THE MEDICAL INDUSTRIAL COMPLEX

AT 97TH STREET AND FIRST AVENUE, AT METROPOLITAN HOSPITAL, A WOMAN AND HER SICK CHILD WAIT EIGHT HOURS TO SEE A DOCTOR IN THE EMERGENCY ROOM. ON WALL STREET, AT THE STOCK MARKET, BROKERS RUSH FOR SHARES OF AMERICAN MEDICAL ENTERPRISES, INC., A CHAIN OF PROFIT-MAKING NURSING HOMES. IN BROOKLYN, A MAN RETURNS FROM A LONG HOSPITALIZATION TO FIND THAT BLUE CROSS LEFT HIM WITH A BILL TOO BIG TO MANAGE ON A CAB DRIVER'S SALARY. IN SANTA MONICA, A MAJOR AEROSPACE FIRM OUTBIDS THE COMPETITION AND ACQUIRES YET ANOTHER SMALL COMPANY MAKING COMPUTERS FOR HOSPITAL USE.

The American medical care system has never been too healthy for people who are sick. But for those who have a loose dollar to invest—whose main interest in health is "healthy" earnings, there couldn't be a better place to turn. Health, in America, has become a big, profitable business, and everybody's getting in on it—from the people who make perfume to the people who make napalm. The "health industry" used to mean just doctors and drug companies. Now it's doctors, drugs, hospital supplies, electronic equipment, computers, health insurance, construction, real estate, and profit-making chains of hospitals and nursing homes.

There's money in health today, big money. In the last 9 years, total U.S. annual expenditures for health care have increased from $27 billion to $62 billion. Despite rising expenditures for war and space, the health share of the GNP is increasing, so that now the U.S. spends relatively more for health care than most other advanced countries. No nation spends so much and gets so little.

Some of the money has been absorbed by the health care delivery system (the people and institutions who take care of patients.) And a fraction of this money has actually gone to buy improvements, albeit marginal: A few, fragile neighborhood health centers for the worst ghetto plague spots; above-welfare level wages for hospital workers and house staff; a few more patient-days of service delivered. But a larger fraction of the new money for the delivery system has, for all social purposes, simply vanished—as inflated costs for supplies and as profits for doctors. Doctors' incomes have nearly doubled since the early sixties. Doctors have not become twice as clever or twice as kind; they have become twice as rich.

The new money for health also surged past the delivery system to fuel an unprecedented boom in the health industry—the private suppliers, equippers, financiers, builders and (sometimes) managers of the delivery system. Here, the dollar-for-dollar return as health benefits is first, shockingly low, and second, perhaps not even that "healthy." From the outset, the aim of health industry is not to promote the general health and well-being (that would be self-defeating), but to exploit existing profitable markets and to create new ones. The emphasis, then, is not on products and services which would improve basic health care for the great mass of consumers, but on what are essentially luxury items: computerized equipment for intensive cardiac care units, hyperbaric chambers, etc. Under the pressure of the industry's barrage of packaged technology, the delivery system is increasingly distorted towards high-cost, low utilization, inpatient services.

Most of the money which flows through the health delivery system to the health industry never returns to the delivery system in any medically useful form—or in any form at all. First, a good five to ten percent is raked off directly as profits, and these by and large vanish into the larger economy, going to stockholders and going to finance company's expansions into other enterprises. More and more of the health industry firms are conglomerates, whose holding in drugs or hospital supplies help finance their acquisitions in cosmetics, catering or pet food.

Investors’ Guide

WASHINGTON doesn't know it yet, but Wall Street does—health is a big and booming business. This BULLETIN sizes up the industry, from drugs to computers—where it's going and what it all means for health services.

The health industry is piously quiet about its profits, but outspoken in defense of its "costs". Prices are high, they claim, because of the enormous costs of research, skilled manpower, meeting exacting standards, etc. But how much of the industry's research goes into a needless and dangerously confusing proliferation of marginally different products—like drugs which differ only in flavor, electronic equipment which differs only in console design, etc.? How much goes to plan the planned obsolescence in expensive hospital hardware? How much of the costs go to clever and appealing packaging? How much for million dollar advertising and promotion campaigns? Money spent on these causes is not simply wasted. The needless proliferation of dazzlingly advertised and packaged products is a health hazard. It prevents the buyer from making informed decisions.
THE BIG BUSINESS OF HEALTH

EVER SINCE FLORENCE NIGHTINGALE, medical care has had an aura of selflessness and self-imposed poverty. The great modern hospital center, for instance, projects itself as a "non-profit" institution where "the few toil ceaselessly that the many might live." But behind the facade of the helpless sick and dedicated healers lies the 1960's greatest gold rush, a booming "health industry" churning out more than $2.6 billion a year in after-tax profits (see Box page 3, for rundown).

This year the nation will spend over $22 billion on medical care, up more than 11 percent over last year and twice the 1960 level. $6 billion of this will flow into the hands of the drug companies, almost $10 billion will go to the companies that sell doctors and hospitals everything from bed linens to electrocardiographs. $35 billion will be spent on "proprietary" (profit-making) hospitals and nursing homes. The nation will purchase $5 billion worth of commercial health insurance and construction companies will build about $2 billion worth of hospitals. Additional billions will be baked in by private physicians. The health industry is big business, profitable business, and booming business. Stockbroker Goodbody and Company clued-in its customers earlier this year: "Steady growth of the health industry...is as certain as anything can be"—as certain as death and taxes, in any event.

The great boom of the 1960's in the health industries is largely the product of government subsidization of the market. For years the government has directly or indirectly fed dollars into the gaping pockets of the doctors in human disease. In addition to direct payments for health care, for educating health manpower, and for hospital construction, it has granted tax deductions to individuals for their medical expenses, making their health dollars cheaper. It has expanded the purchasing power of "non-profit" hospitals by granting them tax exemptions and, until recently, by not applying minimum wage or labor relations laws to them. It has directly supported basic biological and chemical research to the tune of millions of dollars as well as sponsoring the dramatic advances in electronics. These technologies underlie many of the most profitable sectors of the health industry. And in 1966, the biggest government subsidy of all—Medicare and Medicaid—got going. By 1969 federal, state and local governments directly picked up more than a third of the tab for the nation's health needs, and all signals were go for a steadily increasing government-guaranteed market. One likely mechanism: government subsidized national health insurance, to underwrite the entire medical care market.

Only a small part of the new money being spent on health has gone to improve health care. For instance, community hospitals spent 16 percent more money in 1968 than they did in 1967. But they provided only 3.3 percent more days of inpatient care and 3.7 percent more outpatient visits. (Nobody noticed any 13 percent increase in the quality of care). Inflation in the cost of the same old health care has literally priced millions of lower middle income people out of the medical care market. At the same time, the institutions that provide health care to the poor are in a state of complete collapse as rising costs run headon into decaying finances.

DRUGS

The drug industry likes to think of itself as a sort of public service—dispensing life and comfort and at the same time upholding the American, free-enterprise way. Forbes magazine, which likes to think of itself as the "capitalist tool," much more honestly describes the drug industry as "one of the biggest crap games in U.S. industry." Any way you cut it, the drug industry is big and on the way to being bigger:

■ $6 billion worth of drugs (prescription and nonprescription) were sold in 1969, $6.5 billion will be sold next year, and so on, increasing at about 9 percent a year.
■ There are 700 drug firms. Control is concentrated in the top fifteen, who sell more than half of all drugs.
■ 200,000 people are employed by drug companies all over the world. 100,000 of these are Americans and 20,000

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Editorial...

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choices among products and mystifies him to the point where he will accept unquestioningly the industry's definition of what he needs and what he must pay for it.

The doctors and hospitals which deliver health services are not up in arms about their growing subordination to the health industry. Far from it, they rely increasingly on the industry for their mystique. Only a doctor can select a drug for you from among 50 brand-names and 500 minor modifications. Only at the hospital can you receive the benefits of patient-monitoring, automated testing, disposable catheters, etc. In return, the deliverers of care lend their professional prestige to the industry: Doctors have always served as a front for the drug industry, testifying, advertising and dispensing, all in the best bedside manner. Similarly, the emperors of the nonprofit hospital system use the magical aura of their super-technological "centers of excellence" to cover for the inherent irrationalities of the hospital products industry. From the point of view of the health industry, the deliverers of care become little more than a front for the industry. They channel funds on from the consumer and advertise, in tones faced with scientific respectability, the industry's products.

Faced with this growing Medical Industrial Complex, the public is still unarmed and helpless. There exists no public apparatus capable even of regulating the broadening health industry, monitoring quality and controlling prices, much less determining social priorities for spending. The Food and Drug Administration has proved inadequate even to the narrow task of checking drug quality. More Federal money is desperately needed for health, but it will be wasted unless it brings with it mechanisms for controlling the health industry—controlling not just the technical quality of its product, but the developmental programs and spending priorities through which it controls the shape of the health services delivery system.
of them are the "detail men" who push prescription pills to private doctors.

The American drug industry is world-wide. Foreign sales are growing faster than domestic, as drug companies expand their foreign subsidiaries. The two leading drug imperialists are Pfizer, with 48 percent of its business abroad, and Merck with 37 percent. Industry-wide, more than one quarter of sales are abroad.

The industry spends one and a half billion dollars a year on advertising, twenty-five cents out of every sales dollar and more than three times as much as it spends on its much heralded research and development effort.

What makes drugs the "biggest crap game," however, is profits. For the last ten years, the drug industry has held either first, second or third place among all U.S. industries in terms of profitability, outdistancing such obvious money-makers as the cosmetics, aerospace, recreation and entertainment industries.

But the drug industry has seen better days. Earlier leaps in profits grew out of major breakthroughs: antibiotics in the late 40's, tranquilizers in the late 50's and early 60's and birth control pills in the early and mid-60's. Nothing big has come along since "the pill" and even it is something of a disappointment. Efforts to push the pill beyond the 20 percent of eligible women who now use it have been checked by growing mutters about annoying and often lethal side effects. "We're in a tough right now," says a top Merck-man, and some companies are beginning to wonder whether it's worth gambling on another wave of wonder drugs.

According to the industry's own probably inflated estimates, a really new drug takes about 10 years and $7 million worth of research. Hence more and more "new" drugs are not new at all. Over half released in the last 10 years are what are called "me, too" drugs: minor chemical modifications of old drugs, combinations of old drugs, old drugs released in chewable form, time capsule form, half-dose form, in handy dispensers, and so on in endless, meaningless elaboration. Meanwhile some of the old best-sellers are threatened with patent expirations and anti-trust suits. Parke Davis has become too dependent on Chloromycetin, and began to slip in profitability. Pfizer has lost an anti-trust suit which will loosen its grip on tetracycline. Overall drug industry profits slipped below 10 percent of sales in 1968 for the first time in years. (That's still way ahead of most industries).

Then, as if the drug companies didn't have enough problems of their own, the Federal government has shown increasing signs of being serious about regulating drug costs and quality. The Kefauver investigations into drug prices and the resulting federal drug law amendments had drug companies, by their own admission, "running scared" in the early sixties. The stiffer scrutiny of new drugs required by the 1962 law caused a sharp drop in the rate at which new products were introduced, and pushed many companies to expand abroad, in countries where drug-testing laws are more permissive.

But the most potentially far-reaching affront to the drug companies' independence was Medicare. Drug companies knew from the start that a healthy chunk of Medicare funds would find its way to their pockets. What they feared was that there might be some strings attached. The Pharmaceutical Manufacturers Association, in their right-wing public relations throwaway "Medicine at Work," editorialized in early 1965:

What is the logic in socializing medical care

Profits In Health

<table>
<thead>
<tr>
<th>Drugs</th>
<th>$ 600 million</th>
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<tbody>
<tr>
<td>Hospital Supplies</td>
<td>$ 400 million</td>
</tr>
<tr>
<td>Proprietary Hospitals</td>
<td>$ 35 million</td>
</tr>
<tr>
<td>Proprietary Nursing Homes</td>
<td>$ 140 million</td>
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<tr>
<td>Physicians and Surgeons</td>
<td>$1400 million</td>
</tr>
<tr>
<td>Hospital Construction</td>
<td>$ 75 million</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>$ 2.65 billion</td>
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</tbody>
</table>

(This represents about 4.3 percent of total expenditures for health, including expenditures made at nonprofit institutions.) Notes: This is a minimal estimate. The hospital supplies figures does not include sales to private doctors and does not include profits to distributors. Profits for the health insurance business can not be estimated (see text). Physicians' and surgeons' "profits" are estimated as the difference between the average income of self-employed physicians and surgeons and the average income of other professional and technical workers e.g., professors and lawyers, dentists, osteopaths, etc. are not included, nor are physicians on payrolls. Construction figures are for new construction only; repairs are not included.

All figures are after taxes and are projected to 1960 values from 1968 data.

(via Medicare) when health insurance programs can function so effectively and are expanding every day, in fact already covering most of our citizens? . . . If private initiative disappears there may never be enough time to repair the damage that will ensue. . . . But a few months later the Pharmaceutical Manufacturers Association, at their national convention, spent a whole day in seminars on Medicare. When they emerged, the New York Times reported with cautious optimism that "some companies have accepted the fact that Medicare is here and with it has come a new opportunity for the industry."

Even though they reluctantly accepted Medicare (and of course Medicare money for their pills), the drug companies saw the handwriting on the wall. Like the AMA, the drug industry knows that government subsidy can lead to government scrutiny. Drug costs are a big bill to swallow, and have already become the subject of repeated Congressional inquiry. If the government role in financing medical care expands beyond Medicare and the ruins of Medi­caid, the government might begin to insist on generic drugs (as opposed to much more expensive but chemically identical brand-name drugs), price-setting, or other forms of profit-regulation.

When the neighborhood pusher feels the heat coming down on him, he begins to turn to new, but related, rackets. So with the drug companies, menaced by real or imagined regulation, the answer has been to diversify into anything which their technology and marketing skills prepare them for. As if by free association, drug companies have been turning to cosmetics, chemicals, hospitals supplies and electronic equipment for hospitals. American Cyanamid (which owns Lederle Labs) now owns Breck (shampoo). Pfizer has bought Coty, Barbosol, Pacquin and Desitin (baby powders and oils). Richardson-Merrill acquired Clearasil; Smith, Kline and French has Sea and Ski. Syntex, Upjohn and Merck are all reaching into chemicals. Upjohn, Searle and Smith, Kline and French are all into medical electronics, with Searle, for instance, betting on Medidata, which makes computers for futuristic mechanized mass screen- (Continued Page 4)
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(From Page 3)

ing devices. Parke Davis, Abbott and Cutter Labs are getting into the booming hospital supplies industry.

All this diversification by the once-staid drug manufacturers does not represent a flight from drugs. Prescription drugs remain the most profitable line of the diversified companies, and the drug habit, once established, is hard to break. In fact, the most interesting trend in the drug industry is not diversification of the old-guard, but the influx of new industries, all potential drug addicts. Chemical companies are leading the way. Dow Chemicals, of Saran Wrap and napalm fame, began buying up small drug companies in 1960, and is now a major contender in the measles vaccine market. Other chemical newcomers are 3M (formerly Minnesota Mining and Manufacturing, the conglomerate which makes, among other things, Scotch Tape), Rohm and Haas, Union Carbide, Mallinckrodt and Dupont. Cosmetic and soap companies such as Bristol Meyers, Colgate Palmolive, and Helene Curtis are not far behind in the rush for the drug markets. Revlon now owns US Vitamin and Pharmaceuticals; Cheseborough Pond has acquired Pertussin. One other industry which is being invaded by the drug firms has begun a counter-offensive, the medical supplies industry. Baxter, Becton-Dickinson, and Johnson and Johnson have all bought into the drug industry.

You don't have to be a member of the chemical/drug/cosmetics axis to get in on the drug action. For instance, American Home Products, Inc., maker of Boyardee foods, Guldens mustard and Gaypet products for animals also serves up nonprescription drugs such as Preparation H, Quiet World (a tranquilizer) and Sudden Action (breath freshener), and has become a big shot in the ethical drug world, owning Wyeth Labs as well as several smaller drug companies. Then there's Squibb-Beechnut which makes gum, babyfoods, candy, coffee, pastry, airlines meals and operates drive-ins and snack bars, in addition to prescription drugs. Anybody who makes anything which can be swallowed, inhaled, absorbed or applied would like to make drugs... and vice versa.

HOSPITAL SUPPLIES AND EQUIPMENT

The story of the growth of the hospital supplies industry is the story of the explosive growth of the hospital as the central institution in the delivery of health care in America. In 1950 the nation spent $3.8 billion on hospital care. By 1965, the figure had risen to $13.8 billion, and in 1969, three years after Medicare and Medicaid, hospital expenditures are running at a $20 billion a year clip. About $7.5 billion of this goes for goods and services, much of it's mundane—food, bed linen, and dust mops, but billions go for more specifically medical equipment, from scalpels, syringes, and catheters to X-ray equipment, electronic blood cell counters, and artificial kidneys. In addition to the hospital market, physicians, dentists, nursing homes, and medical research labs spend huge sums, measured in the billions of dollars, on similar supplies.

The risks in the hospital supply industry appear to be as low as the profits are high. Medicaid may have its ups and downs, but Medicare, at least, is here to stay. And only a gambler with a compulsion for losing would bet against the likelihood of continued growth in hospital expenditures and increased subsidy of the market by the government. The hospital supply companies have gotten the message. "The start of IPCO's new financial year on July 1, 1969," said the annual report of one of the major distributors and manufacturers of hospital goods, "also marked the beginning of the Federal Medicare program and supplementary state health programs [Medicaid]. The enormous increase in demand for institutional care... will, we believe, create a growing demand for the type of products IPCO distributes and manufactures." Like the man said, in the last dozen years IPCO's earnings have increased at a compound annual rate of 22 percent. In the same vein, an executive of the paper manufacturer Kimberly-Clark, which has applied its technology to disposable bed linen and uniforms for hospitals, said: "The type of care usually provided under Medicare is the type that creates new opportunities for disposables." In 1951, $14 million worth of disposable products (including needles, syringes, and such standbys as paper plates) were sold. By 1965, the last pre-Medicare year the market hit $100 million, and 1970 sales are expected to reach $300 million.

The stock market has been hot on the track. The month Medicare went into operation, stockbrokers Burnham and Co. prepared an analysis of the industry for their customers. One year later, the Value Line Investment Survey spoke of one hospital supply company as "operating in a sector of the economy that is virtually recession-proof!" (The company, American Hospital Supply, has seen its earnings grow at 16 percent per year for the last decade. In the first half of 1969, earnings were up 19 percent over the corresponding period of 1968.) And despite the Medicaid flip-flops, United Business Service lists 8 hospital supply companies on its current list of 200 top growth stocks.

The traditional hospital supply companies—C.R. Bard, Becton-Dickinson, Baxter Labs, Sherwood Medical, Johnson and Johnson, IPCO, and American Hospital Supply—have been the big winners in the Medicare sweepstakes, with earnings up 15 percent to 25 percent a year over the last few years. But the soaring profits and wide-open market are attracting new contenders, as well. Through acquisitions of existing hospital supply companies or through applying the technology of other markets to medical supplies, many of the big guns of American industry are out for a piece of the pie. 3M Company is getting in through its mastery of cellophane—it makes peel-open packages of sterile surgical supplies as well as surgical tapes and drapes and masks. Soapermaker Proctor and Gamble goes for germicidal soaps and cleansers, rubber maker B.F. Goodrich for anti-bacterial mattresses, and chemical company W. R. Grace for carbon dioxide absorbants for anesthesiology. Other big non-medical companies buying in are, for instance, American Cyanamid and the Brunswick Corporation (a conglomerate). Companies with past experience in medical technology are especially active, with such big drug companies as Smith, Kline and French, Searle, Parke Davis, Abbott, and Warner Lambert going into everything from blood bank equipment to cardiac pacemakers.

Supplies aren't the only thing booming in the hospital products industry. Medical electronics is moving out of the realm of science fiction and into the Wall St. Journal. A convergence of several factors has created a market currently running at about $350 million a year and expected to reach $1-$1.5 billion a year by the mid 1970's. For one thing, hospitals are buried under an increasing patient load. The volume of every service, from laundry to lab tests, from medical record-keeping to financial record-keeping, from diagnosis to intra-hospital communications, is growing at a staggering rate. At the same time, the cost of the labor to perform these func-
Senator Gaylord Nelson and Representative L. H. Fountain are vying to pick up the mantle of the late Senator Estes Kefauver in taking on the drug industry. Nelson's Monopoly Subcommittee of the Senate Select Committee on Small Business has held two years of hearings on the failure of the Food and Drug Administration (FDA) to regulate adequately the testing of drugs. "It is clear in the record of our hearings," says Nelson, "that some drug companies cannot be relied on to submit objective, accurate and complete data to the Food and Drug Administration." In particular he castigated Upjohn for failing to submit to the FDA results of studies indicating that the company's Panalba, an antibiotic, was worthless.

Dr. John Adriani, chairman of the AMA's Council on Drugs, recently learned that not even AMA bigwigs are immune from drug company power. Adriani, long an advocate of prescribing drugs by generic rather than brand names, was recently proposed as director of the FDA's Bureau of Medicine. In a case reminiscent of the Knowles affair, he was offered and accepted the position. But three weeks later, before the appointment was announced, he was informed by a top FDA official that the appointment was being withdrawn. The pressure from the drug companies, Dr. Adriani was told, was "too great" for the Nixon Administration to stand.

One pharmacological researcher, Dr. Paul Lowinger of Detroit (now national president of the Medical Committee for Human Rights) wondered whether the dangerous contraindications he was uncovering in testing drugs were ever getting reported to the FDA. His own survey showed that in 19 of 27 cases, they had not been. When he informed the FDA of this, his expose was kept under wraps by the federal agency until the Nelson Subcommittee forced it out into the light.

The Justice Department's Antitrust Division may have had more concrete results than the FDA. A Federal Court ordered five drug companies—Pfizer, American Cyanamid, Bristol Meyers, Squibb, and Upjohn—to make restitution for conspiring to fix prices of tetracycline. The companies, who have not admitted guilt, have offered to settle for $120 million, but some local and state governments and consumers have not accepted the offer and are pressing individual suits.

The Food and Drug Administration's past failures are coming home to roost. The agency asked the National Academy of Sciences to review information on the efficacy of all drugs that had been approved under standards existing between 1938 and the passage of stricter drug laws in 1962. 80 percent of the drugs used in America fall into this category. Academy panels reviewed, among others, drugs in which two antibiotics or an antibiotic and a sulfonylurea are combined. At least fifty such combinations were found to be less effective than the ingredients used separately as well as being dangerous, due to their own toxicity and because combinations promote the emergence of drug resistant strains of bacteria. The study highlights the drug companies' policy of spending much of their fabled research dollars on minor differentiation of products which has no advantage (and sometimes serious disadvantages) over existing products and documents the failure of the FDA to require adequate testing. The chairman of the National Academy panels requested the Journal of the AMA to give wide publicity to their findings, but according to Academy official Duke C. Trexler, JAMA "bluntly, flatly" refused to publish the white paper the panels submitted. One reason: almost half the AMA's revenue derives from drug company ads in its journals.

Another agency "regulating" drug companies is the Federal Trade Commission (FTC), a vestigial regulating body with statutory powers over trade fraud and other product chicanery. For ten years, the FTC has been jostling with the makers of Geritol over the company's misleading advertising of "tired blood" as the root of all illness. Two maverick FTC commissioners recently charged that the majority of the commission has meekly allowed the Geritol people to escape without punishment for repeated "contempt" of the commission's orders.

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Camera and Instrument. It's a "foreign body locator" patterned after mine detectors, for locating pieces of shrapnel, bullets, or the safety pin baby has swallowed. As with the parent electronics industry, a plethora of smaller companies like those lining Route 128 around Boston are appearing on the fringes. Hospital journals feature ads for such companies as Astro Associates, Spacelabs, Inc., Laser Systems and Electronics, Inc., and Medidata Services, Inc.

Like drugs in an earlier era, medical electronics has the potential to revolutionize medical practice. At one level, new vistas in diagnosis and treatment are opened up by the electron microscope, fiber optics, high energy radiation sources, computer analysis of electrocardiograms, and the like. At a second level, the potentials of computer diagnosis may lead to new roles for the doctor and other health workers. Finally, the need for systems analysis to accompany the fully effective use of computers may have fallout in the form of partial rationalizations of hospital operations. There is no guarantee of course, that any of these changes will work to the favor of the patient. Like the drug companies "me, too" drugs, innovations may rebound mainly to the favor of the manufacturers.

COMMERCIAL HEALTH INSURANCE

The growth of private health insurance is superficially one of the great success stories of American business. In 1940 only 12 million Americans had the most common form of medical insurance, coverage for hospital expenses. By 1967, no less than 175 million, or 83 percent of the civilian population were covered by private hospital insurance. 100 million of these were covered by commercial, profit making insurance companies, the rest by Blue Cross, Blue Shield, and independent plans. Many of these subscribers were insured for other kinds of medical expenses than hospitalization, as well. The private companies collected premiums totalling $5.86 billion and paid out $4.84 billion in benefits, administrative and selling expenses comprising much of the remainder.

Demand for health services has risen sharply since the forties, just as the cost of those services skyrocketed beyond the reach of the average consumer. Some sort of insurance against the financial catastrophe of getting sick has become a necessity. Meanwhile, the courts were recognizing fringe benefits as a legitimate area for collective bargaining, and mass purchasers of health insurance in the form of union and employer health and welfare plans emerged. For these reasons, the health insurance industry grew explosively in the late 1940's and early 1950's. By now more than 1000 companies, mainly life insurance companies, write health insurance, the rest by Blue Cross, Blue Shield, and independent plans. Many of these subscribers were insured for other kinds of medical expenses than hospitalization, as well. The private companies collected premiums totalling $5.86 billion and paid out $4.84 billion in benefits, administrative and selling expenses comprising much of the remainder.

The companies get a huge gross income from their health insurance business, but the profit picture is a bit muddy. Insurance companies earn money in two ways: directly, from premiums paid by consumers, and indirectly, from the investment of premiums in corporate and government securities. On the direct sales of health insurance to individuals, the companies generally make an underwriting profit. But on group policies (e.g., policies covering all the employees of a certain firm), the industry claims to lose money overall—about a quarter billion dollars in 1967. And the investment income which the companies attribute to their health insur-

The Lab Business

Next on the acquisition lists of many "health industry" conglomerates are non-hospital based clinical laboratories. More than 20 labs have been snapped up in recent months by companies such as the pharmaceutical giants, Smith, Kline and French and Upjohn as well as by health outsiders like Tastee-Freez Industries, a frozen food chain. The number of laboratory tests performed has multiplied at a 20 to 30 percent a year pace in recent years, and industry spokesmen exuberantly talk of a possible $7 billion-a-year market by 1975. More than half the business will be performed by independent, private labs, they say.

The future lies with the high volume labs, which have decisive cost advantages. Says one pathologist-turned-corporate manager: "I have to live with it. Pathology is not a one-man operation any more." But, he added, having a pathologist as director is good advertising, since the customers are other physicians.

Increased government expenditures in this area (through Medicare, etc.) may lead to increased pressures for regulation of the industry (e.g., fee schedules for lab tests). But since the big labs can control costs better, this will merely help them drive the old, small-time independents to the wall. Whether it will be the public or the corporate owners of the labs that will reap the cost-savings is, of course, another story.
$9.1 billion, and had assets of $180 billion. The availability of such huge funds for investment makes control of the top companies a major source of corporate wealth and power. The health insurance business thus represents a significant piece of a very large pie indeed.

Despite its great size, the health insurance industry is about as functional as a dinosaur. Most Americans do have some kind of basic hospitalization insurance, but relatively few are covered for other medical expenses (40 percent for home or office physician visits, nine percent for nursing home care, two percent for dental expenses). Moreover, the insurance companies, along with their non-profit buddies, Blue Cross, are caught in a cost squeeze: as prices for medical services rise, either the cost of insurance must go up or the expenses covered must be limited. Since commercial insurance companies set their premiums according to the medical experience of the individual group they are insuring, it is the elderly and other relatively high-risk groups who are squeezed out first.

The first consequence of the failures of commercial insurance came in 1965 when the companies were forced to relinquish older customers to Medicare. The companies’ screams in response to Medicare had something of a theatrical quality. After all, the companies were ridding themselves of their least profitable customers. In fact, the year following Medicare saw a drop in company premiums but a much larger drop in benefit payments to consumers. But, as one company official said, “Most of us feel the loss of the over-65 market is not the important thing, but rather what Medicare will do to the business in 10 or 15 years.” They feared that “Medicare has brought the country a giant step closer to socialized medicine” which could “all but eliminate the need for health insurance as it is sold today.” According to the New York Times, the companies, “generally inspired more by the wish to discourage Government expansion of Medicare than by the desire for the business that would be generated,” cooperated with the government in setting up the program. About fifteen companies now serve as intermediaries in the administration of the program.

By 1968 it was again becoming evident that the health insurance companies were not able to provide adequate protection for many Americans. Under the influence of problems affecting other aspects of the insurance industry and under pressure from consumer groups, the companies’ attitude toward the government were shifting. Some industry figures openly hoped that the government would serve as guarantor of the companies’ market rather than as a competitor. One plan for national health insurance, for instance, would have used government funds to subsidize the purchase of private health insurance by employers and employees. According to the president of Aetna: “A program of universal health insurance offers one way to spread the cost of medical care [between employer, employee, and government.] It could be structured to retain the advantages of competition and the profit incentive. . . . I have full confidence in our ability to work successfully in partnership with government.”

HOSPITALS AND NURSING HOMES

The age-old way of profiting from illness is by selling health services themselves. Doctors have always done it; so have what are called “proprietary” (profit-making) hospitals and nursing homes. During all the fuss about glamorous health hardware and electronics industries, old-fashioned health service profiteering hasn’t been going out of style. If anything, nursing homes and hospitals chains have become, at least to the adventurous investor, the hottest things going in the entire health industry, if not the entire stock market. Brokers and investment advisors liken the current boom in nursing homes and hospital chains to the boom in bowling alleys a few years ago, or that in computer software and fried chicken drive-ins today. In 1969 the nursing home industry, almost all of which is proprietary, grossed $2.8 billion, up 21 percent over 1968 and up 52 percent from 1960. Proprietary hospitals trailed with $720 million in total “sales”.

Only four years ago, the nursing home and hospital business was still a cottage industry. A family added a wing to their home and called it a nursing home. A doctor or group of doctors bought and ran their own hospital for their own patients. Four years ago, only five nursing homes and one hospital company were “publicly-owned” i.e., sold stock on the open market. Now there are 50 publicly owned nursing home companies and six hospital companies. For both hospital and nursing home chains profits are running at about 5 percent of “sales,” after taxes.

Medicare Boom

What put the profit into the traditionally “charitable” nursing home and hospital business? Medicare, more than anything else, is underwriting the boom. The expansion of Blue Cross and commercial insurance coverage has helped, of course, to create hosts of paying customers for the health service business. Clever management is another factor. Nursing home and hospital companies are able to cut costs through economies of scale, such as bulk purchasing for an entire chain of facilities, centralized administration, etc. But the voluntary (private, nonprofit) health sector also did much to set the stage for the entrance of the energetic profit-makers. Local voluntary hospital establishments, working with Blue Cross and the regional health planning agency, have done much to keep down the number of hospital and nursing home beds—creating a shortage which the profit-makers are eagerly filling. (See “Death of a Salesman,” in July/August BULLETIN)

Nursing homes are the ideal way to cash in on Medicare and Medicaid. Every older is at least partially covered and every older is a potential customer. Some of the largest publicly owned nursing home companies are: Extendicare, Four Seasons Nursing Centers of America, Medcenters of America (a franchise system owned by Holiday Inns), and American Automated Vending Corp. All are expanding; for instance, Four Seasons projects 100 additional homes per year. Some buy existing homes; others build their own. Some operate their own homes; others are selling franchises.

If hotels are profitable, nursing homes ought to be profitable. But hospitals would seem to be another matter. Costs are wild; manpower is scarce and frequently irascible; funds are unreliable. To make a profit out of hospitals, you would have to forget all the old voluntary-sector inhibitions about hospitals as “a scared trust” and a public service. This is exactly what the new hospital companies are doing: They select well-to-do neighborhoods and turn away any non-paying patients who might find their way in. They avoid out-patient and emergency services insofar as possible. They encourage short-term patients in order to gain a high turnover rate (the first few days in the hospital pay the most.) They avoid expensive and difficult technology, by concentrating on simple illnesses and elective surgery, and by contracting out for services such as pathology and radiology.

(Continued Page 8)
BUSINESS

(From Page 7)

Wherever they spring up, profit-making hospitals offer stiff competition for the local voluntaries. First they sell stock to local doctors, guaranteeing themselves a large medical staff and plenty of private patients. And of course the doctor/stockholders have a special interest in keeping the hospital running efficiently and profitably. Once in operation, the profit-maker skims off the cream of the local patient crop from nearby voluntaries—the not-too-sick, able-to-pay patients. Having cut costs in all the ways listed above, the profit-maker is then able to lure nurses away from local voluntaries by offering higher salaries.

What’s most insulting is for a profit-maker to parasitize off a local voluntary—setting up shop near a voluntary which can handle patient-rejects and unprofitable services like obstetrics and out-patient care. This happened recently in Fort Meyers, Florida, where the Hospital Corporation of America (HCA) decided to locate a new 150-bed profit-maker near the already-underutilized voluntary Lee Memorial Hospital. When Lee Memorial protested against being left with the dregs of the patient supply, HCA president responded, “As proprietary hospitals we pay taxes. These taxes help support the tax-supported hospitals [voluntaries] which are in business to care for the nonpaying patient and were established for that purpose.” Lee Memorial never intended to be that charitable, and is ganging up with the local power structure to drive out Nashville-based HCA. A recent Fort Meyers News-Press editorial was entitled “No Fast-Buck Hospital Needed Here.”

If the hospital boom continues, it is likely to run into more and more organized opposition from voluntaries. Much of the opposition will be, on the surface at least, on moral grounds, although it is not clear why profits made by hospitals are any less “moral” than profits made by drug and hospital supply companies. The voluntary hospital leaders in many localities may be especially resentful because the men who head up hospital companies are not, by and large, the kind of men who would ever be chosen as trustees and directors of voluntaries. American Medicorp, which does business primarily in the south and mid-west, was founded by a couple of young Jewish lawyers from the north. The chairman and founder of HCA is a ex-retail druggist who made his fortune in the Kentucky Fried Chicken chain of drive-ins. To fight the profit-making intruders, voluntaries may have to swallow their traditional antipathy to government “interference,” and lobby for tougher laws regulating licensing and operation of hospitals.

In case government regulation is in the cards, many profit-making hospital companies are already one step ahead of the game-busily diversifying into hospital-related businesses. Beverly Enterprises, which owns 18 hospitals and nursing homes, is forming Career Development Corp., to train health personnel at a profit. Metrocare Enterprises, owner of nine acute care hospitals, has purchased a construction firm and plans to build complete medical centers. Other companies are developing firms to provide ancillary services to hospitals. For instance, American Medical Enterprises, Inc., owns Cario-Pulmonary Services of America, Inc. (inhalation therapy); American Medicorp, Inc. has purchased Metropolitan Diagnostic Labs, Inc.

Coming from the other direction, a number of outside companies are diversifying into the profitable nursing home and hospital field. American Hospital Supply Corp. owns American Health Facilities, Inc., which constructs and furnishes nursing homes. Computer Research, Inc., runs Mental Retardation Centers, Inc.; and Cenco Instruments, Inc., has joined a nursing home consortium in Milwaukee.

Up From Charity

The health industry has come a long way from the days of the one-horse patent medicine peddler with his line of liver pills and elixirs. Replacing him are the mammoth, international drug companies, whose corporate medicine chests are increasingly likely to include hospital supplies, computers and cosmetics along with a growing profusion of pills. Health insurance, which can trace its origins to pre-trade union workers’ welfare funds, is now a key element of the nation’s vast insurance industry. The hospital supply industry has outgrown its bandaid days and is branching into catheters, computers and artificial organs. Proprietaries, which used to be the dark horse of the delivery system, are forging multi-state chains and moving into more and more investors’ portfolios. Two other components of the modern health industry bear watching: the hospital construction industry and the health policy consulting business. The “health consultants” of fifty years ago was likely to be the neighborhood barber; today they include defense-oriented think tanks like Rand, the Institute for Defense Analysis and Research Analysis Corporation.

The health industry has changed rapidly in the last five or ten years, that is, in the short period that the Federal government has begun to play an important role in regulating and subsidizing health services and products. Changes in the future may be just as rapid and unpredictable, but two trends seem to be almost built-in: First, the health industry will move increasingly into the mainstream of American industry. Corporate giants like Dow, Dupont, TRW, Lockheed are busily staking out their claims on the profit-rich health turf. Drug companies, once the heavy-weights of the health business, will be challenged by these newcomers. Second, the health industry will be pulling itself together into a more and more integrated monolith. The drug, hospital supply and hospital equipment industries have already begun to blur into a single “health products” industry. Profit-making hospital chains are creating vertical chains including construction and supplies and equipment. Insurance companies, so far aloof from the promiscuous merging in health products, may be about to take the plunge into hospital-operation, following the lead of non-profit innovators like Kaiser and HIP.

These developments in the health industry may have more impact on health services delivery than anything that happens in the next decade of medical research. What is emerging is an increasingly unified, significant sector of the U.S. economy with a major direct stake in the organization and finances of health services. In the past, drug companies dominated the health industry and they picked up their policy line from between the drug ads in the AMA publications: up with solo, fee-for-service practice, down with government intervention of any sort. There’s more to the health industry today than drugs, and many of the booming newcomers have market perspectives which reach far beyond the traditional, doctor-centered delivery system. And diversification into Medicare-subsidized, hospital-oriented products has seriously compromised the purity of the policy line of the drug companies.

It was Medicare that transformed the old bogeyman of government “interference” into a Santa Claus for the health industry. The drug industry and even the commercial insurance
industry have found that they can live more than comfortably with Medicare and Medicaid. And of course it was Medicare that sent the hospital supply, equipment and proprietary chain industries spiraling giddily into a boom. Within a few years the health industry may begin to outweigh organized consumer groups as the most powerful force lobbying for increased government subsidy for health services. The industry's interest, however, will be in subsidy with a minimum of regulation, as outlined, for instance, in some of the current proposals for a national health insurance. With national health insurance, the health industry could settle down to the kind of guaranteed security which the defense and aerospace industries enjoyed during the heyday of cold war spending.

When it comes to the health services delivery system, the health industry is again likely to line up with the medical “liberals” as opposed to the AMA rear-guard. Although only the proprietaries (hospitals and nursing homes) actually deliver services themselves, all segments of the health industry have an interest in increasing the productivity and efficiency of the delivery system. Insurance companies, which foot part of the bill, want to see health services become cheaper, or at least to see people utilize more of the cheaper services (e.g., clinic visits as opposed to hospital stays.) Drug and supply and equipment dealers have an interest in increasing the total volume of health services delivered, since, for almost every provider/consumer encounter, a prescription is written, equipment is used, or a disposable is disposed of. This interest is not compatible with a fixation on solo physician practice—the least productive means for delivering health services. In fact, as far as the industry is concerned, there is no reason why the dispenser of drugs or the user of supplies and equipment should be a physician at all. The health industry may eventually join the ultra-liberal faction of the medical world in advocating group practice and extensive use of paraprofessionals (if not machines) in direct patient contacts.

The hospital equipment industry has an even more immediate interest in the development of more centralized, institutionalized health services delivery systems. The market for heavy hardware such as computers, patient-monitoring devices, multi-phasic screening equipment, etc., is necessarily health facilities which serve a large number of patients—rather than private offices. Furthermore, in order to absorb such equipment, health facilities must be moderately rational in their internal operations. (There's no point in getting a computer unless some of the hospital's operations are at least rational enough to program into it.) Looking beyond the individual facility, computer and electronics companies even have an interest in rationality at the regional level, i.e., in the development of multi-facility, regionally integrated, health systems. The multi-hospital medical empire is the ideal market for computers to book admissions, for super-speciality hardware, and for TV systems to link outposts with centralized technical staff.

The danger in increasingly centralized, institutionalized health delivery networks is, of course, that they will eventually get wise to the health products industry. Bulk buyers of pills, supplies and equipment could begin to exert significant leverage over prices and quality even before government regulation becomes a serious threat. However, if government subsidy of the health services delivery system is generous enough, hospitals will probably go on as they are now—hardly bothering to ask the price of pills and supplies. So long as the government is standing by to pick up the tab, the health industry's interest is in a delivery system which is boundlessly productive and mindlessly extravagant: organ transplants should be prescribed as frequently as tranquilizers are today; normal people should periodically have their blood cleaned out with an artificial kidney machine; “search and destroy” operations should become part of normal diagnostic work-ups; and so on.

To say that the health industry has an interest in a certain kind of delivery system is one thing; whether it can do anything about it is another question. So far the answer is yes—the health industry is developing increasingly effective ways of influencing public and private policy in health services delivery. At the most obvious level, the very existence of equipment which can be used only in hospitals, of insurance which can be used only for hospital care, etc., gives hospitals an edge over non-institutional delivery modes. At the level of government policy, the health industry can always join oil as an industry-wide lobby, testify in Congressional hearings, etc. Already, health industry people are beginning to show up regularly on important governmental panels and commissions. For instance, the McNerney Taskforce on Medicaid and National Health Insurance (see September BULLETIN) includes the Director of Prudential Life Insurance Company. The Piel Commission, which was the launching pad for New York City's new Health and Hospitals Corporation, (see Winter BULLETIN) included the chairman of the board of the Systems Development Corporation, a leading consulting firm in health.

Growing Rapport

There are more direct and intimate ways in which the health industry influences and interacts with the delivery system. Trustees and upper-level staff of medical schools and hospitals are always welcome on the boards and top-staffs of health industry firms. Many hospital and medical school professionals moonlight as consultants to the health industry, thus acting as human bonds between the two worlds. Consulting in the other direction, industry to nonprofit delivery institutions, is more important in terms of volume and potential policy impact. For instance, Technomics Corporation, a consulting firm with links to the defense hardware industry, did much of the staff work for the Piel Commission. Another consultant, MacKinsey Corp. (see September BULLETIN) is under contract to get the Corporation off the ground. Interestingly enough, such consultants' recommendations invariably feature heavy use of computers and other expensive hardware. (See, for instance, the Piel Commission Report, 1966). And as hospitals install more and more sophisticated “systems,” executives with backgrounds in health industry firms are increasingly moving into jobs in hospital administration.

No one seems to be too alarmed about the growing rapport between the health industry and the health services delivery system. Far from it—it's become fashionable to look to the profit-motivated health industrial forces to lead the way out of the health services crisis. According to this view, what's been wrong with health services all along is that they've been isolated from the business world, cut off from "hard-headed management thinking." And of course, without the profit motive, "unstimulated to really produce." But there is no reason yet to trust that the "rationalizations" that the health industry brings to health services will look like rationalizations to the consumer. Judging from America's experience with the drug industry—the consumer can expect no mercy from the new Medical-Industrial Complex.

—Barbara and John Ehrenreich
Report From The Public Sector

At the very least, everyone expected that the New York Health and Hospitals Corporation, the public authority which will take over the City's 20 Municipal hospitals next July, would "take the City hospitals out of politics." But the Corporation, still not off the drawing boards, has already had its first brush with the seamier side of New York's machine politics. The City's five county Democratic leaders have let it be known that they expect to extract some political patronage from the selection of the Corporation's 16-man Board of Directors. In early October, they announced their "suggestions" for Directors to the all-too-susceptible City Council, which is charged with picking five of the 16 men. For one of the County leaders, Manhattan's Frank Rosetti, this announcement was tactlessly timed to coincide with media disclosures of his former role in designating an underworld figure as County tactlessly timed to coincide with media disclosures of his former role in designating an underworld figure as County

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The New York Times, a long-time Corporation-booster, indignantly editorialized this as "A 'Sick' Development." Rosetti was even too much for one of his own choices, Haryou-Act's former director Arthur Logan, who publicly renounced his candidacy for the Board of Directors. But while everyone fuzzed over the City Council's five choices, no one seemed too upset over Lindsay's announcement of the candidates for the five Board of Director slots he gets to fill. Top choices by the Mayor included three leaders of the private medical establishment, two men who had served on the Piel Commission (which first recommended a Corporation to run the City hospitals), and three men whose business interests could be benefited by closer connections to the City Hospital system—a real estate operator, a construction contractor and a member of an architectural firm. Thrown in as runners-up were three blacks, one a banker. (No women and no Puerto Ricans were named.)

The big question is whether there will be anything for the Board of Directors to direct. All responsibility for setting up the Corporation is in the hands of a mysterious "Implementation Task Force," headed up by Hospital Commissioner Terenzio, which claims it cannot proceed without a $4.5 million Federal planning grant. [See "New York City: A Demonstration Project" in Sept. BULLETIN.] Meanwhile, the Health Services and Mental Health Administration of HEW insists that it cannot grant the funds until the Corporation has a Board of Directors . . .

There are few surprises in the Department of Hospital's revised, king-size grant proposal. One of the few is that $4.5 million is only the beginning of what it will cost to set up the Corporation. Altogether, the Implementation Task Force estimates that it will need $23.5 million! (For the same price, the City could build a whole new major hospital.) If the Feds come through with their $4.5 million contribution, the City will still be left with a $19 million bill. The bulk of the money will go to buy a battalion of new administrative personnel for the City hospitals, at salaries up in the $30,000 to $40,000 a year bracket.

Far more interesting than what is planned for the Corporation is what has been left unplanned. All the "issues which remain to be resolved" are filed in one of the appendices of the Department of Hospital's grant request. Sample issues: What should be done with the affiliation program under the Corporation? What should be the relationship of the Corporation to the City government, in particular to the Health Services Administration? How much freedom should be given to the Corporation's regional subsidiaries when and if they are set up? What should be the powers of the local hospital community advisory boards to be set up under the Corporation? Who should be served by the City hospitals? These are the same annoying issues which opponents of the Corporation kept raising, without effect, last spring. [See June BULLETIN.]

Matters of protest about the way the Corporation planning is being handled can already be heard from inside the Department of Hospitals. There are complaints that upper-level staff spends way too much time haggling over who will get what salary, come the Corporation and freedom from civil service lines. Also, that "the whole thing is being handled like it was a business. No one seems to remember that it is about the people's health".

Hospital Crisis

What happened to the crisis in voluntary hospital funding which had everyone so excited only a few weeks ago? Back in September, an impressive coalition of the city's top private hospital "clubs"—the United Hospital Fund, the Greater New York Hospital Association and the Health and Hospital Planning Council—announced dramatically that 13 of the city's voluntary hospitals might have to close because of budget deficits [see October BULLETIN]. As far as anyone can tell, the 13 threatened hospitals have gotten no richer and in some cases a little poorer since then, with continued hiring freezes and possible lay-offs and service cutbacks in the offering.
Maybe the United Hospital Fund and Company were appealed by recent rumors of future funding. One possibility was that the Federal government would demand a thaw in the State’s current freeze on Medicaid reimbursement rates for hospitals. Taking the lid off of Medicaid rates might salvage the hospitals now, of course, but would drain already-limited Medicaid funds and probably lead to further eligibility cutbacks in the next legislative session.

There is a second, far more ingenious plan for tapping State funds for the voluntary hospitals. The clinics of the afflicted voluntaries would be turned over to the Corporation to operate. This maneuver would qualify them to receive State funds tied to the “Ghetto Medical Bill,” a 1967 sleeper amendment to the New York State Public Health Law. Still largely unused because of ambiguities of interpretation, the Ghetto Medical Bill would potentially outdo Medicaid as a source of State money for ambulatory care. In case it is applied, bear in mind that the guidelines for the Ghetto Medical Bill call for community involvement in the operations of facilities which receive funds.

Health Planning

The City has won its struggle for a Federal grant to establish a comprehensive health planning program. The Health Services Administration (HSA) announced this past October that the Department of Health, Education and Welfare has awarded their offices $258,000, to be matched by $250,000 from the City, for the purpose of organizing, as Dr. Bucove of HSA has said, “a true ‘partnership for health’ among consumers, providers of health services and municipal agencies.”

To begin the implementation of this “partnership” an organizational task force has been selected by the Mayor. Of the 59 member task force, 30 are from consumers groups (at least as defined by HSA) and 29 represent provider groups and City agencies. The 59 people range from Al Cheeks (Lower East Side Neighborhood Association), Charles G. Cushing (New York Chamber of Commerce), and William Taylor (Local 1199)—on the consumer side—to five doctors from the Coordinating Council of the five county medical societies, and Joseph V. Terenzio (Commissioner of Hospitals)—on the provider side. This task force now has the job of developing a comprehensive health planning system with consumer participation at all levels, and also eventually organizing the comprehensive health planning agency for the city.

But there are some limitations to what this body will actually be able to carry out. Federal restrictions placed on the grant rule out the use of this money to set up demonstration projects in consumer participation. HSA originally proposed such projects to help work out what a neighborhood-up system of consumer participation would look like. The task force has also been denied money for a proposed training program to prepare both community residents and health workers to work on local planning councils. While attempting to get a new decision from HEW on these proposals, the HSA is trying to raise the needed funds from private sources.

The Task Force’s worst headache, however, will be how to relate to the Health and Hospital Planning Council of Southern New York, Inc. (HHPC), which was also bidding for the federal grant which went to HSA. The HHPC is not a public agency, but essentially a private “club,” made up of private hospital-related doctors, directors and administrators, medical school deans and private health insurance leaders. HHPC is notorious for its past planning decisions—decisions which have included the closing of St. Francis Hospital in the Bronx and the 10 year delay in the completion of the New Gouverneur Hospital. [See July/August BULLETIN.]

Now that the federal grant to set up the comprehensive health planning agency for New York City has gone to HSA, the question is what role does the HHPC have to play? According to Jack C. Haldeman, president of HHPC, the awarding of the grant to HSA, “... does not alter the current beliefs and responsibilities of the Health and Hospital Planning Council of Southern New York, Inc.”

There seems to be some confusion as to which group now plays what role and gets which job done. Who will be the group that lays out the comprehensive health plans for this city? What is the relation of the HHPC to this new task force? And perhaps the most important question yet to be answered is how and when the consumers of the health services in New York are going to be directly involved in the real health planning decisions?

—Barbara Ehrenreich
—Leslie Cagan

To The People

The Judson Mobile Health Unit, parked on East 7th Street, is not the typical health center in New York City. Since it first opened over the Labor Day weekend the health service has been aimed at treating the special medical and health needs of young people in the area. The unit, staffed by three health workers, is open seven days a week. Funded through the Judson Memorial Church in Greenwich Village, all services offered are free. But what makes this service unique is the attitude toward patients and the approach toward health problems.

Patients are seen as people who are ill and need help, and not as potential fee payers. Whenever possible, the patients are involved in both the diagnostic and treatment end of medical attention. Instead of wordy non-descriptive the doctor uses lay terms to explain what has gone wrong. People are encouraged to ask questions, to look through microscopes at their own blood samples, and to learn how to prevent and treat certain illnesses for themselves. The health workers want to share the knowledge which they have acquired about health with the people who come to them for care.

Preventive medicine is a large part of the unit’s work. The staff understands that many of the medical problems of the area are created by the environment in which people are forced to live. A referral and counseling service has been established to deal with problems of housing, education, and welfare. Discussions are held with the young people who use the services about the living conditions of their neighborhood and what creates those conditions. Encouragement and aid is given those who want to work in a collective way to challenge the social system which creates these medical problems.

Perhaps the single most important thing that sets this unit apart from all other health services is the approach toward decision making. The staff feels that it is their job to meet the needs of the young people in the area. Since the people who are using the service know what it is they need, the staff believes that those people must play the key role in shaping the services of the unit. At this point the staff is working with the neighborhood youth to set up a board which will control the functions of the unit. There will be a few adult advisors, but the responsibility for the decision making will rest with this board of young people from the community.
January, CPB6 met in executive session with representatives, attended a number of community meetings on this question as did the CPC. While Hospitals Department presented a factual and statistical picture of the need for Site 3, CPC decided to intervene in this matter with its own site. Despite the City Charter relationship between the CPC and CPB, CPC did not advise CPB6 of its presence in the community or communicate to it its intention to intervene in this question.

The Fordham Hospital Community Advisory Board held its public meeting on November 6, 1968. Subsequently, Terenzio, or his representatives, attended a number of community organizations' meetings on this question as did representatives of the CPC. While Hospitals [Department] presented a factual and statistical picture of the need for Site 3, CPC appealed to emotionalism and offered the use of its facilities and staff to develop a petition campaign and other forms of community action against Site 3 and in favor of Site 7. I suppose this is community advocacy.

It was not until November 1, 1968 that CPC communicated with CPB6. In December and January, CPB6 met in executive session with representatives of Hospitals [Department] and CPC. In the meantime CPB6 learned of community division on the question of Site 3 and Site 7 and held the public meeting on February 18, 1968 which your article briefly discussed. In view of all that transpired before this meeting it is no wonder that it was indeed 'a stormy public meeting'.

On May 1, 1969 CPB6 held a follow-up public meeting. This meeting offered a great contrast to the meeting of February 18. It was well-managed. The speakers had all done their homework. There was no near-hysteria or histrionics. There was no confrontation politics. Every speaker dealt in facts, not emotion. All eight sites were reviewed in detail. Only the City representatives still did not have facts in hand but only offer conjecture. As a result of this meeting and the accumulation of opinion which preceded it, and the need to reachieve community harmony, CPB6 arrived at its own compromise.

The Site Selection Board met on May 19. It held a hearing on Site 3M [modified Site 3], closed its hearing and adjourned its vote until June 20 to await the outcome of the Primaries. While the Hearing was called for 10:30 AM the question of Fordham Hospital was not reached until 4:00 PM. Consequently, except for members of the clergy, principally, all other community people who attended with the intention of speaking against Site 3M left the Hearing. On June 20, the Site Selection Board voted 4-1 in favor of Site 3M. The lone dissenter was the Borough President. The result "was delays without any meaningful involvement in the planning process" by the community. Unless there is a tremendous outpouring of Tremont people at the site acquisition hearing of the Board of Estimate, Fordham Hospital will probably be built on Site 3M. But, at what cost to the community?

—HARRY KEIFET, CHAIRMAN, Community Planning Board 6, Bronx

Dear Abby

Your Bulletin of September 1969 incorrectly states at page 10 that: "... Charles Miller of Miller and Raved, interestingly enough, is the son-in-law of Sidney Schutz, general counsel for Yeshiva University."

It is not true that Mr. Miller is my son-in-law. I have two lovely daughters, both of whom are looking for husbands, and no sons-in-law whatsoever. I would most certainly appreciate any help you could give me in this regard, as well as a printed retraction of this statement.

Wishing you and your publication the success you both deserve, I remain.

—SHERIDEN SCHUTZ

General Counsel, Yeshiva University

Editor's note: HEALTH-PAC was in error. We apologize to Miller and Raved and Mr. Schutz.