now, with the new initiatives, the FDA is powerless to block generic drugmakers from bringing their products to market.

Drugmakers have had many chances to prolong the patent protection for their drugs. But now, with the new initiatives, they are powerless to block generic drugmakers from bringing their products to market.

That legislation is passed in 1984 to level the playing field between branded and generic drugs. It was signed into law by President Ronald Reagan.

But as clinical trials of the new drugs are being conducted, the FDA is powerless to delay the new products from entering the market. And the public will benefit.

A large part of the reason is that many companies are finding that the new initiatives are not only allowing them to sell their new products, but also allowing them to sell their new products at lower prices.
Canada’s Health Care System Needs More Cash, Panel Says

By CLIFFORD KRAUSS

TORONTO, Nov. 28 — In a long-awaited report, a government commission recommended today a major increase in federal funding for Canada’s national health care program to shore up its finances and prevent the development of a parallel system of private medical services.

Publicly financed health care for all has been a cherished hallmark of Canadian society since the 1960’s, but ever-longer waiting lists for elective surgery and for M.R.I. scans and other diagnostic services in recent years have provoked concern that the system cannot be sustained.

Several provinces have begun introducing private clinics, stimulating a debate in Parliament over whether to reinforce the existing system or totally revamp it.

“The grave risk we will face is pressure for access to private, parallel services: one set of services for the well off, another for those who are not,” said Roy J. Romanow, who headed the commission. “Canadians do not want this.”

The 356-page report released today was more than a year in the making.

Mr. Romanow said the federal government would need to increase its annual spending by $4 billion, about a 25 percent increase, over three years to stabilize the finances of the national health care system and to expand coverage and services, especially in rural areas and among Native Canadians.

The federal and provincial governments share the costs of the system, but in recent years the provinces have borne an increasing share of the burden.

Many hospitals report a growing demand for hip replacements and nonemergency operations because of Canada’s aging population, but fewer operations being performed because of a shortage of staff members and beds.

Mr. Romanow, a former Saskatchewan premier known for his liberalism, recommended that the health care system increase benefits to help care for the mentally ill at home, provide rehabilitation for patients after surgery and pay for expensive drugs for people with chronic illnesses.

He also called for the modifying of patent regulations to lower the price of drugs and the establishment of electronic health record cards for every Canadian that would enable hospitals and doctors to gain quick access to patients’ medical histories and to track costs.

“The new money that I propose investing in health care is to stabilize the system over the short term, and to buy enduring change over the long term,” Mr. Romanow said. “I cannot say often enough that the status quo is not an option.”

Prime Minister Jean Chrétien’s government will now consider the recommendations and may integrate at least some proposals in its new budget, scheduled to be released in February.

The report was criticized by opposition politicians, who argued that the health care system needed more fundamental change than Mr. Romanow had offered.

“This is entirely the wrong direction,” said Stephen Harper, leader of the Canadian Alliance Party, who characterized the recommendations as “pie in the sky.”

Even before the report was issued, the finance minister, John Manley, warned that the government’s ability to increase health care financing rapidly was limited “so we don’t find ourselves slipping back into deficit.”

After years of deficits, the federal budget is now in the black. But there are rising demands from city and provincial governments to increase financing for roads, housing and education.

Meanwhile, military experts say the Canadian armed forces badly need a fresh infusion of money to combat an increased threat of terrorism.

Still, the Romanow report is bound to prompt a national debate on health care that will carry into national elections expected to be held in early 2004.

In an opposing report issued last month, Senator Michael Kirby proposed limited privatization and a new tax that would be equivalent to an insurance premium based on income.
Canadian health care

Prescription for change  

KITCHENER-WATERLOO, ONTARIO

Is Roy Romanow’s report what Canada needs?

AROUND 300,000 people live in Kitchener-Waterloo, a fast-growing city bustling with insurance companies and firms. The city’s central hospitals reflect this growth, with new facilities springing up for cancer and cardiac care. But hospital administrators have many worries: tight budgets, too few doctors, rising drug costs, and long waiting times for elective treatment and sophisticated diagnostic tests.

Such concerns are heard across the country. Canada’s health-care system is not yet at breaking point like Britain’s National Health Service, nor does it have America’s runaway medical inflation and millions of uninsured. But Canadians worry that their taxation-based, “single payer” system will not be able to deliver good care for all who need it in future.

This week, politicians were busy mull-
The NHS
Condition still critical

Despite cheerleading from ministers, the NHS is proving hard to cure

The political imperative is clear. Next week, Gordon Brown is expected to announce plans to raise taxes in his budget. The chancellor of the exchequer will justify this by invoking the need to increase spending on the NHS. So this week, Alan Milburn, the health secretary, has been trumpeting the message that more resources translate into better health care.

The need to demonstrate this link is compelling. The government is increasing real spending on the NHS at an annual rate of 6.4% a year in the five years to 2003-04, much higher than the trend increase of 3.8% a year in the past four decades. This "step change in resources" announced in the 2000 budget is intended to ensure "a step change in results". The NHS Plan later that year set out a plethora of targets to bring this about, of which the most salient was a commitment to shorten waiting times. The aim was to cut the maximum waiting time between seeing a hospital consultant and an operation from 18 to six months by 2005. The plan also announced ambitious recruitment targets to increase the numbers of nurses and doctors.

The government is now well into its spending spree. Overall health expenditure in Britain has risen from 6.8% of GDP in 1998-99 to 7.5% in the financial year that has just ended. That is not so far away from Tony Blair's objective of meeting the average in the European Union, which is 8% of GDP excluding Britain and calculated without taking into account population sizes. So what has been achieved?

On cue for the budget, Mr Milburn said this week that "overall, the NHS Plan is on course to be delivered". By the end of March, the maximum waiting time for an operation had been reduced to 15 months, in line with the NHS plan. A year ago, 10,400 had been waiting more than 15 months. The next stage in the government's "war on waiting" is to cut this to 12 months by March 2003.

The objective of reducing waiting times is preferable to the discredited objective of Labour's first term of office, the mission to cut waiting lists, but it remains a flawed approach. The target only makes sense if it reflects an increase in treatments. In his annual report on the NHS, released on April 10th, Nigel Crisp, its chief executive, acknowledged that there was little increase in activity in the first half of the year to March 2002, but said that growth started in the second half. He highlighted increases in the number of cardiac revascularisations and urgent cancer referrals.

However, the King's Fund, a health policy think-tank, says that there has been little increase in overall hospital activity in the past two years. "This means that meeting the target can only be met by distorting clinical priorities," says Anthony Harrison, a researcher at the King's Fund. Either fewer people get an initial appointment to approve treatment in the first place or those who have not been waiting as long...
but need operations more urgently are pushed aside.

The gap between extra resources and enhanced health-care outcomes explains why the second half of the government's strategy is so important. Ministers have sanctioned greater use of the private sector, so breaking the double armlock of state financing and provision. And more power is in theory being devolved to family doctors operating together with other initial points of contact for medical and social care through primary care trusts. At the start of this month, 302 PCTs came into operation in England. Replacing 95 health authorities, they will control three-quarters of the NHS budget by 2004.

In principle, this should drive better and more effective provision of health care as the PCTs act as more effective agents for their patients. That was what the Conservative government intended when it allowed family doctors to become fundholders which could purchase hospital treatments in the 1990s. But already there are doubts whether this will occur. The main worry is that the PCTs are too big to be effective purchasers: since the local PCT will be the only customer for the local hospital, it cannot threaten to withdraw its custom, so there is no incentive for hospitals to improve their performance.

The most serious difficulty for the government is that even after these big increases in funding, Britain will still have far fewer doctors per head than other countries. This disparity is much bigger than the funding gap between Britain and the rest. In effect, the cost of health in the past has been held down by limiting the number of new medical staff. "This is the most centrally controlled manpower in the country," says Mr Harrison, who largely blames "the dead hand of the Treasury".

All this means the government will face an uphill struggle in convincing the electorate that the extra money is delivering a decisive improvement in the NHS. Against this background, there is likely to be renewed interest in the experience of other models of health care. An obvious template is the system of social insurance funds, which operate in European countries. Individuals and their employers pay mandatory contributions into these funds, but people can choose which one they join. One well-rehearsed argument against this method of financing health care is that it drives up business costs. But a reform strategy outlined by the Adam Smith Institute on April 12th suggests that this obstacle can be overcome by raising money from individuals’ incomes from all sources, not just through pay packets. Eamonn Butler, the institute’s director, says that the reform would create more choice and spur medical providers to do better.

The Conservative party has been taking a keen interest in the operation of social insurance funds in Europe. One problem in applying such a remedy is that the NHS is suffering from reform fatigue. There would be opposition from the medical profession to yet another upheaval. But if the spending bonanza fails to deliver a genuine improvement in the NHS, then a reform applying the best of the European model may start to look more enticing.

The Verwaayen ahead

BT's new boss is off to a flying start

Amazing, but true. It is only a few weeks since BT's new boss, Ben Verwaayen, took over, but the firm already seems to have a renewed spring in its step. Its share price is up 22% since the end of January, and its strategy is rapidly coming into focus. On April 8th, Mr Verwaayen outlined his plans to cut costs, resume dividend payments and reduce BT's debt to below £10 billion over the next three years.

With these plans, and several other initiatives, he seems to be off to a flying start.

Mr Verwaayen makes much of his enthusiasm for high speed, or "broadband", Internet access as an important source of future growth. Having already cut the price of broadband connections offered over its wires, BT this week announced a new, bare-bones broadband product that will be cheaper still. It involves some nifty footwork that may well raise eyebrows at OfTEL, the communications regulator.

BT is expected to argue that Internet-service providers (such as AOL, Freeserve, and BT's Openworld division) offer a bundle of two separate things: access to the Internet and services on top, such as e-mail and web-page hosting. The new barebones product will simply provide Internet access, without any of the related services. Openworld is prevented by OfTEL from cross-selling to BT's existing customers, but this restriction may not apply to its new access-only product; BT hopes to sign up 5m new broadband customers by 2006. Whatever OfTEL may say, this sneaky new approach signals that BT has wisely decided to concentrate on access, rather than services or content.

Another element in Mr Verwaayen's new strategy is an admission that BT should concentrate on its home market. Having spun off its pan-European mobile arm, mmO2, and abandoned Concert, its international joint venture with AT&T, BT will also retreat from loss-making European markets. BT Ignite, which operates in Europe, will henceforth concentrate on large companies, and will no longer try to woo consumers or small businesses. And if that approach fails to yield results by next March, says Mr Verwaayen, he will abandon that too.

On the wireless front, BT announced a number of new initiatives on April 10th,
In Europe, Prescription-Drug Ads Are Banned—and Health Costs Lower

Now, Restrictions May Ease
With Proposal to Give
More Marketing Latitude

March 15, 2002

By VANESSA FUEHMS
And GAUTAM NAIK
Staff Reporters of The WALL STREET JOURNAL

How would drug makers pitch their medicines to consumers without the daily rain of prescription rebates, commercials and magazines ads? Try allergy calendars and Web tips for battling pollen.

In Europe that's as close as Aventis SA can come to peddling its allergy drug Allegra. The French-German company spent about $8 million in ads in 2001 to make Allegra a household name in the U.S. But on its home turf, a European Union ban on prescription drug advertising forbids Aventis from mentioning the product, even on its Internet pages or brochures.

The longstanding ban has aimed to help keep government-subsidized health-care costs under control. But drug makers argue that the ban unfairly cramps patients' access to information, and thereby their access to drugs. Sales of drugs in certain large European countries are far lower than in the U.S. AstraZeneca PLC's ulcer drug Prilosec, for instance, racked up $6 billion in worldwide sales in 2000. Though its population is smaller than Europe, the U.S. contributed two-thirds of the total. Less than one-third came from Europe.

Now, the European Commission is considering a proposal that would allow drug makers to market treatments for AIDS, diabetes and respiratory ailments on their corporate Web sites, in patient-requested pamphlets and in other company literature. The overall guideline will be that consumers must seek or request the information—not have it pushed on them.

The commission said it chose these disease areas as test cases because the treatments for them don't vary radically from patient to patient; also, patients with these diseases have been the most inistent in requesting information. If approved by the European Parliament and member states, a process that could take 12 to 18 months, the measures later could be expanded to cover all diseases.

The measures fall short of American-style direct-to-consumer marketing but they are an indication of the pressures European governments face to loosen restrictions. What's more, European Commission officials say the Internet has already made the ban somewhat moot because it lets consumers seek information on U.S.-based or other Web sites beyond what their doctor tells them. But that can create confusion because drugs are often named differently and are approved in varying doses from country to country.

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Who Buys the Most
Sales share of the world's top 75 prescription medicines.

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<td>Switzerland</td>
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<td>Japan</td>
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<td>France</td>
<td>1.8%</td>
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Note: Prices for drugs are generally higher in the U.S.
Source: ABPI, IMS Health

Many consumer groups—and European government officials—argue that relaxing the ban will merely boost drug companies' marketing budgets, put upward pressure on drug prices, and have no appreciable affect on the health of Europeans. Currently, European governments set some price controls on drugs; in some instances drug prices are 40% to 60% lower than in the U.S. These governments typically reimburse patients for prescription drugs costs under state-sponsored health-care systems. The worry is that consumer advertising will trigger more prescriptions, squeezing health-care budgets already under pressure from Europe's aging population.

"The benefit of direct-to-consumer marketing of drugs is highly questionable," says Charles Medawar, director of Social Audit, a consumer interest group in London. He points out that the total health-care cost per person—a significant portion of which was prescriptions—in the U.S. in 2000 was $3,724, while the average figure in Europe was $1,660, according to the most recent figures available from the World Health Organization. Yet the average time in which Americans live a healthy and full life, 70 years, was slightly less than nearly every Western European country, according to the WHO.

Mr. Medawar and other critics of drug advertising argue that patients already can learn about drug products through the media, patient organizations and other groups. Adding direct advertising only helps turn the dialogue between doctors and patients into a prescription request, they say. "It doesn't help patients seek out the best treatment," says Erika Valovirta, a Finnish allergist and president of the European Federation of Asthma and Allergy Associations. "It usually just happens to be the most expensive."

Direct-to-consumer marketing, American-style, is a two-edged sword, acknowledges John Patterson, a senior marketing executive at AstraZeneca.
Health care in poor countries

Cheap cures

Donors should give more, but the poor should spend what they have more rationally

You can’t put a price on human life. From this truism springs one of the most harmful delusions of the modern world—that when public money is spent on life-saving medical care, no account should be taken of the cost. Given that demand for health care is almost infinite, while budgets are sadly finite, it makes sense to start by spending money on interventions that save a lot of lives, cheaply. If good public health is the goal, treatments that save fewer lives at greater cost should receive lower priority.

This may seem stunningly obvious, but it is rarely practised with much rigour. In poor countries, the consequences can be calamitous. When health spending is as little as $10 per person, per year, as in much of sub-Saharan Africa, and the government blows half the budget on a fancy new hospital in the capital, this may mean that rural clinics, which serve a much larger and needier population, run out of cheap, life-saving drugs. Irrational budgeting kills.

Health-care systems have long been vulnerable to capture by elites. In Europe, the middle classes get more out of nationalised health services because they are pushier than the poor. In the same way, the much smaller elites in poor countries make sure that health budgets are spent disproportionately in cities, and on expensive, high-tech fixes for rich people’s ailments, such as cancer and heart disease.

A recent experiment in Tanzania illustrates how quickly public health can improve when budgets are spent more rationally (see pages 20-22). In a large rural area, researchers took the trouble to find out which diseases caused the most death and disability. They discovered that the amount of public money they had been spending to fight each condition bore no relation to the burden it imposed on the population. So, with a tiny extra infusion of cash (only 80 cents per person, per year), they redirected money towards the diseases that caused the most suffering but were cheapest to treat. Infant mortality then fell by an amazing 28% in a single year.

Following the Tanzanian model

Not all developing countries will be able to achieve such dramatic results. The starting point in Tanzania was that one child in ten was dying before his first birthday, so there was plenty of room for improvement. In, for example, much of Latin America, improvements will come more slowly because health budgets are less distorted to begin with. Over the past two decades, reforms have directed resources away from the middle classes and towards primary care for the poor, with encouraging consequences. At the other end of the scale, some countries, including several of Tanzania’s neighbours, need to end their civil wars before they can rebuild, let alone reform, their health-care systems.

Despite these caveats, most governments could save many more lives by spending their health budgets more sensibly. By and large, they should focus more on low-tech treatments, not just on high-tech ones.

This idea will have many opponents. Politicians will argue that it is tantamount to telling poor countries to remain technologically backward. Aid donors, who should support it,

ثلث من الدول لعبت دورًا محليًا

for around 40% of GDP (compared with 33% in the United States), and spending on education and health has risen.

Nor is it self-evident that the region is responding to recent failures by lurching to the left. Rather, there is a tendency, natural in democracies, to elect the opposition when governments fail. Even then, none of the demagogues vying to lead stricken Argentina looks like a shoe-in. Mexicans have plumped for Vincente Fox, best described as a Christian democrat, and Colombians for Alvaro Uribe, a conservative Liberal.

It is true that a moderately left-wing candidate (Luiz da Silva), and one who is sometimes described as populist (Ciro Gomes), head the opinion polls for Brazil’s October presidential election. The next president may tinker with industrial policy, through selective tariff protection and subsidised credit. If the new IMF loan fails to calm investors, he may also face a choice between defaulting on the public debt and reducing its value through a burst of inflation. But in the main, no new president is likely to stray far from present policies.

Indeed, nowhere in the region does there exist a mass movement calling for a return to the state-led economic nationalism that characterised the populists of Latin America’s past, such as Argentina’s Peronists. Nor is one likely to emerge.

In Venezuela, Hugo Chavez, who claims to be resisting “savage neoliberalism” (yes, it bites) by means of “Bolivarian revolution”, has made a poor fist of running his country, but even he has continued to privatise state firms and steered clear of capital controls. Besides, the region’s old-style populists came from the right, not the left, and appealed to a far less educated electorate than that of today.

A new poll by Latinoametro, whose results we publish on page 29, finds the average Latin American slightly right of centre, interested mainly in electing governments that work. Privatisation has certainly become unpopular across the region, but that may be because so many privatisations have been marred by corruption or have merely transformed public monopolies into private ones. Where they have been well regulated, as in Chile and (mostly) Brazil, they have delivered better and cheaper services.

None of this is to deny that after a wretched half-decade much of Latin America is in need of a set of policies capable of generating growth. But there is little sign that its people think they can achieve this by harking back to the failed policies of the past. This, at least, is a source of comfort. Nor, yet, is there much evidence of a retreat from democracy. Building democracy amid poverty is not easy; in some places, it might still break down. But Latin Americans are learning to separate the performance of their governments from the desirability of democracy itself. That, too, gives modest grounds for hope. ■
THE BACKLASH AGAINST BIG PHARMA
Companies, consumers, and government join forces

After years of double-digit increases in prescription drug costs, employers and state governments that pick up a lot of the tab have reached the breaking point. Now, a battle is erupting in courtrooms, state capitols, the insurance marketplace, and the halls of Congress over the high cost of prescription drugs. At stake are hundreds of billions of dollars in drug sales.

Brand-name drugmakers—among the nation’s most politically well-connected—are suddenly on the defensive. In recent months, an unusual alliance of states, insurers, consumer groups, and large companies has lashed out at the punishing increases in pharmaceutical costs. Democrats, who hope to portray themselves as the party of lower drug prices, are cheering from the sidelines. One strategy: Force down prices by boosting the use of generics.

As everyone piles on, powerful brand-name-drug companies from Merck & Co. to Eli Lilly & Co. may face lower margins in the wake of pressure to cut prices. Generic drugmakers, meanwhile, such as Barr Laboratories and Mylan Pharmaceuticals Inc., hope to tap the mounting anger to gain market share. Employers and states that foot the bill for many drugs don’t care much who profits—they just want to slash costs. Says Paul B. Ginsburg, president of the Center for Studying Health System Change in Washington: “Payers are getting more and more desperate.”

It’s not difficult to see why. Last year, Americans spent a staggering $172 billion on medicines, 17% more than in 2000. Of that, $32 billion went just 10 brand-name drugs, such as the cholesterol reducer Lipitor or the stomach drug Prilosec. Meanwhile, on average, a generic prescription runs $46 less than a brand name (chart). South Dakota, which like other states shoulders the prescription costs for its employees and Medicaid recipients, shelled out $1.4 million in 2001 on Prilosec alone. “Medicaid’s breaking us,” groans Governor Bill Janklow.

Such pressures are galvanizing the opposition. In Washington, General Motors Corp. and other major employers have joined Blue Cross, the AFL-CIO, consumer groups, and governors of at least 11 states. Their goal: Push Congress to speed generic drugs to market. The measure would make it tougher for a brand-name drugmaker to block a competitor from bringing a drug to market just as its patent expires. Brand-name companies say they need such protection to earn the returns required to support costly drug research.

At the same time, the Bush Administration is taking aim at some of the tactics the drug industry uses to prop up brand-name medicines. The Federal Trade Commission has brought cases against companies that effectively paid generic competitors to keep low-cost substitutes off the market for months after patents expired. This summer, the agency will release a study outlining the widespread use of such arrangements. State attorneys general and consumer groups have brought class actions against makers of at least 14 drugs for similar activities. One, involving the anxiety drug Ativan, was partially settled in February.

Consumer groups are pushing generics with campaigns aimed at convincing patients to request Brand X from their doctor or pharmacy. In mid-April, AARP
EMPLOYERS ARE SEEKING
A SECOND OPINION

The pharmaceutical industry likes to say that prescription drugs make up only 9c of every dollar spent on health care. For businesses that insure retirees and employees, however, prescription drug costs can be much higher—as much as 20% of total health-care expenditures. And they are rising. In a recent survey of 3,000 employers with more than 500 employees, Mercer Human Resource Consulting LLC found that prescription drug costs per employee rose 17.2% in 2001.

Some companies that have tried for years to trim drug use are now taking a more sophisticated approach. General Motors Corp. and Verizon Communications Inc., both large employers, are each undertaking extensive reviews, using elaborate mining of employee data. One fertile area for improvement: data on the overuse and improper use of drugs. By identifying, then eliminating, incorrect uses, administrators say they are hoping to cut costs without compromising health care.

They're also mounting educational campaigns to change employees' behavior. General Motors, for example, has launched a program to educate its employees about the cost-effectiveness of generic drugs and to persuade workers to use them when appropriate. The company sends out newsletters, broadcasts, and messages on pay stubs to encourage workers to ask their pharmacists about generic drugs. In 2000, 35% of drugs taken by GM employees were generics. Although that number has only inched up to 39%, the increase has saved GM $46 million over the past two years.

When New York-based phone company Verizon took a closer look at its soaring expenditures for prescription drugs—which amounted to nearly $500 million last year—it found some surprises. Combining through the drug histories of its 380,000 workers and retirees, it discovered it was spending $100 million a year on two classes of drugs—ulcer medications such as AstraZeneca's Prilosec, and cholesterol-lowering drugs, including Lipitor and Zocor, made by Pfizer Inc. and Merck & Co., respectively. "The question is, 'What did people do before these drugs were around?' They took other medications that were less expensive. And for most of the population, they were just as effective," says James N. Astuto, a Verizon regional health-care manager in Atlanta. Patients who can use the less costly medicines are being encouraged to switch, and the newer drugs are reserved for those who really need them, Astuto says. Rather than rand

Workers of America spokeswoman.

The brand-name drugmakers, meanwhile, argue that there's a reason their products cost more. They "have fewer side effects, are easier to comply with, and have greater health benefits," says Alan F. Holmer, president and CEO of industry trade group Pharmaceutical Research & Manufacturers of America. Although critics say that is true of some new drugs, it ultimately depends upon the patient. Some may need the new drugs, they insist, while others will do fine on older, less expensive medications. Companies that are able to make those distinctions have a sterling opportunity to reduce costs—without degrading the quality of care.

By Paul Raeburn in New York, with Amy Barrett in Philadelphia, and bureau reports

By Howard Gleckman in Washington
Growing Health Care Economy Gives Northeast a Needed Boost

By DAVID LEONHARDT

BRIDGATER, N.J. — When Fred Hassan wanted to prove that Pharmacia could become a globally powerful drug company five years ago, he moved it out of its London headquarters to an office park here in the state he considered "the medicine chest to the world."

That shift of 380 of his employees into a gray one-story building that AT&T had abandoned to cut costs proved to be just the beginning.

By 2000, Pharmacia had outgrown the space, and it took over a nearby group of buildings that was once occupied by an investment company. This summer, Mr. Hassan, Pharmacia's chief executive, also bought a campus in Basking Ridge that had been AT&T's headquarters. Not far away, other drug companies have moved into buildings once filled with employees of Exxon and I.B.M.

The expansion is part of a 15-year regional transformation that has provided the Northeast corridor with an important economic cushion during the recent downturn.

With little of the fame that can be claimed by Silicon Valley, the Northeast's urban corridor has quietly built its own economic powerhouse by becoming the nation's health care epicenter. Roughly following the line of Amtrak's Northeast and stretching from Boston to Bethesda, Md., this medical megalopolis encompasses a vast array of facilities.

It is anchored by urban complexes serving as homes for many of the nation's most influential teaching hospitals. It includes the big suburban campuses of most of the world's major drug companies. It also stretches to clusters of research outfits in the Boston area and around the National Institutes of Health outside Washington.

"This is the center of the nation's health care economy," said Mark Zandi, chief economist of Economy.com, a research firm in West Chester, Pa. "Just as chips do it for the Bay Area and Boeing does it for Seattle, health care drives the economy in this corridor."

The growth has come as other traditional engines of the region have faltered. Even as health care companies in the Northeast's medical megalopolis have added 50,000 jobs, since 2000 all other industries combined have lost 220,000, ending a decade-long boom that had left many taking prosperity for granted.

Now, Wall Street has retracted deeply, bringing New York City its worst budget woes in decades and wounding the mutual fund companies in Boston. The fallout from Sept. 11 has hurt tourism, particularly in New York and Washington.

The burst Internet bubble has had its effect too, echoing among publishing companies throughout the corridor that had added workers when advertising was plentiful. And major telecommunications companies like AT&T and Lucent Technologies have cut thousands of jobs, many in the New Jersey suburbs.

"The telecom industry and the financial industry have crashed," said Henry A. McKinnell, the chief executive of Pfizer, the drug company based in New York that recently bought Pharmacia and now owns AT&T's old headquarters. "We're still growing."

Partly as a result, almost one out of every 10 jobs in the Northeast corridor today is in health care, a higher portion than in any other region of the country. That is up from one out of 14 in 1987, according to Economy.com. In New York City, 4 of the 10 largest private employers are medical institutions. In Philadelphia, it is 7 out of 10.

An Economic Engine

Health care's gains have helped to keep unemployment in the region lower than in the rest of the country. By contrast, during the recession of a decade ago, the Northeast suffered far more than most other areas and took much longer to recover.

The rise of this regional health care complex has also solved part of the Northeast's long quest for an economic engine to replace its disappearing manufacturing sector. Moreover, like information technol...
The Medical Megalopolis

Almost 10 percent of the jobs in the urban Northeast corridor are in the health care industry, more than in any other region of the country. That is up from about 7 percent in 1997 - a gain of 2.5 percentage points, compared with a 1.5-point increase for the country as a whole. Health care's strength in the region has helped keep unemployment lower than in the nation over all.

**Health care employment**

Percentage of total employment in health care

<table>
<thead>
<tr>
<th></th>
<th>'87 (%)</th>
<th>'02 (%)</th>
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<tbody>
<tr>
<td>Northeast</td>
<td>7.1</td>
<td>9.6</td>
</tr>
<tr>
<td>United States</td>
<td>6.7</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Within each metropolitan area

- 6% to 8%
- 8% to 10%
- 10% to 12%
- Over 12%

Key:

<table>
<thead>
<tr>
<th>Metro area</th>
<th>Employment in health care</th>
<th>Change from '87</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bergen-Passaic</td>
<td>9.9%</td>
<td>+2.6 pts.</td>
</tr>
<tr>
<td>Middlesex-Somerset-H</td>
<td>6.7%</td>
<td>+2.0 pts.</td>
</tr>
<tr>
<td>Trenton</td>
<td>7.3%</td>
<td>+1.6 pts.</td>
</tr>
<tr>
<td>Monmouth-Ocean</td>
<td>12.2%</td>
<td>+3.7 pts.</td>
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</tbody>
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**East Versus West**

The origins of the health care corridor stretch to the late 19th century, when the nation's largest universities — then all in the Northeast — began to build teaching hospitals.

The modern pharmaceutical industry was born around the same time. New Jersey's proximity to New York and Philadelphia helped attract early drug companies like Johnson & Johnson and chemical companies that expanded into drug making.

By the late 20th century, however, newer industries, concentrated on the West Coast were growing more quickly. Despite repeated attempts by politicians and executives, the Northeast's technology clusters, including Silicon Alley in New York and Route 128 around Boston, never approached the weight of Silicon Valley or Seattle's software industry.

As a result, the Northeast region, while certainly basking in the national economic boom of the late 1990's, lost ground. From 1985 to 2000, the number of jobs in the already crowded metropolitan area that encompasses Silicon Valley grew more than 4 percent a year, according to Economy.com. In the Northeast corridor, the gain was only 2 percent.

"As a home-care worker, you can't go any higher," said Mary Toni, a Bronx resident who 50's who of Pennsylvania Health System. "I faced with budget deficits and increasing medical costs, many states..."
Unemployment Rate

<table>
<thead>
<tr>
<th>Month</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Oct '02</td>
<td>3%</td>
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<tr>
<td>Nov '02</td>
<td>5%</td>
</tr>
<tr>
<td>Dec '02</td>
<td>7%</td>
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<tr>
<td>Jan '03</td>
<td>9%</td>
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Income

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Yale University</td>
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Average Health Care Salary

<table>
<thead>
<tr>
<th>Year</th>
<th>Salary</th>
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<tbody>
<tr>
<td>1998</td>
<td>$15,000</td>
</tr>
<tr>
<td>2000</td>
<td>$17,500</td>
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Income Distribution

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>NORTHEAST</td>
<td>34%</td>
</tr>
<tr>
<td>UNITED STATES</td>
<td>66%</td>
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</table>

Connecticut

<table>
<thead>
<tr>
<th>City</th>
<th>University of Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Haven</td>
<td>Yale University</td>
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New York

<table>
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<tbody>
<tr>
<td>New York</td>
<td>Columbia University</td>
</tr>
<tr>
<td>New York</td>
<td>Mount Sinai School of Medicine</td>
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Philadelphia

<table>
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<tr>
<th>City</th>
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<tbody>
<tr>
<td>Philadelphia</td>
<td>GlaxoSmithKline Bayer</td>
</tr>
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</table>

Baltimore

<table>
<thead>
<tr>
<th>City</th>
<th>University of Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>Johns Hopkins University</td>
</tr>
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</table>

While the jump in drug spending has no doubt been good for the Northeast's economy, it has sometimes come at the expense of the welfare of the nation as a whole. Many scientists believe that drug makers have at times exaggerated the benefits of their costly new products, steering people away from less expensive but equally effective medications.

Health care spending also does not generally make other parts of the economy more efficient, in contrast to technology investments that allow a society to produce more goods and services with the same effort.

But medical spending can contribute to society in ways that many people consider more valuable than money: adding years of healthy life. The newly intense search for longevity — caused by the aging of society, an increase in disposable income and a burst of new treatments, particularly for heart disease — is the prime reason regional medical megalopolises should continue to thrive.

Of the five cities whose institutions receive the most research money from the National Institutes of Health, only No. 3 San Diego is not in the metropolitan corridors. The other four, in order, are Boston, New York, Philadelphia and Baltimore.

 Patients follow this money, looking for advanced treatment. For example, 15 percent of the patients at Johns Hopkins now come from outside Maryland, up from 13 percent a decade ago.

Consider Andrew J. Lee, whose mother in South Korea recently learned that she had thyroid cancer. Her doctors told her that surgery was the best treatment, but the family wanted to know that the world's top doctors agreed with the diagnosis. So Mr. Lee, a young lawyer who lives in northern Virginia, brought his parents to a trip to the United States.

Looking at the cancer centers ranked highest by U.S. News and World Report, he focused on Memorial Sloan-Kettering in New York and Johns Hopkins, he said, because they were a distance that we could travel to in a day.

Doctors at the hospitals, which both have special offices to work with foreign patients, agreed that Mr. Lee's mother should have the surgery. She flew home, where she was insured, to have the operation. Mr. Lee said his family had no regrets about spending $6,000 on travel and doctors' consultations to be sure that they were making the right decision.

"We were able to get total confirmation," he said.
Health Insurance

In sickness and in health

Reform is in the air for health insurance, though it still won't look like Europe's.

Those Europeans who like to claim that America is an uncivilised place sooner or later cite its health-care system. One in seven people in the world's richest country does not have health insurance, that staple of the European welfare state. The uninsured are becoming a contentious political issue inside America—for the first time since "Hillcare", the Clinton's ill-fated attempt to overhaul America's health-care system in 1993-94.

Producing some kind of health-care policy before the 2004 election is one of George Bush's priorities, particularly now that he can no longer blame a Democratic Congress for standing in his way. So far his main focus has been on providing prescription-drug benefits to old people. But the uninsured are a bigger challenge.

Contrary to the stories peddled in Europe, as well as by some Democrats, the uninsured are not some wretched underclass. The poorest Americans, as well as the disabled and the elderly, are insured by the government's Medicare and Medicaid programmes, which together cover one in four people. Most other Americans are covered by employer-sponsored plans. The 41.2% people who had no health insurance in 2001—and the number is rising—are, as Robert Moffit of the Heritage Foundation points out, a mixed bunch.

They are mostly middle-class. Three-quarters of those of working age have a job. A third live in households with more than $50,000 in annual income. Two-thirds are under the age of 35 (college students are often uninsured). Around half go without insurance for less than six months. The typical uninsured household is a youngish married couple, with the husband working for a small firm that does not provide health insurance.

Most of the uninsured are in that position by choice—albeit a slightly forced one. One in four has access to coverage at work, but fails to take it up, either because the premiums are too high (usually they amount to a couple of hundred dollars a month), or because they would rather spend their disposable income elsewhere. Many of those who are not covered at work or are between jobs could afford to buy policies themselves (though they are even more expensive than at work, where risks are pooled), but do not. Young and healthy, they take a rational bet.

There is, however, little reason for complacency. Many of the newly uninsured fall into that category because of redundancy: losing your job often means losing health-care cover. Employers have also gradually been changing their insurance plans, shifting ever more of their ever-rising health-care costs on to employees. And treatment of the uninsured costs more, too, since an uninsured ill person will often leave an illness untreated until it becomes an emergency, at which point federal law requires hospitals to care for them.

An even bigger problem is the uneven structure of health insurance, which, since the second world war—when health insurance costs were exempted from wage controls—has been designed to be routed through big employers. People who get their insurance through their employer enjoy a tax break, which costs the government $141 billion a year. Poorer workers who want to buy health insurance on their own must pay for it out of after-tax income. Mr Moffit calls this "massive discrimination against the poor".

Remembering Hillary

When the Clinton administration tried to create a new health-care system, Republicans portrayed it as a looming Frankenstein bureaucracy that would destroy most Americans' high quality of care and usher in the horrors of waiting lists. This time, it may be a more moderate affair. So far there have been relatively few voices raised in support of a "single-payer" plan, similar to those in Canada or Britain. Al Gore's was one, but he has now dropped out of the presidential reckoning (see Lexington). In November, a referendum to bring a single-payer system to Oregon failed by a margin of four to one.

For their part, Republicans are likely to continue their push for tax credits and rebates to help poor people buy insurance policies from private insurers. One proposal, made last year, is to offer tax rebates of up to $3,000 a year for poor households that pay for insurance out of their own pockets. The Democrats, though now outnumbered in both House and Senate, will try to steer the poor towards the dismal Medicaid system. Last year, when they controlled the Senate, they twice rejected any use of private insurers to help those without coverage.

The most interesting idea is a proposal to require all Americans to buy health insurance. Most of the working poor, armed with tax credits, would go to private insurers, but the truly poor could tap government-sponsored risk pools. Senator John Breaux of Louisiana, a Democrat, has modified one version of this. After all, in nearly every state of this car-crazy country, you can hardly take to the highway without proof of insurance. Perhaps Americans will decide that what is good for the road is also good for their health.
news in brief

Senate move starts run up for triple jump in NIH budget

Washington With the doubling of the budget for the National Institutes of Health (NIH) not yet complete, some in Congress are already talking about giving the agency an even bigger boost.

On 17 October, Senator Arlen Specter (Republican, Pennsylvania) introduced a 'Sense of the Senate' resolution—a non-binding measure that senators can use to pledge support for an issue—that asks his colleagues to boost the NIH's funding to $41 billion by 2008, tripling the agency's budget since the fiscal year 1998.

The NIH's backers outside Congress appreciate Specter's support, but say that their current priority is trying to get this year's budget passed. Many are beginning to worry that the NIH will not get the $3.7-billion increase it needs to complete a doubling of its budget in the fiscal year 2003.

US monitor of clinical trials to step down next month

Washington Greg Koski, head of the US Office for Human Research Protections, has said he plans to quit his post at the end of November.

The office was created in 2000 to improve federal monitoring of clinical trials, and Koski is its first director. Under his leadership, the agency has started developing conflict-of-interest guidelines and has issued guidance for groups that cannot give consent to research, such as prisoners and children.

Koski's announcement, which was made on 9 October, follows the Bush administration's decision to wind up the National Human Research Protections Advisory Committee, a federal advisory panel. Some observers have suggested that the two events may be linked, but others pointed out that Koski had promised changes but was not able to implement them.

"There's been a sense of a lot of bombast but not a lot of follow-through," said one federal official who asked not to be named.

Koski will now return to his former post as an associate professor at Harvard Medical School and an anaesthesiologist at Massachusetts General Hospital in Boston.

Cancer audit reveals spending inequalities

London Just 2% of British cancer-research funding is spent on preventing future cases of the disease, the first major audit of the sector has revealed.

The London-based National Cancer Research Institute, an umbrella body for the government and the major charitable bodies that fund cancer research, revealed that 40% of the £257 million (US$398 million) spent on cancer research each year goes on basic biology, 22% on treatment research and 16% on exploring possible causes. The finding that relatively low sums are spent on prevention, patient care and survival research prompted the institute to set up groups to see what further research could be done in these areas.

Despite the fact that lung cancer accounts for nearly a quarter of cancer-related deaths, research on the disease receives just 3% of available funds. Research into leukaemia, which is much rarer, takes nearly a fifth of the money.

Fast-track plan to double NSF funding hits the buffers

Washington A proposal to double the budget of the US National Science Foundation (NSF) over the next five years has temporarily stalled.
THE U.S. IS the world’s biggest spender on health care, more than $1 trillion a year, and the place where drugs and medical techniques first get deployed across vast segments of the population. It is the world’s health-care laboratory.

And as with other American technology, the U.S. is exporting medical advances, ranging from heart catheterization to cancer-fighting drugs, throughout the industrialized world. The price of these advances, of course, is a rise in medical costs for countries and regions—Canada, Western Europe and Japan—that have long spent less on it than the U.S.

The march of technology—and thus, cost increases—looks inexorable. In today’s world, physicians travel and they read the same journals, the best equipment is available everywhere and patients are increasingly savvy; the Internet has put best-practice information at patients’ fingertips all over the globe. With this in mind, demand for better medical care is, in any event, unlikely to soften.

The high cost of providing better medical care won’t go away, either. Overseas, most governments control health spending, but they couldn’t fully rein in technology in the 1990s and 2000s; scholars largely agree that technological advances account for 50% or more of the rising cost of health care. “At a practical level, countries outside the U.S. could not control the rate of technical change they faced,” says Harvard economist David Cutler.

Throughout the 1990s, for instance, Britain devoted only about 7% of its economy to health care. Just a few weeks ago, the Blair government in the United Kingdom outlined an ambitious 43% real increase in health spending over the next five years. It would raise the U.K. level to about 9.5% of GDP, roughly on a par with the rest of Europe.

“This is a good thing, and long overdue,” says Sir Brian Jarman, the incoming president of the British Medical Association. Doctor-to-patient ratios have worsened. Infant-mortality rates have worsened against Euro-

U.S. Exports Medical-Technology Advances—and High Costs

low the use of expensive drugs, such as those used to fight chronic myeloid leukemia, already deployed in the U.S.

That said, across Europe right now, governments are determined via mandatory price cuts to hold down the rising costs inherent in technologically advanced drugs. It isn’t always as simple as fixing the price of an individual pill, however. Drug companies’ direct-to-consumer advertising, a made-in-America practice on the verge of export, has by all accounts stimulated the demand for pharmaceuticals in total. Prodded by the drug companies, the European Union is now set to begin allowing direct-to-consumer ads, though only as a limited pilot project.

This collision between wanting the benefits of high-tech advances and the problems of paying for them gets ever clearer. The U.K. will raise

Big Spenders
Health spending as a percentage of gross domestic product in 2001.

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>12.9%</td>
</tr>
<tr>
<td>Germany</td>
<td>10.3%</td>
</tr>
<tr>
<td>France</td>
<td>9.3%</td>
</tr>
<tr>
<td>Canada</td>
<td>9.2%</td>
</tr>
<tr>
<td>Italy</td>
<td>8.0%</td>
</tr>
<tr>
<td>Japan</td>
<td>7.9%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6.9%</td>
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Source: OECD

taxes to pay for its expanded National Health Service budgets. Germany has imposed bigger co-payments for drugs on its citizens. Facing big increases in cost, the U.S. is shifting more of the health-care cost burden to employees.

Japan, meanwhile, faces a perfect health-care storm. Japanese doctors use lots of expensive scanning equipment (often owned by doctors), and patients consume huge amounts of pharmaceuticals (often dispensed by doctors). That, plus a rapidly aging population, suggests medical costs will soar. Indeed, one government panel recently estimated that health-care spending on the aged will double between 2001 and 2010. Meanwhile, with its decade-long economic slump, Japan is already running monstrous budget deficits. It can ill afford budget-busting health-care expansion.

Some government efforts to impose higher costs on Japanese consumers have met opposition and been scrapped.

Everywhere, including in the U.S., the spread of technology is raising fresh questions. The big one: Is all of this high-tech worth it? One group of experts argues that much of this health-care technology is clearly worth the expense. Prof. Cutler at Harvard, in a forthcoming book, argues that in many medical areas, the costs are far outweighed by the benefits in longer life—13 years on average, in the case of low-birth-weight babies. In Prof. Cutler’s calculations, every dollar invested in low-birth-weight care returned $5 in terms of extended life. He calculates even greater return on cardiovascular advances.

Other experts take another tack, though. William Schwartz of the University of Southern California questions the lavish use of diagnostic-imaging equipment, to hunt for certain rare occurrences, such as brain aneurysms, when the chance of detection is perhaps one in 2,000 patients. And, he says, “the flow of new drugs will swamp the system if we aren’t prepared to make some hard choices. We can’t afford all of this.”
ClibPDF - www.fastio.com
Prescriptions / By Michael Waldholz

Medicare Seniors Face Confusion As HMOs Bail Out of Program

IT'S NOT HARD to understand why Helen Locasto feels ripped off by the federal Medicare program that the 70-year-old retiree and her 78-year-old husband, Charles, rely on for the bulk of their health care.

Last week, Mrs. Locasto, who lives in West Hempstead, N.Y., learned through the local newspaper that she and 6,000 other Medicare members on Long Island were being dumped by the health maintenance organization that she and her husband joined just in January. The couple were attracted to the HMO, offered by First Health Inc., a closely held company based in New York and Florida, because it provided a range of medical services and a limited drug benefit for no monthly premium. Like most seniors, the Locastos need supplemental insurance to fill in Medicare coverage gaps that can cost thousands of dollars should they incur a serious illness.

But the other supplemental plans that are still available to Mrs. Locasto charge between $160 and $320 a month, which is a prescription-drug plan, an amount that she says will create a financial hardship. "I don't know which way to turn," Mrs. Locasto says.

The Locastos are among the almost 200,000 Medicare members being notified this week that they must seek alternative coverage because their HMOs will no longer be providing supplemental Medicare coverage as of Jan. 1, 2003. Consumer groups are being flooded with phone calls from angry and confused people such as the Locastos who must quickly find another supplemental insurance plan. For many, this also means they will have to find a new primary-care doctor, medical specialists and hospital.

This has become an annual predicament for Medicare beneficiaries for several years now. HMO companies have been reducing services or bailing out of the program since 1996, when the government's reimbursement increases began lagging behind the acceleration of health costs. The Bush administration has asked Congress to raise payments to stem the annual HMO exodus. But even that is unlikely to end the yearly service disruption to Medicare members, many of whom are too frail, frightened or just ill-equipped to effectively shop around for new coverage.

To assist people through their transitions, the Centers for Medicare and Medicaid Services, or CMS, last year began offering the first-ever Internet-based guide comparing costs and benefits of the HMOs and other supplemental insurance plans. But while the site, www.medicare.gov, is filled with the kind of consumer information that is unavailable anywhere else and that health advocates have been demanding for years, it is still an imperfect way to choose a health plan.

For Connie Keever of North Bellmore, N.Y., who also has lost her First Health plan, the site offers no help because she doesn't own a computer. Mrs. Keever bought the HMO coverage last year for her 77-year-old husband, John, who has had several heart attacks and a stroke in recent years. The HMO offered a doctor and hospital closer to their home than the Veterans' Administration hospital, almost an hour away, where John can get his care. Like the Locastos, Mrs. Keever says she can't afford the premiums of the other plans on her fixed income. For her, no amount of information is going to solve her problems.

For people in other parts of the country where more HMO options exist, the site is overflowing with information for the Internet-savvy. For instance, in Phoenix, where many seniors retire, the site lists HMOs offered by eight insurance companies and shows that five supplemental plans are free, while the others charge from $26 to $78 a month. All but one offers a prescription drug benefit, four provide vision services, and three provide dental coverage, though two charge extra for that.

The site also estimates, based on a member's age and health status, what out-of-pocket expenses might be for each plan. For someone 65 to 69 years old and in good health, monthly expenses are expected to range from $151 to $300. The site provides a survey of member satisfaction in a number of categories, Phoenix, the satisfaction for 1 ranged from a high of 52% to 39%. When asked another question—percentage of providers stayed in the plan for at least the percentages ranged from the site says the Web site is frequently and the survey available now are several y CMS spokesman says the is meant to be a foolproof buy but instead provides inform "can help." The site also pr comparative guide to local-a ing homes, dialysis centerscription-drug assistance p.

Diane Archer, a founder of Medicare Rights Group, a New York based nonprofit concern, ca tient information seniors ne at the site all. For instance, doesn't tell people if their d member of an HMO. "People olating that their drug ing covered anymore, their left a plan, or that benefits denly being reduced," Ms. j says. "None of that is on th

Until Medicare undergoes proactive makeover, and benefits become more consistently a amount of consumer informing to help seniors navigate plexities of getting health c they need it most.

Send comments to Prescriptions@wsj.com
Hospitals Feeling Strain From Illegal Immigrants

‘Free’ Care Staggers Providers at Borders

By DANA CANEDY

STUART, Fla. — In the two and a half years since Luis Jiménez arrived at the Martin Memorial Medical Center emergency room with severe brain damage from a head-on car collision, the hospital has become his home.

In that time, Mr. Jiménez, 30, a former gardener, has emerged from a coma, had two birthdays and accumulated medical bills of almost $1 million. By all accounts, he is well enough to be discharged, but the hospital and advocates for the patient are in a conflict over his mounting medical bills and future care that makes his release unlikely without a court order.

A penniless illegal immigrant from Guatemala, Mr. Jiménez has no health insurance, and his injuries have left him with limited mobility and the mental capacity of a 3-year-old. Martin Memorial wants to send him back to his homeland for any remaining medical care. But Mr. Jiménez’s advocates insist that he must remain at the hospital until it can find a suitable place in the United States or Guatemala that is willing to care for him.

The impasse is at the center of a national debate over who is ultimately responsible for illegal immigrants who require extensive medical care but have no means to pay for it. The issue has become an increasing concern for health care providers, particularly in Florida and border states with growing numbers of illegal immigrants.

Federal law requires hospitals to provide emergency care to critically ill or injured patients regardless of their immigration status. But because many illegal immigrants work in low-wage jobs that offer no benefits, and cannot qualify for Medicaid, they use emergency rooms as their primary source of routine and critical health care. As the number of such patients increases sharply in states like Florida, California, Texas and Arizona, so too does the financial burden on health care centers that treat them, hospital administrators say.

“We have been moving to our hospital is left to kind of figure out what to do for itself.”

The hospitals insist that they are not turning away critically ill or injured people, but they are becoming more aggressive in seeking ways to release them. Some hospitals are going to court seeking permission to discharge patients like Mr. Jiménez. Federal lawmakers are seeking financial aid to reimburse hospitals for treating indigent illegal immigrants, and some hospitals have taken unusual steps, including putting nurses on planes to fly the patients back to their own countries.

Such measures, though, have done little to stem the rising costs, the health care providers say.

“We have tried to work on this for years, but the problem has gotten more acute,” said Sheri Jorden, senior policy director for the Arizona Hospital and Healthcare Association. “Hospitals have been writing these bills off with great difficulty.”

According to a study released last month by the National Association of Counties, 86 percent of 150 counties nationwide reported an increase in uncompensated health care expenses in the last five years. Of those reporting an increase, 67 percent cited a growing number of immigrants as a factor in the rising costs for county hospitals and rescue services.

“Most of the counties receive money from the state and federal government,” said Jacqueline Byers, director of research for the association, “but it is not nearly enough to meet the growing need.”

According to the Immigration and Naturalization Service, the number of illegal immigrants in the United States increased to as many as eight million in 2000, the last year for which figures are available, from five million in 1996. By some estimates, hospitals are collectively writing off as much as $2 billion a year in unpaid medical bills to treat the illegal immigrants, who, unlike American citizens and permanent residents, are ineligible for Medicaid.

In one case at Martin Memorial that was resolved in February, an illegal, poor, uninsured and badly injured.

Who pays?

Luis Jiménez in his room at Martin Memorial Medical Center in

“We feel there needs to national program of some sort would cover these individuals.” Ms. Austin said the case of catastrophic even the hospital a chance of repa Martin Memorial has been to release Mr. Jiménez but not patient’s guardian and the cannot agree on a discharge. The hospital has petitioned for permission to send Mr. back to Guatemala. No state center will accept him, since migration status makes hirle for Medicaid.

Mr. Jiménez’s lawyer that the hospital has not enough information about his can be placed and who him. Mr. Jiménez’s family in Jamaica does not have the money for his care.

“The hospital is saving he
Drug cocktail dries up tumors’ blood supply

Cancer patients have long used chemotherapy drugs to treat the disease, but now a new cocktail of anti-angiogenic drugs is being tested. The treatment has been successful in animal models, and researchers hope it will be effective in humans.

Cover Story

J.D. Douglas Bremner

Bremner first worked with Vietnam veterans suffering from post-traumatic stress disorder when he was a psychiatric resident. He was struck by the fact that these individuals struggled to remember appointments or what they had for breakfast, but vividly recalled their experiences in Vietnam, down to the sounds and smells. Since then, Bremner’s research has covered post-traumatic stress disorder, borderline personality disorder, depression, and anxiety.

Bremner suggests that there is no true separation between what happens in the brain and what goes on elsewhere in the body. He cites evidence that stress-related psychiatric disorders are associated with poor physical health. For instance, post-traumatic stress disorder patients have an increased risk of heart disease, and sexually abused women are twice as likely to smoke as other women are.

Bremner discusses the implications of his hypothesis for treating trauma-based mental disorders and how the mind dictates physical health. Norton, 2002, 311 p., hardcover, $30.00.

THE LOST DINOSAURS OF EGYPT

William Nothdurft with Josh Smith

Almost a century ago, Ernst Freiherr Stromer von Reichenbach led an expedition to Egypt’s Bahariya Depression. That journey yielded the discovery of four new species of dinosaurs including Spinosaurus—a Tyrannosaurus rex-size predator. However, Stromer’s maps, fossils, and field notes were lost during the bombing of Munich in 1944.

Three years ago, a group of Philadelphia-based graduate students led by Smith decided to retrace Stromer’s tracks. Once at the Bahariya Depression, they made a discovery of their own: Paralititan, the largest dinosaur to walk on Earth. Science writer Nothdurft teams up with a member of the group to recount its expedition and describe Stromer’s original trek and the fruits of those trips. RH, 2002, 242 p., hardcover, $24.95.
RX for Immune System: Some Dirt

Bacteria Element May Help Kids Develop Resistance To Diseases Like Asthma

By CHARLES FORELLE

Good news for children who hate to clean their rooms: A team of researchers has found that exposure in youth to high levels of endotoxin, the outer membrane of common bacteria, appears to ward off the development of asthma and allergic diseases.

It is the latest piece of scientific research bolstering the increasingly popular "hygiene hypothesis," which says that modern urban and suburban households, where their clothes are washed with an arsenal of detergents and disinfectants, are simply too clean. As society gets progressively more rural, the hypothesis goes, people will miss out on the benefits of being exposed to plant and animal byproducts such as dirt, dust, hair and manure, and will be less able to tolerate their effects when encountering them in the environment. Hence, cats make us sneeze and springtime pollen touches off a well-spring of watery eyes.

In the study, published today in the New England Journal of Medicine, European researchers compared 812 children in Germany, Austria and Switzerland who live in communities that have both farming and nonfarming households. The scientists surveyed parents about their children's asthma and allergies, took blood samples and measured endotoxin loads in their mattresses. Endotoxin, abundant in soil and animal manure, is common on farms.

It has long been suspected that asthma is less prevalent among farming children than in the general population, and evidence suggests that the incidence of asthma and allergies has been rising during the past century. This led scientists to hypothesize that there is something about the bucolic lifestyle that is healthy for young immune systems.

"The kids have a natural way to protect against the microbes in their everyday life," says Charlotte Braun-Fahrlander, one of the study's principal investigators. Her team was motivated to study the link to allergy in the late 1980s when a rural doctor told her he never sees farm kids with hay fever, she said.

Research in the area has burgeoned: Last year, a study showed that children who grew up in households with dogs were less likely to develop allergies to the pets; a major study published last month demonstrated that exposure at a young age to cats or dogs reduced the incidence not only of cat or dog allergy, but also of other respiratory allergies as well. Studies are under way to examine entire cohorts of children from birth through childhood. Allergists have long thought having a pet around the house increased the likelihood of asthma and allergic diseases in children.

Another study published in 2000 by researchers at the National Jewish Medical and Research Center in Denver, showed that endotoxin exposure was associated with lower levels of asthma in a small group of babies. But the European team's findings for the first time provide strong evidence from a large pool of subjects that the presence of endotoxin actually is conditioning the immune system not to overreact to the everyday junk that is floating about in the environment.

The immune systems of people who suffer from asthma or allergies go into overdrive when they are exposed to even small amounts of environmental irritants—such as microbes, pollen or dust—and their white blood cells release a flood of chemicals called cytokines. The cytokines induce an allergic reaction, such as a rash or inflammation, intended to fend off the intruder. Sneezing and watery eyes, for example, help flush out irritants. In non-sufferers, the immune system responds in this way only to significant levels of irritation.

The European study found a sharp correlation between endotoxin exposure and cytokine production: When stimulated with two common microbes in a laboratory, white blood cells taken from children with low levels of endotoxin in their mattresses produced nearly twice as much of certain cytokines as did blood cells from children with high levels of endotoxin exposure.

Overall, researchers found that only 4% of the farm children had hay fever, versus 11% of those who didn't live on farms. In addition, 3% of farm children had atopic asthma, the allergic form of the disease most common in children, versus 6% of their nonfarm peers. Farm children also had about twice as much endotoxin, on average, in their mattresses as nonfarm children.

The study didn't venture into the area of why poor urban children seem to be afflicted much more severely with asthma when they do get it. Various explanations include lack of access to medical care and poor indoor environments, such as being exposed to roaches.

Scientists caution that the study's results don't mean that parents should let their children live in a pig pen. For one thing, advances in hygiene during the past century are largely responsible for curbing the spread of infectious diseases, but all eliminating malefactors such as chlordane in industrial cities in Europe and North America.

Donald Milton, a lecturer at the Harvard School of Public Health not involved in the European study, notes that very high levels of endotoxin exposure can actually induce asthma. In addition, Dr. Milton says, "once you've got asthma, endotoxin does bad things to you. Endotoxin is a complicated problem."
When cells give up

Many cells just cash it in. Understanding why could lead to treatments for devastating diseases

BY RACHEL K. SOBEL

Humans don’t like self-destruction. At least on a cultural level, we tend toward things—seat belts, for example—that preserve life. But on a cellular level it’s a whole different story. Inside the human body, cells are doing themselves in every day without reproach. Indeed, scientists are coming to appreciate our innate self-destructiveness and to explore it as a potential pathway to better health.

A properly functioning body is like a utopia, where each cell serves a well-defined purpose. Even cells that die are important. For example, certain cells create the scaffolding when the body is forming; when the job is done, they in effect commit suicide. Others, confronted with an invading virus, take one for the team to prevent the germs from spreading. But like anything else in biology, the process can go haywire. In some cases, the deep-wired death programs order too many cells to die—or too few. Either can result in disease.

Over the past decade, scores of scientists have discovered that such programming flaws in controlling cell death underpin a variety of medical problems. That idea has inspired many researchers to delve into the field of cell-death research. Their goal is to figure out why cells choose to commit suicide and, then, how that choice can be altered to treat disease. This month, about 100 scientists gathered in San Diego to compare notes on their progress. Researchers reported, among other things, on novel strategies to treat heart attacks, cancer, and sepsis.

This new science took root in the mid-1970s in a lab in Cambridge, England, when two young scientists, Robert Horvitz and John Sulston, took on a project of weighty proportions: How, they wanted to know, do humans begin as a single cell and develop into something so complicated? Though the vision was grand, they decided to first study a less complex organism, a microscopic worm smaller than a grain of rice.

Horvitz and Sulston watched this tiny worm mature under a microscope and made a striking observation. In the
Suicide cells

Source: Richard Kitis, Albert Einstein College Of Medicine

course of natural development, exactly 131 cells in each worm died at the same places at the same times, as if on cue. Biologists had known that normal, healthy cells sometimes die, but no one had yet observed such precision choreography.

The work attracted little notice. "People just didn't think that dying cells were interesting," Horvitz says. Still, he persevered, and in the early '80s his team, then at the Massachusetts Institute of Technology, found a gene that was responsible for all 131 cell deaths in the worm. Then—and this is what finally sparked excitement outside the world of worms—Horvitz reported in 1993 that one of the worm suicide genes had a human counterpart. "The day our paper came out, I got telephone calls from five different pharmaceutical companies," he recalls. That discovery sparked a whole new line of inquiry: If humans also had this self-destruction apparatus, what role did it play in disease, and how could it be exploited for treatment?

Since then, more than 1,000 scientists have joined the search for molecular byways that lead to cell mortality and human disease. Take heart attacks, for example. Investigators have seen evidence of cell suicide in heart muscle tissue after attacks. So Richard Kitis of the Albert Einstein College of Medicine studied mice that had deliberately been given defective suicide programs. After mimicking a heart attack, he found a lot less tissue damage in these mice, pointing to a possible therapy at the cell-suicide level. Working with Idun Pharmaceuticals in San Diego, Kitis is now testing a compound that could inhibit key steps of the death program. The drug has reduced tissue damage after a heart attack by about 50 percent in mice—and has resulted in sustained improvement in cardiac function, the best predictor of long-term survival after a heart attack. Idun hopes to begin clinical trials by early 2003.

Disrupting cell-death programs might also curb damage from sepsis. The condition, which affects more than 300,000 people a year and often occurs in already hospitalized patients, is an unbridled inflammatory reaction to a bloodstream bacterial infection. Medical dogma has been to treat the infection with antibiotics, but in many cases that's not enough. Based on basic cell-death research, the drug company Merck Frosst in Canada is now proposing a radical new approach: treating the deadly disorder by directly disrupting cell-death signals—specifically in suicidal lymphocytes, the cells that normally orchestrate and execute the immune response.

Paradigm shift. This early work suggested that sepsis might be approached as an immune-suppression syndrome—such as AIDS. After the initial storm of inflammation, patients probably die because they lack the artillery, or lymphocytes, to mount an immune response against the infection. The goal then should be to keep those fighting cells alive. Preliminary studies by the company show that preventing death of lymphocytes—by dosing them with a compound that inhibits self-destruction signals—doubles survival time for septic animals.

The approach with cancer is totally different. The problem with heart attacks and sepsis is that they have too much cell death; cancer has too little. Cancers arise not just because cells replicate uncontrollably but also because they die too slowly. So the rationale is to try to restore normal death signals in these cells, says Gerard Evan, professor of cancer biology at the University of California—San Francisco: "It's like judo—you use your opponent's weight as a lever. You use the power of the tumor to kill itself." Several companies are already testing drugs that aim to fix cells' natural suicide programs.

Some issues still need to be resolved. One major concern is treating chronic diseases, such as heart failure, because no one knows yet the effects of altering the self-destruction machinery over the long term. Such processes are fundamental to the biology of all cells, so drugs could have lasting effects on normal ones.

Still, Horvitz believes these matters can be sorted out. "Things are far enough along that the prospect of applying a knowledge of cell death is very real now," he says. "There has been a revolution in biology; we now hope to make a revolution in medicine."
Malaria initiative cries out for action in Africa

Declan Butler, Arusha, Tanzania

The fight against malaria must shift its focus to the poorer African nations that suffer most from it, participants at the largest-ever international meeting on the disease were told last week.

Together, these countries account for 90% of the world’s malaria deaths, attendees at the third pan-African conference of the Multilateral Initiative on Malaria (MIM) in Arusha, Tanzania, heard.

“Africa itself needs to take the lead in the challenge,” says Ibrahim Samba, regional director for Africa for the World Health Organization (WHO). “If we are asking donor countries to write off our debts, we should commit ourselves to using some of the money to combat malaria. We should also use money that is now being spent on arms.”

The meeting brought together 950 experts in all aspects of malaria research and prevention, from physicians, cell biologists, geneticists and vaccine developers to economists, policy-makers and financiers.

Almost half of the participants came from 29 African countries. Such a broad gathering would have been unlikely only a few years ago, when malaria research was languishing after decades of political and scientific neglect. But in 1997, a small group of research agencies, charities, aid donors and scientists set up the MIM and held their first conference in Dakar, Senegal, to explore ways forward and to plan a multifaceted assault on the disease.

Since then, action against malaria has acquired a higher profile, and several international initiatives have been created for malaria research and control, and for drug and vaccine development. The Arusha meeting took stock of their progress — as well as that of the pledges made by African heads of state at a meeting in Abuja, Nigeria, in April 2000. They had pledged to take decisive steps towards halving the world’s malaria burden by 2010, and to ensure that 60% of those affected have access to treatment, protection during pregnancy, and are protected by insecticide-treated bednets.

These promises were made when the African leaders signed up to Roll Back Malaria (RBM), a global initiative created in 1998 by Gro Harlem Brundtland, director-general of the WHO. RBM is now being revamped in line with the recommendations of an external review (see Nature 419, 422; 2002). It will no longer be controlled by the WHO, and its secretariat will report instead to a governing board representing funders of the effort and the countries wrecked by the disease. It will focus its efforts on a small number of malaria-plagued countries where its ideas stand a decent chance of being put into practice quickly.

For, despite the RBM, malaria is still killing thousands of children every day. “We need to go faster,” says Gerald Keusch, director of the Fogarty International Center at the US National Institutes of Health in Bethesda, Maryland, and head of the MIM secretariat.

With no vaccine in sight for at least ten years, Keusch shares the view that the most pressing need is to have adequate control measures on the ground. But he also believes that research must underpin all eradication efforts, and that findings from the recent publication of the malaria parasite’s genome and that of its vector, the mosquito, must quickly translate into new tools (see Nature 419, 426–428; 2002).

The MIM aims to help build a vibrant African research community to scale up the battle against the disease. But an external evaluation of the initiative that was made public at the meeting says that there should be greater efforts to train African scientists and to improve links between researchers there and their colleagues in rich countries.

The MIM’s funding of 36 new multicentre projects in Africa has empowered African labs, says Kojo Koram of the Noguchi Memorial Institute for Medical Research in Accra, Ghana, one of the continent’s leading malaria centres.

Grants from MIM have also allowed Hassan Mshinda, head of the Hakara Health Research and Development Centre in Tanzania, to set up labs for studying molecular markers of drug resistance, allowing country-wide ‘early warning’ maps of its occurrence to be drawn up.

The MIM evaluation suggests that its secretariat, which is now in Sweden, should eventually rotate among African countries, and be supervised by an advisory board with strong African participation. African involvement is fundamental, speakers at the meeting said, because even if money is forthcoming, it will achieve little unless the African countries make malaria a higher priority.

Many speakers also demanded that African states be held to account on the promises they made at Abuja. Only a handful have increased funding and staff to anywhere near the required levels. And only 17 African countries have reduced or lifted taxation on essential items for malaria control, while 26 are still taxing bednets. “No one is monitoring the Abuja claims,” says Mshinda.

Many African researchers nonetheless remain optimistic. “Things are falling into place,” said one of the scientists at the meeting. “We haven’t seen this level of activity for decades.” One area where substantial progress is being made is in the emergence of regional scientific networks, which are now generating continent-wide maps of baseline data on factors such as morbidity and mortality. “Success is inevitable,” says Samba. “We will beat malaria, just as we beat river blindness.”
Accounting Crackdown Focuses Increasingly on Top Executives

BY MICHAEL SCHROEDER, JERRY GUIDERA AND MARK MAREMONT

The federal crackdown on aggressive accounting is setting its sights on more top executives, with the management of Computer Associates International Inc. among the latest to come under scrutiny.

A joint Justice Department/Securities and Exchange Commission probe of the big software maker is focused on whether it improperly boosted its financial results to help produce $1 billion in stock awards for the company’s top three executives in 1998, say people familiar with the matter.

That, along with the SEC’s recent notices to former leaders of Xerox Corp. and other companies that it’s prepared to go after them, signals a new determination in the wake of the Enron Corp. blowup, agency staffers say. “There is a heightened effort at the SEC to hold CEOs and other top officers responsible ... to take the profit out of financial fraud, and to bar them from ever serving as officers or directors” in the future, said Thomas C. Newkirk, SEC associate director of enforcement.

The scale of corporate quarry is also changing. The SEC is increasingly investigating large companies, says Charles D. Niemeier, chief accountant for its enforcement division. He says that was rare five years ago, but “we’ve come to recognize that larger companies are as susceptible to financial fraud as smaller ones.”

This stance comes at a time when the SEC faces a certain “where were

So health care costs go wild!

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After Era of Dominant HMOs, Providers Turn the Tables

By Consolidating Locally

HCA’s $8,465 Chest-Pain Bill

BY BARBARA MARTINEZ

To understand one reason why health-care costs are rising sharply, consider the reversal of fortune at HCA Inc., the country’s largest hospital owner.

Until recently, big insurance companies held the upper hand in the struggle over prices charged by hospitals. HCA says it routinely signed contracts with insurers that barely covered its costs.

But in a little-known power shift since the late 1990s, HCA and other major hospital chains have reshaped themselves into local oligopolists with the muscle to enforce much higher prices. Rebounding hospitals are helping pump up corporate health-care costs at a rate four times as fast as that of overall inflation.

The role reversal is playing out in Houston, where HCA operates 10 hospitals, a 22% share of the market. In 1995, the company ran only five. Twenty-two percent is more than enough leff to push around insurers. That’s because employees—and their employers—have come to expect that health plans will include all local hospitals. So, insurers generally must do business with any hospital company that controls one in five beds in a desirable market.

HCA began warning doctors in Houston last month that it would terminate its contract with Aetna Inc. in April. Aetna, the country’s largest health insurer, says HCA is demanding “double digit” price increases for each of the next two years, far more than what other area hospitals are receiving. HCA declines to discuss the Houston rates.

In Richmond, Va., where HCA owns five hospitals, or about 41% of the market, it has been equally bold in exploiting its strength. In 2000, the company’s hospitals there charged an average of $8,465 for treating a patient with chest pain, excluding doctors’ fees, according to Virginia Health Information, a nonprofit organization. That was 47% more than what those hospitals charged in 1995. The overall U.S. inflation rate was 9.8% over that period. HCA says its patients in Richmond tend to arrive with more serious problems and thus are more costly to treat.
Making Mice Mellow

Rodents yield clues to improved anxiety drugs

Treatment for anxiety disorders often center on drugs that relieve symptoms but can be addictive and cause drowsiness and other side effects. These medications work on brain-cell receptors for either of two chemical messengers, GABA or serotonin.

A new study has taken the first steps toward identifying drugs that may pack a more effective anxiety-fighting punch. Mice bred to lack the gene for an enzyme called protein kinase epsilon (PKCe) display far more calmness and curiosity in stressful situations than do mice who possess the gene, according to a research team led by neuroscientist Robert O. Messing of the University of California, San Francisco.

The scientists theorize that the absence of PKCe enhances the sensitivity of GABA receptors to a class of messengers known as neurosteroids. This boosts GABA's effectiveness at slowing down communication among neurons. Depletion of GABA has been linked to anxiety disorders.

Improved anxiety treatments may emerge if researchers develop medications that indirectly boost GABA's influence by thwarting PKCe. Messing's team concludes in the October Journal of Clinical Investigation.

"Our strategy is to see if we can influence GABA-receptor function through a [biochemical] side door that leads to the discovery of anti-anxiety medications with fewer side effects," says study coauthor Clyde W. Hodge of the University of North Carolina at Chapel Hill.

In 1999, the scientists first studied so-called knockout mice missing a gene for PKCe. Compared with mice carrying the gene, the knockout animals displayed blunted withdrawal symptoms after regular alcohol consumption and were less likely to drink alcohol again if given the opportunity.

In the new study, Messing's team turned up evidence that a GABA-mediated decline in anxiety may represent the fundamental attribute of these knockout mice. Mice lacking the gene PKCe showed few signs of fearfulness and a greater willingness to explore unfamiliar mazes—including one with unprotected pathways raised almost 2 feet off the floor—than did mice possessing the gene. PKCe-deprived mice also had lower blood concentrations of two stress hormones.

Moreover, injections of a substance that obstructs GABA-receptor activity rendered knockout mice as fearful and cautious in novel mazes as animals with intact PKCe genes were. Injections of the same substance had no effect on anxiety in the normal mice.

In contrast, injections of a druglike neurosteroid yielded more dramatic anxiety-related effects—including coordination-impairing drowsiness—in mice lacking PKCe than in normal mice.

The finding that PKCe deficiency in mice diminishes anxiety offers a promising lead in the search for improved drug treatments, comments neuroscientist Joshua A. Gordon of Columbia University.

Researchers now need to identify precise ways in which PKCe, as well as various neurosteroids, modifies GABA receptors, Gordon says. At the same time, Hodge says, to preempt potential side effects, it will be important to discern whether PKCe affects the heart and other organs. —B. BOWER

Cancer

Inducing eye-tumor cells to self-destruct

When their usefulness has ended, most cells succumb to a natural process of programmed cell death called apoptosis. The cells break up and their constituents are recycled.

In contrast, tumor cells don't know when to die, thereby exacerbating the uncontrolled growth of malignancies. By reawakening the apoptosis that seems to fail in many tumor cells, J. William Harbour, an ophthalmologist at Washington University School of Medicine in St. Louis, and his colleagues have now found a way to stop the progress of two eye cancers in cell cultures and rabbits.

His group focused on a key apoptosis-inducing compound, the protein called p53. In two eye cancers, uveal melanoma and retinoblastoma, p53 is rendered unable to induce apoptosis. In the body, p53 has a natural regulator, called HDM2, which keeps p53's effectiveness low until a cell signals unusual growth or other DNA irregularities. Then, HDM2 normally backs off, opening the way for p53 production to rev up and stimulate the manufacture of apoptosis-inducing chemicals. In eye-cancer cells, however, HDM2 doesn't step back. Instead, it relentlessly thrwarts p53.

To induce apoptosis in cancer cells, Harbour and his colleagues synthesized a miniprotein resembling part of p53. They took advantage of studies elsewhere of the human immunodeficiency virus that revealed that it makes a protein, called TAT, that can pass through cell membranes effortlessly. The scientists attached the p53 miniprotein to TAT for delivery into cells.

In the test tube, this combination binds to HDM2 and stops it from inhibiting the full p53. In the presence of the synthetic miniprotein, the unfettered p53 induces apoptosis in both types of cancer cells in a lab dish but not in normal cells, says Harbour.

The researchers next injected the HDM2-blocking treatment into the eyes of a rabbit with retinoblastoma. Within 48 hours, three-fourths of tumor cells in the animal began to undergo apoptosis, while healthy cells remained unaffected.

A TAT-based drug would probably also work as an eye drop, Harbour says, since it could pass through the cornea. —N.S.
Women now make up half of AIDS cases, U.N. study finds

By Steve Sternberg
USA TODAY

For the first time, women account for half of all people infected with the AIDS virus worldwide, a major study reported Tuesday. The demographic change has been driven partly by an increase in heterosexual transmission of the disease.

Much of Western Europe has seen increases in heterosexual transmission rates. In the United Kingdom and several European countries, 50% of new HIV cases diagnosed from 1997 to 2001 occurred through heterosexual sex.

The biggest impact on AIDS demographics comes from southern Africa, where women account for almost 60% of people who are infected with HIV.

"It means more orphans, more mother-to-child transmission and more starvation," says Peter Piot, executive director of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

"When you think of Africa, it's women who work in the fields," Piot says. "That will contribute to a drop in agricultural production."

Already, AIDS and starvation are locked in a deadly embrace as famine spreads through sub-Saharan Africa, says the report, UNAIDS' AIDS Epidemic Update. It was released before World AIDS Day on Sunday.

More than 14 million people are on the brink of starvation in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe, countries where a quarter of a combined population of 26 million adults have HIV/AIDS.

Women and girls, who make up the majority of those infected, are responsible for 50% to 80% of food production, UNAIDS reports. Food production is down by an estimated 60%. Thousands of orphans have been forced to forage or trade sex for food.

Countries that have attempted to tackle HIV, however, have reported some success. In South Africa and Ethiopia, HIV is becoming less prevalent among teenagers. Cambodia's epidemic appears to have leveled off.

The report shows there are 42 million people worldwide living with HIV/AIDS. In other findings:

- Latin America and the Caribbean now report 1.9 million people living with HIV, including 210,000 who were infected this year.
- Russia reports 200,000 new HIV infections, up from 100,000 in 1998. About 90% of the new infections have been linked to drug use.
- In Belarus and Ukraine, AIDS is spreading into the general population. Twenty-eight percent of the AIDS cases in the second half of 2002 have been linked to heterosexual sex, up from 15% in 1998.
- In China, HIV infects 1 million people, a number expected to grow to 10 million by 2010.
- In the USA, most reported HIV infections among 13- to 19-year-olds were among women and girls, and most of them were infected heterosexually. That's especially true in the Southeastern states, says Kathryn Whetten of Duke University.

"One of the reasons this happens here is that, like Africa, there are many more untreated sexually transmitted diseases, which makes it very easy for the virus to go from one person to another," she says.