Would You Buy an Insurance Policy From This Man?

Can a conservative president compete with his liberal rivals on their own ground—national health insurance as a solution to the national health crisis? Amid denunciations from construction workers and farmers, President Nixon is hard-pressed to hold onto his inflation-ridden silent majority. Thus with the 1972 elections only a dice-throw away and with the Kennedy-labor axis in Congress gearing up for an all-out fight for federally-sponsored national health insurance, Nixon has been forced to present a plan of his own.

As revealed in his February health message to Congress, his plan sounds almost like national health insurance. Almost—because the plan is neither “national” nor it is “health” insurance. It proposes at least three different programs: one for the gainfully-employed, one for the poor and near-poor, and one for the aged. Benefits and premiums will vary from group to group, and even within groups, depending on how the states and large employers respond to the new plan.

The Administration’s version of “national health insurance,” as the newspapers have mislabeled it, is actually more regressive in some respects than the AMA’s “Medicredit” plan for national health insurance. At least Medicredit is a universal plan with uniform national standards for all economic classes and age groups.

But then, the Nixon proposals were never meant to solve the health crisis faced by the American people. They were meant to solve the crisis faced by the American health industry—an industry whose unchecked profiteering has backfired into uncontrolled inflation dangerous now even to the profiteers themselves. From the consumers point of view, the plan would only enrich insurance companies, hospital supply and medical equipment companies, doctors and hospitals, while penalizing workers and making medical care less accessible and more costly to most Americans.

Nixon’s solution to the crisis emerges from the Republicans’ philosophical approach to the health issue [see November, 1970 BULLETIN]. A central theme of this philosophy is that the “right to health care,” established by the Kennedy-Johnson Administration, is not the responsibility of the Federal Government.

Health care is the province of private industry and should remain so. As the President put it in his message on health, “I believe the public will always be better served by a pluralistic system than by a monolithic one, by a system which creates many effective centers of responsibility—both public and private—rather than one that concentrates authority in a single governmental source.” In fact, the Republicans believe that the Federal government should retreat even from its present level of involvement in the health system and eventually restore the health industry to “unfettered free enterprise.”

The Republicans place the blame for current medical inflation squarely on the shoulders of consumers. They hold that consumers, suddenly enriched by Medicaid and Medicare programs, put too much “demand” on the health system. Since the “supply” of health services is limited, all this new “demand” naturally led to higher and higher prices.

The problem with this logic is that application of the free enterprise model to the health care marketplace is utterly specious. It neglects the most important economic fact about the health industry—that much of it is a monopoly and that prices in a monopoly rise to maintain profit rather than balance supply with demand. But the Republicans are not prone to blaming their profiteering friends in the health industry.

Consequently, the Republican cure for medical inflation is a little harsh disciplinary medicine for the consumers to discourage them from placing too much demand on the health system. Nixon says in this health message, “... we should remember that only as people are aware of those [medical] costs will they be motivated to reduce them. When consumers pay virtually nothing for services and when, at the same time, those who provide services know that all their costs will also be met, then neither the consumer nor the provider has an incentive to use them efficiently....”

Can Nixon get the consumers’ votes while disciplining them into a new “cost consciousness” about health at the same time? This is the problem that HEW technicians and others on the Administration staff have been wrestling with for months. Their answer, revealed in its mind-boggling detail in the President’s health message, is a masterpiece...
Thus, despite the expenditure of about $100 a year in insurance premiums, a healthy family will get no help where they need it most: for routine care and preventive medicine. Thanks to all the deductibles and co-insurance, such a family will retain an admirable level of medical "cost consciousness." They will thank hard before seeking medical care during the early stages of illness.

Now take a family with more serious health problems. With all the deductibles and co-insurance, this family is liable for possible medical costs of some $1720 per year, in addition to the $100 or so it pays out as its share of the insurance premiums. When the bills reach above $5000 per year (before insurance), what the Administration is defining as a "catastrophic" level, the insurance will begin to be a big help, paying up to $50,000 per year. But an annual outlay of $1820 a year would be catastrophic enough for all but the five or ten percent of American families with the highest income levels.

Nixon's insurance "partnership" does not mean a new kind of health insurance. At best it means a new sickness insurance to soften the impact of the most catastrophically prolonged and expensive illnesses—and this only after it has laid the entire financial burden of early detection and treatment on the shoulders of the consumer.

For most Americans, the financing of this new insurance will also be remarkably regressive—the same amount of contribution (35 percent of the premium) whether the employee is the janitor or the executive vice president. In the words of United Auto Workers President Leonard Woodcock the proposal is "a backward and intolerable imprisonment of medical care financing in the operations of the insurance industry."

For those who are self-employed or who work for very small employers (such as grocery clerks and housekeepers), it is not clear what Nixon's plan will mean. Since insurance companies consider these people a greater risk and do not like to sell insurance to them, Nixon is proposing that each state set up some sort of an insurance "pool," with some state contributions to the premiums, as an inducement to the insurance companies. Benefits and premiums for these people will very likely vary with the generosity of the state, and are likely to add up to a skimpier package than that offered to other workers.

For the POOR AND NEAR-POOR, Nixon has the Family Health Insurance Plan (FHIP). Previously almost all of the poor, and in some states the near-poor, receive...
their health benefits through Medicaid. Nixon proposes to replace these relatively comprehensive benefits with a federal subsidy to purchase private health insurance for the poor. For the very poor, those with incomes under $3000 for a family of four, the government will pay the full cost of their insurance premiums. For the “working poor,” those with family incomes between $3000 and $5000 the government will partially subsidize the cost of their insurance premiums. They will have to contribute a variable sum in proportion to their income. FHIP will be compulsory for both groups.

Key questions about FHIP remain unanswered: What benefits would it provide? The President says vaguely that it will pay for “basic medical costs.” Would it be as comprehensive as Medicaid, covering dental care, drugs, eyeglasses, mental care, etc.? Would it be as inadequate as NHIP for the working poor? Or would it be even less comprehensive than NHIP? How much will the working poor be required to pay for their own insurance? How will they pay for it? The Administration is suspiciously unclear on these points.

For the AGED, there will still be Medicare—a relic of the Johnson-Kennedy Health New Deal—but in slightly revised form. Presently, Medicare is a federal program of insurance for those over 65, made up of Part A for hospital care (paid for through Social Security taxes) and Part B for ambulatory care which is paid for by a monthly premium, shared by the individual and the government. With its gaps in coverage, deductibles, and monthly premiums, Medicare has been so inadequate in meeting the rising health costs that the aged still pay more out of their own pockets for medical care than any other age group.

Nixon plans to give a little and at the same time take a little away from the shrinking pocketbooks of the old. He will merge parts A and B and give $1.4 billion to finance the Part B premiums which the aged presently pay themselves ($5.30 per month). However, in the interest of promoting “cost consciousness,” he will take away $400 million by adding still more deductibles and co-insurance. The net effect of all these changes is unclear. If properly deployed, his new deductibles and co-insurance could wipe out the gain made by total government financing of Part B.

These are the pieces—NHIP, FHIP and the “New” Medicare—which the Administration hopes to pass off as new federal health strategy to rival the liberals’ National Health Insurance proposals. The beauty of the plan, from the Republican point of view, is that it seems to deal with the problem of medical inflation without stepping on the toes of any medical providers. Nowhere, in his discussion of the new insurance schemes, does Nixon mention controls or limits of any providers’ prices. He barely chides the providers for their lack of “cost consciousness,” while the consumers, through the host of proposed deductibles and co-insurance plans, will be brought to a more acute level of “cost-consciousness.” They will become so conscious of the costs of their own health care that they may well be forced to go without it.

The Administration has proposed one device to encourage “cost consciousness” on the part of the providers—the celebrated “HMO” (Health Maintenance Organization). Briefly, an HMO is a group of doctors plus a hospital or hospitals which band together to provide comprehensive, prepaid care to a given population [see the November, 1970, BULLETIN for a full explanation].

The government, in the case of Medicare, or an insurance company, in the case of NHIP or FHIP, will contract with an HMO to provide care to a certain population at a fixed, prepaid price. If the costs of providing the care exceed the prepaid price, the HMO will have to make up the deficit itself. If, on the other hand, it keeps its costs under the prepaid amount, the HMO keeps the difference as a profit. Unlike providers who are reimbursed by insurance plans on a fee-for-service basis, the providers in an HMO will be fanatically cost conscious. For them, the profits will lie in holding services to a minimum, especially expensive inpatient services.

In effect, then, HMO’s are just one more way of reducing consumer demand. Consumers covered by NHIP, FHIP or Medicare may choose to apply their benefits to membership in an HMO plan or to seek care from conventional providers. In the latter case, the deductibles and co-insurance built into their insurance will discourage “excess” use of health services. In the HMO the providers themselves will be the watchdogs over “excessive” consumer demand.

For the time being, however, HMO’s should be seen more as a public relations gimmick than as a serious program. In his health message, the President called for $23 million to finance HMO formation, only enough to pay for setting up about 40 HMO’s, each serving 35,000 people, nationwide. But even at this low level of dollar commitment, HMO’s serve an important function: they make it seem as if the Administration is dedicated to the reorganization—and not just the financing—of the health care system. NHIP, FHIP and Medicare have been termed a “three-layer cake” insurance system, and HMO’s are the attractive, liberal frosting.

So far we have examined the Administration’s strategy from the least flattering perspective—the consumer’s point of view. To be fair, one must also look at the Nixon plan from the point of view of those it is really intended to help—the insurance companies, the hospitals and doctors, and the health products and hospital equipment industries.

The INSURANCE COMPANIES are far and away the clearest beneficiaries. Under NHIP, employees will be required to spend $2.5 billion more than they are presently spending on health insurance premiums. In
addition, 20 percent of the population under 65 presently has no health insurance whatsoever. FHIP will deliver these people—nearly 35 million—directly into the hands of the private insurance market. How much of these premiums are paid by the government and how much by the poor themselves makes little difference to the insurance companies. On top of that, spending required to launch FHIP will add $1.2 billion to the $5 billion now spent annually by the government on Medicaid.

Not only are the insurance companies promised this vast infusion of new funds and customers, but through its array of deductibles and co-insurance provisions, Nixon's program simultaneously promises to cut utilization of the health care system. The program will actively discourage consumers from using health services and therefore from cashing in on any insurance benefits. Increased income, decreased expenses—Nixon's program promises chiefly to insure the profits of the insurance industry. And the primary recipient of these benefits will be Blue Cross.

Business Week comments, "When President Nixon fired off his long-awaited health care message to Congress late last week, no one was listening more rapitly than Walter J. McNerney, the 45-year-old president of the Blue Cross Association, the Chicago-based overseer of the nation's 74 local Blue Cross plans. "The President's health care package promises to add at least $3 billion to the $14 billion that the nation now spends on health insurance. That should mean a bonanza for Blue Cross which writes nearly as much health coverage as all the 1500 commercial insurance companies in the field combined. Further, the whole health message is aimed at easing the crisis in health care that now grips the country. That plainly would help Blue Cross, which as the largest single payer of medical bills, has felt the effects of the crisis as keenly as anyone." (Emphasis added.)

One would almost think that the President's health message was a personal note to McNerney, who chaired Nixon's recent Task Force on Medicaid and Related Programs.

* HOSPITALS AND OTHER PROVIDERS will obviously benefit from any form of health insurance. As medical costs have spiralled, providers are finding it harder and harder to get consumers to pay their bills. Nixon's NHIP and FHIP promise to fill three of the providers' largest gaps.

NHIP promises the hospitals assurance of payment in the case of "catastrophic" illness requiring prolonged and expensive treatment of a patient. Under NHIP $3400 of the first $5000 in medical bills is guaranteed and the program covers all expenses up to $50,000 a year after that.

FHIP is a partial answer to the hospitals' problem of the "in-between" people—those too rich for Medicaid and too poor to pay their bills themselves. Whereas, before they often simply defaulted on their bills, now the hospital will be assured of at least payment through the patients' mandatory private health insurance.

To maintain their teaching and research subjects in the past many large teaching hospitals have been forced to serve poor people free or below cost. Now this expense will be covered in part if not in full by FHIP, and again with no strings attached.

And there will be no strings so long as Blue Cross maintains a near-monopoly on the health insurance industry. No one will be snooping into how the hospitals spend their money or set their prices. At least the commercial companies have a vested interest (their own profits) in keeping down hospital costs. But Blue Cross is a "non-profit" agency, run largely by and for the hospitals, and thus has neither the ability nor will to monitor hospital costs [see March, 1971, BULLETIN). So a very large part of the profits delivered to the insurance companies will be handed over, no questions asked, to the hospitals and medical providers.

Indirectly, the HOSPITAL EQUIPMENT COMPANIES stand ready to reap the benefits of the only aspect of NHIP which can be considered at all generous. This is the level at which the heavy, expensive technology sold by the hospital equipment industry comes into play—the heart-lung, cobalt therapy, kidney dialysis machines, etc. A NHI subscriber may not be able to afford a $20 check-up, but he'll be in good shape should he ever require a kidney transplant. So the hospitals will feel free to invest in even more prestigious, high-technology, seldom-utilized equipment than they already have.

In addition, the President threw an extra bone to the equipment industry. He is instructing HEW to explore and promote equipment for automating diagnostic procedures, such as computers and monitoring machines, since "they can help us deliver more effective, more efficient care at lower prices."

But Nixon's strategy will be of no more use in the long-run to the health industrialists than it is in the short-run to the consumers. Basically, Nixon's program is far more inflationary than the Kennedy plan for universal, federally-financed, cost-controlled health insurance ("which the President is labelling "inflationary"). The President cannot control medical inflation by controlling the consumers. He cannot because they are not the cause of that inflation. The real cause is the profiteering of the health industry, which the Administration plans to boost rather than to control in any way. In effect, medical costs will continue to soar, spelling crisis for the health industrialists just as surely as it spells medical indigency for the consumers.
What Was MOTF's Motive?

After fifteen months of meetings and an expenditure of over $5 million in taxpayers money, the Mayor's Organizational Task Force (MOTF) for Comprehensive Health Planning (CHP) has finally announced its long-awaited plans for New York City's CHP agency. But after all this, MOTF has produced a plan which continues the private domination of the health scene and the public planning process.

MOTF is the planning agency set up to plan a planning agency. Originally all health planning in New York City was controlled by the Health and Hospital Planning Council (HHPC), a private planning body dominated by Blue Cross and the voluntary hospitals. Established during the Depression, the HHPC has grown to a powerful agency which has been granted state and federal authority to review and in essence control all hospital construction and renovation in New York City.

But, the federal Comprehensive Health Planning Act, passed in 1966, mandated the establishment of local Comprehensive Health Planning agencies which would provide "a true partnership for health among consumers, providers of health services and municipal agencies."

In New York City, a protracted struggle ensued between advocates of a publicly controlled CHP agency and the old provider-dominated HHPC. The result was a stand-off: New York City established MOTF, a provider and consumer group to plan for a CHP.

But it is clear who has won the stand-off. MOTF has become the mechanism for continued private provider domination of health planning. Little wonder that MOTF director Frank Van Dyke has nothing more to say when introducing the report than that it is "not a utopian plan."

MOTF's experience is a reflection of the history of health planning in the United States. CHP can be described as a "wonder drug" created to end an illness that, in the end, is not going to change the condition of the patient.

What is the illness? It was—and is—familiar to most ordinary Americans seeking health care. The American Health system itself is ill. As a system to deliver health care, it is fragmented, a jumble of scarce, expensive, seemingly uncontrollable "sickness" services, institutions and programs. This jumble is a system only to those who derive profits or prestige from it. Although we spend more money per capita than any other nation in the world on health care, the United States remains far down the list on most world-wide indices of health.

How could the planners then cure this "diseased" system? The prescription was the Comprehensive Health Planning Act and its subsequent "Partnership for Health" amendments. Recognizing the seemingly "planless" condition of the American health care system, the legislation declared that no less than "the fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person."

To implement this vision grants were authorized for the development of both state and local level planning agencies. Early enthusiasts for the legislation argued that a strong public role in planning efforts seemed certain, since the law required majority consumer representation on each local board or its advisory body.

It soon became evident, however, that CHP agencies at both the state and local levels lacked the operational powers or authority to rationalize existing patterns of health care delivery. For one thing, the power to plan health facilities (e.g. approve the construction, size, and location of all new health facilities—hospitals, neighborhood health centers, etc.) invariably remained in the hands of older planning bodies long-dominated by private provider groups such as HHPC in New York.

The new CHP agencies, lacking real power, settled into an investigative and advisory role, infrequently attempting to coordinate or catalyze more rational, people-oriented local services.

With the coming of 1970s, the Comprehensive Health Planning movement all but evaporated. Federal support for the CHP "cure" never really emerged under the Nixon Administration, as the Washington agency languished for months with no full-time director. Meanwhile the Nixon camp tooled up its own "treatment" for the failing system [see accompanying article].

Recently, the appointment of former Agnew aide, Robert Janes, as national CHP director confirms this assessment of the CHP cure. Informed sources within the agency suggest that Janes' role will be to quietly remove the "C" and the "P" from future CHP efforts, relegating state and local agencies to the status of "booster clubs" for improving health services.

Outside Washington, signs abound that the CHP vision was never quite what it seemed anyway. Many of the health planning "experts" who originally touted the CHP "partnership for health" have since revealed what they really had in mind all along: plans for all-private, multi-hospital mergers on the local level.

For example, nationally-known health planner Robert Sigmond, an early champion of health planning, was a key figure in the preparation of the Perloff Report recently adopted by the American Hospital Association. The Perloff Report advocates the formation of private hospital conglomerates called "Hospital Corporations" with little or no public accountability. These corporate entities supercede any role for the public in hospital planning.
Health Movement:
Storm in The Windy City

Like their natural counterparts, the seeds of political struggle sometimes flourish in the toughest ground. Or so it seems with the health movement in Chicago.

"Welcome to Chicago, Richard J. Daley, Mayor." "Chicago is a beautiful city . . . keep it that way . . . don't litter, Richard J. Daley, Mayor." The billboards of Chicago are a constant reminder of a central political reality: Richard J. Daley is Mayor. As most Americans know, he and his machine have long controlled the "public" life of the city; serious and successful challenges to his power have been nil.

There is another, less obvious fact about the city: it is the home of the American Medical Association, American Hospital Association, the Joint Commission on the Accreditation of Hospitals, and the Blue Cross Association of America. In short, Chicago is a sort of a Pentagon for the Medical-Industrial Complex.

It is in the shadow of these—the strongest of the vested interests in the American health system and the strongest political boss of any American city—that the Chicago health movement erupted. It’s three main thrusts are the opening of free clinics, unionization of health workers and organization of students, interns and residents. These programs have galvanized the Chicago health community and challenged the bosses’ control.

Chicago’s “free clinic” movement, the size of which is unparalleled in the nation, was originally stimulated by efforts of the Black Panther Party to open a local community health center in the fall of 1969. As other local groups joined the health issue, the once-barren wasteland of Chicago’s black, brown and Appalachian white ghettos became fertile soil for the budding movement.

Chicago’s health system has been dominated almost entirely by the private sector. There is only one public hospital, Cook County, and virtually no community-based health services. By early 1970, however, ten free health centers existed. They joined to organize a “People’s Health Coalition” that included a variety of groups—black, brown and white, from organizations with highly-identifiable political ideologies such as the Black Panthers, Young Lords and Young Patriots to groups of welfare mothers and housing project groups. But as an independent health service system sprang up, Daley saw a possible crack in his machine’s control over public service-based patronage.

Daley’s first response was predictable: police harassment of the free clinics. At the Young Patriots’ Uptown Community Health Service, agents of the Chicago Police Department Subversive Activities Squad harassed doctors and patients, raided medical staff meetings, and finally pressured the landlord into evicting the clinic. Similar tactics followed against the Young Lords’ and Black Panthers’ clinics. Yet, the free clinics grew. Literally thousands of people came for treatment.
Daley next resorted to the written law in an attempt to eliminate the clinics altogether. His immediate goal was to find a legal basis for continued police harassment. A 1939 city ordinance governing “free clinics and dispensers” was dusted off and revived. The law mandated that clinics be furnished with cuspidors and comply with other ancient “public health” measures. Most devastating for the clinics, the law allowed the Board of Health or its representatives to inspect clinical records at any time. Thus, a once-reasonable public health statute for protecting the quality of medical care was turned into a repres- sive tool. Personal information collected on any patient using the free clinics could be used against that patient in his neighborhood or on the job.

Board of Health inspectors were denied access to the health clinics operated by the Young Lords, Young Patriots, Black Panthers and the Latin American Defense Organization (LADO). All four clinics refused to apply for licenses as “free clinics,” thereby blocking the legal foundation of the Board of Health’s inspection powers. Despite the fact that many clinics, including the university teaching clinics, had operated for years without Board of Health licenses, court action was initiated against the four clinics for failure to register under the law.

But the court action merely widened the crack in the Daley machine. In July, 1970, the Circuit Court of Appeals ruled that the “ordinance was so vague and indefinite as to be unenforceable” in the case of the Young Patriots’ clinic. The case against the Black Panther Party was thrown out of court for defective subpoenas.

Still, the Board of Health doggedly pursued its prosecution of the Young Lords and LADO under the law. Finally, when the Chicago Sun-Times, a major establishment newspaper, published an editorial entitled “Don’t Badger the Clinics”, it was obvious the Mayor’s tactic has failed. But Daley is an inventive man when his control is questioned.

On December 4, 1970, exactly one year after the murders of Panther leaders Fred Hampton and Mark Clark, the Mayor himself introduced a new ordinance governing the operation of free health clinics. In the ordinance, which is still pending, he called for access to patient records as well as openended regulatory powers over free clinics by the Board of Health. The new law would apply to any clinic “not solely owned or operated by physicians,” a clear statement of Daley’s opposition to community control.

By focussing his strategy on the Board of Health, however, Daley shifted the unwelcome glare of publicity onto the Board itself. Several groups, including the Medical Committee for Human Rights, began to inquire into the performance of the Board of Health, uncovering a virtual indictment of the Board for mal- and non-practice. They found, for example, that:

Veneral disease is epidemic, yet the Board of Health refuses to pay for treatment not provided in its own V.D. center.

Last year Chicago experienced a diphtheria outbreak revealing the lack of any realistic immunization program in the City.

Recent cuts in City funds for a high-risk maternity and prenatal program have left thousands of women without prenatal or delivery arrangements.

The Mayor soon moved to counter this blow to his Board’s image. He announced plans for eight new comprehensive care centers to be sponsored by the Board of Health. That the mayor chooses this time to get into health is no coincidence. He has had money for the clinics since the passage of a 1966 bond issue for health care. Significantly, four of these centers are to be located in areas which are now served by free clinics. Clearly, the free clinic movement has made health a major issue in Chicago.

The intent in the Mayor’s response is obvious: no independent political bases around health services will be permitted. Community control in any form threatens the Daley machine.

(A recent Board of Health application to HEW for additional funding, for example, was rejected by the Comprehensive Health Planning agency for the Chicago region, based partly on the lack of hospital cooperation and inadequate planning of services. But the decisive issue was the total absence of community participation in the Board of Health’s plans.)

The experiences of two Chicago neighborhoods again illustrates the anti-community stance adopted by the Board of Health, which excludes participation by any local organization.

The Kenwood-Oakland Community Organization (KOCO) is a neighborhood group, semi-independent of the Daley machine, located in one of the Model Cities areas on Chicago’s South Side. KOCO recently negotiated an agreement with Michael Reese Hospital, the major medical center in the area. It won recognition as the community board for any future neighborhood health center affiliated with Michael Reese. Each of the Model Cities areas is to have one Board of Health Center funded by Model Cities. Logically, the center in the KOCO area should be affiliated with Michael Reese Hospital. Yet, the Board of Health has refused to sign a contract with Michael Reese because of the hospital’s prior agreement with KOCO.

Another example of the Board’s denial of community participation can be seen in its attitude towards the Uptown Community Health Association (UCHA). UCHA was created by poor community residents, representing blacks, Latins, Indians and Appalachian Americans and is located in another Model Cities area. It managed to win backing from the local hospital planning council, as well as the Model Cities community advisory board as the Uptown health consumer group. Yet the Board of Health has adamantly re-
fused to recognize UCHA as the community health board for the temporary Comprehensive Health Center opened last year by Model Cities in Uptown.

Attention was brought to the Board of Health refusal only after the Young Patriots together with other community groups staged a "heal-in" and takeover of the temporary center, resulting in 43 arrests. Although the action failed to prompt Board of Health recognition of UCHA, it did invoke promises of increased health services in Uptown.

As the free clinic movement developed, it opened cracks not only in the "public" sector of Chicago's health system, but in the bastions of private medical power as well. In contrast to New York City, medical empire-building has been less aggressive in Chicago. The division of "turf" among the large Chicago medical centers in less clear. But, some patterns are emerging.

Northwestern University Medical School and Center (including Wesley and Passavant Hospitals), situated on the wealthy Gold Coast, has long claimed the conservative role of defending private practice.

Meanwhile, the University of Chicago School of Medicine, sunk ostrich-like into research, has resorted to building fences and parks on its periphery to prevent any encroachment from the surrounding black community.

Only Presbyterian-St. Luke's Hospital, now the site of reborn Rush Medical College, has shown faint signs of empire-building behavior. Through involvement in the OEO neighborhood health center at Miles Square, Presbyterian-St. Luke's learned how public grants can be used to finance imperial expansion. More recently, it has begun to line up community hospitals for "affiliations" in anticipation of government grants for prepaid health insurance.

It was to these private bastions of health care that the free clinics brought their demands for responsibility to the community's needs. In the Uptown area, the Young Patriots pressed Weiss Hospital, a local institution reserved for "paying" patients for emergency back-up and the opportunity to make referrals to specialty clinics. Weiss Hospital agreed. When another group, the Young Lords, approached a north-side local institution, Grant Hospital, however, they were flatly refused similar privileges. The demonstrations that followed failed to shake the hospital's refusal.

Perhaps the most serious challenge yet to the private health establishment occurred when the Pedro Alviz Campos Center for the People's Health took its demands not to a local hospital, but to the patrician center itself, Northwestern. Sponsored by the Latin American Defense Organization (LADO), the Center asked not only for back-up services, but also for participation in the health planning process. And they won!

Northwestern agreed to include LADO in any health planning by the medical school which involves the community served by the clinic. Of course, this victory is yet to be tested. But since such agreements are rare in the history of the health movement, it is worth examining what and who prepared the way for Northwestern's concession. At least some of the groundwork was laid by students within Northwestern itself.

In the spring of 1970, as a direct result of their work in free clinics, nursing and medical students at Northwestern Medical Center organized the Northwestern Health Collective. The free clinic experience made students conscious of the huge gap between the
health needs of the people they had seen and the research and teaching priorities of the medical center. As students at the medical center, they assumed the special responsibility of challenging the institution’s priorities from within.

Student concern culminated on May 11, 1970 with the takeover of the administrative offices of one of the medical school deans. Over thirty students announced the creation of a “People’s Health Free University” inside the dean’s office. In the following 24 hours of occupation, community leaders and health workers were brought in as instructors of the Free University. They rapped about community health needs and the necessity to change institutions to meet those needs.

The Northwestern Health Collective listed 25 demands as the basis for its actions. These demands fell into three categories: institutional racism, patient care for the poor, and student oppression. The specific points ranged from the establishment of new admissions requirements and procedures, such that one-third of the entering class be black, Latin or low-income whites, to the right of students to review and to respond to all evaluations by their instructors. Sixty-five percent of the student body signed a petition in support of these demands and an ad hoc faculty committee published its own proposals in consonance with the original demands.

During the subsequent negotiations, the Medical Center administration, made several notable concessions. First, an “Urban Doctors Program” was established, a result not only of the occupation, but also of pressure from the campus of black medical students. This program is designed to admit black, brown, and low-income whites to the right of Indian and poor white students from Chicago.

Black, East Clinic patients are largely white. The clinics cannot even be described as “separate but equal.” The black and the poor are victims of teaching and research. Department Chairman, Frederick Zuspan declares, “Current needs of the Department of Obstetrics and Gynecology are in the general categories of education, basic research and applied patient research.”

When confronted by SHO, the administration said they recognized the problem years ago. In 1968, they established a committee to plan a new OB/GYN clinic. They regretted that an impasse had been reached, in part due to lack of funds. The committee ceased to meet.

The students pointed out that in the same period the administration had funds for a new life sciences research building, renovation of the accounting department, reorganization of the records room, a center for the history of medicine, and an air-conditioned animal quarters.

SHO called a public meeting to discuss the clinic. A proposal was drawn up for eliminating segregation without additional expenditure: random distribution of all patients, staff and medical students to both wings.

When the administration refused to respond to the proposal, SHO took their case to the patients. The patients were outraged and began to raise questions to the nurses, secretaries and doctors. The administration reacted swiftly. The deans confronted the students in the clinic, accused them of “disrupting the doctor-patient relationship” and threatened them with disciplinary suspension.

The students had brought the situation to a boil. Patients and community groups were aroused. In February, Dr. Zuspan announced plans for a single system of patient care in the clinic. A sliding fee scale, based on ability to pay was introduced. Chicago Lying-In has moved one small step toward living up to its motto: “The best medical care in the world for all women regardless of financial means, race, creed or color.”
students. At Cook County Hospital, for example, the housestaff is fighting for better working conditions and improved patient care. The obstacles they face are formidable.

Cook County is the only municipal hospital in Chicago and the largest short-term hospital in the United States. It serves as the "dumping grounds" for the poor and other "undesirable" patients throughout the country. Within the house staff a Residents and Interns Association (RIA) has been formed. But of these 500 doctors, more than 65 percent are foreign-trained, creating natural divisions among staff members that the hospital has been only too glad to exploit in the past. By threats of deportation and visa retraction, the hospital was able for years to stifle political activity by the foreign residents and interns.

It was this oppressive tactic that RIA first attacked by establishing the rights of aliens through legal advisors. By fighting the chauvinism and racism they had experienced directly, the Association fostered a sense of multinational strength among Cook County's house staff.

From this position of strength the RIA stepped up its political activity, and attacked Cook County Hospital's new Governing Commission. This "independent" Governing Commission was created by the Republican-controlled state legislature in an attempt to wrest control from the Daley machine.

As it became clear that the change had merely brightened Cook County's public relations image without improving its patient care, RIA promised to "initiate legal action on behalf of our patients against the appropriate party when the right of patients at Cook County Hospital to quality health care is deprived due to deficient equipment, second rate laboratory and x-ray facilities, unsanitary and unsafe ward conditions, or understaffed medical, nursing or paramedical care."

In keeping with this resolve, RIA exposed to the press the complete travesty of psychiatric services at the hospital.

Due to understaffing, RIA asserted that "psychiatrists are not available to visit patients on the Medical, Surgical or Pediatric Wards even in dire emergency. As a result, many suicidal or dangerously disturbed patients must be treated by doctors basically unprepared to handle mental diseases on wards not designed for psychiatric patients. To prevent physical harm to the patient or other nearby nonpsychiatric patients, doctors at present can only tie the patients to his bed or knock him out with drugs, while waiting for help that isn't there."

RIA's activities culminated in contract talks with the hospital that have since been stalled for 18 months. RIA plans to hold a job action if contract demands are not met.

It is not only the interns and residents but Chicago's health workers in general who are beginning to move. While efforts at unionization have made headway in a few hospitals, elsewhere the resistance has been fierce.

For example, the fight for a union at Wesley Hospital within the Northwestern empire has been waged for over two years. In September, 1970, workers struck the hospital, calling for better wages and in-hospital training programs. The hospital responded with massive firings, intensive scabbing and a series of injunctions—all of which worked to break the strike in December. Although the hospital has lost several court appeals, it persists in refusing to negotiate with the union.

When one steps back to look at Chicago as a whole, however, it is clear that the health movement has come to the windy city. Its development and future growth, of course, will depend on the ability of existing groups to develop continuing strategies that can sustain them in the face of the city's hostile medical and political environment. But it is clear that the health movement is here to stay.—Barbara Bishop, Student, Northwestern Univ. School of Medicine

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