The enactment of Medicaid in 1966 has given rise to a new form of medical practice—the Medicaid mill: New York City now has over 150. Doctors who work in Medicaid mills derive a substantial income exclusively treating patients on Medicaid. Their large incomes have given journalists a field day and dozens of stories have been printed under the headline "Doctors Get Rich off Poor Patients." The headlines contain a grain of truth. However, the headlines obscure a more complex reality.

Spurred by the State’s relatively generous support, New York State families earning less than $6,000 a year became eligible in 1966 for a wide range of services under Medicaid. (See BULLETIN, June, 1969.) Not only could three million New Yorkers receive free medical care under Medicaid, but they were also, in theory, free to choose their doctors and hospitals. Starry-eyed optimists claimed that in New York, Medicaid spelled the end of “charity medicine.” But, if Medicaid heralded a bright new day, the clouds were never far from sight.

To begin with, the alleged freedom to choose doctors depended upon the doctors’ supply in poor communities. Many doctors long ago split for greener pastures in the suburbs. Those who stayed in the city, geared their practice to an economically exclusive clientele. The last thing these doctors wanted was poor patients, Medicaid cards in hand, trudging into their offices to undermine their carefully cultivated posh image. In point of fact, most doctors didn’t want to be bothered with Medicaid’s endless forms, regulations and delayed-payment schedules. The upshot is that only 10 percent of New York City’s medical doctors participate significantly in Medicaid. (The figure is higher for other health professionals—dentists, podiatrists, optometrists, etc.).

Despite the coolness of the medical profession toward Medicaid, it was clear that Medicaid had created a potential gold mine. With several million medically-starved patients to choose from and State-guaranteed reimbursement, it would not be long before this ripe plum was picked.

Before long, storefront medical clinics began to appear in poor communities. Often the premises were owned and renovated by real estate speculators, but some centers were held lock, stock and hypodermic needles by health professionals. Recognizing a lucrative business prospect when they saw one, bankers saw to it that loans were not hard to come by. Most often professionals working in a Medicaid mill pay the owner of the premises rent. Such payment is flexible—space can be rented on anything from an hourly to a yearly basis. Sometimes a flat rent is paid, but in other instances the rent is calculated, with the blessing of State law, on the basis of the number of patients seen.

The result is a hodgepodge of general practitioners and medical specialists sharing space in a building. Although this ar-
The arrangement superficially resembles a group practice, it is, in fact, a far cry from this concept. To begin with, most centers do not have a regular group of doctors present each day. Rather, a doctor may spend only a day or two at the center each week and a different doctor may occupy his space on other days. Further, even those doctors who do practice together owe no loyalty, trust, or even professional interest to one another. They come together simply for business convenience. In terms of the rational delivery of health care to a medically impoverished community, the random mix of doctors and non-professionals makes no sense at all. Worst of all, very few Medicaid doctors seek to provide the services of backup hospitals. When their patients require hospitalization, they are sent to the nearest city hospital emergency room. This is free enterprise with a vengeance.

Nevertheless, it must be admitted that Medicaid mill practitioners venture into wastelands of medical care which have been neglected by most doctors as well as many of the public and voluntary hospital outpatient departments and even some OEO health clinics. While the motives of professionals for offering Medicaid services are so crassly economic that they can hardly be considered angelic, still they have not feared to tread where others won't set foot. As a result, patients have had their long-neglected teeth fixed, eye-glasses fitted, corns removed, diabetes and high blood pressure detected.

Despite successive waves of Medicaid cutbacks in New York State, which have had the effect of decreasing the number of eligible patients from three to less than two million patients, the number of Medicaid mills continues to increase. They are attracting more doctors, often those fresh out of medical school, who see Medicaid practice as a way of developing a fat bankroll while they trudge the slower path of building up their Scarsdale practices. And the mills themselves are becoming fancier and more acceptable to patients. While the academic medical community snubs the Medicaid operations as purveyors of poor quality care, patients are flocking to them in increasing numbers. And no wonder.

Patients, who are accustomed to the brusque treatment they receive at hospital outpatient departments, like the relatively personalized care they receive at the Medicaid mills. It would be surprising if patients did not feel at home when most of the ancillary help—clerks, aids, receptionists—are neighborhood residents. For the non-English speaking population, there are, again unlike outpatient departments, an abundance of Spanish translators. And, if the chintzy decorative touches of the Medicaid Mill—carpeting, Muzak, fluorescent lighting—are merely fake Holiday Inn, so what? It's more appealing than the cold, drab, institutional-looking hospital outpatient department. Finally, the generally neatly-dressed and efficient-looking personnel give the Medicaid mills the appearance of competence. Although there are few nurses working at Medicaid mills, it looks as if nurses are scurrying about because everyone wears a white uniform.

Unfortunately, the appeal of Medicaid mills cannot ultimately overcome their disadvantages. Medicaid mills are hardly a model for the future. Instead, they look backwards at the worst features of American fee-for-service, private, profit-oriented medical practice.

The average private practitioner maintains his earning capacity by adjusting his fees, in tacit consent with other neighborhood doctors, according to what the traffic will bear. Ideally, this permits the doctor to spend an adequate amount of time evaluating his patient's complaints. The Medicaid doctors cannot directly set his own fees; they are set for him by the State Department of Health. Likewise, ser-
vices for which the doctor may be reimbursed are determined by the State. Consequently, running a profitable Medicaid mill is a little bit like General Motors competing with foreign cars. Just as the GM Vega plant in Lordstown must produce 100 cars an hour to remain competitive, so too must the Medicaid doctor process patients with production-line rapidity. Unlike private practitioners, who may make $80 an hour by seeing four patients at twenty dollars each, the Medicaid doctor must see twenty patients an hour at four dollars a visit to make the same amount of money.

In many Medicaid mills, this gives rise to the "ping-pong effect: A patient is shuttled from the general practitioner to the podiatrist, to the eye doctor and then to the dentist. (The game might more accurately be called "pass the patient to relieve the buck."). At each stop, the professional is, of course, paid a fee. In part, this brand of "fiscal" medicine reflects the fact that many Medicaid patients have unmet medical needs. However, it's impossible to determine how many of the extra referrals are simply a way of amassing a fortune for the professionals. Similarly, additional revenue is brought in with each laboratory test, X-ray and electrocardiogram performed. And naturally they are performed with abandon. More complicated laboratory tests are referred to an outside laboratory, from which it is widely suspected that Medicaid mills receive a kickback. (In another variation of the same profit-making scheme, the mill operator sometimes owns part or all of the laboratory.) Of course, injections are an additional source of income for mill operators. Many Medicaid mills almost routinely dispense vitamin B-12 shots at a buck or two a shot.

Although the New York City Department of Health attempts to monitor the quality of care rendered in Medicaid mills, the bulk of the Health Department's quality of care surveillance consists of re-examining a random sampling of patients who have been fitted with prostheses (dentures, eyeglasses, etc.). The program does a relatively good job of screening optometrists, podiatrists, and dentists and seems to have a favorable effect on the quality of patient care. One able dentist remarked that, in his experience, "patients receive better care from Medicaid dentists than from the dentist in more traditional private practice." The surveillance program is, however, considerably less effective in monitoring the care of most doctor services. And, in spite of the Health Department's efforts, unscrupulous businessmen and professionals continue to infect Medicaid operations. An extreme, but by no means unique example, is that of small-time businessman, Joseph Mandel's Manhattan Uptown Medical Center in East Harlem.

The Case of the Mandel Mill

Mr. Joseph Mandel set up shop in December, 1969, when he purchased the dilapidated Harlem Ear and Eye Hospital. Wishing to turn a quick profit, Mandel converted the abandoned hospital into a Medicaid mill without even bothering to renovate the building. Space was leased out to professionals with a heavy emphasis on getting highly visible, comparatively well-reimbursed services, such as dentistry, podiatry and optometry. (Some of the doctors paid Mandel a percentage of their take; others paid on a straight-rental basis.) Mandel's operation was paralleled by others in New York City.

However, the involvement of community activists gives the story a new twist. Two OEO funded anti-poverty groups concerned with housing and community development, the East Harlem Triangle Association and Community Services Association, began to receive complaints about Mandel's Medicaid mill. Community residents objected to the clinic's poor sanitary conditions, as well as to the quality of medical care offered by some of the clinic's doctors. The groups began negotiations and challenged Mandel to clean up the place and establish a methadone detoxification center. The groups were also concerned about the behavior of some of the professionals, including one doctor, a confessed junkie, who purchased

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his own narcotics from his addict patients. After negotiations got nowhere, the groups decided to seize the mill.

On June 8, about fifty community residents invaded the clinic. Observing the filthy floors, blood-stained instruments, fallen plaster and broken liquor bottles in the bathroom, they told Mandel, "You're through!" Without a struggle, the doctors and Mandel packed their bags and scurried pronto out of the clinic. A sign was posted on the front door: "Taken over by the Community! This clinic's sanitary conditions are deplorable and not fit to service the residents of our community." Following the takeover, the Department of Health at long last got around to inspecting the clinic. It found over 100 Health Code violations, thereby confirming the community residents' allegations.

The outcome of the takeover is still unclear.* Protestors, as well as the police (who outnumber the protesters three to one) are still occupying the building. The occupiers are pressing Mandel to "give" them the building at nominal cost. As might be expected, one of the policemen's comments more approximates the legal standing of the occupiers: "As far as we're concerned, this is still private property belonging to Mr. Mandel."

Meanwhile, Mandel's Medicaid business has not suffered an irreparable loss. He is referring his old Uptown Medical Center clients to his more modern Brooklyn Downtown Medical Building. Mandel therefore has something to fall back on; it's not clear that the community activists are so fortunate.

The activists dream of converting Mandel's building into a first-rate medical center. But they have received no offers of private or government financial support. Neither Mt. Sinai nor New York Medical College, the large medical centers in the community, has given the slightest indication that it is ready to help out. And finally, more general support from the community has not been called for, and, in all probability, does not exist. Meanwhile, as the negotiations between the occupiers and Mandel proceed at a leisurely pace, Medicaid business goes on as usual throughout the City.

**Back to Reality**

The economics of Medicaid are that $750 million of Federal and State monies flow through New York City Medicaid channels each year. Eighty percent of the money goes for hospital-based care, which leaves only $128 million for private practitioners, with dentists and doctors accounting for almost three-quarters of the share. Recognizing that it is a relatively handful of professionals whose practices are geared toward Medicaid and who garner the lion's share of this money, it is obvious that we aren't talking about peanuts. Medicaid operators, like the Mafia, may not know how to extract water from stones, but they have learned the secret of extracting money from poor communities.

Unlike the Mafia, it is arguable that the Medicaid operator at least provides needed medical services to the community. While this is sometimes true, in other instances, such as Mandel's operation, the service rendered is perhaps more hazardous than the lack of such service. In either case it's hard to see how, without far greater community input, Medicaid mills can be ultimately guaranteed to serve the communities' health and economic needs.

The media can be expected to continue to play up the rip-off aspects of Medicaid mills. The media does not, however, recognize that mills are merely filling the vacuum left by the large hospitals which refuse to service poor communities. Ironically, it is the same hospitals which are, in reality, ripping off Medicaid. The bias toward the hospitals' financing needs is solidly built into the Medicaid system.

The fact that 80 percent of Medicaid money goes for hospital care, reflects the raw truth that the power to influence and determine the quality of a community's health needs rests with the hospitals. Expropriating a Medicaid mill may be politically good and morally justified, but, in the last analysis, it amounts to little more than guerrilla theatre unless it becomes the tactical launching pad for the expropriation of the hospital-based health system.—Howard Levy and David Mendelson, former Health-PAC student intern and a doctor at Harlem Hospital.

*On July 31, 1972, after this story went to press, the occupation came to an end with the police evicting two remaining protestors and Mandel retaking the building.
New York City has had the Ghetto Medicine Program for four years. Its principal service in that time has been to illustrate the ease with which the private voluntary hospital system can rip off the public hospital system, the taxpayer, etc. In this respect, the program has always been a good one for inflaming outrage (see BULLETINS, January, 1970; April, 1970; March, 1971).

The Ghetto Medicine Program got its start in the 1968 legislative session in Albany. That was the year legislators cut the guts out of New York's Medicaid program. Ghetto Medicine was designed to make up for the deficits that public ambulatory care facilities were undoubtedly going to ring up with such reduced Medicaid incomes. The program was only a token gesture (about $12 million), but it was a gesture that pointed in the right direction. It was designed to strengthen ambulatory "family centered, comprehensive" care; and it was to give an assist to public facilities which couldn't turn patients away, even if they had just lost their Medicaid coverage and couldn't pay for their care. The program even called for citizen participation in determining how hospitals receiving the money should run their outpatient services.

By 1969, a year had gone by and the New York City Department of Health still hadn't gotten itself up to Albany to collect the money. So the voluntary hospitals went up instead. They went to that Man of the People, Governor Rockefeller, and legislation notwithstanding, the State Health Department specified that the Ghetto Medicine money should go only to private facilities! From then on, things went from bad to worse to worser yet. The City Department of Health, which had let the money slip through its fingers, now started giving it out to the voluntaries on the easiest terms. The guidelines for community participation got watered down. The voluntaries weren't required to provide "comprehensive, family centered" care; they only had to subscribe to the idea, and say they were planning to do something about it someday. And then, as the supreme irony, the hospitals that got the lion's share of the Ghetto Medicine money weren't even in ghettos.

After all that, one would think that there could be no more outrages in store. Believe it or not, in the last several months, the Ghetto Medicine Program has gotten even more outrageous. For example:

**Outrage # 1: St. Vincent's Advisory Committee Quits**

Under the Ghetto Medicine contracts arranged by the Department of Health, each voluntary hospital had to create an Ambulatory Care Advisory Committee, 51 percent of whose members had to be consumers. Because of the hand-picked nature of most of the committees, Health/PAC predicted in April, 1970 that "there is little danger of advisory committees getting out of hand." However, nine months later, the consumer members of the St. Vincent's Advisory Committee had taken that hospital and the Department of Health to court.

The consumers' suit focused on St. Vincent's refusal to give the committee fiscal information which they deemed necessary to fulfill their advisory role. The Department of Health was also named in the suit because of its refusal to require St. Vincent's to produce the information.

The Department of Health then started to reveal its true colors: voluntary yellow. It assisted the hospital in attempting to get the suit thrown out of court. This failing, the Department of Health became, in the words of one committee member, "very punitive toward the committee." For
instance, the St. Vincent's committee couldn't get information which other hospital advisory committees were supposed to be getting routinely. The Department claimed, "That's part of your suit." The suit became stuck in judicial backwaters. On May 31, the consumer members of the committee issued a final report and resigned en masse. With their resignation, goes the promise and illusion that consumers can find support in the Ghetto Medicine Law or in the Department of Health.

"We were told to participate, but we were denied power."
Consumer Majority of St. Vincent's Community Advisory Board

The six-page resignation speaks of the consumers' belief that the law "assures the powerlessness of advisory committees" and that the Department of Health operated in collusion with St. Vincent's to resist "some small measure of democratic community participation." The consumers are eloquent in their frustration:

"All of us came to feel, however regretfully, that we were simply window-dressing to be used by the hospital and the Department of Health, each to accomplish its own goals no matter what the community thought. In the struggle for power over state funds between the hospital and the Department of Health, we and the community we represented were pawns... We were told to advise, but we were denied information. We were told to participate, but we were denied power. We were given a job, but we were denied the tools to do the job. Now we feel as irrelevant as the American colonists might have felt if King George had responded to their demands for democratic participation by offering instead to create an advisory board of colonists to consult occasionally with the King."

In parting, the consumers took a final swipe at King George and his colonial governor: "The Board of Trustees of the hospital as presently constituted, and the Department of Health is just another remote bureaucracy insensitive to local needs, resistant to local consumer demands, and frequently an additional obstacle to local change."

Outrage #2: Trussing Up Beth Israel

Ray Trussell (Executive Director of Beth Israel Hospital), with more power than 20 advisory committees, has always been able to call the shots with the Department of Health and the Ghetto Medicine Program. In 1970, Trussell was accused of "robbing the till" when he managed to transfer Beth Israel's affiliation with Gouverneur Hospital's Outpatient Department from the Department of Hospitals to the Department of Health, thus capturing $1,706,700 in Ghetto Medicine funds—almost six times as much as the average grant to other hospitals.

If Trussell had his fingers in the till then, one might now say that he's picked up the till and walked off with it. Where has he gone? Out of the Outpatient Department and straight into the emergency room. Several months ago, Beth Israel pulled its outpatient clinics out of the Ghetto Medicine Program; it now uses the program for its emergency room exclusively. So much for "comprehensive, family centered" care. And so much for all the clinic patients who were receiving care from Beth Israel.

Trussell's maneuver means that any patient coming to Beth Israel's clinics who doesn't have Medicare, Medicaid or the $45 clinic fee doesn't get in the door. Trussell gets to use the Ghetto Medicine money to subsidize the emergency room, where visits cannot be limited by what the patient can afford to pay. Because Trussell has the good fortune of sitting on the Health Department's Ghetto Medicine Contracts Committee, he has been able to write his own ticket. Despite the objections of consumer members of that committee, the Ghetto Medicine contracts now call for the provision of "outpatient and/or emergency department" services (italics added). With the doors wide open, it is anticipated that other voluntaries will follow Beth Israel's lead and withdraw their clinics from the Ghetto Medicine Program also.

Even though Trussell has legitimized the key club status of Beth Israel's clinics as far as the Ghetto Medicine Program and the Department of Health are concerned, the policy is being challenged from another corner. Recent legal actions force HEW to require hospitals which have received federal Hill-Burton construction funds to "provide a reasonable volume of free or below-cost services to individuals unable to pay." According to a class-action suit, being brought against Beth Israel by several individuals and community groups on Manhattan's Lower East Side, Beth Israel has turned away approximately 3000 patients since it instituted its pound-of-flesh admission charge. Trussell claims that the hospital deficit (part of which is reimbursed by Ghetto Medicine) demonstrates Beth
Outrage #3: Closing the Barn Door

Now that the Ghetto Medicine Program has been totally shaped by the needs of the voluntary hospitals of New York City and not by the needs of its population, we discover that the contracts will finally contain an enforcement clause. In the past, when consumer members of the Contracts Committee have urged penalties for contract violations, the Department of Health stopped them cold, saying that, "You can't have a penalty clause without putting in a reward clause." This year the Department is going along with a penalty section which essentially permits the Department to delay its monthly payments to penalized hospitals.

Even though the penalty clause offers no real threat to the voluntaries, their organization, the Greater New York Hospital Association, attempted without success to weaken it further. They submitted a memo to the Department of Health recommending "That disputes arising under the proposed partial default clause of [the] Ghetto Medicine Program contracts be submitted to binding arbitration rather than to the Commissioner of Health for penalty determination. Ever mindful of their "private and amicable relations" with the Department of Health, the voluntaries noted that "arbitration of disputes is preferred when the parties are concerned about the possible notoriety that could surround a controversy . . . the informality, privacy, yet decorous atmosphere of the arbitration hearing room will encourage continued good will between hospitals and the department in their subsequent dealings."

Ghetto Medicine Gutted

In four short years, the voluntary hospitals have gutted the Ghetto Medicine Program as thoroughly as vandals destroying an abandoned building. The Department of Health paved the way by blindfolding and handcuffing the already weak advisory committees. Then it tossed its own guidelines out the windows one by one. The voluntaries charged in, knocking down the doors in the rush to get the treasure. Now that the house is in shambles, the Department of Health has returned to try and protect the place. Meanwhile, as the Department of Health passes out this year's $12 million to the voluntaries, the municipals (which were supposed to be the beneficiaries of the program) will continue their policy of selective personnel attrition in their outpatient departments for lack of money.

—Constance Bloomfield
In this election year, the Nixon Administration is hard at work campaigning for its own brand of health reform. Even though national health insurance proposals are stalled in Congress, having been pre-empted by the presidential campaign, Nixon is trying, by hook or crook, to push his program of Health Maintenance Organizations (HMO's). In so doing, he hopes to place health care in private, corporate hands, where he thinks it belongs. But so far industry's response has been a hesitant one, and Paul Ellwood, one of Nixon's major health advisors and originator of the HMO concept, has been waging a vigorous campaign to convince it.

But what is an HMO? No one knows for sure. The reigning confusion results from a deliberately broad and vague definition. An HMO is any arrangement whereby a provider agrees to furnish a specific set of health services for a fixed price, agreed upon in advance. Because providers are obligated to give whatever care is needed, theoretically they will have an incentive to give preventive care. If a patient uses few services, the provider pockets a profit, whereas, if a patient requires hospitalization or costly treatment, the provider must pay the cost himself.

The provider can be almost anything—a group practice, a medical society, a medical school, or a hospital. Consumer enrollment in HMO's is voluntary, the rationale being that the consumer can choose the HMO as one of many options in the health marketplace. HMO's can be profit-making or non-profit enterprises. HMO's could be, but are not necessarily subject to consumer control. HMO's could service medically understaffed geographic areas, but are not specifically designed to do so. In short, HMO's are a change in the financing of health care, but only an illusion of change where the delivery of health care is concerned.

The unique thing about HMO's is that they attract different supporters for very different reasons. Liberals see HMO's as an extension of progressive aspects of group practice. The conservatives view of HMO's as a way of shoring up the profit-making aspects of health care and entrenching it more then ever in the hands of the private sector. Both see it as a means of controlling medical inflation.

Nixon's HMO campaign has ruffled Congressional feathers, even among those friendly to the idea of HMO's. It seems that Nixon never received Congressional authorization to develop HMO's. Instead, he dipped into other programs to get money for HMO's. Congress finally got so miffed that, during hearings on Congressional HMO proposals, it slapped Nixon's hands for his improper behavior. This resulted in a freeze on stolen funds and a thwarting of Nixon's latest attempt to grab $30 million from Comprehensive Neighborhood Health Center funds.

In spite of the fact that Nixon has already poured $9.6 million into some 110 institutions to plan and develop HMO's, not a single one is in operation, because of the underestimation of HMO start-up costs, the under-enrollment of subscribers, and the unresolved course of national health insurance. (For more information on HMO planning grants, see BULLETIN, December, 1971.)

Pitching for HMO's

Despite these setbacks, HMO campaign manager, Dr. Paul Ellwood, is still on the campaign trail. Ellwood is universally acknowledged as the "chief architect of the HMO strategy," and has achieved national prominence for packaging and selling the HMO concept. Ellwood sees big corporations as natural HMO constituents. And no wonder, given his philosophy about health care. The problem with the health system, he believes, is that professionalism has prevented the "industrial revolution" in health care. By introducing the principles of market economics into the health system, health care
can be mass produced, packaged and marketed more efficiently and at less cost to the provider.

In a speech entitled "Health Care: Should Your Company Buy It or Sell It?" delivered in April at the annual convention of the Industrial Medical Association and the American Association of Industrial Nurses, Ellwood zeroed in on company doctors and nurses to use their influence to convince the nation's biggest corporations to become health care providers. Ellwood posed three major reasons why.

(1) Ellwood argues that companies seeking to diversify should expand into the service sector of the economy. Corporations which are facing the "limits of growth" caused by the "insatiable demands on the environment for energy and for noisy, polluting, space-occupying, resource exhausting, annually obsolescent goods . . . are searching for products that will add to the quality of life and preserve our environment." What better avenue can they pursue than health services? Kaiser Industries is the prototype of a manufacturer turned health care provider.

(2) Moreover, Ellwood argues that corporations could save money by providing HMO services to their employees. Corporations already pay handsomely for employee health benefits ($10 billion in 1969), yet they control neither the cost nor the quality of that care.

Beyond this, many companies are engaged in providing some health services, e.g., pre-employment physicals, periodic check-ups, screening for industrial diseases, etc. More and more corporations are using multiphasic screening tests to weed out bad health risks—drug addicts, alcoholics, etc.—from their employ, as well as to make long range prognoses about the health problems of their workers. Through the latter, companies hope to estimate how long workers will be of use to them. By translating such testing programs into HMO services, corpora-

Corporate HMO Quiz

"Supposing the HMO idea interests you, how can you decide if HMO's are right for your company? I suggest that you begin by taking a simple, self-administered corporate HMO quiz. The results won't give you a conclusive answer, but they should give you a rough estimate of whether or not your firm has the potential to establish an HMO as a new venture. A score of 30 or higher (out of a total of 50 points) is promising and indicates that you should move on the next stage and learn more about the details of HMO's. Ask yourself these questions:

Question 1: Is our profit and cash position a strong and stable one, and will our profit objectives permit us to wait for up to 5 years for any return on an investment of $1 million to $10 million? (A perfect score is 10 points.)

Question 2: Is our firm committed to serving the community, and will its reputation for quality and excellence assure that it would be unwilling to risk the adverse publicity that would result from the provision of shoddy, skimpy, or impersonal services? (A perfect score is 10 points.)

Question 3: Is top management searching for ways to profitably solve problems in the delivery of human services? Is our management team flexible enough, and capable of diversifying into the health field, or is it committed to a single set of related products? Is our growth policy based solely on acquiring fully-developed firms, or will it permit us to start from scratch on a small scale and learn as we grow? (A perfect score is 10 points.)

Question 4: Would we have ready access to enough physicians to make up a skillful and compatible medical group, and is it likely that we could enroll at least 10,000 subscribers? (A perfect score is 10 points.)

Question 5: Is management willing to enter a highly competitive field, in which profitability and growth are not dependent on having exclusive patents and franchises? (A perfect score is 5 points.)

Question 6: Do we have any experience in the management of science and technology, or health-related activities, or other human services such as education? (A perfect score is 5 points.)

by Dr. Paul Ellwood, Industrial Health Conference, April, 1972.
tions could, provided national health insurance is passed and adapted to HMO's, receive federal reimbursement for their trouble.

(3) Finally, Ellwood argues that corporations should go into health care because they have already developed many of the necessary skills and attributes.

- Industry has management skills. "As health delivery shifts into larger, better organized units, with scores of physicians and other personnel and annual incomes in the millions," corporate management know-how will be in great demand.

- Industry has research and development skills. Ellwood thinks that "R & D's greatest impact can be made by focusing on management information and quality assurance systems." Industry can solve the ills of the health system through cost benefit analysis. Industry has the technology at its fingertips to catch the costly slip-ups of the system—"the missed, or unscheduled X-ray appointments, unexpected laboratory findings that are overlooked, failure to do patient follow-up."

- And most important, industry has capital. "HMO's are finding that it's not easy to obtain start-up and expansion capital from private money markets." And public money for planning grants so far invested has been chicken feed. With national health insurance a probability and guaranteed reimbursement for HMO's in the cards, the investment is, Ellwood argues, risk-free.

To complete his pitch, Ellwood administered his "corporate HMO quiz," designed to "help you decide if HMO's are right for your company" (see box page 9). Ellwood had previously distributed this to the medical directors of 59 large corporations. Of 41 replies, about half indicated that "while expansion [into health care] had been considered, the idea was rejected, either permanently or 'for the time being.'" Fears included malpractice suits, governmental control of fees, public rejection of making profits out of sickness, lack of cost and quality controls, and others. The other half showed varying degrees of interest in the idea, and 19 indicated that they are planning to provide health services for their workers.

Nibbling the Bait

Most corporate responses to HMO's have been mixed. However, some defense and aerospace companies, like G.E., Westinghouse, Litton, and Texas Instruments, which are desperately looking for new markets, are weighing, at government expense, the opportunity. (Texas Instruments received federal funds to design an HMO from top to bottom, i.e., determine health plan benefits, analyze the local consumer market, conduct a cost benefit analysis, evaluate legal status, etc.)

New York Bell Telephone has also been testing HMO waters. The rationale, according to the medical director, is that: "The public wants prevention and maintenance [in health care] which the exiting system can't provide. Care has to be provided at a convenient place and under circumstances where people will accept it. The only branch of medicine designed to do this is occupational medicine. Industry has convenient facilities and the technology and a stable population that can be followed over a long period of time."

New York Telephone has already installed an elaborate and sophisticated statewide multiphasic screening program for roughly half of its 106,000 workers. The goal of this program may more nearly reveal New York Telephone's real philosophy about its role in health care: It is to "improve the working efficiency of our people." The medical director clearly stated that "not all parts of the HMO package are equally attractive. We will not go into the [costly] business of running hospitals, nor deliver the entire therapeutical package." So much for health care maintenance.

Blue Cross/Blue Shield are in the process of establishing HMO's and other companies involved with health care, such as drug and insurance companies are showing interest, feeling that if HMO's are the wave of the future, they had better make some start now.

But basically, industry's response to HMO's has been a skeptical one, and for good reasons. Not the least of these is the problem industry will face trying to convince workers to get all their health care from the "company clinic." But this is secondary to the question of whether HMO's can make health care delivery a profitable enterprise. And this has yet to be established, except for very big operations over a period of many years. In fact, if Ellwood's speech is examined carefully, it is clear that Ellwood's pitch suggests that at the moment, corporations have much more to offer HMO's than HMO's have to offer corporations.

Nevertheless, Ellwood's speech is a revealing insight into Nixon's prescription for the ailing health care system and what HMO's, which presently mean everything to everyone, will mean in the hands of the Nixon administration. It is still unclear whether corporations will bite, but if they do, one thing is clear: The public can expect just about as much from HMO's as it did from C5-A transport planes.

—Marsha Handelman
Dear Friends:

We have read your article entitled "Half of Brooklyn Descends on Methodist." . . . The title of the article looks puffed up and egocentric to the people we have been working with. Many groups are working together on the Methodist project, and while there is division of labor, no group is more important than any other, with the exception of the tenants, who have their homes at stake. It looks ridiculous for us to abstract ourselves from our constituency and co-workers and say we are the whole struggle, and indeed we never did do or say such a thing.

It seems strange to us that Health-PAC, which does a lot of research, should publish something as factually incorrect as the paragraph dealing with the Ghetto Medicine Bill and the setting up of the Advisory Committee. Each fiscal year, the hospital and the city negotiate a contract, and upon agreement it is signed, and the hospital receives approximately half of its projected deficit entitled in running the Outpatient Department. In return, the hospital must provide the entire community, regardless of income, good, comprehensive ambulatory care. The law states that the hospital will establish an Ambulatory Care Services Advisory Committee (ACSAC)—51 percent community members and 49 percent provider members, to enforce the law. The community involvement is very well defined. The hospital had no alternative and setting up ACSAC was not an arbitrary move by the hospital to circumvent the law. The intent of this legislation is to have the community directly involved in the planning, developing and evaluation of the ambulatory services of the hospital. It seems to us that Health-PAC has missed the significance of this law, and most of all, the significance of what is actually happening—for one example—that people of different races and incomes are working together to create the beginnings of a community hospital.

We do not understand how you could write that now that two of our women are on the ACSAC, much of our strategy is now centered around a struggle for real power in the Advisory Committee. It sounds as if we are struggling with other community people for power—this would be, if true, disastrous and stupid. The community, in so far as it is organized, is substantially all together. The hospital traditionally has the power, but the committee now has power too, and the point is, not to struggle with fellow community people for power, but to use the power we do have, thereby consolidating our strength and obtaining the object of our struggle—a community hospital which delivers comprehensive health care, but not at the expense of community housing. This is not an easy program, but it will get more results than if we fought among ourselves for power, and a lot more satisfying. A very important element in our unity is the fact that the Advisory Committee is racially mixed at the community end, with three Black women, two Black men and three white women. This is a significant development for the women's movement, which has been unable to involve itself very deeply with Black women, and indicates that possibly the best way to correct this is to get involved in this kind of political and community struggle. We would hope that our friends, such as Health-PAC, could support us in this effort.

Our educational work in the clinic is not patronizing and superior, as it sounds in your article. We have achieved some knowledge, mostly through our own efforts, which we wish to share with other women. The education we ourselves receive from the women we share with, is of great importance.

The sharpness of our response to the article is due to the distress we feel that in a somewhat subtle way it missed the point of our struggle and the importance of our cooperative effort in the struggle with the rest of the community. Though the final paragraph draws the conclusion in the article, the material from which such a conclusion would be drawn is not presented in the article.

Very truly yours,

Half of Brooklyn

Women's Health Collective

Editor's Note:

Half of Brooklyn misinterpreted our article on Methodist Hospital. Health-PAC is well aware of the significance of the Ghetto Medicine Program (see BULLETINS, January, 1970; April, 1970; March, 1971; as well as article on Page 5 of this issue). Nowhere did we state that the establishment of the ACSAC was an "arbitrary move" by Methodist. Also, the "struggle for real power" on the ACSAC obviously refers to a struggle between members and the hospital, not between the two women from Half of Brooklyn who are on the committee and other members. We suggest that Half of Brooklyn reread the article. The material for the conclusion is very clearly present.
News Briefs

A Medical Intelligence Agency?

Testimony at recent Congressional hearings revealed a new addition to the medical-industrial complex. The Medical Insurance Bureau (MIB) of Greenwich, Connecticut, maintains a medical data bank on nearly 12 million persons. It collects information from its 700 member life insurance companies, as well as from some doctors and hospitals, and functions primarily to alert insurance companies to high risk insurance applicants. The executive director refused to comment on whether MIB supplies similar information to health insurance companies. But with the prospect of health insurance companies and large employers, the market for such services looks like a very rich one indeed.

Back Where We Started?

It's taken six years, but out-of-pocket health care expenses for the aged are nearly back to what they were in 1966, before Medicare and Medicaid, in spite of the fact that these two programs now pay two-thirds of all health care costs for the aged. The May issue of the Social Security Bulletin reports that in 1966 medical bills for a person over 65 averaged $234. Today they average $961 of which, however, an older person must pay approximately $225 himself.

Remodeling the Old Blue Cross

Trying to clean up its image as a financial agent for the hospitals, Blue Cross has been fostering the appearance of independence from its parent organization, the American Hospital Association. In the last year, AHA has given up its franchise on the trade name "Blue Cross," and unlocked their interlocking boards of directors. This month Blue Cross acted to remove the AHA symbol from the center of its trademark. But for a moment, the AHA nearly back-slid. Catching themselves in time, critics headed off the nomination of Blue Cross President Walter McNerney, to the presidency of the AHA.

"Experiments" in Cost-Cutting

In spite of the fact that it is illegal, Medicaid patients in California will soon have to pay part of the cost of doctor's visits and drugs themselves. Called "co-payments," the plan is designed to prevent over utilization, or, in plain language, to discourage people from using the medical system. Medicaid legislation permits the Secretary of HEW to waive the law for purposes of "demonstration, experiment, or pilot program." Thus California has dubbed its cost-cutting plan an "experiment," even though its methodology leaves much to be desired. The National Welfare Rights Organization is presently fighting the move in court.

When the Fine Print Looms Large

No one had given much thought to the requirement that hospitals receiving Hill-Burton money for construction must provide a "reasonable" volume of free care to patients unable to pay, until last year when lawyers in Louisiana and Colorado launched two class action suits on the issue.

Then, in mid-April, afraid that the courts would step in and establish standards for what is "reasonable," HEW officials rushed to do the job themselves. They issued guidelines requiring charity services equal to five percent of a hospital's operating income, or 25 percent of its net income.

But when hospital administrators sent up a hue and cry, HEW officials began backing off. First, they said the requirements had mistakenly been published as "standards," when they were only meant as "guidelines" to help states determine what is a reasonable volume. But the din continued and before it was over, HEW had been flooded with over 1400 letters of protest.

As a result, the new regulations reduce the volume of free care required to three percent of operating costs or ten percent of Hill-Burton aid received by the hospital, whichever is less; exempt hospitals which proclaim an "open door" policy of admitting patients regardless of ability to pay; allow hospitals to determine which cases are "charity" cases after discharge instead of at the time of admission (read "bad debts"); terminate the obligation after 20 years in the case of Hill-Burton grants, or whenever loans are paid off; and exempt hospitals in bad financial condition (e.g., many urban hospitals) or hospitals in affluent areas (e.g., the suburbs) which have no natural demand for free services. And with that, the storm seems to have blown over, at least among the providers.