Editorial...

THE GREAT LEAP SIDEWAYS


In fact, however, there are not one, but two health crises. The crisis felt by the users of medical services is the failure of the present system to deliver adequate health care, at any price. Black and Puerto Rican community groups are demanding community control over health institutions which they perceive to be wholly unaccountable to the people they serve and wholly irresponsible to the pressing health needs of the community. Medical care, they say, is fragmented, and is isolated from the social, economic, and environmental causes of pathology. Furthermore, they maintain: People are experimented on and used as teaching material. The doctor's priorities come first. And the patient's needs run a poor second.

Increasingly the middle class is beginning to raise many of the same questions, led on by soaring costs, long waits in overcrowded doctors' waiting rooms, and the growing awareness that despite the wonders of heart transplants, it is increasingly difficult to find a doctor to treat ordinary ills.

Those who provide and pay for health care face a different crisis—the breakdown of the old systems of financing. The hospitals find themselves near collapse as costs skyrocket and financing fails to keep up. This threatens not only the institutions themselves, but also the multi-billion dollar drug and hospital supply companies who depend on the hospitals as a retail outlet for their products. At the same time that the hospitals weep because of "inadequate" funds, the providers of funds groan under the weight of the hospitals. Blue Cross is forced to raise its rates and face its enraged subscribers. The trade unions find themselves allocating an ever-increasing portion of wage hikes merely to maintain their present level of health benefits. Employee health plans cut an ever bigger bite out of corporate profits. Even the government feels the pinch as Medicare and Medicaid costs knock the budget for a loop.

Since the providers and financiers of medical care feel only part of the crisis—the part concerning the financing of medical care—it is little wonder that their solution to the "crisis" concerns only that. The various plans for health insurance proposed by such various groups and figures as the AMA, Walter Reuther, the AFL-CIO, Nelson Rockefeller, Blue Cross President Walter McNerney, the American Hospital Association, and Senators Javits and Kennedy are all simply programs to put the financing of medical care on a more sound basis. The issues which are debated—coverage, benefits, sources of financing, administrative mechanisms, etc.—all attempt to answer the question of how to finance existing health services. None of the proposals confront more basic issues of the organization of delivery systems, the relationship between the providers and recipients of care, power in the health delivery system or priorities in the system. A few plans (e.g., Reuther, the AFL-CIO, Kennedy) are filled with the rhetoric of reorganization. But on closer examination, the

Passing The Buck

- National Health Insurance is everybody's solution to the ever escalating health crisis. What will it do for the health establishment? What will it do for the consumers? [See "American Dream or Scheme?" Page 3.]
- It's no surprise that hospital costs are still escalating. Who's responsible? [See "Prices," Page 7.]
- A new Health Services Administrator and some tricky maneuvering with the Ghetto Medical Bill top the City news. [See "On The Job," Page 10.]

kinds of reorganization proposed (e.g., capitation payments for doctors, prepaid group practice) appear to be motivated more by the money-saving possibilities of these reorganizations than by their implications for patient care. National Health Insurance, to be sure, may well be a useful reform for many Americans. It may help a few people pay for medical services which they would otherwise not get. It may shore up a few hospitals in low income areas whose total collapse would be a tragedy for the people of the community. It is hard to oppose a measure

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which, in however limited a way, may help a few people, at least, to have greater access to badly needed health services. But National Health Insurance (1) won't work, and (2) will have regressive effects as well as progressive ones.

The problem is that National Health Insurance will be a mechanism to funnel money out of the pockets of workers and taxpayers into the hands of the people who now run (and mis-run) the health service delivery system—the doctors, the hospital administrators, and the medical industrial complex which fattens off people's illnesses. It will thus strengthen those forces that insist that all health care must center on the doctor and the hospital, rather than the forces who wish to totally reorganize the delivery of health care.

At the same time National Health Insurance will throw a cloud over what is really happening. To liberals, for whom National Health Insurance has long been a goal, it will appear that the problems of the medical system are being solved. Middle class doubts as to the organization of care may quiet down temporarily if part of the bill is paid by someone else. An aura of good will and liberalism will surround President Nixon. The accelerating movement for more fundamental reorganization of the medical care system will be de-fused, at least for awhile.

At the same time, National Health Insurance will solve nothing. First, it is unlikely that any of the proposed plans will be very effective in meeting people's health needs. For this we have the evidence of Medicaid and Medicare. Medicaid, for example, clearly showed that giving the poor an unlimited credit card for medical service did not end the two class system of medicine. There are other stumbling blocks: institutional inaccessibility, the relation between doctor and patient, the control by the doctors of priorities for allocating funds, time and equipment among research, teaching, and patient care, and the unaccountability of the hospital to the medical needs of the community. Medical care is sold in a monopolistic, not a free, market place. The effect of National Health Insurance, as with Medicaid and Medicare, may well be a sizeable number of individuals who are enabled to pay for better care. But it will not alter the existence and accessibility of high quality medical facilities for the great majority of poor and middle class people.

Second, the hopes of some of the insurance plan advocates that the medical care system can be reorganized through incentives linked to the insurance scheme's repayment system will almost certainly be dashed. For example, one plan has proposed giving hospitals incentives to operate efficiently. This might save money, but at best, it would have no effect on the patterns of care in the institutions, on the relations of the institution to the community, on the quality of care, etc. In fact, unless very stringent controls by the community were introduced, the likely result would be that the hospital would cut down on service in order to save money and pick up its incentive reward. For another thing, economic incentives can at best only conquer economic obstacles to change. They have no power over the other pillars of the two class medical system, for example, economic incentives may encourage a hospital to be more economical, but they are unlikely to persuade a hospital to accept community control, or to convince $50,000 a year doctors to put care of the indigent ahead of prestigious research. Finally, incentives are slow. We can't wait 20 or 30 years just to get doctors into group practices.

The third way in which National Health Insurance will fail will be economically. We have seen in the past few years how Medicaid and Medicare fed galloping medical inflation. The mechanisms are clear: The medical establishment which commanded the use of the funds used them for their own priorities—prestigious and expensive and "interesting" medical technology and high salaries for doctors and administrators. As a result, costs soared, while patient care improved only slightly, if at all. There is no reason to think the same thing would not be repeated under National Health Insurance. No workable cost control law has yet been devised, and, in any case, the impulse of hospital administrators is to cut costs at the expense of patients and hospital workers. It is entirely conceivable that in 1975, under National Health Insurance, the nation will be spending $50 billion a year instead of the present $60 billion for health services, and $200 a day for a hospital bed, without any significant improvement in the quality of care and without any significant increase in access to quality care for the average citizen.

National Health Insurance will fail because it fails to face the fundamental questions about our health system—control, accountability, accessibility, priorities, responsibility to the community. And it fails this test precisely because it is national health insurance. Under an insurance mechanism, no matter how liberal, the private delivery system performs a certain service and the public funding (insurance) system pays for it. The public insurers may try to persuade the controllers of the private delivery system to change the system, but no attempt is made to take the power to control away from them. The key issues about the health system are thus removed from the discussion, right from the start. To this dead end, we can only propose the fundamental alternative: The only way to fundamentally change the health system so that it provides adequate, dignified care for all is to take power over health care away from the people who now control it. Not merely the funding of the health system, but the system itself must be public. It then becomes possible to face such questions as how we decentralize the "National Health Care System" to make it responsible to the community and accountable to it, how we ensure that patient care is the primary priority of the system, how we ensure equal access to health institutions and to practitioners, and so on.

Many people have suggested that National Health Insurance might be a step toward such a national health system. Others argue it will be regressive: By providing financing, it will stave off the collapse of the present system for a few short years, and will strengthen some of the enemies of such a system. At the same time, though it will establish the necessity for the government to guarantee the right to health care for all, and it will arouse ever greater expectations of adequate health care. Thus National Health Insurance is not clearly either a step towards or a step away from a national health care system . . . it's a great leap sideways.
AMERICAN DREAM OR SCHEME?

THE QUESTION IS NO LONGER “IF” but simply “when” National Health Insurance will be enacted by Congress. Some observers predict next year. Others are convinced that National Health Insurance will be THE domestic issue of the 1972 election campaign. Proposals for National Health Insurance have been a recurrent feature of the nation’s health history. In 1914, the American Association for Labor Legislation drafted a model plan and submitted it to state legislatures across the country; not a single state acted. In 1935, National Health Insurance was successfully kept out of the Social Security Act, largely by AMA pressure. Another plan, the Wagner Murray Dingle Bill, was proposed in 1943 without Administration support and never made it out of Congressional committee. Again, in 1948, the bill was pushed, this time with backing from President Truman, only to die in committee. It was only in 1965, by limiting coverage to the elderly, that a nation-wide health insurance scheme (Medicare) was adopted.

So, how come the certainty about National Health Insurance now, when it took so long to get Medicare? Everyone agrees Americans face a massive health care crisis. Public awareness has been aroused by the mad upward surge of medical care costs and the complete failure of Medicaid. Senior citizens are angered by the unfulfilled promises of Medicare of equal access to all hospitals. Even President Nixon, who opposed National Health Insurance during his campaign on the ground that it would lower the quality of medical care, has admitted the existence of a health crisis. The result is a curious coalition of forces that view some form of National Health Insurance as a solution, to their own problems if nothing else.

Labor wants National Health Insurance to eliminate the hassle at the bargaining table over health fringe benefits, which have taken increasingly larger bites out of the wage package. In 1965, steel workers paid 19 cents an hour for life and health insurance, which amounted to 4 percent of wages and fringe benefits. Today, because inflation of medical prices is two to three times that of general prices, as much as 8 to 10 percent of any wage and benefit package must go to life and health insurance just to maintain the existing health benefits. At a time when the real disposable income of American workers has stopped growing for the first time in 35 years (due largely to inflation and increased taxes because of the Vietnam war), labor is desperate to find ways to augment workers wages. Relegating health insurance to the government leaves more dollars and cents for wage increases. Walther Reuther knows this; and even though industry-wide negotiations late this year may come before National Health Insurance is passed, he is looking to the future.

Management also wants National Health Insurance—not just to create bargaining space with labor, but also to stabilize its contribution to health insurance. Predictability of costs permits planning for larger profits. In addition, National Health Insurance may shift part of management’s labor costs (i.e., the health insurance component) onto government, leading to greater profits. This shift of labor costs from management to government would be limited to those large industrial employers whom labor has compelled to make substantial contributions to health insurance. The marginal, small shop and agricultural employer who makes little or no contribution to health insurance for his employees, may find National Health Insurance increases his labor costs. Overall, by spreading the risk among larger numbers of employers, big business may come out paying less, while small business and agriculture may come out paying more. While management is not unified on the issue of National Health Insurance, those that count (big business and industry) are certainly for it.

In the medical-industrial complex—[see November, 1969 BULLETIN] the hospital supply and equipment companies, the medical electronics and computer companies, and those drug companies who are diversified into hospital supplies—all favor National Health Insurance. Their experience with Medicare and Medicaid has been profitable. As Value Line Investment Survey points out, because of programs like Medicare the hospital supply industry is “operating in a sector of the economy that is virtually recession-proof.” National Health Insurance, like Medicare, would provide the dollars to guarantee the demand. An annual report of one of the major hospital supply companies announces: “The enormous increase in demand for institutional care [caused by Medicare] will, we believe, create a growing demand for the type of products IPCO distributes and manufacturers.” Expansion of federal spending programs for health fits well with growth and higher profits of these industries. The hospital supply and equipment companies join the coalition for National Health Insurance.

For the voluntary, private, non-profit hospitals almost any program of National Health Insurance would be better than the present Medicare program. Eligibility has become so restricted under Medicare, that many inpatients and even more outpatients are no longer covered. A National Health Insurance program allows the possibility of universal coverage without eligibility restrictions. But more important, National Health Insurance would stabilize hospital income by guaranteeing a certain level of reimbursement. In New York City, those voluntaries with large numbers of Medicaid patients were almost wiped out by State legislative action which froze hospital reimbursements at the 1968 level. Though this State action has been declared unconstitutional in the courts, the voluntaries would feel far more secure with a National Health Insurance that covered all people. Of course, the voluntaries would prefer a National Health Insurance plan which merely subsidized their operations with minimal interference from government. But some form of National Health Insurance would be better than none.

Similarly, Blue Cross/Blue Shield, the fiscal intermediary of the voluntary hospitals, wants a particular brand of National Health Insurance: one that would expand Blue Cross hegemony over the health insurance market. Although Blue Cross enrollment has flowered over the last decades, its percentage of the health insurance market has been declining. In 1945, Blue Cross insured 61 percent of the hospital insurance market compared to 33 percent by the commercial insurance companies. Today, that figure is reversed for the population under age 65, with Blue Cross garnering only 34 percent of the hospital insurance market compared to 60 percent by the commercial insurance companies. However, Medicare and Medicaid represented a big boost to Blue Cross since virtually

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every state turned over administration of their programs to Blue Cross. It is just such a relationship to National Health Insurance that Blue Cross wishes to foster. With Walter McNerney, President of the Blue Cross Association of America, as chairman of the President's task force to investigate National Health Insurance, there is little doubt that Blue Cross' interests will be represented. Parenthetically, even the commercial insurance companies are not solid in their opposition to National Health Insurance. The president of Aetna has said: "A program of universal health insurance . . . could be structured to retain the advantages of competition and the profit incentive . . . I have full confidence in our ability to work successfully in partnership with government."

Labor, management, parts of the medical industrial complex, the voluntary hospitals and Blue Cross all want some form of National Health Insurance. This is a peculiar coalition indeed. It is based on the power and pecuniary needs of these forces rather than the health needs of the public. Historically, such a coalition has never existed before, explaining in part, the recurrent failures of National Health Insurance in America. However, coalescence of these forces now spells not only the inevitability of National Health Insurance, but also suggests the shape and form it will take.

Three major plans have been proposed for "universal" or "national" health insurance and many others appear to be on the drawing boards. Each plan is best designated by the name of the individual or group that originated it: the AMA Plan, the Rockefeller Plan and the Reuther Plan.

The AMA plan is called "medicredit" because it is based on a system of tax credits for the purchase of health insurance. Voluntary purchase of private health insurance is the primary distinguishing feature of the AMA plan. It resembles an AMA counter proposal to a Medicare-like bill presented by U.S. Representative Aime Forand in 1957. Federal income tax credits would be awarded to those individuals and families who voluntarily purchased health coverage from approved private insurance companies. For those taxpayers in the bottom 30 percent in terms of tax liability, health insurance would be provided without cost to the individual or family. However, for those with higher incomes and taxes, a sliding percentage of tax credit would be given, if health insurance was purchased. Thus poor families would receive a voucher of full pay from the government for health insurance, while rich people might receive nothing. Those with incomes in between would pay lower taxes, provided they could prove they had purchased insurance.

The AMA likes its plan because it will interfere least with the way medicine is practiced in the country. There will be no cost controls, no new administrative apparatus (both patients and providers will continue to deal directly with insurance companies), no change in Medicare and Medicaid. In fact, Medicaid will have to be retained to provide medical services for those who do not pay income taxes, such as the unemployed and those on welfare. Commercial insurance companies are expected to favor the AMA plan because it entails the least risk of regulation for them. Little would be changed by the AMA's plan for voluntary health insurance.

The Rockefeller Plan advocates mandatory purchase of private health insurance (Blue Cross, HIP or commercial). It differs from the AMA plan primarily in its compulsory character, which entitles it to the label, "universal health insurance." Insurance premiums for working people would be paid as they are now, by employer and employee contributions (although all places of work would be required to provide insurance payments, including small businesses and self-employed workers). The unemployed and the poor would have their premiums paid by the government out of general tax revenues. Medicare would continue as it is, but Medicaid would essentially be eliminated. As in the AMA plan, there would be very little new administrative apparatus, since patients and providers would deal directly with private insurance companies. If the voluntary hospitals have anything to say about it, there will be minimal cost controls.

Although the American Hospital Association, representing 7000 voluntary hospitals and nursing homes, has not released its plan for National Health Insurance, it is almost certain that it will favor a Rockefeller-type plan. Ray Brown, past president of the AHA, has said, "We've got to find the additional support for our hospital system, and I think, our whole medical care system, in the private sector. The one way to do this is to . . . set a national standard for minimum benefits for health coverage, then mandate . . . that every employer have this minimum coverage for everyone that he employs."

It is expected that the McNerney task force, representing Blue Cross, will also support a Rockefeller-type plan. Already, the National Governors' Conference in summer 1969 has come out in favor of universal health insurance, as recommended by the Rockefeller plan. The Rockefeller Plan makes mandatory the purchase of private health insurance, but does not make mandatory a reorganization of the health delivery system. It serves the financial needs of the hospitals and the insurance companies, and gets the burden of Medicaid off the backs of the States. But it hardly addresses itself to the basic health needs of the people.

The Reuther Plan for National (rather than "universal") Health insurance would be "an integral part of the national social insurance system." It would be compulsory health insurance for everyone offered by the government, thereby supplanting most of the coverage now offered by private companies (Blue Cross and the commercials). The Reuther Plan would be paid for by employer, employee and government contributions: Tentatively, two-thirds of the cost would come from employer-employee contributions, while one-third would come from general tax revenues. Medicaid would be eliminated and Medicare would be integrated into the National plan without loss of benefits. The Reuther Plan, in contradistinction to the AMA and Rockefeller plans, would require a new administrative apparatus resembling Medicare, since government would preempt private insurance companies in the health insurance market. This apparatus would consist, at the least, of a trust fund within the Department of Health, Education and Welfare and at the most, of complete fiscal administration of the plan. This latter function may be turned over to the privates, including Blue Cross and the commercial insurance companies.
The Reuther Plan is the most explicit of the three plans in its concern for comprehensive health benefits. But it states "further discussion is needed . . . concerning the scope of 'medicines' and 'dental care' as benefits under NHI, and concerning the proposed exclusion of mental hospitals." Reuther plan advocates prefer to see the gradual staging of prescription pharmaceuticals and dental care over several years, rather than see these benefits excluded entirely. Contrary to the other plans, the Reuther Plan acknowledges the need for reorganization of the health delivery system, but no concrete proposals have been advanced for the encouragement of group practice, regional planning, cost controls or capitation payments. The proposal that $1 billion be creamed off the top of the first years collections and allocated to solving delivery system problems, appears no more than an afterthought.

Regardless of these shortcomings, the Reuther Plan has been dubbed the most progressive of the three, and thereby has attracted the support of such health liberals as Michael DeBakey, M.D., heart specialist and originator of the Regional Medical Programs; Mary Lasker, the philanthropist who guided the development of the National Institutes of Health; and, Whitney Young, director of the Urban League. The AFL-CIO has developed the most aggressive forms of cost control that reach beyond the institution to the hospital supply and equipment companies; (4) they lack any meaningful mechanism for community participation and control on the local level. But SHO would like to shift both the discussion and the action from insurance to service.

For the present, even if the discussion is limited to National Health Insurance, the shortcomings of the three proposals are manifest: (1) they support the fee-for-service system; (2) they make the health system dependent on private insurance companies, like Blue Cross; (3) they lack any aggressive forms of cost control that reach beyond the institutions to the hospital supply and equipment companies; (4) they are based on regressive taxing methods; (5) they make no meaningful mechanism for community participation and control on the local level. But SHO would like to shift both the discussion and the action from insurance to service.

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no provision for community/consumer control. Let's take each point individually.

(1) National Health Insurance will reinforce the fee-for-service system.

The AMA and Rockefeller Plans deny an intent to change the patterns of medical practice. The Reuther Plan emphasizes the need to encourage new forms of practice through payment to doctors for providing primary care to a defined population (capitation payment) or through salaried group practice plans. But the Reuther document is clear that "independent physicians and other providers should have the right to elect the need to encourage new forms of practice through payment. Given such a choice, most physicians will opt for fee-for-service. Even if a fee schedule is adopted in order to control doctor fees, these physicians will continue by seeing more patients. So long as fee-for-service is a sector within a National Health Insurance system, this fragile inefficient and costly form of delivering care will be forced, as well as the political strength of this status quo sector. In contrast, if National Health Insurance only reimburses hospital, neighborhood health centers, salaried group practices, etc. and the salaried physicians within those institutions, a positive and real incentive for change would be set in motion.

(2) National Health Insurance, as proposed by all three plans will make the health system dependent on private insurance companies.

Under the AMA and Rockefeller Plans, government's role is merely to subsidize the private insurance companies. At least under the Reuther Plan government sets the benefits and manages the funds. However, the Reuther Plan leaves open the possibility that administrative control of National Health Insurance may be abdicated to Blue Cross. The deficiencies of Blue Cross management are many (see September, 1969, BULLETIN). Since Blue Cross is privately operated, its records are not made public, even though they are reviewed by the State Insurance Commission. Blue Cross has been lax in controlling hospital costs, because of their collusion with the voluntary hospitals. Blue Cross has cut back on coverage and introduced deductibles, while conveying the impression that it is a prepayment plan for all hospital costs. There is no reason to believe that these practices will not continue if Blue Cross is permitted to run a National Health Insurance program. The alternative is to create a publicly supported and administered National Health Insurance program, independent of Blue Cross.

(3) National Health Insurance, as presently proposed, has no aggressive cost control mechanisms built in.

The AMA Plan lacks any mention of cost control. The Rockefeller Plan and the Reuther Plan both bow in the direction of cost controls. Unless the proposals specifically include cost controls at the institutional reimbursement level and at the back-up industrial level (hospital supply, medical electronic and computer companies), inflation of health care costs will be spurred on by National Health Insurance. In addition, cost control must follow certain principles. Within institutions, they must not be used to hold down the just demands of the long underpaid hospital workers for wage increases. Yet cost controls must deal with the accelerating salaries of administrators, full-time doctors and other professionals.

(4) Most of the proposals for National Health Insurance are based on regressive tax methods.

Employer-employee flat rate taxes are regressive since they tax every worker alike regardless of income. General revenue taxation is more progressive since those with higher incomes have to pay higher taxes. The Rockefeller and Reuther Plans call for employer-employee financing up to two-thirds of the cost of National Health Insurance. This differs little from the present distribution of payment for personal health services. At present, 30 percent of the cost of personal health services is borne by local, State and Federal government; approximately 15-20 percent by employers; and over 50 percent by the recipients of care (either in insurance premiums or directly). The Rockefeller and Reuther Plans would not shift the cost of health insurance from the employer-employee to government, but rather from the employee to the employer. In many cases, these employers would be the marginal agricultural and industrial employers who can least afford increased taxation. Ironically, in terms of taxation, the AMA Plan is the most progressive plan proposed. An alternative taxation base for National Health Insurance, which would reflect the progressivity of the income tax, has already been proposed by Senator Kennedy. General tax revenues should be used to pay for 100 percent of the cost of National Health Insurance.

(5) National Health Insurance makes no provision for consumer/community participation in program planning or budgeting.

Only the Reuther Plan mentions consumer participation. This plan is for a National Advisory Council which includes providers of service as well. This national council does not satisfy the demand by insurgent community groups that policy making on an institutional level be transferred to consumer groups and that planning priorities on a regional level be established by consumers. In fact, National Health Insurance, by focusing on the financing of the health system, directs these forces away from a concern with reorganizing the health system.

With these shortcomings, National Health Insurance has a bleak prognosis as a cure for the sickness of the American health system. What makes things worse, is that each member of the curious coalition of labor, management, the hospital supply and equipment companies, the voluntary hospitals and Blue Cross, who are uniting to make National Health Insurance a reality, has a vested interest in maintaining one of these shortcomings. Blue Cross does not want the government to administer National Health Insurance. The hospital supply and equipment companies do not want cost controls. The voluntary hospitals do not want consumer/community control. Management doesn't care if National Health Insurance is based on a regressive basis. Labor will acquiesce to doctors' demands for fee-for-service, just to get the health package off the bargaining table. A National Health Insurance program will result that serves the needs of this coalition, but not the needs of the people. Conclusion: National Health Insurance is inevitable; but so is continued crisis in the health care delivery system.

—Oliver Fein, M.D.
Medical Marketplace Revisited

THE PRICES GO UP, UP, UP...

August: Thirteen non-profit hospitals in New York City announced that they were in "desperate" financial straits—on the verge of closing. The source of their troubles? Rising costs of providing hospital services had outrun any available means of paying those costs.

August: Leon J. Davis, president of the union representing workers in voluntary hospitals, threatened a state legislative hearing with "the biggest crisis this city has ever seen" if a new state law designed to hold down hospital costs were put into effect. Davis denounced the law as "little more than a freeze on the wages of people who work in hospitals." "No other workers' wages are being controlled," union representatives elaborated. "There are no controls on doctors' fees or the profits of the drug companies and hospital supply companies who make billions in profits off of sick people."

September: New York Blue Cross was granted permission to raise the rates it charges to subscribers by an average of 43 percent. As a result of the hike, some New York families will pay as much as $108 a year more for their hospitalization insurance. Blue Cross's explanation of the rate hike? The rates they had to pay hospitals for their subscribers' hospital stays had soared.

You don't have to read the newspapers to know that the costs of health care are soaring. Anyone who has used, or might use hospitals and clinics knows that hospital costs are rising faster than the much heralded price of sirloin steak. The cost of a day in the hospital in the New York area went up 16 percent in 1968, 13 percent in the first seven months of 1969 alone. Prestige hospitals like New York Hospital and Presbyterian charge up to $140-150 a day for a semi-private room, and it's hard to find a hospital room anywhere in the city for less than $80 a day.

At these prices, even a middle class family can have their life savings wiped out by a single illness. As a result, families must buy insurance against illness, through "non-profit" systems such as Blue Cross or through commercial companies. But now even hospital insurance rates are soaring out of people's reach. Blue Cross, which covers more than eight million people in the New York area, now charges families rates as high as $312 a year—for benefits which are shrinking as fast as hospital costs are rising [see September, 1969, BULLETIN].

State Cop-Out

When it comes to purchasing health care, most people have no choice—they have to get it whatever the price. Not so with the government, which pays for more than a third of the cost of running a hospital. The public will have to understand that the cost of the war against disease can only be limited by the nature of the enemy, and that if we are to win, if we are to be a healthy people, the necessary armaments and measures must be paid for.

Pinned down, the hospitals blame the cost rise on two main factors. First, labor costs have soared, and since about two thirds of the cost of running a hospital consists of salaries and fringe benefits for employees, this has boosted costs. Second, you get more for your day in the hospital today than yesterday—more lab tests, more treatment procedures, more artificial kidneys, more radiation therapy, etc. "Expensive?" say the Blue Cross radio and TV ads. "But it's worth it." These explanations cover up more than they reveal.

First, the matter of hospital costs: Salary costs in short (Continued Page 8)
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term non-governmental hospitals in the New York area rose 96 percent in the last five years according to Blue Cross (about 15 percent more rapidly here than in the nation as a whole). Between half and two thirds of this increase reflects higher wages for people who work in hospitals; the remainder stems from a rise in the number of employees required to care for a single patient. (The latter is a result in part of shorter hours for employees, in part a reflection of the greater complexity of care.)

But the increase in hospital labor costs requires closer examination. First of all, hospital workers' wages were historically extremely low, and still remain low. As recently as ten years ago, unskilled workers in major New York City hospitals received $28-30 a week for 44 to 48 hours of work. Many full time hospital workers were on welfare. Hospital costs were thus actually higher than they appeared, but part of the cost was paid through taxes for the welfare system. In effect, the great philanthropic institutions were supported primarily through the philanthropy not of their rich benefactors but of their poor employees, who "donated" their labor to keep the hospitals going. Wages have crept up since that time. In New York City, where most unskilled and semi-skilled hospital workers are unionized, present contracts call for minimum wages of $100 a week (in the voluntary hospitals). In the voluntary hospitals, the average wage for unionized employees (which excludes registered nurses, doctors, supervisors, and administrators) is estimated by union organizers at about $120 a week. This is over $2500 less than the median family income in New York City, and is about $4000 less than the U.S. Bureau of Labor Statistics estimate for a "modest but adequate" standard of living for a family of four in the city.

Outside of New York City and a few other unionized areas, the picture is much bleaker. In late 1968, union and management officials estimated that non-professional hospital workers in Syracuse average less than $70 a week. And until the appearance of union organizers in the late spring of 1969, minimum hospital wages in cities such as Philadelphia and Baltimore were $1.60 an hour.

Whose Salaries?

Second, the 96 percent increase in salary expense can by no means be entirely attributed to employees in the categories represented by unions. The wages of all kinds of hospital employees have risen dramatically. While orderlies' wages went from $60-70 a week to $100 a week over the last four years, the median net annual income of full time hospital staff radiologists jumped from $26,000 to over $34,000. Interns and residents, formerly poorly paid, now receive $9,000-$11,000 a year. Senior physicians get salaries of $40,000 and up, and often find plenty of time for a lucrative private practice on the side. Hospital administrators are also in on the salary splurge. Lenox Hill Hospital is reported to have recently offered City Hospital Commissioner Joe Terenzio their top administrative post at a salary of $75,000 a year and the median income for top hospital chief executives has been estimated at over $40,000. About 35 percent of hospital employees are in categories such as physician, administrator or supervisor, and since these are generally the higher paid positions, a considerably larger proportion of the hospitals' salary expense presumably goes to keep these hospital "workers" in upper income brackets.

In their haste to blame their workers for forcing costs up, the hospitals usually fail to note that non-labor costs have risen just as rapidly as labor costs, nationwide. In New York, according to Blue Cross non-salary expenses in voluntary hospitals rose 63 percent between 1964 and 1969. (This figure actually understimates the costs attributable to increased expenditures on goods and services. For example, a major component of increased labor costs is the increased number of employees required to operate all the new computers, diagnostic equipment, etc., that hospitals have recently purchased.) Part of this rise, according to the hospitals, is the economy-wide inflation. Food, linen, etc. all cost more. But mainly, say the hospitals, the cost rise comes from the greater complexity of present methods of treatment. For example, in...
1963, only 18 percent of all community hospitals had intensive care units; by 1968, 42 percent had installed and were operating such units. Similar statistics hold for such expensive miracles as hyperbaric chambers, open heart surgery units, renal dialysis programs, extensive diagnostic testing programs, etc.

Whose Benefits?

Stockbrokers also enthuse about these miracles [see BULLETIN, November 1969]. Hospital supplies and medical electronics are the glamour stocks of 1969-70. In past years, drugs, another product dispensed by hospitals, have been the most profitable business in America. Now hospital supply companies, with profits growing at a rate of more than 20 percent a year, are nudging their pharmaceutical companions.

But if the hospitals and the stockbrokers go into ecstasy over the new medical miracles, the patients are entitled to some doubts.

First, there is reason to doubt the judgement of the hospitals about the great importance of these items to the overall health of people. As is the case with drugs, most of the information about them comes from the companies which produce them. The buyer of the new medical technology does not generally have the specialized knowledge or the time to evaluate the product or to figure out how much it should cost him. With literally hundreds of companies competing for a share of the market for such devices as electrocardiographs, defibrillators, and patient monitors, the average hospital administrator or the average physician is in no position to determine whether a particular feature of one model which adds several thousand dollars to the cost is really important or whether it is merely the medical electronics equivalent of a chromium tailfin.

Second, there is no reason to think that the hospitals are particularly concerned about the cost of the devices they buy. In the final analysis, the hospitals don't pay the bill, anyhow. The consumer pays, directly or through a third party—Blue Cross, Medicare, etc. But the third party mechanisms are the hospital world's version of the cost-plus contract. The insurers pay the hospitals whatever the hospital claims was its actual cost of providing service [see BULLETIN, September 1969]. If the hospital buys and operates a computer, or an intensive care unit, the cost of providing a day's services rises. Automatically, the rate at which Blue Cross, Medicare, and Medicaid reimburse the hospitals also rises. It makes no difference whether the computer or the intensive care units was really necessary, whether it was overpriced, misused, or whether it adds significantly to the overall quality of health care the hospital can deliver. The hospital has no reason, therefore, to be careful in how it spends its money—it gets paid in any case.

One result of the irresponsibility this permits is the unnecessary duplication of equipment and facilities. Hospitals compete to buy the prestigious pieces of equipment which fit into the physicians' research programs and the trustees' ego trips. According to Montefiore Hospital Director Martin Cherkasky (himself one of the great purchasers of hospital equipment in the city): "We have fifteen open heart programs in the city of New York. Seven of those open heart programs do 83 percent of all the heart surgery: eight of them do 17 percent. Those eight who do 17 percent do about one case a month. Do you know what it costs to maintain the specialized equipment and the specialized personnel when you do one case a month?" Not only is it expensive, Dr. Cherkasky continues, but "the quality is miserable, since only a cardiac surgical team constantly at work can produce the quality care that is needed."

Third, what a hospital considers a necessary expenditure may not be the expenditure which would maximally benefit the public health. Hospitals have other priorities—research, education, prestige—which may compete with community health needs. For example, a few years ago Mt. Sinai Hospital installed a three-quarter million dollar hyperbaric chamber—the only one in New York. The chamber costs more than $600,000 a year to operate. In its five years of operation, it has been used for some 450 major operations and some 400 treatments for other medical conditions that benefit from high-pressure oxygenation—i.e., about 190 times a year in all. No doubt the chamber is a life saver. But for the same cost, Mount Sinai could deliver 20,000 outpatient visits a year, or set up a vast program to screen children in surrounding East Harlem for lead poisoning and anemia. But it is the hospital that chooses how to allocate its spending, not the community. And so, the cost of hospital care goes up, but health care is not, on balance, necessarily improved.

Finally, the hospitals are guilty of open waste of resources. It is widely acknowledged that hospitals are often inefficiently run. Two years ago, a study by the National Advisory Commission on Health Manpower indicated that per diem costs in 12 "distinguished" hospitals, comparable in terms of services performed, teaching functions, quality of staff, varied from $46 to $96 a day after correction for wage rates. Similar variations occurred in all the components of total cost—dietary, housekeeping, nursing, administration, etc. One can only conclude that hospitals vary greatly in efficiency. One hospital administrator, Donald C. Carner, of Memorial Hospital in Long Beach California, has estimated that improved purchasing and personnel practices, better utilization of technology, 
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less duplication of resources, and improved utilization of presently employed manpower could lead to savings averaging about 10-15 percent of total costs.

In addition to inefficiency, there is more deliberate waste and misuse of resources by hospitals. Hospitals hire $20,000 a year public relations consultants to clean up their image. They spend hundreds of thousands in efforts to prevent their employees from organizing themselves into unions. They furnish their directors' offices in Danish modern and their lobbies in wall-to-wall carpet.

Out Of Control

Why, then, are hospitals expensive? In part, because of rising (but still low) wages for non-supervisory employees. In part because good medical care is increasingly complex. But hospitals are also expensive because they have become outlets for the greed and ambition of some of the most profitable private businesses and some of the most grasping private businessmen in the United States—drug and hospital supply companies, physicians, and hospital administrators. Hospitals are expensive because these men and companies have uncontested control over the spending of the dollars of taxpayers and patients—a control which they exercise arrogantly, inefficiently, and with little concern for the health needs of the community. From an economic point of view, hospitals are on their way to being little more than conduits, places where consumer and taxpayer money is funneled into private profits. If the helter-skelter pace is too great and forces a few hospitals in low income areas to close, so what? Hospitals these days aren't run for charity.

Meanwhile, high hospital costs have become a good excuse for cutting back on Medicaid and limiting non-self-supporting community care. And the hospitals and the government are trying to rouse up the anger of the community against the hospital workers who by their wage demands have supposedly forced up hospital costs. When someone profits, someone else loses. The people who lose on the hospitals business are hospital workers and the people who need hospital care.

—John Ehrenreich

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Medicaid reimbursement rates. Then the obscure and misnamed "Ghetto Medical Bill" will be mobilized to provide an additional $13 million worth of State and City funds.

Who could be so callous as to begrudge the voluntary hospitals this sudden pay-off? Residents of some of the city's most depleted neighborhoods, for one thing. The prestigious and established Citizens Committee for Children, for another. Their complaint: that once again, public funds are being generously forth to finance health facilities which are totally unaccountable to the tax-paying, health service-consuming public.

Case I: The Medicaid Cutback Reversal. Last spring the State legislature cut Medicaid three ways—it reduced the eligibility level to an income of $5,000 per family of four; it required the remaining non-welfare Medicaid recipients to pay 20 percent of their outpatient bills themselves; and it froze Medicaid payment rates to hospitals at their 1968 levels in order to halt a wild inflation of hospital prices. Many of the same people who protested the first two cutbacks applauded the third, because they didn't believe that the hospitals should be free to set their own prices under Medicaid. Cutbacks one and two, the ones which directly affect hundreds of thousands of medically indigent people, remain legal. Cutback three, the one which affects hospitals' bank accounts, has been ruled illegal by a Federal court. According to the Federal court ruling, hospitals must be paid at their "costs." It is up to the hospitals to determine their own costs, hence to determine what they need from Medicaid. It is, of course, not up to the medically indigent to determine their own health needs, and hence what they need from Medicaid.

Case II: The Ghetto Medical Bill (or, Laws Are Made to Be Broken). This was invented by liberal State legislators in 1968, as a ploy to circumvent the '68 Medicaid cutbacks. The law said that the State would make up half the budget deficit left by Medicaid cutbacks for public health clinics serving low-income people. For instance, suppose a clinic has expenses of $1 million, and made $600,000 through Medicaid. Then the State would give it $200,000, to be matched by $200,000 from the City—provided that the clinic met certain guidelines: It must be operated by the City, provide comprehensive, family-oriented care, and demonstrate significant community involvement. The idea was to encourage the City to initiate high quality neighborhood health center programs in spite of the Medicaid cutbacks.

Somehow the City health department never got around to applying for Ghetto Medical Bill money. According to State Senator Thaler, the City was unwilling either to take on operating responsibilities or to fork over its half of the deficit costs. According to the City, the State showed a certain lack of commitment by failing to appropriate more than token amounts for the Bill. Whatever the reasons, the City had made no effort to capture the money by the time the fall hospital crisis broke. Then Governor Rockefeller, who apparently keeps a hot-line open to the wealthy voluntary hospital elite, ruled that Ghetto Medical Bill money would be spent, i.e., with no guidelines or strings attached. One of her assistants read out a list of hospitals which have so far applied for Ghetto Medical money. Most are indeed poor voluntaries, located in poor neighborhoods. The interesting exceptions are Mt. Sinai [see "Prices Go Up," Page 7] and Montefiore in the northwest Bronx [see April, 1968 BULLETIN]—both well-endowed, private-patient oriented medical centers.

For an issue which received hardly any publicity in the newspapers, the Ghetto Medical Bill giveaway was met with surprisingly informed and sophisticated opposition. At a meeting held December 13, consumer health groups from all over the city formally protested the handling of the bill as "contrary to the interest of the poor and another sell-out to the private sector." In the words of their statement, "The voluntaries have demanded another pay-off to serve the poor, in the same old way, and the City and State have acquiesced. . . . We call for a citizen protest against the use of public funds to support a system which has no public interest."

Everyone is after Herman Badillo, the former Bronx borough president who resigned from that office to run in the Democratic primary for Mayor last spring. In return for supporting Lindsay in the Mayoral election campaign, Badillo has been offered a spot on the Board of Directors of the still-nimbleous Health and Hospitals Corporation. Then Martin Cherkasky, director of Montefiore Hospital (and hence of the Einstein-Montefiore medical empire) has offered Badillo a faculty position in Einstein's Department of Community Medicine. Nothing unusual about that—the Department of Community Medicine serves as a sort of political "club" for aligning Einstein/Montefiore's influence in the Bronx—except that Badillo has always been an outspoken critic of the empire. Badillo is still equivocating on this—he may accept it on part-time basis.

—Barbara Ehrenreich
NEWS BRIEFS

Imperial Outposts

COLUMBIA P&S HAS BEEN KNOWN to claim that "the world" is its "community." If the folks at Case Western Reserve Medical School in Cleveland have their way, however, Columbia may be in for some rough competition.

The most recent issue of the Case Western Reserve University (CWRU) Medical Alumni Bulletin (Third Quarter 1969, Volume XXXIII, No. 3) features an artsy mezzotint photograph of four smiling black children—captioned "CWRU in the Caribbean." The accompanying story details a study performed by students and faculty members on the West Indian island of St. Lucia. Four hundred islanders were the subjects of a study of schistosomiasis. The article's author, Mark Gibson '72, writes, "there was constant awareness, too, of the fundamental need for diplomacy... St. Lucia is yet another place where the image of the American is not without tarnish."

The study was not completed without difficulty. For example, research studies at the island school often coincided with Banana Day, "during which all members of many families worked at harvesting bananas, so that many subjects were not in school." Ever mindful of "the fundamental need for diplomacy," the article makes no mention of banana-picking pay scales, nor, of course, is there any mention of American domination of the Caribbean banana agri-industry.

The study was performed for the Rockefeller Bilharzia Research Laboratory and was reportedly funded in part by the Department of Defense. Children of the Rockefellers and the Pentangians rarely miss school to supplement the family income by picking bananas.

Other CWRU people spent their summers doing research and public health activities in such far flung romantic places as Nicaragua and the islands of Greece.

CWRU graduates are not content with worldwide medicine and, just like Werner von Braun, are "aiming for the stars." In the same Alumni Bulletin, Dr. Charles K. La Pinta '65 describes his experience as the "deputy team leader of the 17-man Apollo 8 mission." Space-doc La Pinta also boasts of having done the pre-induction physical on Cassius Clay while serving as a medical officer in the recruiting service at Houston, Texas.

And while CWRU personnel sail the seven seas and explore in outer space, poor people in Cleveland are still consigned to receiving second-class medical care at University Hospitals. Then again, perhaps the contradiction is not so stark—after all, it's doubtful whether the citizens of St. Lucia, Nicaragua or Greece will finally fare any better than Muhammed Ali or the poor people of Cleveland for having been treated by the denizens of CWRU. Any bets on the Martians?

—Howard Levy, M.D.

"the community." Next the Hospital unofficially threatened its medical and non-professional staff with job loss if they attended Council meetings. At the same time, hospital administrative personnel started attending Health Council meetings (uninvited), though they refused to meet with the Health Council officially. At these meetings, the administrators expressed concern about "the lack of community support for the Hospital, both moral and financial."

When Council members turned to the unlimited administra tors with questions about community participation, the administrators walked out of the meeting.