

Report from the United States

**A REVIEW OF DATA ON THE HEALTH SECTOR
OF THE UNITED STATES
JANUARY 2002**

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This report presents data on the state of U.S. health care at the end of 2001. It provides information on access to health care, inequalities in incomes and medical care, the increasing costs of health care and health insurance, and the role of corporate money in the provision of health care and the development, marketing, and patenting of pharmaceuticals. The author also looks at the state of health maintenance organizations, the results of some recent surveys on physicians' and public opinion on managed care, and news about the nursing professions. Also provided is an update on Congressional activity on health care legislation, the role of health care industry money in politics, and some developments in health care systems elsewhere in the world.

ACCESS TO CARE

- In 2000, 38.7 million Americans were uninsured for the entire year, a drop from 39.3 million in 1999. (Both figures reflect revised Census Bureau survey methodology, which reduced the baseline figure of the number of uninsured in 1999 by 8 percent. Before the revision, the Census Bureau reported that over 42 million persons lacked coverage in 1999.) The drop was due to an increase in job-based coverage resulting from the strong economy. With the economy now in recession, millions are likely to lose coverage in 2001–2002 (Census Bureau, www.census.gov).

- Hispanic full-time workers are less likely to be offered employer-sponsored health insurance (69 percent) than non-Hispanics (87 percent). Among low-income workers—those earning less than \$15,000 a year—Hispanics are more likely to be uninsured (45 percent) than other low-income workers (29 percent). One-third of immigrant Hispanics remain uninsured after 15 years in the United States, compared with 14 percent of non-Hispanic immigrants (Commonwealth Fund release, June 12, 2001).

International Journal of Health Services, Volume 32, Number 3, Pages 579–599, 2002

- Eighty percent of the uninsured live in working families. Families with two full-time wage earners have a 10 percent chance of lacking coverage. About 80 percent of the uninsured are U.S. citizens, and about half are non-Hispanic whites (Institute of Medicine report, October 11, 2001).

- Middle-aged persons lacking continuous health insurance are more likely to suffer a decline in health than continuously insured persons, according to a study of 7,500 adults aged 51 to 61. “A major decline in overall health” was reported by nearly 22 percent of the continuously uninsured, 16 percent of the intermittently insured, and 8 percent of the continuously insured over the course of the study, from 1992 to 1996. In addition, the study found that 29 percent of people with no insurance reported developing problems walking or climbing stairs, compared with 18 percent of people with insurance (Baker et al., *N. Engl. J. Med.* October 10, 2001).

- Nearly 12 million women of childbearing age (19.2 percent of women aged 15 to 44) were uninsured in 1999, according to a report by the March of Dimes. The percentage of uninsured young women varies from 30 percent in New Mexico to 10 percent in Minnesota, and ranges from 37 percent of Hispanic women, to 25 percent of African-American and Asian women, to 18 percent of non-Hispanic whites. Nearly 14 percent of all pregnant women were uninsured in 1997 (March of Dimes press release, October 17, 2001).

- According to a report from the Center on Budget and Policy Priorities, 4.3 million low-income mothers of school-age or younger children lack health insurance. Eighty-four percent of the uninsured mothers are in working families. Overall, one-third of the nation’s 13.3 million poor mothers are uninsured, often because their modest incomes disqualify them from Medicaid. Between 1995 and 1999, the percentage of uninsured low-income mothers increased from 29.2 to 32.3 percent. The group defined “low income” as less than 200 percent of the federal poverty line, or \$29,260 for a family of three. However, states’ income thresholds for Medicaid eligibility vary widely. In Louisiana, a mother with two children is not eligible for Medicaid if the family earns more than \$3,048 a year (Center on Budget and Policy Priorities, www.cbpp.org, May 10, 2001).

- Workers in low-wage jobs—in the bottom fifth of the pay scale—were less likely to receive employer-sponsored health insurance in 1998 (26 percent) than they were in 1979 (42 percent). Among private sector workers under age 65, employer-sponsored insurance dropped from 66 to 54 percent over the same period. In addition, today’s workers in all jobs are more likely to have to contribute to health premiums, as the percentage of firms covering the full cost dropped from 45 percent in 1983 to 26 percent in 1998 (Commonwealth Fund, “How the New Labor Market Is Squeezing Workforce Health Benefits,” publ. no. 449, www.cmwf.org).

- Immigrants are three times more likely to be uninsured, but represent only a small portion (18 percent) of the nation’s 40 million uninsured, according to a report by the Kaiser Commission on Medicaid and the Uninsured. The report

examined health insurance coverage of “recent” immigrants—defined as immigrants who had been in the country for four years or less. Between 1994 and 1998, a period in which the total number of uninsured in the United States grew by 4.2 million, the number of uninsured recent immigrants fell by 100,000. Among the nation’s 9.8 million low-income noncitizens, 59 percent are uninsured and about 15 percent receive Medicaid. In contrast, about 30 percent of low-income citizens are uninsured and about 28 percent have Medicaid. Immigrants are more likely to be uninsured because they work for businesses that do not offer health benefits (small businesses, agriculture, janitorial, etc.) and because of the ban on Medicaid for new immigrants (those arriving after August 1996) (Kaiser Commission on Medicaid and the Uninsured, April 20, 2001).

- A new San Francisco law requires city contractors and leaseholders to offer health insurance to all employees working more than 20 hours per week. Supporters hope the law will cover 16,000 uninsured workers. The law also stipulates a minimum benefits package and requires that employers pay 100 percent of the premiums for at least one health plan offered to their employees. The proposal was supported by the Bay Area Organizing Committee, a coalition of labor and religious groups working to gain health benefits for low-wage workers (*San Francisco Chronicle*, May 20, 2001).

- California’s state risk pool for people denied individual coverage because of preexisting conditions is facing cutbacks. Currently, only 18,000 of the estimated 125,000 Californians eligible for the program are enrolled, and 6,000 are on a waiting list. The state provides \$40 million a year in funding, but with costs rising and no additional funding, cuts in enrollment are anticipated (*Sacramento Bee*, editorial, March 11, 2001).

- Nearly 50 percent of companies that offer their employees prescription drug benefits plan to add a “third or higher tier” with a higher co-pay, according to a survey by Hewitt Associates. Humana is starting a four-tiered plan that has co-pays of \$10 for the first tier, \$25 for the second tier, \$45 for brand-name drugs with a lower-priced alternative, and 25 percent of the retail cost for “expensive, top of the line drugs.” Aetna is raising the co-pay on its third tier (brand-name medications not on their formulary) to 50 percent of a drug’s cost. Express Scripts, a pharmacy benefits manager, is going to five tiers, in which employers will be able to “tinker with the exact co-pays and which drugs get included in the tiers” (*Washington Post*, November 6, 2001).

- A study by the Kaiser Family Foundation estimated that 37 percent of people who apply for insurance in the individual insurance market are turned down, even for patients with a \$500 deductible and \$20 co-pay for doctor’s visits. The study created seven hypothetical applicants with ailments such as hay fever, a repaired knee injury, asthma, or HIV, and applied for coverage to 19 plans in eight markets across the United States. Thirty-seven percent of the applications were rejected outright (the HIV-positive applicant was rejected by 100 percent of plans). Only 10 percent of the applications were approved without restrictions or higher

premiums. The study is relevant to health policies promoting the use of tax credits to cover the uninsured. A \$1,000 tax credit would do little to help uninsured individuals with even minor health problems (Kaiser Family Foundation, June 19, 2001).

- Weight is the “most obvious and pervasive” reason for rejection in the individual insurance market, according to Emory Dowell, a former Blue Cross vice president who now sits on the board of California’s state high-risk pool. A person with a greater than 10 percent deviation from the norm in weight is automatically denied coverage, making women between the ages of 50 and 65 particularly vulnerable. Dowell has also heard of young women denied coverage because of yeast infections. A former marketing director for Pacificare’s Secure Horizons was denied coverage because her 14-year-old son had acne (*Orange County Register*, September 2, 2001).

MEDICAL AND INCOME INEQUALITIES

- For people with Down syndrome, African Americans have a median life expectancy only half as long as that of whites (25 vs. 50 years), according to a study by the Centers for Disease Control (CDC). The researchers examined 34,000 Down-related deaths in the United States between 1968 and 1997. The 30-year study showed a gradual increase in age at death for whites, from 2 years in 1968 to 50 years in 1997. Among African Americans, Down syndrome was a “childhood killer” until the mid-1990s. Worse access to life-saving surgery, antibiotics, and other necessary health care contributes to the racial gap (Associated Press, “Sharp Racial Divide in Down Syndrome Deaths,” *Boston Globe*, June 8, 2001).

- Three low-income dialysis patients died at Los Angeles County–USC Medical Center in less than a year because of a lack of specially trained nurses for night and weekend shifts, even though as a level 1 trauma hospital it is supposed to provide emergency dialysis 24 hours a day. The hospital is so crowded that patients are waiting up to three to four days in the emergency room for a hospital bed, diagnostic tests are delayed, and heart surgeries are “regularly” postponed because of a lack of operating rooms and staff (“Delays Put Lives at Risk at County-USC,” *Los Angeles Times*, June 26, 2001).

- CEO pay rose nearly 600 percent during the 1990s, to an average of \$13.1 million among the top 365 executives. The 20 highest-paid CEOs made an average of \$117 million, with Citigroup CEO John Reed topping the list at \$293 million (ABCNews.com, April 22, 2001). CEOs now earn 531 times the pay of the average worker. If employee pay had risen proportionately to CEO pay, the average worker would take home \$120,491 instead of \$24,688, and the minimum wage would be \$25.20 an hour, not \$5.15 (well below the poverty level) (Institute for Policy Studies and United for a Fair Economy report, September 6, 2001).

- Seniors with cardiac problems who lack prescription drug coverage are unlikely to receive needed medications, according to a survey of 1,900 patients aged 66 and older with heart disease. Only 4.1 percent of Medicare patients without drug coverage were receiving statins (about \$1.25 a dose), although as many as 60 percent could benefit from their use. Use of inexpensive beta-blockers and nitrates was higher, about 20 percent (Federman et al., *JAMA*, October 9, 2001).
- Elderly African Americans receive flu vaccinations less frequently than white seniors (46.1 percent vs. 67.7 percent), according to data collected in the 1996 Medicare Current Beneficiary Survey. On average, seniors were more likely to receive flu shots if they were enrolled in HMOs (71.2 vs. 65.4 percent), but there was no reduction in racial disparity (Schneider et al., *JAMA*, September 26, 2001).

COSTS

- While official figures on health care costs become available only after a two-year delay, preliminary data show a recent major upswing in health costs. The cost of employer-based insurance premiums increased 11 percent in 2001. The average family premium in an employer-sponsored health plan increased to \$7,053, while individual coverage is up to \$2,650 (*Wall Street Journal*, September 27, 2001).

Employer-based health premiums are expected to rise 13 to 16 percent in 2002, the largest increase since 1990, according to a survey by Hewitt Associates. On average, employers face an increase of \$485 per employee covered. Employees face increases of between \$186 and \$463 for health insurance in 2002—amounts that will put insurance out of reach for many workers. The survey of about 2,700 employers also found that 75 percent of large companies and 42 percent of small firms were likely to increase the employee share of health premiums next year. Small firms expressed reluctance to raise employee health costs because they know their workers cannot afford it (Hewitt Associates release, October 29, 2001; *USA Today*, August 27, 2001; Kaiser survey, *Washington Post*, September 7, 2001).

The Federal Employees Health Benefits Plan announced 2002 premium increases of 13.3 percent, the largest increase since the 1980s. The program is the largest employer-sponsored health plan in the country and is seen as a bellwether of the private health insurance market (*New York Times*, September 22, 2001).

CalPERS—the California Public Employees Retirement System—rejected proposed rate hikes of 25 to 41 percent. After cutting benefits and increasing co-payments, they face an average 6.5 percent increase among the eight HMOs they retained for 2002 (*Managed Healthcare Market Report*, August 15, 2001). The University of Miami is facing a 45 percent increase from United Healthcare for its 15,000 employees, raising its health costs from \$32.7 million

to about \$47 million annually. Like most employers facing large increases, the university plans to increase co-pays on prescriptions and on medical and hospital services.

- The percentage of employees enrolled in HMOs in 2001 declined to 23 percent from its peak of 31 percent in 1996. Only 11 percent of HMO enrollees are now in group/staff model plans, down from 24 percent in 1996. The majority of HMO enrollees are in Individual Practice Associations (IPAs) and mixed model plans. Point-of-service (POS) enrollment increased from 14 percent in 1996 to 22 percent in 2001, while preferred provider organization (PPO) enrollment climbed from 28 to 48 percent of employees over the same period. Indemnity insurance fell from 27 percent of employees in 1996 to 7 percent of employees in 2001 (Gabel et al., "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, September/October 2001).

- Tufts and other HMOs in Massachusetts, and Pacificare's HMOs in eight states, are introducing plans that charge patients higher co-pays if they seek treatment at an academic medical center or high-cost hospital. A patient who has cancer surgery at a community hospital will face one set of co-pays, while a patient whose physician operates at a teaching hospital will pay substantially more. In exchange, the patient's employer will receive a discount on premiums. The policy, which shifts the cost of medical education to other payers, is an example of how HMOs "privatize the profits, and socialize the costs" (*Boston Globe*, August 28, 2001).

- Health care costs rose 7.2 percent in 2000, the biggest jump in a decade according to preliminary estimates. Spending on prescription drugs grew the fastest (14.5 percent), followed by hospital outpatient care (up 11.2 percent), physician services (up 4.8 percent), and inpatient hospital care (up 2.8 percent).

The increases in prescription drug costs and hospital outpatient care accounted for 29 and 31 percent, respectively, of the increase in medical costs between 1999 and 2000. The increase in physician costs accounted for 28 percent of the increase, and hospital inpatient spending accounted for 12 percent of the increase.

Health care costs rose 7.1 percent in 1999 (*Los Angeles Times*, September 27, 2001; Center for Studying Health System Change, September 2001).

- Over the past five years, 93 percent of Fortune 500 companies have reduced the number of health plans they offer their workers, while none have increased their options. In the past two years, Sears has dropped 120 HMOs nationwide, retaining 65; American Express dropped 164 health plans and kept 48; and Xerox dropped 92 health plans, keeping 130 (*New York Times*, November 9, 2001).

- Hospitals charge uninsured Latino patients almost five times as much as they charge HMOs, according to a study by Consejo do Latinos Unidos in Los Angeles. In California, 40 percent of Latinos are uninsured. Researchers analyzed the medical bills of 123 Latinos who were hospitalized or received emergency care in southern California. In addition to being overcharged (in one case a couple was charged \$14,000 for care for which an HMO would have paid \$1,200), patients

who could not pay were harassed by debt collection agencies, forced to put medical bills on high-interest credit cards, and told that their medical debts would threaten their applications for citizenship. Monolingual Spanish speakers receiving emergency care were often made to sign statements in English that committed them to repaying the full charges (Reuters, *New York Times*, June 11, 2001).

- San Francisco General Hospital announced that it can no longer afford to treat patients with private or public insurance, because it costs more to treat them and process their claims than their insurers are willing to pay. Instead, the hospital is going to return to its “core mission” of caring for the indigent. In addition to encouraging patients with insurance to seek care elsewhere, the hospital is avoiding purchasing new equipment and amenities that would attract paying patients (*San Francisco Chronicle*, June 18, 2001).

- Latinos comprise 30 percent of California’s population but only 5 percent of the state’s doctors. A bill sponsored by California Assembly member Marco Firebaugh (AB 1045) would alter California’s licensing requirements to allow about 70 doctors and 50 dentists from Mexico to practice on salary at not-for-profit clinics. The physicians and dentists would work primarily in low-income Latino neighborhoods that have difficulty attracting qualified health care providers (*Los Angeles Times*, June 18, 2001).

CORPORATE MONEY AND CARE

- For-profit nursing homes are more likely to provide poor care than not-for-profit nursing homes, according to a study led by Physicians for a National Health Program (PNHP) member Charlene Harrington, R.N., Ph.D., at the University of San Francisco. Harrington analyzed data from state inspections in more than 13,500 nursing facilities in 1998. For-profits had 40 percent more quality deficiencies and significantly fewer staff. Staffing by licensed nurses was 31.7 percent lower in for-profit nursing homes than in not-for-profits, and 20 percent less than in public homes (Harrington et al., *Am. J. Public Health*, September 2001).

- Between 1996 and 2000, 975 cases of “patient dumping” were reported to the Health Care Financing Administration (HCFA; now renamed the Center for Medicare and Medicaid Services). The violations occurred at 527 hospitals, or about 10 percent of U.S. hospitals, in 46 states. Although most violations (72.5 percent) occurred at not-for-profit hospitals, for-profit hospitals were 1.7 times more likely to violate the law and fail to screen, treat, or transfer patients arriving at their emergency rooms (Public Citizen Report, *Modern Healthcare*, July 16, 2001).

- Philip Morris officials in the Czech Republic distributed an economic analysis concluding that cigarettes are not a drain on that country’s budget, in part because the government saves money on health care, pensions, and housing when smokers die prematurely. Philip Morris issued the report after complaints from the Czech

Republic that the tobacco industry was saddling the country with huge health care expenses. The report calculates that, after adding up all the “savings due to early mortality” and subtracting the costs of smoking, such as caring for sick smokers and lost income taxes, the government had a net gain of \$147.1 million in 1999 from smoking. Philip Morris makes about 80 percent of the cigarettes smoked in the Czech Republic and owns a 77.5 percent stake in a formerly state-owned Czech tobacco company. Tobacco causes about 20 percent of all deaths in the Czech Republic, killing about 23,000 people a year (*Wall Street Journal*, July 16, 2001).

- Federal prosecutors are investigating whether enteral nutrition therapy product manufacturers Abbott Laboratories (Ross unit), Novartis AG, Tyco International (Kendall unit), and Zevex gave kickbacks to hospitals, nursing homes, and physicians who prescribed their feeding tubes, nutritional products (e.g., Abbott Lab’s Ensure), and supplies. The companies allegedly distributed their products to providers at a discount, while the providers billed Medicare and Medicaid a higher amount. Medicare reimbursement for enteral supplies is \$200 or more per month. Abbott affiliate TAP Pharmaceuticals is also under investigation for using similar methods to market Lupron, a drug used to treat prostate cancer. The company is negotiating a settlement in that case that could top \$800 million (*Chicago Tribune*, August 23, 2001).

- Looking to buy a hospital? Gary Taylor, analyst at Bank of America Securities, says hospitals are doing better, with higher admissions, higher fees from private insurers, and better government funding. Not-for-profit hospitals sell at a price of six times cash flow. Many for-profit chains are selling at 12 times cash flow, before takeover bonuses (Reuters, July 9, 2001).

For-profit hospital chain HCA (formerly Columbia/HCA) reported a 47 percent increase in profits in the third quarter of 2001 (to \$256 million, up from \$174 million in the third quarter of 2000). Second-quarter profits for 2001 had also exceeded expectations, at \$263 million. CEO Jack Bovender reported that the company has poured funds into profitable services like cardiology and neurology. The company was fined \$840 million last year for Medicare fraud (*Los Angeles Times*, October 25, 2001; *Modern Healthcare*, July 30, 2001).

For-profit hospital chain Tenet (formerly National Medical Enterprises) reported that profits were up 45 percent, to \$224 million, for the quarter ending August 31, 2001. The firm boasted to analysts that “fiscal 2001 has been a truly outstanding year for Tenet.” The Santa Barbara-based firm operates 114 hospitals, mainly in southern California, Philadelphia, and Florida. Since May 31, 2000, Tenet’s stock has increased 118 percent. Admissions to their hospitals increased 5.9 percent, with higher growth in profitable areas such as cardiology, orthopedics, and neurology. CEO Jeffrey Barbakow received a \$3.4 million bonus in 2001 on top of salary of \$1.2 million and stock options worth \$10 million (Reuters, July 11, and August 21, 2001; *Los Angeles Times*, October 4, 2001).

- A study of 492 HMOs found that the industry is becoming profitable again, at least for the largest companies. Between 1997 and 1999, HMOs had combined losses of about \$1.8 billion. In contrast, the industry posted \$990 million in profits in 2000, its first aggregate profits since 1996. Premium rates rose \$300 per enrollee between 1995 and 1999, while more than 100 HMOs dissolved or merged between 1999 and 2000. The 31 largest HMOs, those with 500,000 or more enrollees, gained most of the profits (Weiss Ratings, *Modern Healthcare*, October 1, 2001).

Pacificare tripled its profits in 2001, to \$17 million from \$5.2 million in 2000 (*Orange County Register*, October 31, 2001). UnitedHealth Group, the second largest HMO in the country, reported profits up 27 percent in the third quarter of 2001. Profits rose to \$231 million for the quarter, up from \$182 million during the third quarter of 2000 (Reuters/*Contra Costa Times*, October 26, 2001). Overall, California's HMOs went from an average 1.3 percent profit on revenues in 1999 to 3.5 percent in 2000 (*San Francisco Business Times*, April 13–20, 2001).

- Anthem, the Indiana-based owner of several state Blue Cross and Blue Shield plans, converted to for-profit status in October 2001. With Anthem's conversion, 20 percent of Blue Cross's 81.5 million membership is in publicly traded plans. If New York's Empire Blue Cross and Blue Shield converts to for-profit, that proportion will rise to 30 percent. The Blues plan in North Carolina is also looking at becoming for-profit (*New York Times*, October 27, 2001).

- Aetna was fined \$1.2 million by the Texas Department of Insurance in November for failing to pay claims on time. With the Aetna fine, Texas levied a total of \$10.4 million in fines in 2001 against insurance companies for delaying payment (*Houston Chronicle*, November 1, 2001).

- A number of U.S. hospitals—Mount Sinai Hospital in New York, New York—Presbyterian, Memorial Sloan-Kettering Cancer Center, Beth Israel, and a consortium of 10 hospitals in Philadelphia—are marketing their services abroad to boost revenues. Currently, the majority of foreign patients come from the Middle East, Latin America, Turkey, and Greece. Mount Sinai “offers some discounts on its retail rate . . . to countries, like Turkey, that have national health insurance and that send a significant number of patients abroad for sophisticated medical treatment.” It also sends its physicians on lecture tours abroad. Turkey paid the full price of \$300,000 for a liver transplant for a Turkish citizen at Mount Sinai. HMOs and other U.S. insurers reimburse hospitals at only 50 to 70 percent of charges (*New York Times*, July 28, 2001).

- The corporation-government revolving door: Two former HCFA administrators have joined the board of for-profit dialysis company DaVita. DaVita receives 60 percent of its revenue from Medicare and Medicaid. Nancy-Ann Min DeParle held the top HCFA post under Clinton, while William Roper was chair under Reagan. Thomas Scully, the new chair of HCFA, resigned from DaVita's board to take the post. DaVita's press release said that “Nancy-Ann and Bill can help us, as Tom already has, to work toward our objective of a more constructive partnership with the federal government.” DeParle is really banking on her

government experience. She's also joined several boards of for-profit hospital, medical equipment, and health care information companies, including Triad Hospitals (Dallas), Guidant Corp. (Indianapolis), Cerner Corp. (Kansas City), and Specialty Laboratories (Santa Monica) (*Modern Healthcare*, July 2, 2001).

HMO Millionaires

- Twenty-three top HMO executives at 15 publicly traded companies received a 60 percent raise to a total of \$63.3 million in pay in 2000, excluding stock options. They received stock options valued at another \$109.2 million.

Among the highest paid executives were Aetna's William Donaldson (CEO from April to September 2000), John Rowe (CEO from September 2000 on), and Richard Huber (CEO until February 25, 2000). Donaldson received \$18.8 million in total compensation, including \$7 million in cash, \$5.6 million in restricted stock, and another \$6.1 million in stock options. Donaldson's successor John Rowe, M.D., received \$16.1 million total compensation in 2000 for four months of work—about \$130,000 a day! Even that was topped by Richard Huber, who resigned as Aetna's CEO on February 25, 2000. He received total compensation of \$8.6 million for two months' work, more than \$150,000 per day (*Managed Healthcare Market Report*, March 31, 2001).

Other HMO millionaires (2000 compensation, excluding stock options) include UnitedHealth Group's William McGuire (\$7.7 million); Cigna's Edward Hanway (\$5.4 million) and Wilson Taylor (\$5 million); Wellpoint's Leonard Schaeffer (\$4.8 million); Humana's Michael McCallister (\$2.7 million) and David Jones (\$1.9 million); Trigon's Thomas Snead (\$1.8 million); First Health's James Smith (\$1.7 million); MAMSI's Thomas Barbera (\$1.2 million) and Mark Groban (\$1.2 million); and Pacificare's Alan Hoops (\$1.1 million).

Stock options included: \$24.7 million for UnitedHealth Group's William McGuire; \$11.6 million for Cigna's Wilson Taylor; \$10.6 million for Trigon's Thomas Snead; \$9.3 million for Pacificare's Howard Phanstiel; \$7.8 million for Wellpoint's Leonard Schaeffer; \$5.5 million for Humana's Michael McCallister; \$5.4 million for Oxford's Norman Payson; and \$5.3 million for Cigna's Edward Hanway (*Managed Healthcare Market Report*, April 30, 2001; also see Families USA report, June 20, 2001).

Phantom Providers

- A survey of 240 physicians listed in California's Blue Cross provider directory for fall 2000 found that one-third had either left the network or were not taking new patients. An investigation by the *Boston Globe* found the least accurate provider lists were for psychiatrists. United Healthcare, for example, listed 19 psychiatrists in Boston on its Web site on May 17. Reporters found that 12 of these (63 percent) were no longer in the network, were not taking new patients, or had moved.

A woman discharged from a San Francisco hospital after attempting suicide was given 13 names of psychiatrists by her health plan, Blue Cross of California. None would see her when she said she had Blue Cross. A mother in Tufts Health Plan had to call 22 psychiatrists and psychiatric nurses before finding one who would see her 15-year-old son—two and a half months after she had started her search. A patient of one of the editors of the PNHP newsletter made a similar search but failed to identify a child-psychiatry provider after 30 phone calls. The American Psychological Association is suing Blue Cross in the D.C. area, accusing the plan of falsely advertising the same network after 80 mental health providers had left (*Boston Globe*, June 17, 2001).

PHARMACEUTICALS

- While drug companies claim that they spend an average of \$500 million to develop a new product, a figure loosely extrapolated from a 1991 study by Joseph DiMasi at Tufts, a reanalysis of DiMasi's original study puts the actual figure closer to \$110 million. Also, data filed by drug manufacturers with the Securities and Exchange Commission show they spend over twice as much on marketing (15 percent of revenues) and profits (17 percent) as they do on research (6 percent of revenues).

DiMasi's 1991 study estimated that the cost of developing a new drug, including research failures, was \$231 million in 1987. Drug companies upped DiMasi's finding to \$500 million by adjusting for inflation and tacking on the "opportunity cost of capital" (the amount of money the firm might have made in profits by investing in something else).

A reanalysis of the study by Public Citizen found that it failed to take into account the massive contribution of taxpayers to medical research, was based on "unrealistic scenarios of risk," and should not have included opportunity costs and the full cost of tax-deductible expenses. After adjusting for these factors, they reached a figure of \$110 million per new drug (Public Citizen report, July 2001).

- An internal memorandum from the National Institutes of Health (NIH) showed that taxpayer-funded scientists conducted 55 percent of the studies that led to the discovery and development of the five top-selling drugs in 1995 (Prozac, Vasotec, Zantac, Acyclovir, and Capoten). Academic institutions abroad performed an additional 30 percent of the research. According to Stephen Schondelmeyer, director of a center at the University of Minnesota that studies the economics of drug development, large drugmakers come in "after the risk and the actual costs of the new drugs" have been borne by the NIH, academic researchers overseas, and smaller U.S. companies that license their products to larger firms (Public Citizen report, July 2001; *San Francisco Chronicle*, July 24, 2001; *Boston Globe*, July 24, 2001).

- Drug companies have an arsenal of tactics to extend their lucrative patents. In addition to paying off potential competitors, they file for new patents on old drugs

for new therapeutic uses, which causes a 30-month delay in generic competition. Or they file a “citizen petition” opposing generic competition. While these rarely succeed, they trigger a Food and Drug Administration (FDA) investigation and stall generic distribution until resolved. However, two new laws allowing drug firms to extend patents promise much larger windfalls. Drug companies will be granted patent extensions when the FDA approves label changes. They will also receive patent extensions for conducting pediatric clinical trials on old drugs.

About 100 drugs will receive a six-month patent extension in exchange for companies testing their products for safety in children. While the cost of the safety tests in children is estimated to be \$727 million, the patent extension for drug companies is worth \$29.6 billion, 40 times more than the pediatric tests. Three of the four sponsors of the bill ranked in the top 10 in campaign receipts from the drug industry: Senators Chris Dodd (D-CT) and Mike DeWine (R-Ohio) and Rep. Anna Eshoo (D-CA) (Public Citizen, “Patently Offensive,” www.citizen.org/congress/reform/drug_patents, November 11, 2001).

- Executives from Merck, Bristol-Meyers Squibb, Bayer, Pfizer, Eli Lilly, and Johnson and Johnson have been showering the Bush administration with offers to lend their scientists to government agencies and “give away” some drugs and vaccines in an attempt to “build political capital” for future legislative battles. Several companies have offered the government free antibiotics in exchange for FDA approval of their products as anthrax treatments. The pharmaceutical industry has 625 registered lobbyists and spent \$262 million on lobbying and campaign contributions in 1999 and 2000—more than any other industry (*Los Angeles Times*, October 27, 2001; *New York Times*, November 4, 2001; *Boston Globe*, July 24, 2001).

- Drug companies overcharged Medicare \$1.9 billion for 24 common prescription drugs last year, according to the inspector-general of the Department of Health and Human Services (HHS). Medicare pays the “average wholesale price” of medications. This price is set by the manufacturers, but other purchasers, such as the Veterans Administration and private insurers, negotiate lower prices. According to the inspector-general, the price Medicare pays “bears little or no resemblance to the actual wholesale prices.” Similar findings were reported by the General Accounting Office (AP, *New York Times*, September 20, 2001).

- Sound familiar? In India, drug companies—many of them local firms making generics of patented drugs—target pharmacists, who routinely (illegally) sell powerful drugs over the counter without a prescription to patients. In exchange for stocking their products, distributors give pharmacists bonuses of extra pills and gifts. Glaxo-Wellcome, the world’s second largest drug company, gave TV sets to pharmacists who bought large quantities of two drugs, Cefum and Fortum, in one promotion. “The ultimate decision [of what to prescribe] is based on what the margins are,” said one pharmacist. He sold ciprofloxacin to everyone with a fever because the Indian manufacturer offered him a 250 percent profit margin and the chance to win a motorcycle. One promotion, called “Mega Merchants: Sell and

Enjoy,” offered tickets for a drawing for vacations in Germany, Nepal, and Indian destinations in exchange for purchases (*Wall Street Journal*, August 16, 2001).

Drug Company Gag Clauses

- Immune Response Corporation is suing researchers at the University of California for defying their corporate sponsor. The researchers published work concluding that the company’s AIDS drug, Remune, did not benefit patients who were already receiving standard therapy. The company is seeking \$7 to \$10 million in damages. Drug companies have harassed other researchers for publishing negative findings. University of Toronto physician Dr. Nancy Olivieri lost her research funding from Apotex, Inc., after she published work in 1998 about a serious side effect of deferiprone. Her contract had a “nondisclosure” clause. In 1999, Knoll Pharmaceuticals was fined \$42 million for making false claims that Synthroid was superior to generic versions of thyroid hormone and for interfering with the publication of University of California, San Francisco, pharmacologist Dr. Betty Dong’s research. Knoll funded Dong’s research and blocked publication of her findings for seven years (*Washington Post*, August 4, 2001).

Profits from Fear

- In 1997, Cipro manufacturer Bayer agreed to pay generic-drug maker Barr Laboratories \$28 million a year until 2003 in exchange for dropping a challenge to Bayer’s patent. According to a *USA Today* editorial, the Federal Trade Commission is investigating the deal, which “sounds suspiciously like a payoff to avoid competition” (*USA Today*, October 29, 2001).

Now, Bayer is seeking to profit from the U.S. anthrax scare. A month’s supply of Cipro costs more than \$300. Doxycycline, a generic, is just as effective and costs one-tenth as much, \$32 per month. Cipro was originally tested as an alternative treatment for anthrax for penicillin-allergic patients, but Tommy Thompson’s HHS will buy it as the first-line drug of choice at a 46 percent “discount.” Bayer sales representatives are dropping off extra free samples in physicians’ offices to encourage prescriptions, and playing dumb about the tens of thousands of patients taking it unnecessarily for prophylaxis (Mark Siegel, *The Nation*, “Profits of Fear,” October 2001).

Bayer will make an extra \$358 million on Cipro as a result of a bill that granted the firm a six-month patent extension. Bayer has spent \$3.7 million on lobbying and campaign contributions since 1999. The six-month extension will pay for all of Bayer’s lobbying expenses in just two days, according to a study by Public Citizen’s Congress Watch.

In Canada, a Health Canada purchasing agent contacted Bayer twice to see if it had Cipro on hand to stockpile against anthrax, and Bayer said no. So Health

Canada contracted with a generic manufacturer (Apotex) for a Cipro-like generic. When Bayer discovered this, it immediately found a stock of Cipro to sell—but now must sell it to Health Canada at a significantly reduced rate. Canada is also proceeding with its contract with the generic manufacturer (*Berger Population Health Monitor*, October 26, 2001).

MEDICARE HMOs

- New Medicare HMO regulations pushed through by new Medicare chief Thomas Scully allow HMOs to drop out of certain communities without having to leave the entire county, thus improving HMOs' ability to cherry-pick locales where they are profitable. Medicare HMOs will also be allowed to develop special benefits packages with employers for their eligible workers and retirees. Scully is the former president of the American Federation of Hospitals and Health Systems, a for-profit health industry trade group (*Los Angeles Times*, August 30, 2001).

- Medicare HMOs are dropping 536,000 elderly and disabled people on January 1, 2002, about 10 percent of the 5.6 million beneficiaries currently in Medicare HMOs. The cuts come on top of 1.6 million seniors involuntarily disenrolled in the previous three years. Medicare HMOs are also cutting benefits and raising premiums nationwide. In Massachusetts, Harvard Pilgrim is raising premiums for the plan's 38,000 seniors from \$35 per month to \$60, while Blue Cross and Blue Shield is raising premiums from \$110 to at least \$135 monthly. In California, Pacificare is dropping 33,000 seniors, while Health Net is dropping coverage for more than 13,000 seniors. In Sonoma County, seniors in Kaiser's Medicare HMO face a \$600 annual increase in their premiums and a drop in the drug benefit cap from \$1,600 annually to just \$1,000.

In Chicago, United Healthcare eliminated drug coverage from its policies last year, then decided to drop seniors altogether, affecting 33,000 enrollees. In Florida, Blue Cross and Blue Shield is dropping 39,000 people. Humana, the third largest Medicare HMO, with 407,000 members in seven states, is dumping 14,000 seniors in its hometown of Louisville. Aetna is dropping 105,000 seniors. The proportion of seniors in HMOs nationwide has fallen to 15 percent. A higher proportion are enrolled in California: 40 percent (*Los Angeles Times*, September 27, 2001; *Chicago Tribune*, September 19, 2001; *USA Today*, September 20, 2001; *San Francisco Chronicle*, September 22, 2001; *Washington Post*, September 22, 2001; *Press Democrat*, October 3, 2001).

- A 17-year experiment with "social HMOs"—blending social services designed to keep frail seniors independent in their homes, with medical coverage—will expire in two years unless reauthorized by Congress, which seems unlikely. The program exists in four sites—Long Beach, Las Vegas, New York City, and Kaiser Permanente in Portland, Oregon. The social HMOs say that their elderly patients are 53 percent less likely to be placed in nursing homes, which cost upwards of \$40,000 a year. A study by Mathematica Policy Research Center found

that social HMOs were too costly given the services they provide (*Chicago Tribune*, August 3, 2001).

PUBLIC AND PHYSICIAN SURVEYS

- A survey of physicians in Sonoma County, California, found that area physicians are frustrated or angry about managed care (91 percent), that their family life has suffered as a result (72 percent), and that managed care has increased their workload (76 percent) (*The Press Democrat*, May 11, 2001).
- The number of practicing physicians who provide charity care slipped from 265,000 (76 percent) to 261,000 (72 percent) between 1997 and 1999, according to a survey by the Center for Studying Health System Change. Physicians who do provide charity care devoted about 11 hours per month to the poor (*Modern Healthcare*, August 27, 2001).
- A survey of 1,200 privately insured Americans under age 65 found increasing levels of dissatisfaction with HMOs. The Kaiser-Harvard survey found that 46 percent of its respondents felt that HMOs were doing a bad job serving the public, up from 25 percent in 1997. An even higher proportion, 56 percent, said they worried that if they became sick their HMO would be more interested in saving money than providing the best treatment, and 70 percent felt that patients should have the right to sue their health plan. In addition, 48 percent reported problems with their health plans over the last year, including hassles over claims, delays and denials of coverage, and poor access to doctors (*Washington Post*, August 31, 2001).

American Medical Association Update

- The American Medical Association (AMA) accepted \$645,000 in donations from eight drug companies and an industry trade coalition to fund an educational campaign to “curb the growing influence of pharmaceutical companies” on physician prescribing. The “Gifts to Physicians Campaign” is funded by AstraZeneca, Pfizer, Merck, Glaxo Wellcome, Eli Lilly, Bayer, Procter and Gamble, and Wyeth-Ayerst, with gifts ranging from \$50,000 to \$100,000 as well as staff support. Drug companies spent \$15 billion on marketing last year. Their 83,000 sales representatives made 61.4 million visits to physicians. The AMA seeks to promote its decade-old code of ethics banning expensive dinners, gifts, and trips—but allowing “modest” meals and gifts of up to \$100 “as long as they benefit patients.” Some AMA branches have called for more specific guidelines as “pharmaceutical companies have become very creative in circumventing the current rules” (Hellander’s note: including funding this AMA campaign!) (*Modern Healthcare*, June 18, 2001).
- AstraZeneca and seven other drug companies are on the cutting edge of “creative” ways to sway physician opinion. They have partnered with

iPhysicianNet, a Scottsdale, Arizona, firm, to interact with physicians via videoconferencing sessions in addition to live visits by sales representatives. In exchange for a least one “e-detailing” session per month with each of eight drug company sponsors, the 7,500 physicians who subscribe to iPhysicianNet receive free use of computers, videoconferencing equipment, and high-speed Internet access (*Wall Street Journal*, November 5, 2001).

HMOs More Important than Doctors to Republican Party

- Republican leaders are irked that the AMA is backing patients’ right to sue HMOs and that the association contributes to Democratic as well as GOP campaigns. Senator Trent Lott has asked HHS Secretary Tommy Thompson to investigate the AMA’s \$18 million annual government contract to define the codes used for billing Medicaid and Medicare. Lott accused the group of enjoying windfall profits on their “statutory monopoly.”

House Speaker Dennis Hastert (R-IL) called the AMA “toadies” of the Democratic Party in a 1998 fight over HMOs, and chastised the AMA this year for losing touch with its membership, whom he claims still view malpractice reform (which the GOP has long championed for the AMA) as their top priority. Hastert based his claim on survey data provided by the American Association of Health Plans, the HMO trade association.

- The AMA spends about \$2 million on federal campaigns each two-year election cycle. Between 1996 and 2000, the proportion of AMA funding going to Republican candidates dropped from 81 to 52 percent. In a letter to colleagues, two GOP health care leaders, Reps. Bill Thomas (R-CA) and Nancy Johnson (R-CT), accused the AMA of deliberately misleading lawmakers on patients’ rights, and said that the AMA “no longer speaks for a majority of physicians and is suffering from declining membership.” President Bush snubbed the AMA and spoke at the annual meeting of the more conservative American College of Cardiology in spring 2001 (*Wall Street Journal*, August 8, 2001).

NURSING NEWS

- The Massachusetts Nursing Association voted in March 2001 to disaffiliate from the American Nurses Association (ANA) because the ANA is too aligned with nurse executives and does not represent the interests of staff nurses and patients aggressively enough. The California Nurses Association disaffiliated in 1995 and the Maine Nurses Association disaffiliated in 2001, citing the same concerns.

- The United American Nurses (UAN), the collective bargaining arm of the ANA created in 1999, became the 65th union to affiliate with the AFL-CIO. With the addition of UAN, the AFL-CIO unions will represent 1.2 million health workers, including 300,000 registered nurses. The affiliation prevents other

AFL-CIO unions (e.g., AFSCME and SEIU) from trying to organize in areas already unionized by UAN, and puts the strength of the AFL-CIO behind nursing. The impact on health policy is unclear. The ANA endorsed single-payer national health insurance in 1999, but AFL-CIO President John Sweeney has repeatedly opposed single-payer advocacy within the national AFL-CIO (*Labor Notes*, May 2001; *Labor Relations Week*, July 5, 2001).

- The Supreme Court ruled 5-4 in May 2001 that nurses and other health care workers at private hospitals cannot join labor unions if they use “independent judgement” to direct the work of others (making them, in effect, supervisors, according to the Court). The decision overturned a ruling by the National Labor Relations Board (NLRB) that registered nurses working for Kentucky River Community Care, Inc., were not supervisors and should be included in collective bargaining. Registered nurses in private nursing homes have been prohibited from unionizing for years based on similar judicial logic.

The new ruling has had a chilling effect on organizing among physicians as well as nurses; the AMA’s two-year-old labor group is suspending efforts to organize physicians in the wake of the ruling. (Organizing medical residents is still possible under an NLRB ruling in 1999.)

The provision barring supervisors from unions dates back to the 1947 Taft-Hartley Act. The goal was to keep managers with hire-and-fire responsibilities from being in the same union with those they disciplined. Professionals were specifically designated as retaining their right to organize, but this right is increasingly limited as the Supreme Court has become more conservative and defined more professional skills as “supervisory” (*Chicago Tribune*, June 7, 2001; *The Progressive Populist*, July 15, 2001; *NLRB vs. Kentucky River Community Care*, 99-1815, www.supremecourtus.gov).

CONGRESS WATCH

- The Conyers-Schakowsky bill, introduced in April 2001, directs Congress to enact universal health care legislation by October 2004. Conyers (D-MI) and Schakowsky (D-IL) are leaders of a newly created Congressional Universal Health Care Task Force with 44 members. Reps. John Tierney (D-MA) and Barbara Lee (D-CA) are also leading the task force and are long-time advocates of single-payer national health insurance (Schakowsky press release, April 17, 2001).

- Rep. Conyers will be following up the successful hearing before the Progressive, Hispanic, and Black Caucuses in May 2001 by introducing single-payer legislation in early 2002. The bill is being drafted by the Physicians Working Group on Single Payer National Health Insurance. The group is led by Drs. Marcia Angell and PNHP National Coordinator Quentin Young. (See PNHP’s Web site at www.pnhp.org for the full text of the group’s proposal.)

- As of December 2001, legislation for both a “Patient Protection Act” and for aid to newly unemployed—and uninsured—workers is stalled. The most recent version of the Patient Protection Act turned into an “HMO Protection Act” by capping HMO liability for killing or injuring patients at \$1.5 million—a liability cap that no other industry, profession, or individual enjoys. Former Humana medical director Dr. Linda Peeno notes that lawyers representing HMOs do not even have to ask their supervisors for permission to settle cases for \$5 million or less.

- Legislation to help laid-off workers keep their health insurance is also stalled. One proposal would provide unemployed workers with a 50 to 75 percent subsidy to help them keep their private insurance under COBRA, or give them tax credits of fixed sums for the same purpose. Another proposal would give small grants to states to expand Medicaid or other state programs. Workers are unlikely to be able to afford even 25 to 50 percent of their health insurance premiums if they are unemployed, and the proposed additional funding for Medicaid—assuming the states actually invested their grants there—is too little to have much impact. (Hellander’s note: the debate appears to be more about seeming to care about laid-off workers—after the multibillion-dollar bailouts of the airline industry—than really addressing the issue) (“Stimulus Debate Centers on Health Insurance,” no. 7, *American Healthline*, October 29, 2001).

- Also stalled is President Bush’s proposal that seniors use “discount cards” to purchase their medications. Private, for-profit pharmacy benefits managers (PBMs) would negotiate lower prices with retailers and make discounts available to seniors in exchange for a membership fee. According to Dr. David Himmelstein, “Medicare already covers some prescription drugs—those administered in a doctor’s office. And the Department of Defense, by law, gets the best prices from drug companies. If the administration were actually interested in covering people inexpensively, they could extend Medicare drug coverage to prescriptions administered outside a doctor’s office. If they, like the Defense Department, insisted on the lowest prices, this would cut drug prices dramatically. But instead, they are telling people they can go to private drug-buying firms, which would negotiate with drug stores and distributors, not the drug manufacturers. This puts a squeeze on the retailers, but lets the big pharmaceutical companies off the hook” (Institute for Public Accuracy release, July 12, 2001).

MONEY AND POLITICS

- Since 1999, the health care industry has spent more money than any other sector on federal lobbying. In the last six months of 2000, the industry spent \$123.3 million on federal lobbying, up \$16.5 million from the \$106.8 million spent in the first half of the year. Within the health sector, the drug industry spent the most: \$44.6 million between June and December 2000. The communications and

technology sector was the second largest lobbyist, spending \$113 million over the same period (*Congress Daily*, September 26, 2001).

- A coalition of over 40 health care companies has kicked off yet another multimillion-dollar advertising campaign—this time in support of individual tax credits “in the range of \$1,000 to \$2,000 per uninsured individual.” The “Healthcare Leadership Council” plans to spend \$5 million and will also deploy its members’ lobbyists to push the plan in Congress. The corporations involved include drug and medical supply manufacturers (Abbot Laboratories and Baxter International), insurers, and for-profit health care providers (*Chicago Tribune*, September 11, 2001). In addition to their other flaws, a study of public subsidies for the purchase of private insurance in Australia found that 95 percent of public funds went to people who were already privately insured and who had higher than average incomes (see below).

INTERNATIONAL UPDATE

- The International Association of Health Policy is to hold its 12th annual meeting May 21–24, 2002, in Mallorca, Spain. The meeting is being hosted by the Spanish group Federation of Associations for the Defense of Public Health. The theme of the meeting is the impact of globalization on health care and “defending health in a polarized world” (see www.fadsp.org).

- Australia introduced universal public health insurance in 1975, but, under pressure from conservatives and private medical interests, allowed people to purchase private insurance, duplicating the public coverage starting in the late 1970s. Initially popular, private insurance fell out of favor and only about 31 percent of the population was covered privately by the late 1990s, as most Australians expressed confidence in the public system. In order to induce more people to buy private insurance, conservatives passed a series of rebates for the purchase of private insurance, culminating in a 30 percent across-the-board rebate starting in 1999. Private insurers also gained the right to end pure community rating, starting in mid-2000.

A follow-up study found that 95 percent of the \$923 million the government spent in the first year’s rebates went to people who already were in the private system. Only 294,000 new people were privately covered. Also, since middle- and upper-income individuals were much more likely to purchase private insurance, much of the rebate went to the affluent.

Since Australian public hospitals treat patients at 91 percent of the cost of private hospitals, the rebate could be applied more efficiently by supporting public hospitals directly. In addition, since private insurance plans have much higher administrative costs (12.0 percent in 1998–99, or \$320 million) than the government’s public health insurance program (3.5 percent), a redirection of the private insurance subsidy to the public sector would result in more funds going directly to the provision of care.

“Concern is being expressed that these initiatives were introduced in an evidence-free policy zone, driven instead by powerful interest groups” (Sharon Willcox, “Promoting Private Health Insurance in Australia,” *Health Affairs*, May/June 2001).

A collection of ten excellent Fact Sheets on Australia’s health system have been written by the Friends of Medicare, an alliance of physicians, nurses, public health professionals, social workers, and women’s health advocates (see Friends of Medicare at www.phaa.net.au; see also Doctors Reform Society at www.drs.org.au).

- Rich and poor Canadians receive the same amount of health care per capita, after adjusting for self-reported health status. Patients who reported being in poor health received an average of \$2,318 in medical services, while those who said they were in good health used an average of \$268 in health care, regardless of income. The study looked at data on 2,170 Ontario patients. “The bottom line is that . . . Medicare works,” says study author and family practitioner Dr. Murray Finkelstein (Canadian Medical Association, September 2, 2001).

- The United States and Switzerland are the only countries to oppose a resolution to the World Trade Organization that “nothing” in its patent rules prevents governments from issuing compulsory licenses (allowing local manufacturers to produce generic versions of patented drugs) or importing generics from other countries (e.g., India) to obtain cheaper medications in times of national health emergencies. The United States maintains that patents are not a significant barrier to AIDS treatment. USAID Director Andrew Natsios defended the policy by declaring that Africans cannot take medication regularly because they “don’t know what Western time is” (editorial, *New York Times*, October 31, 2001; Booker and Minter, “AIDS and Global Apartheid,” *The Nation*, July 9, 2001).

- One of the largest public sector unions in England, GMB, cut its contribution to the Labour Party by as much as one million pounds (U.K.) over the next four years to protest the Labour government’s intention of privatizing management of some National Health Service (NHS) hospitals. The money held back will be used to fund a campaign against the policy. GMB general-secretary John Edmonds cited a survey which found that 90 percent of Britons did not consider privatization the answer to the problems facing the NHS. “They already have bitter experience of 20 years of the great Tory privatization experiment,” said Edmonds, who listened to Blair announce his plans with “surprise and disappointment” (*The Express*, July 17, 2001).

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