Will Bush's insurance scheme help the uninsured?

Jeanne Lenzer *New York*

After the election of George W Bush as US president last week, healthcare specialists are debating the effect his healthcare policies may have on the US population.

The lynchpin of the president's health reform plan is the creation of health savings accounts. The accounts, according to President Bush, will help the uninsured and give consumers more control over their healthcare dollar.

The plan, part of the Medicare reform bill passed by Congress in December 2003, establishes a tax-free account that can be used to pay for medical expenses.

The account must be coupled with a high deductible insurance plan, under which the insured person will have to pay the first part of any large claim themselves. The plans are designed to insure people against exceptionally large medical bills. The insured family will have to take out a plan, in which they pay at least the first \$2000 (£1076; €1544) of any claim, up to a maximum of \$10 000. Families can contribute up to \$5140 tax free into the account annually.

Michael Tanner, director of health and welfare studies at the right wing Cato Institute, says the accounts will reduce healthcare costs as patients will make "cost conscious decisions" about when to seek care and that "cost based selection among competing providers" will drive costs down further.

Critics say the accounts will attract healthy people, increasing market segmentation and driving insurance prices up for patients with chronic medical problems. They also say the plan will help only a fraction of the uninsured.

Uwe Reinhardt, professor of economics and public affairs at Princeton University, said: "If you have a woman with three children who is earning \$25 000 a year at Wal-Mart, and she has a bout with breast cancer and one of her children has mental health problems, and you say you'll give her \$3000 for a policy [in the form of a tax credit] but the [costs] are \$5000 per year, is she going to be able to afford that?"

"Cost conscious" decisions have their downsides too, warns Professor Reinhardt who says patients may forego care for illnesses when they are at an earlier, more treatable, stage.

Michael Cannon, director of health policy studies at the Cato Institute, told the *BMJ*, "The Rand health insurance experiment found that people responsible for the first \$1000 consumed 24-30% less care and had no harmful health effects.

The American Enterprise Institute said that 6.7 million of the projected 49 million uninsured Americans in 2006 will gain insurance under Bush's plan

They eliminate unnecessary health expenditures but they don't hesitate to go see the doctor when they need to."

"It isn't clear that [the Rand experiment] is generalisable," said Professor Reinhardt, who cited a report by the Organisation for Economic Cooperation and Development showing that the United States ranked behind many nations, including Great Britain, France, and Luxemburg, in lives lost due to deaths that could have been avoided with a better healthcare system and an emphasis on primary care.

Even if there are benefits for some, said Professor Reinhardt, "The conservative American

Enterprise Institute calculated that only 6.7 million of the projected 49 million uninsured in 2006 will gain insurance under this plan."

Mr Cannon said the estimates of uninsured are "overstated," and cited a May 2003 report by the Congressional Budget Office that put the number of uninsured people at 21-31 million.

As for the hypothetical woman working at Wal-Mart, Mr Cannon said she could afford the insurance since her premiums would be much lower, but conceded that he "hadn't seen any figures on that." □

Old drugs for heart failure nearly halve deaths in black people

Scott Gottlieb *New Orleans*

Adding a dose of isosorbide dinitrate plus hydralazine to standard treatment for advanced heart failure can help black people live longer, shows a study. However, adding an angiotensin converting enzyme (ACE) inhibitor to the optimal treatment of stable heart disease offers no extra benefits.

Findings from two new studies were published this week to coincide with the annual meeting of the American Heart Association in New Orleans.

Researchers in the first study terminated their study early when they found that black

people with advanced heart failure treated with a fixed dose of isosorbide dinitrate plus hydralazine were 43% less likely to die than those who received isosorbide dinitrate plus placebo (hazard ratio 0.57, $P < 0.0001$, death rate 6.2% v 10.2%, $P = 0.02$) (*New England Journal of Medicine* 2004;351:2049-57).

All of the 1050 black patients in the study (who had New York Heart Association class III or IV heart failure with dilated ventricles) were receiving standard treatment for heart failure. They were then randomly assigned to

receive a fixed dose of isosorbide dinitrate plus either hydralazine or placebo.

Improved survival was accompanied by a 33% relative reduction in the rate of first admission to hospital for heart failure (16.4% v 22.4%, $P = 0.001$) and an improvement in the quality of life among patients on active treatment.

In the second study (the prevention of the events with angiotensin converting enzyme inhibition (PEACE) trial) the researchers found that patients with stable coronary heart disease and preserved left ventricular function who are receiving standard therapy that typically included a daily aspirin (90% of patients), a statin (70%), and a β blocker (60%) received no incremental benefit from the addition

of an ACE inhibitor to their regimen (*New England Journal of Medicine* 2004;351:2058-68).

The PEACE trial was a double blind, placebo controlled study in which 8290 patients were randomly assigned to receive either trandolapril at a target dose of 4 mg a day (4158 patients) or matching placebo (4132 patients).

Over a median follow up period of 4.8 years, the incidence of the primary end point—death from cardiovascular causes, myocardial infarction, or coronary revascularisation—was 21.9% in the group taking trandolapril, compared with 22.5% in the placebo group (hazard ratio in the trandolapril group, 0.96; 95% confidence interval, 0.88 to 1.06; $P = 0.43$). □