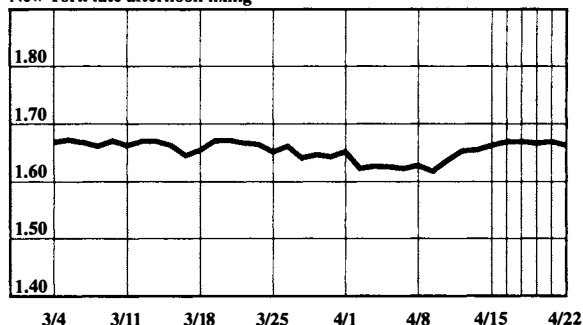


Currency Rates

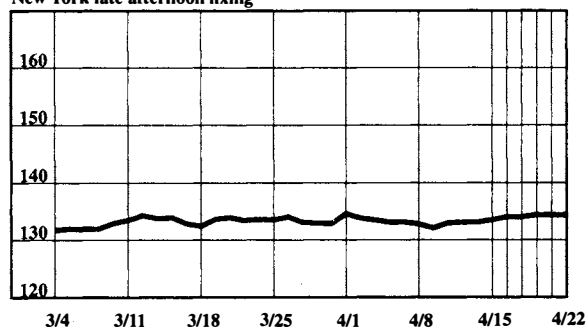
The dollar in deutschemarks

New York late afternoon fixing



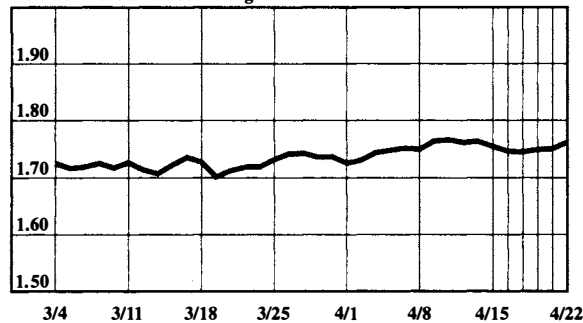
The dollar in yen

New York late afternoon fixing



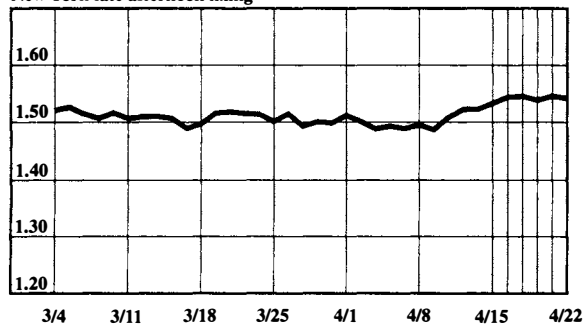
The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing



No health care in Oregon rationing plan

by Linda Everett

Within weeks, the Bush administration is expected to deliver its opinion of Oregon's plan to ration health care services for the poor. To implement its Medicaid experiment, Oregon needs the federal government to waive 15 Medicaid regulations that states are required to follow to qualify for federal matching funds. Although George Bush and the Health Care Financing Administration, which oversees the Medicaid program, appear to favor the plan, a study just released by the Congressional Office of Technology Assessment (OTA) provides fuel for both Congress and the country to defeat it.

The OTA's critique of the plan is useful, but the OTA is neutral about this first step to explicitly institute government-mandated control over your family's life and death. All the ethics studies, rationales, and promises that Oregon's plan provides "more access to care," amount to a river of swill meant to dupe you into accepting as "fair" society's killing of anyone it says is too costly to treat. So, although Oregon's plan denies the innate worthiness of each human life; guarantees *no* minimum set of medical benefits to any patient; denies Medicaid patients constitutional rights; reverses civil rights guaranteed by the Americans with Disabilities Act of 1990; and denies some Medicaid patients benefits they now have; and although OTA is critical of the plan for failing to treat a "substantial number of medical conditions that in absence of treatment would have serious medical consequences," the OTA found the plan "unambiguously good."

Shrinking coverage

Oregon's plan will supposedly expand Medicaid coverage to anyone with a family income less than 100% of the federal poverty level, by cutting costs and restricting benefits through "managed care" programs like Health Maintenance Organizations (HMOs), and by prioritizing 709 health care conditions and their treatments. Each condition-treatment pair is ranked according to a numerical value that measures its cost-effectiveness, "clinical efficiency," necessity, duration of therapy, and "value" to society. Evaluation of a treatment's net benefit is a subjective, value-based judgment, and not scientific, the OTA admits. A costly treatment that could save a life is ranked low if the treatment duration lasts only one or two final years of the patient's life. If you have termi-

nal cancer, only palliative hospice care or "death help," not cures, are attempted.

Don't believe that these treatment preferences were democratically agreed to by the community. The choices Oregonians were given in rigged community meetings and telephone polls on which the rationing plan is based, were about as democratic as concentration camp polls on how to redistribute bread crusts more fairly.

The benefit package expands or contracts according to Oregon's biennial budget allocation. (Benefits will shrink again, because the state is faced with a \$2.2 billion budget shortfall over 1995-97 due to a voter-approved property tax limitation.) Current allocations cut treatments at line 587. Services above that line are allegedly covered, everything below it is not, including, the OTA found, treatment for six of the most frequent diagnoses of Oregon Medicaid hospital inpatients in 1989—including chronic bronchitis, viral pneumonia, asthma, and acute upper respiratory infections. Benefits also shrink with any rise in unanticipated costs like the extra administrative and utilization review costs needed to enforce rationing.

Oregon hopes to enroll most patients in a host of various managed care programs like HMOs, physician care organizations, and primary care providers, in which providers are at full or partial financial risk to cover all treatment costs covered by pre-paid, flat, per patient capitated fees, or flat fees based on actuarial estimated treatment costs. Doctor-gatekeepers receive a monthly fee for each Medicaid patient enrolled, and any savings derived by restricting specialized or hospital care. The OTA says the plan's "greatest payment boon" to clinics, hospitals, and doctors is presumed to come from a reduction in the number of patients unable to pay for their care, since they now will be covered by Medicaid.

That's nonsense. As the OTA admits, some public primary care clinics—rural providers, among others—lose key financial protections if they participate in the plan, and many patients, if they don't. Besides losing money, each time treatment costs exceed a contracted fee, subcontractors of pre-paid plans, like clinics, hospitals, and doctor groups, must continually reduce their rates and gut infrastructure in each negotiated state contract to stay competitive and to keep a percentage of the Medicaid population. Such disincentives, the OTA says, may lead to a lack of Medicaid providers and long waiting lists. So, although many may gain Medicaid services, there is no guarantee that they'll receive them.

GAO studies show that the federal government has refused to stop violations of federal law by HMOs contracted to provide services to Medicare and Medicaid enrollees. But now, Oregon law, which exempts providers from liability when they deny Medicaid beneficiaries medically necessary but uncovered care, including emergency care, openly violates federal statutes that require hospitals to provide basic emergency care to *anyone* in need. The law also denies Medicaid patients their right to legal recourse when denied care.

Brookings leads push for Oregon health plan

by Steve Parsons

Rationing America's Medical Care: The Oregon Plan and Beyond

edited by Martin A. Strosberg, Joshua M. Wiener, Robert Baker, with I. Alan Fein
The Brookings Institution, Washington, D.C.,
1992

238 pages, paperbound, \$12.95

Over the last decade, the Brookings Institution has led the way in making health care rationing an issue for discussion. Henry J. Aaron, Brookings director of economic studies and one of the earliest advocates of rationing, notes with pride how such discussions have not only become "acceptable," but are on the verge of implementation through such innovations as the Oregon plan. "Eight years ago, when William Schwartz . . . and I wrote *The Painful Prescription: Rationing Hospital Care* (Brookings, 1984), we were, I believe somewhat ahead of our time. . . . Our use of the work *rationing* . . . [was] as though we had shouted an obscenity in church. Fashions change, however, and it is gratifying to see a growing recognition in the United States that sustained long-term reduction in the growth of health care spending will occur only if we are willing to ration."

Aaron's self-congratulations were delivered one year ago at a Brookings conference entitled "Rationing America's Medical Care: Opening Pandora's Box?" in which the Oregon plan was the center of scholarly presentations. The papers from that conference were compiled into a book entitled *Rationing America's Medical Care: The Oregon Plan and Beyond*, which was unveiled April 13 at a press conference at Brookings headquarters in Washington.

At the press conference, editors Martin Strosberg and Robert Baker of Union College, and Joshua Wiener of Brookings, stressed that the book "balances" the various sides of the rationing debate. All three, as well as the vast majority of the papers in the book, support the Oregon program as the first step in opening the floodgates for rationing in the United States—a goal long sought by such think-tanks as Brookings on the "liberal left" and the RAND Corp. on the "right."

What was most remarkable about the Brookings presentation was the fact that members of the audience, many from