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  • This hurts government, workers (can we fix it?)

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➤ Some companies did cut health costs

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Employers Expect Health-Care Costs to Rise 13% in 2002

By BARBARA MARTINEZ, Staff Reporter of THE WALL STREET JOURNAL

NEW YORK—The picture for health-insurance costs keeps getting uglier—for employers and consumers alike.

Employers expect their health-care costs to rise nearly 13% next year, with some companies expecting to be hit with increases of 20% or more, according to a survey to be released today by human-resource consulting firm William M. Mercer Inc.

The Mercer survey—of more than 2,800 employers—estimates the average cost to companies for each employee’s health-care benefits rose 11.2% to $4,924 in 2001. It is the largest increase in nine years, and grew at a rate several times faster than inflation.

The double-digit health-care cost increase comes as a weakened economy is eroding corporate profit, putting businesses in a squeeze. Moreover, aging baby boomers will require more medical attention and prescription drugs over the next decade, even as consumers increasingly fight tight health-plan rules.

According to recent government projections, health-care spending in the U.S. is expected to double over the next decade to $2.5 trillion, with U.S. businesses picking up a significant portion of the tab.

In response to costs, according to the survey, 40% of large employers said they will require employees to pay a higher percentage of total costs next year by raising deductibles and co-pays. Already among small employers, the median in-network deductible for preferred-provider plans, or PPOs, rose to $500 from $250, the survey found.

“We’ve been doing this survey for 16 years and the biggest deductible increase” in any year was no more than $50, said Blaine Bos, a Mercer principal and chief author of the survey. Employees also can expect to pay on average 18% more in premiums next year, according to Mr. Bos. And it’s not a temporary problem. “We’re going to be looking at a period of about four years of double-digit inflation,” Mr. Bos predicted. That is a particularly troubling trend for a company like General Motors Corp., which spent $4 billion on health care in 2000. Because of agreements with its unions, GM can’t easily make changes to its health benefits. Instead, the company is focusing on ways to better educate employees about costs. In August, the company named L.L. “Woody” Williams executive director of health-care initiatives after he spent 30 years at GM, mostly in charge of purchasing automotive parts and supplies. Much like that job, he sees his role as finding ways to drive unnecessary costs out of the system and promote quality.

“I don’t think that most people in the U.S. really understand the actual cost of health care,” Mr. Williams said.

Insurers and employers said one of the most effective ways of teaching America’s workers about health-care costs, however, is to make them pay for more of it.

As a result, several insurers are introducing health plans that require patients to pony up daily co-pays when they are in the hospital. The co-pays will generally be set according to the prices that the hospital charges the health plans, so that a more expensive hospital, such as a teaching hospital, will require a higher patient co-pay than a less-expensive community hospital.

Also, many more companies are offering their employees defined-contribution plans, in which employees manage their own health-care dollars. These accounts offer incentives for members to choose generic drugs over brand-name drugs and encourage them to shop around for doctors and medical services. According to the Mercer survey, 29% of employers with more than 20,000 workers said they were somewhat or very likely to adopt such an approach within the next two years.

Though such plans were met with much skepticism a few years ago, many of the companies offering them are now getting much more traction.

One such participant is Definity Health Corp., a Minneapolis company that gives members a medical budget set by the members’ employer. Employees can see whichever doctors they want using that budget, usually between $1,000 and $3,000 annually. Once that money is used up, medical costs will be paid by the employee through a deductible, so employees have an incentive to spend their budget carefully. The deductible is capped by the employer at a set amount, on average of $1,500 to $3,500. Above that level, the employer would pick up 100% of in-network care.

Definity has 6,500 enrolled members from four companies, including Medtronic Inc. In a recent survey of its members, 61% said they were paying more attention to the cost of health care, and 56% said they were actively trying to reduce the amount they spent on health care.

Some evidence of that attention can be seen in a 10% decline in the use of health-care services among Definity plan members, even as health-care usage among traditional plans is increasing. About 91% of Definity members use generic drugs when available, compared with an 80% generic-drug use among members of other plans.
Health care system can be a real headache.

Funny, for all the time Washington has spent discussing how U.S. companies are losing ground to counterparts in places like China, little attention has been given to how skyrocketing health-care costs are putting U.S. companies at a disadvantage to competitors in developed countries.

According to the Bureau of Labor Statistics, medical-care costs have risen 50% since 1994—nearly double the rise of inflation, minus medical costs. According to the National Health Statistics group of the Centers for Medicare & Medicaid Services, U.S. health expenditures now come to about 15% of gross domestic product. Japan spends about half as much on health-care as a percentage of GDP, yet has a higher life expectancy at birth and a lower infant mortality rate. Somehow one doesn’t want to chalk it all up to the benefits of drinking green tea.

U.S. companies willingly point out that they have been bearing the brunt of the rise in health-care costs, which is why so many of them have been passing along a larger share of the expense to employees. Firms with a strong union presence are less able to do this. General Motors says it spends $5 billion a year on medical expenses, or around $1,400 per vehicle.

In contrast, Japan, like most industrial countries, has national health insurance. Many companies still provide health-care benefits for workers, but government-sponsored health insurance helps bring down costs significantly.

Price increases 1994-2003

US medical costs up 14.3%
All other prices up about 2.2%
Dose of Prevention

Six Prescriptions To Ease Rationing In U.S. Health Care

Getting Wired; Using Research; Changing Pay; Managing Disease; Fixing ICUs

Patient: Educate Thyself

By LAURA LANDRO

Scanning a bank of video screens, Joseph Cooke zoomed in on one elderly patient lying in an intensive-care unit across the street. Dr. Cooke gave the man a quick visual exam. Then he checked the vital signs on the computer, looking for any change in blood pressure, heart rate or oxygen levels that might signal an impending cardiac arrest or life-threatening infection.

From his remote command post, Dr. Cooke watches three units on different floors at one hospital. That could help solve a massive nationwide problem: With a shortage of ICU specialists, patients aren’t well-enough monitored, leaving them vulnerable to complications that can lead to longer hospital stays and force hospitals to ration beds. At the New York-Presbyterian Healthcare System, where Dr. Cooke works, two new “eICU” stations cover six units in two different hospitals, and plans call for an expansion into all 30 of its hospitals.

Slowly, the drive to improve quality and efficiency that has swept through corporations is starting to arrive at the famously inefficient world of hospitals. Across the country, rising costs have forced some hospitals to effectively ration services, making life-and-death choices about who gets care and who goes without. But by boosting efficiency, cutting waste and medical error, and sticking to treatments that demonstrably work, medical experts are finding that many harsh decisions about who gets care might not have to be made in the first place. The new strategies range from installing high-tech sys-

Big Losses

Estimated lives and costs that could be saved each year by delivering recommended care

| Program                  | Deaths averted | Cost savings (in millions)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Controlling high blood pressure</td>
<td>28,300</td>
<td>$1,243</td>
</tr>
<tr>
<td>Diabetes care</td>
<td>15,600</td>
<td>$178.5</td>
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<tr>
<td>Prostate control management</td>
<td>2,140</td>
<td>$97.7</td>
</tr>
<tr>
<td>Smoking</td>
<td>2,700</td>
<td>$94.2</td>
</tr>
<tr>
<td>Cholesterol management</td>
<td>3,500</td>
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</tbody>
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Due to heart attacks and stroke.
Source: National Committee for Quality Assurance.

WHO GETS HEALTH CARE? Rationing in an Age of Rising Costs

Last in a Series

hospitals

about who gets care and who goes without. But by boosting efficiency, cutting waste and medical error, and sticking to treatments that demonstrably work, medical experts are finding that many harsh decisions about who gets care might not have to be made in the first place. The new strategies range from installing high-tech sys-

The crusade to bring the quality movement to hospitals, pushed in the past mainly by nonprofit groups, is now starting to get a boost from Medicare and powerful employer groups. Today, the federal Department of Health and Human Services plans to release the first national report on the quality of health care in America, which is expected to acknowledge gaps in key areas such as preventive care and chronic-disease care, and endorse many of the solutions quality experts propose for fixing them.

"We need to take back the money that goes into waste and harm in the system and make it an ethical imperative to free it up for the things that really add value," says Margaret O’Kane, president of the National Committee for Quality

Please Turn to Page AI0, Column 1
Medical Spending Continues to Rise At a Strong Pace

By Heather Won Tesoriero

Spending on hospital care, physician services and prescription drugs rose 8.2% in 2004, only slightly less than the 8.4% rise in 2003, according to a new report by the Center for Studying Health System Change.

The findings support earlier indications that the deceleration in the rate of health spending, which began in 2002, is stalling. As a result, it is likely that as overall health-care costs rise, employers will continue to shift the cost burden to employees.

"It's bad news for patients," says Paul B. Ginsburg, co-author of the study, which appears today on the Web site for Health Affairs, a health-policy journal. "The rate of increase in spending is a lot higher than the rate of increase of their incomes." The Center for Studying Health System Change, a policy-research group in Washington, is funded primarily by Robert Wood Johnson Foundation, a health-care philanthropy group.

For companies, the leveling off of health-cost increases at a high rate suggests the health-insurance premiums they pay also will halt a recent decline and remain high.

Insurance premiums tend to lag behind health-care spending. A recent nationwide survey of employers by human-resources firm Hewitt Associates suggests average health-maintenance-organization rate increases may slip slightly next year, to about 8% to 9%, from 9% this year. Premium increases aren't likely to shrink further if medical costs don't slow more.

The Health Affairs study data were based on price information from the Milliman Health Cost Index, constructed from public and private data on health-care provider revenue, which is paid by insurers, employers and patients. It excludes Medicare but includes Medicaid spending. Milliman Inc. is a consulting and actuarial firm.

In the study, growth in both inpatient and outpatient spending last year changed little from 2003, rising 6.2% and 11.3%, respectively, up from 6.1% and 11.1%. Spending on prescription drugs rose 7.2% last year, down from the 8.9% rise of 2003. That was in line with slowing growth of drug prices last year and might continue as a result of drug-safety concerns, a continued increase in patient cost-sharing for prescriptions and looming drug-patent expirations.

Please Turn to Page A9, Column 4
The Forecast For Health Care Costs: Stormy Weather

Costs Up 8% To 10% A Year

Employees will feel pinch as they pay more from their own pockets

BY GLORIA LAU
INVESTOR'S BUSINESS DAILY

In the next few months, research groups and consulting firms will release national data on 2004 health care costs and predict what 2005 will bring.

What can employers and workers expect?

They can plan on costs rising an extra 8% to 10% each year for the next 10 years, says Glenn Melnick, head of health financing at the University of Southern California and senior economist at Rand Corp.

Health care costs are growing two to three times faster than inflation every year.

They're also outpacing salary hikes and continuing to eat up more company profits.

"The story isn't good for consumers or employers," Melnick said.

Industry consultants Hewitt Associates recently said 2005 HMO rates are expected to climb 12.4% nationally, the mildest pace in five years. HMO rates are projected to rise 13.7% this year.

Last year rates rose 17%.

Though the rate of increase is slowing, employers should still worry, says Paul Harris, Hewitt's senior health care strategist.

"Employers are really struggling with these types of increases," he said. "This is equal to a 72% (premium) increase in the past five years."

If rates continue at this pace, he expects costs to add another 50% to 70% to overall expenses in the next five years.

This means employers will have that much less to invest in salary hikes and new hires. It also means employers will continue to ask workers to pay more out-of-pocket costs.

Insurance premiums, which are usually medical costs plus 3%, are expected to rise 11% to 13% annually.

Melnick says new medical technology is a big reason health care costs are on the rise.

"The 8% to 10% (increase) is driven by underlying demand," he said. "People want new stuff, new cures, new interventions," he said.

The Tufts Center for the Study of Drug Development says it costs $802 million to develop a new prescription drug.

Though the price of new drugs and technology declines with time — especially after generics and newer technology reach the market — that's offset by rising demand.

Someone with heart disease not only demands pricey new cholesterol drugs — if he has severely clogged arteries, he and his doctor might also choose minimally invasive heart surgery.

"Because of generous health insurance over the past 25 years, we've gotten used to the newest and the best," Melnick said. "That's created a very large health tech industry. Americans will continue to demand the newest and best even though they'll have to spend a rising share of income for it."

Hospitals also contribute to rising costs. They account for 40% of total health spending and are the main drivers of premium growth.

In recent years, hospitals, doctors and other health care providers have banded together in larger networks. That gives them more negotiating leverage against health insurers.

It also means fewer providers, less price competition and higher costs for workers and employers.

Workers and employers aren't happy about it.

Both pay more in health premiums every year, yet they get less coverage for their dollars.

Employers still pay 80% of a worker's health insurance premiums. Add out-of-pocket fees, and employers are paying two-thirds of the overall costs, Harris says.

But they're shifting more costs onto workers.

"What's changing in the health care landscape is how much faster workers' out-of-pocket costs are rising," Melnick said.

In the past, growth in workers' out-of-pocket spending always lagged overall spending hikes, shielding workers from the real cost of care.

"That changed in 2003, says Sandy Lutz, director of PricewaterhouseCoopers' Health Research Institute. "2003 was a real turning point," she said.

PricewaterhouseCoopers' latest report on national health spending shows that out-of-pocket spending by consumers was the only funding category in which the level of spending increases grew in 2003, the latest year of data available.

Out-of-pocket spending climbed 7.6% in 2003 vs. 6% in 2002. In contrast, premiums rose only 9.3% in 2003 vs. 10.6% in 2002.

The result: Fewer workers can afford their portion, so they drop employer-sponsored coverage to join the ranks of the uninsured.

It's a Catch-22. The more workers drop health coverage to become uninsured, the more overall costs rise for everyone. That's because the uninsured rely on emergency rooms, and hospitals have to raise other fees to cover those costs.

A recent Families USA study said care for the uninsured who don't pay or are covered by public programs like Medicaid will cost the average U.S. family $922 more in premiums this year.

That will rise to $1,502 by 2010.
Did you know that the United States is the only industrialized nation that still doesn’t provide its senior citizens with comprehensive insurance coverage for prescription drugs? That’s why Medicare, paradoxically, covers the cost of a heart bypass operation but not that of the medicines that might forestall surgery. It’s why Medicare pays to amputate the limb of a diabetic but not for the insulin that could save it. In both human and fiscal terms, this is policy without a purpose.

How did this happen? When Medicare was enacted, in 1965, it followed the patterns and standards of private health insurance, which in those days didn’t cover prescription drugs. The advances in pharmacology in the past 15 years have made such drugs a more vital part of treatment, but Congress has never been able to pass a bill to provide them through Medicare. Now the Senate seems about to do that—which is the good news. The bad news is that the cost of about $400 billion would be astronomical for a program already destined to be massively underfunded by the decade after next—never mind adding dramatically to the nation’s fiscal deficit this decade.

It would be nice if the money were found to give us the medications, and save Medicare, by efficient management. But no one knows for sure exactly where the waste is because Congress limits our ability to find out. It provides a derisory $15 million a year for operations research—about .0038 percent of annual total spending of about $400 billion. Medicare, to put it bluntly, is flying blind.

High and low. How, for a start, do we account for Medicare’s stark differences in regional spending? It costs approximately $8,414 per Medicare enrollee in the Miami area; the comparable cost in the Minneapolis area is $3,341. Miami’s prices for medical services aren’t higher, nor is the difference explained by the average levels of illness or the socioeconomic status of patients. The cost differential, instead, relates to the quantity of medical services provided. As Princeton’s renowned medical economist Uwe Reinhardt reminded us at a recent Siemens salon on healthcare, Congress has known about these spending discrepancies for decades. But it has preferred to keep the money taps open rather than find out what differences in the quality of medical care have been justified by this additional money.

There are some clues, however. Researchers who have studied the Medicare system found that parts of the country where medical costs are higher have more hospital beds, more physicians, a relative predominance of larger hospitals and teaching hospitals, and a higher proportion of urban residents. Physicians there also tend to use more evaluation, more management services and associated tests, more imaging and minor procedures, and they make more use of the hospitals as the site of care. So, for example, among patients in their last six months of life, intensive care units were used on average 2.5 times as often in the costliest areas. Doctors in those areas were also more likely to use medical subspecialists and order more frequent diagnostic tests, while areas of lower spending were more likely to use family practitioners. The use of discretionary services in the high-cost areas seemed to correlate remarkably well to the local supply of physicians and hospital resources. If you got ’em, use ’em.

But here’s the stunner: The residents in the costliest regions received 60 percent more care all right, but they did not seem to have better quality or outcomes of care; indeed, access to care seemed slightly worse.

Everyone has long assumed that more spending means better care, but that doesn’t seem to be the case. Residents in the costlier regions didn’t have lower mortality rates, better functional status, or higher levels of satisfaction than residents in the less costly regions. Nor is the discrepancy explained by more frequent major surgery in the costly regions or more access to advanced technology—long thought to be the driving inflationary force. The higher spending, instead, comes back to the discretionary services essentially associated with the local supply of physicians and hospital resources.

These are the findings of one authoritative study. It is clearly critical to go into more detail on a broader basis so that we know where and how we can safely contain or reduce the runaway Medicare budget without visiting inferior healthcare on patients. The prize is big. If we can safely reduce spending levels in the most costly parts of the country to those of the lowest-spending regions, we could reduce the Medicare budget by 30 percent a year. Over the next decade, that would mean annual savings of $120 billion, or $1.2 trillion in 10 years. That would dramatically change the financial projections of solvency for the Medicare trust fund and pay for the prescription drug program as well. To ignore this kind of amazing evidence would be nothing short of scandal.
Politicians Quiet About Who Pays the Bill

Huge Cost Increases Likely From Patients’ Bill of Rights

BY LINDA CHAVEZ

When it comes to health care, Americans want it all, so long as they don’t have to pay for it. The so-called Patients’ Bill of Rights, which recently passed the Democrat-controlled Senate, is a case in point. Enormously popular with the public, the bill would allow patients increased access to hospital emergency-room care, require insurers to pay for doctor-recommended hospital stays following mastectomies, and give patients the right to sue their insurance company in either federal or state court if insurers refused to pay for some treatments.

But the legislation is likely to fuel big increases in health-care costs, something supporters of the Senate bill, including nine Republicans and all 50 Democrats, don’t want to talk about. And no one seems sure about who will have to pay for it.

Part of the problem stems from the way we Americans pay for our health care in the first place. Most Americans don’t pay directly for health care, unlike food or shelter (which are every bit as necessary to survival). Most of us get our health-care coverage through our employers, who provide health insurance as a non-taxable employee benefit, paying part or all of the premiums. The effect is to lull people into believing that the benefit is free.

Employers Don’t Really ‘Pay’ for Health Insurance

Nothing could be further from the truth. Employers don’t really “pay” for health insurance, even if they write the entire check for the employee’s premiums. Money that goes to pay for insurance comes out of whatever the employer would otherwise provide in salary or other benefits. The only difference is, employees often have little say in what kind of insurance their employers will purchase on their behalf, what benefits it will provide or how much it will cost.

Health insurance, like every other form of insurance, is a way to spread costs and risks evenly among a large group of people. You pay a few thousand dollars a year to insure your car, home or other property against a relatively small risk that it will be stolen or harmed in an accident.

The company can afford to pay for repairing your wrecked vehicle or replacing your burned-down house, even though your yearly premiums amount to only a fraction of the cost, because most of its customers haven’t had a similar accident. If you happen to be particularly reckless—or unlucky—and your insured property keeps getting damaged or stolen, your premiums will go up; often dramatically, and you may find it difficult to buy insurance at any price.

Americans don’t seem to want the same rules to apply to health care, however. We want coverage, with no increased premiums, no matter how often we get sick or how costly our treatment. With most employer-provided health insurance plans, you get no direct benefit from leading a prudent, healthy lifestyle or avoiding expensive, unnecessary procedures. And not only do we expect insurance to pay for catastrophes, such as hospital stays as a result of accidents or serious illness, but we also want it to cover routine health care as well. It’s a little like expecting your home insurer to pay for a new roof or a paint job, or your automobile insurer to pay for new brakes or tires.

Until health insurance companies started imposing cost controls—by restricting automatic patient access to specialists, denying doctors the right to prescribe any treatment they deemed fit and limiting hospital stays, among other things—the price of health care was spiraling out of control. “Managed care” helped curb health-care costs in the early ‘90s, but it also fueled the current backlash.

If the Senate version of the Patients’ Bill of Rights becomes law—by no means a sure thing with the House yet to act and President Bush threatening a veto of the bill in its current form—we’ll all pay for it one way or another.

It would be better if we were forced to do so directly rather than through our employers. Then we could make rational decisions about what services we wanted and how much we were willing to pay for them.

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Miss Chavez, a nationally syndicated columnist, is president of the Center for Equal Opportunity.

July 16, 2001
Living Expenses

How a Hospital Stumbled Across An Rx for Medicaid

Mt. Sinai Helps Patients Avoid The ER, Paring State Costs And Aiding Its Bottom Line

Dr. Chassin Goes After Salt

By John Carreyrou

June 22, 2006

After being diagnosed with congestive heart failure three years ago, Norma Soto became a regular at the emergency room of New York’s Mount Sinai hospital. Each visit was lucrative for Mount Sinai because Medicaid covered Ms. Soto’s expensive treatment.

“I’d end up spending hours there,” recalls the unemployed 54-year-old, who lives alone in public housing in East Harlem. On one visit she could barely breathe and was kept overnight, a service Sinai typically bills at about $7,000.

These days, when Ms. Soto doesn’t feel well, she calls a nurse who checks her weight, gives her advice and adjusts her medicine. Mount Sinai pays the nurse’s salary and misses out on the big fees Ms. Soto used to generate.

Fortunate Outcome

A money-losing Harlem hospital’s turnaround is called a ‘business-school case study,’ article on page B1.

More importantly, New York state, which helps fund Medicaid, avoids having to pay a hefty hospital bill.

The unusual program is the result of a deal between Mount Sinai and the state, and it could offer a way to help ease the U.S.’s seemingly intractable health-care crisis. The hospital provides free preventive care to poor East Harlem residents in exchange for higher Medicaid reimbursement rates at its outpatient clinic. It also expects to fill the beds that become free with better-paying patients. Combined, that will more than make up for the hospital’s lost revenue. The state, for its part, hopes the program will help reduce its ballooning Medicaid expenditures by cutting down on expensive trips to the ER.

As health care grows ever more costly, Medicaid is becoming a growing financial burden for the states. The program saw costs rise 44% between 2000 and 2004 to $296 billion.
Healthy Debates Engage U.S. and Canada

David Gratzer disparages our study’s findings that Canadians are healthier and have better access to healthcare than Americans (“Where Would You Rather Be Sick?” editorial page, June 15). He claims that Americans’ obesity and lack of exercise, as well as “genetics and culture” explain the fact that Canadians live two years longer on average, not differences in care. Yet he neglects to mention that Canadians smoke more than we do—a factor that should negate Canada’s diet and exercise advantage. And there’s not an iota of evidence that genetics or culture explain Americans’ higher mortality.

Strong evidence indeed America’s deficient health care as the culprit. Cana’s infant mortality rate, higher than ours until they adopted national health insurance, fell once universal coverage was implemented and has remained well below the U.S. figure. Though Americans with heart attacks get more heart surgery, their mortality rate is no better than Canada’s rate. The prostate cancer statistics Dr. Gratzer cites to laud U.S. care reflect the enthusiastic pursuit of harmful “cures” in the U.S.—many of which would never be diagnosed in Canada or Europe and would cause neither symptoms nor death. A raft of studies indicate that quality of care in Canada for cancer and many other serious conditions is equivalent to that enjoyed by insured Americans.

Yet Canada spends roughly half what we do per capita on health care, and covers everyone. Lower bureaucratic costs—the result of cutting out the insurance middlemen—account for much of the savings. National health insurance could save Americans $336 billion annually on health-care bureaucracy, enough to cover the uninsured and to upgrade coverage for the rest of us as well.

David U. Himmelstein, M.D.
Steffie Woolhandler, M.D., M.P.H.
Harvard Medical School
Cambridge, Mass.

Canada’s nationalized (socialized) health-care system is wonderful—that is if you’ve never been sick. The members of my family have lived their entire lives in Canada. I could fill several pages of your newspaper with medical care stories that would have Americans up in arms. It’s not that Canadian doctors are undertrained. It’s that Canada is woefully short of hospital beds and hospital facilities, and also short of state-of-the-art diagnostic and surgical equipment.

You have difficulty getting into a hospital unless you’re critically injured or dying of some acute condition. The waiting lines are long for routine surgery despite government denials. Remember, in Canada you cannot purchase non-government-funded private care. It says it all when a recent premier of Ontario sent his mother to the U.S. for her surgery, an option only the very wealthy can usually afford. There is no non-emergency insurance available to Canadians who travel outside the country. This is just another skewed survey trying to seduce the public into Hillary Clinton-style socialized medicine. Don’t buy it.

L. Gene Leiske, M.D.
Rancho Mirage, Calif.

Dr. Gratzer is correct in his criticism of the American Journal of Health Study that judged the Canadian health-care system to be better than the U.S. system. When you are comparing the effects of two policies you have to either keep all other influences constant or correct for their differences.

A correct health-care comparison would have been based on a “what if” analysis on the American population as it is. In essence, the idea is to calculate what would happen to each American’s health outcome if forced to live with the characteristics of the Canadian system (everyone covered, cheaper medications, slower discovery of new medications, fewer doctors per capita, fewer diagnostic machines per capita, longer wait times per patient, less freedom of choice in treatment). Then count improved outcomes and see if the majority would benefit from the Canadian system or not. Easier said than done. But it must be said in order to flag studies we should not accept.

M.A. Sillamata, Ph.D.
Economist
Toronto, Ontario

Overpaid Management: Their Cover Is Blown

Jeremy Siegel (“The ‘Noisy Market’ Hypothesis,” editorial page, June 14) blithely blames advisers for advocating capitalization-weighted indexes when in fact academics were the drivers. While individual advisers can move their small set of clients in any direction, academics have to consider that their research would apply to everyone. By definition everyone constitutes the total market...
President Bush has found the cure for what ails the American health-care system.

"Do you realize the medical field is one where you don’t do any comparative shopping," he told an audience last week. "When you buy tile ... for your house, you’re out there shopping. It. You ... say, ‘Look, what am I bid?’ When you’re buying pipe or things you put in the wall ... you’re out there bidding price."

"There’s no transparency in pricing in medicine," he said. "You don’t know whether the guy next [door] is going to offer a better deal."

That’s true. The issue is what to do about it. Mr. Bush’s reply: Give Americans more skin in the health-care game so they’ll be better shoppers. (That’s what he means when he talks about Health Savings Accounts and policies with large deductibles.) Make health care more like the market for tile and pipes, he argues, and Americans will get better health care for less.

Set aside the case that only a taxpayer-financed, government-organized solution works. A Republican president and Congress aren’t going there, and a lot of Democrats are skeptical, too.

Instead, the U.S. is going to experiment with market forces to solve this problem: that Americans aren’t getting their money’s worth for the $1.3 trillion a year they spend on health care. For that sum, we ought to have more equitable access to health care and have healthier people. Politicians too often boast the U.S. has the best health-care system in the world, marvel at medical technology—and then fail to ask if we should be getting more, given what we spend.

In the 1990s, the U.S. focused market weaponry on providers, not patients. Managed care was about giving groups of health-care providers a flat sum, thus giving them incentives to do what was necessary to keep patients healthy and costs down, rather than underpaying for preventive care and paying up each time a patient showed up ill. Forcing managed-care outfits to compete for patients was supposed to stop them from skimping on care.

Americans tasted that and spit it out. The 2000s “pay for performance” version, one Medicare is toying with, is to pay doctors and hospitals not for how much care they give but rather for how well they care for patients.

Mr. Bush, by contrast, is talking about using market forces to influence individuals, not providers. He reasons that if Americans had to pay more out of their pockets, perhaps with money that employers or government hands them, they’d use health care more judiciously. And if Americans were better shoppers, health-care providers would compete much as cellphone companies and automakers do—to the benefit of consumers.

Implicit in this approach is the notion that Americans use too much health care. So, make them pay for unnecessary emergency-room visits or the costlier one-a-day antibiotic instead of the generic, and they’ll spend less. That’s a sound idea. It may save the system some money by eliminating the cost of processing small claims for essentially healthy patients. But is avoiding the emergency room the big problem that needs solving?

Not really. A bigger problem is that too many healthy (for now) Americans go without preventive care, and too many chronically ill Americans don’t get care that would avoid costly, painful complications later. HSAs don’t help there. And then there’s the uncomfortable fact that 80% of health spending in the U.S. each year is spent on 8% of the population. Giving them tax breaks to buy health-insurance policies with $2,000 deductibles won’t ensure that money is well spent.

"HSAs aren’t a way of responding to the very sick people who are responsible for the bulk of health-care spending," says James Robinson, an economist at the University of California at Berkeley. Is moving to "empower the individual" appropriate to health care? In part, it is. Doctors, hospitals and insurers need a nudge to think of us more as customers than they sometimes do. But choosing floor tile is easier than distinguishing between a headache caused by stress and a headache caused by a brain tumor. The costs of a mistaken decision to avoid a doctor visit are greater than choosing the wrong cellphone plan.

Well-functioning markets require consumers with enough information to make sound choices. That doesn’t yet describe health care. "It’s going to take a lot of effort to get us to the point where we’re confident that using the market is going to improve care, rather than make it worse," says Elliott Fisher, a Dartmouth Medical School professor.
Computer use for Health care

- How to get benefits and avoid bad things and high costs

1. Computer technology for health care can cause trouble, time loss, add complexity and cost.

2. But computer use for health care is definitely necessary and can save time and cost if used well.

3. Be skeptical of ideas that propose a grand computer system for health care and are not well focused on the actual problems.
   - Keep focused on the real problems.
   - Keep the learning time low for doctors and nurses.
   - Don't force awkward work styles onto doctors and nurses.
   - Do not try to solve all problems in one big info tech system.
Tech Glitches Can Slow Patient Care

New Computers May Deliver Turmoil When They Arrive; One Study Cites Death Rates

A CONTROVERSIAL study linking an increased death rate to the installation of a new computer system at Children's Hospital of Pittsburgh reinforces growing concern that such technology, hailed as a panacea for medication errors, can slow down the delivery of care and cause unintentional harm to patients if not properly put into practice.

The study, by researchers at the hospital, was published in the current issue of the journal Pediatrics and describes multiple technology glitches after a computerized physician order entry system was installed at the hospital over a six-day period in October 2002—excluding doctors unable to preregister critically ill children and then laboring over terminals to enter medication orders and tests. Nurses were pulled away from the bedside to work on terminals, reducing the patient-to-staff ratio in critical-care units. System crashes froze terminal screens and delayed the delivery of vital medications from the pharmacy. During the 18-month study period, 76 children admitted from other facilities died. The mortality rate for that group increased to 6.5% in the first five months after the system was in place from 2.8% in the thirteen months before.

The study's findings quickly drew fire from health information-technology experts and patient-safety groups, who said the study's methodology was flawed: the researchers didn't provide firm evidence to link the data directly to the increase in patient deaths, the follow-up period was too short to evaluate, and mortality rates weren't adequately adjusted for variables such as the severity of individual cases, including premature infants with a higher risk of death.

In a rebuttal letter published last week on Pediatrics' online post-publication peer review site, experts from Stanford University, Harvard Medical School and two of the leading business health coalitions said a more accurate summary of the findings is that there were significant problems activating the computerized physician order entry system, and other changes such as centralizing all medications at one pharmacy may have led to improvements.

But the study's authors also acknowledged the limitations of using data only about children who were transferred from another hospital over 18 months, less than 10% of all the patients admitted, and comparing two periods of differing duration.

"Although CPOE technology holds great promise as a tool to reduce human error," the researchers concluded, broader issues of "human-machine interface" need to be addressed, and further study of medication error rates is needed for children dependent on time-sensitive therapies.

For patients, the idea of a child in critical condition while doctors struggle with a computer is alarming, though in any emergency doctors can and do ignore or override computer systems. And studies show that computers can also introduce new types of errors, such as a recent one misreading information on a computer screen or entering the wrong data. Yet, a growing body of evidence—including a study published earlier this year by other researchers at Children's Hospital—shows that the use of computer entry systems sharply reduces common adverse drug events or injuries from medications. Rand Corp. estimates that CPOE have the potential to eliminate 200,000 adverse drug events in hospitals, saving $1 billion a year. But Suzanne Delbanco, executive director of the Leapfrog Group, a coalition of 170 major employers that advocate CPOE systems, says adoption has been "dismally slow," in part because these systems can cost $500,000 to $1 million, depending on hospital size. Of the almost 2,000 hospitals surveyed by Leapfrog, only 58 have the technology, and only 37 more have said they plan to have it in place next year. Leapfrog is designing a certification tool that will help hospitals evaluate systems made by technology vendors.

Cerner Corp., which designed the Pittsburgh system, says it sees no direct link between its product and the mortality rate increases reported in the study. Jim Fackler, Cerner's director of clinical care, notes that other children's hospitals have successfully implemented the systems. Cerner helps hospitals adapt once systems are installed, and it continues to improve for specialty units such as intensive care, Dr. Fackler adds.

There are also growing efforts to better train doctors and nurses. The American Medical Informatics Association, a nonprofit group whose incoming chairman is Palo Alto's Dr. Tang, is starting a program to train 10,000 medical professionals in information-technology use during the next four years, including computerized ordering. At Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del., which also uses Cerner systems, doctors who don’t want to sit in training classes can get one-on-one sessions through interactive Web tutorials at their own pace.

"CPOE isn't the Holy Grail," says Nemours' chief knowledge officer, Stephen Lawless. "But it adds to safety, and that’s the trade-off."

Email me at btformedpatient@wsj.com.

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Case Study: Former AOL Chief Seeks Health-Care Revolution

STEVE CASE HASN'T let his fall from grace sully his self-image. Today, the former America Online chief executive will announce a series of investments in health care that are designed, he says, "to change the world."

He calls his new venture Revolution Health Group. Its goal is to, well, revolutionize the way health care is delivered in this country. Mr. Case says he wants to "put patients at the center of the health system, with more choices, more convenience, more control."

Certainly, the U.S. health-care system could use a revolution. Runaway costs, uneven quality and tens of millions of uninsured patients have turned it into a national embarrassment—an especially big one that accounts for one-seventh of the U.S. economy.

Legions of businessmen, politicians and policy makers have broken their picks on this problem in the past—anyone remember Internet entrepreneur Jim Clark’s foray into Healtheon?—with little to show for their efforts. The question: Is Steve Case the man who can finally fix the mess?

He believes he can, and compares his current effort with building AOL. While others had created online services before him, he was the one who succeeded at bringing the Internet to the masses. And unlike other wealthy entrepreneurs who have turned to government or philanthropy later in life, Mr. Case believes he can do more good as an entrepreneur.

IT'S TEMPTING TO VIEW Revolution Health as a rehabilitation project for fallen CEOs. Mr. Case, of course, merged AOL with Time Warner, resulting in one of the largest evaporation of shareholder value in corporate history. For his new board, he's recruited Carly Fiorina, who was fired earlier this year as CEO of Hewlett-Packard; Franklin Raines, who was forced out of the top job at Fannie Mae; and Steve Wiggins, who built, and then was ousted from, Oxford Health Plans.

Asked why he brought these beleaguered ex-CEOs on board, Mr. Case says he knows them, they are talented and he "thinks them as underleveraged assets." The board also includes former Secretary of State Colin Powell and former Netscape CEO Jim Barksdale. Ron Klain, former aide to Vice President Al Gore, serves as executive vice president and general counsel of Mr. Case's investment firm, Revolution LLC.

Mr. Case argues that the way to fix the health-care system is to put consumers in charge. He favors innovations like health savings accounts, or HSAs, and health reimbursement accounts, which are high-deductible, tax-favored arrangements that allow employers to make fixed-dollar contributions to an employee's care but leave the employee in charge of spending those dollars. The investments he's announcing today are designed to support such “defined contribution” health care plans.

Some worry these sorts of changes simply shift costs from employers to workers. But Mr. Case says, "If you put the consumer at the center of the health-care system, good things will happen."

For starters, Revolution is buying four companies that will become the building blocks of a new Web portal to help consumers manage their care.

The companies are MyDNA Media, which provides up-to-date health information; 1-800-Schedule, which helps consumers find doctors and schedule appointments; Simo Software Inc., which enables users to keep track of their health care spending; and Wonder Inc., a search engine linking users with others who may have answers to their health-care problems. The project, to be launched sometime next year, sounds a little like WebMD, which has a troubled history but enjoyed a successful IPO last week for its portal, WebMD.

Revolution also has acquired a controlling interest in two companies that will help employers handle health-care coverage. One is Extend Benefits LLC, which works with companies to provide individualized insurance plans for their employees. Its clients include AutoNation, Continental Airlines and the PGA Tour. The other is ConnectYourCare, which helps employers offering HSAs by providing additional services, such as debit cards that can be used to pay health care bills directly from accounts.

Finally, Revolution has purchased a minority-position in InterFit Health, which is building low-cost clinics in retail locations, including Wal-Mart and Sam's Club. (See related article on page D1.)

Total investment by year's end will come to about $100 million, Revolution officials say. That's not much in a business that consumes nearly two trillion dollars in the U.S. each year. But given Mr. Case's history, it's worth keeping an eye on.

Email me at business@wsj.com and read reader comments Saturday at WSJ.com/TalkingBusiness.
The Dutch Way of Death

By Richard Miniter
AMSTERDAM—Seven years ago, on a Monday morning that he will never forget, Dr. Nico Wolswinkel’s patient, a 77-year-old woman dying from cancer, asked him to kill her.

As a purely legal matter, he knew he could do it. While euthanasia had not yet been officially decriminalized in the Netherlands, in practice it had. A string of high-profile court rulings in the 1980s made it nearly impossible for prosecutors to win euthanasia cases, and in the few instances in which doctors were convicted, their sentences were suspended. The Royal Dutch Medical Association had publicly approved of euthanasia, which was common even then. All that stood between euthanasia and his patient, Dr. Wolswinkel knew, was his own willingness to comply.

On that day, he searched his conscience. “It is very hard to speak of these things,” Dr. Wolswinkel says. “Thirty years ago, this was something that people didn’t ask for.”

He couldn’t bring himself to kill his patient; doctors are supposed to be healers, not killers. And, as a Christian, he believed it was wrong to take into his hands the power of God. A few days later, his patient died naturally.

Most Dutch have come to a different conclusion; more than 80% favor “voluntary euthanasia,” according to recent polls. Two weeks ago the Dutch parliament passed a measure completely decriminalizing euthanasia and doctor-assisted suicide. The Netherlands is now the first democratic nation on earth to permit, under law, doctors to kill their patients.

They are already accustomed to doing so. Of the 130,000 Dutch who died in 1996, some 11,000 were killed or helped to die by their doctors, according to the only complete report on euthanasia practices from the Dutch government. Some of these deaths are the classic cases cited by right-to-die advocates: a terminally ill patient, in agony, demanding “die with dignity.” But many are not. An estimated 5,581 people— an average of 16 a day— were killed by their doctors without their consent, according to the government report.

And these numbers do not measure several other groups that are put to death involuntarily: disabled infants, terminally ill children, and mental patients. Some 5% of all infants who die in the Netherlands are killed by their doctors, according to a 1997 study published in the Lancet, a British medical journal.

Consider the case of a doctor who killed—with her parents’ consent—a three-day-old girl with spina bifida and an open wound at the base of her spine. The physician never made any attempt to treat the wound, according to Wesley J. Smith, author of the book “Culture of Death.” The treatment was death. Euthanasia critics have talked about the “slippery slope” as a possibility; in the Netherlands, it is a fact.

Many old people now fear Dutch hospitals. More than 10% of senior citizens who responded to a recent survey, which did not mention euthanasia, volunteered that they feared being killed by their doctors without their consent. One senior-citizens group printed up wallet cards that tell doctors that the cardholder opposes euthanasia.

But what makes most Dutch comfortable with euthanasia? One factor is that their doctors have become comfortable with it. “The Dutch have got so far so fast because right from the beginning, they have had the medical profession on their side,” Derek Humphrey, founder of the pro-right-to-die Hemlock Society, told Canada’s Globe and Mail last September.

It’s not that Dutch doctors are naturally more inclined toward euthanasia. In contrast to the doctors of every other Nazi-occupied country, Dutch doctors never recommended or participated in a single act of euthanasia during World War II, according to a 1949 New England Journal of Medicine article. Even Nazi orders not to treat the old or those with little chance of recovery were disobeyed. But it only took a generation, essayist Malcolm Muggeridge noted, “to transform a war crime into an act of compassion.”

The path to the death culture began when doctors learned to think like accountants. As the cost of socialized medicine in the Netherlands grew, doctors were lectured about the climbing cost of care. In many hospitals, signs were posted indicating how much old-age treatments cost taxpayers. The result was a growing “social pressure” from doctors and others, says Arno Heitzel, a spokesman for the Catholic Union of the Elderly, the largest Dutch senior-citizens group, which favors voluntary euthanasia. “Old people have to excuse themselves for living. When they say that all of their friends are dead, people say ‘maybe it is time for you to go too’ rather than ‘you need to find new friends.’”

Then came the bogus ethicists to justify the penny pinching. Many of these “medical ethics experts” are drawn from or influenced by a global pro-death subculture—the World Federation of Right-To-Die Societies lists 36 groups in 21 countries—that stretches from Australia’s Dr. Philip Nitschke (“Dr. Death”) to Princeton University’s Peter Singer.

So, professional restrictions against euthanasia have been progressively cast aside. The Hippocratic Oath has either been abandoned or rewritten. The Dutch Pediatric Society even issued guidelines for killing infants in 1993; the Royal Dutch Society of Pharmacology sends a book to all new doctors that includes formulas for euthanasia-inducing poisons.

Interestingly, the remarkable 33% drop in elderly suicides in the Netherlands over the past two decades coincides with an almost equal rise in euthanasia in the same age group. What Dr. Herbert Hendin, a euthanasia opponent, calls “the Dutch cure for suicide” may simply be evidence of untreated depression. But, of course, treating depression is costly.

If euthanasia began with doctors, it would seem only an awakening of their conscience can stop it now.

Mr. Miniter is an editorial page writer for The Wall Street Journal Europe.
minutes. Price: typically $45. “Redi-Clinic is intriguing” because it could help reduce expensive emergency room and doctor visits, Delbanco says.

Case brushes off concerns about his strategy, board, and timing. His portfolio, he says, is still in its formative stages. He plans to buy and build more banks of health information to fill in the gaps. “Clearly, there is more work to do,” he says. “But over time, there will be more and more synergies.” The board members are “the right team,” he adds. “They are all smarter than me” and have plenty of healthcare experience. Colin Powell, for example, ran one of the nation’s largest healthcare systems as chairman of the military’s Joint Chiefs of Staff. Former executives such as Fiu-rina, Raines, and Netscape’s Jim Barksdale all had to wrestle with health insurance problems.

U.S. News
Oct 17, 2005

Money & Business

AOL founder Steve Case says he wants a revolution in healthcare

By Kim Clark

Admire or revile him, you’ve got to admit that former AOL Chairman Steve Case has RTL, LOM, and FWC: Really Big Ideas, Lots of Money, and Friends With Clout. So when he says he’s going to “revolutionize” American healthcare, it’s smart to RTW: Regard With Interest. But given the strategic and accounting troubles that plagued his last years at America Online, the scattershot nature of his new company, and the sheer difficulty of his new goal, maybe that should be Remain Wary Indefinitely.

In a move reminiscent of financier Michael Milken’s financial and entrepreneurial assault on prostate cancer, Case says he is pouring his cash and energy into making the nation’s health system as easy to navigate and consumer friendly as AOL. Case announced last week that since forming his Revolution Health Group in July, he has spent about $100 million, mostly of his own money, buying all or part of seven private companies that provide healthcare and health information and manage health benefits for employers. And he’s planning to spend hundreds of millions more scooping up other health-related ventures and building a new health information website, RevolutionHealth.com. Twenty percent of the money will come from private investors who, Case says, understand it may take more than 10 years to realize a return. But the profit, for now, is secondary. The real goal of all this money and energy, he says, is to “put consumers at the center by improving their choice, control, convenience, and care.”

There is no doubting his sincerity. Case’s drive comes from having watched
There’s no doubt that Case’s emphasis on consumers is smart. Twenty-six percent of large employers are expected to offer workers a version of the new “consumer directed” health plans next year. These usually set a high deductible and often include an employer-funded savings account to pay for routine and preventive care. Employers like these new plans not only because they control their share of costs but also because they are billed as a way to rein in rampant health inflation. The theory is that consumers who pay out of their own pockets or health savings accounts for doctors’ appointments and MRIs make only the appointments they really need and shop around, forcing prices down. But patients often can’t tell the difference between symptoms that demand a doctor’s attention and those that don’t. Physicians don’t typically give patients the kind of price lists and quality-of-care statistics they need to comparison shop.

Unfortunately, many have tried what Case is aiming to do—and failed. From managed care to DrKoop.com to former President Clinton’s health plan, the landscape is littered with the remnants of previous attempts to reform healthcare. And the folks in charge of Revolution may not have the skills needed for such a tough challenge. Case, it is true, built one of the world’s biggest Internet companies. But he resigned from the AOL chairmanship in 2003 (though he remains on the board) under pressure caused by the controversial merger with Time Warner, a subsequent 75 percent drop in stock value, and allegations that the company had exaggerated revenues. The company, now called Time Warner, settled the accounting charges last year.

A roll call of Revolution Health’s board sounds like a list of who was who: Franklin Raines retired early from the chairmanship of Fannie Mae in December 2004, after Securities and Exchange Commission staffers said the mortgage insurer inflated its revenues. Carly Fiorina was pushed out of Hewlett-Packard in February because of a perceived inability to execute her strategy following the purchase of rival Compaq. Oxford Health Plans founder Steve Wiggins was forced out in 1998 after the insurer reported big losses and glitches in a new computer system left doctors unpaid for months.

Case has tapped as Revolution Health’s CEO John Pleasants, who lacks healthcare industry experience. He made his name at TicketMaster and other divisions of IAC/InterActiveCorp., Barry Diller’s conglomerate of Home Shopping Network, Match.com, LendingTree, and other businesses. While TicketMaster has generally pleased its owners with strong profits, it has long drawn consumer ire for using its control of most concert and event ticket sales to charge high handling and shipping fees. “If his new job is to be a consumer advocate, his background is not the most encouraging,” says Bert Foer of the pro-competition American Antitrust Institute.

Portfolio. Revolution’s strategy is far from clear. Many of the company’s purchases are “peripheral” in the health industry, says Suzanne Delbanco, CEO of the Leapfrog Group, an influential cooperative of corporations that is encouraging hospitals to improve quality by publishing safety and treatment data. Case recently bought a small health cable channel called Wisdom that features many New Age health programs. His new acquisitions include four other little-known providers of health information: MyDNA Media, 1-800-Schedule, Wondir Inc., and Simo Software. While MyDNA does offer disease information, it is not as exhaustive as WebMD or MayoClinic.com. Nor is any of Case’s sites considered to be at the forefront of developing price and quality data for consumers. Wondir is simply an online forum in which members can swap questions and answers about everything, not just their health.

More central to Case’s strategy may well be his purchase of controlling interests in two small benefit-management companies that specialize in helping firms set up consumer-directed plans. And most noticeable of all will be an investment to help Red funClinic open more quick-care facilities in Wal-Marts and drugstores around the country. For example, patients will soon be able to walk into the Duane Read drugstore in Manhattan’s Times Square on any day of the week and be given a pager that allows them to shop in the store until a nurse practitioner is free. The nurses can perform standard physical exams and treat dozens of minor ailments such as strep throat, ear infections, and allergies in as little as 15

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Health Insurance Showdown

When Ron Pollack of Families USA starts screaming, Republicans must be doing something right about health care. And so they finally are.

As early as today the Senate will vote to prevent a Democratic filibuster of legislation that would make it easier and cheaper for small businesses and their employees to buy health insurance. The House has already passed similar legislation, and today's vote is the GOP's best hope to do something significant about health-care affordability before November—and potentially for years to come.

The bill at hand, sponsored by Wyoming's Mike Enzi, concerns so-called Small Business Health Plans, often referred to as Association Health Plans. The idea is that if small businesses are allowed to band together on a nationwide scale, they'll have greater leverage when negotiating prices with insurers. The bill would let them bypass many of the state insurance rules that make coverage so expensive. By creating a larger and freer market for health insurance, the Enzi bill would increase the number of people who have it.

And that's exactly what such government-run health care advocates as Mr. Pollack—and Connecticut Democrat Chris Dodd, who joined him yesterday to denounce the bill—don't like. Some provider groups are also opposed for nakedly self-interested reasons, since it would allow plans to bypass state regulations mandating coverage for, say, chiropractors.

Their claims that the Enzi bill would allow for worthless policies and fly-by-night insurers are unfounded. Big companies are already exempt from state insurance mandates under a federal law known as Erisa, and they haven't engaged in some "race to the bottom" for their employee coverage. Why should small companies do so? The owners who participate in these association plans would be buying the same insurance for themselves—which is reason enough to doubt that all they want is skinflint coverage.

If anything, the Enzi bill's flaw is that it doesn't deregulate the small-business insurance market enough. The plans would cover all major medical expenses, as they should. But while insurers could offer chiropractor-free plans, they would also have to offer the option of a plan equal to one offered state employees in one of the five most populous states. State employee plans—paid for by taxpayers—tend to offer an expensive set of benefits beyond what even the worst-regulated states require via mandates. The Enzi bill would also create a new national insurance regulation board to oversee the plans. This sounds innocuous as currently described, but the tendency of these things over time is to become monsters.

A better approach is being offered by Arizona's John Shadegg in the House and South Carolina's Jim DeMint in the Senate. Their legislation would allow not just small businesses but individuals to buy health insurance across state lines, with those policies regulated by the states from which they are sold. That's the way banking now works. What we really should be aiming for is a national market of portable, individually owned policies that can be bought from many insurers, including over the Internet.

Let's hope Republicans recognize the stakes in today's vote. They badly need something to show voters this fall other than record levels of pork-barrel spending, and making health care more affordable will resonate with Americans everywhere. As for the White House, we hope it's as prepared to twist arms for this reform as it was a few years back for the Medicare prescription drug entitlement. A vibrant national health insurance market would be partial absolution for that expensive new burden on taxpayers.
Health Insurers Are Seen Gaining On Slower Rise in Medical Costs

By Dinah Wisenberg Brin
Dow Jones Newswires

PHILADELPHIA—Prudential Equity Group LLC expects 2005 to be an "exceptionally strong year" for the managed-care industry, marked by slowing growth of insurers' medical costs.

With cost growth rates set to fall from current levels, the firm said in a note Monday, "earnings outperformance should be assured."

Several forces, including the effects of a sluggish economic recovery, should keep health insurers' cost increases in check next year, the firm said.

In general, the market expects premiums to increase by about 10% and underlying medical costs to increase just under the rate, the firm said, but Prudential thinks medical cost trends "can easily decline" to the 7% growth range.

Current managed-care valuations reflect the general market view, but "we believe that view will be way off the mark," the firm said. "Earnings growth is likely to accelerate from 2004 levels, bringing (price-to-earnings) multiple expansion."

Disciplined underwriters with sharp medical-cost controls will benefit the most, the firm said, raising its share-price targets on Aetna Inc., Cigna Corp., Coventry Health Care Inc., UnitedHealth Group Inc. and Sierra Health Services Inc.

The firm said it hasn't found any widespread irrational premium pricing, and that managed-care earnings remain solid.

In 2005, several forces should pressure medical costs in the industry's favor, the firm said.
Beware the B-Readers

Ed.

Jan 23, 2006
Wall St Jour.

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all the unsavory details rolling out of in-
vestigations into the silicosis and asbes-
tos scams, some of the ugliest concern

doctors who abandoned their ethics to cash in.

Even more disturbing is the growing evidence
that what has allowed
them to get away with this is a federal certifi-
cation program.

That’s why a coal-
tion of industry and
other groups has begun pushing the National In-
stitute for Occupational Safety, and Health
(Niosh) to start policing its “B-reader” pro-
gram, which certifies doctors to read X-rays.

The federal agency proposed new ethics rules
in November, after a federal judge slammed
several government-certified doctors who had
igned up sham diagnoses in a silicosis suit.
But Niosh needs to go much further to clean up
this corrupt corner of American medicine.

Niosh’s B-reader program started in the
1970s, as the government tracked coal workers
with black lung disease. Niosh was concerned
about the competence of doctors reading chest
X-rays, so it began a training course and test.

Those who pass become known as “B-readers.”

By all accounts the test is difficult; pass rates
are lower than 50%, a number that’s even
lower for recertification. Over time the pro-
gram has certified some 1,200 B-readers, of
which there are more than 500 today.

Most of these professionals perform valu-
able roles in the occupational-hazard world.

But a growing number of B-readers are now
leveraging their credentials to abet fraudulent lit-
gigation. These doctors churn out staggering
numbers of X-ray “readings” that purport to
find diseases such as asbestosis and silicosis—
readings that are then seen to come with a “gov-
ernment stamp of approval.” Their standing is
so high that litigators often forward their work
as proof of a diagnosis, even though the medi-
cal world universally agrees that X-rays alone
never prove a serious illness. In short, a pro-
gram designed to raise standards has been hi-

jacked for the opposite purpose.

* * *

Reading any X-ray is tricky, and studies
show there is a 30% variance in how even hon-
est doctors read the same chest film. Yet the
B-readers who’ve hired themselves out to law-

yers have proven that their work has little to do
with medicine.

In a 2004 study published in the journal Radi-
ology, Johns Hopkins researchers obtained 492
chest X-rays that had been used in asbestos litiga-
tion. They then had these same X-rays exami-
ned by six independent B-readers, none of
whom were told what the original interpreta-
tions had been, or even that the X-rays had
been used in litigation. The initial (lawyer-re-
tained) B-readers had found that 96% of the
cases revealed abnormalities. The indepen-
dent panel found 4.5%.

Niosh has also found amazing disparities.

workers for asbestosis. Information distrib-
uted to tire workers stated that 64% of those
screened at one location had shown positive for
asbestosis, and 94% at a second location. Yet
when Niosh had an independent panel evaluate
X-rays of tire workers most at risk for the dis-
ease, it found asbestosis in 0.2%.

What kicked off this recent scrutiny of
B-readers was Texas federal Judge Janis Gra-
ham Jack’s withering decision in a giant silico-
sis suit last July, in which she found that doc-
tors had been “manufacturing” claims for
money. Of the seven physicians she singled out
for special criticism, five were Niosh-certified
B-readers. Some of these doctors simply
signed diagnosing language provided to them
by others. Some did not write, read or sign
their own reports. More than 6,000 of the 10,000
silicosis plaintiffs had also filed asbestos
claims, despite the medical rarity of having
both diseases; sometimes the same doctor had
signed both reports.

None of this is surprising considering these
“doctors” have become little more than experts-
for-hire. Certain B-readers long ago came to un-
derstand that their government-issued creden-
tials made them valuable in court, and there-
fore worth a lot of money. Many doctors are
paid more if they find a disease than if they
don’t. Dr. Ray Harron, a key figure in silicosis-
asbestos diagnoses, made an estimated $5 mil-
lion for his work for one screening company.

* * *

In a better world, these doctors would have
been stopped long ago by state medical boards,
which are supposed to enforce medical stan-
dards. These bodies have come in for a lot of de-
served criticism of late for their reluctance to
discipline these doctors, yet so far have shown
no signs of cracking down.

Another possibility is greater involvement
by professional bodies, although that has its
limits. The current ethics committee chair for
the American College of Radiology, Dr. Le-
onard Berlin, tells us that even if the college
has real evidence of wrongdoing, the most it
can do is “either suspend or revoke their mem-
bership. It doesn’t stop them from practicing.”

Which gets, back to Niosh. The agency’s new
ethics rules are a good start, particularly as they
are aimed at B-readers involved in litigation.

But the outside commentators are on to some-
thing when they suggest that Niosh also audit
doctors who receive its government-sanctioned
credentials. The agency already conducts an au-
dit program for respirator devices, and a similar
one could be set up for B-readers. It might start
by investigating the X-rays that Judge Jack still
has in her court document depository.

If Niosh isn’t willing to audit, perhaps it
should abolish the B-reader program alto-
gether. Other countries have managed to turn
out qualified X-ray readers without such sne-
Health care

America's headache

How to start fixing the world's costliest health-care system

EVERYONE, it seems, has a health problem. After pouring billions into the National Health Service, Britons moan about dirty hospitals, long waits and wasted money. In Germany the new chancellor, Angela Merkel, is under fire for suggesting changing the financing of its health system. Canada's new conservative prime minister, Stephen Harper, made a big fuss during the election about reducing the country's lengthy medical queues. Across the rich world, affluence, ageing and advancing technology are driving up health spending faster than income.

But nowhere has a bigger health problem than America. Soaring medical bills are squeezing wages, swelling the ranks of the uninsured and pushing huge firms and perhaps even the government towards bankruptcy. Ford's announcement this week that it would cut up to 30,000 jobs by 2012 was as much a sign of its "legacy" health-care costs as of theills of the car industry. Pushed by polls that show health care is one of his main domestic problems and by forecasts showing that the retiring baby-boomers will crush the government's finances, George Bush is expected to unveil a reform plan in next week's state-of-the-union address.

America's health system is unlike any other. The United States spends 16% of its GDP on health, around twice the rich-country average, equivalent to $6,000 for every American each year. Yet it is the only rich country that does not guarantee universal health coverage. Thanks to an accident of history, most Americans receive health insurance through their employer, with the government picking up the bill for the poor (through Medicaid) and the elderly (Medicare).

This curious hybrid certainly has its strengths. Americans have more choice than anywhere else, and their health-care system is much more innovative. Europeans' bills could be much higher if American medicine were not doing much of their $80 for them. But there are also huge weaknesses. The one most often cited—especially by foreigners—is the army of uninsured. Some 46m Americans do not have cover. In many cases that is out of choice and, if they fall seriously ill, hospitals have to treat them. But it is still deeply unequal. And there are also appalling inefficiencies: by some measures, 30% of American health spending is wasted.

Then there is the question of state support. Many Americans decry the "socialised medicine" of Canada and Europe. In fact, even if much of the administration is done privately, around 60% of America's health-care bill ends up being met by the government (thanks in part to huge tax subsidies that prop up the employer-based system). Proportionately, the American state already spends as much on health as the OECD average, and that share is set to grow as the baby-boomers run up their Medicare bills and ever more employers douse out of providing health-care coverage. America is, in effect, heading towards a version of socialised medicine by default.

Is there a better way? Even a glance around the world shows that there is no such thing as a perfect health-care system: every country treads an uneasy compromise between trying to harness market forces and using government cash to ensure some degree of equity. Health care is also the part of the public sector where market forces have had the most limited success: it is plagued by distorted incentives and information failures. To begin with, most health-care decisions are made by patients and doctors, but paid for by someone else. There is also the problem of selection: private-sector insurers may be tempted to weed out the chronically ill and the old, who account for most of the cost of health care.

In the longer term, America, like this adamently pro-market newspaper, may have no choice other than to accept a more overtly European-style system. In such a scheme, the government would pay for a mandated insurance system, but leave the provision of care to a mix of public and private providers. Rather than copying Europe's distorting payroll taxes, the basic insurance package would be paid for directly by government, though that cash might be raised by a "hypothesised" tax which would make the cost of health care more evident. The amount of cash given to insurers would take account of individual health risks, thus reducing insurers' incentives to compete by taking only the healthiest patients.

Such a system would not be perfect but it could mitigate the worst inequities in America's health-care system, while retaining its strengths. In practice, however, it will not happen soon. American politicians are still scarred by the failure of Hillary Clinton's huge health-care plan (which tried in 1993 to force companies to insure workers). Incremental change, of the sort that Mr Bush is talking about, looks the only way forward.

In fact, there are plenty of incremental changes that could help, especially when it comes to curbing costs. America's health industry is already experimenting with new ways to improve efficiency (see pages 24-26). As the biggest buyer, the federal government has plenty of power to push for "pay for performance". And many of Mr Bush's mooted reforms make sense, such as limiting absurd medical litigation claims, deregulating the stifling state-based insurance market and making insurance policies more portable.

Plastic surgery may work for a while

But there is a flaw at the heart of his proposal. Mr Bush goes straight to one of the biggest distortions in American health care—the generous tax subsidies doled out to firms providing insurance. These help to promote a culture where costs do not matter. But his prescription is the wrong one. Rather than reducing this distortion, which would force firms and employees to be more cost-conscious and free up money to be spent on bringing more people into the system, the president wants to even things out by doling out yet more tax subsidies to others—for instance, letting individuals set more of their out-of-pocket medical expenses against taxes. Such hand-outs may have political appeal, but they will worsen the budget deficit and, most probably, drive up the pace of medical spending. America's health-care system could be improved in small steps. But those steps need to be in the right direction.
Desperate measures

WASHINGTON, DC

The world’s biggest and most expensive health-care system is beginning to fall apart. Can George Bush mend it?

GEORGE BUSH had big ideas for his second term. He promised to fix Social Security, America’s public pensions system, and revamp the tax code. Despite his best efforts, Social Security reform sank last year. Rejigging the tax code has proved so politically tricky that the White House dare not push it. With almost three years to go, Mr Bush seems less a radical reformer than a struggling lame duck.

White House officials, desperate to show that the president still has a domestic agenda, have now changed the subject—to health care. The buzz in Washington, DC, is that health-care reform will loom large when Mr Bush gives his annual state-of-the-union address on January 31st. Al Hubbard, Mr Bush’s top domestic policy adviser, adds that the focus will be on ideas that control costs, boost access and improve quality.

Health care? The idea seems preposterous. How can an administration that is too timid to push tax reform tackle one of the most complicated challenges facing America’s economy? What’s more, the timing looks terrible. Mr Bush’s team is under fire for botching its biggest health-care initiative to date, the introduction of a prescription-drug benefit for elderly people covered by its Medicare programme. Thanks to bureaucratic tangles, thousands of poor old folk have been denied drugs they used to get free, and more than 20 state governments have had to step in to pay for the medicines. Republican lawmakers dread what this fiasco may cost them in November’s mid-term elections.

Yet Mr Bush may be able to push more radical change in American health care than anywhere else. Both politicians and the public recognise that spiralling health-care costs are a problem—second only to the Iraq war, according to a recent Wall Street Journal/NBC poll. Those costs are a big reason for the sluggish growth in workers’ wages, the widespread perception that America’s middle class is being squeezed and the huge job cuts at Ford this week.

America’s health system is a monster. It is by far the world’s most expensive: the United States spent $1.9 trillion on health in 2004, or 16% of GDP, almost twice as much as the OECD average (see charts 1 and 2 on next page). Health care in America is not nearly as rooted in the private sector as people assume (one way or another, more than half the bill ends up being paid by the state). But it is the only rich country where a large chunk of health care is paid for by tax-subsidised employer-based insurance.

This system is a legacy of the second world war, when firms, hamstrung by wage controls, used health insurance as a way to lure in workers. It means that, according to census figures, around 174m Americans get health coverage from their own, their spouse’s or their parents’ employer. Another 27m buy health insurance individually, for which they do not get a tax subsidy. The government picks up the tab for 40m elderly and disabled Americans (through Medicare) and about 38m poor (through the state-federal Medicaid scheme). That leaves around 46m uninsured, though many of these, whether students or workers, go without insurance by choice. In practice, they get emergency care at hospitals, which is paid for by higher premiums for everyone else.

Set alongside other rich countries, which typically offer all their citizens free (or very cheap) health care financed through taxes, America’s system has some clear strengths. Consumers get plenty of choice, and innovation is impressive. One survey of doctors published in Health Affairs claimed that eight of the ten most important medical breakthroughs of the past 30 years originated in America. Equally clearly, the American system has big problems, notably inadequate coverage (no other rich country has armies of uninsured).
Anatomy of a monster

...ured, spotty quality and high cost.

Huge discrepancies lurk within the system. John Wennberg, Jonathan Skinner and Elliot Fisher of Dartmouth College have pointed out that Medicare spends more than twice as much on people in Miami than in Minneapolis, and, if anything, results are better where spending is lower. Up to 30% of Medicare spending, they conclude, is wasted. Poor treatment is rife: a study by the Institute of Medicine has suggested that medical error is the country's eighth-largest cause of death.

For decades, American health-care spending has outstripped income growth, by an average of 3.5 percentage points a year. There have been clear cycles within this trend: for instance, herding employees into managed-care schemes, notably Health Maintenance Organisations (HMOs), which negotiated discounts with doctors and restricted the services available to patients, helped slow down health inflation in the mid-1990s. But voters loathed HMOs, there was a political backlash and in the late 1990s costs shot up again. Although the pace of medical spending has slowed slightly recently (to 7.9% in 2004), spending has risen by 40% since 2000. Typical insurance premiums have gone up by more than 60%.

The great unravelling

With medical inflation far outpacing inflation in general, American firms are scaling back the health coverage they offer. The share of workers who receive health insurance from their own employer has fallen from almost 70% in the late 1970s to around 50% today. In the past five years, the proportion of firms offering medical benefits has fallen from 70% to 60%, with the steepest decline among small firms and those employing the low-skilled.

Those employers who do offer health insurance have pushed more costs on to workers by raising co-payments and deductibles (the expenses before insurance kicks in). Employer-provided health coverage for retirees, once common, has shrunk, although America's big carmakers, including Ford and General Motors, are still hobbled by having to provide it. Mr Hubbard's assessment is stark: "The private market is broken."

At the same time, the burden on government is about to soar. Add together Medicaid, Medicare and other publicly financed health care, such as that for ex-service men, and the public sector already pays for 45% of American health care. (The total is nearer 60% if you include the tax subsidies.) But as America's firms limit their health-care spending and, particularly, as the baby-boomers retire, that share will rise sharply. On current trends, federal spending on health will double as a share of the economy by 2020. That would mean much higher taxes, something Americans do not want to pay.

With employers limiting their exposure and government unable to fund its commitments, America's health system will unravel—perhaps not this year or next, but soon. Few health experts deny this. Nor do they disagree much on the sources of the problem. Health markets are plagued with poor information, inadequate competition and skewed incentives.

Since most bills are paid by a third party (the insurance company or the government), neither patients nor doctors face real pressure to control costs. Overall, Americans pay only $1 out of every $6 spent on their health care out of their own pockets. Doctors are generally paid for individual services and so have an incentive to perform too many procedures. The huge tax subsidies for employer-purchased health insurance encourage expensive care. Rapacious lawyers and the risk of being sued exacerbate the tendency towards unnecessary "defensive" medicine.

The first question is whether to try to make America's imperfect market work better, or to accept that markets cannot work in health care and focus more on government regulation. The second is whether to go for incremental reform or a comprehensive overhaul.

The history of American health policy is littered with failed efforts at radical change. Harry Truman wanted to create a system of national health insurance in the 1940s. When Canada introduced its government-run health system in 1971, many American politicians hoped to do the same. The biggest recent effort was Hillary Clinton's health-care plan of 1993, which mandated health-insurance coverage for all delivered through carefully regulated health alliances with price caps. All these efforts failed, thanks to the enormous power of health-care lobbies and Americans' horror at anything that smacked of "socialised medicine".

Today's debate is scarred by those failures, though some brave health experts still favour comprehensive reform. The Physicians Working Group, for instance, argues that America has to move to a single-payer system, as in Canada or Britain. Victor Fuchs and Ezekiel Emanuel, two prominent health experts, argued in the New England Journal of Medicine last year that the current mess should be replaced with a universal system of health vouchers funded by a hypothesised VAT. In a new book from the Brookings Institution called "Can We Say No?", Henry Aaron, William Schwartz and Melissa Cox argue that America will sooner or later have to restart health care, though they are coy about exactly how.

Washington's politicians, however, have shown little appetite for radical change. Their focus is still on expanding coverage rather than controlling costs. The biggest recent policy initiative, the 2003 decision to add drug coverage to Medicare, was the biggest expansion of a government health programme since 1965.

Some states have been thinking more radically. Massachusetts, for instance, may require everyone to have minimum insurance, with the state helping poorer people with subsidies. Maryland has a new law that requires all large employers to spend at least 8% of their payroll on health care, supposedly to prevent the state's Medicaid system having to pick up the tab. Though that particular law has more to do with Wal-Mart-bashing than health care,
Special report: America's health-care crisis

The most interesting innovations, however, have come less from think-tanks or politicians' offices than from within the health-care industry. One trend, called "Pay for Performance", is to shift doctors' and hospitals' remuneration to being more efficient and better care, by measuring quality and adjusting payments accordingly. According to Karen Davis, president of the Commonwealth Fund, a health-care research foundation, there are now around 100 "Pay for Performance" initiatives in place. Early evidence suggests that they are having some effect.

**Patients as consumers**

The second shift within the health-care industry has been to change patients' incentives with more cost-sharing and larger deductibles. If patients pay more of the upfront costs of their health care, the argument goes, they will become more discerning consumers. And some of the cost saved by employers can be put into special Health Savings Accounts (HSAs), which workers can tap to pay routine health costs. Once the account is empty, workers are responsible for paying for their health care until their deductible is reached. This should make them think twice before visiting a specialist when they get a sore throat.

The trend towards HSAs was given a big push by a tax change in 2003 that was part of the Medicare drug legislation. Provided that an individual buys health insurance with a high deductible (at least $2,100 for a family), he can put the equivalent amount of money into tax-free accounts, whose balances can accumulate over years.

The number of people with high-deductible plans is still relatively small: only 2.4m in early 2005, according to government figures. But health economists expect HSAs to grow rapidly, as ever more employers offer them to try to control costs. A new survey by consultants at Deloitte shows that in these kinds of plans, in 2004-05, costs rose by less than half as much as in traditional ones.

The Bush agenda picks up both these new trends. Without much fanfare, Medicare too has been introducing its own incentive schemes. Hospitals must now provide proofs of quality to qualify for some Medicare payments. Medicare is also experimenting with bonuses for hospitals and doctors that improve their quality and efficiency. Where Medicare leads, many others may follow.

The White House's main focus, however, is the private market. One goal is legal reform. Mr Bush has already pushed (unsuccessfully) for laws that cap payments for medical malpractice lawsuits. He will keep trying. His health advisers would also like to deregulate the health-insurance market, freeing it from the stifling rules, imposed at state level, that can raise the cost of an insurance plan by as much as 15%.

Chiefly, Mr Bush wants to accelerate the trend towards consumer-driven health care. One uncontroversial idea is to encourage doctors and hospitals to provide more information on the cost of treatment. The other is to cut taxes. Mr Bush's team wants to eliminate the bias in favour of employer-purchased, low-deductible health insurance in America's tax code, not by reducing the existing tax subsidies for employers, but by increasing the tax subsidies for individuals.

This philosophy is conveniently summarised in a new book, "Healthy, Wealthy and Wise", by three economists with close ties to the White House, Glenn Hubbard of Columbia University (formerly Mr Bush's top economic adviser), and John Cogan and Glenn Kessler of the Hoover Institution at Stanford. They argue that since it is politically impossible to get rid of tax subsidies for employer-based health insurance, the best way to eliminate the tax bias towards high-cost insurance is to make all health spending tax-deductible and expand HSAs. Legal, insurance and tax reform together, they argue, could reduce America's health spending by $60 billion and cut the number of uninsured by between 6m and 20m. Since overall medical spending would slow, the authors reckon their suggestions would cost a modest $9 billion a year.

To an administration that believes the answer to every problem is lower taxes, the appeal of these ideas is obvious. Many health experts, however, are deeply sceptical, both about whether the shift to higher-deductible plans will actually reduce health-care inflation and, even if it does, whether the government should encourage this trend with more tax cuts.

The logic of consumer-driven health care assumes that unnecessary doctor visits and procedures lie at the heart of America's health-care inflation. And it assumes that individual patients can become discerning consumers of health care. Both are questionable. Most American health-care spending is on people with chronic diseases, such as diabetics, whose health care costs many thousands of dollars a year, easily exceeding even high deductibles.

Instead, critics worry that greater cost-consciousness will deter people, particularly poor people, from essential preventive medical care, a trend that could even raise long-term costs. A classic study by the Rand Corporation in the 1970s showed that higher cost-sharing reduced both necessary and unnecessary medical spending in about equal proportion. The question is, do these people actually behave like discerning consumers in health care, even when they have information. Proximity of hospitals and word-of-mouth reputation often matter more to patients than published quality indicators.

Skeptics of consumer-directed care like to point to Bill Clinton, who chose to have his heart surgery in a hospital that New York state rates as having merely average mortality rates for such operations.

The truth is that the shift to consumer-directed health care and greater cost-sharing involves a culture change that may take decades. It will also come at the price of greater inequality. The burden of health spending will be shifted on to those who are sick, and not just because people will pay a greater share of their health costs themselves. High-deductible insurance policies are attractive to the young and healthy. But as these workers leave traditional insurance, the risk pool in other insurance plans will worsen and premiums will rise even faster. The real losers will be poorer workers with chronic illnesses.

American health care has already become more unequal as employers have cut back, and this will continue. The Bush team argue that "fairer" tax treatment will slow cost rises and enable more people to get basic insurance. The opposite is more likely. Bigger tax subsidies for health care are, if anything, likely to raise overall spending. Worse, since most tax breaks benefit richer people most, more tax incentives are likely to bring more inequality. They will also reduce tax revenue and worsen the budget mess.

Mr Bush's health-care philosophy has a certain political appeal. It suggests incremental change rather than a comprehensive solution. It reinforces existing industry trends. And it promises to be pain-free. Unfortunately, it will not work. The Bush agenda may speed the reform of American health care, but only by hastening the day the current system fails apart.
WASHINGTON — Almost everyone agrees that we ought to “fix the health care system” — a completely meaningless phrase despite its popularity with politicians, pundits and “experts.” Indeed, it is popular precisely because it is meaningless. The people who proclaim it rarely tell you the discomforting choices it might involve. Instead, they focus on a few specific shortcomings of our $1.9 trillion health-industrial complex and imply that, if we correct these often-serious flaws, we’ll have “fixed” the system or at least made a good start. This is rarely true, and so most forays into “health reform” end with disillusion.

We are about to start the cycle again. By most accounts, President Bush plans to highlight health care in his forthcoming State of the Union address. His proposals may or may not have merit, but they surely won’t fix the health system in any fundamental way. The reason is that most Americans don’t want to fix the system in that sense. Most are satisfied with their care. Most don’t see (or pay directly) most of their costs. Because politicians — of both parties — reflect public opinion, they won’t do more than tinker.

Unfortunately, tinkering isn’t enough. As everyone knows, health spending has risen steadily. In 2004, it totaled 16 percent of national income, up from 7.2 percent in 1970. As health insurance becomes more costly, the number of uninsured, now about 46 million, may grow. Worse, health costs may depress wage gains, raise taxes and squeeze other government programs.

Here’s the paradox: A health care system that satisfies most of us as individuals may hurt us as a society. Let me offer myself as an example. All my doctors are in small practices. I like it that way. It seems to make for closer personal connections. But I’m always stunned by how many people they employ for non-medical chores — appointments, record-keeping, insurance collections. A bigger practice, though more impersonal, might be more efficient. Because insurance covers most of my medical bills, I don’t have any stake in switching.

On a grander scale, that’s our predicament. Americans generally want their health care system to do three things: (1) provide needed care to all people, regardless of income; (2) maintain our freedom to pick doctors and their freedom to recommend the best care for us; and (3) control costs. The trouble is that these laudable goals aren’t compatible. We can have any two of them, but not all three. Everyone can get care with complete choice — but costs will explode, because patients and doctors have no reason to control them. We can control costs, but only by denying care or limiting choices.

Disliking the inconsistencies, we hide them — to individuals. We subsidize employer-paid health insurance by excluding it from income taxes (the 2006 cost to government: an estimated $126 billion). Most workers don’t see the full costs of their health care. Nor do Medicare recipients, whose costs are paid mainly by other people’s payroll taxes.

We’re living in a fantasy world. Given our inconsistent expectations, no health care system — not one completely run by government or one following “market” principles — can satisfy public opinion. Politicians and pundits can score cheap points by emphasizing one goal or another (insure the uninsured, cover drugs for Medicare recipients, expand “choice”) without facing the harder job: finding a better balance among competing goals.

Every attempt to do so has failed. Consider the “managed care” experiment of the 1990s. The idea was simple: herd patients into health maintenance organizations or large physician networks; impose “best practices” on doctors and patients as a way to encourage preventive medicine and eliminate wasteful spending; and cut costs through administrative economies. But managed care upset doctors and patients. After a backlash, managed care relaxed cost controls.

Now, some say that because the “market” has failed, greater government control is the answer. Private insurance has high overhead costs and generates too much paperwork. True. Still, there’s not much evidence that over long periods government controls health spending any better. From 1970 to 2003, Medicare spending rose an average of 9 percent annually. In the same years, private insurance costs rose 10.1 percent annually.

Americans want more health care for less money, and when they don’t get it, they indict drug companies, insurers, trial lawyers and bureaucrats. Although these familiar scapegoats may not be blameless, the real problem is us. We demand the impossible. The changes we truly need are political. We need to reconnect people with the public consequences of their private acts. We should curb the subsidization of private insurance. Medicare recipients should pay more of their bills. But these changes won’t happen because people don’t want to see the costs. We don’t have the health care system we need, but we do have the one we deserve.

Jan 25, 2006
Carrera, Boulder, CO

Costs will explode.

We are living in a fantasy world — health care ideas.

Every attempt has failed. (Is it this bad?)
- Roy Faivre
Cut some green. Lower medical costs by up to 20%.

A new study* shows that integrating Medical, Pharmacy and Disease Management benefits with Aetna can help lower medical costs. According to the data, overall costs dropped by 15-20% for high-risk Aetna members with integrated benefits compared to similar members with just medical insurance benefits. That’s because integration allows for a better exchange of information to help high-cost, high-risk members better manage their conditions. To find out more, call your broker, Aetna representative, or visit us today at aetna.com.

We want you to know™

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News—

World-Wide

SHARON had a massive stroke; Israel confronts a political vacuum.
Power was transferred to a deputy, Olmert, after the 77-year-old premier, who suffered a minor stroke Dec. 18 and was due for heart surgery this week, was rushed into an operating room to stanch a brain hemorrhage. Doctors said prospects for full recovery are slim. He was on a respirator. Events inject huge uncertainty into the March 28 vote that Sharon was expected to win easily. He had become the virtually indispensable man of Israeli politics after being thrust into the unfamiliar center of the left’s collapse in the demise of Oslo and the earlier failure of rightist rival Netanyahu’s government over peace policy and corruption inquiries. (Column 6)

Chaos in Gaza spread as hundreds of Palestinians streamed unchecked into Egypt after militants seized bulldozers batter open a border wall. Two Egyptian guards died in the clashes.

IRAQ suffered its worst day in weeks, with at least 53 people killed.
The bloodiest of the attacks by insurgents came as a suicide bomber detonated among mourners at the funeral of a Shiite official’s nephew, killing 36 in Minidadiya, 60 miles north of Baghdad. Victims were first herded with mortar fire into the killing zone amid gravesites. Meanwhile, the Interior Ministry reported the violence claimed more than 7,000 Iraqi lives, most of them noncombatants, in 2005.

Insurgents attacked a convoy of 60 tanker trucks heading to Baghdad from Iraq’s biggest refinery, destroying 20, killing a driver and dealing a blow to government efforts to solve shortages.

Side Effects

As Generics Pummel Its Drugs, Pfizer Faces Uncertain Future

Insurers Gain Skill in Battling Company’s Marketing;
Sales of Lipitor Stagnate

Developing a New Cancer Pill

By SCOTT HENSLEY

Pfizer Inc., the world’s largest drug company, is struggling with a big problem: an escalating campaign by employers and insurers to drive patients toward cheap generics.

Investors and the company have long known that generic copies would pummel several of Pfizer’s top drugs that are losing patent protection. But in a new twist, generic versions of competitors’ drugs are hurting sales of Pfizer drugs that are still patent-protected. Licensing deals, acquisitions and the company’s own research have failed to produce enough products to pick up the slack.

Most critically, U.S. prescriptions for Pfizer’s cholesterol buster Lipitor have stagnated, even though five years remain on the key patent covering the medicine. At Kaiser Permanente, a California health-maintenance organization, fewer than 10% of patients on cholesterol-lowering drugs are getting Lipitor.

The result is trouble for the company that defined an era of heavily marketed pills for masses of patients. In October, Pfizer withdrew preparations for 2006 and 2007, saying it lost a reasonable basis to make predictions. Its share price hit an eight-year low last month before recovering somewhat after a court ruling affirmed Lipitor’s patent.

For years, even as some rivals hedged their bets by developing high-priced specialty medicines and vaccines free from generic competition, Pfizer threw its energy into remedies for common ailments. Among them were Celebrex for pain, Zoloft for depression and Viagra for impotence. Its key weapon was marketing: television ads for the public and an army of sales representatives urging doctors to prescribe Pfizer pills.

Today, insurers and drug benefit managers are becoming adept at overcoming Pfizer’s marketing might. Massachusetts requires 131,000 state employees, retirees and dependents to try two other cholesterol pills before it will pay for Lipitor. Even if patients get Lipitor, they have to pay $40 a month as their share of the cost.

Sweaty Donkey Ears
And Peeping Frogs?
That Must Mean Rain

Brazilian Seers Look for Signs
Of Showers Amid Drought;
A Dentist’s ‘Vigil of Noah’

By MATT MOFFETT

QUIXADA, Brazil—In a parched field of rocks and brush, Antonio Tavares da Silva, swung a stick and...
Calling all Consumers

Drug Costs

Missing the Point

With politicians pushing proposals to expand drug insurance coverage for the elderly, this would seem to be a good time for the public to be informed about the issues involved—which, of course, is necessary for it to understand the likely impact of these proposals.

Thus, Newsweek’s mid-September “special report” on the topic was timely. “From the presidential race to the battle for Congress, candidates are bashing the high prices [of prescription drugs]. And many consumers are clearly angry,” the cover story observed. “But the most interesting—and largely untold—story is how the nation got here: why do our drugs cost so much?”

And the answer? Well, the newsmagazine didn’t really provide a coherent one. All it dug up, with its vast reportorial resources, were observations that overall spending on drugs is rising because we take more drugs than ever, new drugs cost more than old drugs, and drug prices are going up. Sure drug spending is rising as people take more drugs, even as prices have increased, but why? And how is this important in the policy debate?

Without relevant answers, ensuing discussion couldn’t answer this second question either. Rather it presented a confusing and complicated picture about the difficulty of determining a drug’s “fair” price and concerns that, while consumers pay less for drugs in some other countries, pharmaceutical firms make record profits in the United States, which is necessary for innovation. In this context, the central fact that politicians plan to expand insurance coverage for the elderly so they won’t have to pay as much out-of-pocket as they do now, seemed a no-brainer. The policy makers just had their work cut out for them, the story suggested.

Such is consumer journalism these days that reporters don’t know to ask the relevant questions. Readers come away from the story with no more understanding than they began with.

So, what are the policy makers up to? The common thread to all of the main prescription drug proposals, and the reason for their essential shortcomings, is the attempt to insulate the elderly (and other people) to some extent from the costs of drug purchases, small out-of-pocket expenses in particular.

Just as in other sectors of health care, the prevailing mindset—one unquestioned by the typical reports—aims to release people from the financial burden of their health-spending decisions. The net effect, as readers of these pages know, is that when somebody other than the patient pays the tab, the patient and his/her physician have little incentive to conserve on costs; demand skyrockets and those paying the bills are forced to install some species of spending control.

Third-party-payer concern about spending explains the various controls imposed by Medicare, Medicaid, the growth of HMOs, and—to the point here—formularies, benefit-management firms and the like used to restrain drug spending. These controls lurk behind nearly every policy discussion about drug prices and spending, but the standard news story tends to miss the point.

For instance, most coverage begins with talk of people paying “too much” out-of-pocket, but then casually morphs into discussion about “excessive” drug spending—and the need for restraints—as if the two are the same. But this excessive spending isn’t by the patients; it’s by the government, insurance companies, “society.” And it is the controls pushed by these payers to rein in their spending that threaten individual patients: new treatments delayed due to price controls or kept from the patient due to formularies or outright rationing.

Current efforts to achieve “affordability” for the patient do so simply by increasing the role of third-party payers, not by removing the incentives that drive the skyrocketing demand. The sooner public discussion turns to this aspect of the health care debate, the sooner we can hope to see solutions that bring more focus on the individual. Indeed, if we really want to afford the medicines we need, we can begin by looking at how to get patients more involved in spending decisions, not less so.

—Peter Spencer

Drug Spending

| Drug Spending
| When someone else picks up the tab, individuals have less incentive to conserve, others more incentive to ration. |

| Source: Dept. of Health and Human Services

| As out-of-pocket control declined from 93% of Rx drug spending 1965 to 22% today, demand and overall spending has skyrocketed from $18 billion to more than $240 billion. |

<table>
<thead>
<tr>
<th>% Share out-of-pocket</th>
<th>Drug spending $ billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 50 100 150 200 250</td>
<td>0 200</td>
</tr>
</tbody>
</table>

October 2000 43
Erika Check, Washington

Money tensions on Capitol Hill erupted into farce last week when researchers at the National Institutes of Health (NIH) were branded "pigs" by a senior senator during a budget debate.

"The NIH is one of the best agencies in the world," Senator Pete Domenici (Republican, New Mexico) told colleagues at the 11 March debate. "But they have turned into pigs. You know, pigs! They cannot keep their oinks closed. They send a senator down there to argue as if they are broke." Observers said that Domenici also used his hand to mime a pig's snout in front of his face and wiggled his fingers. "Will you listen to what has happened to the NIH in five years and tell me that they should get this much money?" he said.

Domenici was responding to Arlen Specter (Republican, Pennsylvania)—one of the NIH's main champions in the Senate—who successfully proposed that the budget resolution for 2005 incorporate a $1.3 billion boost for the NIH. This is $536 million more than President Bush has proposed for the agency. The resolution guides the appropriations subcommittees who determine actual spending levels.

But the proposal outraged Domenici, a strong supporter of physical-sciences research whose home state houses two huge nuclear weapons laboratories, Los Alamos and Sandia. Backers of the physical sciences have become increasingly frustrated in recent years by the failure of other research agencies to attract the kind of increase obtained by the NIH. These feelings had seldom been publicly expressed, however—until Domenici's outburst.

The NIH is one of the few agencies apart from defense and homeland security that could get a big budget increase next year. On 2 February, President Bush proposed that the agency should get $28.6 billion in the 2005 fiscal year, which starts in October, a 2.6% increase on the 2004 budget. But NIH advocates want 8-10%, to help the biomedical research agency sustain the momentum created by the doubling of its budget between 1998 and 2003.

The budget for NIH (health) recently doubled.

In Feb 2004, Bush proposed that NIH will get a budget of $28.6 billion for year 2005 (an increase of 2.6%).

But NIH advocates say that NIH should have an increase of 8-10%.

The senator gets mad at this speed.

He says NIH has turned into pigs.

P30

Ray F. Jones

April 2005
Are U.S. Doctors Worth Their High Salaries?

Overall, Experts Say Yes
But Problems Are Seen
As Specialists’ Take
Climbs Steadily

First of two parts
By Christine Shenot
Investor’s Daily

These days, people seem to trust doctors the way they trust members of Congress — except for their own, they don’t.

According to a recent survey by the American Medical Association, nearly two-thirds of Americans believe doctors are too interested in making money, while less than a third think physicians spend enough time with their patients. Only 18%, however, saw their own physician as too worried about income, and 78% said they were satisfied with the amount of time they were given in his or her office.

Some physicians say the phenomenon simply reflects an anti-institutional bias in the U.S. that is also illustrated in public opinion on Congress.

But the poor public opinion of doctors, added to growing concern over the nation’s soaring health-care costs, may have a different sort of ring in coming years.

In today’s climate, public criticism of the medical profession, now relatively unfocused, could evolve into support for new restrictions on the way individual doctors practice and on their compensation. Such rules could be established by private insurers or government programs like Medicare.

To be sure, the health-care reform plans proposed so far by business leaders, health officials and Congress do not emphasize the need to control physician costs. The most common suggestions for physician-related reforms are steps to curb growth in malpractice liability costs and to establish practice guidelines that would help doctors avoid unnecessary or inappropriate procedures and services.

It’s Easy to Finish on Back Page
Are U.S. Doctors Worth Their High Salaries?

From page 1

But AMA data show the average physician’s pretax pay after expenses grew between 7.7% and 10.7% annually from 1987 to 1989. During the same period, inflation grew 4.4% to 4.6% a year.

The discrepancy occurred despite an increase in the number of doctors per capita during that period, AMA figures indicate.

Nonetheless, health policy experts are less concerned about physician pay levels per se than they are about the way payments are distributed across different specialties.

“Doctors are extremely well-paid in the U.S. compared to other countries,” admitted Henry Aaron, a health-care economist with the Brookings Institution. But even if physicians’ incomes were cut significantly, he argued, “that wouldn’t make a major dent in total health-care spending.”

“We have to be more moderate in our economic expectations,” conceded Dr. Alan Nelson, an internist and former president of the AMA. But he said doctors’ salaries consume just 20 cents of the nation’s health-care dollar, against 59 cents in 1982.

Procedures Overvalued

Still, there is considerable agreement among physicians and health policy experts that many new procedures have been overvalued relative to patient evaluations and other basic care provided by general practitioners.

AMA data show that from 1982 to 1989, the average net income of family doctors rose only half as fast as those of certain specialists, such as surgeons and obstetricians.

Over the long term, this growing income disparity could make the health-care system even more costly and inefficient than it is today because it draws more physicians into specialties. Already, some experts complain that specialists often are performing services that lower-salaried physicians could provide.

“Our system is top-heavy with specialists,” said Dr. Kevin Grumbach, a researcher at the Institute for Health Policy Studies at the University of California, San Francisco.

In a study published in the New England Journal of Medicine on May 8, Grumbach and UCSF colleague Dr. Philip Lee noted that only 36% of the physicians practicing in the U.S. in 1986 were generalists. In Canada and most of Western Europe, that figure is well over 50%, the authors said.

Nelson believes this imbalance will grow worse as an increasing number of medical students flock to the better-compensated specialties, and surveys of students indicate he is right.

According to the Association of American Medical Colleges, the percentage of graduating seniors choosing general or primary-care specialties — including family practice, internal medicine and pediatrics — dropped to 25% in 1989 from 39% in 1981.

For several years, general practition-
### National Expenditures for Health Care, 1960–2003

<table>
<thead>
<tr>
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<td>$73.1</td>
<td>$245.8</td>
<td>$696.0</td>
<td>$990.2</td>
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<td>Health care expenditures as percent of GDP</td>
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<td>Health care expenditures as percent of GDP</td>
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<td>7.0%</td>
<td>8.8%</td>
<td>12.0%</td>
<td>13.4%</td>
<td>13.3%</td>
<td>14.9%</td>
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Note: Figures may not add to totals because of rounding. 
Source: U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services, Office of National Health Statistics.

### Health Care Spending by Category, 2003

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<tr>
<th>Category</th>
<th>Amount (billions)</th>
<th>Change 2002–03</th>
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<tr>
<td>Hospital care</td>
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<td>Physician and clinical services</td>
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<td>Dental services</td>
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<td>Other professional services</td>
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<td>Other personal health care</td>
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<tr>
<td>Prescription drugs</td>
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<tr>
<td>Durable medical equipment</td>
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</tr>
<tr>
<td>Other medical products</td>
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<tr>
<td>Nursing-home care</td>
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<td>3.9</td>
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<tr>
<td>Home health care</td>
<td>40.0</td>
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<tr>
<td>Administration and net cost of private health insurance</td>
<td>119.7</td>
<td>13.2</td>
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<tr>
<td>Government public health activities</td>
<td>53.8</td>
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<tr>
<td>Research</td>
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<td>10.1</td>
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<tr>
<td>Construction</td>
<td>24.5</td>
<td>7.9</td>
</tr>
<tr>
<td>Total</td>
<td>$1,678.9</td>
<td>7.7%</td>
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Sources: U.S. Dept. of Health and Human Services, Health Care Financing Administration, Office of the Actuary.

### Health Expenditures as Percent of G.D.P. for Selected Countries, 1960–2001

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<tr>
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<tbody>
<tr>
<td>United States</td>
<td>5.1%</td>
<td>6.9%</td>
<td>8.7%</td>
<td>11.9%</td>
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<td>Switzerland</td>
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<td>Germany</td>
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<td>8.7</td>
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<td>Canada</td>
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<td>9.0</td>
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<td>Greece</td>
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<td>6.1</td>
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<td>7.4</td>
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<td>Norway</td>
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<td>Spain</td>
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<td>5.4</td>
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<td>8.4</td>
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<td>Finland</td>
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<table>
<thead>
<tr>
<th>Occupation</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
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<tr>
<td>Number of workers (in thousands)</td>
<td>Median weekly earnings (in thousands)</td>
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<td></td>
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<tr>
<td>All occupations, 16 years and over</td>
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<td>$638</td>
<td>57,001</td>
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<td>Aircraft pilots and flight engineers</td>
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<td>1,418</td>
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<tr>
<td>Architects, except naval</td>
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<tr>
<td>Biological scientists</td>
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<tr>
<td>Brickmasons, blockmasons, and stonemasons</td>
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<td>577</td>
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<td>Bus drivers</td>
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<tr>
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<td>762</td>
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<tr>
<td>Clergy</td>
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<td>Hairdressers, hairstylists, and cosmetologists</td>
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<td>Insurance underwriters</td>
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Fifteen Diseases Named as Drivers Of Health Costs

By Paul Davies

The cost to treat a handful of chronic illnesses such as heart disease and diabetes is driving much of the recent increase in health-care spending, according to a new study.

The study, based on cost data compiled by the U.S. Department of Health and Human Services from nearly 60,000 patients found that 15 medical conditions accounted for half of the inflation-adjusted growth of $200 billion in health spending between 1987 and 2000.

"Most of the growth in spending is among people who are very ill with chronic diseases that are expensive to treat," said Kenneth E. Thorpe, an economist at Emory University and lead author of the study. It is published in the current edition of Health Affairs, a health-policy journal. The findings suggest that more proactive treatment or prevention of chronic diseases could help rein in costs.

The five illnesses where costs increased the most were heart disease, asthma, mental disorders, cancer and hypertension. In heart disease, the cost to treat each case rose nearly 70% between 1987 and 2000, reflecting increased costs of drugs and new medical technology to treat the ailment. While the cost to treat heart disease has gone up, the death rate has gone down, indicating that the benefits may outweigh the costs, Dr. Thorpe said.

By comparison, the cost of treating mental disorders was driven in part by increased prevalence of the conditions: The number of patients treated for mental disorders between 1987 and 2000, nearly doubled to 8,575 cases per 100,000 people, the study found, reflecting improvements in diagnosis. An increase in available prescription drugs also contributed to higher treatment costs.

Diabetes cases rose nearly 44% during the same time period, reflecting a rise in obesity. More than 18 million adults in America have been diagnosed with diabetes. Finding ways to reduce obesity could go a long way toward lowering health-care costs, Dr. Thorpe said.

"We need to have a more proactive model to treat patients," he said. "Today’s system is more reactive."

- People treated for mental disorders doubled from 8,575 cases per 100,000 between 1987 and 2000. This is 1 in 9 people in any one year.
- Diabetes cases rose nearly 44% — a rise in obesity.
Obese Raise Health Costs By A Third
Costs Can Only Worsen

Economist says unless Americans eat less, even the slim will pay

BY GLORIA LAU
INVESTOR'S BUSINESS DAILY

March 22, 2004

A barrage of obesity news has hit the headlines in recent weeks, but how it impacts the average person is unclear.

The Food and Drug Administration is seeking sanctions for false food labels and urging restaurants to start posting nutritional data. The U.S. House passed a bill that blocks diners from suing restaurants alleging the food caused obesity.

And Health and Human Services released a study saying deaths due to obesity rose 33% in the past decade. The study, published in the Journal of the American Association, also says obesity caused 400,000 preventable deaths in 2000. That's second only to the 435,000 deaths caused by smoking.

The study says some 60% of Americans are overweight and 30% are obese. An overweight person has a body mass index of more than 25, while an obese person has a BMI of more than 30.

This data might not hit close to home for non-obese folks. But it probably impacts them more than they realize, says Roland Sturm, senior economist at think-tank Rand Corp.

For one thing, he says, rising obesity rates lead to rising health-care costs for all Americans. Sturm recently spoke to IBID.

IBD: What will obesity affect costs?

Sturm: The conventional wisdom among researchers is that seniors are getting healthier. We all expect that if we get older, we'll lead healthier lives than our parents and even people born 10 years earlier.

And as a consequence, we've expected less need for long-term care (or) Medicare expenditures. But newer data show that the picture is not accurate because of one factor: obesity.

Even though disability rates among the oldest Americans have continued to decline, there's no reason to be complacent about obesity. Severe obesity rates among younger Americans have increased much more than among older Americans.

IBD: How much does obesity increase medical costs?

Sturm: On average, health care costs rise by a third when a person is obese vs. not-obese. At this point, most obese Americans are still just moderately obese — over 30 BMI.

Moderate obesity is associated with 20% to 30% more health care spending when compared to people of normal weight.

But a severely obese person with a BMI over 35 is associated with a 50% to 70% increase in costs. A BMI of 40 or more doubles health care spending.

Why do we care? Between 1985 and 2000, moderate obesity levels have doubled. But severe obesity — people who are 100 pounds overweight — has quadrupled.

Obesity has roughly the same association with chronic health conditions as does 20 years (of) aging. This greatly exceeds the associations of smoking or problem drinking.

On average, obesity is associated with a 36% increase in inpatient and outpatient medical spending and a 77% increase in spending on medications, compared to a 21% increase in inpatient and outpatient spending and a 28% increase in medications for smokers and even smaller effects for problem drinkers.

But smoking and drinking have received more consistent attention in recent decades in clinical practice and public health policy.

IBD: Seniors typically need more costly medical care than younger folks. So if obesity rates are rising much faster among young people, why bother worrying about obesity now? Why not wait until today's young people are older?

Sturm: We are looking up through 2020 because health status today will affect our health care costs in the future. You don't smoke a cigarette and immediately kick over from lung cancer.

(The HHS study) offers backward-looking data. What affects mortality today are things that occurred 20, 30, or 40 years ago.

From a policy issue today, looking at mortality is not that interesting. There's not much we can do about it. If we want to measure future medical costs, we need to look at current health habits and how they affect future health costs, status, mortality, everything.

Health habits today affect what we taxpayers will pay in the future for Social Security, Medicare and other "transfer" programs.

IBD: Where are the obese?

Sturm: Mississippi, Alabama and Michigan. The Deep South has led (in obesity) for 20 years, but everyone else is coming up.

But the most astonishing finding is how absolute weight gain is up across the country. The average American, whether he or she lives in Michigan or California, tends to gain one pound a year.

In 2001, the average person weighed 76 kilograms or 173 pounds. That's an increase of 10 pounds in the prior decade.

Wisconsin Declines Obesity Lawsuit Bill

(A good law)

Wisconsin Gov. Jim Doyle vetoed legislation Wednesday that would have barred overweight residents from suing restaurants and food manufacturers for contributing to their obesity.

Few such lawsuits have been filed nationally, none in Wisconsin, Doyle said.

"Here we haven't even had any disputes to be handled, and it's just sort of saying we don't trust the courts to handle cases," Doyle said. "I just don't think you need to go around and find solutions where problems don't exist."

The legislation would have granted immunity from obesity lawsuits for restaurants, food manufacturers, marketers, packers, advertisers, distributors or sellers.

The sponsor of the legislation, Republican state Rep. Dan Vrakas, planned to ask legislative leaders to schedule a veto override vote later this year. He said just the threat of lawsuits could be enough to drive up business costs for restaurants.

"I think the governor is siding with people who feel we can blame others for decisions and choices that we make," said Vrakas, whose family owned a restaurant for more than 40 years.

In Wisconsin, almost 58% of residents are either overweight or obese. AP
So Who's Really To Blame For Rising Health Care Costs?

Everyone, And No One

Consultant: Critics often choose the wrong target when divvying up blame

BY GLORIA LAU
INVESTOR'S BUSINESS DAILY

How to pay for rising health care costs has been a topic of debate for many decades.

In the 1970s and 1980s, pundits argued that if health care costs ever rose to 10% of the country's gross domestic product, the U.S. would be doomed.

But health costs totaled 14.9% and 15.3% of GDP in 2002 and 2003, respectively.

Health spending nearly doubled to $1.6 trillion from 1992 to 2002, according to the Centers for Medicare and Medicaid Services.

Still, the U.S. has one of the world's strongest economies.

IBD recently discussed health care costs and related issues with Dr. Peter Kongstvedt, vice president of the managed care practice at Cap Gemini and author of "The Managed Health Care Handbook."

IBD: Is this a health care cost crisis?
Kongstvedt: If it's crisis now, it's been a crisis for 25 years.

IBD: Who's to blame? Executives and their high salaries?
Kongstvedt: The issue of executive salaries is completely irrelevant. I have no opinion on them.

But if those salaries suddenly disappeared, there would be no appreciable change in health insurance costs.

Profits of the drug industry are (blamed) by those who wish to redistribute wealth. Others want to blame administrative waste. But ad-

Dr. Peter R. Kongstvedt
- Vice president, Managed Care Practice, Cap Gemini (1994-present)
- Executive vice president, Blue Cross Blue Shield of the National Capital Area (1991-1994)
- University of Wisconsin, BS, 1973; MD, 1977; residency in internal medicine, 1980

All of them have an element of truth, but none of them on their own come close to solving the problem of how to pay for care.

What causes the cost of health care to go up is... hospital costs, outpatient costs, drug costs.

We now treat things that we didn't use to treat. That's good but expensive.

New technology is being invented (and) miniaturized. New devices are invented, new types of transplants, new therapies for chronic illnesses.

Health care is so complex it's impossible to discuss it in the broad public forum. Look how complex topics had to get boiled down during the presidential election and debates. When you start talking about what's really going on, people go to sleep.

We'd like to say it's all due to this one problem — and if we just fixed this one thing, we'd solve it. But that's naive. If it were that easy, it'd already have been done.

IBD: Will giving consumers more choice help cut costs?
Kongstvedt: There's a lot of discus-

It's unclear whether electronic health records will lower costs.

Kongstvedt: Electronic health records will strongly benefit quality and access to care. It's less clear if we'll actually save any money.

There's an argument that we'll save money because we'll reduce the error rate. But health costs are going up anyway, regardless of... electronic health records.

It could help with disease management for patients with significant chronic illnesses. It can very much help with predictive modeling — when you're trying to figure out which of your patients will most likely end up in the emergency room, for example, so you can work with them.

ministrative costs are only about 11% of health insurance costs.

There are plenty of other fingers we can point... at the way physicians practice medicine, how hospitals compete for staff and patients, how consumers demand expensive interventions at the price of a small
FACT AND COMMENT
By Steve Forbes, Editor-in-Chief
"With all thy getting get understanding"

Health Savings Accounts — I doubt they will work — R. J. Parks

No Wonder

Risk taking is the fundamental foundation of economic progress. Societies that allow or encourage it flourish; those that don’t, don’t. Economically sluggish western Europe’s attitude toward entrepreneurship is captured by a provision in Italy’s bankruptcy law. If your business goes broke in Italy, you are prohibited from starting a new one for ten years. The only reprieve: If you can persuade a court that you are making a “good faith effort” to pay your creditors, the ban will be cut to two years.

Health Care Crisis Cure

The salvation of American—and global—health care is at hand. In June the U.S. Treasury Department issued a ruling that removes one of the last major hurdles to the widespread use of tax-free Health Savings Accounts. HSAs are modeled after IRAs—money for medical purposes can be deposited free of tax, it can grow tax free, and it can be spent for medical care, tax free.

Several states mandate first-dollar coverage for certain types of health insurance benefits, no deductibles permitted. One of the key foundations of HSAs is a large deductible. The Treasury Department has mandated a transition period for states to remove regulatory impediments to HSAs. In the meantime consumers will be able to access this fantastic new tool.

The premise of HSAs is to once again put the patient, i.e., the consumer, in charge of the health care market. HSAs allow employers to offer health insurance with high deductibles—up to $2,600 for individuals and $5,150 for families. These levels make health insurance policies infinitely cheaper. In turn, companies—workers, as well—put money into HSAs, tax free, that will cover the lion’s share of the deductible. What an employee doesn’t use stays in the HSA earning tax-free interest for future use. This is the antithesis of Flexible Spending Accounts, in which the worker loses whatever money in the account hasn’t been spent by year’s end.

For years at Forbes we have provided what has been, in effect, Health Savings Accounts. The insurance itself is a bargain (relatively) because the policy deductible is high. What makes the plan so attractive, though, is that we give everyone who works here $2,000 each year, which covers most of the deductible.

Money that isn’t used is rolled over. If medical bills exceed both that $2,000 and the employee portion of the deductible, traditional health insurance kicks in. Our premiums last year went up only a fraction of the national average. When companies initially put such a plan in place, they often see a decline in premiums. Now that employees will have “skin in the game,” employers rightly figure that those dollars will be spent more carefully, more wisely. For instance, why get an MRI when, in certain situations, an X ray would be just as good?

The virtue of HSAs, however, goes well beyond this semi-zero-sum mentality: The way health care is delivered will change as providers find it in their best interest to come up with innovative breakthroughs. The traditional cost-plus mind-set will wither away. We truly will get more for less.

Two examples that have already proved this—plastic surgery and laser vision surgery. Neither is covered by traditional health insurance unless the surgery is needed because of accident or disease. The cost of plastic surgery has not experienced the kind of inflation that has afflicted the rest of the health care industry. In recent years laser eye surgery that reshapes the cornea so a patient no longer needs to wear glasses costs more than $1,500 per eye; today the same procedure can be done for less than $500 per eye. As HSAs become more common, similar results will be seen in the rest of American medical care.

With HSAs consumers will want to know what a procedure costs in advance. Using the Internet, they can comparison shop, not only for price but also for quality. More and more, insurers will make available easily accessible checklists of what patients should expect from various kinds of consultations and procedures. Today if you question a hospital or physician about prices, they’ll look at you like you’re some kind of nut or, even worse, someone who’s uninsured.

Up to now there have been precious few consumer-directed pressures to bring about better care at less cost. Every other facet of a free-market economy experiences technological advances that make for better products and services at less cost. Food outlets as a percentage of our incomes have been declining for more than 100 years. When you adjust for inflation, it’s clear you get more car for your money today than you did a couple of decades ago. Ditto with housing. Ditto with personal computing. In most sectors growing demand is considered healthy, but in health care it’s considered a cri-
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 managed care plans also net based. They are providing Medicare C. Health evidence is open in high-cost regions.

Problems may be the qua the standard approach. James E. slovene high-quality.

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Shannon

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frequently.
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.\footnote{Shannon Brownlee, a senior fellow at the New America Foundation, was formerly a senior writer for Discover and U.S. News & World Report. Her work has appeared frequently in The New Republic, The Washington Post, and other publications.}
How some companies cut health costs

- Car-base has its own clinic
- Putrey Boris has a team to cut costs
- Unusual disease-care plan
  - For chronic disease it helps a lot to manage the costs
- One care & in-house clinics of companies
Boom for Labs

The CDC is building seven facilities that will dramatically expand space for research on infectious diseases.

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Car Insurer Has Medical Clinic To Cut Costs

By Charles Fleming

When James Weeks was in a car accident in southern England late last year, he turned to an unlikely source to treat his whiplash and back injury: insurance company Norwich Union.

The United Kingdom's largest automobile insurer, Norwich Union, has set up its own medical clinic to treat victims of car accidents involving its policyholders. The pilot program is an effort to keep down accident claims and cut Norwich's escalating medical and legal costs.

The insurance company, which is owned by Aviva PLC, figures that by having its in-house doctors and physical therapists provide quick treatment to its policyholders or people making claims against its policyholders, it can speed up their recovery, thereby-cutting costs associated with the injury, and limit the likelihood of adversarial legal claims later, says David Hooker, Norwich Union's head of claims.

At its clinic, which specializes in treating the whiplash cases that make up 80% of the injury claims on the company's car-insurance policies, Norwich Union pays medical costs itself. So Mr. Weeks didn't have to shell out cash for his six weeks of physical-therapy sessions at the company's clinic in Maldenhead in southern England.

The Norwich Union clinic is the latest, and perhaps most extreme, example of how insurers world-wide are looking for new ways to contain rising accident claims. In the U.S. and in Europe, some insurers have their own body shops to repair cars, and many have special agreements for discounts at some garages, called "preferred provider agreements." But Aviva seems to be the first to provide in-house medical treatment to claimants.

In Germany, a recommendation by a national legal-representative body laid down in 2000 that insurance companies couldn't control a rehabilitation center.

In the U.K., the number and monetary value of bodily injury claims have soared since 1999 when legal reforms effectively streamlined access to courts for civil plaintiffs seeking redress for accidents. According to data from the Association of British Insurers, the number of claims increased by nearly 25% in 2003, to 3.5 million. That was more than double the level of claims in 1998.

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Body Blows

Average settlement paid per claim by U.K. motor-insurance companies:

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Note: £1=£1.73
Source: Association of British Insurers

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Please Turn to Page B2, Column 3
Auto Insurer Offers Medical Care

Continued From Page B1

ation of British Insurers, there has been a 250% jump in the amount paid out each year in such claims by U.K. auto insurers over the last five years. About 75% of those claims concern whiplash. In a typical court settlement, an insurer pays a whiplash victim about £3,000, or roughly €3,000, plus £2,000 in legal fees, Mr. Hooker says.

The U.K. national health service provides free medical care to citizens but many people opt for private treatment because of the long waiting times for treatment under the public service. By speeding up treatment, Norwich Union hopes they can get victims back on their feet again more quickly, thereby cutting the amount they can claim for damages.

Aviva's pilot project of providing medical care has a staff of six and a modest initial annual budget of £1 million ($1.7 million). Since opening in January, it has treated a little more than 240 patients. Norwich Union won't assess if the program is successfully cutting costs until it has treated about 500 patients and then it will decide whether to expand the program, Mr. Hooker says. So far, for example, the average number of physical-therapy sessions at each clinic has been cut to four, from eight on a national basis, he says.

Not surprisingly, Aviva's experiment is proving controversial. Insurers face a conflict of interest in treating accident victims while trying to improve their own bottom lines. Why personal-injury lawyers (who themselves can benefit when accident victims sue).

"Rehabilitation has to be done for the good of the patient and not for the good of the insurer," says Jennie Walsh of the U.K.'s largest personal-injury law firm, Thompsons Solicitors in London. "How do we know that what happens in rehab, the medical reports and all, are not being manipulated or led by the insurer's demands?" she asks.

Mr. Weeks, a 67-year-old garage employee whose Fiat Punto was written off as a wreck after last year's accident, was barely aware that the medical team who treated him for whiplash and sore back at the Norwich Union rehabilitation center in Maidstone were employees of the other insurer. "There were a few Norwich Union pens lying around but that was about it," he says.

He ended up at the clinic because, the other driver reported the accident to Norwich Union. "We called him to suggest its own rehab center," Mr. Weeks wasn't hurt badly enough to justify emergency hospital treatment, but in following days, his sore neck and back prompted him to seek physical therapy. Although Norwich Union offers it.

Bank of Italy Governor Antonio Fazio, who is under investigation for abuse of office and insider trading in relation to the summer takeover battles, has brought further delay.

Mr. Fazio is accused of helping Gianpiero Foschi, former chief executive of Banca Popolare Italiana, Scarl, buy shares in Monteforte to fend off ABN Amro's bid.

Unipol Chairman and Chief Executive Giovanni Consorte was interrogated by Milan prosecutors yesterday in connection with the takeover battle for Banca Antonveneta. Mr. Consorte also is under investigation in Rome over possible irregularities in the run-up to Unipol's bid for BNL. He has denied wrongdoing.

Bridgestone Corp.

Plant in China Will Be Added To Meet Increasing Demand

Expecting demand for high-performance rubber to grow in Asia, Japan's Bridgestone Corp. said it will spend about $100 million to build a synthetic-rubber plant in Guangdong, China. The automo-

tive-tire maker said the new plant, which will have an annual production capacity of 50,000 metric tons, will start operations in the first half of 2006. Bridgestone already has two factories in North America to produce synthetic rubber for automo-
tive tires. Bridgestone has signed with tire-related plants in the city of Huizhou, Guangdong province, where it will set up the new synthetic-rubber plant. Under its three-year business plan starting 2006, the Japanese company is aiming to boost its profits by expanding tire sales in the Americas, Europe and growing markets such as China.

iPayment Inc.

Group Led by Chief Executive To Buy Firm, Take It Private

Payment processor iPayment Inc. said it agreed to be acquired by an entity led by Chief Executive Gregory Daily for $43.50 a share in cash, valuing the company at about $770 million. The terms value the Naples, Fla., company at a 6.8% premium to its price of $46.74 in 4 p.m. composite trading on the Nasdaq Stock Market. The acquirer, IPayment Holdings Inc., expects to complete the transaction in the first half, pending shareholder and regulatory approval and the obtaining of financing. Following the deal, iPayment, which provides credit- and debit-card-based processing services to more than 170,000 small merchants in the U.S., will operate as a private company. Mr. Daily in May offered to buy iPayment for $38 a share, but a special committee of the company's board didn't recommend the offer. Last month, Mr. Daily raised his offer to $43 a share, then to $43.50. The committee unanimously approved the latest offer, as did iPayment's board, with Mr. Daily abstaining, iPayment said.
Attacking Rise in Health Costs, Big Company Meets Resistance

Pitney Bowes Finds Culprits, But Can’t Beat Them All; $11,447 Knee Arthroscopy

Marketplace ‘Wasn’t Working’

By Vanessa Fuhrmans

STAMFORD, Conn.—Pitney Bowes Inc., the mailing-equipment and services company, has a team that aggressively seeks out ways to contain ballooning health costs. Last year, it scored a small victory. Employees who went to a hospital in 2003 stayed for an average of 3.7 days, unchanged from a year earlier. The overall number of admissions didn’t rise, either.

So Pitney Bowes was startled to nonetheless discover that the average cost of each hospital visit jumped 9% to $10,600. The average cost per day jumped 17%. One of the biggest culprits? Increasingly powerful hospital groups in California, whose price increases pushed the company’s average cost of a hospital admission in that state to $20,500, twice what it paid elsewhere.

By combing through claims data from its 46,000 U.S. employees and their dependents, Pitney Bowes can pinpoint some of the big contributors to the nation’s surging health-care bill: Local hospital mergers; entrepreneurial doctors prescribing costly MRIs and CT-scans at their own private clinics; marketing for expensive drugs such as the heartburn medicine Nexium, which became Pitney Bowes’s third-highest drug expenditure last year after an advertising blitz by maker AstraZeneca PLC.

What Pitney Bowes learned tells the larger story of why health costs keep rising in America: A dysfunctional market creates few incentives for any of its participants to deliver efficient care. In fact, competition among insurers, health-care providers and producers of drugs and equipment can often lead to higher, not lower prices.

Even a big company with an entire team dedicated to rooting out the source of rising health-care costs has little power to change these dynamics. “We can isolate certain phenomena and try to act on some and advocate policy for others,” says Jack Mahoney, the corporate medical director at Pitney Bowes, who oversees its health-care strategy. “But when you come right down to it, even the biggest company out there will tell you they don’t have much influence on the market.”

The struggle by American businesses to rein in health-care costs is nearing crisis levels. Despite recent benefit cuts, U.S. employers still pay the majority of health-care costs for more than 130 million Americans and have borne the brunt of double-digit annual increases. General Motors Corp., for example, says it spends “significantly” more on health care than steel. Recent surveys suggest costs to employers could rise as much as 10% next year.

Pitney Bowes, which is best known for inventing the postage meter, runs eight state-of-the-art medical clinics for workers who logged 31,000 appointments last year, saving money on doctor visits. It operates its own “Health Care University,” where employees can earn credits toward lower premiums while learning, for example, how to use health care more efficiently. Its seven-member strong strategy team uses complex predictive modeling software to spot the next place where health-care costs will rise, and designs initiatives to counter them. Pitney Bowes, more than many other companies, has had some success in tackling costs by changing the behavior of its employees and improving their health.

Yet in 2003, the total cost of claims Pitney Bowes paid directly—covering about 80% of its employees—rose 11.5%, more than it expected. About 20% of Pitney Bowes’s employees are covered by health-maintenance organizations, for which the company pays a simple premium. That brings the average increase in prices for the entire company down to 7.5%. Pitney Bowes also managed to reduce its overall costs by increasing employee contributions and winning discounts on certain drugs and services.

The Pitney Bowes team headed by Dr. Mahoney, a 60-year-old former White

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July 13, 2004

Wall Street Journal

(page 1)
Pitney Bowes Battles Health Costs

Executive of Connecticut Orthopedic Specialists in New Haven, say they plan to install their own MRI machines to provide patients better, faster and cheaper diagnostic tests. "It will set us apart from other orthopedic practices," says Dr. Elia. The group currently prescribes about 300 to 500 MRI scans a month.

Dr. Elia says he won't order more tests simply because he has a machine in-house, but other physicians aren't as cost-conscious. Cardiologists with their own imaging equipment prescribed cardiac stress tests for 20.2% of the patients they saw, according to a 2003 Connecticut-based study conducted by National Imaging Associates, a company that manages radiology benefits for health plans. Doctors who didn't have their own equipment prescribed tests for 5.1% of patients, the study also found.

Imaging tests performed in hospitals also have become more expensive. Richard Jones, chief financial officer at Stamford Health System, the single hospital in Pitney Bowes' headquarters city, defends the price of such treatments by noting the extra costs hospitals incur. Last year, he says, the hospital provided $24 million in free care, a 6% jump from 2002.

Since January, Pitney Bowes has required employees to pay a deductible of about $250, depending on their health plan, plus 20% of the costs of MRIs, CT scans and other tests, unless they are preventive, such as mammograms. Previously, employees were only required to hand over a $75 co-pay. "We want to give people the impetus to start asking about price," says Dr. Mahoney.

The Pitney Bowes medical analysts saw similarly sharply rising costs from hospitals, and quickly discovered that much of the problem in 2003 came from California. Pitney also suffered from a rash of severe cases among dependents of its California employees that year.

Traditionally, HMOS paid a set fee for procedures, requiring hospitals to keep their costs under that target. In recent years, hundreds of California's independent community hospitals have consolidated into networks so big that insurers can't afford to shut them out. Many are using their economic power to charge for every specific procedure and service. Sometimes, health plans agree to pay a set percentage of billed charges, but hospitals retain control over determining what those charges will be.

In the San Francisco area, where the Sutter Health hospital network has a large presence, the average cost of knee arthroscopy at a hospital climbed 36% to $11,447, according to First Health Group, a managed care company. Sutter, a nonprofit network of 26 hospitals, is one of the largest hospital operators in Northern California, where most of Pitney Bowes' 2,000 employees in the state live and work.

Sutter is unapologetic about raising its prices. "We were at a point where we couldn't continue to make the investments we needed to and hope to serve our communities," says Bill Gleeson, a Sutter spokesman, who says the group barely broke even during the 1990s. Instead of allowing health plans to negotiate with individual hospitals, it now centralizes all such discussions.

Mr. Gleeson says Sutter has to cover other costs, such as meeting regulations relating to staffing levels, serving the uninsured and meeting state-mandated requirements to make buildings earthquake-resistant.

There's little Pitney Bowes can do to fix this problem. The California Public Employees' Retirement System, which provides benefits for 415,000 members, said last month it was dropping from its network 16 of them Sutter facilities—because of soaring hospital costs. Dr. Mahoney says Pitney Bowes isn't powerful enough to make such a dramatic move because hospitals

Wouldn't that help? Dr. Mahoney self-reflects on why so many charges. On a recent foray, he began complaining that serving the area was once "the third 'Now, wait a minute, hospital,'" he said. Drug costs company's buyer: the resistant. Like a drug, the company's buyer: a drug's price is available in the future, to seek cheaper the company's business in the 11% of the time of the battle. The price, Pitney Bowes added the cases, drug-insufficiency in the compa.

Last fall, started market pill Prilosec in that was signified byZeneca's Nexium, the pot plant. Under the employees cost Prilosec, which by AstraZeneca.

But last year spent $223 million in ad company for one drug, according to

Leuca
Pitney's Chart

Where the money goes:
Pitney Bowes medical claims costs

- In-patient hospital services: 47.5%
- Out-patient services: 27%
- Mental health: 5%
- Pharmaceuticals: 15.5%
- Physicians: 17%
- Other: 13%

What drives the cost increases:
Where did 2003's 11.5% increase in medical claims costs come from?

- In-patient hospital: 35%
- Out-patient services: 35%
- Physicians: 17%
- Pharmaceuticals: 13%

Source: Pitney Bowes

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Why, in Shanghai, License Plate Is A Precious Metal

Continued From First Page

of this year, China added an average of 14,195 vehicles to the road each day. Within two decades, the country should surpass the U.S. as the world's biggest auto market.

Changchun, in the Northeast, is levying a ¥73-a-year fee on every vehicle purchased—for "increasing the auto population." Away from China's wealthy coast, Shao yang city collects 1% of the purchase price from car buyers to distribute to laid-off workers.

Such measures have met resistance, and not just from car buyers. Central government authorities, keen to develop China's auto industry, oppose local efforts to curb individual car ownership. In 2000, they ordered cities across China to cancel 238 different types of auto-related fees. Assistant Commerce Minister Huang Hai recently berated Shanghai over its auction, saying it violates the rules and hurts car sales.

"The car is a commodity that a modern society can't be short of," Mr. Huang said.

Mr. Li, who has wanted to own—and drive—a car all his life, listened to his father's tales of driving supply trucks for the U.S. Army on the island of Saipan during World War II. Later, his father taught Chinese soldiers to drive jeeps so they could fight the Americans in the Korean War. Even Mr. Li's wife drives, as a chauffeur for China's military brass. Mr. Li is itching to buy a car. "It's a matter of individual freedom," he says.

So on a drizzly Saturday morning, he put on his black Nike baseball cap and pulled down the metal shutter on his street-side office. A friend, a Buick sales agent, had earlier predicted that 16,000 yuan, or $1,932, would be enough to buy a plate at auction. Mr. Li mulled the tip as he crossed the parking lot. "Sounds about right," he said.

Shanghai implemented its auction system in 1986, after a group of traffic policemen visited Singapore and liked what they saw. Singapore's system is complicated, but it effectively keeps down the car population. Drivers must bid for a 10-year permit to put a car on the road, with different classifications based on engine size. One type applies to cars driven only on weekends or in off-hours.

Shanghai's system, in theory, is simpler: The highest bidders get a license plate. The system requires participants to enter the amount they are willing to pay without knowing what anyone else is bidding.

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Leucadia Mau Seek MCT Stake
Unusual Disease-Care Plan to Be Unveiled

BY RON WINSLOW
Staff Reporter of The Wall Street Journal

Blue Cross and Blue Shield of Minnesota and American Healthways Inc. expect to announce today a 10-year agreement under which American Healthways will help manage the care of the plan's patients with heart disease, diabetes, asthma and other chronic diseases.

The pact, unusual in both its length and the scope of illnesses handled by a single company, represents a significant advance for the field known as disease management, in which patients with chronic ailments are given special support to help them manage symptoms and avoid costly hospital visits.

The agreement also comes in the midst of a resurgence of health-care inflation that is causing many employers to look for new strategies to contain medical costs. Officials at Blue Cross and American Healthways said the program being launched offers a way to mitigate costs while improving outcomes for patients, especially those who are heavy users of medical services.

"This is really the next evolution of where health plans should go to try to improve the health of our members and, through that, lower costs," said Mark W. Banks, president and chief executive officer at the Blue Cross plan.

Precise terms of the deal, which the parties describe as a strategic alliance, aren't being disclosed. Thomas G. Cigarran, chairman and chief executive officer of American Healthways, Nashville, Tenn., said that fees paid to his company over the entire 10-year length of the agreement could amount to between $200 million and $300 million. The actual amount will depend not only on cost savings, but on how well the company performs on a variety of measures, including evidence that patients' health improved and that they were satisfied with the program.

In 4 p.m. trading on the Nasdaq Stock Market Friday, American Healthways shares were at $33.40, down $1.15.

Initially, the program will focus on the "15% to 20% of the population that drives 75% to 80% of the medical costs," Dr. Banks said. But over the duration of the contract, the parties plan to roll out services for all of Blue Cross and Blue Shield of Minnesota's 2.1 million members, in the belief that disease-management techniques also can be used effectively to aid in prevention of disease and maintaining a person's health.

American Healthways uses registered nurses who work with patients by telephone to encourage them to take their medications, get necessary checkups and take other steps to manage disease symptoms and follow recommendations made by their physicians. The nurses have access to an electronic medical record that tracks patient medical claims, drug prescriptions and laboratory tests. They also are specially trained to develop trust with patients, a crucial factor in the approach's success, said Bill Gold, chief medical officer at the Blue Cross plan.

The intent is that regular contact with nurses will, for instance, help patients meet blood-sugar, blood-pressure and cholesterol-level targets that, according to a large body of medical research, help stave off serious consequences of chronic diseases. "Compliance [with the targets] across the health system is very low," Mr. Cigarran noted. "The gap is what causes suboptimal health and the unnecessarily high cost of health care. People who are sick don't use the health-care system enough in ways that make them healthier."

The parties face challenges. Disease management has emerged in recent years in a variety of forms, with mixed results. Typically, disease-management companies have focused on just one disease, yet many patients suffer from several chronic conditions, rendering the single-disease approach ineffective or cumbersome.

"Managed-care plans were having to contract with five or six different firms, and doctors would have to refer patients to these different firms," said David Nash, professor of health policy at Jefferson Medical College, Philadelphia, and editor of the journal Disease Management. "That was way too complicated for the market to make it work." American Healthways will handle more than 15 chronic conditions under the new users of medical services, one reason Dr. Nash considers it "a breakthrough" for the field.

In addition, doctors and patients alike, wary after a decade of managed-care controversy that cost-saving strategies could be good for care, may be skeptical. In part to address that issue, American Healthways and Blue Cross said researchers at Johns Hopkins Medical Institutions will evaluate the program, measuring both costs and outcomes, and will be free to publish such data in medical journals, whether the results are favorable or not. "When done well, disease management has a significant impact on the health of members and on the cost of care," said Dr. Gold.
One Cure for High Health Costs:
In-House Clinics at Companies

Wisconsin Firm Saves Money
By Hiring Its Own Doctors;
Patients Get More Time

A Hard Sell for Some Workers

By Vanessa Fuhrmans

WEST ALLIS, Wis.—Last year Quad/Graphics, one of the nation’s biggest printing companies, spent about $6,000 per employee on medical costs, 30% less than the average company in its home state of Wisconsin. Its 12,000 workers spend fewer days in the hospital and take their medicines more regularly.

Even more unusual: Quad provides most of the care itself. Starting with a small plant clinic in 1998, Quad has brought nearly all of its primary health care in-house. As the whir of its giant presses hums through the waiting-room wall, company doctors and nurses practice everything from pediatrics to gynecology.

"Instead of trying to put a Band-Aid on a broken model, we wanted to build primary care from scratch," says Leonard Quadracci, the brother of Quad’s late founder and head of its medical operations.

Quad is fast becoming a model for companies desperate to control double-digit rises in health-care costs. Dozens of companies have toured Quad’s clinics looking for inspiration. Those weighing plans to build their own in-house clinics include Toyota Motor Corp., Kohler Inc. and Miller Brewing Co.

Other companies already do so, among them Perdue Farms, Sprint Corp. and Pitney Bowes Inc. Perdue runs its own medical center with specialists in fields such as pediatrics and neurology and a pharmacy stocked heavily with generic drugs. In 2004, its medical costs per employee rose just 1%, after falling 0.75% in 2003.Quad’s costs have risen less than 5% annually over the past five years, although preliminary estimates show the rise last year was about 9% because of some catastrophic claims and higher drug costs.

Many employers probably couldn’t replicate the Quad or Perdue model. Companies need to have a large number of employees concentrated in a few places for in-house clinics to make economic sense. And Quad has a history of harmonious relations between management and workers. Its workers aren’t unionized. At many other companies, workers would be less likely to trust a company-owned clinic to protect their privacy and put medical need over cost-saving.

"Quad is more creative...than most large employers," says Ford Titus, chief executive of ProHealth Care, which owns two hospitals and several primary-care groups in greater Milwaukee. He adds that it’s possible more companies will provide limited health care, “but do I see the Quad approach as a widespread movement? No, I don’t.”

Nonetheless, the early success of these efforts amounts to an indictment of the U.S. health-care system’s inefficiencies. Though the U.S. spends more on medical care than any other country, it ranks behind many developed nations in bottom-line measures such as life expectancy. Employers, who pay much of the health-care bill, point to a disjointed market in which doctors and hospitals are motivated to push as many patients as possible through the system, rather than making them healthier.

And while the managed-care industry negotiates discounts and tries to control costs on companies’ behalf, they often increase them by adding multiple layers of administration.

"The U.S. health-care delivery system is neither a system nor does it deliver health," says Roger Merrill, chief medical officer at Perdue. Besides running its own clinics, the chicken giant contracts directly with outside doctors and hospitals instead of using a health insurer’s provider network.

Quad, too, has devised a system that seeks to cut out middlemen, bureaucracy and reimbursement paperwork. The company employs its own internists, pediatricians and family practitioners—26 doctors in all. It operates its own laboratory, pharmacy and rehabilitation center, and contracts directly with local hospitals.

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One Health-Cost Cure: In-House Company

Continued From First Page

and specialists for advanced care.

Doctors’ bonuses are tied to patient evaluations and health outcomes—not how many patients they can squeeze in every day. Quad doctors see only one patient every half-hour, using the extra time to ask about other health problems and give advice on disease prevention.

Employees pay just $5 a visit.

Quad’s medical division, called Quad/Med, has had such success that the company has started a business operation for other companies. Quad says revenue from the outside medical business is still small compared to the company’s $1.9 billion in total annual revenue.

Decades ago, it was common for factories to keep a company doctor on hand to take care of on-the-job aches and pains. The new wave of in-house clinics, however, seeks not to supplement doctors but to replace them with a full lineup of primary care.

Quad spends more on primary care than most companies—$715 for each person in 2003 compared with an average of $755 at other local employers, according to Quad’s figures. It says the time and money devoted to prevention help keep employees and their families from the offices of high-priced specialists and the hospital.

Quad spent an average of $1,540 per employee in 2003 on hospital costs, compared with a local average of $2,250.

“What we’ve learned here is that when primary care is done right, the results can be amazing,” says John Neu- berger, business manager of Quad’s medical division.

Harry Quadracci started Quad as a print shop with 11 employees in 1971. Even after it developed into a major player in the industry with contracts to print Newsweek and other magazines, Mr. Quadracci still lunches with employees in the company cafeteria. They often brought up problems with medical claims or doctors’ appointments. Meanwhile the company’s medical costs were surging. Quad built its own printing machinery, made its own ink and did its own catering, thought the boss. Why not its own health care?

“I told him, ‘You’ve got to be crazy,’ “ recalls Leonard Quadracci, Harry’s younger brother. Harry had pitched the idea to Leonard, then a doctor in Seattle, over the Christmas break in 1988. The more Harry talked, though, “he made good sense,” says Leonard, who eventually left Seattle to run Quad/Med. (Harry died in 2002 at age 66.)

The first Quad clinic opened in 1990 at the company’s Pewaukee plant with just one doctor, a nurse, a receptionist and a closet-sized laboratory. Since then, it has built two bigger medical centers for workers at its southeastern Wisconsin plants. The centers have X-rays, electrocardiogram machines, optometry and physical-therapy facilities.

Marine Haverkamp, a 49-year-old production manager at Quad, felt extreme fatigue and thirst one morning two years ago. When she called the clinic, she learned her doctor was out, but the receptionist pressed her to come in within the half-hour anyway. A quick test established that her blood-sugar count was 600 milligrams per deciliter, a level that can be life-threatening. Though she was fit, the diabetes that ran in Ms. Haverkamp’s family had caught up with her.

“Anywhere else, I would have waited for an appointment or ended up in the hospital,” says Ms. Haverkamp. She now sees the doctor every few months and sometimes sends her an e-mail with a question. A diet and exercise program that the clinic and company wellness center help her maintain has kept the diabetes in check since.

About 80% of Quad employees and their families use the Quad clinics as their main source of primary care and other common services such as prenatal and skin care. The other 20% prefer going to outside doctors although that plan costs more. Together, the Quad clinics logged 66,500 patient visits last year, plus another 19,000 in its dental clinics.

Quad pays its doctors about $150,000 to $160,000 a year—comparable to what the average general practitioner makes in Greater Milwaukee. On the outside, the typical doctor needs to rush through 25 to 50 patients a day to make more than that. Drs. Quadracci and Neuberger describe traditional health care as a “production” model, where doctors and hospitals are rewarded by how many patients they can see or admit.

Because Quad invested early in electronic medical records, it can easily collate data to see how well it’s meeting national health standards and to determine doctors’ bonuses. Of patients with high blood pressure, 92% of those who go to Quad take regular medication to keep it in check. The U.S. average is 40%, according to data from health plans collected by the National Coalition on Quality Assurance. Nationally, 26% of mothers give birth by Cesarean section, but only 12% of women who get prenatal care at Quad do.

The information “is a real eye opener, but it also shows where we have to do better,” says Dr. Quadracci as he shakes his head with impatience. He has been looking at the clinics’ patterns on prescribing antibiotics and found overuse.

Some Quad doctors were initially skeptical about working in a corporate clinic. “When I interviewed, I said ‘I don’t want to just take care of sore throats,’ “ says Ann Merkow, an internist who left the general medical practice she took over from her father to join Quad nine years ago.

But she says she found it rewarding to work with incentives built around patient doctors are reimbursed per visit but don’t get paid for preventive care. “In the other model, you almost get punished for taking time for patients,” she says, “There were 10 years I made less than teachers in the area.”

For employees, privacy is a big issue: “They don’t want personal details about their health to end up in their boss’ hands. Quad says all medical staff must sign confidentiality agreements promising to keep patient details within the clinic. Its computer systems are separate from those of the factories.

Wally Parrott, a recently retired trainer of pressroom workers at Quad, says the biggest obstacle for him was the fear that the clinic’s doctors would overcharge. For several years, he dropped by the clinic when he had a cold or other minor ailment. But for his diabetes, he saw a renowned specialist with a large practice. “He had a lot of credentials,” says Mr. Parrott, “but I wasn’t getting much individualized care” — even when he started to feel odd stomach pains six years ago. He landed in the hospital with a heart attack and ended up switching to a doctor he knew at Quad for all his basic care. “I don’t worry that’s sending me for all sorts of tests or medicines just to do it,” he says. “I trust him, just like a good mechanic.”

One of Quad’s early challenges was negotiating directly with hospitals and doctors for specialty care, such as Mr. Parrott’s heart surgery, that the in-house clinics don’t handle. No other local employers had done it before: They all used health-insurance companies such as UnitedHealth Group Inc. or Humana Inc. to make those contracts. Some hospitals balked. They’d say, “What if every company wanted to have a special arrangement?” says Mike LaPenna, a consultant based in Grand Rapids, Mich., who has helped Quad and other companies set up their own clinics.

Quad got around the problem by contracting with a limited number of hospitals, promising higher volume in exchange for discounts. While Quad employees can still sign up for traditional health plans, to outside providers and cheaper Quad health care for primary care.

Quad is not its health-care names. In some cases, the early pension fund, a popularization in C states. It has system for the shipyard’s employees. It uses 401(k) and medical plans.

Two WtBriggs & Stratton In Quad to run two of their employees. R engines for 16 door equipmen.

“We can’t do that either,” says Jeffery A. But the shipyard has been of big employ the success Quad-operated Bluff. Mo has been the big employers.

“There’s more work and more to exec,” says John executive, “an get back into the town employees.

Class-Action Bill Sails

Continued From Page A2

publican, questioned if the chairman’s bill, as now drafted, could “generate sufficient support to get out of committee.”

The new unity between House and Senate Republicans seems soon be strained by another divisive issue: immigration overhaul and border security.

On a 251-161 vote, the House yesterday approved tougher federal standards intended to force states to do a better job of verifying the citizenship of applicants for a driver’s license. But the measure included legal per se.

House Judiciary Committee, as well as some said the bill w remote possible authors who need some inarguably argue that the bill has the f
Big firms embark on insurance ‘experiment’

Part-time workers among beneficiaries of low-cost program

By Rachel Brand
ROCKY MOUNTAIN NEWS

Seven large employers are banding together to offer low-cost health insurance to part-time, temporary and contract workers as well as early retirees.

The participants employ more than 10,000 people in Colorado. Those with Colorado operations include Sprint, IBM, Caterpillar, General Electric and Sears, Roebuck & Co. They are the first companies to sign up for a two-year national experiment that starts in September.

The companies pay $20,000 an administration fee, and employees bear the full brunt of health insurance premiums. Through sheer numbers, the costs will be lower than if employees bought individual insurance.

“This is a grand experiment,” said Jeff McGuiness, president of the HR Policy Association, the program’s organizer.

The plans will cost as little as $5 a month for a card that provides up to 40 percent in discounts off pharmacy and medical services. Employees and their families are guaranteed acceptance into the plans.

There will be a conventional plan that pays for hospital stays and emergency room visits and can cost more than $300.

Also, United Healthcare, delivering services in Colorado, will offer two health savings account plans.

As many as 60 Fortune 500 firms drafted the program.

“If this works, I’m sure others will want to participate,” McGuiness said.

Employers want to help the uninsured because hospitals and doctors pass the cost of charity care to businesses, said Jennifer Bosshardt, a spokeswoman for Sprint.

The program may especially benefit early retirees and people with chronic illnesses, who are stunned to find out that health insurance costs as much as $2,000 a month.

“It’s a really wonderful idea,” said Donna Marshall, who heads the Colorado Business Group on Health. “It helps people who are already disqualified and can’t get health insurance on their own.”

Retiree activist Ron Olbrish agreed.

“While the insured is putting up the entire cost, it is still a better value,” said the executive director of the National Association of Retired Sears Employees.

The most basic $5-a-month policy provides a card that passes along the prices that health insurers pay.

Hospitals typically charge the uninsured full retail price, while managed care plans get discounts.

For $49.83 a month, the plan pays for 80 percent of doctor’s visits and 100 percent of preventative care up to the plan limit. The plan also covers two dental and one vision visit, plus five prescription drugs up to $20 each.

As coverage levels get higher, the price varies by employee age, sex and city.

Paul Fronstin, a director of health and research programs at the Employee Benefit Research Institute, said he believes the program is already a success because “no one else has ever been able to do it before.”

So if just 5 percent of employees participate, “I would see that as something very positive,” he said. The number could grow year by year, he predicted.

The HR Policy Association says success means the program pays out less in benefits than it draws in premiums.

Sprint, which employs 400 in Colorado at its retail stores, direct sales department and billing center, says most of its employees already have health care coverage.

Still, the uninsured drive up the cost for everyone.

“In the long run,” Bosshardt said, “it’s going to benefit us all.”

brandr@RockyMountainNews.com
or 303-892-5269

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Medical Legal Suits

Tort Reform Saves Lives

July 19, 2004
Tackling Malpractice
The California Way

June 1, 2004
State has taken sensible approach to tort reform
Without damage caps
everyone's a victim

Oct 2004
Trial lawyers see obese America as ripe for fat lawsuits

Lines are drawn in fight over limits on malpractice awards

Sep 27, 2004
By David Crane
Associated Press

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Roy Jenne
June 2006
Rule of Law / By Paul H. Rubin

'Tort Reform Saves Lives

In the classic theory of tort law, the law compels potential injurers to pay the costs of harms caused to others. This creates incentives for injurers to spend resources reducing harm.

This is the theory espoused by the American Trial Lawyers Association and other advocates of the current system. On this view, tort reforms that reduce liability or damage payments would lead to increased risk to consumers. However, this theory depends on several assumptions: that injurers and victims are “strangers,” not in a pre-contractual relationship; that most payments go to victims to compensate for economic losses, such as lost wages or medical expenses; and, most importantly, that actions subject to tort law increase risk, which can be reduced by the threat of liability.

None of these assumptions are true in modern product liability and medical malpractice law. First, those injured are often in a pre-contractual relationship with the injurers—as patients and doctors, or as consumers and manufacturers. This means that consumers pay in advance for expected tort damages through higher prices for goods and services. For example, the price of a medical procedure includes money to compensate the physician for his malpractice insurance premiums. Second, only about 22 cents of every $1 going through the system compensates for economic losses, with the rest going to legal fees (54 cents) and compensation for non-economic losses such as “pain and suffering” (24 cents).

Legal fees provide no benefit to consumers. Payments for pain and suffering are worth much less than their actual cost, and no one voluntarily buys insurance against pain and suffering. This means that much of the money consumers pay for expected tort damages is largely wasted. Finally, many actions subject to tort law, such as the practice of medicine and the sale of medicines and protective equipment, are risk reducing, not risk increasing.

One result is that, on net, tort law increases prices paid by consumers and patients for risk-reducing goods and services. These higher prices may lead consumers to choose not to purchase these goods and services in some circumstances where they would actually reduce risk. Theoretically, expansions in tort law might increase risk—and tort reform might reduce risk, by reducing the prices and increasing the consumption of risk-reducing goods and services.

Thus, tort reform might lead to either increased or reduced accident rates; theory is ambiguous. To determine which effect is larger, my colleague Joanna Shepherd and I examined the effect of tort reform on non-automotive accident death rates from 1981-2000.

During that time, states passed 141 “tort reform” measures, enough to allow us to perform a statistical analysis using the powerful tool of panel data regression analysis. This analysis allowed us to essentially compare death rates in each state before and after each tort reform was passed. It also allowed us to adjust for other factors, such as the age distribution of the state’s population and the number of hospital beds per capita. We used non-automotive death rates because automobile accidental and death rates are influenced by other factors such as passage of no-fault auto insurance laws.

Most individual tort reforms lead to statistically significant reductions in death rates, although some lead to increased rates. Specfically, we found that caps on noneconomic damages, caps on punitive damages, a higher evidence standard for punitive damages, product liability reform, and prejudgment interest reform led to fewer accidental deaths, while reforms of the collateral source rule led to increased deaths. (The collateral source rule says that victims can collect both from their own insurance company and from the injurer; reforms limit this ability to collect twice.)

Overall, we found that the risk-reducing effects of tort reform greatly outweigh the risk-increasing effects. Tort reforms in the states from 1981-2000 have led to an estimated 14,222 fewer accidental deaths. We also tested the “robustness” of our results by examining 16 additional statistical models and sets of variables; the results were roughly consistent for every specification. For example, if we include automobile death rates, the effects of some reforms become statistically insignificant; but for most reforms the effects remain significant, and the direction of the effects does not change.

Our methods do not allow us to determine the exact source of these reductions in the risk of death. However, there is much evidence that, for example, physicians, and particularly emergency room physicians, are more willing to work in states which have passed tort reform.

Greater availability of emergency room doctors following tort reform would mean that many victims of accidents who might otherwise die recover thanks to better and faster medical treatment.

Modern American tort law, it is well known, leads to increased costs of doing business, increased insurance costs, and reduced rates of economic growth. Still, proponents of the current system could always claim that these costs were offset by increased safety. Our results cast doubt on that claim. The current system’s costs are not offset by fewer lives lost; and tort reform may save lives.

Our methods only enabled us to examine effects of reforms at the state level. However, it is likely that reforms at the federal level, such as the recent Supreme Court-imposed limitation on punitive damages and the “Class Action Fairness Act of 2005,” will also lead to increased safety and reduced accidental death rates. Further tort reform at both the state and the federal level would undoubtedly provide further increases in safety.

Mr. Rubin is Samuel Candler Dobbs Professor of Economics and Law at Emory University and an adjunct scholar at the American Enterprise Institute. The study referred to here, “Tort Reform and Accidental Deaths,” by Paul H. Rubin and Joanna M. Shepherd, is at SSRN.com.
Without damage caps everyone’s a victim

If you need further evidence that life is unfair, consider two recent cases of tragic death, both of which raise questions about tort reform.

The first is the Paul Childs shooting and Denver’s unusual decision to settle before the family filed a civil rights lawsuit. The city agreed to pay Childs mother and sister $1.325 million.

Although we supported the settlement, plenty of people, not just cops, think the city should have fought the case in court. After all, they say, it was the family that called police; Childs was wielding a knife; James Turney, the officer who shot Childs, was suspended but never charged with a crime.

The other case involves the collapse of a girder over Interstate 70 that killed a family of three from Evergreen May 15. If ever there was a case of apparent negligence, this would appear to be it. If millions were paid out to somebody, few would probably complain.

But legal experts believe no lawsuit will ever be filed because there’s no “somebody” to collect. Under Colorado law, only a spouse or descendant can recover in wrongful-death actions.

Had there been a surviving plaintiff, damages wouldn’t have reached the Childs’ level. State laws limit payouts in wrongful-death suits to $150,000 per person and $600,000 per incident. Non-economic losses such as pain and suffering, which weren’t even allowed until a few years ago, are also capped, at $341,250.

Why did the Childs family get so much money, you may ask. Because it was prepared to file its suit in federal court under federal civil rights statutes instead of in state court. There’s no limit on the possible recovery from a government that has deprived a victim of his civil rights, including his life.

There is apparently no precedent in law for finding those who negligently install girders guilty of a civil rights violation.

Are Colorado’s caps on wrongful death “outdated” and “well below contemporary litigation standards,” as attorney Scott Robinson has argued? We don’t think so. There is in fact a good reason legislatures cap damages: runaway juries.

Which is one reason the city settled in the Childs case. It might have won — but it might have lost really big.

Individuals, companies and their insurers, and even government must be able to keep an actuarial handle on their exposure to lawsuits. “In civil cases tragedy hits everybody right between the eyes, but at the same time you have to look at the big picture,” says defense attorney John Grund. “If you throw out the restrictions, you can increase insurance costs significantly.” And when insurance rates go up, it’s consumers and taxpayers who end up paying.

Will the state and its subcontractors walk away scot-free from the girder accident if no civil suit is successfully brought? Probably not.

There are possible governmentally imposed penalties for negligence, and the companies and individuals involved could face a loss of reputation and possibly even bankruptcy.

Not all punishments have to be measured in civil judgments, which are sometimes brought as much for the lawyers’ benefit as the plaintiffs. Instead of removing caps on wrongful death judgments, why not impose them on civil rights suits?
Tackling Malpractice
The California Way

BY GLORIA LAU
INVESTOR'S BUSINESS DAILY

To address growing concern about the cost and availability of medical malpractice insurance, California regulators added a new law that limited what plaintiffs could receive for pain and suffering.

That was in 1975. Today other states, including Nevada, New Jersey and Florida, also struggle with malpractice insurance problems.

In some cases, doctors are reportedly fleeing states or quitting the profession altogether when they can’t pay insurance premiums.

Such concerns are driving Congress to consider imposing national restrictions on malpractice litigation. In doing so, many look to California’s nearly 30-year-old law, the Medical Injury Compensation Reform Act (MICRA), as a model.

California’s law caps at $250,000 the amount a plaintiff can get at trial for noneconomic damages such as pain, suffering, emotional or mental distress. It doesn’t cap economic awards for lost wages, medical fees and other out-of-pocket expenses.

In a study released last week, Rand Corp.’s Nicholas Pace, a researcher and behavioral scientist, studied the impact of the California law on malpractice trials. He spoke with IBD.

IBD: What was the purpose of the California law, and did it succeed?

Pace: The initial goal was to stabilize expenditures. Back in 1975, some medical malpractice insurers were withdrawing from the market. Some were raising their rates 400% and doctors were going on strike in Northern California.

What’s going on today is eerily reminiscent of what was going on in California back in 1975. The same things you hear today about Nevada or New Jersey or Florida were first discussed in California.

The big concern was that doctors would simply stop buying malpractice insurance. You’d then have an epidemic of uninsured doctors, so if you were injured by doctors — and it does happen — then there’d be no defendant with resources to sue. If doctors don’t have insurance, you’re sunk.

IBD: Your data suggest the California law succeeds in limiting non-economic damages and attorneys’ fees.

Pace: The cap on noneconomic awards was imposed in 1975 by plaintiffs in the sample. Defendants’ overall liabilities were reduced by 30% as a result of MICRA. Certain types of claims and plaintiffs are most affected by MICRA. Death cases are capped more frequently than injury cases. Plaintiffs with the severest nonfatal injuries, such as brain damage and paralysis, had their noneconomic awards capped far more than injury claims generally.

Those whose injuries led to most economic damage awards of less than $100,000, such as disfigurement to the face, also see big noneconomic reductions.

IBD: Physicians groups and insurers credit MICRA with solving the problem. What do you think?

Pace: MICRA was useful, but the system isn’t perfect. It took awhile for people to believe it was there. Until the Supreme Court came down and said this withheld constitutional challenge, plaintiff attorneys and adjusters operated as though MICRA never happened. In terms of settling cases, their behavior didn’t change, even though in court the $250,000 caps were instituted.

IBD: How did limiting attorneys’ fees reduce litigation?

Pace: The law prohibits attorneys from charging more than 40% of the first $50,000 of any recovery. (It prohibits charging more than one-third of the next $50,000, more than 25% of the next $500,000 and more than 15% of any amount over $600,000.

Absent MICRA, these cases would have generated $140 million in fees for the plaintiffs’ attorneys — assuming a typical contingency fee rate of one-third the recovery and using the jury’s original verdict for calculating that fee.

IBD: What were the effects of MICRA on attorneys’ fees?

Pace: The $250,000 noneconomic damages cap, without any attorney fee caps, cut total attorney fees by 30%. The reverse — attorney fee limits without any $250,000 cap — cut total attorney fees by 46%. And caps on attorney fees and noneconomic damages of $250,000 led to a 60% drop in total attorneys’ fees.

IBD: What are some lessons learned from MICRA that other states can consider?

Pace: Adding the attorney fee limit does seem to be an effective way to reduce litigation. The California $250,000 cap hasn’t changed since 1975, but the economy has changed. If $250,000 was reasonable in 1975, you really need to adjust that cap today.
Trial lawyers see obese America as ripe for fat lawsuits

By Marguerite Higgins
THE WASHINGTON TIMES

An overhead projection on display on Sept. 19 at a public health law conference summed up the group's efforts: "Pain. Hell. Let's sue somebody."

While public health advocates, trial lawyers and nutritionists had bandied about ideas of regulating food ads, obesity-related lawsuits were the forefront issue for the conclusion of the three-day conference at Northeastern University:

A panel of four lawyers argued that the fat lawsuit movement, which started after a U.S. surgeon general's report in 2001 classified obesity as an epidemic, would need to extend beyond the obvious targets like restaurants, fast-food chains and food manufacturers to bring about substantial policy changes like tobacco lawsuits did.

George Washington University law professor John Banzhaf III, said the fat suits were still the group's best weapon in using legal action to combat the U.S. obesity problem.

Obesity, which triggers chronic diseases like heart disease, diabetes and sleep apnea, is the second-largest cause of preventable deaths in America, after tobacco, with 400,000 annual deaths, according to the Centers for Disease Control and Prevention. Sixty-four percent of Americans are overweight or obese, the CDC said.

"Movements start with legal action," Mr. Banzhaf said, noting that the obesity lawsuit drive had achieved more in the last five years than the first tobacco lawsuits. The tobacco suits eventually resulted in four major tobacco companies reaching a historic $246 billion legal settlement in 1998, three decades after the first suits were filed.

"We must remember that the anti-tobacco movement did not just sue the tobacco companies. Wounded lots of people," Mr. Banzhaf said. He advised his colleagues to consider suits against doctors who do not warn obese patients about their health risks.

Even parents of morbidly obese children, where it could be shown the parents did not try to protect their children from related health risks, could be fair game in custody disputes, he said. Those suits would follow the lead of ones where parents who smoked around their children lost partial or full custody.

Within the lawsuits against the food industry, most of the ideas centered on targeting for lawsuits ads that the panel called "unfair" and "deceptive."

"A lot of current and recently past marketing practices deserve to be sued" for misleading consumers or targeting young audiences, said Dallas lawyer Steve Gardner.

Mr. Gardner showcased a mari-nara sauce with the words "all natural" on its label as an example. The problem, he said, was the sauce had high-fructose corn syrup, a sweeter used in many fast foods. Some scientists have claimed the corn syrup is a main contributor to America's bulging waistline.

If plaintiffs' attorneys strike out against food companies, they also should try suing media entities that publish deceptive ads, said Mr. Gardner, the litigation director for the Center for Science in the Public Interest, a Washington public health advocacy organization often dubbed the "food police."

But not all the lawyers on the panel were on board with the fat suits. Eddie Correia, speaking as a lawyer who has consulted with the food and beverage industry, said the suggested suits would essentially argue unfairness, one of the most difficult law theories for private litigation.

"The kind of ads that you talked about regulating are unarguably unfair," Mr. Correia, counsel at the Washington office of international law firm Latham & Watkins LLP. But the ads are not deceptive, and the burden of proof becomes greater for the plaintiffs' attorneys, he said.

Mr. Correia suggested the group, meeting under the umbrella of the Public Health Advocacy Institute, should cooperate with the Federal Trade Commission, which polices deceptive ads, rather than file the suits.

Scott Riehl, spokesman for a Washington, D.C. trade group, the National Food Processors Association, questioned the constitutionality of bringing lawsuits against food ads that comply with FTC rules. "It certainly sounds like it would become a First Amendment issue," said Mr. Riehl who was not at the conference.

Other speakers at the conference urged more state and federal legislation to correct factors blamed for enlarging America's waistline.

There are several bills pending in Congress and state legislatures that propose nutritional labeling on restaurant menus, limiting the number of vending machines in public schools and raising nutritional quality for public school meals. Meanwhile, there are opposing bills in the states and Congress that would insulate restaurants and the food industry from fat suits.

Group eyes doctors for legal action

BOSTON — A single lawsuit against the food industry is not enough to reduce the number of overweight and obese Americans, according to panelists at a Sept. 18-19 weekend health law conference.

It will take numerous suits, federal laws and government regulations sweeping across the food and several nonfood industries to make a significant impact.

That message was the underlying theme for the conference on legal approaches to obesity that co-sponsored the event, the second annual conference, made up of trial lawyers, dietitians and public-health advocates, follows a year in which several obesity-related suits have been filed against food manufacturers and fast-food chains.

While the suits — modeled after lawsuits that took on tobacco companies for causing health problems for smokers — were ultimately thrown out of court or withdrawn, the group said the success this anti-obesity movement has had in pressuring the food industry is already ahead of their expectations.

"We know that litigation ultimately wins," said George Washington University law professor John Banzhaf III, one of the leaders for the obesity lawsuits. But Mr. Banzhaf pushed the 90 or so participants at Sherman Hall at Northeastern University to think beyond suing the food industry.

Mr. Banzhaf spoke to the panel about potential lawsuits such as suing doctors who do not warn and counsel obese patients at risk for triggering other chronic diseases such as diabetes, hypertension, gallbladder disease and various cancers.

"Still, most of the discussion on Sept. 18 at the conference centered around addictive qualities in sugary foods and how to regulate foods advertising to children. "What we see as a hallmark of addiction is loss of control and we see that in a lot of obese people who have lost control with eating," said William Jacobs, anesthesiology and assistant professor of psychiatry at the University of Florida.

Mr. Jacobs, who works in the university's brain institute, said obese subjects in his studies often demonstrate addiction symptoms such as preoccupation, relapses, narrowed interests, loss of control and continued detrimental behaviors despite knowing the harm associated with excessive weight gain.

Princeton University psychology professor Bart Hoebel noted that rats in one study that were given sugary drink diets gave off brain receptors similar to those reported for rats that were given illegal narcotics such as cocaine and amphetamines.

Mr. Hoebel was quick to say the study did not conclusively find sugar addictive. "Food addiction is much milder than drug addiction and not everyone that indulges in it becomes obese," he said.

Marshall Manson, spokesman for an Alexandria, Va., nonprofit advocacy group promoting individual freedom, said the talk of more obesity lawsuits is troubling.

"We are worried that there has been some progression toward limiting choice and waging a war against personal responsibility," said Mr. Manson with the Center for Individual Freedom.
ROCKVILLE, MARYLAND

Health-care litigation costs America far too much

As anyone thinking of having a baby in Maryland will know, it’s not easy to find an obstetrician in the Old Line state. The main reason, says Debbie Redd, the head of Capital Women’s Care (CWC), the largest group of obstetrician/gynaecologists in the Washington, DC, area, is that it costs $118,000 a year to insure just one of them against malpractice lawsuits. That is more than the total cost of employing a doctor in most countries.

Trial lawyers argue that malpractice lawsuits deter negligence. Craig Dickman, an obstetrician affiliated to CWC, says they mostly deter the kind of behaviour that might get you sued, which is not the same thing. To cover himself, he says, he orders excessive tests, monitoring and consultations with specialists. He guesses that 12%-15% of the procedures he bills for are unnecessary. If he fails to order every imaginable test, even if there is “no clinical evidence of efficacy”, he is exposed if something were to go wrong. A trial lawyer can scour the country for the one expert who thinks that his omission might have caused the patient’s injury.

Dr Dickman has been sued five times in 21 years on what he (inevitably) describes as specious grounds. That is not unusual for an American obstetrician: 76% of them have been sued at least once. (They are more at risk than most doctors, since they typically operate on healthy patients, who may then blame them if they become ill.)

When doctors win cases, as they usually do, they still lose, because they have to pay their legal bills. And when they lose, they lose big. In jury trials, the average award of damages against a doctor is $4.7m. How much they have to pay to insure against these costs depends on where they practice. In St Clair County, Illinois, neurosurgeons paid an average premium of $228,396 in 2004, five times more than their colleagues in Wisconsin did. Inevitably, doctors (and insurers) flee the states that are friendliest to plaintiffs. Pennsylvania lost a third of its general surgeons between 1995 and 2002.

The cost of medical-malpractice lawsuits has risen more than 2000% since 1975, to $26.5 billion in 2003, according to Tillinghast, an actuarial consultancy. And to what end? A study of malpractice suits in New York by the Harvard Medical Practice Group found that plaintiffs had actually been injured by doctors’ negligence in only 17% of cases. Those patients with small claims often cannot find a lawyer to represent them, while those who win find their lawyers have swallowed half the etc, not here

Health litigation costs far too much.
Lines are drawn in fight over limits on malpractice awards

By David Crary
Associated Press

Rivaling Bush vs. Kerry for bitterness, doctors and trial lawyers are squaring off this fall in an unprecedented four-state struggle over limiting malpractice awards. The volatile issue is in voters' hands and each side is desperate to win, spending millions of dollars to make their cases and portray the other side as greedy.

In all four states — Florida, Nevada, Oregon and Wyoming — doctors and health insurers pushed to get measures on the Nov. 2 ballot, and trial lawyers are campaigning hard for a "No" vote.

"We have open warfare here with the personal injury lawyers," said Larry Matheis of the Nevada State Medical Association. "It's a national test of whether, in trying to solve the devastating medical liability crisis, we have to go directly to the people."

Never before have voters in so many states simultaneously had a chance to weigh in on the debate.

The doctors say caps on awards are needed to rein in soaring insurance rates that otherwise will drive many of them out of high-premium states and high-risk specialties. The lawyers say there should be tighter controls on insurance companies, not on juries who may be a victimized patient's only hope for justice.

"The insurance industry, the drug industry, the hospital and nursing home industry have far more money than people injured by medical malpractice and their lawyers," said Carlton Carl of the Association of Trial Lawyers of America.

The American Medical Association has been lobbying tenaciously for federal legislation, supported by President Bush, that would place a nationwide $250,000 cap on non-economic damage awards. Those are awards for pain and emotional distress as opposed to awards for medical bills, lost wages and other quantifiable costs.

The federal legislation has passed the Republican-controlled House but not the Senate, where the trial lawyers' Democratic allies — although in the minority — have been able to block it.

Caps of varying types have been implemented in 27 states. The AMA contends that most of the other 23 states face a "medical liability crisis" in which doctors are moving away, retiring or scaling back essential, high-risk services because of rising insurance costs.

The four ballot proposals differ from each other:

- **Wyoming's** is a proposed constitutional amendment that would allow lawmakers to place a not-yet-determined cap on non-economic losses.
- **Oregon's** would cap non-economic awards at $500,000.
- **In Florida,** where lawmakers imposed a $500,000 cap last year, the proposal would limit lawyers' share of any malpractice settlement to 30 percent at most, less in the case of large awards.
- **Nevada's** measure would remove all exemptions from an existing $350,000 cap, and also limit attorney fees.

Doctors depict the fee limits as an appropriate swipe at greedy lawyers.

"The voters can make their own judgment," Mathais said.

"Is having enough doctors more important than personal injury lawyers becoming very wealthy?"

The lawyers say fee limits would deter them from handling complex malpractice cases on behalf of low-income clients. "All that those limitations do is make it impossible for victims to hire lawyers as good as the lawyers the doctors and hospitals can hire," said Bill Bradley of the Nevada Trial Lawyers Association.

The doctors and lawyers disagree on almost every facet of the dispute — for example, the extent to which doctors are leaving no-cap states and whether caps have lowered insurance rates.

"It will be interesting to see how voters sort through all the rhetoric," said Tom Throop, head of a government watchdog group in Wyoming that opposes the proposed cap. "It will probably be the most expensive ballot item we've seen."
Saddam Hussein still in power. And Turkish opinion polls show large opposition to an Iraq war. But then the role of political leaders is supposed to be to shape public opinion, not follow it, especially when the benefits of assisting the U.S. are so obvious.

The badly needed cash (and U.S. goodwill) aside, Turkey would benefit as much as any nation from a neighboring Iraq that was free of both a dictator and U.N. sanctions. Turkey would also give itself a larger voice in postwar Iraq, especially in dealing with the Kurds. The

Democrats for Tort Reform

Democrats in Washington have long styled medical malpractice reform at the behest of their check-writing supporters in the plaintiffs' bar. But maybe these politicians should look at a new poll that suggests they are out of step with the views of their own party's rank-and-file.

The poll, commissioned by the pro-reform American Tort Reform Association, finds that seven out of 10 Democratic voters believe medical liability lawsuits threaten access to quality health care. These voters don’t buy the trial lawyers’ argument that liability suits improve the quality of care. By a margin of 2-to-1, Democrats say the suits make lawyers rich instead. Some 56% of Democratic voters also say they’d be more likely to vote for a candidate who supported measures to stop frivolous lawsuits and improve the liability system.

At least a few Democrats holding office have begun to catch on. A crisis in medical care in West Virginia drove Governor Bob Wise to put the interests of patients over those of the trial bar and call for serious reforms. He’s proposed caps on pain and suffering awards, a $500,000 limit on liability for medical providers (including doctors) and reforms that would hold people responsible only for the share of the injuries they cause.

Back inside the Beltway, Senator Dianne Feinstein announced plans in January to introduce a bill to create a national medical malpractice system similar to California’s successful and popular Micra program. In 1975, Micra imposed a $250,000 cap on non-economic damages and limits on the attorneys’ contingency fees. The bill rescued California from doctor shortages and sky-high malpractice insurance premiums.

Since her announcement, however, Senator Feinstein has taken her time preparing the bill. A spokesman says she’s been meeting with “stakeholders.” We hope that by stakeholders she means the patients, doctors, and nurses hurt by runaway legal claims and not the trial lawyers who profit from them.

Philippine Flip-Flop

Reports that cornered Abu Sayyaf guerrillas have bribed soldiers to let them escape have the ring of truth. It is alleged as well that some unscrupulous officers have sold arms to the terrorists. Opposition leaders in government protest that Ms. Arroyo is hesitant to crack down on misconduct by generals because their support was the essential step in outing the former president and installing her without an election two years ago.

There are other concerns about Ms. Arroyo’s poor judgment these days. Manila’s Daily Tribune reported yesterday that Ms. Arroyo has been negotiating with Libya to try to pull in $100 million in investment for a palm-oil production center. The installation would be run by an outfit headed by Moammar Gadhafi’s son, Sayf al-Islam. Cozying up to Libya has proven disastrous in the past.

more “compassionate” treatment of combatants. Specifically, they urge members of groups like al Talib who should be presumed to be innocent otherwise through an enhanced case legal process.

Believing that the peace time system’s rules should govern, the Association has just overwhelmed resolution, urging that unlawful use of force to access and engage in judicial review, all to be opened up. Numerous human rights abuses and the Bush administration’s use of unlawful combatants these have helped to call against Americans and is now numerous al Qaeda and Talibans.
Paying for health care

Employers’ liability

Sep 20, 2003
The Economist

American employers struggle with rising health-care costs

Health care is expensive in America, so those workers and their families fortunate enough to be insured by employers take their benefits very seriously. Earlier this year, employees at General Electric (GE) struck, and others at Verizon protested, against proposed changes to their health-care coverage. This week, however, America’s car workers appear to have done an effective job of resisting change. The United Auto Workers union (UAW) reached agreement with Daimler-Chrysler and Ford on labour contracts that, while yielding to the employers over plant closures and job losses, largely maintained health benefits (see previous story).

This is a remarkable accomplishment for the union, and a problem for car companies, according to Michael Taylor of Towers Perrin, a benefits consultancy. The car industry already pays $9,000 a year per employee for health insurance, about 50% more than the rest of corporate America. An ageing workforce and an army of pensioners compound the problem of benefits already sweeter than in other sectors, thanks to the power of the UAW.

Carmakers, like all big American employers, are struggling to cope with health insurance premiums that have risen by almost 14% on average this year, according to a recent survey by the Kaiser Family Foundation (KFF) and others. Most of the increase was to cover higher spending on hospital services and prescription drugs, due largely to tough bargaining by hospitals and a loosening of the restrictions on what employees can receive that were imposed through the shift to “managed care” in the 1990s.

Big employers are not yet reducing health benefits, or cutting back on choice for their workers, but they are trying to shift more of the cost on to the workers, through heftier co-payments for brand name drugs and doctor visits and bigger deductibles that must be paid by patients before the company health plan kicks in.

A few firms are trying a more sophisticated approach to health care, which aims to simultaneously improve health and save money, says Arnold Milstein of Mercer Human Resource Consulting. Ford, for example, has joined a pilot project on diabetes management, in Louisville and Cincinnati, giving bonuses to doctors who achieve treatment goals and rewards for employees (such as fitness club memberships) who agree, for instance, to monitor such things as blood glucose levels. With GE and 146 other big firms, Ford is part of the Leapfrog Group, an initiative to gather information on the quality of care provided by almost 1,000 hospitals for employees to use to inform their choices. The firms are also structuring their payments to reward the better hospitals.

Medtronic, a medical devices maker, is paying up to $2,000 a year per worker into a “personal care account”. Employees can spend the money as they choose, as long as it is on health care. The hope is that better information and greater personal responsibility will lead to better choices.

Even so, most big firms remain resigned to ever higher health-care bills for themselves, and to imposing higher bills on their employees as well. Although American unemployment is rising, points out Peter Kongstedt, a healthcare consultant with Cap Gemini Ernst & Young, few big firms are willing to risk losing good people by trimming health benefits too far.

Nor does the government, faced with mounting medical bills, want employers to cut their provision. One stumbling block in Congress to devising new legislation to meet the cost of prescription drugs for America’s elderly Medicare population is the danger that it would prompt firms to end the prescription-drug benefits they now give to retirees. Firms have already reduced their cover for retired workers. According to the KFF survey, less than 40% of big firms questioned now offer their pensioners health coverage, down from two-thirds in 1988. Congress is now scrambling to find ways to encourage more corporate largesse, including tax credits and other subsidies. But there is no cure in sight for America’s health-care crisis.

Business

Global pattern

Air France’s alliance with KLM reveals a new industry pattern

Air France is in advanced negotiations with KLM Royal Dutch Airlines with a view to “intensive co-operation”, although “critical points” were still under discussion, the two airlines confirmed on September 17th. Shares of KLM have been soaring in expectation of the two carriers announcing some sort of marriage.

Most countries ban cross-border airline mergers. International traffic rights are tied to designated domestically-owned carriers under bilateral government deals. So a full merger is hard to do. Ideally, the carriers would form a jointly-owned company with the KLM brand kept alive as a Dutch subsidiary exercising the international traffic rights from the Netherlands. But the Dutch carrier tried twice to tie up with British Airways, in 1991 and in 2000, only for talks to break down over British Airways’s refusal to pay what KLM asked for a non-controlling stake. The same concerns may well rule out a full merger of KLM and Air France.

More likely is a looser tie-up. KLM will

Airline

1993
1995
1997
1999
2001
2003

Sources: KFF, INSEE, KPMG, Bureau of Labour Statistics

Feverish

Costs in America, % increase on a year earlier

Health insurance premiums

Inflation

Average earnings

10
6
0
-4
-8

1991
1995
1997
1999
2001
2003

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HMO Costs Spiraling Sharply Up

Rise in Premiums to Be 3d in Row for Many Firms

By Milt Freudenheim
New York Times Service

NEW YORK — Managed health care, which was touted at its introduction as a way to stop spiraling health care costs, now appears to be failing to fulfill that promise.

Health insurance premiums are increasing from 10 percent to 30 percent across the United States, according to employers, insurers and regional business groups familiar with rates being paid by dozens of companies.

Driven largely by escalating drug costs, the double-digit increase in annual premiums is the third in a row for many companies.

The rising premiums suggest that apart from the most restrictive, bare-bones health maintenance organizations, managed care is no longer keeping medical costs down.

Indeed, many of the companies facing steep premium increases actively encouraged their employees to join managed care plans in the past, even though some health care experts warned that managed care plans would not control costs in the long run. Now those companies are starting to turn away from HMOs or raise insurance, that does not entail the high administrative costs of managed care.

The double-digit increases come at a time of rising concern in Washington and in the presidential campaign about health care costs, particularly for drugs, in the Medicare program. Both Governor George W. Bush, and Vice President Al Gore have proposed ways to add drug coverage for Medicare beneficiaries.

Meanwhile, managed care company profits are on the rise and the industry is consolidating, weakening the ability of employers to bargain on rates.

The effect of the increasing premiums is likely to ripple through the economy. In contrast to the 1970s, when companies were able to pass along higher health care costs in the form of higher prices to their customers, today’s rising premiums will cut into many companies’ profits by adding to their operating costs.

Many technology companies, facing particularly fierce competition for workers, are among those absorbing the higher premiums. Higher rates would be "as unaffordable for employees as they are for the company," said Kathy Reinhard, benefits director of Analog Devices, a chip maker based in Norwood, Massachusetts. "Fortunately, we can do it this year. It is real important that we continue to be able to attract and retain key employees."

But other employers, particularly smaller companies in low-margin businesses, may force their employees to pay the increasing costs, or even stop offering health care altogether.

In a survey of 506 businesses released by the National Blue Cross and Blue Shield Association and the Employee Benefits Research Institute, one in seven businesses with fewer than 100 employees said they would drop health insurance if their premiums increased by 20 percent.

Even when companies continue to offer health insurance, some workers facing higher premiums may decide to drop their coverage and join the 45 million Americans without insurance. In individuals with employer-provided insurance, are likely to be hit hard as well.

Many large employers are frustrated by the costs of the elaborate central administrative systems of many HMOs, and by the need to pay in advance for all their employees to be covered. Big companies are also de-emphasizing more flexible managed care plans, known as point-of-service plans, that let employees visit doctors outside their HMO network if they are willing to shoulder more costs.

Instead, companies are stepping up efforts to shift employees into preferred provider organizations, plans that are much closer to old-fashioned fee-for-service insurance.

Preferred provider organizations, or PPOs, are based on networks of doctors and hospitals that agree to reduced rates for their services. Employees can go to any doctors in the network without obtaining permission beforehand, and employers pay only when their workers use medical services. There were 89 million people in PPOs and 81.3 million in HMOs in July 1999, the latest count, according to the American Association of Health Plans, a managed care industry group.

Costly new drugs and rising prescription volumes account for much of the premium increases. At General Motors Corp., for example, spending on drugs increased 20 percent last year to $762 million in its self-insured plans, and the company expects its pharmacy costs to continue rising at that rate, said Bruce Bradley, director of managed care plans at GM.

Insurers say that in addition to rising drug costs, greater demand for other medical services, increasing hospital and physician fees, and uncertainty about new laws regulating health care are all forcing them to raise rates, and making it impossible for them to commit to premium rates for more than a year.

David Snow, executive vice president of Empire Blue Cross and Blue Shield, said heavy investments in new technology and higher salaries to retain skilled employees were also adding to costs.

At the same time, however, profits of managed care companies are rising slightly after losses in the mid-1990s, and a wave of insurance company mergers has reduced competition in many markets.

Several large employers said that 2001 would be the second consecutive year of double-digit health care premium increases. For many smaller companies, which generally face steeper rate increases, 2001 will bring their third annual increase of more than 10 percent.

This year, the employer’s share of health benefits averages $4,911 for each employee with a family, according to John Cookson, a principal at Milliman & Robertson, an actuarial firm.
New HMO
to compete with Kaiser

Anthem bids to win back cities, schools

By Rachel Brand
ROCKY MOUNTAIN NEWS

Anthem Blue Cross Blue Shield, the state's largest health insurer, will roll out a low-cost HMO this fall in a bid to win back government business.

It is also Anthem's attempt to compete directly with No. 3 insurer Kaiser.

Anthem in recent years has lost business among local government customers such as cities and school districts, while Kaiser is a mainstay in that market.

HMOSelect will cost about 10 percent less than Anthem's most comparable HMO plan, making it "competitive" with Kaiser's rates, said Anthem General Manager Joe Hoffman.

"Without this type of product, we don't think we would have been able to grow our presence in that (local government) market," he said.

Like Kaiser, HMOSelect will employ a limited network of hospitals, including Denver Health Medical Center, University Hospital, Children's Hospital and six Centura Health facilities, but it will exclude HealthOne and Exempla facilities.

The move comes as schools, fire departments and cities are struggling with rising health care costs.

"Those types of groups have always been a mainstay for the Kaiser Permanente business," said Jean Barker, Kaiser's executive director of sales and account management.

"We've always been really focused on affordability, and they've been really frugal with their money," Barker said.

Hoffman hopes Anthem's plan will allow it to win back some of the several hundred thousand metro-area government employees.

The plan also will be available to small businesses later this year.

Kaiser is good

And Blue Cross always had a good reputation.
Letters to the Editor

**A Bill to Harness Draconian HMOs**

In regard to your June 21 editorial “Patients’ Right to Sue”: The suggestion that we in the United States, and the Democratic Party in particular, “believe that no private institution will act in good faith absent the possibility of being torn to pieces by a law suit” is fallacious. The HMO-health insurance industry is the only one in this country protected from accountability by act of Congress (Erisa, 1974). Doctors, hospitals, corporations and every entity can be held accountable in court.

The purpose of patients’ right to sue legislation is not to promote litigation, but to encourage the HMOs to modify their plan behavior, which all too often delays or denies life-saving diagnosis and treatment.

Your editorial tells in detail of the money contributed by the lawyers in the 2000 election cycle, but neglects to report the millions spent by the health insurance industry for lobbying and advertising against patients’ rights legislation. The first bill, approved by the president and Republican Party, gives only a token right-to-sue. It limits HMO financial exposure and requires suits to be filed in federal courts. Often geographically remote from many patients, federal courts tend to have docket delays of a year or more. In contrast, the McCain bill allows suits in state courts and redress for economic loss, for pain and suffering, and permits punitive damages. The McCain legislation is supported by the American Medical Association, the American Nurses Association, the American Hospital Association and overwhelmingly by the public at large.

There must be a reason for the managed care-health insurance industry’s furious opposition to the McCain bill.

As a cardiologist with many years in clinical practice, I can attest to the unconscionable limitation that the managed care-health insurance industry has imposed on the access of thousands of patients to the benefits of today’s medical science. I am a Republican who has long admired the clarity, depth and fairness of your editorials. Sadly, this one falls far short of that high standard.

SYLVAN LEE WEINBERG, M.D.
Director, Medical Education
Dayton Heart Hospital
Dayton, Ohio

(Dr. Weinberg is also clinical professor of medicine, Wright State University School of Medicine and recent past president, American College of Cardiology.)

**I admit to struggling with the latest “crisis” (HMOs), and I was pleased to see your effort at giving both sides in your June 21 editorial. The sad thing is that I came away with the feeling that neither the Democrats nor the Republicans are serving anything but their money sources (lawyers vs. insurance companies).**

At this point, I trust none of those involved (politicians, lawyers and insurance companies) to act in the best interest of the general public. What does strike me, however, is that all of this will certainly lead to higher health-care costs and screams for government intervention. Volia! Government-provided health care by stealth, Hillary is ensnared as a visionary, and the lawyers and Democrats get richer.

J.V. FITZSIMMONS
Hickory, N.C.

Educated Consumers
In Health-Care Market

In his June 22 editorial-page commentary “Medicine Isn’t an Economics-Free Zone,” James Blumstein cites new evidence that does not support his conclusion supporting managed care.

The fact is, both of the health-care policies he describes, the pre-HMO “professional” model and the “managed care HMO” model, have been operated under the unproven assumption that a free market cannot work in health care because physicians can convince “ignorant” consumers to purchase too much unnecessary care. Under both models the nation has attempted to control the health-care spending controlled by physicians by limiting the supply of physicians (through government subsidization of medical education), even though skyrocketing cost inflation has resulted under the laws of supply and demand. The major difference between the two models is that HMOs have also attempted to control the spending of individual physicians through market power.

Now, Mr. Blumstein claims that new evidence shows that patients can be informed about health care after all. This new evidence supports a free-market model, which could potentially foster competition among physicians to deflate costs enough to make health-care consumption and conservatives. It held steady among moderates and independents. (A private Arizona survey recently showed a similar trend there.)

This may not be surprising since President Bush is a divisive figure—very popular with his GOP base and unpopular with the opposition—and because recently the Arizona senator has been a Bush foe on a number of issues. Even if a survey before McCain forces, he was forced to quell—of him leaving the GOP.

But if this represents the beginning of a permanent shift, it has political implications. It would signal the final straw for any McCain influence within the Republican Party, as well as offer encouragement that the senator could run an independent presidential run with broad-based appeal.

This is the dream of the hard-core McCain brigade. It may occur. But there’s a fatalism about John McCain—more than five years of torture in a POW camp will do that to you. He muses about possible scenarios, but hasn’t any real notion how the next few years will unfold.

As asked in the WSJ/NBC News survey whether Mr. McCain’s outspokenness on major opposition to this limited

Politics & People

By Albert R. Hunt

John McCain remains an enormously popular figure. His favorability ratings are eclipsed only by unelected icons such as Colin Powell and Alan Greenspan.

But, according to this week’s Wall Street Journal/NBC News poll, the McCain base has changed significantly, and in just a few months. His popularity with Democrats and liberals has soared, while it has dipped among Republicans and conservatives. It held steady among moderates and independents. (A private Arizona survey recently showed a similar trend there.)

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The Wall Street Journal Thursday, June 28, 2001

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Letters to the Editor

Doctors Become Puppets of the HMOs

The latest health-care news out of California ("Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses," page one, Sept. 17) has a dreadful twist: HMOs are giving cash bonuses to doctors for providing patients with good medical care. This is ironic when you consider the U.S. Supreme Court recently granted HMOs virtual immunity from prosecution for providing negligent care, thus limiting any damages they might pay their victims. This sweeping lack of accountability should be every American's number one fear, especially in light of a shocking 1989 National Institute of Medicine study that showed 88,000 Americans die every year from medical errors. That's 268 patient deaths every day. How's that for an attack on Americans!

California HMOs are paying doctors as much as $60 million in bonuses to provide high-quality care. But, read closely: When HMOs say high-quality care what they really mean is cost-effective care, and to HMOs, cost-effective care means making profits through less care and less treatment. HMOs have no incentive to stop their tradition of denying treatment. Pay-for-performance bonuses are just one more way to rack up profits. And even if HMOs have it right with the pay-for-performance model, their epidemic of medical errors will never be cured unless they are held accountable. Americans deserve not to live in fear of going to the doctor or an HMO.

Vickie L. Milazzo, R.N., M.S.N., J.D.
Certified Legal Nurse Consultant
President
Medical-Legal Consulting Institute Inc.
Houston

The responsibility and reward for disease prevention and health maintenance needs to be placed on the insured, not the overburdened provider. Insurance companies should give a checklist of procedures according to age and previous diagnoses and then adjust premiums and/or co-payments for those who comply with their lists. It would be simpler and more cost-effective to expand the database of the insurer than to ask each individual provider to do so. Then, rather than having doctors chase and cajole patients, the patients themselves would be requesting and following through with that colonoscopy, cholesterol-reducing medication, or specialist referral—certainly before their next annual premium review.

The current system of reward and punishment for doctors misses the mark. It's like giving owners a biscuit when their dog learns how to heel.

Marianne Kehoe, D.D.S.
Glen Ellyn, Ill.

In Venezuela, the Fox Guarded the Chickens

In regard to John Graham's Sept. 13 letter to the Editor "Carter Didn't Whitewash Venezuelan Voting Process"—Mr. Graham got it wrong. Mary O'Grady may have quoted him out of context (Americas, Aug. 27), but she got it right: 1. The Aug. 18 sample was not a random sample. And, even if it was, it had zero credibility, having been created by the CNE computer using the CNE's software (CNE is the Venezuelan government's electoral council). That's akin to putting the fox to guard the chickens. As you apparently are not aware, the Carter Center ignored opposition pleas that the center create the sample using the Carter Center computer. In short, as Ms. O'Grady says, "an impartial audit of the ballot was not allowed."

Ron M. Aryel M.D., M.B.A.
Kansas City, Mo.

Politics & People / By Albert R. I

George Bush is itching to "bring it on," or take it to John Kerry in tonight's foreign policy debate; it was the grand deal of the negotiations: Vernon Jordan got three debates for Sen. Kerry and Jim Baker got the first debate exclusively on foreign policy for Mr. Bush.

The Bush team thinks this is Mr. Kerry's Achilles' heel—weak on terrorism, vacillating on Iraq—and he can be knocked out of the race with a poor showing this evening.

The president's supporters depict George Bush as a resolute, consistent and tough world leader. Even if you disagree with him, they reply, he is, to paraphrase Bill Clinton's formulation, "strong even when wrong."

The facts belie that. On national security, President Bush has been inconsistent, contradictory and irresponsible. He has confused allies and emboldened adversaries. Tonight, as well as offering a coherent world view of his own, it's up to Sen. Kerry to make this case.

In attempting to explain away the shifting rationales of the Iraq war and what we did not anticipate, the president is either duplicitous or delusional. A small example: Exile leader Ahmed Chalabi initially was the Iraqi George Washington—he sat next to the first lady at the president's State of the Union speech this January—but recently, under U.S. direction, was arrested.

Mr. Kerry will be painted tonight as a flip-flopper on Iraq—with some merit—and then accused of planning to cut and run. None of that cowardly stuff for our gun-slinger president. Except last week, conservative columnist Robert Novak, who has...
Supreme Court denies HMO suits

Americans can’t sue managed-care plans in state courts, justices say

By Mary Deibel
Scripps Howard News Service

WASHINGTON — The 130 million Americans who get health coverage through work cannot use state malpractice laws to sue their managed-care plan for refusing to cover treatment their doctor prescribes, the Supreme Court held Monday.

A unanimous court agreed that a 30-year-old federal law that covers employee benefits allows patients to sue in federal court only for the dollar amount of services that are improperly denied and does not allow state lawsuits seeking damages for care that was wrongly withheld.

The 1974 law’s enforcement rules are “essential to accomplish Congress’s purpose of creating a comprehensive statute for the regulation of employee benefit plans,” Justice Clarence Thomas wrote for the court.

Justices rule against state HMO suits

Continued from 1A

The decision marked a major victory for insurers.

America’s Health Insurance Plans President Karen Ignagni praised it for “putting the brakes on efforts by trial lawyers to turn every coverage question into a costly lawsuit. Encouraging more lawsuits would have unnecessarily put coverage for more workers at risk.”

Employer groups including the U.S. Chamber of Commerce and the National Association of Manufacturers also sought the curbs on state-court suits, warning that consumers would “pay the ultimate price” in higher co-payments, deductibles and premiums.

The ruling also scored a win for the Bush administration, which argued that the growing number of state laws regulating managed care threatens to upset the “careful balance” Congress struck in the Employee Retirement Income Security Act of 1974.

Medical professionals and patients’ rights groups denounced the decision after Congress and the White House were deadlocked for years over regulating managed care.

American Medical Association President John Nelson called the Supreme Court ruling “sad” and warned that, “by reserving the right to decide what is — and what is not — medically necessary, managed-care plans can now practice medicine without a license and without the same accountability that physicians face every day.”

Ron Pollack, head of Families USA, called it “astounding” that George W. Bush could campaign in favor of the law in 2000 but then oppose it in the Supreme Court as president.

The case challenged a 1997 Texas statute, which was the nation’s first “patients’ bill of rights” to become law and let people sue managed-care plans over denied treatment. Then-Texas Gov. Bush let it become law without his signature but embraced it in the 2000 campaign, declaring in a televised presidential debate: “I support a national patients’ bill of rights.”
The Health-Care Crisis: States Are Rushing In

HEALTH COSTS ARE SKYROCKETING, the number of uninsured is growing steadily, and squeezed companies are bailing out of the benefits business. Yet Washington is sitting on its hands. Enter the states. Governors and legislators are trying in a variety of ways to expand coverage while reining in their own expenses.

Business is watching warily to see whether states can achieve health-care nirvana: widespread coverage and lower costs without steep, job-crushing taxes.

The hottest debate is in Massachusetts. On Nov. 3 state representatives passed a bill that would achieve near-universal coverage by making their state the first to impose a so-called individual mandate—a requirement championed by Governor Mitt Romney—that directs all residents who can't get coverage at work or from Medicaid to buy their own insurance. In Illinois, Democratic Governor Rod Blagojevich on Nov. 15 signed into law his $45 million "All Kids" plan, which would make the Land of Lincoln the first to extend comprehensive coverage to all children under age 18. And in 2006, 22 states across the political spectrum will be expanding eligibility for Medicaid programs, according to the Henry J. Kaiser Family Foundation.

Increasing health coverage is a laudable goal. But visionary governors should study the results of past state experiments. Hawaii launched an employer-financed universal-coverage plan in 1974, but today up to 12% of its residents still remain uninsured. Tennessee tried to expand coverage dramatically in 1994 with a massive state-run insurance program called TennCare, but its staggering costs fueled a taxpayer backlash. And California dropped plans to require employers to cover workers or face new taxes because of widespread opposition from the business community.

Yet Romney thinks a more market-based solution to the health-care crisis can be a winning issue. The Republican governor is expected to announce his Presidential candidacy before Christmas and figures expanding coverage could win him praise as a can-do compassionate conservative. Rather than force employers to provide coverage, he would require individuals who don’t qualify for Medicaid to buy their own health insurance. Massachusetts would encourage insurers to offer less expensive but more restrictive policies costing about $200 a month, or half current levels. The state would help subsidize the cost for people earning less than triple the poverty level. Those who don’t buy insurance would face stiff tax penalties—a stick designed to encourage participation. House Speaker Salvatore F. DiMasi, a Democrat, estimates the plan would extend coverage to 95% of the 500,000 residents who are now uninsured. "This could become a model for other states," he predicts.

Pack-Up Time?

But health plans that work on paper often fail in the clinics. The individual mandate could create a backlash among healthy young singles who often choose to go without insurance. And DiMasi’s troops in the Democratic-controlled Massachusetts House are adding a wrinkle that is strongly opposed by business: a 5%-to-7% payroll tax on companies that don’t insure their own employees. "This would clearly undercut job creation at a time when we are already a very high-cost state," says Michael J. Widmer, president of the Massachusetts Taxpayers Foundation, a business-oriented research group. And for employers who already provide coverage, the tax could prove a cheaper alternative, inducing them to dump workers onto the state plan as costs rise.

Romney, who knows his 2008 prospects could vanish if he endorsed a steep tax hike, is counting on the state Senate to nix the tax: It’s pushing a less sweeping plan that would cover no more than half the uninsured. "If you try to do too much, too fast, you end up with nothing," says Senate President Robert Travaglini (D).

Even that modest progress could prove appealing to voters in states where coverage is shrinking. Slammed by increasing health-care costs, 14 states—almost all of them carried by George W. Bush in 2004—are scaling back their Medicaid programs. Tennessee has already slashed 20,000 from TennCare, and Missouri has cut some 100,000 residents off Medicaid.

Over the past five years, the number of companies offering insurance has fallen from 69% to 60%, says Gary Claxton, a Kaiser vice-president. Where coverage is offered, premium hikes have more employees opting out. The upshot: The number of uninsured rose from 15.3% to 18% between 2000 and 2004. Faced with those facts and with Washington’s inaction, governors like Romney and Blagojevich feel they have little choice but to ignore the grim record of state reforms and take action on their own.

—By William C. Symonds in Boston, with Howard Gleckman
President Bush and John Kerry profess similar goals for American health care. "President Bush," his campaign says, "believes that all Americans should have access to affordable, high-quality health care."

Mr. Kerry seems to believe something similar. "I am offering a plan that improves health care for all Americans...that makes a priority of both holding down costs and expanding coverage," he says.

But the two promise to achieve those goals in strikingly different ways.

Mr. Kerry, no fan of the ill-fated Clinton health plan, opts for raging incendiarism. "This is a health-care plan that can pass," he says pointedly. He embraces the familiar approach, in which employers or the government pool the risks of covering a large number of people, and would expand to cover more people. And he proposes to spend a lot of taxpayer money to do that, about $853 billion over 10 years, according to estimates by Emory University's Kenneth E. Thorpe.

Mr. Bush has a proposal more radical than is generally understood. He would move the country from its group-insurance model to one in which individuals, some armed with new tax credits, shop for health care like they do any other product or service. You want more, you pay more.

"Under the system that currently exists," the president has said, "consumers really don't know how far their health-care dollars are going. You pay the premium and then you just show up and collect the benefits. There's no demand for better prices. There's no selectivity in the marketplace. When consumers don't have the incentive to get better prices, costs go up."

The idea is that people will be choosier consumers the more they spend their own money. These Bush ideas anticipate a big change in the current system: a bigger, more efficient market for individuals— as opposed to employers—to buy health insurance than we have today.

Some of the president's critics fear he might succeed, irrevocably weakening the group-insurance system by diverting healthier (and thus cheaper-to-insure) people into the individual market.

Similar differences emerge in the candidates' prescriptions for containing costs.

Mr. Bush believes that unleashing the forces of competition—by making individuals pay more so they shop more shrewdly, by using the Internet to post prescription drug prices—is key.

Mr. Kerry isn't so sure that competition will suffice. He would use the government's clout to negotiate better deals for drug prices. He would reduce private insurance premiums by having the government pick up 75% of the cost of any illness above $30,000, essentially hoping that this carrot will allow the government to lure employers to make other changes to health plans so that the net result will be a smaller national health bill.

In the cacophony of a presidential campaign, it is sometimes hard to tell when candidates are offering serious, contrasting approaches to pressing problems that reflect their competing political philosophies. If you listen carefully to Mr. Bush and Mr. Kerry talk about health care, though, you can hear just that.
BY JAMES F. BLUMSTEIN

The Democrats, now back in control of the Senate, have wasted no time in pushing a patient's bill of rights, legislation that would impose new terms and obligations on private health plans and may allow patients to sue their health-maintenance organizations.

Despite all the rhetoric, some critical policy issues have been ignored: Will the scope of benefits continue to be a matter of contractual negotiation or become subject to government fiat? If HMOs or health plans can be sued, will liability turn on contract or tort? Unless these issues are addressed, the proposed legislation could rigidify the health-insurance marketplace, elevate costs and, as an unintended consequence, restrict access to medical care.

Competing Visions

Some background is necessary. The debate over the patients' bill of rights is actually a battle between competing visions of medical care—the "professional" model, and an economic model (as reflected in managed care). Medical care has traditionally followed a "professional" model, based on two assumptions: that patients are unable to become sufficiently informed about their own care to allow them a pivotal role, and that medical judgments are based on science, with economic incentives playing no significant role.

Under this model, professionals, as experts, make core decisions for patients. These are technical judgments that use scientific knowledge to determine appropriate treatment. The only question is scientific: Is the procedure or treatment safe and effective? If so, the role of the payer is merely to write a check and not ask questions. Market factors such as cost-benefit trade-offs are not only seen as irrelevant, but as corrosive of medical judgments.

But a number of these assumptions have become called into question. Evidence shows that incentives do affect behavior in health care, both among providers and consumers, and that patients can be informed about medical issues. The existence of clinical uncertainty challenges the assumption that science dictates a single standard of care. And many decisions involve nonmedical personal preferences.

In short, personal preferences and economic trade-offs matter, and incentives influence conduct. The assumption that third-party payment (by employer-provided health plans) would not affect decisionmaking proved erroneous and led to deregulation of medical care. Medical care looks more like a market than many believed (or feared).

The proliferation of managed care, a response to the rapid cost increases of the early 1990s, introduced an economic dimension to medical decisions. HMOs ask if the treatment, even if effective, is of sufficient benefit or priority to warrant expenditure from a common pool of insurance money. The patients' bill of rights reflects a backlash against this principle and the way in which it has been implemented, an attempt to resurrect the spare-no-expenses model and restore physician hegemony. Some backlash is understandable, but the urge to reform should not prevent reasoned, market-based decisionmaking.

The managed-care industry never has acknowledged majorly in the name of cost restraint, it asks an economic question—is the procedure or treatment cost-justified?—in addition to a traditional medical question—is the procedure or treatment safe and effective? Consumers were not adequately informed that a market model was being used, while physicians denied the relevance of economic considerations. Improved communication and disclosure rules could address this disconnect between HMO performance and consumer expectations.

Real Risk

The real villain here is the retention in contracts of the "medical necessity" concept. If a procedure or treatment is safe and effective, it is "medically necessary." Courts have held that it must be paid for unless deemed "experimental." Cost effective is defined as that, there is no third category, allowing denial of payment because a procedure is of some, but not great, benefit with very high costs. Managed care has applied that third category implicitly; it is now paying the price for lack of candor and for not altering contract terminology and expectations.

Congress seems poised to impose mandates on plans that use the "medical necessity" standard. Perhaps consumer expectations cannot be undone when that term defines a plan's benefits. But in protecting consumers against a bait and switch—plans' defining benefits in accord with "medical necessity" while imposing an additional, implicit standard of cost-benefit—Congress should explicitly allow plans to cover "rational, medically necessary" services if they clearly disavow any such intention. This would allow managed care to survive and retain the use of economic factors to restrain costs, but it would require acknowledgment of what is going on by the adoption of new contract language to define the scope of coverage.

The terms of coverage in a health plan are contractual, potential plan liability for determination of coverage decisions should be based on contract principles. If federal legislation extends liability to health-plan coverage determinations, it should expressly specify a contractual basis of liability.

Such a liability regime could include a supplementary tort claim in the event of bad faith. This could allow recovery when no responsible medical authority could reach a determination of benefits under the terms of the contract, but it would not externally impose a level of benefits on a plan. The nation declined the invitation, in 1994, to specify through the front door a uniform and mandatory package of benefits. A tort standard risks doing to the health-care system that through the backdoor of litigation.

Besides, if health-plan liability were to hinge on a one-size-fits-all tort principle, rather than on contract, this would turn every benefits determination into a potential malpractice case.

Consider a plan where the parties contract and pay a premium for a limit of 20 days of inpatient coverage. If a physician asserts that 30 days is "medically necessary," could liability attach to the plan for "negligent" plan design (as opposed to bad faith plan administration)? If so, that would be far-reaching and could wreak havoc with actuarial cost calculations because policy limits, which influence costs, could not be enforced when confronted with adverse professional opinion.

Mr. Blumstein is a professor at the Vanderbilt Law School and director of the Health Policy Center at the Vanderbilt Institute for Public Policy Studies.
HEALTH CARE

June 3, 2002

The Workplace

NURSING: ON THE CRITICAL LIST
An acute shortage of RNs threatens to cripple U.S. hospitals

When nurse Sherri Stoddard finishes her shift at Sierra Vista Regional Medical Center in San Luis Obispo, Calif., she's routinely wracked with anxiety. Stoddard has so many patients in the maternity ward to look after that she often doesn't immediately notice when a fetal heart rate has slowed or an expectant mother has requested more pain medication. "It's a horrible feeling," she says.

Registered nurses such as Stoddard are finding their jobs so difficult that they're bailing out in droves. The current 20% turnover rate among nurses is the highest in decades. Some hospitals have resorted to offering sign-on bonuses up to $15,000 and finders’ fees of $5,000.

The dissatisfaction among nurses could spiral into a crisis. Squeezed by skyrocketing drug costs and decreasing insurance reimbursement rates, hospitals have been skimping on RNs to the point where nurses complain they can barely do their jobs safely. Revolts are brewing. As many as 8,000 University of California RNs are poised to strike if administrators don’t agree to improved working conditions. This would be one of the biggest strikes ever by the largest nurses’ union in California, threatening such medical centers as the University of California facilities in Los Angeles and San Francisco.

Long aware of the nursing crisis, California is phasing in new nurse-patient ratios: one nurse for every six patients, down from patient loads of 10 to 20 per shift today. This could cost the state's hospitals more than $400 million per year, but it's a case of pay now or pay later. Without enough nurses, hospitals may be forced to close units or turn away patients, exacerbating the health-care crunch. Five other states are also considering the new ratios.

As it stands, recruiting is tough. Beyond the workload, the average RN struggles with mandatory overtime and reams of paperwork—not to mention the middling average annual pay of $47,000. Hospital executives have avoided buying new technology that would make administrative tasks easier so nurses could spend more time with patients. Almost half of acute-care nurses are so unhappy they say they will leave before they reach retirement age.

Demographic and economic factors coming into play threaten to make the situation worse. The average age of nurses has risen 7% since 1995, to 45, while nursing-school graduation rates have fallen 23%. Hiring nurses from foreign countries—a favorite tactic during past crunches—won’t work now because shortages are a problem worldwide. And the recession has not driven nonpracticing nurses back into the profession, as many had hoped. At this rate, hospitals will be short 515,000 nurses by 2020—exactly the time most baby boomers will be pushing 70 and flooding the system.

Recruiting and retaining nurses will add yet another layer of expense to an industry that is already under strain. Net profit margins at hospitals have fallen from 5.5% in the late 1990s to 2% today. Paying more for nurses will drive up costs further. Those will get passed on to patients in the form of higher health-insurance premiums, which have jumped 11% in the past year alone.

Of course, no fix is cheap. In California, complying with the new ratios would cost about $200 per patient. But hospital operator Tenet Healthcare Corp. says that if it could reduce its RN turnover rate by just 1%, it would end up saving $12 million a year. If hospitals don't act fast, they will find themselves short of caregivers just when they need them most.

By Arlene Weintraub in Los Angeles

Rx FOR RNs | The number of unfilled nursing slots will quadruple by 2020, creating strains on the health-care system

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<th>PROBLEM</th>
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<td>Hospitals are treating overwhelmed nurses with mandatory overtime and inadequate patient loads.</td>
<td>California will impose nurse-patient ratios of 1:6 starting next year. Five other states might follow suit.</td>
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<td>Hospitals have been busy, and it comes at buying new equipment that would make nurses’ jobs easier.</td>
<td>Hospitals are starting implementing new technologies that automate administrative and scheduling tasks.</td>
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<td>The number of nursing-school seats has eliminated 1990.</td>
<td>New hospitals could provide more seats for scholarships, but health-care companies will need to unwind</td>
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Factual Deficit:
Kent Conrad’s
Medicare Politics

Thank you, Fritz Hollings. The courtly curmudgeon from South Carolina never met a tax increase he didn’t like, but at least he’s honest about it.

So this week the Democrat demanded a Senate vote to repeal this year’s tax rebate on grounds that the federal budget surplus is vanishing. He lost, 94-3. Only Joe (say it ain’t so) Lieberman and Maryland’s Barbara Mikulski joined him. Keep that vote in mind as you hear other, smoother Democrats—notably North Dakota’s Kent Conrad—suddenly shouting that the Bush tax cut has re-opened a budget “deficit.” These Democrats don’t want to be seen opposing popular tax cuts; 12 of them even voted for the Bush plan. And 47 Senate Democrats endorsed a $1.3 trillion tax cut this year; only slightly smaller than the one that eventually passed.

* * *

So why all the deficit “yin yao” now, as Ol’ Fritz likes to say? The answer relates, as it usually does, to next year’s election. Democrats are trying to set up a 2002 campaign theme pitting Medicare against allegedly budget-busting Bush tax cuts. To do so, they first have to ignore the history of their own tax-cut votes. And then they have to blame the tax cuts for somehow driving the country into a “fiscal ditch,” the facts notwithstanding.

We’ve seen this scary movie before. In 1993, Democrats picked up eight Senate seats running against GOP votes to trim Social Security and Medicare benefits. Bill Clinton repeated the line against “Dole-Gingrich” in 1996. The problem this year is that there are no such GOP votes. So Democrats are trying to manufacture the crisis of a new budget “deficit” that somehow is an assault on both programs.

In Mr. Conrad, Democrats have just the man for this snow job. Nobody is better at using the rhetoric of fiscal conservatism to disguise demands for larger government. And it’s best to shield grandma’s ears when he’s on TV because no one sounds scarier about nefarious threats to her health care and pension.

With this in mind, Mr. Conrad invited White House Budget Director Mitch Daniels to a hearing for some 2002 target practice yesterday. The senator brought along a slew of charts, and even the glamorous freshman Democrat from New York showed up. His message, helpfully written in red ink, is that the Bush tax cuts have so sapped the federal Treasury that they are going to require a “raid on Medicare.”

Even by Washington standards, this is ridiculous. Despite America’s near-recession, there is nothing even close to a federal deficit. This year’s surplus will be somewhere north of $160 billion, the second largest in history after last year’s. And this is after accounting for a tax cut this year of $74 billion.

Aha, replies Mr. Conrad, the feds will still have to dip into this year’s “Medicare surplus,” which is what Al Gore and “Saturday Night Live” were going to protect with their “Medicare lockbox.” But there is no such thing. Medicare is in deficit this year by $56 billion. The only way Mr. Conrad can invent a modest surplus is to measure only Part A of Medicare, the hospital fund, which is financed by a steep payroll tax.

But this is like saying the flight was smooth except for the crash landing. Mr. Conrad entirely ignores the bleeding Part B, which is financed by general tax revenues. And the only reason Part A is in even modest surplus is because Bill Clinton transferred home-health-care payments from A to B in his second term. This was purely an accounting gimmick to make Medicare look sounder than it is and so hold off calls for reform.

Mr. Conrad knows all of this. But he’s counting on the fact that the details are too obscure for everyone but nerdy columnists. (Don’t look for any of this on the evening news.) He’s also betting the facts are too complicated for Republicans to explain in a political campaign. As one House member says, “Once you’re into those details, you’ve already lost.”

Mr. Conrad’s deeper dishonesty is that he isn’t worried about Medicare’s insolvent in any case. As Texas Republican Phil Gramm pointed out, the idea of a Medicare surplus is nothing but a “cruel political hoax.” Not a single penny of surplus Medicare or Social Security taxes has ever gone to finance those programs; instead the excess revenue pays off federal debt, much of which is held by “bondholders in Zurich.”

If Mr. Conrad really cared about Medicare’s fiscal health, he’d join his fellow Democrat John Breaux in trying to reform it. But instead his main political goal is to add even more benefits to the shaky, hemorrhaging Medicare status quo, in particular free prescription drugs.

Which gets to Mr. Conrad’s real political frustration with the Bush tax cut: It is accomplishing one of its goals, which is to reduce the surplus before all of it is spent. Democrats and Republicans alike had grown accustomed to treating the growing surplus as a kind of annual political dividend. They’d spend it in a frenzy at the end of each year. But this year slow growth and the tax cut are dampening their revels.

Meanwhile, if Mr. Conrad and Senate
Medicare's Big Experiment

The coming changes aim to cut costs while improving care. Sound familiar?

In 16 years of practicing internal medicine, Yul D. Ejnes has learned to cope with the fast-changing world of medical economics. A decade ago, under tremendous cost pressures from big insurance companies, Ejnes merged his tiny practice in Cranston, R.I., into what has since evolved into a 16-office, 50-physician operation. Since lab tests and X-rays can be more profitable than office visits, he and his partners set up an in-house lab and are planning to develop their own medical-imaging business. His practice, Coastal Medical Inc., even leverages its in-house computer system into a lucrative sideline: billing insurers and patients for other docs.

Now, Ejnes is about to get the biggest dose of change yet. Medicare, the giant federal health program that covers the country's 42 million seniors—and about one-third of Ejnes' patients—is set to radically overhaul the way seniors get their health care. Washington has already started giving insurance companies billions of dollars in subsidies to encourage seniors to join managed-care plans—the networks of doctors and hospitals that are now the near-universal model for employer-provided health care.

Washington will also aggressively promote disease management in Medicare, where chronic illnesses are identified and treated early. It will urge doctors to adopt costly new information technology. And it may soon take steps to tie physicians' compensation to the quality of care they provide. Taken together, "this is really about shifting the focus to helping people stay well in the first place," says Mark McClellan, administrator of the federal Centers for Medicare & Medicaid Services, which oversees both programs.

Perhaps. But these changes are also about saving money. Over the next few years they'll not only remake the way medicine is practiced on seniors but also shake up the world for physicians and hospitals and change the way taxpayers pay Medicare's unimaginably huge bill.

In the new world of Medicare, seniors will face the same option workers have confronted for years: Accept limited choices of doctors and hospitals or pay more. Like their younger counterparts, seniors may be getting streamlined care—more of their surgery will be done in walk-in clinics, for example, rather than in hospitals. And they'll have to become more aggressive consumers of health care. Take Medicare's new drug benefit. With help paying for their prescriptions, seniors should be able to better integrate their medication with other care—but only if they make sure their drug plan covers the specific pills they take. Says Patricia Neuman, a health economist at Henry J. Kaiser Family Foundation: "This could fundamentally change patient care."

Doctors, meanwhile, may be pushed to provide more preventative care rather than costly treatments for the very ill. And the small medical practice may go the way of the neighborhood pharmacy.

After years of battling reform, Ejnes and many of his colleagues are open to change. Medicare's old fee-for-service system, where doctors are paid a piece rate for each procedure or test they perform, is like "a dog doing a trick and getting a biscuit afterward," Ejnes says. Trouble is, for years doctors have heard that Medicare would pay more for better care, only to see payments slashed. Patients, too, have heard unfulfilled promises of better care for less cost.

Indeed, Medicare has experimented with managed care twice before, but the system imploded when budget pressures forced Washington to cut subsidies to insurers. Without the extra cash, insurers raised premiums, cut benefits, and eventually dumped the no-longer-profitable plans. Doctors and senior advocates wonder if the result this time will be the same: a system that merely pays less.

BOOMERS LOOM

BUDGET PRESSURES are only getting worse. The government spends 2.7% of the nation's total economic output on Medicare. In the coming four decades, as baby boomers retire and demand costly new technologies to keep them healthy, Medicare threatens to break the federal bank. Spending for the program will nearly quadruple—to almost 10% of gross domestic product.

The drive to managed care is nothing new for people who get their health insurance from their employer. Just 3% of working people today are in old-style plans that give them an unlimited choice of doctors and hospitals and do little to restrict their access to costly medicines or procedures. By contrast, nearly 90% of Medicare recipients are treated under that old fee-for-service model.

The new system, established by the same 2003 law that created the Medicare prescription-drug benefit, aims to make managed care—known as Medicare Advantage—nearly universal among the elderly. Insurance companies are expected to use Washington's subsidies to provide extra benefits, such as vision or dental care, and lower premiums. Emory University health economist Kenneth E. Thorpe figures those added benefits will...
be worth an extra $615 a year. In return, however, members will face more limits on their choice of doctors and hospitals.

The carrot of subsidies is accompanied by a stick: sharply rising premiums for traditional Medicare. In 2006 seniors are likely to pay $120 or more a month for basic Medicare plus the new drug insurance. Many can expect to spend $100 to $200 more for a supplemental Medigap plan, which pays deductibles and other fees left over by basic Medicare. That’s a lot, especially for a senior living on a small pension and Social Security, which pays an average of roughly $1,200 a month. And with health costs skyrocketing, those premiums will explode in coming years. A 2004 Urban Institute study estimates that Medicare premiums alone will rise to nearly a quarter of total Social Security benefits by 2040. Add Medigap premiums, and many retired baby boomers could be spending 40% of their Social Security on health care.

That will drive a steady shift to the new Medicare managed-care plans offered by insurers and HMOs. Even so, it’s likely to be a gradual process because many seniors will hang on to traditional Medicare as long as they can. “The potential for managed care to become dominant is many years off,” predicts Paul B. Ginsburg, president of the Center for Studying Health System Change, a Washington research organization.

Backers of managed care hope the real benefit will come in Medicare’s ability to coordinate care for the chronically ill. Seniors typically suffer from multiple chronic illnesses, such as arthritis, congestive heart failure, and high blood pressure. If managed-care plans can coordinate all that treatment, there’s at least a chance that care can improve at less cost.

INFO-TECH UPGRADES
Achieving that goal will require a major retooling of physicians’ practices. To start the transition, Medicare will demand more information on how doctors care for their patients. It’s establishing a series of specific quality measures aimed at encouraging docs to use “best practices” in treating patients. For example, physicians will have to show whether they have performed specific blood tests and foot exams on diabetics to prevent complications that lead to amputations and kidney disease.

Gathering that data, in turn, will require new computer systems that are in use at only a handful of medical practices today. Doctors recognize the need for the technology upgrade but wonder how they’ll pay for it. One study suggests that installing the PCs and highly specialized software needed to manage tasks such as writing prescriptions and tracking patient care costs a small fraction of what they will cost.

The New World of Medicare
The federal health program for 42 million seniors will get a radical overhaul as the 2003 Medicare modernization act kicks in. Here’s what to expect as it steers more recipients into managed care and disease-management programs and sharply expands the use of info tech in hospitals and doctors’ offices:

SENIORS
New Medicare-managed care will shift more of the burden of the chronically ill to taxpayers and hospitals. The shift will be greatest for the poorest and sickest.

DOCTORS AND HOSPITALS
Doctors and hospitals will be paid more to care for Medicare patients under the new programs.

TAXPAYERS
Many voters will see their tax bills rise to cover the costs of Medicare.

A key goal is shifting focus from treating to preventing illness

practice as much as $44,000 per doctor. Together, all these changes may mean the demise of the solo practitioner, who probably won’t be able to shoulder the new burdens alone. “One-, two-, and three-physician practices are, by definition, undercapitalized and inefficient,” says Scott Latimer, regional vice-president for senior products at Humana Inc., a Louisville-based health insurer.

Just as small physician practices will fundamentally change, so will big hospitals. They’ll still do intensive, high-tech, high-profit procedures such as heart bypasses. But less complex surgeries and nearly all testing will be done at smaller walk-in centers. That should save money. But will it improve care?

That’s where the next step will come in—and it’s a big one. Medicare wants to start tying doctors’ payments to results. Backers hope such financial incentives will encourage doctors and hospitals to keep patients healthy. Managed care has made the same promise for 20-plus years—but has rarely delivered. Instead, the system has tried to slow spending growth by limiting care. Insurance execs say it will be different this time. But the key to managed care’s future may depend on how long those big government subsidies continue. And in an era of high deficits, it is a good bet they’ll dry up. If it does, the move to managed care may blow away as well.

In that environment, both traditional Medicare and the new managed-care plans will be under tremendous pressure to control costs. Inevitably, they’ll be tightening the screws on doctors and hospitals. Just as Wal-Mart demands the best quality at the lowest price from its vendors, those that pay the health-care bills will demand that physicians and hospitals do the same.

But health care is not home electronics. Often, attempts to save money end up costing more—at least in the short run. For instance, big subsidies to Medicare HMOs will raise the government’s costs at first. Similarly, disease management may result in more intensive treatment for the chronically ill. That could improve their health, but at a higher cost.

Experts have never had much luck guessing what the medical system will look like 5 or 10 years down the road. And the results of changes as big as these are even tougher to predict. Says former Congressional Budget Office Director Robert Reichschaier: “These are the first steps down very long roads, filled with lots of potholes and overhanging branches.”

But with many seniors, doctors, and taxpayers all convinced they were getting a raw deal from the existing system, it’s little wonder Congress was willing to roll the dice in a major way. The poles have assured the public that a decade from now health care for seniors will be much different than it is today. The question remains: Will it be better?

—By Howard Gleckman in Washington
Medicare Drug Folly

Runaway trains are hard to stop, but someone has to try and derail the bipartisan folly now moving ahead under the guise of Medicare "reform." Permit us to put a few facts on the table, in the (probably fanciful) hope that somebody in the White House still cares more about the long-run policy than the short-term politics.

Let's start with the amusing irony that the supporters of this giant new prescription drug benefit are many of the same folks who were only recently moaning that a $550 billion tax cut would break the budget. That tax cut will at least help the economy grow. But the new Medicare entitlement is nothing more than a wealth transfer (from younger workers to retirees) estimated to cost $400 billion over 10 years, and everyone knows that even that is understated.

The real pig in the Medicare python doesn't hit until the Baby Boomers retire. Social Security and Medicare Trustee Tom Saving told us last week that the "present value" of the Senate plan—the value of the entire future obligation in today's dollars—is something like two-thirds the size of the current $3.8 trillion in debt held by the public.

Bill Clinton's Medicare administrator, Nancy-Ann DeParle, correctly calls it the "biggest expansion of government health benefits since the Great Society." She's delighted to see it, but for the rest of us it is a recipe for tax increases as far as the eye can see.

And these estimates are before Democrats "improve" the benefit, as they are already agitating to do. That's because the dirty secret of this bipartisan lovefest is that the proposed drug benefit isn't all that great. The bill that passed the Senate Finance Committee last week would cover just 50% of drug expenses between $276 and $4,500 annually, then zero up to $5,800, and 90% thereafter.

That's nowhere near as good as many seniors currently have with employer-sponsored coverage. Most employers will drop or scale back that coverage once they realize that the feds are willing to pick up part of their tab. The Congressional Budget Office estimates that 37% of those with employer coverage could lose it.

A Goldman Sachs analyst last week called this bill the "automaker enrichment act," saying companies like Ford and GM would see a 15% reduction in their annual drug spending and a huge decrease in unfunded liabilities. So unborn taxpayers will soon have to pick up the tab for sweetheart labor deals negotiated by carmakers and their unions a generation or two ago.

Understand in these terms, a universal drug benefit is neither necessary nor morally justifiable. Some 76% of seniors already have some prescription drug coverage, as the handy chart shows. The average Medicare beneficiary spends an affordable $99 a year out of pocket on prescription drugs, and less than 5% have out of pocket expenses over $4,000.

Seniors already own 60% of all the wealth in this country, and are getting richer. A report in Health Affairs estimates that by 2030 about half will have incomes of $40,000 and about 60% will have assets of $200,000 or more. We're all for a prosperous old age, but it is hardly a step toward social justice for the elderly to be further subsidized by working taxpayers with mortgages and kids. The problem of genuinely poor seniors can be handled with a drug discount card or a means-tested subsidy.

We understand, of course, that these facts are unlikely to interfere with the political calculus driving this giant step toward Canadian health care. The Democrats want to expand the welfare state, while Republicans have convinced themselves that they'll get credit with seniors and be able to take health care off the table for 2004.

The Republicans are fooling themselves in the long run, and perhaps even about next year. Republicans can never win an entitlement bidding war. They will spend the rest of their public lives sounding like Scrooge for not expanding benefits, or raising taxes on their own voters to pay for the subsidies, or imposing price controls on drug makers that will stifle innovation. This is how parties of the right became neo-socialists in Europe.

The sheepish support for this from the likes of otherwise conservative Senators Rick Santorum and Mitch McConnell gives the game away. They're playing loyal spinners, but their hearts don't seem to be in it. They're going along for the ride with a Republican White House that seems to have forgotten that it has an obligation to more than its own re-election.

By Ruth Wisne

JERUSALEM—The day after the assassination attempt on Hamid Karzai, a "deeply troubled" President Bush joined the call for a "two-state" solution to the Palestinian crisis, with the Israeli government in the West Bank and the Gaza Strip. The president's remarks came in a speech in Casablanca, where he said that the United States would "recommit" to the two-state solution.

The United States has a stake in the peace process because it is essential for stability in the region. The president's statement is a welcome development, but he must also be prepared to take action to ensure that the process moves forward.

The peace process has been stalled for years due to a lack of leadership and a failure to address the core issues. The president's call for a two-state solution is an important step, but it must be accompanied by concrete actions to support the process.

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By Michael Judge

If you thought Hans Blix, the chief weapons inspector for the International Atomic Energy Agency, was the last word on weapons of mass destruction in Iraq, you might be surprised to learn that he was not the last word on the issue.

In a recent interview with The New York Times, Blix said that the United States had not provided enough evidence to support its claims of weapons of mass destruction in Iraq.

Blix's comments are significant because they challenge the United States' assertions about weapons of mass destruction in Iraq. The United States has repeatedly claimed that Iraq possesses weapons of mass destruction, but Blix's comments suggest that there is not enough evidence to support these claims.

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By Michael Judge
When is a rebate a kickback?

Discounts by pharmaceutical companies to middlemen are under fire

BY JULIAN E. BARNES

by the time the Senate defeated a measure last week to reduce prescription drug costs for senior citizens, Democrats and Republicans had squabbled over everything from the cost of the Medicare benefit to the role that bureaucrats would play. But there was one point on which everyone seemed to agree: All the proposals—and most likely any legislation that eventually emerges—would have vastly expanded the power of middlemen who tout themselves as the free-market solution to containing drug costs.

Already more than 70 percent of Americans with private health insurance buy their drugs indirectly through these pharmacy benefit managers, or PBMs. Working for employers and insurance companies, PBMs provide a wide range of services, including promoting lower-cost generics and running mail order pharmacies. Most important, however, they extract rebates from pharmaceutical manufacturers in exchange for putting the manufacturers’ products on their lists of approved drugs. "We generate competition," says David Halbert, chief executive of AdvancePCS, the nation’s biggest PBM. "We are in the business of lowering drug costs."

Except, that is, when they aren’t. PBMs are coming under increasing attack by employers, state legislatures, and a federal investigation that is fast gathering steam. Their claims are essentially the same: that manufacturers’ rebates are nothing but illegal kickbacks that the PBMs use to line their own pockets instead of to reduce costs to consumers.

Critics say these secret payments add up to 10 percent of the $122 billion Americans spend on prescription drugs every year. "Are the PBMs driving up health-care costs?" asks Gerry Purcell, a former PBM executive turned industry critic. "I think the answer is yes."

Favored products. The power of PBMS—the top four companies earn $57 billion a year in revenue—rests in their ability to decide which drugs an employer will pay for. Just as an HMO chooses a network of preferred doctors, the PBM compiles a list of favored drugs known as a formulary. If a doctor prescribes a drug that is not on the formulary, an employer or insurance company might refuse to pay for it. If another drug is "preferred" over one that a doctor prescribes, the PBM might call the doctor and ask him to switch it. In theory, PBMs push drugs that are not only effective but also less expensive.

In practice, however, prescribing decisions are often driven not by the price of a drug but rather by how much the drug company is paying the PBM to recommend it. Critics say drug companies are paying ever bigger chunks of money to PBMs to boost sales of expensive drugs that are no better than cheaper alternatives. And while some of that money is passed on to the PBM’s clients—the insurance companies or employers—much, if not most, is kept by the PBMs themselves. "The PBMs are driven by collecting rebates, not containing costs," says Chris Nee, a benefits consultant.

Now a spate of private lawsuits seeks to force the PBMs to share that rebate money with their clients and to open their books. According to Michael Ferrara, one of the lawyers suing the industry, PBMs owe $32 million to the health plan of the state of California alone.

Drug makers and PBMs guard their rebate deals jealously. But one arrangement is laid out in a lawsuit against drug giant Wyeth, the maker of Premarin, a leading estrogen therapy. Duramed Pharmaceuticals, a company that makes a cheaper estrogen product called Cenestin, contends that Wyeth signed agreements in 1999 with several PBMS, including industry leaders AdvancePCS, Express Scripts, and Caremark RX. At the same time, Wyeth raised the price of Premarin 12 percent. According to the lawsuit, Wyeth offered the PBMs broad rebates but in some cases agreed to pay only if the PBMs excluded Cenestin from their formularies. Unwilling to forgo millions in profits, says Stephen Susman, a lawyer for Duramed, the PBMs complied.

Soaring drug costs

The prices of brand-name pharmaceuticals have more than doubled in a decade.
Today's debate: Prescription drug coverage

Pricey drug plans offer seniors little relief

Our view:
Democrats, GOP fail to acknowledge costs of new benefit.

The Senate's debate next week on prescription-drug coverage for seniors is sure to bring forth sad tales of cash-strapped retirees struggling to pay for the spiraling costs of their medicines.

Already circulating are stories about seniors who sneak off to pharmacies in Canada and Mexico, where U.S. drugs sell for 30% or more off their prices here. There are examples of elderly people who risk illness by cutting pills in half to stretch out their prescriptions. Or of those who choose between buying groceries and buying medicine.

Indeed, the need is desperately real. But such stories should carry a disclaimer: Most of the plans being debated in Congress are, at best, partial solutions. And the government doesn't even have the money to pay for what's being proposed.

At its core, the problem is 37 years old. When Medicare was established in 1965 to provide medical coverage for the elderly and disabled, hospital care was the top priority.

Since then, however, seniors' use of prescription drugs has jumped dramatically — and drug costs have spiraled. Today nearly 40% of those on Medicare have no prescription insurance. With out the clout of government or managed-care contracts, they pay the highest prices for drugs.

Estimates vary, but average prescription costs for the nation's 40 million Medicare beneficiaries are up nearly 30% in the past two years.

Understandably, both parties feel a political imperative to help. Seniors vote in big numbers and are well known for punishing lawmakers who dismiss their concerns. But each plan is seriously flawed:

> Senate Democrats are pushing prescription insurance that would be available to everyone on Medicare. Yet even this high-end plan might fall short of what seniors want. It would require a $25-per-person monthly premium, plus co-payments of $10 for generics, $40 for brand-name drugs and $60 if a doctor orders a "non-preferred"

> House Republicans have already passed a voluntary plan seniors could join. It would use federal subsidies as an enticement for insurance companies to offer prescription-drug policies. But to hold costs down, there would be no coverage once a senior's annual drug costs reached $2,000, until they exceeded $3,700. This "doughnut hole" could invite a backlash from those who found themselves suddenly without coverage as drug bills mounted. Further, there's no assurance the industry will offer the policies.

Many fear that healthy and wealthy seniors would opt out, companies would be stuck with insuring only the sickly, and costs would quickly outrun resources.

Again, paying for the program is a problem. Optimists claim to see a return to budget surpluses in 2005, when the GOP plan would start. Still, there's no assurance the government will have the money for its $350-billion 10-year cost.

Other proposals are variations on these themes. But the history of government health programs is that costs quickly outrun all projections. That's why Medicare and the parallel Medicaid for the poor are in deep trouble already. Any new drug program isn't likely to break that mold, especially when both sides' mechanisms for controlling costs are based primarily on hope.

Cost sharing with seniors isn't much of an option. Polls and focus groups consistently show that seniors resist out-of-pocket costs beyond $35 a month. In 1988, an attempt at expanding Medicare coverage caused an ugly backlash when seniors living in relative comfort objected to funding benefits for those poorer or sicker than themselves.

Unrealistically priced plans that come without workable tools for cost containment present a recipe for slapping taxpayers with runaway costs. The tab for a pioneering Pennsylvania state drug program has shot up an average of 13% a year since 1997, while lottery revenues earmarked for it in boom times have been flat.

Seniors, particularly those on fixed incomes, need help with prescription-drug costs. So far, though, neither lawmakers nor seniors themselves have been willing to honestly confront the viability or price tag of any plan. Until they do, there may be a perverse silver lining to the frustrating partisan standoff that has blocked action so far.

cut, the Treasury is already deep in the red. Few Democrats will say what they'd give up to pay for a new drug benefit.

34%
Price Becomes Factor In Cancer Treatment

Costly ‘Targeted’ Drugs Extend Lives, But Confront Patients With Wrenching Choices

BY AMY DOCKSER MARCUS

Cancer patients have always depended on their physicians to discuss the latest treatment options. But now another difficult topic is increasingly being raised in the doctor's office: drug prices.

In one of the most promising turns in cancer treatment in years, new drugs are getting approved that appear to extend lives and are far less toxic than standard chemotherapy. While that has the potential to vastly improve quality of life for patients, many of these treatments are extraordinarily expensive—particularly ones that target cancerous cells but don't destroy normal ones.

The upshot is that for the first time, doctors say, the cost of drugs is now a critical part of their dialogue with patients about how to treat certain cancers. Iressa, a lung-cancer drug, costs about $1,800 a month, and patients can be on it for months or years. Gleevec, another drug that patients can be on for years, runs more than $500 a month. The much-talked-about Erbitux, used for advanced colorectal cancer, runs $16,000 to $30,000 for a seven-week course, and may be continued for months if successful.

Even for people who have health insurance, the patient's share in such cases can be exorbitant. The standard regimen for advanced colon cancer, which can include Erbitux in the mix, is close to $250,000 for 19-20 months of treatment, according to Leonard Saltz, a physician at Memorial Sloan-Kettering Cancer Center in New York. A 20% co-payment would amount to $50,000. While many policies have caps on patients' out-of-pocket expenses, those caps don't always cover drug expenses, and those that do can still amount to several thousand dollars.

While patients are often willing to pay any price to fight their disease, these drugs have limits that can make that decision harder than it might seem. Many of these newer targeted therapies don't cure cancer, but rather keep it in check while being less toxic than older drugs. If the anticipated difference between a high-cost drug and a lower-cost option amounts to only a few weeks or months of extended life, patients are sometimes torn. And if the drug offers just a couple of extra months, patients face leaving behind a huge bill for their families.

Steven Nelson, who was diagnosed with advanced lung cancer six months ago, is participating in a trial for Ligand Pharmaceuticals' Tarxentin, where he can get the drug free. A 30-day supply of the pills can cost more than $500, far beyond the 45-year-old truck driver's means, despite the health insurance he has through his wife.

But Mr. Nelson, of Marietta, Ga., says he has already decided that if the drug on the trial stops working, he will refuse it. He can't afford more.

Please Turn to Page D5, Column 4
Consumer advocates say advertising campaigns, doctor visits go too far

By Theresa Agovino

NEW YORK — It was marketing gone amok.

A few weeks ago, up to 150 people in southern Florida received Prozac in the mail. They didn’t ask for it, and there are conflicting stories whether there were prescriptions for it.

Outraged consumer advocates said the promotion was just another example of drug companies caring more about profits than patients. Privacy proponents feared patients’ medical records were being mined for direct advertising campaigns without their consent.

“There is a real hysteria out there about privacy, so that Prozac situation touched a nerve,” said Douglas Wood, a partner at Hall, Dickler, Kent, Goodstein & Wood, a law firm specializing in advertising.

Pharmaceutical companies are using every angle to advertise. They’ve just gotten more aggressive — using print, direct mail, coupons. There are many people that just don’t like what has happened.”

The widely criticized Prozac incident comes at a time when everyone from doctors to governors to senators has been trying to muzzle messages from pharmaceutical companies in hopes of protecting patient privacy and lowering skyrocketing prescription drug costs. The Centers for Medicare and Medicaid Services estimates that overall spending on prescription drugs last year rose 16.4 percent to $142 billion.

Some see ballooning prescription drug costs as surging pharmaceutical promotion spending. Such expenses, including consumer ads, more than doubled from 1995-2001 to $19 billion, according to the research firm IMS Health. Last year, promotional spending jumped 21 percent.

Pharmaceutical companies are under enormous pressure lately because many of their blockbuster products’ patents have expired and they don’t have new medicines to replace sales lost to generic drugs. Prozac sales have virtually evaporated since it lost its patent last August. The promotion was for a weekly version of the drug with limited sales that is still under patent.

In June, Vermont passed a law requiring pharmaceutical sales reps to register every gift, fee or payment worth more than $25 to doctors and other health providers. The records will be made public. A bill based on that law was recently introduced in Congress, and another bill would end pharmaceutical companies’ tax deduction for advertising.

Meanwhile, some doctors are now charging sales representatives for the opportunity to pitch their products in hopes of curtailing unnecessary visits. And in July, Florida’s attorney general reached an agreement with Eckerd Corp. that will force the drugstore chain to make it easier for customers to avoid pharmaceutical promotions.
More Senate Drug Games

Now they tell us. Last week Senate Democrats assured America’s seniors that the only drug benefit worth having was a $594 billion universal program that hooked every grandmother in America on Uncle Sam. Then it flopped on the Senate floor.

So now those same Democrats have decided that seniors can live with dime-store socialism after all. Suddenly they’re pushing, in this final week before summer recess, a “means-tested” benefit that will go to poorer seniors and won’t bust the federal fisc. Or at least that’s the new pitch, though once you inspect the fine print you discover that this isn’t quite true either.

But why didn’t Tom Daschle and Ted Kennedy tell us that in the first place? They knew they could have had plenty of GOP votes for a genuine means-tested bill; a version of such a bill, sponsored by Nebraska Senator Chuck Hagel and Nevada’s John Ensign, got 51 votes last week, despite Mr. Daschle’s opposition.

The answer is that Democrats want a “universal” benefit so they can hook all American seniors and the entire drug industry on government. They’re only too happy to ask taxpayers to finance the prescription drugs of even David Rockefeller if it means taking the U.S. health-care system one step closer to Canadian-style government care.

We can assert this with confidence because even their new, “scaled down” bill is a Big Government stalking horse. It would still pay for all drug costs above $4,000 a year, including for the Rockefellers, and would still carry a whopping price tag of a minimum of $400 billion over 10 years. Instead of going only to those who lack coverage now, it would also apply to all seniors with incomes up to 150% of the poverty rate. And it would be administered by the same dysfunctional Medicare bureaucracy that already sets prices for all other types of senior care and has driven many doctors into refusing Medi-care patients.

The political question this week is whether Senate Republicans are going to be suckered into going along. By holding fast so far, they’ve moved the Democrats halfway to their philosophy. By staying united this week, as a smart minority party should, Republicans have the chance to drive the debate even more in the direction of solving the problem instead of creating a huge new federal entitlement. That problem is helping poor seniors afford drug coverage, not to substitute Uncle Sam for the private coverage that two-thirds of seniors now have.

One good idea for the GOP to pick up is the Prescription Drug Security Card suggested by Joe Antos of the American Enterprise Institute and Grace-Marie Turner of the Galen Institute. Low- and moderate-income seniors would get an up-front $600 dollar subsidy for routine drug expenses. Then privately administered catastrophic coverage with means-tested premiums would pick up 80% of costs between $2,000 and $6,000, and everything above that. This plan is targeted at people who need it most, and it would also create the infrastructure for the market-based Medicare reform that will be necessary to control costs in future.

The larger political reality is that Senate Democrats need a drug bill this year more than Republicans do. They’re in charge of the Senate, and if they can’t pass anything while House Republicans can, voters are likely to take it out on them. Republicans should help Mr. Daschle pass something only if it won’t trample their principles and nationalize (even if slowly) drug innovation.

With President Bush able to provide ideological air cover, GOP Senators needn’t rush to make concessions the way Oregon’s Gordon Smith has in backing the Kennedy bill. Republicans can win the senior drug debate, unless they panic in the final innings.

O’Neill vs. Rubin

Treasury Secretary Paul O’Neill doesn’t get much respect, sometimes not even from us. But this Sunday he showed why all of the anguished Beltway yearning for the return of Clinton-era financier Robert Rubin is so misguided.

Mr. O’Neill: “No, he’s not. He’s saying raise the taxes, Tim. I’m sorry. You know where he said it from? He said it from Singapore while his company was losing $30 billion worth of market capitalization.” In pro wrestling, they call
Overuse of Medical Scans Is Under Fire

As Billings for CT-Scans, MRIs Soar, Medicare Panel To Recommend More Scrutiny

By Vanessa Fuhrmans

The government is likely to join a growing number of private health plans that are attempting to rein in the use of diagnostic scans.

This week, a Medicare advisory panel is expected to make several recommendations to Congress on the best way to curb the sharply escalating costs of MRIs and other scans. The recommendations will be voted on by the panel today or tomorrow and aren’t final. But one that is being considered would let Medicare edit claims to possibly reduce payment for tests that scan two body parts at once but have often been billed as two separate procedures. Another would require doctors and imaging centers to meet certain quality criteria in order to bill Medicare for services.

The idea is to join efforts already begun by private insurers to curb the costs of advanced imaging, which are fast approaching $100 billion a year. WellPoint Inc.—the health-insurance giant newly created from the merger of Anthem Inc. and WellPoint Health Networks—now requires doctors in several states to get authorization first for advanced, nonemergency scans. And several Blue Cross plans are considering following the lead of Highmark, an operator of Blue Cross and Blue Shield plans in western Pennsylvania that is setting rigorous quality standards for imaging staff and equipment.

For patients, these efforts may lead to higher-quality imaging services and fewer repeat procedures. But they could also mean hassles and delays in getting approval for nonemergency scans, such as MRIs to diagnose back pain. And many physicians who have bought imaging equipment to beef up their practices will likely find it difficult to meet insurers and Medicare’s quality demands. If fewer doctors and imaging centers can meet the tougher standards, it could mean patients will have to travel farther or have difficulty finding a provider.

The government and insurers say they have virtually no choice but to take action to stem the staggering increases in costs for diagnostic imaging. In recent years, use of imaging services by Medicare recipients has been rising at three times the rate of overall physician services, according to the advisory panel, Medicare Payment Advisory Commission, or Medpac.

The cost of an MRI generally runs between

Please Turn to Page D4, Column 2
Effort Grows to Curb Medical Scans

Continued From Page D1

$700 and $1,000, though it can be as high as $2,000 at a New York hospital, according to National Imaging Associates Inc., a company that manages radiology benefits and costs for health plans. PET scans—positron emission tomography—cost $1,800 to $2,000. And CT, or computed tomography, scans can cost $300 to $500.

The growing volume of scans performed is contributing to higher costs—and to concerns about quality. Rapid advances in technologies, and new applications such as using PET scans to diagnose Alzheimer's disease, are helping drive demand. But there is so much else of con-
sumer advertising for scans, which have involved fairly low out-of-pocket ex-

The growing use of scans is

Source: National Imaging Associates

Highmark estimates that some

Providers in western Pennsylvania will fall out

of its imaging network due to the tougher stand-

gards it is beginning to im-

plement this month. But hundreds more are investing in higher-grade equipment or hiring full-time radiologists to make the grade.

Instituting more hands-on involve-

ment in doctors' decisions has led to bet-

ter testing, some health insurers say.

WellPoint has implemented imaging cost controls in Colorado, Nevada, New Hampshire, Connecticut and Maine, and plans to extend the program to Indiana, Ohio, Kentucky and Virginia this spring. The company says that where it has imple-
mented controls, it has lowered the annual rate of increase in spending on scans to below 10% from the 20% to 25% increases it sees in other areas. But in 10% of all cases it reviews, its clinicians redi-

care, sometimes to a more-advanced and expensive test because it might be more appropriate.

"In many cases we're suggesting go-

ing right to a [more-expensive] PET scan, versus a CT scan first, because we can prevent that patient from having du-
plicate tests," Dr. Nussbaum says.

Concerns Over Red Tape

But some doctors say these efforts smack of the old-style managed-care con-

trover-
sies that have largely fallen out of favor in recent years because of concerns that they placed too many limits on access to care. In addition, the perception that decision making will only delay patients' care and produce more red tape, these doctors say.

That already happens in seeking authori-

zation to perform scans for worker's com-

pensation cases, says Shahid Mian, an

orthopedic surgeon in New York. "Some-
times it takes weeks, even months," says Dr. Mian, who worries the same might happen in regular medical cases.

He and other doctors also argue that overly stringent criteria will restrict ad-

vanced medical scanning to hospitals and big diagnostic imaging centers able to make such costly investments, forcing patients to make an extra appointment and trip to get a scan.

Requirements for Providers

In Pennsylvania, one of Highmark's most-stringing changes is that it will pay for CT or MRI scans only at locations that make the testing available for at least 40 hours a week, plus some Saturdays, and have at least one accredited radiologist on site during normal business hours. The idea is to ensure that only the most-experienced providers will be eligible for the program.

Mark Goodman, an orthopedic onco-

logist in Pittsburgh and president of the Allegheny Medical Society, says, "We see a lot of poor tests done or from centers where no one is in attendance, so from that point of view, Highmark is right on." Highmark says it has made some ex-

ceptions to its standards in rural areas to avoid access problems.

If Congress approves the recommenda-

tions for Medicare, they could spur imaging centers, radiologists and other doctors to implement nationwide standards. Congress often passes the recommenda-

tions of Medpac, an independent panel set up to advise it. It would then be up to the Department of Health and Human Services to draft the specific guidelines for imaging professionals and equipment.
Health Care in the Service of Science?

Uwe E. Reinhard

Citizens of the United States pride themselves on having the best health system in the world, bar none. The jewel of this system is a vast medical research enterprise, which truly is the envy of the world. It may therefore come as a shock to see a distinguished American ethicist and student of health policy take this research enterprise behind the woodshed, so to speak, for a solid verbal spanking.

In *What Price Better Health? Hazards of the Research Imperative*, Daniel Callahan, director of the International Program at the Hastings Center, takes the U.S. medical research community to task for marching blithely to its own scientific, ethical, and economic drummers without regard for the long-run social and economic consequences it visits on the rest of society. In the process, he explores in depth the many ethical dimensions of modern medical research—including the risks and benefits associated with technologies such as genetic engineering, stem cell research, and cloning; safeguards for research on human subjects; and the proper roles in society of government, universities, and the pharmaceutical industry.

Callahan acknowledges the great contributions America's medical research has made, and will undoubtedly continue to make, to human well-being here and abroad. But he argues for a new public science policy that integrates medical research fully into the nation's health care system. Instead of a policy governed by the self-serving moral imperatives medical science finds congenial to its purpose, or by the pure profit motive that contemporary medical research increasingly finds congenial as well, he advocates one that is inspired by the overarching goal of equitably enhancing the state of health of entire populations.

Callahan has more collectivist vision of social welfare than that guiding contempo-

ery medical research (which, he argues, develops more and more to the dictates of the market). In his view, the social value of medical research and the health care it begets should not be determined by the economic position of its recipients—as it is in a market economy (1)—but by more egalitarian norms. On such norms, it does not make sense to spend billions upon billions on technical innovations that merely produce marginal improvements in the health and well-being of well-to-do or well-insured Americans, when millions of other Americans (including millions of children) must go without already well-established medical technologies known to be highly cost-effective. He sees marginally beneficial medical technologies as one of the major culprits for the rising prices that push ever more Americans out of the health insurance system and into the growing corps of the uninsured.

Callahan develops his critique by raising a series of provocative questions, each of which he explores in a separate chapter. Some of these chapters seem longer than necessary, and occasionally the author wanders far from the topic at hand. Even so, the book contains so much thoughtful discussion and valuable insight that it is bound to become a staple in courses on science policy and a must-read for anyone concerned with medical research and, indeed, with health policy at large.

After providing a brief history of medical research in the United States, Callahan sets forth the moral foundation on which all research should rest and the social responsibilities that foundation implies. Against this backdrop, he rejects the idea that science has a moral mandate to pursue new knowledge wherever it may lead. He considers it folly to fund, with taxes or high prices for research, the pursuit of new medical technologies "with no foresight or strategy in place to deal with the economic and social consequences, many of which can be realistically imagined." Callahan also rejects the idea that society should rely on the professional ethics of medical researchers to prop-

eraly assess these consequences or to balance the potential benefits from research against the associated physical risks. Instead he advances the rigorous public oversight now imposed on research on human subjects "as a model for all research, as an antidote to an overweening research imperative."

Many readers will take issue with some of Callahan's propositions, as is to be expected from a provocative book. In his chapter "Doing Good and Doing Well," for example, Callahan asks whether the pharmaceutical industry will ever be "willing to sacrifice some significant profit to carry out its altruistic mission."

That question betrays a misconception of Anglo-American capitalism, which defines the social responsibility of a publicly traded corporation simply as maximizing the market value of the shareholder's stake in the corporation without violating the laws of the land. That pharmaceutical companies often style themselves as altruistic enterprises may strike Callahan as hypocritical, but it is merely effective public relations in the pursuit of society's mandate to the industry: to maximize shareholders' wealth, period. If a nation chooses to entrust a large part of its medical research to the power of this mandate, it cannot fairly expect these companies to behave like nonprofit institutions.

Callahan's plea for a science policy that serves an egalitarian health system clashes with the newly emerging, 21st-century vision of American health care, which increasingly treats health care as inherently a private consumption good, just like food, clothing, and shelter. Of these basic commodities, all civilized societies with the means to do so allocate to every individual, regardless of ability to pay, a basic ration. But beyond that basic ration, present-day societies allow the quantity and quality of these commodities to vary enormously according to their recipient's ability to pay for them. Current political winds suggest that, in the United States at least, this distributive ethic is likely to be imposed also on many of tomorrow's wondrous but costly new medical technologies.

In the end, then, *What Price Better Health?* represents less as a critique of the nation's medical research enterprise—which strikes me as perfectly attuned to American
More Physicians Make Spiritual Well-Being Part of Health Profiles

THE QUEST FOR good health is turning inward.

Increasingly, the medical profession is promoting the notion that a person’s spiritual well-being may be as important a factor in long-term health as are diet and exercise.

The value of spiritual health has been recognized by certain health-care professionals for some time, but now it has become a widely accepted area of medical study. A search in the Medline database of medical journal articles shows more than 600 papers dealing with the issues of spirituality and health. The Harvard University Medical School’s department of continuing education this month hosted a conference on spirituality and healing.

In these instances, spiritual activity is broadly defined—moving beyond religion to include meditation or even just relaxation exercises and calming experiences.

In the fall, Alternative Therapies in Health and Medicine published a small study highlighting the role spiritual well-being may play in the reversal of heart disease. In it, North Carolina physician Edwin Morris reviewed a well-known heart disease study that found participants who made significant lifestyle changes, including regular meditation along with diet and exercise, posted a reversal in heart disease, unlike the group that didn’t make such changes.

Dr. Morris tracked down 14 members of the original Dean Ornish study and gave them a widely used questionnaire to assess each individual’s spiritual well-being. Questions focused on issues such as a person’s sense of meaning and purpose, level of materialism, altruism and idealism, and feelings about things considered sacred or tragic.

In the study, Dr. Morris found that, on average, the group with the highest reversal of heart disease also scored 24% higher on the spirituality scale. Some scored as much as 50% higher.

Because the highly spiritual patients also had adopted other lifestyle changes, including diet and exercise, it is impossible to know how much of a factor spiritual health had on physical health.

Also, the study was too small to be conclusive.

The spiritual chasm between the two groups is so significant, however, the study strongly suggests that spiritual well-being plays a profound role in physical health.

“You don’t know the cause and effect, but what you do know is the spirituality scores correlated with a reversal of disease,” says Dr. Morris, medical director of the Franklin Cardiac Rehabilitation Program in Franklin, N.C. “I think there’s enough evidence that it’s an important risk factor.”

One explanation for the health benefits of spirituality and religion involves the body’s ability to manage stress. Stress is a well-documented culprit in heart disease, insomnia, hypertension, depression, chronic pain and sexual dysfunction, among other health problems. Stress triggers a biological response that includes the release of adrenaline and other chemicals.

The body also can evoke a relaxation response that triggers a variety of chemical and body changes, including decreased brain activity and lower blood pressure and heart rate. The response can be evoked by repetitive thoughts during meditation, breathing exercises, repetitive movements used in martial arts like T’ai Chi, or repetitive prayer, such as saying a rosary.

A study last year in the Brain Research Review found that the relaxation response as well as the placebo effect—in which patients report improvement despite taking only a placebo—are both linked to the body’s production of nitric oxide, which controls other chemical changes. A May 2000 study in the medical journal Neuroreport used magnetic resonance imaging to document the effects of meditation on the part of the brain involved in attention and control of the autonomic nervous system.

A number of studies have found that patients who take part in behavioral programs that include relaxation techniques report fewer medical symptoms.

The benefits may go even beyond health. Last spring, the Journal of Research and Development in Education found middle-school students who were exposed to relaxation techniques had higher grade-point averages, work-habit scores and cooperation scores than other students.

Harvard University Medical School Associate Professor Herbert Benson is studying the effects of daily prayer on physical health. “Every single culture of humankind has evolved quiet prayer or meditation,” says Dr. Benson, founding president of the Mind/Body Medical Institute in Boston.

“These are ways to escape the stress of everyday life, and when people do that, they tap into the innate evolutionary-derived healing capabilities nature has given us.”

But while techniques for diet and exercise are obvious, many people don’t know how to focus on spiritual health, or are turned off by the notion. People who don’t consider themselves religious, however, may rate high on the spiritual scale, while a regular churchgoer may score low.

Doctors recommend that patients, particularly those with significant health problems, find a daily spiritual activity such as meditation, yoga or prayer. Job satisfaction, volunteer work or time spent enjoying nature also can be beneficial. “Anything that helps you connect to other people is an important factor, as is anything that enhances the sense of mission or purpose in your life,” says Dr. Morris.

E-mail comments to healthjournal@usj.com.
Mere Magazines

By Thomas P. Stossel

Recently I was working in a Zambian orphanage when a young woman with worsening shortness of breath and chest pain asked me for help. Armed only with a stethoscope, I could do nothing other than diagnose a probable lethal tuberculous infection of the heart. Without devices and drugs developed by companies, doctors are not very useful.

It was therefore discouraging to return to my Boston-based medical center and witness leading medical journals sanctimoniously denouncing not only the technologies developed by drug companies but also the companies themselves. The Journal of the American Medical Association has declared industry-sponsored research categorically untrustworthy, and, to publish it, demands that an academic researcher be an author and take responsibility for its integrity, and also that an independent academic statistician analyze its data. This and other journals rail obsessively against "financial conflicts of interest" of academic researchers working with companies and conduct inquiries to identify every possible financial motive that might corrupt researchers' objectivity.

The ongoing Merck situation is a case in point. The New England Journal of Medicine wants the company to correct a five-year-old paper that, they allege, inappropriately excluded three late-breaking adverse events associated with the painkiller Vioxx. The company has correctly responded that published research projects always have defined beginnings and endings, and that it reported all adverse events to the FDA. With the drug off the market and Merck mired in litigation, what problem this correction would solve is unclear. Nevertheless, a Dec. 11 New York Times editorial excoriated Merck for "manipulating a journal article" and informed doctors "that they will need to take the findings of industry-backed studies with skeptical caution."

The message in all this is clear: Medical academics are saints—devoted selflessly to patient care—and corporate people are sinners, morally blinded by greed. But having worked in academic medicine for over 35 years and consulted for companies, this Manichean duality is inconsistent with my experience and a woeful distortion of reality. In a Sept. 8 article in the New England Journal of Medicine, I reported that no systematic evidence exists that corporate sponsorship of academic research contributes to misconduct, bias, public mistrust or poor research quality.

Why are scientific journals regarded with such reverence?

On the other hand, many academic colleagues working in my field of basic biological research (I study how your body cells crawl around, which has no obvious commercial value) would run over their grandmothers to claim priority for a discovery, impose their pet theory on the field, obtain a research grant, win an award or garner a promotion. It's the same in other scientific fields, and no wonder, because for relatively modest remuneration we compete for scarce resources and labor in obscurity to achieve small advances few understand or appreciate. We exercise our ambitions by publishing research papers in high-profile journals.

The research journal revolutionized scientific communication in the 17th century. But until the scientific enterprise grew larger than the first journals could accommodate, no peer review restricted publication. Once restrictions arose, human competitiveness established a journal prestige pecking order that grew in importance as research became more prevalent and complex. The more obscure one's research, the greater the premium on publishing it in a prestigious journal, where those who administer limited rewards might see it, and where the news media are more likely to hype it.

But unbeknownst to the media, the journals at the top got there because of herd behavior by researchers, not because they are better than lower-tier journals at vetting research quality. Here's why: Researchers submit their best work to the top journals, which can therefore afford to maintain their prestige by rejecting, not publishing, many high-quality papers. That's brand creation—not science. Most of their editorial effort goes into deciding which submitted papers are sufficiently newsworthy. Anonymous peer review by jealous competitors has its merits, but it has a tendency to select for fashionable if relatively unoriginal and inoffensive papers. Top medical journals compete for papers describing large clinical trials reporting small effects of treatments for diseases affecting many people, although these reports often do not substantively advance scientific knowledge, and many subsequently are invalidated.

And no description of medical research in a medical journal comes close to the detail level or intense scrutiny imposed by the FDA on companies' documentation of drug or device development before approval. Space constraints for readability and cost-savings preclude journals from publishing detailed information on the order of what companies file with the FDA, and unpaid journal peer reviewers, not to mention practicing doctors, would never read it anyway. The recent Korean cloning fiasco, in which the leading science journals published blatantly fraudulent papers, wasn't the first such incident to afflict prestige journals, and it could never happen under conditions of FDA review. Indeed, doctors should take all studies published in "prominent medical journals" with "skeptical caution."

The lower stringency of journals compared to the FDA is a good thing, because academic biomedical research would come to a screeching halt if subjected to anything even approximating FDA examination. Scientific knowledge advances reasonably efficiently, and new technologies emerge, despite the looseness of journals. And researchers' craving for prestige goads them to greater efforts.

If reporters understood that journals are magazines, not Holy Scripture, we might not be witnessing ever more onerous regulations inhibiting interactions between academic and industry science. Prestigious biomedical journals are good for our health—provided they stick to their core business of facilitating imperfect communication between researchers. Leave drug and device monitoring to the FDA—and theology to theologians.

Mr. Stossel is American Cancer Society Professor at Harvard Medical School and co-director of the division of hematology at Brigham and Women's Hospital.

Daniel Henninger is on vacation.
How health costs are causing big problems
(The economic effects on state budgets and worker pay)

- Health costs decrease the take home pay of workers.
- State spending on health care goes up.
  - This decreases spending for other purposes.
- Federal spending on health goes up & up.
  - And the states try to shift their costs to the federal budget.

The USA health spending is much higher than any other country, yet health outcomes are not better (or so they say).

The real compensation of workers keeps going up because of more production per worker (from machine use, automation, etc.), but health costs keep the take home pay from rising much.
The companies have to pay more for "benefit" — health care & social security. The effect of those added costs is to lower the hourly wages.

Source: Econ Report of President Feb 1994

Government budgets keep spending more and more for health care.
Chart 1-2 shows the remarkable slowdown in productivity that occurred around 1973—from an annual average of 3.1 in the 1947–73 period to just 1.0 percent since 1973. In downturn is exaggerated by the fact that the first few were aberrant: There was much catching up to do an Depression and the Second World War. But America's average productivity growth rate over the century leading 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. Even seemingly modest changes in productivity can have dramatic effects on living standards in the long run. Thus the Nation has much at stake in improving its productivity growth rate.

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 as profit-oriented firms reacted to higher labor costs by trimming their work forces. It is only steady productivity gains that enable the economy to generate more jobs and rising real wages at the same time. Chart 1-2 shows
Chart 4-4  Health Expenditure and Life Expectancy in Industrial Countries
The United States spends more on health care yet has lower life expectancy than would be expected given its level of income.

Deviation from predicted life expectancy (years)

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Worse outcome, lower expenditure

Worse outcome, higher expenditure

Deviations from predicted health spending per capita (dollars)

Note: Health spending and life expectancy are deviations from what would be expected given per capita income. The sample consists of the member countries of the OECD.

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- This is a sad chart for the US
- The USA has higher health costs and less benefit than other countries
- What gives us such high costs?

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