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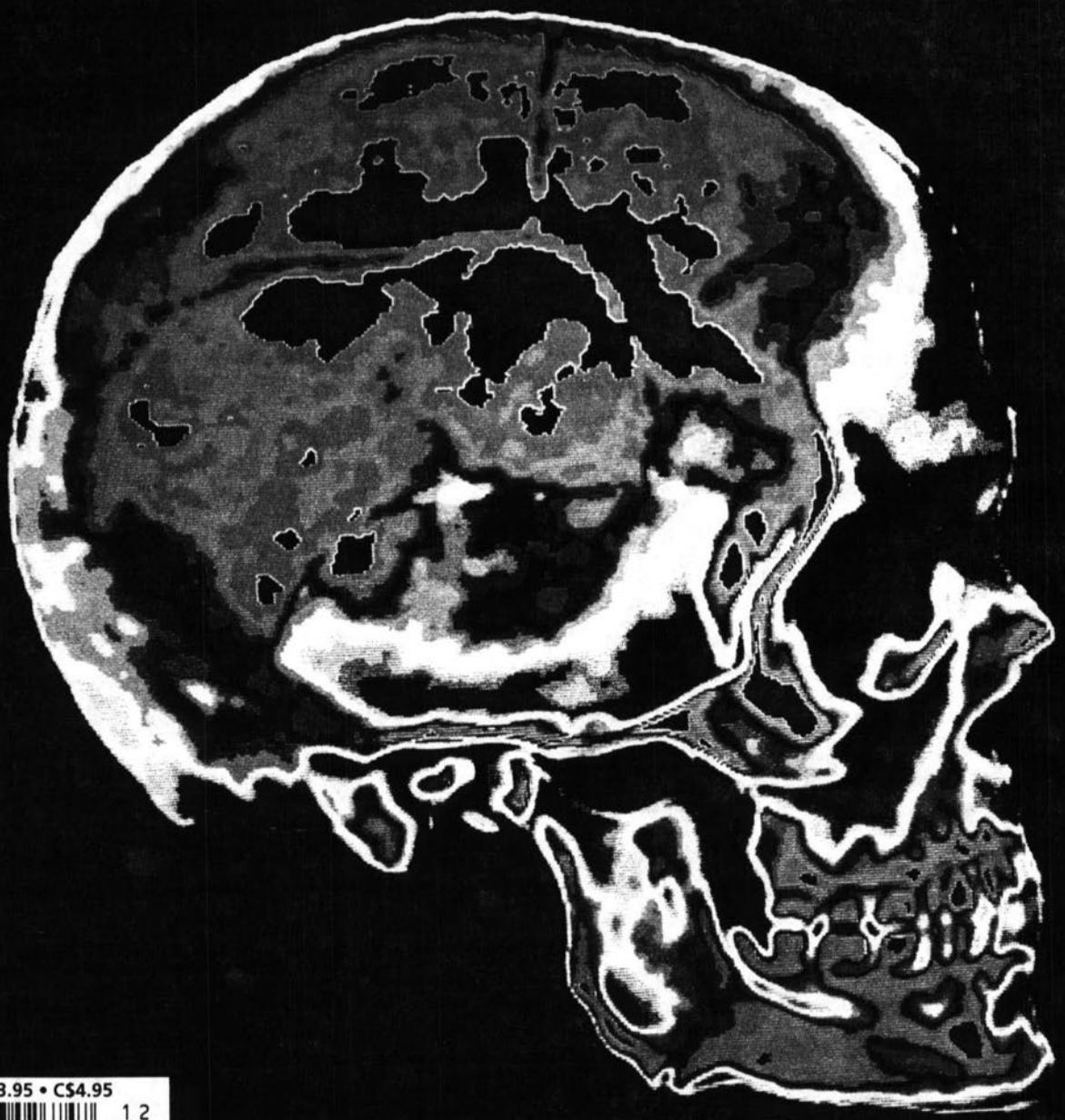

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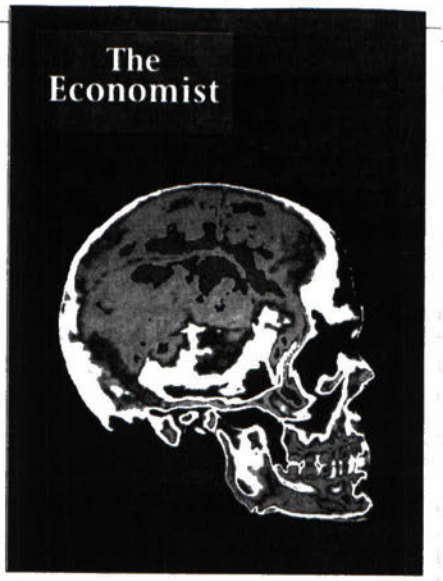

ON THE COVER

This week an inquiry began into how Britain fell victim to the human form of mad-cow disease. How many people will die from BSE is still unclear. Scientists cannot even say whether the disease will remain quite rare or become a large-scale epidemic: leader, page 15; why the science of BSE is so difficult, pages 21-23

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THE SCIENCE OF BSE

Bungled

The mad-cow saga has become a squabble over what sorts of beef should be sold. Another issue matters more: is enough money and effort being devoted to research into the disease?

IN OCTOBER 1996, six months after the British government caused panic by announcing that mad-cow disease (BSE) had probably killed ten people, a panel of independent scientific experts delivered a confidential report on the disease to the European Commission in Brussels. The report listed the experiments needed to guess at the size of a potential epidemic of the disease in people. It makes depressing reading: the list is very long.

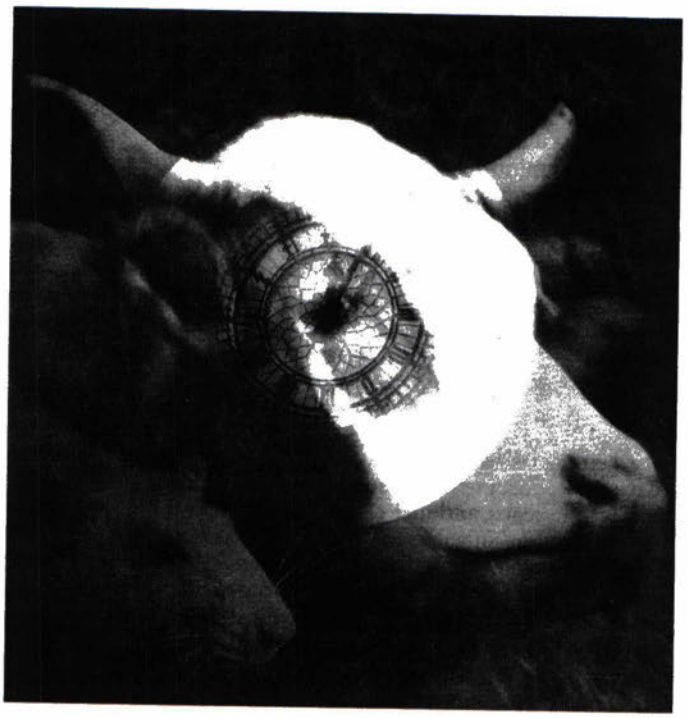
Partly, this is because BSE is a very curious disease. Along with scrapie in sheep and Creutzfeldt-Jakob disease (CJD) in humans, it is a member of a class of strange degenerative diseases of the brain known as transmissible spongiform encephalopathies, or TSEs. Until the BSE epidemic began, few scientists studied these diseases and little was known about them. A lot of work was, and is, necessary just to discover the basics.

But the list of needed experiments was also long because of incompetence and secrecy, particularly in Britain's Ministry of Agriculture, Fisheries and Food (MAFF). Its officials refused to assist outside researchers, and important aspects of the ministry's own research were botched.

Now the whole sorry affair is to be investigated by an official committee of inquiry. That, however, is scant comfort to farmers whose livelihoods have been destroyed, still less to those who will fall victims to the disease. Nor will the inquiry do anything to answer the crucial question: how many more people are going to die as a result of eating infected meat?

The reason TSEs are so unusual is that they are thought by most scientists to be caused not by a virus, nor by any other conventional parasite, but by infectious proteins called "prions".

Prions, the theory runs, are misfolded versions of a protein (known confusingly as the "cellular prion protein") that cells make all the time. When present in a brain, prions alter the way that the normal cellular prion proteins fold, so that they too become misshapen. These newly recruited proteins then go on to engage in the same sort of mischief, recruiting yet more prions. Eventually, the misshapen forms predominate, and the animal dies with its brain full of holes. Exactly how or why the accumulation of prions causes death remains unknown. Even the role played by normal cellular prion proteins is as yet a mystery.



In people, prion diseases are generally rare. Most deaths from them are due to "sporadic" CJD—that is, CJD which occurs for no known reason, and does not appear to be transmitted from person to person. Sporadic CJD has a worldwide incidence of one person in 1m every year (so Britain experiences about 50 cases a year). But since 1994 two dozen people—23 in Britain and 1 in France—have died from a new prion disease, known as new-variant CJD (nvCJD), and others appear to be sick with it. Exactly how many others is hard to say. At the moment nvCJD, like other prion diseases, cannot be diagnosed in a living person. Its lingering course means that a year can pass between the onset of symptoms and death.

Just the facts

Over the past two years, several different lines of evidence have shown that nvCJD is indeed the human form of mad-cow disease. But the only firm fact on which to base guesses about the size of a possible human epidemic is that at least 710,000 infected cows entered the human food chain before 1996. This was the year that the "specified bovine offal ban", supposedly put in place in 1989 and designed to prevent people from eating tissue that might be infective, began to be policed properly.

Prion diseases are hard to study. Since there is currently no diagnostic test, the only way to be sure that somebody (or some animal) is sick with one is to wait until the victim dies and then examine the brain (itself a risky procedure). Since prion diseases have long incubation periods, experiments on them take years—two years in mice, seven in cows and as many as ten in primates—and so are extremely expensive. Setting up a prion-diseases laboratory from scratch is, therefore, a major enterprise.

Nonetheless, it is not just wisdom of hindsight to say that far more could have been done than actually was. Between 1992 and 1995, MAFF spent just over £5m every year on research into BSE—and by the end of 1997 had spent, in all, a mere £38m on research during the entire course of the epidemic. Last year alone the government spent £1½ billion paying for cattle to be destroyed.

That might not have mattered if other researchers had been able to fill the gap. But the government had in effect a monopoly on research into the disease because all samples that were taken from infected cattle had to be delivered to its laboratories.

Since BSE was disproportionately a British phenomenon, independent researchers who wanted BSE samples could not get them from anywhere else, and many report that they could not get them from the British government either. Likewise, until 1996, only government scientists had access to data on the course of the disease in cattle. Again, outside requests for information were rejected.

Worst of all, however, was the appalling execution of what research there was. Experiment after experiment was hopelessly botched, a shocking waste of time and money. For example, in an experiment designed to determine whether BSE can be transmitted from cow to calf, calves in the control group were fed with infected feed. As a result, the research, which took seven years, was inconclusive—unable to distinguish between maternal transmission and the possibility that calves from susceptible mothers might be genetically more susceptible themselves.

A question of time

Normally, the best way to predict an epidemic is to consider the epidemiology of the disease. But with a new disease, this is tricky. For the moment, the number of deaths from nvCJD is too small to say much of significance about them. Men get sick as frequently as women. The average age of the victims has been about 27; the youngest was 16. So far the elderly appear to have been spared; it is unclear why.

To date, there is no observable link between nvCJD and occupation. Farmers who have come down with CJD in the past decade, for instance, have had the old, sporadic form rather than the one linked to BSE. And despite much popular excitement over the fact that several victims had spent some time in Kent, the numbers are still too small to say whether this is a genuine cluster, or, as one scientist put it disparagingly, a "media cluster". Indeed, the only consistent observation that can be made is that all of the victims of nvCJD so far have had identical forms of cellular prion protein.

Proteins are chain-like molecules whose links are composed of smaller molecules called amino acids. The order of the amino acids in the chain (there are 20 different sorts to choose from) gives each protein its distinct characteristics, but some variation in that order often occurs. Cellular prion protein, for example, has 253 amino acids in its chain and the 129th one can be either methionine or valine.

Since everyone has two copies of the gene that specifies cellular prion protein (one from each parent), a given individual's proteins at this point on the chain may be all methionine, all valine or a mixture of both. So far, every case of nvCJD has been in people with all methionine at position 129. However, this trait is far from rare: 40% of Europeans are like this. Earlier research anyway raises doubts over whether the others will continue to be immune.

Position 129 had already been implicated in human susceptibility to TSEs. Between 1959 and 1985 2,000 people in Britain received human growth hormone derived from corpses. Some 30 of them have now died from CJD, presumably because some of the people from whose bodies the hormone was extracted had themselves died of CJD. This "medically induced" disease (which has also been caused by transplanted corneas and contaminated electrodes being placed into people's brains) is known as iatrogenic CJD. In contrast to victims of nvCJD, those who first succumbed to the iatrogenic form of the disease had valine, rather than methionine, at position 129. Some with other genotypes became sick too, but it took longer, suggesting that what goes on at position 129 may affect incubation time rather than susceptibility.

The incubation period of BSE in humans is the decisive variable for predicting the size and timing of any epidemic. If the average incubation period for the disease were 10 years or less, Britain might al-

Birth of a disaster

MAD-COW disease is the most expensive catastrophe ever to have befallen Britain's farmers. It now appears to be dying out. But how did it start in the first place, and why did the catastrophe strike in Britain?

The conventional explanation is that BSE was originally a form of scrapie (a prion disease of sheep). It entered the bovine food chain, according to this view, because of the practice of feeding chopped-up sheep to cows as a protein supplement. This practice was not unique to Britain. But only Britain (in 1979) changed the rules controlling how such supplements should be produced—and in such a way as to allow new techniques, no longer capable of destroying the agent that causes scrapie. The result, the argument runs, was BSE, the bovine equivalent of scrapie in sheep.

This explanation is comforting for those who hope that BSE will not prove a serious hazard to human health. Scrapie has been around for centuries (it has been documented in British sheep for over 200 years), and there is no evidence that it is transmissible to people. The most common prion disease of humans, CJD, is completely unrelated to the prevalence of scrapie, so if BSE came from scrapie it would seem reasonable to assume that it is difficult to transmit to mankind.

Unfortunately, it now appears that this comforting story is wrong. For one thing, experiments with various different processes for rendering offal into animal feed have shown that few of them destroy the agents that cause either scrapie or BSE. Therefore, any connection with the changed method of production was probably a coincidence. Moreover, the evidence suggests that the two diseases are quite different. This is not just because BSE is transmissible to people whereas scrapie is not. Infect a cow with scrapie and it develops a disease that, despite similarities, is not BSE. Infect a sheep with BSE and it develops a disease that, despite similarities, is not scrapie.

However, it is clear that BSE did come from something in the food that cows were given. Once they were no longer being fed with animal-derived protein, the BSE epidemic started to decline. But sheep were not the only components of the feed. Cows were also being fed on ground-up cows. If, as seems likely, BSE occurs spontaneously in cows just as CJD does in people, the epidemic could have arisen as a result of bad luck. Given that consumption of less than a gram of infected tissue can kill a cow, a single case of BSE in the bovine food chain could have been enough to start things rolling (just as a single case of CJD is thought to have been responsible for kuru, a human prion disease that is transmitted by cannibalism).

This view of the origins of BSE suggests that cannibalism must be ended—and not only for people. Although most countries have now stopped feeding cows to cows, the practice of feeding pigs to pigs and chickens to chickens continues in many places.

ready be at or close to the peak of cases of nvCJD: the disease in humans would remain extremely rare. But if it is 25 years or longer, the peak might be a decade or more away—and the present small number of cases would offer no guidance whatever on the eventual toll.

Several factors besides genetics are known to affect the incubation period of prion diseases:

• **Dose.** A low dose means a long incubation period. Up to a point, the converse is also true—though once the dose has grown to a certain size, increasing it further makes little difference. But there are two important unknowns.

First, is there is a minimum dose below which infection does not happen? Experiments to determine whether there might be minimum infective doses in cows were among the ones that were bungled. A great deal turns on this. In some diseases, a single virus particle is enough to make you sick. In others, you have to be exposed to millions of them. Second, does the risk of disease increase with the number of separate exposures? Prions are hard to destroy. They can persist in the environment for years and it seems likely that repeated doses could cause them to build up in the body.

• **Route of exposure.** The assumption is that humans have mostly been exposed to BSE by eating the flesh of infected cattle (although the Frenchman who died from nvCJD is thought to have become sick from bovine-derived growth hormone that he was using for body building). It also seems that prions are largely confined to nervous tissue. But there are hints that they may lurk in the lymphatic system as well, including the white blood cells.

This holds out the possibility that iatrogenic nvCJD might be spread by transfusions of blood products such as clotting factors that are pooled from many donors, though precautions are now in place to stop this happening. Evidence from animal experiments suggests that even a minute exposure by direct injection is enough to start the disease.

• **Species barrier.** Prion diseases do not always move easily between species: scrapie does not infect people, for example. Moreover, even when they do cross over, the incubation period usually increases until the disease adapts to its new host. For instance, mice infected directly with BSE from cattle take longer to get sick than those infected with brain material from mice who died from BSE. This suggests that something happens to the prions during their first encounter with a new species. As a result, nvCJD transmitted from person to person—through the blood supply, say—could be expected to have a shorter incubation period than disease caused by eating infected beef.

Little is known about the species barrier between cows and people. Experiments carried out by John Collinge and his colleagues at Imperial College, London showed that mice which have had their prion-protein genes replaced by human versions of the gene do succumb to BSE—but it takes roughly twice as long as it would for them to get a mouse prion disease. Unfortunately, the human prion protein that the mice produced had valine, rather than methionine, at position 129. This was deliberate: when the experiments started, it was thought (on the basis of the data about iatrogenic CJD) that this variant would increase susceptibility. Now it seems that relatively unsusceptible mice were used.

In any case BSE appears to be excellent at crossing species barriers. It has caused illness in a number of other animals not previously known to harbour prion diseases, including domestic cats. In this respect, according to Nora Hunter, a scrapie geneticist at the Institute for Animal Health in Edinburgh, BSE was unlike anything that her group had seen before. It worried them so much that they decided to make their safety precautions much more stringent.

• **Expression of the prion-protein gene.** Different strains of inbred mice produce different levels of the cellular prion protein. Those strains that manufacture more of it get sick from prion diseases faster. Knowing how much natural variation exists in the expression of the human prion-protein gene would help to predict how much variation in nvCJD's incubation period might be expected.

• **Age at exposure.** There have been suggestions that calves may be more susceptible to BSE than older animals. Whether or not the same is true in people is unknown—but if it were the case, it could help to explain why no old people have died from nvCJD.

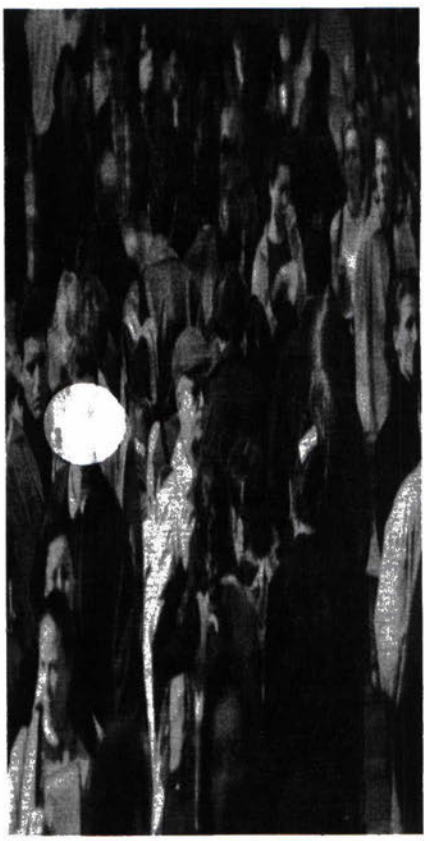
• **Infectiveness of tissue.** One of the main obstacles to estimating the scale of any epidemic of nvCJD is uncertainty over which bovine tissues are infectious. Also unknown is the stage of the disease at which different tissues become infectious. For instance, does the risk to human health come only from cows that entered the food chain when their BSE was well advanced? Or are animals infectious before they have developed symptoms?

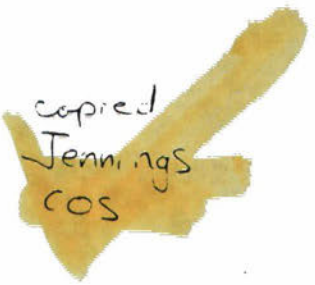
Just guessing

Despite these unknowns, there are some clues about the incubation period of nvCJD. The pathology of the illness is similar to that of kuru, another prion disease which arose from eating infected meat. (In this case it was human flesh: the disease is confined to the Fore peoples of Papua New Guinea, who were cannibals until recently.) Kuru occasionally worked its course in as little as five years, but the average incubation period is reckoned to be 12-15 years. Iatrogenic CJD from human growth hormone has an average incubation period of 15 years. Since one of the victims of nvCJD was only 16, the minimum incubation period cannot be longer than that (although the *average* incubation period, which is what matters for these purposes, could be).

It is likely that the first cases of nvCJD arose as a result of exposure long before the peak of the epidemic in BSE (which came in 1993), and probably well before the first clinical cases of BSE had been diagnosed in cows. This is broadly consistent with a guess at the average incubation period of 15-20 years. This would put the peak of the nvCJD outbreak in 2005-10. If that turns out to be right, the number of cases of nvCJD is likely to accelerate in the next five years. If the number fails to accelerate, it will mean one of two things. Either the average incubation period is longer, or nvCJD is very difficult to catch. Pending answers to the questions posed earlier, it will possible to know which of these is true only when the number of new cases declines—clearly enough and for long enough to indicate that the worst is over.

Conceivably, the few people who have died may have been unlucky—exposed through some dreadful fluke to huge lumps of infected brain, or predisposed in some as-yet-unknown way to the prion's attentions. But given the ghastly nature of nvCJD, the possibility of an epidemic must continue to be taken very seriously—even though it may be unclear for years yet whether there will be one.

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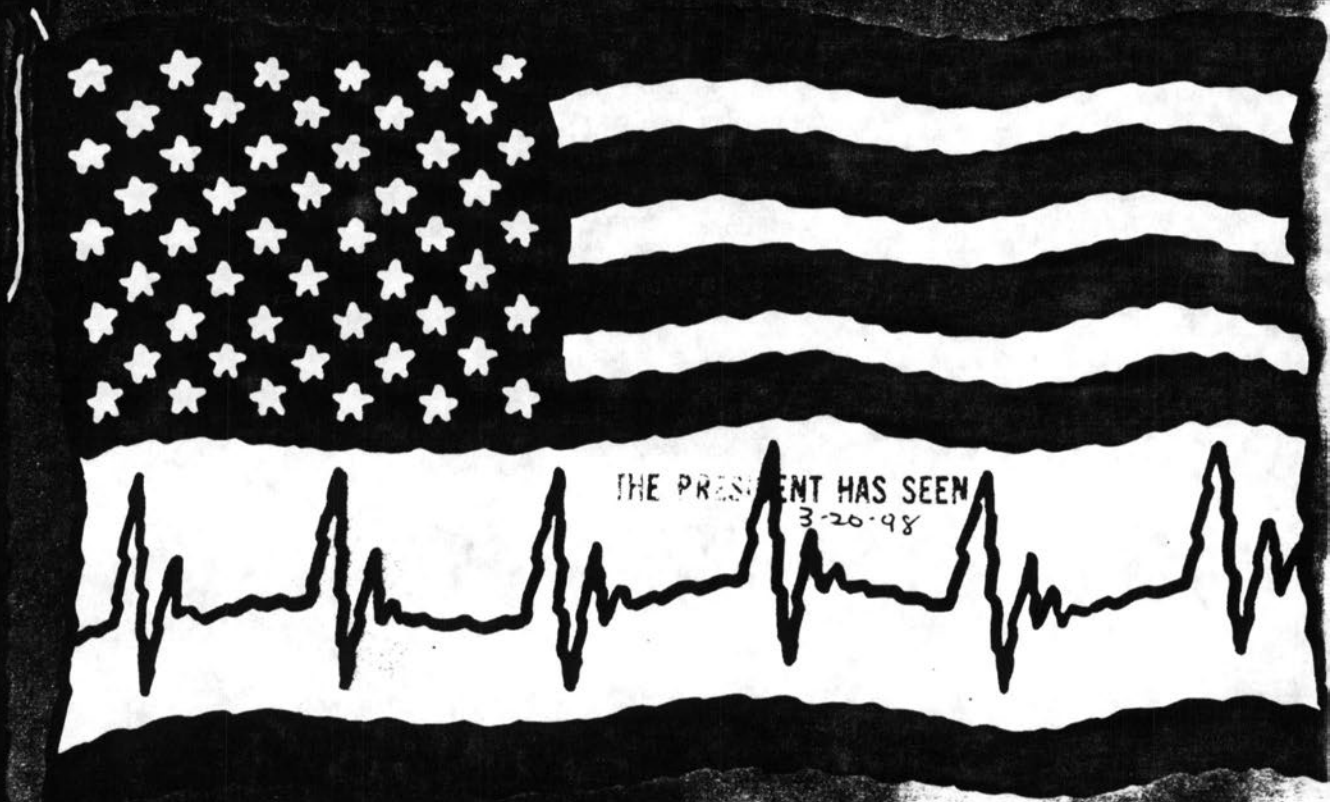

May the HMO revolution must be sustained

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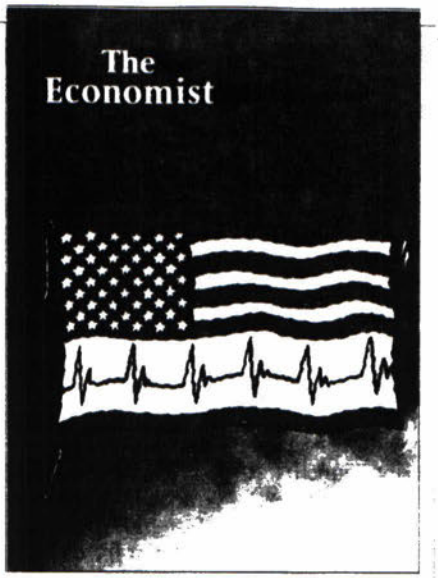

ON THE COVER

Contrary to widespread public belief, America's health-care system has changed for the better in recent years. Now, it is vital that the HMO revolution is sustained: leader, page 15; your money or your life, pages 23-26

SURVEY: EAST ASIA

After three decades of whirlwind growth, many of East Asia's tiger economies are in the doldrums. Need this be the end of the Asian economic miracle? No, says Pam Woodall; but governments must abandon their bad habits, after page 58

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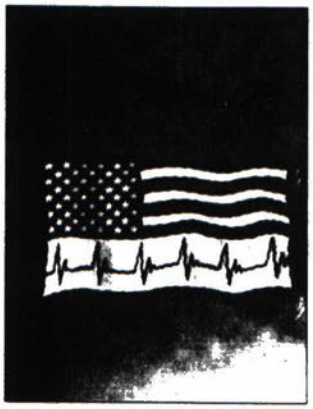
Patients or profits?



AMERICAN medical technology is the best on earth, but its health-care system is the most wasteful. Americans spend roughly twice as much on doctors, drugs and snazzy brain scanners as Europeans, but live no longer. In contrast to the all-inclusiveness of other countries' socialised medical services, 40m Americans have no coverage at all. Chinese children are more likely to be vaccinated against disease than Americans, despite the fact that health spending per head in the United States is about 150 times higher. The government, many Americans agree, should do something. Sadly, most of their politicians have misdiagnosed the ailment and are proposing a battery of quack remedies.

Bill Clinton seems to believe that the problem is not waste, but frugality. Yet again he has caught the popular mood: many voters fear that the "managed care" firms which have all but taken over America's health-insurance industry in the past few years have grown rich by denying treatment to defenceless arthritic grandmothers and children with leukaemia. Mr Clinton's "Bill of Rights" for patients, to be unveiled this month, aims to make them more generous. In bashing HMOs (health-maintenance organisations, the most common type of managed-care firm), the president is following the lead of state legislatures, 40 of which have passed laws seeking to micro-manage health insurance.

Who could disagree? Who could be against banning "drive-through deliveries", the practice of booting mothers out of hospital within a few hours of giving birth? Who could condone "gag clauses", which prevent a doctor employed by an HMO from telling patients about costly drugs or operations which HMO accountants are unwilling to pay for? Who, after reading all the headlines about managed-care firms' penny-pinching, could quarrel with Mr Clinton's plan to set out "minimum standards" of treatment for various illnesses, and compel insurers to pay for them?

HMOs are hugely unpopular, so Mr Clinton is politically astute to attack them. But he is wrong. The evidence shows that managed care has curbed medical inflation without compromising the quality of care (see pages 23-26). The trouble is, HMOs' drawbacks are more visible than their benefits. Under the old fee-for-service system, insured Americans could demand almost any treatment they wanted, with little regard for cost or efficacy. Under managed care, they cannot. Understandably, they resent this. What they fail to see is that without the savings brought by HMOs, they might by now have no insurance at all. Before managed care came on to the scene, premiums were rising so steeply that smaller employers had begun to drop health coverage altogether. Many of the ones that retained it cut pay instead.

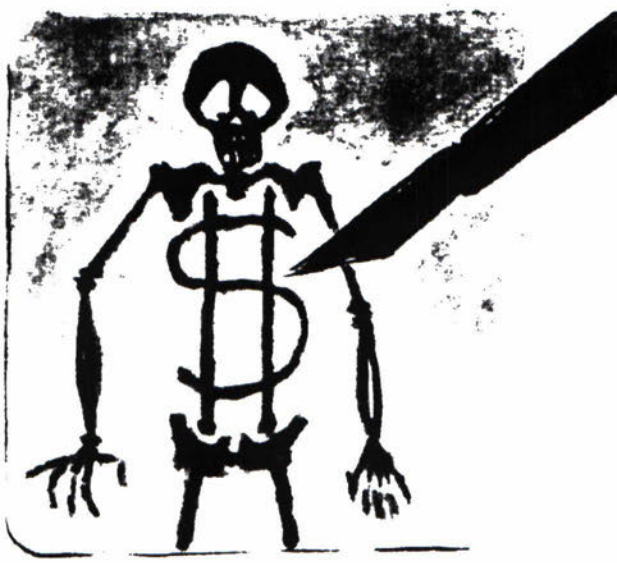
Mr Clinton's latest stab at health reform is essentially a watered-down version of the disastrous plan his wife devised in 1994 to have the government take over the whole sector. His new proposals, combined with state-level meddling, will have three bad results. First, since medicine advances too fast for any politician to keep up, the reformers will cast in stone a set of standards that will be out of date before they are even passed into law. Second, they will discourage innovation. Ruling that, say, a man with prostate cancer must be offered surgery discourages doctors from developing non-surgical alternatives that may be more effective and less painful. Fixing the number of days that a patient should stay in hospital after a hip replacement discourages the development of techniques to get him up and walking sooner. Third, they will push up premiums. Some firms will respond by ceasing to provide health insurance for their staff. Others will compensate for increased benefits bills by squeezing wages. Either way, ordinary workers, whom health mandates were designed to help, will suffer.

A modest proposal

Rather than imposing rules, it would be better to stimulate competition. The place to start is the tax code. Currently, health benefits provided by employers are tax-free; insurance taken out in any other way is not (although the 20m self-employed get a partial deduction). This anomaly dates back to the 1940s, when it provided a loophole to let firms reward staff without violating the wartime wage freeze. Now, its effect is to force workers to accept whatever health packages their employers offer. A typical American earning $25,000 a year and receiving $2,000 worth of health insurance from his company would have to pay an extra $500 if he tried to buy the insurance himself. This reduces choice: half of insured workers report that their employers contract with only one health plan. And since insurers are answerable to employers, rather than to the people who actually enjoy or endure their services, their incentives are skewed.

HMOs have made admirable efforts to cut costs (so deeply in some cases that they have seriously offended Wall Street). This pleases the payers. But they have not made such a good job of providing prompt, convenient and ungrudging service to their patients. Equalising the tax code, so that people could get similarly tax-deductible health insurance as individuals or through their unions, churches or whatever, would force HMOs to compete as fiercely on quality as on price. A more market-friendly approach offers no panacea for America's health-care system—but it would be a useful shot in the arm.

Your money or your life



In the space of a few years, the HMO has revolutionised America's health-care system. In many ways, the new regime is a great success. The trouble is, patients seem to hate it

THE managed health-care industry is one of America's newest, largest and most reviled. Ten years ago, firms that tried to curb health costs by rationalising and rationing treatment were a little Californian fad. Now, they cover roughly 160m people. As managed-care companies continue to squeeze out traditional health insurance, doctors are fuming at their loss of income, patients are livid at restrictions on the treatment they can receive, and politicians are scrambling to see who can bash the industry hardest. More than 1,000 bills seeking to ban alleged abuses by medical profiteers have been tabled in state legislatures in the past year. By the end of this month, a commission set up by President Bill Clinton is expected to recommend that a "Patients' Bill of Rights" be passed, making it illegal for insurers to deny their charges any one of a long list of services.

This sort of law is popular because health-maintenance organisations (the term commonly used for managed-care providers, HMOs for short) are not. Survey after survey shows that most Americans fear that managed-care firms care more about money than medicine. The popular view is that HMOs make their money by denying potentially life-saving surgery to sick children, and then award their managers seven-figure bonuses. In American bars you hear jokes like this:

> Q: How can you tell that a death certificate was filled out by an HMO doctor?
> A: He signs his name under "cause of death".

Yet most of this opprobrium is misplaced. Managed-care firms have their faults, to be sure, but the fact remains that thanks to HMOs America's health-care system works better than it used to. The advantages of managed care outweigh the drawbacks.

Before the managed-care revolution came to America, medical costs were swelling out of control. They are still high by world standards, but the pace of inflation has been drastically curbed—and this has been achieved without a measurable drop in the quality of care. In some respects, HMOs look after their members better than old-style insurance ever did. The shift from traditional indemnity coverage to managed care is arguably the most important development in America's health-care system since the invention of health insurance. The best HMOs have devised techniques for allocating resources and measuring outcomes that the rest of the world would do well to study.

The origins of managed care

The first big managed-care organisation, Kaiser Permanente, was founded in 1945. Henry Kaiser, a Californian industrialist, was looking for a way to keep the employees at his construction firm healthy. His idea was to contract with a group of doctors to look after his builders, in return for a flat fee per head. This gave the physicians an incentive to provide cheap preventive care to ward off future sickness. The programme was such a success that it grew into what is now the second largest non-profit HMO, with 9m members.

Kaiser's ideas took a long time to catch on. As recently as 1990, over 90% of Americans with jobs that provided health coverage still received traditional, fee-for-service insurance: if they fell ill, they went to the doctor, and passed the cost on to the insurer. The more consultations, tests and operations the doctors performed, the more they earned. This gave them an incentive to order batteries of unnecessary tests, overprescribe pills to the point where drug-resistant bacteria flourished, and perform invasive surgery when doing nothing might have been more prudent. Medical costs soared, with insurance premiums rising 13.6% a year between 1988 and 1992. Doctors bought BMWs, and employers found it increasingly hard to pay for their workers' health coverage.

Two possible solutions were offered. Mr Clinton recruited his wife to propose a comprehensive reform. She called for a monstrously complex system to bring the entire medical industry under the government's wing, enforcing low costs, high quality and universal access by presidential fiat. Attacked from all sides, the idea was abandoned. A number of entrepreneurs decided that the alternative was managed care—the Kaiser model or some variant of it.

Attracted by significantly lower prices, employers rapidly switched. By 1996, three-quarters of workers with insurance were in an HMO or some other kind of managed-care plan. Of the remaining quarter, most were in schemes that contained elements of managed care—such as the requirement that, to be sure of reimbursement, patients obtain the insurer's permission before undergoing an expensive operation. Today just 3% of insured Americans remain in "unmanaged" fee-for-service plans.

From its earliest days, managed care has upset traditionally minded doctors. When the first for-profit HMOs appeared on the west coast, several states tried to ban them. In New Jersey last year, several hundred doctors tried to unionise to fight the HMO menace. Most HMO foes argue that managed care, by allowing managers to second-guess or overrule the verdicts of medical professionals, puts lives at risk. Anecdotes of dangerous parsimony are not hard to come by. A few examples:

- A girl was born with retinopathy, an eye disorder that is usually correctable if treated in time. Her family's HMO stalled for eight weeks before referring her to a specialist. She is now blind.
- A Californian housewife complained to her doctor of abdominal pains and rectal bleeding. For three months, she was denied

a referral to a specialist. When she finally saw one, she was diagnosed with colon cancer. She died at the age of 34. Her husband sued the medical group involved and was awarded $3m, later reduced to $700,000.

• A teacher from California was diagnosed with breast cancer. Her doctor ordered a bone-marrow transplant. HealthNet, her HMO, refused to pay on the ground that the treatment was "experimental". Her university paid for it, but she died anyway. Her husband sued HealthNet for breaching its contract and won $1.2m.

For and against

Terrible mistakes are going to be made under any system of medical care. The question is whether they happen more often under managed care than under other schemes. On the face of it, because of the emphasis that managed care places on economy, you might expect it to provide worse treatment, albeit cheaper. Nearly all Americans seem convinced of this. Yet the evidence suggests that, overall, the HMO revolution has not only saved a fortune (thus helping to keep America's health-care arrangements affordable), but has done so while maintaining and sometimes improving upon previous medical standards.

Managed care cuts costs in several ways. First, big HMOs have the bargaining power to squeeze discounts from their suppliers, whether hospitals, drug firms or doctors. All three have long been dearer in America than anywhere else in the world—doctors' fees ruinously so. Second, they have cut the number of unnecessary tests, operations and days spent expensively languishing in hospital. Third, they focus more on preventive care, which may save money in the long run. Fourth, they make better use of information technology to crunch reams of data about patients in order to discover which treatments work best and which are the most cost-effective.

An analysis published in the *Journal of the American Medical Association* in 1994 showed that HMOs reduce hospital stays by 30% (although HMO members are slightly more likely to visit their doctors). A study of firms with more than 200 employees by KPMG, a consultancy, found that as managed-care enrolment soared between 1992 and 1996, inflation in health-care premiums fell from 10.8% a year to 0.5%. According to a Lewin Group study sponsored by the American Association of Health Plans (an HMO lobbying group), the total savings attributable to managed care in 1996 were between $23.8 billion and $37.4 billion. These savings are enjoyed by employers, who save money on benefits payments; by workers, who receive a substantial chunk of the savings in the form of higher wages; and by taxpayers, who pay less for beneficiaries of Medicare (the government health scheme for the elderly and disabled) who opt into an HMO.

Standards of care are much harder to measure than money. It is impossible, for example, to demonstrate a link between health-care delivery and life expectancy, because factors such as diet, exercise and smoking are much more important than the number of costly gadgets in hospitals. But according to the National Committee for Quality Assurance (NCQA), an independent accreditation agency, the average HMO does better than traditional fee-for-service medicine on several counts.

Take, for example, the benefits of reducing needless operations. Under fee-for-service, almost 30% of births are by Caesarean section. This is more expensive than normal delivery—but it also takes longer to recover from, can cause infection and other complications, and is agreed to be uncalled

for in at least 50% of cases. Mothers in managed-care plans are only two-thirds as likely to be subjected to a Caesarean.

More important, HMOs are better at preventive medicine. Under the old fee-for-service system, doctors had no financial interest in keeping healthy people out of their surgeries—quite the opposite. They devoted comparatively little time or effort to inoculating patients, advising them to stop smoking, providing breast-cancer screening and so forth. A smoker in a managed-care plan is 50% more likely to be advised to quit than one with fee-for-service insurance, according to the NCQA. A heart-attack victim in an HMO is more than twice as likely to be prescribed beta-blockers (which help prevent second heart attacks) than someone with a similarly dodgy heart but more traditional health coverage. Female HMO members are 40% more likely to be screened for breast or cervical cancer while in the at-risk age range.

The inability of the fee-for-service system to provide good preventive care is arguably one of the main reasons why the average American is no fitter than, and lives no longer than, people from European or Asian countries that spend far less on health care. Socialised medicine, as practised more or less everywhere outside America, scores better in this respect. In 1990 American diabetics were twice as likely to go blind or need their limbs amputated as their British fellow-sufferers, because Britain's National Health Service, which has a limited budget to cover the entire population, worked harder to make sure that they took their insulin injections and turned up regularly for eye tests. Under fee-for-service in America, only about three-quarters of children under two are inoculated against diphtheria, tetanus, measles, mumps, rubella and polio. In China, over 90% of toddlers get their jabs.

Since every dollar spent on vaccinations slices ten dollars off future medical bills, this state of affairs is a financial waste as well as a cause of needless suffering. Managed care should, in theory, correct it. Often it does—but not always. In the best HMOs, the assiduous tracking down and nagging of negligent parents leaves 95% of infants inoculated against all major inoculable diseases. In the worst, however, only 20% receive the necessary shots. This sort of variation is typical of most aspects of care. Rates of screening for cervical cancer at HMOs range from 25% to 100%, rates of screening for breast cancer from 30% to 90%, rates of beta-blocker prescription after a heart attack from 15% to 100%, and so on. Care varies greatly by region as well. Children are a third more likely to be properly immunised in New England than in southern states like Alabama and Kentucky.

Patient power

This great variation in the quality of health plans is largely the government's fault. First, it makes the job difficult by imposing mountains of confusing regulations—22,000 pages of them governing Medicare alone. Most states have passed laws attempting to micro-manage the way HMOs are run. Many of these mandate specific treatments for specific conditions. Big firms often find it simpler to enter a new market by buying up a local health plan rather than setting up afresh. For this reason, few HMOs are truly national. This makes it harder for them to contract with large national employers, and harder to squeeze suppliers. It also makes administration, cost calculations and information systems needlessly complex and expensive.

More important, the government suppresses competition through the tax code. Health benefits provided by employers to their employees are tax-free. Health insurance bought in any other way is not (although the self-employed are granted a partial deduction). Workers are forced in effect

Medicine for export

FOREIGN doctors hate HMOs just as much as their American counterparts. In Asia, physicians (particularly specialists) are in short supply and command the sort of respect not seen in the West since Dr Kildare. Persuading them that the system would be more efficient if they accepted lower fees and less autonomy will be difficult. The Malaysian Medical Association's website provides a link to an American site called "Managed Care Atrocity of the Month". In Europe, for-profit medicine is barely more respectable than loan-sharking. There too, HMOs have to tread softly. One of Germany's troubled public-sector health insurers has America's United HealthCare as a partner: it keeps quiet about this association.

Without a doubt, however, the skills developed by America's best HMOs would be useful overseas. In Britain, a version of managed care is practised, if anything, even more cost-effectively than in America, but American HMOs could still offer tips on how to use information technology better. More generally, national health-care systems everywhere are under financial strain—above all in the third world. As populations age and chronic ailments such as heart disease and cancer take a heavier toll, governments there face demands for expensive treatment from a growing middle class. Managed care could help. For countries like Russia, with its widespread alcoholism and plunging life expectancy, and South Africa, with its plagues of AIDS and tuberculosis, an emphasis on preventive medicine and primary care might prove invaluable.

Most American HMOs are busy enough at home, but a few of the bigger ones—including Aetna International, United Healthcare, Kaiser Permanente International and Cigna—are feeling their way in the developing markets of Latin America, Asia and Central Europe. Whereas premiums paid to managed-care firms in America have levelled off since 1994, private medical spending abroad is growing. In Asia, despite the recent financial crisis, the World Bank predicts that total health spending will reach $1.5 trillion by 2025. Cigna made just $200m from its overseas managed-care business in 1997, but expects revenues to grow by 20% a year from now on.

to take whatever package their employer chooses, rather than the one they might prefer themselves. This would matter less if firms offered plenty of options. But most do not. Roughly half of the firms in America offer their staff no choice at all, according to KPMG, and another 20% offer a choice of only two plans.

Since the employer is the customer, HMOs compete more than they otherwise would on price rather than quality or convenience. Their margins are now so thin that the slightest miscalculation can push them into the red—and miscalculations are common in a business where premiums have to be fixed long before anyone knows what inflation in medical costs will be. In 1996 only 35% of HMOs made a profit. The managed-care organisations that prospered tended to be the ones which used information technology best to make predictions about how many drugs and visits to doctors they would need to buy, and at what price.

This task is made harder by the fact that many HMOs, such as PacifiCare Health Systems and Aetna, have merged or made big acquisitions, and had hideous trouble integrating their systems for estimating costs and billing. Even firms that have not merged with others have had trouble—spectacularly so in the case of Oxford Health Plans, of Norwalk, Connecticut. Its shares plunged 62% on October 27th last year, on news that errors in software had caused its first loss-making quarter. (The firm has yet to recover; the chairman and founder, Stephen Wiggins, was ousted on February 24th.)

Where now?

The HMOs' balance sheets may be sickly, but the number of members shows no sign of shrinking. Many individual firms will disappear—some analysts predict that today's 1,000 or so managed-care organisations could shrink to 30 within a decade—but the stronger firms will battle to attract their customers. Whether the industry will eventually evolve into something that the public does not hate depends largely on how much the government continues to distort competition. There are already signs that some firms are trying to give patients more of what they want.

Oxford was one of the first to provide cover for alternative medicine for those prepared to pay extra, noting that about a third of people use it anyway. Several plans, including both Oxford and United HealthCare of Minneapolis, have been trying to develop plans that feel less restrictive than the usual HMO package. United does not require most of its members to seek a gatekeeping doctor's permission before consulting a specialist. Oxford lets patients visit doctors not on its approved list if they pay 20% of the cost.

HMOs that specialise in looking after the elderly tend to try harder to please their members, because retired people can choose plans for themselves, rather than following their employers' dictates. Those over 65 are covered by the government's Medicare scheme, but have the option of switching to an HMO if they prefer. The government pays the HMO a bit less than what it estimates it would pay itself. If the HMO can provide a more attractive care package for less still, it can keep the difference. Firms such as PacifiCare offer more preventive services than Medicare and are more generous with prescription drugs, which pleases pensioners (who often spend thousands of dollars on pills) and can save money by obviating the need for surgery later on. Medicare HMOs are now the fastest-growing part of the industry.

Pessimists argue that managed care has already realised the easiest savings in costs, and that finding new ways to trim will be harder. They have a point. Medical-cost inflation falls dramatically when large numbers of people first start joining HMOs in a given region. But after a few years it starts to pick up again. This is inescapable.

Medical research is forever throwing up new and horribly expensive ways of prolonging the lives of the very sick, so medical costs are always bound to outstrip general inflation. On the other hand, with the vast majority of insured Americans now in some kind of health plan, competition for customers should hot up. The benefits of this competition would be all the greater if the government could only bear to meddle a bit less.

WM. V. BILL ALEXANDER
ATTORNEY AT LAW

'98 MAR 20 AM10:55

March 20, 1998

President Bill Clinton
The White House
Washington, DC 20500

RE: Cuba

Dear Mr. President:

Your decision to permit the shipments of food and medicine to Cuba by Americans will do more to advance the cause of democracy there than a thousand more Radio Marti radio stations broadcasting anti-communist doctrine from the coast of Florida. Most Cubans already know that communism does not work!

I was among the first to offer the humanitarian food and medicine amendment in Congress more than a decade ago. I believed then, as now, that Cuba and Castro are ready for change. In fact, Fidel Castro told me so, if we can believe him, when I was Special Envoy to negotiate the US-Cuba "agenda" in 1986. See attached article.

Furthermore, your humanitarian exception to the embargo shows that you are a world leader worthy of a great and powerful nation.

Your friend,

Bill Alexander

10699 Oakton Ridge Court
Oakton, VA 22124
TEL (703) 255-1566
FAX (703) 255-1567

3-20-98
Send to Berkhardt?
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Attachment
One (1) page

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Arkansas Democrat Gazette

• • SUNDAY, JANUARY 25, 1998 • 3J

Sitting down to talk with Fidel Castro

BY BILL ALEXANDER
SPECIAL TO THE DEMOCRAT-GAZETTE

Commentary

"I am a Christian."

I heard that extraordinary declaration, so familiar to Americans, from Fidel Castro—whatever he may have meant by it. The dreaded dictator stands accused of heinous crimes against humanity, including murder and torture of political prisoners.

I was a member of Congress from Arkansas and the chairman of the congressional delegation assigned to go to Cuba in 1985 on a special assignment. The mission: establish a U.S.-Cuba agenda. A sub goal, important to me, was to open up Cuba's $100 million rice market to Arkansas, the nation's largest rice-producing state. The other congressman was Jim Leach, a Republican from Iowa, now chairman of the U.S. House Banking Committee.

What was I hearing?

I've thought about this remarkable statement this week as Cuba prepares an extraordinary welcome for Pope John Paul II. Was this a Castro different from the strident revolutionary, the longest serving head of state in the world today?

This was surely a departure from the vociferous condemnation of the CIA attempts on Fidel's life; the "pollution" of the airwaves by Radio Marti, the U.S. sponsored anti-communist propaganda radio station in Florida; the harassing "invasions of national sovereignty" by U.S. Air Force SR-71 flights that were announced by offensive sonic booms; and the infiltration of American "spies" to corrupt the struggling nation's economic progress.

Amidst the usual diplomatidc effort to discover a bilateral agenda of mutual interests there appeared this unique opportunity to look into the soul of Fidel Castro.

The Cuban president seemed to mellow and the tone of his voice sig-

place. I observed a man in introspection as he analyzed his feelings about the hereafter. This was not just about a political leader's vision of thinking about his standing in the eyes of his maker.

President Castro patiently explained his view of how socialism and Christianity served the same goals of helping the poor. He detailed the social progress since the revolution that produced the highest standard of living in the Caribbean.

"Why don't the Americans like me?" Castro probed.

Fidel seemed to be honestly puzzled about the persistent negative response from Americans, in addition to the Cubans living in Miami, to "the revolution that liberated Cuba from the decadent Batista regime." Castro had labored to explain how Batista was managed by the New York-based Mafloso that ran the Havana casinos and brothels that had "recruited young girls into prostitution for the sensuous pleasure of the bosses." Cuban society was corrupt and needed to be reformed. In his eyes Castro's revolution saved Cuba, bringing the highest living standards in the Caribbean.

Seizing the opportunity to encourage the dialogue in this new direction, I responded quickly. "Two reasons. First, Americans are frightened by your constant reference to revolution. Many Americans prefer to forget that our nation was born of revolution. They would respond more favorably to a different speech," I explained.

El Supremo's irritation grew. "Thank you for the lesson on politics! What's the second reason?"

Gently nudging the political wedge, I continued: "It was reported that you had offended his Holiness recently (this was 1985). There are many Roman Catholics in the

almost 100 years to free the slaves following the revolution." and "longer to grant the right to vote to women." He talked of establishing private ownership of property, free elections, freedom to the press, organizing political parties and the introduction of a market economy in certain areas.

Although he spoke enthusiastically about his social and political reforms he exhibited a touch of paranoia when he talked about his relations with the United States. He insisted that progress in Cuba was slowed because of interference from his "neighbor to the North" and said that the speed of the implementation of his reforms had to be linked to the establishment of an "official" dialogue with the United States. We focused on a softball agenda that would lead to a dialogue.

Four issues of mutual interest were identified at the three day meeting: international drug trafficking; air piracy; lost sailors and boats at sea; and fishing grounds.

The famous revolutionary must know that the pope will bring with him a momentum for change. The visit will be reactive: a consequence of natural and spiritual forces that cannot be predicted nor fully controlled. However threatening, Fidel is willing to take the risk.

The pope remembers the oppression of the Marxists in his native Poland. The pontiff's staunch anti-communist determination to do something about it is credited with the eventual downfall of communism there. This was the beginning of the end of the Soviet Union.

Castro always gambles when he plays out his grand strategy of politics. But if the aging leader means what he has professed to be his faith, there is likely to be more simpatico between the two titans than anyone expects. At the very least we will see the high drama of world politics played out between two larger than life actors on the world stage. I predict a new era for the island nation

noted a mood change when he began to focus on religion. He reiterated that he was a Christian, admitting however, that he had not been to confession in a long time. He revealed, perhaps for the first time, that his plans were to restore religious freedom in Cuba along with the reforms that were taking

United States. They are likely to be offended as well. Making peace with the pope would be popular in the United States."

I showed intense interest as Castro cautiously broadened his new theme to include social and political reform. He referred to human rights, noting that "it took America

that begins this week that will lead to a dialogue with the United States and the re-establishment of a substantial rice market for Arkansas farmers.

Bill Alexander is a former Arkansas congressman. He is now a lawyer in Washington

'98 MAR 20 AM9:53

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You have been invited to join a cast of characters who all **WAG THE DOG** in their own particular way for an evening of **TITANIC** proportions at ...

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If you are IN & not OUT, you must complete your ballot, play on-line at our website, return the ballot by fax or mail to RSVP to come Boogie the Night away.

Entries must be postmarked no later than Saturday, March 21, or faxed to 202-393-0151 or e-mailed to www.podesta.com/contest no later than 5:00 p.m. EST on Monday, March 23.

So whether you are Jackie Brown or Mrs. Brown, this is AS GOOD AS IT GETS when it comes to celebrating the *70th Annual Academy Awards*.

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BALLOT FOR TONY PODESTA'S ANNUAL ACADEMY AWARDS CONTEST

OFFICIAL RULES: To enter please complete the attached ballot and fax to Tony Podesta at 202-393-0151 or mail to 1001 G Street NW, Suite 900 East, Washin DC 20001. All entries must either be postmarked by Saturday, March 21, or received by fax before 5 p.m. EST on March 23. The person who has the highest numb correct guesses wins a free round-trip ticket to Hollywood or preferred domestic destination (of course, frequent flyer restrictions apply--but who would want to fly duri "blackout period" anyway?!) Palm greasing and bribes are strictly encouraged. And as always, Employees of the Academy, the Motion Picture Association, or any comp with a film nomination will be assigned a two-point handicap. *Former* clients of Podesta Associates are certainly not eligible to win, nor are past year's winners. Dependin their support of human cloning, Hill and White House employees may be disqualified (based on their genetic model). The ballot can be found on-lin www.*podesta.com/contest*. Good Luck!

(Please Circle One Selection in Each Category)

PICTURE
"As Good As It Gets"
"The Full Monty"
"Good Will Hunting"
"L.A. Confidential"
"Titanic"

ACTOR
Matt Damon "Good Will Hunting"
Robert Duvall "The Apostle"
Peter Fonda "Ulee's Gold"
Dustin Hoffman "Wag the Dog"
Jack Nicholson "As Good as It Gets"

ACTRESS
Helena Bonham Carter
"The Wings of the Dove"
Julie Christie "Afterglow"
Judi Dench "Mrs. Brown"
Helen Hunt "As Good as It Gets"
Kate Winslet "Titanic"

ART DIRECTION
"Amistad"
"Kundun"
"L.A. Confidential"
"Men in Black"
"Titanic"

SUPPORTING ACTOR
Robert Forster "Jackie Brown"
Anthony Hopkins "Amistad"
Greg Kinnear "As Good as it Gets"
Burt Reynolds "Boogie Nights"
Robin Williams
"Good Will Hunting"

SUPPORTING ACTRESS
Kim Basinger "L.A. Confidential"
Joan Cusack "In & Out"
Minnie Driver "Good Will Hunting"
Julianne Moore "Boogie Nights"
Gloria Stuart "Titanic"

CINEMATOGRAPHY
"Amistad"
"Kundun"
"L.A. Confidential"
"Titanic"
"The Wings of the Dove"

COSTUME DESIGN
"Amistad"
"Kundun"
"Cream and Lucinda"
"Titanic"
"The Wings of the Dove"

DIRECTOR
Peter Cattaneo "The Full Monty"
Gus Van Sant "Good Will Hunting"
Curtis Hanson "L.A. Confidential"
Atom Egoyan
"The Sweet Hereafter"
James Cameron "Titanic"

DOCUMENTARY FEATURE
"Ayn Rand: A Sense of Life"
"Citizen Stanley Up"
"4 Little Girls"
"The Long Way Home"
"Wings: The Rules of Engagement"

DOCUMENTARY SHORT SUBJECT
"Alaska: Spirit of the Wild"
"Ataxia"
"Daughter of the Birds"
"Still Kicking: The Fabulous Palm Springs Follies"
"A Story of Healing"

EDITING
"Air Force One"
"As Good as It Gets"
"Good Will Hunting"
"L.A. Confidential"
"Titanic"

MAKEUP
"Men in Black"
"Mrs. Brown"
"Titanic"

FOREIGN FILM
"Beyond Silence" (Germany)
"Character" (The Netherlands)
"Four Days in September" (Brazil)
"Secrets of the Heart" (Spain)
"The Thief" (Russia)

MUSICAL OR COMEDY SCORE
"Anastasia" Stephen Flaherty, Lynn Ahrens and David Newman
"As Good as It Gets" Hans Zimmer
"The Full Monty" Anne Dudley
"Men In Black" Danny Elfman
"My Best Friend's Wedding"
James Newton Howard

DRAMATIC SCORE
"Amistad" John Williams
"Good Will Hunting" Danny Elfman
"Kundun" Philip Glass
"L.A. Confidential" Jerry Goldsmith
"Titanic" James Horner

ANIMATED SHORT
"Famous Fred"
"Gretl's Comet"
"La Vieille Dame et Ses Pigeons (The Old Lady and the Pigeons)"
"The Mermaid"
"Red is Riding Hood"

SOUND
"Air Force One"
"Con Air"
"Contact"
"L.A. Confidential"
"Titanic"

SONG
"Go The Distance" from "Hercules"
Alan Menken and David Zippel
"How Do I Live" from "Con Air"
Diane Warren
"Journey To The Past" from "Anastasia"
Stephen Flaherty and Lynn Ahrens
"Miss Misery" from "Good Will Hunting"
Elliott Smith
"My Heart Will Go On" from "Titanic"
James Horner and Will Jennings

SOUND EFFECTS EDITING
"Face/Off"
"The Fifth Element"
"Titanic"

LIVE ACTION SHORT
"Dance Lexie Dance"
"It's Good to Talk"
"Sweethearts"
"Visas and Virtue"
"Wolfgang"

VISUAL EFFECTS
"The Lost World: Jurassic Park"
"Starship Troopers"
"Titanic"

ORIGINAL SCREENPLAY
Mark Andrus and James L. Brooks
"As Good as It Gets"
Paul Thomas Anderson "Boogie Nights"
Woody Allen "Deconstructing Harry"
Simon Beaufoy "The Full Monty"
Ben Affleck & Matt Damon
"Good Will Hunting"

ADAPTED SCREENPLAY
Paul Attanasio "Donnie Brasco"
Brian Helgeland & Curtis Hanson
"L.A. Confidential"
Atom Egoyan "The Sweet Hereafter"
Hilary Henkin and David Mamet
"Wag the Dog"
Norman Ansin "The Wings of the Dove"

Tiebreakers: 1. _____ Size of Titanic Apparatus 2. _____ Pageant Location 3. _____ see web-site for riddle

NAME _____ Phone: _____ Fax _____ E-mail _____

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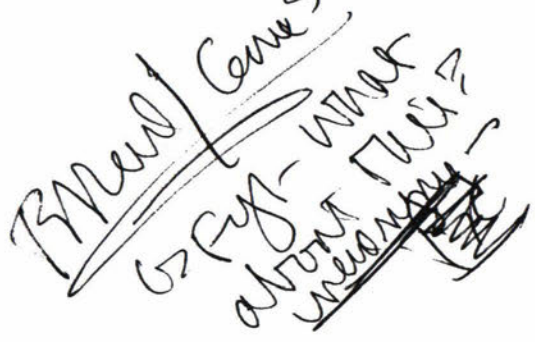
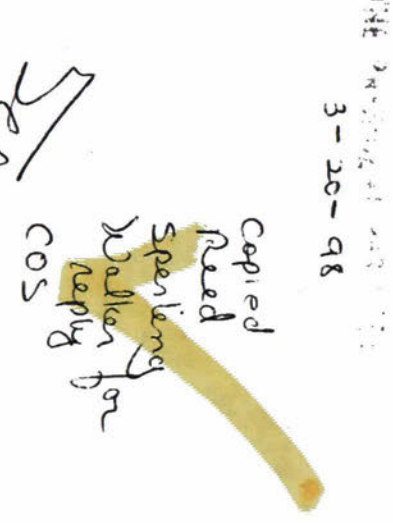
STROM THURMOND

United States Senate

WASHINGTON, DC 20510–4001

Strom Thurmond
U.S.S.





STROM THURMOND
SOUTH CAROLINA

COMMITTEES
ARMED SERVICES, CHAIRMAN
JUDICIARY
VETERANS' AFFAIRS

PRESIDENT PRO TEMPORE
UNITED STATES SENATE

United States Senate

WASHINGTON, DC 20510–4001

March 20, 1998

3-20-98

President William J. Clinton
The White House
1600 Pennsylvania Avenue, Northwest
Washington, District of Columbia 20500

Dear Mr. President:

I am writing concerning a matter of great interest to me and one that potentially effects the health of millions of Americans.

As you may already be aware, Secretary Rubin and I are in disagreement regarding a change to wine labeling regulations that the Bureau of Alcohol, Tobacco & Firearms is proposing at the whim of the wine industry. More specifically, this change would allow information on labels that would suggest there is a health benefit associated with alcohol. This proposal, and the Treasury Department's seeming willingness to enact it, causes me great concern.

My objections to this change are extremely strong and based on a number of considerations, not the least of which is that permitting this change would be tantamount to getting the federal government into the business of marketing wine. Furthermore, I am deeply concerned that allowing language on labels that imply the health benefits of consuming alcohol are greater than the risks might encourage people to begin drinking, or drinking in greater quantities than they already do.

Mr. President, your commitment to working to promote health among Americans and to protect our children against harmful products is commendable. I am certain that if you were to review the correspondence and materials I have collected in the last nine months, you would agree with me that the proposal currently being considered by Secretary Rubin and the Treasury Department should be abandoned immediately.

Thank you for your attention and interest in this matter and I hope you will urge Secretary Rubin to cease his consideration of this proposal.

With kindest regards and best wishes,

Respectfully,

Strom Thurmond

Strom Thurmond

ST/jd

Your support will benefit the children of America.

3/20/98

Send to Burkhardt:

Yes ✓

no ____

response necessary. C.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503
March 18, 1998

'98 MAR 20 PM5:18

FOR THE PRESIDENT OF THE UNITED STATES

From: Clifford A. Skelton, White House Fellow (97-98)

Dear Mr. President:

Thank you very much for meeting with the White House Fellows yesterday. We were honored to hear your perspective on so many issues of great importance to the American people. Thank you for spending so much time with us; it was more than we imagined.

Your recommendations on running for office—"a higher calling"—were particularly germane. I will long remember your advice:

--"Liberty"
--"The Pursuit of Happiness"
--"Forming a More Perfect Union"

As the Executive Assistant to General McCaffrey here at ONDCP and a proud naval officer - Keep getting up every morning as you said, with a smile on your face. Thank you again for being with us and for what you're doing for America.

Very Respectfully,

Clifford A. Skelton
Commander USN

THE WHITE HOUSE
WASHINGTON

Date 3/20

To: Bruce Lindsey

From: The Staff Secretary

I'll have this put through the "honorary chair" process -- I'll let you know if it's a problem.

Phil

The G & P Charitable Foundation

copied
Lindsey
COS

BL

THE PRESIDENT HAS SEEN
3-20-98

I would very much like
to do this if it's not
a problem — Read this
article — very moving
Bob

The G & P Charitable Foundation For Cancer Research

770 LEXINGTON AVE 16TH FLOOR NEW YORK, NEW YORK 10021 PHONE 212-486-2575 FAX 212-486-9527

March 10, 1998

Dear Mr. President,

My daughter Gabrielle unfortunately passed away last year after a long, valiant struggle against AML Leukemia. Gabrielle's strength and feistiness never failed throughout months of painful treatment. Her courage and love of life are an inspiration to all of us who fight in life. Her last wish was to create a foundation that would help spare others the suffering that she endured. In honor of Gabrielle's vision, her devoted husband Philip Aouad and I, together with our family, have formed The G & P Charitable Foundation.

The mission of the Foundation is to promote and improve scientific research in the fight against Leukemia, related cancers and immune deficiency diseases. The foundation will enhance the interaction between leading multi-disciplinary research scientists around the world through the co-sponsoring of seminars. The focus of these seminars will be to develop innovative opportunities and awareness within the fields of conventional and integrative medicine. The Foundation is also dedicated to promoting patient care and helping financially underprivileged patients in receiving access to available therapies including bone marrow transplantation.

We are planning a number of exciting projects to help the Foundation fulfill its mission. Our first event will be a gala dinner-show on Monday, October 5th, 1998 at the Plaza Hotel in New York, honoring Milton Berle, "Mr. Television." That evening, we will be celebrating his 90th birthday and 85 years in show business! Major recording artists and comedians will be contributing their talent in support of our cause. In keeping with our commitment to pledge 100% of contributions directly to cancer research, general and administrative expenses are underwritten by our family.

As you know, producing such an event is an ambitious undertaking, but with the help of a few very important people such as yourself, we feel confident that we will accomplish our goals. This project is one of love and dedication to such an important cause, and with your willingness to help by lending your name as our Honorary Chairman, and participating in our event miracles can and will happen! It would mean so much to me and Gabrielle's memory, to have you among us, even for a few precious moments, and I would be ever so grateful to you.

I am enclosing an article about Gabrielle so that you can better understand the impact of this disease on a person who had such a passion for life. Your help is greatly needed, and Philip, the family and I hope you will join us in the realization of Gabrielle's dream.

With Love,

Denise Rich

Denise Rich

If you want to contact me, you can reach me at: (212) 758-7940, or my director Michele Laurent - Rella at: (212) 486-2575.

"Love defies all pain, even in death"

Dear Mr. President,
You have always been so kind and compassionate to me and seemed to feel my pain. I want to thank you for that. It has been such a terrible time for me. I feel your pain + Hillary's also and ya have my prayers + support + love - I would appreciate your help + support so much.

The G&P Charitable Foundation For Cancer Research
770 LEXINGTON AVE 16TH FLOOR NEW YORK, NEW YORK 10021 PHONE 212-486-2575 FAX 212-486-9527

BASIC FACTS ABOUT LEUKEMIA

- **Without treatment 90% of acute leukemia victims would die within a year.**
- **Leukemia kills more children between the ages of 2 and 15 than any other disease (only accidents kill more children).**
- **Leukemia kills more adults than children. People over 60 are most affected.**
- **Over 100,000 Americans will contract leukemia or related blood diseases this year. More than 57,000 others will die from these diseases.**

WHAT IS LEUKEMIA?

Leukemia is a disease of the parts of the body that make blood. In Leukemia the body makes too many abnormal white blood cells, causing the following conditions: Infections (Leukemic cells lack the infection-fighting ability of normal white blood cells). Anemia (production of red blood cells drops as leukemic cells flood the system. Excessive bleeding (clotting ability decreases as number of platelets drops.

WHAT CAUSES LEUKEMIA

It is believed that a change in gene structure causes the abnormalities and uncontrolled multiplication of white cells in leukemia. The cause of this change is unknown, but several factors are suspected:

- Environmental factors
- Certain birth defects
- X-rays
- Other forms of radiation
- Viruses
- Chemical irritants

HOW IS LEUKEMIA TREATED

There is no known way to prevent leukemia, but it can be treated effectively. Today, modern treatments offer more hope than ever before to people who have leukemia. Treatment may include chemotherapy, radiation and bone marrow transplantation.

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WHO CONTRACTS LEUKEMIA

Leukemia can occur in either of two forms.

Acute Leukemia progresses rapidly and is the type most often seen in children, though it can occur at any age. Life expectancy is short without treatment (a few weeks to a few months). But drugs and/or bone marrow transplants have extended life expectancy for children with acute Leukemia cured about 72%. (A smaller proportion of adults with acute leukemia are also cured)

Chronic Leukemia progresses slowly and occurs most often in adults. With proper treatment, life expectancy is 3 to 20 years or more from the onset of the illness.

WHAT HAPPENS IN LEUKEMIA

In both acute and chronic leukemia, an extremely high number of abnormal white blood cells are produced, flooding the bone marrow

WHAT ARE THE SYMPTOMS OF LEUKEMIA?

Symptoms are similar to those of many common ailments, but eventually become more persistent and severe:

- Anemia
- Weakness and chronic fatigue
- High fever
- Bleeding, without clotting
- Bruising easily
- Recurrent infection
- Pain in joints and bones
- Swelling of lymph nodes, spleen and liver

LOOKING AHEAD IN THE FIGHT AGAINST LEUKEMIA

There's reason to expect new and better treatments for Leukemia. Research continues in a variety of fields including:

Cell growth and structure: What changes make leukemic cells behave as they do? How can they be made more susceptible to anti-leukemic drugs? How do they differ from normal cells?

The G&P Charitable Foundation For Cancer Research

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Possible causes of Leukemia including viruses, chemicals, radiation and defects in body chemistry

New treatments such as: Safer more effective drugs which will kill leukemic cells with minimal damage to normal ones and Better supportive therapy to counteract the complications of chemotherapy and radiation.

Immunotherapy: the study of the body's natural defense system. Is leukemia partly a result of a defect in this system? How can the body's immunity be strengthened so it would destroy any leukemic cells not killed by drug therapy?

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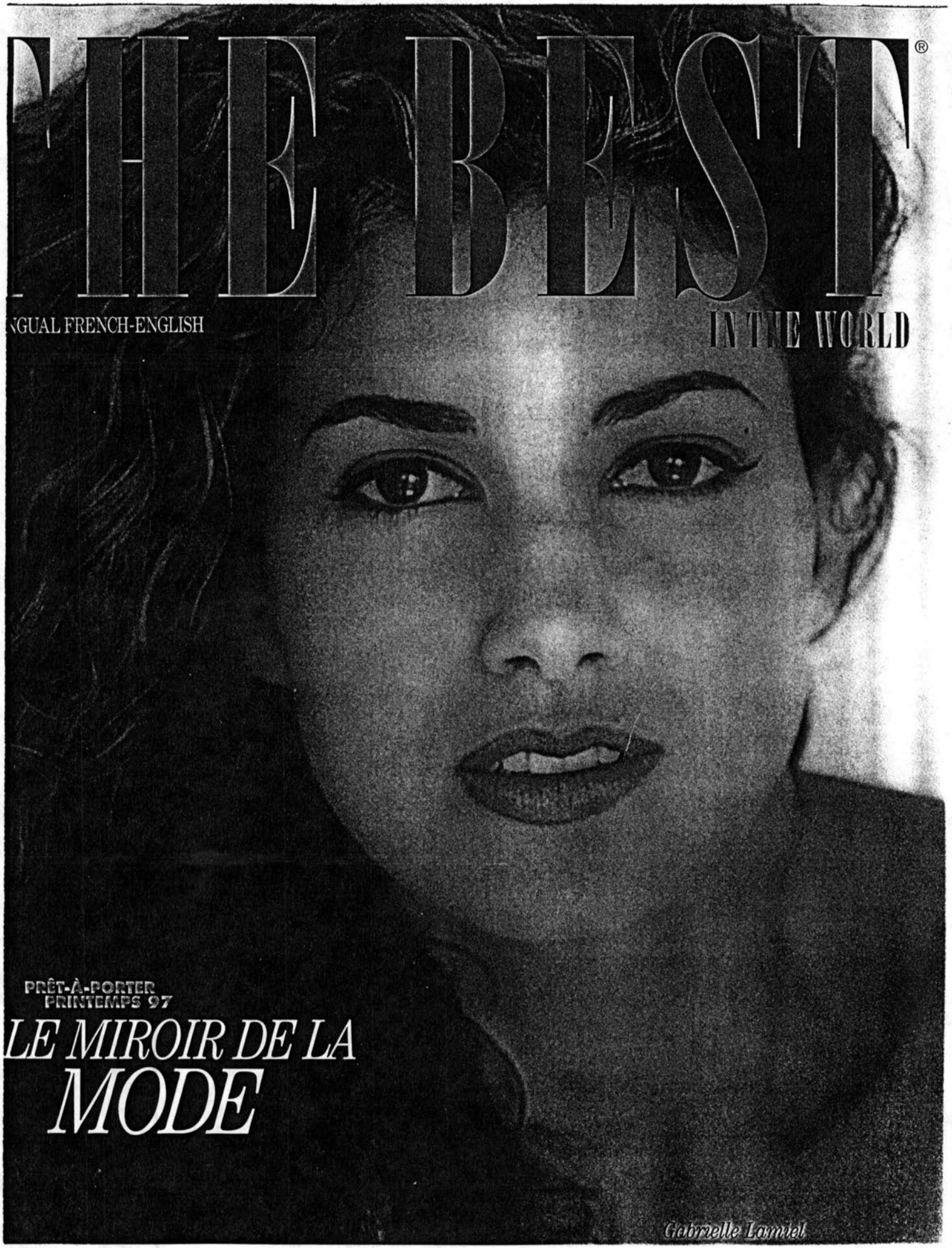
(voir article page 16)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