Reagan's Health Care Revolution

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To the Editor:

Thanks for the "Profits Without Honor" article (Vol. 13, No. 4. I think it's great! That's a gem of a quote by Pharmaceutical Manufacturers Association's Engman at the end (and a gem of a response!).

There are a few extremely recent tidbits regarding Bangladesh, just to let you know. For one, there have already been measurable effects (compromises) on the original law, in that:

— the 236 drugs which were to have been destroyed on 12 September were not, because export licenses have been granted for these drugs (and 233 others), permitting their shipment to West Africa, other parts of Africa, and Saudi Arabia;
— 41 drugs originally to be phased out have been reinstated in the national formulary;
— the original time periods for "phasing out" have been extended.

This information comes mainly from "War on Want" in London. The last thing is that foreign news articles have mentioned "hints at reducing the annual $160 million in US aid" from the US embassy if the Drug Reform Law isn't reconsidered.

The enclosed letter was sent by someone who wishes to remain anonymous.

Best Regards,
Erica Gollub
New York, NY
Notes & Comment

Huntington Health Services, Inc., is listed on the American Stock Exchange. It owns four acute care hospitals, seven long term care facilities, four retirement homes, a pharmacy company, two physical therapy companies, a medical office building, and two real estate holding companies.

According to a report issued by the General Accounting Office (GAO) of Congress this January, Huntington also has some very creative accountants. Through a series of complex entries, they were able to obtain reimbursement overpayments of $215,000 for fiscal years 1979 and 1980 for purchases of intravenous (IV) solution by Huntington's North Las Vegas Hospital from a related enterprise. After the GAO audit the hospital reduced its fiscal 1981 reimbursement claim by $441,000. The GAO also found that North Las Vegas had gotten $188,000 more than it should have from the government by "buying" inhalation therapy services from another Huntington company which paid excess salaries to employees assigned to the hospital.

The GAO found a similar pattern at Woodruff Community Hospital in California, a facility owned by two physicians through a holding company. Woodruff got an extra $600,000 in reimbursements by overpaying a related company which has a contract to manage it and juggling the books to obscure transactions with other related companies from routine audits.

Mad River Community Hospital in California inflated its operating costs by more than $500,000 by a sham sale and leaseback arrangement with a related company. Brookwood Hospital in California ran up excess costs of over $450,000 through management contracts and leases with related organizations.

The magnitude of these overcharges is particularly impressive because all of the hospitals involved are small, under 100 beds. The GAO doesn't have the resources to audit all such hospitals, but the selective investigations so far indicate taxpayers are being taken for a multimillion-dollar bath. Blue Cross/Blue Shield customers in some states are paying for similar fraud in higher premiums.

Federal regulations on reimbursement are too clear to permit the companies involved to claim errors in judgement with any credibility. Because there is no price restraint through competition when items or services are purchased from a related company, Medicare and Medicaid reimbursement for such transactions is limited to the lower of (1) the cost to the related firm or (2) the market value. In every case the hospital engaged in fraud attempted to conceal the relationship or the nature of the transaction.

Responsibility for evasions and overcharges lies not only with the hospitals involved, according to the GAO, but with the insurance companies which serve as their fiscal intermediaries. They are supposed to be the government's auditors, but under one of the more peculiar provisions of Medicare law a hospital chooses which insurer it wants to perform the audit. The hospital is likely to drop a company which is too tough, depriving it of a profitable sideline. Presumably the individual accountants might be concerned that if their employer loses the job, they might lose theirs. The GAO believes a better system could be introduced.

Free copies of the GAO report, No. HRD-83-18, may be obtained by writing to the U.S. General Accounting Office, Document Handling and Information Services Facility, P.O. Box 6015, Gaithersburg, MD 20760.

Herb Semmel

(herb semmel is dean of the antioch law school and director of the consumer coalition for health.)

This is apparently an information organization which keeps subscribers informed on the activities of selected international organizations. This particular report contained a summary of the "Bangladesh drug issue" and indicated that the multinational drug companies are continuing their efforts to change the new policy. Of course, it is in their interests to do so. Pfizer will be particularly hurt if the Bangladesh Government does indeed ban Vibramycin, an extraordinarily expensive form of tetracycline.

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It has recently come to my attention that another American consulting organization, Business International, plans to join this debate. Business International (BI) has scheduled a so-called Roundtable Discussion with the Government of Bangladesh, to be held in February in Dacca. The conference has the full support of the Chief Martial Law Administrator, Lt. General H.M. Ershad.

Pfizer, the American multinational drug company with substantial interests in Bangladesh, is conducting an active campaign to encourage other corporations in other industries to participate in the BI program. Pfizer plans to use this conference as a forum to “pressure” the Government to depart from its new drug policy. Pfizer calculates that it can embarrass the Government by pointing to this new policy, which of course deprives Pfizer of significant profits in Bangladesh, as evidence that the Government is not really sincere in its attempts to attract foreign investors. It hopes that such embarrassment would be fanned by questions and comments from other multinationals represented at the conference.

In fact, if Pfizer plans their actions carefully, they could make a persuasive case. There is a lot of good “pr” material in the situation. After all, Pfizer could argue, here is a case of an honest and sincere foreign investor coming to Bangladesh, constructing a plant, creating jobs etc., and making available a modern medicine to cure disease. And what happens? After the plant is in full operation, the Government tells the investor that it can no longer manufacture and sell that drug. How sincere can the government be about attracting investment? How far can other potential investors trust the government to live up to its initial promises?

Of course, Pfizer would not include in this presentation any reference to the total cost to Bangladesh of this particular drug, Vibramycin. Nor would they refer to the fact that Vibramycin is a form of tetracycline, a well known and established broad spectrum antibiotic which is available from a large number of sources around the world at prices as low as 10% of the Vibramycin price. Above all, Pfizer would not want to include in their presentation any information at all about the method by which their Bangladesh plant acquires the raw materials to “manufacture” Vibramycin in the country. There are very good reasons why they would not want to discuss these issues.

In the first place, the Pfizer plant in Dacca is required by Pfizer policy to purchase the bulk Vibramycin from Pfizer, U.S.A. It must pay for these purchases in foreign exchange—namely in U.S. dollars. Pfizer, U.S.A., places a price on this bulk product which permits it, Pfizer U.S.A., to realize a healthy profit on the sale of bulk Vibramycin to its own subsidiary, Pfizer Bangladesh. This “transfer price” creates capital flight from Bangladesh. It contributes toward the depletion of the country’s foreign exchange reserves. It jacks up the bill for health care in the country by an unjustifiable factor. The Government of Bangladesh does not know, and Pfizer refuses to provide this information, just how much profit Pfizer makes on this sale from the parent company to its own subsidiary. Consequently, Pfizer pays no taxes to Bangladesh on this profit.

Pfizer Bangladesh, receives the bulk product, puts it in capsules or compresses it into tablets, and then sells the product locally—realizing yet another profit on the finished product.

Now, Vibramycin is a good and useful drug. For those who can afford it, the benefits outweigh the disadvantages. The question is whether or not it is an appropriate drug for Bangladesh, particularly when other, cheaper forms of tetracycline are available.

This involves a cost/benefit judgement. But how can the Government of Bangladesh make such a judgement in the absence of all pertinent information. They cannot.

I guess my main point here is that it appears Bangladesh is being ripped off. Maybe the country needs this drug, although it does not appear on the WHO list of Essential Drugs. Maybe it is proper for large volumes of foreign exchange to be allocated toward the purchase of Vibramycin. But I wonder if it is proper for a multinational drug company to enjoy unconscionable profits (mostly in foreign exchange) from this or, for that matter, any other drug. And I do understand that Pfizer’s profits from Vibramycin are very substantial. In fact, my friend who works at Pfizer has expressed the opinion that Pfizer’s profits from Vibramycin are not very substantial. In fact, my friend who works at Pfizer has expressed the opinion that Pfizer would probably be forced to “close up shop” in Bangladesh if the Government proceeds to ban Vibramycin. Without knowing any of the details, I think this one “fact” speaks for itself.

There is little doubt that Pfizer plans to raise the issue of the new drug policy during the BI meeting in Dacca. They will probably arrange for someone else to ask a pertinent question, continued to p. 6
Vital Signs

Washington Update

In response to the clamor for cost-cutting, the first major change in Medicare reimbursement since the program was established in 1965 has sailed through Congress. Whether it will actually cut costs is another matter.

Until now, hospitals have been reimbursed on the basis of "reasonable" costs of providing care, a method which gave them a free hand in spending with virtual assurance of reimbursement. Under the new system, by 1987 hospitals will get their Medicare money entirely according to Diagnostic Related Groups (DRG's), i.e. a flat amount for each patient based on the diagnosis, regardless of length of stay or utilization of services. (For a fuller explanation of DRG's, see the previous Bulletin's Report from Washington.)

Studies in New Jersey, where DRG reimbursement has been used since 1980, differ on whether it has achieved savings. A leading hospital attorney in Washington predicts off the record that hospitals will adjust to DRG's by upping the diagnosis to a higher, more costly, category or by putting through multiple admissions for a patient who might have been treated in one hospital stay. Thisploy is so widely known in the industry that it already has a name—"DRG creep."

Whether DRG's curb hospital costs or not, they will surely be a boon to accountants. Instead of one national rate for each DRG, there will be nine regional rates, each with a separate rate for rural and urban areas. Since there are 467 DRG's, there will be a total of 8406 rates nationwide. In addition, reimbursement under DRG's will be phased in. Beginning this October, 25 percent will be based on DRG's and 75 percent on the old reasonable cost method. In the second year the ratio goes to 50-50 and in the third to 75 percent DRG, 25 percent cost. Not until October 1985 will the changeover be complete, so hospitals will have to keep dual records for three years.

As if this isn't enough to keep the government computers busy, the Department of Health and Human Services is permitted to grant adjustments, including special allowances for sole community hospitals, public and teaching hospitals, and hospitals serving a disproportionate number of low income patients and Medicare beneficiaries. In addition, teaching hospitals will continue to be reimbursed on a cost basis for medical education expenses such as salaries of residents and interns. Since residents provide most of the patient care in teaching hospitals, these institutions may be the big gainers under the new system.

Certified Cash

Look up on your doctor's wall and you're likely to see a certificate indicating he or she has passed an oral and written exam in a medical specialty. Almost three quarters of all physicians practicing in the U.S. have at least one. Among office-based specialists, the proportion ranges from 67 percent for psychiatrists and 69 percent for internists to 100 percent for family physicians. Board certification has always been regarded as professionally prestigious as well as a testimonial of competence to deliver high quality specialty care.

It is also, a recent study published in Medical Economics shows, a good indicator of prosperity. In 1981 the median annual gross income for uncertified specialists was only $112,000 and the net a modest $70,000. The median certified specialist, however, took in $152,000 gross and $93,000 net; almost 30 percent grossed over $200,000.

The 1983 incomes will probably be considerably improved. If America is on the mend, it is only natural that menders should be doing well. Unemployed steelworkers might consider a career in specialty medicine.
so that Pfizer is not singled out as the "troublemaker." It seems to me that it would be relatively easy to expose Pfizer’s strategy and to discredit it. All it would take is for someone with stature and the appropriate credentials to guide the discussion toward transfer prices and then raise the point that, while no one argues that Vibramycin is not a good drug, it is not substantially more useful that other forms of tetracycline and it is far too expensive for Bangladesh. And perhaps the telling point is that bulk Vibramycin (generic doxycycline) is available from a number of non-Pfizer sources at substantially cheaper prices!! I apologize for this lengthy epistle; however I thought you might be interested in this case in Bangladesh. To me, it is a classic example of inappropriate behavior by a multinational drug company. Pfizer does a lot of good things, no doubt. This isn’t one of them! You could be helpful in discrediting the move to cause the Government of Bangladesh to abandon their new policy which does appear to be beneficial for the country. Best regards.

X
Hong Kong

Summer Internships at Health/PAC

If your school participates in the Urban Corps Program (consult your financial aid office) and you qualify for work-study, you may be eligible for a paid summer internship with Health/PAC through the Health Research Training Program (346 Broadway, Rm. 712, New York, N.Y. 10013; tel. (212) 566-6992). Projects for the summer will include research on: the Civilian-Military Contingency Hospital System, aspects of for-profit health care, international comparisons of the nursing profession, affirmative action in the medical professions, and updating our inventory of progressive health advocacy organizations.

If you have your own project that you’d like to work on this summer (with guidance from Health/PAC) and would like to be a volunteer intern, please send us a resume and a one-page description of the project.
Who Cares for Health Care?
The First Two Years of Reagan Administration Health Policy
by Geraldine Dallek

In this present crisis,” President Reagan declared in his Inaugural Address, “government is not the solution to our problem; government is the problem.” The solution he has proposed is to free American enterprise and the American spirit by cutting Federal domestic spending; shifting powers to the states; and easing Federal tax and regulatory burdens.

As a primary area of Federal activity, health care has been a major target of this effort from the beginning. The Reagan Administration has moved on several fronts, attempting to slash its Federal funding, shift responsibility for the poor and the elderly to the states and the voluntary sector, and promote competition through deregulation and a change in tax and insurance policies. This revolution was to be bloodless, causing no harm to those dependent on Federal assistance. “We can continue to meet our responsibility to those who through no fault of their own need our help,” the President promised.¹

At the halfway point in the Reagan Presidency, it seems appropriate to assess how far this revolution has gone, the changes it has wrought, and its future prospects.

Federal Budget Cuts

In 1981 and again in 1982, the Reagan Administration proposed massive cuts in Federal health and social programs. In his February 19, 1981, address to Congress, the President asked for a five percent cap on increases in the Federal contribution to Medicaid; a 25 percent or more reduction in funding for a number of other health and social programs; and trims of several billion dollars in appropriations for food stamps, welfare, energy, and housing programs.

“Safety net” programs—those which serve the “truly needy”—would be spared. Inexplicably, however, programs such as Medicaid, food stamps, welfare, maternal and child health, and community health centers, all programs that provide care only to the poor, were excluded from this category. On the other hand, Medicare, the Veterans Administration, and Social Security programs serving many non-poor individuals were included among the inviolable.

According to one study, 60 percent of Americans below the poverty line received either no benefits at all from the Administration-defined safety net programs or only free school lunches.³

In 1982, the Administration once again proposed drastic cuts, but shuffled the safety net definition. Medicare and Social Security were tossed out with Medicaid, food stamps, welfare, and maternal and child health.

Although Congress balked at giving the President all he requested, programs for the poor were slashed severely, especially the first year. The 1981 Omnibus Budget Reconciliation Act (OBRA) trimmed or totally eliminated outlays for approximately 200 programs. Health care was a prime OBRA victim. Medicaid matching funds were cut three percent for 1982, four percent for 1983, and four and a half percent for 1984. States were given increased flexibility to cut their Medicaid programs—

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which they promptly did, by approximately $300 million for Fiscal Year 1982 and then $250 million more for FY 1983. In addition, a squeeze on welfare shrunk Aid for Dependent Children (AFDC) rolls by ten percent, and those excluded lost their Medicaid coverage as well.

Categorical health programs—Federally funded and administered programs targeted to serve specific low income populations or attack specific health problems—suffered the greatest proportional loss in 1981. Twenty-two programs were combined into four block grants, and their total funding was slashed 25 percent.

After performing this radical surgery on categorical health programs in 1981, as well as gutting health education and school nutrition and sharply reducing funding for other programs such as food stamps, welfare, and housing, Congress lost much of its taste for going after domestic spending. In 1982 the legislators ignored an Administration proposal to take away 22 percent of the funding for the Women's and Infant Care (WIC) program and fold it into the Maternal and Child Health Block Grant. Some funds—not much—were restored to the MCH and Primary Care (community health centers) block grants. The President called for an additional $1.9 billion slice out of Medicaid; he got only $256 million removed. Only Medicare, relatively untouched by cuts in 1982, was hard hit, suffering cutbacks totaling $13 billion for the fiscal years 1983 to 1985. (See Report from Washington in the previous Bulletin).

This year President Reagan is once again proposing massive cuts in domestic spending, but even Republican leaders say there is little chance they will make it through Congress. Paul Laxalt (R-NV), the President's closest friend in the Senate, admits that domestic programs have already been cut to "the bone."

There is no doubt reaching the bone has hurt. But perhaps even more suffering has resulted from the Reagan tax cuts and other fiscal policies. They played a key role in creating the worst economic downturn since the Great Depression and lowered the revenues of state governments while increasing state expenditures for interest payments, unemployment compensation, and other uncontrollable items. Coupled with the Federal cutbacks, the result was enormous gaps between projected revenues and expenditures. To balance their budgets states were forced to squeeze health and social programs to a far greater degree than the Federal cuts in themselves required. California, for example, lost $60 million in Washington but slashed its own programs in this area by $200 million in FY 1981 and $500 million in FY 1982.

Despite all these cutbacks, no basic revolution has transformed health care funding. The Federal government is still in the health care business, shouldering the major financial responsibility for meeting the health needs of the poor and the elderly.

The perceived Reagan mandate to reduce Federal domestic spending notwithstanding, the rush to cut was braked by two important factors. First and most obviously, by the worst recession since the 1930's. By the end of 1982, 10.8 percent of the workforce was unemployed, and over 14 percent of Americans were living below the poverty line. As more and more of their constituents suffered drastic reductions in income and lost their private health insurance, the need for government health programs grew dramatically, and members of Congress were reluctant to continue seeking "savings" in health programs for the poor and elderly.

Second, this congressional resolve was strengthened by broad and increasing public support for Federally funded health programs. Over the decade and a half since their inception, Medicare and Medicaid have enjoyed consistent backing in opinion polls, along with the precept that no one should be denied health care for lack of money. Generally, the public did support the first round of Reagan cuts, but not, as political columnist William Schneider put it, because they felt that "social welfare should be curtailed as a legitimate government function." Analyzing two polls taken early in the Reagan presidency, Schneider concluded that, "people want to cut spending on social programs, but they do not want to cut services to the poor, the elderly, the unemployed, and the disadvantaged." Rather, the public was persuaded both that the early Reagan cuts were needed to curb inflation, considered the number one priority in 1981, and that by eliminating waste and inefficiency these reductions could be made without harming those in need.

Convinced that the "fat" had been taken out of government health programs, the vast ma-
Majority now opposed further reductions. A recent Harris poll found that 62 percent of Americans would rather cut the military budget before touching health care outlays in general, while only 34 percent hold the opposite view. The sentiment for going after Pentagon funding first jumps to three to one for Medicaid and an overwhelming four to one for Medicare. "There is something sacred about Federal health programs to the American people," concluded Harris, "the public gets 'fighting mad' when it seems that America could well be systematically stripped of all its compassion for decency and humanity."

Shedding Federal Responsibility

As part of his campaign against the Federal government, which he attacked as a bloated monster depriving states and localities of "discretion," "flexibility," and "decision-making" authority, President Reagan proposed a shift in responsibility for health and social programs. "Now we know, of course," he declared, "that categorical grant programs burden local and state governments with a mass of Federal regulations and Federal paperwork. Ineffective targeting, wasteful administrative overhead—all can be eliminated by shifting the resources and decision-making authority to local and state government." This shift, he promised, would bring "government closer to the people" and save "$33.9 billion over the next five years."

Shortly after taking office, the President proposed combining 40 categorical items for health and social services into four block grants to the states—with a 25 percent funding cut. The health proposal entailed consolidating 26 programs into two massive block grants. Even apart from the budget reductions, community groups strenuously opposed the concept of block granting, fearing that valuable programs without a powerful local constituency would get shortchanged. Nevertheless, the President, strongly backed by the National Governors Association, got much of what he asked for. Congress gave him the full 25 percent cut and combined most of the targeted programs into seven block grants. Four of them combined 22 health programs. However the legislation did attach strings. State discretion in block grant funding was restricted. Use of one health block grant was limited in such a way that few states were likely to assume responsibility over it. Several health programs were kept out of the blocks, including health planning, migrant clinics, and family planning.

Despite these setbacks, the Administration was riding high from its triumphs and set to work developing the most radical reordering of Federal-state responsibility since the 1930's. Yet when President Reagan unveiled the "New Federalism" in early 1982, his proposal fell flat.

Why the abrupt reversal? State and local lobbies, most notably the National Governors...
Association (NGA), had lost their enthusiasm for the entire concept. Shocked by the magnitude of the 1981 cuts and the proposals for more, the governors had learned that devolution of Federal responsibility to the states came with a very hefty price tag. As early as August of 1981, Georgia governor George Busbee, the departing NGA chairman, and a strong supporter of the President’s program only a few months earlier, responded to the New Federalism agenda with an acid prediction that “I fear that it’s only a matter of months before some of our friends in OMB [the Office of Management and Budget- ed.,] attempt to impose their own brand of sorting-out...guided by one sole criterion: What makes it easiest to balance the Federal budget? From the point of view of budgetary tunnel vision, Federalism becomes an easy matter—pick out the most expensive, the most difficult to manage, the most politically controversial Federal programs and hand them over to the states and localities with a heartfelt sigh of relief.”

Opposition also hardened at the predominantly Democratic grouping of large cities, the U.S. Conference of Mayors, following a survey of 100 cities in November 1981. “Recently-enacted Federal budget cuts are imposing immense burdens on city budgets, resulting in massive layoffs, service reductions, tax increases, and postponement of needed capital investments,” the Conference statement complained.

Suspicious that the rhetoric of bringing control closer to the people was a cover for budget-cutting and nothing more were heightened by the Administration proposal to eliminate Federal funding for National Health Service hospitals and turn them over to community control. When Congress attempted to appropriate transition money for these hospitals, the Administration tried to block the transfers, preferring to close the facilities instead. “The Administration did not support the transfer to community control,” a study of the transfer of the Seattle Public Health Service Hospital bitterly concluded, “instead it acted repeatedly to prevent the possibility the hospital would continue under local control. From February 1981, when the President’s budget was presented to Congress, until November 1981, when the transfer actually took place, representatives of the Reagan Administration used a variety of political, legislative, and bureaucratic maneuvers to close the hospital, effectively refuting the New Federalism.”

The Administration’s New Federalism program was certainly bold: a $20 billion swap, with the Federal government assuming responsibility for Medicaid and the states taking over welfare and food stamps and accepting a “turnback” of 43 other Federal programs. The President and his officials maintained that the swap was basically even since it included a $28 billion trust fund financed by excise and oil windfall profits taxes to pay for the turnback programs and make up any difference to states which lost money in the swap.

The balance sheet, however, was bogus. States already had use of revenues from the excise tax. The oil revenues would be unequally distributed to a few oil-rich states. The costs to the states of assuming AFDC and food stamps had been grossly underestimated and the Federal burden in taking over Medicaid had been exaggerated. The Congressional Budget Office estimated that the swap would cost the states $1.5 billion and the turnback program $13.4 billion during the first year.

The American Federation of State, County, and Municipal Employees (AFSCME) warned that the states would be out $17 billion in FY 1984 and a total of $86 billion by FY 1991, when most states would be left high and dry by the phase-out of the trust fund.

After a year of tough bargaining between the National Governors Association and the Administration, in December 1982 the governors proposed the Federalization of Medicaid (including funding of long-term care costs and assumption of medically needy programs, which the Reagan team had wanted to leave
with the states) in return for a state takeover of a limited number of relatively small health programs. AFDC and foodstamps were not mentioned. The Administration decided to drop swap idea entirely. It is now proposing a large block grant for 22 health and social programs with guaranteed funding for five years. However, with seven new Democratic governors in formerly Republican state houses, the likelihood of any New Federalism transfers during the rest of the Reagan years appears slim.

The block grant strategy may not be so successful either, since those already in effect have not fulfilled the President's promise that the needy would be protected. Lead poisoning programs within the Maternal and Child Health grant, for example, have not fared well under state control. Distressed by the estimated sharp 42-55 percent drop in the number of children who will be screened from FY 1981 to FY 1983, supporters of the program are asking Congress to restore Federal responsibility for it. Representative Henry Waxman (D-CA), Chairman of the House Subcommittee on Health and the Environment, hopes to introduce legislation on their behalf.

Similar outcries are coming from those involved in other block granted programs. The increased efficiency and support at the state level which was supposed to mitigate the impact of the 25 percent funding reduction have not materialized. Instead, states have passed the cuts on to grant recipients. One 1982 50-state block grant survey found that a majority of respondents felt that "there had been a decline in the quality of services provided in the last year." Neither did public accountability increase as had been promised. In fact, as a study by the Center for Law and Social Policy noted, "the entire block grant implementation process largely took place in the absence of meaningful public comment." Several mayors also complained that states "had not consulted with them or offered an opportunity to participate in the state's decision-making process."

The President also assured the public that an outpouring of good will and money from a mobilized private sector would reduce the impact of Federal reductions. "How can we love our country and not love our countrymen? And, loving them, reach out a hand when they fall, heal them when they're sick, and provide opportunity to make them self-sufficient?" he asked rhetorically.

Health Care for the "Truly Needy"

Although a Private Sector Initiative Task Force to encourage community effort was established and, in his second State of the Union Address, the President declared, "The volunteer spirit is still alive and well in America," even maintaining past levels of aid in real dollars is proving difficult. As one study noted, "Government has historically used the non-profit sector as the conduit through which it delivers services, with the result that government cutbacks are also private cutbacks!" Furthermore, according to an Urban Institute analysis, a private sector giving would have to be up 26 percent in 1982, 39 percent in 1983, and 44 percent in 1984 to make up for Federal cuts passed in the Omnibus Budget Reconciliation Act of 1981 alone. In addition, the President's Economic Recovery Tax Act of 1981 reduced financial incentives to donate for both corporations and individuals—at a time when high unemployment, business failures, and economic hard times leave them less able to give. Even if these hurdles were overcome, any conceivable increase would be woefully inadequate to cover the gap torn by Federal cutbacks. The following discussion explains why.

The Reagan Administration has steadfastly maintained that its budget will not and has not harmed those truly in need. Shortly after taking office, the President stated that "our spending cuts will not be at the expense of the truly needy." A year later, in his 1982 State of the Union Address, Reagan again reiterated his Administration's commitment to the impoverished: "Contrary to some of the wild charges you may have heard, this Administration has not and will not turn its back on America's elderly or America's poor." Unfortunately, the reality is quite different. Cuts in health care programs during the past two years have inflicted great harm on these groups.

In the Medicaid program, what began as deep cuts in Washington became worse in states. Frantically looking for ways to adjust to Federal reductions and shrink their recession-starved budgets, some states went on a Medicaid rampage, slashing their programs to pieces. During 1981 and 1982, Medicaid programs were severely cut in 35 states; dental services in 22; funding for drugs, prosthetic devices, or medical supplies and equipment in 31; emergency hospital services in five; inpatient hospital services in 17; optometrist
services and eyeglasses in 17; outpatient services in nine; rehabilitation and physical therapy services in ten; physician services in nine; psychiatric care in 15.2

Some of the cutbacks were drastic. For example, South Carolina, New Hampshire, and New Jersey imposed a 12 day ceiling on Medicaid hospital coverage. The case of South Carolina indicates what this can mean: In 1979, 23 percent of hospitalized Medicaid recipients there required more than 12 hospital days. South Carolina has also limited any combination of emergency room visits, outpatient hospital visits, and physician visits to 18 a year—far fewer than the chronically ill and children often need. In addition, South Carolinians on Medicaid are now reimbursed for only three prescriptions a month. There are no exceptions.

Unfortunately, these punishing cutbacks are not atypical. Pennsylvania eliminated eye care altogether. West Virginia now covers emergency care only for accidents, injuries, and trauma. Missouri limits prescriptions to two a month except for emergencies.

From early 1981 to the end of 1982 unemployment soared from 7.4 percent to 10.8 percent. Yet, while millions of Americans were losing their health insurance along with their jobs and the number of people living below the poverty line was climbing precipitously, Medicaid rolls did not increase. This apparent paradox is a consequence of tighter Federal and state welfare and Medicaid eligibility rules. During 1981 and 1982 nineteen states have already reduced the number of persons eligible for Medicaid. California alone, under Democratic Governor Jerry Brown dropped 270,000 Medically Indigent Adults from the program. Washington, Kansas, Pennsylvania, and South Carolina also reduced or eliminated care for adults living on general assistance. Tennessee virtually eliminated its Medically Needy Medicaid program. Six states terminated Medicaid coverage for families with unemployed parents, and ten for all or some recipients between the ages of 18 and 21.24

In 1981 AFDC changes cut Medicaid eligibility for women and children by ten percent. In 1982 almost 700,000 more children lost their coverage.

There is no question that these cutbacks harmed the "truly needy." A few specific cases from Tennessee, which in 1981 virtually eliminated its Medically Needy Medicaid program covering the aged, the blind, and disabled single parent families with incomes slightly above Social Security and AFDC eligibility, will illustrate the tragedies inflicted:

"A middle-aged woman from Moore County, who supplements her $3000 a year farm income by cleaning other people's homes, required two operations for cancer within a period of six months. She exhausted her life savings during the first surgery and became eligible for the Medically Needy Medicaid program. But the hospital refused to perform the second operation because of the restrictions on her Medicaid coverage, even after she borrowed $1000 from her teenage daughter who had earned the money to try to put herself through college.

"A carpenter from Morgan County was disabled after being bitten by a brown recluse spider and started losing his vision in both eyes. When he presented his Medically Needy Medicaid card, the hospital refused to perform the surgery necessary to save his vision, because the cutbacks had already taken effect.

"A resident of Clay County with a crushed foot and degeneration of the spine qualified for a Medically Needy Medicaid card, but when the hospital realized that his card would not cover hospital services, his scheduled surgery was cancelled."22

California hopes to save almost $400 million in FY 1983 through Medicaid cuts in physician and hospital reimbursement, stricter eligibility requirements, and reductions in eligibles and services. For a 16 year old boy with muscular dystrophy this will mean the once a week 40 minutes of physical therapy is gone; he must make do with 30 minutes twice a month. Medicaid will stop paying $216 a month for medicines needed by a severely disabled 11 year old girl. A 75 year old man suffering from diabetes, bladder problems, high blood pressure, and arthritis, with $30 left each month after paying rent at a board and care facility, will have to pay $181 a month before he qualifies for Medicaid. A recently unemployed 27 year old diabetic suffering from a myriad of disease complications will have to spend half of her $524 income on medical care each month before becoming eligible for Medicaid.

These are not isolated cases. Thirty-four million Americans are uninsured at least part of the year.24 Over one half of the nation's poor cannot get Medicaid; in Texas and Mississippi only a quarter are covered. Denied Medicaid,
the uninsured poor must depend on other Federal, state, and local health programs—all of which have been slashed in the past two years. During 1982, 725,000 people lost services in funding cuts which hit 239 community health centers (28 percent of the total) and 47 states reduced their Title V Maternal and Child Health block grant programs. A recent survey of 55 American cities found that during 1982 health programs serving indigents have been cut 42 percent.

Some hospitals and doctors have increased their efforts to provide charity care, but for the most part the private medical sector has made little or no attempt to cover the widening holes in the safety net. "Current economic constraints are forcing providers to ration more and more," concluded a special committee of the American Hospital Association, "Patients who can afford to pay or who have insurance coverage will receive care, while other may be denied."

Hospitals in many communities have increased rather than decreased pre-admission deposits required for treatment. A few documented cases, again from Tennessee, will demonstrate the consequences: During 1982 a young wife and mother was denied cervical cancer surgery when she and her husband, a construction worker, could not raise $3,200; a three year old boy's eyesight deteriorated for lack of hospital care; a 49 year old woman who had worked as a tobacco stripped was denied an operation for her stomach cancer because she did not have a $700 cash deposit.

These cases also are far from unique. Children's Hospital in Washington instituted pre-admission cash requirements in 1982. A hospital in Kentucky coerced patients into signing postdated checks and borrowing from the bank; in at least one case, this institution threatened to hold a newborn hostage until the bills for the delivery were paid. In central Georgia, a public hospital administrator asked county commissioners to direct their health departments to stop sending poor women in labor to his hospital, recommending that they be shunted to the state hospital 120 miles away.

Chicago's Cook County Hospital reports that since July 1981 the number of Medicaid and uninsured patients dumped on its doorstep by local private institutions has quadrupled. Many of those dumped are doubly devastated because they aren't used to being treated as the poor often are. "The transfers affect people losing their jobs and with them their health benefits," explained one Cook County physician, "People who never thought they would wind up being shoved off to County."

The first broad signs that these cutbacks and similar ones in food programs are damaging health have already emerged. Reports of increased malnutrition among children, indigents delaying medical care because of inability to pay, and doctors and hospitals unwilling to care for the uninsured poor indicate we are in the opening acts of what could become a national disaster.

"There is increasing evidence that both inpatients and outpatients in public and voluntary hospitals are now presenting themselves with more serious disease states," declared the American Hospital Association study on the impact of the health cuts. "This manifestation seems to indicate that many patients have delayed seeking treatment. The committee concluded that "cuts have triggered a much more rapid deterioration in health status than most officials responsible for the cuts are now willing to acknowledge."

Reductions in maternity care services have been particularly tragic. Cuts at the county and city health department level, in the MCH block grant, and in Medicaid, coupled with the unwillingness of many obstetricians to accept Medicaid reimbursement, have created a crisis in pregnancy care. The consequences are no less distressing for being predictable.

Poor women are not getting the pregnancy care they need. A September 1982 Oregon survey of 1,458 pregnant women in the WIC program found that 10.2 percent were receiving no prenatal care, 13.3 percent didn't know what to do about or hadn't made plans for delivery; 9.3 percent were planning to show up...
at a hospital in labor; and 4.5 percent (66 women) reported they will be having home births because they had no money for hospital care. In 11 poor communities in New York City, 20 percent of women delivering babies had late or no prenatal care. In 11 poor communities in New York City, 20 percent of women delivering babies had late or no prenatal care.

Between 1980 and 1981, 15 states reported a rise in infant mortality rates. Eleven other states reported a rise during 1982. It is too early to know whether these increases are the beginning of a trend or a reflection of the normal cyclical changes in infant mortality rates. Yet, it appears certain that in poverty areas with rampant unemployment a crisis exists. The Michigan Department of Public Health reports that "Neighborhoods in Detroit are experiencing an epidemic in infant deaths" reaching 33 per 1000 live births, a rate comparable to that of Honduras.

Because the absence of preventive or primary care increases long term and even lifetime deterioration in health, the failure to care for the truly needy will weigh on the nation as well as the individuals concerned for a long time.

Deregulation and Competition

The effects of the budget cuts were exacerbated by continued cost inflation in medical services. Although the recession did brake the overall inflation rate, it seemed to have much less impact on health care. In 1981, hospital costs jumped 19 percent while the overall rate was climbing 8.9 percent. In 1982, hospital costs were up 12.6 percent when the general rate slowed to 3.9 percent.

The Reagan Administration answer to this problem was to promote competition by freeing states and private health care providers from "excessive" regulation and promoting a "competitive" health plan.

The assault on the "virtual explosion of government regulations" was announced by President Reagan in his February 1981 State of the Union Address. He pledged to "come to grips with inefficiency and burdensome regulations—eliminate those we can and reform the others." His appointees have tried hard to keep this promise in health care as in environmental, health and safety, and other areas where the Federal government exercises oversight.

Health care "regulatory reform" has two purposes from the Administration's perspective. One is to free hospitals, nursing homes, and other health care providers from the expensive and wasteful demands of an overblown bureaucracy. The other is to carve additional pieces from programs when Congress refuses to go along.

In fairness, it must be said that the Reagan deregulatory fervor is not blind. Some new regulations are favored, such as the notorious "squeal rule," which would require family planning services to notify the parents of a teenage who came to them for assistance, and other regulations which would require the physical separation (including separate entrances) of abortion services from Federally financed family planning activities. Aside from being burdensome, such regulations, particularly the latter, would substantially increase costs for hospitals and other abortion providers.

Nevertheless, the President was able to proclaim in his 1982 State of the Union Address that "Together we have cut the growth of new Federal regulations nearly in half. In 1981, there were 23,000 fewer pages in the Federal Register, which lists new regulations, than there were in 1980."

Over the past two years his Department of Health and Human Services has done its part, consistently trying to fashion the regulatory process to the Administration model. It has issued regulations which do little more than parrot vague statutory language, thus leaving massive loopholes; reinterpreted old regulations to eliminate health program recipients and agencies; and substantially weakened Federal enforcement of existing regulations. In one of the more egregious efforts to promote this strategy, 318 pages of categorical program regulations were replaced with six pages of block grant regulations which left states free to spend the funds in almost any manner they wished. In the words of the preamble to the block grant regulations, "to the extent possible, we will not burden the state administration of the programs with definitions of permissible and prohibited activities, procedural rules, paperwork and recordkeeping requirements, or other regulatory provisions." In addition, without statutory authority, HHS has added new Medicaid regulations allowing states to restrict the number of persons eligible.

More action is planned on the regulatory front in 1983, including proposals to eliminate critical Hill-Burton Act requirements that compel hospitals which have received capital funding through the act to provide some services for the poor and regulations which weaken standards which must be met by hospitals and nurs-
ing homes wishing to obtain Medicaid and Medicare reimbursement.

Despite all this activity, on balance the Administration's regulatory crusade has met with more failure than success. Congressional opposition, public outcry, and court decisions have thwarted its efforts time and again.

One major defeat came in the Primary Care block grant. In the October 18, 1981 Federal Register, HHS published a list of 1,500 places no longer considered a medically underserved area (MUA). Because the funding for a community health center (CHC) is predicated on its MUA service, the "dedesignations" would have terminated Federal funding of approximately 85 CHC's. HHS based its decision on faulty analysis of old census data; according to its calculations, parts of Harlem in New York and Watts and East Oakland in California—impoverished communities with high infant mortality rates and few physicians—were no longer medically underserved. Congressional complaints and appeals from affected community health centers and the threatened communities themselves compelled HHS to back off. Of the 77 CHC's which appealed and submitted their own census data, 71 won their cases, only three lost, and the remainder are still under review.

HHS lost another round in its efforts to undermine CHC's last December when a Federal Court in the District of Columbia prohibited it from turning over administration of centers to two states under the Primary Care block grant. Congress joined in the CHC defense by attaching a rider to the "orphan" drug bill requiring HHS to issue separate regulations for the Primary Care block before putting the CHC's in state hands. Congress also, in the Tax Equity and Fiscal Responsibility Act of 1982, nullified HHS's Medically Needy regulations and prohibited it from promulgating changes in nursing home survey and certification requirements for several months.

Such setbacks haven't deterred Health and Human Services from its appointed deregulatory path. In what may be the most audacious move to date, HHS tried to scrap the rule which requires the publication of proposed regulations for public comment. The Washington Post headlined this initiative "Calls for Comment on Plans to Shrink Calls for Comments." The public did comment, vehemently and with rare unanimity. Every one of the 1,103 responses received from HHS program beneficiaries, advocacy groups, members of Congress, health care providers, labor unions, state attorneys generals, and others opposed the regulations.

As this storm of protest indicates, resistance to the Reagan regulatory reform attempts has been widespread. Americans may question why so many regulations are needed, but they generally believe government rules protect them. A majority of those surveyed in an August 1979 Gallup poll declared that although government health regulation may boost the cost of health care, "the benefits of regulations outweigh the drawbacks." Americans want their government to set nursing home standards, protect them from harmful drugs, and ensure that tax money is spent on programs which meet government purposes.

The Administration asserts that a competitive health system would obviate the need for oversight such as health planning and PSRO's, as well as reduce costs by making even the poorest more aware of what their health services cost. Currently, the argument goes, comprehensive first dollar health insurance coverage insulates patients from the economic consequences of their decision to seek medical care since they don't pay a penny for it outside of premiums. If they become more price conscious, says the pro-competition logic, consumers will shop around for the best, most economical insurance plan or service to meet their needs. Insurance companies, forced to compete for enrollees, will in turn pressure hospitals and physicians to organize and compete with one another.

To drop these dominoes into place, the Administration seeks several Federal policy changes. First, tax laws must be altered to require workers to pay income taxes on employer contributions to health insurance premiums above a specified level. Second, Medicare recipients should be given the option of dropping the program in return for a voucher or credit to buy private health insurance. Third, the spread of Health Maintenance Organizations (HMO's) and other groups of physicians and hospitals should be encouraged by easing Federal requirements.

As with the Administration's "New Federalism" and "regulatory reform" efforts, this "competition" strategy is limited to actions which serve ideological goals. For example, the Administration supports the rapidly increasing involvement of large for-profit corporations in health care even though their market share in many areas is already sufficient to inhibit competition. Nor has the conserva-
The Administration has been singularly unsuccessful in promoting its competition strategy. During 1982, a proposal in the Senate to cap tax-free benefits of employer paid health insurance and a Medicare voucher proposal in the House went nowhere in the face of bipartisan opposition. This year instead of a grandiose "competitive" plan the Administration has proposed limiting the tax exemption for employer-paid health insurance and establishing a voluntary Medicaid voucher system—but even this slimmed-down initiative is given little chance of passage by most analysts.

These setbacks are hardly surprising given that the competition strategy has no support from labor, the Chamber of Commerce, the health insurance lobby, senior citizen groups, or hospitals and physicians. In addition, even supporters of the competition philosophy concede that it would be many years before the Administration plans could curb health care cost inflation significantly. One of them, Senator Robert Dole (R-KN), spoke for most members of Congress last year when he declared, "We can't wait for long-term competition plans."[6]

The Administration has also been defeated, sometimes unexpectedly, in other competition initiatives. Two years ago the demise of health planning and PSRO's appeared imminent. Although weakened, both may survive. Last year, despite intensive provider lobbying, the Federal Trade Commission retained authority to oversee (i.e. regulate) physician and dental practices.

The only clear Reagan victories were in HMO deregulation and in giving the states more freedom to assign Medicaid contracts competitively and limit the freedom of Medicaid patients to choose their own doctors and hospitals.

Instead of competition, Congress turned to regulations. In passing TEFRA, the Federal government for the first time seriously tackled the issue of rate regulation and controlling hospital Medicare costs. Stricter controls on physician Medicare reimbursement may follow this year. (See Report from Washington in the previous Bulletin for more details—ed.)

Ironically, the Reagan Era may be marked by a significant increase in Federal control of the health care industry, the opposite of what the President sought. Moreover, during his first two years in office, Federal health programs suffered less financially than other programs for the poor such as food stamps, welfare, housing, and education. There was, it seems, no way the attempted revolution from above could overcome the deep support for a strong Federal role in the financing of health programs—especially Medicaid and Medicare—among the American people and their state and local representatives.

Even so, the Reagan Administration has weakened the Federal support system. Health care funding has been reduced at all levels of government; the nation's impoverished suffer the consequences. Under the Administration's aegis the for-profit health care sector has continued to grow at a phenomenal pace, consuming an ever-larger piece of the health care pie. Health care programs will remain vulnerable as long as there is no consensus on how to transform our chaotic mishmash of a system into a coherent program which guarantees equal access to quality care for all Americans. There is little likelihood of advances on the Federal level soon. National health insurance seems many years off.

In the intervening years, health advocates might look again at some of the Reagan agenda—not the part which says less is better, but the part which says that the responsibility for providing health care should be shared by state and local governments and the voluntary sector. In essence, while fighting Federal cuts we can seize opportunities at the state and county level.

The Federal government assumed the major burden of financing health care because the states and local government were unable and, in many cases, unwilling to do so. Nevertheless, even an activist Federal policy would leave space for important state initiatives. Existing laws in areas of state and local responsibility could dramatically improve health care if their intent were vigorously pursued and the relevant agencies adequately funded. For example, legislation requiring states or local governments to provide medical care for indigents is often vague or ignored. New state laws requiring employers to provide health insurance to all their employees would increase
access to care for millions of low-income and marginally-employed workers and their families.

The voluntary sector should also be pushed to assume a "fair share" of the responsibility for providing care to the poor. The growing body of evidence on the brutal consequences of the health cuts must be used in community efforts to increase charity or reduced cost care by hospitals and physicians.

Of course, despite Administration claims to the contrary, state and voluntary programs cannot take the place of a strong Federal commitment to ensuring equal access to quality health care. And this is what the American people want and have come to expect in time of need. Because they do, President Reagan's health care revolution is doomed to fail. The challenge is to create a new, rational, and compassionate system from the ruins he will leave behind.

1. President Ronald Reagan's Address on the State of the Nation's Economy, 1981.
13. Id.
21. Id.
32. Heise Kenan, " 'Dumping' the Poor at County Hospital," Chicago Tribune, Sept. 3, 1982.
36. Statement by Edward N. Brandt, Jr., M.D., Assistant Secretary for Health, Department of Health and Human Services Before the Subcommittee on Rural Development, Oversight and Investigations Committee on Agriculture, Nutrition and Forestry, U.S. Senate, March 14, 1983.
**Help Wanted**

The National Health Law Program is looking for an experienced Medicaid/health care reform advocate. Prior employment as an attorney at a local legal services office is preferable but not required. The opening is in Los Angeles, but applicant preference for the D.C. office will be considered. Salary is $25-$40 thousand, commensurate with training and experience. For further information, write Sylvia Drew Ivie, Executive Director, National Health Law Program, 2639 S. La Cienega Blvd., Los Angeles CA 90034.

**Planning Ahead**

Cornell University’s Department of City and Regional Planning will hold its fourth Progressive Planning Summer Program June 6-August 5. Most of the academic courses and shorter institutes will be concentrated in June, when there will also be evening lectures and social events. Courses include National Planning and Industrial Policy (Howard Wachtel), Neighborhood Housing Strategies (Chester Hartman), and Rural Planning Issues (Charles Geisler and Mark Lapping). Tuition is $700 for courses, $150-$375 for the institutes. Some partial aid is available. For more information, contact Pierre Clavel or Lynn Coffey, Dept. of City and Regional Planning, 201 West Sibley Hall, Cornell University, Ithaca, NY 14853.

**Creeping Reaganism**

The National Health Law Program (NHeLP) has published a concise summary of the Administration’s 1984 health budget. It’s title is *Hard Facts*, an apt description of the contents. A $3 contribution will help defray costs, including postage and handling. Write to the National Health Law Program, 2639 La Cienega Blvd., Los Angeles, CA 90034.

**The In Crowd**

If you want to know what's left of the health left, the best place to find out is the Inventory of Progressive Health Organizations. More than 50 organizations which participated in the first national meeting in 1981 are profiled. Copies are $6.50 from Health/PAC, 17 Murray St., New York, NY 10007.

**Better Living Through Activism**

The innovative City of Toronto Department of Public Health has just published a 60-page booklet entitled “Our Chemical Society: A Manual for Action.” The focus is on identifying ways in which individuals and groups can participate in efforts to control the use and disposal of toxic chemicals from cigarettes to PCB’s. Copies are $4 (checks payable to the Treasurer, City of Toronto) from the Health Promotion & Advocacy Section, Toronto Department of Public Health, 7th Floor, East Tower, City Hall, Toronto, Ontario, Canada M5H 2N2.

**Ninety Miles To Another World**


The Conference will focus on developing a multi-disciplinary approach for achieving the WHO goal of “Health for All in the Year 2000;” on understanding the development, structure and functioning of the Cuban health care system and the health status of the Cuban people; on understanding Cuba’s role in contributing to higher health levels among Third World peoples; and on exchanging information and experiences on the organization and delivery of primary care services. Participants are coming from over 100 countries.

For a full conference brochure or further information contact:
Robert Guild, Program Director, Marazul Tours, 250 West 57th Street, New York, New York 10107.
Maggie Kuhn:
"All of us are in this together."

The Polish Veterans Hall is two flights up from one of downtown Montreal's chic new pedestrian malls lined with expensive restaurants and boutiques. The hall, however, is a barren stage looking out on a worn dance floor and a balcony scattered with park benches and folding chairs.

Filled with some 400 health activists from around the United States and Canada gathered for the American Public Health Association's annual convention, it resembles the Pennsylvania wedding scene in The Deer Hunter. Many in the audience comment that such a setting is a perfect antidote to the sterility of the modern convention halls of the conference. Attractive or not, its modesty recalls the broom-closet beginnings of the Gray Panthers, whose National Convener and co-founder is this evening's guest of honor.

Maggie Kuhn arrives accompanied by a small entourage of younger Gray Panthers, who surround her like bodyguards. She climbs the stairs to the hall carefully, pausing at each step, but in continuous conversation with those around her. She graciously accepts the long stem rose offered her and the other Gray Panthers and gives me a kiss and a compliment.

Her party takes its place in the buffet line and then brings dinner up another flight to the balcony, where she asks her younger companions to "bring me interesting people to meet." For the next hour she holds a salon-like audience with a stream of old friends and new acquaintances. She then joins about 15 other Gray Panthers on stage.

They receive a long standing ovation. She leads everyone in We Shall Overcome. The audience responds with the Internationale. In a brief speech Maggie's crisp, tart voice stirs the audience until it eagerly accepts her instruction in the Gray Panther growl.

"Health has always been one of the Gray Panther's major issues," she tells me later, launching into an interview before I can ask a question or turn on the microphone. "We have continued it, and we've related it to the international scene, to the spread of multinational corporate power to the Third World, to the environmental destruction that has been part of a greedy, profit-centered system, and also the reforms of nursing homes and the organization of patients rights committees. Our newest priorities are housing and Social Security. We consider the Number One public health problem to be the arms race and the real and present danger of nuclear destruction. Related to that is the prospect of widespread radiation damage because of the nuclear weaponry that we're building and the way in which we have put our hopes for energy into nuclear power plants.

"A lot of people criticize us for not being a single issue group the way many are," she acknowledged. "That's a hazard, but it also suits our style because we believe in coalitions. We believe in networks. We've chosen the Gray Panthers to maximize the network—we call our publication the Network. We call the chairs of our local groups 'convenors.' People will say, 'What's a convenor? Who's in charge?' And we say, 'The convenor is the person who brings people together.' That, in a sense, epitomizes what we are trying to do. We believe in getting people together who have been working independently and fighting turf wars, wasting a lot of time and energy in those competitive battles. Now is the time to come together.

"We've forged a coalition of young people and old people because they are caught in the same ageist society. It's just as hard to grow up as it is to grow old. What we've identified in many groups are the commonalities that old and young people have. We realize how much we need each other and how much rigid age segregation leads to age alienation. We realize what that has done to the society as a whole—divided it and increased the conflict between generations and the fear of old people by the
young and the fear of young people by the old."

A division, I suggest, which seems to be exploited like those between black and white and between men and women.

"It is exploited," she responds energetically. "It also diminishes the impact and socialization and opportunities that the old and the young would have to work together if they could get together."

Perhaps, I wondered aloud, in part because of the way our lives have become so mobile. People don't live and grow up in the same place with their parents and grandparents.

"I think it's mobility," she says. "It's super­technology that has made many of the skills that older people have obsolete and obsolescent. Even in a relatively short time, it has contributed to the waste and downgrading of historical perspective and of human experience."

I comment that often my generation doesn't seem to have much interest in history because it's not seen as relevant to the present or future; certainly many have talked about the Old Left and the New Left and how they couldn't talk to each other.

"Well," she answers, "I feel that in forging our coalition between and among different age groups we put together the New Left and the Old Left. There's a difference in life styles. There's a difference in leadership style that we're just beginning to perceive and deal with. A more controlling, autocratic style of leadership, in many ways, characterized the Old Left—but it was necessary, you know, to have that kind of vigorous, male leadership. But with the women's movement and the large numbers of women who are now in the labor force and in social groups of different kinds that have social and political impact, the more consensus, egalitarian leadership style is just beginning to emerge.

"I believe that in coalition-building we'll have to come to grips with new styles of leadership. It's very hard to bring people together who have come from different parts of the human enterprise. But when they are together and have discovered a common goal, a new kind of humanness enables them to work together. Most of the older Gray Panthers have their roots in the Old Left, and in the peace movement."

Margaret E. Kuhn herself is part of that majority. She was born in 1905 in Buffalo, although at the time her family was living in Memphis. Her mother delivered Maggie in the front bedroom of her own mother's house because she did not want her baby born in the segregated South. Maggie's aunt, a secretary and suffragette, lived with their family after her husband died; she taught her niece to read and served as a role model. Their household also included her younger brother and their great and great, great aunts; a four generation family. Maggie's father worked his way up from office boy in the Bradstreet Company, a credit agency that later merged with its chief competitor to form Dun and Bradstreet. He managed branch offices in Buffalo, Memphis, Louisville, and finally Cleveland, where Maggie grew up and graduated from the College for Women of Case-Western Reserve. There she began writing and helped organize the college chapter of both the League of Women Voters and the Young Socialists League. Her first post-graduation job was with the YWCA, where she found political mentors organizing young women in poorly paid clerical jobs.

"The Young Women's Christian Association at that time was very radical," she tells me, "much more so than now, always stocked with socialists. It was a very powerful influence in my life. I had mentors there—some very gifted and courageous women who were doing some great things. I was really inspired. I was on the staff of two YWCA's locally and on the international staff of the YWCA in New York during World War II as head of publications in the USO division. That made me very sensitive to the whole military establishment. I've been blessed that there has been a certain reinforcement in different directions throughout my life. I'm privileged, really, that this happened."

From the YWCA she went to Boston to work with the Unitarian Church until 1948, when she began her 25 year association with the national staff of the United Presbyterian Church. This was the Church in which she had been raised and in which her parents had always been active.

Working out of Philadelphia, she wrote for and edited the church magazine, Social Progress (later the Journal of Church and Society). In the mid-50's she did a study on the costs of medical care for older people which stimulated her interest in health care and led to a confrontation with the medical establishment—the American Medical Association, the American Hospital Association, and Blue Cross. In 1961 she helped plan and then chaired the section on national agencies for the first White House Conference on Aging, a convocation which recommended what four years
later became Medicare. Her other work with the Church's national staff included civil rights, sexuality, race relations, women's rights, housing, and the problems of the aged.

In 1970, just before the Presbyterian Church applied its mandatory retirement rule to her, Maggie gathered five friends in a similar situation at the Interfaith Center in New York to found the Consultation of Older and Younger Adults for Social Change. During the weeks before her retirement Maggie took advantage of her secretary, duplicating machine, and basement broom closet-office in the old Witherspoon Building in Philadelphia to organize the group.

In 1972 when she was appearing on a New York TV talk show, the producer suggested that her fledgling organization be called the "Gray Panthers." The name stuck.

In 1973 the Gray Panthers merged with Ralph Nader's Retired Professional Action Group and added their projects on hearing aids and nursing homes legislation to the Panther's anti-war effort. Since then the Panthers have mushroomed into a 60,000 member organization with more than 120 decentralized networks in 40 states. Its concerns range far beyond the problems of ageism and aging which absorb most "senior citizen" groups to peace, housing, health, and Social Security. The Panther's major proposal for solving Social Security's financial deficit, for example, was full employment. To focus on specific issues, the Panthers have spawned a number of other coalitions and organizations, including the National Citizens' Coalition for Nursing Home Reform, the Pension Rights Center, the Older Women's League, and the Caucus and Center for the Black Aged.

I had read a comment of Maggie's that "the nicest thing about growing old is that you can speak your mind." When I tell her this, I add that as I was growing up I was often told, "When you get older you'll outgrow all your radical ideas, you'll know better"—a common belief in a society where most people portray aging as growing more conservative and reluctant to face change.

"There are a lot of very conservative old people who have made it," she responds, "or who have been broken by life and many disappointments and losses and have never been able to regroup on the basis of the larger public interest to transcend their own pain and to see that it's part of the whole human predicament.

"The tragedy that I experienced with my brother made me very sensitive to the whole mental health field," she continued. "My brother and my father could never agree, and I think it damaged my brother emotionally. He was a tragic person—they were both tragic in that my father couldn't appreciate his son. Sam was institutionalized, and it was most painful to see my father. He went every week to see Sam, to try and work it through, until the day Sam collapsed. I tried to help, but I couldn't. My feeling has been throughout my life that your own personal pain has to be put to some social use. We must use our personal pain for organizing.

"I think that a number of us in the Gray Panthers have had that same drive. It's one of our distinguishing characteristics. There's a commitment that the Gray Panthers have to social justice and different agendas, but the product and the goal are a just and peaceful society. In our best moments we have felt a movement that epitomizes that. One that brings together confluent streams of protest."

The day after the dinner in her honor Maggie participates in a panel on "Older People as Actors Rather than Acted Upon". She stands at the dais commenting on the papers that she has
HIGHLIGHTS OF GRAY PANTHER HEALTH ACTIONS: 1971-1983

1971 Gray Panthers in Philadelphia participate in an OEO-funded University of Pennsylvania Health Law Project nursing home patient organizing project. By 1972, the project operates in several nursing homes, and drafts a nursing home bill of rights.

1972 Elma Griesel of Ralph Nader’s Retired Professional Action Group (RPAG), begins a study of the hearing aid industry, with help from Gray Panthers in Baltimore, New York City, and Los Angeles. In 1973, the report *Paying Through the Ear* is released, and Griesel joins the Gray Panther staff.

1973 National and New York Gray Panthers sponsor an alternative health conference during the American Medical Association meeting in New York City. Health/PAC, the Medical Committee for Human Rights, and several unions take part; speakers include H. Jack Geiger, Maggie Kuhn, Marshall England, Elma Griesel, John Ehrenreich, Judy Wessler, and Lillian Roberts. A Gray Panther pamphlet “Toward a National Health Service” is prepared for the conference. Maggie Kuhn calls for a national health service in testimony before the Senate Committee on Aging subcommittee on health.

1974 Maggie Kuhn is keynote speaker at the Medical Committee for Human Rights annual meeting, and addresses the American Nurses Association on “Death and Dying—The Right to Live, The Right to Die.” At the AMA meetings in Chicago, 200 Gray Panthers picket and stage street theater. Maggie Kuhn attempts to read a joint Gray Panther-MCHR resolution before the AMA House of Delegates, but the microphone is taken from her.


1976 The Berkeley, California, Gray Panthers open the free Over 60 Health Clinic.

1977 The Dellums National Health Service Bill is introduced in Congress. The Gray Panthers invite Rep. Dellums to address their second convention, and endorse the bill. Gray Panther networks around the country begin to pressure for doctors to accept Medicare assignment. The Gray Panther convention passes a resolution calling upon the Department of...
Health, Education and Welfare to issue local listings of MD's who accept assignment.

With the National Senior Citizen Law Center representing them, the Gray Panthers bring a class action suit against HEW to allow administrative hearings for Medicare claims of less than $100.

1978 The San Francisco Gray Panthers protest the closing of the Post Street nursing home. Despite opposition from the Oregon and American Dental Associations, an Oregon Gray Panther statewide ballot measure wins permitting purchase of dentures from dental technicians.

1979 Rep. Thomas Downey introduces a Gray Panther bill to halt abuses in medigap (Medicare supplement) insurance.

1980 The Public Citizen Health Research Group publishes *Your Money or Your Health: A Senior Citizen's Guide to Avoiding High Changing Medicare Doctors*, with a forward by Maggie Kuhn, and assistance from Gray Panther Health Task Force chair Frances Klafter. Local Gray Panther campaigns follow, using the guide's methods for compiling directories of MD's who accept assignment.

New York Gray Panthers conduct an outreach campaign to older New Yorkers on prescription drug abuse.

1981 Frances Klafter testifies for the Gray Panthers and the Coalition for a National Health Service before the House Ways and Means subcommittee on health to oppose Medicare vouchers.

A Gray Panther position paper for the White House Conference on Aging reiterates support for the Dellums National Health Service bill, calls for continuing protest against physician refusal to accept Medicare assignment, demands improved nursing home care, and protests the Reagan Medicaid cuts.

1982 San Francisco Gray Panthers provide counseling on Medicare supplementary insurance plans.

The Gray Panthers endorse the Health Service Action Council HALT program calling for a price freeze on health services provided by doctors, hospitals and nursing homes.


1983 Gray Panthers locally and in Washington DC continue protests against proposals to restrict access to health care by cutting Medicare and Medicaid benefits.

Roger Sanjek
heard that afternoon, demonstrating her intelligence, wit, and comfort with detail, drawing out the common threads.

"We have made a fetish in America of independence," she tells the audience, "I have survived my entire family, and I suffer with arthritis. If I am not interdependent, I'm utterly dependent! We must use our personal pain to organize." She goes on to critique the "massively paternalistic" field of gerontology, complaining of gerontologists who have made careers studying aging and the elderly by "quite objectively removing themselves from the fact that they themselves are aging." As always, she emphasizes the growing awareness that aging is something that we all have in common, "all of us are in this together."

The papers on her panel, she notes, share a concern with "community diagnosis" recognition of the "universal needs" of housing and health. She points out that each examined "gerontophobia—the irrational fear of old people and growing old," and recommended intergenerational contacts and organizing.

She challenges "the pathology of the health care system," saying "to a large extent we have practiced health as a private, individualized affair—us and our symptoms. The privatizing of health care has removed patients from their societal networks and roles and settings, quite far from where we live and work. Individualized diagnosis and treatment have obscured the social conditions and structures in which human beings live and die."

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"To some degree," she tells me later, "I think there's a very strong thread of interest in ethics—social ethics—that goes back through the Gray Panthers' thinking. We have very different religious persuasions. We have a number of people who are Jewish with different degrees of commitment to the Jewish community. We have a number of young Jews who are very much interested in the radical Jewish left. They're marvelous people; they relate to the old Jewish socialists from Poland and Russia. And we've got a lot of Roman Catholics who are in and out of habit. Then there's some of us who have had seminary training and long term connections with some kinds of liberal Protestant faiths. But there's this common understanding of what the Lord requires of us. It's that sense of justice. . . , 'Thus saith the Lord.' You don't say it in the meeting, and we never pray, but maybe we should."

When I ask for an example of how the Gray Panthers mesh the Old and New Lefts, she grins and says, "We have fun. We have a lot of arguments—we're very strongminded people—but there's a certain kind of exuberance, too. We're good at guerrilla theatre. We've done some great stuff. The Boston and Twin Cities Gray Panthers and the Gray Panthers in the greater Chicago area were part of a free street theatre. This was built out of reminiscences of Old Lefties. The injustices they have worked against and all that stuff. You know, that's great. There's no substitute for it. And when you get people together, there's exuberance and excitement. There's a lot of energy. We've got two men on the Steering Committee who were with the Abraham Lincoln Brigade in Spain fighting fascism. You see what I mean?"

On the last morning of the convention Maggie Kuhn receives the Presidential Citation from the American Public Health Association. The theme of the convention is "Aging and Health: An International Perspective." Stanley Motel, the APHA president, notes that this award is presented only in cases of "unusual merit to persons who are not professionally engaged in public health practice." After listing her many accomplishments and awards, he describes her as having "an uncanny ability to deal with issues and causes which allow her to be critical of social injustice while remaining supportive of people." He attributes the success of the Gray Panthers to this quality.

When Maggie accepts her award, she first asks all the other Gray Panthers in the great
auditorium to stand and share in the applause. Then she calls upon all the Gray Panthers in spirit to stand. Soon she has everyone up.

Her acceptance speech is punctuated with the language of the social gospel and liberation theology, what she has called the "prophetic witness of the Church." She expresses both her outrage and her delight. "In truth," she tells her audience, "there is an overriding public health issue before us all—disarmament in a world just one bomb blast away from annihilation. Disarmament and ending the arms race requires the efforts of us all, young and old." As she continues, her voice sharpens, and the acceptance speech takes on the character of a sermon, rich in hell-fire and radical faith:

"It is important now to take stock of the historical perspective that we all enjoy and give a new kind of commitment to whistle-blowing on that powerful interlock of private interests in health: the private insurance industry, including the two Blues; the multinational pharmaceutical houses, those pushers of Valium and Thorazine; the manufacturers of medical supplies and hospital equipment; and the American Medical Association. We spend more than any other Western country for private medicine, and yet the chronic cripplers that afflict us later-life bloomers have not been attacked very successfully. Arthritis, gout, lupus, emphysema still defy even amelioration. Some of the side effects of drugs for arthritis are almost as bad as the pain. I speak out of experience."

The litany continues: abuse of pesticides, industrial pollution, the nuclear arms race, withdrawals from Social Security, the soaring costs and declining service of "our present competitive profit-centered health system."

She calls for a "radical critique of health for profit" and collaboration between consumers and public health professionals, "so that our society, our sick society, might indeed be healed." For this she prescribes mass education, mobilizing outrage, alternative approaches, new awareness, applied research—the time-honored solutions. She calls upon her audience to join the "International Giraffe Appreciation Society" which "honors those who stick their necks out."

Moments later she teaches the entire APHA the Gray Panther growl. With this ritual cheer she leads an audience of sedate professionals into their first act of sticking their necks—and tongues—out. Maggie Kuhn's optimism—more accurately, she might say, "hope" or a radical's faith—is infectious. For a moment her vigor and determination make everyone in the ballroom feel young.

After the presidential gavel has been passed and the new president officially calls the convention to a close, Maggie is surrounded by a crowd of well-wishers and friends. She makes a luncheon date and arrangements for returning to her hotel and the airport, while a young Philadelphia Gray Panther passes the responsibility of her care on to me.

I ask her if there are senior citizen groups that represent a traditional conservative perspective. She nods vigorously. "Yes, there's a new group that is really dangerous. They are Reagan's favorite people, the National Alliance of Senior Citizens. It was organized by a young, ultraright Republican who Reagan nominated as one of the delegates to the World Assembly on Aging—Klingscables. He has written terrible things about the Gray Panthers. He published a four page diatribe in their journal about our 'Communist leanings.' So there are people on the Right and in the Republican Party, and we just can't be bothered to worry about them.

"We're not going to be a huge movement," she continued, "I think that it would be counterproductive if we had millions and millions. We'd have a hell of a time getting consensus. Our meetings would be spent trying to bring all those people aboard. Our groups have a core of 20, 30, 40, 50 people who are absolutely of one mind—not in detail but in a general goal. And they don't need persuasion. You don't need a seminar on Reaganism or Reagonomics, they know it!"

I comment that there's a certain irony in our current president being the oldest we have ever had.

"But it's social class that sets him apart," she responds. "He's old and rich!"

"Of course," I say, "we don't call heads of major corporations who are 75 or 80 'senior citizens.' "

"The class differences are so immense," she adds, "when you look at the people who come to one of the senior centers or the nutrition sites or who are homebound and on the receiving end of different kinds of home services compared to the rich and powerful people who are still on boards."

Our talk ends abruptly as we realize that she is due back at her hotel for her luncheon date. She invites me to come along. With six of us in
the hotel restaurant, she neither dominates nor withdraws from a conversation that reviews the events of the convention, the plight of nurse practitioners, the crime of Medigap insurance, the ethical dilemmas of grantspersonship, and the exodus of non-profit employers from the Social Security system. Maggie demonstrates a knowledge of detail and curiosity that one does not expect of a public figure and seems to be learning much more than she is teaching.

After lunch she joins a friend for an afternoon of shopping before catching her flight back to Philadelphia for a brief stop at home. She is especially excited because there is a newborn baby there, adding still another generation to her multi-generational shared living arrangement. We take a taxi with two other friends on their way to Philadelphia. They inform the cab driver that his fare includes an American celebrity. “I only carry winners,” rejoins the cabbie. He then explains why the Canadian health system is superior to the American, concluding with a disquisition on how to extort uppers and downers from your local G.P.

At the airport we get separated at the ticket counter. The others disappear through Customs without saying goodbye. When I get to the gate, the waiting area is filled with familiar faces from the convention, all heading back to New York. It’s standing room only. The flight is called, and a long line forms to board. From behind me someone calls my name. When I turn, Maggie Kuhn reaches up to hug me saying, “I just wanted to say goodbye.” Thus my three days in Montreal with her ended as they had begun, with a kiss and a compliment.

Hal Strelnick

(Hal Strelnick teaches in the Social Medicine program at Montefiore Hospital in the Bronx and is a member of the Health/PAC Board.)

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**Bulletin Board**

**Rx for Change**

Nurses’ Network, an independent organization of nurses, and Tamerik Productions need help in producing a video documentary on nursing.

Their project:
The predicament of nursing today is both a symptom and a part cause of the continuing American health care crisis. Ninety-eight percent of nurses are women; they suffer all the traditional ills associated with a female occupation—chronic underpayment, especially in proportion to the skills and responsibility involved; long hours, unhealthy rotations and working conditions; inadequate child care; lack of recognition and input; and a low rate of unionization. Nursing faces many complex issues and challenges, not the least of which is motivating nurses themselves both to understand the issues affecting them better and to play a more aggressive role in promoting change. Through the testimony of nurses the documentary will try to further these aims while increasing public awareness of the true nature of nursing and its problems.

Twenty-five hours of footage have been shot.

Research is continuing. Funds are still needed for further taping and editing. Inquiries, suggestions, and contributions may be sent to Nurses Network, c/o Health/PAC, 17 Murray St., New York, NY 10007, or Tamerik Productions, 237 Second St., Jersey City, NJ 07302.

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**Paper Chase**

The Association for Faculty in the Medical Humanities, a section of the Society for Health and Human Values, is planning a conference to be held during the annual meeting of the Association for American Medical Colleges, November 5 - 7, 1983, in Washington D.C. Papers with a maximum reading time of 20 minutes on any topic relating health care and traditional concerns of the Humanities will be considered. The papers will receive blind review, so the author’s name should appear only on a cover page. The deadline for receipt of essays is July 1, 1983. Five copies should be sent to Peter C. Williams, J.D., Ph.D., Department of Community & Preventive Medicine, Health Sciences Center, Stony Brook, N.Y., 11794.
A Brush – Up
On Teeth
by Arthur A. Levin

Periodontics, which concentrates on treating gum disease and related tissue diseases with deep curettage and surgery.

Endodontics is treatment of disease affecting the inside of the tooth, pulp, and nerves. Root canal work is one example.

Orthodontics takes care of teeth that are out of position and other oral defects. Children with braces know such specialists all too well.

Pedodontics is a general dentistry for children.

Oral Surgery is concerned with extraction. While many generalists do simple extraction, complicated or extensive surgery will most likely be referred to a specialist. Oral surgeons have more experience with inhaled and intravenous anesthesia, and therefore are deemed better able to avoid or treat any anesthetic complications.

Oral Pathology involves diagnosis and treatment of diseases of the oral cavity, including malignancies.

With the exceptions of oral pathology work and orthodontics, most generalists can probably do much of what the specialist can. Whether they do it as well is a matter of debate within the profession. There is evidence in medical literature that greater experience and exposure to cases and procedures often produces better results.

To their credit, dentists have long practiced preventive care through educating their patients about the dangers of sugar and the need to brush and floss effectively as well as by providing dental hygiene services. In this respect they are different from physicians, who have traditionally been less concerned with prevention and education than with invasive, curative approaches.

Dentistry as a profession differs from medicine in other ways as well, although many people believe that the educational requirements are equally rigorous. Unlike medicine, for example, it remains a generalists' profession, although there has been an increasing trend towards specialization over the past decade. As in medicine, specialists are required to complete at least two years of training beyond the basic four year course. The specialty areas include:

Pedodontics, which concentrates on treating gum disease and related tissue diseases with deep curettage and surgery.

Endodontics is treatment of disease affecting the inside of the tooth, pulp, and nerves. Root canal work is one example.

Orthodontics takes care of teeth that are out of position and other oral defects. Children with braces know such specialists all too well.

Pedodontics a general dentistry for children.
tional areas of poor quality den-
tistry that could benefit from
health care, particularly brush-
ing and flossing tech-
niques.

- Does not discuss treatment
  plans and fees in advance.
- Does not use a lead apron
  when taking x-rays to
  shield reproductive or-
gans and does full mouth
  x-rays frequently (see the
  Body English column in
  the May/June 1982 Bul-
  letin for a more detailed
discussion of this.)

- Does not have the nec-
  essary equipment to treat
  you for an allergic reaction
to anesthesia.

- Does not appear to realize
  your mind is in the same
  head as your teeth and
  mouth. The practitioner
  should answer all your
  questions, fully describe
  the treatment plan, and
  discuss the pros and cons
  of options based on your
  individual needs, re-
  sources, and preferences.

No list can be complete,
nor can it assure quality
care. Choosing a good den-
tist is not an easy task and will
most likely involve some trial
and error. Many of the above
practices can be checked
during a first visit. If your
judgement is that the care
you are getting is not what it
should be, or unnecessary,
it's time to change dentists.

Because the number of prac-
titioners is growing much
faster than the number of pa-

- Does not provide instruc-
tion in good preventive

Arthur A. Levin is a member
of the Health/PAC Board
and Director of the Center
for Medical Consumers,
publisher of the newsletter
Healthfacts.

The Social Transformation of American Medicine has received ecstatic reviews from a broad spectrum of health academics. Jack Geiger, a noted critic of the health care system, wrote in the New York Times that if you read only one book on American medicine it should be this one.

Such praise is deserved if one reads the book as a factual account of the development of the health care system. But Starr has set himself a higher task, that of explaining the reasons for the transformation of medicine from a cottage industry of many healers from different social classes into a system dominated by an elite group, physicians.

In this latter effort the book is unsatisfactory and somewhat misleading. Furthermore, Starr ignores the consequences of the system of physician dominance and its impact on quality of and access to health care; his concern about the enormous financial cost arises primarily in the context of the threat this poses to continued physician control. Indeed, the most negative statement in the book about the current health care system is a quote from Fortune Magazine.

On the historical level, the book is almost encyclopedic in its breadth of detail about doctors and their rise to power in the United States. Similarly, there is sufficient information about the health care delivery system to recommend the volume to novice students of health care and others interested in learning something about this service sector that currently consumes 10% of our GNP.

The book is divided into two parts (later to be published as two books for the paperback market). The first describes the birth of medicine as a dominant profession; the second analyzes emergence of bureaucratic and corporate structures encompassing both medicine and its various workplaces and the financial systems for payment.

In Part I, physician control is seen as a response to "...forces that transformed medicine into an authoritative profession [involving] both its internal development and broader changes in economic life. ...At the same time there were profound changes in Americans' way of life and forms of consciousness that made them more dependent upon professional authority and more willing to accept it as legitimate." (Page 18). ...[It is] authority that inheres in the status of physician because it has been institutionalized in a system of standardized education and licensing."

Starr argues that consumer acceptance of this mode of control is a natural consequence of the dependency engendered by the development of scientific medicine, although public perceptions were generally greater than the science available to physicians.

Chapters two through four explain how this control was solidified as American society emerged from the Jacksonian era, in which every individual was assumed to have the ability to provide health care, and at the turn of the century entered the Progressive era, when specialized technical knowledge and authority became linked to a specific group (in this case physicians) identified as expert through shared experience in education, socialization and membership. Justification for these new professionals was provided by the "Progressives" who believed that "science provided the means of moral as well as political reform and who saw in the professions a new and more advanced basis of order."

According to Starr, "[T]he growth of medical authority was related more to the success of science in revolutionizing other aspects of medicine and the growing recognition of the inadequacy of the unaided and uneducated senses in understanding the world." In this context of physician dominance and a perceived scientism in medicine, hospitals replaced the home as the focal point of health care. Public reliance on physicians' services increased as physicians became more accessible through developments such as growth of public transportation and private automobiles, increased urbanization, and geographic mobility. Traditional forms of medical practice, including those offered by peddlers of patent medicines, homeopaths, and lay and faith healers, lost most of their earlier legitimacy and often even their legal status.
With physicians in control, the next step was to minimize the degrees of variance among M.D.'s. In the 19th century, physician training ranged from education of an elite group in Europe in current scientific knowledge to a rudimentary formal education obtained primarily in apprenticeships to physicians. Those in the latter group might also spend some months in one of the many hundreds of proprietary medical schools. Most of these institutions lacked even the most rudimentary laboratory equipment; their clinical staffs varied widely in knowledge, ability, and commitment to education.

Starr's analysis of the educational changes runs something like this: a lot of well meaning people, mostly physicians, had a lot of trouble in the pre-scientific era deciding what good medicine was; as the science got better the best doctors by sheer force of talent won the right to decide that about 10 years after high school was a goodly amount of time to complete the requirements for becoming a doctor; that this limited the profession to a wealthy strata able to afford the direct and indirect financial costs was inevitable but not intentional.

Once physicians established their power base as the group who would determine the shape of medical care services, they set out to control and limit the influence of public health professionals, pharmaceutical companies, hospitals, government agencies, and supporters of health insurance—that is, of any group or institution that might threaten physician control and thus income.

Part II of the book describes the growth of the modern health care system, including major teaching institutions and hospitals, and the development of private health insurance and governmental programs. In the section entitled "The Triumph of Accommodation," the author describes the uneasy equilibrium between physicians, private insurers, and Social Security. "The Liberal Years" details the expansion of public programs and their redistributive effect, and is followed by an examination of the crisis in financing them in "End of a Mandate." The book closes with a good account of the rise of profit-making health care enterprises.

Starr distinguishes five separate dimensions, each of which contributes to corporatization of health care in a different degree:

(1) Change in ownership from public and voluntary to profit-making;
(2) Horizontal integration and the rise of multi-institutional systems;
(3) Diversification and corporate restructuring, leading to conglomerates under a holding corporation;
(4) Vertical integration - the shift from the single-level-of-care organization, such as a hospital or clinic, to comprehensive care organizations such as health maintenance organizations (HMO's);
(5) Concentration of ownership of health facilities.

In contrast with his excellent historical account, Starr's analysis of the rise of physician dominance contains substantial weaknesses. Although he expressly recognizes the relevance of political economy, historical process, and institutional development to an understanding of the particular development of the health care system in the United States and offers considerable relevant information, he treats the development of physician hegemony as an inevitable historical process even while acknowledging that it was not.

For Starr, first and foremost, the rise of the profession was the "outcome of a struggle for cultural authority as well as for social mobility," an evolutionary process which in his formulation implicitly approaches a theory of political natural selection in which the inherently superior, namely professional groups, prevail. It seems as if Starr has studied the profession so long that he has unconsciously become its champion.

Translated into plain English, the "cultural authority" of physicians, which Starr defines as "the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true," means that the public accepted the adage "Doctor knows best!" But as even champions of current medicine such as Lewis Thomas admit, in the crucial time period of the rise of physician dominance, 1900-1924, doctors knew little more about healing than in the 19th century. In this stage of scientific development, the diagnostic abilities of doctors had vastly improved but their ability to cure had not yet progressed. Starr never explains why the cultural authority of doctors was established at a time when their expertise lagged so far behind public perception.

On the contrary, he argues that the dominance of the profession arose directly from scientific developments in medicine and the public's growing faith in the potential of science. Medical doctors became the high priests of scientific health care just at a time when science and technology were replacing...
the church and the family as the cultural and social bases of society.

Science did open the way for public acceptance of physician authority, but Starr downplays or ignores political and economic factors that encouraged scientism and its cultural ascendency. Science and technology were the magic path to the new world of industrial capitalism the United States was bounding into at the beginning of the twentieth century. It is not surprising that this political economy fostered a culture in which medical practitioners with years of formal training commanded an authority not deserved then, if it is now.

Further, Starr downplays the relationship of this scientific transformation to the immediate interests of capital. He dismisses E. Richard Brown’s *Rockefeller Medicine Men* as simplistic Marxism and factually incorrect in arguing that capitalism encouraged an emphasis on medical care of the sick rather than public health and prevention.

Starr is right that the early “philanthropists” contributed to both aspects of health; the question is where they put the major part of their contributions. Starr ignores Brown’s documentation of the massive absenteeism that plagued industry in the early part of this century, but even so ends up affirming Brown’s basic thesis, that capitalism supported scientific research, medical education, and hospital construction to create a healthier work force.

This is a rare concession. Starr is a firm believer that cultural authority precedes economic and political power. In discussing the change in the control of the distribution of drugs—from manufacturer directly to consumer into manufacturer-doctor-consumer, for example, Starr asserts that “Once again, cultural authority was being converted into economic power and effective political organization.”

By the postwar era, Starr says, the cultural authority of medical interest groups had been transformed into a political and economic control structure in which their wealth and power were sufficient to deny any reform movements for national health insurance. In material resources alone, the American Medical Association spent $2.25 million in 1950 to combat a national insurance program; the chief proponent, the Committee for the Nation’s Health, spent $36,000. “During that period,” Starr notes, “the AMA also offered businessmen the opportunity to join in sponsoring advertisements denouncing compulsory health insurance. Companies paid over $2 million for this privilege.”

During a two week period in October of that year, wrote Monty Poen as quoted by Starr, “every bone fide weekly and daily newspaper in the United States (10,033 in all) carried a five-column-wide, fourteen-inch-deep ad from the AMA or from one of its business allies decrying the enemies of free enterprise, while 1600 radio stations broadcast spot announcements and 35 magazines carried similar advertisements.”

Starr sees this material advantage as “itself only a reflection of the ample *social foundations* of the opposition’s strength” (emphasis added). Cultural and social organization are the foundation or substructure; financial and economic strength are relegated to superstructure. The engine that drives the wheel of social change is cultural hegemony.

Starr’s almost exclusive focus on professional authority is particularly evident in his last chapter, in which he warns against the “Coming of the Corporation”—that is, the control of health care by private, profitmaking corporate conglomerates. The entire focus of this chapter, thirty pages in length, is on the impact of corporate dominance on physician “autonomy.” Only one paragraph expresses concern that “a corporate sector in health care is also likely to aggravate inequalities in access to health care.”

Starr’s vision of the health care system of the future is bleak. “Instead of public regulation, there will be private regulation, and instead of public planning there will be corporate planning. Instead of public financing for prepaid plans that will be managed by the subscribers’ chosen representatives, there will be corporate financing for private plans controlled by conglomerates whose interests will be determined by the rate of return on investments.” But ever the optimistic liberal, Starr concludes, “Perhaps this picture of the future of medical care will also prove to be a caricature. Whether it does depends on choices that Americans have still to make.”

*The Social Transformation of American Medicine* does not suggest how the American people will understand they have a choice to make, any more than they understood there were alternatives to physician sovereignty. Nor does it explain how they will be able to exercise choice in the face of new forms of cultural authority, let alone the economic and political power of the corporate sector that Starr docu-
ments. Starr’s assertion that the choice will be made by “Americans” assumes a model of decision-making in which every citizen has an equal voice, a model which has no relation to the reality of political power.

The beauty of such Panglossian sociology is that it affirms not only that we live in the best of all possible worlds, but that we have chosen to do so democratically. It is easy to imagine that if Paul Starr’s disturbing picture of a corporatized health system becomes a reality, he might add a chapter in thirty years explaining why this too was inevitable and right. There is a conspicuous failure to suggest what our alternatives to this or the status quo are, or how a more humane, patient-oriented system providing superior care at reasonable cost might be achieved.

If this were a more traditional sociological study of the structure of the medical profession, one might not expect so much of its author. But he has aspired to broader questions, asking “what explains the forms of medical practice, hospitals, private health plans, and public programs that emerged in America out of the diverse possibilities that were historically available.” He has not answered his own question. The cultural authority of physicians is an insufficient base on which to build an understanding of the present system.

Louanne Kennedy

(Louanne Kennedy teaches in the Health Care Administration department at Baruch College, CUNY, and is a member of the Health/PAC Board.)