

G. PUBLIC HEALTH

PUBLIC HEALTH

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PUBLIC HEALTH

Over the past 50 years, public health departments have successfully fought to prevent numerous diseases once thought fatal or debilitating - tuberculosis, polio, small pox, measles and many more. In addition, they combat social problems that have serious health impacts - violence, substance abuse and smoking. As a result, public health efforts have significantly contributed to extending life expectations of current generations well beyond those of their grandparents.

Yet, new problems continually arise, and old ones still need substantial attention. AIDS, low-birthweight babies, childhood disease, homicide, brain injuries, abuse, heart disease, lung cancer - all are highly preventable yet continue to kill or disable millions of Americans prematurely. In addition to preventing disease, public health workers have become an integral part of the nation's system to deliver medical services to poor populations.

Despite the breadth and importance of the public health mission, only \$24.5 billion of the nation's \$800 billion health tab was spent on such efforts in 1991. Ninety percent (\$21.8 billion) came through state and local health departments. Most federal expenditures went to the U.S. Public Health Service's Centers for Disease Control and Prevention and the monitoring arm of the Food and Drug Administration.

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PERSPECTIVES

July 20, 1992

THE HEALTH OF THE NATION: MIXED

The U.S. met or came closer to two-thirds of its public health goals in the 1980s, according to the federal government's annual health status report. Childhood mortality dropped 23 percent between 1977 and 1989, the death rate for adults reached a record low, and overall life expectancy at birth increased very slightly, to 75.3 years.

The results show that disease prevention efforts can work, according to HHS Secretary Louis Sullivan, MD. "For example, the progress in preventing deaths of children owes much to the use of car safety seats — and we can credit changes in personal lifestyle for the decline in mortality among America's adults," Sullivan said in announcing the Public Health Service's (PHS) annual report on the nation's health.

However, many problems persist. In particular, the disparity between minorities' health and the health of the nation as a whole grew. While the overall life expectancy of Americans has increased, for black male Americans the expected life span has decreased slightly. The death rate among teenagers and young adults aged 15-24 also rose during the last decade, in part reflecting rising rates of homicide and suicide. The HIV epidemic continued to claim new victims, and there were increasing incidences of syphilis and measles.

Health care expenditures also continued to soar. The U.S. spent \$666 billion on health care in 1990, an average of \$2,500 per person, up from \$900 per person in 1979. National health care spending in the 80s totalled \$4.8 trillion.

Those and other statistics are gathered together in the PHS' *Health, United States, 1991*, the most comprehensive statistical profile of the nation's health. The statistics form a complete picture of where the U.S. has advanced in health — and where it has dropped back.

LIVING LONGER

Most Americans who are born today can expect to live a lot longer than their great-grandparents. Thanks in large part to improvements in medical science and public health, an American born today can expect to live 28 years longer than an American born at the beginning of the 20th century.

In fact, the U.S. has reached the PHS' 1990 goal for adult mortality of 400 deaths per year per 100,000 people. The death rate for adults aged 25-64 declined by 30 percent from 533 per 100,000 people in 1977, to a fraction over 400 per 100,000 people in 1989.

As infectious diseases such as small pox have been eradicated, the importance of personal behavior as a predictor of mortality has increased. For the last 50 years, the leading causes of death in the U.S. have been heart disease, cancer, and stroke — all of which are tied to personal behavior. As Americans have reduced their cigarette smoking, lowered their blood cholesterol, and increased control of high blood pressure, they have reduced the number of deaths from heart disease and stroke.

The greatest single risk factor for Americans is cigarette smoking, the PHS says. During the 1980s, there was a 24 percent reduction in cigarette smoking, but in 1990 slightly more than one-quarter of adult Americans still smoked. Americans who did not finish high school were almost three times as likely to smoke as college graduates.

However, while the picture has been improving for most Americans, it has been growing bleaker for many Americans who are black or members of other minorities. That trend in part reflects the rising rate of homicide among young black men.

- In 1984, a black American could expect to live 69.7 years; by 1989, the life expectancy for black Americans had declined to 69.2 years; for black males, life expectancy had declined to 64.8 years.

- In 1989, the HIV death rate for black men was three times that for white men and the HIV death rate for black women nine times that for white women.

- In 1990, 15 percent of black Americans said their health was fair or poor, compared with 8 percent of white Americans.

- Black American babies are twice as likely to die before their first birthday as white babies.

STRIDES IN INFANT HEALTH

One area where the U.S. has made some strides is infant health. At the turn of the century, one in 10 infants died in their first year of life. In 1950, of every 1,000 babies born, 29 babies died in their first year of life. By 1989, that number had declined to 10 of every 1,000.

However, much of the improvement in infant mortality is due not to improvements in prenatal care, but to advances in technologies that keep infants alive (*Perspectives* 5/11/92). The U.S.' infant mortality rate is still low compared with other industrialized countries.

And the mothers who bear the infants too often are in their teens and did not intend to get pregnant. Teenage mothers have higher rates of infant mortality, are more likely to have low birth weight babies, and are more likely to be poor and have low educational levels. Of the approximately 1.1 million girls aged 15-19 years who become pregnant each year, about 84 percent did not intend to get pregnant.

A MIXED PICTURE FOR CHILDREN

When it comes to children's health, the news, in part, is good. In 1977, 42 of every 100,000 children aged one to four years died. By 1989, that rate had declined to 32 childhood deaths per 100,000 people — so the U.S. has surpassed the 1990 PHS goal of 34 childhood deaths per 100,000 people.

Much of that improvement can be attributed to a reduction in the number of deaths from unintentional injuries, including motor vehicle crashes, drowning, fire, and suffocation. The use of child safety seats and safer automobile design has greatly reduced the number of childhood deaths from car crashes.

The picture for older children, adolescents, and young adults is troubled, due in part to rising levels of interpersonal violence (*Perspectives* 6/22/92). In 1977, the death rate for adolescents and young adults aged 15-24 years was about 115 deaths per 100,000 people. Between 1981 and 1985, the rate declined rapidly, approaching the 1990 PHS goal of 93 deaths in this age group per 100,000 persons. Since 1985, however, the rate has leveled off and slowly climbed to about 104 deaths per 100,000 people in 1990.

HIV CONTINUES TO SPREAD

The threat of AIDS has not diminished with time. It is currently estimated that one million persons in the U.S. are infected with the HIV virus — and that number is rising.

AIDS is now the eleventh leading cause of death in America, and the third leading cause of death for those between 25 and 44 years of age, surpassing heart disease as a killer of young adults. The incidence of the virus among women also is soaring: The proportion of people with AIDS who were women almost doubled from 6 to 11 percent between 1984 and 1990.

The death rates keep spiralling upward despite rising federal outlays to combat the disease. Federal expenditures for HIV-related activities rose from \$8 million in 1982, to almost \$3 billion in 1990, the PHS says. Of that 1990 total, 39 percent was for research, 38 percent for medical care, 16 percent for education and prevention, and 7 percent for cash assistance in the form of disability insurance and supplemental security income.

The incidence of certain other infectious diseases also has risen alarmingly. In 1990 there was a 79 percent increase in the incidence of syphilis and 28,000 cases of measles were reported — twice as many as in 1980, and an eight-fold increase over 1988.

HEALTH CARE COVERAGE

Age, health, and socioeconomic status all affect whether or not a person is likely to have health insurance. Not surprisingly, people who are older, and those with more education, higher incomes, and better health are most likely to have some form of private health insurance. From 1980 to 1989, the percent of persons under the age of 65 who had no form of health care coverage rose from about 13 percent to 16 percent.

The people most likely to be uninsured include the unemployed (39 percent), people with incomes below the federal poverty threshold (36 percent), people with less than 12 years of education (30 percent), and black Americans (22 percent). The reasons given most frequently for not having insurance were cost (mentioned by 70 percent of those without insurance), unemployment (8 percent), and being healthy (5 percent).

More than three-quarters of Americans said they had a regular source of medical care in 1990. Females were more likely than males to say they had a constant source of medical care, and about 94 percent of the total population said they regularly patronized a doctor's office. However, among those with incomes below the federal poverty level, about 85 percent used a doctor's office, while another 12 percent used a health center or hospital emergency department.

How wealthy a family was continued to be associated with how often they paid a visit to the dentist. In 1989, 42 percent of those with incomes of less than \$14,000 paid a visit to the dentist, while more than three-quarters of those with incomes of more than \$50,000 did the same.

SOARING EXPENDITURES

Exploding national health expenditures are common knowledge, and the report backs up would-be reformers who call for cost containment. In 1990, national health expenditures grew 10.5 percent, compared to the 5 percent increase in the Gross National Product. That same year, Medicare hospital expenditures totaled \$67 billion, and physician and outpatient payments totaled \$44 billion.

Rising prices continued to explain the largest portion (63 percent) of growth in personal health care expenditures. Nearly one-third of the growth is attributed to changes in use or kinds of services and supplies, while one-tenth is tied to population increases.

In 1990, the major sources of funds for hospital care were the government (55 percent) and private health insurance (35 percent). Medicare provided almost half of government funds for hospital care. Nursing home care was financed almost equally by Medicaid and out-of-pocket payments (45 percent each). Physician services were primarily funded by private health insurance (46 percent) and the government (35 percent), with Medicare providing nearly 70 percent of government funds.

Over the past three decades, the question of who pays for health care has shifted. From 1965 to 1980, the share of health care costs paid by households declined from 61 percent to 38 percent, while the shares paid by businesses and government increased. However, during the past decade, health care costs have been divided almost evenly among households, government, and businesses.

The explosion in costs also has meant an explosion in jobs. The number of civilians employed in health services grew to 9.4 million between 1985 and 1990, a 19 percent increase, compared to a 9 percent increase in other industries. In 1990, half of all health service industry workers were employed in hospitals, down from 54 percent in 1985.

Not surprisingly, economic circumstances and level of education affected how people assessed their health. Nearly 20 percent of people with annual incomes of less than \$14,000 told the PHS that their health in 1990 was fair or poor, compared to 4 percent of people with incomes of \$50,000 or more. The split between rural and urban circumstances was about even: In 1990, 10 percent of Americans living in rural areas said their health was fair or poor, compared to about 9 percent in metropolitan areas.

SHORTER STAYS

The report substantiates that outpatient surgery — which can be less expensive and safer for the patient than inpatient surgery — has become much more popular. One-half of all surgery in acute care hospitals was performed on an outpatient basis in 1989 — three times the proportion of outpatient surgery performed in 1980. The smaller the hospital was, the greater the proportion of outpatient surgery that it performed: Hospitals with 500 beds or more performed 42 percent of their surgeries on an outpatient basis, while hospitals with fewer than 100 beds performed 54 percent of their surgeries on an outpatient basis.

In 1990, there were almost 31 million discharges from non-federal acute care hospitals. The most common diagnoses among men were heart disease, followed by cancer and pneumonia. Women were hospitalized most often for delivery, followed by heart disease and cancer.

Between 1985 and 1990, occupancy rates in acute care hospitals remained fairly stable at 65-67 percent, after declining from 76 percent in 1980. Smaller hospitals continue to have lower occupancy rates than larger hospitals. In 1989, hospitals with fewer than 100 beds had an occupancy rate of 49 percent, while hospitals with 500 beds or more had an occupancy rate of 77 percent.

Enrollment in health maintenance organizations continued to increase slowly to 34 million in 1991. The growth in enrollment slowed after a period of rapid expansion in the early to mid-80s. Although enrollment has continued to increase, the number of plans has declined from a high of 647 in 1987, to 553 in 1991.

MOVING AHEAD

Currently, the PHS is focusing on reaching public health goals set in 1990 for the turn of the century. In its efforts to achieve the "Healthy People 2000" objectives, the PHS is focusing on improving the health of those groups that are most likely to suffer premature death, disease, and disability — which includes certain racial and ethnic groups, and people with low incomes.

"The 1990 objectives taught us that we need to target the priority problems of minority populations," said U.S. Assistant Secretary James Mason, MD. "And while heart disease and stroke deaths are down to unprecedented levels, we still lose too many Americans — and too frequently at the younger ages — to injury, violence, and HIV." — CK.

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Health Status of the Population

The health status of the population varies by age, education, and income.

Personal assessment of one's health varies widely according to age, education, and family income.

Table 6.29 presents these differences in perceived health status.

Table 6.29
Health Status

Americans' Health Status by Age, Years of Education, and Income, 1987

Age, Years of Education, and Income	All Persons	All Health Statuses	Respondent-Assessed Health Status				
			Excellent	Very good	Good	Fair	Poor
	(thousands)		(percentage distribution ^a)				
Total Americans	238,550	100.0%	39.0%	27.7%	22.7%	7.2%	2.7%
Age							
Under 18	63,279	100.0	53.0	26.8	16.8	2.1	0.3
18-44 years	102,143	100.0	42.1	30.8	21.0	4.6	1.0
45-64 years	44,975	100.0	27.2	26.4	28.7	11.6	5.6
65 years and over	28,153	100.0	15.3	20.8	32.6	21.1	9.5
Total Aged 18 and over	175,271 ^b	100.0	34.0	28.1	24.9	9.1	3.6
Education							
8 years or less	17,934	100.0	14.3	17.8	31.5	22.8	13.0
9-11 years	22,129	100.0	22.9	24.1	32.0	14.9	5.7
12 years	68,059	100.0	32.0	30.1	27.1	8.0	2.5
13-15 years	33,900	100.0	41.5	30.7	20.6	5.3	1.6
16 years and over	31,437	100.0	50.1	29.7	15.6	3.4	0.9
Income							
Less than \$5,000	8,685	100.0	22.2	24.8	26.4	17.1	9.1
\$5,000-\$9,999	14,026	100.0	18.9	22.0	29.9	18.5	10.4
\$10,000-\$19,999	32,808	100.0	26.6	26.4	29.4	12.5	4.8
\$20,000-\$34,999	44,387	100.0	35.6	30.0	25.4	6.8	1.9
\$35,000-\$49,999	26,948	100.0	42.5	30.9	20.5	4.6	1.1
\$50,000 or more	23,529	100.0	49.1	29.7	16.4	3.5	1.0

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, *Vital and Health Statistics, Americans Assess Their Health: United States, 1987*, series 10, no. 174 (Washington, DC: U.S. Government Printing Office, 1989).

^aTotal includes persons with health status not assessed.

^bIncludes persons with unknown years of education and unknown family income.

Table 6.9

Causes of Death (1988)

Cause of death	Deaths per 100,000 population	Percent of total deaths
Diseases of the heart	311.3	35.3
Malignant neoplasms	197.3	22.4
Cerebrovascular diseases	61.2	6.9
Accidents and adverse effects	39.5	4.5
Chronic obstructive pulmonary disease and allied conditions	33.7	3.8
Pneumonia and influenza	31.6	3.6
Diabetes mellitus	16.4	1.9
Suicide	12.4	1.4
Chronic liver disease and cirrhosis	10.7	1.2
Nephritis, nephrotic syndrome	9.1	1.0
Atherosclerosis	9.0	1.0
Homicide and legal intervention	9.0	1.0
Septicemia	8.5	1.0
Conditions originating in perinatal period	7.4	0.8
AIDS	6.8	0.8
All other causes	118.1	13.4

SOURCE: National Center for Health Statistics, Monthly Vital Statistics Report, November 28, 1990.

TABLE 2 COSTS OF TREATMENT FOR
SELECTED PREVENTABLE CONDITIONS

CONDITION	OVERALL MAGNITUDE	AVOIDABLE INTERVENTION ¹	COST PER PATIENT ²
Heart disease	7 million with coronary artery disease 500,000 deaths per year 284,000 bypass procedures per year	Coronary bypass surgery	\$30,000
Cancer	1 million new cases per year 510,000 deaths per year	Lung cancer treatment Cervical cancer treatment	\$29,000 \$28,000
Stroke	600,000 strokes per year 150,000 deaths per year	Hemiplegia treatment and rehabilitation	\$22,000
Injuries	2.3 million hospitalizations per year 142,500 deaths per year 177,000 persons with spinal cord injuries in the United States	Quadriplegia treatment and rehabilitation Hip fracture treatment and rehabilitation Severe head injury treatment and rehabilitation	\$570,000 (lifetime) \$40,000 \$310,000
HIV infection	1 million-1.5 million infected 118,000 AIDS cases (as of January 1990)	AIDS treatment	\$75,000
Alcoholism	18.5 million abuse alcohol 105,000 alcohol-related deaths per year	Liver transplant	\$250,000
Drug abuse	Regular users: 1 million-3 million, cocaine 900,000, IV drugs 500,000, heroin Drug-exposed babies: 375,000	Treatment of drug-affected baby	\$63,000 (5 years)
Low-birth-weight baby	260,000 low-birthweight babies born per year 23,000 deaths per year	Neonatal intensive care for low-birthweight baby	\$10,000
Inadequate	Lacking basic immunization series: 20-30%, age 2 and younger	Congenital rubella syndrome treatment	\$354,000 (lifetime)

Notes: Examples (other interventions may apply). Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.

Source: U.S. Department of Health and Human Services, Public Health Service, *Healthy People 2000* (Washington, D.C.: U.S. Department of Health and Human Services, September 1990).

National Governors' Association, A Healthy America: The Challenge for States, 1991

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Table 1. AIDS cases and annual rates per 100,000 population, by state, reported July 1991 through June 1992, July 1992 through June 1993;¹ and cumulative totals, by state and age group, through June 1993²

State of residence	July 1991– June 1992		July 1992– June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	424	10.4	704	17.0	2,154	43	2,197
Alaska	16	2.8	29	4.9	150	3	153
Arizona	371	9.9	1,138	29.7	2,874	13	2,887
Arkansas	200	8.4	429	17.9	1,160	18	1,178
California	8,448	27.8	15,402	49.7	57,672	344	58,016
Colorado	429	12.7	1,100	31.8	3,337	19	3,356
Connecticut	480	14.6	1,444	43.8	3,980	91	4,071
Delaware	104	15.3	305	44.0	756	7	763
Distrit of Columbia	806	134.7	1,083	183.6	4,812	78	4,890
Florida	5,246	39.5	8,765	64.4	30,073	713	30,786
Georgia	1,653	25.0	2,194	32.4	8,595	85	8,680
Hawaii	166	14.6	204	17.6	1,088	10	1,098
Idaho	39	3.8	69	6.4	194	2	196
Illinois	1,838	15.9	2,851	24.5	9,880	136	10,016
Indiana	379	6.8	768	13.5	2,312	16	2,328
Iowa	86	3.1	192	6.8	550	5	555
Kansas	168	6.7	300	11.9	957	5	962
Kentucky	178	4.8	296	7.9	1,058	13	1,071
Louisiana	864	20.3	1,130	26.4	4,586	62	4,648
Maine	57	4.6	77	6.2	371	2	373
Maryland	1,036	21.3	2,058	41.7	6,580	146	6,726
Massachusetts	858	14.3	1,933	32.3	6,535	122	6,657
Michigan	826	8.8	1,556	16.5	4,587	61	4,648
Minnesota	241	5.4	593	13.2	1,732	12	1,744
Mississippi	225	8.7	399	15.3	1,370	20	1,390
Missoun	706	13.7	1,660	31.9	4,456	31	4,487
Montana	21	2.6	28	3.4	123	1	124
Nebraska	61	3.8	152	9.5	425	4	429
Nevada	249	19.4	541	39.6	1,522	15	1,537
New Hampshire	53	4.8	92	8.4	353	6	359
New Jersey	2,213	28.5	3,482	44.7	16,836	419	17,255
New Mexico	109	7.0	277	17.5	785	2	787
New York	8,061	44.6	14,099	77.8	59,312	1,258	60,570
North Carolina	643	9.5	1,007	14.7	3,521	74	3,595
North Dakota	1	0.2	5	0.8	30	—	30
Ohio	771	7.0	1,156	10.5	4,445	66	4,511
Oklahoma	244	7.7	670	20.9	1,701	15	1,716
Oregon	290	9.9	663	22.1	2,077	9	2,086
Pennsylvania	1,370	11.5	2,122	17.6	8,331	118	8,449
Rhode Island	122	12.1	238	23.7	762	9	771
South Carolina	345	9.7	1,076	29.6	2,609	35	2,644
South Dakota	9	1.3	23	3.2	56	2	58
Tennessee	407	8.2	834	16.6	2,481	24	2,505
Texas	3,184	18.4	6,223	35.1	21,881	210	22,091
Utah	129	7.3	276	15.2	785	18	803
Vermont	22	3.9	29	5.1	133	2	135
Virginia	656	10.4	1,365	21.4	4,340	79	4,419
Washington	520	10.4	1,180	22.8	4,297	18	4,315
West Virginia	70	3.9	71	3.9	339	5	344
Wisconsin	224	4.5	625	12.5	1,562	16	1,578
Wyoming	11	2.4	33	7.1	90	—	90
U.S. total	45,629	18.1	82,946	32.4	300,615	4,462	305,077
Guam	2	1.5	2	1.5	13	—	13
Pacific Islands, U.S.	—	—	—	—	2	—	2
Puerto Rico	1,814	51.0	2,535	70.7	9,911	243	10,154
Virgin Islands, U.S.	20	19.5	42	40.8	139	5	144
Total	47,465	18.5	85,525	32.9	310,680	4,710	315,390

¹Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²During the second quarter of 1993, CDC received reports of 25,964 cases and 12,313 deaths among adults/adolescents and 230 cases and deaths among children.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1991 through June 1992, July 1992 through June 1993;¹ and cumulative totals, by area and age group, through June 1993

Metropolitan area of residence ²	July 1991– June 1992		July 1992– June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	42	6.3	38	5.7	199	—	199
Albany-Schenectady, N.Y.	97	11.2	194	22.1	615	14	629
Albuquerque, N.M.	67	11.1	169	27.4	461	1	462
Allentown, Pa.	39	6.5	73	12.0	261	4	265
Ann Arbor, Mich.	37	7.4	49	9.7	173	4	177
Atlanta, Ga.	1,186	38.9	1,490	47.4	6,371	41	6,412
Austin, Tex.	264	30.2	505	56.0	1,574	14	1,588
Bakersfield, Calif.	51	9.0	125	21.2	307	3	310
Baltimore, Md.	588	24.4	1,394	57.0	4,104	110	4,214
Baton Rouge, La.	97	18.0	123	22.5	437	4	441
Bergen-Passaic, N.J.	272	21.2	402	31.4	2,103	51	2,154
Birmingham, Ala.	106	12.5	250	29.1	674	11	685
Boston, Mass.	760	13.4	1,707	30.3	5,871	107	5,978
Buffalo, N.Y.	80	6.7	191	16.0	622	7	629
Charleston, S.C.	76	14.5	218	40.4	554	4	558
Charlotte, N.C.	124	10.4	232	19.0	709	9	718
Chicago, Ill.	1,607	21.4	2,500	33.0	8,700	121	8,821
Cincinnati, Ohio	118	7.6	180	11.5	702	10	712
Cleveland, Ohio	237	10.7	354	15.9	1,260	25	1,285
Columbus, Ohio	153	11.2	236	16.9	938	6	944
Dallas, Tex.	776	28.3	1,686	60.2	5,574	24	5,598
Dayton, Ohio	78	8.2	118	12.3	451	8	459
Denver, Colo.	354	21.2	926	54.0	2,767	14	2,781
Detroit, Mich.	631	14.7	1,092	25.4	3,256	45	3,301
El Paso, Tex.	41	6.7	110	17.4	286	1	287
Fort Lauderdale, Fla.	856	66.5	1,080	81.9	4,845	103	4,948
Fort Worth, Tex.	148	10.6	381	26.6	1,254	14	1,268
Fresno, Calif.	80	10.2	153	19.0	464	4	468
Gary, Ind.	40	6.5	77	12.5	228	1	229
Grand Rapids, Mich.	52	5.5	111	11.5	307	2	309
Greensboro, N.C.	133	12.5	147	13.6	598	11	609
Greenville, S.C.	47	5.6	208	24.3	437	2	439
Harrisburg, Pa.	48	8.1	64	10.6	289	6	295
Hartford, Conn.	144	12.8	428	38.0	1,200	18	1,218
Honolulu, Hawaii	119	14.0	166	19.2	826	7	833
Houston, Tex.	1,177	34.2	2,160	60.8	8,537	87	8,624
Indianapolis, Ind.	177	12.6	349	24.4	1,100	5	1,105
Jacksonville, Fla.	309	33.1	813	84.6	1,964	49	2,013
Jersey City, N.J.	365	66.0	421	76.0	2,685	69	2,754
Kansas City, Mo.	291	18.2	738	45.5	2,124	7	2,131
Knoxville, Tenn.	33	5.5	60	9.8	213	2	215
Las Vegas, Nev.	192	20.8	425	42.6	1,176	14	1,190
Little Rock, Ark.	67	12.9	173	33.0	455	8	463
Los Angeles, Calif.	3,072	34.2	5,196	57.1	20,192	142	20,334
Louisville, Ky.	87	9.1	150	15.5	466	8	474
Memphis, Tenn.	153	15.0	334	32.3	883	8	891
Miami, Fla.	1,691	85.5	2,063	102.3	8,777	249	9,026
Middlesex, N.J.	209	20.3	333	32.2	1,447	31	1,478
Milwaukee, Wis.	122	8.4	322	22.1	837	10	847
Minneapolis-Saint Paul, Minn.	207	8.0	530	20.2	1,541	9	1,550
Monmouth-Ocean City, N.J.	122	12.2	339	33.7	1,198	33	1,231
Nashville, Tenn.	125	12.5	228	22.3	765	9	774
Nassau-Suffolk, N.Y.	309	11.8	876	33.3	2,927	63	2,990
New Haven, Conn.	294	18.0	883	54.1	2,440	70	2,510
New Orleans, La.	498	38.5	579	44.4	2,732	35	2,767
New York, N.Y.	6,979	81.6	11,798	137.9	51,112	1,126	52,238
Newark, N.J.	922	50.6	1,283	70.6	6,853	185	7,038
Norfolk, Va.	120	8.2	274	18.4	917	22	939
Oakland, Calif.	571	27.0	1,106	51.6	3,908	26	3,934
Oklahoma City, Okla.	123	12.7	299	30.4	798	1	799

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1991 through June 1992, July 1992 through June 1993;¹ and cumulative totals, by area and age group, through June 1993 — Continued

Metropolitan area of residence ²	July 1991– June 1992		July 1992– June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Omaha, Neb.	42	6.5	115	17.4	308	1	359
Orange County, Calif.	590	24.2	602	24.3	2,642	19	2,661
Orlando, Fla.	357	28.1	850	64.8	2,145	38	2,183
Philadelphia, Pa.	1,044	21.1	1,756	35.4	6,502	85	6,587
Phoenix, Ariz.	280	12.2	809	34.6	2,100	9	2,109
Pittsburgh, Pa.	147	6.1	164	6.8	936	4	940
Portland, Oreg.	235	15.0	615	37.8	1,820	6	1,826
Providence, R.I.	114	12.4	221	24.1	715	8	723
Raleigh-Durham, N.C.	119	13.5	189	20.8	754	18	772
Richmond, Va.	158	17.9	359	40.0	951	13	964
Riverside-San Bernardino, Calif.	399	14.7	901	31.6	2,455	26	2,481
Rochester, N.Y.	91	8.5	205	18.9	684	8	692
Sacramento, Calif.	252	18.2	408	28.4	1,348	14	1,362
Saint Louis, Mo.	376	15.0	783	31.0	2,111	21	2,132
Salt Lake City, Utah	115	10.4	247	21.8	697	13	710
San Antonio, Tex.	234	17.4	330	24.1	1,427	14	1,441
San Diego, Calif.	607	23.8	1,400	53.9	4,588	30	4,618
San Francisco, Calif.	1,986	122.4	3,862	235.3	16,228	26	16,254
San Jose, Calif.	172	11.4	402	26.6	1,365	11	1,376
San Juan, P.R.	1,092	58.8	1,645	87.7	6,316	159	6,475
Sarasota, Fla.	68	13.6	134	26.1	526	12	538
Scranton, Pa.	29	4.5	53	8.2	183	3	186
Seattle, Wash.	366	17.6	904	42.6	3,249	10	3,259
Springfield, Mass.	87	14.5	183	30.5	525	15	540
Stockton, Calif.	37	7.5	78	15.5	264	8	272
Syracuse, N.Y.	59	7.9	143	18.9	448	6	454
Tacoma, Wash.	37	6.1	97	15.5	305	8	313
Tampa-Saint Petersburg, Fla.	516	24.6	1,314	61.6	3,529	52	3,581
Toledo, Ohio	38	6.2	83	13.5	254	5	259
Tucson, Ariz.	68	10.0	256	37.3	585	3	588
Tulsa, Okla.	67	9.3	219	29.7	513	5	518
Ventura, Calif.	66	9.7	119	17.4	352	1	353
Washington, D.C.	1,465	34.1	2,087	47.8	8,627	133	8,760
West Palm Beach, Fla.	444	50.1	837	92.0	2,791	105	2,896
Wichita, Kansas	61	12.4	84	16.8	257	2	259
Wilmington, Del.	76	14.6	231	43.5	561	6	567
Youngstown, Ohio	21	3.5	27	4.5	140	—	140
Metropolitan areas with 500,000 or more population	39,678	25.2	71,621	44.9	264,665	3,971	268,636
Metropolitan areas with 50,000 to 500,000 population	4,969	10.8	8,946	19.1	29,476	465	29,941
Non-metropolitan areas	2,618	5.0	4,629	8.7	15,343	253	15,596
Total³	47,465	18.5	85,525	32.9	310,680	4,710	315,390

¹Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Based on Metropolitan Statistical Area definitions revised June 1993. See notice to readers (page 2) and technical notes.

³Totals include 1,217 persons whose area of residence is unknown.

PERSPECTIVES

May 11, 1992

SLOW PROGRESS AGAINST INFANT MORTALITY

In 1991, for every 1,000 American babies born alive, 8.9 infants died before their first birthday. In announcing the 1991 figure, HHS Secretary Louis Sullivan, MD, noted that the new rate was 2 percent lower than it was in 1990, when 9.1 out of every 1,000 live births died in its first year of life.

Where Sullivan sees sunshine, others see darkness. Critics of the American performance note that the U.S. infant mortality rate places 22nd on a list of developed countries around the world and behind such nations as Singapore and Spain. In 1991, 36,500 American infants died before their first birthday. And there are some indications that things are getting worse.

Recent federal statistics indicate that the incidence of low birthweight has increased for the first time since 1978. Low birthweight infants are 40 times more likely to die in their first month of life than other babies, and those who survive are more likely to suffer from respiratory problems and other disabilities, according to a recent report from the National Commission to Prevent Infant Mortality. Low birthweights can be prevented by prenatal care, but many women, lacking insurance or knowledge, do not get such care.

And the historical gap between infant mortality rates among black and white Americans continues to yawn. In 1989, the infant mortality rate among African Americans was 17.7 deaths per 1,000 births, compared to 8.2 deaths per 1,000 births for whites.

One reason for the sluggish progress on infant mortality is the growth of poverty in America, says the Commission. The number of families living in poverty — and therefore much less likely to receive preventive health care — is growing. In 1990, the number of children below age 18 who lived in poverty reached an all-time high of 12 million, or about one in five. If that trend continues, one in four children will be living in poverty by the year 2000.

While the social costs of a high infant mortality rate are intangible, the economic costs are measurably high. Hospital care costs for one low birthweight child average \$21,000, compared to \$2,842 for a normal delivery. While only 7 percent of babies born in the U.S. are low birthweight, those children incur nearly 60 percent of the costs of all newborns.

The relatively high infant death rate in the U.S. is upsetting more than public health professionals. Employers are so alarmed by those statistics that the Commission, the CIGNA Corp., the American Academy of Pediatrics, and the Washington Business Group on Health held an Apr. 30 "Corporate Summit for Children" in Washington DC. At the time, CIGNA released a pair of studies showing that in 1992, American businesses and their employees will pay about \$5.6 billion in health care costs for mothers and infants.

And the problems aren't limited to those who don't have health insurance. CIGNA's report indicates that one out of 22 infants born to insured women has severe problems. Giving women increased access to prenatal education and care would save billions of dollars and thousands of infant lives, says G. Robert O'Brien, CIGNA's executive vice president.

BORN AT RISK

The recent improvement in infant mortality cited by Sullivan isn't the product of improved prevention efforts but rather is due to improvements in technology that help keep unhealthy newborns alive, says Rae Grad, executive director of the Commission. "What is troubling us is that the number of babies who are born at risk is rising. Overall infant mortality is going down but the number of babies born at low birthweight is going up. . . . The interventions we're using are after the fact, rather than before the fact."

The nation's infant mortality rate began to decline rapidly in 1965 and continued on that trend line until the 1980s, when the progress greatly slowed. Child health advocates cite many reasons, including deep budget cuts in welfare assistance by the Reagan Administration, which meant that a lot of people no longer had access to the health benefits provided by Medicaid. And there were also severe cutbacks in programs such as the National Health Service Corps and the maternal and child health services block grants that go to state health departments. And the dramatic rise in the number of uninsured Americans hit families particularly hard, as many employers dropped dependent coverage or priced it out of the reach of many young families.

In the latter part of the 80s, Congress responded to the discouraging infant mortality statistics by expanding Medicaid coverage of pregnant women and young children. Today, states are required to cover such people if their family income is below 133 percent of the federal poverty line.

But the government certainly wasn't the only villain. Such social factors as rising abuse of alcohol and drugs by men, women, and teenagers endangered fetuses and led to more premature births and infant deaths. Calls for more substance abuse treatment programs have generally been met with enthusiastic rhetoric but underwhelming financial support. In 1990, less than 14 percent of pregnant women in need of substance abuse treatment were able to get it, says the Commission.

The rate of adolescent pregnancy and unmarried motherhood also rose in the late 80s, after decades of decline. Studies show that unwed and teenage mothers are much more likely to be poor than other mothers. Finally, the incidence of AIDS and other sexually transmitted diseases among men, women of childbearing age, and pregnant women rose sharply during the 80s. That too has often-fatal effect on fetuses; 40 percent of newborns who contract syphilis from their mothers die.

FEDERAL EFFORTS

The Bush Administration says it is committed to reducing infant mortality and, as proof, points to increases in funding for community and migrant health centers, the maternal and child health block grant, the National Health Service Corps, and other programs. Sullivan recently called on experts from outside government to form a Secretary's Advisory Committee on Infant Mortality, and in speeches and articles, constantly hammers home the point that smoking and other bad health habits contribute to low birthweight. An Interagency Committee on Infant Mortality patrols spending of federal dollars.

The showpiece of the Administration's efforts is the "Healthy Start" program, unveiled in 1991, which gives money to 15 communities to develop ways to combat infant mortality in those areas by 50 percent in five years. Programs could focus on factors such as improving participation in Medicaid, increasing the number of pregnant women and infants who participate in the women, infants, and children (WIC) supplemental nutrition program, and integrating smoking and drug abuse cessation programs into prenatal care programs.

Healthy Start will demonstrate what works, says Robert Harmon, MD, administrator of HHS' Health Resources & Services Administration (HRSA). "To make a difference, you have to put considerable resources together," he says. "We know that if Healthy Start is a success, it can be expanded." President Bush plans a May 11 press conference at the White House to release information on Healthy Start and infant immunization.

The program got off on the wrong foot in fiscal 1991, when the Administration sought to redirect funds from maternal and child health and other programs to pay for Healthy Start. That infuriated members of Congress and advocacy groups, who argued that those programs should not have their already meager

funds cut. But Sullivan points out that the same lawmakers who criticized him for trying to rechannel existing funds consistently have anted up less money than the Administration has requested for Healthy Start. In FY91, Bush wanted \$57 million; Congress appropriated \$25 million. In FY92, the pattern was the same, with Bush requesting \$139 million and Congress giving him \$65 million.

Lawmakers have instead put more money into existing programs that spread the effort nationwide, such as community and migrant health centers.

Despite the support for Healthy Start, critics say Bush has done too little about infant mortality, a topic the President highlighted in his 1988 campaign. A White House task force on infant mortality produced a report that contained strong recommendations to expand government efforts to save infant lives. But the proposals were "politically incorrect" and were never released, charges Joseph Liu, senior health associate with the Children's Defense Fund (CDF), a Washington-based advocacy group. Harmon calls the report an internal working document that was amended to reflect the Healthy Start program and released as a background paper.

An aide to House Select Committee on Children, Youth, and Families Chairman Patricia Schroeder (D-CO) calls the Administration's proposed funding increases "pretty token." Programs such as the National Health Service Corps "were so demolished during the Reagan years that it will take a long time to catch up," she says.

As for Healthy Start, "the Administration says we need to find out what works," says Laura Summer, health policy analyst for the Center on Budget & Policy Priorities. "But we really know what works — we know that women need good prenatal care. What we need is funding to get the job done."

One thing the Administration and Congress could do is provide more money to the WIC program, which has been judged to be effective but has never been fully funded, Summer says. Congress appropriated \$2.6 billion for WIC in FY92, but that sum is enough to serve only 50-to-60 percent of the eligible population, Summer says. A recent General Accounting Office report found that the \$296 million that the federal government spent on prenatal WIC benefits in 1990 averted \$853 million in health-related expenditures during the first year of life.

"While Healthy Start is important for the 15 sites that will receive the money, it will do little on a national level," Liu says. The CDF agenda: national health reform, expansion of Medicaid to cover all pregnant women and children with incomes below 200 percent of the federal poverty level, and full funding of WIC.

STATES MOVE AHEAD

As the federal government wrestles with change, states are coming out with their own programs. In 1991, states passed 350 new laws and resolutions that address the health of women and children, says Martha King, manager of the Maternal & Child Health Project of the National Conference of State Legislatures. Despite the severe budget crunches that many states face, the vast majority of those measures are designed to improve children's health; only a few reduce existing services.

Southern states — which have traditionally had higher infant mortality rates than other regions — are attacking the problem vigorously. "The federal government has got more than they can handle right now," says Alabama State Sen. Ted Little, who is the lead legislator on the Southern Regional Project on Infant Mortality. "We are people of pride and we know that this [high infant mortality rate] is not acceptable." A recent report from the Southern Governors' Assn. (SGA) and the Southern Legislative Conference details state efforts. Copies are \$10 from SGA, the Project, N. Capitol St. NW, #240, Washington DC 20001.

Coordination of care is the most essential element of a successful prenatal care program, according to the report. In the typical program, a nurse or social worker oversees prenatal and postpartum care by scheduling periodic risk assessments, health screenings, nutrition and parenting education, child care, transportation, and family counseling. The comprehensive approach helps ensure that a woman and her family receive preventive health care.

North Carolina's "Baby Love" program, begun in 1987, combines care coordination with childbirth and parenting classes, counseling, and home visiting. Medicaid recipients in North Carolina automatically are eligible for WIC; state care coordinators help pregnant women apply for both programs. Program officials estimate that between 1987 and 1989, the program saved \$2.10 in Medicaid funds for every \$1 spent on care coordination, accounting for a total savings of \$2.3 million. Participating women also had higher birthweight babies.

Another important contributor to infant deaths is the shortage of obstetrical providers, especially those that accept Medicaid. Over the past decade an increasing number of physicians have stopped providing obstetrics because of costly liability insurance, the fear of being sued, and unpredictable and late hours. Nationwide, it's estimated that about two-thirds of all nonmetropolitan counties have no obstetrician.

North Carolina's Rural Obstetrical Care Incentive Funds program subsidizes medical malpractice premiums for providers who agree to practice in medically underserved areas of the state. Doctors can get grants of \$6,500 or the difference between the physician's premium with and without obstetrical coverage, whichever is less. Certified nurse midwives also are eligible for malpractice premium grants. State officials report that from 1989 to 1990, participating counties increased the number of public health department professionals who provide prenatal care by 8.9 percent, while counties without program funds lost 18.6 percent of their providers.

Substance abuse during pregnancy is another crucial concern. In 1991 Maryland and the Francis Scott Key Medical Center in Baltimore formed the Center for Addiction & Pregnancy, which provides all the services addicted pregnant women may need, ranging from substance abuse counseling to an early childhood development program. Clients stay in the center with their infants for a week following delivery to allow them to adjust to their new responsibilities. The center reports that of the first 38 deliveries between May and Nov. 1991, only 10 babies (28 percent) were born with low birthweight, compared to the national average of 40 percent for that population.

OUTLOOK

The immediate outlook for maternal and child health is budget battles over funding for Healthy Start and other maternal and infant health programs. The Administration wants to provide Healthy Start with \$143 million in FY93, but it's unlikely that Congress will devote that amount of resources to a program that serves only 15 communities. Ron Carlson, an associate administrator at HRSA, says providing less than the requested amount would "dash the trust" of the communities that are already heavily invested in the program. "We're really off to a good start," Carlson says.

To fully address the problem of infant mortality, the U.S. will have to address the problems of poverty and inadequate access to health care, says CDF's Liu. "Nine trips to the doctor while pregnant is not going to overcome 20 years of not going to the doctor," Liu says. "If we're going to make a difference in infant mortality, we're going to have to go beyond what happens in clinical settings. We have to provide families with the resources they need to be healthy."

Infants and children tend to get the short end of the stick because they don't vote and don't form a well-organized constituency, says Harmon. Instead, they have to rely on advocacy groups. "My opinion is that we're coming around to the fact that we must invest more in our children," Harmon says. "We've done well by our elderly, and now it's time to take care of the children." — CK.

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**HEALTHCARE
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PERSPECTIVES

June 22, 1992

PUBLIC HEALTH ATTACKS VIOLENCE

When Los Angeles erupted in violence and looting for three days in Apr. 1992, Americans were stunned. The rampage was a reaction to the Apr. 29 acquittal of four Los Angeles Police Department officers charged with using excessive force in the beating of motorist Rodney King. To many, it appeared as though the white officers had gotten away with assaulting a black man, and the city's southeastern section exploded in rage.

When the tumult was over about 50 people were dead and hundreds were injured. The violence shocked the country, and a number of federal officials, including President Bush, visited the area and promised to address the situation.

But Range Hutson, MD, director of major admitting at Los Angeles County-University of Southern California Medical Center, says the number of deaths from the LA riots is small compared to the thousands killed every year in other violent incidents.

Hutson estimates that LA County (population: 8.9 million) averages 11 drive-by shootings a day. Within the last three months, those shootings have killed at least seven children; one was a four-year-old, asleep in his bed. Much of the violence is gang-related. In LA County, "gang members kill 64 people a month and injure over 5,000 people a year," Hutson says. He estimates that gang-related violence costs the county \$1 billion a year in medical care and lost earning potential.

Some believe such brutality lives only on the mean streets of major cities. But public health officials say violence is poisoning communities across the U.S. Violence can be defined as intentional injury either to oneself or others, and can include homicide, suicide, domestic violence (including child and elder abuse), and other deliberate injuries. In about half of all homicides, the victim knows the assailant, a handgun is the weapon of choice, and alcohol and an argument are involved. Only 15 percent of all homicides take place during a burglary or robbery.

The U.S. homicide rate (approximately 10 homicides per 100,000 people) is the fifth highest in the world — 10 times that of Britain, 25 times that of Spain, and 50 times that of New Zealand, says Deborah Prothrow-Stith, MD, assistant dean at the Harvard School of Public Health and an expert in violence prevention.

The toll is especially high among young black and Hispanic males. A white female infant currently has a one-in-496 chance of being murdered; a black male infant has a one-in-27 chance of being murdered.

BEYOND LAW ENFORCEMENT

Traditionally, violence control and protection has been left to law enforcement agencies and the social and behavioral sciences. Health care professionals generally have seen their role as giving succor to the victims of violence, rather than preventing the violence itself. Prothrow-Stith notes that when she practiced emergency medicine the attitude was that it was "okay to stitch up the victims of violence and send them back out." In contrast, "in every other area of health care, we focus on prevention."

The health care community wasn't alone in its detachment. The public "easily dismissed [violence] as a problem of the poor and minorities, as 'other people's' problem," says Lawrence Green, MD, former HHS official and currently director of the Institute of Health Promotion Research at the University of British Columbia. Like HIV and drug abuse, it was easy for middle-class America to dismiss violence as a distant issue — until they began to feel its effects.

But increasingly as the emergency departments fill up, the health care community is saying it should do more to prevent violence. In January, the American Medical Assn. announced formation of the Physicians' Coalition Against Family Violence, a nationwide network of physicians who will share information on the diagnosis, treatment, and prevention of abuse. As part of that effort, on June 16, AMA released three practice guidelines on the identification and treatment of children who are physically or sexually abused in the home, as well as adult victims of domestic violence. Guidelines on elder abuse will be released in October.

The physical abuse of wives or girlfriends is a common occurrence, according to U.S. Surgeon General Antonia Novello, MD. In 1990 more than 800 women were killed by their husbands and an additional 400 women were killed by their boyfriends, she says. Violence is the leading cause of injury for women ages 15-44, and about 20 percent of all women victimized by husbands or ex-husbands report they have been injured repeatedly by the same person.

Despite the repetition of symptoms, a number of studies in the June 16 *Journal of the American Medical Association* show that physicians often fail to diagnose abuse. Physicians usually are not trained to recognize behavior associated with abuse, and are likely to believe that domestic violence is rare and should be resolved without outside intervention. According to one study, emergency department physicians identified one in 35 of their female patients as battered, although a review of the medical charts shows that one in four was likely to have been battered. The guidelines will help "frontline," primary care physicians recognize, treat, and prevent abuse, says AMA Vice Chairman Robert McAfee, MD. Copies can be obtained by calling 1-800-AMA-3211.

Public health officials say they also should play a leading role. In the public health arena, violence is defined as "intentional" injury, and classified as a subset of injury control.

HHS Secretary Louis Sullivan, MD, recently gave the U.S. Centers for Disease Control chief responsibility for achieving the Public Health Service's "Healthy People 2000" public health goals for reducing deaths from violence. Among other things, CDC Director William Roper, MD, has called for creation of a new National Center for Injury Prevention and Control. "Our biggest obstacle is how to heighten people's awareness that public health has something to offer [to violence prevention]," Roper says. "Once we're over that, the other obstacles won't be nearly as large."

"People look at violence and say it's a fact of life, but we say it's a problem that can be controlled," says Mark Rosenberg, MD, director of CDC's Division of Injury Epidemiology and Control, which is responsible for violence prevention as well as prevention of various accidental injuries.

He estimates that the approximately 27,000 suicides and 23,000 homicides that took place in the U.S. in 1990 cost the country \$60-\$70 billion in medical care and lost earning potential. "But because violence is accepted as a fact of life, you have the ironic situation that a major health problem is not understood as such," Rosenberg says.

"Violence is a learned behavior, just like smoking or using your seatbelt is a learned behavior," says Beverly Coleman-Miller, MD, president of the Washington DC-based BCM Group, a consulting group that initiates disease prevention strategies for inner cities. "The game here is to unlearn it. It's going to take a lot of serious effort, but [violence] can be prevented."

TV PROVIDES ROLE MODEL

Interpersonal violence has been around since Cain slew Abel. Health officials say they don't know why violence is so pervasive in the U.S., although they know a number of factors are linked to it, including

easy access to firearms, alcohol and substance abuse, drug trafficking, poverty, unemployment, racial discrimination, and in some situations, the cultural acceptance of violent behavior.

The experts believe that another significant factor is violence on television, especially when seen by young viewers. Infants as young as 14 months of age imitate behavior they see on TV, Brandon Centerwall, a Seattle WA-based psychiatrist wrote in the June 10 *JAMA*. Up through four years of age, many children are unable to distinguish fact from fantasy, Centerwall writes. Their first impressions are laid down in those years, and in moments of stress, adults are likely to revert to their earliest, most visceral memories of violence being depicted as exciting and powerful.

Given all the causes of violence, it is not surprising that many federal agencies, universities, and private nonprofit groups are studying it and setting up anti-violence programs. The Alcohol, Drug Abuse, and Mental Health Administration, for example, has a long history of researching which individuals are most at risk for violent behavior and developing appropriate interventions. Private foundations also play a big role: According to one estimate, foundations have funded about half of all existing community violence prevention programs.

BACK TO THE CLASSICS

Public health officials say it is time to apply classic public health techniques — including epidemiological research, surveillance, program development and evaluation, and national implementation of proven interventions — to violence. Such techniques eliminated diseases such as smallpox in the U.S., says Rosenberg. And similar methods have been used to lower the number of deaths that occur from car crashes, drug abuse, cigarette smoking, drowning, and lead poisoning.

To lower the number of fatalities from car crashes, for example, researchers isolated the factors that contributed to morbidity and mortality, such as alcohol use, unsafe car construction, lack of seat belts, and dangerous driving conditions. The public then was educated that it is not safe to drink and drive, that cars should be equipped with seat belts and air bags, and that speeds should be adjusted according to driving conditions. In the 1960s, 300,000 Americans died each year in motor vehicle accidents; today, for the same number of miles driven in the 60s, there are only 40,000 auto fatalities each year, Rosenberg says.

To try to achieve violence prevention goals, CDC is developing a National Plan for Injury Control that recommends that federal, state, and local governments, as well as private sector groups, address violence at the community level. The panel also recommended that firearm injuries be prevented. Rosenberg notes there is much controversy about the best way to do this; at least, he says, parents could be taught how to keep loaded firearms away from children.

CDC is in the final stages of developing a booklet called "The Prevention of Youth Violence: A Framework for Community Action." That booklet will be made available to communities that wish to address violence. CDC also is accepting grant applications for community anti-violence projects. The \$750,000 program, announced in the June 3 *Federal Register*, is an innovative approach because instead of just handing out grants, CDC plans to work with academic institutions, health departments, and community organizations to evaluate youth violence prevention programs, Rosenberg says.

"In the past, people tended to see [violence] as a subset of something else, as a subset of drugs or alcohol abuse, for instance," says Herbert Kleber, MD, director of the Division on Substance Abuse at Columbia University College of Physicians and Surgeons in New York City. "We figured if we did something about drugs or alcohol, we would be doing something about violence. But now people are recognizing that violence has to be looked at in its own light. Even if you wipe out drug abuse, you're not going to diminish violence. It's taken on a life of its own."

One of the biggest problems violence prevention experts face is that their subject traditionally has been split up among many disciplines. The police, teachers, doctors, nurses, and criminal justice, mental health, and social service experts who deal with violence tend not to interact on a regular basis, says

Stu Cohen, senior associate at the Newton MA-based Education Development Center (EDC). As a result, individuals who may benefit from a coordination of care, don't.

Another problem is that few community-wide programs have been funded, tested, and evaluated, Cohen says. Evaluation is a particularly difficult area because it requires following individuals for many years and coordinating information from social service agencies, police, doctors, and others. The riots in Los Angeles may have been "a great wake-up call for America," but many problems remain, Cohen says. "Rhetorically at least people are paying more attention [to violence prevention], but I don't know that it's filtered down to [establishment of new] programs or funding for programs."

In general, communities are taking three routes to violence prevention, says Susan Sorenson, associate director of the Southern California Injury Prevention Center, at the UCLA School of Public Health. Those routes are regulatory and legislative (such as allowing only a certain number of liquor licenses within a given geographic area); environmental (such as lighting playgrounds at night and using metal detectors in schools); and educational (including training in conflict resolution and awareness of the magnitude of the problem).

MIDNIGHT BASKETBALL

In Sept. 1991 the Washington DC-based Carnegie Council on Adolescent Development released an EDC survey of "state of the art" community-based violence prevention programs for young adolescents. The study found communities using a plethora of methods — education, counseling, therapy, trips, theater play, parent education, referral, and well-baby care — to try to achieve goals such as conflict resolution, gang formation prevention, and self-esteem development.

For example, the Centro de la Comunidad Unida/United Community Center in Milwaukee WI, provides that city's Latino community with court advocacy, job placement, counseling, and referrals to drug programs. One of the center's main goals is persuading youths not to join the gangs where they will likely kill and/or be killed. Gang prevention activities range from prevention talks by former gang members, to instruction for parents and teachers in recognizing gang hand signals, to field trips for at-risk youth to adult prisons for presentations by inmates.

The center is proud of its late-night basketball program, run Friday nights from 8 p.m. to midnight, when young people are most likely to be drinking or otherwise getting in trouble, says center Director Walter Sava. "Young people have a lot of energy. If it's not channeled in the right direction, it can go in the wrong one."

On Capitol Hill, Rep. Pat Schroeder (D-CO) is pushing a measure (H.R.3102) that would provide an additional \$2.5 million a year to a "midnight basketball league" program run by the U.S. Dept. of Housing and Urban Development. The program, based on a league established by the Chicago Housing Authority, provides unemployed male youths in housing projects with job training and adult role models, as well as night-time recreation. So far, none of the youths involved in the four-year-old Chicago program have been in trouble with the law, says a Schroeder aide. The bill currently is languishing in Congress as an amendment to the Violent Crime Prevention Act of 1991 (H.R.3371).

Violence experts have many views on what should be done to prevent mayhem, but they tend to agree on at least one point: that to be effective, violence prevention ultimately must address issues like poverty, unemployment, and racism. But they add that those huge problems should not be allowed to stymie the health care community's efforts. "We can start to go into homes and schools and change behavior before violence occurs," says Rosenberg. "The key to this is to empower the community." — CK.

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HEALTHCARE
INFORMATION
CENTER

H. THE PLAYERS IN WASHINGTON

Section H

THE PLAYERS IN WASHINGTON

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THE PLAYERS IN WASHINGTON

■ CONGRESS

HOUSE OF REPRESENTATIVES

House Committees

The key House legislative committees involved in health care are the Committee on Energy and Commerce and the Committee on Ways and Means.

The Energy and Commerce Committee shares jurisdiction over Medicare Part B with Ways and Means and has exclusive jurisdiction over Medicaid. It also has oversight responsibility for the U.S. Public Health Service and deals (though not exclusively) with insurance-related issues in the House.

The Ways and Means Committee has oversight of all tax laws. In health care, the Committee has exclusive jurisdiction over Medicare Part A (hospital services -- financed by the Hospital Insurance payroll tax) and shares jurisdiction over Medicare Part B (physicians and other services) with the Energy and Commerce Committee.

Another important committee is the Education and Labor Committee, which handles non-tax aspects of the Employee Retirement Income Security Act (ERISA), and such areas as workers' compensation, corporate alliances and other parts of reform to be enforced by the Department of Labor.

The House Appropriations Committee also plays an important role in health care, determining how much money most federal health programs will actually receive. Two big exceptions are Medicare and Medicaid--they are "entitlements," which means that funds are automatically provided to cover anyone meeting eligibility criteria.

Among the other committees that will be involved in specific parts of health reform legislation are Veterans' Affairs, Judiciary, and Post Office and Civil Service.

Committee on Energy and Commerce

John Dingell, Chair; Carlos J. Moorhead, Ranking Minority Member

Contact: Majority Staff--Donald Shriber, 225-2927;
Minority Staff--Howard Cohen or Mary McGrane, 225-3641

Subcommittee on Health and the Environment

Henry Waxman, Chair; Thomas J. Bliley, Jr., Ranking Minority Member

Contact: Majority Staff--Karen Nelson, 225-4952;
Minority Staff--Howard Cohen or Mary McGrane, 225-3641

Committee on Ways and Means

Dan Rostenkowski, Chair; Bill Archer, Ranking Minority Member

Contact: Majority Staff--Janice Mays, 225-3625;
Minority Staff--Phillip Moseley, 225-4021

Subcommittee on Health

Pete Stark, Chair; William M. Thomas, Ranking Minority Member

Contact: Majority Staff--David Abernethy, 225-7785;
Minority Staff--Robert Mercker, 225-4021

Committee on Education and Labor

William D. Ford, Chair; William F. Goodling, Ranking Minority Member

Contact: Majority Staff--Karen Vagley, 225-4527;
Minority Staff--Jay Egan, 225-6910

Subcommittee on Labor-Management Relations

Pat Williams, Chair; Marge Roukema, Ranking Minority Member

Contact: Majority Staff--Phyllis Borzi, 225-5768;
Minority Staff--Russ Mueller, 225-5494

Selected Additional House Members Active in Health Care Reform*

Jim Cooper (D-TN) Contact: Caroline Chambers, 225-6831.

Rep. Cooper is a member on the House Energy and Commerce Committee and chairs the Conservative Democratic Forum's Task Force on Health Care Reform. He introduced the Managed Competition Act of 1993, which uses strong tax incentives to encourage providers and insurance companies to form health partnerships which will be publicly accountable for costs and quality. This proposal has been endorsed by the Conservative Democratic Forum.

Richard Gephardt (D-MO) Contact: Andrea King, 225-0100.

Rep. Gephardt, the House Majority Leader, has been the Democratic leadership point person on health reform. He introduced the Health Care Cost Containment and Reform Act of 1992 with Congressman Pete Stark; it focused on cost-containment and small market reform.

* This is a partial list. Many House members have taken strong positions on health care reform.

Nancy Johnson (R-CT) Contact: Laura Phelps, 225-4476.

Rep. Johnson is a member of the Ways and Means Health Subcommittee. She has introduced legislation which would establish standards for health insurance carriers offering plans to small employers, and is a lead co-sponsor of Rep. Coopers managed competition bill.

Barbara Kennelly (D-CT) Contact: Dave Buonora, 225-2265.

Rep. Kennelly is a member of the Ways and Means Committee and has introduced legislation to expand Medicaid and regulate the small group market.

Jim McDermott (D-WA) Contact: Barbara Smith, 225-3106.

Rep. McDermott, a physician and member of the Ways and Means Committee, is the principal sponsor of the single payer bill sponsored in the 102nd Congress by Rep. Marty Russo, who was defeated for reelection.

SENATE

Senate Committees

Two key Senate committees have legislative jurisdiction over most health care issues: the Finance Committee and the Labor and Human Resources Committee.

The Finance Committee has oversight of Medicare (both Parts A and B) and Medicaid. Because the Committee deals with the federal tax code, it can use its tax policy jurisdiction to affect other health-related issues.

The Labor and Human Resources Committee oversees the Public Health Service programs, including the National Institutes of Health; Food and Drug Administration; Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Administration. The Committee also handles non-tax aspects of the Employee Retirement Income Security Act (ERISA).

As in the House, the Senate Appropriations Committee appropriates funds to government-sponsored health programs, with the exception of Medicare and Medicaid.

The task of the Senate Special Committee on Aging is to sensitize and educate members on key aging issues, and it has no legislative jurisdiction.

Among the other Senate Committees that will be involved in specific parts of the health reform legislative process are Veterans' Affairs, Judiciary, and Governmental Affairs.

Finance Committee

Daniel Patrick Moynihan, Chair; Bob Packwood, Ranking Minority Member
Contact: Majority Staff--Faye Drummond, 224-4515;
Minority Staff--Ed Mihalski, 224-5315

Subcommittee on Health for Families and the Uninsured

Don Riegle, Chair; John Chafee, Ranking Minority Member
Contact: Majority Staff--Debbie Chang 224-4822;
Minority Staff--Katherine Hayes, 224-2921

Subcommittee on Medicare and Long-Term Care

Jay Rockefeller, Chair; Dave Durenberger, Ranking Minority Member
Contact: Majority Staff--Mary Ella Payne, 224-6472;
Minority Staff--Susan Foote, 224-3244

Labor and Human Resources Committee

Edward M. Kennedy, Chair; Nancy Kassebaum, Ranking Minority Member
Contact: Majority Staff--David Nexon, 224-7675;
Minority Staff--Andrew Patzman, 224-6770

Appropriations Committee

Robert Byrd, Chair; Mark Hatfield, Ranking Minority Member
Contact: Majority Staff--Jim English, 224-7200;
Minority Staff--J. Keith Kennedy, 224-7335

Special Committee on Aging

David Pryor, Chair; William S. Cohen, Ranking Minority Member
Contact: Majority Staff--Theresa M. Forster, 224-5364;
Minority Staff--Mary Berry Gerwin, 224-1467

Selected Other Senate Members Active in Health Care*

Bob Kerrey (D-NE) Contact: Sheila Nix 224-6551.

Senator Kerrey, a former Presidential candidate who made national health insurance a major issue in his campaign, introduced the Health USA Act of 1991, which would replace the current private and public health systems with a state-administered, federally assisted program.

* This is a partial list. Many Senate members have taken strong positions on health care reform.

George J. Mitchell (D-ME) Contact: Christine Williams 224-5344.

Senator Mitchell, the Majority Leader and member of the Finance Committee, was the principal sponsor in 1992 of "Health America: Affordable Health Care for All Americans Act," which proposes an employment-based, play-or-pay plan and permits state all-payer systems.

Harris Wofford (D-PA) Contact: Darrel Jodrey 224-6324.

Senator Wofford won his 1991 senatorial race by pushing health care reform. With Senator Tom Daschle, he introduced in 1992 the American Health Security Plan, a single-payer plan.

John Breaux (D-LA) Contact: Laird Burnett, 224-4623.

Senator Breaux, a Finance Committee member, is the principal Senate sponsor of the Managed Competition Act of 1993, the proposal developed largely by the Conservative Democratic Forum.

CONGRESSIONAL TASK FORCES/CAUCUSES/COALITIONS

Senate Republican Health Care Task Force John Chafee, Chair.

Contact: Katherine Hayes 224-2921

Senate Rural Health Caucus

Tom Harkin (D-IA) and Bob Dole (R-KS), Co-chairs.

Contact: Peter Reinecke with Sen. Harkin, 224-3254;
Sheila Burke with Sen. Dole, 224-3135.

House Rural Health Coalition

Charles Stenholm (D-TX) and Pat Roberts (R-KS), Co-Chairs.

Contact: Colleen Kepner with Rep. Stenholm, 225-6605;
Heidi Hixson with Rep. Roberts, 225-2715.

This bipartisan coalition is comprised of 175 Members interested in access to quality care in rural America.

Congressional Caucus on Women

Pat Schroeder (D-CO) and Olympia Snowe (R-ME), Co-Chairs.

Contact: Lesley Primmer 225-6740

Conservative Democratic Forum

Jim Cooper, Chair (D-TN), 225-6831.

The Forum is comprised of approximately 60 conservative and moderate Democrats. In September 1992, several CDF members--Jim Cooper (D-TN), Mike Andrews (D-TX) and Charles Stenholm (D-TX)--introduced legislation to encourage providers and insurance companies to form "Accountable Health Partnerships" (AHPs). This plan was endorsed in September 1992 by the Forum. Rep. Cooper and others introduced a revised version in October 1993.

CONGRESSIONAL AGENCIES

Congressional Budget Office, U.S. Congress, Washington, DC 20515

Robert D. Reischauer, Director

Sandra Christensen, Senior Analyst-Health

202-226-2700

202-225-7509 (FAX)

The Congressional Budget Office was established in 1974 to help the House and Senate Budget Committees prepare the congressional budget and to provide technical assistance to other committees. This office is Congress's principal resource for analyzing budget, tax and spending proposals.

Congressional Research Service

LM-320

The Library of Congress

Washington, DC 20540

202-707-5863

202-707-7338 (FAX)

Contact:

Janet Kline, Section Head

Division of Education and Public Welfare

The Congressional Research Service is a non-partisan agency that provides informational support to Congressional members throughout all aspects of lawmaking.

General Accounting Office

NGB--Suite 500

441 6th Street NW

Washington D.C. 20548

202-512-6806

202-336-6642 (FAX)

Contact:

Janet Shikles, Assistant Controller

General for Human Resources Programs

The General Accounting Office is the investigative arm of Congress. Its primary role is to evaluate and assure that funds are administered properly by the Administration.

Office of Technology Assessment

U.S. Congress
Washington, DC 20510
202-228-6500
202-228-6218 (FAX)

Contact: Roger C. Herdman
Acting Director

The Office of Technology Assessment, a congressional support agency, examines the effectiveness and efficiency of technical proposals.

■ **EXECUTIVE BRANCH**

WHITE HOUSE

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160 Old Executive Office Building
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This quick-reaction "delivery room" will coordinate all communications, press inquiries, and interviews and speaking requests throughout the administration.)

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These officials in the Office of Public Liaison coordinate all contacts on health reform with all non-governmental groups.

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The Office of Management of Budget examines costs of new and old programs and makes recommendations to the President. OMB has gained in influence in recent administrations and plays a large role in the health care policy debate.

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404-639-2657 (FAX)

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2101 East Jefferson Street, Suite 600
Rockville, MD 20852
301-594-6662
301-594-2168 (FAX)

■ HEALTH CARE INDUSTRY

PHYSICIAN GROUPS

American Academy of Family Physicians
Washington Office
2021 Massachusetts Ave. NW
Washington, DC 20036
202-232-9033
202-232-9044 (FAX)

Contact: Charles Huntington, Director of Washington Office

AAFP, which represents 71,000 family practitioners and students, released The Family Physician's Access Plan: A Proposal by the American Academy of Family Physicians in April 1992. This plan supports an employer mandate on large businesses and a "play-or-pay" option for small businesses. It is a member of the Health Care Reform Project.

American Academy of Pediatrics
601 13th St. NW
Suite 400 N
Washington, DC 20004
202-347-8600
202-393-6137 (FAX)

Contact: Jackie Noyes, Director, Department of Government Liaison

The Academy released and published in the New England Journal of Medicine "A Proposal to Provide Health Insurance to All Children and All Pregnant Women" (1990; 323:1216-1220). The Academy's plan emphasizes preventive care and universal access for children through employer mandates and state-funded insurance systems. It is a member of the Health Care Reform Project.

American College of Physicians
700 13th Street NW Suite 250
Washington, DC 20005
202-393-1650
800-633-9400
202-783-1347 (FAX)

Contact: Howard B. Shapiro, Director of Public Policy

The American College of Physicians, representing 77,000 internists, released a proposal in September 1992 which would place a national cap on health care spending to finance a new program that would assure basic benefits to all Americans. It is a member of the Health Care Reform Project.

American Medical Association
1101 Vermont Ave. NW
Washington, DC 20005
202-789-7400
202-789-7485 (FAX)

Contacts: James Stacey, Director, Media and Information
Brenda Craine, Assistant Director, Media and Information

The American Medical Association, a professional society of 300,000 physicians, is promoting Health Access America, a health reform plan which calls for universal health care coverage through a private/public partnership. The plan would, among other things, require employers to insure employees and their families, provide tax incentives to small employers, expand Medicaid to cover everyone below poverty level, and create state risk pools to make private coverage available to small businesses and those who remain uninsured.

American Society of Internal Medicine
2011 Pennsylvania Ave. NW, Suite 800
Washington, DC 20006
202-835-2746 ext. 281
202-835-0441 (FAX)

Contacts: Alan R. Nelson, M.D., Executive Vice President
Alex Gramling, Public Relations Director

Representing the nation's largest physician specialty, the American Society of Internal Medicine is made up of 26,000 member physicians in 50 states and the District of Columbia. In 1990, ASIM became the first major medical specialty society to release a detailed proposal for comprehensive health care reform. ASIM's reform blueprint calls for a pluralistic health care system that would ensure the availability of quality, affordable health care for all Americans. Other issues of importance to ASIM include the enhancement of primary care; reducing Medicare red tape; and the preservation of choice of physician in a reformed health system.

Physicians for a National Health Program
c/o Center for National Health Program Studies
Cambridge Hospital-Harvard Medical School
1493 Cambridge Street
Cambridge, MA 02139
617-498-1032
617-498-1671 (FAX)

Contact: David Himmelstein, M.D., Co-Director, CNHPS; Board, PNHP

The Physicians for National Health Programs, a membership organization representing over 5,500 physicians, advocates a single payer plan, modeled after the Canadian system.

HEALTH CARE FACILITIES ORGANIZATIONS

American Association of Homes for the Aging
901 E Street NW Suite 500
Washington, DC 20004-2037
202-783-2242
202-783-2255 (FAX)

Contact: Sheldon Goldberg, President

AAHA represents nearly 3,400 non-profit long-term care facilities including nursing homes, retirement communities, housing facilities, and community service agencies serving the elderly.

American Health Care Association
1201 L Street NW
Washington, DC 20005
202-898-2800
202-842-3860 (FAX)

Contacts: Linda Keegan, Vice President of Public Relations
Angela Thimis, Director of Public Relations
Claudia Askew, Director of Media Relations

The American Health Care Association is the largest nursing home association, representing about 11,000 voluntary, for-profit, voluntary single-owner, and multi-facility nursing home chains. The organization is working to add long-term care services to current health care reform proposals.

American Hospital Association
Capitol Place, Building #3
50 F Street NW Suite 1100
Washington, DC 20001
202-626-2322
202-626-2345 (FAX)

Contacts: Richard Pollack, Executive VP, Federal Relations
Richard H. Wade, Senior VP, Communications

In 1992 AHA, representing 5,400 hospitals, released Public Policy Priority Summary, which calls for universal coverage of basic health services through employer sponsored programs, and a consolidated public program to cover those without employer-sponsored or individual plans.

The Catholic Health Association of the United States (CHA)
1776 K Street, NW, Suite 204
Washington, DC 20006
202-296-3993
202-296-3997 (FAX)

Contact: Jack Bresch, Washington Office

The Catholic Health Association of the United States (CHA) represents more than 1,200 health care institutions and organizations. CHA members constitute the nation's largest group of not-for-profit health care institutions under a single sponsor. The Association's reform proposal, Setting Relationships Right: A Proposal for Healthcare Reform, is anchored in a core set of values, calls for delivery system reform, and defines a new role for government. Key features of the plan include a specified financing mechanism, explicit expenditure controls, and a consolidation of public programs under a new health care trust fund. CHA is a member of the Health Care Reform Project.

Federation of American Health Systems
1111 19th Street NW #402
Washington, DC 20036
202-833-3090
202-861-0063 (FAX)

Contact: Michael Bromberg, Executive Director

The Federation of American Health Systems, an association representing 1,480 proprietary hospitals, is supporting health insurance reforms similar to those sponsored by Representative Cooper (D-TN), Senator Breaux (D-LA) and Senator Chafee (R-RI). FAHS opposes global budgets.

National Association of Community Health Centers
1330 New Hampshire Avenue, N.W., Suite 122
Washington, DC 20036
202-659-8008
202-659-8519 (FAX)

Contacts: Thomas Van Coverden, Executive Director
Tara Newman, Data Base Administrator

Founded in 1970, the National Association of Community Health Centers, Inc. (NACHC) is a national membership organization which advocates on behalf of community-oriented primary health care programs and the millions of medically underserved and uninsured people they serve.

OTHER PROFESSIONAL GROUPS

American Nurses Association
600 Maryland Ave. SW Suite 100
Washington, DC 20024
202-554-4444 x300
202-554-2262 (FAX)

Contact: Judith Huntington, Director of Field Services, Labor and Workplace Advocacy

ANA, along with 66 other nursing and health care organizations, released Nursing's Agenda for Health Care Reform in April 1991. This proposal advocates universal access to care through an employer-mandate system with special emphasis on preventive care, alternative providers, and community-based settings for care. ANA supports external cost controls. It is a member of the Health Care Reform Project.

National Association for Home Care
519 C Street NE
Stanton Park
Washington, DC 20002
202-547-7424
202-547-3540 (FAX)

Contacts: Val J. Halamandaris, President
Chris Laxton, Vice President for Communications

The National Association for Home Care works with various organizations and lawmakers to bring health care home, where it belongs, and to assure that home care services are part of any health care reform package. It has also helped to organize "HealthRIGHT," a project which demonstrates that comprehensive health and long-term care coverage is a right for all Americans.

National Association of Social Workers
750 First Street NE Suite 700
Washington, DC 20002
202-408-8600
202-336-8311 (FAX)

Contact: Susan Hoechstetter, Director, Government Relations

National Association of Social Workers, representing 145,000 members, proposed a national health insurance plan in 1991 which calls for a federally administered, single payer system, with states ensuring the delivery of services according to federal standards and guidelines. This plan was introduced by Senator Daniel Inouye as the National Health Care Act of 1992, and reintroduced in 1993. The National Association of Social Workers is a member of the Health Care Reform Project.

INSURANCE INDUSTRY

American Council on Life Insurance
1001 Pennsylvania Ave. NW
Washington, DC 20004
202-624-2000
202-624-2319 (FAX)

Contact: Richard Schweiker, President

Blue Cross and Blue Shield Association
655 15th Street NW Suite 350
Washington, DC 20005
202-626-4810
202-626-8654 (FAX)

Contact: Pam Kelch, Senior Consultant, Media Relations

The Blue Cross and Blue Shield Association has proposed the Community Partnerships for a Healthy America. This proposal advocates an employer-mandate approach to reform with a creation of "Community Care Partnerships" to control costs. The proposal also supports insurance reform, requiring insurance companies and self-funded entities to be licensed as Accountable Health Plans. Blue Cross and Blue Shield Association is comprised of 69 independently operated Blue Cross and Blue Shield insurance companies located nationwide.

Group Health Association of America, Inc.
1129 Twentieth Street NW #600
Washington, DC 20036
202-778-3200
202-331-7487 (FAX)

Contact: Diana Jost, Vice President, Government Affairs

The Group Health Association of America, which represents 323 HMOs nationwide, has not endorsed a specific health care reform plan. The group supports an approach that includes small market reform and is working with various groups and lawmakers to assure that the role of HMOs/managed care is clearly defined and encouraged in their proposals.

Health Insurance Association of America
1025 Connecticut Ave. NW
Washington, DC 20046
202-223-7780
202-223-7897 (FAX)

Contacts: Willis Gradison, President
Judy Finney, Director of Communications
Richard Coorsh, Associate Director, Communications
Barbara Gracey, Media Relations

HIAA is the nation's trade association for the commercial health insurance industry. Its 270 members are large, medium, and small health carriers, although some of the very largest of the nation's carriers -- Aetna, CIGNA, Metropolitan, and Travelers -- have dropped out of the association. In 1991, HIAA put forward a reform proposal consisting of model legislation for small-group market reform in the states and a call for expanded funding of Medicaid. In December 1992, it put forth a call for greater federal oversight, including an individual mandate to require every American to purchase coverage, support for a package of essential benefits to which all U.S. citizens should be entitled. In February of 1993, having installed respected former Representative Bill Gradison as president, HIAA endorsed requiring employers to help pay for the cost of an essential benefit package for workers and dependents.

Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
703-836-6200
703-836-6550 (FAX)

Contacts: Greg Scandlen, Executive Director
Jack Strayer III, Director of Federal Affairs

Representing 28 small insurance companies so far, the newly formed group serves as the voice for small insurance companies that oppose government mandates. The Council has introduced its own eight-point health reform plan, which advocates employer-backed Medical Savings Accounts (MSAs), among other changes. (See MSA discussion in "Incremental Reforms," REFORM OPTIONS section.)

OTHER PROVIDER GROUPS

Pharmaceutical Manufacturers Association
1100 15th Street NW
Washington, DC 20005
202-835-3469
202-835-3429 (FAX)

Contact: Jeff Trewhitt, Director of Media Services

PMA, representing over 100 research-based pharmaceutical companies, is supporting small-group market reform, and expansion and improvement of Medicare and Medicaid services.

Health Industry Manufacturers Association
1200 G Street NW Suite 400
Washington, DC 20005
202-434-7242
202-783-8750 (FAX)

Contact: Holly Glass, Associate Vice President, Public Affairs

HIMA represents over 300 manufacturers of medical devices, diagnostics and health care information systems, and is supporting a market-based approach to reform that will build and improve upon the current system.

■ HEALTH CARE CONSUMER GROUPS

Alzheimer's Association
Washington Office
1319 F St. NW, Suite 710
Washington, DC 20004
202-393-7737
202-393-2109 (FAX)

Contacts: Stephen McConnell, Senior Vice President, Public Policy Division
Judith Riggs, Director, Federal Issues

The Alzheimer's Association includes over 210 local chapters, 1,600 support groups and 35,000 volunteers. Its mission is to support families who are dealing with Alzheimer's disease and related disorders and to search for medical answers. The Association is advocating a comprehensive, federal long-term care program and is a lead partner in the 137-organization Long Term Care Campaign.

American Association of Retired Persons
601 E Street NW
Washington, DC 20049
202-434-2560
202-434-6499 (FAX)

Contacts: Peter Ashkenaz, Media Liaison
Christine Kirby, Assistant Media Liaison

The American Association of Retired Persons, representing 33 million individuals age 50 and over, recently drafted a health care reform plan that calls for universal health and long-term care access for all Americans through an employer-mandate plan accompanied by strict cost controls. This plan was approved by the AARP board of directors, and the group is conducting a massive member education project about the plan and the issue. AARP Director John Rother is the President of the Health Care Reform Project.

Children's Defense Fund
25 E Street NW
Washington, DC 20001
202-662-3549
202-662-3550 (FAX)

Contact: Carol Regan, Director of Health Division

The Children's Defense Fund, an advocacy organization, has not introduced a health care plan of its own, but as a long-term goal the group is supporting comprehensive proposals that will assure universal health care to children and pregnant women. Within the boundaries of the current health care debate, the group is supporting public/private sector initiatives, such as an employer-mandate plan.

Citizen Action
1120 19th Street NW, Suite 630
Washington, DC 20036
202-775-1580
202-296-4054 (FAX)

Contact: Cathy Hurwit, Legislative Director

Citizen Action is a non-partisan consumer advocacy group that conducts seminars and writes reports on various consumer related issues, including health care reform. It favors a single-payer reform plan, and is a member of the Health Care Reform Project.

Consumers Union
1666 Connecticut Avenue NW, Suite 310
Washington, DC 20009
202-462-6262
202-265-9548 (FAX)

Contacts: Gail Shearer, Manager of Policy Analysis
Linda Lipsen, Legislative Director

Consumers Union is a non-profit membership organization that provides information and counsel on consumer goods and services, and management of the family income. The group has released several studies on the value of health and long-term care insurance policies. They have editorialized in Consumer Reports in support of a single-payer reform plan and a Medicare-like long-term care plan.

Families USA
1334 G Street NW
Washington, DC 20005
202-737-6340
202-347-2417 (FAX)

Contacts: Arnold Bennett, Media Director
Aviva Shlensky, Deputy Media Director

Families USA advocates comprehensive health and long-term care reforms for American families. Affiliated with the Families USA Foundation (formerly the Villers Foundation), the group has a special interest in low-income Americans, especially the elderly poor. It is a member of the Health Care Reform Project.

March of Dimes Birth Defects Foundation
National Government Affairs Office
1901 I Street NW, Suite 260
Washington, DC 20036
202-659-1800
202-296-2964 (FAX)

Contact: Vivian Gabor, Senior Associate for Federal Affairs

The mission of the March of Dimes Birth Defects Foundation is to improve the health of babies by preventing birth defects and infant mortality. The March of Dimes carries out its mission through the Campaign for Healthier Babies, which funds programs of research, community services, education and advocacy.

National Council of Senior Citizens
1331 F Street NW
Washington, DC 20004
202-347-8800
202-624-9595 (FAX)

Contacts: Bette Cooper, Communications Office
Dan Schulder, Director of Legislation

NCSC is an activist senior organization with a strong base of union retiree members, among others. It favors a single-payer health plan.

National Health Policy Council
1601 NW 114th Street, Suite 130
Des Moines, IA 50325
515-222-7270
515-222-7257 (FAX)

Contacts: Stephen C. Gleason, Chair
Liz Shannahan, Director

The National Health Policy Council (NHPC) was founded in 1987 as a non-partisan, not-for-profit educational foundation. Dedicated to educating Americans about the need for health care reform, the Council has sponsored dozens of national events educating providers and consumers on health care reform -- and developing consensus among traditionally divergent groups. These include town meetings with national and state focus, presidential candidate debates and national conferences. Through these efforts, the Council has involved thousands of providers, consumers, business and union leaders, government officials and others in the health care reform debate.

People's Medical Society
462 Walnut Street
Allentown, PA 18102
215-770-1670
215-770-0607 (FAX)

Contact: Charles B. Inlander, President

The People's Medical Society is America's largest consumer health advocacy organization with over 85,000 members. Founded in 1983, the organization conducts studies, issues reports, and publishes numerous books in consumer health advocacy.

Public Citizen Health Research Group
2000 P Street NW
Washington, DC 20036
202-833-3000

Contact: Dr. Sidney Wolfe, M.D., Director

The Public Citizen Health Research Group, founded by Sidney Wolfe and Ralph Nader, has conducted studies spotlighting some of the major shortcomings of the health care system, including unsafe drugs, foods, medical devices and workplaces.

■ EMPLOYERS AND UNIONS

LABOR AND RELATED GROUPS

AFL-CIO

815 16th Street NW
Washington, DC 20006
202-637-5000
202-637-5058 (FAX)

Contacts: Lane Kirkland, President
Gerald M. Shea, Director for Employee Benefits
Colleen O'Neill, press contact

The AFL-CIO has long championed national health care reform. The Federation strongly supports President Clinton's reform proposal, as announced to Congress on September 22, 1993.

Service Employees International Union

1313 L Street NW
Washington, DC 20005
202-898-3200
202-898-3304 (FAX)

Contacts: John Sweeney, International President
Peggy Connerton, Director of Public Policy

SEIU is the fourth-largest and fastest growing affiliate of the AFL-CIO, with a current membership of over one million. SEIU's membership includes 400,000 nurses, medical technicians, doctors and hospital and nursing home service workers, making it the largest union of health care workers in North America. SEIU supports comprehensive, national reform of the US health care system that will guarantee health coverage to all, provide for comprehensive control of health spending and increase the quality of health services. Its President, John Sweeney, chairs the AFL-CIO health committee. SEIU is a member of the Health Care Reform Project.

American Federation of State, County and Municipal Employees

1625 L Street NW
Washington, DC 20036
202-452-4800
202-429-1293 (FAX)

Contacts: Robert E. McGarrah, Jr., Director of Public Policy
Bob Harman, Director of Public Affairs

AFSCME's 1.2 million members include about 300,000 public and private health service workers, and it has been a vocal advocate of a single-payer reform plan. It is a member of the Health Care Reform Project.

United Auto Workers
1757 N Street NW
Washington, DC 20036
202-828-8500
202-293-3457 (FAX)

Contact: Alan Reuther, Legislative Director

The United Auto Workers, an international labor union representing 1.4 million active and retired members, advocates plans that would ensure universal access and cost containment, and address retiree health insurance liability. The UAW has endorsed President Clinton's health care plan.

National Association of Retired Federal Employees
1533 New Hampshire Ave. NW
Washington, DC 20036
202-234-0832
202-797-9698 (FAX)

Contact: Judith Park, Legislative Director

NARFE believes that any national health care policy should include: long-term care and universal coverage for all Americans; affordable and accessible quality benefits; portability; cost containment measures on medical malpractice suits, doctor and hospital costs, laboratory and prescription drug costs; the elimination of administrative waste and complexity; and a greater emphasis on health promotion, wellness and disease prevention. In addition, NARFE has joined with other senior organizations in requiring that long-term care must be addressed in any national health care reform plan that NARFE supports. Moreover, the fate of The Federal Employees Health Benefits Program (FEHBP), and the 10 million employees, retirees and family members covered by it are of great concern to NARFE.

BUSINESS GROUPS

Washington Business Roundtable
1615 L Street NW, Suite 1100
Washington, DC 20036
202-872-1260
202-466-3509 (FAX)

Contact: Samuel Maury, Executive Director

The Business Roundtable, comprised of over 200 Fortune 500 CEOs, supports a voluntary employer-based system that would allow employers to maintain their role as purchasers and managers.

National Federation of Independent Business, Inc.
600 Maryland Ave. SW, Suite 700
Washington, DC 20024
202-554-9000
202-554-0496 (FAX)

Contact: Leslie Aubin, Health Care Policy Analyst

The National Federation of Independent Business, representing over 550,000 small businesses, supports market approaches to health care reform. In its efforts, the Federation helped create, and now houses, the Health Care Equity Action League (HEAL. See "Coalitions" title).

Chamber of Commerce of the United States
1615 H Street NW
Washington, DC 20062
202-659-6000
202-463-5836 (FAX)

Contacts: Kristen Bass, Manager, Human Resources Policy
Lisa Sprague, Manager, Employee Benefit Policy

The Chamber of Commerce has some 215,000 members, 96 percent of which are businesses with fewer than 100 workers. In 1991, the Chamber of Commerce proposed a plan that would expand Medicaid, promote expanded voluntary coverage through the workplace, and promote the development of national medical practice standards to assure appropriate and effective care. In March 1993, the Chamber announced that it supported achieving universal coverage through the shared responsibility of employers, individuals, and government, who all would be obliged to contribute toward health insurance costs. The Chamber still will oppose any mandate that does not include adequate subsidies for low-wage workers and their employers.

National Association of Manufacturers
1331 Pennsylvania Ave. NW
Suite 1500 - North Lobby
Washington, DC 20004
202-637-3124
202-637-3182 (FAX)

Contact: Sharon Canner, Assistant Vice President and Director of Employee Benefits

The Board of Directors of the National Association of Manufacturers, representing 12,000 businesses, approved a resolution in February 1993 stating that the NAM would be flexible in reviewing reform proposals, and would judge the proposal in its entirety and not reject it because of individual provisions it might have opposed in the past. NAM's key objective is to eliminate cost-shifting and reduce the rate of health care inflation. The Clinton proposal has many important positives for manufacturers as well as negatives. NAM is working with the administration and Congress to fashion a reform plan that can win bi-partisan support.

Washington Business Group on Health
777 North Capitol Street NE
Washington, DC 20002
202-408-9320
202-408-9332 (FAX)

Contact: Stephanie L. Poe, Director of Communications

This organization, founded in 1974, is one of the first business groups formed specifically to examine health care issues. The group includes 200 Fortune 500 and public employer members and supports the development of competing organized systems of care.

National Small Business United
1155 15th Street, NW, Suite 710
Washington, DC 20005
202-293-8830
202-872-8543 (FAX)

Contacts: John Paul Galles, Executive Vice President
Todd McCracken, Legislative Affairs

National Small Business United, which represents more than 65,000 small businesses, presented a comprehensive health care reform proposal in 1991. NSBU endorses a "managed competition" framework, which includes the forming of private, competing Health Insurance Purchasing Cooperatives, the development of a federal basic package of benefits and federal assistance to help individuals afford health care expenditures. NSBU's plan aims to provide universal access alongside a program of strong cost containment. NSBU is able to provide small business owners from many areas of the country, who can address policy concerns as well as personal experiences with health care issues. Contact Marcia Bradford or Diana Schnittka for more information.

Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154
708-531-9600

1050 17th Street, NW Suite 700
Washington, DC 20036
202-296-2920
202-223-9771 (FAX)

Contact: Wendy Herr, Group Executive, Policy Services Group (DC)

HFMA offers to help reporters with issues that include healthcare reform, administrative simplification/electronic data processing, Medicare payment, and financial reporting by healthcare organizations. HFMA, representing more than 31,000 individuals concerned with financial management of hospitals and other organizations, has introduced a framework to guide development of the final healthcare reform plan; and, has developed legislative language for administrative simplification.

■ COALITIONS

Alliance for Aging Research
2021 K Street NW, Suite 305
Washington, DC 20006
202-293-2856
202-785-8574 (FAX)

Contact: Dan Perry, Executive Director

Founded in 1986, the Alliance is a non-profit, public interest advocacy organization that promotes greater investment in scientific and medical research, and new technologies to improve the health and independence of older Americans.

Health Care Equity Action League
600 Maryland Ave. SW
Suite 700
Washington, DC 20024
202-872-0885
202-285-0586 (FAX)

Contacts: Alan Kranowitz, Senior Vice President of Government Relations (NAWD)
Leslie Aubin, Health Care Policy Analyst (NFIB)

HEAL was formed and is led by the National Association of Wholesaler-Distributors (NAWD) and the National Federation of Independent Business Inc. (NFIB), but numbers several providers and provider organizations among its 600 members. HEAL opposes any government-mandated health care plan.

Health Care for America
418 C Street, NE
Washington, DC 20036
202-546-3507
202-429-9574 (FAX)

Contact: Phillip Johnston, Chairman

Health Care for America, founded in 1991, is working to mobilize a grass-roots campaign in support of a universal health care system.

Health Care Reform Project
2550 M Street, N.W., Suite 250
Washington, D.C. 20037
202-296-2777
202-296-4501 (FAX)

Contact: Charlie Leonard

The Health Care Reform Project is a nonpartisan coalition representing more than 50 million consumers, business, labor and health care providers whose members are aggressively using lobbying, grass-roots, advertising and media relations to advocate comprehensive reform of the U.S. health care system through the passage of national legislation. Project members include the AFL-CIO, American Airlines, AARP, League of Women Voters, American Nurses Association, American College of Physicians, and Citizen Action.

National Leadership Coalition for Health Care Reform
555 13th Street NW
Washington, DC 20004
202-637-6830
202-637-5910 (FAX)

Contacts: Henry E. Simmons, M.D., President
Margaret Rhoades, Executive Director

This coalition is comprised of 49 corporations (most in the Fortune 500), three business groups, seven unions, seven health care provider groups, and five consumer advocacy groups. Growing out of the National Leadership Commission on Health Care, this coalition was formed in 1990 with former Presidents Carter and Ford as honorary co-chairmen. The coalition has put forward a "play-or-pay" style employer-mandate reform blueprint embracing many elements of managed competition.

National Long-Term Care Campaign
P.O. Box 27394
Washington, DC 20038
202-434-3744
202-434-6477 (FAX)

Contact: Deborah Briceland-Betts, National Campaign Director

The Long Term Care Campaign is a coalition of 137 national organizations dedicated to enacting comprehensive national long term care legislation. The Campaign, which is principally sponsored by AARP and the Alzheimer's Association, works with about 40 state-level coalition to achieve its goals.

Save Our Security Coalition
1331 F Street NW
Washington, DC 20004
202-624-9557
202-624-9595 (FAX)

Contacts: Arthur S. Flemming, Chair
Roberta Havel, Executive Director

Save Our Security Coalition brings together consumer and labor organizations to promote social insurance to protect health and income security for all Americans.

Healthcare Leadership Council
1500 K Street NW, Suite 360
Washington, DC 20005
202-347-5731
202-347-5836 (FAX)

Contacts: Pam Bailey, President
Claire del Real, communications

This health industry group is made up of chief executive officers from the hospital, insurance and pharmaceutical companies, medical products manufacturers and health service corporations, as well as some physician leaders. It has endorsed a managed competition reform plan similar to that of the Jackson Hole Group (See "Managed Competition" subsection in REFORM OPTIONS), except it would not mandate employer contributions to coverage.

■ FEDERAL COMMISSIONS AND AGENCIES

Physician Payment Review Commission
2120 L Street NW, Suite 510
Washington, DC 20037
202-653-7220
202-653-7238 (FAX)

Contacts: Paul Ginsburg, Executive Director
John M. Eisenberg, Chairman

PPRC provides Congress independent advice on policies concerning medical care payments to physicians. This Commission was active in the development and implementation of the Relative Value Scale (RVS) method of physician payment under Medicare, which was adopted in January 1991. (See discussion of RVS in introduction to HEALTH PROFESSIONALS section.)

Prospective Payment Assessment Commission
300 7th Street SW
Washington, DC 20024
202-401-8986
202-401-8739 (FAX)

Contacts: Stuart H. Altman, Chairman
Donald A. Young, Executive Director

ProPAC advises Congress and the Department of HHS on policy changes that affect the Medicare Prospective Payment System for hospitals, and conducts studies to help Congress set PPS annual payment policies.

■ THINK TANKS AND ACADEMIC CENTERS

The Brookings Institution
1775 Massachusetts Ave. NW
Washington, DC 20036
202-797-6000
202-797-6003 (FAX)

Contacts: Henry Aaron
Program Director

Joshua M. Wiener
Senior Fellow

Center for Health Policy Studies
Georgetown University
2233 Wisconsin Ave. NW
Suite 525
Washington, DC 20007
202-342-0107
202-625-6685 (FAX)

Contacts: William Scanlon
Jack Hadley
Co-Directors

Center for Health Policy Research
George Washington University
2021 K Street NW Suite 800
Washington, DC 20052
202-296-6922
202-785-0114 (FAX)

Contact: Peter Budetti
Director

Employee Benefit Research Institute
2121 K Street NW Suite 600
Washington, DC 20037
202-659-0670
202-775-6312 (FAX)

Contact: Dallas Salisbury
President

The Heritage Foundation
214 Massachusetts Ave. NE
Washington, DC 20002
202-546-4400
202-544-2260 (FAX)

Contact: Stuart Butler, Director
Domestic Policy Studies

National Health Policy Forum
George Washington University
2021 K Street NW
Suite 800
Washington, DC 20052
202-872-1390
202-785-0114 (FAX)

Contact: Judith M. Jones
Director

Urban Institute
2100 M Street NW
Washington, DC 20037
202-857-8666
202-331-9747 (FAX)

Contacts: John F. Holahan
Director, Health Policy Center

Marilyn Moon
Senior Research Associate

Center on Budget and Policy Priorities
777 North Capitol Street NE
Suite 705
Washington, DC 20002
202-408-1080
202-408-1056 (FAX)

Contact: Robert Greenstein
Executive Director

The Center on Budget and Policy Priorities analyzes public policies that affect low and moderate income Americans.

Center for Policy Alternatives
1875 Connecticut Ave. NW Suite 710
Washington, DC 20009
202-387-6030
202-387-8529 (FAX)

Contact: Linda Tarr-Whelan
President/Executive Director

The Center mainly focuses on state issues. Through their women's economic justice project, issues such as reproductive outcomes, preventive care and abortion are addressed. The Center recently conducted a comprehensive poll, with the Ms. Foundation, on women's views on economic problems.

Health Security Action Council
1757 N Street NW
Washington, DC 20036
202-223-9685
202-293-3457 (FAX)

Contacts: Douglas A. Fraser
Chair

Denise Holms
Executive Director

The Committee has developed the "Health Security Partnership," a national health reform proposal that advocates universal access with state administration. Members are primarily labor and consumer groups.

■ ACADEMICS AND OTHER EXPERTS:

Drew Altman, President, Henry J. Kaiser Family Foundation	415-854-9400
Larry Atkins, Director of Employee Benefits Policy, Winthrop, Stimson, Putnam & Roberts	202-775-9818
Robert Blendon, Professor, Harvard University	617-432-4502
Lawrence Brown, Professor, Columbia University	212-305-3925
Deborah Chollet, Professor, Georgia State University	404-651-3397
Alan Cohen, Professor, Brandeis University	617-736-3806
Richard Curtis, President, Institute for Health Policy Solutions	202-857-0810
Karen Davis, Senior Vice President, Commonwealth Fund	212-535-0400
John Dunlop, Professor, Harvard University	617-495-4157
Paul M. Ellwood, Jr., President, Jackson Hole Group	307-739-1176
Alain Enthoven, Professor, Stanford University	415-723-0641
Lynn Etheredge, Consultant, Bethesda, MD	301-654-4185
Bruce Fried, The Wexler Group	202-638-2121
Robert Friedland, National Academy of Social Insurance	202-452-8097
Eli Ginzberg, Professor, Columbia University	212-854-3410
Robert J. Haggerty, M.D., University of Rochester Medical Center	716-275-0225
David Helms, President, Alpha Center	202-296-1818
William C. Hsiao, Professor, Harvard University	617-496-8820
Robert Kane, Professor, University of Minnesota	612-624-1185
Rosalie Kane, Professor, University of Minnesota	612-624-3198
C. Everett Koop, Former Surgeon General	301-493-6603
Robert Laszewski, Principal, Health Policy and Strategy Associates	202-862-6380
Harold S. Luft, Professor, University of California, San Francisco	415-476-5147
Walter Maher, Director of Federal Affairs, Chrysler Corp.	202-862-5431
Theodore Marmor, Professor, Yale University	203-432-3238
David Mechanic, Director, Institute for Health, Health Care Policy and Aging Research, New Brunswick, New Jersey	908-932-8415
Jack Meyer, President, New Directions for Policy	202-289-3907
Joseph Newhouse, Professor, Harvard University	617-432-1325
Mark Pauly, Professor, University of Pennsylvania	215-898-5411
Patricia Riley, Executive Director, National Academy for State Health Policy	207-874-6524
Uwe Reinhardt, Professor, Princeton University	609-258-4781

Thomas Rice, Professor, UCLA School of Public Health	310-206-1824
Ronald W. Richards, Program Director, W. K. Kellogg Foundation	616-968-1611
Sara Rosenbaum, George Washington University Center for Health Policy Research	202-296-6922
Diane Rowland, Professor, Johns Hopkins University; Senior Vice President, Kaiser Family Foundation	202-347-5270
Steven A. Schroeder, President, Robert Wood Johnson Foundation	609-452-8701
Jane Sisk, Professor, Columbia University	212-305-4081
Jacque Sokolov, Sokolov Strategic Alliance	310-201-5902
Deborah Stone, Professor, Brandeis University	617-736-3838
Reed Tuckson, M.D., President, Charles R. Drew University of Medicine and Science	213-563-4987
Stan Wallack, Professor, Brandeis University	617-736-3901

■ CONSULTING FIRMS

Consulting firms are rich sources of information and expertise on many aspects of the health care system and health reform. Some are benefits consultants, which help employers design their benefits packages and project their costs. Others are econometric firms, which forecast costs and effects of various theoretical changes in health care systems. Leading firms, with corporate headquarters (and public affairs office numbers when separately located):

Abt Associates, Cambridge, Mass.	617-492-7100
Buck Consultants, New York. (benefits)	212-330-1000
DeltaMed Corp., Richardson, Texas. (health care pricing)	214-953-1174
A. Foster Higgins & Co., New York. (benefits)	212-574-9000
Press office, Princeton, N.J.	609-520-2766
Hewitt Associates, Lincolnshire, Ill. (benefits)	708-295-5000
Lewin-VHI, Arlington, Va. (formerly Lewin-ICF. health care econometrics)	703-218-5500
William Mercer Inc., New York. (benefits)	212-345-7248
Noble Lowndes/Johnson, Langhorne, Penn. (benefits)	215-579-9800
Towers Perrin, New York. (benefits)	212-309-3400
The Wyatt Co., Washington, D.C. (benefits)	202-508-4600

LEGAL TIMES

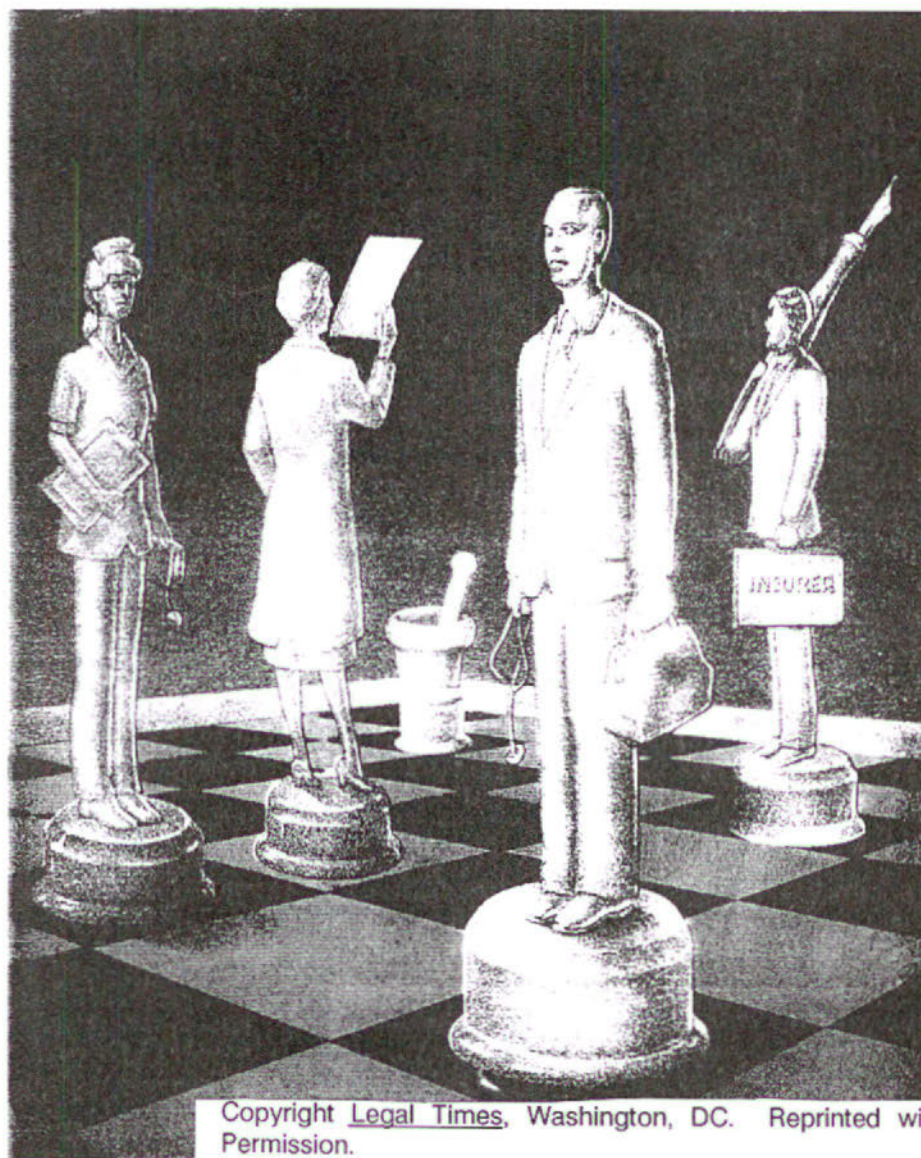
LAW AND LOBBYING IN THE NATION'S CAPITAL

WEEK OF OCTOBER 11, 1993 • VOL. XVI, NO. 21 • \$10.25

Special Report

HEALTH-CARE REFORM: THE CLASH OF INTERESTS AND AGENDAS

The Clinton plan has split old alliances, spawned new ones, and altered the landscape of interest-group politics in ways that could outlast the current debate. This special report features a group-by-group rundown of 25 major players, providing insights into their competing strategies, strengths, and prospects. Plus, commentary and analysis on major policy problems brewing in the plan.



Handicapping Health Care's Major Players

Months of pre-season jockeying are over. Position papers have been distributed; slogans have been drafted. The TV ads are on the air. The Clinton health reform package has been unveiled. And the greatest lobbying bonanza in memory has begun.

In an effort to sort out who's doing what to whom, Legal Times presents a user's guide to 25 major health-care players—their wish lists, lobby weapons, and field position in the titanic battle to overhaul American health care.

This guide was written by Naftali Bendavid, T.R. Goldman, and Sheila Kaplan, with assistance from Robert Schmidt. Political action committee data are included where applicable; figures were compiled by the Federal Election Commission, except where otherwise indicated.

Health-Care Providers



AMERICAN MEDICAL ASSOCIATION

- **BUDGET:** \$205 million total, \$8 million for D.C. office.
- **MEMBERS:** 300,000 physicians.
- **KEY LOBBYISTS:** James Todd, executive vice president. Lee Stillwell, senior vice president of government and political affairs. Richard Deem, director of federal affairs.
- **PAC:** Spent \$6,263,920 in the 1991-92 election cycle and \$747,250 in the first eight months of 1993.
- **BOTTOM LINE:** Wants patients to have the power to choose their own doctor.

The American Medical Association has a credibility problem.

Although its advocates maintain that the group supports health-care reform, the doctors lobby has hit the administration package hard in newspaper ads and in missives to its members.

For instance, the AMA has sent leaflets to 630,000 doctors for display in their offices, with the heading: "Is the Clinton proposal for health reform good for you and your family? You need to think about these 10 questions." That's followed by questions designed to raise public concerns about the plan, from "Will I still be able to see my own doctor?" to "Will the quality of care my family



receives be maintained under a new system?" The AMA literature meant for public consumption omits the doctors' foremost concern—reduced medical fees.

At the heart of the AMA's advocacy is the claim that it is speaking for patients, not just for doctors. The group's

"1993 Campaign Action Kit" offers the following comments for doctors when addressing local business and civic groups and, as encouraged, television and radio talk shows.

"I am a doctor, and the more I hear politicians and pundits talk about health system reform, the more I realize the one voice they don't hear anymore is the voice of my patients," the script reads. "... It has been left to physicians to stand up as the only advocates with enough clout to speak out for what is best for their patients."

But the AMA's pro-patient line has been undercut by a rival group, the 80,000-member **American College of Physicians**, which backs the Clinton plan. Naturally, relations between the two groups are not friendly.

The AMA is a federation of medical-specialty groups ranging from radiologists to eye doctors; the ACP, which is a member group within the AMA, represents internists and other doctors who treat internal organs. While the ACP has generally been a loyal follower of its parent's lead, President Clinton's health package has created a rare public rift between the two. ACP leaders have not been shy about publicizing their disappointment with the AMA's stance.

"I think the AMA is frankly somewhat duplicitous," says **Robert Chlopak**, who lobbies for a health reform coalition that includes the ACP. Despite AMA members' objections to the Clinton plan, "they don't want it to appear as if physicians have a real problem with this. ... It's important that they clarify where they are," Chlopak says.

Some insiders believe that when the smoke clears from the debate, the ACP's profile and clout will have risen—at the AMA's expense.

"There's one overarching issue that permeates everything," observes one health-care advocate, "and that's who is going to represent medicine in Washington—the AMA or ACP?"

The challenge to the AMA's influence from within the physicians' community comes at an especially tough time for the group. Once the undisputed dominant force in medical politics, the AMA since the 1970s has seen a decline in the percentage of doctors who sign up. And unlike some groups in the current health-care fray, who are free to focus on one or two discrete parts of the package, the AMA's members stand to be affected by virtually every facet of the massive Clinton plan.

In addition to the issue of patients' choice of physicians, which the group fears will be limited by the proposed regional health alliances, the AMA is lobbying on several other fronts. The group is using its longtime counsel, Chicago's **Sidley & Austin**, in a bid to prevent Clinton from including limits on physicians' fees—an idea the administration's health team has batted around, but did not include in the proposal. The law firm issued a pre-emptive strike, reporting to the AMA that fee limits could constitute an illegal taking under the Fifth Amendment.

The AMA will continue to push for relief from existing antitrust laws, which bar physicians from combining to negotiate with larger entities. The Clinton plan eases the antitrust restrictions on hospitals, but not on doctors.

The AMA will also be lobbying Congress to keep two benefits that it has already secured in the package: deregulation of clinical laboratories and increased protection for doctors charged with malpractice. The malpractice protections include permission for those found liable to pay compensation in installments, rather than the lump-sum payments required under current law, as well as a provision limiting plaintiffs lawyers' fees to one-third of the total damages in a case. Attorneys in medical malpractice cases rarely charge more than that, but in the ongoing tug of war between doctors and lawyers, the provision is a clear win for the doctors' camp.

Doctors can also claim victory over the administration's proposal to change the "collateral source" rule. Under the Clinton plan, jury awards would be offset by any amount the victim received from other sources, such as workers' compensation or health insurance. That offsetting amount could reduce the amount paid out by doctors. The change represents the kind of practice guideline that doctors have long pushed for.

But the AMA faces formidable opposition on the malpractice provisions from the **Association of Trial Lawyers of America**, which keeps watch over the interests of plaintiffs attorneys, and from **Congress Watch** and the **Health Research Group**, both affiliates of consumer crusader Ralph Nader's **Public Citizen**.

As it girds for battle, the AMA is not relying much on outside help. Its political strength has traditionally stemmed from its grass-roots lobbying strength and its political action committee, which consistently ranks among the most generous PACs in the country. The group is advancing its cause via an extensive ad campaign and the trench work of some 20 in-house lobbyists. And the AMA's executive vice president, Dr. **James Todd**, has been a fixture on the press-conference circuit.

—Sheila Kaplan

AMERICAN COLLEGE OF PHYSICIANS

- **BUDGET:** \$41 million overall, \$1 million in D.C. office.
- **MEMBERS:** 80,000 physicians practicing internal medicine and its subspecialties.
- **KEY LOBBYISTS:** John Ball, executive vice president. Howard Shapiro, director of public policy.
- **BOTTOM LINE:** Backs most of the Clinton plan; has some concerns about medical malpractice and the threat posed by regional health alliances to doctors' autonomy.

First, the American College of Physicians called for universal health care. Next, it endorsed a national health budget and backed most of the Clinton reform plan, calling it "a moderate and uniquely American approach to reform that will be the vehicle for building consensus and moving legislation through Congress."

More noteworthy than this enthusiastic endorsement by a doctors group, however, is the ACP's lobbying strategy on the Clinton plan. The ACP has sent shock waves through the medical community by picking a public fight over the plan with the longtime kingpin of health politics, the **American Medical Association**. The division among doctors, who normally close ranks on health-care policy, could be a harbinger for the Clinton administration—a sign that the health-care package will not die due to monolithic opposition from physicians.

The two doctors groups differ in several ways. While the much larger AMA represents the range of medical specialties, the ACP, whose members are technically part of the AMA, represents doctors who practice internal medicine and its subspecialties, such as cardiology and gastroenterology. As a result, ACP members are more likely to be providers of primary care and much less likely than specialists, such as surgeons, to see their fees cut under the Clinton plan.

As a rule, the ACP's members are younger than the AMA's. As for D.C. lobbyists, the ACP has about five professional staff members, while the AMA has 20. The AMA dwarfs the ACP financially, with an annual budget roughly five times larger. And while the AMA is an old hand at lobbying, the ACP, which considers itself more research-oriented than the AMA, is still shy about lobbying, or at least acknowledging it.

"We don't use the word *lobbying*," says a spokeswoman in the group's Philadelphia headquarters. "We educate." Hiring outside consultants is not part of the ACP's "education" program.

The AMA initially stated its support for the notion of reform, then blasted much of the Clinton package once it was unveiled. The ACP, on the other hand, jumped aboard the Clinton train early and began working closely with other groups to try to ensure the plan's passage on Capitol Hill.

"Physicians recognize that the system wasn't serving patients and wasn't serving physicians," says **Howard Shapiro**, the group's director of public policy.

In addition to its grass-roots operation, the ACP has joined forces with one of the more potent health coalitions, the **Health Care Reform Project**, whose member groups, ranging from the **AFL-CIO** to the **League of Women Voters**, represent an army some 55 million strong.

The ACP does not march in lock step with its coalition-mates on every issue, however. The group has expressed concerns about the medical malpractice portion of President Clinton's plan, arguing that it does not provide adequate protection for doctors. In contrast, most members of the Health Care Reform Project worry that it does not provide adequate protection for consumers.

The ACP also parts company from many in the umbrella organization in its concern that the Clinton plan will subject doctors to several tiers of confusing federal and state government control.

—S.K.

GROUP HEALTH ASSOCIATION OF AMERICA

- **BUDGET:** \$10 million annually.
- **MEMBERS:** 350 health maintenance organizations, who treat 32 million patients.
- **KEY LOBBYIST:** Karen Ignagni, president. Formerly top health lobbyist for the AFL-CIO.
- **PAC:** Spent \$24,050 in the 1991-92 election cycle and \$5,500 in the first half of 1993.
- **BOTTOM LINE:** Wants nationwide standards for health providers so that HMO chains won't have to vary programs from state to state. Wants complete freedom for HMOs to sign up only those doctors and hospitals they want.

Founded in 1959, the Group Health Association of America is the lobby of the HMO industry. HMOs have a huge advantage in the health fray: They've been doing "managed care"—that is, administrative control over doctors to cut costs—longer than anyone else. And managed care is the heart of the Clinton reform.

On the other hand, some view HMOs as an experiment that has failed. Critics paint HMOs as places where patients get substandard care and can't choose their doctors.

The GHAA raised its profile significantly several months ago by hiring **Karen Ignagni**, a well-known, well-connected health lobbyist for the AFL-CIO. This signals a major change in style for the group. Former GHAA President **James Doherty** was tough and ideological; Ignagni is young and polished. Most of all, she's a consensus-builder.

Ignagni is a former staffer at the Senate Labor and Human Resources Committee. That committee, chaired by Sen. **Edward Kennedy** (D-Mass.), is central to health reform.

"We think it's important to raise the profile and visibility of our industry to an even greater level," says GHAA spokeswoman **Susan Pisano**, noting that Doherty was scheduled to retire in any case. "We believe she's a person who can do that."

The GHAA is largely happy with the Clinton plan. That's not surprising; it would dramatically shift the way most Americans get health care from a fee-for-service system to the HMO approach, under which patients pay a flat annual fee.

GHAA leaders have no plan for an advertising campaign in support of the plan, Pisano says, and they've hired no outside consultants. While that may save the group money, it may not do much to help President Clinton—who needs all the active and vocal supporters he can get.

In lieu of high-profile advocacy, the GHAA is pursuing low-key goals in quiet ways, pushing nationwide standards for all health providers and opposing caps on health premiums.

The GHAA also would like to weaken the health alliances, or large consumer purchasing cooperatives, envisioned in the Clinton plan. The alliances will be haggling with HMOs over prices and benefits, so the less leverage they have, the better for HMOs.

—Naftali Bendavid

AMERICAN NURSES ASSOCIATION

- **BUDGET:** \$21 million annually.
- **MEMBERS:** 200,000 nurses.
- **KEY LOBBYIST:** Donna Richardson, director of governmental affairs.
- **PAC:** Spent \$336,050 in the 1991-92 election cycle and \$25,024 in the first half of 1993.
- **BOTTOM LINE:** Wants to increase insurance reimbursement for nursing services.

The American Nurses Association provides a case study in the benefits of playing heads-up politics.

The group, which moved its headquarters from Kansas City, Mo., to Washington in March 1992, was the first major trade group among health-care providers to endorse candidate Clinton. That decision paid off when President Clinton's advisers began charting the course of health-care reform. The **American Medical Association** ended up without a single seat on the 47-member professional advisory review committee to Hillary Rodham Clinton's health task force. The nurses had 12.

Not surprisingly, the ANA is pleased with the emerging shape of the Clinton package. While the plan as currently written does not specify a larger role for nurses, the final version is expected to expand their role as providers of everyday medical care by qualifying nurses for insurance reimbursements for their services.



An ANA spokeswoman says the group's leaders have met with Ira Magaziner of the White House health task force three times in recent weeks and have been assured that the legislative language will support them.

"This plan means that consumers will be able to choose an advanced-practice nurse for care if they wish," says ANA President **Virginia Trotter Betts**. "It means that advanced-practice nurses will be able to diagnose, treat, and prescribe medications for everyday health-care needs without unnecessary, costly oversight."

Still, the ANA is leaving nothing to chance as the package winds its way through Congress. The group has increased its political action committee contributions in the past six months. It has six people regularly meeting with Magaziner and dozens more in its Washington office working the issue. And it has spawned an offshoot, the **Nurses Strategic Action Team**, to mobilize grass-roots members.

The ANA's primary pitch: that there are more nurses than doctors in the United States, and that nurses are far less expensive. The group tries to ram that point home in a line from its ad campaign: "In the future, your family doctor may be a nurse."

Doctors will be the nurses' primary foes in the health reform fight, which is not surprising. Tensions between the two groups, who work side by side on the front lines of health care, are time-honored. The biggest doctors group, the **AMA**, "has always lobbied against nurse practitioners and other kinds of advanced-practice nurses—particularly when it comes to getting the money," says **Debra Hardy Havens**, a nurse and lobbyist with **Capitol Associates Inc.**, who is helping the ANA as an outside consultant.

The ANA has brought in other outsiders for support, notably the lobbying and public-relations giant **Burson-Marsteller** and a D.C.-based shop, **Health Policy Alternatives Inc.** The group has also sought to expand its reach by joining no fewer than 40 coalitions, many featuring various consumers groups. It is particularly active in the **Health Care Reform Project**, the **National Leadership Coalition for Health Care Reform**, the **Campaign for Women's Health**, and the **Long-Term Care Campaign**.

—S.K.

AMERICAN HOSPITAL ASSOCIATION

- **BUDGET:** \$70 million annually.
- **MEMBERS:** 5,000 hospitals and more than 50,000 hospital personnel.
- **KEY LOBBYISTS:** Richard Davidson, president. Richard Pollack, executive vice president for legislative affairs. James Bentley, senior vice president for policy. Beryl Anthony Jr., partner, D.C. office of Chicago's Winston & Strawn.
- **PAC:** Spent \$757,825 in the 1991-92 election cycle and \$264,140 in the first eight months of 1993.
- **BOTTOM LINE:** Wants to ensure that hospitals enjoy a prominent decision-making role within community health plans. Opposes cuts in Medicare.

If lining up heavy-hitters is any key to how well a group will fare in the coming battle over health care, then the American Hospital Association is off to a good start. The group, which represents 5,000 of the nation's hospitals, has enlisted the lobbying help of former Rep. **Beryl Anthony Jr.** (D-Ark.), one of the most sought-after legislators among those who retired from Congress last year.

Anthony, who served as chairman of the Democratic Congressional Campaign Committee and held a seat on the House Ways and Means Subcommittee on Health before landing in the D.C. office of Chicago's **Winston & Strawn**, is constrained by the rule that bars a former lawmaker from making direct contact for one year with ex-colleagues on Capitol Hill. But that hasn't prevented Anthony from lobbying the executive branch on health care or from helping the AHA map out its congressional strategy.

"There's no question that, given his background, he is able to help us understand how these [Arkansas] folks view a variety of different situations," says **Richard Pollack**, the group's vice president for legislative affairs. "He's helpful in terms of presenting things to them in a way that is easy for them to understand and easy for them to digest, from the perspective that he knows how those folks react and how to appeal to them."

Anthony may also enjoy an inside track on any legal developments that could crop up over health care: His wife, **S' Foster Anthony**, is assistant attorney general in legislative affairs.

Anthony's efforts so far haven't hurt. The AHA supports the concept, included in the Clinton package, of grouping community-based health providers into integrated partnerships that oversee all facets of patient care. Where the group may differ from the president is over control.

The AHA would like hospitals to play a central role in overseeing patient care in the new health plans. President Clinton has not committed to that idea.

"We hope that hospitals will provide a leadership role as being more than a vendor," Pollack says. "We think they should be part of the building of the plan."

While the Clinton plan is still sketchy in this area, Pollack is confident that his group's voice is at least being heard. "They heard us on a lot. On other things, they just listened," he says.

The AHA is pressing for federal guidelines that would, among other things, give community-based hospitals and clinics an advantage over for-profit health companies from out of town. On that score, the group has an ally in the **American Medical Association**, which is also troubled by the network plan, viewing it as a threat to doctors' autonomy.

The AHA is also seeking to avoid cuts in Medicare, which it fears would come out of its members' hides, and is wary of the plan to earmark hospitals for about \$80 billion in cuts.

Joining Winston & Strawn in the hospital group's campaign is New York-based **Ogilvy Adams & Rinehart** and D.C.'s **Health Policy Alternatives Inc.**

Also making a splash in the health-care waters is the trade group of for-profit hospitals, the **Federation of American Health Systems**, which represents more than 1,400 privately owned hospitals, management companies, and other health providers. FAHS has geared up to fight Clinton's proposal for a national health-care budget and also has targeted the proposed cap on increases in insurance premiums.

FAHS, whose executive director, **Michael Bromberg**, is viewed as one of the savvy trade-association lobbyists in town, has enlisted the help of **Thomas Scully**, a former Office of Management and Budget official now at D.C.'s **Patton, Boggs & Blow**. The group has also lined up its own Arkansans, the Little Rock firm of **Williams & Anderson**.

FAHS participates in several coalitions, most notably the **Healthcare Equity Action League**, a large business-and-insurance coalition opposing Clinton's plans to require that employers provide health insurance for their workers and to cap insurance premiums.

—S.K.

MENTAL HEALTH LIAISON GROUP

- **BUDGET:** Coalition members fund their own activities.
- **MEMBERS:** Includes the 38,000-member American Psychiatric Association, 114,000-member American Psychological Association, and about 50 other mental-health service providers and consumers groups.
- **KEY LOBBYISTS:** Leslie Scallet, director, Mental Health Policy Resource Center. Tipper Gore, wife of the vice president.
- **BOTTOM LINE:** Wants mental-health benefits treated like other medical benefits, with no financial caps and no limits on visits.

Mental-health problems may carry less of a stigma than they did 10 years ago, but paying for them hasn't gotten much easier.

And it won't any time soon under the Clinton health plan. The plan does call for phasing in stronger mental-health benefits through the year 2001. But

overall, the package is a disappointment to mental-health advocates.

Their key objections are that the plan covers only 50 percent of the costs of mental-health care and that it limits to 30 the number of annual visits for outpatient psychotherapy.

But the plan does boast some important mental-health benefits, including reimbursement for



Leslie Scallet

alternatives to hospitalization and for medication for mental-health disorders.

The mental-health lobby is now turning to Congress to protect its gains and achieve non-discriminatory coverage in the final health plan.

"We want mentally ill patients treated the same as the physically ill patients," says **Jay Cutler**, director of government relations for the **American Psychiatric Association**.

Cutk... association is among those in the Mental Health Liaison Group that decided in 1990 to spawn yet another group to lobby for non-discriminatory access, the **Access to Health Care Committee**. Advocates were concerned about the disparity between insurance benefits for mental illnesses and those for other medical problems.

Now the Access to Health Care Committee is applying the same test to the Clinton plan—and seems better positioned than ever before to get results. Headed by **Leslie Scallet**, director of the **Mental Health Policy Resource Center**, the group has a major advocate in **Tipper Gore**, a longtime crusader on mental-health issues who headed the administration's health reform task force on mental health and substance abuse.

And Gore, the wife of Vice President Albert Gore Jr., has a number of strong supporters in the administration, including **Robert Boorstin**, chief White House spokesman on health-care reform, who has talked publicly about suffering from manic-depressive illness; **Philip Lee**, assistant secretary for health in the Department of Health and Human Services and a longtime friend of the mental-health community; and **Bernard Arons**, recently named acting director of HHS's Center for Mental Health Services.

But Scallet says the biggest boost for mental-health advocates is the generational change in the nation's leadership.

"There are a lot of people now in the administration who are baby boomers or younger, many of whom have had good experiences with mental-health care or for whom mental-health care is something they or people they know have relied on," she says.

Still, the Clinton plan does not provide all Scallet and others sought. They don't, however, blame Tipper Gore.

"She is extraordinarily effective," says Scallet. "But she doesn't have the right to make decisions. I think she's done an excellent job of making sure the mental-health issues are being treated seriously. This never would have happened without Tipper Gore."

Scallet lays the blame on the number-crunchers in the administration, whom she says are basing their economic calculations for mental-health costs on outdated medical practices that are more costly than those now used.

Challenges to those numbers will be among the lobby's many tasks on Capitol Hill, where the chief allies on mental health are likely to be Rep. **Mike Kopetski** (D-Ore.), who has introduced a resolution calling for non-discriminatory coverage, and Sens. **Pete Domenici** (R-N.M.), **Edward Kennedy** (D-Mass.), and **Paul Wellstone** (D-Minn.).

—S.K.

AMERICAN DENTAL ASSOCIATION

- **BUDGET:** \$50 million annually.
- **MEMBERS:** 140,000, or three out of every four dentists.
- **KEY LOBBYISTS:** John Zapp, executive director; a dentist and vice president for government affairs at the American Medical Association for 19 years. Dorothy Moss, the ADA's top D.C. lobbyist; formerly Zapp's top deputy at the AMA.
- **PAC:** Spent \$1,661,000 in the 1991-92 election cycle and \$205,400 in the first eight months of 1993.
- **BOTTOM LINE:** Wants dental benefits for no- and low-income people.

Dentists like to say that they've always followed the dictates of President Clinton's health reform plan. Unlike medical doctors, most dentists are general practitioners, not specialists. They've long practiced preventive dentistry, such as cleaning and X-rays. And consequently, dental costs have gone up at just about half the rate of the rest of medical care.

"The model dentistry has today is probably the model they're trying to create for the entire medical system," says Dr. **John Zapp**, a longtime lobbyist for the

ADA **American Dental Association** who was recently appointed executive director of the American Dental Association. "Very competitive with good cost containment."

Unfortunately, despite that track record and one of the wealthiest PACs in the medical profession, dentists got their teeth kicked in by the Clinton health plan.

Employer-mandated coverage under the plan provides only minimal dental benefits—far less than the benefits the 100 million people who currently have dental insurance enjoy.

And instead of a plan that offers dental care to the poor and low-income—a population plagued by what Zapp describes as an "incredible backlog of dental diseases"—the Clinton plan provides a dental package only to children. Regular checkups, X-rays, and teeth cleanings will be offered to everyone 18 years or younger. In what ADA members hope is an oversight, fillings are not included.

"Why count a cavity if you're not going to fill it?" wonders Zapp.

To give itself a fighting chance in fashioning the final package, the ADA, which employs 400 staffers in Washington and Chicago, is paying the politically connected **Wexler Group** about \$200,000 for a six-month contract to prepare background papers and push the ADA's views on Capitol Hill. (The contract runs through December.) Wexler recently added **Betsey Wright**, Clinton's longtime chief of staff in Arkansas, to its bipartisan roster.

The ADA is also planning to add three more in-house lobbyists to its stable of five already in Washington.

—T.R. Goldman

AMERICAN HEALTH CARE ASSOCIATION

- **BUDGET:** \$8 million annually.
- **MEMBERS:** 11,000 providers of long-term care in nursing homes and other facilities.
- **KEY LOBBYISTS:** Bruce Yarwood, legislative counsel. D.C.'s Policy Research Group, a division of R. Duffy Wall and Associates. D.C. office of Miami's Greenberg Traurig.
- **PAC:** Spent \$559,050 in the 1991-92 election cycle and \$187,620 in the first eight months of 1993.
- **BOTTOM LINE:** Wants increased government funding of nursing-home care for the poor and increased insurance coverage for nursing-home care.

Despite their presence in almost every U.S. community, nursing homes have been virtually omitted from the Clinton health plan. Long-term care through nursing homes is a major expense for Americans—it cost some \$65 billion in 1992—but the president's plan gives their woes short shrift. Instead, the focus is on keeping people out of such facilities in the first place.

That hasn't set well with groups like the American Health Care Association, a federation of 51 affiliated associations that represent 11,000 providers of long-term care.

"Sometimes we feel like the poor stepchild of the health-care debate," says **Winthrop Cashdollar**, a lobbyist for the group. "We think home care should be available to people who need it, but you need to be careful not to mistake it as a substitute for nursing-home care. They serve two different populations."

AHCA's members, which are mainly for-profit companies, care for about one million people in nursing homes and other long-term care facilities.



Nancy Taylor

The group has a small Washington office, with only six lobbyists, led by Legislative Counsel **Bruce Yarwood**. It has also relied on **Don Muse**, president of the **Policy Research Group**, a division of R. Duffy Wall and Associates, and of counsel **Nancy Taylor** and associate **Stuart Kurlander** of the D.C. office of Miami's **Greenberg Traurig**. Taylor previously lobbied for AHCA while working with **Deborah Steelman** at Steelman's D.C. firm; an AHCA lobbyist says Steelman no longer works for the group.

AHCA's lobbying is buttressed by the efforts of the larger chains. **Manor Care Inc.**, based in Silver Spring, Md., has used D.C.'s **Patton, Boggs & Blow**, for example.

The other major trade group in the long-term care field is the **American Association of Homes for the Aging**, which represents some 4,500 not-for-profit nursing homes, senior-housing providers, and other long-term care providers. With a budget of \$8.4 million and a Washington staff of about 15, the AAHA has usually relied on in-house lobbyists.

This year, though, the AAHA brought in D.C.'s **Cassidy and Associates**, "to help us get some access," according to spokesman **Scott Parkin**. "It was difficult in the early part of this to be heard," Parkin says.

The nursing-home industry has made some gains under the Clinton plan. There are additional tax incentives to encourage people to buy long-term care insurance, as well as a loosening of the requirement that the elderly "spend down" to their last \$2,000, exclusive of housing, to qualify for Medicaid. Under the administration proposal, individuals can qualify with \$12,000 in assets.

And the nursing homes got another break in the plan's Medicare provisions: Most of the funding cuts appear to be taken from hospitals, not nursing homes.

"We hope that's true," Cashdollar says.

AHCA and the AAHA may also pick up some support from the **American Association of Retired Persons**, which will discuss the issue at its meeting next month. The AARP could decide to mobilize its forces to urge that protection against rising nursing-home costs be added to the health reform package. —S.K.

Health-Care Consumers



AFL-CIO

- **BUDGET:** \$62 million annually.
- **MEMBERS:** 87 unions, comprising 14.1 million members.
- **KEY LOBBYISTS:** John Sweeney, chairman, Health Care Committee. Gerald Shea, director, Employee Benefits Division.
- **PAC:** Spent \$1,174,500 in the 1991-92 election cycle and \$189,100 in the first eight months of 1993.
- **BOTTOM LINE:** Wants employers to pay a hefty share of workers' health premiums. Does not want health benefits taxed. Wants unions with excellent health packages to keep them.

Organized labor has long been a supporter of a Canadian-style "single payer" system, under which all citizens buy health care as a single bloc. But the AFL-CIO has decided that the Clinton plan is the best it's going to get and is throwing its considerable weight behind the administration's package.

"At this stage of the game, we must face the fact that this is the plan, not some hypothetical alternative," AFL-CIO President **Lane Kirkland** told reporters Sept.

21. "There were a variety of views about the most desirable way of organizing the system, but we have reached a complete consensus in support of this plan."

As the Clinton proposal gets battered about in Congress, the

AFL-CIO and its member unions will fight especially hard to keep certain elements from being knocked out. They want universal coverage, so if their members lose their jobs they won't lose their health insurance, too. They want employers to pay a big part of the premiums; under President Clinton's plan, employers pay fully 80 percent.

And labor's guardians want guarantees that unions that have negotiated better benefits than those in the Clinton reform will get to keep those benefits.



John Sweeney

And labor likely can count on support from senators like Majority Leader **George Mitchell** (D-Maine), **Edward Kennedy** (D-Mass.), and **Tom Harkin** (D-Iowa), who have always been attentive to labor's concerns.

The AFL-CIO has magnified its influence by joining a broad coalition called the **Health Care Reform Project**, which includes the **American Association of Retired Persons**, the **American Nurses Association**, and other groups generally supportive of Clinton's initiative.

Inside the AFL-CIO, the powerful **Service Employees International Union**, which represents more health-care workers than anyone else, is taking the lead. SEIU President **John Sweeney** heads the AFL-CIO's Committee on Health Care, and he has just brought in **Gerald Shea**, who was the SEIU's top health-care expert, to fill a similar role for the AFL-CIO.

Kirkland, meanwhile, has named **John Perkins**, the AFL-CIO's retired director of political education and a longtime Washington operator, to head a task force charged with getting health reform passed.

Unions will spend an estimated \$4 million to pass health care, says AFL-CIO spokeswoman **Colleen O'Neill**. The AFL-CIO has hired no outside consultants, she says; while an ad campaign is likely in the future, none is imminent.

Instead, the AFL-CIO is working the grass roots. It has 180 "legislative action committees" whose job is to lobby lawmakers back home; 80 of these were created specifically to push health reform. The AFL-CIO faxes regular updates, on health reform and other issues, to

Despite recurring rumors of its political demise, the labor movement has a lot of ammunition for this battle. Several of its top warriors have landed administration positions—most notably **Jerry Klepner**, formerly the top lobbyist for the **American Federation of State, County, and Municipal Employees**, who is now assistant secretary for health and human services.

700 local labor leaders. Many unions, of course, are running their own campaigns in addition to the AFL-CIO push.

At least one union, the 90,000-member **Oil, Chemical & Atomic Workers**, is bucking the AFL-CIO line and loudly proclaiming the superiority of a single-payer system. But it will be tough for any union dissidents to compete with the might, money, and members of the AFL-CIO.

"We are going to approach it as though it were a very, very important election campaign, which in effect it is," Kirkland said at the Sept. 21 press briefing. "We will leave no stone unturned."

—N.B.

AMERICAN ASSOCIATION OF RETIRED PERSONS

- **BUDGET:** \$305 million annually.
- **MEMBERS:** 33 million people who are 50 years and older, roughly two-thirds of whom are retired.
- **KEY LOBBYIST:** John Rother, legislative director.
- **BOTTOM LINE:** Wants Medicare funding for drug prescriptions and some form of long-term care.

Charitably described by one House staffer as "a 900-pound gorilla," the American Association of Retired Persons, the nation's largest membership organization, has a habit of getting its way on Capitol Hill.

The 33 million-member group—which represents one out of every two Americans 50 years and older—probably made out better than any other special



interest when the Clinton health plan was unveiled. A host of the AARP's wish-list items was fulfilled: Under the plan, prescription drugs are included in Medicare coverage, a home- and community-based package of long-term care is put in place, and a large chunk of medical insurance for many early retirees is picked up by the government.

"We see this as a promising package," says **John Rother**, the AARP's top lobbyist for nearly 10 years,

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DISABLED AMERICAN VETERANS

with evident understatement.

"They played it very well," agrees **Jon Lawniczak**, senior health policy analyst at the **National Council of Senior Citizens**, a labor-oriented lobby for older Americans with five million members, which often works alongside the AARP. "They set out to get what they wanted, and they did."

It's not surprising. The group suffered a major setback when a 1988 catastrophic health-care initiative backed by the AARP was overturned following a roar of public disapproval. But the group made a swift recovery and has returned to its legendary levels of influence.

The AARP's power derives in part from sheer size. With an annual budget of \$305 million and a staff of some 1,000 in its ultra-modern Washington headquarters, the group boasts a membership base that reaches into virtually every community in the nation.

Bolstering its clout is a legislative and research division that is 100 staffers strong and a cadre of 16 full-time lobbyists working the Hill, seven of whom concentrate on nothing but health care. Last year, the AARP's governmental affairs division had a lobbying and research budget of \$27 million.

"Every Congress is terrified by them," remarks one lobbyist.

The AARP says that it's not hiring any outside lobbyists to help push its position, but it has spearheaded a wide-ranging alliance formed this fall: the **Health Care Reform Project**. Ranging from the **AFL-CIO** to the **League of Women Voters** to the **Catholic Health Association**, the two-dozen members—each of whom has chipped in \$5,000—represent an underlying membership of some 55 million people.

The Health Care Reform Project is paying the D.C.-based public-relations firm **Chlopak, Leonard, Schechter & Associates** \$20,000 a month to advocate health-care reform and "take on anyone who is irresponsible, dishonest, or uses misinformation," according to partner **Charles Leonard**. The group's first target: the **Health Insurance Association of America**, a

group of 250 health insurers. After the project and other groups complained, the HIAA pulled an allegedly misleading ad criticizing the Clinton plan for excessive bureaucratic meddling.

The AARP's carefully cultivated image as a membership-service organization and advocate for the elderly sometimes obscures the group's own very commercial elements. Founded in 1958 by a retired school principal incensed that the elderly had trouble getting health insurance, the group quickly started offering its own. And it still does. Fully \$84 million of the group's \$305 million operating revenue last year was generated by its supplemental health plans, sponsored by the Prudential Insurance Co.; its auto insurance plans, sponsored by the Hartford Insurance Co.; and its mobile-home insurance, sponsored by the Foremost Insurance Group. Another \$102 million came from member dues, and \$40 million came from its magazines, *Modern Maturity* and the *AARP Bulletin*. (The remaining revenue came from programs, royalties, interest, and the like.)

With its aggressive legislative agenda, the AARP has no shortage of critics. One Senate staffer who deals with the group says it's developed a "certain Darth Vader reputation" over the years. "They drop in without making an appointment and expect everybody to drop everything because AARP is here."

But, as evidenced in the health reform plan, AARP lobbyists often come out on top. "Nobody wants to take them on," says the House staffer. "Why would they?"

—T.R.G.

- **BUDGET:** \$60 million annually.
- **MEMBERS:** 1.2 million veterans with war-related injuries.
- **KEY LOBBYIST:** John Heilman, legislative director.
- **BOTTOM LINE:** Wants to protect the \$16 billion nationwide system of VA hospitals, but also to allow veterans the chance to opt out and participate in any other health-care system.

Chronically underfunded, the \$16 billion hospital system run by the Department of Veterans Affairs is often criticized for providing poor care and being overly bureaucratic. Veterans groups entered the battle over the Clinton health plan hoping to save the VA system—both by preserving its autonomy and by opening it up more to competitive market forces to prevent it from becoming isolated and technologically obsolete.

The groups are succeeding on both fronts.

"It's a win-win plan conceptually for veterans," says

David Gorman, assistant national legislative director for medical affairs at the Disabled American Veterans, which has taken the lead in lobbying on health care for the community of veterans groups. The DAV's 1.2 million members have a special interest in the VA system: They've all suffered service-related injuries during wartime.

Even before he was elected, President Clinton pledged that the VA system would be an active participant in any health reform plan. And the appointment of **Jesse Brown**, the DAV's former Washington director, as secretary of veterans affairs helped ensure a front-line position in the debate.

The VA system of 171 hospitals and 350 outpatient clinics now services just 9 percent of the nation's 26 million veterans, and many of those are either indigent or don't have work-related medical insurance of their own. Many veterans groups had feared that with Clinton's package providing medical care for all Americans, there would be little reason to maintain a special health-care system open only to veterans.



Under the Clinton plan, the VA medical system will survive, but with one caveat: It will compete head to head with other health-care providers. And that's good news for VA supporters, who argue that only through competition will the oft-maligned system be forced to improve.

"The VA has been called on to compete, which has been our goal all along," says **John Hanson**, director of veterans affairs and rehabilitation at the **American Legion**, whose three million members make it the country's largest veterans organization.

Congressional pressures to pare down the system, or close it entirely, are a constant threat. But it is a fight the veterans groups—which also include the **Veterans of Foreign Wars of the United States**, the **Paralyzed Veterans of America**, and the **Vietnam Veterans of America Inc.**—feel they have no choice but to fight.

"Vets should be well-served if the plans go through as proposed," says Hanson. "The problem is, there are still 535 people who have something to say about it."

In fending off congressional encroachment, the veterans groups can rely on some powerful and loyal allies. Rep. **G.V. "Sonny" Montgomery** (D-Miss.), chairman of the House Veterans' Affairs Committee, barely survived a challenge to his leadership at the outset of the 103rd Congress, but Montgomery, who spent more than half his life in the Army and the National Guard, is not about to abandon his pet cause. And Vietnam veterans have a well-placed friend in Rep. **David Bonior** (D-Mich.), the House majority whip, who served in Vietnam.

—T.R.G.

SINGLE-PAYER ADVOCATES

- **BUDGET:** Roughly \$8 million, the vast majority of which represents Public Citizen's budget.
- **MEMBERS:** At the heart of this loose cluster are three groups—Public Citizen, Physicians for a National Health Program, and the Campaign for Health Security—which have a mailing list of 345,500.
- **KEY LOBBYIST:** Sidney Wolfe, Public Citizen Health Research Group.
- **BOTTOM LINE:** Wants it to be easy for states to choose a single-payer system.

The boosters of a Canadian-style "single payer" system, under which all citizens buy health care jointly through the government, are a ragtag assortment of consumer groups, labor unions, seniors groups, and churches. They function less as a formal coalition than as voices who form a chorus from time to time.

The Clinton plan presents left-leaning activists with a choice: Do they hold out for a single-payer system? Or do they jump aboard the Clinton bus, figuring it's the

last, best chance for health reform?

The result is a split. Many consumer organizations—**Families USA** and

Consumers Union, for example—are cheerleading for the Clinton reform. "The president has given us a plan we can work with," says **Gail Shearer**, a policy analyst with Consumers Union. "We continue to believe single-payer is the best system, but we can work with this plan."

But a vocal band of warriors continues to insist that the Clinton plan won't cure the nation's health problems and that the only logical route is a single-payer system.



Sidney Wolfe

It's simple and it's fair, they argue. And according to the Congressional Budget Office, a Canadian-style system could cover everyone in the United States and still cut the nation's health bill by \$14.2 billion a year.

A loose confederation called the **Campaign for Health Security**—spearheaded by the **Communication Workers of America**, the **International**

Ladies Garment Workers Union, and the consumer group **Citizen Action**—sends mailings to 200,000 people and organizes rallies and town meetings.

Public Citizen, the consumer group founded by Ralph Nader, has 140,000 members and a star spokesman in the form of the bespectacled, tousled Dr. **Sidney Wolfe**. Public Citizen sends reams of suggestions to the White House, members of Congress, and local activists.

Then there's the **Universal Health Care Action Network**, a coalition of roughly 900 local groups favoring a Canadian-style system, and **Physicians for a National Health Program**, whose 5,500 members concentrate on convincing their fellow doctors that single-payer is the way to go.

These groups are rallying around a single-payer bill written by Rep. **Jim McDermott** (D-Wash.), the only psychiatrist and one of only two trained physicians serving in Congress.

The McDermott measure has 89 co-sponsors; a companion bill introduced in the Senate by Sen. **Paul Wellstone** (D-Minn.) has five. Single-payer supporters say they are now going after wavering lawmakers such as Sens. **Barbara Boxer** (D-Calif.) and **Russell Feingold** (D-Wis.).

"Twenty to 40 members of Congress said they wouldn't co-sponsor single-payer until they saw the president's plan," says **Sara Nichols**, a Public Citizen health lobbyist. "Now that it's out, groups are going to organize furiously at the grass-roots level."

The **Congressional Black Caucus**, many of whose members support a single-payer system, is a pivotal bloc. "They'll hold out longer than anyone in the single-payer crowd," Nichols predicts. "They made power plays on the budget, and it worked. They've seen how to get their way."

The caucus will release its position on health reform within days, says **Joyce Larkin**, spokeswoman for Rep. **Louis Stokes** (D-Ohio), who heads the caucus's health-care task force.

The debate seems to be moving away from the Canadian option, but that doesn't mean the coalition can't fight for changes in President Clinton's plan, like making it easier for individual states to choose a single-payer system. Many believe that if a handful of states experiment successfully with a Canadian-style system, it will spread through the country.

McDermott has even taken the unusual step of lobbying the lobbyists, urging them not to lose hope despite the momentum of Clinton's plan.

In a Sept. 17 letter to activist groups, the congressman exhorted: "Now is not the time to argue that any health plan that can pass in Congress is better than no reform at all. Now is the time to force a national debate using single-payer as the measure of success."

Says McDermott spokesman **Barry Piatt**: "It may have been an unusual letter, but this is an unusual time."

—N.B.

Business Groups



PHARMACEUTICAL MANUFACTURERS ASSOCIATION

- **BUDGET:** \$32 million annually.
- **MEMBERS:** More than 100 research-oriented pharmaceutical companies.
- **KEY LOBBYIST:** Gerald Mossinghoff, president since 1985. A former commissioner of patents and trademarks.
- **PAC:** Spent \$39,500 in the 1991-92 election cycle and \$7,500 in the first half of 1993.
- **BOTTOM LINE:** Wants to avoid price controls by allowing the marketplace, not the government, to determine drug pricing.

Pharmaceutical companies coasted through the late 1980s by raising prices at more than twice the rate of inflation. But they are paying for it now. Their fat profits have made them one of the Clinton administration's prime examples of what's wrong with the nation's bloated health-care system.

The Clinton health reform, unlike many private insurance plans, does include coverage for prescription drugs, and for that, the Pharmaceutical Manufacturers Association is happy. PMA members are also pleased with the proposal to add prescription drugs to the items covered by Medicare, the government's health program

for the elderly that now covers 32 million people. As a result, unit sales of individual drugs are bound to increase under the Clinton plan.

Most health care analysts still see the plan as a net minus for drug companies, however, and the industry is feeling decidedly beleaguered.

"They still need somebody to beat up on" is one industry executive's rationale for the rough treatment the industry has received at the administration's hands.

For starters, the extended Medicare coverage is not cost-free for drug makers. They will be required to pay back to the government 15 percent of the price of the drugs purchased under Medicare. The idea was

borrowed from Medicaid, the government-sponsored plan for the poor, which already requires a 15-percent rebate on prescription drugs purchased under its auspices. The potential impact on drug companies' income is substantial; people covered by Medicare and Medicaid are expected to make nearly half of all drug purchases under the Clinton plan.

The PMA is also livid about two other proposals in the plan: a blacklisting provision that would allow the Department of Health and Human Services to refuse Medicare coverage for drugs it believes are grossly overpriced; and the creation of a National Health Board with the power to examine a drug company's confidential pricing data if it believes consumers are paying too much.

"The Medicare rebate and blacklisting are our two No. 1 issues," PMA President **Gerald Mossinghoff** told a press briefing on Sept. 23, the day after the Clinton plan was released. "But the price commission [the National Health Board] is a very close second."

Pharmaceutical executives argue that price controls of any type, even indirect ones, will discourage companies from spending the vast sums necessary to develop and market new drugs.

The changes outlined in the Clinton plan come at a particularly bad time for the industry, whose profits have begun to dip in the last year and a half as managed-care plans take up more and more of the health-care landscape. With their bulk buying power, HMOs and other managed-care outfits can demand cheaper prices from drug companies, squeezing the companies' profits in the process.

The PMA, a large, often fractious trade group whose members represent both large and small pharmaceutical interests, has been on the counterattack for several months, with a \$7 million ad campaign that stresses how drugs can hold down the cost of medical care by helping patients avoid expensive operations. The PMA offensive is being engineered from its spacious D.C. headquarters at 15th and L streets, N.W.; some 90 employees work out of three floors that cost the group \$1.3 million a year in rent. There are two smaller satellite offices in Sacramento, Calif., and Tokyo.

Also hired for the fall offensive: **Robinson, Lake/Sawyer Miller**, the recently merged public-relations and advertising agency, brought on to do strategic counseling; and the public-relations firm **Hugh C. Newton and Associates**, whose sole professional is paid \$5,000 to visit editorial boards around the country pushing the PMA message. The association has also brought on former Sen. **Paula Hawkins** (R-Fla.) to assist longtime lobbyist **R. Duffy Wall**, who has his own lobby shop.

For several of the association's largest members, this apparently is not enough. Six drug companies have banded together to press their own message and are paying more than \$2 million to the well-connected lobby shop **Powell Tate** to do so. The firm's leaders, **Jody Powell** and **Sheila Tate**, respectively, as press secretary to President In-

Nancy Reagan. The firm **Beckel Cowan**—which, like **Powell Tate**, is a **Cassidy and Associates** subsidiary—has also been brought aboard by the six companies for grass-roots lobbying.

As they wage their battle, drug companies have to protect their flank against assault from the pharmacists, who became upset during the 1980s with the drug companies' profiteering. The **National Association of Retail Druggists**, representing the mom-and-pop drugstores where the majority of prescriptions are still filled, and the **National Association of Chain Drug Stores** have formed a loose coalition to press for proposals in the Clinton plan that will make sure drug prices aren't allowed to skyrocket again. Says **John Rector**, general counsel of the retail-druggists group: "We oppose the PMA on almost all issues."

Even opponents acknowledge that the new marketplace of the 1990s and the bulk buying power of HMOs has quietly ratcheted down drug companies' profit levels. But the ill will of the past won't go away overnight.

"A leopard changes its spots very slowly," says **John Coster**, a professional staffer for Sen. **David Pryor** (D-Ark.), one of the industry's fiercest critics. "There's still the perception that they are such a rogue industry."

—T.R.G.

HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

- **BUDGET:** \$9 million annually.
- **MEMBERS:** 325 manufacturers nationwide.
- **KEY LOBBYIST:** Alan Magazine, president.
- **PAC:** Spent \$15,100 in the 1991-92 election cycle and \$2,000 in the first half of 1993.
- **BOTTOM LINE:** Opposes price controls, spending caps, and any requirement that employers provide health insurance for their workers.

Some groups would benefit directly from the Clinton health-care package; others stand to suffer a direct hit. But the Health Industry Manufacturers Association is in the awkward position of weighing the consequences of being ignored.

"The plan is silent about how technology will be introduced into the health care system," says **Steven**

Speil, associate vice president and special counsel of **HIMA**. The group's members, who produce medical technology ranging from CAT scanners to hospital computers to artificial limbs, account for 90 percent of the \$45



Gerald Mossinghoff

billion in domestic sales of medical technology.

Being left off the list has its advantages. The Clinton plan contains no direct controls on industry prices, leaving HIMA's members free from an unwanted form of government intrusion. Neither does the plan contain any explicit efforts to limit the kinds of expensive procedures that the association specializes in facilitating.

Still, HIMA remains wary. "We're not directly targeted, but we worry about bureaucratic shrapnel,"



Alan Magazine

Speil says.

Already, there is pressure in the cost-conscious health-care industry to curb the use of high-tech equipment. And HIMA's four registered lobbyists are desperate to keep technology assessment from being added to the duties of the National Health Board proposed by the Clinton plan. Should that happen, the board would be empowered to decide which

technologies become part of the standard benefits package—and which technologies are left out in the cold. The group also fears that any bid to limit insurance premiums could also indirectly curb the use of medical technology.

HIMA is represented on the public-relations battlefield by its president, **Alan Magazine**, a respected former head of the private-sector Council on Competitiveness, who joined the trade group in 1990. Though he doesn't lobby the Hill, Magazine serves as the industry's spokesman and is responsible for the group's increasingly visible profile.

His work will be buttressed by a strengthened grass-roots effort. The group plans to phase out its PAC by the end of the year, preferring to focus on visits by HIMA members to congressional district offices.

HIMA has also revamped its government affairs office in Washington, installing a new three-person team this year. The association employs 73 staffers in all.

These efforts are intended to ensure that HIMA's interests are not inadvertently trampled by a Congress bombarded by groups more directly affected by the health plan.

"We're worried about how medical technology will be treated in any kind of health-care reform plan," says

HIMA's vice president for government affairs, **Greg Raab**, who is a former lobbyist for Medtronic, a Minneapolis-based manufacturer of medical devices. "If there's any fallout, we want [members of Congress] to be making conscious decisions, to let them understand what they're doing to medical technology." —T.R.G.

NATIONAL ASSOCIATION OF MANUFACTURERS

- **BUDGET:** \$16 million annually.
- **MEMBERS:** 12,500 companies, with more than 200,000 employees.
- **KEY LOBBYIST:** Sharon Canner, assistant vice president for industrial relations and director of employee benefits.
- **BOTTOM LINE:** May accept employer-mandated health insurance with subsidies for small businesses and lower-wage employees, depending on the rest of the package. Worried about payroll tax on self-insured companies.

In a move that surprised many business lobbyists, the National Association of Manufacturers has indicated a willingness to accept the Clinton administration's proposal to require employers to pay for employee health insurance.

"It may be the bitter pill we have to swallow," says NAM health-care lobbyist **Sharon Canner**.

Canner says that NAM may go along with the employer mandate—depending on the rest of the package. One reason for the group's support is surely the sweetener the administration has thrown in: a bailout for companies paying health-care costs for employees who accept early retirement during downsizing.

But NAM is still in a wait-and-see mode. The group's health task force met last week in California with its executive committee and board of directors to discuss the Clinton plan. NAM has not yet given its full endorsement.

Staffers at NAM's 50-person Washington lobby shop and NAM member companies have been sponsoring a

series of breakfast meetings with lawmakers and administration officials to discuss their concerns. In late September, the heavy hitters of the group—including **Ashland Oil Inc.**, **Merck & Co.**, the **Ford Motor Co.**, the **Eastman Kodak Co.**, the **Hewlett-Packard Co.**, and **RJR Nabisco Inc.**—had a breakfast meeting with White House aide **Ira Magaziner** to try to unearth the details of the plan.

"A lot of members feel that this is such a moving target right now. Every three weeks we get new pieces," says NAM spokesman **Andrew Smart**. "The more people sift through what's in the proposal, the more they come up with things that may concern them."

Should the NAM decide to back President Clinton to the hilt on the employer insurance mandate, the group will not be alone in the business sector. The U.S. **Chamber of Commerce**, noting that health insurance premiums for its members have risen as much as 30 percent in recent years, has also offered to go along with the employer mandate. The chamber, which represents about 215,000 companies and 1,200 trade groups, and has a \$70 million annual budget, is not mounting a major effort.

One proposal that has raised eyebrows among NAM members is the possibility of a 1-percent payroll tax on self-insured companies to finance teaching hospitals. They're also concerned about the possibility that Clinton will move to impose wage-and-price controls.

Considered one of the most effective business lobbies in town, NAM has been having a great year. The group formed a coalition that proved instrumental in defeating the BTU energy tax and having it replaced with a tax on transportation.

NAM's strength derives not from outside hired guns, but rather from its own members' clout; together, they represent 85 percent of all manufacturing companies in the country. In recent years, NAM has also emerged as a voice for non-manufacturing businesses.

Canner says that NAM has held numerous regional conferences and meetings to inform its membership about the health plan.

"I spend a lot of time on the phone," she says. "There's a misunderstanding by some companies that because the administration puts out a plan, that that's the plan. We need to explain that that's just the beginning."

—S.K.

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NATIONAL FEDERATION OF INDEPENDENT BUSINESS

- **BUDGET:** \$65 million annually.
- **MEMBERS:** 607,000 small-business owners, who employ an average of five to eight workers.
- **KEY LOBBYISTS:** John Motley, vice president of federal governmental affairs. Jack Faris, president; former executive director of the Republican National Committee's finance panel.
- **PAC:** Spent \$303,180 in the 1991-92 election cycle and \$28,600 in the first eight months of 1993.
- **BOTTOM LINE:** Opposes requiring businesses to pay for employee health insurance.

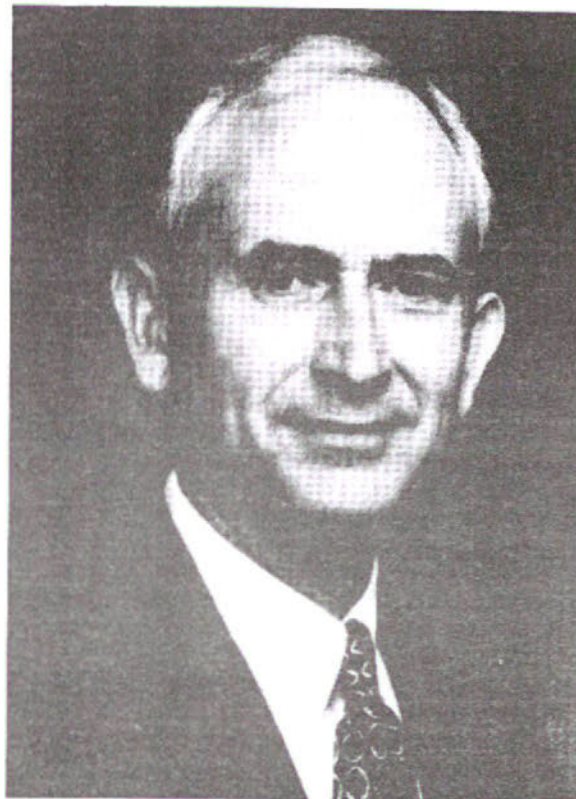
The leading trade groups representing big business—the U.S. Chamber of Commerce and the National Association of Manufacturers—may be amenable to the notion of employers paying a portion of employees' health insurance. But on that issue the nation's small-business advocates have drawn a line in the sand.

"Even when sugar-coated with promises of a government subsidy, small business isn't swallowing this bitter pill," says **Jack Faris**, president of the National Federation of Independent Business.

The largely Republican group let its opposition be known shortly after it became clear that President Clinton's package would include a proposal to mandate employer insurance—a proposal that advocates claim would save money.

The NFIB released a study concluding that the plan would cost up to 1.5 million jobs.

NFIB members are using such dire predictions as a lobbying weapon, arguing that the plan could jack up unemployment in lawmakers' districts and cost them precious constituent support. And when the NFIB talks, lawmakers tend to listen, mindful of the economic clout



NFIB's Jack Faris

of the group, whose business owners rack up gross annual sales of about \$250 billion.

Also effective on Capitol Hill is another small-business group, the **National Association of Wholesaler-Distributors**, which echoes many of the NFIB's concerns about the Clinton plan.

Lobbyists for both groups bristle at administration suggestions that small-business owners are looking for a free ride. To the contrary, says one recent NFIB survey, most of its members would be pleased to pay for employee health insurance—if only they could afford it.

The NFIB has strengthened its hand by joining a coalition called the **Healthcare Equity Action League**. HEAL has a \$160,000 annual income from its 80 steering committee members, including the **Aetna Life & Casualty Co.**, the **Pharmaceutical Manufacturers**

of America, and the **Federation of American Health Systems**, the trade group that represents for-profit hospitals.

Besides fighting the employer mandate, HEAL is helping the NFIB with its campaign against Clinton's proposed national health-care budget, which it rejects as health-care "rationing," and against the administration's plan to permit regional health alliances to cap insurance premiums.

"Premium caps are price controls by another name, and we know from history that price controls do not work," says **Alan Kranowitz**, senior vice president for government relations of the wholesaler-distributor group and executive secretariat of HEAL.

The NFIB is getting a big boost from the alliance it has forged with the Federation of American Health Systems. One health lobbyist describes it as a classic political horse trade.

Recalling a conversation he had with **Michael Bromberg**, executive director of the federation, this lobbyist says: "Bromberg said, 'We have this deal with NFIB. We're going to fight back to back and protect each other. If they help me on cost containment, I'm going to help them on employer mandate.'"

Ironically, the NFIB may also benefit from the Chamber of Commerce's strong support for the Clinton plan. "The Chamber of Commerce and NFIB compete for members," Kranowitz says. "I suspect that the chamber's position is going to be a big membership boon for NFIB."

Both the NFIB and HEAL have praised the two major Republican proposals on health care, which omit the employer mandate, as well as legislation introduced by Reps. **Jim Cooper** (D-Tenn.) and **Charles Stenholm** (D-Texas), which also spares employers.

As they wade into battle, NFIB members have one intangible factor weighing in their favor. The group suffered a major defeat when Congress liberalized rules that govern employees' ability to leave work to tend to pressing family concerns. Fresh from that defeat, the NFIB is determined not to take another loss.

"They have been very aggressive, very focused on this one issue," says one health lobbyist. "They have a good chance of winning."

—S.K.

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HEALTH INSURANCE ASSOCIATION OF AMERICA

- **BUDGET:** \$20.6 million annually.
- **MEMBERS:** 250 insurance companies, boasting 189 million policyholders.
- **KEY LOBBYIST:** Willis Gradison Jr., president. Former ranking Republican on House Ways and Means Subcommittee on Health.
- **PAC:** Spent \$301,400 in the 1991-92 election cycle and \$50,900 in the first half of 1993.
- **BOTTOM LINE:** Does not want purchasing cooperatives to determine what health plans consumers can buy. If that happens, the HIAA is terrified that many of its members will be shut out and, ultimately, forced to fold.

The Health Insurance Association of America is probably the most desperate of the health lobbies, and its tactics reflect its panic. The citizens' cooperatives envisioned under President Clinton's plan will buy policies only from insurance companies that meet certain standards, and this could drive many companies out of business.

Not only does the prospect of health reform have the group on the run; it has depleted the HIAA's power. Four mammoth insurance companies—which, unlike the rest of the industry, will prosper under Clinton's reforms—abandoned the HIAA to form their own group. (A fifth joined them without actually quitting the HIAA.)

And two dozen of the smallest companies, which have the most to lose under reform, also have created their own organization.

The HIAA is left to flail away in the middle. And the White House, figuring the insurance industry is the one entity despised more than government, has been happy to engage in a public fight.

On Sept. 7, the HIAA distributed to the press a statement headlined, "Bureaucrats choose, consumers



HIAA's Willis Gradison

lose under Clinton health reforms." The next day, the White House shot back in its daily newsletter that "HIAA appears to be saying they don't want health care reform." HIAA President **Willis Gradison Jr.** answered with a letter saying, "The White House Communications Office should know better than to say what it said."

Meanwhile, **Goddard*Claussen/First Tuesday**, a media company based in Malibu, Calif., is running a \$1.5 million advertising campaign on the HIAA's behalf. It includes newspaper ads that shout "Surprise!" and insist that insurance companies strongly favor reform. On the day of Clinton's Sept. 22 speech unveiling his health-care package, the HIAA ran full-page ads consisting of an open letter from Gradison to Clinton, saying, "We in the health insurance industry

want reform as much as the American people, and you do."

But what has upset the HIAA's opponents most have been its television commercials, on CNN and targeted local stations, showing a middle-aged, middle-income couple distraught that Clinton's plan won't let them choose their insurance.

The **Democratic National Committee** aired counter ads stressing that the HIAA spots were funded by the insurance industry. The consumer group **Families USA** jumped in with commercials declaring the HIAA ad misleading. And a broad coalition called the **Health Care Reform Project**—with members ranging from the **AFL-CIO** to the **Chrysler Corp.**—blasted the ads in a Sept. 15 statement.

The ads have been withdrawn. An HIAA spokeswoman said they've "served their purpose."

HIAA spokesman **Richard Coorsh** says insurance companies are being unfairly attacked. "This is a well-orchestrated campaign to somehow come up with a villain," Coorsh says. "Regrettably for us, we've been cast in that role."

The HIAA has signed up **CMF&Z**, a Des Moines-based firm, which is getting \$200,000 for public-relations work; **Mellman-Lazarus-Lake**, a D.C. Democratic polling outfit; and **O'Brien Calio**, a D.C. political consulting firm, to plot legislative strategy.

But the HIAA's big gun is Gradison, an 18-year House veteran who joined the group in February, bringing his connections and an extensive knowledge of health-care policy. As ranking Republican on the House Ways and Means Subcommittee on Health, Gradison, a moderate, worked closely with subcommittee Chairman **Pete Stark** (D-Calif.). Stark will have a central role in shaping whatever health-care reform package emerges from Congress.

The HIAA has apparently settled on the ever-popular "choice" slogan as its chief sales message—in this case denoting a consumer's freedom to choose his or her own insurance company. Consumer groups ridicule the notion that anyone cares about that.

The HIAA is also spearheading a group called the **Coalition for Health Insurance Choices**, which includes insurance agents, small businesses, and others.

Despite its wounds, no one doubts the HIAA's power to influence the health-care debate.

"They have tremendous clout because they have the agents on their side," says **Robert Hunter**, president of the **National Insurance Consumers Organization** and a longtime HIAA critic. "And the agents are politically powerful because they are the small-business people in every town."

—N.B.

ALLIANCE FOR MANAGED COMPETITION

- **BUDGET:** Roughly \$1 million.
- **MEMBERS:** The five largest insurance companies, with a clientele of 60 million policyholders.
- **KEY LOBBYISTS:** Executives of the top five insurance companies.
- **BOTTOM LINE:** Wants no caps on insurance premiums.

When the CIGNA Corp. left the Health Insurance Association of America in 1991, it was a bad omen for the group. CIGNA, with its chain of 49 HMOs, had much to gain from changes in the health-care system stressing HMO-type care, and its executives were impatient with what they perceived to be the HIAA's dillydallying on reform.

For the HIAA, decisions about reform have meant reconciling the often competing interests of its members. Many small firms in the group could fold if they're shut out by the large purchasing cooperatives envisioned in the Clinton plan. But large insurers—many of which, like CIGNA, own lots of HMOs—are favored under the reform and so support it.

Eventually, three other large insurers followed CIGNA out of the HIAA. And early this year, these four defectors and one other who has kept ties with the HIAA went a step further.

CIGNA, the Prudential Insurance Co., the Metropolitan Life Insurance Corp., The Travelers, and the Aetna Life & Casualty Co.—the nation's five largest health insurance companies—formally created a brand-new trade association, the Alliance for Managed Competition, to throw their weight behind the Clinton effort.

The alliance has no office suite. Instead, its lobbying is coordinated by two Washington political consulting firms, The Ridley Group and Oldaker, Ryan & Leonard.

Formed in March, Oldaker, Ryan & Leonard is especially well-positioned to push its client's agenda. William Oldaker is a major Democratic fund-raiser, having cemented ties to congressional leaders as a top aide to then House Speaker Jim Wright. Robert Leonard was staff director of the House Ways and Means Committee until earlier this year. And Thomas Ryan was the top staffer at the House Energy and Commerce Committee several years ago.

The alliance's advertising has thus far been confined to a single ad earlier this year, taken out in such inside-the-Beltway publications as *National Journal* and *Roll Call*, says CIGNA spokesman Randall Gerber.

"We believe in immediate and fundamental reform of America's health care system," says the ad, apparently intended to contrast with the HIAA's less-enthusiastic endorsement of reform.

In recent weeks, the alliance has hired as media director John Gibbons, who had been working as a consultant to the Pharmaceutical Manufacturers Association. Before that, Gibbons was deputy spokesman to then Health and Human Services Secretary Louis Sullivan.

The alliance's lobbying has been quiet. "We have chosen not to be as strident as the HIAA," Gerber says. "We find we're most effective in sharing our vision of health care and managed care in one-on-one meetings with decision-makers."

The alliance mostly likes the Clinton plan; its main goal is killing the cap on insurance premiums. The Big Five also would love to weaken the consumer cooperatives that will be bargaining with them over prices and benefits.

Among the group's likely champions is Rep. Barbara Kennelly (D-Conn.). She's from Hartford—where most big U.S. insurance companies are based—and, as the Democrats' chief deputy whip in the House, is in charge of lining up votes on key issues.

—N.B.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

- **BUDGET:** \$131 million annually.
- **MEMBERS:** 69 Blue Cross and Blue Shield plans, boasting 68 million policyholders nationwide.
- **KEY LOBBYIST:** Mary Nell Lehnhard, senior vice president.
- **PAC:** Spent \$228,070 in the 1991-92 election cycle and \$72,610 in the first half of 1993. Including regional PACs, Blue Cross spent \$307,450 in the 1991-92 cycle, according to the Center for Responsive Politics.
- **BOTTOM LINE:** Wants no caps on health premiums. Wants purchasing cooperatives to be voluntary, not mandatory.

The nation's 69 Blue Cross and Blue Shield companies are odd creatures in the health-care jungle.

Unlike other insurance firms, they are non-profit, are tied to specific regions of the country, and were originally created to insure those with lower incomes.



This gives them the aura of being above the profiteering of the rest of the health-care industry.

Yet Blue Cross operations have been torn by mismanagement scandals over the past decade, draining their resources, hurting their image, and reducing their clout. New York's Empire Blue Cross and Blue Shield, for example, is accused of filing misleading data with the state.

The Blue Cross and Blue Shield plans, which are independent, together insure more than one-quarter of the U.S. population, at all income levels. And they rely heavily on managed-care networks like HMOs; this positions them to take advantage of the Clinton reforms, which also stress such networks.

For more than a year, the Blue Cross and Blue Shield Association has depended on Joseph O'Neill, president of the lobbying firm Public Strategies Washington, to coordinate its attack. O'Neill was a top staffer to Treasury Secretary Lloyd Bentsen when Bentsen was in the Senate.

The Blue Cross programs are pushing much the same things as other insurance companies. They want to kill the cap on insurance premiums, and they want the health alliances—groups of consumers who will buy health care jointly—to be voluntary, not mandatory.

The alliances will become huge bureaucracies otherwise, they argue. But it's also true that making the alliances voluntary would weaken them, to the advantage of those—like the Blue Cross and Blue Shield plans—who will be selling the alliances health and bargaining over the terms.

B.

Miscellaneous

DEMOCRATIC NATIONAL COMMITTEE

- **BUDGET:** Plans to raise \$1 million to \$3 million by year's end.
- **MEMBERS:** 45 million people voted for Clinton in 1992.
- **KEY LOBBYIST:** Richard Celeste, former Ohio governor.
- **BOTTOM LINE:** Pass the president's plan, or watch the party's political fortunes plummet.

It's got bumper stickers, campaign buttons, television ads, a petition drive, an 800 number, even a slogan: "Health care that's always there."

Never has a political party so resembled a lobbying group. And never has a lobbying effort so resembled a political campaign.

The Democrats' unprecedented National Health Care Campaign is chaired by former Ohio Gov. **Richard Celeste**, who served his years in office, 1983-91, alongside then Gov. Bill Clinton. Political consultant **Celia Fisher**, who ran the Clinton-Gore campaign in Pennsylvania, is handling nuts and bolts for the group. **C. Everett Koop**, the popular former surgeon general, has been enlisted as a liaison to physicians. And the party plans to raise \$1 million to \$3 million for the campaign by year's end, says Democratic National Committee spokeswoman **Catherine Moore**.

A coordinator is heading up the effort in each state, and a dozen staffers have been assigned to the campaign at DNC headquarters on Capitol Hill. Teams of doctors,

nurses, and business representatives are being assembled to speak in their communities.

About 500 health-care "house parties" were held Sept. 22, the night of President Clinton's address to the nation on health care. More parties are planned, and a video is being prepared for showing at these events.

"This is not a usual political campaign, where you target your opponents if they happen to be Republicans," Celeste says. "We need to draw in people we might not ordinarily be working with."

The Democrats originally planned to create an independent health reform campaign with offices outside DNC headquarters. But that plan was dropped in June, following protests over the Democrats' intent to keep contributors' names a secret.

The goal, of course, is to prime the pump for a torrent of letters and calls to congressional offices urging enactment of the Clinton reforms. The campaign's message: Clinton's plan will give you security, and the cost of doing nothing is greater than the cost of change.

The war-room mentality of Clinton's presidential campaign is fresh in the minds of Democratic activists, and they relish taking on such enemies as the insurance

and pharmaceutical industries. The DNC has already aired one ad directly attacking an insurance-industry commercial that was critical of the Clinton plan. The insurers wound up pulling their ad.

"Part of our responsibility as a campaign is to identify the opposition," Celeste says. "If people will take on the Clinton health-care reform, they need to be held accountable."

It's become a cliché that the political parties have largely lost their traditional roles of forging platforms, selecting candidates, and keeping officeholders in line. By using the DNC to sell a huge social program instead of a candidate, the Democrats just may have found a new role for the party, a role more in tune with current politics: The political party is becoming, in many ways, one more big lobby.

The **Republican National Committee**, in contrast, has nothing so grand in the works. The GOP is not especially eager to make health care a partisan fight, or so its congressional leaders have suggested. And there's a further obstacle to following in its rival's path: Unanimity would be difficult to achieve, given that there are now three Republican plans afloat, one introduced by Sen. **John Chafee** of Rhode Island, another by Sen. **Phil Gramm** of Texas, and a third circulating in the House.

—N.B.

DISTILLED SPIRITS COUNCIL OF THE UNITED STATES

- **BUDGET:** \$9 million annually.
- **MEMBERS:** 24 liquor manufacturers.
- **KEY LOBBYIST:** Timothy Dudgeon, federal relations director.
- **PAC:** Spent \$70,760 in the 1991-92 election cycle and \$18,270 in the first half of 1993.
- **BOTTOM LINE:** Opposes using alcohol taxes to pay for health care.

If there's been a big victory in the early skirmishing over health reform, it belongs to the Distilled Spirits Council.

President Clinton's health-care team was eyeing a tax on alcohol during the planning stages. But when the package was unveiled, liquor manufacturers had dodged the bullet—an achievement looked upon with envy by their comrades in the tobacco fields.

The stage was set by the beer and wine lobbies, which are not part of the Distilled Spirits Council. These two groups had made it clear that if the president tried to tax them, they would drum up opposition from Joe and Jane Six-Pack. They have powerful congressional allies like House Majority Leader **Richard Gephardt** (D-Mo.), whose St. Louis district is home to the Anheuser-Busch brewery, and the delegation from California's wine region.

So the threat of a beer and wine tax was quickly shoved out of the picture. That ratcheted up the pressure on the much smaller hard-liquor industry, represented by the Distilled Spirits Council.

With a small staff and little time, council staffers ran a scrappy campaign, designing ads in-house. They conceived the idea of buying a four-page insert in *The New York Times*' Washington-area delivery run. They saved thousands by running ads on *The Washington Post*'s "Federal Page" on a standby basis—whenever a slot opened up, rather than on a scheduled day.

"The issue was changing daily, if not hourly, and we couldn't afford the time for an agency or a designer," says **Elizabeth Board**, the council's public-issues director. "We're talking about [using] a PageMaker [software program] on our own computer. These ads were literally delivered at the last minute."

TOBACCO INSTITUTE

- **BUDGET:** \$38 million annually.
- **MEMBERS:** 13 cigarette companies, led by RJR Nabisco and Philip Morris.
- **KEY LOBBYIST:** Walker Merryman, vice president.
- **PAC:** Spent \$184,650 in the 1991-92 election cycle and \$46,900 in the first half of 1993.
- **BOTTOM LINE:** Wants to kill the cigarette tax.

First lady Hillary Rodham Clinton and presidential adviser Ira Magaziner refused to meet with the liquor makers. So they turned to a strategy of wooing reporters, who then pressed administration officials on points the council wanted to make.

The group's pitch went as follows: When the alcohol tax was raised in 1991, fewer people drank, so revenue actually went down. Liquor is already the most heavily taxed product in American stores. A tax is unfair to those who drink responsibly.

"The problem was to make sure, in this morass of people running around talking about health care, that the important people became familiar with our arguments," says council President **Fred Meister**. "We had to find a way to cut through the noise level."

The Distilled Spirits Council also had to fend off an attack on its flank from tobacco boosters like Rep. **Martin Lancaster** (D-N.C.), who is urging the president to ease the burden on cigarettes by hitting the alcohol industry also.

"At least in the perception of my constituents, alcohol creates as many health problems as tobacco," Lancaster wrote Hillary Clinton on July 19. "Tobacco does not cause the injuries from spouse abuse, child abuse, automobile accidents, etc., that alcohol does."

And 57 groups, ranging from the **American Medical Association** to the **National PTA**, have signed onto a statement favoring alcohol taxes as a way to cut down on unhealthy drinking.

In the end, President Clinton simply realized he didn't need another enemy, says **George Hacker**, director of the **Alcohol Project** at the **Center for Science in the Public Interest**. "The administration decided they didn't want to fight too many fighters in the ring," Hacker says.

But the match is not over. There is much pressure to find more money for health reform, and liquor taxes have always been tempting to politicians. To ward off the temptation, the Distilled Spirits Council will pound away at the point that raising taxes doesn't mean more revenue if fewer people drink.

"We're going to keep that information in front of people as long as we can," Board says. "It's hard to explain to people why you want to tax them more when the tax isn't even working."

—N.B.

The July 19 letter from Rep. **Martin Lancaster** (D-N.C.) to first lady Hillary Rodham Clinton did not bother with niceties. "A plan which focuses only on tobacco is political dynamite in my district," wrote Lancaster, who represents a major tobacco-growing region. "It will break my heart to do so, but please know that I will do everything in my power to defeat a health care reform package which singles out tobacco for a confiscatory tax."

Meanwhile, back in rural Seven Springs, N.C., a group called **Friends of Tobacco** is running a "green ribbon" campaign, modeled on the yellow-ribbon movement that sprang up during the Persian Gulf War. To protest the tobacco tax in the Clinton health plan, Tobacco Belt residents are pinning green ribbons on everything from trees to stores to lapels.

Such is the range of the tobacco lobby, which includes the powerful Tobacco Institute in Washington, the independent campaigns of mammoth corporations like the **Philip Morris Cos.** and **RJR Nabisco Inc.**, and farmers' groups like **Friends of Tobacco** and the **Tobacco Growers' Information Committee**.

So far, the tobacco lobby has failed in its only health reform goal—keeping cigarette taxes out of the Clinton plan. In contrast to his decision to spare the alcohol industry, the president is proposing a tax of 75 cents to \$1 per cigarette pack.

Clinton can get away with this because tobacco has become so despised. In an April 1989 Gallup poll of 1,000 adults, the Tobacco Institute was the only interest group with an unfavorable rating higher than its favorable rating—61 percent to 26 percent.

"They make their living selling a lethal product, and they lie about it," says **Phillip Wilbur**, spokesman for the **Tobacco Tax Policy Project** of the **American Cancer Society**. "It's not a way to get popular."

The tobacco lobby also must contend with **C. Everett Koop**, the popular former U.S. surgeon general, who is publicly pushing for a 50-cent tax as high as \$2 a pack.

Ads are not an effective tool for tobacco lobbyists because 70 percent of the public has already decided it disagrees with them. "It has never been part of the strategy to go mass marketing with this," says Tobacco Institute spokesman **Thomas Lauria**.

But the tobacco industry is not to be underestimated. While they've given up on killing the tax outright, industry leaders argue that it's only fair to spread the pain to other "luxury" products, especially alcohol.

The Tobacco Institute Political Action Committee gave \$184,650 to congressional candidates in the 1992 campaign. And its two biggest members made contributions far exceeding that: RJR Nabisco's PAC gave \$846,363, and Philip Morris' PACs gave \$694,741. All gave additional cash to the political parties themselves.

As Rep. Lancaster's plaintive letter suggests, lawmakers from tobacco regions—led by the likes of Rep. **Charles Rose** (D-N.C.) and Sen. **Jesse Helms** (R-N.C.)—will fight fiercely. And tobacco country is not defined by the North Carolina border; according to industry supporters, 23 states are home to tobacco farmers.

At a Sept. 28 congressional hearing, Rep. **Jim Bunning** (R-Ky.) asked Hillary Clinton why alcohol was not hit, too. The first lady answered that, unlike alcohol, cigarettes are unhealthy even when used as intended. Such skirmishes are likely to define the cigarette-tax debate.

A legion of lobbyists is helping the Tobacco Institute make its arguments. Perhaps the key figure is **James Healey**, a principal at Alexandria, Va.'s **Black, Manafort, Stone & Kelly**. He formerly worked for Rep. **Dan Rostenkowski** (D-Ill.), chairman of the House Ways and Means Committee, which will have a big part in crafting the health-care reform.

Healey estimates that 13 to 20 House members will vote against any plan that contains a tax on tobacco alone, a bloc that could prove critical to the plan's chances.

Some tobacco-industry leaders, feeling pummeled, want to strike a compromise with Clinton now on a 48-cent tax. Others argue that such a compromise would be premature, that the tax would only be raised in later negotiations.

Tobacco's most potent argument is that a cigarette tax will cost jobs, unfairly targeting the Southeast. In case anyone in Congress misses the point, the Tobacco Institute has drawn up lists of how many jobs would be eliminated in each state.

Says Lauria: "Name a state and a tax amount, and I can give you what the impact could be."

—N.B.

ASSOCIATION OF TRIAL LAWYERS OF AMERICA

- **BUDGET:** \$19 million annually.
- **MEMBERS:** 60,000 plaintiffs lawyers.
- **KEY LOBBYISTS:** Alan Parker, deputy executive director; a former chief counsel to the House Judiciary Committee. Thomas Boggs, partner, D.C.'s Patton, Boggs & Blow.
- **PAC:** Spent \$4,433,590 in the 1991-92 election cycle and \$959,300 in the first half of 1993.
- **BOTTOM LINE:** Fiercely opposes curbing patients' right to sue doctors.

The advantage held by the Association of Trial Lawyers of America in the health-care battle is that it cares about only one thing: squashing any proposal that would interfere with suing doctors.

The group faces big obstacles. Much of the public supports changing the malpractice system. And the **American Medical Association**, whose cooperation the administration badly needs, is pushing hard for reforms like capping pain-and-suffering awards and limiting attorney fees.



Alan Parker

But lawyers warn that it is patients who will suffer, and careless or unscrupulous doctors who will benefit, if malpractice suits are curtailed. President Clinton has split the difference, proposing no cap on pain-and-suffering payments, but limiting attorney fees to one-third of the jury award. This balancing act has not satisfied anyone, and both doctors and lawyers are carrying the fight to Congress.

The trial lawyers' style has always been to fight behind the scenes. **Eugene Pavalon**, a partner at Chicago's Pavalon & Gifford, chatted with Vice President Albert Gore Jr. about health reform at a Democratic fund-raiser earlier this year. **Philip Corboy**, a partner at Chicago's Corboy & Demetrios, sent a letter recently to first lady Hillary Rodham Clinton, whom he's known for years.

ATLA's high-powered staff of 150 is supplemented by such outside talent as **Thomas Boggs**, perhaps the most influential lobbyist in Washington. And the trial attorneys boast numerous friends (and ex-lawyers) in Congress, notably Sen. **Ernest Hollings** (D-S.C.).

ATLA gives lots of money to congressional candidates, mostly Democrats, through its PAC. In addition, individual trial lawyers gave \$481,179 to the Clinton campaign—eight times what they gave George Bush—according to a study by the Center for Responsive Politics.

While ATLA has worked quietly, holding private meetings and sending volumes of information to the White House, it has also created a united front with consumer groups like **Public Citizen** and the **Public Interest Research Groups**—which don't work so quietly.

Public Citizen held a dramatic press conference June 29 featuring five people who had lost children or suffered terrible injuries because of medical malpractice. The Public Interest Research Groups plan to stage similar events throughout the country.

Says one typical Public Citizen statement: "We should not try to cure the economic problems facing the health care system on the backs of seriously injured victims of medical malpractice." —N.B.

NATIONAL GOVERNORS' ASSOCIATION

- **BUDGET:** \$10 million annually.
- **MEMBERS:** Governors from 50 states and five territories.
- **CHIEF LOBBYIST:** Raymond Scheppach, former deputy director, Congressional Budget Office under then Director Alice Rivlin.
- **BOTTOM LINE:** Wants ultimate enforcement and budgetary control over the health alliances, which are run by the states under the Clinton plan. Wants to fold Medicaid into the new health-care package.

States now spend nearly one-fifth of their entire budget on Medicaid, contributing about \$43 billion of the program's \$100 billion annual cost—and hemorrhaging money from hard-pressed state treasuries in the process. Health-care reform has long loomed large on governors' radar screens.

So, how'd they do? So far, not so well. True, the new



NGA's Raymond Scheppach

regional health alliances, in charge of buying health-care packages and ensuring their quality, will be run by the states. The problem for the governors is that the authority for making sure those alliances serve all citizens, and the fiscal power to ensure they don't run over budget, stays with the federal government.

"The rub is, who's going to enforce those budgets, and what is our accountability?" says **Raymond Scheppach**, executive director of the National Governors' Association.

Under the plan, a newly created National Health Board would oversee the alliances. In addition, if a state fell short of meeting its federally mandated obligations to provide adequate health care, the Treasury Department could step in, imposing a payroll tax to cover the cost of operating the system. That sort of federal intrusion riles the nation's governors.

"If this is a state-based system, then we ought to be in charge," argues Scheppach, who adds that the states ought at least to be given the option of running the show. "But those issues are still somewhat up in the air."

Medicaid, too, remains outside the health-care reform package. The states had wanted that massive federal program included, so that they would be in charge of just one health plan, not two, thus streamlining their health bureaucracy.

The early setbacks for the states are somewhat surprising, given that the NGA has a powerful friend in

the process. President Clinton was the group's chairman in the mid-1980s and remained on the NGA's health task force until two years ago.

Early on in the debate, Scheppach brought top state health officials to Washington for days at a time, making sure their perspective was represented in the working groups that met weekly with task force co-chairs Ira Magaziner and Judith Feder.

But the NGA has its own particular problems that make getting its way a bit difficult. For one thing, Congress has historically treated the states like poor stepchildren, treading on their jurisdiction and giving them short shrift in financial aid. For another, getting 55 headstrong members to agree on anything but the broadest of policy outlines is challenging. And Scheppach and his lobbying team must stay within strict policy parameters established at the group's biannual meetings.

"It's not a free-wheeling organization," says one health-care consultant who knows the group well.

—T.R.G.

NATIONAL RIGHT TO LIFE COMMITTEE

- **BUDGET:** \$13.5 million annually.
- **MEMBERSHIP:** Does not release membership figures, but estimates range up to 400,000.
- **KEY LOBBYIST:** Douglas Johnson, legislative director.
- **PAC:** Spent \$2,088,890 in the 1991-92 election cycle and \$84,440 in the first half of 1993.
- **BOTTOM LINE:** Wants to remove coverage for abortions now provided under the Clinton plan.

Among the myriad competing groups in health-care reform, most are at least willing to sit down at the bargaining table, separate fact from hype, and work out a compromise on their differences. Not these folks.

In the battle over whether abortion will be covered under the Clinton health plan, two implacable foes are facing off: the National Right to Life Committee Inc., a grass-roots organization with 3,000 local chapters, and the **National Abortion Rights Action League**, the political arm of the abortion-rights movement.

Though the right to an abortion is not explicitly spelled out in the Clinton plan, administration officials have made it clear that under the plan's "family planning and pregnancy related services," abortions are included.

And this has set the stage for a firestorm of activity among those opposing abortions as a matter of religious principle and those favoring a woman's right to choose abortion as a matter of basic health care. The fight could end up on the floors of the House and Senate.

Abortion foes brag that they have the political clout to kill the entire health-care package if the coverage of abortions is not removed.

Already the National Right to Life Committee has run ads in Washington political journals pillorying the plan on two fronts—that it rations health care and compels every taxpayer to fund abortion services on demand.

"The president won't be able to pass health-care reform that includes taxpayer funding for abortions—in either house," says **Ralph Reed Jr.**, executive director of the **Christian Coalition**, a politically active, 400,000-member, pro-family group. "This is an up-or-down vote, and the momentum is on our side."

Leading the abortion-rights battle is the 700,000-member **NARAL**, whose longtime president, **Kate Michelman**, is a well-known Capitol Hill figure.

NARAL, whose D.C. office has a staff of 35 and a budget of \$4 million, is already airing two television ads and placing two print ads, produced by its longtime advertising agency, D.C.-based **Greer Margolis Mitchell Burns & Associates**. "America: Protect Women's Health" is the message that shouts from the print ad.

Both sides have very strong grass-roots operations—the National Right to Life Committee with its 3,000 chapters and **NARAL** with its 40 state branches.

And they have their traditional allies to bolster their positions. For the anti-abortionists, there's the Chesapeake, Va.-based **Christian Coalition**, as well as the D.C.-based **National Conference of Catholic Bishops**.

The abortion-rights position is touted by a loose coalition known as the **Campaign for Women's Health**, featuring dozens of national organizations devoted to women's health-care needs. Chief among them is the New York-based **Planned Parenthood Federation of America** and the D.C.-based **Women's Legal Defense Fund**.

—T.R.G.

I. OTHER COUNTRIES

OTHER COUNTRIES

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OTHER COUNTRIES

The U.S. operates a unique health care system - one dependent on a private marketplace that produces many of the medical marvels in the world. Yet it spends more per person than any other nation while leaving 15 percent of the population with no insurance coverage. In contrast, other industrialized nations, and many developing ones as well:

- Assure universal coverage for all citizens
- Spend less on health as a percentage of gross domestic product
- Report higher levels of consumer satisfaction.

Those countries demonstrate that the three goals - universal coverage, lower costs and consumer satisfaction - are feasible. But each took equally unique roads to achieve those goals. In Britain the government is the health care-deliverer, as well as the insurer. In Canada, the government is the insurer, but the delivery system comprises independent fee-for-service practitioners and hospitals. Germany offers a variety of publicly financed "sickness funds," analogous to insurance companies, but leaves practitioners to carry on in independent practices. Korea used employer mandates to move from its 1976 nadir, when only 10 percent of Koreans had insurance, to total coverage in 1988. Some countries, like England, ration expensive technology, forcing "queuing," while in others, like Germany, consumers "use" the health care system more often than Americans.

SOURCES:

Michael Rachlis (Canada), physician, policy analyst and author, Toronto, Ontario.
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Uwe Reinhardt (Canada, Germany), professor of political economy, Princeton University.
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Laurene A. Graig (Canada, Germany, Japan, Netherlands, Britain), senior researcher, The Wyatt Co. (international consulting firm), Washington, DC. (202) 508-4652.
Graig authored Wyatts 1991 book-length six nation comparison of health systems, Health of Nations.

UNITED STATES

PERCENTAGE OF POPULATION WITH COVERAGE:

65% private.
22% public (13% Medicare, 9% Medicaid).
13% uninsured.

ELIGIBILITY:

Private: Most but not all employers offer health insurance; individuals who meet the health criteria of the insurer can purchase insurance themselves.

Public: *Medicare*—Age 65 and over, and some disabled. *Medicaid*—Income at or below poverty level (varies by state).

WHAT'S COVERED:

Hospital care: *Private*—varies from 80% to 100%.

Medicare—100% for the first 60 days, after a \$628 deductible; after 60 days patient pays fixed daily fees.

Medicaid—100%.

Outpatient care: *Private*—varies from 0% (for routine or preventive care) to 100% (often with copayments).

Medicare—80%, after a \$100 annual deductible.

Medicaid—100%.

Prescription drugs: *Private*—varies from 0% to 100% (often with copayments).

Medicare—not covered.

Medicaid—100%.

HOW FINANCED:

Private: employer and employee contributions (% varies); self-paying subscribers.

Public: *Medicare*—employer and employee payroll tax and general revenues. *Medicaid*—50% federal, 50% state taxes.

DELIVERY SYSTEM:

Private physicians on fee-for-service basis; managed-care organizations (some with salaried physicians); public and private hospitals and clinics.

NOTE:

US physicians are unique in the autonomy with which they set their fees. With the exception of salaried HMO physicians, most are reimbursed by private insurance companies, Medicare and Medicaid, and, in many cases, may bill the patient the balance of the fee not paid by the primary payor. Public and private hospitals are subject to a variety of state and federal price regulations.

CANADA

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

100%.

ELIGIBILITY:

Automatic for all residents.

WHAT'S COVERED:

Hospital care: 100%.

Outpatient care: 100%.

Prescription drugs: varies by province. In all provinces, 100% for elderly.

HOW FINANCED:

38% by national taxation, 62% by provincial taxation.

DELIVERY SYSTEM:

Private physicians in fee-for-service practices who bill Provincial Health Ministries monthly for services provided; in five provinces, physician fees are governed by expenditure targets.

Trustee- or community-owned hospitals that negotiate an annual prospective budget with the provincial government; capital expenses are covered through provincial capital budgets.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

90% have supplementary coverage.

SOURCE OF PRIVATE INSURANCE:

Employers, who may pay from 50 to 100%.

NOTE:

Provinces prohibit private insurance from covering anything that is already covered by public insurance, so private insurance typically covers "extras" like private hospital rooms, prescription drugs, ambulance service, and nursing-home care.

GERMANY

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

90%.

ELIGIBILITY:

All residents (mandatory for employees earning less than \$33,000/year).

WHAT'S COVERED:

Hospital care: 100%, with a small daily copayment for the first two weeks.

Outpatient care: 100%.

Prescription drugs: 100%, with a \$2 copayment per prescription.

HOW FINANCED:

Decentralized "sickness funds" are financed through payroll taxes, with equal contributions by employees and employers; also a 6.5% tax on social security pensions plus an income-based tax on private pensions for retirees. Unemployed, disabled, elderly and poor are covered under social security.

DELIVERY SYSTEM:

Outpatient physicians are paid on a fee-for-service basis through sickness-fund associations which they must join; fees are governed by overall expenditure targets; hospital physicians are salaried.

Sickness funds reimburse hospitals, which are community- or individually-owned, for operating costs. Capital costs are covered by state governments.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

8% have primary private coverage; 7% have secondary private coverage (supplemental to public).

SOURCE OF PRIVATE INSURANCE FINANCING:

Primary: 50% employer, 50% employee.

Secondary: 100% employer.

NOTE:

Germans who earn more than \$33,000/year can opt out of public insurance for private coverage. However, once this choice is made, they cannot rejoin the public plan.

SWEDEN

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

100%.

ELIGIBILITY:

Automatic for all residents

WHAT'S COVERED:

Hospital care: 100% (\$10 daily fee, up to \$150/year maximum).

Outpatient care: 100% (\$10 fee/visit, up to \$150/year maximum).

Prescription drugs: 100% for "essential" drugs.

HOW FINANCED:

10% by employer payroll tax, 65% by local tax, 6.5% by federal tax, plus some government subsidies.

DELIVERY SYSTEM:

County councils employ salaried physicians and own and operate regional hospitals which have prospective annual budgets; most outpatient care is provided in regional primary-care centers, or "polyclinics."

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

7% have supplemental coverage.

SOURCE OF PRIVATE COVERAGE:

Employers.

NOTE:

Private supplemental insurance is most commonly reserved for business executives and their families, and covers such things as private hospital accommodations and privately provided nonemergency surgery, for which there would otherwise be long waiting periods.

GREAT BRITAIN

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

100%.

ELIGIBILITY:

Automatic for all residents.

WHAT'S COVERED:

Hospital care: 100%.

Outpatient care: 100%.

Prescription drugs: 100%, with nominal copayment per prescription.

HOW FINANCED:

85% by general taxation through the National Health Service (NHS);

15% by employer and employee contributions to the National Insurance Fund.

DELIVERY SYSTEM:

Outpatient physicians are reimbursed through a combination of capitation and negotiated and binding fees; hospital physicians are salaried. NHS-owned hospitals receive an annual prospective budget.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

9% have supplementary coverage that is often used to cover elective surgery and to avoid NHS waiting lists.

SOURCE OF PRIVATE INSURANCE:

Employers, who may pay from 0-100%.

NOTE:

The NHS is currently undergoing some significant changes as a result of the 1989 adoption of a White Paper on health-care reform. The White Paper strengthens competitive elements within the NHS by allowing hospitals to become self-governing trusts that compete for patients, and by giving general practitioners with over 11,000 patients a fixed amount of money to purchase hospital services previously provided free by the NHS.

JAPAN

PERCENTAGE OF POPULATION WITH PUBLIC COVERAGE:

100%: 52% through Health Insurance for Employees (HIE), 48% through National Health Insurance (NHI).

ELIGIBILITY:

HIE: all employees (employers with more than 700 employees may contract out of the government plan and establish an independent plan).

NHI: those not covered by HIE.

WHAT'S COVERED:

Hospital care: HIE—90% (employees), 80% (employees' dependents) (out-of-pocket maximum = \$392/month).

NHI—70% (100% for elderly with \$3/day copayment) (out-of-pocket maximum = \$392/month).

Outpatient care: HIE—90% (employees), 70% (employees' dependents).

NHI—70% (100% for elderly with \$6/month deductible).

Prescription drugs: HIE—90% (employees), 70% (employees' dependents).

NHI—70% (100% for elderly).

HOW FINANCED:

HIE: 4.15% payroll taxes on employers and employees, plus copayments.

NHI: 50% through federal taxes, some local government subsidies, plus income-adjusted premiums up to \$2,543/year.

DELIVERY SYSTEM:

Physicians practice in clinics (with fewer than 20 beds), or hospitals (with 20 or more). Clinic physicians, who are paid negotiated and binding fees-for-service, are not permitted to care for hospitalized patients, where services are provided by salaried physicians.

PERCENTAGE OF POPULATION WITH PRIVATE COVERAGE:

0% (some supplemental benefits can be purchased through HIE).

NOTE:

Japan suffers from a duplication of services and equipment because of traditional and continuing political rivalries between clinic physicians and hospital-based physicians. Japanese patients tend to visit doctors frequently and have long lengths of stay in hospitals, including long-term care for the elderly.

Source: Harvard Community Health Plan Annual Report 1990

Desperately Seeking Solutions

By John K. Iglehart

Though we can learn valuable lessons from other nations, Americans still must make painful decisions for themselves.

The American health-policy community, wracked by uncertainty over how best to curtail the uncontrolled growth of spending for medical care, has become fascinated with how other industrialized nations provide their citizens with these services, usually on a universal basis and for considerably less money. The findings have been enlightening, but they do not provide any real American-style answer to the essential question that haunts all advanced industrialized nations: How should finite health-care resources be allocated when the very human instinct to relieve the burdens of illness, disability and death is without limit?

Over the last decade, I have examined how other industrialized nations (Canada, Germany, Japan and the United Kingdom) have organized their health-care systems and have addressed this eternal resource-allocation question. Along the way, I was asked innumerable times why *The New England Journal of Medicine* would send its national correspondent to other nations to examine their health-care systems when, as conventional wisdom holds, America has "the best system in the world." I readily recognized the pitfalls of such cursory examinations and, for the most part, avoided direct systemic comparisons, given the countless variables that

make them suspect, if not totally misguided. I settled on a rationale that was best summed up by Canadian economist Robert G. Evans, who wrote:

"Nations do not borrow other nation's institutions. The Canadian system may be 'better' than the American. I believe it is, though that is a very complex question, and as I have just pointed out, my views, like yours, are contaminated by my origins. Even if it is better, I am not trying to sell it to you. You cannot have it. It would not 'fit' because you do not see the world, or the individual, or the state, as we do.... The point is that by examining others' experience you can extend your range of perceptions of what is possible."¹

Whatever the experience of a country in formulating its health-care policies, an ever-present reality punctuates the dialogue. It is represented by the ideologic pendulum that swings between individual accountability and social responsibility. This dynamic, which is constantly in motion, is particularly important in the new environment of freedom that has provided the countries of Eastern Europe the opportunity to chart reforms that redress imbalances that favored centralized decision-making over individual freedom. It applies as well to the industrialized democracies that are driven by capitalism because governments and individu-

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als live in a constant state of tension on questions of resource allocation.

To elaborate, the peoples of Czechoslovakia, Hungary, Poland and former East Germany yearn for systems that reflect meaningful private-public collaboration in the provision of medical care, rather than systems run by government fiat, to which they were long subjected. Thus, health-care system reforms in these newly free nations are moving in that direction.

In Western Europe, where mature health-insurance schemes feature universal coverage financed through taxation or employer-employee contributions, there is pressure to mix some market-oriented features with government regulation in an effort to give individuals a greater voice in decision-making and to encourage providers to become more efficient. The Netherlands and the United Kingdom have embraced reforms that reflect these priorities without changing their basic systems. These reforms reflect the influence of the thinking of economist Alain Enthoven of Stanford University, whose proposed "managed competition" model has been embraced by key Washington policy-makers as well.

Lastly, in the United States, the world's bastion of individual freedom and unfettered capitalism, there are pressures for government to adopt more compulsory policies that would guarantee universal coverage, mandate "play-or-pay" financing schemes and not allow physician billing of patients beyond health-insurance reimbursement limits. These proposals represent swings of the political pendulum. While they are strong and growing as a consequence of the millions of Americans who lack health insurance, they are as yet no match for our steadfast beliefs in low taxation and limited government. Nevertheless, even the most conservative reform approaches, including the one advocated by the Bush administration, call for an unprecedented degree of government intervention in the

American health-care system.

As the United States moves ahead, in the halting fashion that has become a trademark of its paralyzed processes of health policymaking, what might we take from other industrialized nations that would be meaningful to our debate? I believe three essential lessons can be derived from studying the health-care systems of the other major industrialized democracies. Overriding all three is the fundamental reality that all nations approach their problems differently, based on their cultural beliefs, political priorities, medical imperatives and economic standings. In this respect, it is important to recognize that the United States is distinguished by its sheer physical size and diverse population. The subpopulations of the United States are no less diverse in many respects than are the Greeks and the Swedes, or the Dutch and the Italians.

Lesson One: All major democracies have placed government in a more prominent position in relation to their health-care systems than has the United States. Not only do more of the monies flow directly through governments via taxation or indirectly through quasi-government structures that collect employer-employee contributions, but other governments also chart policies that affect entire systems, regardless of the financing mechanism. The principal government mandate in all of the other major democracies is to guarantee access to medical care for all citizens.

This has been a priority in other nations since World War II. One way to illustrate it is to point to Canada's experience. Although the flow of people, commerce and culture—including television programming, sports teams and a wide variety of other exchanges—have long marked the dynamic relationship between Canada and the United States, the health-care systems of these two neighboring powers have diverged sharply in the last three decades. In 1960, the systems of both nations were dominated by solo, fee-for-service

The principal mandate in all other major democracies is to guarantee access to medical care for all citizens.

The profit motive is far less pervasive in the health-care systems of other countries.

practitioners and nonprofit community hospitals. Medical care was financed through a multiplicity of private insurance plans, out-of-pocket payments and minimal government support. And millions of citizens in both countries lacked adequate coverage.

Underscoring its binding belief in equality, many of Canada's 10 provinces, led by Saskatchewan's initial step in 1947 to create a health-insurance plan for its people, developed schemes that eventually forced the national government to bring the programs into conformity. By 1971, all the provinces had adopted insurance programs that met the basic conditions set out by Parliament to qualify for federal funds covering 50 percent of the programs' costs. In the process, Canada made illegal the sale of private health-insurance benefits that were offered by the provincially based plans.

This action, an impossible step for American policymakers to seriously contemplate given the domination of the U.S. system by private interests, arose from "deep-rooted suspicion of class-based systems of any kind," Evans wrote recently. Private schools are only a small part of Canada's educational system before college, private universities do not exist, and in public transportation only a single class of travel is usually available, except in some air and train travel. As Evans put it, "equality before the health-care system" in Canada is a political principle similar to equality before the law.²

The health-care systems of other major democracies better reflect the value that Americans attach to private-public collaboration than does Canada's system, but they also place government in a far more commanding position. For example, as the General Accounting Office pointed out in its study³ of the systems of France, Germany and Japan, they resemble the U.S. system in four important ways: They provide health insurance using multiple quasi-public insurers, or payers. People typically get

health insurance for themselves and their dependents at their place of employment, and they have free choice of doctors, who charge on a fee-for-service basis. Both private and public hospitals deliver inpatient care. But a key differentiating characteristic is that the French, German and Japanese systems are extensively regulated by government. Among the consequences of this regulation: All citizens are guaranteed access to health insurance; insurers' payments to physicians and hospitals are standardized, thus avoiding cost-shifting between payers; and all three countries use price controls that place ceilings on physician fees or daily hospital charges.

Lesson Two: The profit motive is far less pervasive in the health-care systems of other countries than it is in the United States. Though the private companies—indeed, many are multinational, American-based companies—that manufacture pharmaceutical products and medical devices are operated on the same for-profit basis in other countries as they are in the United States, the insuring function in other countries is performed for the most part by nonprofit organizations with a more social orientation than is the case with commercial health insurers and many Blue Cross and Blue Shield plans in the United States.

The values Americans attach to profits, wealth and business acumen are also influencing their health-care system. Arnold S. Relman, M.D., whose 1980 essay⁴ on the medical-industrial complex underscored the growing importance of these trends, acknowledged 11 years later that his earlier paper painted an incomplete picture. He wrote: "What I had not fully appreciated in 1980 was that the pressures on our voluntary hospitals would lead many of them to behave not like their investor-owned competitors. We are witnessing a pervasive change in the ethos of the voluntary hospital system in America from that of a social

service to that of a business."¹

I am struck by the different nature of the health-insurance organizations that operate in other major Western countries. Most of these organizations are either heavily regulated private carriers or are quasi-public insurers with more socially oriented objectives than is the case with their U.S. counterparts. U.S. commercial health insurers offer no excuses for their reluctance to protect medically risky people who are employed in marginal industries; they are in business to make a profit. But a number of nonprofit Blue Cross and Blue Shield plans, launched as part of a social movement in the 1930s to help people pay their hospital bills, now are difficult to differentiate from their commercial competitors in terms of their restrictive medical underwriting practices, their reluctance to insure people in need of financial protection and their entrepreneurial instincts.

Lesson Three: The health-care systems of other nations maintain a better balance of medical generalists and specialists than does the United States. Other systems, through a variety of mechanisms, assume that primary-care doctors will act as gatekeepers to specialist care. This places the primary-care doctor in charge of the patient and generally provides for a more efficient allocation of resources. In some countries, governments regulate the number of training positions in given specialties and do not rely on the marketplace to sort out this ratio, as is the case in the United States.

There is no precise ratio of generalists to specialists that all countries strive to achieve, but the accepted standard is about 50-50. Canada has been able to maintain such a balance over a long period of time. If Canada has a problem in this regard, it is a surplus of primary-care doctors. In the United States, the opposite is true. Medical training programs in family medicine and internal medicine are experiencing difficulty in filling their positions, although such

doctors are in great demand, particularly as managed-care enrollments rise.

In conclusion, American health policymakers have identified a number of important differences between the systems of other industrialized nations and the United States. The differences have shown that other systems have a more social orientation and that their overriding emphasis is on providing all citizens with access to medical care. On the other hand, these exercises have not uncovered a magic pill that is going to spare the United States the painful decisions that lie ahead in its debate over reforming the American system. To paraphrase the advertisement of a Wall Street brokerage firm, American policymakers are going to have to address a range of very difficult issues "the old-fashion way," by debating the pros and cons and then actually making decisions, painful though they may be.

In the absence of such decisions, the United States remains an outlier in the advanced industrialized world. It does not provide universal health-insurance coverage to all its citizens, and that which is provided is the most costly in the world. Americans seem prepared to accept paying a premium for quality medical care, but the system's inequity of coverage may be a shortcoming that will ultimately determine whether we are indeed "our brother's keeper." **HMC**

Notes

1. R. Evans, "The Spurious Dilemma: Reconciling Medical Progress and Cost Control," *Health Matrix* 1(1986): 25-34.
2. R. Evans, "We'll Take Care of It For You, Health Care in the Canadian Community," *Daedalus* 117(1988): 155-89.
3. U. S. General Accounting Office, *Health Care Spending Control: The Experience of France, Germany, and Japan*, GAO/HRD-92-9 (Washington, D.C.: Government Printing Office, 1991).
4. A. S. Relman, "The New Medical-Industrial Complex," *New England Journal of Medicine* 303(October 23, 1980): 963-970.
5. A. S. Relman, "The Health Care Industry: Where Is It Taking Us?" *New England Journal of Medicine* 325(September 19, 1991): 854-859.

Other systems assume that primary-care doctors will act as gatekeepers to specialist care.

DataWatch

Health Spending, Delivery, And Outcomes In OECD Countries

by George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald

Abstract: Data comparing health expenditures in twenty-four industrialized nations show that the United States continues to lead the world in health spending as a percentage of gross domestic product. In 1991 the United States spent \$2,368 per person on health care, compared with an average of \$1,305 in Organization for Economic Cooperation and Development (OECD) countries. The U.S. figure exceeds spending in Canada, the next-highest spender, by 50 percent. Measures of health care use and health status do not provide convincing evidence that the United States has a superior health care system for its larger expenditure levels.

This DataWatch provides current information on health spending patterns, availability and use of services, and gross health outcomes in the twenty-four member countries of the Organization for Economic Cooperation and Development (OECD). It updates information presented in *Health Affairs*, Fall 1991, and the *Health Care Financing Review*, Summer 1992.¹ First, we present and analyze data on health expenditures for 1985–1991. We next discuss the latest available information on the availability and use of inpatient medical care and physician services in the twenty-four countries. We then present the latest available data on infant mortality and life expectancy.

Health Care Spending

Exhibit 1 contains the ratios of health spending to gross domestic product (GDP) for the twenty-four OECD countries for 1985–1991. As is always the case, previously reported data for a number of countries have been slightly revised as countries reestimate their health spending and GDP on the basis of more up-to-date information.² In 1985 health expenditures ranged from 2.8 percent of GDP in Turkey to 10.5 percent in the United States. In 1991 the ratios ranged from 4.0 percent in Turkey to 13.2 percent in the United States. Over this period, the average OECD health-to-GDP

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Exhibit 1
Total Health Expenditures As A Percentage Of Gross Domestic Product (GDP),
1985-1991

	1985	1986	1987	1988	1989	1990	1991	Compound annual rate of growth
Australia	7.7%	8.0%	7.8%	7.7%	7.8%	8.2%	8.6%	1.9%
Austria	8.1	8.3	8.4	8.4	8.4	8.3	8.4	0.6
Belgium	7.4	7.6	7.7	7.7	7.6	7.6	7.9	1.1
Canada	8.5	8.8	8.9	8.8	9.0	9.5	10.0	2.7
Denmark	6.3	6.0	6.3	6.5	6.5	6.3	6.5	0.5
Finland	7.2	7.4	7.4	7.2	7.2	7.8	8.9	3.6
France	8.5	8.5	8.5	8.6	8.7	8.8	9.1	1.1
Germany	8.7	8.6	8.7	8.8	8.3	8.3	8.5	-0.4
Greece	4.4	5.4	5.2	5.0	5.4	5.4	5.2	1.0
Iceland	7.1	7.8	8.0	8.6	8.6	8.3	8.4	2.8
Ireland	5.2	5.1	7.7	7.3	6.9	7.0	7.3	-1.9
Italy	7.0	6.9	7.4	7.6	7.6	8.1	8.3	2.9
Japan	6.5	6.6	6.7	6.6	6.6	6.7	6.8	0.3
Luxembourg	6.8	6.7	7.3	7.2	6.9	7.2	7.2	1.0
Netherlands	8.0	8.1	8.3	8.2	8.1	8.2	8.3	0.6
New Zealand	6.5	6.7	7.0	7.1	7.2	7.3	7.6	2.6
Norway	6.4	7.1	7.4	7.7	7.4	7.4	7.6	2.9
Portugal	7.0	6.6	6.8	7.1	7.2	6.7	6.8	-0.5
Spain	5.7	5.6	5.7	6.0	6.3	6.6	6.7	2.7
Sweden	8.8	8.5	8.6	8.6	8.6	8.6	8.6	-0.4
Switzerland	7.6	7.6	7.7	7.8	7.5	7.8	7.9	0.6
Turkey	2.8	3.5	3.6	3.8	3.9	4.0	4.0	6.1
United Kingdom	6.0	6.1	6.1	6.1	6.1	6.2	6.6	1.6
United States	10.5	10.7	10.9	11.1	11.5	12.2	13.2	3.9
OECD average	7.2%	7.3%	7.4%	7.5%	7.5%	7.6%	7.9%	1.6%

Sources: OECD *Health Systems: Facts and Trends* (Paris: Organization for Economic Cooperation and Development, 1993); and S. Letsch et al., "National Health Expenditures, 1991," *Health Care Financing Review* (Winter 1992).

Notes: Health and Welfare Canada uses a slightly different definition of gross domestic product (GDP) than is used in GDP figures reported to the OECD. Using the Health and Welfare Canada GDP figures produces slightly different health-to-GDP ratios; these alternative ratios are 8.5 percent for 1985, 8.8 percent for 1986, 8.8 percent for 1987, 8.7 percent for 1988, 8.9 percent for 1989, 9.4 percent for 1990, and 9.9 percent for 1991.

ratio increased from 7.2 percent to 7.9 percent. The United States had both the largest absolute and second-largest percentage increase in its ratio. No other country spent more than 10 percent of GDP on health care in 1991.

Exhibit 2 presents per capita health spending denominated in U.S. dollars on the basis of GDP purchasing power parities (PPPs) for 1985-1991. In 1985 per capita spending ranged from \$66 in Turkey to \$1,711 in the United States, with an OECD average of \$855. By 1991 per capita health expenditures ranged from \$142 in Turkey to \$2,868 in the United States, with an OECD average of \$1,305. The United States had the largest absolute increase and the fourth-highest percentage increase in health spending. In 1991 health spending in the United States exceeded spending in Canada by 50 percent; in Switzerland, by 67 percent; in Germany, by 73

Exhibit 2
Per Capita Health Spending In U.S. Dollars, 1985-1991

	1985	1986	1987	1988	1989	1990	1991	Compound annual rate of growth
Australia	\$ 998	\$1,072	\$1,112	\$1,171	\$1,225	\$1,310	\$1,407	5.9%
Austria	984	1,046	1,109	1,191	1,298	1,383	1,448	6.7
Belgium	879	931	992	1,081	1,153	1,242	1,377	7.8
Canada	1,244	1,364	1,461	1,544	1,666	1,811	1,915	7.5
Denmark	807	818	80	972	1,013	1,051	1,151	6.1
Finland	855	911	99	1,044	1,147	1,291	1,426	8.9
France	1,283	1,135	1,193	1,245	1,415	1,528	1,650	7.3
Germany	1,175	1,215	1,287	1,409	1,412	1,522	1,659	5.9
Greece	282	323	321	334	354	400	404	6.2
Iceland	889	1,073	1,220	1,331	1,373	1,379	1,447	8.5
Ireland	572	580	596	620	651	748	845	6.7
Italy	814	844	955	1,054	1,150	1,296	1,408	9.6
Japan	792	839	916	992	1,092	1,119	1,307	8.7
Luxembourg	930	978	1,135	1,219	1,267	1,392	1,494	8.2
Netherlands	931	990	1,046	1,101	1,176	1,286	1,360	6.5
New Zealand	747	806	871	900	954	995	1,047	5.8
Norway	846	1,066	1,043	1,112	1,128	1,193	1,305	7.5
Portugal	398	389	434	493	548	554	624	7.8
Spain	452	472	522	598	682	774	848	11.1
Sweden	1,150	1,165	1,240	1,303	1,390	1,455	1,443	3.9
Switzerland	1,224	1,267	1,332	1,435	1,498	1,640	1,713	5.8
Turkey	66	89	100	110	118	133	142	13.6
United Kingdom	685	739	795	858	912	985	1,043	7.3
United States	1,711	1,824	1,962	2,146	2,362	2,601	2,868	9.0
OECD average	\$855	\$914	\$940	\$1,055	\$1,126	\$1,212	\$1,305	7.6%

Sources: OECD *Health Systems: Facts and Trends* (Paris: Organization for Economic Cooperation and Development, 1993); and S. Letsch et al., "National Health Expenditures, 1991," *Health Care Financing Review* (Winter 1992).

Note: National currency units are converted to U.S. dollars using gross domestic product purchasing power parities.

percent; and in France, by 74 percent. U.S. spending exceeded Japanese spending by 119 percent and British spending by 175 percent.

We analyzed five additional measures of health spending performance for Canada, France, Germany, Japan, the United Kingdom, and the United States for the 1985-1991 time period (Exhibit 3). These measures are all based on national currencies, thus avoiding the problems in conversion to a single numeraire currency. In particular, Exhibit 3 contains the compound annual rates of growth for 1985-1991 in nominal per capita health spending, real (medical price-adjusted) per capita health spending, real (GDP deflator-adjusted) per capita health spending, and excess health care inflation, as well as the nominal elasticity of per capita health spending relative to per capita GDP.

These measures offer additional insights into the spending performance of these countries' health systems. Nominal per capita health spending

Exhibit 3

Growth In Health Sector Components, In National Currency Units, Compound Annual Rate, For Selected OECD Countries, 1985-1991

	Canada	France	Germany	Japan	United Kingdom	United States
Nominal per capita health spending	7.5%	6.9%	4.9%	6.2%	9.9%	9.0%
Real (medical price deflator) per capita health spending	2.6	4.3	1.8	4.5	2.0	2.7
Real (GDP deflator) per capita health spending	3.6	3.3	2.0	4.8	3.8	5.0
Excess health care inflation	1.0	-1.0	0.3	0.3	1.7	2.3
Elasticity of nominal per capita health spending relative to nominal per capita GDP	1.35	1.19	0.88	1.10	1.13	1.70

Sources: OECD *Health Systems: Facts and Trends* (Paris: Organization for Economic Cooperation and Development, 1993); and S. Lersch et al., "National Health Expenditures, 1991," *Health Care Financing Review* (Winter 1992).

Note: GDP is gross domestic product.

provides a measure of the increase in actual spending per person in each country's own currency. Adjusting this figure for medical price inflation provides a measure of the increase in the volume and intensity of health services per person. Deflating nominal per capita health expenditures by the GDP deflator provides a measure of the nonhealth-sector consumption and investment opportunities that have been forgone because of the growth in health spending. Excess health care inflation measures the rate of growth of medical prices relative to overall prices as measured by the GDP deflator. The nominal elasticity of per capita health spending relative to per capita GDP relates annual increases in nominal per capita health spending to annual increases in nominal per capita GDP.³

In the context of three of these five measures, U.S. spending growth far exceeded growth in the other five countries. The United States had the highest rates of growth in real (GDP deflator-adjusted) health spending and excess medical care inflation, as well as the highest nominal elasticity of health spending relative to GDP. In light of the fact that the United States had the highest 1985 base-year spending level and growth rates in its health-to-GDP ratio and per capita health spending in U.S. dollars (Exhibits 1 and 2), U.S. health spending performance certainly appears rather robust when compared with that of other major industrialized countries.

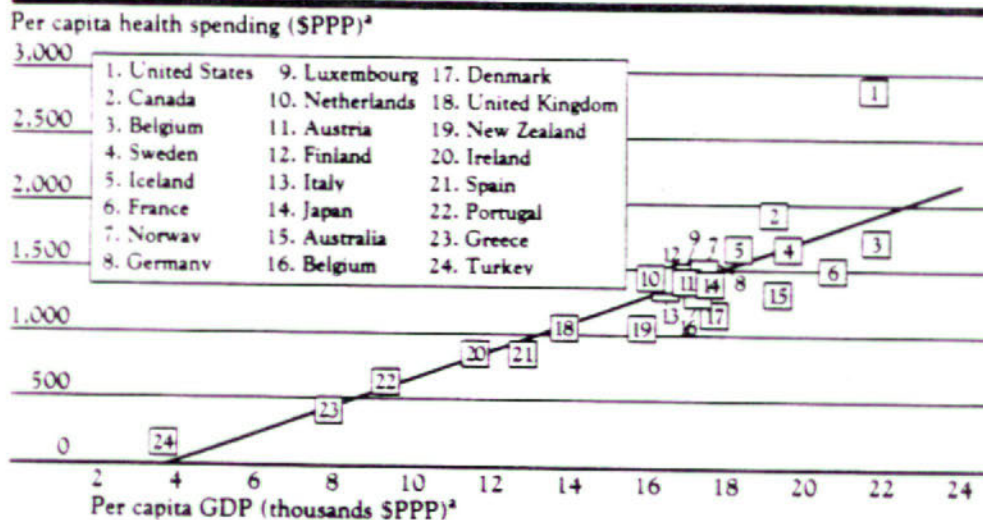
With regard to the other two measures, growth in nominal per capita health spending and real (medical price-adjusted) per capita spending, the United States ranked second and third, respectively. Concerning growth in nominal per capita health spending, the United States's 9.0 percent compound annual growth rate was only slightly below the 9.9 percent figure for the United Kingdom and well above the 7.5 percent for third-ranked

Canada. Moreover, 1985 base-year spending in the United States (Exhibit 2) was 2.5 times the 1985 British level and over 35 percent higher than spending in any of these other countries. In addition, comparing growth in nominal per capita spending may not be a meaningful measure of relative health spending performance, given the sizable differences in the rates of inflation across countries.

Concerning the growth in real (medical price-adjusted) per capita spending, a proxy for growth in the volume and intensity of services, the United States ranked third, after Japan and France. This type of comparison (as in the case of excess health care inflation) is heavily dependent on the reliability and comparability of the medical care price deflators. As we have discussed elsewhere, both methodological and comparability problems exist in this area.⁴ Nevertheless, if one discounts France, where the deflators appear to be the least comparable, only Japan, with a 1985 per person spending level less than half that in the United States, had a higher rate of volume and intensity growth.

Exhibit 4 displays the trend line between nominal per capita GDP and nominal per capita health spending for the twenty-four OECD countries in 1991. Health spending in the United States continues to be well above the

Exhibit 4
Per Capita Health Spending And Per Capita Gross Domestic Product (GDP) In Twenty-Four OECD Countries, 1991



Sources: OECD Health Systems: Facts and Trends (Paris: Organization for Economic Cooperation and Development, 1993); and S. Letsch et al., "National Health Expenditures, 1991," *Health Care Financing Review* (Winter 1992).

Notes: PCH is nominal per capita health spending. PCGDP is nominal per capita gross domestic product. $PCH = 409 + 107 \times PCGDP$. Both the constant term and the regression coefficient are statistically significant at .01 level. $R^2 = .77$ (correlation coefficient squared; also significant at .01 level).

^a Purchasing power parity.

level that would be predicted on the basis of the average relationship found for all of the OECD countries. In 1991 U.S. expenditures of \$2,868 were almost \$1,000 above the amount that would be predicted based on the average relationship found for the twenty-four countries. U.S. per capita health spending continues its unabated ascent above the trend line.⁵

Taken together, all of these measures provide a picture of spending performance in which U.S. spending is the highest in the world. By most measures, U.S. spending is increasing at much higher rates than is true in other countries. The United States is giving up larger amounts of non-health-sector consumption and investment opportunities compared with other countries. Excess health care inflation is a far more serious problem in the United States than in other countries. Perhaps most telling is that between 1985 and 1991 U.S. nominal per capita health spending each year increased 70 percent faster than nominal per capita GDP (Exhibit 3), compared with only 35 percent in Canada, 19 percent in France, 13 percent in the United Kingdom, and 10 percent in Japan. Nominal per capita health spending increased 12 percent less rapidly than nominal per capita GDP in Germany. Moreover, the United States is moving increasingly away from the average relationship between health spending and GDP found in other OECD countries.

Availability And Use Of Services

Exhibit 5 contains information for 1990 (or the latest available year) on inpatient medical care beds per thousand population, inpatient days per capita, admission rates, average lengths-of-stay, occupancy rates, number of employees per bed, number of physicians per thousand, and physician contacts per capita.⁶ The number of inpatient medical care beds ranged from 2.1 beds per thousand in Turkey to 16.7 beds in Iceland, with an OECD average of 9.0 beds. The United States (4.7 beds per thousand) had the fourth-lowest bed-to-population ratio. Days per capita ranged from 0.4 days per person per year in Turkey to 5.1 days in Iceland, with an OECD average of 2.7 days. The U.S. rate of 1.2 days per person per year ranked fifth from the bottom. The percentage of population admitted to an inpatient medical care facility varied from 5.6 percent in Turkey to 27.5 percent in Iceland, with an OECD average of 16.6 percent. The United States (13.7 percent) was well below average. Average length-of-stay per admission varied from 6.9 days in Turkey to 50.5 days in Japan, with an OECD average of 15.7 (14.2 excluding Japan). The United States (9.1 days) tied with Norway at fourth lowest. Occupancy rates ranged from 56.9 percent in Turkey to 88.5 percent in the Netherlands, with an OECD average of 78.5 percent. The U.S. occupancy rate (69.5 percent) was sixth lowest. The

Exhibit 5
Inpatient Medical And Physician Care In OECD Countries, 1990

	Beds per 1,000 population	Bed days per capita	Admission rate (percent of population)	Average length-of- stay (days)	Occupancy rate	Employees per bed	Physicians per 1,000	Physician contacts per capita
Australia	9.8 ^a	2.9 ^a	21.0% ^a	12.0 ^a	82.40% ^a	3.9 ^a	2.0 ^d	8.8
Austria	10.2	3.0	25.2	11.9	81.7	0.8	2.1	5.8 ^a
Belgium	9.8 ^a	2.6	18.0 ^a	14.4 ^a	86.7 ^a	1.9 ^c	3.4	7.6 ^a
Canada	6.6 ^a	2.0	14.1	13.9 ^a	84.9 ^b	2.4 ^b	2.2	6.9
Denmark	5.7	1.7	21.2	9.0	82.0	2.5	2.8	5.6 ^a
Finland	10.5	4.1	23.3 ^a	18.2	83.6 ^a	1.9	2.4	3.3
France	9.7	2.9	23.3	12.3	80.4	1.1	2.7	7.2 ^a
Germany	10.4	3.3	20.9	16.5	86.5	1.3 ^a	3.1	11.5 ^b
Greece	5.1	1.1	12.6 ^a	9.8 ^a	66.2 ^a	1.5	4	5.3 ^f
Iceland	16.7 ^a	5.1	27.5 ^a	19.0 ^a	85.8 ^a	-	2.8 ^a	4.2 ^a
Ireland	6.0	2.8	15.2 ^b	8.0 ^a	80.1 ^b	1.7 ^a	1.5 ^b	6.6 ^b
Italy	7.2 ^a	1.8	15.3 ^a	11.7 ^a	68.4 ^a	1.4 ^a	1.3 ^a	11.0 ^b
Japan	15.8	4.1	8.3	50.5 ^a	83.6	0.8	1.6	12.9 ^b
Luxembourg	11.8	3.7	19.9	17.6	81.0 ^b	-	2.0	-
Netherlands	11.5	3.7	10.9	34.1	88.5	2.1	2.5	5.5
New Zealand	8.5	2.1	13.9	12.0	87.3	2.0 ^c	1.9	3.88
Norway	14.5 ^a	5.0	16.7 ^b	9.1 ^a	84.5 ^a	2.8 ^a	3.1	5.7 ^e
Portugal	4.6 ^a	1.1	10.8	10.8	69.4	1.9	2.8	2.8 ^a
Spain	4.3	1.1	9.8	12.2	76.9 ^a	2.0 ^a	3.8	6.2 ^a
Sweden	12.4	3.5	19.5	18.0	84.2	1.9 ^c	2.9	2.8
Switzerland	9.5 ^a	2.9	13.9	25.3 ^b	82.4	1.9	2.9	6.0 ^c
Turkey	2.1	0.4	5.6	6.9	56.9	1.5	0.9	2.0 ^e
U.K.	6.4	2.0	15.9 ^b	14.5	80.6 ^d	2.6 ^c	1.4	5.7 ^a
U.S.	4.7	1.2	13.7	9.1	69.5	3.4	2.3	5.5
OECD average	9.0	2.7	16.6%	15.7	78.5%	2.0	2.4	6.2

Source: OECD Health Systems: Facts and Trends (Paris: Organization for Economic Cooperation and Development, 1993).

^a 1989.

^b 1988.

^c 1987.

^d 1986.

^e 1985.

^f 1982.

^g 1981.

^h 1980.

number of employees per bed ranged from 0.8 employees in Austria and Japan to 3.9 employees in Australia, with an OECD average of 2.0. The United States ranked second with 3.4 employees per bed. Only Australia and the United States had more than three employees per bed.

Concerning the availability and use of physician services, the physician-to-population ratios of the OECD countries ranged from 0.9 physicians per thousand in Turkey to 3.8 physicians in Spain, with an OECD average of 2.4 physicians. The United States (2.3 physicians per thousand) was close to the OECD average, although the U.S. mix is oriented much more toward specialists than toward generalists. Physician contacts per person per year

ranged from 2.0 contacts in Turkey to 12.9 contacts in Japan, with an OECD average of 6.2 contacts. The United States (5.5 contacts) was below the OECD average.

As would be expected, these newer data on availability and use of inpatient medical care and physician services paint the same picture as those presented in *Health Affairs*, Fall 1991. Compared with the other major industrialized countries, the United States has fewer inpatient medical care beds, fewer days of care per person, the shortest lengths-of-stay, the lowest admission rate except for Japan, and the lowest occupancy rate. The fact that the United States has twice as many employees per bed as the average for the other five major countries is consistent with the hypothesis that more intensive care is rendered during a shorter stay in U.S. medical care facilities. In terms of physician service availability and use, while the numeric comparisons indicate an average physician-to-population ratio and fewer contacts per capita, significant differences in specialty mixes across countries temper the utility of these comparisons.

Health Outcome Measures

Exhibit 6 contains information for 1990 (or the latest available year) on infant mortality, life expectancy at birth, and life expectancy at age eighty for the twenty-four OECD countries. The 1990 infant mortality rates ranged from 4.6 deaths per thousand live births in Japan to 59.3 deaths in Turkey, with an OECD average of 9.7 deaths (7.5 excluding Turkey). The United States (9.1 deaths) had the fourth-highest infant mortality rate of the twenty-four countries.⁷

Male life expectancy at birth ranged from 75.9 years in Japan to 64.1 years in Turkey, with an OECD average of 72.6 years. The United States (72.0 years) ranked eighteenth along with Denmark. For females, life expectancy at birth ranged from 81.9 years in Japan to 68.4 years in Turkey, with an OECD average of 78.8 years. The United States (78.8 years) ranked fifteenth. A different picture emerges for life expectancy at age eighty. Male life expectancy at age eighty ranged from 7.4 years in Iceland to 5.2 years in Turkey, with an OECD average of 6.4 years. The United States (7.1 years) ranked second along with Canada. A similar picture emerges for females. Female life expectancy at age eighty ranged from 9.3 years in Canada to 5.9 years in Turkey, with an OECD average of 8.0 years. The United States (9.0 years) ranked second along with Iceland.

Implications Of The Data

One can hypothesize that the far more favorable ranking for the United

Exhibit 6
Health Outcome Measures In OECD Countries, 1990

	Infant mortality (deaths per 1,000 live births)	Life expectancy at birth, males (years)	Life expectancy at birth, females (years)	Life expectancy at age 80, males (years)	Life expectancy at age 80, females (years)
Australia	8.2	73.9	76.2	6.8	8.6
Austria	7.8	72.5	74.0	6.6	7.6
Belgium	7.9	72.4	73.1	6.1	7.9
Canada	6.8	73.8	76.4	7.1	9.3
Denmark	7.5	72.6	73.7	6.4	8.1
Finland	5.6	72.9	74.6	6.1	7.5
France	7.1	72.7	75.6	6.8	8.6 ^a
Germany	7.1	72.6 ^a	74.7 ^a	6.1 ^c	7.6
Greece	9.7	74.1 ^c	75.6	6.7 ^d	7.6 ^d
Iceland	5.9	73.7	76.3	7.4	9.0
Ireland	8.2	71.0 ^a	72.0 ^a	5.5 ^f	6.4 ^f
Italy	8.2	73.4 ^a	75.0 ^a	6.4	8.0 ^a
Japan	4.0	75.0	77.9	6.9	8.7
Luxembourg	7.4	72.6 ^a	73.5	8.1 ^a	6.8 ^d
Netherlands	7.1	73.8	76.1	6.6 ^a	8.6 ^a
New Zealand	8.3	72.4	74.6	6.3	8.4
Norway	7.0	73.4	76.0	6.4	8.1
Portugal	11.0	70.9	72.9	6.1 ^b	7.2 ^b
Spain	7.3 ^a	73.0	76.3	6.7 ^e	7.7 ^e
Sweden	6.0	74.8	76.4	6.6	8.3
Switzerland	6.8	74.0	76.9	6.8	8.5
Turkey	59.3	64.1	68.4	5.2	5.9
U.K.	7.9	73.0	75.5	6.2	8.2
U.S.	9.1	72.0	73.8	7.1 ^a	9.2 ^a
OECD average	9.7	72.6	74.8	6.4	8.0

Sources: OECD Health Systems: Facts and Trends (Paris: Organization for Economic Cooperation and Development, 1993).

^a 1989.

^b 1988.

^c 1987.

^d 1986.

^e 1985.

^f 1980.

States in terms of life expectancy at age eighty may result from both widespread availability of technology and the aggressive treatment of elderly patients. The poor U.S. ranking in life expectancy at birth may reflect in part the underlying social problems in the United States as well as the lack of a coordinated and comprehensive system for providing preventive and prenatal care to the entire population. While the figures for life expectancy at age eighty may suggest that the U.S. system produces good outcomes in some areas, two basic questions still remain: Are outcomes actually better in the United States compared with outcomes in other countries? And, even if such outcomes are better, are these "benefits" worth the substantially higher costs of the U.S. system? Clearly, without more refined measures of outcomes and more disaggregated measures of costs, one cannot

readily answer these questions.

These more recent data continue to reinforce the notion that by international standards the U.S. health care system is out of control. The United States generally has fewer beds, an average number of physicians, and lower service volumes, although the intensity of services appears to be higher. In the absence of more refined measures of outcomes, queuing costs, and consumer attitudes, it is difficult to assess what, if any, additional benefits accrue to Americans as a result of their far higher spending levels and rates of increase. Surveys of consumer and provider satisfaction give the American system low marks.⁷ Health care reformers in the United States face an enormous task in reforming the country's health system. But as these data show, the United States has a much larger pool of money than any other country with which to transform its current system into one that meets other nations' standards of universal coverage and containment of costs.

The views expressed in this paper are those of the authors and do not necessarily represent those of their respective organizations.

NOTES

1. G.J. Schieber, J.P. Poullier, and L.M. Greenwald, "Health Care Systems in Twenty-Four Countries," *Health Affairs* (Fall 1991): 22-38; and G.J. Schieber, J.P. Poullier, and L.M. Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," *Health Care Financing Review* (Summer 1992): 1-87.
2. See Organization for Economic Cooperation and Development, *OECD Health Systems: Facts and Trends* (Paris: OECD, 1993) for a detailed discussion of the most recent methodological changes and data revisions.
3. For a detailed discussion of these measures as well as the need to interpret some of them in the context of the base-year spending level, see Schieber et al., "U.S. Health Expenditure Performance."
4. *Ibid.*, 8-9.
5. *Ibid.*, 3-6.
6. For definitions of the terms see Schieber et al., "Health Care Systems in Twenty-Four Countries;" and OECD *Health Systems: Facts and Trends*. Employees per bed includes all categories of staff salaried by hospitals, including medical personnel, aggregated to a full-time-equivalent (FTE) level. As in all areas of international comparisons, variability in aggregation and weighting exists, and the volume of contracted services varies across countries as does the scope of inpatient services.
7. One of the factors responsible for the high U.S. infant mortality rate is its far higher percentage of low-birthweight babies. See K. Liu et al., "International Infant Mortality Rankings: A Look Behind the Numbers," *Health Care Financing Review* (Summer 1992): 105-118.
8. See R.J. Blendon et al., "Physicians' Perspectives on Caring for Patients in the U.S., Canada, and West Germany," *The New England Journal Of Medicine* (8 April 1993): 1011-1016; R.J. Blendon et al., "Satisfaction with Health Systems in Ten Nations," *Health Affairs* (Summer 1990): 185-192; and R.J. Blendon and H. Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989): 149-157.

J. GLOSSARY

MASTER GLOSSARY

Accountable Health Partnership/Approved Health Plan (AHP): Under the Jackson Hole Plan and other reform plans, AHPs would provide health care coverage (and services). The pressure of compete among qualified AHPs is expected to lower costs and promote quality and efficiency.

Adverse Selection: A tendency of individuals with poorer than average health expectation to apply for, or continue, insurance to a greater extent than those with average or better health expectations.

Alliance: In the Clinton health proposal, used for both "regional health alliance," its name for "health insurance purchasing cooperative" (see below), and for "corporate alliance," the label attached to how large employers not a part of regional health alliances organize the delivery of coverage to their workers.

All-payer system: A way of regulating payments for health care services where "all payers" pay the same rate for the same service. Because the payment is the same from all payers -- both private and public insurance plans -- the service provider cannot shift costs from one payer to another.

American Academy of Family Physicians: A physician specialty organization whose 74,500 members provide primary care services.

American College of Physicians: The second-largest organization of physicians, ACP's 70,000 members are all internists, and many are primary care physicians.

American Medical Association: The oldest and largest physician organization in America, the AMA's 300,000 members engage in all areas of medical practice.

Capitation: A way of paying a health care provider a fixed amount for each person served in a given time period, such as a year, regardless of how much service is actually used by each person. This is the method of payment typically used in health maintenance organizations (HMOs).

COBRA: See "conversion privilege," below.

Community rating: Setting health insurance premiums based on the average cost of paying for services for all covered people in a geographical area, regardless of their history of (or potential for) using health services.

Coinsurance (copayment): The portion of the bill for a medical service that must be paid by the patient (coinsurance refers to a percentage; copayments are stated as flat amounts, e.g., \$5 per office visit).

Congressional Research Service (CRS): This organization is part of the Library of Congress, and performs numerous studies and issues reports to help Congress in legislation and oversight.

Conversion privilege: The right to keep coverage without regard to having to meet health or other "insurability" standards, usually by converting to an individual policy when coverage under a group contract ends. Conversion privileges are guaranteed to many workers under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Cost-sharing: Payments made out-of-pocket by patients for a part of the cost of covered services. This includes deductibles, coinsurance and copayments, but not the share of the premium paid by the person enrolled.

Cost-shifting: The practice by which a seller of a health service, such as a hospital, makes up for charging a particular payer less than normal -- usually because of that payer's bargaining power -- by charging other customers more. This also applies to sellers who provide services to those with no way of paying, such as the uninsured poor.

Customary, Prevailing, and Reasonable (CPR): The method of paying physicians under Medicare from 1965 until implementation of Medicare Fee Schedule in January 1992 (the fee schedule is being phased in over four years). Under CPR, payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Private insurers use a similar system, "usual, customary, and reasonable."

Deductible: The amount that the patient must pay to the provider directly (usually each year), before the insurance plan begins paying for benefits. An example is the \$100 annual deductible for doctor's services under Medicare.

Diagnosis-related groups (DRGs): A system used by Medicare to classify patients on the basis of diagnoses for purposes of payment to hospitals (see also Prospective Payment System).

Employee Retirement Income Security Act (ERISA): Aimed principally at securing workers' pension rights by setting federal standards, this 1974 law also preempts state regulation of employee benefits. While health insurance an employer buys is subject to state insurance regulations and premium taxes, state insurance rules do not reach an employer providing coverage by self-insuring. ERISA, however, contains no standards for the content of health coverage.

Employer mandate: See mandate.

Enterprise Liability: Proposal to hold hospitals or HMOs liable for negligent harm in medical malpractice cases, rather than holding individual physicians liable.

Experience rating: Setting health insurance premiums based on the actual expenses incurred in paying for services in a particular group, such as the employees of a firm.

Federal Employee Health Benefit Plan (FEHBP): System under which federal civilian employees choose among a number of approved private plans, with the Federal Government paying a major portion of the cost of the coverage. (See "Heritage Consumer Choice Health Plan," in REFORM OPTIONS Section.)

Fee-for-service: A way of paying a health care provider, such as a physician, an amount (fee) for each service rendered. Under this arrangement, spending rises if more services are rendered, if higher priced services are rendered, or if fees increase.

First-dollar coverage: Insurance plans that provide benefits without first requiring payment of a deductible.

Gatekeeper/care manager: A primary care provider, usually a physician, who serves as the initial point of contact for any effort to seek care, provides basic care, and must first approve before specialists may be called in. Managed care networks that use gatekeepers -- also called CARE MANAGERS -- usually require the enrollee to select a gatekeeper in advance.

General Accounting Office (GAO): The investigative arm of Congress, which, either independently or at the request of Congress, performs studies and issues reports on health and other topics.

Global budget: In many reform proposals, a single entity (acting with governmental power) sets a "global budget," an amount intended to cover all spending on an specific health services. The global budget includes spending by government and, where other major buyers of care exist, spending by those buyers as well. In plans where the budget is binding, sanctions are imposed later if spending exceeds the amount budgeted.

Health Care Financing Administration (HCFA): Federal agency within the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Health Insurance Purchasing Cooperative/Corporation (HIPC): Under the Jackson Hole plan and other reform proposals, HIPCs would be private non-profit entities set up to act as collective purchasing agents for small employers, buying coverage from "Accountable Health Partnerships" (see above).

Health maintenance organization (HMO): A prepaid, organized health care plan. People enroll in the HMO, and receive services only through a group of affiliated doctors and other providers. Benefits are often comprehensive, and copayments, if any, are usually limited.

Indemnity insurance: Traditional insurance, in which the insured person receives services and submits a claim to the insurer, from which providers are paid fees for the services rendered.

Independent Practice Association (IPA): An HMO that contracts with individual physicians to provide services to HMO members at a negotiated rate, either per capita or fee-for-service. Physicians maintain their own offices and can contract with other HMOs and see other fee-for-service patients.

Inpatient: See outpatient.

Insurer/insurance function: A way of responding to the risk of an adverse event, such as having to pay large health care expenses, by spreading those risks among many people. Insurance provides a way to substitute a small, predictable payment (a premium) for the risk of having to make a large payment in the event of an uninsured accident or illness.

Jackson Hole Group: An informal group of people concerned about health care policy, who meet occasionally at the Wyoming home of one of the group's conveners, Paul Ellwood of InterStudy. The group proposes a reform plan based on cost containment through "managed competition" and changing the tax preferences for health insurance. Employers would be required to pay for workers' coverage.

Long-term care: The continuum of maintenance and health services provided to chronically ill, disabled or retarded persons. (See LONG-TERM CARE Section.)

Loss Ratio: The ratio of the total incurred claims made against an insurance policy divided by the total premiums. Loss ratios are used as a method of indicating the amount of benefits returned to policyholders.

Managed care: General term for any system of health care delivery organized to enhance cost-effectiveness. Managed care networks -- different types of providers that agree to provide services to those covered under the plan -- are usually organized by insurance carriers, but also can be organized by employers, hospitals or hospital chains. Managed care is also called COORDINATED CARE.

Managed competition: A way of organizing health care delivery and financing that attempts to combine the best elements of government regulation and free-market competition. Those paying for care are organized into large groups, and providers then compete for their business. (See "Managed Competition," in REFORM PLANS Section.)

Mandate: Used in two senses in the health reform debate. (1) Employer mandate, in which the government imposes a requirement on some or all employers to provide insurance coverage for their workers (and their families, typically). (2) State mandate, a requirement imposed on insurance companies include, as part of any health insurance policy they sell, coverage for a specific service or provider, such as well baby care.

Medicaid: Medical assistance program that provides coverage for some low-income persons and families for acute care and long-term care. It is financed by state and federal funds (the Federal Government pays at least 50% of the total cost), and is administered by states within broad federal guidelines. The program's coverage and benefits vary widely from state to state.

Medical underwriting: See underwriting.

Medicare: Federal program providing health insurance coverage for virtually all persons age 65 and older, and some severely disabled persons under age 65. It consists of Part A, Hospital Insurance (HI) and Part B, Supplementary Medical Insurance (SMI). (See INSURANCE Section.)

Medigap Insurance: Private health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance, and balance bills, and payment for services not covered by Medicare, such as outpatient prescription drugs.

Open Enrollment (open season): The health insurance enrollment period during which coverage is offered regardless of health status and without medical screening. Open enrollment periods are characteristic of some Blue Cross-Blue Shield plans and HMOs.

Out-of-pocket cap/maximum: An annual limit on how much in deductibles and co-payments the patient has to pay. Also called "stop-loss" provision.

Outcomes research: Medical or health services research that attempts to identify the clinical results -- outcomes -- of a particular health service (death, illness, ability to function, etc.).

Outpatient/inpatient: A description of health care services based on whether the person receiving the service has been admitted ("inpatient") to a hospital or not.

Payer: Any person or organization paying a health care provider for services or goods. Typically, insurance companies and government health programs like Medicare and Medicaid or the major payers. Some employers pay for services directly, and individuals pay for some services out of their own pockets.

Payroll tax: a flat percentage tax collected on salaries and wages. The Social Security tax that finances both cash benefits and Medicare Part A is a payroll tax of 7.65% each on employers and employees. Of that, 1.65% is allocated for Medicare.

Peer Review Organization (PRO): An organization that reviews, for the Health Care Financing Administration, the medical necessity and the quality of care provided to Medicare beneficiaries.

Pepper Commission: An advisory panel, consisting mostly of senior members of Congress with major health leadership, which in 1990 recommended the adoption of a "pay or play" approach to universal health coverage and a universal plan to cover long-term care services for all Americans. Also called the U.S. Bipartisan Commission on Comprehensive Health Reform.

Physician Payment Review Commission (PPRC): Independent body established by Congress to advise it on Medicare policies for paying physicians.

Play-or-pay: An approach to increasing insurance coverage by requiring employers to make a contribution toward covering workers and their families. They may choose either to "play" -- buy private insurance for their workers -- or "pay" a set amount, usually a percentage of payroll, to help pay for covering the workers in a government-sponsored plan like Medicare. This is one form of an employer mandate.

Point-of-service choice plan (POS): A coverage plan where members need not choose how to receive services until the time they need them. In a simple preferred provider organization, for example, members commonly receive greater coverage if they use preferred providers than if they choose not to. Other plans, including some HMOs, offer less generous coverage if members choose an "out-of-network" provider.

Practice guidelines/parameters: A statement of what is known about the benefits, risks and costs of particular courses of medical treatment to achieve the best possible patient outcome. Proposals for quality improvement typically propose developing more and better practice guidelines, so that physicians have access to the best information about treatment alternatives.

Pre-existing condition: A physical or mental condition of an insured individual which first becomes known before the policy is issued. Insurers may choose not to cover treatment for such a condition, at least for a period, or may raise rates because of it.

Preferred Provider Organization (PPO): A financing arrangement in which "networks" or panels of providers agree to furnish services and be paid according to a pre-set negotiated fee schedule. Patients have a financial incentive -- for example, lower co-insurance payments -- to use doctors on the preferred list. (See "Thumbnail Guide to Managed Care, MANAGED CARE Section).

Pre-natal care: Services to pregnant women designed to insure that both she and the newborn are in the best health. Not receiving adequate pre-natal care early in the pregnancy is associated with higher rates of low birth weight and infant mortality.

Preventive health services: Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (immunizations), at early detection of disease (Pap smears) and at stopping further deterioration (exercise).

Primary care: Care at "first contact" (with the health care system), including an array of non-specialist services provided by physicians, nurse practitioners or physician's assistants -- more simply, the care that most people receive for most of the problems that bother them most of the time.

Primary care physician: Refers to a group of physicians -- general practitioners, family practitioners, some internists, OB/GYNs, and pediatricians -- who serve as first point of contact for individuals with the health care system. (See HEALTH PROFESSIONALS Section.)

Prospective Payment Assessment Commission (ProPAC): Independent body established by Congress to advise on issues related to Medicare's hospital payment system.

Prospective Payment System (PPS): The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system.

Provider: Any health care professional or institution that renders a health service or provides a health care good. The most important ones are hospitals, nursing homes, physicians and nurses.

Rating bands: Amounts by which insurance rates for a specific class of those insured may vary. Many small group market reform proposals restrict or eliminate these allowable variations.

Relative value scale (RVS): An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. To fix the fee for a service, the index for that service is multiplied by a constant dollar amount. The RVS used in the development of the new Medicare physician fee schedule consists of three cost components: physician work, practice expense, and malpractice expense.

Resource-Based Relative Value Scale (RBRVS): A relative value scale that is based on the resources involved in providing a service. The RVS used in the new Medicare physician fee schedule is resource-based.

Single Payer System: A health reform plan that would designate one entity (usually the government) to function as the only purchaser of health care services. (See REFORM PLANS Section.)

Small group market reform: A series of proposed changes to improve the way the health insurance market functions for small employers buying coverage for their workers, with the aim of making coverage more affordable and accessible. (See INSURANCE Section.)

State mandate: See Mandate.

Tax credit: An amount that can be subtracted from the actual tax owed; under some reform proposals, moderate income persons are given a tax credit to help them free up money for health insurance. A tax credit is much more valuable than a tax deduction of the same amount.

Tax deduction: An amount that can be subtracted from taxable income if spent on a specific purpose. Currently, businesses can deduct the cost of health insurance provided to employees, but health insurance premiums and other health expenses are a deduction for families only after they reach 7.5% of income. Under some reform plans, health insurance premiums for families would be fully deductible, up to a certain limit. Because a deduction reduces taxable income (a percentage of which is then owed as tax) instead of reducing taxes owed, a deduction is less valuable than a tax credit of the same amount.

Tax preference (of health benefits): Employer-paid health benefits are treated under federal tax law as a deductible business expense for the employer, and not as taxable income for the worker. This creates incentives for workers to prefer extra compensation in the form of more health coverage rather than wages, and lowers tax revenues by some \$145.8 billion a year.

Underwriting: The way insurers decide whether or not to accept an application for insurance, and, if the applicant is accepted, what conditions to apply. If the insurer decides that a particular individual or group poses higher than normal risks, it might charge higher premiums, offer more limited benefits, exclude from coverage specific persons in a group, or refuse to pay for services relating to a particular ("pre-existing") condition.

Utilization review: The after-the-fact review of services delivered by a health care provider to determine whether those services were medically necessary, when viewed against pre-established standards. In the case of a hospital, the review might also include the decision to admit and the length of stay.

Volume Performance Standard (VPS): A mechanism to adjust Medicare physician fee updates based on how annual increases in actual Part B expenditures compare to previously predicted rates of increase. This is intended to help check the tendency by physicians to make up for restraints in Medicare-allowed fees by increasing the number of services provided.

Voucher: In various reform proposals, a certificate given to usually a low-income or moderate-income person that can be used to pay all or part of the cost of a basic insurance plan.

Well-baby care: Services provided in the first months of the newborn's life, to identify and deal with any specific problems and prevent problems from occurring.

K. MASTER SOURCE LIST

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