Editorial: Health "Reforms:"

Consumer Beware

The men who brought you the invasion of Cambodia, preventive detention and the campus FBI program have a new line on health. It doesn't sound like Mitchell; it doesn't sound like Agnew. It sounds, in fact, just like what the medical liberals have been urging for decades: As HEW Undersecretary Veneman puts it, "We must reform the health system, not just pump money into it" (Emphasis added).

But not "just" putting money into the health system means, to this Administration, not putting money into it—period: slashing health budgets across the board, cutting the Medicaid program, and rejecting all proposals for National Health Insurance. And the Administration's "reform" line amounts to a shabby, desperate salvage program for all private factions of the crisis-ridden Medical Industrial Complex. Meanwhile, the Nixon Administration is increasingly attacking the "radical liberals" who propose National Health Insurance (See January, 1970, BULLETIN) and profit regulation and public surveillance of the Medical Industrial Complex. Left out of the confusing national debate altogether are the consumer and health worker forces who favor "nationalization" or "socialization" of the entire health system with maximum community-worker control and real emphasis on human service.

The more myopically you examine the new Nixon "reform" proposals, the better they look. Forget all the hard issues of financing and control, and the Nixon line sounds like a replay of familiar liberal reform slogans: "The health system should be concerned with maintaining people's health, not just with treating illness." "People should be able to pay in advance for any medical care they might need, not on a fee-for-service basis at the time they are sick and can least afford it." "Doctors should practice in groups so that people can get convenient, one-stop care." And the Nixon Administration agrees right down the line: Preventive care is America's top priority health need. Prepaid group practice is the model of medical practice for the future.

Outside of Washington, too, these old concepts seem to be catching on everywhere, and veteran reformers are waking up to some very strange bedfellows indeed. For example, the AMA, longtime defender of solo, fee-for-service practice, is showing a growing fascination with group practice and even some softening towards prepayment. Readers of the AMA's house organ, American Medical News, did a double-take when they read the September 14 editorial—a lengthy quote from the founder of America's most successful prepaid group practice, the Kaiser-Permanente Plan. The commercial insurance companies, whose refusal to cover preventive care and routine medical care has done more than anything else to orient the American health system towards sickness and away from health, are unabashedly beating the drum for preventive care programs and prepaid group practice.

Few medical liberals are embarrassed—or even suspicious yet—about the company they now find themselves keeping. They see a certain inevitability in the conservatives' sudden interest in the old reform proposals: With the American health crisis deepening every year, with medical costs soaring beyond control, even the most reactionary forces have been forced to acknowledge the need for basic reform. A preventive care emphasis and prepaid group practice, the liberals argue, are simply ideas whose time has come.

There is an element of truth to this naive analysis: The conservatives, medical and political, would never even bother to talk about reform if they were not confronted by extreme crisis. But the crisis that Nixon and his allies in the medical establishment are concerned about is not the crisis that the consumer faces: The middle class family suddenly impoverished by a catastrophic illness, the welfare mother waiting in an emergency room with a sick child, the farmer who lives 50 miles from an ambulance, let alone a hospital.

No, the crisis that the conservatives are concerned about is the political and fiscal crisis that they themselves are confronting: Government health expenditures are out of control. Insurance companies are finding that medical inflation is wiping out their profits from health insurance sales. A liberal/labor coalition is more and more insistently demanding increased Federal spending on health. The entire Medical Industrial Complex—doctors, hospitals, drug and equipment companies—fears that, if something is not done now to patch up the system, consumer demands will mount for tough government regulation of profits in the health system, if not for nationalization of the industry.
It is to solve these problems—not out of any suddenly acquired humanitarian zeal—that the conservatives are turning to some of the old liberal recipes for reform. First, the liberal slogans are useful simply as rhetoric. It's better for public relations to say, "We aren't going to pour money into the health system until we reform it," than to say simply, "We aren't going to pour money into the health system."

But, in the long-run, the conservatives need more than rhetoric, and they know it. What they're dreaming of is a health system which will be cheap and stay cheap for the government and insurance companies while continuing to be profitable for the providers. The strategy is to reduce, or control, the public's use of expensive health services. For this, concrete reorganizational "reforms" may be necessary:

- **Prepayment**, as opposed to fee-for-service, is the key. To the conservatives, prepayment is a mechanism to give health care providers a financial incentive to cut down on their services to consumers, and hence on the government's or insurance company's overall medical bill. Providers' profits and consumer services will have to come out of the same prepaid sum. When the government acts to keep that overall sum low, providers will be forced to cut consumer services in order to maintain their own profits.

- **Group practice**, to the conservatives, is a secondary consideration, but necessary to make prepayment work smoothly. From a bookkeeping standpoint, it wouldn't be economical to pay separate advance sums for the services of every specialist or special facility that a set of patients might require. Besides, by prepaying a "group" which includes both doctors and hospitals, you give each member of the provider group an incentive to cut down on the amount of services provided by each of the others, in order to make a higher profit for the entire group. To the AMA and to the Nixon Administration, it doesn't matter if the prepaid "group practice" really functions as a team for medical purposes, or whether it's just a collective bookkeeping arrangement linking otherwise independent and uncoordinated providers.

- **Preventive care**, to the conservatives, looks like a cheap alternative to acute care. Offer mass "preventicare," as Nixon's men call it, to the poor and the elderly, and forget about the occasional individual who requires expensive, high-technology life-saving therapy. At this point the preventive care emphasis may be more rhetorical than real—a device to distract attention from the critical failings of the acute care system—almost like telling a man with lung cancer to go home and give up smoking.

There is nothing secret about this strategy. The conservatives who are picking up the banner of "reforms" are quite open about it: Their objective is to limit and control consumer utilization of health services. Lest that sound unduly harsh and repressive, the conservatives' academic apologists, such as Eli Ginsberg and Sydney Garfield, are ready with an elaborate, scientific-sounding, rationale:

The current medical inflation, they argue, is a direct result of Medicaid and Medicare. By putting money in the hands of consumers, these programs increased the "effective demand" for health services. The health care marketplace is characterized by a chronic undersupply of doctors, hospital beds, etc. When you increase demand in the face of a limited supply, then—according to all the textbook equations—the prices must rise. There are two ways out: decrease the demand or increase the supply.

The Nixon Administration, and now even the AMA for that matter, talk a good line about the need to increase the "supply"—build new medical schools, and health centers, train more paraprofessionals, etc. But, when it comes to action, the Administration has consistently and ruthlessly cut funds for manpower development and health facility construction. The trouble with increasing the supply (besides the fact that it costs money) is that more doctors and hospitals mean lower profits for the existing doctors and hospitals. More doctors and hospitals mean more chance for the consumer to "cash in" on his Medicare or insurance benefits, hence higher bills for the government or insurance company. Thus, according to the supply/demand analysis, the only way the conservatives can control medical inflation is to control demand, i.e., to limit consumer utilization of health services.

Some liberal observers are challenging the Administration's policy of controlling the demand, rather than the supply end of the equation. But almost no one is questioning the equation itself, or its relevance to the health care market place. It has become fashionable for liberals and conservatives alike to blame the current cost crisis on consumer "demand," that is, on the consumers themselves. From this, it is only a short step to the conservatives' policy of restricting consumer utilization of health services.

But the supply/demand analysis is itself totally false—a hasty justification for repressive policies. In the first place, it is theoretically wrong: The health care marketplace, as everyone knows, is not a competitive one. The free marketplace "laws" of supply and demand simply do not apply. Prices
are set, not by Adam Smith’s “invisible hand,” but by the willful decisions of the suppliers. In the second place, it is empirically wrong: The data show that Medicaid and Medicare did not lead to any significant increase in consumer utilization of hospital services where the price increases have been concentrated. (See Box, page 4). The medical inflation that has resulted from the Medicare and Medicaid programs cannot be blamed on consumer misuse, or overuse, of health services.

There is one simple and obvious reason for the current medical cost crisis—the rampant profiteering of the Medical Industrial Complex. All the major public and quasi-public forms of health insurance—Medicaid, Medicare, Blue Cross—give doctors and hospitals almost unrestricted freedom to set their own prices. Medicare and Medicaid were especially generous—to the providers. Hospitals set their prices higher and higher, using their “profits” to expand their real estate empires, hire public relations men, or invest in esoteric research equipment. Stocks soared for the hospital supply and equipment industries, for the hospital and nursing home chains, and for the hospital construction industry. Totally unregulated, prices leap-froged, and profits soared, in every sector of the health industry.

One sure way to control medical inflation is to control the profits in the health industry. But neither conservative nor liberal administrations, both equally committed to a profitable, free enterprise health system, can take this step. The liberals used the taxpayers’ money to fatten medical profits. Now, under the conservatives, the consumers will pay once again for the liberals’ mistakes. Instead of controlling the Medical Industrial Complex, the conservatives plan to control the consumers. All the new talk of reorganizational “reforms” has no other ultimate purpose than this.

In a consumer-controlled, consumer-oriented health system, people might very well choose to institute many of these reforms themselves. To consumers, prepaid group practice, with a heavy emphasis on preventive care, has many real advantages over a fragmented, sickness-oriented medical system. But, in the context of the existing system—a system in which consumers are forced to compete with politically powerful medical profiteers for a shrinking public health dollar—these “reforms” are thinly disguised acts of repression.

**Federal Health Policy: let Them eat Cake**

A lower level HEW official, interviewed by HEALTH-PAC last spring, said, “You want to do a story on Federal health policy? You can do it in three words: There is none.” (Since then this official, and his boss, and his boss’s boss, have all resigned in frustration). The President himself has done little to contradict this view. Ever since Nixon’s one announcement, in July 1969, that the U.S. health system faces a “massive breakdown,” Presidential statements on health have been as rare as vice-presidential statements in civil rights. It looked as if Nixon was planning to give health what his house “liberal,” Patrick Moynihan recommends for race relations—a dose of “benign neglect.”

But the clamor over the national health crisis has become too loud and too insistent to ignore. The liberal campaign for a tax-supported system of national health insurance is picking up steam, and could help unseat Nixon in 1972. So the Presidential silence is about to be broken—the Nixon Administration has evolved a strategy for health. The hard facts are that Federal expenditures for health will be cut; Federal efforts to regulate and reorganize America’s private, profit-motivated health system will be abandoned. The Administration’s rhetoric, however, centers on the fashionable, liberal concept of prepaid group practice. If the re-formist rhetoric doesn’t seem to fit the repressive reality—no matter. All the Nixon Administration needs is a show of reform—a smoke-screen to counter the rising demands for consumer-oriented reforms in the health system—from the liberals’ demand for national health insurance, to the radicals’ demands for a nationalized health system.

Admittedly, President Johnson was a hard act to follow. His “Great Society” brought Roosevelt’s New Deal—only thirty years late—to the area of health services. In the rhetoric of the Kennedy and Johnson Administrations, health care was for the first time a “right,” and it was the Federal government’s duty to enforce it. The Democratic Administrations produced a spate of new health programs: Medicare for the aged, Medicaid and neighborhood health centers for the poor; and Regional Medical Programs and Comprehensive Health Planning, to make sure the whole thing added up to a rational health “system.” Between 1965 and 1967, Federal spending on health leaped from $5 billion to $11.8 billion, and a vast new Federal bureaucracy of health took root in Washington.

With the Great Society, the Federal government emerged as a new force in the otherwise privately dominated American health system. The Democrats had no plans to give the government a controlling role in the health system—that would be (as the AMA put it) “totalitarianism”—but they did feel that the government should be more than a passive bystander. In the language of the Comprehensive Health Planning Act of 1966, the government was to be a “partner” to the
HOSPITAL COSTS: According to both liberal and conservative experts on the health system, hospital costs have risen so rapidly in the last few years because "demand" has outrun "supply." Medicare and Medicaid supposedly amounted to pouring consumer demand for more hospital services onto an antiquated hospital system that couldn't handle the flood. Add Adam Smith, and presto, out comes skyrocketing prices for hospital care. The significance of this analysis lies in what the medical gurus conclude from it: that the health care system must be reformed before any more Federal money is pumped into it. More money at this point would only fuel the inflationary flames, generating higher hospital charges but not leading to any increase or improvement in badly needed medical services. More specifically, the problem the experts want to solve before adding more funds is how to keep hospital utilization down when we subsidize it.

The only trouble with the accepted wisdom is that the facts don't bear it out. The August 1970 issue of Hospitals (The Journal of the American Hospital Association), the definitive source for hospital statistics, provides the following information about US non-federal, short term hospitals: Comparing the four year periods preceding and following the introduction of Medicare (1961-65 and 1965-69 respectively).

- Hospital per diem costs rose continuously throughout the decade, but during the post-Medicare period, they rose 34 percent more rapidly than during the pre-Medicare period. While labor costs rose more rapidly than non-labor costs during the pre-Medicare four years, they rose substantially less rapidly than non-labor costs during the post-Medicare period. The rate of growth of hospital assets also sharply accelerated in the post 1965 years. Hospital costs went up in large measure because the hospitals spent their Medicare money on new equipment, new buildings, etc., not because they necessarily provided more or better care.

- Admissions to hospitals also rose throughout the decade, by 21 percent over the 1961-69 period. But the supply of hospital beds (certainly one major indicator of the supply of hospital services) more than kept pace, rising 25 percent over the same period. While the rate of increase in supply of beds was about the same during the four year periods before and after Medicare (12.4 percent after), the rate of increase in admissions to hospitals sharply declined in the years after Medicare and Medicaid took effect (admissions in 1965 were up 13.2 percent over 1961; in 1969 they were up only 6.8 percent over 1965). In other words, during the post-Medicare period, the number of beds in-

and Federal intervention in health. Low income consumers' expectations, barely whetted by inadequate Medicaid and neighborhood health center programs, were rising militantly by the late sixties. While the Republicans might have been able to ignore the poor, they couldn't just brush aside the mounting protests of unions and working people. Unions, tired of watching their wage and benefit increases eaten up by medical inflation, were demanding that the Federal government step in with a program of national health insurance (see BULLETIN, January, 1970). Under the leadership of Walter Reuther, the United Auto Workers drew up their own plan for a comprehensive, universal health insurance system which would require considerable government spending and control of the health system. Even AFL-CIO President George Meany, who has otherwise grown increasingly friendly to the Nixon Administration, says he has been goaded "by pressure from the bottom" to fight for a national health care system financed like social security and covering every man, woman and child. . . We will be putting on a real drive for enactment of a national health care law," he said in late September, "hopefully in the next session of Congress."

Less than a year ago it seemed inevitable that the Nixon Administration would be forced to abandon its conservative principles and yield to the pressure for some form of Federally sponsored health insurance. But
now, it is clear that this is exactly what the Nixon Administration is not about to do. All signs point to sharp right turn away from the 1960's trend towards an expanding Federal role in health—with reduced Federal spending for health and a reduced Federal role in planning and regulating the health system. The Nixon Administration is trying to disentangle itself even from the feeble public/private "partnership" envisioned by the Democrats: Health care, according to Republican philosophy, must be "restored" to our free enterprise system.

The Administration's approach to the national health insurance (NHI) issue provides the most clear-cut example of the new "disentanglement" policy. A year ago, following the passage of a pro-NHI resolution by the Republican-dominated National Governor's Conference, the Nixon Administration made some vague noises about the need for "long-term methods of financing." A brief flurry of hope ran through the liberal-labor coalition for NHI. But by early 1970, the administration was pooh-poohing NHI as a potential re-run of the Medicare-Medicaid disaster. Adding more money to America's over-inflated health system, they argued, would only compound the crisis.

It hasn't been fully spelled out yet, but Nixon's alternative to NHI appears to be an almost total Federal retreat from direct health care financing. Currently, the Federal government contributes to the nation's health care financing through Medicare, for those over 65, and through Medicaid, for the poor. Despite its many inadequacies (see June, 1969, BULLETIN), Medicare in many states pays for fairly comprehensive services (medical care, dental care, drugs, etc.) for millions of people including many who are 'medically indigent' but not on welfare. According to Nixon's present plans, Medicaid would be scrapped and replaced by a system of Federal payments of premiums for private health insurance for welfare recipients. For the "near poor" (those who are medically indigent but not on welfare) the government would offer partial subsidy of the cost of private health insurance. For the middle class, most of which already has private insurance coverage for hospital costs, the government will offer "some financial relief". This relief will probably take the form of Federal subsidies to insurance companies, to enable them to stabilize the price of their insurance policies.

The details won't be known until early 1971, but the intent of this plan, which Administration officials are calling the "three-layer cake strategy" (since there's a different "layer" for each social class), is already clear: To reduce Federal health spending and to channel the Federal health dollar towards the private insurance companies rather than the consumers. As far as the poor are concerned, it might as well be called the "let-them-eat-cake" plan: They will "move up" from Medicaid to the the kind of inadequate private insurance coverage now enjoyed substantially more rapidly than admissions. The pressure of increased admissions, paid for with Medicare and Medicaid dollars, does not seem, then, to be the cause of rising hospital prices.

The only figure that might give comfort to the supply and demand theorists are hospital occupancy rates (the percentages of a hospital's beds that are filled, on the average). Occupancy rates have risen throughout the sixties, reaching 78.8 percent in 1969. But almost two-thirds of the increase has come in the last four years, i.e., since Medicare. The Hospitals statistics indicate, however, that the increased occupancy rates of the latter period are virtually entirely due to a sharp hike in the average length of stay of patients in the hospital (7.6 days in 1961, 7.8 days in 1965, 8.3 days in 1969). We may speculate that with Medicare or Medicaid insuring that a patient's full stay in the hospital would be paid for, the hospitals took advantage of the situation and held onto patients longer, thus increasing their income. (It costs the hospital almost as much to maintain an empty bed as a full one, but with an empty bed, there is no income to offset the expense). In any case, hospitals' patient loads are still far below capacity, even after the increase in occupancy rates of the last decade. We would not expect the relatively small hike in occupancy rates of the last few years to have had a major impact on prices.

From the Hospitals figures, it seems clear that hospital prices did not rise under the impact of a soaring demand. Rather the critical feature of the post 1965 period was that Medicare and Medicaid, like Blue-Cross, paid hospitals whatever they claimed as their true costs for providing patient care. The costs (the "price" paid by the reimbursement agencies and the basis for the price paid by patients who pay their own bills) were not set in a free marketplace, where the supply and demand argument might have some relevance. Instead, the hospitals were able to set their cost virtually arbitrarily. Equipment, higher salaries for everyone from poorly paid service workers to well paid doctors and administrators, building renovation and expansion—whether or not the expenditures were necessary for or relevant to the patient care, the hospital could add them into their "costs" and get reimbursed.

The free-flowing government funds of Medicare and Medicaid did indeed drive hospital costs up. But not by stimulating consumer overuse (relative to supply) of hospitals. Costs rose because the hospitals appropriated (and often misappropriated) the money for their own benefit. The hospitals profited, the hospital directors and doctors profited, the companies that sell hospitals supplies, services, and equipment profited. And sometimes, the patients got a little better or more readily available service.
joyed by the middle class. Like the middle class, they will be able to buy private insurance, but they will find that it does not cover preventive care and routine medical care. In addition, many of those now covered by Medicaid will have the "dignity" of helping to pay for their own insurance premiums.

Another example of the Administration's retreat from responsibility in health is its handling of the HEW budget. Vietnam-inspired cuts in domestic spending began in 1966, but upcoming health budgets will make the mid-sixties look like a spending bonanza by comparison. In a five-year plan released to top HEW officials in December, 1969, then-Secretary Finch announced that within HEW, health would take a special beating, and that agency heads would have to cut down their already slim budget requests for 1971. In melodramatic tones, Finch described the hard choices ahead: "... It is the kind of choice where, to help some children, some of the aged may go without help, to alleviate illness today through the provision of services may mean the loss of an opportunity to alleviate illness through research a few years hence, and vice versa."

Already, Federal budget requests are low enough to provide significant revolt from Congressional liberals. Early last spring, Congress rallied to overrule a Presidential veto of funds for the Hill-Burton program of hospital construction. In July, a bill to add $360 million to the HEW appropriations bill was defeated much more narrowly than expected, and Congressional liberals are now lining up for a new fall effort to beef up health appropriations, particularly for research and manpower training. The Administration, in turn, is threatening to simply not spend any unasked-for health dollars.

The Administration's refusal to spend for health directly contradicts its own rhetoric about the need to build up our "severely strained" health resources before investing in any form of NHI. Summarizing the Administration's rejection of NHI, Roger Egeberg, HEW's top health official, said in August: "... You have to start with the education of the people who are going to do the job [of delivering health services.] And this is what disturbs me about the talk of 'national health insurance.' I think we aren't ready: we don't have either the people or the places to deliver the health care to the extra 10, 15 or more million people who would be entitled to it if we had national health insurance."

This—just as the Administration was busily working to cut funds for medical manpower development and facilities construction. One Congressman, embittered by the Administration's health spending policy, is quoted by the American Medical News (August 3, 1970) as saying, "We clip the wings, tell the bird to fly, and then wonder why she is grounded."

But despite its rejection of NHI and refusal to even maintain existing health programs, the Administration is not simply abandoning the health system—as is—to the private sector. As the President himself observed, the present health system is no longer viable without major reform. Doctors and hospitals are unevenly distributed across the country; the quality of care is inexcusably poor for middle income as well as poor people. Worst of all, medical care costs are escalating at a rate three times greater than the cost of living. The cost crisis creates the most urgent political problems, and it is this that the Administration is concentrating on.

The Nixon Administration's interest in controlling medical inflation does not flow from any humanitarian concern about the plight of the health care consumer. Private insurance companies, for example, are hard hit by the current inflation, unable to raise their premiums fast enough to keep up with medical price increases. In the long run, the entire Medical Industrial Complex—hospitals, doctors, drug companies, hospital supply and equipment companies—has an interest in stabilizing medical prices. For, if prices continue to rise at their present rate, public demand will mount irresistibly for firm government intervention in the health system— for government-imposed limitations on the profits of doctors, drug companies, etc., and for a Federally controlled system of NHI, if not for a national health service. Such measures would cut deep into medical profits across the board, and would have a damaging spill-over effect on non-health companies, such as aerospace and defense firms, which are now expanding into the health business. Private health insurance companies would, of course, be put out of business by a Federally operated NHI program.

Thus, for a Federal Administration dependent on a big business constituency, a laissez faire policy in health is out. In order to head off demands for serious governmental intervention in the health system, such as a strong NHI program, the Nixon Administration must intervene to stabilize costs. Or, at least, it must make a good enough show of stabilizing costs to distract the angry masses of consumers. One way or another, the Administration must take steps to make the health system "safe" for private enterprise.

This is the Nixon's Administration's basic dilemma: How to intercede now to control costs without setting a longterm pattern of government "control" of the health system— since government control is exactly what the Medical Industrial Complex is ultimately trying to avoid. Faced with these seemingly paradoxical requirements—government intervention now in order to avoid government intervention later—the Administration sees only one possible longterm solution: To try to nudge the health system in the direction of self-regulation of costs.

The first problem is the control of the costs of individual services, such as a visit to a doctor or a day in a hospital. In the Republican's ideal health system, these "unit costs"
would be held down by making the health market more like other commodity markets, where (supposedly) competition between suppliers keeps prices down. In the words of ex-Secretary Finch, "We're working towards a system where the doctor is rewarded financially for keeping the patient healthy, where the hospital is rewarded for efficiency . . . and where the consumer—the individual or the government—has a choice between competitive alternatives when he buys health care." (Note: Health would still be profitable, for doctors and hospitals, but to make a profit, they would have to work harder to keep their costs down).

To the Administration, however unit costs are the less important, and less manageable, part of the problem. No matter how low the unit costs are, the overall cost of providing health care to the population will still be high if too many people use too many health services. The government and the insurance companies, both of which finance care for large populations, are concerned chiefly with controlling consumer utilization of health services. As it is, doctors and hospitals have no incentive to keep people from seeking care. In fact, the greater the volume of consumers, the more money they make. As a result, people are often hospitalized unnecessarily, or over-treated for simple illnesses. In the self-regulating health system envisioned by the Republicans, utilization would be controlled by giving doctors financial incentives to keep people out of their offices and, especially, to keep people out of hospitals. (Hospital care is, of course, far more expensive than care in a clinic or doctor's office.) Dr. James Cavanaugh, one of Egeberg's Deputy Assistant HEW Secretaries, told HEALTH-PAC in an interview that, in the long-run "we may have to forget about [the unit costs of services] and just concentrate on keeping people out of hospitals."

What would the Administration's utopian, self-regulating, health system look like? The basic unit would be hospital-based, prepaid group practices, such as the Kaiser-Permanente Plan (see page 11). These groups would contract to the government, to an insurance company or other health care financier, for the care of a given population at a predetermined price per person. Since the price is set in advance, the group would have a strong incentive to hold down its cost per service (e.g., by using manpower efficiently), and to hold down its costs per person (e.g., by avoiding unnecessary hospitalization).

In spite of the frequent references to the Kaiser model, Administration planners stress that they are not trying to impress a uniform style of health care delivery on the nation's "pluralistic" health system. On the contrary, they envision a growing diversity of delivery styles, all based on the group concept. The hoped-for "groups" might be exact replicas of the Kaiser plan, they might be more like the current medical school-insurance company plans, they might be loosely linked groups of doctors operating internally on a fee-for-service basis but accepting prepaid contracts from the government and insurance companies—or whatever. The idea is that the different types of groups in a given region would compete with each other—to attract patients and, especially, to hold down their costs.

Nixon's home state of California provides the model. There, alarmed by Kaiser's success, county medical societies formed competing organizations in which doctors could practice out of their own offices on a fee-for-service basis, such as the San Joaquin Medical Foundation. An HEW spokesman is quoted by Medical Economics as saying, "The California Medical Association [the California unit of the AMA] is one of the most vigorous [in the country], and just the presence of Kaiser there has precipitated a whole variety of arrangements for the delivery of care. That's what we hope for across the country."

The Administration, of course, has no intention of coercing doctors and hospitals into prepaid group practice arrangements. Its basic tactic for fulfilling its "hope" for a restructured health system is the Health Maintenance Organization (HMO) plan—a scheme to encourage doctors and hospitals to band together to form hospital-based, prepaid group practices. As defined in a proposed amendment to the Medicare law, an HMO would be any organization that can guarantee to the Federal government to provide all the health services currently covered under Medicare—from physician care to hospitalization—for an annual price per patient that is less than the average Medicare bill in the same area. If an HMO can manage to cut its costs below the flat sum paid in advance by the government, it gets to keep the difference. Conversely, if an HMO's costs run above the prepaid sum, the HMO must make up the loss itself. The experience of existing prepaid groups, such as Kaiser, suggests that HMO's will be able to hold their costs well below the amounts the government will be offering and thus make considerable profits.

How will this work out in dollars and cents? The Administration is planning to offer organizations which qualify as HMO's an amount equal to 95 percent of the average annual Medicare bill per person in that area. If Medicare patients are averaging yearly bills of $100 in a given area, the government will offer HMO's in that area $95 per year for each Medicare patient they enroll. Suppose an HMO in this area finds it can cut down the cost per Medicare patient to $80 per year. Then it will make a profit of $15 per year per Medicare patient, and the government will save $5 per year per Medicare patient (relative to those who do not choose to use HMO's.) Lured on by the prospect of such easy profits, doctors are expected to band together in association with hospitals to form the kind of organizations which can
provide comprehensive care (hospital and doctor services) and qualify as HMO's.

The HMO plan so far applies only to Medicare patients, but the Administration is talking about extending HMO's to other groups in two ways: By adding an HMO amendment to the Medicaid law, which affects poor people, and by requiring HMO's to enroll a fixed proportion (perhaps 50 percent) of non-Medicare patients. Eventually, HMO's should serve the entire population.

An astounding new departure? HEW spokesmen describe the HMO plans as "a bold step towards the reorganization of the entire health care system." Medical Economics, a magazine aimed at private practitioners, heralded the HMO plans as "... a set of proposals so dramatic that, if followed through, they could totally change the way medicine is practiced in this country."

So it would seem ... until one discovers just who it is that the Administration is counting on to implement the HMO program—namely, the medical societies. According to Dr. Paul Ellwood, the HEW consultant who dreamt up HMO's, HEW didn't "crystallize" the HMO program until a number of country and state medical societies had expressed an interest in similar programs. Like their parent organization, the AMA, local medical societies have traditionally opposed group practice (especially the Kaiser type in which doctors are salaried) as threats to doctors' individuality and incomes. Yet, according to HEW, medical societies from all over the country have been discreetly inquiring about the guidelines for HMO formation. Even the AMA, which opposed Medicare, Regional Medical Programs and almost every other government health program since compulsory vaccination, has confined itself to noting that the HMO plan "... is not a panacea."

In HMO's, doctors have nothing to lose and, potentially, a lot to gain. To make a profit, all they have to do is to keep their Medicare patients out of the hospital (or out of the office), and thus reduce per-patient costs to below the government's pre-paid grant. Furthermore, HEW has made it abundantly clear that if "explicitly seeks to avoid interfering with the internal arrangements of health maintenance organizations." So by joining an HMO, a doctor will not be submitting to any form of government regulation in his affairs. In fact, in the kind of HMO's envisioned by medical societies, a doctor need not change his practice in any way, except that he will send his claims for Medicare reimbursement to the "group" rather than to the government, and he will be under pressure from the "group" to avoid unnecessary hospitalization of Medicare patients—a small price to pay.

Finally, medical societies, like other elements of the Medical Industrial Complex, have a defensive interest in HMO's. If the Administration can't "sell" HMO's, Congress or some future Administration may come along with a far more drastic plan to overhaul the health system. (For example, some proposals for NHI include financial disincentives for physicians who remain in fee-for-service practice.) HEW's Dr. Egeberg stated, somewhat ominously, that "health maintenance organizations may represent the last chance physicians will have to carry the ball in solving the problems of health care delivery and cost."

Politically, HMO's represent a goodwill gesture from the Administration to its private doctor allies in the struggle against NHI and other government "intrusions" into the nation's private health system. As conceived by the Administration and the medical societies, HMO's are potential fortresses for the preservation of fee-for-service medical practice. For—underneath all the pious talk about prepayment and group practice—the HMO's are simply a bookkeeping arrangement designed to give doctors an interest in cutting down on hospital use. In forming HMO's, the medical societies gain profits and the prestige of "doing something" about the health care crisis. At best, the consumer will notice no change at all. At worst, he will find doctors tending to undertreat, perhaps even to neglect, his ills—all in the name of "health maintenance."

That is, if HMO's get off the ground at all. Even for the formation of the paper "groups" envisioned by the medical societies, the obstacles are considerable: Hospitals may be unwilling to join with doctors' groups to form HMO's; some states have laws forbidding various forms of prepaid group practice; groups wishing to form HMO's may need some initial capital, if only to set up the required bookkeeping arrangements. At present, according to HEW's own estimates, prepaid group practices are so rare that only five million Americans are currently enrolled in groups which could qualify as HMO's.

Curiously enough, the Administration is doing very little to overcome these obstacles to HMO formation. Back in the early part of 1970, Administration spokesmen told Congress that they would like to take two measures to stimulate the formation of HMO's: (1) setting aside a certain percentage of Medicare revenues as seed money to help new groups get started, and (2) forcing states which now outlaw group practice to change their laws or risk loss of Federal matching money for Medicaid. Both proposals have since been dropped. Administration officials claimed, in an interview with HEALTH-PAC, that Congress had urged HEW to drop them. But staffers for the Congressional committees responsible for Medicare and Medicaid deny this, saying that Congress was sympathetic to the proposals and that HEW simply withdrew them on its own. "The Administration doesn't even have the guts to carry through on its own programs!"—the chief staffer for a key Senate committee told us.

But for the upcoming battle over Federal health policy, the HMO's don't need to actually happen. Good intentions, supported by
elaborate technical rationales, should do the trick for the Nixon Administration—or so they hope. Watch what happens in early 1971:

Congressional liberals will line up for an all-out battle for national health insurance. Unions, and millions of working people (the Republicans’ heavily wooed “silent majority”), will be watching expectantly. Enter Nixon, stage right, with a scene-stealing routine about the “three layer cake” plan for health care financing, and—more impressive—the HMO plan for health system reorganization. In his 1971 health message, Nixon may present HMO’s as an interim measure, to help get the health system “ready” for NHI, or as part of an alternative to NHI. Either way, HMO’s are a meaningless embroidery on the shabby fabric of Medicare, not a real program. But they will have served their purpose which, according to HEW’s consultant Paul Ellwood, was “to quiet the clamor for national health insurance” and to reverse the trend towards greater government involvement in the health system.

Can Nixon pull it off? In health, as in other areas of the economy, the needs of the Republicans’ big business constituency are in direct conflict with the needs of the great majority of the population. The contest over Federal health policy provides a key test of the viability of the conservative Federal Administration: Can it meet the needs of its friends—in this case, the Medical-Industrial Complex—and at the same time distract the public from the possibility of real reform?

—Barbara Ehrenreich

**Prepaid Group practice: Panacea put on**

For decades the American Medical Association (AMA) has staunchly opposed any form of prepaid group practice. It has spent tens of thousands of dollars on public campaigns invoking fear of “socialized” medicine; successfully lobbied for state laws forbidding prepaid group practice; and encouraged professional ostracism of doctors brave enough to serve in prepaid group practices. But in recent months, the AMA has joined other conservative forces in shifting towards acceptance, if not advocacy, of prepaid group practice.

At its 1970 Annual Convention, the AMA adopted a resolution more permissive than ever before. It stated, in part, that there is a “need for multiple methods of delivering medical care and... a multiplicity of practice options.”

Since that convention, the American Medical News, the official organ of the AMA, has published three major articles sympathetic either to group practice or to prepayment.

During the summer of 1970, President Nixon proposed amendments to the Medicare law encouraging the formation of “Health Maintenance Organizations” (HMO’s) on a prepaid basis, with barely a squeak from the AMA, even though in theory HMO’s resemble prepaid group practice (see page 7).

In September, 1970, the newly-formed U.S. Health Corporation announced a series of seminars on such topics as “Professional Corporations, Partnerships and Associations” and “Profit Sharing, Pension and Benefit Plans for Physician Groups.” The Board of Directors of the Corporation ranges from former AMA president Charles L. Hudson to health liberals such as American Public Health Association President Paul Comely.

Why are the historic advocates of solo fee-for-service practice joining hands with their traditional foes, the proponents of prepaid group practice? It is not altruism that forges this alliance, but rather preoccupation with the preservation of power and profits. Belatedly, the medical conservatives have come around to the proposition stated 18 years earlier by Henry J. Kaiser, industrialist who founded the Kaiser-Permanente Health Plan, the largest prepaid group practice plan in America: “If doctors fear socialized medicine, if industry is anxious about the widening powers of the state, why not venture now, boldly, into the activity that will forestall the super-planners in their schemes to direct medical service into the channels of distributive bounty.” For them, prepaid group practice has become the last chance for free enterprise in medicine and the best hope for stopping National Health Insurance.

The medical schools, commercial insurance companies and the government, itself are also jumping on the group practice bandwagon. Harvard Medical School and at least six other schools of medicine around the country have set up prepaid group practices as “models” of medical care delivery. William S. Thomas, senior Vice President of Metropolitan Life Insurance Company speaking on behalf of the commercial insurance industry, recently stated that the commercials are very interested in developing cooperative relationships with prepaid group practices. In fact, Connecticut General Life Insurance Company, Metropolitan, and other insurance companies have provided much of the financing for the new medical school prepaid group plans. And, the U.S. Public Health Service has broken with years of tradition to conduct an informational campaign on prepaid group practice.

What is all this ballyhoo about? Ideally, prepaid group practice has two components: prepayment and group practice. “Prepayment” means that for a fixed monthly payment (premium), the consumer is guaranteed a relatively comprehensive set of health services—doctor and hospital services, laboratory and X-ray services, etc.—
with no more than a nominal additional payment when the services are used. This differs from the usual "indemnity" health insurance, which pays only a limited amount of money towards care the consumer provides for himself. The insurance benefits are usually insufficient to cover the full doctor or hospital charges, leaving the patient to foot the rest of the bill out of his own pocket. Indemnity insurance has also traditionally covered only a limited number of services, often excluding preventive check-ups and routine laboratory testing. Prepayment, by contrast, offers the assurance of health services, so that the consumer can feel free to seek health care as early and as often as is necessary, without the fear of unpredictable additional medical expenses. The availability of preventive and ambulatory care, moreover, should reduce the overall cost of health care.

"Group practice" means that doctors offer services together rather than alone, and share resources such as personnel (nurses, receptionists, etc.) and equipment (cardiographs, X-ray machines, etc.). In its fullest development, group practice means that doctors practice as multi-specialty teams with a family orientation. Innovative use of paraprofessional personnel, a single complete medical record, rather than one dispersed among specialists, and quality control through "medical auditing" and mutual consultations among team members are other likely characteristics of such groups. Group practice implies a reorganization of the health care delivery system to permit the integration of the various medical specialties required to adequately treat all of a family's health problems.

When prepayment and group practice are combined, according to its advocates, it means better care at less cost. The new alliance of the AMA, the commercial insurance companies, the medical schools, private industry and the government to encourage prepaid groups seems, then, to be in the public interest. But let's take a look at what these groups mean by their prepaid group rhetoric.

Within the AMA there are two groups who claim to favor prepaid group practice, but who really don't. One faction is talking about group practice without prepayment. The other advocates prepayment but not group practice. Meanwhile, the oldtime, more liberal doctors, crusaded for prepaid group practice on the theory that doctors could control muchof the medical record and personnel with pooled income," American Medical News has documented a 300 percent increase in the number of doctors in group practice over the last decade. (In 1969, there were 38,834 physicians employed in 6,162 groups compared with 1959, when there were only 13,008 employed in 1,546 groups.) But most of these groups (94 percent) are fee-for-service groups without any form of prepaid. Almost half of them are single specialty groups obviating the advantages of many kinds of specialists under one roof and a single medical record. The average group size is six physicians, indicating that most group practices are more a business arrangement than a health delivery system reform.

The rare multi-speciality fee-for-service group practices, if they establish ties with hospitals, will be candidates for certification as Health Maintenance Organizations under the Nixon Administration's plans. However there will be no reorganization of health services for the patient. Fee-for-service will remain the dominant form of reimbursement for the doctors. The only change will be the mechanism whereby doctors make profit. Rather than having the incentive to keep patients sick by being reimbursed for each episode of illness, under the HMO the doctor will have the incentive to keep his patient out of the hospital in order to maximize his profits. Fee-for-service group practice offers little improvement for the patient over the existing health delivery system. A second set of AMA newcomers to the prepaid group practice bandwagon in reality advocate prepayment without group practice. The Foundation for Medical Care of San Joaquin County, California, represents the model for this organization form. Established by members of the San Joaquin
County Medical Society in 1954, the San Joaquin Foundation was formed to block the creation of a prepaid group practice within the county. The officers of the Foundation are the same as the officers of the County Medical Society. The Foundation consists of 98 percent of all physicians within the County. The heart of the San Joaquin system is the agreement by these physicians to accept the Foundation's schedule of allowable fees as full payment for their service. The doctors also agree to an audit for medical quality and acceptability of fees conducted by a rotating committee of physicians from the Foundation. Consumers pay monthly premiums to any of a number of commercial insurance carriers which in turn contract with the Foundation to cover a relatively comprehensive set of health services. The patient has a free choice of which of the private-practicing doctor-members he wishes to see. The Foundation handles all claims itself: it reviews all claims for financial and medical irregularities and may insist that a physician accept an adjusted fee. The Foundation thus has a mechanism for cost control. The Foundation will not, under any circumstances, interfere with the pattern of practice in the community. Thus the Foundation acts as an effective defense of solo, fee-for-service private practice.

As prepaid group practice spreads to other parts of the country, more and more county medical societies are likely to turn to the Foundation concept as a self-defensive tactic. Already sixteen such foundations have been established in California. In Rochester, New York, the Monroe County Medical Society has initiated plans to start a similar foundation in response to a threat by Eastman Kodak and other local industrial firms to open a Kaiser-like prepaid group practice. The spread of these foundations will also be spurred on by Health Maintenance Organization legislation. The Foundation concept may be the means of organizing that complies with HMO federal guidelines while retaining the least interference with existing patterns of practice. In this way, Health Maintenance Organizations will buttress traditional solo private medical practice.

While AMA'ers adopt new organizational forms to ward off changes in the health system, the old-time prepaid group practice crusaders keep pushing out the same old answers, without admitting their limitations. Even though prepaid group practice is an improvement over fee-for-service, it is not a cure-all for the crisis facing the American medical system. Prepaid group practice is just one technical maneuver dealing with the arrangement and reimbursement of doctors. It has nothing to say about ending the two-class system of medical care, about improving distribution of health resources, or about creating consumer involvement in the health care delivery process.

For example, most existing prepaid group plans are only available to the employed and non-poor. In 1969, of the two million Kaiser-Permanente subscribers, only 1500 were drawn from Medicaid rolls—and these were families on a pilot project. As with commercial insurance, many prepaid group practice plans charge higher premiums and offer less coverage to the individual subscriber in comparison to the subscriber who enrolls through a union or some other group. In contrast to the group subscriber, the individual subscriber tends to be poorer, older, black or Puerto Rican, or employed in marginal non-union establishments. Thus a subtle two-class system of charges and benefits persists within some prepaid group practices. In Kaiser-Permanente, for instance, individual subscribers have to pay individual fees for laboratory and X-ray tests which are usually covered in group contracts, and have only 60 days of hospital coverage compared with 111 days for most group subscribers.

In terms of the maldistribution of medical resources, both doctors and hospitals, prepaid group practice again offers no immediate solutions. The medically barren wastelands of rural and ghetto America beg for resources now concentrated in urban areas, serving middle and upper class populations. But prepaid group practices are just as badly distributed as private practices and hospitals. Practice conforms, in most of their characteristics, to the patterns of American medicine; they will not, by themselves, change the American medical system.

Although many prepaid group practices were born out of the consumer co-op movement of the 1930's and 40's, the emphasis on consumer involvement has distinctly fallen off in recent years. Long before the present day black and Puerto Rican demands for community control, advocates of prepaid group practice stood firmly for consumer-oriented and consumer controlled health services. It is not surprising then that the Group Health Association of America (GHAA) was founded in 1949 on the principle: "Control of policy and administrative functions by or in the interest of consumers." (Emphasis added.) However, it became evident that many prepaid group practices are retreating from that position, when GHAA recently changed its principles to read merely: "... the direction of policy and administrative function be in the interests of consumers..." (Emphasis added.) Group practice can no longer be considered a step toward consumer involvement in the health system.

But, many advocates of prepaid group practice would argue, we have not really been fair to the idea. There are real prepaid group practices, they would say, which, while they do not pretend to provide all the answers for the health crisis, do at least provide cheap, high quality care for their patients. But let's take a look at these real prepaid groups—what do they really have to offer the consumer?

There is considerable diversity among the various prepaid group practice plans through-
out the nation. For instance, the Health Insurance Plan of Greater New York (HIP) offers prepaid doctors' services only, while the Kaiser-Permanente Plans are hospital-based prepaid group practices. Seattle's Group Health Cooperative of Puget Sound is a consumer-sponsored prepaid group practice, while the Community Health Association of Detroit is sponsored by the United Auto Workers. But the largest and most successful prepaid group practice plan in the United States is the Kaiser-Permanente system. Since it is regarded by many as the "model" plan, we will use Kaiser-Permanente to illustrate the limits of prepaid group practice.

The Kaiser-Permanente Medical Care Program was organized in the 1930's by Kaiser Industries to provide medical care for its workers. It has since opened its doors to people who are not employed by Kaiser Industries, and has expanded from its original Southern California base, to its present day spread over six regions: Northern California; Southern California; Portland, Oregon; Hawaii; and more recently Cleveland, Ohio and Denver, Colorado. Kaiser-Permanente provides medical and hospital care for two million members through nineteen hospitals, two extended care facilities and fifty-two clinics. In 1968 alone, the Kaiser-Permanente program generated revenues of $216 million, without dependence on rich trustees or substantial government subsidy.

The organization of the Kaiser system is based on four principal groups.

1. The Kaiser Foundation Health Plan is a non-profit enrollment and dues collecting organization that contracts with individuals or groups to provide medical services.

2. The Permanente Medical Groups are independent, profit-making partnerships of fulltime medical specialists providing all professional services to the Health Plan membership. Payment to the medical group are made by the Health Plan on a capitation basis (i.e., the Health Plan pays the medical groups a fixed payment for each person they care for, regardless of the amount of services used by the particular individual).

3. The Kaiser Foundation Hospitals are a group of voluntary, non-profit community hospitals that provide all hospital services to Kaiser members. The hospitals are also reimbursed by the Health Plan on a capitation basis.

4. Permanente Services, Inc. is a profit-making corporation located in each region which provides administration, housekeeping, and an employment bureau and which manages retail profit-making pharmacies at the Kaiser hospitals and clinics. Permanente Services, Inc., is owned by Kaiser Foundation Health Plan and Kaiser Foundation Hospitals.

Management decisions affecting all four organization units are generally reached through a top level management committee consisting of the regional manager, the Health Plan manager, the hospital administrator, the medical director (chairman of the executive committee of the Permanente Medical Group), the chief of the Department of Medicine and the regional comptroller. But the real decisions are made by the Board of Trustees of the Kaiser Foundation Health Plan (which is the same as the Board of Trustees for the Kaiser Foundation Hospitals). This twelve member board reads like who's who of the Kaiser Industries. For example, Edgar F. Kaiser, President of the board of Kaiser Industries is also president of the Board of the Kaiser Foundation Health Plan. Other Health Plan Board members include Roy E. Hughes, executive vice president of Kaiser Industries; George D. Woods, former president of the World Bank and now director of the First Boston Corporation (the third largest investment banking house in the U.S.) and a board member of Kaiser Industry; Paul S. Marrin and George E. Link, both partners in Thelen, Marrin, Johnson and Bridges, the general counsel to all Kaiser enterprises.

Although the Kaiser family stresses the independence of the Health Plan from Kaiser Industries by pointing to the fact that only three percent of the total Health Plan membership is made up of Kaiser Industries employees and their families, it is evident that top-level decision making in both organizations is made by the same people.

One of the major innovations of the Kaiser system, spearheaded by its business-oriented leadership, is a built-in incentive for efficiency. As explained by Fortune, "The providers of medical care—the doctors and the hospitals—share the financial risks of illness with the patient. Member's monthly charges are set for a year, and during that period the program must operate on the revenue generated by these charges. If costs exceed revenues during that period, the Kaiser system must absorb them. But any reduction in operating costs below management's projections swells a bonus fund that is shared by doctors and hospitals." Kaiser doctors are reimbursed by salary rather than on a fee-for-services basis; they receive a stable annual income ranging from $20,000 to $53,000. On top of this, each doctor receives the bonus referred to by Fortune, which in 1968 for Kaiser's Northern California region amounted to $7,900. The bonus theoretically stimulates efficiency because the doctor knows that any excessive treatment (such as hospital admission for a procedure that could be performed on an ambulatory basis) means that his bonus will be less.

The profit-motive runs through much of Kaiser-Permanente philosophy and operations. For example, take Kaiser's obsession with controlling patient utilization of health services. Kaiser-Permanente has made its reputation and its profits on lowering patient use of hospitals. In 1965, for instance, the average Kaiser member spent only 68 percent as much time in the hospital as his non-Kaiser member neighbors in Northern California. While the "bonus" incentive accounts for part of this decreased utilization, other less benign fac-
tors appear to be involved.

First, there are personnel shortages which function to inhibit patient utilization of services. In Kaiser's San Francisco branch, the doctor shortage is most acute in orthopedics. Patients wait up to 4 hours in the orthopedic outpatient clinic for diagnostic evaluation or cast removal, just as they do in most city hospitals. Although Kaiser-Permanente brags that it has been able to cut doctor-patient ratios from the nation’s average of one doctor to 750 population to one doctor to 935 population, it has done so at the expense of providing convenient, immediately accessible services to the patient.

Doctor shortages are probably the least of Kaiser's personnel problems. Nursing and other personnel shortages are more severe. The shortages and resulting overwork is reflected in the high turnover rate of nursing personnel at Kaiser's San Francisco Hospital. One nurse complained, "There are never enough nurses. We are constantly overworked. Sometimes at night I am the only nurse around to cover two floors. I don't blame other nurses for leaving. It's a lot better at the other hospitals in town." The cause of these personnel shortages is Kaiser's willingness to enroll members beyond its capacity. For example, within the Northern California region, Kaiser hospitals and clinics were constructed for a fixed capacity, yet the region now has gone well over that enrollment. And the economic incentive is to keep things this way. With oversubscription and underemployment, hospitals and doctors make more profit, by taking more money in from subscribers and passing less money out to personnel.

The effect of these practices is to force Kaiser patients to seek medical attention elsewhere. A study done in the early 1960's showed that 14 percent of Kaiser Plan members used doctors outside of the Plan for office visits and 33 percent did so for home calls. Since Kaiser will not reimburse members for use of doctors outside the Plan (unless in an emergency), Kaiser's economic incentives encourage this practice. The more medical services Kaiser subscribers obtain outside of the Plan, the less expenses there are for the Plan. It is important to note that Kaiser has a "multiphasic screening" program, Through the use of computer analyzed psychological tests, medical questionnaires, blood, cardiovascular and x-ray tests, the patient's need for a doctor is determined. What happens to the patient with an apparent simple cold? Will he have to take a 3 hour long battery of tests, medical questionnaires, blood, cardiovascular and x-ray tests, the patient's need for a doctor is determined. What happens to the patient who demands to see a doctor without prior testing be treated? The net effect is to preserve doctors' profits at the expense of the patient, who will be subjected to increased discomfort, loss of work time, and indignity, just as in the city hospital outpatient clinics.

If decreasing utilization of health services is to work for the consumer's benefit and not simply for the provider's profit, then consumer control of the health plan is absolutely necessary. Yet, Kaiser-Permanente has vigorously opposed any form of consumer participation on its Board of Trustees. Henry J., father of Edgar Kaiser, summed up the health plan's stand in 1957: "You don't ask your corner grocer to share his ownership with the people who buy at the store." It was Kaiser's anti-consumer control attitude that forced the

Kaiser's plan for decreasing "doctor" utilization is explained by Dr. Sidney Garfield, founder of the first Permanente Medical Group, in the April 1970 Scientific American. Dr. Garfield describes a patient channelling mechanism which "regulates patient flow" by sorting patients according to their needs and routing them to the appropriate paraprofessional for those needs. Thus the nutritionist or nurse practitioner, who costs less than the expensive doctor, is used more often, and the doctor is used less.

The primary measure of patient need proposed by Garfield is the Kaiser-pioneered "multiphasic screening" program. Through the use of computer analyzed psychological tests, medical questionnaires, blood, cardiovascular and x-ray tests, the patient's need for a doctor is determined. What happens to the patient with an apparent simple cold? Will he have to take a 3 hour long battery of tests before he can see the doctor? How will the patient who demands to see a doctor without prior testing be treated? The net effect is to preserve doctors' profits at the expense of the patient, who will be subjected to increased discomfort, loss of work time, and indignity, just as in the city hospital outpatient clinics.

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changing of the Group Health Association of America's founding principles. Kaiser refused to join until all references to consumer control were deleted.

Even though unions make up roughly one half of all group enrollment in the Kaiser-Permanente Health Plan, there are no union representatives on the Plan Board of Trustees. But there has been increasing pressure to expand the Board membership to include consumers. In response, the old nine member board recently voted to expand to twelve members including two presumed consumer representatives: Mary I. Bunting, president of Radcliffe College, Cambridge, Massachusetts (Kaiser doesn't have an outpost in Massachusetts, so Dr. Bunting is probably an infrequent user of Kaiser services) and Art Linkletter, of radio, television and anti-dope pushing fame.

But consumer control is not merely a luxury; it is an absolute necessity for guaranteeing quality medical care delivery. Some advocates of prepaid group practice argue that this does not apply to such practices. Prepaid groups avoid the abuses stimulated by the profit motives of the fee-for-service system, such as unnecessary surgery, they claim, and they point to several studies comparing frequency of surgical procedures on prepaid group enrollees and on Blue Shield (fee-for-service) enrollees to prove it.

But such evidence does not mean that the profit-motive is less active within the prepaid group practice setting. Rather the incentives for profit-making are just reversed. Instead of stimulating excessive and unnecessary utilization of health services, prepaid group practice encourages underutilization. Some consumers fear that without their involvement as watchdogs, this tendency may escalate into excessive underutilization of necessary health services. For example, take the case of the elderly patient with cataracts. With incentives stacked against utilization, this patient's operation may be delayed for years with the hope that death will preclude the necessity for providing the service. Or the case of the elderly patient with an infected foot. The incentive for decreased hospital utilization might lead to early amputation rather than the prolonged hospitalization required by chemotherapy.

Kaiser is widely heralded as a model for change in the health care delivery system because of its claim to provide high quality care at low cost. But with profits taking priority over service to patients, and in the absence of avenues for consumers to assert their primacy over the system, even the highly touted Kaiser system leaves serious problems for the patient.

[Note: We wish to thank Judy Carnoy of the Pacific Study Center for making available to us unpublished research on Kaiser.]—Oliver Fein, M.D.

ABORTED ABORTIONS: Since July 1 when New York State's liberalized abortion law went into effect. But on October 13, a ruling by the New York City Department of Health effectively limited abortions to hospitals and hospital affiliated clinics. The new regulations mean free-standing, unaffiliated, clinics will need new facilities costing approximately a quarter of a million dollars to install.

Dr. Mary McLaughlin, the City's Health Commissioner, stated that the complication rate in hospitals since July 1 seemed high enough to warrant limiting abortions to hospitals only for the "safety of the women concerned." She added that the hospitals could handle the increased demand for the procedure. But the reality appears to be much different:

- In September both Lincoln and Cumberland hospitals were refusing to register patients for abortions.
- Morrisania Hospital does not accept anyone over 10 weeks pregnant unless referred by the courts.
- Roosevelt Hospital will soon be reducing the number of abortions performed there.
- At many hospitals it takes up to one week to get an appointment for an examination and then a further two weeks before the abortion can be performed. This means that a woman who is 7-9 weeks pregnant when she first seeks help may become ineligible while she is waiting for the schedule.

At public hearings about the new regulations held on October 16, the availability and safety of the in-hospital abortions were questioned. Testimony by both women and doctors gave evidence of inhumane treatment, unsanitary conditions, and inflexible regulations in the hospitals. Some doctors felt the hospital use of general anesthetic was more dangerous than the use of local anesthetic in clinics and doctor's offices. The complication rate has been 1.0 percent in pregnancies less than 12 weeks in hospitals, and only 6 percent in clinics.

It is obvious that the hospitals, already overburdened, will not be able to handle the demand. Thus the profiteering will continue: One private hospital is charging $575 for abortions, excluding doctor's fees. Since the cost in clinics has ranged from $50-300, the new regulations will mean poor women will flood the already overcrowded municipal facilities or be forced back into the hands of the kitchen table abortionists.

CORRECTION: In the last issue of the BULLETIN we published a "corrected" chart of medical school and nursing school admissions. The original chart had appeared in the September BULLETIN. Alas, we goofed again. Two figures remained incorrect. The percentage of black students enrolled in the first year of medical school in 1968-69 should have been 7.94 percent, and in 1969-70 it should have been 10.05 percent. We regret the error.