

The State of the U.S. Health Sector

**A REVIEW OF DATA ON THE HEALTH SECTOR
OF THE UNITED STATES
MAY 2001**

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This report presents data on the state of U.S. health care in early 2001. It provides information on the numbers of uninsured and underinsured and their difficulties in obtaining health care; the increasing costs of care; and medical, social, and economic inequalities. Data are presented on the state of the nations' health maintenance organizations (including Medicare HMOs), pharmaceutical industry, and hospital industry, and on the role of these industries' money in U.S. politics. The author also looks at some proposals on the Congressional agenda, and gives a summary of some reasons why tax credits won't work. Also provided is some recent information on the status of health care and health care systems elsewhere in the world.

UNINSURED AND UNDERINSURED

- In 1999, 42.6 million Americans (15.5 percent) were uninsured, a drop of just 4 percent from 1998, despite the economic boom. Eleven percent of non-Hispanic whites were uninsured, versus 21 percent of blacks, 33 percent of Hispanics, and 21 percent of Asians. Forty-one percent of the uninsured have been without coverage for at least three years (Census Bureau, Employee Benefits Research Institute, November 13, 2000).
- Nearly 40 percent of Hispanics under age 65 do not have health insurance. Nine million of the 11 million Hispanic uninsured are in working families. Only 43 percent of Hispanic adults and children are insured through employer-sponsored coverage—far below the national average of 64 percent. Public coverage for low-income families fails to provide a safety net: half of Hispanics

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with family incomes below the federal poverty level are uninsured. In the past year, almost half of uninsured Hispanics have gone without needed doctor's visits, medications, tests, or treatment. Two-thirds faced collection agencies for medical bills or could not pay their bills ("Latino Community at Great Risk," ACP-ASIM, March 2000).

- Thirty-five percent of seniors do not have any prescription drug coverage at any given time, compared with 23 percent of people under age 65. Sixteen percent of the elderly say they have not filled a prescription because of the cost, and 9 percent say they have had to give up basic necessities to pay for medications. Seventy-six percent of Americans favor guaranteeing drug coverage to everyone on Medicare. Americans prefer "expanding Medicare to pay directly" for drugs two to one over "having the federal government help people age 65 and over to buy private health insurance" to pay for drugs (Kaiser Family Foundation, September 2000; Families USA, July 2000).

- Craig Venter, the President of Celera Genomics, the company that sequenced the human genome, observed that "a lot of people don't realize that we would all become uninsurable very quickly if we knew the construction of our genetic code. What really needs to happen is the implementation of universal health insurance. We need to get back to a system of shared risk" (Fast Company, "The Secret of Life," September 2000).

- Seventy percent of long-term uninsured Americans (uninsured for more than one year) in poor health were unable to see a physician when needed in the past year because of cost. Twenty-six percent of individuals with diabetes or hypertension who were uninsured for over a year had not had a check-up in the past two years (Ayanian et al., *JAMA*, October 25, 2000).

- Cost-sharing for medications reduces low-income individuals' and seniors' use of essential drugs and increases their risk of serious adverse events, including emergency department visits, according to a study of over 140,000 patients in Quebec. Prior to 1996, welfare recipients and low-income elderly received their medications free of charge; all other seniors paid \$2 per prescription. In 1996 the plan instituted 25 percent co-pays, with expenses capped at \$200 (Canadian dollars) for low-income persons and at \$200 to \$750 for the elderly. McGill researchers found that the use of essential drugs decreased 9.1 percent among the elderly and 14.4 percent among low-income persons after the cost-sharing took effect. The rate of use of nonessential drugs decreased 15.1 percent among seniors and 22.4 percent among welfare recipients. The rate of "serious adverse events associated with a reduction in use of essential drugs" doubled from 5.8 to 12.6 events per 100,000 person-months in the elderly and from 14.7 to 27.6 per 100,000 among low-income persons. The authors concluded that "increased cost-sharing for prescription drugs had the desired effect of reducing the use of less essential drugs but also had the unintended effect of reducing the use of drugs that are essential for disease management and prevention" (Tamblyn et al., *JAMA*, January 24, 2001).

- Half of New York State’s children participating in the state’s Medicaid and CHIP (Children’s Health Insurance Program) lose their coverage at re-enrollment time. Cumbersome income documentation requirements, rules mandating multiple in-person meetings, and the time staffers must spend transferring children from the CHIP program to Medicaid (over 250,000 so far) “cause people to lose coverage they are clearly eligible for.” Over 26,000 children lose coverage each month, according to a study by the New York State Coalition of Public Health Service Providers (*Rochester Democrat and Chronicle*, January 16, 2001).
- An estimated 1.5 million Californians suffering from mental illness are not receiving treatment. Instead, government “criminalizes” the mentally ill, and the Los Angeles County Jail is functioning as the largest de facto mental health facility in the nation (Little Hoover Commission Report, *Los Angeles Times*, November 21, 2000).
- Seventy percent of California’s 1.4 million farm workers are uninsured. Among males, one-half have never been to a dentist and one-third have never been to a doctor. The workers suffer high rates of high blood pressure, anemia, obesity, and dental disease. Most live on annual wages of \$7,500 to \$10,000 (California Institute for Rural Studies study, “Still a Harvest of Shame,” *San Francisco Chronicle*, December 15, 2000).
- Eighty-eight percent of 175 businesses surveyed by the Watson Wyatt consulting firm say their employees view their health plans as “average to poor.” Still, costs are firms’ major concern, with 58 percent of firms planning to look for ways to cut costs, while only 39 percent intend to take steps to improve employee satisfaction (*Wall Street Journal*, July 5, 2000).
- In 32 states, a parent working full-time at the minimum wage (\$5.15 per hour) exceeds the income limits for Medicaid. As a result, parents leaving welfare for work often lose their Medicaid coverage. Single adults and childless couples, no matter how poor, are excluded from Medicaid in the vast majority of states (unless they are disabled) (Families USA press release, November 20, 2000).
- An estimated 70,000 people with mental illness are being improperly housed in nursing homes nationwide, according to an investigation by the Health and Human Services (HHS) Inspector General. Up to 20 percent of nursing home residents are young adults with mental illness. State governments place them in nursing homes (where they become Medicaid-eligible) instead of in apartments or state psychiatric hospitals (which states must fund) so that the federal government will subsidize their care. In 1998, Illinois “secretly and improperly” moved thousands of patients with mental illness into nursing homes to bolster Medicaid funding (*Chicago Tribune*, January 23, 2001).
- Flu vaccine supplies were so late and poorly allocated this winter that many young healthy people were vaccinated ahead of the more needy elderly and chronically ill, prompting one internist to note “in a business-based health system, why shouldn’t the vaccine be sold to the highest bidder? For that matter, why shouldn’t insurance carriers try to monopolize all scarce drugs and vaccines to

better sell their health policies? Insure with us and live” (*Internal Medicine World Report*, December 2000). Both the Institute of Medicine and the U.S. General Accounting Office (GAO) issued reports highlighting a major gap in public health infrastructure and calling for more federal involvement to increase immunization rates. Flu accounts for 20,000 deaths and 110,000 hospitalizations in the United States each year (*Los Angeles Times*, November 8, 2000).

COSTS

- Health spending is projected to rise as a share of gross domestic product (GDP) from 13.6 percent in 1999 to 16.2 percent by 2008. Health spending is expected to approximately double, to \$2.2 trillion by 2008, according to the Office of the Actuary (Health Care Financing Administration, *Healthcare Leadership Review*, September 2000).

- Families with incomes of at least \$100,000 spend 3 percent of their income on health care each year, according to a study by Consumers Union. Meanwhile, families making \$45,000 spend 6 percent of their income, and families making under \$10,000 spend 17 percent of their incomes, six times more than wealthy people (Consumers Union, “The Health Care Divide,” October 2000).

- Prescription drugs are the fastest growing component of health spending, increasing at double-digit rates almost every year since 1985. Between 1993 and 1998, 18 percent of drug inflation was due to higher prices on existing drugs; 39 percent was due to newer, more costly drugs replacing older ones; and 43 percent was related to an increase in the number of prescriptions. Drug companies continue to be the most profitable firms in the country, with average 1999 profits of 18.9 percent compared to 5.0 percent for all Fortune 500 firms (Kaiser Family Foundation, “Prescription Drug Trends,” July 2000).

- While the nation’s total prescription drug costs rose from \$93.4 billion in 1998 to \$111.1 billion in 1999, spending on drug marketing rose 10 percent from \$12.4 billion in 1998 to \$13.9 billion in 1999 (*New York Times*, September 20 and November 16, 2000). The 25 drugs with the highest marketing expenditures accounted for 40 percent of the increase in pharmaceutical spending in 1999. U.S. spending on prescription drugs is expected to rise to \$243 billion by 2008 (Kaiser Family Foundation, September 2000; Associated Press, February 7, 2001).

- Health insurance premiums for the state of Minnesota are rising 17.5 percent in 2001, on top of a 12.2 percent increase in 2000. The state was long considered a managed care showplace and a cost containment model; today, monthly premiums for single coverage range from \$266 to \$375 (*Managed Healthcare Market Report*, January 31, 2001).

- Health insurance premiums are expected to rise 11 percent this year, on top of an average 8.1 percent increase last year, according to a survey of 3,300 companies

by William Mercer, Inc. Prescription drug costs account for much of the increase. Companies continue to drop retiree health coverage. In 2000, 31 percent of large firms provided coverage for retirees under 65 (down from 35 percent in 1999) and 24 percent offered supplementary Medicare coverage to retirees (down from 28 percent in 1999). Drugs now account for 14 percent of total employer health costs. Employers are expected to raise co-pays and deductibles and increase employee payroll deductions to offset rising costs. On average, employees will pay \$1,401 for health premiums in 2001 (up 18 percent), while employers will pay \$4,026 per employee (up 9.8 percent) (Mercer, Inc., “National Survey of Employer Sponsored Health Plans,” February 2001).

- In the California Public Employee’s Retirement System (CalPERS) premiums are rising 9.2 percent for HMOs (health maintenance organizations). A 24 percent increase is looming in the state’s financially troubled PPOs (preferred provider organizations) (*New York Times*, December 10, 2000).

- Average annual out-of-pocket expenditures for services not covered by Medicare were \$3,142 (about one-fifth of seniors’ income) in 2000 and are expected to rise to \$5,248 (one-third of income) by 2025, according to the Urban Institute. Poorer, sicker, and older Medicare beneficiaries will be disproportionately affected. Among low-income women in poor health, the findings are even more striking—health care already consumes 52 percent of their incomes and is predicted to rise to 72 percent without changes to the program (Urban Institute report, February 2, 2001; *Journal of Gerontology and Social Science* 55B(1): S51–S62, 2000).

- In the Federal Employees Health Benefits Program (FEHBP), HMO premiums are rising 8.5 percent and fee-for-service (FFS) premiums are rising 10.9 percent. Since 1998, premiums are up 36 percent in the FEHBP. The Heritage Foundation and other right-wing groups often cite the FEHBP as a model for a Medicare voucher program (*Washington Post*, November 7, 2000).

- Hidden health care costs: Health insurance brokers handle most policies sold to companies with less than 200 employees, taking a commission of between 4 and 10 percent of the premium dollars paid by subscribers. Brokers also receive perks from health plans, such as free trips, “Omaha steaks,” and golf outings (*Managed Care*, May 2000).

- Addiction and mental health treatment spending accounted for 7.8 percent of U.S. health expenditures in 1997, down from 8.8 percent in 1987, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). In 1997, the United States spent \$73.4 billion on mental illness and \$11.9 billion on alcohol and substance abuse treatment. Over half of mental health expenditures and two-thirds of substance abuse treatment costs are publicly funded (SAMHSA, August 2000). *Hellander’s note:* These figures understate the drop in funding for clinical mental health and substance abuse care; the growth of managed mental health firms has diverted a growing share of funds to administrative costs and profits.

MEDICAL AND SOCIOECONOMIC INEQUALITY

- In the District of Columbia, 22.8 women die per 100,000 live births, the worst rate in the nation. New Hampshire's maternal death rate is 1.9 per 100,000 live births (National Women's Law Center, August 2000).

- Blacks are less likely to receive kidney transplants than whites, regardless of clinical appropriateness, according to a recent study. Of 792 blacks in the study, 48 underwent transplantation procedures, compared with 183 of 726 whites. In addition, blacks deemed appropriate for kidney transplants were less often referred for evaluation and placed on a waiting list. Evaluation rates were 98 percent for white women and 99 percent for white men, versus 94.1 percent for black women and only 86.5 percent for black men (Epstein et al., *New England Journal of Medicine*, November 23, 2000).

- U.S. income inequality is growing rapidly. As the *PNHP Newsletter* goes to press (May 2001), it's estimated that the highest-income 1 percent of the population would receive 43 percent of President Bush's proposed tax cut (an average of \$46,000), while the bottom 60 percent of taxpayers would receive an average of \$227 (Public Campaign, *Ouch Bulletin*, No. 68, February 9, 2001).

In 1960, CEOs averaged \$190,000 in annual income, 40 times the earnings of the average worker. Today, CEO pay averages \$12.4 million, or 475 times an average worker's pay (The Jim Hightower Lowdown, January 2001).

The average after-tax income of the top 1 percent of tax filers jumped 31 percent between 1995 and 1997, after adjusting for inflation. That compares to an increase of 3.4 percent for the bottom 90 percent of tax filers. Over the longer-term, the picture is even worse. From 1977 to 1995, the average after-tax income dropped for the bottom two-fifths of the population, was stagnant for the middle fifth, and rose for the upper 40 percent, including an increase of 27 percent for the top fifth. Meanwhile, the average after-tax income of the top 1 percent of the population soared by 87 percent ("The Not-Rich are Getting Not Richer," *Los Angeles Times*, October 9, 2000).

- In 1999, 32.3 million Americans (11.8 percent) lived in poverty, despite the strong economy. The average poverty threshold for a family of four was \$17,027. Seventeen percent of all children lived in poverty. Among children under six living with a female head of household, 50.3 percent lived in poverty (Census Bureau press release, September 26, 2000).

- The number of applicants to medical school declined 6 percent in 1999, the third decline in a row. While blacks make up more than 12 percent of the population, they represent only 4 percent of physicians. The number of underrepresented minorities in medical school has dropped 15 percent since its 1995 peak.

Since 1993, the number of black and latino students at the University of California's five public universities has decreased by 46 percent.

The average student graduating from a public medical school had \$80,000 in debt, while the average private school graduate had \$105,000 (Barzansky et al., *JAMA*, September 6, 2000; *Contra Costa Times*, August 10, 2000; *New York Times*, October 27, 2000).

CORPORATE MONEY AND CARE

- The fox guarding the henhouse: The giant accounting firm KMPG helped Columbia/HCA defraud Medicare from 1990 to 1992, then received government contracts to perform audits for Medicare and other federal health programs from 1997 to 2000 (General Accounting Office, *New York Times*, December 1, 2000). Eli Lilly's corporate vice-president, Mitchell Daniels, was appointed director of the Office of Management and Budget. Last year, he testified for Eli Lilly against adding a prescription drug benefit to traditional Medicare—arguing that it “could quickly translate into price controls”—before the Senate Special Committee on Aging (*Wall Street Journal*, December 26, 2000).

- You can sue HMOs in Texas, right? Wrong. A federal appeals court ruled that Texans cannot sue HMOs for denials of claims and benefits, for example, if a plan claims a treatment is not medically necessary. The court also ruled that patients are not allowed to appeal coverage decisions to an independent panel of doctors, as written in state law. The only grounds for suing are HMOs' offering financial incentives to doctors to limit care; making medical decisions; and contracting with “demonstrably bad doctors” (*Fort Worth Star Telegram*, June 21, 2000).

- After purchasing eight Blue Cross and Blue Shield plans in seven years, Indianapolis-based Anthem insurance company (formerly Blue Cross and Blue Shield of Indiana) is converting to a for-profit. The company covers 7 million people in eight states (Maine, Colorado, Nevada, New Hampshire, Connecticut, Ohio, Kentucky, Indiana) and had \$8.8 billion in revenues last year. The conversion will make Anthem one of the five biggest publicly traded health insurers (*Modern Healthcare*, February 5, 2000).

- The actuarial consulting firm Milliman and Robertson (M&R) is being sued in several states for its guidelines for skimpy health care. A study of 3.5 million pediatric hospitalizations found a “wide gap” between what M&R recommends and actual average lengths of stay. For example, while the firm recommends three hospital days for pediatric bacterial meningitis, the average actual length of stay in 1998 was 8.5 days (*Wall Street Journal*, September 14, 2000).

HMO Millionaires

- Aetna's new CEO, John Rowe, M.D., received a \$2 million signing bonus last year and will receive a \$1.4 million retention bonus in July 2001. The former head of Mount Sinai-NYU Health will also receive an annual salary of at least \$1 million and a yearly bonus of \$1 million to \$3 million (*Modern Healthcare*,

October 23, 2000). Meanwhile, Leonard Abramson, former CEO of U.S. Healthcare, which was acquired by Aetna, is still receiving \$3 million a year for “consulting.” In addition, Aetna has paid Abramson’s two daughters and his son-in-law more than \$18 million for various consulting contracts (*Modern Healthcare*, July 19, 2000).

- HMO CEOs who made millions in total compensation (excluding stock options) in 1999 include Cigna’s Wilson Taylor (\$7.5 million), United Health Group’s William McGuire (\$4.8 million), Wellpoint Health Network’s Leonard Shaeffer (\$3.4 million), Pacificare’s Alan Hoops (\$2.9 million), Aetna’s former CEO Richard Huber (\$1.8 million), Trigon Healthcare’s Thomas Snead (\$1.3 million), Coventry Health Care’s Allen Wise (\$1.3 million), Sierra Health Services’ Anthony Marlon (\$1.1 million), and American Medical Security’s Samuel Miller (\$1.0 million) (*Jenks Healthcare Business Report*, September 24, 2000).

HEALTH MAINTENANCE ORGANIZATIONS

- California-based Wellpoint paid \$700 million for Georgia’s largest health insurer, Cerulean. Cerulean converted to for-profit status in 1998 in anticipation of the sale (*Wall Street Journal*, December 30, 2000).

- Oxford Health Plans is back to profitability after CEO Norman Payson cut physicians’ fees, raised premiums by 10 percent a year, and abandoned the Medicaid market. The firm now boasts a low “loss ratio” of just 81 cents per dollar of revenues, compared with the industry average of 84 cents (*Forbes*, December 11, 2000).

- The Minnesota attorney general is suing Blue Cross and Blue Shield of Minnesota for engaging in a “pattern of misconduct” in denying mental health and substance abuse treatment to children and young adults. The lawsuit alleges that Blue Cross routinely sought to shift the costs of care to either the family or the state, including instructing parents to use the juvenile justice system or place their children in foster care, instead of providing coverage. Blue Cross subjected patients and their families to a “barrage of unwarranted delays, unlawful excuses, and unnecessary hurdles,” according to the suit filed by attorney general Mike Hatch (*Corporate Crime Reporter*, November 20, 2000).

- HMOs are leaving the Oregon Health Plan, Oregon’s Medicaid managed care program, abandoning patients, who must find other plans or providers. Regence Blue Cross and Blue Shield is exiting the program by April, leaving 48,000 enrollees stranded. Statewide, the share of HMO enrollees dropped from 85 percent of Medicaid patients in 1998 to 65 percent in 2000 (*Portland Oregonian*, November 30, 2000).

- Washington State is looking for ways to reduce an expected \$600 million deficit in its medical assistance program over the next two years. Officials are looking at eliminating dental and vision coverage, reducing funding for

emergency medical care for the uninsured, reducing CHIP outreach and tightening requirements for medical assistance, hiring 78 additional staffers for claim reviews and audits, requiring the use of generic medications, and seeking an increase in federal Medicaid funding. “We are now down to a place where the cuts are not pretty,” said one staffer (*Spokane Spokesman-Review*, February 7, 2000).

- An audit of the Colorado CHIP program found that the program spent \$6 million on administrative overhead and \$16.2 million on health care, for an overhead of 27 percent. Premiums in the program are also among the highest in the nation, and the program takes a “punitive approach” to parents who miss payments. Children whose parents miss a premium payment are not eligible for health care under the CHIP program for three months; a plan to send collection agencies after poor families delinquent in premium payments (37 percent of families enrolled) has been postponed (*Denver Post*, August 1, 2000).

- Round ’em up: 16,000 Sacramento-area patients were “reassigned” to new physicians when Blue Cross of California decided to drop their physician group, Sutter Health (December 21, 2000). About 250,000 patients in California were left scrambling for care when one of the state’s largest medical groups, KPC Medical Management (formerly MedPartners Provider Network), filed for bankruptcy in August 2000. Just weeks before, another California medical group, Family Health Care, closed its doors to 135,000 patients (*Modern Healthcare*, November 27, 2000).

- One out of six people with private insurance changed plans in 1996–1997. More than two-thirds of these switched because they changed jobs (32 percent) or their employers switched plans (36 percent) (*Health System Change Data Bulletin*, No. 18, July 2000).

- Market “efficiency”: A study of the health insurance of a sample of 2,277 patients in greater Seattle found that they were covered by 189 different PPO, HMO, POS (point of service), or “other” delivery systems and a total of 755 different policies (Grembowski, *Health Services Research* 35: 707–734, 2000).

- The not-for-profit Harvard Pilgrim Health Plan has turned over mental health coverage for its 900,000 enrollees to a for-profit managed mental health firm, ValueOptions. Virginia-based ValueOptions already controls mental health care for Massachusetts’ 500,000 Medicaid recipients. Despite skimping on inpatient and outpatient care, ValueOptions overspent its \$280 million state budget by \$22 million last year. ValueOptions plans to reduce psychiatrists’ fees to \$70 for a 50-minute session. Ironically, the ValueOptions contract goes into effect the same day that a law takes effect guaranteeing Massachusetts “parity” for mental health care (*Boston Globe*, November 19 and December 31, 2000).

- Medicaid managed mental health care in New Mexico has decreased access to health care, particularly for children. Advocates say bureaucracy has increased, and 7 of 11 types of services have been cut by more than 50 percent. “There are no services, very few beds. And when they discharge you, there’s nowhere to go,” said one parent (*Albuquerque Journal*, September 6, 2000).

- A highly publicized study found that average office visits for HMO patients increased from 15.4 minutes in 1989 to 17.9 minutes in 1998, while FFS visit lengths increased from 16.4 to 18.5 minutes. In contrast, a 1999 Kaiser study found that 83 percent of physicians and 64 percent of patients said visits were shorter because of managed care. Physicians' and patients' perceptions that visits are shrinking may reflect the many sicker patients (who require more time) who are being treated as outpatients. Even an occasional very ill patient could drive up the average visit length while reducing time for other patients. In addition, increasing administrative hassles probably eat up considerable time. Visit lengths for both HMO and FFS patients have declined since 1995 (Mechanic et al., *New England Journal of Medicine*, January 18, 2001).

PHARMACEUTICALS

- Hospitals across the country are dealing with a growing number of medication shortages. Some of the medications in short supply are "critical" life-savers and others, like the flu vaccine, have major public health implications. Drugs in short supply in Chicago hospitals include two drugs commonly used during surgery (fentanyl and succinylcholine), as well as Compazine, Narcan, tetanus vaccine, intravenous penicillin, and intravenous Benadryl. "This past year's shortages have been the worst I've seen in 26 years of hospital practice," said one Georgia hospital pharmacist. Many of the shortages are in generic versions of older, lower-priced medications, forcing hospitals to spend tens of millions of dollars to replace them with more costly (and less desirable) alternatives (*New York Times*, January 3, 2001; *Chicago Sun Times*, February 20, 2001).

- Bayer was fined \$14 million for engaging in wholesale drug price manipulation. Since the early 1990s, Bayer has inflated its average wholesale prices, which are used by the states to set Medicaid reimbursement rates. Bayer then sold the drugs to physicians for large discounts, allowing their practices to reap the difference and making Bayer's products (Kogenate, Koate-HP, and Gamimune) more attractive. Twenty other drug companies are under investigation for similar charges (e.g., TAP Pharmaceuticals for the prostate cancer drug Lupron). Wholesale price manipulation costs taxpayers more than \$1 billion annually (*New York Times*, January 24, 2001; *USA Today*, January 24, 2001).

- Six pharmaceutical companies will pay civil fines of \$335 million to settle charges of vitamin price-fixing. These civil penalties are in addition to a \$725 million criminal fine levied against pharmaceutical giants Hoffman-La Roche and BASF AG last year. The conspiracy affected not only vitamins but also the nutritional supplements used to enrich bread and other fortified foods, animal feed, cosmetics, and so forth. The other four firms fined are Aventis SA (France) and Takeda, Eisai, and Daiichi Pharmaceuticals of Japan (WSJ and Reuters, October 11, 2000).

- The Food and Drug Administration's (FDA) annual budget for safety reviews of drugs on the market is \$17 million—roughly equal to what Americans spend on prescription drugs every 90 minutes (*Philadelphia Inquirer*, January 7, 2001).

- The FDA has withdrawn 10 drugs and one vaccine from the market in the past four years, which is unprecedented in the agency's history. Nearly 20 million patients, almost 10 percent of the population, received prescriptions for these medications before they were banned. Seven of the medications were approved since 1993, when new legislation, the Prescription Drug User Fee Act, was implemented that called for the FDA to speed its review of new drug applications. In exchange, drug companies started paying a "user fee" (currently about \$300,000) for each application. The average time for new medications to be approved by the FDA fell from 34.3 months in 1993 to 14.6 months in 2000. But scientists say speed replaced safety as the agency's top concern. In 1988, only 4 percent of new medications worldwide were approved first by the FDA. In 1998, 66 percent of all new medications were first approved for use in the United States.

The seven medications approved and withdrawn between 1993 and 2000 (Rezulin, Redux, Posicor, Duract, Raxar, Lotronex, and Propulsid) have been linked to over 1,000 deaths, but the true number of fatalities is likely to be much higher. The vaccine Rotashield was recalled in 1999 after it was associated with serious bowel problems in over 100 infants. The diabetes drug Rezulin was approved in 1997 over a scientific reviewer's strong opposition; it was withdrawn in 1999 after being shown to cause liver failure. The diet drug Redux was approved in 1996 despite the opposition of an FDA advisory committee; it was withdrawn in 1997 after being linked to heart-valve damage. The anti-hypertensive Posicor was approved in 1997, despite findings by the FDA that it could cause fatal cardiac arrhythmia; it was withdrawn in 1998 and is suspected in over 100 deaths. The painkiller Duract was approved in July 1997 over the objections of an FDA staffer that it caused liver failure; the drug was withdrawn less than a year later and is suspected in more than 65 deaths. The antibiotic Raxar was approved in late 1997, despite several deaths from cardiac arrhythmia in clinical trials; it was withdrawn in October 1999 and is suspected in 13 deaths. Lotronex was approved for irritable bowel syndrome in 1999 and withdrawn 11 months later; it has been linked to 5 deaths. Propulsid was approved in 1993, despite evidence that it caused arrhythmia; it was withdrawn in 2000 and is suspected in over 300 deaths, including 24 deaths of children younger than age 6 (David William, *Los Angeles Times* and *Contra Costa Times*, December 31, 2000).

The FDA also banned the use of the over-the-counter drug phenylpropanolamine (PPA) linked to strokes in a small percentage of users; PPA was a popular ingredient in cold medications (*New York Times*, December 13, 2000).

- More than half of the experts hired to advise the FDA on drug safety have financial ties to the drug industry, according to a survey by *USA Today*. The survey found that between January 1998 and June 30, 2000, the FDA granted 803 full or limited conflict-of-interest waivers to advisory committee members. These

conflicts include helping a drug company develop a medicine, then serving on the FDA committee evaluating it; holding stock in the company; or receiving consulting fees or research grants from the company. At 88 of 159 meetings, at least half of the members had a financial stake in the proceedings (*USA Today*, September 25, 2000).

- A U.S. District Court's decision has delayed implementation of Maine's pioneering drug law. Enacted last May (2000), the program would allow the state to negotiate with drug companies for lower prices for uninsured residents and to fine drug companies for price gouging or limiting supplies. The judge agreed with Pharmaceutical Research and Manufacturers Association (PhRMA) lawyers that the program was unconstitutional because it "regulated out-of-state commerce" (*Wall Street Journal*, October 27, 2000).

- Glaxo Wellcome and SmithKline Beecham are merging in a \$68 billion deal to create the world's second largest drug firm. Pfizer, which bought Warner-Lambert for \$90.2 billion in 2000, is the largest (*New York Times*, December 13, 2000).

- Eli Lilly received a 6-month patent extension on Prozac, worth an additional \$1 billion in sales to the firm, for agreeing to (a much less costly) study of the use of the medication in children. Generic competition is banned until August 2, 2001, although Lilly is in court to push the expiration of its patent back even later (*Philadelphia Inquirer*, November 16, 2000).

Schering-Plough received the same 6-month extension for its best-selling allergy drug Claritin, which boasted sales of \$2.7 billion in 1999. The soonest a generic version may be released is December 2002 (Associated Press, August 17, 2000).

The Federal Trade Commission is investigating whether Bristol-Myers Squibb is illegally preventing competitors from selling generic versions of its cancer drug Taxol (*Wall Street Journal*, December 17, 2000).

HOSPITALS, INC.

- Welcome to Pfizer Hospitals? Beth Israel Deaconess Medical Center in Boston is planning to sell blanket rights to all future discoveries made by Harvard Medical School faculty at the Center to a single drug company, in exchange for a multi-million dollar annual fee. Beth Israel's President, Michael Rosenblatt, is a former Merck executive. Critics are concerned about the impact on patient care, the loss to the public of important publicly funded research findings, especially those with little commercial appeal, and the precedent it sets for other hospitals in financial trouble. Previous drug company-hospital deals have been less sweeping. Massachusetts General Hospital received \$180 million over the past decade from cosmetics firm Shiseido for first rights to dermatology-related findings, and the Dana Farber Cancer Institute has a contract with Novartis for new cancer drugs (*Boston Globe*, February 13, 2001).

- A study of 431 hospitals from 1991 to 1998 found that when not-for-profit hospitals convert to for-profit status, the level of uncompensated care falls from 5.3 percent of total expenses to 4.7 percent. A steeper drop occurs when public hospitals are converted to for-profits; uncompensated care drops from 5.2 percent of expenses to 2.5 percent of expenses (Thorpe et al., *Health Affairs*, November/December 2000).

- Emergency department physicians in Detroit report that they are seeing patients with diseases at stages typically seen only in developing countries. In recent years, three of the city's hospitals—Mercy, Saratoga, and Sinai—have closed, along with more than 50 percent of primary care clinics. Eight thousand health workers have lost their jobs. Emergency department patient loads are up 30 percent to 40 percent. After falling for five years, the number of deaths attributed to preventable and treatable conditions rose in 1998. Twenty percent of Detroit residents are uninsured, up from 15 percent in 1996 (*Detroit News*, June 28, 2000).

- D.C. General Hospital is on the verge of closing its doors. The hospital would be the sixth to close on Washington's east side since 1950, leaving little care in that area. As the *PNHP Newsletter* goes to press, city officials have started negotiations with a private firm to take over medical care for displaced indigent patients (*Washington Post*, February 13, 2001).

- Hospital emergency departments across the country were on “divert” status in January and February. In Baltimore, 17 of the region's 21 hospitals were on divert status one January afternoon. In Philadelphia, patients waited in hallways on gurneys for open beds. In Boston, the area's 27 emergency departments (EDs) shut down for a total of 631 hours one month. Hospitals from New York City to Seattle, Tucson to Los Angeles, reported overloaded EDs, ambulance diversions, and a lack of inpatient beds. In the past decade, 830 hospitals and 232,000 hospital beds in the United States have closed, while the number of ED visits climbed 15.7 percent. The nursing shortage, the rising number of people without alternative sources of care, the shortage of doctors willing to take ED call, and flu season are also contributing factors to ED overcrowding (*Baltimore Sun*, January 11, 2001; *New York Times*, January 12, 2001; ABCNews.com, January 15, 2001).

On a typical day, one-third of L.A. County's hospitals are closed to new emergency patients. Fifty EDs closed in California in the 1990s, while the number of ED visits increased by 1 million. A California Medical Association (CMA) report calls for declaring trauma and emergency care “an essential public service.” “The state needs to . . . make a commitment to them just like we do for public safety,” urged Steve Thompson, CMA vice president (*Los Angeles Times*, January 18, 2001).

- “Los Angeles County is the Chernobyl of health care,” according to L.A. County Medical Association board member Dr. Brian Johnston. Thirty-two percent of the county's residents (2.7 million people) are uninsured, and two massive federal bailouts since 1995 were needed to keep the county Department of

Health Services solvent. In addition, there is a nursing shortage, physicians' groups are failing, and the 13-hospital trauma network was "just pulled back from the brink of collapse" (*Los Angeles Times*, November 25, 2000).

- Stanford University and the University of California, San Francisco, dissolved their hospital merger, but not before spending \$125 million on a joint billing system, now unusable. The hospitals lost \$176 million during their 29-month merger, on revenues of just over \$4 billion (*Los Angeles Times*, December 14, 2000).

- Quorum Health Group, the nation's largest manager of not-for-profit hospitals, will pay \$95.5 million to settle charges of Medicare fraud. The Tennessee-based hospital firm allegedly kept two sets of cost reports, one for itself and (an inflated) one for billing Medicare (*Modern Healthcare*, October 9, 2000). "In a pattern that has become increasingly familiar," Quorum followed the settlement announcement with notice that it is being acquired by Triad Hospitals for \$2.4 billion (*Modern Healthcare*, October 30, 2000).

- Charter Behavioral Health System was fined \$7 million for "fraudulently billing federal health programs for services and falsely documenting inpatient and outpatient psychiatric services that were not needed." Charter, once the nation's largest chain of private psychiatric facilities, has filed for bankruptcy (*Philadelphia Inquirer*, August 19, 2000).

- According to *Forbes* magazine, for-profit hospital stocks are on the upswing: "Thanks to an aging population, security analysts are optimistic about this industry's ability to deliver consistent, solid earnings growth for years to come" (*Forbes*, November 2000). Tenet (formerly National Medical Enterprises), the nation's second largest hospital chain, said it expects a 20 percent increase in profits in 2001 (*Philadelphia Inquirer*, January 5, 2001). HCA's Thomas Frist Jr. told Wall Street analysts "these are good times for this industry . . . we're in the early stages . . . of a good, positive cycle" (*Modern Healthcare*, October 30, 2000).

MEDICARE HMOs

- "Medicare+Choice [the Medicare HMO program] . . . has not been successful in achieving Medicare savings," according to a GAO review of the program launched in 1997. The Health Care Financing Administration (HCFA) paid Medicare HMOs an extra \$3.2 billion in 1998, or 13.2 percent more than it would have paid under the traditional Medicare program (*Modern Healthcare*, August 28, 2000). A separate report by the HHS Inspector General's office found that Medicare overpaid HMOs in fiscal year 2000 by \$1.8 billion, because HMO enrollees are generally healthier and less costly to treat than beneficiaries in traditional Medicare. Investigators found that "Medicare payments were being used to fund unnecessary administrative costs, excess profits and investment income that was not accounted for in the Medicare payment formula" (*Modern Healthcare*, September 25, 2000).

- Medicare HMOs dropped 934,000 elderly and disabled people on January 1, 2001, bringing the number of beneficiaries who have been involuntarily disenrolled to 1.6 million in the past three years. Aetna alone dropped 355,000 enrollees. Of 237 Medicare HMOs, 147 have fully or partially discontinued their Medicare plans. Seniors who kept their coverage are paying a price, with steep premium increases and reductions in benefits, particularly drug coverage (*Los Angeles Times*, September 13, 2000; *Springfield Union News*, September 12, 2000; *Washington Post*, November 8, 2000).

- Medicare is a more generous payer than private managed care plans for inpatient care, according to a survey of 51 hospitals by the GAO. Of the 15 large teaching hospitals surveyed, all reported making a profit on their Medicare patients, with an average profit of 22 percent. By contrast, 12 teaching hospitals said they lost money on HMO patients; the average loss was 2 percent (*Modern Healthcare*, September 4, 2000).

- Medicare HMO enrollees who need coronary angiograms are less likely to receive them than their FFS counterparts. Among patients for whom angiography would be “beneficial, useful, and effective,” 46 percent of FFS patients and 37 percent of HMO patients received the procedure. The rate of inappropriate use was 13 percent in both groups (Guadagnoli et al., *New England Journal of Medicine*, November 16, 2000).

MONEY AND POLITICS

- Massachusetts’ HMOs poured more than \$5 million into defeating ballot Question 5, the universal-coverage initiative. Despite outspending the physicians and nurses supporting the initiative 50 to 1 and running a massive ad campaign in the final weeks before the election, the HMOs only narrowly defeated the initiative, 52-48 (State House News Service, December 20, 2000). Data on CEO salaries for Massachusetts HMOs were not released to the public until after the vote. Tuft’s Healthplan CEO Harris Berman made \$955,000 in compensation in 1999, the year that HMO lost \$41.8 million. Harvard Pilgrim’s Charles Baker took over the company in May 1999 and made \$420,000 in a year in which the HMO lost \$227 million. Blue Cross CEO William Van Fraasen earned \$1,062,205 in 1999 (*Boston Herald*, November 16, 2000).

- During the presidential debates, George W. Bush asserted that Texas spent \$4.7 billion a year on care for the uninsured. Well, not quite. The state of Texas spent \$1.2 billion on care for the indigent. The other \$3.5 billion was charitable care provided by hospitals, private physicians, charities, local governments, and free clinics (*New York Times*, October 16, 2000). Twenty-four percent of Texans have no health insurance (U.S. Census Bureau).

- The free market in health care: Tenet Corp. provided free health care to delegates and journalists at the Republican and Democratic National Conventions. The presence of Tenet medical personnel represented the majority of a \$250,000

donation Tenet made to each convention. Most other corporate health care entities also paid for a presence; Blue Cross and Blue Shield provided free fried chicken and beer to “thousands of reporters, editors, and broadcast crew members” at its media lounge (*Modern Healthcare*, August 7, 2000).

Drug Companies Spent \$80 Million to Influence 2000 Election

- The pharmaceutical industry spent a record \$80 million dollars (the costliest corporate campaign in history) to prevent Democrats from regaining control of Congress and passing a Medicare prescription drug benefit in 2000. According to the *Wall Street Journal*, “they won.” Six months before the election, the prescription drug issue threatened to “bury” Republicans. The drug industry’s efforts made the issue “disappear”; exit polls showed that the prescription drug issue had fallen off the radar screen, below “world affairs” in influencing voters’ choices. In the 26 House races that the industry targeted, only four industry-backed candidates were defeated. The industry, led by Bristol-Myers Squibb, Pfizer, and Johnson & Johnson, spent more than \$50 million on television ads, “millions more” in radio, print, and direct-mail ads, \$10 million on ads run by the Chamber of Commerce (see below), and \$19 million on direct campaign donations, primarily to Republicans (*Wall Street Journal*, November 9, 2000).

- Drug companies helped the Chamber of Commerce fund a \$20 million ad campaign attacking prescription drug coverage for Medicare and bolstering Republican candidates. “Call [Democratic Senate candidate] Debbie Stabenow” and “tell her Michigan doesn’t want the bad medicine she is prescribing.” Funding for “issue ads” is not subject to federal election law regulation (*Wall Street Journal*, October 6, 2000).

- Between 1997 and 1999, the drug industry spent \$235.7 million to lobby Congress, not including advertising, direct mail, and telemarketing. It spent an additional \$38 million on ads through its front group Citizens for Better Medicare. Drug companies employ 297 lobbyists—one for every two members of Congress. Seventy percent of campaign contributions and 80 percent of soft money donated by drug firms go to Republicans. “There isn’t any other industry that has spent this kind of money” on an election, said Kathleen Hall Jamieson, Dean of the Annenberg School for Communication, which tracks ad spending during political campaigns (*Wall Street Journal*, September 22, 2000; Public Citizen, *Congress Watch Report*, July 2000, www.citizen.org/congress/drugs/home.htm).

The Smoking Gun?

- Bush’s secretary of HHS, former Wisconsin Governor Tommy Thompson, is chummy with the tobacco industry, particularly Philip Morris (Wisconsin’s largest employer). As governor, Thompson vetoed legislation that would have allowed cities to impose strict rules on tobacco. Between 1993 and 2000 he received

\$100,000 in campaign contributions from tobacco executives and political action committees (PACs), made trips to England, Africa, and Australia largely funded by Philip Morris, and went scuba diving in Australia with tobacco lobbyist Jack Lenzi. Following a 1995 trip to Africa, Thompson wrote to Philip Morris senior vice-president Andrew Whist: “I value your loyalty and friendship” (Wisconsin Democracy Campaign, Associated Press/*Baltimore Sun*, January 11, 2001).

- Only six states (Arizona, Indiana, Maine, Massachusetts, Minnesota, and Mississippi) are using their tobacco settlement dollars to fund even “the minimum” the Centers for Disease Control (CDC) recommends for antismoking campaigns (20 percent of settlement dollars). Less than 10 percent of the \$8.2 billion in settlement money allocated in fiscal years 2000 and 2001 is going toward antismoking efforts. Illinois used its first allotment to fund a property tax refund; Virginia may use its funds to phase out a property tax on cars (*New York Times*, January 11, 2000).

- Tobacco giant Philip Morris is using television ads to clean up its public image. In 1999, the company gave \$60 million to charity, including \$2 million to domestic violence programs. That same year, the firm spent \$108 million on an advertising campaign to publicize its donations (*New York Times*, December 27, 2000).

- The European Union has filed a lawsuit against Philip Morris and R.J. Reynolds alleging that the companies “facilitated the smuggling of cigarettes illegally” into E.U. member countries. E.U. antifraud investigators estimate that cigarette smuggling cost E.U. governments \$4.1 billion in taxes in 1998 (*Wall Street Journal*, November 7, 2000).

CONGRESS WATCH

- Where was Chris when we needed him? Former White House health policy advisor Chris Jennings: “I think a lot of people don’t know this, but a single-payer system would be a lot more cost effective, it would be a lot more efficient, would be a lot cheaper per person to cover than these targeted reforms that we’re pushing” (Kaiser Family Foundation, *Daily Health Policy Report*, February 9, 2001).

- The National Governors’ Association (NGA) wants to limit Medicaid benefits to “basic coverage.” States would be required to provide “comprehensive” coverage only to the “poorest” families, according to the NGA proposal. The governors couched their proposal for skimping on Medicaid coverage as a plan to free up resources to cover more families. *Hellander’s note*: There is little savings to be had out of the chronically underfunded Medicaid program for expanding coverage to the uninsured. Studies show that Medicaid recipients already have limited access to health care, often barely better than the uninsured. This is a repeat of the claims five years ago that pushing the Medicaid population into restrictive managed care plans was going to free up funds for coverage

expansions—expansions that never materialized (*New York Times*, February 26, 2001).

- Medicare vouchers and privatization are back on the Congressional agenda. Rep. Bill Thomas (R-CA), the new chair of the House Ways and Means Committee, is a strong supporter of HMOs/vouchers as a way of limiting government's responsibility for seniors' health care. GOP leaders may try to attach privatization of Medicare to any prescription drug benefit (favored by Democrats) in order to get it passed. PNHP board member Dr. Douglas Robins testified before the Medicare Commission headed by Thomas in 1999. (For a copy of his testimony, see the News and Updates section of the PNHP Web site, www.pnhp.org.)

- The Health Insurance Association of America (HIAA), Families USA Foundation, and American Hospital Association are jointly backing a proposal for additional tax subsidies to employers to buy health coverage for low-wage workers, combined with a Medicaid/CHIP expansion. HIAA sponsored the "Harry and Louise" ad campaign to defeat reform in 1994. The proposal would expand taxpayer financing for private plans (hence HIAA's support) while covering less than half of the uninsured.

Why Tax Credits Won't Work

- Several groups have proposed tax credits to individuals to buy private health insurance as a way to expand coverage. This is a bad health policy idea that just won't go away. PNHP member Dr. Edie Rasell summarized the arguments against tax credits for us. (1) Individual and single family policies are extremely expensive and wasteful. The administrative overhead for single coverage can consume 40 percent or more of premiums, compared to 2 to 3 percent for large group plans. (2) Unless insurers are required to take all comers, they will deny coverage to older and sicker patients. Insurers will only agree to insure everyone if they are guaranteed adequate risk-adjustment of premiums—but there is no known way to accurately make adjustments. Further, insurers are still likely to find subtle ways to cherry-pick healthier patients in order to increase profits. (3) Most tax credit proposals would cover only a portion of the cost of insurance (e.g., \$1,500 for a typical \$6,500 family policy). The only insurance that people could buy for that amount would be a very skimpy plan or medical savings account (MSA). This is not really coverage; it may not improve access over being uninsured. (4) The tax credits would most likely be targeted toward low-income people, making the program politically vulnerable (like welfare) and probably chronically underfunded. Alternatively, if everyone received the credits, it would primarily benefit the affluent who already have insurance, while the poor would still be excluded by the high additional cost to purchase coverage. Hence, it would function as a regressive tax. Analysts from the Kaiser Foundation recently estimated that a \$13 billion tax subsidy would cover only 4 million of the uninsured. Even \$40 billion annually would still leave 28 million uninsured.

- A final strike against tax credits: The working poor who apply for tax credits accounted for 44 percent of all Internal Revenue Service audits in 1999. Among taxpayers who did not apply for a tax credit, the audit rate was just one in 370 returns, down from one in 60 in 1996 (*New York Times*, February 16, 2001).

PUBLIC OPINION

- “If Rosa Parks had taken a poll before she sat down in the bus in Montgomery, she’d still be standing”—Mary Frances Berry.
- Ninety-one percent of Americans agree that the new president and Congress should make “passing laws to help the uninsured receive coverage” a priority (RWJF release, January 10, 2000).
- An initiative in Alachua County, Florida, carried 65 percent of the vote in November 2000. The initiative read “Do you favor legislation to create a system of universal health care in Florida that provides all residents with comprehensive health coverage (including the freedom to choose doctors and other health care professionals) and eliminates the role of insurance companies in health care by creating a publicly administered health insurance trust fund?” (Reed, *Progressive Magazine*, February 2001).
- Eighty-four percent of Latino voters think the “federal government should guarantee health insurance for every legal resident and citizen,” and 80 percent say improving access to health care should be a top priority for the new administration. Almost one-third of Latinos polled said that they have difficulty getting medical care (Mercury News poll, October 15, 2000).
- An initiative for universal health care in three Massachusetts districts garnered 69 percent of the vote in the eastern, more urban part of the state and 60 percent of the vote in a western district. The initiative asked voters whether legislators should initiate universal health care legislation, including “comprehensive health service that includes the freedom to choose doctors and other health professionals, facilities and services; eliminates the role of the insurance companies in health care and creates an insurance trust fund that is publicly administered and fairly funded; and in order to safeguard the availability of quality health care stops the buying, selling, managing and closing down of health care facilities by for-profit corporations” (Reed, *Progressive Magazine*, February 2001).
- Seventy-two percent of Americans say “business has too much power” (*Business Week*, September 11, 2000).
- Seventy-five percent of nurses say the quality of care in their place of employment has declined over the past two years, and 56 percent say they have less time to care for patients, according to a survey of over 7,000 nurses. More than 54 percent say they would not recommend their profession to their children or friends (American Nurses Association, February 6, 2001; for copies: 202-651-7038).

- Physician membership in the American Medical Association has dropped again to about 290,000, about 37 percent of U.S. physicians (*Modern Healthcare*, December 1, 2000). The group lost \$6.6 million on its operations in 2000, the fourth straight year of operating deficits.
- Physicians and scientists have the “most prestigious” occupations, according to a Harris poll. Sixty-one percent of Americans rate physicians highly (that figure is 56 percent for scientists), while only 15 percent of Americans rate business people and bankers highly (*Rocky Mountain News*, September 7, 2000).

INTERNATIONAL UPDATE

- Physicians in the United States are more concerned that their patients cannot get needed drugs and care than are their counterparts in Australia, Canada, and the United Kingdom. Fifty-one percent of U.S. specialists believe that it is a “major problem” that patients cannot afford necessary prescription medications, compared with 11 percent of specialists in Australia, 14 percent in Canada, and 13 percent in the United Kingdom. Fifty-four percent of U.S. primary care physicians are “very concerned” that patients will not be able to afford needed care, compared with 23 percent of GPs in the United Kingdom, 32 percent in Canada, and 34 percent in Australia (Harris Poll No. 63 press release, October 20, 2000).
- The British Medical Association recently issued a “fundamental review” of the 50-year-old National Health Service (NHS) that rejected alternative methods of financing. “On the grounds of both equity and efficiency, retaining a centrally tax-funded system which remains essentially free at the point of delivery is preferable.” The Blair government has pledged to increase health care spending by 6 percent above general inflation for the next four years, add 7,000 hospital beds, and ensure that the NHS has enough staff to treat all non-urgent outpatients within three months and non-urgent inpatients within six months (*Financial Times*, July 27, 2000).
- Canadian health spending increased to \$95.1 billion (all figures in Canadian dollars) in 2000, \$3,094 per capita. Under pressure from the public to increase funding, government health spending increased 7.7 percent in 2000 to \$67.6 billion, while private spending increased more slowly (5 percent) to a total of \$27.5 billion. The private sector share declined to 29 percent in 2000 from its peak of 30.2 percent in 1997. Spending on physicians is expected to rise sharply as new contracts with the provinces—some offering up to 50 percent pay increases—take effect (*National Post*, December 12, 2000).

In September 2000, the Canadian federal government announced \$21.2 billion in additional funding for health care over the next five years. A joint federal-provincial agreement on “Medicare renewal” reaffirmed Canada’s commitment to the five principles of the Canada Health Act (1984) and laid out goals for

increasing the supply of physicians and nurses, expanding primary health care, strengthening home and community-based services, managing drug costs, upgrading equipment, and greater use of information technology (an additional \$2.3 billion was allocated for the latter two purposes) (*Toronto Globe and Mail*, September 20, 2000).

- The number of Canadian physicians moving abroad hit a five-year low in 1999, according to data from the Canadian Institute for Health Information. In that year, 585 physicians left the country, while 343 physicians moved back to Canada and 243 doctors moved to Canada from the United States and other countries, for a net gain of one physician. A total of 56,990 physicians worked in Canada in 1999 (186 per 100,000 population), up from 55,006 in 1995 (*Toronto Globe and Mail*, August 10, 2000).

- How does Australia manage to pay one-third less in drug costs than other developed countries? Britain, the Netherlands, and Portugal, among others, have decided to follow the “Australian model.” In Australia, drug companies apply to have their products covered by the public insurance plan. An advisory committee decides whether a particular drug will be subsidized by examining its effectiveness, advantages over other drugs in its class and alternative treatments, and cost-effectiveness. Patients pay no more than \$11.75 for an approved drug, but pay the full price for a drug that fails to pass the test (*Wall Street Journal*, August 31, 2000).

- Health centers in Spain must provide free health care to illegal-immigrant pregnant women, ordered Madrid’s Superior Court. The court noted that the U.N. Convention on Children’s Rights, passed in 1989, extended to mothers. Until now, Spanish law only recognized the right to health care in “emergency cases” such as delivery (*Lancet*, October 16, 1999).

- In Italy, free health care (including medications) was extended to all people living in Bologna but not covered by the Italian national health service. About 7,000 such patients were treated in 1998, mostly immigrants (*Lancet*, October 16, 1999).

- HMO executives eager to export for-profit managed care to Mexico, South America, and other regions met at the International Summit on the Private Health Sector in Florida in December 2000. “Economic health security, once an unquestioned government responsibility, is slowly shifting to the private sector,” quipped the conference’s promoter, Jonathan Lewis. Argentina was promoted as a lucrative market, followed by Mexico, as both countries are close to privatizing their social security systems, unleashing billions in investment capital. Currently, private health plans account for 11 percent of health expenditures in Argentina and 2 percent in Mexico. Mexico is being cautious—having already experienced one wave of HMO mismanagement and bankruptcies. The Mexican government also fears that for-profit HMOs will cut into funding for the public system and health care for the poor. (Conference proceedings available on CD-ROM; *Managed Healthcare Market Report*, December 15, 2000; “Experts, Industry Look at

Private Sectors Role in Health Care,” IBFAN–Asia Pacific news service, January 25, 2001).

- Not everyone in Argentina welcomes the rise of health care as a for-profit commodity. Before his suicide shocked Argentines last year, renowned cardiac surgeon Dr. Rene Favaloro wrote, “I have always practiced medicine with a profound social pledge. For me, all patients are equal.” An article in the *Washington Post* said that “Favarolo, who had returned to his native Argentina [from the Cleveland Clinic] to champion the cause of universal health care, had grown distraught, believing only the affluent were enjoying what he once called ‘the right to live.’ He had come to blame globalization and the free-market revolution of the 1990’s for a ‘growing callousness’ toward health care for the poor. And his suicide, family say, grew from a failed struggle to save the heart foundation here that he had built into a symbol of altruistic health care in the developing world” (*Washington Post*, August 25, 2000).

- A Malaysian colleague, Dr. Chan Chee Khoo, reports that private hospital administrators are upset with the glut of private beds in the Klang Valley. One CEO also complained that there were more magnetic resonance imaging (MRI) machines in the Kuala Lumpur/Klang Valley area than in the whole of Australia and appealed for government licensing to regulate the acquisition of expensive medical equipment. “So it appears that the private sector’s attitude towards government intervention depends on whether you’re a would-be entrepreneur wanting in, or an established enterprise worried about market share” (personal communication, September 17, 2000).

- The Pharmaceutical Research and Manufacturers’ Association and 40 multinational drug companies are in court to block South Africa from implementing a 1997 law that would allow it to manufacture and import generic versions of brand-name drugs for treating people with HIV. Over 400,000 South Africans have died of AIDS since the legal action began in 1998. At the same time, the U.S. government has filed a complaint with the World Trade Organization against Brazil for making generic versions of patented AIDS medications. Brazil’s generics industry has allowed over 90,000 people to be treated with anti-retroviral therapy and drastically reduced AIDS deaths in that country (Canadian HIV/AIDS Legal Network, Action Alert, March 9, 2001).

NURSING UPDATE

- A nursing shortage in rich countries is draining skilled nurses from poor countries, deepening their health problems. Trinidad and Tobago, the Philippines, South Africa, and Jamaica are losing nurses; South Africa has proposed that rich countries pay compensation (*Wall Street Journal*, January 24, 2001).

- A “school for nurse activists” on health care reform was held in California, September 17–19, 2000. Over 300 nurses from across the country attended; PNHP’s past president Dr. Claudia Fegan spoke on the impact of corporatization

on health care. The conference was hosted by the California Nurses Association and cosponsored by nursing associations from Pennsylvania, Maine, Massachusetts, Rhode Island, and Canada (www.calnurse.org; for a listserve on nursing: Sandy Eaton at SandyERN@aol.com).

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