Box 1: Facts on the United States

Demographics
- Area: 9 826 630 km²
- Population: 301 139 947
  - Median age: 36.6 years (35.3 male, 37.9 female)
  - Age structure: 20.2% under 14; 67.2% 15-64 years; 12.6% over 64
  - Birth rate: 14.16 births/1000 population
  - Death rate: 8.26 deaths/1000 population
  - Infant mortality rate: 6.37 deaths/1000 live births (7.02 male, 5.68 female)
  - Life expectancy: 78.00 years (75.15 male, 80.97 female)

Economy
- Gross domestic product per capita: US$43 800 (2006 estimate)
- Unemployment rate: 4.8% (2006 estimate)
- Population below poverty line: 12% (2004 estimate)
- Government revenues: US$2.409 trillion (2006 estimate)
- Government expenditures: US$2.66 trillion (2006 estimate)
- Public debt: 64.7% of gross domestic product (2005 estimate)

Health
- Total health expenditures as a percentage of gross domestic product: 15.4%
- Government share of total health expenditure: 44.7% (2004)
- Per capita total expenditure on health: US$6096.20 (2004)
- Number of physicians: 730 801 (2000); density per 1000 population: 2.56
- Number of nurses: 2 669 603; density: 9.37

Sources: Central Intelligence Agency World Factbook, World Health Organization.

ened, private health care was deemed patriotic. State medicine "is contrary to American tradition and is the first and most dangerous step in the direction of complete state socialism," railed the *Journal of the American Medical Association* in 1948, when Britain introduced universal medical care.

By the 1950s, Blue Cross enrolment trailed that of commercial insurers, forcing the abandonment of identical-rate coverage. Starting in 1954, US companies were allowed to deduct health insurance costs, a benefit worth $189 billion by 2004. But when unit labour costs came under pressure in the 1970s, companies began to cut benefits and cover fewer workers. Today, Wal-Mart, the country's largest private employer, provides health benefits to less than half its employees.

Now activist CEOs like Burd are touting the virtue of universal coverage to their corporate colleagues, some of whom helped torpedo the Clinton health care initiative over a decade ago. Unions and business leaders are becoming strange bedfellows as they jointly lobby for health care reform under the rubric of umbrella organizations like "Divided We Fail" and "Better Health Care Together."

Patients, meanwhile, look to alternative means of obtaining treatment, like signing up for clinical trials or travelling abroad to obtain surgery at cut-rate prices. Blue Cross and Blue Shield of South Carolina now cover treatment at a Bangkok hospital. Others bypass insurance company co-payments by buying drugs directly from discount stores like Target and Wal-Mart, which introduced $4 generic prescriptions this year.

Employers, meanwhile, now offer weight-loss incentives to overweight workers, levy charges on the obese or reduce deductibles for non-smokers. Supermarkets and discount stores now rent space to low-cost health clinics.

With the National Coalition on Health Care projecting that spending will reach 20% of gross domestic product by 2015, America may have moved past the point where inaction is an option. — Janet Brooks, Salt Lake City, Utah

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Pharmacists to red flag risky drug interactions

Proponents bill it as a potential lifesaver. The more immediate goal of Ontario's "MedChecks" program, though, is patient awareness.

Under the initiative, Ontarians taking 3 or more prescription medications for a chronic condition can book a free, 30-minute consultation with their local pharmacist once a year. The consultation is designed to help patients take their medications as prescribed and better understand how they interact with each other and with over-the-counter drugs they may be taking.

It's hoped such knowledge will alert patients to the risks associated with combining medications or failing to take drugs as prescribed. According to Ontario's Ministry of Health and Long-Term Care, only 50% of people actually follow dosage recommendations, while up to 12 000 Canadians die annually from adverse drug reactions.

Under the program, pharmacists will draw up a complete list of prescription, over-the-counter and natural medications that a patient is taking, and therein, identify any potential "red flags." A copy of that list will go the patient and another to his or her family physician.

"This gives patients an extra layer of security," says Canadian Pharmacists Association Director of Practice Development Barry Power. "The list will reveal, for example, whether a patient is taking 2 drugs of the same class, in which case the pharmacist will refer them back to their general practitioner to eliminate the duplication."

"We still don't have electronic medical records that allow medical practitioners to know exactly what a patient is taking," says Carol Kushner, board member of the non-profit agency PharmaWatch. "The potential for adverse effects, suboptimal dosing or overdosing can be a real issue for vulnerable people. Having a skilled pharmacist look at this issue is important. It may even open up new lines of communications with medical practitioners." — Sylviane Duval, Ingleside, Ont.

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