

EDITORIALS



No Child Left Uncovered

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In the grand tradition of bare-knuckle American politics, the reauthorization of the State Children's Health Insurance Program (SCHIP), which provides health coverage for low-income children, has become part of a war of political philosophies between a bipartisan group of legislators in the House and Senate on the one hand and President Bush and his administration on the other. In a Perspective article in this issue of the *Journal*,¹ Iglehart provides a summary of the current state of this political confrontation, and his article is amplified by an audio interview with Sara Rosenbaum, a professor at the George Washington University School of Public Health and Health Services (available at www.nejm.org).

SCHIP was launched on October 1, 1997, as a joint federal–state program that offers a capped amount of federal funds to states on a matching basis to provide health insurance coverage to the children of families whose income is too high for them to qualify for Medicaid but too low for them to purchase their own coverage. The majority of SCHIP coverage is provided through private insurance companies. The program has been enormously successful, and it now provides coverage to more than 6 million children and some adults who would otherwise be uninsured. This has been accomplished at a cost to American taxpayers of \$5 billion per year at the federal level (which is less than 1% of federal Medicare and Medicaid spending).

SCHIP must be reauthorized by September 30, 2007, or it will expire. Last March, Congressman John Dingell (D-MI) and Senator Hillary Clinton (D-NY) introduced bills that would have not only reauthorized SCHIP but also increased the federal contribution by \$50 billion over the next 5 years. The intent of the bills was to expand the program to cover even more children living in poverty. Without coverage, their medical expenses will have to be picked up by the states or by hospitals in

the form of free care. On July 19, the Senate Finance Committee passed by a bipartisan margin of 17 to 4 a compromise version that would provide an additional \$35 billion to the program over 5 years, somewhat less than the amount proposed by Dingell and Clinton but still a substantial increase. This bill was later passed by the full Senate. The House passed a bill that includes a \$50 billion increase. Lawmakers have proposed that the additional funds be obtained in part by increasing the federal tax on tobacco products.

Despite the considerable bipartisan support for the bills, President Bush has made it clear that he will veto any measure that increases costs by more than \$5 billion over 5 years, an amount that, instead of providing coverage to additional children, would require ending coverage for children who are already covered. Some senators from his own party are astounded that he has already announced his intention to veto the legislation, even before the two versions of the bills have been brought to a conference committee. His objection to the legislation rests solely on ideological grounds; he believes that expansion of the program will be just another entitlement moving the country toward government-sponsored health insurance, an approach that he has consistently opposed. He further argues that the additional SCHIP funds would be used simply to replace existing private insurance coverage. Instead, the president favors a program of tax incentives to encourage the uninsured to purchase private insurance. In late August, the Bush administration placed new limitations on the use of SCHIP funds for any but the very lowest income children. But in turning his back on SCHIP, the president is finding precious little company; organizations as diverse as the American Medical Association, the Pharmaceutical Research and Manufacturers of America, the AARP, and the Children's Defense Fund all support the legislation.

The possible merits of the president's tax-incentive approach deserve debate, but tax reform is a long-term issue that should not stand in the way of the necessary expansion of SCHIP and its September 30 deadline. We believe that the president is making a serious mistake in holding children hostage for the sake of his personal political agenda. SCHIP, a small block-grant program of inarguable merit, is scarcely a stalking horse for universal health care. It is a shining example of

what is good about our country. We have enormous wealth, and in our best moments we have been willing to share it with the most fragile members of our society. If the president is sincere in his commitment to leave no child behind, he must begin by leaving no child uncovered.

1. Iglehart JK. The battle over SCHIP. *N Engl J Med* 2007;357:957-60.

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Targeting Anemia with Erythropoietin during Critical Illness

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The overall goals of clinical research in the intensive care unit (ICU) are to improve clinical outcomes through enhanced understanding of how critical illness develops and how such illness is best prevented, diagnosed, treated, or palliated. Several "normal" physiological measurements and laboratory values have been abandoned as therapeutic targets during critical illness, since in some randomized trials, attempts to normalize these measurements and values have shown either harm or no benefit with respect to clinical outcomes.

One such target is the hemoglobin concentration. Anemia is commonly acquired in the ICU owing to hemodilution, blood loss, reduced red-cell production, and enhanced red-cell destruction. Furthermore, critical illness is characterized by decreased erythropoietin production, a blunted cellular response of erythropoietin, disordered iron metabolism, and nutritional deficiencies.

An important contribution to the literature appears in this issue of the *Journal*, with Corwin et al.¹ posing this clinical question: What is the effect of weekly treatment with epoetin alfa on the percentage of critically ill patients receiving a red-cell transfusion? In this randomized, concealed, multicenter trial, 1460 medical, surgical, or trauma patients were assigned to receive epoetin alfa (40,000 U weekly for up to 3 weeks) or placebo between 48 and 96 hours after admission to the ICU. The primary outcome was the percentage of patients receiving any red-cell transfusion — an end point traditionally dependent on the transfusion threshold of individual physicians. Although more liberal transfusion of red-cell units contributed to higher transfusion rates among controls than among treated patients in

previous trials involving critically ill patients,² the trial by Corwin et al. used a target hemoglobin concentration of 7 g per deciliter to 9 g per deciliter, consistent with the restrictive transfusion strategy favored by the Transfusion Requirements in Critical Care (TRICC) Investigators.³ No difference was found in the percentage of patients who received a red-cell transfusion (46.0% in the epoetin alfa group and 48.3% in the placebo group, $P=0.34$) or in the number of red-cell units transfused per patient (4.5 ± 4.6 and 4.3 ± 4.8 , respectively; $P=0.42$).

The transparent reporting of the recruitment and retention of patients in this trial is welcome. The reported data underscore the challenges of clinical research in critically ill patients. Of 6168 potentially eligible patients, 3587 (58.2%) patients or surrogates were approached to participate, of whom 2127 (59.3%) did not provide consent. Overall, 109 patients were lost to follow-up, 54 (7.4%) in the epoetin alfa group and 55 (7.6%) in the placebo group.

In this trial, approximately 95% of all patients experienced at least one adverse event, and approximately 44% experienced at least one serious adverse event. These rates reflect the maxim that critical illness is a series of established and acquired evolving, static, or resolving complications. However, such comprehensive reporting of adverse events, while fulfilling regulatory requirements, may induce either inappropriate alarm or a false impression of safety. From a clinical perspective, adverse events are interpreted in the context of the population enrolled. For example, since the physical examination is insensitive for identifying proximal deep-vein thrombosis and pulmonary embolism in semirecumbent patients