Some health care debates in several countries.

How can we give good care and control costs?

Example of Medicaid fraud in New York.

Health costs go up, companies have employees pay more.

States try to shift health costs to federal government.

Hospitals have been pushed to control costs.

The high costs are hurting health care itself.
  • Is there any way to get a balanced system?

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Roy Jenne
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For Kara J. Trott, becoming an entrepreneur meant leaving her corporate law career. It meant resigning from a nonprofit board she no longer has time for and giving up her vacations. And in the early days it meant taking out a home-equity loan and moving to a smaller house.

But the new Kara Trott—the super-busy one in the more modest home—has never been happier. The company she started in 1999, Quantum Health in Columbus, Ohio, helps patients navigate the complexities of the health-care system. “When someone is diagnosed with cancer or diabetes, it is the most difficult time in their lives,” says Trott, 44. “It gives me the greatest satisfaction that I help people make the right decisions during those critical moments.”

In her prior life many of Trott’s legal clients had been hospitals or doctors. She witnessed the insurance industry’s attempts to shift health-care costs by cutting reimbursements to physicians and hospitals and by increasing employees’ deductibles and co-payments. Trott also had worked as a consumer products consultant, and she thought some of the techniques used in that industry, such as providing incentives to get people to buy, could be applied to health care to encourage patients to reduce spending. That would help everyone in the system, from patients on up. “I wanted to create something and make a change in people’s lives,” says Trott. “Of course, everybody was skeptical.”

Undeterred, she tracked health-care decisions from 2,800 patients, 260 physicians, and 140 employers, using data supplied largely by her law firm’s clients. She found that half of patients left their physicians’ offices not knowing what to do. Only 15% got answers to their questions, and 61% of the time patients chose the wrong type of specialist. That misstep generated an average of $3,500 in extra costs. And Trott found that most patients wanted more guidance in choosing health care.

Data in hand, Trott quit her job. She told employers that her company would call their employees when they made doctors’ appointments. Quantum would arm the employees with pertinent questions, help them choose the right specialists, give them advice about which tests to take, and ensure that tests weren’t duplicated. Quantum would get a percentage of any savings the employers reaped. It would also offer workers incentives to stay well, such as by slashing co-pays for preventive care visits.

Her pitch worked. Trott’s first customers, mostly small, self-insured companies, averaged 6% increases in their health-care expenditures in 2001, compared with a national average of about 11% at the time. In 2004, according to a study of 600 patients by Appleton (Wis.) benefits consultant Associated Health Group, Quantum made 970 telephone calls to patients, compared with 27 by a disease management company assigned to assist employees with chronic ailments. “Quantum takes disease management to the nth degree,” says Associated’s vice-president, Jeff Prickett.

Still, the first few years were slow going. “In the health-care business it takes an average of three years before people believe that results you’re generating aren’t an anomaly,” says Trott. She invested $400,000 of her own money and raised $300,000 from family and friends before taking out a Small Business Administration-backed loan in 2004 for $730,000. In 2002 she hired a professional management team, including her husband, strategy consultant Randy Gebhardt, as COO.

Now, Quantum is on a tear. Last year the number of patients Quantum oversees doubled, to 52,000. Trott doubled her own employee base, to 55, and 2005 revenues shot up 40%, to $7 million. “If we had gone to employers in 1999 talking about the importance of wellness and disease management, they would have laughed me out,” says Trott. Now they’re begging her to come in.
Medicare premiums increasing in 2006

Growth in services blamed, along with aging population

By Kevin Freking
ASSOCIATED PRESS

WASHINGTON — Senior citizens and the disabled will have to pay a monthly Medicare premium of $88.50 next year for doctor's visits and other services, a $10.30 boost in the fee.

The 13.2 percent increase in premiums for Medicare Part B was in line with what government actuaries had been predicting.

The Bush administration tried to lessen the pain of the announcement by touting the prescription drug benefit that begins Jan. 1.

However, conservative Republicans plan to call next week for a one-year delay in implementing the new Medicare prescription drug benefit as a way of paying for Hurricane Katrina recovery.

"Most seniors are not going to know what to do with it anyway," said Rep. Lynn Westmoreland, R-Ga.

Under the program, millions of low-income Americans will have their prescription drug costs covered almost entirely, and many other beneficiaries should see their out-of-pocket costs for prescription drugs decrease.

"Next year, people on Medicare will be getting much more in benefits than they had previously received," said Herb Kuhn, director of the Center for Medicare Management, part of the Health and Human Services Department.

Beneficiaries, through their premiums and other fees, pay about a quarter of the expenses for Part B, or supplemental insurance. Taxpayers pick up the other 75 percent.

Kuhn said an increase in the number and intensity of services that doctors provide is driving the increase in the premiums. The volume of physician services grew at a rate of 6.3 percent last year and is expected to grow 5.6 percent this year. The volume of hospital outpatient services has grown at a similar rate.

Kuhn said the Centers for Medicare and Medicaid Services did not have a good understanding of whether the increasing volume of lab tests, office visits and the administering of drugs by physicians was entirely necessary.

CMS officials say the rapid growth in services proves the need to move away from a reimbursement system that pays simply for more services, regardless of their impact.

The American Medical Association, in news releases issued earlier this year, defended the increase in services by noting that conditions once requiring hospitalization are now routinely treated in a physician's office at a lower cost to the government and patients.

"Americans are living longer than ever, more are entering Medicare, and chronic disease continues to increase, which naturally leads to an increased need for physician services," Dr. James Rohack, a member of the AMA Board of Trustees, said at the time.
Whenever Washington decides to fix something, it only gets worse. Take Medicare. New government mandates on health insurers will force a lot of poor senior citizens to pay their medical costs out-of-pocket.

Right now, about 17% of the 36 million seniors on Medicare get their health care through health maintenance organizations. Under this arrangement, the federal government pays the HMO a fixed annual fee to provide care. Many seniors like it this way. HMOs often cover things that Medicare doesn’t, such as prescription drugs. And most plans reduce seniors’ out-of-pocket expenses, so they don’t have to buy supplemental “medigap” policies.

The Medicare+Choice program, passed as part of the ’97 Balanced Budget Agreement, would allow seniors even more private-sector options. Assuming, of course, the private sector doesn’t pull out of the program first.

That’s a real possibility. Thirty-three of the 347 HMOs that offer Medicare services for seniors announced in early October that they intend to pull out of some 300 counties they currently serve.

The reason: dwindling returns. HMOs can no longer expect decent compensation from the federal government for their services. Some 195,000 beneficiaries will be affected. And another 31 HMOs have decided to curtail benefits for 44,000 seniors. Several more HMOs have said they plan to take similar measures soon.

Washington’s response? Sen. Christopher Dodd, D-Conn., says he may introduce a bill to prevent HMOs from leaving the Medicare system for at least six months, in an effort to halt the exodus. And President Clinton has hinted recently that he may impose a moratorium on health plans leaving Medicare.

How did this happen? The Health Care Finance Administration, the agency that oversees Medicare, made health plans submit cost estimates two months before the new rules for Medicare+Choice were written. Naturally, the new regulations will raise HMOs’ administrative costs, which weren’t covered in the original bids. When some firms asked to resubmit their bids after the new rules came out, HCFA turned them down.

Critics say HMOs could stand to provide coverage for a little less in return. Rep. Pete Stark, D-Calif., claims that health plans overcharged Medicare by 3% in ’97.

Said HCFA Deputy Administrator Michael Hash recently: “Given such extensive evidence of overpayment, there can be no doubt that what we are paying plans is adequate.”

If most health plans were making big profits by overcharging the government, wouldn’t you expect to see them lining up to join the program? They aren’t.

In fact, the oldest and best established health plans are pulling out, while several smaller start-ups are applying. That raises real concerns about the quality of care.

Even if health plans made large profits in the past, several years of intensifying competition and pressure from employers to cut costs have reduced profits significantly. A recent analysis of 506 HMOs by Weiss Ratings Inc. found that 57% of them lost money in ’97.

Under the proposed new rate increases, many plans would get only the minimum of 2%. But costs are rising 5% to 6%, as private health spending is expected to increase — from a 2.9% average annual rate to a 7.2% rate by ’01. Faced with such potential losses and the prospect of providing inadequate care, HMOs have little incentive to stick with the program.

That’s bad news for seniors, especially those who live in rural areas. They’ll be hurt the most because the HCFA has decided that reimbursement increases will be disproportionately lower for many rural areas of the country.

The irony is that organized medicine has been trying for years to increase medical access to “underserved areas,” since few physicians are willing to sacrifice higher incomes to serve low-income, rural populations. Some Medicare HMOs were willing to work on correcting that problem. Not anymore.

Backers of national health insurance point to the Medicare program as one model for a nationwide system. But the reality is that HCFA intrusion, often at the behest of Congress, is undermining the quality and availability of care — a fact thousands of unfortunate seniors may soon learn the hard way.

Merrill Matthews Jr. is vice president of domestic policy at the National Center for Policy Analysis in Dallas.
Creative Accounting for Medicaid

Bush Budget Proposal Targets Loopholes That States Use to Garner More Federal Funds

By Sarah Lueck

WHEN THE NATION’S governors go to the White House on Monday, they are likely to deliver a blunt message to President Bush: Keep your hands off our Medicaid loopholes.

In his latest budget request, Mr. Bush took aim at an array of strategies that he says states use to improperly inflate their Medicaid costs and thus qualify for more federal matching funds for the state-federal health program for the poor. Health and Human Services Secretary Michael Leavitt called the tactics, long a source of friction between Washington and the states, the “seven harmful habits of highly desperate states.” By outlawing many of them, the administration figures, it could save $40 billion over 10 years in the fast-growing program.

But the states are fighting back and their governors will make their case in the coming White House meeting during their conference in Washington. Carol Herrmann, who is head of Alabama’s Medicaid program and considered one of the most effective state officials in procuring federal funds, says states’ use of creative accounting methods, “is exactly what all of us do when we do our income taxes every year: We looked at the law and used the law to our advantage.” In Alabama, she says, the extra federal funds have been spent on better prenatal care for poor women—care that couldn’t be provided if the funds disappeared.

Officials in other states agree. The maneuvers used by some states to draw down more federal dollars often are hatched by the most ingenious and entrepreneurial people in state government, the equivalent of Wall Street investment bankers. They pursue new ways to raise money—not because the funding partnership, "he told the Senate Finance Committee last week.

States get federal matching payments for 50% to 77% of their Medicaid spending, depending on their per-capita incomes. But some states have in effect increased their matching rates by using accounting to artificially inflate their contributions, according to the HHS Inspector General and the Government Accountability Office.

“There are 50 different sets of rules and no one’s playing by the same ones,” says Tom Scully, a health-care lobbyist who fought states on the issue first as a White House budget official in the 1990s and more end up in state coffers.

A county nursing home may submit a claim to a state, which the state sends on to the federal government to receive a matching payment. Then the state keeps some of the federal payment, rather than sending it back to the nursing home. In some cases, federal officials say, that federal payment may be recycled for another federal matching payment. The result: The federal government kicks out extra matching payments without comparable spending by the state or local government.

This fiscal year, Alabama expects to bolster its Medicaid spending by about
Sunshine for Medicaid

Congress is patting itself on the back for trying to pass a budget that makes small reforms in Medicaid and saves a few billion dollars. But as usual the real policy action is in the states, and especially in Florida.

Last week Governor Jeb Bush signed a far-reaching set of reforms in Medicaid, the healthcare entitlement that covers 2.2 million Floridians and is breaking budgets in all 50 states. However, instead of eliminating services, reducing payments to providers or limiting access, the Sunshine State is rethinking how to deliver care to the poor over the long term.

Florida will spend a record $15.5 billion on Medicaid this year, or 24% of the state budget. "We have a system now that costs a huge sum of money and yet the sick continue to get sicker," Governor Bush tells us. With the reforms, the state expects to cut spending growth to 6% a year compared with 13.5% a year over the past five years. And it will do so "with better health-care outcomes," the governor says.

The hallmarks of the Florida reform are consumer choice and competition. Each participant will be assigned a premium with which to purchase coverage for basic and catastrophic care from a menu of state-approved options. If this sounds familiar, it is. Many private companies offer similar options to their employees, as does the federal government, which allows workers to select from a list of competing private plans.

For critics who argue that competition won't work for the sick and disabled, Florida has an innovative answer: risk-adjusted premiums. Under the new legislation, someone with a serious illness or disability will receive a higher premium than a generally healthy person. The aim is to encourage private insurers, HMOs and local networks of physicians and hospitals to compete for their business.

Mr. Bush points to two other innovations. Patients who follow the medical plan laid out for them by their doctors—take their medication, stop smoking, have their children vaccinated—will earn extra money that will be deposited in flexible-spending, health savings accounts. They can use that money for services not covered under their basic plan or to purchase more expensive coverage. That financial cushion will also help participants shift to the private healthcare sector, if they return to work. So too will a feature allowing recipients with jobs to use their state-funded premiums to buy employer-provider health insurance if they prefer.

The Sunshine State's program is expected to go into effect next summer in half the states. The aim is to introduce choice statewide within five years.

Some of these ideas may not work in the end, but the point is to experiment to see what does. Medicaid is growing by 8% a year, and it has changed over the years from a program solely for the poor into a long-term insurance substitute for the parents of middle-class baby boomers. Something has to change, or taxes are going to keep rising everywhere.

To implement its reforms, Florida needed a waiver from Health and Human Services in Washington. And legislation that has already passed the House would provide more such state flexibility, including the option of charging premiums and higher co-payments for services. South Carolina, where 20% of the population is on Medicaid, is experimenting with reforms similar to Florida's, and Governor Bush says Texas, Kentucky and Mississippi have also expressed interest. State innovation is the way welfare reform began, and we're glad to see it now happening on Medicaid.
How to Bring Medicaid Spending Under Control

BY PETER FERRARA

Medicaid’s runaway costs are ravaging federal and state budgets. The program is expected to cost $338 billion in the current fiscal year, up $80 billion, or about 31%, in just the last three years.

The feds pay about 57% of the program’s costs, the states the rest. The Congressional Budget Office says that Medicaid will be one of the main causes of the looming explosion in federal spending over the next few decades. If current trends continue, federal Medicaid spending alone will grow from 1.5% of GDP today to about 4.5% by 2050.

State Medicaid spending has now grown to almost one-fourth of total state budgets—more than state governments spend on education. Conservatives who believe in smaller government must lead reform of this program to stop these exploding costs. Fortunately, practical and feasible reforms have already been developed that would achieve precisely this.

Block Grant Approach

The model is the mid-1990s reform of the old Aid to Families with Dependent Children (AFDC) program. Following that model, federal Medicaid spending would be replaced by block grants to each state for their own programs for the poor. The state programs would have to be based on a work requirement for able-bodied recipients for the state to receive the federal funds.

After such reforms, the number of recipients in the old AFDC program dropped by over 50% nationwide, with states with the strictest work requirements reducing their rolls by close to 80%. The reforms succeeded because they changed the incentives for the states as well as the recipients.

As with Medicaid today, the states received a dollar or more in federal funds for each dollar they spent on the old AFDC program. So the states had the incentive to sign up more welfare recipients, bringing more federal money to the state.

But the reforms provide for a fixed block grant amount for each state, regardless of how much the state spends on its program. Any excess costs the states incur under their programs are now paid by each state alone. Moreover, any savings each state achieves under its program is kept by the state, freeing up state funds for other uses.

With these reversed incentives, the states moved aggressively to get recipients off welfare, and limit assistance to new applicants who were truly needy. The states were helped in this because work requirements for the able-bodied eliminated incentives to go on welfare. If you have to work anyway to receive assistance, then you may as well take a job in the private sector, where you can get raises and promotions over time.

These same reforms adopted for Medicaid would again produce major savings. Yet, even keeping total federal spending on the block grants at the current level of federal Medicaid spending, with no federal reductions for the state savings, would still save the Feds almost a trillion dollars over the next 10 years in increased Medicaid spending that would have otherwise occurred without the reforms.

After that first 10 years, the federal block grants could be limited to grow no faster than GDP. Medicaid would then not cause any future increase in federal spending relative to GDP.

As an added benefit, such Medicaid reform would also make Social Security reform involving large personal accounts more feasible. The enormous long run federal saving would be more than enough to cover the transition to large personal accounts as proposed by Rep. Paul Ryan (R.-Wis.) and Sen. John Sununu (R.-N.H.). Those large personal accounts, averaging roughly the employee share of the Social Security payroll tax, would in turn make Medicaid reform more feasible. With workers saving and investing in such large personal accounts over their lifetimes, they would each retire with several hundred thousand dollars in their accounts in real terms, close to a million or more for average, two-earner couples.

If conservatives want to reduce big government, rather than see it explode into full grown, old-fashioned, Scandinavian socialism, then such Medicaid reform needs to be an urgent priority.

Mr. Ferrara is director of entitlement and budget policy for the Institute for Policy Innovation and a senior fellow at the Free Enterprise Fund.
THE RISING COST of health care is
becoming an American obsession—
among business executives, politicians,
workers and retirees. Would-be reformers
everall gloom across the Atlantic,
or to Canada, and wonder if
their systems, though plagued by long
waiting lists and other well-publicized
shortcomings, offer ways to slow the
growth of health-care spending.

But economists at the Organization
for Economic Cooperation and Devel-
opment, a think tank in Paris backed
by 30 developed countries from
Australia to the U.S., are waving a
red flag.

In a recent report, these econ-
omists say government spending on
health care in industrialized countries
is on track to increase from an average
of 6.2% of gross domestic product today
to 12.8% by 2050 “in the absence of pol-
icy action to break with past trends.”

The trend, they say, is for government
spending on health, even adjusted for
aging populations, to rise 1% faster
than incomes.

And even if governments somehow
find a way to eliminate that extra one-
percentage point of spending growth,
the OECD expects public spending on
health care, including long-term care
for the elderly, to reach 16% of GDP
on average. The projected increases are
sharp even in countries that have
kept overall spending on health care
far below the U.S., which spends
more per person and a greater fraction
of its GDP on health care than any other
country.

“If you add these costs with other
rising social expenses—education, pen-
sions and poverty [reducing] pro-
grams, it becomes quite difficult to
manage. This makes it very important
that governments control spending and
set clear [budget] priorities,”
says Joaquim Oliveira Martins, one of
the report’s co-authors.

The urgent implication, says Ger-
ard Anderson, an economist at the
Johns Hopkins Bloomberg School of
Public Health, is that governments—
especially the U.S.—need to focus the
added spending in ways that lead to
better medical outcomes. “We’re go-
ing to spend more, but the question is
whether health care is going to get
better in the future,” he says. The
OECD report “tells all the countries
that they’ll have to do something” to
try to control spending, he continues.

“The next question is ‘What do they
do?’ Each country has a different pre-
scription.”

Adds economist Karen Davis, presi-
dent of the Commonwealth Fund, a
philanthropy that studies health- and
social-policy issues: If health spending
“is well directed, it can get a good re-
turn” in terms of education and worker
productivity. “Just spending more
doesn’t mean you’re spending on the
right things.”

AMONG THE BIGGEST drivers of
health spending around the globe are
the cost of medical technology and
the effect of aging incomes. “When people become richer, they
spend more on health care,” says Mr.
Oliveira Martins.

Aging populations also will push up
health-care costs: Older people tend
to use more health care. But the OECD
says a less commonly recognized
driver is the cost of long-term care for
disabled or elderly people who cannot
eat, bathe or dress themselves. Fami-
lies are less likely to provide this care
in the future, the OECD predicts, as
more women in nations such as Italy,
Ireland and Spain enter the work
force and other workers remain on the
job longer. That’s likely to increase
the government tab for long-term
care. Today, government-paid long-
term care accounts for 1.1% of GDP
on average among the 30 OECD na-
tions. By 2050, it is projected to triple
if current trends persist, and more
than double even under the OECD
“cost containment” scenario.

The OECD did the projections, in
part, to warn governments around the
world that the economic burden of
aging populations isn’t limited to pen-
sions, a subject of perennial political
debate in several countries, including
the U.S., where President Bush tried
unsuccessfully to reshape Social Secu-
ritv. “Despite the orders of magnitudes
involved, policy discussion in many
countries has focused less on health and
long-term care spending than on pension
spending,” the report says. It suggests
that analyzing problems and identifying
solutions with pensions is easier than
with health care.

IN MOST OECD countries, including
Canada and Britain, health-care sys-
tems are financed primarily through
taxes. In the U.S., by contrast, about
55% of the health-care bill is paid by
indivduals and their employers. Yet U.S.
government spending on health care—
mainly Medicare and Medicaid—
amounts to an above-average 7.2% of
GDP. (Overall U.S. health-care spending,
private and public, this year is projected
equal 16.2% of GDP.)

Averages, of course, mask striking
differences among countries. Italy, Ja-
pan and Spain are aging more rapidly
than other countries, and health-care
spending will rise accordingly. Mexico,
where government health-care spending
already accounts for 3.1% of GDP, is
likely to see rapid increases because it
begins from such a low base. Countries
with relatively low fractions of adults
in the workforce, such as Italy, Ireland
and Spain, may see a substantial in-
crease in demand for formal long-term
care if those adults go to work. And
countries like Sweden, which has an
older population than some other coun-
tries and whose government already
spends 8.6% of GDP on health care,
may not see as much of an increase.

Though their circumstances differ, in-
dustrialized countries face a common
challenge: An inexorable rise in the
share of government budgets devoted to
health care, a widespread conviction
that current trends are unsustainable and
little political consensus on what to do
about it.

ThyssenKrupp Is Preparing for Potential Sale of Big Automotive Unit
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, Camara, Boulder, CO
EARNINGS

Wal-Mart Stores Inc.: The giant retailer reported a 13.4 percent increase in fourth-quarter profits, beating Wall Street estimates, but also offered a cautious — and disappointing — profit outlook Tuesday as it struggles with higher interest expenses resulting from international acquisitions. Wal-Mart said net income rose to $3.6 billion, or 86 cents per share, for the quarter ended Jan. 31 from $3.2 billion, or 75 cents per share, a year earlier. Minus 2 cents per share from a one-time tax benefit, it earned just above the 83 cents per share projected by analysts surveyed by Thomson Financial. The retailer forecast first-quarter earnings per share between 58 and 62 cents and said it expected to earn $2.88 to $2.95 for fiscal 2007, which ends next Jan. 31. Analysts surveyed by Thomson Financial projected per-share earnings of 62 cents in the first quarter and $2.98 for the year.

Home Depot Inc.: The home-improvement retailer said fourth-quarter profit rose 23 percent, the biggest gain in two years, on sales of refrigerators, washing machines and kitchen cabinets. Net income at the world’s largest home-improvement retailer climbed to $1.29 billion, or 60 cents a share, exceeding analysts’ estimates. A year earlier, profit was $1.04 billion, or 47 cents. Sales increased 16 percent to $9.5 billion, Atlanta-based Home Depot said Tuesday.

US Airways Group Inc.: The airline blamed high fuel prices for its quarter-billion-dollar loss in the fourth quarter. But the company’s chief executive said the task of merging US Airways and America West was going smoothly, and he predicted the nation’s fifth-largest carrier would be profitable on an operating basis in 2006. The loss for the quarter ended in December was $261 million, compared with $69 million a year earlier. However, the per-share loss narrowed to $3.26 from $4.66, as the latest period had a greater

Health care may gobble 20% of economy by 2015

By Kevin Freking
The Associated Press
Feb 22, 2006

Washington — Within a decade, an aging America will be spending one of every five dollars on health care, according to government analysts.

The nation’s total health-care bill by 2015: more than $4 trillion. Consumers will foot about half the bill, the government the rest.

Hospital costs will rise more quickly than previously anticipated, reflecting a construction boom for urban hospitals.

Meanwhile, drug costs are expected to be somewhat restrained, in part because of the new Medicare prescription drug program.

The projections, published in the journal Health Affairs, come as President Bush focuses on the rising cost of health care. In his State of the Union address last month, the president pushed health savings accounts and the high-deductible insurance plans that go with them. The administration predicts Americans would become more thrifty if they had to pay more of the upfront costs, which occurs with health savings accounts.

The report, written by analysts with the Centers for Medicare and Medicaid Services, attributes rising costs to the aging of the baby-boom population and the changing nature of health insurance. They forecast a 7.2 percent annual increase in health-care costs over the coming decade. That’s in line with the 7.4 percent increase in 2005.

Still, the overall economy is projected to grow at a rate of 5.1 percent over the coming decade, which means health care will play an ever-growing role.

SKI: Lift tickets lure college students

< CONTINUED FROM IC

"Part of the advantage of pulling in college students is they’re able to pick up on the nuances a little more quickly," said Copper spokesman Carlos Garcia. "It’s not the really technical jobs. It’s a matter of needing the manpower."

Spring-break compensation at Winter Park and Copper — the two Colorado resorts run by Intrawest Corp. — will start at $8.25 per hour, plus a free lift ticket for each day worked. Other perks include free lessons, discounts on food and retail and temporary employee housing.

Copper is seeking roughly 80 student workers; Winter Park plans to hire about 40.

Students must commit to working at least four days over a one-week period in March.

Steamboat is looking to hire 20 students to work between March 11 and March 26, offering a free lift ticket for every five.

"It’s a good way to get some extra money if you have a busy spring break," said Steamboat’s Jeni Maron. St Wolters, the human resources director at Colorado State University in Greeley, said they have had to hire more workers to handle the influx of students over the past few years.

"But we have had student employees say that they’ve had a great experience as a result," she said, adding that some have even been hired full-time after the winter."
Canada’s ‘Free’ Health Care Has a High Price Tag

For many Canadians their 37-year-old universal health-care system is the symbol of their national identity. Last November, Canadian Broadcasting held a contest to pick the greatest Canadian ever. The clear winner out of 1.1 million votes cast was Tommy Douglas, a politician known as the “father” of Canada’s nationalized medicine.

But last June, a majority of Canada’s Supreme Court struck down a Quebec law that banned private health insurance and held that the public system inflicted cruel and unusual punishment on many of its patients. The Fraser Institute has found it takes an average of 17 weeks between the time a patient makes an appointment to see a general practitioner and when he can then see a specialist. He will then be treated by a system that ranks 13th out of 22 advanced countries in access to MRI technology; 17th out of 21 in access to CT scanners and seventh out of 22 in access to radiation machines. The safety valve in the system is that nearby U.S. hospitals can provide treatment for emergency cases and patients willing to pay.

But Canada’s public care doesn’t save money. As the satirist P.J. O’Rourke once noted, “If you think health care is expensive now, wait until you see what it costs when it’s free.” When adjusted for the age of its population, Canada vies with Iceland and Switzerland as the highest spender on health care among the 28 most developed nations with universal systems. Dr. David Gratzer, a Toronto physician affiliated with the Manhattan Institute, calculates that a Canadian earning $35,000 a year pays a stunning $7,350 in health-care taxes.

In Canada, the ban on private insurance results in truly loopy law. Dr. Sheldon Elman, the personal physician for Liberal Prime Minister Paul Martin, says the system is “disastrously terrible” in key areas. “You can buy an MRI for your dog and you cannot buy it for your daughter,” he said in the Montreal Gazette.

“You’d think the court’s ruling would lead to dramatic changes. A new Ipsos-Reid poll finds that 53% of doctors view the court’s decision “favorably.” But only 52% of Canadians, who have been conditioned for years to think that their health care is free, share that view. That has led to an abundance of caution among politicians. “The opposition Conservative Party has been extremely timid in proposing changes and this year even called for creating a new prescription drug benefit,” notes Michel Kelly-Gagnon, president of the Montreal Economic Institute.

Take Alberta, the country’s energy capital and the province that most represents Canadian individualism. With oil at $35 a barrel, it is awash in revenue and could afford to forego the health-care money it gets from the federal government. But for a decade Conservative Premier Ralph Klein has claimed he faced sanctions by federal officials if he went too far on reform. The June Supreme Court decision gave him the legal and political cover to be bold. Nonetheless, his new “third way” proposal to reform health care expressly bans Albertans from buying insurance to bypass waiting lists. It would instead allow them to buy insurance to upgrade to a better hospital room.

“Klein probably misses having the feds to blame for his inaction,” says Ezra Levant, publisher of the Western Standard, a feisty Calgary-based magazine. “Luckily, free-market entrepreneurs will fill the void, and they’ll have the courts on their side if politicians try to stop them.”

A milestone in private health care could come this October, when the Cope- man Healthcare Center plans to open a Vancouver facility that offers an array of elective services, no waiting times, and even house calls for an annual fee of $2,300 a year. The British Columbia nurses union denounces the clinic as “check-book medicine,” and is demanding it be blocked from opening.

Those who believe Canada’s debate isn’t relevant to the U.S. should think again. The Vermont House has approved a bill to establish a government-run health care system. So too has the California State Senate. Nationally, a 1997 law pushed through by the Clinton administration banned Medicare patients from paying for medical service covered by Medicare unless the physician agreed to forego reimbursement from all Medicare patients for two years. Regulatory modifications have softened the restriction, but it remains on Medicare’s books. Could it be revived under a Hillary Clinton administration?

A good way to prevent bad policy in the U.S. is to encourage reform in Canada. The door is already open. Ontario officials haven’t acted on their threats to close the dozens of private clinics operating there. Maybe it’s the Mayo Clinic or another major U.S. health care provider tested the limits of Nalda and floated stories that it wants to enter the Canadian market. The nationalistic feelings that would stir up might finally prompt Canadian politicians to accept home-grown private care.

If Canada wants to stop sending people to an early grave it will have to modify a health-care ideology that its own Supreme Court concludes is “disconnected from reality.”

Mr. Fund writes regularly for Opinion Journal’s Political Diary.
Canada Relents on Health Care
Strains on Its Model Public System Bring Private Growth, Concern

By ELENA CHERNET

Montreal

UNTIL SHE WAS HOBBL ED by hip pain last year, 73-year-old Gloria Gauvin went for a three-mile walk near her home in the Quebec countryside every day.

Now, 16 months after a nearby public hospital put Ms. Gauvin’s name on a waiting list for a hip replacement, she is barely able to get around the house. So she and her husband, Yves Cyr, are taking advantage of a new development on Canada’s health-care front. They have made an appointment to have the operation at a private clinic near Montreal in early April. The cost: about $10,000.

“We’re borrowing against our property,” says Mr. Cyr, a 22-year veteran of the Canadian Armed Forces. “If we have to sell our house because of this, we’ll go into an apartment. We don’t have a choice. We can’t wait.”

The couple’s willingness to absorb such financial strain to get medical help is a sign of the growing dissatisfaction here with the national health system and the increasing acceptance of private care. As provinces struggle to contain waiting lists for medical treatment under the country’s vaunted publicly funded health-care system, private care is starting to play a bigger role.

Canada, whose universal medical coverage has often been held up as a model for the U.S. health-care system, has long stood out as one of the only countries in the world to rely on a single-payer public system with no private-sector alternative for most services. Indeed, Canada’s federal health laws place strict limits on providing private care.

In some parts of the country, a so-called second tier of private, U.S.-style care options is taking root. In Quebec, the government is lifting its ban on private insurance for some services and plans to pick up the tab for hospitals to send orthopedic and cardiology patients to private clinics when queues get too long.

Alberta, the country’s most right-of-center province, proposed last week to go a step further than Quebec by setting up a more comprehensive second tier to create a system the province’s health minister has likened to that of some European countries. The Alberta model, which faces a public–private split period, would permit doctors to work in both the public and private systems and would allow patients to pay cash for a broader array of private services. Under Quebec’s new plan, doctors will have to continue to choose between billing the government or billing patients, and private insurance will be allowed only for hip, knee and cataract surgery. British Columbia’s government is also looking at a new model.

Alberta’s announcement is sharpening the national debate. Most Canadians still believe in their universal health-care system, and don’t want to see radical moves toward a U.S.-style system. Many policy makers worry that private systems, unless carefully circumscribed, would further drain resources—doctors and nurses—away from the public systems. Another concern: Wealthier Canadians might “queue jump” ahead of others in the public system by paying to get test results quickly from private providers.

Prime Minister Stephen Harper, whose Conservative government was elected in January, said Ottawa will review Alberta’s proposals carefully and expects the province to adhere to the Canada Health Act, which doesn’t allow private providers to charge for services that are covered by the public system as core medical services. Mr. Harper, an Al bertan who promised during his campaign to preserve the public-health system, said Quebec’s plan does respect the federal health legislation.

The provinces, which run the public system, are increasingly worried about the same trends straining health-care systems across the developed world: steadily rising medical costs and growing demand from an aging population. In Canada, the system’s $141 billion price tag already represents 10% of the country’s gross domestic product, compared with the 15.3% of GDP that U.S. health expenditures represented in 2003.

Most provincial governments have tried to bolster their systems by pouring in money, with federal help, and tweaking management of waiting lists. Hospitals deal with crowding by devoting more beds and operating-room hours to the sickest patients. Ted Marmor, a health-policy expert at Yale University, says there is no evidence that delays are having “devastating consequences” on Canadians’ health.

Yet glaring problems persist: waiting times of as long as two years for nonemergency orthopedic surgery; overcrowded emergency rooms where patients lie on gurneys in corridors; and operating rooms idled because of staffing shortages.

While a few private providers have offered limited services for years, private care got a big boost last year, when Canada’s Supreme Court ruled that the Quebec ban on private insurance was causing people to suffer and die unnecessarily, and therefore violates the province’s Charter of Rights and Freedoms. The high court’s ruling “unleashed a deluge of enthusiasm for change,” says Yale’s Prof. Marmor.

Doctors who have opted out of the public-insurance program say they became frustrated with the system, and disturbed that their patients were forced to suffer. “Telling someone they have to wait 18 months—this isn’t what they taught me in medical school,” says Nicolas Duval, the orthopedic surgeon who will do Ms. Gauvin’s hip replacement.

Dr. Duval practiced for 12 years at hospitals run by the Université de Montréal, where operating rooms were made available for nonemergency hip and knee surgery only when not needed for more urgent procedures, he says. Dr. Duval was allowed to operate only one day a week, performing 120 to 150 surgeries a year.

Dr. Duval four years ago became one of the province’s first orthopedic surgeons to opt out of the public program. Fewer than 100 doctors in the province work outside the system; most do laser eye surgery and plastic surgery.

Sick and Tired

Stealth rising costs are squeezing Canada’s publicly funded medical system and spurring more Canadians to consider a role for private-sector health care.

<table>
<thead>
<tr>
<th>Total health expenditures, in billions of Canadian dollars</th>
<th>Total health expenditures as a percentage of GDP</th>
<th>Number of total hip-and knee-replacement procedures performed</th>
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Note: C$1 = $0.8774 at current rate

Source: Canadian Institute for Health Information
Trimming the fat

The NHS needs to diet

NURSES heckled Patricia Hewitt when she addressed them on April 26th. The reception that the health secretary got earlier in the week at the annual health conference of Unison, a big public-sector union, was also hostile. Ms Hewitt had made a rod for her back with a foolish claim that the deficit-ridden National Health Service had just enjoyed its best year ever. But the unions' disaffection is a sign that the government is doing something right.

The unions are worried about redundancies as NHS trusts struggle to get their finances in order. Over 7,000 job losses have been announced, and the tally seems sure to grow in the months ahead. However, such staff reductions are tiny compared with the boost to NHS employment since Labour took office nine years ago.

Official figures released this week show the scale of the expansion. Between 1997 and 2005, the total NHS payroll in England rose by over 300,000 to 1.37m (see chart). That increase of 29% was almost matched by the increase in hospital and community nurses, whose ranks swelled by over 80,000. The number of other clinical staff grew even faster. There are now 49% more hospital consultants than in 1997.

The increased supply of doctors is welcome because Britain has historically had rather few in relation to its population. The number of administrators working in hospitals to help clinicians and in NHS central support functions has increased at a similar pace, however. And, while, given the size of the health service, there are not that many managers—fewer than 40,000 in 2005—their number has risen fastest of all, by 78% since 1997.

The distinction often drawn between "front-line staff"—who are seen as good—and administrators—bad—makes little sense. Consultants work more efficiently if they have medical secretaries and other clerical support. Indeed, the current financial mess in many parts of the NHS shows a lack of effective management.

Even so, the rapid expansion of administrative personnel is a worry. The suspicion is that many of the jobs have been generated simply to help hospital trusts comply with a plethora of targets. The NHS may thus, paradoxically, have become over-administered in the past few years while remaining under-managed in the functions that really matter.

Another cause for concern is that so many of the extra jobs have been in hospitals. The number of family doctors and GPs in practice, staff, by contrast, has risen rather modestly. Piling people and resources into hospitals has been a strategic mistake. The government is now, belatedly, pushing for a shift in treatment out of expensive hospitals. It also wants GPs to play a bigger role in commissioning hospital care in order to curb costs.

A recent report from Reform, a think-tank, said that centralised manpower planning had "produced a staffing investment which is unbalanced and unaffordable". It estimated that the NHS pay roll could fall by 10% as market pressures begin to bite within the health service. Not before time, the new imperatives to raise efficiency and to meet financial targets are bringing the NHS jobs boom to an end.

M&S and Debenhams

A tale of two retailers

How two shopkeepers followed different paths in search of wealth

FORMER investors in Debenhams are kicking themselves. After selling Britain's second-largest department-store chain to private-equity groups in 2003 for £1.7 billion ($2.9 billion), 38% more than the shares were worth before the bid, they have watched others make far bigger profits from it. Texas Pacific, CVC Capital and Merrill Lynch Global Private Equity put up £600m to buy the company. By some estimates they will have quadrupled their money when they float it again next week.

Meanwhile the owners of Marks & Spencer, Britain's biggest clothing retailer, are feeling smug. Its share price has risen by nearly two-thirds since the board brought in a new chief executive, Stuart Rose, almost two years ago to fend off an unwelcome takeover. The company's market value has increased by £2 billion.

Both these companies, with similar strategies and structures, have generated spectacular wealth in just four years. But they managed it in very different ways. How they did it, and why it worked, provides a more durable model for the British business community that has been discomfited by the recent debt-fuelled takeovers.

Debenhams, say its fans, is an equity pin-up. Its managers have enjoyed a 15% rise in sales, increased the company's market share of the department-store market by 15% to almost 19% (according to a retail research company) and increased its operating margins to almost 16%. But critics argue that the rise in profits is unsustainable: the restructuring of the firm may harm its prospects in the long run. Debenhams has fewerphy sets underpinning its increased sales, it sold all of its prime property that year to finance some of the £400m in dividends paid out to its shareholders. Selling property isn't enough for Tesco, Britain's largest supermarket, which announced record after-tax profits of £1.6 billion this week, said it plans to float £600m from its supermarkets, but Debenhams' strategy—leasing property to keep its stores, but keeping the leases—ensures the company will remain profitable.

Debenhams also has fewer problems with debt. It sold all of its prime property that year to finance some of the £400m in dividends paid out to its shareholders. Selling property isn't enough for Tesco, Britain's largest supermarket, which announced record after-tax profits of £1.6 billion this week, said it plans to float £600m from its supermarkets, but Debenhams' strategy—leasing property to keep its stores, but keeping the leases—to ensure the company will remain profitable.
The NHS is running out of time and excuses

The Royal Free in north London and the Princess Alexandra in Harlow, a few miles away from Stansted airport in Essex, are two very different hospitals. One is a teaching hospital with a turnover of £350m ($615m) a year. The other is a much smaller district hospital with an annual turnover of £120m. But they have a common problem. Each will be in the red in the financial year ending this March.

Across the National Health Service, a deficit of around £800m is now expected for 2005-06. This is far worse than the £250m shortfall in 2004-05, which followed a period of small surpluses (see chart). And it also marks a deterioration from the position in December, when a deficit of £620m was forecast for this year.

The inability of the NHS to balance its books despite unprecedented growth in its funding from taxpayers has caused trouble at the top. This week Sir Nigel Crisp, the 54-year-old chief executive of the NHS, said that he would be taking early retirement. Only a few months ago, his stock was so high that he had been in the running for the top job in the civil service.

Sir Nigel may be going but the big political questions remain. Why should there be any deficit at all after seven years in which the NHS budget has doubled? And how are its finances to be put right?

At both the Royal Free and the Princess Alexandra, generous pay awards conceded by the government are contributing to their financial difficulties. John Gilham, chief executive at the Princess Alexandra, says that the funding it received for "agenda for change", the pay deal for nurses and non-medical staff, has not fully covered the extra cost. This shortfall is contributing about a third of the hospital's £4.8m deficit this year.

This fits in with the overall picture in the NHS. According to the King's Fund, a health-policy think-tank, higher pay swallowed 50% of the cash increase for hospitals in 2005-06. The outlook for next year is not much better, with almost 40% of the planned boost to spending set to be absorbed by extra pay. The King's Fund also highlights other pressures on hospital budgets, such as greater spending on new drugs and compensation payments for clinical negligence.

Yet despite these big general cost pressures, the overall deficit is not spread uniformly across the health service. In December, when the deficit was forecast at £620m, a quarter of the 600 NHS organisations ran a gross deficit of £950m, with some offsetting surpluses elsewhere. In January, the government identified 62—the Royal Free and Princess Alexandra were not among them—which accounted for most of the gross deficit. Of these, 18 required urgent intervention, with managerial and financial "turnaround" teams sent in to help them.

This suggests that the NHS's financial malaise reflects a set of local difficulties caused by poor managerial performers rather than a more general problem. Understandably, this is an explanation that the government has tended to stress. What has happened, arguably, is that stricter accounting rules have exposed underlying financial problems that should have been tackled long ago.

The main response of hospitals to these financial strains must be to raise efficiency. At the Royal Free, where the deficit was heading for £15m, savings of £10m have been made in this financial year to bring it back to £5m. According to Peter Commins, the trust's finance director, these have been achieved mainly by shortening the time patients stay in hospital and by increasing the rate of day-case surgery.

At the Princess Alexandra, annual efficiency savings of 3% have been made in the past three years. Mr Gilham is introducing "lean management"—a technique that is common in industry—and the hos-
pital. The main goal, he says, is to reduce waste by getting things right the first time. That requires standardisation of treatment procedures wherever possible.

The pressure for higher efficiency will increase next month for all hospitals, whether or not they are having to deal with deficits. A new payments system is being introduced to sharpen competition among hospitals. It sets a national tariff for treatments, which means that hospitals are paid according to how busy they are rather than receiving budgets based on previous funding levels. At present, the new system is limited for most hospitals to elective care, such as cataract removals, but in April it will be extended to emergency work and outpatient visits.

Mr. Commnis says that the payments change will have a big effect, leading hospitals to shed services when they cannot provide them competitively. With so much riding on the new payments system, it was thus a grave embarrassment to the government when the tariff for 2006-07 had to be withdrawn for amendments to wards the end of February. That should prove a temporary setback, but it was an unfortunate prelude to what will be a turbulent and crucial financial year.

The NHS is running out of excuses and time. The big boost to spending is due to end in spring 2008, when the NHS will have to adapt to much tighter budgets. Quite simply, the health service has got to work harder for its money. In some places, there will have to be closures of excess capacity. The deficits spell out in red ink the case for reform.

Immigration

Pick and mix

The British government tries to calm fears over immigration

WHEN it comes to managing immigration, there is nothing like distance. Canada and New Zealand are a long way from the world's poor, and can therefore be finicky about who they let in. Britain is not so isolated, although (in this as in some other respects) it thinks it is. On March 7th, the government unveiled a system for screening would-be settlers that, it promises, will be the most precise in Europe.

The new immigration system will be more "structured"—which, in practice, means more rigid—than the current one. Foreigners wanting to settle in Britain will henceforth be placed in one of five tiers, depending on their skills and on whether or not they have a job offer or a university place. To get in, they will have to meet the criteria for each tier, measured in points.

Those who have a job offer in hand, and therefore fall into Tier 2, must, for example, amass 50 points before packing their bags. To them, a salary offer of between £18,000 ($31,000) and £95,000 will be worth 10 points, and a PhD another 15 points. They will earn more points if they fill a job where there is a labour shortage—as identified by a new "skills advisory body", which will draw up a list of such occupations twice a year. Yet more points will be awarded if their employer has been approved by the Home Office.

Aside from a likely increase in the number of bureaucrats, though, little will change. The new system will work so closely with the grain of current practice that it seems less a revolution than a mere re-labelling. The new system's Tier 1, for instance, duplicates a programme for highly skilled migrants that has been around for four years. Even the points system is largely a way of putting numbers on existing methods of judging would-be immigrants. As before, the system will be driven
Special report  America’s health-care crisis

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—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

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 Maine than in Minneapolis, and, if anything, results are better where spending is lower. Up to 30% of Medicare spending, they concluded, 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 2.5 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-servicemen, 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 hypothecated 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 ration 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, un
ions are pushing for similar legislation in 30 states.

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' incentives towards providing 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 costs saved by employers can be put into 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 $2,500 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 down, 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 poorer 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.

Nor is it obvious that 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. Sceptics 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 high-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 falls apart.

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Looking for deductibles
Health Care for 1.3 Billion People? Leave It to the Market.

By Scott W. Atlas

The economic reforms of the past two decades have been accompanied by a breakdown of the health-care system in China. Ironically, overall data shows that health and nutrition indicators have improved—nobody, for instance, doubts the increased prosperity. But the government seems to recognize that access to quality health care is essential to the nation’s further development, and its absence is becoming a major cause of public unrest among urban populations.

The fifth plenary session of the 16th Central Committee held last October confirmed that “economic development is the top priority,” but the government wants development to be “comprehensive, harmonious and sustainable.”

This implies a shift in government spending, from a focus on investment to one on social programs like health and education. This philosophical shift is based on the belief that if government takes more financial responsibility for areas such as education and health care, it will add security and free up money for private consumption and support the drive to a “harmonious society.”

Although complex, one fundamental change regarding China’s health-care system has been the central government’s shift away from financial responsibility without having an alternative system of health insurance and other steps in place. This has shifted responsibility for funding health care to regional and local governing authorities and, in fact, to patients who are uninsured and cannot afford out-of-pocket payments.

Other factors, including misaligned incentives for providers, have also contributed to the problem. Moreover, patients in China are less equipped than many in the ability to navigate the complex issues in formulating their own health-care decisions.

The question for China is: What is the appropriate role for government in health care? In an attempt to curb over-usage of medical services by the insured, China’s government has focused on cost-sharing by patients through a complex system of medical savings accounts. These accounts put patients in charge of purchasing decisions, with the idea that they will be more likely to consider price when they directly spend their own money. Empowering patients with decision-making authority and control of the health-care dollar is generally the correct direction.

Yet there is a problem when “empowerment” occurs without knowledge. China has not made sure patients have the information to make appropriate purchasing decisions. While at least some degree of information asymmetry between provider (seller) and patient (buyer) will always exist in medicine, China needs to become far more focused on information access and education of their consumers.

True empowerment means unfiltered access to information. This presents an important opportunity for China to demonstrate freedom of information that is truly essential to the health of its people—limited, government-controlled access to health information will not suffice.

China’s government should not follow the misguided path of much of the world by interfering with prices. In what was undoubtedly a well-intentioned attempt to ensure access and affordability of basic medical care, the Chinese government set prices at levels that make basic care a money-loser while higher level pharmaceutical and technology-dependent care became profitable.

This has incentivized providers to tilt practices away from low-tech care to drugs and high-tech procedures.

This is not just an illustration of a mistake in setting the price of the medical service by the insured, it is an illustration of the flaw in the entire logic of price-setting for medical care. Setting prices based on bureaucrats’ calculations rather than on a consumer-driven market to determine what is fair and worthwhile is always erroneous. It interferes with supply and demand, creates false incentives for sellers and results in shortages of supply, or rationing.

As China has forged ahead in its quest to become a world economic leader, its health-care system must undergo dramatic modernization and restructuring to meet the explosive growth in its urban centers, while not ignoring health services in rural provinces. The government can therefore play an important role in health care by: supporting a medical education system; devising a health insurance system without overregulation; enforcing hospital standards; facilitating the dissemination of accurate, unrestricted information to its citizens about health; and creating an environment which fosters innovation and facilitates the funding and delivery of health services to those without means.

But the government must also be determined to avoid repeating the mistakes of the West.

Those mistakes include sheltering patients from direct payment of health costs, overregulating health insurance, linking health insurance to employment and giving special tax treatment to health-care expenses. With the right decisions, a new health-care system can be both a positive force for advancing China’s position in the world economies. China has a unique opportunity to build a successful, modern health-care system that could once again be viewed as a model. It has a chance to accomplish what other countries have so far failed to do—create a health-care system that works well—and they are starting almost from anew.

It is essential, however, for China’s government to encourage policies that empower patients with knowledge and with control of the money for their own health care. It must resist the temptation to artificially set the prices of health-care services by top-down pronouncements, which skew the forces of supply and demand and interfere with physician-patient decisions about what could be considered the most personal choices of all, medical care.

The temptation is to listen to health policy “experts” from the West on how important it is to prevent health care from being exposed to the free market. But China would do well to heed its own ancient proverb: “Those who say it cannot be done should not interrupt the one doing it.”

This time, China can show the way, not only for emerging nations, but even for the most developed countries of the world, all of whom are grappling with their own health-care mistakes.

Dr. Atlas, a senior fellow at the Hoover Institution, is a professor of radiology and chief of neuroradiology at Stanford University Medical School. He is editor of “Magnetic Resonance Imaging of the Brain and Spine” (Lippincott Williams & Wilkins, 3rd edition, 2002).
Ailing Patient

In Rural China, Health Care Grows Expensive, Elusive

Until Reforms, Farmers Had Decent Access to Coverage; SARS Strains the System

Mr. Liu Bolts From Hospital

TAIYUAN, China—Suffering from a fever and pneumonia, Liu Ruqiang, a 31-year-old farmer from a small nearby village, was turned down by three hospitals last month. Some staff even refused to take his temperature for fear of being infected with severe acute respiratory syndrome.

When a fourth, the No. 2 Hospital of Shanxi Medical University here in this northern Chinese city, did decide to admit Mr. Liu, it asked for a deposit of $72 in yuan, according to his family and hospital registration workers who confirm the deposit as standard practice. The average annual income for a rural resident in China is $286.

Like the vast majority of China’s 700 million rural residents, Mr. Liu has no insurance. The hospital agreed to admit him for a daily fee of $60 instead, which he was able to pay after his mother raised money in his home village. But after four days, he sneaked out of the hospital, bought a bus ticket and fled home, to escape the cost of his care.

“We are really poor,” said Mr. Liu’s father, Liu Shufa. “We can’t afford to get sick.”

In contrast to dramatic improvement in other parts of everyday life over the past 20 years, health care in China’s new profit-oriented economy has been declining sharply. And now as China struggles to combat the SARS epidemic, the Chinese are relying on a crippled health-care system that covers far fewer people than it did decades ago.

The decline is hitting hardest in China’s rural areas, heightening the danger of faster transmission of SARS in vast parts of the country. Under Mao Zedong, China nearly accomplished the utopian goal of full medical coverage in the countryside. In 1975, about 85% of rural residents had community-financed health care, under a commune system. Today, about 16% do. Although the government now says it’s picking up the tab for the treatment of confirmed SARS cases, confusion over the new policy introduces an odd dilemma: Patients who seek treatment and don’t have SARS could be stuck with the bill.

As part of its economic reforms, the Chinese government has been steadily cutting the percentage of funds it spends on health care, shifting more of the cost onto its citizens. In 1991, for example, 39% of China’s total health-care expenditures came out of the pockets of individual citizens. By 2000, individuals paid for 60% of the nation’s health-care costs.

In rural areas, the difference is particularly striking. Through the 1990s, farmers’ incomes roughly tripled, but medical costs soared more than eightfold, according to Wang Yanzhong, an expert on rural public health at the Chinese Academy of Social Sciences. Three years ago, the World Health Organization ranked China 138 out of 191 countries, in terms of “fair...
SHANGHAI—Hu Cunxi thought he understood the financial risks of "big sickness"—or "da bing"—the common Chinese term for cancer, stroke and other life-threatening diseases.

He had edited a popular Chinese manual on household finances that encourages readers to load up on medical insurance. He himself had bought a policy from a unit of New York-based insurer American International Group Inc. He saw it as prudent backup to the government-mandated coverage he received as an editor at the state-owned Shanghai Financial News.

Five years ago, Mr. Hu's wife, Cao Meihua, a high-school teacher, was diagnosed with "big sickness." Then Mr. Hu himself fell ill. Now both husband and wife, who are in their late 40s, are battling advanced cancer, and occupy adjacent wards of a Shanghai hospital.

China's high-cost hospital system swiftly overwhelmed the insurance coverage they had through their state jobs. Mr. Hu's AIG policy wasn't designed to cover such medical calamities. Their treatments have consumed their life savings and his parents' retirement nest egg. They are now broke.

“We used to be white-collar workers,” says Mr. Hu, who seethes with anger about the quality of his government insurance. “Now, we're in poverty.”

More than two-thirds of China's 1.3 billion people have no health insurance at all, and many cannot afford any medical care. But under China's pay-as-you-go health-care system, even those with insurance are often forced to make agonizing decisions about whether they can afford treatment for serious illness. Problems with insurance coverage have become a crisis for China's growing urban middle class, eating into support for the ruling Communist Party.

As recently as the late 1970s, the Chinese government controlled all hospitals, employed all doctors, and offered almost universal health-care coverage. In the cities, the state provided insurance to civil servants, factory workers and their families. Collective farms provided care in the countryside. But the entire system began breaking down in the early 1980s as market-style reforms led collective farms to disband and money-losing factories to close. Tens of millions of workers were left without jobs or insurance.

A decade ago, Beijing began looking for a new health-insurance model. In 1998, government authorities introduced a national program called Basic Medical Insurance. All employers are required to provide employees with some coverage for both routine medical problems and "big sickness." To fund the plan, workers contribute 2% of their salaries, on average, and employers contribute an additional 7.5%. Family members, however, are not covered, and children must rely on limited
China's Health Insurance Leaves Workers Exposed

Continued From First Page

insurance programs provided by schools. Authorities enforce the requirements for state companies, but large parts of the booming private sector ignore it. The government plan has many gaps. At the end of 2003, it offered insurance protection to 160 million urban workers. That constitutes less than 20% of China's approximately 600 million urban dwellers. Coverage in rural areas is even spottier. Studies show that three-quarters of private-sector employees remain uninsured.

The Basic Medical Insurance itself is limited. Typically, it covers 70% to 80% of hospital charges. Patients must pay the rest, in cash. Seriously ill patients who cannot raise sufficient money are forced to check out of hospitals, or to opt for less expensive courses of treatment. Basic drugs are covered, but expensive new medicines, such as powerful and cancer drugs are not.

"It's a real problem," concedes Mao Quan, a spokesman for the Ministry of Health. "People should consider commercial insurance." Chen Allian, a 56-year-old volunteer at the Shanghai Cancer Recovery Club, was diagnosed with breast cancer 17 years ago. "If I had died today, I would never have survived," she says. She needed surgery, so her state-owned sewing-machine factory sent a note to the hospital promising payment. The operation cost $30, but she didn't have to pay any of it. Today, hospital emergency rooms demand cash up front, whether or not a patient has insurance. Insured patients pay for everything from gurneys to emergency surgery, then apply for reimbursement later. Those without cash are denied treatment.

A Wrenching Decision

In 2003, He Guofu turned up at a Shanghai emergency room six hours after suffering a stroke. The surgeon told Mr. He's wife, Sun Yuanzhen, that her husband needed surgery to relieve pressure on his brain. He told her it would cost $7,000 to operate, paid in advance, but warned her there was only a 50-50 chance the procedure would help.

Mr. He, who worked at a state-owned construction company, and his wife, a retired teacher, were not poor. They both had insurance. But they didn't have that kind of cash on hand, and Mr. He's employer refused to advance it, even though insurance was likely to reimburse at least some of it.

Ms. Sun was distressed. It was a Friday night. She decided to think about it over the weekend. The 50-50 odds worried her. By Monday, she had decided to borrow the money, but the surgeon told her it was too late to operate.

Her indecision still tortures her. Her husband, who is 54, is now bedridden and requires spoon-feeding, and Ms. Sun struggles to pay her teenage son's school fees. She regrets that she didn't scramble to raise the money and gamble on the surgery. "Everything was a blur," she says. "I was so confused."

Health-care costs in China are rising rapidly, turning hospitals into symbols of unfettered capitalism. Chinese and international health experts blame runaway costs in part on an effort to make treatment more affordable for the poor. Authorities capped prices for basic drugs and procedures at below-market rates. But they let hospitals compensate by profiting on almost everything else, from advanced drugs to sophisticated diagnostic tests.

That decision created an incentive to provide high-end treatment that has transformed Chinese hospitals, making world-class care available to those who can afford it. Even small-city hospitals, market, you will have a disaster," he argues. The government needs to play a leading role, he says.

The practices of hospitals and doctors are only lightly regulated by Beijing, and the "lack of self-regulation. China lacks the kind of transparency, public ac- cessions that set ethical standards, hears complaints and punish wrongdoers in the U.S. and other countries.

When Chinese authorities decided on the national insurance plan, they failed to recognize an inherent design flaw: The system reimburses hospitals for at least a portion of whatever care they choose to deliver. In effect, government economists acknowledge, the state has become a blank check for doctors. The system encourages doctors to overprescribe expensive drugs and tests, economists say, then to charge patients for whatever their insurance does not cover.

In the U.S., health insurers are afraid to antagonize that outcome through "utilization review," a process under which they evaluate the medical necessity of hospital treatment. Tests and procedures deemed unnecessary are not reimbursed. Although the effectiveness of such reviews varies, the process discourages blatantly unnecessary treatments. In China, there are typically no such review procedures.

Most health-insurance plans in the U.S. also set out-of-pocket maximums for patients facing medical catastrophes. In addition to protecting seriously ill patients from financial ruin, the caps provide another incentive for hospitals to control costs: Large bills have to be justified to the insurance companies responsible for paying them.

A World Bank study of China by economists Adam Wagstaff and Magnus Lindelow concluded that patients with insurance are sometimes persuaded to undergo far more care than the uninsured. Chinese doctors have "strong incentive to favor high-tech care over basic care," which may be more costly and sophisticated than necessary, the report said. Insurance may "acturally increase the probability of large out-of-pocket payments," the report concluded. There is no formal complaint procedure for patients, the economists added.

The Ministry of Health's Mr. Mao says the government has spent two years negotiating with hospitals over how to make drug prices and profit incentive systems more reasonable. "It's a very complicated issue," he says. "It takes time. We don't want to get it wrong and then have to start all over again." The government's share of total health spending has plummeted. Between 1978 and 2003, private outlays as a percentage of total health-care spending rose from 6% to 20%, government figures show. The shift comes as chronic diseases such as cancer, which are often treat, replace contagious ones like beruulism as the biggest burden on medical system.

Chinese government officials have acknowledged that health care has become a financial burden to the 51% of those with insurance, that it threaten- cial stability. President Hu Jintao pledged to increase government he spending.

The government is trying to ex- state insurance coverage to more pe in cities and the countryside. Officials are trying to set up a network government-funded community centers as a first step for patients. T would provide basic care and advise tients about treatment options, d and hospitalization.

Adding Coverage

Before "big sickness" struck in 2 Mr. Guo, a 56-year-old, and Ms. Cao, his w were making nearly $5,000 a month in China, that put them at the bottom e of the middle class. They had man late and were childless, which gave t some financial freedom. They bought a house and a "big sickness" policy that offer lump-sum cash payments policyholders who fall ill. She says: tells her customers that extra medi insurance isn't a nice-to-have, it must-have.

Ms. Wu says that after selling Mr. the accident policy, she tried to persuade him to buy "big sickness" cover. But then, Mr. Hu's wife l contracted breast cancer, and Mr. had no spare money for premiums or new policy.

Ms. Cao, who had retired from teaching job, still had government ins ance coverage, but it did not cover expensive form of chemotherapy she needed. Mr. Hu went into overdrafts, make ends meet. He set out to earn ex cash at night by editing books he hog would sell to China's hobbyists. dished off 11 books in four years, inc a history of Chinese women. He collector's guide to subway tickets. I sales were disappointing, and the ex work has earned him to date only $1,5
Battle

In regard to Vernon Smith’s March 8 editorial page commentary “Trust the Customer!”, his suggestion of “channeling third-party payment allowances through the patients who are choosing and consuming the service,” so that they can control costs, really does nothing to meet this end. The large insurance groups have already negotiated discounts with the hospitals and medical-care providers on the services they provide. A hospital may bill $10,000 for a surgical procedure that has been pared down to $2,500 by the insurance company. If the patient can now pay the $2,500 to the hospital, how does this help lower costs? The discounts that the Amish and Mennonites received in Lancaster County, Pa. (40% for cash payments) was just an example of being “self-insured” and negotiating in the same way the insurance companies did.

The notion of the ability of patients to “make choices” and become “competent” is slightly simplistic. A patient really has no metric to measure the care he is receiving. There are basic studies about “quality” and “outcomes” for hospital care, but these are fraught with danger, as there are so many variables that enter into these results that they can render these studies practically meaningless. The same evaluations for physicians are practically nonexistent and probably will not matter anyway.

Also, patients have different perspectives of their physicians apart from those that can be objectively measured. Would they rather receive their medical care from a sympathetic and kind physician who spends a great deal of time listening to their complaints but may not be the most stellar physician clinically, or an arrogant, unemotional one who spends as little time listening as possible but one who has been rated “the best” by some subjective evaluation?

The comments that “Service providers are oriented to whoever pays: physicians to the insurance companies” is absolutely true. But it is usually an orientation that is acrimonious and adversarial, since these companies want to pay less than the patient wants to receive. Is this the type of relationship a patient wants with his doctor by holding his fee over his head in return for treatment? Right now both parties can “blame” the insurance company and get on with the doctor-patient relationship, one that should be built on trust and mutual respect—not negotiation skills.

Perry Solomon, M.D.
San Ramon, Calif.

I am grateful to Mr. Smith for crystallizing the cause of the uncontrolled rise of health-care costs. When a service is provided to one party (the patient) but paid largely by another (the insurance company) there is no incentive to reduce costs. There is also a second adverse effect to such an arrangement that Mr. Smith did not mention: There is no incentive to improve quality.

The physicians who allow insurers to set the price for their services have very little incentive to delight their patients. They can increase their earnings only by seeing more patients at the fixed price. It’s not surprising that patients increasingly complain that the amount of time, attention and counseling they receive from their physician is lacking.

By withdrawing from all relationships with insurance companies and asking my patients to pay me directly for my services, I am applying Mr. Smith’s advice. Many other doctors are as well—we’re trusting the customer. When the patient pays me, he is very attentive to my fees, and I am very motivated to deliver excellent care.

Albert Fuchs, M.D.
Beverly Hills, Calif.

Latest Data Show Coke Attaining Growth Targets

We think two key points were missed in your page-one article describing an important issue facing the Coca-Cola distribution system in the key North American market (“Soda Rebellion: A Suit by Coke Bottlers Exposes Cracks in a Century-Old System,” March 12).

First, we think readers interested in how the Coca-Cola Co. is performing would have been better served by more recent comparative data, rather than figures from 1997. In 2005, the first full year of Chairman and Chief Executive Officer Neville Isdell’s tenure, which we said would be a transition year, world-wide volume growth was 4%, at the upper range of our long-term targets. Importantly, the growth was balanced, with 2% in carbonated soft drinks and 13% in non-carbonated beverages. In North America, our 2% volume growth was in fact

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Pork Promises Get Votes, So . . . Reform the Voters

Bruce Bartlett, in his March 13 editorial-page commentary “Don’t Reinvent the Wheel,” wishes for a return to either a presidential line item veto or impoundment authority, but neither will solve the problem of pork barrel spending. The problem is the voters who elect politicians on their promises to deliver pork to their constituents.

How can this be reformed against the voters’ wishes? All reform must ori...
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serious injuries and deaths for which it bore
some blame. During the Vietnam War, the Pen-
gon bought the herbicide Agent Orange from
chemical manufacturers and sprayed huge quan-
tities of it in large swaths of the war zone.
Beginning
in the 1970s, American and foreign soldiers
and civilians sued the government and its suppli-
ers for the injuries they claimed resulted from
exposures to Agent Orange. During the same
period, federal uranium mining and testing pro-
grams in western states engendered lawsuits
against the government by miners, workers,
nd downwind residents for their injuries and
daths.

As in asbestos, the government invoked sover-
eign immunity in each of these cases, citing a
statute that shields it from liability for harms
caused by its discretionary policy choices. The
courts upheld this defense, as the law required.
But it is wrong for the government to hide be-
ind this legal immunity and walk away from
aware of some of its risks; those risks were
much clearer and larger for asbestos than they
were for Agent Orange, radiation and other dan-
gers produced by government activities.

The government's insensitivity is also politi-
cally and economically irresponsible. Its refusal
to contribute its fair share to a congressionally
mandated trust fund may permanently doom
that solution. Yet leaving asbestos-related harms
in the tort system will predictably bankrupt even
more companies whose links to asbestos are far
more peripheral than those of the government.
This penny-wise, pound-foolish and morally ob-
tuse policy will only multiply the immense dam-
ge that asbestos has already wrought on inno-
cent workers and communities.

Messrs. Schuck and Sebek are law professors
at Yale Law School and Brooklyn Law School,
respectively. Both advised the Asbestos Study
Group in 2003.

Health

Trust the Customer!

By Vernon L. Smith

Health-care costs doubled over the decade
ending in 2004, in fact reaching an all-time high
measured as the share—16%—of GDP; and they
continue to greatly outpace inflation. Similarly,
education costs from primary levels up through
college continue to grow faster than other catego-
ries of national spending. Why? Medical

Here is a bare-bones way to think about this
situation: A is the customer, B is the service
provider, B informs A what A should buy from B, and
a third entity, C, pays for it from a common pool
of funds. Stated this way, the problem has no
known economic solution because there is no
equilibrium. There is no automatic balance be-
tween willingness to pay by the consumer and
willingness to accept by the producer that con-
strains and limits the choices of each.

In the U.S., you go to see your physician, who
says you need to buy X from her. You pay a part
of the price, and, if you are employed, your
health-insurance company reimburses the physi-
cian for the remainder. Next year all rates in the
insured pool have to be increased to pay for the
rising cost. In most foreign countries you wait in
line for the provision of the service (surgery, an
MRI scanner, etc.), if they are even available,
and after the service is delivered, the govern-
ment reimburses the provider. Next year the gov-
ernment increases taxes on the pool of taxpayers.

Another example. You want to get a college
degree in field X. The college says: Here is the
tuition price and this is the program of study in
X. If it's a public university the price you pay is
perhaps 20% of the cost to the college, and the
college collects the difference from the state bud-
get levy on the taxpayers. If it's a private univer-
sity, the tuition you pay is closer to the cost of
service, but most private universities still rely
heavily on donors and public sources for the
support of education costs.

In these examples, if third-party deep pock-
ets pay whatever is the price B charges A this
year, the effect is to reinforce the incentive to
raise the price next year. Spending escalates,
which leads to a demand for cost control. In
health care there is increasing control over ac-
cess to medical services. Insurance companies
disallow patient free choice of physicians, clinics
and hospitals outside their approved network.
Physicians and medical organizations face esca-
lated administrative costs of complying with
ever more detailed regulations. The system is
overwhelmed by the administrative cost of at-
tempts to control the cost of medical service
delivery. In education, university budget re-
quests are denied by the states who also limit
the freedom of universities to raise tuition.

If there is a solution to this problem, it will
take the form of changing the incentive struc-
ture: empowering the consumer by channeling
third-party payment allowances through the pa-
tients or students who are choosing and consum-
ing the service. Each pays the difference be-
tween the price of the service and the insurance
or subsidy allowance. Since he who pays the
physician or college calls the tune, we have a
better chance of disciplining cost and tailoring
services to the customer's willingness to pay.

Many will say that neither the patients nor
the students are competent to make choices. If
that is true today, it is mostly due to the fact that
they cannot choose and have no reason to be
come competent! Service providers are oriented
to whoever pays: physicians to the insurance
companies and the government; universities to
their legislatures. Both should pay more heed to
their customers—which they will if that is where
they collect their fees.

Significantly, in Lancaster County, Pa., an
Amish and Mennonite delegation, whose people
pay cash for medical services, negotiated dis-
counts up to 40% with their hospital for services.
If they can make it work, surely we can as well.

Would one please just trust the cus-
tomer?

Mr. Smith, a 2000 Nobel Laureate in Eco-
nomics, is a professor at George Mason Univer-
sity.

Not Do Sure
Strong Medicine

A Doctor's Fight:
More Forced Care
For the Mentally Ill

Torrey's Push for State Laws
Sparks Growing Debate
Over Rights of Patients

Mr. Hadd Goes Underground

By Mark Fritz

Every other week, Jeff Demann drives to a clinic in rural Michigan, drops his pants and gets a shot of an antipsychotic drug that he says makes him sick.

"If I don't show up, the cops show up at my door and I wind up in a mental ward," says the unemployed 44-year-old, who lives on disability in Holland, Mich.

Mr. Demann's routine reflects a national trend toward forcing people with psychotic tendencies to get treatment—even if they haven't committed violent acts. Driving the trend are E. Fuller Torrey, a 68-year-old maverick psychiatrist who believes the laws help prevent crime, and memorabilia mogul Ted Stanley, who has contributed millions of dollars to the cause.

Dr. Torrey keeps an online database with hundreds of grisly anecdotes about mentally ill people who killed the innocent. They include a jobless drifter who pushed an aspiring screenwriter in front of a subway train and a farmer who shot a 19-year-old receptionist to death. Influenced by such stories, Michigan, New York, Florida and California are among the states that have toughened their mental-health treatment laws since 1998, when Dr. Torrey formed the Treatment Advocacy Center to lobby for forced care.

The laws have become the subject of a heated debate among mental-health specialists, with some seeing a threat to civil rights. "There should be a high standard before you take someone else's liberty," says Tammy Seltzer, senior staff attorney for the Bazelon Center for Mental Health Law, a Florida nonprofit group that has fought the Treatment Advocacy Center in statehouses nationwide. Others say the connection between mental illness and violence isn't as well-established as Dr. Torrey's anecdotes imply.

Mary Zdanowicz, executive director of Dr. Torrey's center, retorts that such opponents "want to preserve a person's right to be psychotic."

It has long been common for states to compel people to undergo psychiatric evaluation after they have committed acts of violence. If mental illness is confirmed, they are likely to end up in the psychiatric ward of a prison or hospital.

Dr. Torrey was a key adviser to the National Alliance on Mental Illness when it began lobbying in the early 1980s for laws that would permit states to impose treatment on people even if they hadn't done something violent. The number of states to adopt such laws has jumped from 25 in 1998—when Dr. Torrey and Mr. Stanley created their own, more aggressive organization—to 42 currently. Those targeted by the laws usually are people picked up for behaving strangely in public, threatening family members, or refusing to take prescribed medication after being released from a psychiatric ward.

The laws are enforced haphazardly, sometimes because of inadequate funding or opposition from mental-health activists. Implementation varies not just from state to state, but from county to county and judge to judge. Many mental-health departments already are overburdened with existing patients and have little interest in pushing police to round up more people to throw into the system.

It isn't clear whether the laws have led to an increase in the number of people receiving forced care. Roughly 250,000 people in 1997 who weren't institutionalized or jailed were forcibly evaluated, monitored and sometimes medicated, according to federal statistics. Federal health officials have begun a six-month study to update

Please Turn to Page A12, Column 1
For the Mentally Ill: Caring or Incarceration?

One of the great tragedies of modern psychiatry is the large number of incarcerated individuals who are mentally ill or drug addicted ("A Doctor's Fight: More Forced Care for the Mentally Ill," page 1, Feb. 1). This is the inevitable consequence of our reluctance to use caring, coercive approaches, such as assisted outpatient treatment. A person suffering from paranoid schizophrenia with a history of multiple hospitalizations for being dangerous and a reluctance to abide by outpatient treatment is a perfect example of someone who would benefit from these approaches. We must balance individual rights and freedom with policies aimed at coercing treatment. Our responsibility to each other and our respect for personal rights lie at the center of our social and moral choices as Americans.

The Treatment Advocacy Center is to be commended for its sustained advocacy on behalf of the most vulnerable mentally ill patients who lack the insight to seek and continue effective care and benefit from assisted outpatient treatment.

Steven S. Sharfstein, M.D.
President
American Psychiatric Association
Arlington, Va.

While forced care is sometimes necessary when a person is a danger to himself or others, the call to expand its usage underestimates the risks of imposing a different standard of civil liberty onto people with mental illness than is guaranteed to the rest of us.

E. Fuller Torrey’s movement is part of an attitude of paternalism from which people with mental illness are working hard to break free. Moreover, his database of anecdotes on violence is misleading since most people with mental illness aren’t violent and are more often the victims of crime, not the assailants. There is a long history of our country taking away the rights of people with mental illness who are penalized merely for being “scary” and “burdensome.” It is time to go forward, not backward.

Anthony M. Zipple, Sc.D., M.B.A.
Chief Executive Officer
Thresholds Psychiatric Rehabilitation Centers
Chicago

My 41-year-old brother has suffered from serious mental illness since he was 15. At times, his behavior has become sufficiently threatening or dangerous to require involuntary hospitalization. Like many others with this disease, he doesn’t believe that he is ill (a neurological deficit known as anosognosia) and therefore refuses to voluntarily comply with treatment or to take medication, even though it has proven remarkably effective. As a result, my smart, funny and talented brother has spent much of the past 25 years homeless, jobless and delusional. I can safely say to the civil libertarians that this isn’t the life he would have chosen for himself; it was chosen for him by his untreated illness.

Before Kendra’s Law, there was nothing my family could do to force him to obtain treatment. Although the law isn’t a panacea and the mental health system is a disgrace, being forced to stay in treatment is the only chance he has of resuscitating his life.

Shari L. Steinberg
New York

Dr. Torrey complains about “taking heat” for being “politically incorrect,” but he’s not really paying any penalty for his position. A real penalty, however, is being paid by those who are targeted by the laws he pushes through. To force an outpatient “treatment” on anyone who has ever been on the wrong end of the mental health system because of the actions of the criminals in Dr. Torrey’s database is as unfair as it would be to force such treatment on all physicians because of the actions of Dr. Menenge.

Kent Reedy
San Diego

MindFreedom International sends out alerts as part of our “MindFreedom Shield” to encourage and support people who are seeking an underground railroad to shelter them from coerced psychiatric drugging. Such underground railroads provide support and assistance in a manner that is completely legal and essential for these individuals. But an underground railroad itself isn’t a program of MindFreedom, as you report.

You described MindFreedom as an organization of “mentally ill people that opposes coerced drug treatment.” While many members are people who have experienced abuse in the mental health system, or “psychiatric survivors” as we call ourselves, we don’t refer to our membership as “mentally ill.” In fact, many have spent much of their lives passionately defending themselves against such damaging, false, and unscientific labels.

While you quoted several proponents of forced drugging, you ought to have quoted even one of the many organized groups of psychiatric survivors. After all, we are the ones who end up on the sharp end of the needle.

David Oaks
Director
MindFreedom International
Eugene, Ore.

Using the term “force” to describe state laws authorizing court-ordered treatment overlooks the point about what these laws are actually for.

Low cholesterol and triglycerides by Southerland exp...
President Bush made health care a big part of his State of the Union address last night, which is rare for a Republican. Thankfully we're not talking about another new entitlement like the Medicare drug benefit, which is being implemented this year to far less fanfare than the GOP had hoped.

Instead, the President wants to fix defects in the market for health care. This is an area where he can do a great deal of good at little cost to the Treasury. And it's high time. The inefficiencies of the current system are a drag on wage growth that's been felt even by the United Auto Workers union. And health care costs may partly explain why many Americans don't feel as good as they might about the current economic expansion.

Longer term, it's also increasingly obvious that the U.S. is approaching a tipping point where the reforms needed to preserve an innovative, market-based health system may become politically impossible. That's because almost half of our health-care dollars are already spent by government. Do nothing and the inevitable growth of Medicare alone will lead us far down the path toward government-rationed health care in Europe or Canada.

Even the half of our national health-care spending that remains a "private responsibility" bears little resemblance to an efficient market. That's because the vast majority of Americans with private insurance get it from their employers, a relic of World War II when companies adapted to wage and price controls by offering insurance as a benefit to attract the best employees.

A tax exemption for employer health spending was later codified and will be worth about $126 billion this year. This enormous subsidy has created a system of overgenerous employer-provided plans that give individuals little incentive to pay attention to costs. It's also unfair to people who aren't lucky enough to get insurance from their employers, and therefore must pay for it with after-tax dollars.

So the first principle of reform must be to equalize the tax treatment of individually purchased and employer-provided insurance. Health Savings Accounts, which were part of the 2003 Medicare bill, are already a step in the right direction, since they have a high-deductible insurance policy with a tax-free savings account to help pay pre-deductible expenses. Mr. Bush is usefully going further by asking for the premiums on the HSA insurance policy to be tax-free as well.

Equally important is creating a national market for individual insurance. Right now employers large enough to "self insure" can do so mostly as they see fit. But individuals and small businesses who want to buy insurance are at the mercy of state regulators where they live or operate. In overregulated states like New York and New Jersey, residents can pay 10 times as much for insurance as they would in neighboring states, and might not even be able to buy the high-deductible insurance necessary for an HSA. Individually purchased insurance also isn't portable across state lines, contributing needless anxiety to normal life decisions such as moving or switching jobs.

The Founders put the Commerce Clause in the Constitution precisely so Congress could act against internal restraints on trade such as today's 50-state insurance market. We hope Mr. Bush endorses and fights for the bill from Representative John Shadegg of Arizona that would let individuals buy insurance from vendors in any state, no matter where they live.

The overall goal here is to move from the inefficiency and insecurity of the employer-dependent system to one where all workers have portable, individually owned insurance. A good analogy is portable, 401(k) retirement plans, which are more appropriate to the mobile nature of the modern economy than traditional pensions. They are also more secure, as the increasing number of defined-benefit pension plans in default (United Airlines) amply demonstrates.

Achieving this won't be easy, especially given the ideological stances of many politicians who have a government-run system. They like the leverage of determining payment rates to hospitals and doctors, not to mention being able to take credit with voters for providing more benefits. But there is no free lunch in health care, any more than there is in any other part of the U.S. economy.

Health care is either going to be allocated by prices or by government, which in the latter case means price controls and waiting lines. Though it represents one-sixth of the U.S. economy, health care is the one industry in which the purchasers actually have no idea what anything costs. An individual market for health insurance would allow more freedom of choice while making consumers more cost conscious.

Market-based health-care reform could be a big political winner for Mr. Bush and the GOP. Americans have shown themselves averse to rationing via brute force, both in their rejection of HillaryCare and in the backlash against HMOs. And while the opponents have skillfully played on fears, consumer-driven plans—which let individuals "ration" care for themselves—have proven popular when they've been offered. Just last week the insurance industry announced that enrollment in HSAs had tripled in 10 months to three million people.

That's a small part of the entire market, but an important start. Policy inertia on health care will inevitably lead to more government and Canadian or British-style waiting lists. But there's still a chance to change course. Republicans in Congress should join Mr. Bush in seizing it.
Protection racket

May 19, 2001

Brand-name drug makers are going to great lengths to spin out their patents

"If you can't beat them, bribe them" is an age-old business tactic, but it is coming under fire in the pharmaceutical industry. On May 14th, 15 American states sued Aventis, a Franco-German drug group, and Andrx, an American generic drug maker. The suit claims Aventis paid Andrx almost $90m to delay the introduction of a cheaper, generic version of one of Aventis's bestselling heart drugs when its American patent expired in 1998. The states are claiming $100m in compensation for the higher prices they have had to pay in the absence of generic alternatives.

Last month, the Federal Trade Commission (FTC) concluded that the arrangement between Aventis and Andrx had blocked others' entry to the market.

The FTC has several other drug companies in its sights. It has filed suit against Schering-Plough and two generic-drug companies for similar machinations to delay the launch of generic versions of Kupur, another patented heart medicine. It is investigating possible collusion between Bristol-Meyers Squibb and American Bioscience over Taxol, an anti-cancer drug. And it is preparing to launch a wider probe into anti-competitive practices among brand-name and generic-drug makers, which could put as many as 90 American drug companies under the microscope.

For Aventis and other firms in the risky business of developing new drugs, patents are crucial to both present and future profitability. In the industry's lucrative western markets, patents last for 20 years from the date of filing (although it can take half that time to get a drug to the market). While their product is patent-protected, drug companies can charge whatever the market will bear, in the hope that they can recoup the vast sums—$500m, on average—that go into making the drug in the first place, and still have enough left over to invest in developing new drugs and to give attractive returns to shareholders.

Once the patent expires, however, generic versions are allowed on to the market, usually at a heavy discount. The first generic rival in America, for example, usually cost two-thirds of the price of their branded counterparts, and they eventually fell to a fifth of the price of the patented original. Not surprisingly, generic drugs are popular with private insurers and state health-care systems: generic medicines account for 42% of all prescriptions dispensed in America (see chart).

Given that drugs with annual sales of roughly $28 billion are due to go off patent in America by the end of 2005, it is not surprising that the big firms want to stretch their patents out. Some are more desperate than others: around 40% of AstraZeneca's total sales, for example, come from a single drug, Losec, whose American patent is scheduled to expire this year.

Apart from the dubious methods cited in the lawsuits, drug firms have a variety of legal means to spin out their patents in America. Some come from exploiting loopholes in the Hatch-Waxman act, which regulates the marketing of copycat drugs. For example, when a generic-drug maker submits an application to launch a medicine with America's drug regulator, the FDA, the patent-holder is entitled to file an infringement suit that automatically delays the release of the generic version by 30 months. Such lawsuits are strengthened if the brand-name drug company files a new patent covering, say, the colour of the pill bottle just before the main patent is about to expire. A bill recently introduced in Congress may well close these loopholes. William Nixon, head of America's Generic Pharmaceutical Association, agrees it is time to end such "systemic mischief".

But as Martyn Postle of Cambridge Pharma Consultancy points out, patent-holding firms have a variety of other fixes at their disposal. Technical tinkering, such as changing the formulation of a drug from a fast-acting pill to a slow-release system, is a common tactic. Also popular with cunning firms is an FDA provision that allows a six-month patent extension on products to encourage firms to test the safety and efficacy of their drugs in children.

Balancing the interests of industry with public-health needs is no easy task. According to Stephen Rosenfeld, a lawyer with the Prescription Access Litigation Project, which has launched a class-action suit against AstraZeneca and Barr Laboratories over Tamoxifen, an anti-cancer drug, delays to generic drugs mean that 42m Americans who lack health insurance pay a high price, and may not get essential medicines at all. It is not only Africa, it would seem, that has a problem with access to high-cost, high-tech drugs.
Many primary care physicians closing private practices

By Michael Perrault
ROCKY MOUNTAIN NEWS

Primary care physicians across the country earn average annual salaries of $149,000, a national survey shows, but many primary care doctors in Colorado say they're doing well to earn $100,000.

Specialists across the country, meanwhile, earned $265,254 on average last year, according to a national survey of physician pay released Tuesday by Denver-based Medical Group Management Association.

Cardiovascular surgeons averaged the highest annual pay nationwide — between $379,118 and $524,847 — according to the survey. Neurological surgeons followed with annual salaries of $308,652 to $406,400.

The MGMA annual physician pay study reported that primary care doctors' salaries rose 1.2 percent last year, while specialists' pay rose 2.6 percent overall. Next year, however, physicians could be reporting declines in annual income, MGMA officials anticipate.

A 5.4 percent cut in Medicare reimbursement rates that took effect Jan. 1 and soaring medical liability premiums are among factors likely to hit physicians' wallets hard this year, said Dr. William Jesse, MGMA's president and chief executive officer.

Already, many primary care doctors in Colorado are opting to close up shop, leave the state, work for HMOs or retire early amid increasing financial pressures that make running a medical practice a daunting task.

Dr. David Downs, president of the Denver Medical Society, which represents doctors in metro Denver, and Dr. Jim Regan, past president, said the $149,000 national average for primary care doctors is more than most Denver internists earn in a year.

"I've had several years, including last year, when I didn't break the $100,000 line," Downs said.

Regan estimates annual pay for primary care physicians in Denver hovers around $110,000 to $120,000. But doctors must see more patients, slash expenses and operate efficiently to realize such an income.

Regan said he and other doctors prefer not to complain about their income levels, which are relatively healthy. Rather, doctors resent mounting managed care and government demands and red tape to justify payments.

Doctors point to national health insurers that have purchased software to automatically cut physician payment requests, as well as a steady string of Medicare reimbursement cuts slated to extend through 2006.

"Doctors are having to work so many hours, they're less and less happy because that's all they do," Downs said, noting some physicians have little time for their families.

Regan has boosted his patient load, but cuts in Medicare reim-

bursement rates and other factors still resulted in a 32 percent drop in income from patients over the past two years, he said.

Regan had to bolster his income last year by taking on research and survey projects nationwide with other doctors. That enabled him to supplement his annual paycheck and earn slightly more than the $149,000 national average, he said.

Downs said some of his colleagues in Denver manage to earn as much as $200,000 annually with good business models, even as others who have struggled to keep overhead down have gone bankrupt.


"But in health care, there are so many layers of regulation and bureaucracy that (medical practices) keep having to add staff."

Medicare reimbursement cuts for doctors that are slated through 2005 will affect Colorado physicians in at least two ways, said Anders Gilberg, MGMA's government affairs representative.

Because most managed care companies rely on Medicare fee schedules as a benchmark to base contracts with physicians, doctors will receive less from health plans, Gilberg said.

The low reimbursement rates have prompted more Colorado doctors to stop accepting Medicare patients, which has made it difficult for many Coloradans to get access to a doctor.

Those reimbursement cuts particularly affect specialists who have a large percentage of Medicare beneficiaries, he said.

perraultm@RockyMountainNews.com
800-334-2319
New York Medicaid Fraud May Reach Into Billions

Program for Poor, State’s Biggest Expense, Becomes Target for Egregious Abuse

By CLIFFORD J. LEVY and MICHAEL LUNO

It was created 40 years ago to provide health care for the poorest New Yorkers, offering a lifeline to those who could not afford to have a baby or a heart attack. But in the decades since, New York State’s Medicaid program has also become a $43.5 billion target for the unscrupulous and the opportunistic.

It has drawn dentists like Dr. Dolly Rosen, who within 12 months somehow built the state’s biggest Medicaid dental practice out of a Brooklyn storefront, where she claimed to have performed as many as 900 procedures a day in 2003. After The New York Times discovered her extraordinary billings through a computer analysis and questioned the state about them, Dr. Rosen and two associates were indicted on charges of stealing more than $1 million from the program.

It has drawn van services, intended as medical transportation for patients who cannot walk unaided, that regularly picked up scores of people who walked quite easily, when the driver was watching nearby. In cooperation with medical offices that order these services, the ambulettas typically cost the taxpayers more than $50 a round trip, adding up to $200 million a year. In some cases, the rides that the state paid for may never have taken place.

School officials around the state have enrolled tens of thousands of low-income students in speech therapy without the required evaluation, garnering more than $1 billion in questionable Medicaid payments for their districts. One Buffalo school official sent 4,434 students into speech therapy in a single day without talking to them or reviewing their records, according to federal investigators.

Nursing home operators have received substantial salaries and profits from Medicaid payments, while keeping staffing levels below the national average. One operator took in $1.5 million in salary and profit in the

Continued on Page A18

Dr. Dolly Rosen with her lawyer, Jeffrey A. Granat. She is charged with a $1 million Medicaid fraud.
icaid than any other doctor in the state. Thirty of his patients each received more than $100,000 worth of the drug.

The State Department of Health did not try to discipline Dr. Maklin until late 2003, seeking to suspend him from the program for five years and fine him $164,000. But Dr. Maklin has successfully fought the penalties, and retains his Medicaid privileges while an administrative law judge in the department weighs his case.

"I did not intentionally or knowingly violate any Medicaid regulations," Dr. Maklin said in court papers. "I was simply exercising my best medical, professional judgment."

It was not until 2004 that the amount of Serostim purchased by New York Medicaid returned to where it was before the spike.

The true identity of the woman who received the prescriptions from him in February 2002 will probably never be known. The real Pamela Borden was found in Brooklyn and said her Medicaid card had been stolen in late 2001. She said no one from the state had contacted her about Dr. Maklin.

The Ambulettes

With an immense public transit system and fleets of taxis and car services, New York is one of the nation's easiest cities to get around in, even for the old and the sick. But instead of reimbursing patients for a $2 bus ride to their doctor's office, or a $10 fare for a car service, Medicaid typically pays $25 or $31 each way for these rides, and it adds up.

New York Medicaid paid far more than any other state to get patients to hospitals and doctor's appointments: $316 million in 2003. The state accounts for about 15 percent of all the nonemergency Medicaid transportation spending in the country, according to a 2001 report by the Community Transportation Association of America, and spends more than the next three states—California, New Jersey and Florida—combined.

The largest chunk of the $316 million spent on transportation went to some 450 ambulette services, about a fifth of which are clustered in Brooklyn.

And much of that spending appears to be entirely unnecessary.

That was clear on a recent afternoon in southern Brooklyn, when an elderly woman strolled out of a doctor's office and clambered into the front seat of a van owned by M.J. Trans Corporation, a medical transport company that billed Medicaid for more than $2 million last year. After a 25-minute ride across the borough, she got out in front of her apartment, again without help, and walked inside.

The van is called an ambulette, and Medicaid is supposed to pay for it only when a patient cannot walk without help or requires a wheelchair. In fact, the state refers to the service as an "invalid coach." But on three days spent following M.J. vans over several months, a Times reporter found that almost all of the company's passengers walked easily, without assistance. The pattern was repeated as recently as last month.

Many doctors, therapists and clinics regularly order ambulette transportation for their patients when cheaper alternatives should have been used instead, according to a 2003 audit of Medicaid transportation expenses in New York City by the state comptroller, Alan G. Hevesi.

The state has known about abuses in the ambulette industry for years, and about the neighborhoods where kickbacks and other questionable activity takes place. In the early 1990's, regulators discovered that a quarter of the entire state's transportation billings were coming from Brighton Beach, Brooklyn, where a few companies had cornered the market with an elaborate set of kickback arrangements, according to a 1996 report on waste in the industry by the New York City public advocate's office. The report, along with others on the industry, suggested that many ambulette services billed Medicaid for rides that were never delivered.

But even though these schemes date back years, government records show that the state has spent almost no time looking into the ambulette industry. Prosecutors and outside auditors say that fraud, including the kind in which van services pay kickbacks to medical offices that order rides, remains rampant.

Only five ambulette providers who billed Medicaid in the 2004 state fiscal year had even a portion of their billings audited by state officials, according to state records.

Mr. Whalen, the senior state health official, maintained that the industry was properly regulated, adding that in an effort to detect fraud, the department had begun requiring providers to supply more information on their operations. "Transportation and ambulettes are on our radar screen as an active area of inquiry," he said.

One of the ambulette companies that has never been audited is M.J. Trans, though it had more billings per vehicle than almost any other of its size in the state. Its Medicaid billings jumped to more than $2 million annually in 2004 and 2003 from $700,000 in 2001.

Yuri Levitas, a manager at the ambulette company, said none of its billings were illegal or improper.

"We do only legal business," he said.

In fact, an analysis of its Medicaid billings raises questions about whether the company is abusing the system, or possibly allowing individual patients and doctors to do so. The records indicate that the company has business relationships with medical practices in southern Brooklyn that often bill Medicaid for what seem an inordinate number of trips.

A doctor at a pair of clinics that specialize in pain relief and massage therapy often ordered more than 90 trips a day, as did a col-

Medicaid in New York

This is the first of a series of articles that will examine the security, the effectiveness and the cost of New York's Medicaid program, the largest of its kind in the nation and the state's biggest expense.

Tomorrow: How the state's protections against fraud have grown increasingly frail.
$2 Million for Brooklyn Rides Billed by an Ambulance Company in 2004

Though intended for patients who need help walking, M. J. Trans Corporation's medical vans regularly transported people who required no assistance.

league of his.

At another doctor's office, Medicaid was billed 153 times by M. J. for transporting a single passenger in 2003, or essentially two or three times a week for an entire year. Another recipient went 152 times. Still others made the trip in M. J. vans, more than 150 times.

M. J. Trans said most of those rides were ordered by the office for recipients receiving physical therapy there.

"They order, and we go," Mr. Levitas said, adding that he was not responsible for ensuring that the rides were necessary.

Several physical therapists expressed skepticism that anyone would need so much therapy.

"There is always the difficult or complicated case here and there that requires extensive and intensive therapy, but as a general rule, 153 visits seem excessive," said Gabriel E. Yankowitz, a physical therapist for more than two decades and an official with the New York Physical Therapy Association.

But Gail Bednik, the manager of the office, at 280 Quentin Road in Gravesend, that is in the records as having ordered the 153 rides, said there was nothing surprising about the patients who took scores of ambulances annually at taxpayer expense.

"It's old people," Ms. Bednik said. "They want to come every day because they're bored at home."

The School Districts

In just a few hours on a single day in Sep-

policy at the American Speech-Language-
Hearing Association, which has 115,000 members. "At times, folks in the schools have been just plain making it up on their own."

This spending was routine approved by the state, but the federal government was not as credulous. The questionable spending touched off two audits of the company in 2003 by the inspector general, and a civil inquiry by the federal Department of Justice.

In an audit released last month, the inspector general revealed that in New York City schools, 86 percent of the Medicaid claims that were paid from 1993 to 2001 lacked any explanation for why the services had been ordered or violated other program rules. In Buffalo and other upstate schools, the auditors concluded that the figure was 56 percent for the same period, according to a report released last year.

The audits should not have come as a surprise. In the mid-1990's, a private consultant told New York City school officials that their record-keeping was in such disarray that 51 percent of attendance forms for speech students could not be found. But school officials did not change their practices, according to the subsequent audit.

When the upstate schools districts found out about the mid-1990's, some tried to cover their tracks, the inspector general found. Digging through their filing cabinets, they backdated records to justify Medicaid spending for services performed as many as eight years earlier.

Now, after the audits, federal officials say they are unlikely to begin demanding its money back, and so this millions of Medicaid money could haunt either the districts that it is, or the state, or both. Many districts are worried that the repayment could devastate their education budgets.

although owners are often executive directors or chief executives of the homes, allowing them to benefit financially.

Consider three homes in the Bronx. The operator of the Lacoita Nursing Home, which receives 90 percent of its revenues from Medicaid, earned $3 million in salary and profit. At the Grand Manor Nursing Home, also 90 percent financed by Medicaid, the operator and three family members earned a total of $2.4 million in salaries and profit. The owner and operator of the Morris Park home, 75 percent financed by Medicaid, took in $1.5 in salary and profit.

Advocates for nursing home residents acknowledge that the homes' operators and executives are entitled to make decent profits and salaries. But the advocates insist that it is unseemly for the profits and salaries to reach such high levels, given what the advocates contend is the industry's long-standing record of poor care. They point out that at New York nursing homes, the staffing levels are lower than the national average, a crucial indicator. All three of the Bronx homes have staffing levels lower than the national average, according to federal statistics.

"It's unconscionable to give yourself high salaries and not give some more money to hire people so some of these quality problems can be dealt with," said Cynthia Rudder, executive director of the Long Term Care Community Coalition, an advocacy group for nursing home residents.

Trade groups representing nursing homes counter that most homes in the state are actually in financial distress because Medicaid does not pay enough.

Although owners are often executive directors or chief executives of the homes, allowing them to benefit financially.
The School Districts

In just a few hours on a single day in September 2000, a senior official in the Buffalo school system wielded a rubber signature stamp and cost millions of dollars in questionable Medicaid payments for children.

Her name was Sheryl Carswell, and at the time she was Buffalo's director of special education. Moving her rubber stamp with assembly-line speed that day, she put 4,454 special-education students on the Medicaid rolls by recommending that they receive speech therapy, according to a federal audit. That represented nearly 60 percent of

Licensed speech professionals quickly realized what was happening, and many have complained that schools are cutting corners and using the funds to pay for services that have nothing to do with helping poor children speak or hear better. "We have been seeing a lot of very suspicious billing practices in New York," said James G. Potter, director of government relations and public

School officials, including those in New York City, have sharply disputed the audits, and called for them to be withdrawn.

The Justice Department suspended its civil inquiry after complaints from Senator Charles E. Schumer, Democrat of New York, and other politicians, and federal health officials have agreed, for now, not to seek restitution from school districts. But the state itself could still be liable, and could then in turn penalize the districts.

Pataki administration officials say Washington has never been clear about what kind of school services it will pay for and how children should be referred to these programs, accusing Washington of changing the rules.

"There is no question that school districts actually provided health services to poor, disabled children," wrote Kathryn Kuhmerker, a deputy health commissioner, in her response to the upstate audit.

The state, however, did not meet its responsibility to make sure the money was properly spent, the audit found. The State Health Department reviewed the books of the Buffalo district only once from 1993 to 2001, and told the district its records were "well organized."

The Executives

Among the biggest beneficiaries of the Medicaid program have been executives of the state's nursing homes and clinics, many of whom earn substantial salaries and profits from the program.

According to records obtained from the Health Department under the Freedom of Information Law, 70 executives of nursing homes and clinics personally made more than $500,000 in 2002, the last year for which figures are available. Twenty-five executives made more than $1 million.

For the nursing home executives, that money was earned in salaries and profits, some of which came directly from the daily fee that Medicaid pays for caring for each low-income patient, usually in the range of $200. Salaries are earned by employees of the homes, and profit is earned by owners.

Many hospital executives in New York also receive high salaries, but hospitals earn significant revenues from sources other than government social programs, including H.M.O.'s and private insurance. The 550 public, private and nonprofit nursing homes around the state, by contrast, earn more than two-thirds of their revenues from Medicaid, taking in roughly $6 billion last year from the program, according to state records. Many clinics receive most of their revenues from Medicaid as well.

Morris Berkowitz, operator of the Morris Park home, said he deserved his profits because he worked long hours and provided excellent care.

"Do you know how much I have invested in this place?" he asked. "A lot of money. And I am constantly investing in this place."

Earlier this year, after residents repeatedly wandered from Morris Park, federal and state officials accused the home of grievously poor supervision, and it was fined $85,000.

Mr. Berkowitz said the home had done nothing wrong. "It was a political thing, and we got caught up in it," he said. "People with power, they abuse their power."

Martin Liebman, operator of Grand Manor, said it was misleading to focus on salaries and profits.

"This is a family-owned business," said Mr. Liebman, an officer of the state trade group of private nursing homes. "I'm third generation in the business. We have taken care of thousands of residents and given quality care for many, many years."

Barry Bronstein, operator of the Lacoinia home, did not respond to three calls seeking comment.

Besides their high salaries, some executives profiting from Medicaid were also taking part in another tradition: cheating the program.

In 2002, two of the owners of the AllCity Family Healthcare clinics in Brooklyn collected a total of $1.4 million in salaries, according to state records. Last year, the company was forced to return $6 million to the state, and one of its owners, Rossia Pokh, pleaded guilty to grand larceny in a case brought by the attorney general.

At the AllCity clinics, it turns out, thousands upon thousands of the Medicaid claims were fraudulent.
Spending on Medicaid

A Growing Burden

New York's annual Medicaid spending dwarfs that of other states, including California, which has far more recipients...

<table>
<thead>
<tr>
<th>Recipients (millions)</th>
<th>Spending (billions)</th>
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</thead>
<tbody>
<tr>
<td>N.Y. 4.2</td>
<td>$44.5</td>
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<tr>
<td>Calif. 6.6</td>
<td>33.4</td>
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<tr>
<td>Tex. 2.8</td>
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<tr>
<td>Fla. 2.1</td>
<td>14.4</td>
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<td>Pa. 1.7</td>
<td>13.3</td>
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<tr>
<td>Ill. 2.0</td>
<td>11.2</td>
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<tr>
<td>Ohio 1.7</td>
<td>10.6</td>
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...and it spends far more even after adjusting for the numbers of recipients and state residents.

<table>
<thead>
<tr>
<th>Spending per Recipient</th>
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<tbody>
<tr>
<td>N.Y. $10,644</td>
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<tr>
<td>Pa. 7,626</td>
</tr>
<tr>
<td>Fla. 6,706</td>
</tr>
<tr>
<td>Ohio 6,206</td>
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<tr>
<td>Tex. 6,158</td>
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<tr>
<td>Ill. 5,818</td>
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<tr>
<td>Calif. 5,038</td>
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<table>
<thead>
<tr>
<th>Spending per Capita</th>
</tr>
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<tbody>
<tr>
<td>N.Y. $2,314</td>
</tr>
<tr>
<td>Pa. 1,072</td>
</tr>
<tr>
<td>Calif. 930</td>
</tr>
<tr>
<td>Ohio 921</td>
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<td>Ill. 881</td>
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<td>Fla. 827</td>
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<tr>
<td>Tex. 769</td>
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</tbody>
</table>

New York's spending on Medicaid has risen rapidly...

...and is consuming an increasing proportion of the state's budget.

Despite this growth, the New York State Department of Health has been recovering less from fraud and abuse investigations.

Sources: State Medicaid programs; New York State Division of the Budget; Centers for Medicare and Medicaid Services; U.S. Census Bureau

New York Times
July 18, 2005

The New York Times
New York Medicaid Fraud May Reach Into Billions

Continued From Page A1

same year he was fined for neglecting the home's residents.

Medicaid has even drawn several criminal rings that duped the program into paying for an expensive muscle-building drug intended for AIDS patients that was then diverted to bodybuilders, at a cost of tens of millions. A single doctor in Brooklyn prescribed $11.5 million worth of the drug, the vast majority of it after the state said it had tightened rules for covering the drug.

New York's Medicaid program, once a beacon of the Great Society era, has become so huge, so complex and so lightly policed that it is easily exploited. Though the program is a vital resource for 4.2 million poor people who rely on it for their health care, a yearlong investigation by The Times found that the program has been misspending billions of dollars annually because of fraud, waste and profiteering. A computer analysis of several million records obtained under the state Freedom of Information Law revealed numerous indications of fraud and abuse that the state had never looked into.

"It's like a honey pot," said John M. Meekins, a former senior Medicaid fraud prosecutor in Albany who said he grew increasingly disillusioned before he retired in 2003. "It truly is. That is what they use it for."

PROGRAM DISORDER
Exploiting a Safety Net

In defending the department's performance, Mr. Whalen, the executive deputy commissioner, said it had saved $9.3 billion in recent years through investigations of providers, a new computer system and other measures.

Asked repeatedly to provide an in-depth explanation of their claim of major savings or for any state records or other documentation to back up the figures, department officials would not supply any.

The Times investigation drew upon interviews with scores of current and former officials and health-care providers, including several former investigators who say they left the state disillusioned about its commitment to fighting fraud. A review of thousands of pages of state, federal and local records turned up repeated examples of cost savings and waste reduction used by the federal government and other states, but not by New York.

$5.4 Million for Dental Work in 2003

A Barker lured customers to Dr. Dolly Rosen's Brooklyn office, which had extraordinarily high Medicaid billings.
The investigation found audits on Medicaid spending that were brushed aside, and reports on waste that appear to have been shelved. There have been multiple warnings from watchdog agencies in New York and in Washington that indicate that the program is becoming increasingly porous. Prosecutors said state regulators had all but lost interest in bringing Medicaid thieves to justice, preferring instead to focus on recouping money through a few civil cases that have little deterrent value.

The Dentist

On the streets of Downtown Brooklyn, the young men would regularly fan out to drum up business for Fulton Gentle Family Dentistry. “Got a Medicaid card?” one of the men shouted one day last November. “Come in and get your free CD player right now!”

But inside the office at 575 Fulton Street, Dr. Dolly Rosen seemed to make money whether or not the barkers did their job. She simply invented the dental work she did, according to state prosecutors alerted by The Times, and then billed it to Medicaid. And the breadth of her deception was enormous, the prosecutors said.

In 2003, less than two years after joining Medicaid, Dr. Rosen and an associate reaped $5.4 million, more than the amounts garnered by 85 percent of providers of all types in the entire New York program, according to the analysis of Medicaid billings.

Dr. Rosen claimed to be doing thousands of procedures each month, far more than any group of dentists could possibly perform, according to the analysis and interviews with dental experts.

In September 2003, she charged Medicaid roughly $725,000 for 5,500 individual dental procedures, many of them expensive and complicated, such as filling cavities that had rotted away much of the tooth. On a single day that month, she billed for 991 procedures, or more than 100 an hour in a typical workday, more than even prominent AIDS specialists with large practices. From 2000 to 2003, Dr. Makhlil prescribed 12 percent of all the Serostim purchased by New York Medicaid, costing the program $11.5 million, according to the Times analysis of Medicaid billings.

The AIDS Drug

The woman said her name was Pamela Borden, but it was not. She told the doctor that she had AIDS and had been losing weight rapidly, but she did not have AIDS and was overweight. Yet when she walked out of Dr. Mikhail Makhlil’s Brooklyn office in February 2002, she was clucking a prescription for a very expensive synthetic growth hormone intended to treat wasting syndrome, a side effect of AIDS.

The cost of the drug, entirely borne by taxpayers, was $4,000 a month.

The woman’s real intention for the synthetic hormone, Serostim, had nothing to do with AIDS. Serostim is highly sought in a thriving black market among bodybuilders, who use it like a steroid to bulk up.

And Dr. Makhlil wrote far more prescriptions for Serostim than any other Medicaid doctor in the state, more than even prominent AIDS specialists with large practices. From 2000 to 2003, Dr. Makhlil prescribed 12 percent of all the Serostim purchased by New York Medicaid, costing the program $11.5 million, according to the Times analysis of Medicaid billings.

T2

$5.4 Million for Dental Work in 2003

A Barker lured customers to Dr. Dolly Rosen’s Brooklyn office, which had extraordinarily high Medicaid billings.

T3

on the drug.

The money was spent despite national publicity that had led other states to realize that Serostim was being abused, and to begin reining in their spending on the drug. Florida, for example, put restrictions on Medicaid payments for Serostim in 1997. The same year, federal officials broke up a Medicaid fraud ring that recruited people from Washington Square Park and paid them $20 to $50 to get Serostim illegally.

At the Health Department, Mr. Whalen and his aides described the department’s handling of the drug as a success. They said they had detected the increase in Serostim prescriptions and required doctors to get special approval to prescribe the drug after January 2002. But billing records show that Dr. Makhlil wrote 80 percent of his Serostim prescriptions after the restrictions were adopted.

Serostim was approved in the mid-1990’s to treat wasting syndrome, a side effect of AIDS. It is injected under the skin and causes a significant increase in lean body mass and weight.

The drug’s manufacturer, Serono Laboratories, is the subject of an extensive federal criminal investigation into whether its executives paid kickbacks to doctors to prescribe Serostim. The company said it was cooperating with the inquiry.

Federal authorities would not say whether Dr. Makhlil had been questioned in the federal inquiry. What is clear is that Dr. Makhlil played a pivotal role in the epidemic of Serostim abuse on the East Coast. Even now, he retains his Medicaid privileges and medical license, and has not been a subject of a state criminal inquiry.
ton and others have estimated that 10 percent of all health care spending nationally is lost to "fraud and abuse."

James Mehmet, who retired in 2001 as chief state investigator of Medicaid fraud and abuse in New York City, said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal. "So we're talking about 40 percent of all claims are questionable," Mr. Mehmet said — an amount that would approach $18 billion a year.

Despite the debate, and the enormous sums at stake, Albany has never formally studied how much of the huge government investment in Medicaid is lost to criminal activity and abuse.

For their part, federal auditors have made New York a leading target for inspections as Washington has begun to crack down on Medicaid spending abuses. The federal government shares the cost of Medicaid with the states. In New York, it pays half the bill; Albany splits the rest of the cost with its counties and New York City.

The lack of regulation of the program did not come about by chance. Doctors, hospitals, health care unions and drug companies have long resisted attempts to increase the policing of Medicaid. The pharmaceutical industry, which has spent millions of dollars annually on political contributions and lobbying in Albany, has defeated several attempts to limit the drugs covered by Medicaid; other states have saved hundreds of millions of dollars annually with such restrictions.

Earlier this year, after the Legislature agreed to impose such a limit and steer patients to generic drugs, the industry won a major loophole that allowed any doctor to substitute a higher-priced brand name with a simple phone call to the state.

Governor Pataki would not be interviewed about Medicaid for this article, and his aides referred questions to the State Department of Health, which is part of his administration. The health commissioner, Dr. Antonia C. Novello, also declined to be interviewed.

Dr. Rosen, who is 48 and lives in Manhattan, was licensed in 1985 and joined the Medicaid program in 2002. Since then, she has billed taxpayers more than $7 million. She and her lawyer, Jeffrey A. Granat, would not comment.

The allegations of fraud in this case involve dentistry, but in the world of New York Medicaid, this kind of scheme is not unusual in any specialty, although it rarely occurs on such a scale. Many doctors, clinics, pharmacists and other providers routinely exaggerate their billings, investigators say, often claiming to do more work than they really performed, or substituting an expensive procedure for a minor one. Others invent visits that never occurred.

"This is an age-old problem in New York," said Professor Malcolm Sparrow of Harvard, who has written extensively on health care fraud.

Albany stood by as Dr. Rosen's Medicaid billings went from zero in 2001 to $4 million in 2003, according to the analysis of her billing records.

Her 2003 billings were by far the highest of the 50,000 dentists or doctors in New York on Medicaid — $1 million more than those of the next highest, the records show.

Dr. Rosen had an associate in the Brooklyn office, Dr. Alex Silman, who sent his own bills to Medicaid. His billings showed a similar spike, rising to $1.4 million in 2003 from $115,000 in 2002, records show.

The Department of Health and the state attorney general's office blamed each other for failing to stop Dr. Rosen and Dr. Silman. The department said it had alerted the office that it should investigate possible improprieties with their practices. The office said the department had botched its inquiry.

Last fall, The Times brought its findings on Dr. Rosen and Dr. Silman to the attention of the Medicaid Fraud Control Unit, which is in the state attorney general's office. On March 24, prosecutors in the unit had Dr. Rosen and Dr. Silman arrested.

This month, the two were indicted on charges of first-degree grand larceny, each accused of stealing more than $1 million from the program. Another associate, David Ibragimov, who handled billing for the office, was also indicted. All three have pleaded not guilty.

The Times found Dr. Rosen's extraordinary medical record and interviews with state officials suggest that the woman's visit was part of an elaborate series of scams involving Serostim that stole tens of millions of dollars from New York Medicaid, long after other states realized what was going on. In 2006, New York Medicaid paid $7 million for Serostim, but the following year, after the schemes took off, the state spent $50 million in a single year.

Dr. Makhlin, who was educated in Russia and arrived in New York in 1988, maintains that he was unwittingly duped by a parade of patients who tried to help, and received no benefit for prescribing a drug he considered necessary. But he and his lawyer, Nathan Dembin, will not explain how he ended up prescribing far more Serostim under Medicaid.

All in a Day's Work

A Brooklyn dentist, Dolly Rosen, was paid by New York Medicaid for 991 procedures on a single day in September 2003, costing $63,967. Here are the claims.

- X 454 = $41,803
  Filling

- X 35 = $2,070
  Tooth removal

- X 178 = $10,249
  Cleaning

- X 6 = $1,702
  Dentures

- X 203 = $4,588
  X-ray

- X 14 = $602
  Tooth sealant

- X 89 = $2,566
  Examination

- X 11 = $387
  Other

Source: State Medicaid records

The New York Times
Governors Urge Medicaid Changes To Trim Expense

By Sarah Lubck

WASHINGTON—To curb escalating government spending on Medicaid, the nation's governors said drug makers should pay larger rebates to the program and states should be able to charge Medicaid recipients more for services.

The proposals, among a slate of changes endorsed by a bipartisan majority of governors, mark the opening move in this year's debate over how to trim costs in the joint federal-state program for the poor. Some of the governors' ideas closely track proposals that members of Congress are considering to save as much as $10 billion over five years from Medicaid. It is unclear which changes might be made. Lawmakers still could look to other programs for savings.

June 16, 2005
Wall St. Journal

Radical Surgery For Medicaid?

South Carolina Governor Sanford has a plan to slash costs—but a political battle looms

Aug 8, 2005
Business Week

Pataki Said to Favor $1 Billion Cut in New York Medicaid

Jan 15, 2005
The New York Times
Radical Surgery For Medicaid?
South Carolina Governor Sanford has a plan to slash costs—but a political battle looms

The 40th Anniversary of Medicaid is on July 30, but few will celebrate. The state and federal program that provides essential health benefits for the poor is in big trouble across the country—under fire for providing often substandard care even as it breaks the budgets of many states. Now, in what could be the first step toward a fundamental remake of the huge public program, South Carolina's Republican governor, Mark Sanford, has quietly asked the federal government for permission to redesign Medicaid for the 800,000 low-income residents of his poor, largely rural state.

Under Sanford's proposal, Medicaid would be dramatically transformed. It would no longer provide unlimited care, instead offering beneficiaries—mostly mothers with children—a fixed amount of money each year to buy insurance and pay out-of-pocket costs. If they run through their accounts, they would have to pay for additional care on their own. But if they hold spending...
down, they could bank the leftover money to pay future medical costs—or even use it to buy private insurance if they leave the program. "This is the biggest change ever for Medicaid," says Cleveland State University finance professor Michael Bond, who helped design the plan.

Republican governors in "red states," such as Florida and Georgia, and in "blue states," such as Massachusetts and Vermont, are mulling similar proposals. The rethinking is part of a move by states to lighten the burden of rising medical costs for the poor. Those obligations have doubled over the past decade as the ranks of the uninsured have risen, high-tech care has increased, and nursing care for the elderly has exploded.

Because Washington splits the cost of this spiraling health-care burden, it must approve a plan such as South Carolina's. But that won't be a big hurdle given the Bush Administration's interest in "ownership society" ideas, such as trying to create markets by replacing open-ended benefits with vouchers and other one-time payments. The Centers for Medicare & Medicaid Services, which oversees Medicaid, already backs the concept. "These kinds of approaches can lead to lower costs and more effective treatment," says CMS director Mark B. McClellan. "You can't treat chronic illness without active patient involvement. And you can't get that through some government pricing program."

A green light from the feds will spark two huge political battles. Liberals will object to any plan that turns Medicaid from a guaranteed benefit into the same sort of defined-contribution program that many employers now use. Such cost shifting is especially unfair for the poor, they say, and for those who have little experience with private insurance. "All Medicaid beneficiaries would face a significant increase in out-of-pocket costs," says Judith Solomon, a health-policy analyst at the Center on Budget & Policy Priorities, a liberal Washington think tank.

But the plan could also pave the way for an overhaul in the way Medicaid is funded, which is sure to spark more controversy. Instead of Washington reimbursing states for a fixed percentage of their costs, President George W. Bush wants the feds to contribute a fixed dollar amount, leaving states on the hook for big unanticipated hikes. Faced with opposition from the National Governors Assn., the White House is no longer pushing a nationwide change. But some governors, including Sanford, may accept such a deal in exchange for the flexibility to run Medicaid their way.

The benefit, says Robert M. Kerr, director of South Carolina's Health & Human Services Dept., is that patients will become better consumers if they have to pay for part of their care. "People are going to manage their accounts more carefully," he says. "We're exposing beneficiaries to the type of market the rest of the population has to deal with."

The plan would work like this: A 45-year-old would receive $3,300 from the state; a 5-year-old might get $900. The funds—called personal health accounts—would be distributed as vouchers or debit cards, not cash. Accounts would be adjusted based on a beneficiary's age, sex, and health. For now, seniors in nursing homes would remain in traditional Medicaid.

Beneficiaries would have several ways to pay for their health care. If they have insurance at their jobs, they could use the accounts to pay their premiums. If they do not have such coverage, they could buy hospital insurance through Medicaid and use remaining funds to buy care from any doctor they choose. Or they could use a portion of their account for private managed-care insurance and for copayments and deductibles. Another option: They could use the entire account to join a medical home network—a group of local doctors who serve as gatekeepers for specialty care, pharmaceutical drugs, and the like. Those additional services would be paid by Medicaid, though patients would still be responsible for small out-of-pocket costs.

A GAPING HOLE

THE SOUTH CAROLINA plan will require wide use of managed-care plans. The problem is, fewer than 10% of poor South Carolinians have such coverage. There are no plans in 16 counties and competing plans in only one. Even backers say that must change for the idea to work. "You've got to have competition," says Cleveland State's Bond.

It's no surprise that states such as South Carolina are desperate to hold down Medicaid costs. The program is now the biggest single expense for most states—and costs are rising at close to double-digit rates. South Carolina spends $1 billion a year on Medicaid benefits, or about 14% of its budget. So state officials say they have only two options: slash benefits for all but the poorest patients, or boost costs modestly for all.

The jury is still out on whether health accounts—which are increasingly common in the employer setting—can save money or improve care. But with Medicaid costs threatening to overwhelm his budget, Sanford is willing to roll the dice on private accounts. And if, as anticipated, the feds give him the O.K., expect other governors to follow suit.

—By Howard Gleckman in Washington

Blueprint for a Revolution

Sanford's plan aims to use individual accounts, an idea that echoes President Bush's push for an "ownership society" to transform South Carolina's Medicaid program, which provides health care for the poor. His goal: Unleash market forces to help rein in costs. Recipients would get an account they could use to buy one of the following:

**MEDICAL NETWORK** The poor would use their entire accounts to join a network. Patients would still have modest copayments and deductibles. A primary-care gatekeeper would coordinate treatment.

**PRIVATE INSURANCE** Beneficiaries would purchase a managed-care plan with conventional premiums, copays, and deductibles. Insurance companies or HMOs could offer extras such as dental or vision coverage.

**SELF-DIRECTED CARE** Patients would use their accounts to buy limited insurance for hospital care and pay out-of-pocket costs for all other services. The state might still negotiate discount rates with Medicaid doctors.
Governors Urge Medicaid Changes To Trim Expense

By Sarah Ludick

WASHINGTON—To curb escalating government spending on Medicaid, the nation’s governors said drug makers should pay larger rebates to the program and states should be able to charge Medicaid recipients more for services.

The proposals, among a state of changes endorsed by a bipartisan majority of governors, mark the opening move in this year’s debate over how to trim costs in the joint federal-state program for the poor. Some of the governors’ ideas closely track proposals that members of Congress are considering to save as much as $10 billion over five years from Medicaid. It is unclear which changes might be made. Lawmakers still can look to other programs for savings.

The governors’ preliminary recommendations, unveiled in separate House and Senate hearings, aimed to reduce Medicaid spending in ways that won’t harm the states. They also would increase states’ ability to reconfigure their programs. The governors suggested tax breaks and credits to help people buy private long-term care insurance, as well as incentives for seniors to take reverse mortgages on their homes to pay more of their long-term-care costs.

The governors made a pitch for broad flexibility to charge higher co-payments and to vary benefits packages in Medicaid. Current law limits co-payments to $3 in many cases. Governors want to increase that amount, though they said the poorest recipients should not have to pay more than 5% of total family income and higher-income Medicaid patients shouldn’t have to pay more than 7.5% of their income toward the program. Advocates for the poor say even minimal cost-sharing could discourage Medicaid recipients from getting needed care.

“This may be touchy for many people,” said Arkansas Gov. Mike Huckabee in Senate testimony. He said governors want Medicaid recipients to have “some skin in the game.”

Some Democrats criticized some of the proposals and said Medicaid cuts wouldn’t be needed if Republicans weren’t focused on cutting taxes. Rep. John Dingell (D., Mich.) said in a statement he was “afraid” that some of the governors’ proposals would “shift costs to the poorest and most vulnerable” Medicaid recipients.

On prescription drugs, the governors went beyond a Bush administration proposal to revamp the pricing formula in Medicaid. The governors said the minimum rebates states collect for Medicaid prescription drugs should be increased, too.

“The concern with the administration’s approach is that it took all the savings out of the hides of pharmacists,” said Virginia Gov. Mark Warner.

The governors also said “authorized generics”—drugs that are licensed by brand-name companies to generic makers when a product is about to lose patent protection—should be included in the Medicaid rebate calculations. Not including them “results in hundreds of millions of dollars in lost revenue” for states, according to the governors’ report. They also said states should be given greater ability in Medicaid to steer patients toward less expensive products.

Ken Johnson, a spokesman for drug-industry group PhRMA, said spending on medications “is not the major cost-driver” in Medicaid and that patients should continue to have access to needed medicines.
Paying for Medicaid’s Safety Net

Rulings on Immigrant Coverage Add to Pressure on Albany

BY JENNIFER STEINHAUER

Each year, Gov. George E. Pataki has a goal in mind for the Medicaid budget: lower it. Yet this year it seems that with every month that passes, that budget is pushed in the opposite direction, and there is very little the governor can do about it.

News

Analysis

Sometimes it is because of political pressures, as was the case last spring when union and hospital leaders begged him to sign on to a public health insurance program for the working poor and to hold the line on Medicaid cuts to hospitals.

Other times, Mr. Pataki is confronted with unanticipated responsibilities. This week, New York’s highest court ruled that the state had violated the state and federal Constitutions by denying Medicaid benefits to legal immigrants who arrived after August 1996, and that now it must pony up.

The court decision came on the heels of another ruling that eliminated federal money for a program for pregnant immigrants, and the state must decide whether to dip into its Medicaid till for that group as well.

All this comes at a time when the governor is holding steady on his position that the overall state budget — now two months overdue — should be tightened.

Medicaid, at a cost of roughly $30 billion a year, is the single largest component of the state’s budget. New York spends more on the program than any other state.

Any Medicaid increase “has to be done in the context of the overall budget,” said John J. Faso, the Assembly’s Republican leader. “You can’t do everything for everyone.”

So who among those looking for more Medicaid dollars, does Mr. Pataki most need to please?

There are plenty of candidates, most notably immigrants, who appear to have accounted for the state’s tremendous growth in the past 10 years. Then there is Dennis Rivera, the leader of 1199/S.E.I.U., New York’s health and human service union, who wants $250 million of fresh government money to increase staffing in nursing homes. Can the governor afford to alienate him?

In the past few years, Mr. Pataki has agreed to extend New York’s public health insurance to a wide swath of people whom other states have ignored — the children of illegal immigrants and poor single adults, among others.

But that was before this week’s ruling. The state’s Court of Appeals found that by denying Medicaid coverage to legal immigrants who arrived here after August 1996, as the federal government does, New York had violated its own Constitution. The court ruled that the state must now pay for the coverage.

The governor said that he would comply with the ruling, but demurred on whether he believed the state would have to foot the bill for legal immigrants who want to participate in a new program, Family Health Plus.

A budget the governor wants to tighten, and a list of people to please.

Plus. That program, financed by the state and the federal government, will provide free health insurance for many of the working poor who earn too much to be eligible for Medicaid. Another legal decision last month found that pregnant women who are in this country illegally have no right to prenatal care under Medicaid. Before that ruling, issued by a federal appellate court, New York State was reimbursed for about 50 percent of its annual costs for a program that covered roughly 13,000 of these women. Governor Pataki has not said whether the state will pick up the tab for that program.

Avoiding the Family Health Plus additions and declining to pay for prenatal care for illegal immigrants may seem fiscally prudent. Just covering the legal immigrants will cost the state “in the nine figures,” according to Mr. Pataki, although the Commonwealth Fund, a health care research foundation, puts the figure substantially lower at about $2.5 million a year.

But the state had already been under pressure to extend insurance benefits to legal immigrants. Bills in both the Senate and the Assembly proposing an extension of enrollment insurance programs to legal immigrants were already pending before the ruling on Tuesday, and advocacy for such bills was coming from many directions. For instance, a letter signed by several business leaders, including George Soros, ran in an upstate newspaper recently urging health care coverage for legal immigrants.

While illegal immigrants — and many legal ones — cannot vote, their issues often resonate strongly with immigrant citizens. “We certainly have seen the governor courting New York’s immigrants,” said David Sandman, a program officer at the Commonwealth Fund. He cited the governor’s consistent position that the federal law denying health care to legal immigrants was wrong.

“His increasingly receptive stance would seem to indicate that he would want to add them to his health care agenda,” Mr. Sandman said.

New York City’s population, which has fueled the state’s growth in the past decade, has grown by 56,000 people to 8,008,278 since 1990, according to the latest census figures. While the percentage of those people who are immigrants is yet to be determined, there are strong hints that immigrants have been behind much of the population expansion both in the city and elsewhere.

Could the Medicaid budget be cut in other places? Not likely. This year, Mr. Pataki proposed a $300 million cut in the state’s contribution to nursing homes, but both the Senate and the Assembly pronounced it dead on arrival.

For his part, the governor plans to do what many states do in the face of rising costs: ask for more from the federal government.

“These are some substantial new and unanticipated costs,” said John F. Signor, a spokesman for the State Health Department. “We will be looking for some help from the federal government and our Congressional delegation to ensure that New York State gets its fair share of its federal dollars to cover the costs of these programs.”
Pataki Said to Favor $1 Billion Cut in New York Medicaid

BY RAYMOND HERNANDEZ
and AL BAKER

ALBANY, Jan. 14 — Seeking to close the state budget gap, Gov. George E. Pataki will propose at least $1 billion in spending cuts to Medicaid, the health care program for the poor, according to people who have been briefed on the governor's budget plan for the coming fiscal year.

In the budget address he will deliver on Tuesday, Mr. Pataki will also call for at least $500 million in additional taxes and surcharges on hospitals, nursing homes and other health care providers, to help the state wrestle with a projected budget shortfall of $4 billion, those briefed on the plan said.

The cost of Medicaid has exploded in recent years, placing a burden on local and state finances. It now consumes about 44 percent of the state's $100 billion budget, but state officials have been unable to curb the program, which has political clout in Albany.

The cuts, if they go through, will cause a ripple effect. Since the state's contribution to Medicaid generates matching contributions from the federal government and New York localities, a $1 billion cut in state financing could mean a decrease of at least $3 billion in overall Medicaid spending across the state, according to health care analysts.

Hospital trade groups predicted that cuts on that scale would stun the health care industry, a major sector in the state's economy, and perhaps lead to cuts in service or even hospital closings.

At the same time, the governor is planning to do something to address what local governments have long complained is a strain on their budgets and a force driving up local property taxes: He wants to place a cap on local Medicaid costs and have the state pick up a larger share of them over time.

And to make proposed Medicaid cuts easier to sell to lawmakers, health care representatives and union leaders, his advisers are floating proposals that would, among other things, finance hospital construction and renew a program to provide coverage for the uninsured.

Kevin C. Quinn, a spokesman for Mr. Pataki, declined to comment last night on the governor's Medicaid package, other than to say: "We will give details of the budget on Tuesday. But the governor has not made clear that this is the year we must reform New York's Medicaid system. bedroom system and property taxpayers and ensure our health care system remains the best in the world."

Mr. Pataki's proposed Medicaid cuts will set the stage for a bitter and possibly protracted fight with lawmakers in both parties, who have resisted making deep cuts to New York's struggling health care industry. While Medicaid is considered a program for the poor, it has an impact on communities throughout the state because hospitals, nursing homes and other health care providers count on Medicaid dollars to cover their operating expenses.

The cuts the governor is seeking will almost certainly make health care one of the most contentious issues confronting lawmakers, who also must comply with a court-appointed panel's ruling that an additional $5.6 billion a year must be spent to improve New York City schools. And they also face demands that the state provide more aid to the Metropolitan Transportation Authority.

The proposal to cut Medicaid defines a stark turnabout for the governor, both substantively and politically. Mr. Pataki, a Republican, has presided over sizable spending increases in the program over the years, most recently when he ran for re-election in 2002 seeking the support of the politically potent hospital workers' union.

The program now costs $44.5 billion, up from $24 billion in 1995, when Mr. Pataki first took office. It is, in fact, the fastest-growing part of the state's $100 billion budget. Mr. Pataki led the charge for major cuts in Medicaid in 1995, but he abandoned that goal after meeting with fierce political opposition in and out of the State Legislature.

Mr. Pataki's advisers are apparently giving consideration to several proposals that may make his proposed Medicaid cuts more palatable to legislators, hospital administrators and, perhaps most important, the leaders of 1199/S.E.I.U., the hospital workers' union, according to officials in the Legislature monitoring the issue.

One proposal said to be under discussion would include the reauthorization of the Health Care Reform Act, a $5.5 billion program that finances several expensive but politically popular items, like hospital subsidies and health insurance for low-income individuals. The law authorizing the Health Care Reform Act is set to expire in June, giving Mr. Pataki leverage in budget negotiations, since the program would cease to exist without his support.

The other proposal that the Pataki administration may offer to offset the pain of the Medicaid cuts is along the lines of a plan that representatives of 1199 and the Greater New York Hospital Association, a trade group, have been seeking for several years: an infusion of cash for an assortment of construction projects.

People monitoring the issue in Albany said the Pataki administration had floated the idea of proposing a $1 billion capital plan that would allow hospitals to finish existing construction projects or begin new ones. Mr. Pataki mentioned such a proposal in his State of the State address to legislators last week, but did not offer any details.

The program that union leaders and hospital executives proposed was called HEAL New York. It had two main components: one to provide capital money for new information technology systems for hospitals, and the other to make cost-saving consolidations of hospital programs, if the hospitals agreed to them. The Legislature last year approved $250 million for a similar program, but the governor vetoed it.

Hospital trade groups said the scope of the Medicaid cuts that Mr. Pataki is contemplating would devastate New York's struggling health care industry.

"We are bracing ourselves," said Kenneth E. Rasche, the president of the Greater New York Hospital Association. "Right now, I am dealing with one basket case of a hospital after another. It's a looming disaster."
Health care in Canada

Theatre of discontent

TORONTO

Despite extra funding, one of the world’s best health-care systems is showing signs of wear and tear.

Winter rarely comes early to the balmy bits of Canada, but a chill has already settled over the country’s health services. On October 1st, doctors in Newfoundland shut their surgeries, refusing to treat all but emergencies, hospital inpatients and expectant mothers. In Saskatchewan, 2,500 pharmacists, paramedics and ancillary workers have entered the third week of a walkout. In Quebec, meanwhile, general practitioners are fuming at a new provincial law which requires them to provide services at far-flung, understaffed emergency rooms on top of their normal work.

Canadians are both proud of, and chronically anxious about, their health system, known as Medicare. As enshrined in the Canada Health Act it aspires to combine the public spirit and universal coverage of Britain’s creaking National Health Service with the quality of America’s high-tech medicine. It does this through delicate balances between public and private funding, and provincial and federal power. “Medically necessary” hospital treatment and doctor services are publicly financed, making up 71% of Canada’s C$95.1 billion ($64.3 billion) spending on health care in 2000. But other medical goods and services, such as drug dispensed outside hospitals, are not always covered. Since their cost is rising, there are calls for a national publicly-funded insurance scheme for these expenses.

But the politics of health are complex. Each province has its own definition of “medical need”. It is the provinces, too, that organise and provide health care, raising revenues to pay for it through local taxes, and disbursing money to providers according to local fee scales. The federal government chips in with payments aimed at ensuring that spending per head on health is the same in rich provinces, such as Alberta, as in poor ones like Newfoundland.

To conservative critics, this is a straitjacket that stifles innovation. Alberta, for example, is experimenting with private for-profit provision of publicly-funded services. On October 1st, Action Democra-tique du Quebec, a rising force in that province’s politics, called for greater private involvement in providing and paying for health services, to increase choice. But these are still minority views. Most Canadians would agree with Adrienne Clarkson, the governor general, when she calls Medicare “a practical expression of the values that define us as a country”. Translation: in health care, Canadians do not want to copy the United States.

But paying for health has risen to the top of Canada’s political agenda. In both Newfoundland and Saskatchewan, the strikers complain that their wages are lower than those in neighbouring provinces, leading to staff shortages. The provinces blame the federal government in Ottawa. Last week, Canada’s 13 provincial premiers began an advertising campaign to publicise their complaint that the federal share of health spending has fallen by almost three-quarters over the past 20 years, to 14% of the total (30% says Ottawa).

Traditionally, the federal government has used its financial leverage to cajole the provinces to apply the principles of the Canada Health Act. “But if the federal government wants to carry a big stick,” says Michael Docter, of the Canadian Institute for Health Information, “it is going to have to write a big cheque as well.”

Recently, Jean Chrétien, the prime minister, has opened the cheque book. Two years ago, on the eve of an election and with the federal finances in good health, he promised to pour an extra C$32 billion into Medicare by 2005. With the provinces chipping in more too, the freeze in health spending of the 1990s has been reversed. Even so, in a speech opening the new ses-

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Economical, or just mean?

Health spending, per 1,000 population

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<th>Country</th>
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Source: OECD
Politics in Argentina

Delinquent

BUENOS AIRES
Tackling crime needs police reform

STILL reeling from a four-year economic slump, Argentines now have another big worry: a wave of violent crime. Every day, the media carry grisly details of robberies, murders and kidnappings. Last month, thousands took to the streets of Buenos Aires for a protest march against crime—and the role of the police in some of it. But just how bad has the problem got?

Excitable journalists, such as those at Radio 10, the leading station, have suggested that Argentina is heading the way of Colombia or Brazil, with violent death and kidnaps becoming endemic. Juan Jose Alvarez, the justice minister, dismisses such talk as an “exaggeration”. He is right that crime in Argentina has yet to reach the levels elsewhere in Latin America. But that is small comfort. “People don’t compare their situation to that of other cities, but to the change in their own lives,” he says.

By that measure, the quality of life in Buenos Aires, formerly Latin America’s safest capital, has been declining for a decade. In Buenos Aires province, which includes the capital’s depressed suburbs and is home to one Argentine in three, recorded crime has more than doubled since 1991.

Contrary to public perception, however, the incidence of most crimes has not risen over the past four years, says Marcelo Sain, the province’s under-secretary of security. Figures for the capital’s wealthier inner core also show falls in many crimes since July—perhaps because Mr Alvarez has ordered a lot more police on to the streets. In the surrounding province, what has increased, says Mr Sain, is kidnaps, mafia-style killings (still only a handful), and “media coverage that has nothing to do with the reality of the crime situation”. He claims that such media stories have been whipped up by opponents of Felipe Sola, the province’s executive governor, who is seeking a second term next year.

Such official reassurances are disbelieved by the many ordinary Argentines who have been recent victims of crime or know someone who has. Many, perhaps most, crimes go unrecorded. That is because the police, and especially the notorious Buenos Aires provincial force (known as the Bonarese), inspire fear as much as confidence among law-abiding citizens.

Since Argentina’s military dictatorship of 1976-83, the police have been involved in organised crime. “In the last decade there has not been any major illegal business

Fear and loathing in Buenos Aires

without police participation, from prostitution to gambling, robbery or kidnapping,” says Maria del Carmen Verru, a lawyer at the Centre for the Prevention of Police Repression, a pressure group.

Mr Sain disputes that. He says that his police are no longer involved in criminal gangs. But he admits that around a tenth of the Bonarese’s 44,000 members have been accused of abuse or corruption. Accusations range from collecting fraudulent payments for services not provided, to theft of vehicles, murder and rape. Officers from the force are suspected of involvement in a particularly grisly kidnap in July. Meanwhile, last month, a youth drowned when thrown into a river after being arrested and robbed by federal police (12 of whom are being held over the case).

Ms Verru claims that police death squads still exist. In one case, several officers have been charged with using local juvenile offenders to burgle the homes of those who refused to pay protection money. The youths were subsequently tortured and murdered. A macabre photo album of the victims was apparently used to promote the effectiveness of the officers’ private “security agency”.

Mr Sain dismisses this as an isolated case. He also claims that Mr Sola’s administration is reforming the Bonarese’s outdated organisation. As well as a refusal to tolerate abuses, it has introduced new procedures, such as crime mapping to pinpoint trouble spots. But the regime has only been in place for three months and Mr Sain admits that improvement will “require political will, consensus and time”. Argentines can only hope that all of these will be available.
Canadian leaders reach pact on spending for health care

By Clifford Krauss
The New York Times

Toronto — Prime Minister Paul Martin gained a major victory for his flagging government Thursday by reaching an agreement with provincial and territorial leaders that would substantially increase federal spending for Canada’s ailing $60 billion national health care system.

After three days of contentious negotiations, the officials agreed to send $14 billion in federal money over six years to the 13 provinces and territories that administer health care, with guarantees of 6 percent annual increases through 2015.

Still, the agreement will fall far short of fulfilling Martin’s upbeat pledges in the recent election campaign to “fix the system for a generation,” since the increases in spending will barely keep up with rising costs. It will also cut into the government’s capacity to manage growing urban problems such as homelessness, and to fulfill promises to improve education and rebuild the armed forces, especially if the currently robust economy slows.

But Martin was beaming during his announcement just after midnight, describing the agreement as a new day for the health care system, which for many Canadians is a source of pride and a defining characteristic of the national character.

“It will improve access to health care professionals so Canadians can see a doctor when they need to and where they need to,” said Martin, who is struggling to build momentum after barely winning a parliamentary plurality for his Liberal Party in the June election.

Much of the meeting in Ottawa between Martin and the provincial and territorial premiers was televised, and it highlighted stark shortcomings in the health care system, including the growing shortage of doctors and nurses, the lengthening of waits for cancer care and surgery, and the mounting cost of drugs for an aging population.
Canadian health care

Prescription for change

KITCHENER-WATERLOO, ONTARIO

Is Roy Romanow's report what Canada needs?

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

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

This week, politicians were busy mull-
admission to a hospital sometimes find themselves waiting for hours and even days on gurneys in the corridor, and receiving treatment there.

Waiting is the giant flaw in many national health-care plans. A study this year by the Organization for Economic Cooperation and Development found waiting times for elective surgery are a “significant health-policy concern” in about half of the group’s 30 members, including the United Kingdom, Australia, Sweden, Canada, Italy, Denmark and Spain. Waiting times weren’t a problem in the U.S., the group said.

In Canada, the long waits stirred a public outcry and a government inquiry when a 63-year-old heart patient at St. Michael’s died in 1989 after his surgery had been canceled 11 times. While the inquiry concluded the death wasn’t caused by the delays, it highlighted the long waiting lists and called for better management of patients in the line.

To tackle this crucial problem, Canada is turning to Donna Riley and others like her. The 51-year-old nurse is one of Ontario’s “cardiac-care coordinators.” Her job: to make sure waiting doesn’t kill patients.

Hospitals across Canada struggling with their own waiting-list woes are now trying to follow Ontario’s model. The experience in Ontario, the largest of Canada’s 10 provinces, spotlights one of the essential problems with health-care rationing and a possible solution.

In Canada, one way hospitals restrain costs is by trying to always run at capacity. It’s more efficient to run a hospital that way, just as it’s more efficient to fly

Please Turn to Page A12, Column 1
The NHS's financial difficulties highlight why reforms are so urgent

At the general election in May, Labour convinced voters that it should be given a third chance to sort out the National Health Service. Since then, however, there have been some worrying signs that things are not going to plan.

A recent survey of medical directors by the British Medical Association (BMA) painted a depressing picture. Three-quarters of those working in acute-care hospitals reported that their trusts were facing a funding shortfall. Some 40% said this would lead to a recruitment freeze and around 25% that their trust was considering redundancies.

The spectre of financial famine appears perplexing at a time of financial feast. Record sums of money are coursing into the NHS. Since 1998, cash spending has risen by nearly 10% a year, equivalent to real annual increases of over 7%. The Treasury is committed to keep boosting the health budget at these rates until the financial year ending in spring 2008.

Against this background of tax-funded abundance, critics of the government, not least the BMA, are suggesting that reforms to inject more market forces into the NHS are to blame for its financial problems. The doctors' trade union is too modest. A big reason for the distress is the BMA's success in negotiating lucrative pay deals for its own members.

New contracts for hospital consultants and family doctors (GPs) are proving far more costly than the government expected. The consultants have got a large pay increase for very little so far in return, says John Appleby, an economist at the King's Fund, a health-policy think-tank. GPs are now earning £100,000 (£175,000) a year on average from the NHS, according to Aisma, an association of medical accountants. Their income has been lifted by a big increase in performance-related pay, which Chris Ham, professor of health policy at Birmingham University, says is much more generous than in other countries. With nurses and other NHS workers also getting a boost in earnings, higher pay accounts for about half the increase in this year's budget, estimates Mr Appleby.

The NHS is in a financial fix not because of reform but because of a lack of it. Not before time, that is starting to change. One step is the introduction of a new payments system. Until this year, most hospital trusts were paid through "block contracts" which mainly reflected previous budgets, adjusted for cost inflation, with no direct link to how much work they actually did. But since April, every patient admitted for elective (non-emergency) operations has had a price-tag attached to his treatment, so that hospitals are rewarded according to how busy they are.

The potential gains in efficiency are well worth having. "Payment by results" will generate strong pressures within the NHS to boost efficiency as relatively expensive hospitals strive to push down their costs and cheap ones try to get more business. According to a report this week from the Audit Commission, a public-spending watchdog, the introduction of a similar system in Australia resulted in a big productivity improvement.

The new payments system was used in 2004-05 for both elective and emergency admissions to foundation hospitals, a select group that have won more freedom to run their affairs. Already, there are signs that it is starting to work. Foundation trusts cut the length of hospital stays in 2004-05, whereas it rose among other hospitals (see chart).

Foundation trusts are also improving their performance because they now face more rigorous financial discipline than other hospitals. But the commission expects payment by results to encourage similar efficiency gains to those achieved in other countries. James Strachan, its chairman, said on October 10th that the new system is "fundamental to the modernisa-
tion of the NHS."

However, this positive endorsement drew less attention than worries in the report that payment by results may destabilise NHS finances at local level. There are two main risks. Primary-care trusts (PCTs), the 300 local organisations that purchase hospital treatments, could face a funding shortfall if hospitals do more work than budgeted for. Hospitals, for their part, will run into trouble if they fail to get enough work or to control their costs.

The government has already delayed the full implementation of payment by results in most acute-care hospitals, deferring its use for emergency care until next April. The commission suggests that it could be introduced then in a less stringent form, by including, for example, a standing charge for emergency capacity. A snag with this proposal is that hospitals may then try to shift some of their overhead costs on to the emergency-care budget.

The government is determined to press ahead with payment by results. Indeed, Patricia Hewitt, the health secretary, has said that any instability that it will create is an essential part of raising efficiency. Ministers are planning to try to restrain demand by means such as blocking or discouraging referrals, and by further spreading private-sector provision of NHS health care.

The OECD also calls upon the government to slow the growth in the country’s health budget. In his review for the Treasury in 2002, Sir Derek Wanless envisaged that real spending would continue to rise at an annual rate of 4.4-5.6% in the five years after 2007-08. According to the OECD, this would mean average real growth of 6.6-5.7% in the 15 years to 2022-23, which among the advanced countries would be an unprecedentedly big increase over so long a period. It questions whether the NHS can absorb these extra resources without cost inflation and waste, and says it would be better if growth were to slow to 2-2.5% a year after 2007-08.

The Treasury recently confirmed that it will revisit the Wanless review as part of its spending settlement in 2007. The NHS has to prepare for a stretch of modest years after so many abundant ones. Which is why it must become more efficient.

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The policeman’s dilemma

Oct 15, 2005

Is it better to help someone die or leave them in unendurable suffering?

A LORRY-DRIVER is trapped in the cab of his burning vehicle after an accident. The police, fire-fighters and ambulance service are at the scene, but it is clear he will burn to death before he can be freed. He is in agony. He begs a policeman (who happens to be armed) to shoot him rather than let him burn. The officer does so. This choice—between killing someone and leaving them to die in unbearable pain—is known as the "policeman’s dilemma".

It is difficult to imagine anyone, however religious, condemning the policeman’s conduct as wicked. Yet, argue the supporters of Lord Joffe’s private member’s bill on assisted suicide shortly to be introduced to the House of Lords, if society concedes that, then it concedes the principle of assisting death in extreme distress, where the condition is clearly terminal—as the lorry-driver’s was. Only in very rare cases, reply its opponents, and the principle behind them cannot, and should not, be codified in law. Life is sacred and should not therefore be terminated by others, even on request.

And so the battle over one of the most complex, sensitive and fraught moral issues facing society rages on. This week, the House of Lords debated a select committee report on Lord Joffe’s Assisted Dying for the Terminally Ill bill, an earlier version of the peer’s forthcoming proposal. Under it, helping someone to end his life would become lawful, provided the patient was adult (over the age of 18), terminally ill (had only a few months left to live), mentally competent, was suffering unbearably and had made a written request for such assistance. In cases where the patient was not able on his own to administer the lethal dose, a doctor or nurse would be permitted to do so.

Since the 1961 Suicide Act, it is no longer a crime to commit suicide or attempt to do so. However, it remains unlawful, punishable by up to 14 years in prison, to "aid, abet, counsel or procure" a suicide. And deliberately taking the life of another person constitutes murder, even if the person is dying and has asked to be killed. A patient’s refusal of treatment does not constitute suicide, which in law requires a "positive act". Nor is it murder if, to relieve pain, a doctor administers a drug that as a side effect shortens the patient’s life—the "double-effect principle".

The last time Parliament picked its way through this moral mire was in 1994, when another House of Lords select committee decided not to change the law. It said you could not set limits on voluntary euthanasia (mercy-killing at the patient’s request) to ensure that the law would not be abused. It foresaw a "slippery slope" in which mercy-killing slid ineluctably towards involuntary euthanasia. It was particularly worried that elderly, lonely, sick or distressed people would feel pressure, whether real or imagined, to request help with an early death, fearing they were becoming a burden on their families.
Foreign doctors pour in to ‘plug gap in the NHS’

By Nigel Hawkes
Health Editor

FOREIGN doctors have responded to advertisements by the Department of Health to stay in the UK because of the gap in the NHS.

A single advert running for six months in medical journals produced 1,500 expressions of interest and 150 applications.

The greatest numbers are from Germany, India, Israel and the United States. They have come from doctors with several years’ experience. A Department of Health spokesman said “the quality is certainly there.”

This is the first time since the 1970s that the department has tried to recruit doctors from abroad, but the problems of achieving the NHS Plan leave little choice. Although places at medical schools in Britain are increasing, it will be years before they have any effect on the supply of doctors.

Alan Milburn, the Health Secretary, yesterday set a target of 1,000 overseas doctors and 2,000 nurses with the same qualifications.

He was on a visit to Spain, which a year ago signed an agreement with Britain covering the recruitment of doctors and nurses. Since then about 400 nurses have been recruited, mainly to hospitals in North West England. They are expected to be joined by about 50 hospital doctors and GPs by the end of the year.

“Well-trained, experienced and ambitious doctors and nurses want to come and work in Britain’s NHS,” Mr Milburn said.

“We are already training thousands more hospital doc-

rors and GPs. Training doctors takes time, so these new recruits from countries such as the US, Spain, Germany and Israel will help us to plug the gap.”

Unlike Britain, where medical school places have been tightly controlled, many countries have a surplus of doctors.

Mr Milburn said that there were 6,700 more doctors working in the NHS than in 1997, and 17,100 more nurses. These increases have yet to affect the level of patient services. By almost every index — hospital activity, waiting lists and waiting times — the NHS is merely keeping up with rising demand.

Given the evidence that an increasing proportion of doctors intend to retire early and the limitations of junior doctors’ hours which will be imposed by adoption of the European Working Time Directive in 2004, meeting the promises made in the NHS Plan appears to be almost impossible.

Mr Milburn, who praised cooperation between the public and private sector in Spain’s health service, said: “The involvement of the local community in the running of our hospitals is vital. Here that is very much the case.”

Nov 8, 2001
The Times, London
If Tony Blair wants a European-style health service, he should ask how Europeans meet the cost.

Britain's National Health Service stands out as an exception among health systems in rich countries. It is exceptionally cheap. It is exceptionally state-dominated, with the government providing both the cash and the care. It is also, according to many indicators, exceptionally poor, with Britons suffering long waits for treatment and scoring badly on a wide range of international comparisons such as infant mortality and the survival rates of patients with cancer.

Public disquiet with the state of the NHS has led Tony Blair's Labour government to drastic action. Money is now being poured into the service in the biggest sustained expansion of resources in 30 years, and the government has committed itself to raising the level of funding to the European average. The NHS's monopoly on provision is being eroded. Private hospitals and clinics are being allowed to offer more services to NHS patients, as they do on a large scale in other European countries.

Yet the government's enthusiasm for the European model is oddly lop-sided. It wants European levels of care; it wants to encourage all sorts of different providers of health services; it wants European levels of funding; but it draws the line at European models of funding. The government refuses to countenance the idea of encouraging the higher levels of private insurance or mandatory contributions into social insurance funds which finance much of the cost of health care elsewhere in Europe. Public financing is sacrosanct: the taxpayer must stump up the money for the NHS. There is nothing wrong, says the government, with the way we pay for the NHS. We just need to pay more for it.

As Gordon Brown, the chancellor of the exchequer, prepares the ground for a budget on April 17th which is expected to raise taxes, the need for more tax money to finance the NHS is central to his argument. Tax funding, he maintains, delivers a more equitable service. Unlike employer-financed health contributions, which cause much grumbling among businessmen in France and Germany in particular, it does not weigh heavily upon companies. Unlike private insurance, tax fund-

More money, and more useful money

One good reason for bringing more private money into the system is that private money usually means more money. As a rule, the more a health service relies on tax, the poorer it is. It is not surprising that much of the extra money available for health care on the European mainland comes from private contributions, not from those countries' exchequers. People are generally keener to spend their money on themselves and their families than they are to pay more tax. What's more, if they buy health insurance, they can choose what they buy and who they buy it from. If they get more health care indirectly through the tax system, they can't.

New sources of money should make the system work better, too. The government is struggling to introduce competition among providers, by encouraging private hospitals to compete with NHS hospitals for custom. But turning the NHS into a discerning buyer is hard work. It involves setting up an internal market; and though an internal market may be better than no market at all, it is never going to work as well as the real thing. Private insurance companies operate in a real market. They have to try to get the best care at the best price, or they go out of business. Bringing more of them into the system should ginger up the performance of the NHS hospitals.

In a recent speech, Gordon Brown expressed confidence that a national consensus could be built "around making the NHS the best insurance policy in the world". Somehow he forgot to say "compulsory". The NHS's failure to excel, after 54 years, is not the result of some failure of national will. The problem with having one insurer is that it does not face competition to drive up standards. That is why the debate about financing the NHS will not go away.
Germany: Misprescribing for health care

WHAT is Germany's new health minister, Ulla Schmidt, up to? First, she lifted the collective financial penalties imposed on doctors who overshot spending limits on prescription drugs, thus, in effect, killing off that eight-year-old attempt to keep down soaring health costs. Now she has announced that there will be minimum rates for health-insurance contributions. This will restrict the ability of the rival schemes to compete, and so, again, to bring down costs.

Germany has a generous and expensive health-care system. Nearly 11% of GDP goes on health, a proportion second only to the United States' 14%. Yet patient satisfaction is low, lower even than in Britain, which spends only 7% of GDP on health. And in last year's World Health Organisation survey of health-care systems, Germany was ignominiously ranked 29th, again behind Britain (though ahead of the United States, in 33rd place). In quantity and quality, Germany's health care was good, said the wire, but its cost and efficiency were dismal.

As the population grows older, and medicine more elaborate and expensive, reform becomes ever more necessary. The government of Gerhard Schröder has tried. But health reform, never easy, is especially difficult in Germany because of the complexity and power of the many interests involved. These include the big pharmaceutical companies, the 300,000-strong doctors' lobby, dozens of health-insurance schemes, which reimburse doctors and run hospitals, and the 16 state governments, which build and maintain the hospitals.

The government has had one success. Under a law of 1999, hospital financing is being revamped. Instead of receiving a standard fee per patient per day, hospitals are now to get a lump sum reflecting the type of complaint being treated, regardless of length of stay. But the doctors are a tougher nut.

When it came to power in 1998, the Schröder government warned them that it would make them pay out of their own pockets if they exceeded the spending limits on prescription drugs. Much of the effect was good. Some doctors who had previously fiddled out drugs like lollipops began thinking twice before writing an unnecessary prescription, or turned to cheaper, generic medicines. But there were bad effects too. Sometimes doctors avoided prescribing the best, but also costliest, medicines. Worse, some turned away patients who needed particularly expensive medication. Many, however, reckoning that they, not some bureaucrat, knew what was the best medical practice, simply carried on as before.

As the government repeated its warning of sanctions, doctors replied with demonstrations and even strikes. What especially angered them was a decision to make all doctors within a given region collectively responsible for over-prescription. As soon as she became health minister in January, Mrs Schmidt announced that doctors would not, after all, have to pay for the accumulated DM1.8 billion ($800m) drugs overshot of the past two years. She also promised there would be no collective sanctions in future, without proposing anything to replace them. Doctors swiftly sent spending on prescription drugs up 13% higher in January this year than last.

The health insurers, which bear the cost, were not amused. They were already threatening to put up their contribution rates next year—when a general election is due—unless health spending were brought under control. In an effort to let competition make schemes more efficient and keep rates down, patients have been allowed since 1996 to transfer from one scheme to another. Millions of mostly young and healthy people have done it, pulling out of the statutory, regionally-based schemes, with rates up to 15% of a typical member's gross income, for new company-run ones, whose rates can be as low as 11%.

The exodus has left the statutory schemes with a disproportionate number of the old and infirm, who usually cost more and contribute less, putting further pressure on rates. So Mrs Schmidt recently announced a minimum contribution rate of 12.5%. It is now employers, who pay half their workers' contributions, and the clients of the cheaper schemes who are hopping mad.

Germany
A New Swedish Model of Consumer Choice in Healthcare
by Johan Hjertqvist

European governments have struggled to combine their traditional ethos of equity in healthcare with the demands of a more sophisticated, consumer-driven society. Few expected that their inspiration for reform might come from Sweden. Yet this country, known for its deeply-rooted belief in the welfare state, has changed as it has come under pressure from both patients and health service workers.

The shift from a healthcare system characterised by public service monopoly, hierarchy, and top-down attitudes to one having diverse providers, networks, and consumer power has been most striking in Stockholm. But all over Sweden, consumers have gained access to a healthcare market which allows individuals to use public funding for treatment throughout the country. The number of contracted private healthcare providers has risen, reflecting consumer choice and the apparent preference of many young doctors and nurses to work for private contractors.

Stockholm's revolutionary approach – public funding, public-private co-operation, and freedom of choice – has begun attracting international attention. National and regional officials in states such as Canada, Norway, the Netherlands, Germany, Japan and the UK have all begun visiting Stockholm to analyse the outcomes.

The most striking consequence so far has been the British government's recent decision to modify its National Health Service, long the untouchable 'sacred cow' of UK politics. The NHS is slowly being reformed from a monopolistic and bureaucratic entity into a more decentralised agency with greater consumer focus. Most important, it is becoming more efficient in delivering health services.

Much of New Labour's plan will have a familiar ring to Stockholmers. Waiting periods for treatment are to be reduced to three months at most (equivalent to those in the Stockholm region), though not until 2008. 'Perverse incentives' within the NHS are to be replaced with constructive ones. Hospitals are to be paid for what they actually deliver – as is the case with Stockholm's Diagnosis Related Groups (DRG) system (which is itself akin to that of the U.S. Medicare programme). The DRG system allocates a price to every diagnosis or treatment and only compensates hospitals once the service has been delivered. In Stockholm, this step has dramatically reduced waiting lists. British patients will be able to choose freely among healthcare providers, in order to reduce waiting times and improve quality. As in Stockholm, healthcare authorities will be required to inform people of the options available to them. To strengthen freedom of choice and expand supply, publicly-funded private care providers are to be contracted, as in the Stockholm County Council (Sweden's elected regional authority responsible for funding and delivery of health services). Independent hospitals are also to be introduced under NHS auspices, as is already the case in Stockholm.

With this combination of decentralisation, consumer influence, and productivity incentives, the UK Government hopes to remould the NHS. But the Stockholm County Council is not the only source of inspiration. Elements of Sweden's national model are now also being exported. Local authorities, for example, are to be made financially responsible for so-called 'bed-blockers' (elderly patients who remain in hospital beds longer than is medically necessary because they do not have access to long-term care). Budgeting responsibility is to be moved down to Primary Care Trusts, freestanding bodies within the NHS responsible for commissioning and providing community healthcare services. These Trusts will in future control 75 percent of all NHS funding allocations, along the same lines as Swedish County Councils.

British Prime Minister Tony Blair's NHS advisers are taking a pragmatic view of developments in Stockholm and other reformist county councils. As they see it, public healthcare cannot stand still in a changing world.

The UK and Sweden are not the only countries struggling with these problems. The challenge to reform healthcare is universal. Other Scandinavian countries such as Norway, Denmark, and Finland could also benefit from the Stockholm approach. Basic financial incentives and options for workers to start their own businesses could revolutionise the delivery of healthcare in eastern Europe, and Sweden's independent hospitals are already attracting interest in the Netherlands and Germany. In future, healthcare consumers in the developed world will become less and less tolerant of long waiting lists, inadequate information, and lack of influence.

The new Swedish model – consumer-driven, and incorporating positive economic incentives – is the future of healthcare. Governments neglect it at their peril.

Johan Hjertqvist is Director of the Timbro Health Policy Unit. Timbro (www.timbro.com) is a free-market think tank based in Stockholm, Sweden.

To read other articles in the series, visit www.pfizerforum.com
its leaders organised a rally in Ho Chi Minh City. The authorities said they were planning mass suicide, pointing to the self-immolation of a woman in the sect. She was protesting at the arrest of a Buddhist leader, Le Quang Liem, an octogenarian.

Buddhist monks are routinely detained. As in its dealings with other Christians, the Communist Party interferes with the running of the Buddhist order, claiming the right to appoint abbots at monasteries. Despite government assertions that Vietnam allows generous and growing religious freedom, Human Rights Watch, a monitoring group based in New York, suggests in a recent report that it remains sharply curtailed.

But the report generally explains the troubles in the central highlands. The government blames foreign agitators, especially Americans, for stirring up the hill folk. To a limited extent, foreigners do indeed hold some influence. The hill tribes, collectively known as Montagnards, had close ties with American forces before the unification of Vietnam in 1975. Today, many have relations in the United States, where the Montagnard Foundation, in South Carolina, campaigns on their behalf. The executive director, Koke Soro, admits that he advises protesters by telephone on how to confront the officials peacefully and in unity.

Land, he says, is a bigger problem than religion. "If somebody takes our land away, we take our life away." The hill tribespeople say that large numbers of lowland Vietnamese are migrating to higher ground and threatening their traditional way of life. Lowlanders, who see ethnic minorities as backward, are clearing land and forest to make way for plantations of coffee, which does well in the cooler climates higher up, and for other cash crops, all of them valuable for the export market.

Such deforestation in the hills is a contributing factor to the floods that now strike Vietnam nearly every year. And clashes over the land itself have generated unusually open dissent in many parts of the country. In the past few years, disgruntled, land-hungry farmers have marched into Hanoi, the capital, and into the largest town, Ho Chi Minh City, to stage demonstrations, sometimes lasting for several weeks at a time.

While acknowledging that such protests take place, the government tries to play them down, though its television station did show a few seconds of footage of the recent riots. State-controlled newspapers blame "reactionary elements" for causing trouble. But party leaders are preparing for their five-yearly congress, which is due to begin on April 9th. That big political set-piece makes the party even more than usually sensitive to signs of protest.

In a typically communist response, a propaganda unit from the army has been sent to the highlands to "educate" the tribespeople. Meanwhile, local authorities have been forced to admit "errors", and a minister for ethnic affairs, Hoang Duc Nghia, has been ticked off. A party newspaper, Nhan Dan, last week scolded officials who have "stayed away from the people and have not really understood all the difficulties they face". The government seems to be trying to meet some of its critics' demands. A May-June health ministry survey predicted 20,000 new cases of the disease in 1993, but the revised figures now put infections at 4,000.

Mr Abe, however, argues that, although the virus was aware of the danger of hiv infection, he could not have anticipated the consequences of the disease, because so little was known about AIDS. The judge dismissed the evidence of Mr Abe's two colleagues as lacking credibility. They testified, he suggested, to save their own skins.

Nor did the ruling deal with the question of Mr Abe's motivation. Prosecutors had sought to show that Mr Abe had delayed the introduction of heat-treated clotting agents in order to help out Green Cross, a Japanese pharmaceuticals company. Green Cross had invested heavily in unheated products. The firm also trailed behind its competitors in the development of sterilised blood products. Mr Abe enjoyed close relations with Green Cross. Between June 1983 and November 1984, for instance, he received $112,750 (then $185,000) from Green Cross, as well as money from other drug companies. The Green Cross donations went towards conference and symposium costs and an endowment fund that supported Mr Abe's foundation. This foundation promoted the use, at home, of unheated blood products.

Some good has come from the tragedy. The health ministry's continuing attempts to cover up the truth have caused Japan's deferential voters to look at their government through new eyes. Last year, Mrs Kawada became a member of parliament, from where she campaigns on human-rights issues. Her son Ryuhel is a focus for protest at the often arbitrary and accountable exer-
Health care in Japan

Up go the doctors' bills

Japan

Problems of an ageing nation

THANKS to a mandatory national health insurance system, medical care, most of it competent, is available to almost everyone in Japan. Patients can go to any hospital or doctor. The service is not free, but medical bills have been reasonable. The Japanese live longer than any other people in the world, and the infant-mortality rate is one of the lowest. But the system is a big and rising cost to the state: currently ¥31 trillion ($265 billion) a year, roughly 6% of GDP. More than a third of the money goes to treat people over 70, one-eighth of the population.

By 2025, predicts the Ministry of Health and Welfare, one in four Japanese will be over 70. Health-care costs will balloon to ¥70 trillion, half of which will be used to treat the elderly. From April 1st, in a controversial move by the government to find more money for the service, salaried workers will have to pay 30% instead of 20% of their medical bills. Doctors, traditionally stalwart vote-collectors for the ruling Liberal Democratic Party, fear that hard-up patients will forgo visits. The sagging economy has already forced a number of clinics to close. Opposition parties have submitted a bill in parliament calling for a freeze on dearer health care.

Some critics say that hospitals and clinics should be made to cut their expenses before their patients are made to pay more. They point to the practice—admittedly, allowed by the government—of medical centres buying medicine below prices set by the government, and pocketing the difference. Nor have patients escaped criticism. They are over-medicated, it is claimed, and are put through too many costly tests.

Hideya Sakurai, of the Japan Medical Association (JMA), says these practices are changing. He points out that doctors’ consultation fees, also regulated by the government, were lowered a bit last year. He says the government should raise money for health care by increasing taxes on cigarettes, which are cheaper in Japan than in many other rich countries.

The government is also under pressure to raise the quality of medical care. Though good for standard procedures, Japan is said to be falling behind other industrialised countries in keeping up with new medical technologies. Private companies are not allowed to operate hospitals or clinics for profit. Much cossetting by the health ministry has led to complacency among doctors.

The government is now considering partially deregulating the medical industry to allow medical groups to operate in special “structural reform zones” on a businesslike basis. This has won plaudits from medical-reform advocates, who believe successful hospitals could offer even better care based on top technology. The biggest problem for the government is how to placate the JMA. It is staunchly opposed to the plan—and doctors remain an important influence at election time.

March 15, 2003

The Economist

Japan

One in four Japanese over age 70 by 2025.
Shifting Burden Helps Employers Cut Health Costs

By Vanessa Fuhrmans

EMPLOYERS SLOWED their runaway health-care costs more sharply than expected this year, but they did it mostly by shifting an unprecedented share of the expenses to employees.

The average cost of employer health plans rose 10% per employee in 2003, less than the 14% that was predicted heading into 2003, a new survey of 3,000 employers found. Earlier surveys this year indicated that soaring costs were finally slowing after several years of ever-larger increases. But the new study, conducted by Mercer Human Resource Consulting, offers a more comprehensive picture of 2003 health-care costs and suggests employers have been even more successful at reining in health-care expenses than anticipated.

Still, health-care costs continued to climb at a double-digit pace. And without raising employees' premium contributions and deductibles and trimming coverage, employers wouldn't have seen costs slow much at all. "The last three or four years, employers really didn't pass on much of the cost increases," says Blaine Bos, a Mercer health-benefits consultant. But this year, "they took out their scalpels.

Another wave of cost shifting is likely next year. A quarter of the companies surveyed said they expected to increase employee contributions, and 23% said they would pass on more costs by making changes to the health plans they offer workers. Nonetheless, companies in the survey said they anticipated that their health-care costs in 2004 will surge again, this time by 13%. Mr. Bos notes that chief financial officers at many companies believe that unless they are able to cut annual health-benefit cost increases to 6% sometime soon, those costs soon will become unsustainable.

"But that's very difficult to do without creating a huge disruption with your work force," he says.

Some employers, particularly larger ones, are trying to find additional solutions to the rising costs, rather than just passing them on to employees. The number of companies that adopted disease-management programs for employees' chronic conditions and other wellness initiatives to make work forces healthier jumped this year. "To the extent these bear fruit, we may see a lessening of more draconian measures over time," Mr. Bos says.

In the meantime, though, the struggle over shifting costs has made health benefits a hot-button issue at companies around the country. In California, 70,000 workers at several grocery chains, including Albertsons Inc., Kroger Co, and Safeway Inc., have been involved in a protracted strike over proposed cuts to their health care. The three grocers say that competition from Wal-Mart Inc. requires them to cut costs.

At Lucent Technologies Inc., hundreds of retired workers reacted angrily earlier this fall to plans to raise premiums and make other benefit cuts. The Murray Hill, N.J., company says that after watching its health-benefit expenses soar 50% in the past five years, it had no choice. Health benefits for Lucent's retirees and their dependents alone cost the company $850 million a year, about 10% of the company's annual revenue.

"We are still committed to a subsidy for our retirees' health benefits, but we have had to make some changes," says Bill Price, a Lucent spokesman. "We have to make sure we're going to be around as a competitive company to offer those benefits in the first place."

Many companies have been paring, and even phasing out, retiree benefits for years. According to the survey, only 21% of large employers still offered medical coverage to Medicare-eligible retirees, down from 46% a decade ago. Just 28% offered coverage to early retirees, compared with 46% 10 years ago.

Cost shifting by employers is prompting some

On the Rise?

Shift the cost from the company to the workers.
Keep insurance affordable

Gov. Bill Owens wants health insurance companies to be able to offer bare-bones, minimum policies in Colorado, meaning they no longer would be required to provide coverage for 15 illnesses or procedures but would only cover “catastrophic” illness. The legislature should seriously consider the proposal, because it might lower premiums and help insure some of the 780,000 Coloradans who lack any medical coverage.

However, Owens must address several crucial concerns if he expects state lawmakers and the public to support the changes.

Over the years, the legislature heeded consumer requests and mandated that health insurers cover, among other things, mental illness, mammograms, prostate screenings, medical complications of newborn infants and several other conditions or procedures. Each mandate was well-intentioned.

In health insurance, though, the law of unintended consequences often prevails. Owens now believes what insurance companies long have claimed: that these required coverages, or mandates, significantly drive up the cost of insurance, making medical coverage of any kind too expensive for small businesses.

Owens hasn’t said which of the 15 mandates he wants repealed.

But in the past year, employers’ premiums rose 13 percent or more and thousands of Coloradans found themselves without any health insurance after rounds of layoffs and business failures. Owens rightly says that the worsening health insurance crisis demands innovation and action.

Yet several aspects of his plan need more explanation:

- Common sense indicates that reducing mandates should also reduce costs. Owens needs to supply independent, credible evidence that premiums will fall, or that more small businesses will provide medical benefits, if mandatory coverages are repealed.

- Two years ago, the legislature ordered insurance companies to cover serious mental illnesses on par with serious physical diseases. A large body of national research says that covering mental illnesses is both more humane and cost-effective. The requirement that insurers cover mental illnesses represented enormous progress in the social and political understanding of what mental illness really is and how it should be addressed. This mandate must not be repealed.

- Employers who now offer health care benefits may rush to buy stripped-down policies, so thousands of Coloradans could find themselves with less complete medical coverage than they have now.

It’s important to avoid stripping Coloradans of coverage they depend on already. Thus, we would ask the legislature to limit bare-bones plans to small businesses that don’t now offer benefits or that are in danger of being priced out of their existing plans.

- In any case, if mandatory coverages are repealed, then employers who offer stripped-down coverage of catastrophic illness must also make sure that employees have the right to purchase additional coverage, in a “cafeteria-style” benefit plan.

Although serious, these worries shouldn’t stop lawmakers from reviewing the Owens proposal. Certainly, lawmakers must carefully weigh the consequences of making changes.

However, with increasing numbers of Coloradans going without any health insurance, the costs of inaction have become unacceptable.

Jan 5, 2002

In this column alone is The Denver Post’s opinion expressed.

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Workers are picking up an increasing share of expenses

By Theresa Agovino
Associated Press

NEW YORK — The rate of growth in health-care spending fell for the second year in a row in 2003 as demand for health services dropped because workers were forced to pick up more of the tab for their care and a surge from a change in managed care policies ebbed.

However, experts said costs are still outpacing inflation and remain a grave concern as more people can’t afford health care.

Health-care spending per privately insured person increased 7.4 percent last year, down from a 9.5 percent rise in 2002 and 10 percent gain in 2001, according to a report being released today by the Center for Studying Health System Change, a public policy research organization in Washington, D.C.

The growth rate is still historically high. The inflation rate in 2003 was 1.9 percent. And the gap between the rise in health spending and Gross Domestic Product, which was 3.8 percent last year, widened to 3.6 percent percentage points, compared with a 30-year average of 2.5 percentage points.

"The bad news is this is still a high rate of increase, and the fact that it is lower than last year doesn't mean it has gotten easier to find affordable health care," said Paul Ginsburg, the center’s president.

The cost shifting was most prevalent in prescription drug plans, Ginsburg said.

More health insurers instituting three-tiered drug plans, which force employees to pay more for brand name drugs, making cheaper generic medicines more popular. That’s a major reason pharmaceutical spending rose 9.1 percent, down from the 12.3 percent rise in 2002.

According to pharmacy benefit manager Express Scripts Inc., the average price of a prescription drug before discounts rose 7.9 percent last year, down from a 13.1 percent spike a year earlier. The company cited increased use of generic drugs.

The Center for Studying Health System Change study also said drug price inflation shrank to 3.1 percent last year, down from just over 5 percent a year earlier.

Spending on hospital outpatient centers rose 11 percent—the largest jump in the study. A year earlier, spending in that sector increased 12.9 percent.

Ginsburg said spending in such centers is growing because advances in technology allow more procedures to be conducted outside the hospital.

The 6.5 percent increase in spending on hospitals worried Ginsburg because it resulted from higher costs, not more utilization. In fact, utilization was only up 0.9 percent last year. Hospital prices for both inpatient and outpatient care increased 8 percent in 2003, compared with a 5.2 percent jump in 2002.
Healthy Trend

New Way to Curb Medical Costs: Make Employees Feel the Sting

Whole Foods Plan Tries to Give Workers a Reason to Save; Risk for Chronic Conditions

A Question for the Podiatrist

When Patrick Bradley visited a podiatrist last year, the vice president at Whole Foods Market Inc. was asked to walk up and down the hallway so the specialist could check his gait. The itemized price for his stroll: $50.

Most people with medical insurance simply would have swallowed hard and forwarded the claim to their insurer. Mr. Bradley, who is 44 years old and was suffering from an inflamed nerve in his toe, complained. The doctor ended up waiving the charge. "He actually said that no one had ever questioned it before," Mr. Bradley says.

Whole Foods is on the forefront of a campaign to change that. The 159-store grocery chain last year adopted a health plan that encourages its 30,000 or so workers to feel a bit of the pain every time a doctor sends out a bill. The new "consumer driven" medical coverage gives employees more of a financial stake in what they pay for medical care in hopes of slowing the growth in medical costs.

With more traditional plans, workers pay a premium that is taken out of each paycheck and must meet an annual deductible of at least a few hundred dollars. After that, insurance picks up most of their health-care costs. In health-maintenance organizations, there are generally lower premiums and no deductibles, but employees pay a small fee each time they visit a doctor—and often have to jump through hoops to see doctors outside the HMO.

The Whole Foods plan, which workers themselves chose over two competing plans after a series of votes last summer, has no premiums at all for many workers. But the deductible is a relatively hefty $1,500. Whole Foods each year puts money into an account for each worker to use for health-care expenses. If employees don't spend their money in one year, they get to carry it over to future years. After the deductible is reached, the plan operates more like a traditional one, picking up 80% of most medical expenses.

The hope is that once the money feels as though it belongs to them, people won't get an MRI when an X-ray (or an ice pack) might do. Already at Whole Foods, the plan is inducing the company's butchers, bakers and baggers to take responsibility for cutting costs by buying generic drugs, asking for fee waivers on lab tests and other procedures, and keeping a closer eye on what doctors charge for their services.

The plans have one big drawback: People with chronic conditions can take a big hit, since they have little choice about how

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Shifting Burden

With Medical Costs Climbing, Workers Are Asked to Pay More

Faced With Rising Expenses, Companies Boost Copays, Premiums for Employees

Ms. Simms Rations Her Meds

By Barbara Martinez

Audrey Simms can’t afford to get all three of her prescriptions filled each month. So she alternates, sometimes skipping her thyroid medication, at other times forgoing her acid-reflux pills or her hormone treatment.

It’s a familiar story for the millions of Americans who lack a prescription-drug benefit. But Ms. Simms, 46 years old, does have that benefit through her Missouri government job. She simply can no longer afford the copayments.

Drugs that used to require copays of $5 and $10 just a few years ago are now costing her as much as $40 each in copays. Ms. Simms, who takes home about $1,200 a month, would have to spend more than $100 for her three prescriptions each month.

“So I decide between the medicine and the food,” says Ms. Simms, who works with the mentally ill in St. Louis. “And I have a 12-year-old daughter to feed.”

After years of generous health-insurance benefits, American workers increasingly are paying much more for their health care. Though the consumer price index is beginning to show a slowing in the rate of price increases, overall spending on health care by employers continues to climb as aging Americans use more medical services. Employers, saying they can no longer afford the 12% to 15% annual increases in the cost of providing health benefits, are raising workers’ copays, deductibles and monthly premiums.

According to the Bureau of Labor Statistics. Americans’ average annual out-of-pocket expenses for health care rose 26% between 1995 and 2001, to $2,182. The Kaiser Family Foundation, a nonpartisan research group based in Menlo Park, Calif., that tracks health-care spending, says that workers’ average monthly contribution to premiums for family coverage alone more than tripled to $174 from $52 between 1998 and 2002. Copays for brand-name drugs that have generic equivalents jumped 62% to $26 last year from $16 in 2000, while generics rose to an average of $3 from $8, Kaiser says.

Health plans and employers are also instituting copays for services that never required one. Ms. Simms’s employer, the state of Missouri, this year added a $200 copay in some plans for hospital admissions.

The big shift of health-care costs from employers to employees comes at a bad time. Many workers who manage to keep their jobs in the wobbly economy already face wage freezes and wage cuts. An in-

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Sore Subject

As health costs rise...
Total cost for health benefits of current employees, per employee

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Sources: Mercer Human Resource Consulting; Kaiser Family Foundation

Workers dig deeper
Average monthly worker contribution for family coverage

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Sources: Kaiser Family Foundation
Growth in Medical Costs Slows As Firms Shift Tab to Workers

By VANESSA FUHRMANS

U.S. employers’ health-care costs rose an average 6.1% in 2005, one of the lowest rates of increase in recent years, and are expected to climb at a similar clip next year, a new nationwide survey shows.

Employers, however, pulled off the reduced rate of increase largely by shifting more costs onto employees, said Mercer Health & Benefits, which conducted the survey. Rather than raise employees’ share of the premiums, many employers opted to increase deductibles and co-payments for medical services and drugs, shifting costs to those who use health benefits the most.

While the rate of increase is the lowest since 1998, the jump in absolute dollars remains large. Per employee, the cost of company health plans rose to $7,088 from $6,679 in 2004. The survey of 2,999 employers by Mercer, which sells consulting services to employers, is one of the largest of its kind and typically offers a more conclusive picture of employer medical-cost trends than surveys conducted earlier in the year.

Next year, employers predict the average health-benefit cost per employee will rise 6.7%.

After several years of passing on more of the cost of health benefits to workers, employers are fine-tuning their approaches. “Earlier approaches were blunter,” says Michael Thompson, a principal at PricewaterhouseCoopers in its human-resources consulting division. “The newer ones are trying to get it right.”

American Standard Cos., a manufacturer of plumbing, air-conditioning and automotive products with 20,000 U.S. employees, has charged higher co-payments for brand-name drugs versus generic alternatives for several years. But it saved an additional $740,000 in prescription-drug costs this year after a campaign at its Tyler, Texas, plant that included mailing employees pamphlets encouraging generic-drug use and meeting with local doctors who prescribe medicines. Its overall health-care costs have risen 7% this year and are expected to rise an additional 6% next year, says Joe Checkley, director of employee benefits.

Pitney Bowes Inc., a Stamford, Conn., mailing equipment and services company, still doesn’t require employees to pay a general deductible for medical care. But last year it began charging one ranging from $250 to $1,000 for imaging tests, such as magnetic-resonance-imaging procedures. While the number of MRIs hasn’t declined, the cost per MRI has, “which tells me people are asking the right questions,” says John Mahoney, company medical director. Pitney Bowes says it also has saved money overall by lowering copayments for maintenance medicines for chronic diseases such as diabetes, hypertension and asthma.

Canadian company RBC Financial Group, which has 15,000 U.S. employees, says growth in its U.S. health-care costs has slowed from double digits a few years ago to a projected 3.1% next year after it implemented a disease-management program and consolidated dozens of health plans to a handful administered by a single health-plan provider. This year it joined a large drug purchasing coalition with other large employers.

Some 22% of the country’s largest employers surveyed by Mercer offered a so-called consumer-directed plan, which combines high deductibles and savings accounts to encourage more careful health-care consumption. But despite hopes such plans would appeal to small businesses, only 2% of employers with fewer than 500 workers offered them. In the study, the portion of employers with fewer than 50 employees providing health coverage fell to 58% from 63% in 2003.

Macquarie Bank Ltd.

Group of Investors Purchases Icon Parking for $634 Million

Australian investment bank Macquarie Bank Ltd. said it led a group of investors to buy New York parking company TMO Parent LLC, operating as Icon Parking Systems, for $634 million. Macquarie, which will hold a 52.5% stake in the company, said the price includes transaction costs and is subject to working capital and other adjustments. Established in 1947, Icon Parking is owned by the company’s founders and Goldman Sachs Group Inc.’s Whitehall Street Real Estate Funds. It owns or operates 125 off-street car-parking locations in New York City. The Macquarie-led investor group includes four Australian pension funds: MTAA Superannuation Fund, Australian Retirement Fund, Westscheme and Statewide Superannuation Trust. The group will contribute $237 million in equity, of which Macquarie will commit $124.5 million, the company said. The remainder of the enterprise value will be funded by assuming Icon Parking’s debt.

Save 50% on a Journal Subscription
HELP RID US OF DRUG GANGSTERS

Family’s plea after shooting

BY JASON COLLIE
CHIEF REPORTER

THE family of last week’s Caversham shooting victim have begged for help to tame drug-dealing gangsters terrorising their neighbourhood in west Reading.

Imran Ishtiaq’s family met detectives, Reading West MP Martin Salter and the Evening Post to make their heartfelt appeal for police, political and community help following the shooting.

Mr Ishtiaq, 18, was shot in the stomach and arm by a hooded gunman as he filled his car with petrol at the Total service station in George Street on Tuesday about 6.20pm.

His family told on Friday how the gang, which deals in heroin, was trying to control the streets around the Oxford Road.

In an appeal to Mr Salter for more police in the area, one of Mr Ishtiaq’s uncles said: “The police are doing their best – that’s not up for dispute – but the best is not good enough for these families. I realise there is no magic in the system and we have to go step by step but I am very afraid.”

Another uncle added: “It is a very frightening situation. Give up the guns or someone is going to die. It could happen to anyone, not just Imran.”

Please turn to page 3 column 4

Nov 5, 2001
Reading Evening Post
England

Drug dealing gangsters
Going to pot?
Reclassifying cannabis isn't enough to break the link to hard drugs

THE great cannabis debate has been reignited in Britain by a government proposal to reclassify weed as a “softer” drug. If it’s passed, Britain will become one of many countries that are reducing the penalties for cannabis use.

So is this move part of a dangerous liberal trend that will lead to an explosion in the use of cannabis and other, more dangerous drugs? Or is it a long overdue step that does not go far enough towards breaking the link between marijuana, hard drugs and crime?

In Britain’s three-tier classification system, cannabis is currently in Class B, along with amphetamines—a position that many argue is out of keeping with the danger it poses. The proposal is to reduce it to Class C, along with drugs such as anabolic steroids. This would mean milder penalties for possession, although it falls short of legalisation or decriminalisation.

Supporters of the scheme argue that it will free up police to tackle more dangerous drugs such as crack. In 1999, nearly 70 per cent of people arrested for drugs offences in Britain were charged with possession of cannabis. Processing each offender can take a police officer up to three hours.

What’s more, figures from last year’s British Crime Survey show that 44 per cent of 16 to 29-year-olds have tried cannabis at some point in their lives, with 22 per cent having used it in the last year. Clearly the law isn’t holding everybody back. But will relaxing the law increase its use?

The evidence from countries that have gone even further than Britain proposes to is clear. In the Netherlands, where authorities have tolerated cannabis use since the 1970s, there has been no significant increase in use (New Scientist, 21 February 1998, p 30).

In South Australia, where users face civil sanctions such as fines rather than criminal penalties, there has been a small rise. But surveys by the National Campaign Against Drug Abuse between 1985 and 1993 showed that the rise was in line with that in states where use was still criminalised.

Results were similar during the temporary decriminalisation of pot in 11 US states in the 1970s. It seems that cannabis consumption has more to do with individual tastes and popular culture than the law. Or maybe lax policing means that changing the law makes little difference.

So reclassification is unlikely to result in an explosion of teenage potheads. What it could do is make youngsters more likely to trust the drugs information given by authorities. If those who take cannabis believe its legal status exaggerates the risks, they may be more likely to try more dangerous drugs.

For this reason, several drugs charities have welcomed the reclassification proposal. “Young people in particular may be less inclined to try other substances if they have more accurate information on the potential risks of each one,” says Roger Howard, chief executive of the charity DrugScope.

But does cannabis lead to hard drugs regardless of what information is given? “Ecstasy killed my teenage daughter but her death began with that first cannabis joint,” screamed a typical headline in one British tabloid last week.
A study published last year revealed that 99 per cent of young New Zealanders who took hard drugs had started on cannabis. The link is undeniable, but it’s not clear if cannabis really is a “gateway to hard drugs” or whether the kind of people who take dope are more likely to try hard drugs too.

“I’m standing in the middle of the road on this debate,” says David Fergusson of the Christchurch School of Medicine, who led the New Zealand study. His group actually set out to prove that progression to hard drugs is the result of people’s personalities and peer group rather than the fact that they use cannabis. But they weren’t able to.

They followed 12,65 New Zealanders from birth to the age of 21, gathering detailed information on their background and behaviour. They found that 70 per cent of the group had tried cannabis, and a quarter had tried other drugs. Although two-thirds of cannabis users did not progress to other illicit drugs, nearly all hard-drug users started off on cannabis. And heavy cannabis users were most at risk.

Even when Fergusson took account of confounding factors, he found that there was still a link between heavy cannabis use and progression to harder drugs. “We have probably made the strongest effort anyone has made, but we cannot explain [the correlation] away,” says Fergusson.

So what is the connection, if any? The most obvious link is that many cannabis users are in regular contact with drug dealers who can make more money from drugs such as cocaine than from dope. “We need to consider the options available to us regarding supply,” says Howard.

The experience in the Netherlands, where allowing “coffee shops” to sell small amounts of dope means users don’t usually come into contact with illegal dealers, suggests this does make some difference. According to an analysis published in Science in 1997, only 22 per cent of cannabis smokers in Amsterdam have tried cocaine, compared with 33 per cent of those in the US.

So trying to separate the markets for cannabis and hard drugs such as cocaine does appear to weaken the gateway effect. “But whether you can separate them or not is a big question,” says Michael Farrell, a consultant psychiatrist at the National Addiction Centre in London.

Claire Ainsworth

Doing drugs Dutch style

WITHIN half an hour of arriving in Amsterdam, I’ve been offered sex, cocaine and ecstasy. It makes me think the critics are right about the effects of Amsterdam’s soft drugs policies. But after three days of talking to the police, the “coffee shop” owners, treatment clinics and locals, I’m convinced that the approach is doing more good than harm.

The coffee shops began selling marijuana as early as 1976, and today there are about 900 such shops. Roel Kerssemakers, who works for the state-run Jellinek drug-abuse clinic, says this hasn’t increased the number of smokers. “The forbidden-fruit effect is gone,” says Kerssemakers. “There’s very little peer pressure to smoke.”

More importantly, the shops seem to have been fairly effective at separating soft-drug users from dealers who peddle harder drugs. “Coffee shops are the most hard-drug-free places in town,” laughs Kerssemakers, thanks to regular visits from the police.

And most smokers seem content to try cannabis in their youth and then give up drugs completely. “Cocaine and ecstasy have more to do with nightclubs than with cannabis,” Kerssemakers says. Police officers on the street agree. They say that the dealers I encountered are small-timers who target tourists rather than locals.

But recent changes in the drugs policy may have unintentionally jeopardised the separation between dope and harder drugs. In 1996, coffee shops were banned from selling to anyone under 18, which has “thrown a big vulnerable group onto the street”, says Arjan Roskam, head of a union for coffee-shop owners.

While the amendment was intended to delay the age at which teenagers start experimenting with drugs, it has probably only diverted users to less regulated sources. According to the Trimbos Institute, a mental health and addiction centre in Utrecht, about 10 per cent of under-age smokers now buy from criminal suppliers.

The government also increased the penalty for growing marijuana from two years to four, discouraging smaller growing operations. “Now the crooks are in again,” says Roskam. “I think it would be better if it were all legal.”

He may have his wish. “There’s a majority in parliament who are for legalising it, on the condition that we don’t do it alone,” says Kerssemakers. “If other big countries decide to, we would follow.”

Nicola Jones, Amsterdam
Stop drug abuse: sell crack in corner shops

God may have equipped me with stupid knees, a stomach like a Space Hopper, inverted nipples and a perm, but despite this I shall for ever be in His debt because He also gave me an allergy to cannabis.

I need only be in the same postcode as someone who is smoking a joint and it feels like Stomu Yamashita is working out on my cerebral cortex while Eminem is hosting a chain saw party in my frontal lobes. Pain is too small a word.

This means I’m completely unqualified to comment on the drug debate, but what the hell; since the only other option is to write about the most boring war in the whole of human history, I’ll give it a go.

Susan Greenfield, a leading brain specialist, has said that cannabis reconfigures the subtle connections in the brain, causing the user to suffer mood swings, paranoia, schizophrenia and a dark sense that he’s going to wake up with a dead builder in his swimming pool.

It all sounds very terrible, but then she says that one joint can kill about 50% of neurons in the hippocampus — the part of the brain related to memory. Really? So this means that after two joints, 100% of the neurons are dead and you forget who you are and where you live.

I’m not sure this can be true. I know loads of people who have smoked two joints and they are able to remember all the words from Peter Gabriel’s first album. What’s more, they even know what he was on about.

This, I think, is the worst and most dangerous thing about smoking cannabis. It turns you into a crashing bore. But then so does Melvyn Bragg and he’s not illegal.

There is nothing worse than finding that the people you’ve invited to stay for the weekend have arrived with a car boot full of resin. It means that after dinner they’re going to find the fireplace funny and I’m going to have a headache.

But let’s be honest, shall we? Giggling a bit and wanting to eat a sherry trifle garnished with frozen peas at two in the morning is not the end of the world.

People who’ve been smoking dope all evening do not parade through the streets at 2am looking for something to lob through the window of the local Kentucky Fried Chicken. If you spill their ash, they don’t spend the rest of the night banging your head against a wall. Cannabis, so far as I can tell, makes you mellow.

The worst and most dangerous thing about cannabis is that it turns you into a crashing bore.

Have you ever wondered, for instance, how the Dutch managed to solve the crisis with the Moroccans? Before the mid-1970s these guys were hijacking trains and taking control of schools, whereas just last month the ringleader chose to make his point by roller-skating from the Hague to Geneva. Why the change in strategy — could it have anything to do with the relaxed attitude over there to smoking?

Who knows, maybe this tedious war in Afghanistan could be ended and we could have our new programmes back if Dubya invited some of the Taliban over for a smoke.

Really and truly, I struggle to see why people have a problem with cannabis. Unlike alcohol and tobacco, it does not kill you — and even if it did, what business is that of the government?

I’ve always maintained that all drugs should be legal. Sure, in 1999, 87 people died from cocaine abuse — they probably bored themselves to death — but to put that in perspective, 2,500 people were killed by paracetamol, two died in accidents involving trousers and half a million died from being fat.

Look at it this way: if a lazy Mr Patel put packets of magic mushrooms and phials of smack among the Zoom lollies and the Bird’s custard, you’d cut the drug dealer out of the loop, which would enable inerocity residents to get some sleep. It’s nearly impossible at the moment thanks to all the machine gun fire and the screams of young Jamaicans having their arms cut off.

There are other advantages, too. You wouldn’t have pushers outside the school gates trying to convince your eight-year-old to try ecstasy because it’s much better than the weed he had last week.

And if the crackheads could buy coke at the newsagent for 60p a gram rather than £50, you would have your mobile phone and your car stereo stolen only once a week, rather than every 15 minutes.

What about this for an idea: the entire war effort in Afghanistan could be funded by tax raised on Afghan heroin. Then it would be their fault that our bombs keep hitting them.

Of course, it could be argued that the legalisation of all drugs would lead to a massive increase in drug use. I’m not sure. A 15-year-old can buy dope more easily now than he or she can buy cigarettes or whisky. Even here in Chipping Norton I reckon I could lay my hands on a rock of crack within the hour. So it might as well be on sale at the paper shop.

A mad idea, perhaps, but not as mad as fighting the multi-billion-dollar drug trade with entries in a statute book. That’s as daft as fighting terrorism with an air force.
Some Heirs Find A Costly Surprise: Bill From Medicaid

As Spending Surges, Officials Claim Assets of Estates To Recoup Nursing Costs

Fighting to Keep Mom’s Home

By Sarah Lueck

As Medicaid spending surges, many states are embracing an aggressive way to recoup some of their costs: going after the estates of Medicaid recipients when they die.

State officials promoting the idea say Medicaid is a program for poor people, so if beneficiaries leave behind significant property it should be used to lessen taxpayers’ burden. Critics call the practice "the other death tax" and say it’s a posthumous slap at people who worked hard to hand down something to their children. Sometimes heirs are forced to sell the home of the deceased to pay the bill for years of nursing-home care. While alive, people on Medicaid are generally allowed to keep their homes.

For many families, the Medicaid bills come as a surprise. Medicaid applicants are supposed to be told that their estates may be subject to claims after they die.

Myree Sparks, a 72-year-old retiree who lives in Richmond, Va., got an $89,000 bill from the state of Tennessee for her late mother’s nursing-home care. To pay off the debt, Mrs. Sparks auctioned the 80-year-old farmhouse and surrounding land that she inherited from her mother, along with all the contents of the house.

“I wanted to keep it in the family,” she says. “I was born there in that house.” The auction brought in $96,000, which after costs was about enough to pay the state’s bill. Mrs. Sparks spent $900 to buy two family heirlooms at the auction, a Hoosier kitchen cabinet and a cupboard for storing pies. Other than that, the state “got everything,” she says.

The debate over estate recovery is part of the growing battle over the high cost of Medicaid, the health-care program for the poor that is jointly funded by the federal government and state governments. Altogether Medicaid cost an estimated $290 billion in 2004, a 7.9% rise from the previous year. Of that, $89 billion went to pay for long-term care including $46 billion for nursing-home care, according to Medstat, a health consulting firm. Medicaid covers nearly half of the nation’s nursing-home bills. The Bush administration and Congress are looking for ways to reduce federal spending on Medicaid. Congress is aiming to trim it by $10 billion over five years.

Placing claims on estates isn’t a new Medicaid practice—the federal government has ordered states to do it since 1963—but it has taken a bigger role amid the cost crunch. Until a few years ago, many states declined to follow the federal order or did so half-heartedly. Some figured it was a waste of time because few Medicaid recipients leave behind estates of significant value. Others didn’t feel like pressuring bereaved heirs, typically people of modest means, into sell-

*Please Turn to Page A6, Column 3*

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June 24, 2005

Wall Street Jour
about $52 million last year to $58 million in 2004, tour officials say.

Scott also has shown a deft political touch. He persuaded the WTA board to restructure the tour’s budget—now in the black—so that players and tournaments receive their share of sponsor money only after the WTA meets its operating and marketing costs. He has made pre-tournament interview sessions mandatory and enlisted stars to make more appearances for sponsors.

“Anything Larry has asked us to do has made sense,” says two-time Wimbledon and U.S. Open champ Venus Williams, who at Scott’s urging has met with potential sponsors such as Vodafone Group PLC and Bed Bath & Beyond Inc. “He has a handle on what our brand is all about and what we can offer in the marketplace.”

“FEMININE SIDE”
CRITICS OF TENNIS as a business have long pointed out that it lacks a major U.S. TV broadcast deal because each tourney controls its own rights. Ratings for women’s tennis on ESPN have been flat or in decline for the past couple of years, and the U.S. Open’s women’s final has slipped in 2002 and 2003. Insiders say Scott played an important behind-the-scenes role in helping the U.S. Tennis Assn. cobble together its recently unveiled U.S. Open Series. The novel TV package groups 10 formerly independent men’s and women’s tourneys on CBS, ESPN, and NBC leading up to the Open, providing more coherence for fans.

Scott is also troubled by the rash of injuries. He is looking at everything from pushing back January’s Australian Open a week or two to allowing top players to compete less and still maintain their rankings.

Some insiders worry that the tour’s pipeline of emerging stars is dangerously thin. With head-turners like Martina Hingis and Anna Kournikova either retired or close to it, the tour is banking on relatively unproven newcomers such as sassy 17-year-old Russian Maria Sharapova to keep sponsors and fans engaged. Sharapova has been featured in the tour’s “Get In Touch With Your Feminine Side” marketing campaign and will be among the first subjects of a new magazine-style TV show debuting on the Tennis Channel this summer. “You can’t fabricate the personality factor,” concedes Scott. But as he’s demonstrating, you can play to your strengths—and boost your chances of winning.

—By Douglas Robson in Paris

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ROONEY
A decade-long fight against “ungodly” health-care costs

Making Hospitals Cry Uncle

June 7, 2004

Has insurer J. Patrick Rooney found an unorthodox way to turn up the heat?

CONSERVATIVE MILLIONAIRE J. Patrick Rooney is on a mission from the Almighty: Bring down crushing and “ungodly” health-care costs. For more than a decade, he has worked to replace traditional insurance with tax-free health savings accounts (HSAs), which people can use to pay for their own medical care. “I’m doing the right thing, and I think the Lord will be pleased about it,” he says.

Using his fortune to open doors in Washington, Rooney has relentlessly preached his gospel. Last year, Congress saw the light: GOP lawmakers inserted a $6.4 billion tax break for HSAs into a Medicare prescription-drug bill. And a recent survey by Mercer Human Resource Consulting says 75% of employers are likely to offer the accounts by 2006.

A courtly 76-year-old, Rooney has never hidden the fact that he stood to profit from his crusade. After pioneering HSA sales with his old company, Golden Rule Insurance, he sold out to UnitedHealth Group Inc. for $893 million just before Congress passed the tax break. He promptly founded Medical Savings Insurance Co. to sell more HSAs.

PR HARDBALL
BUT ROONEY ISN’T relying on just the power of his ideas and political connections to make his company profitable. The Indianapolis-based insurance entrepreneur also is backing a nonprofit group
that uses hardball tactics to get hospitals to cut prices. The nonprofit, called Consejo de Latinos Unidos, campaigns on behalf of uninsured Hispanics.

Last year, Consejo pressured the nation's No. 2 hospital system, Tenet Healthcare Corp., to cut rates for uninsured patients and revamp its collection practices. At the same time, Rooney's Medical Savings won about $2 million in debt forgiveness from Tenet.

Now, Consejo's leader, Republican strategist K.B. Forbes, has turned his attention to Florida. Hospitals being pilloried there say Rooney's company owes them millions in unpaid bills, too. And Rooney has suggested that a new Consejo target—HCA Inc., America's largest hospital operator—could take a lesson from Tenet and shake up its bad press by cutting a deal to forgive Medical Savings' debts.

Rooney, who pledged seed money to Consejo and hired a Washington public relations firm to draw attention to its cause, says he doesn't control Forbes. "K.B. has to paddle his own canoe," Rooney says. Besides, says Rooney, his drive to cut health-care costs, especially hospital fees, is about more than money: It's a moral crusade. As such, he makes no apologies for unorthodox methods.

ARM-TWISTING?
THAT INCLUDES BACKING FORBES, a onetime Medical Savings employee. "Forbes presents himself as an advocate of the consumer," says Linda S. Quick, president of South Florida Hospital & Healthcare Assn. But Consejo "seems to be initiated and financed by Rooney and others selling individual insurance."

With his folksy demeanor, Rooney comes across as an endearing do-gooder. He is also one of the most powerful voices on the Right. Since he pioneered HSAs in 1990, Rooney, his family, and employees have poured more than $5 million into Republican causes.

Rooney's new model of health coverage, which has won support from President George W. Bush, replaces traditional insurance with tax-free health savings accounts and high-deductible policies. The argument: If patients must pay out-of-pocket for, say, the first $1,000 in bills, they will seek more cost-effective care. That, Rooney maintains, will unleash market forces to hold down costs. Big insurers, including Aetna Inc. and many regional Blue Cross Blue Shield Assn. plans, began rolling out HSAs this year.

For hospitals, the plans pose a threat: bad debts. Patients accustomed to first-dollar coverage find they must pay before insurance kicks in, and many don't. In April, HCA blamed a rising tide of unpaid bills for its soft first quarter.

It's not just patients who aren't paying. Medical Savings routinely marks down its policyholders' hospital bills by as much as 80%. "Yes indeed, we're making unilateral decisions," Rooney says. "But by God, we have to hold the hospitals down to a reasonable price." Medical Savings tells providers to accept its checks as full payment—or collect from patients.

But as Forbes has demonstrated, hospitals pursuing low-income patients are vulnerable to attack. Last year, Consejo stoked press coverage of poor patients being hunted down by bill collectors. "Nobody wants these cases where someone was sick and the big, bad hospital is suing them," says Richard Morrison, a vice-president at Orlando's Adventist Health System, which says Medical Savings owes it some $1 million.

Consejo zeroed in on Tenet in 2001 after Forbes uncovered examples of bare-knuckle collection practices—such as a lien on a Louisiana patient's beat-up mobile home. His timing was perfect. Tenet was trying to acquire hospitals in four cities and had drawn fire from the feds over its Medicare billing. At critical junctures, Forbes would trot out patients to portray Tenet as intent on gouging the poor. Tenet lost three of the acquisition deals.

Behind the scenes, Tenet was in talks with Medical Savings over its unpaid bills. In January, 2003, Tenet caved. It forgave nearly all of Medical Savings' debt and lowered prices for the uninsured. In return, Consejo dropped 10 lawsuits. The deals with Consejo and Rooney were "contemporaneous and simultaneous," a Tenet executive says.

Like Tenet, HCA has sought a truce. In mid-2003, Chairman and CEO Jack O. Bovender Jr. set up a meeting with Rooney to explain HCA's discount policy in hopes that Rooney would persuade Forbes to back off. But prior to the meeting, Rooney forwarded a memo to Bovender from Medical Savings President Randy Sutliff that drew parallels between HCA's situation and Tenet's. In the memo, which HCA made available to BusinessWeek, Sutliff notes that Tenet had shaken some of its bad press after making a deal with Medical Savings. "HCA is in similar circumstances," Sutliff wrote. A vivid Bovender canceled the meeting.

When asked about the e-mail to Bovender, Rooney says: "The one thing hospitals can't afford is a loss of public trust." And he isn't afraid to get in their faces. "If we go to the hospital and beg, they'll say: 'We'll give you 20% off,'" says Rooney. "Well phooey—that's still an outrageous price. And we're not going to pay it." Indeed. More than 20 Florida hospital groups—including HCA—are suing Medical Savings for some $7 million in overdue payments.

HCA and other Florida hospitals figure they have better odds of bucking Forbes and Rooney than Tenet did: They're not under serious regulatory scrutiny, and they're moving to help the uninsured. Rooney paints a different picture, saying hospitals are lining up to deal: "Tenet is not the only one." Both he and Forbes—indeed, of course—predict victory.

—By Lorraine Woellert In Washington

A Little Help from a Nonprofit?

FALL, 2000 Talks break down between health-care insurer, Medical Savings and hospital operator Tenet over some $2 million in unpaid bills.

JANUARY, 2001 With $100,000 in pledges from J.

Patrick Rooney's Fairness Foundation, which shares an address with Rooney's Medical Savings, K.B. Forbes launches nonprofit Consejo to fight for the health-care rights of lower-income, uninsured Hispanics.

JANUARY, 2002 Thanks in part to a PR firm hired by Rooney, newspapers start running positive stories about Consejo.

FEBRUARY, 2002 Consejo sues Tenet on behalf of the uninsured.

WINTER, 2002 Forbes takes credit for upsetting Tenet's bid to buy three hospitals. Tenet CEO Jeffrey Barbakow tries to enlist Rooney's help in dealing with Forbes.

JANUARY-FEBRUARY, 2003 Tenet forgives about $2 million owed by Medical Savings and reaches a deal with Consejo to charge the uninsured discounted rates.
services to the U.S. Defense Dept. and intelligence agencies and has generated an average return on invested capital over the past three years of 32.5%, among the highest on our list. No. 33 Engineered Support Systems is also using cash generated by war-time demand for its heavy-duty air conditioners to build out a portfolio of military offerings and push annual sales increases to more than 15%.

While some on the list are helping the government wage war, others are simply aiding bigger companies in their everyday battle for market dominance. No. 13 Cognizant Technology Solutions Corp. does IT outsourcing for big companies like MetLife and J.P. Morgan Chase using teams of software developers in India. And Charles River Laboratories International Inc., No. 57 on our list, provides biomedical research products and services, including genetically altered animals for drug safety testing, to Big Pharma players. "They are utilizing our staff and facilities to do things faster," says Charles River Chairman and CEO James C. Foster. "Everything in this business is about speed to market."

BARGAIN HUNTING In that drive to market, some opportunities are always left behind. Those tasty scraps are meat and potatoes for some Hot Growth companies. No. 18 Bradley Pharmaceuticals Inc. acquires, enhances, and markets drugs developed by larger drug companies but deemed too tiny to be worth promoting. A moisturizing cream the company bought from Syntex Corp. in 1994 has spawned a whole line of skin products, which helped generate $84.8 million in sales over the past year. Similarly, Encore Acquisition Co., the No. 73 company run by the father-and-son team of I. Jon Brunley and Jonny Brunley, acquires and develops the relatively small oil fields that their larger competitors aren't interested in expanding. In 1999 the company bought a field in southeastern Montana from one of the major oil producers, and after reengineering it has boosted production from 8,600 barrels a day to 12,600. That has helped send earnings up an average of 91.8% annually over the past three years.

Of course, rising energy prices have also given Encore a boost, as they have to No. 77, Matrix Service Co., which provides maintenance, repair, and construction services to refineries, pipeline and marketing terminals, and power plants. With oil at $40 a barrel, it's hard to see that trend ebbing.

Lucky, however, cuts both ways. Regular readers of this list will note that information technology, long a staple, has been hurt by the anemic economy of recent years, which forced Corporate America to hold back on capital spending. The number of hardware, software, and semiconductor companies on our list has withered—from 41 in 2001 to 11 this year.

Of course, a reinvigorated economy will help technology and nontech players alike in the year ahead. But it won't dampen the pressure to outsmart rivals with innovative new products and services. This year's crop of dynamos are eager for that challenge.

-By Amy Barrett in Philadelphia with Christopher Palmeri in Los Angeles and Stephanie Anderson Forest in Covington, La.
Hospital business booms as population gets older

By Julie Appleby
USA TODAY  Aug 6, 2001

Boosted by relaxation of managed care restrictions — and aging baby boomers — hospitals are seeing a surge in admissions.

The change comes after years of belt-tightening among hospitals, which saw declines in their payments, admissions and the number of days patients stayed as managed care tried to control costs.

Now hospital admissions are on the way back up, and so is medical inflation. In the last quarter, for-profit hospitals saw an average increase of 6% in admissions, compared with 1% to 2% historically, according to stock research firm Lehman Bros. Boosting admissions:

- A relaxation of requirements by insurers that patients and doctors get "permission" before expensive tests or procedures or hospitalizations.

"The whole concept of managed care got dismantled in recent months," says Lehman analyst Adam Feinstein. "It’s harder to restrict access to health care. As a result, utilization has gone up dramatically."

- An aging population, combined with new treatments and technologies, especially for cardiac and orthopedic care. Such techniques are being used more often on the very elderly, a rapidly growing demographic.

- The consumer attitude of the baby boom generation.

"Baby boomers are being smart about coming in for preventive cardiology and orthopedic treatments," says Harry Anderson, spokesman for Tenet, the nation's second-largest hospital chain. "Fifty-five-year-olds are coming in for knee replacements so they can continue to play golf. A generation ago, that just wasn’t done."

At Tenet, overall admissions rose 3.6% for fiscal 2001 ending in May. Cardiology admissions rose 7.8%; orthopedic and neurology admissions grew 6.9%. The biggest jump was among those in the 51- to 60-year-old age group, followed closely by the 41- to 50-year-olds.

Many analysts expect the trend to continue, but Clifford Hewitt of Legg Mason also cautions that baby boomers are healthier than previous generations and may not use hospital services to the same extent as they age.

Not all hospitals are benefiting. About 40% of the nation's hospitals are still bleeding red ink in terms of operating profits, Hewitt says. Many of those are in the not-for-profit sector, inner cities or rural areas. But in the for-profit sector, the news lately has been mainly good.

Along with the rise in admissions, hospitals have been able to demand larger payments from insurers, boosting hospital revenue but helping fuel double-digit increases in health insurance premiums.

"This is about the best top-line growth we've seen in years and among the best I've seen in my entire career," Jack Boavender, CEO of HCA, told analysts in a conference call late last month. The nation's largest hospital chain saw admissions rise 4.2% in the second quarter. Revenue per admission increased 10.9%."
HOSPITALS MUST TAKE A SCALPEL TO EXCESSIVE COSTS
THE REAL ATTENTION getter in "Weaker vitals signs at hospitals" (News: Analysis & Commentary, May 3) is not unpaid bills but the size of this bill: $7,300 for a few hours in the hospital for diagnosis from a couple of CAT scans and a prescription for painkillers. Unless the decimal was in the wrong place, turning $730 into $7,300 by mistake, we are all in trouble today, not just the hospital industry.

-Mabelle Alexander
Littleton, N.H.

ONE PRACTICE that can dramatically affect some patients' bills is the unnecessary and sometimes excessive use of diagnostic imaging studies by physicians practicing defensive medicine. A frequent example I've encountered is the overuse of head computer topography (CT) scanning in adolescents and 20-year-olds who come to the emergency room with headaches. The rule, rather than the exception, is that these patients get a head CT even when they lack any focal neurologic deficits to warrant the study and generally in the absence of a neurology consultation (specialist in headache syndromes). This can add hundreds or thousands of dollars to one's bill.

-James Bradley Summers, M.D.
Mobile, Ala.

INDUSTRIAL ENGINEERS: THE UNSUNG HEROES OF SIX SIGMA
I WAS DISAPPOINTED not to see the field of industrial engineering mentioned in "How Xerox got up to speed" (Industries, May 3). Industrial engineers invented both lean manufacturing techniques and the Six Sigma approach to process quality. Toyota developed lean manufacturing in the 1950s based on the work of Frederick Taylor and W. Edwards Deming, both industrial engineers. Similarly, Motorola Inc.'s Six Sigma methodology emerged in the 1980s from Total Quality Management, a core element of industrial engineering. You quoted Deborah Nightingale of Massachusetts Institute of Technology but never mentioned that she is the former president of the Institute of Industrial Engineers, the premier professional society for industrial engineers and an authoritative source of information and training for both lean manufacturing and Six Sigma.

Much of the credit for Lean Six Sigma must be assigned to the insight and hard work of the industrial engineers that General Electric Co.'s program is based on. That was a fundamental omission from an otherwise excellent article.

-Marc Resnick
Miami

Editor's note: The writer is Secretary, Board of Trustees, Institute of Industrial Engineers.

'AN ATTITUDE OF GRATITUDE' FOR A VACCINATION PUSH
HARDY GREEN REVIEWS The Paradox of Choice by Barry Schwartz in a succinct and entertaining manner ("Clobbered by the Cornucopia," Books, Apr. 26). The challenges associated with an abundance of choice pale to insignificance when contrasted with the realities highlighted in "Vaccinating the world's poor" (Science & Technology, Apr. 26). The vision and collaboration behind efforts by GlaxoSmithKline PLC's Dr. Jean Stephenee, the Bill & Melinda Gates Foundation, and public-health agencies appear to be making fundamental changes for the better.

Perhaps those struggling to maximize minor consumer choices could redirect their energy. Schwartz suggests an "attitude of gratitude" as one cure for the negative effects of too many choices. My gratitude certainly extends wholeheartedly to Stephenee and his partners.

-Dennis J. Crane
Covington, Ky.
Medical Markup

California Hospitals Open Books, Showing Huge Price Differences

State Law Requires Disclosing Charges for Goods, Services; Big Bills for Uninsured

Why a Leech Retails for $81

By Lucette Lagnado

How much does a Tylenol cost? In California, that depends on what hospital you’re in.

At some California hospitals, a tablet of Tylenol, or its generic version, acetaminophen, is billed at $5 or $5.50. Others charge $7, or even $9, for a single pill. One Los Angeles hospital charges just 12 cents a tablet, while at a few facilities it’s free. The retail price of brand-name Tylenol is about eight or nine cents each. The generic goes for a nickel or less.

A new law in California mandates that hospitals there do what few hospitals in America will: open up their “chargemasters,” books that show thousands of list prices for medical goods and services. An examination of chargemasters at several hospitals shows that pricing strategies fluctuate wildly—one thing from brain scans to painkillers to leeches. Depending on a hospital’s pricing method, the charge for the same commodity or service, such as a blood test, can vary by as much as 17-fold from one institution to another.

Virtually every business marks up the wholesale cost of supplies and services. But in the hospital business, pricing is an increasingly sensitive and controversial issue. List prices are usually charged only to uninsured patients. Health plans negotiate big discounts and the government essentially dictates what it will pay.

Meanwhile health-care costs are surging and are likely to go up by 8% or 9% per year over the next five years, according to Glenn Melnick, a professor of health-care finance at the University of Southern California. Economic growth is expected to be about 3% per year, he says, prompting a national debate over how to pay for all this.

Dozens of lawsuits have been filed in recent months by lawyers alleging that nonprofit hospitals are price-gouging the poor and uninsured. Hospitals long seen as charitable organizations are being forced to defend themselves against allegations they have preyed on patients for debts that were inflated.

For years, details on hospital charges were kept secret. Hospitals deemed their prices proprietary, to be kept off limits from institutional rivals, insurers and even consumers. Patients often had no idea what costs they were racking up until they got their bill.

California’s law, which went into effect earlier this year, requires hospitals to make their chargemasters available to the public. These lists show how much each hospital charges for everything from drugs and patient rooms to bandages, X-rays and CT scans.
Huge Differences in Costs of Hospital Care

Continued From First Page

than 500 hospitals, has contended all along that the charge master bill wouldn't help consumers. So far, in fact, there have been few takers, with several hospitals reporting only a couple of patients coming in to examine the document.

But the consumer group that pushed for the legislation says it will be useful in many ways. "This information matters a lot to the uninsured patient who has the ability to decide where they are going for care," says Anthony Wright, executive director of Health Access. "It gives consumer groups and major purchasers the tools to try to get a handle on the overall issue of why health-care costs are rising so much."

For now, the public disclosures offer a look into a system that even some insiders say is askew. "There is no method to the madness," says William McGowan, chief financial officer of the University of California, Davis, Health System, a large teaching hospital in Sacramento. "As we went through the years, we have had these cokamamie formulas," says Mr. McGowan, a 30-year veteran of hospital finance. "We multiplied our costs to set our charges."

Modern Pricing

Take that ancient treatment the leech. It has made a comeback in medicine, but with a newfound price. UC Davis and Scripps Memorial Hospital in La Jolla are among those that use the creatures for certain treatments. The leech sucks blood in the course of delicate surgical procedures.

At Scripps, leeches are kept in a big jar and not fed—to make them hungry, so they'll consume more human blood. They are priced at $19 apiece in the hospital's chargemaster, where they appear under the listing "Leech, Live." Scripps won't discuss how it arrives at its prices. The markup formula used to set the list price is proprietary. The hospital

How Much Is That Chest X-Ray?

A new California law allows patients to look up the retail prices of many goods and services at hospitals. A survey of several hospital price lists shows dramatic differences in price.

<table>
<thead>
<tr>
<th>Service</th>
<th>Scripps Memorial LA Jolla, San Diego</th>
<th>Sutter General, Sacramento</th>
<th>UC Davis, Sacramento</th>
<th>San Francisco General, San Francisco</th>
<th>Doctors, Modesto</th>
<th>Cedars-Sinai, Los Angeles</th>
<th>West Hills Hospital, West Hills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-ray (two views)</td>
<td>$120.90</td>
<td>$79.00</td>
<td>$451.50</td>
<td>$120</td>
<td>$1,519</td>
<td>$412.90</td>
<td>$396.77</td>
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<tr>
<td>Complete blood count</td>
<td>$47</td>
<td>$234</td>
<td>$166</td>
<td>$50</td>
<td>$547.30</td>
<td>$165.80</td>
<td>$172.42</td>
</tr>
<tr>
<td>Comprehensive metabolic panel</td>
<td>$196.60</td>
<td>$743</td>
<td>$451**</td>
<td>$97</td>
<td>$1,732.95</td>
<td>$576</td>
<td>$387.18</td>
</tr>
<tr>
<td>CT-scan, head/brain (without contrast)</td>
<td>$881.90</td>
<td>$2,807</td>
<td>$2,868</td>
<td>$950</td>
<td>$6,599</td>
<td>$4,037.61</td>
<td>$2,474.95</td>
</tr>
<tr>
<td>Percocet* (or Oxydode, hydrochloride and acetaminophen)</td>
<td>$110.46</td>
<td>$26.79</td>
<td>$15</td>
<td>$6.68</td>
<td>$35.80</td>
<td>$6.50</td>
<td>$27.86</td>
</tr>
<tr>
<td>one tablet, 5-325 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tylenol* (or acetaminophen)</td>
<td>$7.06</td>
<td>No charge</td>
<td>$1</td>
<td>$5.50</td>
<td>No charge</td>
<td>12 cents</td>
<td>$3.28</td>
</tr>
<tr>
<td>one tablet, 500 mg</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Hospitals carry either generic version, name brand, or both. **Represents the added total of 14 tests that make up the comprehensive metabolic panel
Sources: Scripps Memorial La Jolla; Sutter General; UC Davis Health System; San Francisco General; Doctors Medical Center; Cedars-Sinai Health System; West Hills Hospital and Medical Center

For medicines that cost the hospital more than $40 but less $100 wholesale, the formula is 7.5 times cost, he says. UC Davis works under the theory that the higher the unit price of a pharmacuetical or supply, the lower the markup.

Drugs that the hospital buys for $500 per dose wholesale are marked up 2.5 times wholesale. Some drugs that cost several thousand dollars a dose are not marked up at all. But the markups are significantly lower for procedures and items done on an outpatient basis because they don't include some overhead costs associated with overnight stays. For example, a blood count that would have cost $55 was marked up to $120.

As a result, there are great discrepancies in prices. At San Francisco General, a public hospital, a chest X-ray—two views, front and side—is priced at $120 to $125. The same service costs more than twice as much at Mills-Peninsula Health Services, also in the Bay area, which is part of a nonprofit chain.

Two hours away in Sacramento, the price differences are even greater. Mercy General, a Catholic hospital, charges $413 for the same two-view chest X-ray. At nearby Sutter General, a nonprofit, the basic two-view X-ray goes for $750.

Michael Blaszyk, an executive vice president at Catholic Healthcare West, and other items were set under a previous management. Tenet now gives patients without insurance about 50% off its list prices, he says, and hasn't raised its prices for a year.

Why not just lower the list prices? A key problem with changing the system is that high list prices have been a "negotiating tool" for hospitals in dealing with HMOs that demand big discounts, Mr. Anderson says. A new system must be invented, he says, that protects the public and makes sure hospitals are reimbursed fairly.

The industry's list prices have been "like a secret handshake—understood within the industry, not understood by
Anatomy of a Hospital Bill

Uninsured Patients Often Face Big Markups on Small Items; 'Rules Are Completely Crazy'

By Lucette Lagnado

HOW MUCH does an overnight stay at a Virginia hospital cost? If Medicaid is paying, the answer is $5,000. If Paul Shipman is paying, it's $29,500.

A year ago, Mr. Shipman, a 43-year-old former furniture salesman from Herndon, Va., experienced severe chest pains during the night. An ambulance took him first to a community hospital emergency room, and then to Inova Fairfax Hospital, Fairfax, Va. Suspecting a heart attack, doctors first performed a cardiac catheterization to examine and unblock the coronary arteries. Then, they inserted a stent, a small metal device that props open a blocked artery so the blood flows better to the heart.

Lacking health insurance, Mr. Shipman says he was worried about the cost. The next morning, too anxious about his bill to stay, Mr. Shipman checked himself out of the hospital against medical advice.

Since then, Mr. Shipman and his wife, Alina, have received hospital bills totaling $29,500 for what they say was a 21-hour hospital stay. In addition, there were other bills: some $1,000 for the ambulance trip, $6,800 from the cardiologist who performed the stent procedure, and several thousand dollars for the local emergency-room visit. In all, the two-day health crisis left the Shipmans saddled with medical bills totaling nearly $40,000.

Once solidly middle class, the couple says the debt triggered a gradual unraveling of their lives. "Middle class or not, when you have a bill of $37,000 hanging over your head, that's all you think about," says Ms. Shipman, 36 years old and until recently a secretary at George Washington University. "You eat, sleep and breathe that bill."

Like many of the 45 million Americans who don't have health insurance, the Shipmans gambled—unwisely, it turns out—that they could make do without it. Among the many factors they didn't take into account was the high markups hospitals tag onto care for uninsured patients, charging them far more than what they charge big private or government plans for the same care.

Because Mr. Shipman was given an itemized bill listing each charge, his situation offers an unusually detailed view of the size and scope of markups in the medical-care market. With some lawmakers suggesting that consumers should be able to shop around for their own health care using health-savings accounts, the Shipmans' experience shows just how difficult it can be to evaluate what medical procedures really cost—not to mention the difficulties a person in medical distress would experience in trying to shop for health care.

Mr. Shipman filed a lawsuit in August in federal district court for the Eastern District of Virginia, charging that hospital and physician charges were "excessive and unconscionable." He is seeking a refund of $23,500 of the $29,500 bill.

Free Market?

Paul Shipman, who lacks health insurance, incurred a multitude of bills for health-care services and supplies in connection with an apparent heart attack. Doctors, drug companies and other industry
Starwood to Name a Coke Veteran as CEO

By CHRISTINA BINKLEY
And CHAD TERHUNE

WHAT DO YOU get when you tap top executives from the worlds of soda, television and fancy bed sheets? A new strategy for Starwood Hotels & Resorts Worldwide Inc., which is set to announce today that...
Big Buying Groups for Hospitals May Not Always Deliver Savings

By MARY WILLIAMS WALSH and BARRY MEIER

Two groups that dominate the purchasing of medical products for about half the nation's nonprofit hospitals have long said they exist to save money, pooling the influence of thousands of hospitals to negotiate a good price on the best products.

But some hospitals are finding otherwise. They have learned that they can do better on their own, and are now raising questions about the need for the huge buying groups, which negotiated contracts last year for $34 billion in supplies.

A new, preliminary study by the research arm of Congress, the General Accounting Office, is also challenging the buying groups' claims.

In the study, a copy of which was obtained by The New York Times, the GAO found that using a big buying group "did not guarantee that the hospital saved money." In fact, prices negotiated by buying groups "were often higher than prices paid by hospitals negotiating directly with vendors" — in some cases "at least 25 percent higher," the GAO said.

At issue are hundreds of millions, if not billions, of dollars in annual health care costs, much of it paid indirectly by taxpayers through programs like Medicare and Medicaid and by private insurers.

The GAO report is to be presented today at the first Congressional hearing on the operations of these buying groups. The hearing will be held by the antitrust subcommittee of the Senate Judiciary Committee. The subcommittee is headed by Herb Kohl, Democrat of Wisconsin.

The report comes a day after one of the nation's largest buying groups, Premier Inc., took out a full-page ad in Roll Call, a newspaper covering Capitol Hill. In the ad, Premier took credit for "holding down the costs of health care for American businesses, taxpayers, and consumers."

The GAO cautioned that its fin-

Continued on Page C6
A medical-industrial complex

President Dwight Eisenhower’s 10-minute farewell address to the nation in 1961 is well remembered for its warning about the “military-industrial complex.” His parting admonition has fresh meaning for today’s “medical-industrial complex.” Look no further than the current collision between the National Institutes of Health’s National Cholesterol Education Program and a watchdog group, the Center for Science in the Public Interest.

The case in point is the NCEP call, through its new guidelines, for lowering America’s cholesterol levels. The new target would only be achieved by tripling the current number of people taking the cholesterol-lowering drugs called statins—a bonanza for drug companies. Unlike earlier guidelines for people with known heart disease, the new ones focus on the healthy and their future heart risk. If followed, 36 million American adults—close to 1 in 5—will be popping statins or a similar drug for the rest of their lives.

But this debate goes way beyond cholesterol. So-called evidence-based guidelines are becoming codes of medical practice. Doctors will be using them to direct everyday care, and woe to those who dare not follow new rules that carry the imprimatur of medicine’s research elite.

COSPI took on the experts and petitioned NIH to take another look at the guidelines, particularly those relating to women and those over age 70. The response was quick and negative. But the issue stays alive because eight of the nine experts on the panel had financial ties to companies that would benefit greatly from expanding the ranks of lifetime statin takers. It’s been ugly. In a heartbeat, the panel members, a distinguished group called upon to do a hard job (after disclosing their financial interests to NIH), have had their motives questioned. This is neither fair to them nor good for the well-regarded NCEP. And it is a foul for doctors and patients who are left wondering what to do.

If only we had remembered Eisenhower’s less famous second warning: that “public policy could itself become the captive of a scientific-technological elite” in which the “power of money is ever present.” He feared elites would dominate the nation’s scholars by virtue of their federal employment or their control over large research grants. Eisenhower was thinking about the solitary tinkerer overrun by task forces of scientists, but his instincts were prescient.

Inspired by Ike. With Eisenhower-inspired wisdom, we could prevent messes like the cholesterol debacle. How about medical grand juries made up of public and private medical scholars to oversee, analyze, and give final approval to guidelines emerging from expert task forces? These “jurists” would be screened ahead of time, as judges are, for expertise, independence, and judicial temperament: compassion, decisiveness, open-mindedness, and the ability to see patients holistically. Their freedom from financial influence goes without saying. Disclosure of a conflict of interest is not enough: Such a conflict would designate an individual as technically nonindependent and thus ineligible to serve on the overarching panel that delivers the final verdict or reviews appeals. Those with conflicts would be eligible to be part of the groups that develop proposed options.

Some claim you can’t find experts available these days who don’t have industry ties. That is nonsense, based on my own experience running the NIH and elsewhere. Plenty of independent clinicians and scientists are up to this duty, highly skilled in analyzing medical data and wise in the ways of patients. There are also younger experts who have not yet attained the national reputation that would make industry seek them out, and an older group, just retired from active academic life or practice but steeped in wisdom and experience. These people are known and respected in every community and in every medical school in the country, even if they have not achieved national visibility in government or research.

NIH and the Centers for Disease Control and Prevention, whose work drives the evolution of medical practice, could together create a center to enable such a process, as long as the center itself is independent of other agency forces. Great Britain fashioned something along these lines in 1999, charmingly called NICE: the National Institute for Clinical Excellence. Wouldn’t it be nice if Americans could have one, too? “

How about medical grand juries to oversee, analyze, and approve the experts’ health guidelines?

PARTING WORDS. Eisenhower at his 1961 farewell address, in which he warned about a military-industrial complex.
Nursing Homes Face Insurance Crunch

Wave of Consumer Lawsuits Pushes Cost of Malpractice Policies Higher; Some Doctors Stop Seeing Seniors

BY ANDREA PETERSEN

A MALPRACTICE-INSURANCE crisis is rolling through the nursing-home industry. The cost of malpractice insurance for nursing homes has jumped an average 51%, according to a study funded by a long-term-care trade group to be released today. The situation is particularly severe in several states with large populations of seniors, including Texas, Arkansas and Florida.

The industry's malpractice problems are a result of a wave of consumer lawsuits against nursing homes, centering on issues ranging from wrongful death to inadequate care resulting in painful bedsores. According to the new study, the number of claims against nursing homes rose to 15.3 for each 1,000 beds in 2003, up from 13.8 the previous year.

The flurry of litigation follows the establishment of consumer-protection laws designed to safeguard the elderly from sloppily and abusively run care facilities. California, for example, has an elder-abuse law that allows people to sue for abuse and neglect.

It comes against a backdrop of rising nursing-home bills for consumers. The average cost of a private room in a nursing home reached $181.24 a day last August, up 8% from just 15 months earlier, according to a survey from MetLife Inc.

Nursing homes, however, say they have little leverage to shift their rising insurance and litigation costs to consumers. That's because about 80% of nursing-home costs are paid by the federal Medicaid and Medicare programs, which pays set fees. The industry says the average $118 a day that Medicaid pays for nursing-home care hasn't kept up with the costs of care.

Prospective residents are also starting to find that nursing homes are asking people to forgo the right to sue and instead to rely on arbitration. The rising malpractice and litigation costs are driving nursing homes to cut their insurance coverage, or drop their liability insurance altogether. Currently, about 25% of California's nursing homes carry no liability insurance, according to the California Association of Health Facilities, a trade group. Dropping liability insurance—also known as "going bare"—is on the increase in other states as well.

In Arkansas, 103 facilities of 205 had no liability insurance, according to a survey by the Arkansas Health Care Association last May. Some states don't require nursing homes to carry liability insurance, or have

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In New Deal, Hyatt Joins Race to Add Wi-Fi to Hotel Rooms

BY JESSE DruCKER And CHRISTINA BINKLEY

HYATT HOTELS & RESORTS and T-Mobile USA Inc. are expected to announce a deal today that will bring high-speed wireless Internet access to nearly all of Hyatt Corp.'s more than 200
By ROBERT PEAR

WASHINGTON, Sept. 7 — President Bush’s spokesman denounced a plan to ease regulatory requirements on nursing homes today and said the White House had rejected the proposal, devised at the Department of Health and Human Services.

The spokesman, Ari Fleischer, said: “We’re going to beef up and strengthen nursing home regulations. We’re working to strengthen accountability.”

Mr. Fleischer said the proposal, described today in The New York Times, had been “rejected out of hand” more than two weeks ago because “the president believes very strongly that it’s a federal responsibility to protect seniors in nursing homes.”

But as recently as Thursday night, department officials were saying that they wanted to refocus enforcement efforts to reduce the frequency of inspections at nursing homes that had good records of compliance with federal health and safety standards.

Today Mr. Fleischer insisted, “The administration has no plans to reduce the frequency or the intensity of nursing home oversight, no plans to reduce the penalties.”

The proposal to refocus enforcement activities was described in detail in government documents and in interviews with officials at the Department of Health and Human Services.

Thomas A. Scully, administrator of the federal Centers for Medicare and Medicaid Services, spoke freely about the idea in a speech on June 4, in a conference call with experts on long-term care on Aug. 28 and in conversations with Congressional aides this week. In his remarks, Mr. Scully gave no hint that the proposals had been rejected by the White House.

But today Mr. Fleischer said, “Any options dealing with any changes in the nursing home procedures that could lead to less inspections were rejected out of hand” — more than two weeks ago — some time before Aug. 24.

Mr. Scully said tonight that he had not been aware that the White House had made a decision on the issue.

“I never knew it was discussed at the White House,” Mr. Scully said, adding “I was not at the meeting. I didn’t know there was a meeting.”

Mr. Scully moved briskly today to align his agency with the White House position enunciated by Mr. Fleischer:

“We are pursuing initiatives to strengthen accountability and improve monitoring of nursing homes on behalf of all Medicare and Medicaid beneficiaries,” Mr. Scully said in a statement issued by his office.

In the conference call on Aug. 28, Mr. Scully was still suggesting that the frequency and intensity of inspections should vary with the past performance of nursing homes.

“We ought to take the pot of money that we have, come up with reasonable quality measures in coordination with the industries wherever we can, and reward good providers with less scrutiny and less harassment, and go after bad providers with more scrutiny and more harassment,” Mr. Scully said then.

Under current law, nursing homes that participate in Medicaid or Medicare must be inspected once a year on the average, with no more than 18 months between inspections. But with respect to the “trustworthy providers,” Mr. Scully said in the conference call, “maybe we should be in there every two years instead of every 15 months.”

Joyce Winslow, a spokeswoman for the agency, said on Thursday that Mr. Scully was committed to “reviewing good nursing homes less often and bad ones more often.” William A. Pierce, a spokesman for the Department of Health and Human Services, confirmed the essence of the plan late Thursday night, in response to questions from The Associated Press.

Mr. Pierce said today that he had based his comments on outdated information.

For years, nursing home owners have lobbied for changes in the inspection process, which they see as rigid and onerous.

Consumer advocates welcomed today’s statement by the White House. But they worried that it might represent a temporary commitment and that cutbacks in enforcement might occur later.

A lawyer at one consumer group, Toby Edelman of the Center for Medicare Advocacy, asserted that “cutbacks in the survey and enforcement process have already begun.”

In May, she said, the Bush administration pulled back a Clinton administration policy that said inspectors must revisit nursing homes to verify that deficiencies in care had been corrected.

Today’s statements suggested that the White House was still trying to work out the lines of control and communication with agencies of the federal government.

On several occasions, Mr. Scully has spoken out on behalf of the administration at a time when White House officials were trying to keep a low profile.

In June, Mr. Scully caught the White House off guard when he announced that his agency would publish report cards evaluating the quality of care provided by health maintenance organizations, nursing homes, hospitals and doctors. The administration plans to make more information available to the public but not in that form.

Dr. Steffie Woolhandler, an associate professor of medicine at Harvard University, said it was unrealistic to think that some nursing homes were so good they did not need to be inspected every year. “Only one in four nursing homes is totally free of deficiencies in any given year,” Dr. Woolhandler said, “and it’s not the same ones from year to year.”

Sharon A. Brigner, a health policy analyst at the National Committee to Preserve Social Security and Medicare, an advocacy group, praised the administration’s plan to disseminate data that would help people choose nursing homes.

But Ms. Brigner said the government must not relax standards for hiring home aides so that employees allow the hiring of unskilled workers to perform tasks like pushing wheelchairs or helping patients at mealtime. Nursing homes, unable to find enough people trained as nurses’ aides, have asked the government to allow the hiring of such workers.
More Money, Less Care

Ever higher outlays aren't getting the U.S. a better health-care system, but the pols aren't doing much to redress this miserable equation >> BY CATHERINE ARNST

T HIS IS WHAT passes for good news in health care: U.S. spending will increase by only 9% to 10% in 2005, about the same rate as last year, according to UBS Securities. That's still three times the rate of inflation, but at least it's less than the gains the nation saw in the first two years of this century, when costs rose by 12% to 13% a year.

All told, the U.S. will probably spend an estimated $1.9 trillion on health care in 2005, $100 billion more than the prior year. That's 15.7% of the gross domestic product. Despite such mammoth sums, hospitals will continue to struggle to stay solvent, employers will continue to face higher insurance premiums, employees will continue to shoulder a higher percentage of those premiums; and insurers—well, insurers will continue to do very well, thank you, because they get to pass on their higher costs to the policy holders. Though not, of course, to the 45 million people who are uninsured—15.6% of the population.

At some point, and probably in the not-too-distant future, this level of spending will almost certainly become unsustainable. Expensive new drugs and medical technologies, a growing number of uninsured, and an aging, overweight population virtually guarantee cost increases will climb back to the 12% to 13% range in a few years. By 2010, UBS Securities estimates that health care will consume 17.4% of the GDP. "In my view, the pressure is not off costs at all," says William McGeever, a UBS health-care analyst. "I see nothing on the horizon that will moderate increases."

All of this might be O.K. if we were getting maximum bang for all those bucks, but we're not. Other industrialized nations, which have universal health coverage, spend less of their GDP on health care—8% to 10%. Yet they rank well above the U.S. in average life expectancy and infant mortality rate, standard measures of a nation's health. The U.S. ranks in the bottom quartile of all industrialized nations on those two measures.

Nor does the U.S. do well on more specific quality measures. In a study of a broad range of procedures in five highly industrialized nations, released last spring in the well-regarded journal Health Affairs, researchers determined that the extra spending on health care in the U.S. is "not buying better experiences with the health care system, with the exception of shorter waits for nonurgent surgery." That conclusion was backed up by a study released in December by Veteran's Administration researchers: They found that only 51% of patients nationwide receive medically recommended care for their conditions. So much for the oft-heard claim that the U.S. has the best medical system in the world.

Despite this dire situation, there are no serious proposals in Washington to redress the miserable cost/quality equation. President George W. Bush's main health-care reform initiative, the introduction of tax credits for Health Savings Accounts, is likely only to siphon off healthy adults from existing insurance plans, making it harder to offset the costs of treating the sick. At the same time, the shift to high-deductible policies by many employers is likely to cause some consumers to delay health care until their conditions become serious—and more expensive to treat.

If change is going to come, it needs to be driven by the companies now picking up the nation's health-insurance tab, as well as their beleaguered employees. The annual Towers Perrin Health Care Cost Survey predicts that employers can expect, on average, an 8% increase in health-care costs in 2005, to an annual rate of $7,761 per employee. Those employees will see their share of insurance premiums increase by an average of 14%, while benefits will be reduced by 2%.

A Henry J. Kaiser Family Foundation survey found that the cost of job-based health coverage has risen 59% since 2000, while the percentage of U.S. workers who receive health benefits through their jobs has dropped from 65% to 61%. Paying more, getting less. Isn't it about time that policymakers—and the people who vote for them—come up with a better way?
Iedicaid

Government Is Likely to Pay 49% Of All U.S. Health Costs by 2014

By SARAH LUECK

Growth in health-care spending will continue to slow, but federal, state and local governments will be picking up nearly half of all U.S. health costs within a decade, a shift that largely reflects Medicare's new prescription-drug coverage, federal analysts forecast.

Government will pay 49% of health costs by 2014, up from 46% currently, according to the agency that runs Medicare, the federal health program for the elderly and disabled. The government's portion has been rising steadily, from 43% in 1980 and 38% in 1970.

"The public sector will feel more deeply the financial burden associated with supplying health-care benefits to Medicare and Medicaid enrollees," the federal analysts wrote in an article published by the Journal Health Affairs.

The data underscore the strain on the nation's health-care system at a time when government officials, especially Republicans, are eager to rein in spending on public programs like Medicare and Medicaid, the state-federal health program for the poor. Meanwhile, employers spending will outpace growth in the overall economy, and by 2014, health care's share of gross domestic product is projected to be nearly 19%, up from 15% in 2003.

On the private side, health-care spending is projected to slow to 7.4% between 2003 and 2004 from a peak of 9% between 2001 and 2002. The government analysts attribute the slowdown in part to a "quiet reemergence" of managed-care tools that tamp down use of medical care, such as increased cost-sharing for patients. Private health-insurance premium growth is also expected to slow to 7.7% in 2004 from 9.9% in 2003.

However, the strain remains for private health spending, especially in the employer-based system that covers most insured Americans. The government projects that premium growth will outpace disposable personal-income growth by 1.4 percentage points from 2004 to 2014.

The Medicare analysts emphasized that their numbers aren't certain, in part because it's difficult to predict the impact of the new Medicare drug coverage. In addition, the data are based on current law, not possible future policy changes.

The analysts say the drug benefit will cause an initial jump in prescription-drug use by Medicare beneficiaries and a minor rise in spending on medications. But the impact will be largely offset by lower drug prices, they said. The analysis assumes that savings on drugs will be 15% off retail prices when the drug benefit starts and will grow to 25% off retail over time. In 2006, the first year of the Medicare drug benefit, total spending on prescriptions is expected to grow nearly 12%. Drug-price growth, including the Medicare drug benefit, will account for 2.4 percentage points of that surge, the analysis said.

Spending on drugs is expected to represent the largest share of total out-of-pocket spending—24% in 2004. That means the public's attention on price will likely continue. Marilyn Moon, an economist and Medicare expert at the American Institutes for Research, said that Medicare beneficiaries will see a growing share of their Social Security checks going toward Medicare premiums and deductibles. "In the long run the only way to save this program ... is to put a crowbar in our wallets and pay for it," she said.

Already, members of Congress are proposing legislation that would legalize importation of prescription drugs from other countries and give the government power to negotiate with drug makers for lower prices in Medicare.

Bearing the Burden

Public payers are funding an increasing share of the nation's health-care costs.

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<th>Share of national health expenditures (left scale)</th>
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Sources: CMS, Bureau of the Census; Bureau of Economic Analysis

are complaining about the high cost of providing health care to workers, and individuals are paying a growing share of their own medical costs without seeing a comparable increase in their wages.

If nothing changes, we can't get the health care we really want," said Richard Foster, the chief actuary for the Centers for Medicare & Medicaid Services. When the Medicare drug benefit begins in 2006, an estimated $67 billion in
A Bad Case of Sticker Shock

Next year’s health benefits will cause you to say “Ouch!” Here’s what the most important changes will look like—and how painful they’ll be.

BY LAUREN YOUNG

If you work for a company that starts its fiscal year on Jan. 1—and 70% of employers do—the 2006 benefits package should soon hit your mailbox. Brace yourself for sticker shock: You may even feel a little sick when you see the combination of higher costs and reduced coverage. That’s because your employer is paying an average of 8% more, an extra $600, for your health insurance in 2006, according to human resources consultant Towers Perrin in Stamford, Conn. And since employers are foisting more of the burden off on employees, your tab will go up even higher: an average $155 more for health care in 2006, up 10% from 2005. To keep costs in line, there’s a good chance you’ll be offered the option of a high-deductible plan that lets you choose how you spend your health-care dollars. You can also expect to see higher costs for prescription drugs and larger deductibles. Also new: More companies are offering financial incentives to participate in wellness studies. Here’s a look at some of the key changes to 2006 benefits plans and what to consider before signing up:

High-Deductible Accounts

Just a few years ago, these plans—which make the employee responsible for a bigger portion of their medical costs in exchange for a lower premium—were scarce. Now 20% of employers offer a high-deductible plan, according to the Henry J. Kaiser Family Foundation. Ray Herschman, a health-care consultant at Mercer Health & Benefits in Cleveland, predicts that half of the companies with 5,000 or more employees will offer a high-deductible plan next year, in addition to more standard choices such as indemnity, point of service, and health maintenance organization (HMO) plans. Some smaller companies may even replace conventional plans with high-deductible versions.

High-deductible plans come in two flavors: health reimbursement accounts (HRAs) or health savings accounts (HSAs). The key difference is that the HRA is funded by the employers and any unused cash belongs to the company. With the HSA, employees make contributions with pretax dollars—and employers may or may not match them—and unused cash belongs to the employee. Because more of the financial burden is on the employee, consultants say more companies will choose HSAs.

With either account, employees can expect to pay deductibles of at least $1,000 for individuals and $2,500 for families. HSA participants may fund an account well beyond the deductible with pretax contributions, up to $2,500 for individuals and $5,000 for families. (There’s no limit on HRA contributions.) Both plans cover 100% of medical expenses once the deductible has been reached. And both usually pay 100% of preventive-care costs that don’t count toward the deductible. There are no co-payments.

Viewed as investments, HSAs are similar to a 401(k)—the participants choose among an array of investment options. The account’s earnings are not taxed—whatever isn’t used is rolled over to the following year.

HRAs and HSAs should appeal to you if you are generally healthy and don’t rack up many bills. (The average person spends less than $700 for health care an-
nually, according to David Stacey, senior consultant at Hewitt Associates in Lincolnshire, Ill.) That’s why Ron Sussman, president of CPI Cos., a financial-services firm in Voorhees, N.J., plans to add an HSA at his 13-employee company. “The amount of money we are paying for health insurance is ridiculous, and it drives me nuts because we are not using the benefits,” says Sussman, 47.

HSAs also are a good tool for self-employed workers who need tax shelters. “You not only get to write off premiums, but you get to make tax-deductible deposits into your HSA,” says Steve Sharkey, a brokerage representative at John Alden, a unit of Assurant, in Philadelphia.

Before you sign up, pay attention to fees. Some plans charge up to $50 per year in administrative fees, although larger plans may drop those costs. In addition, look at the underlying investment options to make sure they’ll help you meet your savings goals.

>>CO-PAYS AND DEDUCTIBLES

Those $15 or $20 co-payments you shell out for your point-of-service or preferred provider organization plan every time you visit the doctor may disappear for some plan participants. Instead, you’ll be required to pay an up-front deductible of about $300. After you meet that deductible, expect your insurer to pay 90% of any costs if your doctor is within the plan’s network. (Insurance often pays only 70% if it’s out of network.)

>>PRESCRIPTION DRUGS

Co-payments for brand-name drugs (typically $20 to $30 each time you fill a prescription) will be about $5 higher in 2006, although generic-drug co-payments ($10 to $15) should be about the same, consultants say. Pharmacy-benefit managers say that fewer than 20% of all employees currently take advantage of mail-order drug plans, but if you use one, you can save as much as half on any medications you take on a continuing basis. Plus, it’s convenient. “It’s a heck of a lot easier to have the stuff arrive in your mailbox every 30 days,” says Tom Billet, a senior consultant at benefits firm Watson Wyatt in Stamford, Conn.

If you don’t go for online purchases, your plan might force you. More employers are implementing mandatory 90-day mail-order programs for maintenance drugs such as Lipitor, a cholesterol-fighting drug, to cut costs. If you take a drug on an ongoing basis, your only option may be to buy three months’ worth through the mail. “You can’t keep going back to your pharmacy and buying it over and over,” Billet explains.

>>WELLNESS SURVEYS

More companies are asking their employees to fill out online health assessments with financial incentives. At Xerox, for instance, employees who participate in an online health appraisal earn $200 in health-care discounts. “After answering questions on stress, their weight, cholesterol, and other health topics, employees who are deemed to be high-risk in three areas are eligible to work with a free health coach,” says Kara Choquette, a Xerox spokeswoman.

At international pharmaceutical giant AstraZeneca, employees save $50 a month if they take part in a new online health survey—a quick $600 off their annual health-care bill. “In the first 10 days, we already had over 50% of employees participate in the assessment,” says Carla Burigato, an AstraZeneca spokeswoman. With health-care benefit costs continuing to move in just one direction, who wouldn’t jump at any opportunity to save? ■

It won’t be easy to figure out which type of plan to choose
Open Bar for Health Costs

There’s hope for medical cost control, but it won’t be easy. Try telling someone with a deadly ailment that he shouldn’t use a promising but expensive remedy. Still, costs have skyrocketed because demand and supply are completely divorced from the discipline of the marketplace.

Americans’ incentives to seek the most expensive and expensive care has risen as their share of the bill has nose-dived. In 1960 out-of-pocket payments covered 55% of total medical costs, but in 2001 only 17%. Meanwhile health insurance pay-outs, mostly employer-provided, are up from 21% to 35% of the total while government’s share jumped from 21% to 43%.

To put it bluntly, a certain amount of what goes on is recreational medicine. A minor ache means a half-day off work and a battery of medical tests. Think of the demand when the postwar babies retire. Americans also insist on the latest, most expensive drugs, especially since the Food & Drug Administration in 1997 permitted drugmakers to advertise to consumers. Hence the demand for the risky painkiller Vioxx, really suitable for only a tiny fraction of patients with bleeding ulcers. Health maintenance organizations, with their scale economies and gatekeeper role, contained medical costs a decade ago. But doctors’ groups and consumer complaints pushed them back in favor of more expensive plans like preferred provider organizations.

On the supply side, heavy government involvement via Medicare and Medicaid creates waste since government efficiency is an oxymoron. Estimates are that 15% to 30% can be cut from government medical outlays without reducing service. Hospitals aren’t run for patients but for physicians, the guys who get the “Doctors Only” close-in parking spots, as I explained in my Oct. 9, 1995 column (“The Parking Lot Indicator”). Yet doctors have no financial responsibilities to the institutions, so they order unnecessary tests and services freely.

Lots of medical outlays go for paperwork. Drug development is overly expensive. The medical system also encourages the most expensive procedures and equipment. Intensive care units, where 25% of their patients die, involve 1% of patients but eat up 27% of all health care costs.

Still, the tide is moving toward lower-cost care. Bigger insurance deductibles and copayments are making consumers aware of costs. Health savings accounts are even more effective, because with them the patients’ own money is on the line. While only 1% of workplaces offered them this year, 26% of large employers say they will sponsor HSAs by 2006. If this approach is extended to Medicare, recreational medicine and much reimbursement paperwork will be history.

Medical centers are hiring “hospitalists,” doctors who follow patient needs from admission to discharge and don’t have the perverse incentives that attending physicians do to order up unnecessary tests. Hospitals are also assembling in-house SWAT teams to handle emergencies without consulting attending physicians.

In the medical-cost-containment future, look for winners among pharmacy benefit managers, diagnostic testing labs and diagnostic equipment makers, outfits that provide home health care services and supplies and outpatient services and clinics. Also consider manufacturers of noninvasive diagnostic and surgical equipment, companies that provide health care information and services on and off the Internet and companies involved in doctor and hospital management information systems as well as market research services.

HMOs may regain favor as consumers become better medical service shoppers, to the benefit of former Blue Cross-Blue Shield plans and other health care managers. And as the postwar babies age, don’t forget the funeral business. Pressures on costs will not bother the price-insensitive wealthy. So companies managing upscale nursing homes, assisted-living homes and rehab clinics will thrive. Ditto those aiding costly elective procedures, like laser eye-surgery equipment. The rich and desperate will also pay for biotech hopes when the alternative is death.

Avoid Medicare- and Medicaid-reimbursed nursing homes and long-term-care homes. Government limits on pricing may offset the future huge demand for them. Producers of expensive medical equipment (like exotic X-ray scanners) are vulnerable.

Even though drugs are often cheaper than surgery, I’d shun the big drug companies since their oversize costs will take years to work off. Generic drug providers are a better bet. Hospital chains may be unattractive until attending physicians agree to become employees. And HSAs may ax much of the reimbursement business of traditional medical insurers.

The era of medical cost containment is at hand. Invest accordingly.

A. Gary Shilling

It works like this: A doctor sends a patient sample to an outside lab for testing. The lab charges the doctor a discounted price—say, $30—for a skin biopsy. The doctor then gets reimbursed by the patient’s insurer for a much higher amount, say $100. The difference, $70, is profit for the doctor.

Typically the doctor doesn’t tell the insurer that an outside lab did the work for a steep discount. Insurers could put a stop to the practice by refusing to pay the inflated reimbursement, but they are often unaware of the arrangements.

Critics say referral deals are harmful because doctors have an incentive to send work to the cheapest lab, not necessarily the best one, to maximize their profit margins. Also, by enticing doctors to order many tests, the arrangements drive up the nation’s health-care bill.

“Patients should wonder if this dermatologist is doing this biopsy because I need it or he is going to make money from it,” says Lisa Lerner, a Boston area dermatopathologist.

While referral deals aren’t new, people in the industry say they have grown rapidly in recent years as doctors seek new sources of income and demand grows for expensive lab work to detect diseases such as prostate cancer. “Five years ago, no one was interested in this,” says Bernie Ness, the owner of a laboratory industry consulting firm in Toledo, Ohio. “That has changed dramatically. I get calls every week from people who want to get in on the billing.”

One of the few private insurers to block doctors from profiting on outside lab work is Blue Cross Blue Shield of Georgia. Starting Aug. 1, it required those performing lab tests to do the billing themselves, a practice known as direct billing. That eliminated deals where doctors bill for work they didn’t perform. It isn’t clear why other insurers don’t do the same. Several of the biggest ones declined to comment. Medicare requires direct billing, as do
Lucrative Operation: How Some Physician Groups Mark Up Lab Work

Continued From First Page

a few states. In some other states, doctors and local medical societies upset at the prospect of losing revenue have thwarted such legislation. Some doctors still bill MediCare for lab work performed off-site by owning “condo” labs within a larger facility.

The American Medical Association’s code of ethics says under the heading of laboratory services that a “physician should not charge a markup, commission, or profit on the services rendered by others.” It adds, however, that doctors can levy a “processing charge on such services. The AMA code says that a doctor “who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit is not acting in the best interest of the patient.”

Federal laws broadly prohibit doctors from receiving inducements for referrals or engaging in “self-dealing”—referring patients for services in which they have a financial interest. Doctors and companies involved in lab referrals say they do what they can do legal. Companies say they’re just offering a service, and doctors say that doesn’t add up to illegal inducement. In general, doctors don’t own a stake in the outside labs, which they say clears them of any charge of self-dealing. They say they’re entitled to mark up work farmed out to a contractor to cover costs such as billing for the work and delivering results to patients.

Last year, the U.S. attorney in Oklahoma City indicted three former executives of a lab, UroCor Inc. The indictment says UroCor charged discounted prices to doctors who turned around and billed private insurance companies at a much higher rate for the lab work. Doctors were charged as little as $6 for a common analysis to detect prostate cancer, called the PSA test, and got reimbursement of $25 and up, the indictment says. It says the discount was a kickback to induce the doctors to also refer work covered by Medicare, which

markup of more than 700%.

LabCorp Executive Vice President Bradford T. Smith says the company has a policy of not discussing specific billing arrangements. He says another case in which a Nashville doctor group was charged only $17 for a biopsy analysis appears to be an “outlier.” That doctor group could yield a profit of more than $80. About 10% of LabCorp’s business comes from “client billing,” or arrangements in which LabCorp bills the doctor and then bills the patient or an insurer, Mr. Smith says.

LabCorp, with sales of $3 billion last year, is the country’s second-largest lab company. The biggest is Quest Diagnostics Inc. of Lyndhurst, N.J., with revenue of $5.1 billion last year. Quest says client billing accounts for 6% to 7% of its revenue.

No Choice

At a recent conference of the American Urological Association in San Antonio, doctors took seats at the exhibition booth of Lakewood Pathology Associates of Lakewood, N.J., as the firm touted its “revenue share” model. If urologists send their tests to Lakewood, the company’s marketing director said, they could generate up to $35,000 per year. Lakewood’s chief executive, Raza Bokhari, says the lab is careful to obey federal laws barring kickbacks to doctors, in part by making sure that doctors don’t get a discount based on the volume of referrals.

Some of the labs engaged in client billing say they have no choice. “A lot of labs do it and if you get out of it the other guys will take you to the cleaners.” says Clay Cokerell, a Dallas dermatopathologist who is on the board of Ameripath Inc., a national lab based in Palm Beach Gardens, Fla.

Dr. Cokerell, who is also the president of the American Academy of Dermatology, concedes the practice raises ethical issues. “Is the physician billing for it the one looking at the slide? No,” he says. “From that perspective, does it

Balboa, Calif. Ms. Hansen, of Cary, N.C., says she asked a local pathologist, Keith Nance, to review her biopsies after hearing that they were “atypical.” Dr. Nance found no abnormalities.

Dr. Nance, who considers client billing unethical, prompted a unsuccessful effort to ban the practice in North Carolina, urged her to report the situation to the state medical board and helped write a complaint. He helped her find out how much the California lab was charging doctors by contacting the lab and pretending to be a potential customer.

In her October 2003 complaint to the medical board, Ms. Hansen cites an email in which National Dermatopathology quoted Dr. Nance a rate of $35 to analyze a biopsy. Ms. Hansen, who had four biopsies analyzed, says in the complaint that the lab must have charged her dermatologist, William Ketcham, no more than $140 for her lab work. Insurance records show Dr. Ketcham was paid $328 for the work by her insurance company.

Dr. Ketcham declined to discuss dollar figures but says his deals with labs are “not profit.” He says he sends his patients to a lab that doesn’t cost anything. He says paperwork is easier when he doesn’t have to exchange patient information with the lab. The North Carolina Medical Society has said that “markups are a legitimate business practice” for lab services.

Dr. Ketcham says he has stopped using National Dermatopathology because the state medical board told him he must send his biopsies to pathologists licensed by North Carolina. The board took no disciplinary action against Dr. Ketcham. He now sends his lab work to Dermatopathology Laboratory of Central States in Dayton, Ohio.

Central States won’t say what it charges doctors for lab work. But a 2003 fee schedule from the state lab indicates that doctors were charged $25 for the first biopsy and $15 for each additional specimen. The same fee schedule indicates that when Central States billed insurers the owner of a home assessed at $4.1 million on the same street in Bel Air where the actress Elizabeth Taylor lives.

According to a court filing, the pathologist who analyzed Ms. Hansen’s biopsies was Hong Li, who worked at National Dermatopathology between July and December 2003. Dr. Milani is suing Dr. Li, accusing her of breaking a one-year employment contract. In the court filing, Dr. Li says her daily volume “far exceeded the generally accepted workload” in her specialty and “directly affected the quality of patient care.” She says she quit from fatigue. Dr. Milani says Dr. Li’s allegations are false.

Getting Around Medicare Ban

Although Medicare refuses to pay doctors for work performed by others, some companies have figured out a way to let doctors bill Medicare for off-site lab work. It involves doctor groups creating a “condo” or “pod” lab within a building that also houses labs for many other practices. Since the doctors own the “condo” lab, they believe they can bill Medicare for work performed there.

One such facility is operated by Uro...

Well-Tested

Laboratory industry revenue, in billions

Source: Washington 6-2 Reports

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Although Medicare refuses to pay doctors for work performed by others, some companies have figured out a way to let doctors bill Medicare for office lab work. It involves doctor groups creating a "condo" or "pod" lab within a building that also houses labs for many other practices. Since the doctors own their "condo" lab, they believe they can bill Medicare for work performed there.

One such facility is operated by Uro...
Medical Technologies Improve Health Care, But At What Cost?

That's A Key Issue, Study Says

Opinions vary on whether innovations should move beyond core clinical uses. Oct 10 2005

BY GLORIA LAU
INVESTOR'S BUSINESS DAILY

When does the cost of medical technology outweigh the benefits? It's a tough question, given that you can't put a price tag on someone's health. Still, a new study from the Rand Corp. tried to analyze the cost/benefit equation of certain technologies.

The study was led by Dana Goldman, director of health economics at Rand.

Goldman and researchers looked at spending hikes that might face the elderly through 2030 under different scenarios — including potential cost spikes caused by 10 new medical technologies that are expected to emerge soon.

Some technologies, such as cancer vaccines and better drugs for strokes, are expected to have little cost impact. But other technologies, such as expanded use of implantable defibrillators, might drive costs up considerably.

Implantable defibrillators, which use a brief electric shock to restore a normal heartbeat, also show promise in treating other conditions such as heart attacks and heart failure.

Goldman's assumption: If half the patients with new cases of heart failure and heart attack get the device, Medicare spending would shoot up by $14 billion in 2015 and $31 billion in 2030. This would add almost 4% to total Medicare spending.

Even without further medical innovations, rising costs are already an issue. The 2006 Towers Perrin Health Care Cost Survey released in September says employers and workers are respectively paying 64% and 78% more now than they did five years ago.

The technologies that Goldman's study looks at are especially likely to boost costs because they target the elderly, a group that spends far more on medical care than the general population.

Not surprisingly, the study also has that share of critics. One of Goldman's fears is that medical device makers will try to sell their gear into areas beyond the core clinical benefit, thus creating a ripple effect: More spending on expensive equipment, more payments from insurance companies and other payers, and higher costs.

Analyst Thom Gunderson of Piper Jaffray & Co. says he doubts that will happen.

"I don't believe you can sell medical devices beyond the areas of true clinical benefit because payers won't pay for it," said Gunderson, whose employer has done banking work with device maker Medtronic since in the past 12 months.

John Ross, vice president of business economics for Medtronic's Cardiac Rhythm Management unit, also disputes Goldman's conclusions.

"The historical numbers suggest the future (cost) number will be nowhere near where (the Rand study) is projecting," he said. "It's disingenuous to suggest that there'll be $14 billion in new costs."

Expanding the market for some devices is worthwhile, he says. He points to the Sudden Cardiac Death in Heart Failure trial, which studied 2,500 patients on three different treatments over 2.6 years.

People who haven't had an episode of sudden cardiac arrest, but were put on the defibrillator, were 23% less likely to die than patients in the control group. Medtronic, Wyeth and the federal government sponsored the study.

The study prompted the Centers for Medicare and Medicaid Services (CMS) to approve expanding Medicare payments of defibrillator for this new group of patients.

CMS Administrator Dr. Mark McClelan said the move would save "thousands of lives each year."

Goldman doesn't disagree with the clinical benefits. Still, he urges Medicare and the Food and Drug Administration to start thinking about cost as well as medical benefits. People need to be more conscious about who will foot the growing bill, he says.

When someone is cured of a disease a lot of people assume it saves the health system money. Often it doesn't because that person lives longer and uses more health services.

The one exception is obesity. If you help deal with the obesity epidemic, you could save $38,000 over a lifetime in Medicare per person, the Rand study shows. Obese people don't typically die sooner — they simply develop more expensive illnesses.

"There's a certain amount of trust that insurers place on manufacturers to demonstrate their products are of value," Goldman said. "Manufacturers that take a cautious approach might engender more goodwill."
Britain Stirs Outcry by Weighing Benefits of Drugs Versus Price

Nov 22, 2005

By JEANNE WHALEN

LONDON—Millions of patients around the world have taken drugs introduced over the past decade to delay the worsening of Alzheimer’s disease. While the drugs offer no cure, studies suggest they work in some patients at least for a while.

But this year, an arm of Britain’s government health-care system, relying on some economists’ number-crunching, said the benefit isn’t worth the cost. It issued a preliminary ruling calling on doctors to stop prescribing the drugs.

The ruling highlighted one of the most disputed issues in medicine today. If a treatment helps people, should governments and private insurers pay for it without question? Or should they first measure the benefit against the cost, and only pay if the cost-benefit ratio exceeds some preset standard?

The U.S. generally follows the first course. Even the most cost-conscious insurers say they’ll pay the price if a drug works and there aren’t other options. Britain openly and unapologetically adopts the second course. If a drug or type of surgery costs a lot and helps only a little, it says no.

“There is not a bottomless pit of resources,” says Phil Wadson, finance director for the National Health Service unit that oversees hospitals and doctors’ offices in Liverpool. “We reached the point a while ago where there is far more medical intervention available than any health-care system can afford.”

The decision on the Alzheimer’s drugs has sparked protests from pharmaceutical companies including Pfizer Inc. and Eisai Co., which co-market the leading Alzheimer’s drug, Aricept. They say Britain is using a flawed economic model and will end up spending more on nursing-home care. More than 8,000 patients and caregivers sent angry letters to the National Institute for Health and Clinical Excellence, or NICE, which made the cost-benefit analysis.

NICE “has this strange mathematical formula they put heaven knows how many numbers into and out comes: ‘Yes, it’s affordable,’ or ‘No, it isn’t,’” says Antony Dennis, a Web-site designer in the village of Ramsbury whose mother takes Aricept. “Things like the relationship my mum has with her grandnephew are probably not easy to only to new Alzheimer’s patients and isn’t final. Following the protests, the institute set a meeting for next month at which drug makers will try to show that the Alzheimer’s drugs are cost-effective in at least some patient groups. Until then a previous directive from January 2001 that recommended the drugs remains in force.

NICE doesn’t have the power to force a doctor to prescribe in a certain way. Its decisions are officially just guidance.

But in practice, if the institute chooses in December to reject the Alzheimer’s drugs, it is likely to choke off prescriptions for new patients across the United Kingdom (except Scotland, which has its own health system). That’s because most British doctors are employees of local units of the National Health Service such as Mr. Wadson’s in Liverpool. The local units must keep costs within an annual budget. When NICE says a drug doesn’t pass muster, doctors are under pressure to avoid it and let the local funds be used elsewhere.

Since NICE was founded in 1999 it has reviewed 93 drugs, surgical procedures and other treatments, starting with those it feels are most in need of a rigorous cost-benefit analysis. In eight cases it has called on doctors to stop prescribing treatments because their benefits were judged not to be worth the cost. Rejected treatments include Kineret, a drug from Amgen Inc. for rheumatoid arthritis. In 57 cases it has recommended restricting use of a treatment. It said Eli Lilly & Co.’s Evista should be prescribed only for osteoporosis patients who can’t take another class of drugs.

In 28 cases NICE encouraged full use of a treatment, even if it costs more. Andrew Dillon, NICE’s chief executive, says this demonstrates that the institute’s aim isn’t to save money but to make spending more effective.
New-drug demand spurs rise in costs

By Joe Richter
Bloomberg News

LITTLESTOWN, Pa. — The $12,000-a-year injections that finally relieved Doreen Negley's rheumatoid arthritis help explain why medical costs are rising faster than overall consumer prices.

Patients like Negley are looking for new, more effective medicines, such as Immunex Corp.'s arthritis drug Enbrel, that can be more than double the cost of the therapies they replace.

"More Americans are taking more pills, and the new drugs in particular are expensive," said Steven Findlay, director of research and policy at the National Institute for Health Care Management, a nonprofit research group partly financed by Blue Cross insurance plans. "We're eating a lot more steak and a lot less hamburger when it comes to prescription drug use."

Medical care costs rose 0.5 percent in February after gaining 0.6 percent in January, the U.S. Labor Department reported Wednesday. February's rise included a 0.8 percent increase in prescription drug prices.

The jump in health costs isn't likely to push overall inflation higher, though, because it accounts for 6 percent of the government's consumer price index.

Consumers are clamoring for new drugs.

The number of prescriptions written in the nation increased 6 percent to 2.98 million in 2000, according to IMS Health, which tracks prescription trends. That's about 34 percent higher than in 1995, as new drugs including Merck & Co.'s Vioxx painkiller, Pfizer Inc.'s impotence treatment Viagra and Forest Laboratories Inc.'s Celexa anti-depressant came to market, IMS figures show.

The average price of drugs introduced between 1992 and 1998 was $38.47 per prescription, Findlay said. That figure more than doubled to $71.49 between 1992 and 1998.

Drug companies attribute the price increases to higher development costs that come with increasingly complex compounds, wider clinical trials and higher fees for third-party researchers.

"It's much more expensive to bring drugs to market now, and the final price is in part a reflection of that," said Ken Kaitin, director of the Tufts Center for the Study of Drug Development, a policy research group.

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Study: Drugs cost U.S. $400B

1 in 4 deaths linked to alcohol, tobacco, controlled substances

By Donna Leinwand
USA TODAY

WASHINGTON — Young people are beginning to use drugs earlier and are increasingly likely to choose Ecstasy and hallucinogens over marijuana and cocaine, according to a report to be released today by Brandeis University.

The report, which tracks drug and alcohol-use trends over several decades, also indicates that drug use, alcohol consumption and smoking cost the USA more than $400 billion a year in health-care claims, lost productivity and criminal justice expenses.

The report was funded by the Robert Wood Johnson Foundation, a philanthropic group in Princeton, N.J., that supports health-care research. Analysts who reviewed hundreds of substance-abuse studies linked one in four U.S. deaths to tobacco, alcohol or drug use.

Although overall levels of drug and alcohol use peaked in the 1970s and 1980s and have fallen substantially, some substances favored by teens are bucking the trend, the report says.

Alcohol remains the most commonly used substance among teens. Marijuana use, which rose among teens in the early 1990s, began to drop in 1996. And cocaine use, which peaked in the 1980s, also is down. The study calls Ecstasy a "notable exception." It links the overall rise in heroin and hallucinogen use with the drugs' popularity among those younger than 26.

A decade ago, 14% of eighth-graders had tried illicit drugs other than marijuana. That percentage had risen to 16% by 2000, the report says.
Drug-Stock IIs Are Hard to Cure

By GREGORY ZUCKERMAN
And SCOTT HENSLEY

FOR YEARS, pharmaceutical companies were popular growth stocks. They traded at high price valuations, made up a sizable chunk of leading market indexes and attracted a loyal following of investors. Not only did they churn out impressive current earnings, but they promised more high-powered growth in the years ahead, as the U.S. population aged.

Even in recent years, as the industry dealt with stream of challenges, the stocks held up reasonably well, as Wall Street figured the setbacks were temporary, and business would come storming back amid new treatments.

But with new-drug pipelines snarled, and worries growing about the safety of current blockbuster drugs such as Merck's Vioxx and Pfizer's Celebrex, among others, investors are re-evaluating the entire pharmaceuticals business. Rather than anticipate a strong comeback, such as the rebound experienced in the mid-1990s after jitters about pricing pressures, more investors are beginning to worry that the pharmaceutical industry's maladies will linger.

While these companies are likely to generate steady profits for the next several years, the market is becoming convinced that the difficulties, such as too few new profitable drugs and growing competition, will keep a lid on growth for the foreseeable future. And much like the utility industry, the pharmaceutical business could see more government regulation and pressures on pricing, making the stocks less attractive over the long haul, these investors say.

The industry's problems "are not just a cyclical phenomenon—things have slowed down and it doesn't sound like things will be solved soon," says James Paulsen, chief investment officer at Wells Capital Management. "Today there's greater competition that permanently notches down growth, and a higher risk premium" has to be applied to the shares in light of the recent problems with current big sellers.

How drastic is the fall from grace? In late 1998, pharmaceutical stocks traded at 40 times

Please Turn to Page C3, Column 1.
Cholesterol Standards to Boost Drug Use

Continued From Page BI

cade. He probably wouldn’t be a drug candidate. But people whose 10-year chance of a heart attack is 20% or more and whose LDL is above 130 should automatically be on drugs, the guidelines say. The cholesterol-lowering drugs will decrease a person’s risk by about one-third, says Dr. Grundy.

Some say the recommendations are too complex. “The average doctor is going to have a lot of trouble making sense of these recommendations,” says Lee Newcomer, medical director of a health-insurance consulting company and former medical director of insurer UnitedHealth Group.

While the new guidelines also urge dietary changes, some doctors think these don’t go far enough. Dean Ornish, an internist at the University of California at San Francisco who generally urges very low-fat diets before prescribing drugs, says, “It’s so easy to write a prescription for a statin drug. Most people don’t even know they have a choice because most doctors assume people can’t change diet and lifestyle.”

Dr. Grundy responds that, in the case of a person with coronary disease and LDL above 130, the vast majority won’t drop below LDL of 100. “But,” he adds, “we certainly hope that people don’t ignore the dietary approach.”

Some doctors suggest the financial ties to drug companies may be driving the guidelines. “This whole program has the flavor of a drug industry/NIH cabal,” says Sidney Wolfe, director of the Health Research Group of Public Citizen, a Washington-based consumer advocacy group who are purists and impartial judges, but you don’t have the expertise.”

In any case, managed-care and insurance executives generally endorsed the recommendations. “These guidelines are catching up to standards of practice that have evolved in recent years,” says Raoul S. Frear, vice president of clinical services at pharmacy-benefits company Express Scripts Inc. “We have already forecast a tripling of cholesterol-lowering drug expense over the next four years.”

But will people follow the recommendations? Research has shown that a fairly low percentage of people who are theoretically candidates for cholesterol drug treatment actually undergo it. And many who do start it don’t stick with it longer than a year. “There are many, many, many people who are eligible for treatment who are not getting it,” says James McKenney, a professor emeritus of pharmacy at Virginia Commonwealth University and a member of the NIH panel. “So we’re coming up with new guidelines when we haven’t gotten the old ones right yet.”

Of course, drug companies will try to correct that. “The pharmaceutical industry will promote them widely,” says Dr. McKenney about the new recommendations. “If you were in the business of selling drugs and you were told your population tripled, you would be doggone happy.”

“This brings in a lot of people who are

### King Cholesterol

U.S. sales* by category of prescription drugs, in billions.

<table>
<thead>
<tr>
<th>Category</th>
<th>Sales</th>
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</thead>
<tbody>
<tr>
<td>Cholesterol reducers</td>
<td>$9.66</td>
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<tr>
<td>GI ulcer drugs</td>
<td>$8.91</td>
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<tr>
<td>Antidepressants</td>
<td>$8.77</td>
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<tr>
<td>Cancer drugs/chemotherapy</td>
<td>$5.56</td>
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<tr>
<td>Calcium blockers</td>
<td>$4.57</td>
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<tr>
<td>Antipsychotics</td>
<td>$4.38</td>
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<tr>
<td>Anemia drugs</td>
<td>$4.17</td>
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<tr>
<td>Arthritis</td>
<td>$4.05</td>
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<tr>
<td>Antiseizure</td>
<td>$3.81</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>$3.63</td>
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</tbody>
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*For 12 months ending March 31, 2000
Source: IMS Health
DENVER — Several Democratic state lawmakers said Thursday they plan to propose bills this year to make prescription drugs more affordable to low- and fixed-income Coloradans.

The measures, to be introduced during the legislative session that starts next Wednesday, include proposals for getting the state more involved in negotiating drug-pricing pacts with pharmaceutical manufacturers.

"We can, in essence, increase the value of the state’s dollar through volume discounts and preferred drug lists," Rep. Alice Madden, D-Boulder, said. "And the savings will benefit thousands of seniors who currently aren’t able to participate in Medicaid."

Nederland Democratic Rep. Tom Plant said he’ll sponsor a bill to have a state prescription benefits manager negotiate volume discounts for low-income Coloradans on Medicaid — much as health-maintenance organizations already do for their customers.

Madden said she’ll introduce legislation to create savings in Medicaid through a preferred-drug list for prescribed medications.

Madden said she expects state Medicaid savings could then be used to underwrite a separate proposal from Rep. Alice Borodkin, D-Denver. Borodkin plans to introduce a measure to lower drug costs for seniors not covered by Medicaid whose retirement incomes are too small to afford prescription drugs at current prices.

Under Borodkin’s bill, elderly Medicare recipients would have to contribute “a small co-pay” when they purchase drugs, but total costs could not exceed state-established Medicaid reimbursement rates.

"Prescription drug prices have risen twice as fast as inflation," Borodkin said. "We can’t stand by and watch them become completely unaffordable to so many Coloradans when we’re talking about people’s health."

Sen. Penfield Tate, D-Denver, a member of the Legislature’s Joint Budget Committee, said he’ll propose two bills, one directing the state to negotiate rebates for Medicaid patients’ drugs and the other to standardize information on prescription-drug benefit cards.

"The Medicaid budget is now the second largest general-fund expenditure and is rapidly growing," Tate said. "We need to consider a number of strategies that will lower costs for the state while continuing to keep necessary medicines available for patients.”

Tate said his bills were not an effort “to try to put pharmaceutical companies out of business.”

However, the House Democrats’ bills may get initial hearings in the House Health, Environment, Welfare and Institutions Committee.

Centennial Republican Rep. Lauri Clapp, who chairs the panel, said she shares concerns about health-care costs.

"We’re very aware of it and we all feel it and we want to address it," she said.

But Clapp also said the Democratic proposals might wind up causing drug manufacturers to shift manufacturing, research and development costs to consumers.

With the current budget crisis, Clapp said, “I’m worried about startup costs of any new programs this year.”

Madden said studies indicate that prescription-drug prices have increased 116 percent nationally over the past five years, while the overall cost of health care has risen only 34 percent.

She and her Democratic colleagues noted that the same pharmaceuticals are much cheaper in Canada and Mexico.

Borodkin said “in a nation like ours, it’s absolutely ludicrous” that some people have to choose between food, shelter and medication.

Clapp, however, said prices are higher in the United States partly because the high-quality medications are heavily regulated.
Flaws in Drug-Patent Laws Cited

Continued From Page A3

Drugs. "Pharmaceutical companies have far less time than other industries to recoup their huge research and development costs," he said.

The report comes as Congress is embroiled in an election-year debate over how to lower drug costs, especially for the uninsured elderly. Ms. Chockley said it is important for lawmakers to scrutinize the repercussions of shielding the pharmaceutical industry from competition in the making and marketing of drugs.

The report examined six laws enacted between 1983 and 1987 that strengthened the patents of brand-name drugs, extended their exclusivity on the market and eased the transfer of government discoveries to pharmaceutical companies. Brand-name drugs account for about 96% of total spending and about three-fifths of prescriptions in the U.S. market.

The laws also have helped the industry maintain its position as the most profitable in the nation. "These laws have been a key driver in the industry's profits," Ms. Chockley said.

The industry, however, faces challenges. According to Mr. Holmer, 150 drugs with $50 billion in combined annual sales will lose patent protection over the next five years. That development will offer "even greater choice to consumers," he said, as generics come on the market. The report notes that many manufacturers are seeking to extend their patents.

Counterfeit-Cash Problem Hits Small Towns

Continued From Page A2

add $10 bills— a project that began in 1995 and is costing taxpayers millions of dollars— suppose to reduce counterfeiting?

According to the Secret Service division of the U.S. Treasury, which is responsible for the handling of counterfeit bills, the redesigned bills will thwart counterfeiting, but only if shopkeepers are watching. or passed were computer-generated, according to the Secret Service. Last year, however, 46% of all forged notes were made on a computer.

"In the past these folks were knowledgeable in printing operations and had expertise," says Rick Floras, a Secret Service agent in Salt Lake City. "Now a kid who wants to take his girlfriend out for the venience stores and mom-and-pop operations. In Andalusia, police officers say drug dealers are getting paid with counterfeit bills because they are the least likely to complain to the cops.

But all around there are signs that businesses are doing their best to cope. Some retailers have equipped their cashiers with special pens that are supposed..."
The Great Multivitamin Debate

The effects of the pills, if any, are modest and may require taking them for decades. But that's good enough for me.

For years, doctors advised their patients that the only thing taking multivitamins does is give them expensive urine. After all, true vitamin deficiencies, such as scurvy and pellagra, are practically unheard of in industrialized countries. Now it seems those doctors may have been wrong. The results of a growing number of studies suggest that even a modest vitamin shortfall can be harmful to your health. Although proof of the benefits of multivitamins is still far from certain, the few dollars you spend on them is probably a good investment.

Or at least that's the argument put forward in last week's New England Journal of Medicine. Ideally, say Dr. Walter Willett and Dr. Meir Stampfer of Harvard, all vitamin supplements would be evaluated in scientifically rigorous clinical trials. But those studies can take a long time and often raise more questions than they answer. At some point, while researchers work on figuring out where the truth lies, it just makes sense to say the potential benefit outweighs the cost.

The best evidence to date concerns folate, one of the B vitamins. It's been proved to limit the number of neural-tube defects in embryos, and a recent double-blind randomized trial found that folate in combination with vitamin B12 and a form of B6 also decreases the reblockage of coronary arteries after angioplasty. Look for a supplement that contains 400 micrograms of folate.

The news on vitamin E has been more mixed. Healthy folks who take 400 IU daily (standard multivitamins usually contain 30 IU) for at least two years appear somewhat less likely to develop heart disease. But when doctors give vitamin E to patients who already have heart disease, the vitamin doesn't seem to help. It may turn out that vitamin E plays a role in prevention but cannot undo serious damage.

Despite vitamin C's great popularity and near ubiquity, consuming large amounts of it still has not been positively linked to any great benefit. The body quickly becomes saturated with C and simply excretes any excess.

The multivitamins question boils down to this: Do you need to wait until all the evidence is in before you take them, or are you willing to accept that there's enough evidence that they don't hurt and could help?

If the latter, there's no need to go to extremes and buy the biggest horse pills or the most expensive bottles. Mega-doses can cause trouble, including excessive bleeding and neurological problems. One important caveat: it's easy to get too much retinol (preformed vitamin A) from supplements and diet, which may increase the risk of hip fractures and birth defects. So make sure that retinol is not the only source of vitamin A in your pills.

Multivitamins are no substitute for exercise and a balanced diet, of course. But it's hard to be healthy all the time. As long as you understand that any potential benefit is modest and subject to further refinement, taking a daily multivitamin makes a lot of sense.
Nursing a Grudge

The Governor’s decision to allow bigger hospital work loads has ignited a bitter battle in California

By MARGOT ROOSEVELT  LOS ANGELES

Perhaps someone should have warned Arnold Schwarzenegger that nurses are no pushovers. For weeks, California’s famously tough Governor has been locked in a furious feud with the state’s R.N.s over his decision to suspend new state rules that would limit the number of patients a nurse must care for. The rift took off at a statewide women’s conference in Long Beach last December, when the Governor ridiculed a group of nurses who were there to protest. To be sure, the R.N.s were provocative, unfurling a banner that read HANDS OFF OUR RATIOS—a not-so-subtle reference to allegations of female groping by Schwarzenegger that had dogged his gubernatorial campaign. But his response set a combative tone. “Pay no attention,” the Governor told the 10,000 women in attendance. “They are the special interests … I am always kicking their butts.”

The nurses took that as an invitation to keep Schwarzenegger’s derriere pinned to the hot seat. As they see it, the Governor is just bowing to another set of special interests—hospital and insurance companies—that want to keep profits up by employing fewer nurses than California law requires. And so the nurses have produced a Hollywood caper of a showdown, putting unrelenting public pressure on Schwarzenegger to back down. In two protests, thousands of uniformed R.N.s stormed the steps of the capitol in Sacramento, shouting, “Arnold, Arnold, you can’t hide—we can see your corporate side!” Nurses have buzzed his fund raisers with “Air Arnold” planes that drag banners reading DON’T BE BIG BUSINESS’S BULLY! They piqued a celebrity-studded party the Governor threw at his Brentwood home for retired NBC anchor Tom Brokaw.

According to a recent Gallup poll, nurses are more popular than he is. “The nurses care about patient safety,” says state senator Sheila Kuehl, author of the ratio law. “The Governor insulted them. It was a big misstep.”

When the A&E channel ran a biography called See Arnold Run, the California Nurses Association punctuated it with commercials of R.N.s denouncing him as “driven by greed and profits,” part of a $100,000 TV campaign. Their full-page ads in Washington and California newspapers accused him of kowtowing to the hospital lobby to “put vital health policy up for sale.” The headline: KICKING BUTT OR KISSING UP? Wherever Schwarzenegger turns up these days, nurses are sure to follow.

The nurses, retorted Schwarzenegger, “can’t tear me down, because I am with the people.” But he may not be able to make his get-tough position stick. The Sacramento Superior Court will hear arguments this week on the ratio issue in a lawsuit brought by the nurses’ association. California’s 1999 law, which took effect last year, is the first in the nation to mandate fixed nurse-to-patient ratios after takeovers of community hospitals by for-profit chains led to cutbacks. But two days after the November election, Schwarzenegger officials loosened nurse staffing requirements for emergency rooms and delayed until 2008 putting into effect a rule requiring a 1-to-5 nurse-to-patient ratio for medical-surgical units. “We don’t have enough nurses—nor can the hospitals afford that,” the Governor said. “Our hospitals are already closing down.”

The R.N.s claim their campaign has contributed to a 10-point drop in Schwarzenegger’s approval rating since September, although it still hovers at 55%. “They’re spending a lot of money to vilify him,” says press secretary Margita Thompson, “but it doesn’t faze him.” Yet when he attended a recent Sacramento film screening the very sight of a nurse in pertinence-hued hospital scrubs unnerved his security guards, who pulled the ticketed civilian out of her fifth-row seat and interrogated her for an hour before releasing her. “They treated me like I was a terrorist,” says Kelly Di Giacomo, a Sacramento cardiac nurse.

Whatever happens in court this week, Schwarzenegger’s butt kicking has hardly improved his image.
Medicare sales pitches to begin

PREScription-DRUG BENEFIT EXPANDS

Forty-two million Americans on Medicare will face a dizzying array of choices for government-subsidized prescription-drug coverage next month when private health insurance companies begin jockeying to sign them up for the new benefit.

Ten large insurers have been given the green light to market the new drug plans to consumers starting Oct. 1. Medicare officials said Friday.

Because other companies will offer coverage on a regional basis, participants in every state will have at least 11 providers to choose from. In some they will have as many as 20 choices, with some providers offering multiple plans.

Enrollment begins Nov. 15. Coverage takes effect Jan. 1.

"Medicare is taking a historic step," said Mark McClellan, administrator for the Centers for Medicare and Medicaid Services. "Thanks to the strong competitive response, everyone with Medicare will be able to choose a drug plan that addresses their individual concerns about cost and coverage and convenience. These premiums will be lower than expected in many cases."

No details were available Friday about specific plans. McClellan said plans with premiums of less than $20 a month will be available in every state. Plans with premiums exceeding $37 should be rare, he said.

Beneficiaries also can choose to get drug coverage through Medicare Advantage plans, which offer comprehensive health care through HMO- and PPO-like systems and serve about 10 percent of Medicare beneficiaries.

The new drug benefit, passed amid furious political wrangling on Capitol Hill in 2003, is the most significant and expensive expansion of Medicare since the creation of the federal health program for the elderly and disabled in 1965.

The cost to the federal government is expected to be $720 billion over the first 10 years. The benefit is being rolled out at a time of persistent budget deficits and mounting expenditures for military operations in Iraq and Afghanistan and relief and recovery efforts from hurricanes Katrina and Rita.

In general, the drug benefit will work like this: After an individual pays a $250 annual deductible, Medicare will cover 75 percent of drug costs up to $2,500. The coverage then stops until the recipient has spent an additional $2,850 out of pocket, after which Medicare covers 95 percent of drug costs.

President Bush has said the new benefit will save retirees an average of $1,900 a year.

The government expects as many as 30 million people will sign up for it for 2006.

Tricia Neuman, director of the Medicare Policy Project at the nonprofit Kaiser Family Foundation, said the large number of providers means the new benefit is off to a good start. But there is still uncertainty over how many people will enroll, how easily they will sort through the options and whether some providers will drop out over time.

"Choices can present opportunities, but the question is: What will seniors do when they face so many choices?" Neuman said. "Some will comparison shop, others might be heavily influenced by marketing and some may be paralyzed by so many choices. Not everybody should sign up, because some people already have adequate coverage."

Robert Hayes, president of the Medicare Rights Center, a nonprofit group that helps seniors navigate Medicare rules and benefits, said the number and complexity of the plans mean consumers will be hard-pressed to make informed decisions. The fact that so many companies will be angling for market share by emphasizing the most appealing features of their plans, and perhaps playing down the negative ones, will only make the task harder. And because the companies can make their pitches through telemarketing, there are concerns about fraud and identity theft, Hayes said.

"It's going to be open season for bad guys to exploit vulnerable older Americans," he said. "Some legitimate companies will play by the rules, but let's face it — it's an open invitation for confused consumers to give out personal information."

McClellan said the Medicare agency will provide tools to help consumers find a plan that best fits their needs, he said.

Beginning in mid-October, consumers will be able to call an 800 number and check the agency's website (www.medicare.gov) to get help with plans. Also, next month, the "Medicare & You" handbook distributed to beneficiaries each year will contain details about plan choices.
The economics of health care

Heal yourselves

AMERICA offers the best health care that money can buy. The problem is, it takes an awful lot of money to buy it. One in seven Americans has no health insurance, and those who do pay outrageous premiums. A new report by McKinsey, a consulting firm, looks closely at this mixture of high quality and high prices.

The ambitious study looks at the comparative costs of health care in America, Britain and Germany between 1985 and 1991, and assesses how far each country has gone since then to remedy its own shortcomings. Some of its conclusions are familiar. In 1990 America's health-care spending per head was 120% more than Britain's and 65% greater than Germany's (in purchasing-power terms). It blames this on the relative size of American doctors' fees and hospitals' administrative expenses. More interesting, however, the study also finds that in the treatment of specific diseases, American hospitals are more productive than German ones, and arguably more so than British ones as well.

For four ailments—breast cancer, diabetes, lung cancer and gallstones—it compares the benefits of treatment per unit of medical inputs. Benefits are measured by

Nov 9, 1996

The Economist
FINANCE AND ECONOMICS

"quality-adjusted life years" (QALYs): one of these is equivalent to one year in perfect health. Inputs are represented by a weighted sum of labour, medicines, equipment and so forth; contentiously, administrative costs are excluded. The weights depend on relative prices. If a course of treatment involves a one-hour consultation with a doctor and an X-ray, and an X-ray costs half as much as a doctor-hour, the total inputs would be equivalent to 1.5 doctor-hours.

However, relative prices vary from one country to the next. So total inputs will depend on the choice of weights. In fact, because medicine men in each country ought, in theory, to economise on their most expensive inputs, each country will be flattered when its own price weights are used. So the McKinsey team uses four sets of weights: the three national ones and an average. Only if all four give the same ranking can a conclusion be drawn.

The study finds that American doctors kept their breast- and lung-cancer patients healthier—ie, they produced more QALYS—than their German counterparts, despite using fewer resources. They had slightly less success than the Germans in treating gallstones, but used far less time, equipment and drugs in doing so. Compared with their British counterparts, American hospitals were far better at treating lung cancer and gallstones, were on a par in the battle against breast cancer, and less productive only in dealing with diabetes.

These results imply that hospitals and medical insurers on both sides of the Atlantic could learn from one another. In Germany, for instance, hospitals have an incentive to keep patients in beds longer than necessary: the government chops a hospital's budget if its occupancy rate falls below roughly 85%. Another rule dictates that the more public beds are filled, the more private patients may be admitted, so German doctors boost their earnings by letting the nationally insured clog the wards for twice as long as Americans do.

Britain is slower than America in adopting new technology. This may reflect the high cost of American physicians' time relative to that of equipment, and the risk that they will lose patients and attract lawsuits if they do not use the fanciest techniques available. But it is also partly the result of British hospitals' rigid budget caps, which have stopped them buying some cost-effective new gadgets.

America has two clear weaknesses. One, reflected in its record on diabetics, is its lack of incentives to provide long-term, low-priced care. Because Britain's National Health Service (NHS) is responsible for all patients throughout their lives, it can ensure that diabetics are supplied with insulin and are encouraged to take it. In America, by contrast, health insurers do not want to attract too many diabetic customers, so few of them have similar, life-long programmes of treatment. As a result, American diabetics are less well-informed than British ones about their illness, less likely to take their medicine, and roughly twice as likely to suffer horrid complications as a result.

The other weakness is the high cost of doctors' time and administration. American doctors have no monopolony buyer of their skills, like the NHS, to force down their fees. And the country spends about three times as much on health administration per head than either Britain or Germany.

In the past few years both America and Britain have been to press their failures: Britain has made less progress. In America, health-maintenance organisations (HMOs), which specialise in providing limited, but cheap, health care, are starting to curb costs. In Southern California, where HMOs cover 45% of the population, compared with a national average of 20%, health-care costs declined 5.2% between 1994 and 1995; over the same period, the national medical bill increased by 4.8%. In Britain, reforms to the NHS are encouraging limited competition between doctors and the uptake of new technology is accelerating. In all three countries, however, health-care systems still have plenty of ills.

Eastern Europe's economies

Saving graces

ECONOMIC expectations about Eastern Europe have usually been wrong. Forecasters were too impressed by communism, too depressed after its collapse. Now that growth and stability are becoming commonplace in the region, it is tempting to become complacent once again. If so, the annual Transition Report by the European Bank for Reconstruction and Development (EBRD), published on November 4th, should be a useful corrective.

The bank, which lends in 26 post-communist countries, highlights some of Eastern Europe's more ominous remaining problems. The first few years of transition may have been the easy part. Ending the wealth-destroying practices of communism and resuscitating people and raw materials for other uses; low wages (as little as a dollar a day in 1990) helped make businesses competitive. Six years on, the fact that 19 of the economies are growing is perhaps more surprising than the fact that seven—all of them appallingly governed—are not.

Wages are now well over a dollar an hour in most transition economies, and rising fast (see chart). To stay competitive, East European businesses will have to keep increasing their productivity. But without cheaper capital, better infrastructure and more competent government, that will be an uphill struggle.

Reducing the cost of capital will require huge changes in saving habits. The average savings rate in the transition economies has fallen to 18% of GDP, about half the current figure for the tigers of East Asia. To raise it, post-communist countries will need to develop properly run mutual funds, life insurers and private-pension providers. Few have even made a start. Improving infrastructure will not be an easy task. Eastern Europe is plagued by rickety, state-owned transport and telecommunications systems. These are either unprofitable and therefore overstretched or, in the case of international telephone calls, exorbitantly expensive. The obvious answers, firmly advocated by the EBRD, are to deregulate these industries, and to bring in foreign capital and expertise.

Pressure on state budgets may encourage the sale of some of these firms—but not to everyone's benefit. Even western countries find regulating privatised utilities tricky. In the post-communist world, where cronyism is rampant, the interests of free and fair competition are likely to come last.

Fair, transparent public administration will be the scariest resource in most post-communist countries for years to come. Customs services are notoriously corrupt and incompetent. Tax collectors, too, tend to make highly personal judgements (in some countries, even obtaining a written copy of the tax code is a challenge). For some countries, though, membership of the European Union offers some hope in coming years. The troubling thought that by post-communist standards the eu is an exemplar of good government should curb any unwarranted optimism.
Student survey may prompt health curriculum revisions

Continued from 1A

Phillips said the results reinforce the need to revise the district’s 23-year-old health curriculum to “target the issues that kids have in their lives.”

The proposed revisions have drawn criticism from some parents who disagree with the inclusion of sexual orientation. But Phillips said the survey shows that both the schools and the community aren’t doing enough to ensure that gay students feel welcome.

About 60 percent of gay, lesbian and bisexual students reported that they were harassed at school, half met one of the criteria for clinical depression and about 23 percent felt too unsafe to go to school.

The school board is scheduled to vote on the revised health curriculum May 25.

The county health department also conducted the survey among Boulder Valley high school students two years ago and plans to continue conducting it among students in both districts every two years.

“If we don’t change some of these outcomes, we’re going to be held accountable,” said Chuck Stout, director of Boulder County Public Health.

In this year’s survey, a little more than 25 percent of students reported feeling sad, or hopeless almost every day for two or more weeks in a row — one of the criteria for clinical depression. Nineteen percent said they considered suicide.

Of the 25 percent of students who reported that they’re currently sexually active, about 65 percent said they used a condom the last time they had sex, and about 24 percent said they used alcohol or drugs.

Barrett Dunn, a community health specialist with Boulder County Public Health, said the survey is only the first step in addressing the issues.

“The numbers tell us what behaviors are occurring,” she said. “They don’t tell us why or what the students are thinking.”

Individual school district results will be presented to Boulder Valley and St. Vrain Valley school boards next week.

Seriously considered attempting suicide in the last year: 19 percent
Attempted suicide in the last year: 16 percent
Harassed at school in the last year because someone thought they were gay, lesbian or bisexual: 7 percent
Received unwanted sexual comments or attention: 19 percent
Ever had sexual intercourse: 34 percent
Condom use during last sexual intercourse: 65 percent
Alcohol or drug use at last sexual intercourse: 24 percent

Max Taffet, a junior at Boulder High, said the survey “will enlighten many adults on the youth perspective of what’s really going on.”

He said it’s also important to remember that risky behaviors aren’t just a youth issue. “Adults are where we are getting our examples,” Taffet said.

Contact Camera Staff Writer Amy Bounds at (303) 473-1341 or boundsa@dailycamera.com.

May 7, 2004
Health Benefits Offered by Firms Shrink for Retirees

By CHRISTOPHER CONKEY

WASHINGTON—Employers are offering health insurance to a shrinking number of retired workers, particularly early retirees, and the trend is expected to continue, the nonpartisan Employee Benefit Research Institute said.

Examining the latest data from the Census Bureau and the Department of Health and Human Services, the institute estimates that 29% of early retirees—those who retire before age 65 and thus generally ineligible for Medicare—had employer-sponsored health insurance in 2002, down from 33% in 1997.

For retirees older than 65, who generally are eligible for Medicare, the percentage who were offered employer-sponsored health benefits declined to 25% from 25% in 1997.

The institute said it expects the decline to continue and that more future retirees will have to rely exclusively on the Medicare and Medigap government health-insurance programs or purchase private supplemental policies, known as Medigap.

Paul Fronstin, the senior research associate at the institute who conducted the survey, said the percentage of all retirees covered by employer-sponsored plans probably peaked at around 45% in the late 1980s.

"The lucky few who had it to begin with are losing coverage," he said.

About 13% of private employers offered health benefits to early retirees in 2002, down from 22% in 1997, the institute said. It also said that 13% of employers offered health benefits to retirees over age 65, down from 26% in 1997.

While an aging population and rising health-care costs partly explain employers' reluctance to offer health insurance, the institute's report singled out a 1990 Federal Accounting Standards Board rule that forced employers to report retiree health-benefit liabilities on their financial statements.

James Klein, president of the American Benefits Council, a group that represents large employers who offer health plans, said the rule change forced companies to switch from unlimited promises to specified contributions. "They said, 'We're going to give retirees $3,000 or $1,000 per year, but at least we know what the expense is going to be,'" Mr. Klein said.

Messrs. Klein and Fronstin agree that today's workers should lower expectations for employer-based health coverage in retirement and begin saving to pay for future health expenses. A survey by the EBRI last year found that 35% of current workers expected their employers to provide health benefits when they retire; another found that health-care costs are five times higher than individuals tend to estimate.

"Unless Congress acts quickly, the future for retired health care is going to be very bleak," Mr. Klein said. His group is lobbying to increase the limits on contributions to tax-favored Health Savings Accounts and to establish a new category of tax-deferred investment accounts, akin to 401(k) retirement accounts, to provide for future health-care expenses.

John Rother, chief lobbyist for the lobbying group AARP, said the EBRI report offered further evidence of "employers abandoning benefits for retirees" and carrying out a "cost shift to people who have no way to protect themselves from it."
Higher salaries to depend on health insurance costs

By Amy Bounds
Camera Staff Writer

The Boulder Valley School District and the teacher's union have reached a tentative salary agreement after two days of negotiations with the help of a federal mediator.

The mediator was called in after the two groups failed to reach an agreement. The teachers wanted a higher base salary increase than the 4 percent the district offered and didn't want to start contributing to their health insurance premiums.

"We're a lot closer now," said Mike Altenbern, Boulder Valley Education Association president.

While neither side will discuss specifics, human resources executive director Bob Lopez said the new deal is contingent on finding a relatively low-cost health insurance provider through the district's bid process.

If the cost of health insurance doesn't increase as much as the predicted 25 percent to 30 percent, he said, the district will have more money to spend on teacher salaries.

"We haven't found new money," he said. "We would just shift the money we have. People really came together to try to make this work."

The district is estimating an increase of about $7.3 million next year that could go toward salaries and benefits. The increase is made possible by Amendment 23, an initiative passed by voters in 2000 that requires the state to increase funds for school districts annually at Colorado's inflation rate plus 1 percent — a total of between 5.3 percent and 5.9 percent.

But the district also estimated that the cost of next year's salary and benefits package for all employees would come to an additional $8.2 million — if health insurance costs rose by 30 percent.

The $8.2 million includes a 4-percent raise, but teachers countered by asking for at least 5.9 percent to keep pace with the cost of living and catch up after several years of small raises.

Boulder Valley's starting teacher salary ranks third from the bottom out of eight metro-area school districts. Last year's 4-percent base salary raise for Boulder Valley teachers was the smallest increase out of those districts.

At an emotional protest attended by more than 600 teachers last month, several vowed not to approve a contract with less than a 5.9 percent raise.

Another issue is that, while the district originally predicted a 5.8 or 5.9 percent increase in funding from Amendment 23, that increase could drop to as low as 5.3 percent, depending on final inflation figures.

District officials are hoping to reach a decision on the insurance provider by the end of the month. If the insurance costs stay low enough, the teachers and the school board will then vote on the new contract.

But if the costs go too high for the district to offer teachers more than a 4 percent raise, then the two groups would go back to the bargaining table. They could also decide to try mediation again.

Contact Amy Bounds at boundsa@thedailycamera.com or (303) 473-1341.
Rationing Health Care: The Choice Before Us

HENRY AARON AND WILLIAM B. SCHWARTZ

Rapid technological advances and upward pressure on wages of hospital personnel are leading to a steady increase in health care spending that is absorbing an ever-larger fraction of gross national product. Eliminating inefficiencies in the system can provide brief fiscal relief, but rationing of beneficial services, even to the well-insured, offers the only prospect for sustained reduction in the growth of health care spending. The United States, which has negligible direct experience with rationing, can learn about choices it will face from the experience of Great Britain where health care has been rationed explicitly for many years.

RISING SALES CAUSE JOY IN MOST INDUSTRIES, BUT INCREASING OUTLAYS FOR HEALTH CARE ARE CAUSING DISTRESS NOT ONLY AMONG THOSE WHO MUST PAY THE BILLS BUT AMONG HEALTH CARE PROVIDERS THEMSELVES. AFTER ADJUSTING FOR INFLATION, TOTAL AND PER CAPITA PERSONAL HEALTH CARE EXPENDITURES HAVE RISEN AT ANNUAL RATES OF 5.5 AND 4.1 PERCENT SINCE 1950 (1). THE PROPORTION OF GROSS NATIONAL PRODUCT DEVOTED TO PERSONAL HEALTH CARE HAS NEARLY TRIPLED. OFFICIAL FORECASTS PROJECT THAT THE UNITED STATES WILL BE DEVOTING 15 PERCENT OF TOTAL PRODUCTION TO HEALTH CARE BY THE YEAR 2000 (2). SUCCESSIVE ADMINISTRATIONS HAVE PROPOSED A VARIETY OF MEASURES INTENDED TO CONTAIN MEDICAL COSTS, BUT THE RESULTS HAVE BEEN SO UNSUCCESSFUL THAT SOME OBSERVERS SPECULATE THAT THE UNITED STATES MAY BE FORCED TO RATION HEALTH CARE (3, 4).

The term “rationing” is used in two distinct senses. First, market economies persistently deny goods to those who cannot afford them. All goods, including health care, are rationed in this sense, especially for the poor and some others who face large expenses and lack insurance. Such price rationing of medical care has a long and, in our view, ignoble history in the United States. This problem affects about 15 percent of all Americans. Second, the term “rationing” is used to refer to the denial of commodities to those who have the money to buy them. In this sense sugar, gasoline, and meat were rationed during World War II. The question now being raised is whether health care should be rationed in this sense, whether its availability should be limited, even to those who can pay for it. This kind of rationing would affect the 85 percent of all Americans who currently have health insurance and any others who may later be added to their ranks. While the first question is urgently important, we shall be focusing on rationing in the second sense.

In this article, we address key questions surrounding rising health costs. Why have recent efforts at cost containment failed? Can the United States afford unlimited, high-quality care for everyone? If not, is rationing unavoidable? If so, how will it be carried out and what will be its effect on the health and lives of most Americans?

The Economic Basis of Rising Outlays on Health Care

Standard economic theory suggests that spending on health care is excessive. According to this doctrine, when people pay less than the full cost of what they buy, they will consume more than is socially optimal unless their consumption benefits not only themselves but others. This line of argument suggests that insurance induces excessive health expenditures because people pay for only part of the cost of care.

Patients in 1987 paid, on the average, only about 10 cents of each dollar devoted to hospital care, a share that has changed negligibly for two decades. And they pay about 26 cents of each dollar paid to physicians, a share that has fallen steadily. Although these averages conceal large differences among patients, the fully insured (or those who have exceeded ceilings on patient outlays) and physicians acting in the patients’ interests have the incentive to seek any service, however costly, that provides any benefits at all. Because of insurance, these decisions impose large costs on others.

The Unavoidable Dilemma

The intersection of this payment system and three distinct features of the health care system leads inevitably to rising costs. The first and most important is technology. Diagnostic procedures and therapies that are now routine were unknown when most physicians now in practice began their training. Computed tomography, magnetic resonance imaging, nuclear medicine, organ transplants, many of the drugs for control of ulcers and of the symptoms of coronary artery disease, open heart surgery, total parenteral nutrition, and a host of other diagnostic and therapeutic procedures have been introduced or become standard in the past two decades. Other technologies, described later, indicate that the rate of innovation is not abating. Nearly all of these innovations promise to increase the number and cost of beneficial interventions.

A second factor driving up costs is the tendency for the price of services characterized by low growth in productivity to rise relative to the price of commodities (5). Although a day in the hospital today differs in many ways from a day in the hospital in, say, 1960, the hotel services of feeding and space rental and most services of nurses and orderlies are produced with little more efficiency than in the past.

The final factor is the aging of the population. Although the average annual cost of health care rises sharply with age, this factor

H. Aaron is a senior fellow at The Brookings Institution, Washington, DC 20036 and professor of economics at the University of Maryland, College Park, MD 20742; W. B. Schwartz is Vannevar Bush University Professor and Professor of Medicine, Tufts University, Boston, MA 02111.
accounts for only a minor proportion of the 651 percent growth of real personal health care outlays between 1950 and 1987 (6).

Each of these inflationary forces shows every sign of continuing for decades.

Many observers deny any imminent need to consider rationing. They argue instead that we can continue to provide whatever beneficial services are available if we eliminate inefficiencies and wasteful practices. But, as we shall show, such reforms, although potentially important in absolute size, promise one-shot savings and can only briefly defer the need to consider whether and how to ration medical care.

Why One-Time Savings Cannot Solve the Cost Problem

Various methods have been proposed for cutting costs and improving efficiency—elimination of redundant medical capacity, cessation of useless medical procedures, increased competition, better management, and reduced fees for certain physicians. Unless they are used to reduce the availability of beneficial services—in short, unless they are used to compel nonprice rationing—all promise to arrest or slow the growth of medical costs only temporarily.

The potential savings from eliminating chronically empty beds, now numbering some 300,000, are surprisingly small because the same number of patients will presumably be cared for whether or not the duplicated facilities are closed and because the marginal costs of alternative care is high relative to the marginal savings from closing excess facilities (7).

The potential savings from eliminating useless medical procedures, by contrast, could run into many billions of dollars. Health maintenance organizations (HMOs) claim that through superior efficiency and elimination of useless services (mostly excess hospital days) they deliver high-quality service at costs well below those of other providers. One study supported these claims (8), in that it was found that one HMO provided comprehensive care for approximately 25 percent less than did providers reimbursed on a fee-for-service basis for fully insured patients. However, the HMO was no less costly than fee-for-service care for patients who faced an annual deductible of $450 per family or 95 percent cost-sharing (8). If costs of all fee-for-service hospital and physician care were reduced by 15 percent, an estimate based on the difference between costs of HMOs and the mixture of other insurance plans, there would have been a once-and-for-all reduction in expenditures of approximately $20 billion (8, 9).

Additional savings that entail no rationing will become possible as evaluation of established medical procedures identifies classes of patients in which selected procedures now in use produce no medical benefits (10). Even a small percentage saving in an industry currently absorbing more than $500 billion per year is a high-stakes effort that should be vigorously pursued, but continuation of annual growth of real personal health care expenditures of 4.1 percent per capita would quickly dwarf the savings from increased efficiencies (1).

For a variety of reasons, not all providers could become as efficient as the best run HMOs, and economies would be realized over many years. As a result, savings would be achieved gradually and, therefore, would be hard to detect against the strongly rising trend in medical outlays. In short, the United States faces a choice between letting medical outlays claim an ever rising share of output, while recognizing that some will go for services producing small but positive benefits, and trying to devise socially acceptable arrangements under which some patients who have the means to pay, directly or through insurance, are denied some beneficial care.

Policy Attempts to Control Spending on Health Care

The past two decades have seen repeated and highly touted efforts fail to slow the growth of spending on medical care.

Regulation. Starting in 1974 Congress sought to curtail growth of investment in medical structures and equipment by requiring advance authorization (a certificate of need or CON). Although potential penalties for noncompliance were severe, evaluations found that they were seldom invoked and that many hospitals allocated to other activities the resources not used in disapproved investments (11).

Former President Richard M. Nixon’s price control program, begun in 1971, temporarily lowered the growth of spending on hospital services. The controls were so complex that they could not be sustained. When controls were removed, real hospital spending rose at an average annual rate of 6.9 percent in 1975 and 1976. President Jimmy Carter responded in 1977 by proposing a cap on growth of revenues per patient day. Hospitals promised to slow spending growth voluntarily but, after brief success, the effort wilted following congressional rejection of President Carter’s proposal.

In 1984 the Health Care Financing Administration (HCFA) began to reimburse hospitals fixed sums for Medicare patients based on primary and secondary diagnoses at the time of admission (the “diagnosis-related group” or DRG, system). Under the prior system, HCFA had paid hospitals the audited cost of services covered by the Medicare program. Under the DRG system, hospitals receive the same amount whatever they spend, except in relatively rare outlier cases. Preliminary evidence suggests that the program has slowed growth of hospital spending under Medicare (12). However, it is not clear how much of this slowdown is simply the realization in the Medicare program of economies being achieved throughout the health care system, how much entails shifting of costs outside the hospital setting, and how much represents the rationing of beneficial services.

Competition. Some analysts have claimed that competition among health care providers can greatly reduce growth of spending on health care without any loss in the quality of care or the imposition of rationing. In pursuit of this goal, some have supported a cap on the exclusion from the personal income tax of employer-financed health insurance premiums, development and dissemination of statistics on the quality of care rendered by various hospitals and physicians, solicitation of competitive bids by employers from various groups of providers, and a host of other measures to promote efficient provision of medical care and to narrow margins.

Table 1. Health care outlays as a percentage of gross domestic product, 1960–1986 (29).

<table>
<thead>
<tr>
<th>Country</th>
<th>1965</th>
<th>1980</th>
<th>1986</th>
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<tbody>
<tr>
<td>Australia</td>
<td>4.9</td>
<td>6.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Canada</td>
<td>6.1</td>
<td>7.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Denmark</td>
<td>4.8</td>
<td>6.8</td>
<td>6.1</td>
</tr>
<tr>
<td>France</td>
<td>5.2</td>
<td>7.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Germany (West)</td>
<td>5.1</td>
<td>7.9</td>
<td>8.1</td>
</tr>
<tr>
<td>Italy</td>
<td>4.0</td>
<td>6.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Japan</td>
<td>4.5</td>
<td>6.6</td>
<td>6.7</td>
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<tr>
<td>The Netherlands</td>
<td>4.4</td>
<td>8.2</td>
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<tr>
<td>New Zealand</td>
<td>4.3</td>
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<td>Norway</td>
<td>3.9</td>
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<td>Sweden</td>
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<tr>
<td>United States</td>
<td>6.0</td>
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</table>
Low-carb foods: less than meets the eye

A few years ago the cry was “low-fat” or “nonfat,” as new food products came on the market positioned to appeal to the weight-conscious and health-conscious. You could avoid most fat but still eat your ice cream and cookies. In some ways the trend to low-fat and fat-free foods was beneficial; in other ways it was not. Nonfat milk is a good thing, but nonfat junk food is still junk food, of course. Many consumers failed to notice that a low-fat cookie often has as many calories as the regular kind, and many assumed it was okay to eat the whole box.

Now the craze is for low-carbohydrate foods. If you’ve been to the grocery store lately, or even to McDonald’s or Blimpie, you’ve seen promotions for “low-carb” foods. Many breads, sandwiches, muffins, pasta, cereals, tortillas, pizza crusts, beer, cakes, cookies, and other foods now bear “low-carb” labels. While the health claims are seldom spelled out, the implications are clear.

If you’re following a low-carb diet (such as Atkins) that forbids or severely limits bread, pasta, and other starchy foods, especially those made with white flour, you might think, well, here’s a way to eat some bread and still stay on the diet. Indeed, many low-carb products are sold under the Atkins brand name. Or perhaps you’re not on any diet but are just calorie-conscious.

Wellness facts

- Sea salt, a favorite at health-food stores and gourmet shops, has no nutritional advantages over regular salt, despite the claims. It is coarser, so it may be a little less salty per teaspoon—but if you season by taste, you’ll use more of it. Unrefined sea salt, simply made by evaporation of sea water, would contain small amounts of magnesium, sulphur, and calcium, but it is never sold as edible salt. By the time sea salt is cleaned and processed for the table, it’s virtually identical to regular salt—though much more expensive. Actually, ordinary table salt often does contain an essential mineral that sea salt seldom offers—iodine, which is added by processors.

- About 14% of Americans newly diagnosed with HIV are over 50, and the percentage is expected to continue to rise. Older HIV-positive adults are least likely to be tested and usually find out late, when they have full-blown AIDS. Detecting more cases earlier not only gives people a better chance to treat the disease, and thus have longer healthier lives, but also helps in preventing transmission to others. By the way, there’s a new rapid HIV test that provides results in the doctor’s office in 20 minutes.

You may conclude, logically enough, that a food lower in carbs is also lower in calories. Or you may buy the new stuff because you’re attracted to new products, and you think that there’s a law against false claims on food labels, so you conclude that low-carb claims must be (a) true and (b) meaningful.

In fact, “low-carb” is not what it seems. And any benefits these foods might offer for weight loss or nutrition are debatable, at best. If you replace carbohydrates with protein (that’s the main change), you still have just as many calories. Furthermore, the labels are, essentially, meaningless. The FDA has no definition of “low-carbohydrate” and has never approved any low-carb labels. Any food can be so labeled.

Bringing down the carbs

Here’s how manufacturers reduce the carbs in various foods:

- They replace refined wheat flour with soy flour (higher in protein), soy protein, or wheat protein.
- They add extra fiber, such as wheat bran, oat bran, or other fiber (this is not a bad thing, but read on).
- They add high-fat ingredients such as nuts (again, not so terrible: nuts are good food, containing healthy fats).
- They replace sugar with sugar alcohols (maltitol, lactitol, or sorbitol) or artificial sweeteners. This has been going on a long time—ever hear of sugarless or “dietetic” candy?
- For beers, they use certain chemicals in the brewing process to reduce carbohydrates in the brew. But the result is not very different from “lite” beers, long a market staple.

Is the difference real, though?

None of these changes are unhealthy. But these products end up having nearly as many calories as their regular counterparts, and cutting calories is still the key to weight control. Protein has as many calories as carbs do, and fat has more than twice as many calories.

The products often have nearly as many carbs, too, but the labels disguise this fact with several tricks. Most often they subtract certain carbs, and provide a separate section listing a lower number, which designates the remaining ones “effective carbs” or “net impact carbs.” The idea is that since fiber, for instance, doesn’t affect blood sugar the way other carbs do, it

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