© JOSEPH SCHWARTZ COLLECTION/CORBIS

44.3 MILLION IN US Lack Health Insurance

An estimated 44.3 million people in the US, or 16.3% of the population, had no health insurance in 1998—an increase of about one million people since 1997, according to a Census Bureau report.

"Those more likely to lack health insurance continue to include young adults in the 18- to 24-year-old age group, people with lower levels of education, people of Hispanic origin, those who work part-time and people born in another country," noted Jennifer Campbell, author of the report, *Health Insurance Coverage: 1998*.

The status of children's health care coverage did not change significantly from 1997 to 1998, with 11.1 million, or 15.4%, of all children younger than age 18 uninsured. Thirty percent of Hispanic children were uninsured, as were 19.7% of black children, 16.8% of Asian and Pacific Islander children, and 10.6% of non-Hispanic white children.

Other findings include:

- The proportion of people without health insurance ranged from 8.3% among those in households with annual incomes of $75,000 or more to 25.2% among those in households with less than $25,000 in annual income.
- About half (47.5%) of low-income full-time workers did not have health insurance in 1998.
- The Medicaid program insured 14.0 million poor people, but about one-third of all poor people (11.2 million) had no health insurance.

The data in the report were from the March 1999 Current Population Survey (CPS). The CPS, primarily designed as a survey of the labor force, underreports Medicare and Medicaid coverage.

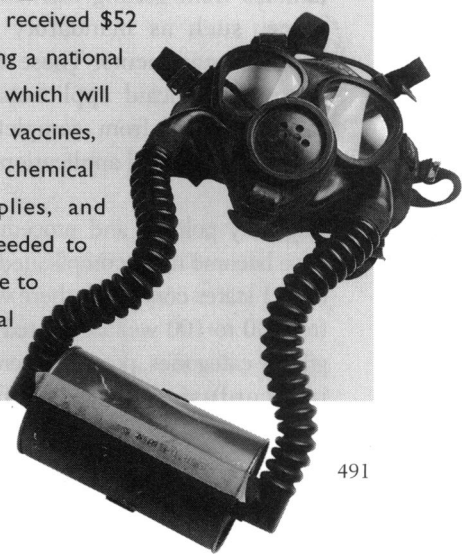
For more information, contact the Housing and Household Economic Statistics Division, US Census Bureau; tel. 301-457-3242; e-mail <hhes-info@census.gov>. The full text of the report, Health Insurance Coverage: 1998, *is available at* ***http://www.census.gov/hhes/www/hlthin98.html***. ■

$40 Million for Bioterrorism Preparedness

The Centers for Disease Control and Prevention (CDC) have awarded $40 million to states and major cities to expand and upgrade their ability to detect and respond to biological and chemical agents and to provide a public health response to terrorist acts in the United States.

Included are $8.8 million to expand state and local biological laboratory capacity and $19 million for an improved electronic communications network that will include Internet access for local health departments, allowing them to share information on unusual disease outbreaks.

In addition, CDC has received $52 million to begin establishing a national pharmaceutical stockpile, which will ensure availability of the vaccines, prophylactic medicines, chemical antidotes, medical supplies, and equipment that will be needed to support a medical response to a biological or chemical terrorist incident. ■



GAO Looks at State MEDICAID ENROLLMENT Post–Welfare Reform

National declines in Medicaid enrollment raise questions about whether states have been able to "de-link" welfare and Medicaid policies in a way that ensures Medicaid coverage for eligible individuals, notes a report by the US General Accounting Office. The report recommends that Congress consider a legislative revision allowing states to lesson or eliminate periodic income-reporting requirements for families receiving transitional Medicaid and to instead allow a full year of transitional Medicaid coverage to eligible beneficiaries. *(See related article on page 540.)*

According to the report, national enrollment in Medicaid among adults and children declined by about 1.7 million, or 7%, from 1995 to 1997. The authors identify four approaches used by state welfare programs that may influence Medicaid enrollment:

- Many states use diversionary policies intended to discourage families from getting cash assistance, such as mandatory job search requirements. These may confuse Medicaid applicants or dissuade them from completing separate Medicaid applications.

- Eligibility policies and procedures have become more complicated. In the 21 states contacted, there were from 30 to 100 welfare-related eligibility categories, potentially creating confusion for eligibility workers, especially in states without updated computer systems.

- Transitional Medicaid assistance varied among states, and there was little consistency in data tracking across states. Participation rates ranged from 4% of the families losing cash assistance in Idaho to 94% of the families in Connecticut. Though many of the states contacted expected eligibility workers to provide beneficiaries with information on transitional Medicaid, only nine states said they had developed simple materials explaining the concept to both workers and beneficiaries.

- Some states have initiated education and outreach efforts aimed at minimizing confusion about Medicaid eligibility after welfare reform. And some states reported that outreach for the Children's Health Insurance Program (CHIP) has had a positive effect on Medicaid enrollment.

Copies of the report, Medicaid Enrollment: Amid Declines: State Efforts to Ensure Coverage after Welfare Reform Vary *(GAO/HEHS-99-163), can be ordered online from the GAO website at* ***http://www.gao.gov/cgi-bin/ordtab.pl****. The text of the report is downloadable in PDF format from:* ***http://www.gao.gov/new.items/he99163.pdf***. ■

NIH Launches New Publishing Website

The National Institutes of Health (NIH) are establishing a repository for electronic distribution of primary research reports in the life sciences.

PubMed Central will begin receiving, storing, and distributing content—including peer-reviewed articles, preprints, and other screened reports from existing journals, new journals, and scientific organizations—in January 2000.

Peer-reviewed reports will be provided by participating publishers and societies at any time after acceptance for publication, at their discretion.

Non-peer-reviewed reports will be submitted to PubMed Central by independent organizations, which will be responsible for screening the material. Many of the non-peer-reviewed reports will be "preprints" of reports that will also be submitted for peer review. In other cases, a report may never be submitted to a journal for traditional peer review yet will be deposited in PubMed Central because, in the judgment of the screening organization, they provide valuable data to the research community.

For more information, contact <pubmedcentral@nih.gov>. ■

Providers, Health Plans CLASH OVER PATIENT CARE

The results of a national survey provide insight into how frequently clinicians and health plans disagree about patient care and how clinicians view the consequences of these disagreements.

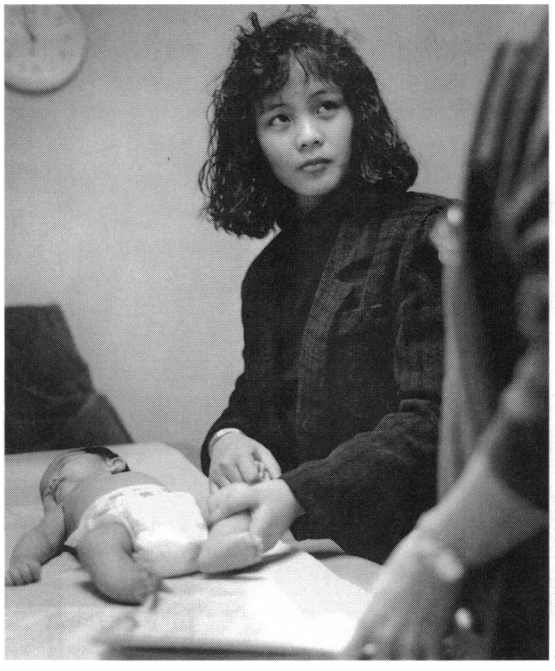
Researchers at the Kaiser Family Foundation and the Harvard School of Public Health surveyed 1053 doctors and 768 nurses about their experiences in providing care to non-elderly patients. Survey data were weighted by age, gender, and region.

While both doctors and nurses gave positive marks to health plans for preventive care as well as for practice guidelines and disease management protocols, members of both groups saw the growing influence of managed care as having negative effects on medical care.

Specialists (71%) were more likely to say that managed care had a negative impact on patients than primary care physicians (58%). Doctors who contracted with multiple health plans were more likely than doctors who worked predominantly with a single HMO to report negative effects of managed care on patients.

Eighty-six percent of doctors and 82% of nurses said that managed care had decreased their patients' ability to see medical specialists; 83% of doctors and 85% of nurses said managed care had decreased the amount of time they spent with patients; and 72% of doctors and 78% of the nurses said that managed care had decreased the quality of care for people who were sick.

On the positive side, 68% of the doctors and 51% of nurses said that managed care had increased the use of practice guidelines and disease management protocols, and 45% of doctors and 42% of nurses said that managed care had increased the likelihood that patients would get preventive services.



© DEAN WONG/CORBIS

The survey's findings suggest that clinicians and health plans frequently disagree about patient care. Eighty-seven percent of physician respondents said that their non-elderly patients had experienced denials of coverage for health services over the previous two years.

Two-thirds of doctors said they "sometimes" or "often" intervened with plans on their patients' behalf, noting that their interventions often led to resolutions in the patient's favor. Almost half of the doctors (48%) and nurses (46%) responding to the survey said that they had exaggerated the severity of a patient's condition to get coverage for medical care they felt was needed.

"There is a great deal of inappropriate care in the health care system and it is the managed care industry that has taken on the unpopular job of controlling costs, but this level of conflict and administrative haggling between doctors and plans can't be good for our health care system or for patients, who are often caught in the middle," said Drew Altman, PhD, president of the Kaiser Family Foundation.

In reflecting on their own experiences, 58% of doctors described spending too much time on administration and not enough time with patients as a "great concern." Not having enough clinical autonomy was cited by 47% of responding physicians as a "great concern," while not making as much money as they had planned was cited by 26%. Almost seven in ten nurses (69%) cited inadequate staffing levels as a "great concern." A third pointed to not having enough clinical autonomy, 28% to inadequate training to cope with changes, and 26% to not making as much money as they had planned as "great concerns."

Information on the 1999 Survey of Physicians and Nurses *is available online at* ***http://www.kff.org/content/1999/1503****. Copies of the report are available from the Kaiser Family Foundation's Publications Request Line; tel. 800-656-4533 (ask for document #1503).* ■