'Managed' care is destroying medicine, and killing people

by M.M. Baker, J. Hoefle, A.K. Wikrent

In the early 1970s, at the time of the shift of the U.S. economy to the "post-industrial" policy of decline and decay, the U.S. health care system likewise began a process of degradation. For example, whereas in 1970 there was an average ratio of community hospital beds per 1,000 people of close to 6.0, by 1994 this ratio had fallen to 3.7. Everything that went with hospital beds (physicians, nurses, diagnostic equipment, and treatment) has likewise fallen below levels of per population ratios considered as the modern medical standard.

At the same time, in the early 1970s, the "post-industrial" argument was made, that lower ratios of health care logistics per household were acceptable in the general economy, because "experts" could be brought in to make decisions on how to "manage" health care provision, so as to "maintain" health for a subsection of people who signed up for this "expert" service. This rhetoric rationalized the creation of the new structures called "health maintenance organizations" (HMOs) and similar "managed care" entities, such as "preferred providers," by mostly major insurance and international financial networks, out to make a financial killing off the declining health care base of the nation.

Even if you didn't swallow the rhetoric, millions of Americans signed up with HMOs, because, relative to their paycheck, the costs of medical care and the costs of traditional insurance (Blue Cross/Blue Shield and similar programs) were going up so fast, that the relatively cheaper HMO member fees seemed to be the only alternative, and therefore worth the risk.

Figure 1 shows the percent of population now insured by some form of HMO, by state. Nationwide, the number of people enrolled in HMOs grew from fewer than 5 million in the 1970s, to over 60 million today. The prominent HMOs are shown in **Table 1.**

The HMOs took over in spectacular ways. They picked over traditional hospitals (city, county, and state; religious, philanthropic), as the latter fell into financial distress over the 1970s-90s, with the loss of tax revenues and donations, and high costs.

The HMO mandate is to restrict the care available to the subscriber, and thus make profits off the "cost efficiencies." HMOs range in operation from merely managing networks of participating medics and facilities, to owning and running medical centers. As traditional hospitals and clinics faced

FIGURE 1
Percentage of population in HMOs

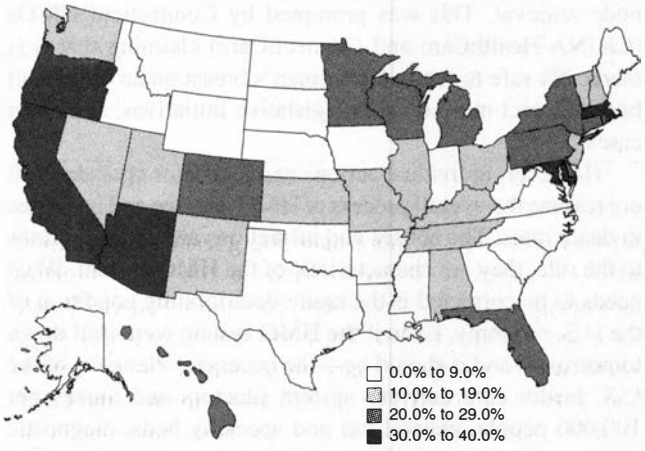


TABLE 1
The top national managed care firms
(ranked by enrollment, as of July 1993)

Firm (No. of Plans)	Enrollment (Number of Individuals)
1. Kaiser Foundation Health Plans, Inc. (12)	6,598,644
2. Blue Cross and Blue Shield System (76)	6,187,444
3. U.S. Healthcare (8)	1,475,543
4. Prudential Health Care Plans, Inc. (29)	1,430,457
5. Cigna Healthcare Plans, Inc. (45)	1,180,379
6. United Healthcare Corporation (18)	1,157,337
7. Health Insurance Plan of Greater New York (3)	1,133,972
8. Aetna Health Plans (25)	1,059,403
9. Humana, Inc. (18)	1,051,384
10. PacifiCare Health Systems, Inc. (5)	1,045,670
Others of note, shown in rank order of enrollment:	
22. MetLife Health Care Management Corp. (14)	269,572
31. Travelers Health Network, Inc. (8)	98,298
Total enrollment for above 12 firms:	22,688,103
Percent of national Health Management Organization total enrollment:	57%

Source: The InterStudy Competitive Edge, Vol. 3, No. 2., March, 1994

ruin, the HMOs picked over the assets, in waves of mergers, acquisitions, and takeovers.

The result? People are suffering and dying; and HMOs are posting record rates of profit. The courts are full of cases, showing HMO non-treatment, or malicious lack of attention. And 33 states this year alone have passed legislation to correct various specified HMO life-threatening "routine" cost-cutting practices.

On Sept. 24, Congress passed legislation requiring insurance companies (mostly HMOs) to pay for at least a 48-hour hospital stay for mothers giving birth. U.S. Rep. Rosa DeLauro (D-Conn.) is now drafting legislation to require insurers (meaning, in fact, HMOs) to pay for a minimum 48-hour hospital stay for a mastectomy, and a 24-hour stay for lymph-node removal. This was prompted by Connecticut HMOs (CIGNA HealthCare and ConnectiCare) claiming that it is medically safe to remove a woman's breast on an outpatient basis. Expect more of such legislative initiatives, and court cases.

However, individual actions and legislator crusades will not reverse the overall process of HMO damage and increases in death rates. The abuses and infractions are not exceptions to the rule, they are characteristic of the HMO system. What needs to be corrected is the entire deteriorating condition of the U.S. economy. Even if the HMO system were shut down tomorrow—and it should be—the necessary elements of the U.S. health care delivery system (doctors and nurses per 100,000 people, general use and specialty beds, diagnostic equipment, etc.), including public health services (vaccinations, x-ray equipment, etc.), do not exist at the ratios needed to deliver standard care to the population.

How to replace HMOs? Look at the economy in the mid-1960s, when, whatever the problems, it still functioned. At that time, the U.S. health care system was characterized by an active public health program (for dealing with communicable diseases, for example, the anti-polio program, and for preventive care, and so on), by a network of government and private hospitals and clinics, and by a working population, whose employers or, who, themselves, were able to afford health insurance. Hospitals could, in turn, care for indigent in the community. And to assist the process, in 1965, Medicare and Medicaid were set up.

In this report, we provide an initial picture of today's "managed care" menace, and we give a few key elements showing the decline in the U.S. health care medical delivery system overall. *EIR* has periodically reviewed the decline in the U.S. economy, most recently, in the survey, "U.S. Market Basket Is Half What It Was in the 1960s" (see *EIR,* Sept. 27, 1996).

To illustrate the general point, we turn to examples from Pennsylvania and Arizona, because each is in the forefront of the national political policy fight to restore the economy, and medical care in particular. In Pennsylvania, an impeachment campaign is under way against Gov. Tom Ridge (R), for the decision he forced through the legislature, to eliminate state medical care benefits for 220,000 Pennsylvanians in need. The consequences of this will be, within six months, 3,500 needless deaths, according to an analysis of similar cuts in California, published in the *New England Journal of Medicine.*

In Arizona, Congressional candidate Maria Elena Milton (D) is leading the campaign to defeat her opponent, freshman incumbent John Shadegg (R-4th C.D.), because he is promoting, as chairman of GOPAC and an associate of similar groups, the HMO-serving policies of privatization and deregulation that are killing people (see p. 26).

Rise of HMOs

In 1980, HMOs covered approximately 5 million Americans. In 1986, those enrolled in HMOs rose to 26 million; in 1995, the total reached 53 million. As of September 1996, 60 million Americans are enrolled in HMOs.

In the meantime, the number of Americans with no health insurance rose from 31.026 million in 1987, to 39.718 million in 1994, according to the U.S. Department of Commerce Bureau of the Census. Again, the culprit was the general economic collapse, or "economic restructuring," as the pundits call it, which has thrown millions out of work. In 1987, 75.5% of Americans were medically insured by private plans, but as the economy was "downsized," this percentage steadily declined, reaching a low of 70.2% in 1993, and barely budging upward to 70.3% in 1994. Medicare, Medicaid, and the military health care system have not been able to take up the slack: The percentage of Americans with government medical insurance increased only 3.5%, from 23.3% in 1987, to 26.8% in 1994, not nearly enough to make up for the 5.2% decline in private coverage. There is some overlap in the numbers and percentages, because some of the 24 million insured by the government's Medicaid plan are now covered by private plans, for which Medicaid pays.

The top ten-largest managed care firms, as of summer 1993, when total enrollment in HMOs was about 45 million nationwide, are shown in Table 1. At that time, these companies—plus a couple other notables—accounted for 22,688,103 people enrolled in HMOs.

Since then, a wave of mergers and acquisitions has created an even more elite selection of names controlling the HMO trend, which is dominated by mega-insurance firms. For example, the 1993 No. 3 ranked company, U.S. HealthCare, has recently merged with the No. 8 company, Aetna Health Plans, to form an HMO group with 3.3 million enrollees.

Mega-insurance companies

The major insurance companies which write general insurance, including life, casualty, property, with subdivisions represented in the HMO line-up, include: Prudential of America, CIGNA Group, Aetna Life and Casualty, Metropolitan Life, and the Travelers Group. In addition, there are an-

other several hundred health insurance entities of various kinds; and there is the nationwide system of 73 Blue Cross/Blue Shield plans, many technically classified as not-for-profit.

As of 1993, for lobbying purposes, the insurance companies were organized roughly into these groups: 1) Alliance for Managed Competition, the association of the giants (Aetna, CIGNA, Prudential, Metropolitan Life, Travelers); 2) the Health Insurance Association of America (HIAA), with 270 mostly medium- and small-sized companies. Blue Cross/Blue Shield are outside these action groups. Some 65 million Americans are insured by one of the HIAA companies, and over 65 million, or fully one-third of the market, are under the five giants of the Alliance for Managed Competition group, either in HMO or non-HMO programs. Another 70 million Americans are covered under Blue Cross/Blue Shield.

HMOs reap huge profits

The profit growth of HMOs has been phenomenal. The average growth rate of 12 HMO firms for which data for revenues in 1990 and 1995 are readily available, was 617.4% between those years. That means that average revenues were more than doubling each year.

Look at the spectacular growth rate of Oxford Health Plans, Inc., not the largest, but strategically placed in providing Medicare and Medicaid plans, and third-party administration of employer-funded medical benefit plans, as well as traditional HMO functions. Oxford's number of enrollees was 1.2 million, in New York, New Jersey, Connecticut, Pennsylvania, and New Hampshire, at the end of March 1996. From $60.3 million in revenues in 1990, Oxford grew 2,827.7%, to revenues of $1.765 billion in 1995. Profits grew even faster—5,200%, from $1 million in 1990, to $53 million in 1995.

There are other, similar cases. For example, HealthSource, Inc., which operates HMOs for 404,300 enrollees in the Northeast, and 423,800 enrollees in the South. HealthSource also provides third-party administration for another 1.7 million people, and wrote indemnity group health insurance for 390,000 people. Revenues of $61.4 million in 1990, grew by 1,800%, to reach $1.167 billion in 1995. Profits grew "only" by 578.3%, however, from $8.3 million in 1990, to $56.3 million in 1995.

Even the big HMOs enjoyed impressive growth. U.S. HealthCare Corp.'s 1990 revenues of $1.330 billion almost tripled, to $3.610 billion in 1995. U.S. HealthCare's profits did even better, increasing fivefold, from $77.5 million in 1990, to $380.7 million in 1995. Revenues of FHP International Corp., one of the more notorious HMO operators, jumped fourfold, from $980.4 million, to $3.909 billion; but profits "lagged," jumping only from $34.0 million to $83.9 million.

The HMOs are making money so fast that the *Wall Street Journal,* in December 1994, ran a front-page feature entitled "Money Machines: HMOs Pile Up Billions in Cash, Try to Decide What to Do with It." Leading the pack was United HealthCare Corp., which had amassed $2.6 billion in cash and investments. United HealthCare is 6% owned by the Equitable Co., and another 6% owned by Metropolitan Life Insurance Co. WellPoint Health Networks, which owns and operates the managed care business of Blue Cross of California, had socked away $1.918 billion. The HMO of Kaiser Permanente, which also operates hospitals, had $1.347 billion lying around. U.S. HealthCare, Inc. had a stash of $1.164 billion. And Humana, Inc., which is 5.3% owned by J.P. Morgan and Co., had piled up $887 million.

HMO methods

The HMO *modus operandi* involves all manner of looting the basis of medical care—doctors, nurses, staff, facilities, and patients alike.

Start with the method by which HMOs select enrollees, which begins to explain their huge build-up of cash. By "cherry picking," the HMOs selectively deny care for the seriously ill or injured, and look to insure the well. At present, about 80% of the general population is considered relatively healthy, and requires few medical services other than regular checkups, and a few prescriptions for colds, flu, and so on. Statistically, in 1993, for example, 19% of Medicare enrollees cost nothing, and 53% cost less than $500 each. HMOs have developed methods of recruiting to ensure that the 20% of the population more prone to chronic illnesses and medical problems, is not enrolled.

When recruiting the elderly, for example, HMOs have mailed out free dance tickets as incentives to attend meetings—to select out those who are immobile.

The other side of the HMO coin, is to limit or even deny medical care to its enrollees. In the 1960s and before, hospitals and doctors were paid for what they did: The more patients they admitted and treated, the more surgeries and other procedures they performed, the more medicine and other treatments they dispensed, the more they were paid. The physician, therefore, had every financial incentive to fulfill the Hippocratic Oath, and do everything he or she possibly could for the patient.

In the new regime of HMOs, however, the less physicians and other health care "providers" do, the more they are paid. HMOs generally pay a "capitation" fee to a doctor or provider (a flat fee for every patient under the care of the physician or provider), and also set aside a "bonus" pool of money. The HMO then sets strict limits on how much can be spent on the "average" patient. If more is spent on a patient than the limit, the excess amount is deducted from the bonus pool.

For example, on Jan. 8, 1996, *Time* magazine reprinted the limit clauses for one physician's contract with U.S. HealthCare Corp. The contract stipulated that if the 925 people under the doctor's care averaged fewer than 178 days in the hospital per year, the doctor would be paid a bonus of $2,063 per month. If there were more than 363 patient-days, the doc-

tor would be given no bonus. In all, therefore, the doctor could have no more than 121 patients stay in the hospital for three days, and, preferably, less than half that many patients.

HMOs' deadly record in Arizona

As shown in Figure 1, the highest percentages of the populations enrolled in HMOs, in rank order, are in California (38.3%), Oregon (37.5%), Maryland (36.2%), Arizona (35.8%), and Massachusetts (35.2%). California, Florida, and Arizona have a high percentage of retired people enrolled. Wherever the enrollment is high, the reports of mistreatment are high.

Among the ranking HMOs in Arizona, according to *U.S. News & World Report*'s Sept. 6, 1996 survey, are Intergroup of Arizona (305,608 enrolled), CIGNA HealthCare-Phoenix (170,703), CIGNA Private Practice Plan (129,632), HealthPartners-Tucson (112,462), HealthPartners-Phoenix (52,430), and CIGNA HealthCare-Tucson (45,640).

In Arizona, according to a review by the U.S. General Accounting Office, one case of lack of access to proper care resulted in death. The GAO stated, "The physician diagnosed the [89-year-old] enrollee as suffering from a lack of oxygen in his blood 14 days after being discharged from a hospital following ankle surgery. The elderly enrollee was not readmitted to the hospital until two days after the diagnosis was made, and died on the day of admission."

According to the Health Care Financing Administration (HCFA), the federal agency that administers Medicare, about one-fifth of the elderly who sign up with HMOs for their Medicare treatment, called "Medicare Risk HMOs," then ask to drop out of these plans. Depending on which HMO they got into, elderly drop their coverage at a rate that ranges from 6% to 46%, to avoid bad care.

Reflecting this, the National Committee on Quality Assurance (NCQA), the foremost independent reviewer of managed care, has denied accreditation to many Medicare Risk HMOs, particularly in Florida, California, and Arizona, where the largest groups of the elderly reside. The NCQA has pointed to the way the HMOs shorten hospital and nursing home stays, and frequently refuse to honor claims for senior citizen treatment.

Five Arizona Medicare recipient residents have filed a class action lawsuit against HCFA for care allegedly denied them by their HMO. Their suit charges that the HCFA failed to take action when their HMO denied them care in the early 1990s. Their HMO, Family Health Plan (FHP, second nationwide in number of Medicare enrollees), is contesting. California and Oregon plaintiffs have now joined those from Arizona. Among their complaints:

- A 71-year-old woman, Grigoria Grijalva, claims that her HMO left her in a wheelchair. She has diabetes and high blood pressure, and suffered congestive heart failure, anemia, and a uremic bladder, which made her wheelchair bound. Her lawyers state, "Her right leg was amputated at the knee after her Family Health Plan doctor failed to respond to her complaints of pain in her foot until amputation was required."
- A 92-year-old woman, Ms. Knox, who had a broken hip, was denied payment for physical therapy. According to her lawyers, "FHP advised Ms. Knox's guardian that physical therapy for an Alzheimer's patient would not be productive because 'she could not follow commands.' " In fact, medical experts on disability say that this HMO denial of payment for therapy is a pervasive pattern, and medically unwarranted.
- Ms. Lea, a woman in her 80s who broke her hip while at home, was denied payment by FHP to cover an ambulance journey to the hospital; her daughter drove her instead. The emergency room x-rays showed possible multiple fractures, but FHP refused to cover Ms. Lea's admission to the hospital.

In Arizona, Stuart Grabel of the Pima Council on Aging in Tucson, says his office gets three or four complaints a week from Medicare recipients enrolled in HMOs. "They range from the deadly serious, to 'I can't get my medication,' " he says.

The National Council on Aging records many instances of HMO malfeasance. In one published case, a woman with Parkinson's disease called her HMO's primary care physician after falling down at home. The doctor sent her to the HMO's specialist, who scheduled additional tests with another specialist. The primary care physician decided the additional tests were unnecessary, so the HMO refused coverage. In the end, because of receiving no further treatment, the woman's legs deteriorated to a point that she required a wheelchair. Then began a new round of requests to the HMO; a month passed from the time of authorization, until a wheelchair was delivered—of the wrong type.

Horrors in Philadelphia hospitals

In Pennsylvania, 21.5% of the population is covered by HMOs. The ranking HMOs, according to the Sept. 6 *U.S. News & World Report* survey, are: Keystone Health Plan East (436,247 enrolled), Keystone Health Plan West (155,497), Keystone Health Plan Central (153,217), HealthAmerica Pennsylvania-Pittsburgh (148,737), HMO Blue-Newark (139,685), First Priority Health (101,490), HealthAmerica of Central Pennsylvania (99,997), and smaller HMOs associated with Prudential and CIGNA.

The indirect and direct effects of the degrading of the Pennsylvania medical system are evident throughout the state. One aspect is the reduction in nurse-to-patient ratios.

Recently, the deadly consequences of this reduction in Philadelphia hospitals were reported to the Pennsylvania House Health and Human Services Committee, by Laura Gasparis Vonfrolio, a registered nurse for over 20 years, who also teaches and publishes a national journal. She stated, "There is a redesigning of health care in the name of profit," and "hospitals are relying on two strategies to cut costs: substitute cheaper labor for RNs, and increase their work responsibilities. . . . Cost-cutting hospital administrators are replacing nurses with individuals with no training and expertise in caring for the sick."

Vonfrolio stressed that the unskilled "technicians" being hired to replace nurses are clearly not qualified to handle patients in need of acute care—which is now almost all patients in hospitals, since previous years' cost-cutting has already reduced the length of hospital stays. Vonfrolio testified that she had received phone calls from hundreds of nurses from 16 Philadelphia hospitals. (Her testimony will be published in a forthcoming issue of *EIR*.) Some instances reported:

- Medical College of Pennsylvania and Hahneman Hospital (part of Allegheny University Hospital Centers). A registered nurse noticed a patient suffering an adverse reaction to an intravenous medication, and turned off the valve. Shortly after, a "technician" noticed the valve closed, and turned it back on. As a result, the patient suffered kidney damage.
- Misericordia Hospital. A "technician" with two weeks of training, failed to note that a patient's catheter had become misplaced in a wedge position. Since no corrective action was taken, the patient developed a pulmonary infarction.
- Temple University Hospital. A "technician" assigned to report abnormalities to a registered nurse, overlooked a post-operative patient's symptoms, imparted no urgency, and the patient suffered cardiac arrest, and expired due to fat embolus.
- Krozer Chester Hospital. A patient died when no one noticed, and no one called a "code" (resuscitation) cart.

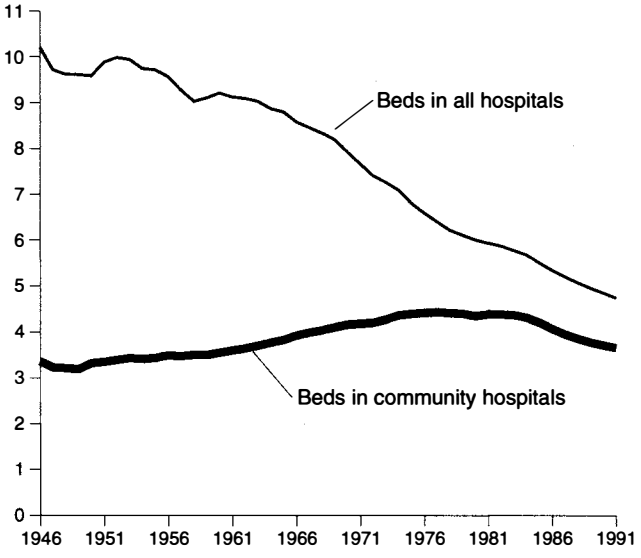
Decline in U.S. medical market basket

The "market baskets" of essential medical goods, services, and infrastructure are no longer being produced or consumed in the U.S. economy at the levels obtaining in the late 1960s. This decline in the U.S. health care system is coherent with the same decline of all other market basket "essentials" (water, power, consumer goods, food, producer goods, and so on), which overall are being produced and consumed at about half the per household level of the late 1960s. In many dramatic ways, the declines in one sector reinforce declines elsewhere. For example, as the U.S. rail and mass transit system declined per household (in less track length, frequency of service, and other measures), highway accidents came to rank as one of the largest burdens on hospital emergency rooms, and staff and bed-use ratios.

Here we look at per population ratios of community hospital beds as a "marker" for the national medical care system. The beds ratio is commonly used in this way, because adequate hospital bed numbers imply the presence of other essentials of the general public "market basket" of medical care—physicians and nurses, x-ray equipment, biochemical analysis laboratories, bassinettes and incubators, nuclear medicine machinery and staff.

In fact, by all these basic parameters, the U.S. health care system is declining. Fewer than 50% of all children under age are fully vaccinated against preventable diseases. Only 38% of women in the relevant age brackets (50 years old and over) are getting annual mammograms—which, if done, would detect the most common breast cancer earlier, and save lives and billions of dollars and facilities-use of the medical system.

FIGURE 2
Hospital bed availability, 1946-91
(beds per 1,000 people in the United States)



Sources: *U.S. Statistical Abstracts*; *Historical Statistics of the United States.*

Availability of beds declines

Figure 2 shows the numbers of hospital beds in the U.S. (community, and all-types, including specialty) over 1946-90, shown as a ratio of beds per 1,000 people. Look at the community beds curve. First, the ratio of beds per 1,000 rises through the 1970s, reflecting the impact of the 1946 "Hospital Construction Act," known as the "Hill Burton Act," after co-sponsors Sens. Lister Hill (D-Ala.) and Harold Burton (R-Ohio).

The Hill Burton Act, only nine pages long, specified a beds-ratio goal for every community, of about 4.5 to 5.5 beds for "general hospital" use, plus 5 for mental hospitals, and 2 for chronic diseases of all types. The large number of non-general hospital beds shown in the graph for the 1940s and 1950s reflects the beds for tuberculosis, polio, and war-related medical needs. The average of 12 beds per 1,000 people was maintained in many regions.

However, after about 1970, the turning-point marking the decline in maintenance of essential levels of "hard" infrastructure systems (water, power, transport), the desired number of beds per 1,000 people fell below the 5.5-community-bed standard (and way below the 12-bed margin for all uses), as similar declines set in for all types of "soft infrastructure" (schools, research, etc.).

In 1972, the national U.S. average of beds per 1,000 persons was over 4.5. Then, in the post-industrial shift, the Hill

FIGURE 3
Arizona: hospital beds per 1,000 population

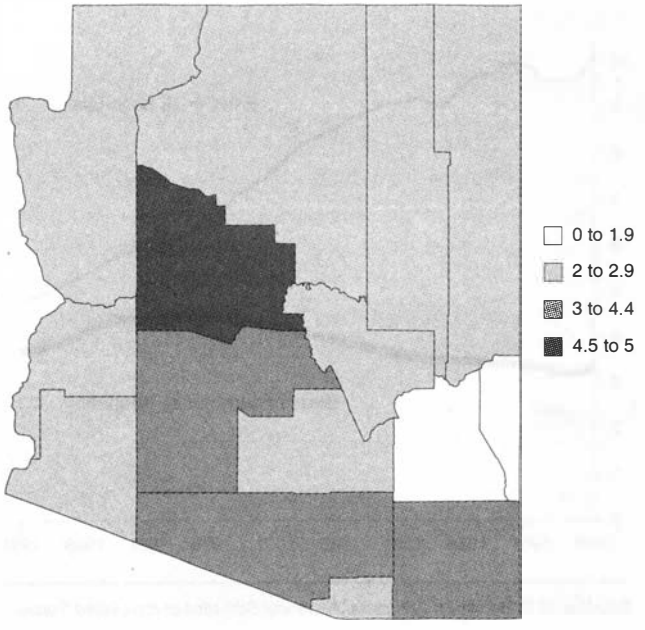
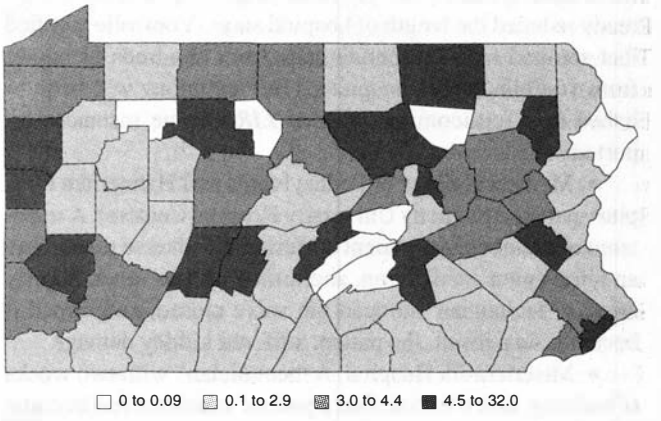


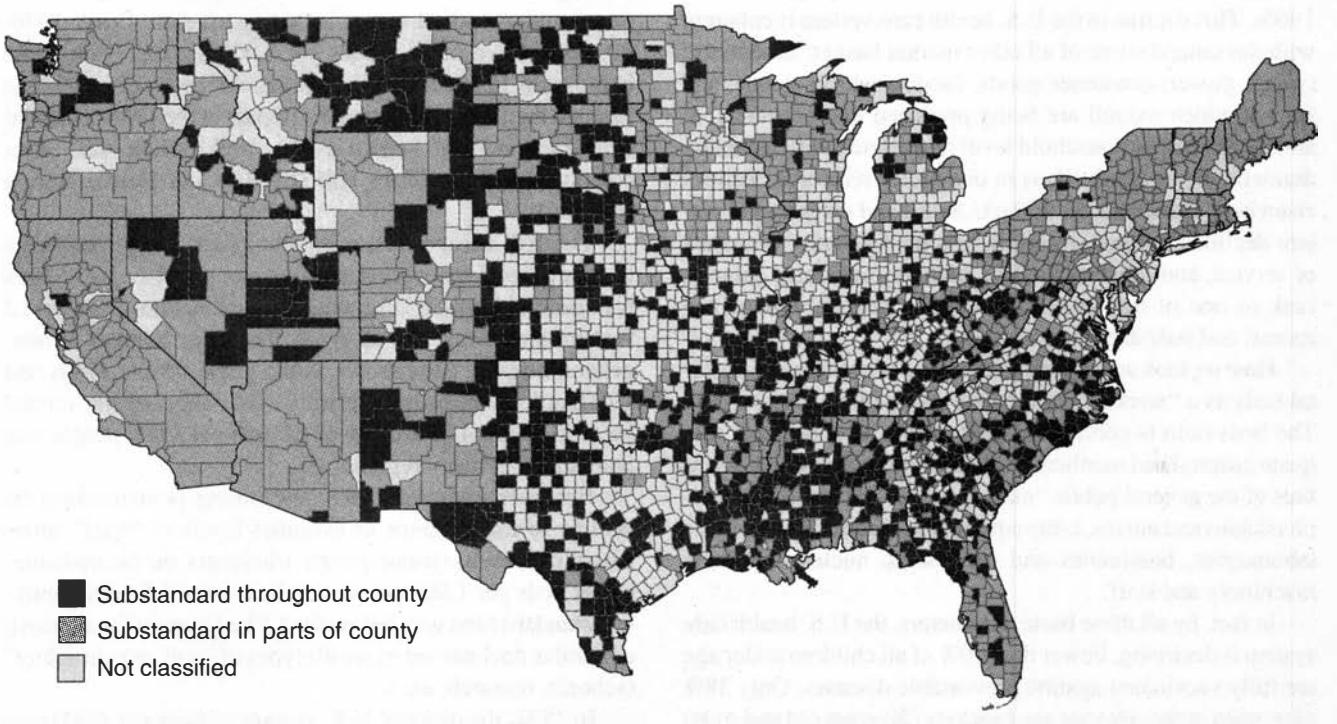
FIGURE 4
Pennsylvania: hospital beds per 1,000 people



Burton Act was abandoned in law and in spirit. Bed ratios fell. Today, the national average for community hospital beds is below 3.7 per 1,000 people.

The import of the declining availability of beds is *not* that outpatient care and healthier people have made beds redun-

FIGURE 5
Classification of U.S. primary medical care, March 1994



dant. Far from it. People just aren't getting care. A bogus argumenthas been advanced that hospital stays have been replaced by outpatient treatment. In 1972, there were about 219 million outpatient visits in the United States; in the late 1980s, this was up over one-third, to 336 million visits. But, at the same time, the beds for all kinds of routine (e.g., childbirth) and specialty (e.g., orthopedic) needs are no longer there.

Over the 1980s alone, 761 hospitals were shut down across the country. Every week, some rural and inner-city area sees the downsizing, or outright shutdown of a hospital. What the national average beds ratio means on a local level, is that millions of Americans, especially in inner-city areas and rural counties, do not have adequate facilities for their medical needs, no matter whether they are insured or not.

Figures 3 and **4** take two examples, Arizona and Pennsylvania. The statewide average of beds per thousand in Arizona is only 2.5 (as of 1992). This rate is among the lowest in the nation. The statewide average in Pennsylvania is 4.3.

Now look at the disparity of availability of beds shown by the county averages of beds per 1,000 population, for the 15 counties of Arizona, and the 67 counties in Pennsylvania. Arizona's population overall as of 1994, was only 4,075,088. In the two eastern mountainous counties of Greenlee (population 9,035) and Graham (28,876) there are, respectively, no beds, and 1.3 beds per 1,000. It is to be expected in a state nicknamed the "Grand Canyon State" that there are wilderness locations with neither people nor medical facilities. Yavapai County (the darkest tone) with 4.5-5 beds per 1,000, reflects the centralized location of certain medical centers. However, the statewide average ratio of 2.5 beds per 1,000 shows a serious lack of medical care provision in Arizona.

In Pennsylvania (population 12,052,410), forty-nine of the state's 67 counties fall below the desired ratio of 5 beds per 1,000 people, of which seven have no community beds at all (one county of which, to be sure, is the home of the Allegheny National Forest). The highest average bed ratios in the state are at the level of 8 per 1,000, in rural Bradford, Clinton, and Elk counties. (Montour County has 32 beds per 1,000, because Geisinger Medical Center serves a multi-county region, requiring long drive times.)

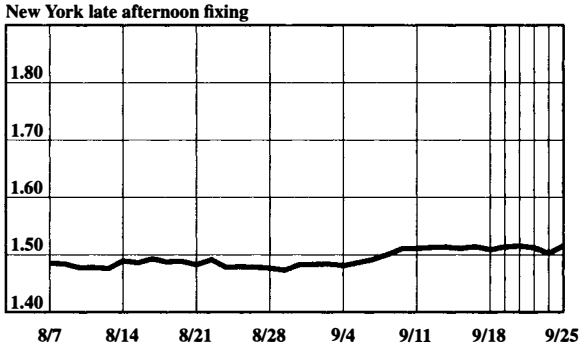
Pennsylvania's county beds ratios are worsening radically, as hospitals face the consequences of Governor Ridge's elimination of state medical assistance for 220,000 Pennsylvanians, which means the immediate lack of revenue for hospitals and medics in the state, that will downsize and shut down facilities.

Figure 5 is a map of the 3,076 counties across the country, shaded differentially to reflect a measure of the adequacy of physician availability. The map was prepared by federal agencies, and released by Sen. Jay Rockefeller (D-W.V.) in August 1994. Darker tones signify counties in which local officials reported a countywide health care inadequacy. Medium tones indicate counties with localized problems. The remaining counties did not report any problems.

Currency Rates

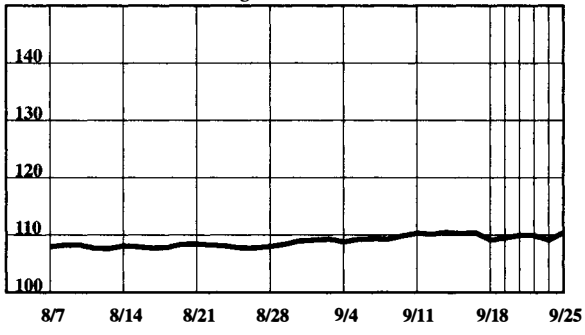
The dollar in deutschemarks

New York late afternoon fixing



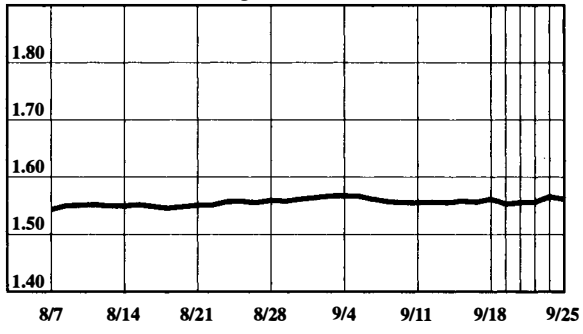
The dollar in yen

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