Health Research Guide

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This issue of the HEALTH-PAC BULLETIN marks a departure from previous BULLETINS. In the several years that HEALTH-PAC has been involved in research and analysis of the health system, a method of research has evolved. It includes the shortcuts to getting information; those issues and questions that reveal institutional powers and priorities; and a familiarity with basic publications and documents of the health system.

This month we pulled this information together to distribute as a methodology guide for our readers. Since we have received many requests for bits and pieces of information about specific institutions, as well as broader requests for a way to figure out the total health picture in a community, we hope that this guide will not only be of general interest, but also of specific use to readers.

This guide is made up of three interwoven components. First, it is a schematic guide to the health system—the components of the system, their interrelationships, key issues, etc. Second, it is an annotated bibliography, listing both primary sources of information and a selected set of articles and books about the health system. Finally, it is a research guide, in that it suggests ways of finding out about various institutions, programs, and issues—the publications, organizations, libraries, etc. to turn to.

A few words are in order about the functions and techniques of research, and their relation to organizing around the health system. No guide like this one can actually tell you how to find out the most important issues or the most important power relationships in a particular setting. The way power works in a given institution rarely corresponds to a formal organizational chart. Those who hold power will rarely tell you they hold it; even more rarely will they reveal their vulnerability. Understanding an institution is like the work of a spy. You must talk to people who work in the place, use the place, or know about the place—doctors, medical students, patients, community groups, newspapermen, etc. The kind of formal information you can get through the sources and procedures discussed in this guide help in knowing what and whom to ask and in interpreting the answers, but that is all. Similarly, the way in which power comes down on people, the way in which they feel it, be they workers or consumers, cannot be read in a book. Finally, power that isn't used may be power unrevealed. The questions you ask, the agitating you do, and the organizing that comes from it evoke responses, and it is those responses, more than anything else, that are the real source of understanding how and why an institution works, how decisions are made and in whose interests, etc.

Research itself can be a powerful organizing tool. Interviews can be part of the process of helping people understand their own grievances and their own situation with respect to an institution. A workshop of people who collectively research a subject or an institution may be the nucleus of an action and/or an action group. Research even by a
small group can help identify points of leverage and points of weakness in an institution. The goal of research is often interchangeable with at least short-run organizing goals. One may find that attempts to get information (e.g., about how a hospital is planning to set up a certain program) are met with continued rebuffs. The demand for information itself then may become an organizing and agitating goal, one easily coupled to a more strategic demand for an on-going release of information to the people affected by it and for an on-going role of those people in making decisions based on that information.

I. Health Delivery Institutions

Hospitals, clinics, nursing homes, community mental health centers, extended care facilities, etc.

A. Classifications: There are several ways of classifying health delivery institutions which are relevant to understanding and interpreting statistics and other information about them. The most common classifications are by ownership and by function.

1. Ownership

- Public: includes city and county general hospitals, state and mental hospitals, Public Health Service and Veterans Administration Hospitals, etc. These are publicly owned and are financed almost entirely by tax money (directly — e.g., a city budget appropriates money for the hospital; or indirectly — e.g., through Medicare or Medicaid paying for individual patients). These institutions may be entirely and directly operated by the governmental entity, or the government may contract with a private hospital or medical school to provide certain services at the institutions, under an “affiliation” agreement (see Robb Burlage: New York City’s Municipal Hospitals: A Policy Report, available from Health-PAC, for a detailed study of the nature and impact of such agreements). In a small but growing number of cases, municipal governments are turning the operation of the public hospitals over to an “authority”, similar to the regional authorities that run transit systems. (See Health-PAC BULLETIN, Winter, 1969)

- Private, proprietary: i.e., profit-making, privately controlled. These are essentially businesses; seeking to provide health care at a profit. Many so-called “doctors’ hospitals” are in this category. In the last few years, chains of such proprietary hospitals and/or nursing homes have been formed (e.g., Medicenters of American; Extendicare); in a number of cases they sell stock to the public (see Health-PAC BULLETIN, November, 1969; Barrons, February 10 and 24, 1969; Modern Hospital, March, 1969; American Health Empire, Ch. 7). In both private control cases — voluntary and proprietary — the institution’s income comes largely from charges to patients (which may be paid by commercial insurance companies, Medicaid, Medicare, Blue Cross, or others).

2. Function

- Acute care hospitals: this is the ordinary general hospital, normally complete with emergency room, outpatient departments, maternity, pediatric, medicine, surgery departments, etc.

- Chronic (or “long term”) hospitals: may include mental hospitals, TB hospitals, etc. These provide substantial medical care for patients staying longer than thirty days.

- Extended care facilities: includes a hospital and a nursing home in terms of medical facilities and intensity of medical care offered; generally for moderately extended convalescences.

- Nursing homes: more or less custodial. They provide food, unskilled care, etc. but only minimal medical services. There is a growing category of “skilled

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>Public</td>
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nursing homes" which, under Medicare regulations, provide slightly more care. Length of stays are indefinite.

**E. Various special categories: clinics, community mental health centers (see American Health Empire, Ch. 6), specialty hospitals (e.g., Memorial Hospital in New York City is a cancer hospital), etc.**

**3. Other categorizations: In statistics, hospitals are often divided by size (number of beds), location (urban vs. rural, or part of country), relation to medical schools, whether they have programs for interns and residents (i.e., are a "teaching hospital"), special facilities or services, etc. These factors clearly affect interpretation of statistics (e.g., two hospitals differ in per diem costs or average cost per day.) This could reflect different degrees of efficiency—possibly politically interesting—or it could merely reflect differences in kind of patient population, differing roles of outpatient departements, location, age of plant, etc.).**

**B. Groupings and Associations of Health Delivery Institutions**

1. Medical centers: a somewhat vague term, implying a grouping of several institutions usually geographically contiguous, under a more or less common administration. The complex may include acute care institutions, chronic care institutions, and various special facilities (e.g., an outpatient psychiatric clinic). It may or may not include a medical school, but always includes a "teaching hospital" (i.e., a hospital with training programs for interns and residents).

2. Empires: a medical school or medical center may control, through formal or informal mechanisms, a number of other health care institutions. Control may be formal through contracts to provide staffing, grants to operate a community mental health center, etc. or it may be informal through overlapping staffs, faculty appointments for certain staff members, teaching arrangements, etc. One of the most fully-developed examples is the empire centering on Einstein Medical College and Montefiore Hospital in the Bronx (see Health-PAC BULLETIN, December, 1968 and April, 1969; on empires in general, American Health Empire, Ch. 1-6).

3. Associations: The American Hospital Association (AHA, 840 North Lake Shore Drive, Chicago, Illinois 60611) represents hospital interests through activities such as lobbying and provides various services to hospitals by collecting data, etc. *Hospitals*, a bimonthly magazine, is the AHA journal. There are also state hospital associations in most states (e.g., New York State Hospital Association) and often city or country associations (e.g., Hospital Association of Greater New York). There are also associations of special groups of hospitals (e.g., Catholic Hospital Association, 1438 S. Grand Boulevard, St. Louis, Missouri 63104; which also puts out a journal, Hospital Progress.) Locally, there may also be other special associations. For example, in New York City, the League of Voluntary Hospitals and Nursing Homes, originally formed to enable the hospitals to bargain jointly with the hospital workers union, now plays the role of a general association of voluntary hospitals for its thirty-odd members. The Association of Private Hospitals of New York acts similarly for the proprietaries.

**4. Other representatives of hospitals: As will be discussed below, such organizations as Blue Cross, local health facilities planning agencies (Health and Hospitals Planning Council in New York City), Comprehensive Health Planning Agencies in some places, and local joint fund raising organizations (United Hospital Fund and Federation of Jewish Philanthropies in New York) act in some respects as associations of local hospitals—in lobbying, planning, etc. This reflects the fact that in most cases these agencies are wholly or largely controlled by the hospitals. (see American Health Empire Ch. 10 and 14; Health-PAC BULLETIN, July/August and September 1969).**

**C. Researching Health Delivery Institutions**

1. Health delivery institutions in general

**a. Hospitals Guide Issue: the August issue of Hospitals, available separately from AHA, (see I.B.3) at $4.50, contains the most complete collection of statistics on beds, costs, personnel, services provided, utilization, etc. for US hospitals, broken down by year, state, type and size of hospital, etc.**

**b. Local Blue Cross, hospital associations, fund-raising groups, state and local departments of health all gather statistics, prepare reports on various subjects (e.g., New York State Department of Health report on wages in hospitals; New York Health and Hospital Planning Council report on capital needs of local hospitals).**

**c. Group health organizations such as Kaiser-Permanente and the Health Insurance Plan (HIP) of Greater New York provide details about their programs, as well as reprints of articles written about them. Increasingly, prepaid group practices are being set up as experimental programs in medical schools; e.g., Harvard, Johns Hopkins, Washington University (St. Louis), Yale University, Georgetown, etc. On a national level, prepaid group practices have united in an organization called the Group Health Association of America (1321 14th Street, N.W., Washington, D.C. 20005), which publishes a monthly newsletter about changes in group practice organizations.**

**d. Council of Teaching Hospitals (COTH, One Dupont Circle, Washington D.C. 20036), is a national organization that publishes periodic surveys of information**
about teaching hospitals (i.e., those that train interns and residents). They have particularly concentrated on surveys of data on salaries, organizations, and activities of interns and residents.

**E. Other publications**: several periodicals carry articles about hospitals, nursing homes, and their problems; new developments; new laws affecting institutions, etc.


2. *Hospital Topics* (monthly), 2737 W. Peterson Avenue, Chicago, Illinois 60645.

3. *Hospital Progress*, 1438 S. Grand Boulevard, St. Louis, Missouri 63104. The journal of the Catholic Hospital Association.


5. *Modern Nursing Home* (monthly), same address as Modern Hospital.

6. *Nursing Homes*, 4015 West 56th Street, Minneapolis, Minnesota 55435.


8. *Hospital Tribune* (twice weekly), 120 E. 56th Street, New York, New York 10022. *Medical Tribune* is a slightly varied edition of the same thing.

Of these first six periodicals listed, *Modern Hospital* and *Modern Nursing Home* are the most interesting on issues of relevance to health activists—hospital response to unions and to criticism of rising costs, new ways of using hospital facilities and workers, etc. They are also good on news about hospitals (strikes, conflicts with Blue Cross, etc.) and on political developments affecting or potentially affecting hospitals and nursing homes. *Hospitals* and *Hospital Topics* are okay on news, and *Hospitals’* statistics are useful, but the articles tend to be more technical (e.g., advances in how to run a hospital laundry). American Medical News and Hospital Tribune carry a lot of political news relevant to hospitals; the former presents the AMA outlook on these issues.

**F. Hospital Literature Index**, available in libraries or by subscription from the AHA at $10 a year, indexes articles about hospitals available in the periodicals above as well as in a few hundred lesser magazines. One use of this—familiarity with how the index is organized permits you to find articles about specific hospitals or hospitals in specific cities. There is also an index by author, so you can find damning quotes from your favorite enemy in the hospital world.

**G. The Department of Health Education and Welfare Publications, Medical Care: Financing and Utilization and Medical Care. Financing and Utilization (revisions) (Vol. I and 1A of the Health Economics Series) have useful breakdowns of statistics (e.g., utilization by sex, age and race). Others in this series are more specialized—e.g., *Maternal Care: Utilization and Financing*. These statistics are all somewhat dated, but still useful.

**2. Individual hospitals**

**a. Service and financial statistics and other information**

1. The *Hospitals Guide Issue* (see L.C.I.a) is indispensable. It gives annual expenses, annual payroll, annual income, number of beds, number of admissions, number of workers, number of outpatient visits, etc. as well as information on control, type of hospital, accreditations, teaching program, etc. for every hospital in the US.

2. Local planning agencies and the like may have similar compilations on local hospitals, which provide information beyond the Guide Issue. e.g., in New York City the Health and Hospitals’ Planning Council puts out an annual *Hospitals and Related Facilities in Southern New York* (from HHPC, 3 E. 54th Street, New York, New York 10022). Agencies such as Blue Cross certainly collect similar information; the problem is in getting it out of them.

3. The hospital itself may have an annual report (large hospitals invariably do—it’s useful for fund raising). If they do, you can probably get it from their public information office. Local libraries specializing in health may have it (see VIII. A. on libraries). These frequently have financial information, information on expansion plans, etc.

4. Non-profit institutions must file a report in lieu of a tax return with IRS (Form 990A). These are public documents—copies available by mail, for a fee, from IRS. In New York the state requires a similar document, filed with the Department of Social Services. These give financial and service data, sources of funds, etc.

5. Hospitals do collect extensive data on themselves, both for internal purposes and for Medicare, Blue Cross, etc. (For example, see the questionnaire at the back of the *Hospitals Guide Issue* which is the basis for their figures; not all the information reported is published). Knowledge that they have the information may be a tool for prying it out of them.

6. Publicly-owned chains (i.e., those that sell stock) must have an annual report and a prospectus for their stock offering. They must also file certain information with the US Securities and Exchange Commission (SEC) on stock holdings of officers, etc. Available from SEC, the company or stockbrokers.

**b. Power Structure**

1. Board of directors and administration: names are usually available from the
II. Health Education Institutions

Over the past decade, there has been the growth of health science centers, consisting of medical schools, dental schools, nursing schools, social work schools, and other bioscience careers schools, all based within the university framework. These health science centers are not merely educational institutions; they shape the delivery of health services in a profound way. Through teaching affiliations with university hospitals, municipal or county hospitals, Veterans' Administration hospitals and other community hospitals, the university-based center (called an empire by Health-PAC) exercises control over the delivery of health services and garners the needed "teaching material" (patients) to discharge its educational function.

A. The University: most medical schools and many nursing schools are part of the university and must be researched in this context. The methodology for such research has been extensively developed (i.e., see NACLA Research Methodology).

B. The Medical and/or Dental School

1. Separate Incorpations: Although most medical/dental schools are part of a university, very often they are incorporated separately—i.e., there is a different board of trustees for the university and the medical...
school. This means that the medical/dental school has its own power structure, its own real estate holdings and its own research activities (see I.C.2). The relationship between the university and the medical/dental school—boards, financing, real estate—may suggest revealing interconnections.

2. Regional Planning: Medical schools have developed a special relationship to the Regional Medical Programs (RMP) of the federal government. Some medical schools have used this program to consolidate their hegemony over state or regional health service delivery institutions. Look for the local medical school's role in this program (see V.D.2).

3. Associations: Medical schools have traditionally been accredited by the American Medical Association. But in recent years, they have achieved increasing independence from the AMA, as indicated by the growth in the importance of the medical school's own national organization, the American Association of Medical Colleges (AAMC, One Dupont Circle, Washington, D.C.). AAMC publishes a monthly Journal of Medical Education ($15 a year) which is useful for its opinions on national legislation and its statistics on medical school admissions.

C. The Nursing School

1. Nursing education is in transition: In the past, most nursing education was done through hospital-based programs. But recently, there has been a move to make it a part of the university. In most universities, however, nursing does not have the endowment, independence and power of the medical school.

2. Types of nursing education leading to RN degree

a. Hospital-based nursing education: these are three year nursing programs—called diploma schools—conducted within the hospital and leading to a certificate of nursing. These programs were used by large hospitals as a cheap source of nursing labor, since students often work in the hospital during their training and several years afterward to pay back the cost of their training.

b. University-based nursing education: these are four-year college programs—called Baccalaureate Degree programs—leading to a B.S. degree in nursing. Graduates tend to become supervisory nursing personnel, nurse educators or more independent public nurse practitioners.

c. Junior college or community college nursing education: these two-year programs—called Associate Degree programs—are the most rapidly expanding form of nursing education. However, two-year graduates are very clearly tracked. They usually become staff nurses and rarely enter supervisory or teaching positions. In many large urban areas, these programs have a concentration of black and Puerto Rican graduates, in contrast to three- and four-year graduates who are largely white.

3. Licensing: Licensing of nurses is a state function. The State Nurses Association, in many states, has developed strong ties to the licensing process.

4. Organizations: Nationally, nurses are represented by two organizations. The American Nurses Association (ANA) sets standards for nursing practice (see VII.B.1). It is comprised entirely of nurses. The National League for Nursing (NLN, 10 Columbus Circle, New York, New York) sets educational standards for nursing and accredits nursing schools. It consists of doctors, nurses, as well as others. The League publishes a monthly magazine, Nursing Outlook, ($6 a year) which gives opinions on national legislative issues and trends in nursing education.

5. Student Groups: The Student Nurses Association (10 Columbus Circle, New York, New York) publishes a quarterly magazine, Imprint ($3 a year). Nationally, it is the student wing of the ANA, but locally there is considerable variation among chapters, with some groups actively involved in community service projects.

III. Doctors and Their Associations

Doctors and the AMA have lost some of their power over national and local politics and health policies in the last decade but still remain, in many instances, as the chief obstacle to change.

A. Doctors in general

1. The AMA (535 N. Dearborn, Chicago, Ill. 60610) publishes various statistics and studies. For example: Distribution of Physicians, Hospitals and Hospital Beds in the United States (by census region, state, city, and metropolitan area); Survey of Medical Groups in the United States; Physician Characteristics, 1963 and 1967.

2. Government publications: The US government publishes similar studies—generally done by the Public Health Service in HEW. See, for example, Health Resources Statistics: 1969. State and local health departments and county and state medical statistics—numbers, distribution by area, distribution by specialty, etc. (E.g., you could get statistics from the city to document that ghetto areas have far fewer doctors per capita than middle class areas.)
3. Other publications: The American Medical News and Medical Tribune (or Hospital Tribune)—see I.C.1.e. for addresses—as well as Medical World News (weekly, 299 Park Ave., New York, New York 10017) contain technical news in semi-popularized form, legislative news of studies about doctors, news of conferences, etc.

B. Individual doctors

1. Reference books: American Men of Medicine and American Men of Science available in the reference section of most libraries, are limited, but sometimes useful.

2. Newspapers and magazines: Newspaper files may have news items in which a person you are interested appears. Check the New York Times Index and The Readers Guide to Periodic Literature.

3. Other sources: The sources of information on research at a hospital (see I.C.2.d) generally contain listings by the doctor's name. The various abstracts discussed in that section are most useful here. (For numerous other sources of biographical information see the NACLA Research Methodology).

C. Doctors' Associations

1. National: The AMA is, of course, the big one. The American Medical News, the AMA publication, is a good source on current goings on, policies. Several exposés books exist on the AMA, and any book or article on history of health legislation, recent or ancient, will have information in its policies.

2. State and local: There are also state and local medical societies and societies of specialists, all of which are likely to have local branches. Publications are common but not universal—sometimes technical, but often newsletter-like.

IV. Health Financing Institutions

Almost two-thirds of the cost of personal health services is borne by insurance companies, government, Blue Cross, etc. These are the so-called "third parties" (The patients and the providers are the first two parties). With the private mechanisms (Blue Cross, commercial insurance) failing to cover health needs of Americans, government financing has become increasingly important during the '60's (Medicaid and Medicare). The outlook is for more of the same, but look for the private third parties to control profits from new government financing mechanisms. (For example, they now serve as "intermediaries" for the Medicare and Medicaid programs).

A. General Information

1. For historical perspective: see Herbert and Anne Somers, Doctors, Patients, and Health Insurance (Brookings Institute, Washington, D.C. 1961); Herbert and Anne Somers, Medicare and the Hospitals (Brookings Institution, Washington, D.C. 1967); and Eugene Feingold, Medicaid: Policy and Politics (1968).

2. For statistics: see Department of HEW, Medical Care: Financing and Utilization, and Medical Care: Financing and Utilization (Revisions). More recent figures are put out by the Social Security Administration which has an annual review on the subject (generally by L. Reed and co-workers). Cost indexes can be found in the Bureau of Labor statistics monthly, The Consumer Price Index, or in slightly less detail in the Department of Labor's Monthly Labor Review.

3. For industry data: see Health Insurance Institute (227 Park Ave., New York, New York, 10017)—publishes an annual Sourcebook of Health Insurance Data. (It's free).

B. Blue Cross

1. Nationwide network: There are 70-odd Blue Cross's, each providing hospitalization (not medical, Blue Shield does that) insurance in a state or part of a state. The various Blue Cross's are linked by the Blue Cross Association (840 N. Lake Shore Drive, Chicago, Illinois 60611) which lobbies, collects data and performs studies, runs a bank which permits travelers to use their Blue Cross benefits out of their region, etc. Note that the Blue Cross Association address is the same as that of the AHA. In general, Blue Cross is tightly tied to the big voluntary hospitals, both locally and nationally. Blue Cross locally is also often tied to the State Insurance Department, which supposedly regulates them. See American Health Empire, Ch.10, for more on Blue Cross.

2. Non-profit status: Blue Cross is a non-profit, tax-exempt health insurance agency. It is set up in most states under special enabling legislation, generally providing that it should be regulated by the state insurance department. In some states, it must submit to a public hearing before raising its rates. To the extent that its records are public, the state insurance department is the place to look. The information available in New York State includes fairly detailed financial information, either gathered routinely or in connection with rate hike requests. Watch out though—the latter information is designed to prove a case and may be seriously distorted.
3. Publications: The Blue Cross Association publishes several periodicals and newsletters.

4. Note: many local Blue Cross's may have some other official name. In New York City, it's "Associated Hospital Service of New York."

C. Commerical Insurance

1. Power structure interlocks: Several hundred companies, generally life insurance companies, write health insurance (both hospitalization and medical), but the business is dominated by a half dozen or so (Prudential, Equitable, Aetna, Metropolitan, Connecticut General, etc.). Power structures of these companies overlap with medical schools and hospitals, and participation by insurance company big-wigs on government policy making or advisory boards on health matters is increasingly common (see Health-PAC BULLETIN, November, 1969 or American Health Empire, Ch.7). Insurance companies are also becoming involved in setting up health services, generally in cooperation with medical schools (see Health-PAC BULLETIN, January, 1971) as in Boston, St. Louis, and Baltimore.

2. Financial data: Industry-wide financial data is available in references above (see IV.A.2). On individual companies, annual reports are available from the companies in The Insurance Almanac (annual, Underwriting Printing and Publishing Co., New York, New York) in the library.

3. Trade association: The trade association for the health insurance companies is the Health Insurance Institute, (see IV.A.2).

4. Publications: The business press (e.g., Wall Street Journal, Forbes, etc.) cover developments in the field, since it's big business (billions a year in premiums). Try the Wall Street Journal Index and the Business Periodicals Index in the library. The latter covers trade journals, major stock analysts reports, etc. There are several insurance trade journals oriented toward insurance brokers, but they are not very useful.

D. Independent Private Insurance: A small part of the nation's health insurance is written by independent, generally non-profit plans, e.g., the Kaiser Health Plan in California, Oregon, Denver and Cleveland; Health Insurance Plan of Greater New York (HIP), some independent union plans such as that of District 65 in New York. Legally, these are usually incorporated under the same enabling legislation as Blue Cross and must file similar reports with the state insurance department. Research can be done along similar lines to Blue Cross research. Many of these plans are some variation on prepaid group practice (see Health-PAC BULLETIN, November, 1970), and have a trade association, the Group Health Association of America (1321 14th Street, N.W., Washington, D.C. 20005), which publishes material on many of the plans, a newsletter, etc.

E. Government Financing

1. Generally: Government at all levels finances close to 40% of health care expenditures. These expenditures include those for operating patient care facilities (city and state hospitals, Public Health Service and V.A. hospitals, clinics, etc.); public health activities; aid for construction of health facilities (the Federal Hill-Burton act and Medicaid, Hill-Burton, etc.); as well as Medicare (federally sponsored and subsidized health insurance for the aged) and Medicaid (federal-state-local matching funds for health care for the poor). A summary of the Federal role including detailed statistics can be found in The Federal Role in Health, a report of the Sub-committee on Executive Reorganization, Committee on Government Operations, US. Senate, 91st Congress. Statistics on the various programs can be found in the Statistical Abstract of the United States (annual, US Government Printing Office, Washington, D.C.—an indispensable volume), in periodic articles in the Social Security Bulletin, and in state Statistical Abstracts (a list of which can be found at the back of the Statistical Abstract of the US The Senate hearing referred to above also has extensive statistics. For local and state government expenditures, try the state statistical abstracts. Also, the state and local operating (or expense) budgets and the capital (or building) budgets are public information. They are generally available in larger libraries or in municipal or state reference libraries. If you are lucky (in New York City you are), there will be a summary version of the budget available as well as the detailed line item budget. For specific programs, both budgetary and programmatic, the agency that runs the program will generally be the major source. They may or may not be cooperative, but summary information, at least should be fairly easy to come by.

2. Specific funding: On Medicare and Medicaid, Hill-Burton, etc.: Detailed statistical reports appear periodically in the Social Security Bulletin. Changes in the legislation and in the regulations are well-covered by the hospital and medical trade journals (see I.C.1.e and III.A.3). If you are really gung-ho about following it, HEW will put you on the appropriate list for releases about the programs. The Hearings on Medicare and Medicaid, and the Staff Report on Medicare and Medicaid: Problems, Issues, and Alternatives of the Senate Committee on Finance, 91st Congress, are a current discussion of the programs. On Hill-Burton, the program itself (in HEW) puts out a fairly endless array of reports, surveys, histories, etc.

F. Philanthropy: Philanthropy is no longer a major factor in financing hospital operations (less than 2% of total operating funds of hospitals, although for a few indi-
For a complete run-down, see the hearings on neous agencies operate smaller programs.
The Federal Role in Health (see IV.E.1).

A considerable chunk of philanthropy is centralized in fund raising organizations, which service several hospitals and nursing homes, e.g., in New York, the United Hospital Fund (UHF), the Federation of Jewish Philanthropies, and Catholic Charities. These organizations are major meeting places for various hospital interests (e.g., the United Hospital Fund Board is made up of representatives from big voluntary hospitals of the city; in turn, the UHF Board overlaps with and plays a major formal role in selecting the Blue Cross Board of Directors). These agencies prepare statements on hospital needs, compile statistics, maintain health libraries, etc. They have annual reports.

V. Governmental and Quasi-Governmental Agencies

Government, at all levels operates services, finances the health system and to a limited degree, regulates it.

A. Federal Government

1. Note: According to federal law, virtually all documents and records except those “necessary for national security” are public information. The problem is knowing that the documents even exist, or who has them. A lawyer or the threat of one may help in prying documents loose; agencies don’t like the law.

2. Operating agencies

a. The Veterans Administration: operates a chain of hospitals for veterans. Some, but not all, are pretty grim—see the Life Magazine expose, summer 1970.

b. The Department of Defense: operates medical facilities for men on active duty in the armed forces and their dependents.

c. Department of Health, Education and Welfare: funds research through the National Institutes of Health (NIH) and National Institute of Mental Health (NIMH). Both are part of the Public Health Service (PHS). It operates hospitals for Indians and several other groups through the PHS. It administers the Comprehensive Health Planning and Regional Medical Programs through the Health Services and Mental Health Administration (HSMHA) and it administers the Medicare program through the Social Security Administration, and Medicaid through the Social and Rehabilitation Service.

d. Other agencies: A lot of miscellaneous agencies operate smaller programs. For a complete run-down, see the hearings on The Federal Role in Health (see IV.E.1).

3. Regulatory agencies

a. HEW does some regulation in the guise of regulating Medicare and Medicaid. For example, there are some (minor) cost controls in these programs. To be reimbursed under these programs, the hospital must pass certain quality standards (generally set by Joint Committee on Accreditation of Hospitals approval—(see V.D.3 below).

b. The Food and Drug Administration (FDA) and the Federal Trade Commission (FTC) regulate drug research, quality, and advertising. There have been many exposes of the failures of the agencies. See, for example, Morton Mintz, By Prescription Only, (HOUGHTON-MIFFLIN COMPANY, 1967) and the series of articles in Science magazine on the Panalba and cyclamate stories (1969-70). For more details, see Report of the (Fountain) Subcommittee of the House of Representatives Committee on Government Operations (1970). The Pharmaceutical Manufacturer’s Association Newsletter Commentary and Bulletin (free, from PMA, 1155 15th Street, N.W., Washington, D.C. 20005) provide a detailed and biased commentary on FDA and FTC affairs, hearings, proposed changes in regulations and laws, etc.

4. Policies: The hospital and medical trade journals (see I.C.1.e and III.A.3) are reliable and generally adequate guides to what’s going on in Washington, health-wise. They cover everything from new laws to why the President doesn’t like the Secretary of HEW’s tie—all a suitable tribute to the twenty-odd billion dollars in health money that comes from Washington. If your budget is limited, Modern Hospital and the American Medical News alone are indispensable and will enable you to know more than the average hospital administrator. If you are rich or have access to a library, the Washington Report on Medicine and Health ($60 a year, National Press Building, Washington, D.C. 20004) and the American Public Health Association’s Washington Newsletter ($40 a year from APHA, 1740 Broadway, New York, New York) are even more up to date and com-
plete. The Congressional Quarterly (in libraries) helps keep track of where health legislation is, and the AFL-CIO News (815 Sixteenth Street, N.W., Washington, D.C.) provides the labor viewpoint, often not unimportant in health matters and neglected by the hospital journals.

B. State government

1. State laws: Various states have different laws relating to health care. In the case of New York State, the laws are detailed and far-reaching. The state licenses doctors and facilities, runs hospitals, sets standards, run inspections, can veto even private hospital construction, sets regulations and pays part of the bill for Medicaid (as well as determining coverage and eligibility), and can even order a hospital to start providing a service or to buy a piece of equipment. Many of these powers are seldom used. The state also collects voluminous information on the health system, prepares studies, etc. You can get on their mailing list and get them all.

2. Other sources: State legislators are generally accessible. Ask them to put you on the list to receive reports, mailings, press releases from the Legislative Committee dealing with health legislation. Local community service organizations may also have a continuing watch on health legislation. In New York City the Community Service Society of New York prepares reports on pending legislation and an annual prospective report on Health Legislation in New York State (both free from the Society, 105 E. 22nd Street, New York, New York 10010).

C. Local government

1. Power structures: Again, local laws and practices vary, but don’t be fooled. Health policy is almost invariably controlled by private interests—either by the local power elite in general or often, by the private hospitals and/or county medical society. The mechanisms and implications of such private sector domination is the central area for research on urban health policy; far more than the ins and outs of local laws: i.e., who controls appointments, the make-up of advisory committees, who sets policy, etc. For more on researching local power structures, see the NACLA Research Methodology; Lamb, How to Research your own Hometown; Hamburg, Where It’s At: A Research Guide to Community Organizing; and Minnis, The Care and Feeding of Power Structures (all but Lamb from New England Free Press, 791 Tremont Street, Boston, Massachusetts 02118; for Lamb, try Radical Education Project, P.O. Box 561A, Detroit, Michigan 48232; it was originally published in Human Organization, summer 1952).

2. Other sources: Information on policy shifts can be found in local newspapers (they may have an annual index—e.g., New York Times Index), in the mayor’s annual budget message, in speeches by local health or hospital department officials (check the Hospital Literature Index under their name; see I.C.L.I.). There also have been special commissions with reports on health policy, which have been published (e.g., in New York City, the Piel Commission Report which was one of the building blocks for setting up the recent Health and Hospitals Corporation).

Mayors and city departments generate lots of public relations material. Try the public relations office of the city Department of Health and also the Mayor’s office. If you get on their list, your problem will be sifting through the daily stack of press releases.

There may be public hearings on various health issues. For example, in New York there were hearings on recently proposed changes in the regulations governing the performance of abortions.

Some public agencies or departments may have an annual report. These reports are half public relations, half political speech, but they do give the department budget, some operating figures, and possible hints of policy directions. They are also good sources of quotes to hang people with, and if you’re lucky, you can discover and reveal the outright lies.

D. Quasi-governmental agencies

1. Planning agencies: During the post-war period there has been a movement to develop various kinds of health planning agencies. The 1940’s Hill-Burton Act, which provided Federal funds for hospital construction, required that each state set up an agency which would have to approve applications for Hill-Burton money. Although vested with governmental status through their Hill-Burton role, the agencies that were set up were generally private non-profit organizations. The spread of these agencies came about because it was in the interest of the large voluntary hospitals and Blue Cross. For both, maximum economic advantages were found when hospitals operated at close to full capacity; this required a mechanism to ensure that bed supply would be kept limited. In a few states, most notably New York, the resulting agency was granted legally binding veto power over all decisions to build new hospital facilities. These agencies are called “facilities planning agencies” since their planning role extends only to facilities, not to programs, organization of services, etc. In general, these agencies have been pawns of the big voluntaries and Blue Cross.

In 1965, the Federal “Partnership for Health” act provided money for states to set up comprehensive health planning (CHP) agencies (which would now take on programs, etc.). Under the law these agencies were to be a partnership of government, health care providers, and consumers, with consumers being in the majority on the boards of directors. In most places, one of two things has happened. Either the old voluntary hospital-dominated facilities plan-
new CHP agency, with an expanded board giving "consumers" (like as not a bank president is listed as a "consumer") a theoretical majority. Or there has been a struggle between local government and the old facilities planning agency which has resulted in a compromise, such as both joining in setting up an agency to plan the new CHP agency. (The latter is what happened in New York City.) For more on facilities planning agencies and CHP agencies, see American Health Empire, Ch.13 and 14.

These agencies, in any case, may play a major role in setting health policy, and are often a mechanism for private health interests to exert power over the city's health resources, both public and private. They also collect and publish useful statistics and other studies. The New York agency, the "Health and Hospitals Planning Council" (3 E. 54th Street, New York, New York), puts out an annual report with useful information about the council itself and with a review of developments on the health scene in New York City and State in the past year, as well as of upcoming issues.

2. Regional Medical Program (RMP): Another 1965 law provided money for medical schools and other existing health resources to set up "regional cooperative arrangements" to improve patient care and bring the fruits of research to day-to-day medical practice more rapidly. Medical schools and medical societies moved to set up such regional organizations, which they have since used almost solely for their own advantage and not to any great extent for the purposes of the act. The New York Metropolitan area RMP organization, dominated by the city's seven medical schools, is the "Associated Medical Schools of Greater New York, Inc." For more on the program and on the New York experience, see American Health Empire, Ch.13 and 15.

The National RMP office (in HEW) puts out a newsletter describing policy, local decisions, local grants, etc. Some of the local RMP organizations also put out newsletters. The various hospital and medical magazines carry some RMP news, primarily at the national level.

3. Joint Commission on Accreditation of Hospitals (JCAH, 925 N. Michigan Avenue, Chicago, Illinois). This is a group, made up jointly of representatives from the AMA, the AHA, and several medical specialist organizations, that is the medical profession's self-policing agency to maintain hospital quality. Every two years, hospitals are inspected, and if they pass (most do), they are "accredited." The standards for accreditation have recently (1971) been revised (available for $5 from JCAH). Groups such as the National Welfare Rights Organization have attacked the JCAH, demanding a consumer role in the accreditation process, publication of the results of the JCAH studies of individual hospitals, etc. A few big city hospitals (Cook County, Boston City, etc.) have recently either lost their accreditation or been put on probation—potentially serious in terms of obtaining staff and of being eligible for Medicare and Medicaid payments (not to speak of what it suggests about the quality of care in these hospitals). The Hospitals Guide Issue (see I.C.I'a) tells whether a particular hospital has JCAH accreditation. If it doesn't, finding out why may be useful. The demand for access to the JCAH report on the hospital favorable or not, and for participation in the next evaluation may be useful organizing issues.

VI. Health Products Industries

The health products industry is a multi-billion dollar sector of American capitalism. Prominent trends are increasing integration among the various sub-sections of the industry; diversification of health products companies with other fields and or outside companies into health products; growing interlocks between health products companies and health delivery institutions; and a growing interest of health products companies in health policy issues.

A. For general information on the whole industry, see American Health Empire, Ch.7, or Health-PAC BULLETIN, November, 1969. Also, Fortune, January, 1970. Stock analysts' reports (Value Line, etc.) and stock brokerages (the late Goodbody & Co.) put out interesting surveys of the industry, with both general information and statistics and details on individual companies. Also, check the New York Times Index, the Wall Street Journal Index, and the Business Periodicals Index for survey articles (the last of these indexes major stock analysts reports as well business magazine).

B. Sectors of the Industry

1. Drug Companies

A. General references

(1) Morton Mintz, By Prescription Only
(2) Estes Kefauver, In a Few Hands: Monopoly Power in America
(3) US Department of Education and Welfare, Second Interim Report of the Task Force on Prescription Drugs, and background papers for the report, especially The Drug Makers and the Drug Distributors; The Drug Prescribers; and The Drug Users (all 1969). These make up a very useful and current survey of the industry and some of the issues—although it's hardly very penetrating or radical in its analysis.
(4) US Senate, Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary, Report on Administered Prices of Drugs (1961). This is the Kefauver report. There are also volumes of hearings.

(5) US Senate, Subcommittee on Monopoly, Select Committee on Small Business, Hearings on Competitive Problems in the Drug Industry (14 volumes so far, 1967-70).

(6) American Health Empire, Ch. 7, or Health-PAC BULLETIN, November, 1969 have sections on the drug industry.


**Trade associations**

(1) The PMA (see above) puts out weekly Newsletter and occasional commentaries and Bulletins.


**Hospital Supply Companies**

**VII. Health Workers and Their Organizations**

Health workers, including hospital workers, technicians, nurses, social workers, etc., are growing in numbers and power within the health system.

A. Sources of information on health workers, other than doctors

1. The US Department of Labor puts out various studies on health manpower. For example, Health Manpower, 1966-1975 (a survey); Technology and Manpower in the Health Service Industry, 1965-1975 (a useful study of the impact of developing health technology on various types of health workers); Industry Wage Survey: Hospitals (a detailed study of hospital wages, issued every three years).

2. The US Department of Health Education and Welfare put out similar studies. For example, Health Manpower Perspective: 1967; Health Manpower Sourcebook (Sections 1-19) (each section deals with another aspect of health manpower and new sections continue to appear. HEW will send you a list of the entire series.); Health Resources Statistics (an annual compilation of statistics on all the major health occupations—numbers, distribution, etc. with a short essay on shifts, future supply, changes in training requirements.)


4. The American Nursing Association (ANA, 10 Columbus Circle, New York, New York 10019) publishes a lot of material on nursing, including the annual compilation of statistics, Facts About Nursing.

5. The New Careers Association (Rm. 238, 239 Green Street, New York, New York 10003) is primarily concerned with the movement for training community people as para-professionals; it also deals with the development of training and upgrading programs (i.e., “career ladders”). It publishes a newsletter and occasional papers.

6. The various hospital and medical journals (see I.C.1.c. and III.A.3) have articles on changing manpower practices, new types of jobs (like physicians assistants), on unionization of hospital workers, etc. The Hospital Literature Index (I.C.1.f.) is useful in locating these.

7. H. I. Greenfield, Allied Health Manpower (Columbia U. Press, 1969) is a good survey of health manpower other than nurses.

B. Organizations of Health Workers

1. Professional associations: The most important is the American Nursing Association (10 Columbus Circle, New York, New York). In addition to the material referred to above (see VII.A.4), the ANA publishes...
the monthly American Journal of Nursing, which carries both technical articles and news on changing nursing education as well as ANA affairs. There are also state nursing associations in every state. In recent years, the ANA and its state units have come to act increasingly like a union: it enters National Labor Relations Board representational elections, engages in collective bargaining and signs contracts for its members, wages strikes, and increasingly cooperates with AFL-CIO unions. It still has an extensive overlay of professionalism, however, with supervising nurses and staff nurses sharing the same organization.

Virtually every other health profession or quasi-profession (e.g., practical nurses, X-ray technicians, lab technicians) have their own professional organization (check the Directory of National Trade and Professional Associations in the United States to locate them). These are likely to compile statistics and material on current developments in the trade.

2. Unions: Unions are big news in hospitals these days. See Health-PAC BULLETIN, July-August, 1970, for brief history and analysis. Several major unions are organizing hospital workers.

A. National Union of Hospital and Nursing Home Employees, a division of the Retail, Wholesale and Department Store Union, AFL-CIO. It is better known as 1199, after the original and largest local in New York City. Locals in other cities are called 1199A, 1199B, etc.—the latter in many cases relating to the name of the city. The union seeks to organize primarily voluntary hospitals and nursing homes, although in a few cases it has been involved in government or proprietary institutions. 1199 has also organized university workers. It organizes all levels of hospital workers except doctors and registered nurses. On 1199, see Health-PAC BULLETIN, July-August, 1970.

B. American Federation of State County and Municipal Employees (AFS-CME), AFL-CIO, as its name suggests, is active mainly in city, state, and county hospitals (as well as other types of government workers). It organizes both skilled and unskilled hospital workers, but has concentrated mainly on the less skilled. In New York City, it represents most workers in the city hospitals.

C. Service Employees International Union (SEIU), AFL-CIO is a union of service workers in all sorts of institutions. In hospitals, it concentrates on less skilled employees. In New York City it is restricted to proprietary hospitals and nursing homes, but elsewhere (as in San Francisco and Chicago) it is not so limited.

d. Others: Everyone and his brother is out for hospital workers. The Teamsters and the American Federation of Government Employees probably have the largest number of hospital workers enrolled in this category. There are no good sources of information and no useful single study on hospital unions. Unions themselves publish newspapers—but the statistics they provide tend to be unreliable. The hospital journals have had a series of poor and biased articles on the hospital unions, but their news sections do often carry news of organizing drives, strikes, etc.

3. Radical health workers organizations: In a number of cities, there are now radical groups of health workers active in hospitals. The local Medical Committee for Human Rights (MCHR) chapter is likely to be the organization or to be able to guide you to it (see VIII, C.I.c.). Revolutionary Unity Movement (HRUM, 150 Fifth Avenue, Rm. 843, New York, New York) is a third world health workers group organizing within the hospitals. HRUM publishes an occasional newspaper, “For the People's Health.” In addition, social workers groups around the country are turning to health issues. The Social Welfare Workers Movement (SWWM, Box 2492, Cleveland, Ohio 44112) publishes a bimonthly newspaper, Hotchpot. Social Work Action for Welfare Rights (SWAWR, 242 East 14th Street, New York, New York 10003) is a New York City group which publishes an occasional newsletter.

VIII. Libraries, General Reading, Organizations

A. Libraries

1. In addition to university and public libraries, there are more specialized health libraries. Medical school libraries usually have some material. Local Blue Cross, fund raising organizations, facilities planning councils, etc. are good bets. In New York, try the United Hospital Fund reference library (3 E. 54th Street,) the Department of Hospitals library (125 Worth Street) and the New York Academy of Medicine library (101st Street and 5th Avenue) (at the last, tell them you are "general public", not a "student"). There exists a Directory of Special Libraries and Information Centers, edited by A.T. Kruzas, available at the library, to help you find such libraries locally if the above organizations fail you. On local government, there often is a municipal reference library.

B. General Reading

Health-PAC BULLETIN ($7 a year. Health-PAC. 17 Murray St., New York, New York 10007). Many of the chapters are available in earlier and less complete versions in individual issues of the BULLETIN, and, of course, subjects covered by the BULLETIN since early 1970 are not included. The only systematic and more or less complete radical analysis.

2. **NACLA Research Methodology Guide** (North American Congress on Latin America, P.O. Box 57, Cathedral Park Station, New York, New York 10025; $1.25).


5. *Milbank Quarterly*, January, 1968, Part 2, Dimensions and Determinants of Health Policy. A compilation of a dozen or so articles on various aspects of health policy, generally from the point of view of "health liberals" open to change in the health system as long as it doesn't go too far, (contrasted with the reactionary or stand-fast attitudes of the AMA).

6. Herbert and Anne Somers, *Doctors, Patients, and Health Insurance* (Brookings Institute, Washington, 1961), is dated in its statistics but is a good history of health financing and related matters. The same authors' *Medicare and the Hospitals* (Brookings Institute, Washington, D. C., 1967) along with Eugene Feingold's *Medicaid: Policy and Politics* bring the story almost up to date. Beyond that, magazine articles such as Health-PAC BULLETIN, January, 1970 (or American Health Empire, Ch.12) are required.

7. Women and Their Bodies (distributed by, the New England Free Press, 791 Tremont Street, Boston, Massachusetts 02118 for $0.75). A comprehensive booklet prepared by the Women's Health Collective of Bread and Roses of Boston. It includes chapters on birth control, pregnancy, abortion, sexuality, and women and the health system.

C. **Organizations**

1. Liberal and Radical: There are several liberal or radical organizations active in the health field who will provide information. Try:


c. Medical Committee for Human Rights, 1520 Naudain Street, Philadelphia, Pa. 19146 plus numerous local chapters.

2. **Student Organizations**: There are two dominant national student organizations: the Student Health Organization (SHO, 1613 East 55th Street, Chicago, Illinois) started as a liberal organization and has transformed itself into a locally-based, more radical group. Its constituency is not only medical students, but also nursing, dental work and dental students. The present orientation of SHO is to build locally-based health collectives. The Student American Medical Association (SAMA, 2365 Flossmoor Road, Flossmoor, Illinois) is a medical student organization which has traditionally been a conservative group. Recent attempts at liberalization have resulted in SAMA's involvement in some community service programs. The New Physician is its monthly magazine.

3. **Legal Organizations**: There have been several groups formed to work on issues of health law. These groups have much of the expertise in health legal matters.

a. **National Legal Program on Health Probelms of the Poor** is an OEO financed center that has concerned itself with issues of medicaid, housestaff organizations in municipal hospitals and the JCAH. Write to: Laurens Silver, UCLA School of Law, 405 Hilgard Avenue, Los Angeles, California 90024.

b. **Health Law Project** (c/o Ed Sparer, University of Pennsylvania Law School, 133 S. 36th Street, Rm. 310, Philadelphia, Pa. 19104) is a newly formed group of lawyers in Philadelphia concerned with issues of quality and the dual system in health care.

c. **Columbia Center on Social Welfare Policy and Law** (401 W. 117th Street, New York, New York 10027) is concerned largely with medicaid and medicare litigation around issues resembling welfare litigation of the mid-1960's.

d. **Health Advocates** (c/o Health-PAC see VIII.C.I.d) affiliated with Health-PAC—a new group of lawyers concerned with offensive legal strategies for community organizations concerned with health.

e. **Martin Luther King Health Advocacy Program** (c/o Liery Wynn and/or Bob Borsody, 400 E. 196th Street, Bronx, New York 10456) concerned with patients' rights issues.

f. **The National Institute for Education in Law and Poverty** publishes a monthly Clearinghouse Review which has articles and citations on health law cases. Copies may be obtained from the National Institute, Northwestern University School of Law, 25 West Chicago Avenue, Suite 500, Chicago, Illinois 60610.

—John Ehrenreich