No sooner had Richard Nixon begun his second term than he startled the country by announcing bold cuts in health, education, welfare, poverty and other social and domestic programs. In so doing, he took steps to reverse growing federal involvement in domestic social problems—a policy of some forty years standing.

Many believe that this move is personally and politically motivated—that the President is anti-black and anti-poor, an indifferent, reactionary and even vicious man. However, they ignore the growing economic crisis in the country which forces Nixon’s hand, as it would the hand of any other president, Democrat or Republican, conservative or liberal, at this point in time.

For the roof is caving in on the overextended American economy. The dollar is battered on all sides—by international competition, overseas military spending, the continuing war in Southeast Asia, the declining U.S. balance of trade, uncontrolled domestic inflation, and worldwide loss of confidence in American political and economic leadership. Almost daily business newspapers and magazines warn of impending crisis and admonish Nixon to “do something.” And he has tried to “do something”—from dollar devaluation, to ping-pong and vodka diplomacy, to wage and price controls. But these measures have been insufficient, so now Nixon has turned to cuts in the domestic budget, particularly in health.

Congressional Democrats, of course, have raised up their expected hue and cry. But the problem is as much theirs as it is his. Great Society health programs, of which they were architects, failed to achieve significant health gains despite vast outpourings of money. Even more important, they have been unwilling to face up to the irreconcilable conflict between meeting social needs at home and protecting, maintaining, and extending the “Empire” abroad. In fact, the vast increases in the cost of the “Empire” since World War II have taken place under Democratic, not Republican, administrations.

Hardly less vociferous, and just as expected, has been the hue and cry of the health establishment, especially its academic-institutional sector, which has suffered badly at Nixon’s hands. Its rallying cry, of course, is “Stop the Budget Cuts,” and its goal a restoration of the status quo and a return to foot-loose and fancy spending.

“Stop the Cutbacks” is an instinctive cry to health activists as well. For it is difficult to see programs, however inadequate or costly, cut and their beneficiaries hurt as a result. Not incidentally, many socially-concerned health workers who gravitated to the more innovative, if marginal, programs are losing their jobs as well. The immediate response is outrage and a desire to resurrect the protest movement of the ‘60’s. And, as if this could be done by invocation, various leaders of that era have called for coalitions, marches, demonstrations and nonviolent action to turn Nixon’s domestic policy around.
But the strategies of the ‘60’s will not work for the ’70’s. With hindsight, the present predicament has much to teach the health movement about the limitations of those strategies. First, it is clear that America’s health problems cannot be solved by a patchwork of narrowly-based federal health programs. Such an approach builds only small, fragmented, “no-win” constituencies. But more than this, it exacerbates racial and class antagonisms between taxpayers, who finance the programs, and the recipients, who reap their benefits.

Second, it is now clear that the issue is not money. Over the last seven years, massive infusions of money through Medicaid and Medicare have left health care unchanged, if not worsened, by the medical inflation they have caused. Only the health of the health care providers has flourished as a result. The real issue is who controls the health system and to what ends. Unless the control and priorities are changed, similar infusions of money—whether they be from the restoration of cutbacks or establishment of national health insurance—will come to no better end.

For those who would address this issue, the problem is one of building a constituency. Until there is a strong base for such thorough-going change, health activists will forever be the tail trying to wag the health establishment dog. The temptation now is to short-circuit this process, opting instead for the quick and easy route of building broad “cutback coalitions.” But in choosing this route, the health movement risks putting itself in a defensive posture, seeking to restore an indefensible status quo, making money rather than control the issue, and fighting for the right of the research superstars, hospital administrators and medical school deans to continue to mismanage and misdirect both the health system and the federal monies coming into it.

Building a base for thorough-going change in the health system will be a slow, arduous process, which must be done from the bottom up. An opportune place to begin is in and around those bastions of power in the health system—institutions which provide care for ever-growing numbers of health consumers and jobs for increasing numbers of health workers. Here is where the real power in the health system lies, as well as the ability to meet the real health needs. Here too is where the vast majority of public monies are spent and misspent. In fact, institutional providers are increasingly dependent on public monies (over half of all hospital income in the country is now paid by Medicare and Medicaid). To the extent that health institutions are publicly-financed, there is now a real basis for the demand that they also be publicly-controlled.

In the long run Nixon’s health policy may even unwittingly assist in building such a movement. For it is now the Administration which has raised the issues of priorities, effectiveness, accountability and the inflationary impact of federal health spending. And while it would use these as rationalizations to cut back the federal commitment to health, the health movement must use them as cornerstones in building the foundations of a truly responsive and responsible health system. Likewise, it is Nixon who has made clearer than ever the limits set on domestic and health spending by America’s commitments to its “Empire” abroad. In so doing, he unwittingly reminds the health movement that, however strong, its success depends also on the success of a larger movement to change US policy not only at home, but abroad.
FEDERAL HEALTH CUTBACKS

I. The Causes

The Watergate affair isn’t Richard Nixon’s only problem. The President is likely losing sleep, as well, over the crisis of American capitalism. The crisis is far more than an occasional article in the Wall Street Journal or a series of conferences of high level economists. It means life or death for many federally-supported health programs, because one of the President’s ways of handling the crisis is to slash federal spending on health. To understand the specific spending cuts, a more general appreciation of the crisis is called for.

Fortune Magazine (November, 1972), a leading corporate bellweather, warns of “galloping inflation, probably an international monetary crisis of vast proportions and, at the extreme, perhaps even another great economic recession.” Six months later Business Week (May 12, 1973) called for Nixon to cut $20 billion from the federal budget to avert such a crisis. The Wall Street Journal agrees. Behind these warnings lie a panoply of problems plaguing the US economy.

- First, the US is losing its competitive edge in the world market. Compared to American industry, European and Japanese factories are more modern, efficient and profitable. They can sell their products to the world’s markets, including the US itself, cheaper than can American industrial giants. In sundry fields—electronics, home appliances, ship-building and automobile manufacturing—American industry is being outpaced and outsold by more vibrant foreign competitors. The result is that American dollars pour out of the US to buy foreign products, creating a negative US balance of trade and concentrating billions of dollars in foreign countries, especially Europe.

- With its enormous wealth and power, the US might absorb these trade losses were it not for the cost of maintaining the “American empire.” Troops in Europe, B-52’s in Thailand, Navy bases in Japan and, very importantly, the immense cost of the Indochina war contribute to the enormous drain of dollars from the US.

- The recent emergence of multi-national corporations has also exacerbated the problem. However much money they may ultimately bring into the US, in the short run they pump excessive dollars into the international monetary market.

With all these dollars flowing out of the US, foreign governments and banks hold over $60 to $80 billion in US currency. With so many dollars, and with few profitable investment options, the dollars are rapidly losing value. International capitalists have been converting dollars to German marks, French francs, Japanese yen and gold, thereby making the dollars worth even less. If confidence in the dollar as a stable medium of exchange goes much lower, international trade could experience multiple revaluations of currencies, erection of tariff barriers, and a worldwide depression like that of the 1930’s.

Foreign investors are scarcely reassured when they look at escalating prices in the US. Inflation makes the dollar worth even less, thus aggravating the crisis. And American inflation is exported to other nations with consequent consumer and worker unease and political instability. So Nixon must act dramatically to reduce inflation and convince world business that America’s economy is under control. The easiest thing for him to do is to balance the federal budget.

The federal budget has grown by leaps and bounds during recent years and gov-
Government expenses have exceeded income at a rate to make even Keynesians blush. Two solutions are always at hand to deal with the problem: raise taxes or cut spending (or some combination of the two).

The US could certainly increase taxes, since its citizens are taxed less than citizens of many other industrialized countries. And, according to the Brookings Institution, federal taxes have actually been cut three times in the last decade (1964, 1968 and 1971), reducing federal income by $35 billion a year in 1972. This provides little solace for taxpayers, however, since local and state taxes have been increasing, and more importantly and inequitably, there has been a sharp increase of payroll taxes (ten percent during the past ten years). The latter monies go to mandated social security programs, including health programs like Medicare.

Nixon, however, does not want to raise taxes. Owing his loyalty (as well as campaign income) to corporate interests, increases in these taxes are out of the question. They would only be passed on to the consumer in the form of higher prices anyway, further fueling inflation. And owing his electoral success to millions of working class men and women who already bear the brunt of most taxation, Nixon is loath to jeopardize this support by increasing personal taxes. (Recent statements indicate that Nixon's hand may be forced on the tax issue anyway.) If tax increases are unpalatable, Nixon still has the option of tax reform or spending cuts.

Tax reform is appealing to many Americans. Unfortunately, the large corporations and wealthy individuals who wrote the tax loopholes to begin with show no sign of rolling over and playing dead while their privileges are taken away. Both Democrats and Republicans are beholden to these groups; therefore significant tax reform is likely to remain a seductive, but utopian vision.

The logic of Nixon's position leaves him, so it turns out, only one option: hold the spending line. Even this tactic isn't as easy as it looks. Some programs are beyond the reach of the Executive office and for all practical purposes the Congress (e.g., Social Security). According to Fortune Magazine (November, 1972), these virtually uncontrollable expenditures will increase by about $77 billion by 1977.

As for the controllable portion of the budget, many point to the fat-laden Defense Department (DOD) as a good place to begin slashing away. But it's not that simple. Even without major new weapons expenditures (inevitable given Nixon's priorities), years of liberal opposition to the military draft have resulted in the "volunteer" Army. Unfortunately, its maintenance and support will cost billions. Military personnel costs already account for 56 percent of the DOD budget and, as recruits begin to get $288 a month starting pay, this figure will rise in the future. As it is, the DOD will spend $12.3 billion more in 1974 for its "volunteers" despite the fact that military manpower has been cut 37 percent. (These figures also include more generous retirement pay.)

The problem is that a large military must be maintained if only to protect America's financial interests abroad; on this issue there is no discernible difference between Republicans and Democrats. The sobering truth is that the largest increases in Defense Department spending in this nation's history occurred during the Kennedy-Johnson era ($44.7 billion in 1961 to $78.0 billion in 1968).

Thus, with large chunks of the budget out of reach of the axe, Nixon had to look for other spending programs to cut. When it comes to matching Nixon's political biases to large, potentially expendable government programs, social welfare programs are hard to miss. Overall the fact is that, at least as a percentage of government spending, aero-space and defense-related spending has decreased from 53 to 34 percent of the federal budget during the last decade. It has been non-military spending which has leaped from 47 to 66 percent. Most of the increases, concentrated in HEW, can be accounted for by Great Society programs. And when it comes to cutting down Health, Education and Welfare to size, health, having grown from $2 billion in 1964 to $22 billion in 1974, is an irresistible target.

Aside from sheer size alone, there are additional reasons for cutting federal health spending. As surely as the average health consumer, Richard Nixon knows that the health industry has been the most inflationary of any major industrial sector. By cutting health spending, Nixon hopes to save scarce treasury dollars as well as curtail health care inflation.

More important perhaps, federal spending on health contains an almost built-in escalator. This factor has already been seen with Medicare and Medicaid. Though less obvious, it also applies to service-oriented health programs. It's almost as difficult for the government to build only one...
model health center as it is for someone to eat only one potato chip. As soon as one community is satisfied, hundreds of others rightly demand their due. And so it is with most federal health service-oriented programs. Unlike one-shot cuts of other parts of the federal budget, cutting health is a preemptive, as well as an immediate saving. A federal dollar not spent today on a demonstration project may save ten federal dollars a few years hence.

Finally, of course, in the real political world some are favored and some are not. There is little question but that the proponents of missile-bearing nuclear submarines and even construction of new federal prisons carry infinitely more political influence with Nixon than poor people clamoring for better health care.

The Health View from the White House

Not only has federal health spending shot from $2 billion to $22 billion in the last ten years (a 1000 percent increase), largely as a result of the liberal Great Society health programs enacted during the mid-sixties, but there is painfully little to show for the investment. Even worse, there is mounting evidence that particular programs, like Medicare and Medicaid, are at the heart of runaway health care inflation.

The Great Society health programs represented the liberal approach to solving America's health problems. Were there large groups who couldn't afford health care? Give them health insurance in the form of Medicaid for the poor and Medicare for the elderly. Were there other urgent needs going unmet by the existing health system? Create special health service programs to meet them, such as maternal and child health and family planning programs, community mental health and neighborhood health centers. Did health care seem irrational and unsystematic? Give it a shot of planning through Comprehensive Health Planning and Regional Medical Programs.
The Great Society health programs of the '60s demonstrated best that money alone, without restructuring the power and priorities of the health system, is no solution.

While the liberals prescribed a lot of money gilded with a little planning, the real problem lay in the issue of who controlled the health system and for what ends. After decades of fighting the reactionary AMA, it was hard for many to realize that, by the mid-sixties, power in the medical system had shifted to the liberal, academic, institutionally-based medical establishment, or that its self-interests might be as pernicious to the delivery of good health care as those of the AMA.

It was natural for the government to rely heavily on this group, both in the design and the administration of the Great Society health programs. The result, however, was programs that benefited the institutional-academic medical establishment as much if not more than they did the groups for whom they were ostensibly intended—programs that gave away large chunks of money with few, if any, cost controls or performance standards.

This is especially true of Medicaid and Medicare which account for the vast majority of all federal health spending (see box, page 12). Medicare and Medicaid costs are often called "uncontrollable" because, on the one hand, these programs are not subject to the Congressional appropriations process and, on the other, they are obligated to pay for whoever is eligible and claims their coverage. Medicare and Medicaid reimburse health institutions on the basis of "cost" without stringently specifying what makes up that "cost." Thus it has been possible for hospitals to add staff, compete for big-name researchers, buy exotic equipment, expand facilities, pay lavish doctor and administrative salaries, hire public relations firms and do virtually anything else they wanted, all at the taxpayers' expense. In the seven short years since their inception, Medicare and Medicaid have come to cost the government $17.3 billion—80 percent of the federal health budget. They now pay over half of all hospital income in the country. Last year alone, Medicare expenditures increased 23 percent and federal contributions to Medicaid rose by 21 percent.

But aside from the increased cost to the government (with little evidence of equivalent improvements in care for the poor and elderly), Medicare and Medicaid, lacking significant controls on spending, have acted to drive up the cost of health care for everyone. In the five years following their passage, medical costs escalated at nearly twice the rate of the previous five years. The cost of the nation's health care reached $83.5 billion last year—topping for the first time what the country spends for defense. Medical costs have risen so much that today the elderly actually pay more out-of-pocket medical expenses than they did in 1966 when Medicare was passed! The average American last year paid $394 for medical expenses—nearly twice that spent in 1966.

Hardest hit by the legacy of the "Health New Deal" has been the working class. They benefit from none of these programs (except Medicare), yet pay a disproportionate part of the taxes for these (as for all) programs, while suffering under the burden of inflated medical costs.

But what is tax burdens and inflation to some is power, profits and prestige to others. Doctors' fees have risen by 7 percent and hospital fees by 15.6 percent a year since 1965. Over 80 percent of Medicare and Medicaid went to institutional providers of health care, consolidating their already growing dominance in the health system and making possible a whole new industry of profit-making providers—Hospital Corporation of America, Extendicare, American Medical International, American Medicorp, etc. Nor did the bonanza stop with institutions. Profits accruing to pharmaceutical companies, hospital supply companies, construction companies, management firms, banks, etc. have made health one of the hottest and surest investments on Wall Street.

Health service delivery programs, such as neighborhood health centers, maternal and child health and family planning pro-
grams, have been less inflationary than Medicare and Medicaid, if only because they are small in comparison and are narrowly targeted to meet specific health needs. But they have hardly been more effective. They have been so limited as to constitute a patchwork of tangled, fragmented, bureaucratically-encumbered projects and so small as to represent at best a token gesture in the face of the need. While they have made possible some exemplary and much-heralded local projects, health insurance could have lived up to such expectations or not is an academic question because, for the time being, the light has faded (see box, page 19). And without it these programs were left stranded, demonstrating only that the federal government was getting into a very expensive commitment indeed.

In fact, what the Great Society health programs of the sixties demonstrated best is that money alone, without restructuring the power and priorities of the health sys-

SUMMARY OF HEALTH BUDGET
HEALTH DIVISIONS OF HEW†
(In Millions)

<table>
<thead>
<tr>
<th></th>
<th>FY72</th>
<th>Revised FY73</th>
<th>FY73</th>
<th>FY74</th>
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<tr>
<td><strong>National Institutes of Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Research Institutes</td>
<td>1,467</td>
<td>1,571</td>
<td>1,483</td>
<td>1,532</td>
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<tr>
<td>B. Health Manpower</td>
<td>673</td>
<td>535</td>
<td>440</td>
<td>382</td>
</tr>
<tr>
<td>C. Miscellaneous</td>
<td>69</td>
<td>79</td>
<td>75</td>
<td>51</td>
</tr>
<tr>
<td><strong>TOTAL NIH</strong></td>
<td>2,308</td>
<td>2,185</td>
<td>1,888</td>
<td>1,865</td>
</tr>
</tbody>
</table>

| **Health Services and Mental Health Admin.** |       |              |      |      |
| A. St. Elizabeth's Hospital | 28    | 31           | 36   | 38   |
| B. Health Services Planning & Development | 468   | 330          | 157  | 163  |
| C. Mental Health          | 603   | 657          | 604  | 1,282*|
| D. Health Services Delivery | 674  | 751          | 706  | 852**|
| E. Preventive Health Services | 145  | 157          | 139  | 125  |
| F. Miscellaneous          | 53    | 61           | 73   | 85   |
| **TOTAL HSMHA**           | 1,971 | 2,007        | 1,715| 2,543|

**TOTAL, NEW HEALTH EXPENDITURES, EXCLUDING MEDICAID AND MEDICARE**

<table>
<thead>
<tr>
<th></th>
<th>FY72</th>
<th>Revised FY73</th>
<th>FY73</th>
<th>FY74</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,179</td>
<td>$4,192</td>
<td>$3,712</td>
<td>$4,508</td>
</tr>
</tbody>
</table>

†Underlined figures represent cutbacks.

*Includes $645 million in forward funding for CMHC's.

**Includes $117 million in transfers from OEO.

these have been at such cost as to make their replication across the country inconceivable.

Many Great Society architects were aware of these shortcomings, but they assumed that the health service delivery programs would serve as demonstrations. When national health insurance—the light at the end of the tunnel—was passed, not only would it pick up their costs, but it would make possible similar models throughout the country. Whether national tem, is no solution. Rather, it may exacerbate the very problems it was intended to solve. Nor has the lesson been lost on Richard Nixon who, having a different political philosophy and facing different economic circumstances, has little interest in solving health problems or restructuring the health care system. His single consuming interest is saving money, and health—bloated with often ineffective, exorbitantly expensive, inflation-producing programs—is tailor-made for the Nixon axe.
II. The Casualties

Trimming the Fat (and the Lean)

If there was any doubt about the seriousness of Nixon’s intent in health, it should have been dispelled a year ago when he issued his Fiscal 1973 (FY73) budget request. Although the total for HEW increased substantially over the previous year, health items, with the exception of Medicaid and Medicare, were cut by $40 million. Nixon then took up cudgels with Congress, twice vetoing an HEW appropriation which exceeded his request. (Consequently Congress never passed a FY73 appropriation, and HEW has been operating since July 1, 1972 under continuing resolutions.)

But even with this forewarning, Nixon’s FY74 budget message came as a bombshell to the medical world. More startling than the actual FY74 budget was a revision of the budget for the remaining six months of FY73, issued simultaneously, which slashed health by another $500 million. The FY74 budget will “hold the line” after that, although “holding the line” in this era of spiraling general inflation will mean cutting the budget by 6 to 8 percent across the board.

Health programs were shaped according to three considerations, says the HEW budget document: (1) ... “Emphasis on programs that directly support individual economic well-being and access to the marketplace; (2) ... Decentralization of authority and decision making to states and local governments and away from central control in Washington, and (3) ... An assessment of federal demonstration and special project programs. Those that carry out genuine national priorities and are believed to be producing real results have been strengthened; those that are poorly designed or unproductive are proposed for reduction or elimination.”

To substantiate what Nixon already suspected of being “poorly designed or unproductive,” he hired a bevy of consultants to evaluate the Great Society health programs. Such evaluations are commonplace, but generally they have been conducted by medical and public health school people—representatives of the very sector that benefits most from these programs. This time, however, Nixon brought in his friends from the defense industry to do the evaluating. Although the results have not been released to the public, it is clear that they differed dramatically from those of the past.

Intertwined with critiques of effectiveness and productivity are several other recurring themes: “Aid to individuals, not institutions ... getting the government out of the direct delivery of services ... an end to government intervention ... and a return to private market mechanisms ... individual self-sufficiency, self-reliance and thrift.” Together they reveal a relatively coherent philosophy, geared not to solving problems of health care, but rather to rationalizing the federal role in health care and reconciling it with the fiscal needs of the state.

Hardest hit have been health services planning and development programs, research, training and manpower programs, and health service delivery programs. Many of these were terminated outright or cut back severely. Medicaid and Medicare, the big spenders, could not be cut in the same manner, but Nixon is hoping to put a lid on them through reductions in benefits or eligibility, plus a number of regulatory measures. The following is a more detailed examination of these cuts and why they were made.

**PLANNING AND DEVELOPMENT PROGRAMS—**Two health services planning and development programs are slated for termination: the Hill-Burton program for hospital construction and the Regional Medical Program. **Hill-Burton, a long-standing political favorite, goes only to voluntary hospitals, primarily those in suburban and rural areas. During its 26-year history, Hill-Burton funds have paid for 13 percent of the national costs of voluntary hospital**

### HEALTH SERVICES PLANNING AND DEVELOPMENT†

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<thead>
<tr>
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<th>FY73</th>
<th>FY73</th>
<th>FY74</th>
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<tbody>
<tr>
<td>Research &amp; Development</td>
<td>$52</td>
<td>$65</td>
<td>$52</td>
<td>$50 **</td>
</tr>
<tr>
<td>Comprehensive Health Planning</td>
<td>26</td>
<td>42</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Reg. Medical Programs</td>
<td>99</td>
<td>130</td>
<td>60</td>
<td>—</td>
</tr>
<tr>
<td>Health Maintenance Org.</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>60</td>
</tr>
<tr>
<td>Medical Facilities Construction (Hill Burton)</td>
<td>278</td>
<td>91</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
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</tbody>
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†Underlined figures represent cutbacks.
**Includes $15 million in transfers from RMP.
construction. But recently hospital occupancy has begun to drop (falling from 78.0 to 74.8 percent in two years) and it seems clear nationally that additional beds are not presently needed. While the program has responded to these trends by moving more toward modernization and construction of ambulatory facilities, it has left untouched the most serious problems: the deteriorating and overcrowded urban voluntary and public hospitals. Given their indifference in the past, objections now by the medical establishment and Congress that Hill-Burton should be saved and restructured to meet this need ring of opportunism, if not hypocrisy.

Destined for the same fate is the Regional Medical Program (RMP) which has distributed over $500 million, mostly into the coffers of medical schools, since its beginning in 1966. RMP, originally directed at the treatment of heart disease, cancer and stroke, went to fund anything that could be rationalized as helping to “get research advances into regular medical practice.” And, needless to say, a lot of things (particularly otherwise unfundable research) could be so rationalized, leading some critics to call RMP “the WPA for medical schools.” Defenders of the program have been hard to come by, in part perhaps because RMP is all but unknown except to those whose program budgets or salaries depend on it. And Congress, while up in arms about Nixon’s attempt to terminate a program without its approval, talks only half-heartedly of reforming the program to make it more viable.

HEALTH SERVICE DELIVERY PROGRAMS, such as maternal and child health and family planning programs, community mental health and neighborhood centers, have received a great deal of public attention because they have created local projects which are concrete, visible, and in many cases exemplary. While they are actually small in terms of the federal health budget (4 percent for health services, 6 percent for mental health), they are exactly the kinds of programs Nixon likes least. In his view, the federal government is pouring money into a bottomless pit of unmet health needs through narrowly-based categorical programs that serve token numbers of arbitrarily chosen recipients, and inefficiently at that. More serious, however, is the precedent these programs represent. For unless the federal government is really willing to meet the health needs they serve, the existence of these programs is a nagging reminder of what might be. So they will be cut.

For example, the Community Mental Health Center (CMHC) program will be terminated when present grant commitments expire. This nine-year-old program has brought 515 CMHC’s into existence and has been credited with helping to reduce institutionalization of the mentally ill by one-half. (But whether the credit for this should go to CMHC’s or tranquilizing drugs is unclear.) The program has been plagued from the beginning with disagreements about approaches to treating mental illness, the direction of community-based programs and the scope of services which should be included. Consequently the National Institute of Mental Health which administers the program has never been able to formulate criteria by which to judge the success of a CMHC, and has
come under increasing fire for disregarding the criticisms of even its own evaluators in funding particular CMHC's. (See Health/PAC's study, *Evaluation of Community Involvement in Community Mental Health Centers.*)

**PREVENTIVE HEALTH SERVICES**

(In Millions)

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<th></th>
<th>FY72</th>
<th>FY73</th>
<th>FY74</th>
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</thead>
<tbody>
<tr>
<td>Disease Control</td>
<td>90</td>
<td>95</td>
<td>84</td>
</tr>
</tbody>
</table>
| Community Environmental Management | Underlined figures represent cutbacks.
| (Lead poison, rats) | 26   | 29   | 27   | 22   |
| Occupational Health | 25   | 29   | 24   | 26   |

MATERNAL AND CHILD HEALTH, FAMILY PLANNING AND NEIGHBORHOOD HEALTH CENTERS have all been cut slightly. Apparent increases in the latter two represent transfers of OEO programs, not additional funding (see budget box, page 7). OEO projects will be maintained and administered like their former HEW counterparts. In the case of Family Planning, the Administration claims that the cut will be compensated for by increased funds from Medicaid and Social Services provided under HR 1. More serious for existing *Maternal and Child Health* programs than the cutbacks is the fact that project grants, which go to specific applicants and comprise 40 percent of grant monies, will be incorporated into formula grants which go to all states according to a population-income formula. This will hurt many areas, particularly urban areas, where a high degree of awareness, organization and skill in grantsmanship have caused a concentration of maternal and child health services in the past.

If health service delivery cuts don't seem so serious at the moment, it's only because HEW is saving its punches. HEW has announced its intention eventually to terminate many of these programs, forcing them to rely on state and local support, fees and third party reimbursements for their survival. Last year it notified neighborhood health centers to prepare plans for becoming financially self-sufficient. This year HEW instructed them to stop serving those not covered by third party reimbursements. Presently, it is auditing their records to determine their "management efficiency" and potential for self-sufficiency, upon which federal support in the immediate future will be based. The same will no doubt be the case for other health service delivery programs. The handwriting is on the wall: the federal government is getting out of the business of supporting direct health services. It's back to the states and localities, to the private market, or to no services at all. If these programs wish to survive, they must begin dropping their less profitable patients as well as their more innovative, but less reimbursable, services.

**RESEARCH, TRAINING AND HEALTH MANPOWER PROGRAMS**—Less than three years after President Nixon signed into effect three major bills designed to relieve health manpower shortages (the Allied Health Act of 1970, the Health Professions Educational Assistance Amendments of 1971, and the Nurse Training Amendments of 1972), he has reversed his position almost entirely. *Health Manpower* support will be cut in half, ending institutional support for nursing, allied health manpower, and public health, as well as veterinary medicine, optometry, podiatry and pharmacy. Only doctors, dentists and osteopaths will receive continued, in fact, increased support.

The shaky economy has also tightened the job market for health workers and caused many to question whether there still is a health manpower "shortage." Nixon's health cutbacks promise to tighten the market even more. Moreover, expectations that the "new professions" would provide more health services at lower costs have changed. Doctors and institutions have generally been unprepared to utilize these health workers and their presence has caused duplication rather than increased services. Where private doctors have used allied health workers most often it was to increase their own income, not reduce the cost to the patient.

If the medical schools survived on the health manpower scene, they and their scientific colleagues lost badly on two other fronts. *Research training grants and fellowships*, which support 38 percent of all researchers-in-training, will be eliminated after this year. Half of these monies support researchers-in-training; the other half goes to support salaries of medical school
HEALTH MANPOWER PROGRAMS†
(In Millions)

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†Underlined figures represent cutbacks.

faculty. The Administration argues that because it is cutting back biomedical research, the need for researchers will be reduced. As one HEW spokesman said, "If we're going to cut research efforts, then we're certainly not going to keep on training more researchers who are just going to turn around and pressure us to beef up research." The impact will be substantial. For instance, Massachusetts General Hospital will lose 190 fellowships and 14 career development awards amounting to $2 million; the Medical School of the University of California at San Francisco will lose support for 264 trainees for a total loss of $4 million. Stanford will lose $3.4 million.

The second major blow to medical schools and their scientific colleagues took the form of biomedical research cutbacks. Although the overall National Institutes of Health research budget increased slightly (see budget box, page 7), the increase, plus additional money derived from cuts (averaging 14 percent) in all the other research areas, will go to cancer and heart research. Although there will be a rush to rationalize present research proposals in terms of their relevance to cancer and heart disease, it is as yet unclear what impact this emphasis will have on medical school research funding. What is clear is that Nixon is moving away from basic research and general research support to applied, targeted, publicly-appealing research.

Because academic medicine has been established on a particularly shaky federal funding foundation, it is extremely vulnerable to research cutbacks. This situation is largely due to opposition of the AMA, which until recently has blocked direct federal support for the training of doctors. The AMA was less concerned about federal research support which had the allure of improving the scientific nature of medicine without the threat of increasing the supply of doctors. Consequently, biomedical research has become the cornerstone of medical education. Federal research funds, often entailing overhead payments of up to 60 and 70 percent, presently supply over half of all medical school budgets. Another 10 percent comes from research training grants. In addition, medical schools have been in a good position to turn other programs—RMP, preventive health, health service delivery programs, to name a few—to their benefit. All in all, medical schools estimate that their incomes will be trimmed 25 percent at least by federal cutbacks.

NIH RESEARCH INSTITUTES†
(In Millions)

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†Underlined figures represent cutbacks.
MEDICAID AND MEDICARE—The above simply slice dollars off these two programs. Instead, he must pursue the more tortuous route of obtaining Congressional approval for reductions in eligibility and benefits, and other cost-cutting regulations. The Administration already took a long

### Medicaid — Medicare Cuts

The effects on Medicare and Medicaid of HR 1 and the new legislation proposed by Nixon are:

- **INCREASES IN THE COST OF PHYSICIAN SERVICES UNDER MEDICARE**
  HR 1 increased the monthly premium which the elderly must pay to receive physician services from $5.80 a month to $6.30. It also increased the amount the elderly must pay for physician services before they begin receiving Medicare benefits (the deductible) from $50 to $60 a year. Now Nixon would like to increase this to $85. After that, he would build in automatic increases in both the premium and the deductible, proportionate to increases in Social Security benefits. He would also increase the share of physician costs paid by the elderly (co-payment) from 20 to 25 percent.

- **INCREASED COSTS IN HOSPITAL SERVICES UNDER MEDICARE**—Nixon is now proposing substantially increased deductibles and co-payments for hospital care under Medicare. Presently when a Medicare patient enters the hospital, he pays on the first day $72, the average national cost of one day of hospital care. After that he pays nothing until the 61st day. Between the 61st and the 90th days, he pays $18 (one quarter of the initial amount). After the 90th day, the Medicare beneficiary begins to use his lifetime reserve of 60 additional days, during which time he pays $36 a day (one half of the initial amount).
  
  Under Nixon's proposal, the Medicare beneficiary will pay the actual cost of the first day of care (which can run as high as $200 in some hospitals) and 10 percent of the actual daily cost for each day thereafter. The Administration hopes this “consciousness of cost” will lead the Medicare patient to choose less expensive medical facilities, even though this decision is in the hands of the doctor, not the patient. For the Medicare beneficiary who is hospitalized, average costs will increase from $84 to $189. If the patient cannot pay the increased amount, presumably he can turn to Medicaid. Nixon estimates that these measures, if passed, will save Medicare an estimated $893 million in FY74.

- **MEDICARE BENEFICIARIES RESPONSIBLE FOR COST MONITORING**—HR 1 will establish limits for “reasonable” costs of medical services under Medicare, and the beneficiary, not the provider, will be held liable for costs determined to be in excess of these limits.

- **INCREASED COSTS FOR MEDICAID BENEFICIARIES**—HR 1 mandates states to charge “medically indigent” persons (those above the welfare level but still eligible for Medicaid) monthly premiums, graduated by income, for Medicaid coverage. States can also charge “nominal” deductibles and co-payments (not graduated by income) to the medically indigent for all services, and to those below the welfare level for “optional” services. Because both premiums and co-payment/deductibles will be determined by each state, and federal guidelines have not yet been issued, the impact of these measures is not yet clear.

- **CUTBACKS IN MEDICAID SERVICES**—HR 1 also removed the provision that states move toward the provision of comprehensive medical services under Medicaid by 1977. Also dropped was the requirement that states not reduce their aggregate shares in the Medicaid program from year to year.

- **LOSS OF ADULT DENTAL SERVICES UNDER MEDICAID**—Adult dental services under Medicaid would be dropped by further legislation that Nixon is proposing, saving an estimated $75 million a year.
step in this direction in its support for HR 1, the amendments to the Social Security Act, passed last year. HR 1 increased deductibles under Medicare, allowed states for the first time to charge Medicaid recipients co-payments, deductibles and premiums while reducing the scope of services they are required to offer. Nixon is now proposing new legislation which would more than double what the average Medicare patient, undergoing hospitalization, would have to pay in deductibles and co-payments. (In the present climate of Executive-Congressional relations, this proposal has little chance of passing, particularly since many Congressmen are loath to go on record voting against the elderly—see box on Medicare and Medicaid, page 12.)

Through HR 1 and his newest proposal, Nixon expects not only to save what beneficiaries will now have to pay out-of-pocket, but to create in them a "cost consciousness." If Medicare and Medicaid patients must pay a more substantial portion of their medical costs, presumably they will seek less expensive service. Many, it is hoped (although not stated), will simply be discouraged from seeking services altogether.

Interestingly, HR 1 made at least a gesture toward instilling "cost consciousness" in institutions as well as in individuals. For example:

■ To reduce hospitalization costs under Medicaid, HR 1 requires states to establish utilization review systems, including pre-admission review and pre-determination of length of stay. As a result the Administration expects to save $152 million in FY74.

■ In a similar vein, HR 1 also mandated the establishment of a nationwide network of Professional Standards Review Organizations (see BULLETIN, February, 1973) which will review institutional services provided under Medicaid and Medicare to assure that they are medically necessary and conform to appropriate professional standards of care.

■ HR 1 also gave a boost to Health Maintenance Organizations, a long-standing Administration hope for reducing the costs of health care (see BULLETIN, April, 1971). As a result, the elderly can now use their Medicare coverage to enroll in an HMO if they wish.

■ Finally, HR 1 seeks to beef up the almost non-existent power of Comprehensive Health Planning Agencies by denying Medicare and Medicaid depreciation allowances to institutions whose capital im-

What effect these measures will have on institutions is harder to discern. The Administration is optimistic, however. PSRO's, HMO's and CHP were among the few items in the federal health budget to receive substantial increases ($33 million, $60 million and $12 million, respectively.) Significantly, Nixon apparently recognizes that health institutions cannot by themselves be expected to guard the government's till. Whether it comes from the hides of individuals or institutions, the Administration says it is looking forward to saving $900 million on Medicaid and $1.3 billion on Medicare in FY74.

### Expiring Health Programs

President Nixon picked an opportune year in which to cut health. Legislative authority for the following programs expires on June 30, 1973, and Nixon let it be known that many of these programs will never be renewed under his tenure.

- Hill-Burton Hospital Construction
- Allied Health Professions Training Act
- Professional Public Health Personnel Traineeships
- Medical Library Assistance
- Health Services for Migrant Workers
- Maternal and Child Health and Crippled Children Services
- Programs under Title V of the Social Security Act
- Community Mental Health Centers and Mental Retardation Facilities
- Regional Medical Programs
- Health Services Research and Development
- Comprehensive Drug Abuse Prevention and Control
- Lead-based Poisoning Prevention
- Federal-State-Local Health Statistical System Authority
- The Partnership for Health Programs
- Family Planning Services and Population Research Act
- Developmental Disabilities Services and Facilities Construction Amendment
Megantorphosis

In the hustle and bustle of officials coming and going at HEW, it's easy to lose the path the agency is following. Elliott Richardson, former HEW Secretary, did at least establish the terms of the debate and strategic options before departing. He outlined a direction and provided a hint of the administration's thinking in an omnibus plan to reorganize HEW—called by some the Megaproposal, or simply MEGA.

MEGA, whose full title is Comprehensive HEW Simplification and Reform, was prepared at Richardson's request by HEW officials, most of whom are still at their posts. It is over two hundred pages long. Among other things, it contains a devastating critique of Nixon's own national health insurance proposal (see BULLETIN, November, 1970 and April, 1971), making its official adoption by the White House unlikely. Still, by and large, little of MEGA is incompatible with expressed Administration policy.

MEGA's jumping off point is an attack against the categorical grant-in-aid system. It argues that there is a crisis of complexity, fragmentation and overpromise.

- Complexity—"Since 1961, the number of different HEW programs has tripled, and now exceeds 300; 54 of these programs overlap each other, 38 overlap programs of other Departments. The Federal Government as a whole had no less than 530 categorical programs of aid to States in 1971.

- Fragmentation—Federal rules and regulations for these myriad programs are narrow, restrictive, conflicting and overlapping; neither Federal nor State and local resources can be shifted from one narrow authority to another when the need arises. . . .

- Overpromising—We are progressively promising more and delivering less. . . . We calculate that HEW's service delivery programs, which now cost $9 billion, would cost $250 billion if they were actually extended to all who need them. The inequities and the disappointments in the gigantic short-pull are fundamental to general unhappiness with government."

Reform is needed, MEGA argues, because "the federal program has become so complex that it is unmanageable. Interdependencies among programs are ignored because they cannot be understood, leaving rational choice difficult, if not impossible."

MEGA's suggested reforms hinge upon these special revenue-sharing proposals to be administered by State and local governments. Under special revenue-sharing, three programs—education, health and social services—would receive a total of $7.5 billion a year. The simplification comes in because 42 State formula grants and six project grants would be reduced to only seven broad funding categories, one of which is health.

The thrust of Richardson's MEGA proposal is to give governors, county executives and mayors the power to decide—within very broad guidelines—how money is to be spent. The entrenched bureaucracy in Washington and its suitors would be the big losers.

For now, the Nixon Administration cannot, even if it wanted to, implement all of MEGA. Though the Administration talks about, and MEGA strongly argues for, decentralization of decision-making, so far it remains only talk. Even at HEW itself, decentralization is little more than an idea. HEW regional directors, for example, still have virtually no power to make funding decisions. While MEGA sits on the back burner, however, the President continues to streamline and simplify much decision-making under the aegis of his Domestic Council, OMB and the White House Staff itself.
Tightening the Ranks

To carry out what is sure to be an unpopular policy, President Nixon needs an army of loyal administrators in HEW who can wield an axe without flinching. This means replacing administrators who have exhibited loyalty or attachment to their own programs with functionaries, mostly from the Office of Management and Budget (OMB), who are imbued with "budget-mindedness and management capability."

Step one was the replacement of the Secretary of HEW, Elliot Richardson, who had shown himself to be simply too committed to HEW—hardly the kind of man needed when HEW is on the chopping block. Richardson's assistant secretary for health and scientific affairs, Dr. Merlin K. DuVal, was sent packing back to the University of Arizona College of Medicine. Though denied on all sides, it's no secret that DuVal was fired. His vigorous backing of RMP earned him the White House's ire. Even worse, perhaps, he tried to prevent the firing of the former director of the National Institutes of Health (NIH), Dr. Robert G. Marston. NIH is largely recognized as a goldmine for medical schools. As one Nixon HEW spokesman put it—"NIH has mostly been a subsidy for medical schools and we find that objectionable." Well, Dr. Marston didn't. So he bit the dust as well.

Following the first few ousters, health officials leaving Washington turned into a mass exodus. Departing in late December, 1972 were John Veneman, HEW deputy secretary; Dr. Vernon E. Wilson, administrator of the Health Services and Mental Health Administration; John D. Twiname, administrator of the Social and Rehabilitation Service; and Dr. Jesse L. Steinfeld, Surgeon General of the US Public Health Service. The only one of the old crowd left was Dr. Charles C. Edwards, head of the Food and Drug Administration. He has since been promoted to HEW assistant secretary for health. As a former surgeon, head of the AMA Division of Socio-Economic Affairs and organizer of a medical program for Cuban refugees, he is a perfect Nixon appointee.

Nixon next set about filling the leadership void he created. After the dust had settled, the OMB emerged as the general of the new Nixon army. Previously a small, obscure sapling nurtured by the executive department, OMB has grown in the last year or so into a towering redwood of power. Washington insiders, Nixon people included, admit that domestic policy matters are decided upon by OMB. Roy L. Ash, wheeler-dealer president of Litton Industries, has been appointed to run the operation.

HEW has been snared by OMB. HEW's new head is Caspar (Cap the Knife) Weinberger, former director of OMB. Weinberger, a "fiscal Puritan," has been called upon to tighten the leash on HEW's galloping spending. The arch-conservative newswEEKLY, Human Events, hailed the good tidings: "If anybody can hold down the runaway HEW budget, Weinberger should be the one."

Second in command at HEW is Frank Carlucci, previously the deputy director of OMB. Moreover, no less than five other major appointees in HEW, including the assistant secretaries for Planning and Evaluation, and Administration and Management; the director of Social and Rehabilitation Service; the director of Medicaid; and the deputy chief of PSRO's, all come from OMB.

Men like Weinberger and Carlucci have principles, but they are few and simple. Weinberger himself summed them up in a book review he wrote for Fortune Magazine: "No matter how demonstrable it is that extensive government interventions fail to do what they are supposed to do, the standard prescription is more of the same. The time has come to consider a virtually untried alternative: substituting private-sector remedies for ever-increasing and frequently disappointing reliance on the public-sector."

Prior to the Watergate fiasco, Nixon's strategy was to build and consolidate his loyal forces while preventing Congress from interfering with his executive command. He has made unstinting use of his veto power. Last year the President vetoed two HEW appropriations bills because they exceeded his fiscal guidelines. This year, he has promised to veto any bill whose price tag threatens the $268 billion level he has set for total federal spending. One of the vetoes, for example, occurred in late March concerning a bill authorizing the spending of $2.6 billion for vocational rehabilitation of the disabled. The choice, Nixon said, was a "Congressional spending spree" with a 15 percent increase in personal income tax or holding the spending line even if it meant use of veto power.

If the veto does not hold the line, the President will probably use a heavier weapon, impoundment, the refusal to spend money already authorized and/or appropriated by Congress. Impoundment has been used by Presidents throughout...
"...a virtually untried alternative: substitute private sector remedies for ever-increasing and frequently disappointing reliance on the public sector."

—Caspar Weinberger Secretary of HEW

American history, but Richard Nixon has raised the stakes.

So far most of the impoundments (estimated from $8.7 to $12.2 billion) have not directly affected health programs (with the possible exception of $159 million for the food stamp program). The largest impoundments have been in Federal Aid Funds for highway construction ($2.5 billion), the agriculture department and military construction and shipbuilding, and water pollution ($6 billion). Whether or not in the face of Watergate the President can continue to use so heavy a hand, time will tell.

What It All Means

The decision to cut health programs was dictated by the fiscal crisis of the US economy as well as by irreversible commitments by the government to other priorities and interest groups. What to cut within health, however, was dictated by Nixon's own political predilections and what he felt was politically possible. Within health he has moved to do three things: diminish the federal role in health care; efficiently and effectively manage such health commitments as the federal government will retain; and weaken or dismantle what to him are unfriendly constituencies. He accomplishes many of these objectives in the same moves.

- Diminishing the Federal Role—Nixon believes that health, like other social services, should be the domain of private enterprise. Where the government must "intervene," there are two appropriate roles: it should develop "models" which can be adopted by private enterprise so that it can meet the needs (e.g., health maintenance organizations); and it should enhance individual access to the private market (e.g., national health insurance). In practice, however, it is unclear whether Nixon is serious about these principles, or whether he is using them to simply rationalize reducing the federal commitment to health care.

If the health service delivery programs were intended as "models" for meeting health needs (and there is some doubt), the Administration believes that the time is long since past to decide upon their success or failure and to get them off the books. So by 1976, the federal government will have ceased "intervening" in community mental health and neighborhood health centers, maternal and child health and family planning programs, as well as in hospital construction, the production of health manpower, and a host of other endeavors.

Nixon has a double-pronged strategy for shedding these federal commitments. First, he would like to turn many of the problems of health care delivery over to private enterprise. But the task may be a tough one. HMO's, Nixon's first "model" for making health care delivery into a profit-making investment, failed to immediately convince his hard-nosed business cronies. Nixon is still optimistic about the potential of HMO's (to the tune of $60 million in the FY74 HEW budget), and the concept is gradually being picked up, particularly by private doctors and insurance companies, but on a longer time scale than Nixon would have hoped.

Second, Nixon would like to turn health care delivery over to states and localities in the form of health revenue sharing, if he can get this measure through Congress. This would mean pooling monies from all the categorical programs (or what's left when he gets through cutting) into one lump sum and turning it over to state and local government to spend as they see fit within the broad confines of health. This strategy is consistent with the more general rubric of Nixon's "New Federalism" in which he would "reverse the flow of money and power from states and localities to the federal government," primarily through the mechanism of revenue sharing. Many suspect revenue sharing is nothing more than a way to reduce expenditures and get the federal government out of its involvement in domestic social issues.

- Getting His Money's Worth—Because Nixon feels no obligation to support traditional health constituencies through federal largesse, he would accomplish such commitments as the government has in a
single-minded, task-oriented and cost-effective manner. For instance, there is public pressure to increase the production of practicing doctors. So Nixon has re-invested saving from other manpower cuts in medical training and closed off research training funds, the route by which doctors go into research and super-specialities rather than into general practice. This, combined with research cutbacks, will reduce greatly the pre-clinical scientific orientation of medical education, giving doctors what Nixon considers the bare bone essentials, and turning them out as quickly as possible.

Likewise, in the area of research, Nixon wants concrete, publicly-salable products. He is through with the old post-Sputnik notion that the more research the better, and with programs whose main function was general support of the medical research establishment.

- Dismantling Constituencies—Nixon’s use of the cutbacks reveals a clear strategy for dealing with at least three groups in health care. Nixon would use particularly research, research training and health manpower cutbacks to dramatically reduce the size and power of the liberal, academic sector in health which he considers to be expensive, non-productive and politically unfriendly.

He would deal similarly with the poor, whose organization as a constituency he believes depends on programs such as those in health. But to this objective Nixon brings a more complex strategy than simple cutbacks. For example, by forcing

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**NHI: Feldstein’s The One?**

Former HEW Administrator Richardson proposed a new national health insurance plan—Maximum Liability Health Insurance (MLHI)—to replace the Administration’s existing proposal. MLHI is based upon a plan advanced by Harvard economist Martin S. Feldstein, and set forth in the MEGA proposal.

The Feldstein strategem would cover all Americans except the elderly who would remain on Medicare. The costs would be graduated according to income. Families earning more than $12,000 a year would pay the full premium while those earning less than $3,000 would pay zero.

The plan would also feature both deductibles and co-insurance, again graduated along the same income scale. No family, however, would have to pay more than $1,050 a year for medical expenses regardless of their yearly income. The plan is, therefore, a form of catastrophic illness insurance.

It is estimated that a family of four with average health expenses would have to pay about 3 to 5 percent of their income; the maximum amount rarely being more than 10 percent even in the event of a prolonged illness.

The cost to the Federal government would be about $20 billion per year. Most of the expenses would be paid through compulsory premiums—an anathema to Nixon—collected by the Internal Revenue Service from middle and upper income groups.

Under the Feldstein plan, a family earning $5,000 per year could expect initially to pay an average out-of-pocket expense of $234 a year and a maximum expense of $572. Despite being graduated by income, the expenses are not altogether progressive. For example, a family earning $3,000 a year could expect a maximum out-of-pocket expense eating up 13 percent of its income; whereas, for a family earning $15,000 the bite would be only 7 percent.

However, the most serious defect of the Feldstein plan is its almost total lack of cost controls, thus insuring that profits made off health and consequent medical inflation will continue. In fact, the plan’s only cost-control mechanisms are deductible and co-insurance provisions which seek to discourage consumers from purchasing health care altogether. Aside from the dubious medical wisdom of this tact, the consumer is not responsible for the escalating cost of health. Neither Richardson’s MLHI nor its source, the Feldstein Plan, would do anything to control the profits of the health providers.
health service delivery projects to become financially self-sufficient, Nixon will not only force them to exclude many poor and medically-indigent patients while seeking more affluent clientele, he will force them to drop the less orthodox (and less reimbursable) services such as outreach, community education, etc., which have frequently played an important community organizing role.

Again, Nixon would undercut constituencies organized around health service delivery programs by switching from project grants (which must be specifically applied for and approved) to formula grants. Because formula grants will go automatically to all states (on the basis of a population-income formula), this switch will drastically reduce amounts going to many highly organized, usually urban communities and institutions that applied for and received the bulk of funds in the past. Yet this move is shrewd: no one can argue that the latter group should get an unfair share of the funds.

Health revenue sharing would, of course, extend this policy across the boards. But it is even more insidious to the interests of the poor. Because many state and local governments have been unsympathetic to the problems of poor and minority groups in the past, it is hard to believe that now, with health revenue sharing funds, this policy will change. Furthermore, by pooling monies, health revenue sharing would also pool constituencies and, Nixon assumes, would set constituency fighting against constituency for their particular share of the pool.

Finally, Nixon's actions sound a small warning to health care providers, particularly institutional providers. The Health New Deal brought them into their heyday of power, prestige and expansionism, and with them the supporting complex of hospital suppliers, drug companies, banks, real estate and construction enterprises, management companies and the like. The Great Society helped to deliver health care full-blown into the age of corporate capitalism. But if the health industry is to take its place among other corporate giants, it must learn the ground rules for "responsible" behavior, and the first ground rule is not breaking the bank. To reinforce this message to the young industry, the Nixon Administration has begun to set forth some regulations—the extension of Phase III price controls for health (one of only three industries for which it was extended), the creation of PSHO's, the strengthening of CHP, the pushing of HMO's. None of these are terribly strong or effective at the moment, but together they may begin to define the outer limits of how "responsible" capitalists in the health system must act.

Nixon may not get away with all his measures for cutting health care programs, particularly in light of the harm Watergate has done his credibility and power. But it is clear that he will leave an indelible mark on the health system for years to come. Those who attribute this to his personal qualities ignore the larger economic and political realities as well as the contradictions that were built into the Great Society health programs. For given these, it is unlikely that any president would have acted in a substantially different manner. And it is only by incorporating these lessons that the foundations of a viable and adequate health system can be built.

—Ronda Kotelchuck

Howard Levy

Selected Sources
Whatever Happened to NHI?

Interviews with key Congressional health policy movers indicate beyond a doubt that national health insurance (NHI) has been “put on the back burner.” Passage is minimally two years off and may well be as long as six years away. Old NHI proposals, including Kennedy’s, Nixon’s, AMA Medicredit and Rep. Ullman’s xerox-copy of the American Hospital Association’s Ameriplan, have been, with slight modifications, re-introduced into Congress this year. The re-introductions are, however, a perfunctory exercise. The conversion of the “bright promise” of NHI into a shadowy mirage is due to many factors:

- Health in general, and NHI in particular, did not create any sparks on the 1972 presidential campaign trail.
- Congressmen have become wary that NHI might further fuel existing medical care inflation.
- The disappointment over the ineffectiveness of Medicaid is rampant.
- Savvy Congressmen, in particular key figure Wilbur Mills of the House Ways and Means Committee (not to mention Richard Nixon, himself), worry about federal spending in light of the severe constraints in the larger economy. Every NHI proposal would insure an enormous additional outlay of federal dollars. Mills, in fact, has indicated his strong desire to tackle tax reform and trade regulation prior to any consideration of NHI, thus delaying action on it by a year at least.

More striking than the waning interest in NHI is the turnaround on support for the Kennedy bill. There is growing opinion on Capitol Hill that the proposal is economically unfeasible at best and conceptually naive at worst. Although the AFL-CIO labor leaders still formally support the Kennedy bill, dollars and cents manifestations of their support appears to be dwindling. Most revealing, perhaps, is the rumor that a group of ex-Johnson Administration officials, many of them connected to the National Institute of Medicine, are busy at work drawing up plans for yet another NHI proposal. Details are not available, but if true this development is an indication of the depths of distrust of the Kennedy proposal.

Meanwhile two other developments bear watching:

- Many fear that, in the lull, Senator Russell Long’s (D-La.) catastrophic health insurance proposal will pass Congress, thus pre-empting for many years a more comprehensive health insurance bill.
- In April, a blue-ribbon panel of business leaders (including former officials of the Johnson Administration) offered a new NHI proposal which is striking in its similarity to the Nixon proposal. The 105-page plan by the Committee of Economic Development would include mandatory insurance for all employed people and their dependents, Medicare for the aged and disabled, and federally financed “community trusteeships” for everyone else not covered. Its cost is estimated at $5 billion for the first year with increases implicit as additions are made in subsequent years. Prominence is given in the report to presumed cost-saving measures like health maintenance organizations.

All in all, prospects for the immediate passage of any NHI proposal are poor. With the new entry of the prestigious and powerful Committee for Economic Development’s proposal, chances of passage of a remotely-progressive NHI bill seem dismal.
THE CUTS
IN A MICROCOSM

The Bronx is one of New York City’s five boroughs. It defies comparison. Those who live there love it or hate it. Those who don’t live there are generally glad. The Bronx will probably always get a few laughs in a stand-up comic’s routine. While the Bronx is home to rich and poor, black and white, and young and old, the Bronx is not typical of anything.

Why then does the Bronx keep popping up in Health/PAC BULLETINS (see April, 1969; September, 1969; September, 1970; October, 1970; January, 1971; November, 1971)? And why is yet another article being written about the Bronx? For reasons which no one has bothered to figure out, the Bronx, while typical in no area, including health, has been home territory for a number of health institutions and programs which are prototypical. This article is going to examine the repercussions of the Nixon Administration’s health budget and cutbacks on three such institutions: a model neighborhood health center, the Martin Luther King, Jr. Health Center; the renowned TV serial-type medical school and research center, Albert Einstein College of Medicine; and the classically wretched and chronically underfinanced four public hospitals of the Bronx. The crisis facing these institutions is the same facing these types of institutions throughout the country.

The effects of the Nixon budget will not be confined to these organizations. In an informal survey Health/PAC has counted at least 20 programs which will be terminated, cut back or otherwise negatively affected. Nor, of course, are the effects limited to organizations. Up to 100,000 patients are served in these programs. At best, they will be inconvenienced; at worst, they will lose their health care. As always, most of these people are poor; some have given up and some are still trying to get out of the borough’s slums. For them, living conditions which are now barely tolerable will get less tolerable. They don’t laugh at jokes about the Bronx.

The Martin Luther King, Jr. Health Center

The Martin Luther King, Jr. Health Center (MLK) was created in 1966 with a demonstration grant from the Office of Economic Opportunity (OEO). MLK was run by Montefiore Hospital and quickly became a national showplace for community-oriented, comprehensive family health care. With patient advocates, family health workers, nurse practitioners and multidisciplinary team delivery, the Center offered enviable care at a cost some estimated as high as $100 per patient visit. In the last year or so, MLK has been “trimming its fat” in anticipation of a federal crackdown on health spending and on OEO. Now that the crackdown has come, MLK and centers like it are not sure where they stand.

MLK’s Fiscal Year 1973 budget request of $4.3 million was down $1 million from the previous year. This unusual decrease contradicts the Parkinson Law of bureaucracy that dictates that programs must keep on spending more and more money ad infinitum. MLK took the step in order to ingratiate itself to OEO as an efficient cost-cutting operation. (The strategy worked and MLK’s full request was approved in March on a month-to-month basis.) MLK pulled down its costs through job attrition (“not replacing workers who leave”) and by cutting out duplicative jobs. For example, MLK administrators observed that pediatric nurse practitioners duplicate doctors’ work and yet don’t increase doctors’ productivity (i.e., the number of patients seen). As a result no more pediatric
In addition to cutting costs MLK is looking to other sources of revenue in order to sandbag its budget. The Center has turned to Medicaid as the most obvious other source. Since MLK has been up until now a well-funded federal program, it has not had to bother with the hassle of Medicaid. Furthermore, since Medicaid requires that the City and State kick in a combined 50 percent of Medicaid reimbursements, there has been no local incentive or pressure to get programs like MLK involved with Medicaid. Not surprisingly then as one MLK doctor says, “The Center never really got serious about Medicaid until a year and a half ago.” Now, it’s trying to increase its enrollment of Medicaid eligible families and increase its Medicaid collections. As one staff member said, “We are zeroing in on the poor and the near poor.”

Larg-scale registration efforts are aimed at getting new enrollees and, for the first time, the Center is assisting patients in obtaining Medicaid coverage. In 1969, 112,000 patients were enrolled; now the figure is closer to 195,000. Approximately 55 percent of the Center’s total enrollment is covered by Medicaid.

Since the Martin Luther King, Jr. Health Center is getting more serious about Medicaid it is inevitable that it also get more “business like” in its approach to patients, staff and program. As the emphasis changes from getting grants to getting reimbursements or fees, productivity becomes the name of the game. Productivity at MLK, as well as at other health programs, means: increasing both the total patient enrollment and the number of patient visits while actually decreasing the size of the staff. In the “business world” this would automatically: threaten the quality of care; result in an employee speed-up; and certainly risk turning MLK into a Medicaid Mill (where patients are given the least expensive care, by the smallest staff, over repeated visits, each of which is reimbursed by Medicaid). Administrators at MLK do not believe that these disasters will befall the Center, implying naivete on their part or that MLK has been awfully “unproductive” in the past.

MLK’s push for more reimbursable patients has pushed it beyond its neighborhood. The Center is straying from its initial objective of being primary family doctor for all people in its defined neighborhood. MLK is attempting to “package” its services and is trying to interest the City in a Health Maintenance Organization deal. MLK would guarantee services to City employees whose medical costs would be paid for through some sort of pre-paid insurance plan. The package would guarantee a steady and dependable income for MLK. The Center is even doing “market research.” For instance, what private insurance carriers do people use, and can MLK make a deal with them to provide “packages” of service?

The Center is instituting other “business-like” practices. It has recently adopted a sliding scale fee structure (from $3 to $25 a visit). This policy is in keeping with overall Nixon health policy; HEW-funded centers are now under orders to establish sliding scale fee systems. In theory, this will enable MLK to receive some income from patients while not closing its doors to the uninsured. In practice, however, centers must still have grants to make up the deficit between the fee and the cost of service. Moreover, it is unclear whether MLK will actually make money on the arrangement. The director of a Manhattan health center estimates that the cost of implementing a fee schedule at her center will be $16,000 while the income produced from the fees will only amount to $10,000. Furthermore, some administrators at MLK are thinking the unthinkable; the day may come when MLK will have to turn away patients who cannot pay and have no medical insurance or Medicaid.

The next few months will be critical for MLK. First there is the obvious disruption caused by OEO’s demise. According to Bill Lloyd, MLK’s retiring project director, “As long as OEO’s in business, we’re OK.” Now that OEO is going out of business, the Center will probably be transferred to HEW. This will mean a loss in flexibility and a likely 10 to 20 percent cut in grant funds. MLK obviously must strive to become independent of the federal government. Delores Smith, who will take over the project director’s job soon, is tentative: “We can become self-sufficient in a year or two, but not by 1974.” Thus far, MLK is doing exactly what the Nixon Administration would hope for. It is getting more efficient (it’s even using a computer for billings). It’s cutting back on staff and dropping large parts of its training programs. While self-sufficiency may even be an obtain-
able goal, in the present health system good, comprehensive, quality care must be sacrificed in its pursuit. The Martin Luther King, Jr. Health Center will never look the same. In fact, in another few years, it is doubtful that MLK and its counterparts in other cities will look all that different from most run of the mill health centers and clinics.

**Albert Einstein College of Medicine**

In health, as in most federally supported domestic affairs, much political mileage can be made from attacking "hand outs" to the poor while fistfuls are being given away to the big guys. In the Bronx, Albert Einstein College of Medicine (AECOM) is a big guy.

When one turns from the cuts in health delivery programs in the South Bronx to cuts in the federal research and training funds which go to the Albert Einstein College of Medicine, one realizes where the really big money has been going all along. As of March 9, AECOM was estimating that it would lose over $3.5 million in Fiscal Year 1974 in research and training grants alone. (Its total research and training money being $34 million—mostly from federal sources.) While $3.5 million may not seem overly important out of a $77 million annual college budget, the nature of the cuts is a stunning blow to Einstein. Even at that, some observers at Einstein believe that the administration hasn't even begun to fully appreciate the impact of the blow.

Einstein is a young medical school—it is celebrating its twentieth birthday this year. The research and research training funds that the Nixon Administration is now cutting have also been growing steadily since their birth some years earlier. These federal funds, though marked for research, have been used by Einstein and every other medical school to supplement their teaching programs. The reason for this diversion—or double use—of funds is simple: thirty years ago the American Medical Association would not tolerate direct federal subsidy of medical education. So this objective was accomplished indirectly through research subsidies. The government and the schools were partners in this indirect subsidy of medical education, the by-product of which was an emphasis on biomedical research rather than on clinical practice.

Another by-product has been that medical schools, like hospitals, have become dependent on federal support, despite their frequent posture as elite private institutions. Rosemary Stevens, author of *American Medicine and the Public Interest* notes that "At least 50 percent, and perhaps as high as 75 percent, of current medical school expenditures—taking the private and state medical schools together—is derived from the federal government. The federal government has become the medical schools' new proprietor."

As proprietor, the federal government poured its money into research, largely basic research (which would not interfere with the practice of medicine). In the 1940's, the budget of the National Institute of Health (the dispenser of funds) was around $2.5 million (less than Einstein's cut this year); the budget is now $1.6 billion. Medical school full-time faculty, paid for by these research funds, also grew by leaps and bounds. In 1950 there was an average of 70 faculty members per school and now there is an average of 250. Practically half of the faculty at most medical schools receive all, or large portions, of their salaries from the federal government research grants. Teaching is the part-time diversion of most of these faculty. Research is their pre-occupation and that's what they are paid to do.

Einstein has been dependent upon research funds to develop its teaching capacities. It has, in its youth, less support from other sources—namely, endowment. Einstein's major philanthropic bequests have gone to its buildings (paid for at higher interest rates than older institutions), so it has less of an endowment sitting in the bank churning out interest to be used for operating expenses. Einstein made an upwardly mobile living for itself on federal funds and now the money is being withdrawn. It has little to fall back on.

Einstein is going to have to lower its standard of living: the General Research Support Grant is one grant made to the college. It is used to supplement more restricted grants made to individuals or departments for specific research projects. Einstein had expected to get $350,000 to $400,000, but only received $134,000 for the calendar year 1973. Because research support money is more flexible than most other funds, its loss amounts to more than these dollars would indicate. This money is used for a wide variety of purposes: it can pay anything from a newly-hired researcher's moving expenses to start-up costs before other grant payments arrive from Washington. General Research Sup-
port Grant money is just the kind of money that Nixon is most suspicious of—it is unaccountable, free-wheeling, and not product-oriented. For Einstein, it is just the kind of money it needs to lure scientists away from other medical centers and pick up the costs that fall through the cracks.

Research Training Grants pay for the post-graduate students and fellows who work in the labs—"the lifeblood of the scientific part of the community." The training grant program is being phased out over the next three years and no new trainees have been accepted since January. Einstein's 1972-73 training grants amounted to $3.7 million. It is anticipated that this year's grants will be down by $1.5 million—lost will be $660,000 in trainee stipends; $349,000 in faculty salaries; and $518,000 in other salaries, equipment and so on.

Research Grants—Einstein has been experiencing a 10 percent cut in all its research awards since the end of January. An anticipated $1.75 million will be lost in faculty and staff salaries due to these cuts. In all, Einstein has a $13 million research payroll in its clinical departments.

Over the long haul, Einstein must come up with ways to finance itself. It has not given up altogether on the federal government, by any means. Thus far the cuts have only taken a small piece of the federal pie. The Nixon Administration is not cutting, but increasing, research in cancer and stroke. Asked whether medical scientists wouldn't just re-write their basic research project in terms of cancer and stroke, one Einstein staff member replied: "You'd be wrong to think that everybody's not thinking of ways to survive and go underground."

While the crassly manipulative and "political" nature of Nixon's "War On Cancer" is rightly deplored, the manipulative and "political" basis of earlier research cannot be overlooked. Einstein scientists have long been involved in putting together improbable research proposals which capitalize on their access to research material (i.e., poor patients) and federal funds, but have had little connection to demonstrated health needs or the usefulness of their research findings. Einstein scientists have always had to define their skills and their projects to win research contracts—"going underground," if you will.

The funding cuts and the switch to cancer are not the only significant aspects of Nixon's policy for Einstein. Among others is the fact that faculty at Einstein and their friendly competitors at other research centers are losing control of decisions about research priorities, about the distribution of remaining research funds, and about what constitutes useful research findings. Nowhere is this more clear than in the depression and dilemma that confront the school's staff when they see the emerging favor that contracts, rather than grants, are receiving around HEW.

Einstein and institutions like it can try, but are having difficulty, getting federal government "contracts" instead of "grants." Contracts are not nearly so easy to get, nor are they as lucrative as grants. Grantsmanship involves broad competition among institutions for loosely defined project purposes and funds. Grant applications are received by "peer review study sessions of colleagues from other institutions"—often, one hears, with the applicants and members of the study session coming and going from the room as their grants are approved. Grants involve a standard overhead payment, one which is determined by the federal government and is based on the institution's programs, facilities and costs. Einstein's overhead rate is 60 percent—a typical figure for institutions like it.

Contracts are more difficult. The government requests proposals for bids, usually on such a narrowly defined set of requirements that few candidates need apply. Short notice is given for the bids to be received and then decisions are made not by peer review but by internal federal government staff. Contracts have cost-sharing provisions (i.e., the institutions must absorb some of the cost of doing the job) and while outfits like Texas Instrument and Grumman Aircraft will be allowed payments for profit, educational institutions fear they will not be allowed generous overhead costs.

Medical schools, like hospitals, have become dependent on federal support, despite their posture as elite private institutions.
Now that research doesn’t seem to be the easy trick it used to be, Einstein can look with new favor on its many affiliation arrangements. When Einstein’s clinical faculty is not supported by research grants, it is supported by affiliation contracts, which pay the college to staff health delivery programs in the Bronx, including 2 municipal hospitals; 2 community mental health centers; at least one drug program; the Neighborhood Maternity Center; Bronx State Hospital; and others. Affiliation arrangements provide full or part-time salary for Einstein faculty (as well as interns and residents), administrators, and overhead costs which can go as high as 30 percent.

While Einstein claims it can’t save any money on affiliations (because it must hire staff to fulfill the terms of the affiliation contracts) it is an open secret that affiliation arrangements are universally used to defray medical school costs. An example: equipment purchased by Bronx Municipal Hospital Center is actually used for the institutional training and research purposes of Einstein. If Einstein had its way, no doubt its affiliation payments would increase substantially. Already it is clear that untenured staff (like former research trainees) must get themselves on the affiliation payroll or be terminated. Furthermore, while the New York City Health and Hospital Corporation is beginning to make noises about cracking down on the affiliation contracts it lets, and tightening up on the overhead payments, Einstein will be pushing “now more than ever” for latitude and abundance in its affiliation arrangements.

In the meantime, Einstein must meet its payroll, pay its suppliers and somehow keep its institutional head above water. Einstein’s fiscal troubles have been apparent for some time; only last fall, the federal government turned down its application for a Financial Distress Grant. These are difficult times. Last year the dean was dismissed and with no new dean yet appointed, strong leadership is absent.

Since January, a Task Force on Fiscal Stability (composed of students, administration and faculty) has been meeting to chart Einstein’s fiscal course. The Task Force has largely addressed itself to the use of “university funds,” which consist of philanthropic gifts, tuition, overhead payments. It recommends, for a starter, that all departments take a five percent cut in university funds. (This will hit hardest those preclinical basic science departments which have the most university funds.) There will be no cost-of-living salary increases for faculty; tuition will be raised to $3,000 and class size will be increased. Departments may be merged, duplication eliminated and Program Planning and Budgetary Systems, the overrated savior of management disasters, may be instituted.

None of these measures, as well as others which have been suggested, appears to come close to filling the hole left by the

### Terminations and Cutbacks

**Selected Community Health Program Cuts in the Bronx**

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<thead>
<tr>
<th>Type of Program</th>
<th>Neighborhood</th>
<th>Source of Funding</th>
<th>Outcome</th>
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<tr>
<td>Mental Health Centers</td>
<td>Lincoln Hospital&lt;br&gt;Sound View-Throgs Neck&lt;br&gt;Tremont&lt;br&gt;Hunt's Point</td>
<td>HEW&lt;br&gt;HEW&lt;br&gt;N.Y. State&lt;br&gt;HEW (administered by N.Y. City)</td>
<td>Terminates in 3 years&lt;br&gt;Terminates in 2 years&lt;br&gt;No funds cut&lt;br&gt;Uncertain</td>
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<td>Child Health Centers</td>
<td>Morrisania Hospital&lt;br&gt;Bronx Municipal Hospital</td>
<td>HEW&lt;br&gt;HEW&lt;br&gt;OEO&lt;br&gt;HEW&lt;br&gt;HEW (administered by N.Y. City)</td>
<td>Terminated&lt;br&gt;Terminated&lt;br&gt;Terminated&lt;br&gt;Terminated&lt;br&gt;Terminated (City will take over)&lt;br&gt;No funds cut</td>
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<tr>
<td>Women's Health Centers</td>
<td>Bronx Maternity&lt;br&gt;Neighborhood Maternity&lt;br&gt;Family Planning (7 centers)</td>
<td>OEO&lt;br&gt;HEW&lt;br&gt;HEW</td>
<td>Terminated&lt;br&gt;Terminated&lt;br&gt;Terminated&lt;br&gt;Terminated&lt;br&gt;No funds cut</td>
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<tr>
<td>Comprehensive Family Health Centers</td>
<td>Hunt's Point&lt;br&gt;Morrisania&lt;br&gt;North Haven</td>
<td>HEW&lt;br&gt;Medicaid&lt;br&gt;Medicaid</td>
<td>Uncertain&lt;br&gt;No funds cut&lt;br&gt;No funds cut</td>
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<tr>
<td>Health Manpower Training</td>
<td>Bronx Ad Hoc&lt;br&gt;Manpower Comm.&lt;br&gt;Lincoln Non-Professional Mental Health Workers&lt;br&gt;MLK Comm. Health Workers&lt;br&gt;South Bronx Health Careers Training</td>
<td>HEW&lt;br&gt;HEW&lt;br&gt;OEO&lt;br&gt;HUD</td>
<td>Terminated&lt;br&gt;Terminated&lt;br&gt;Severely cut&lt;br&gt;Terminated</td>
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federal cutbacks. (Not to mention the $6 to $7 million deficit AECOM faced before fund-raising started this year.) Einstein is in such bad straits right now that it is having difficulty making its payroll and has been trying to ignore its creditors for several months.

It may be surprising that in all this fiscal analysis, nothing has been said about medical students, whose education is, presumably, the central purpose of the institution. The reasons are complex, but Einstein, maybe even more than other institutions, has found itself going far afield from education to finance itself. In the words of Malcolm X: “The chickens have come home to roost!” One can only speculate on the long-term effects of this fiscal crisis on medical education at Einstein.

**Municipal Hospitals**

There are four municipal (public) hospitals in the Bronx. Two, Lincoln and Morrisania, are not merely obsolete facilities, but are among the most decayed of New York’s 18 municipal hospitals. The third, Fordham, was spared the wrecking ball last year, not because it is a good hospital, but because it would not be replaced soon. The fourth hospital, Bronx Municipal Hospital Center (BMHC), is actually two hospitals—Jacobi and Van Etten. BMHC is located away from the slums of the Bronx and is, in comparison to the others, a modern hospital. This is because it was built across the street from Albert Einstein College of Medicine (see above) for the teaching and research convenience of that institution rather than for the convenience of its patients. There are two more municipal hospitals nearing completion in the Bronx. One is the new Lincoln, a replacement for the old hospital which has been on the drawing boards for more than a generation. The second is North Central Bronx Hospital, on the drawing boards less than ten years, and next door to Montefiore Hospital and Medical Center—again at a great distance from the Bronx’s poorest patients and again for the convenience of Montefiore, another teaching and research center.

Patients know some of these institutions as “butcher shops”; administrators and planners call them “hospitals of last resort”; the executive director of Morrisania even referred to that hospital recently as a “colony.” The two hospitals were built expressly for the convenience of the private medical centers, their services are organized around the teaching and research needs of their affiliates; and they receive those patients who are of no medical or economic interest to the private hospitals. Because of their colonial status, while first-class institutions like Einstein and Montefiore grew and prospered from federal health expenditures, the second-class municipals possibly even lost ground.

Paradoxically, however, now that federal money is getting tight, the municipals, not the voluntary hospitals, are going to be hurt most severely. Not only will they be called upon to pick up out-patients formerly served in neighborhood programs being cut and terminated, they will also be receiving in-patients who will not be welcome at the voluntaries anymore. In addition, they will in all likelihood come under increasing pressure from Einstein and Montefiore to compensate them for the cuts they’ve received in the research, training and teaching areas. Just as the poor patients of the city will shoulder the burden of the Nixon health budget, so will the poor hospitals.

The New York City Health and Hospitals Corporation has management authority over the municipal hospitals. Observers are virtually unanimous in the opinion that the Corporation is at least bungling and incompetent. Many also agree that Corporation officials are unresponsive, lie, mislead and are generally not to be trusted with the hospitals. “Establishment” groups, like the City Hospital Visiting Committee, are “convinced that the Corporation is not directing its energies toward [its] primary goal of good patient care.” There is a credibility gap. The president of the Corporation recently tendered his resignation rather than face the threat of dismissal. The municipal hospitals must rely on this
organization to get them through the difficult times they face. Meanwhile, the Corporation staff have been secretly cooking up the West Bronx Health System Plan to cede half of the health services in the Bronx over to Montefiore Hospital. The Corporation seems determined to lead the municipal hospitals down the drain.

More Cuts

Bronx Municipal Hospital Center

- If the Neighborhood Maternity Center closes, BMHC will pick up 5,000 pre-natal visits a year.
- The Children and Youth Project run by Einstein at BMHC has 13,500 patient visits per year. The children will now have to be seen in Jacobi's ordinary pediatrics clinics.
- Included in BMHC's cutbacks are 36 fellowship/residency "lines" and $75,000 in faculty support for these positions. While these are cuts actually suffered by Einstein (see above), the 36 fellows presumably were involved in some patient care at BMHC. Einstein will undoubtedly attempt to get these positions covered through its affiliation contract with the Corporation.
- Also listed as a cutback for BMHC is a three-person pediatric neuro-audio testing program, which again is an Einstein program. The program is being cut so that only the research component remains!

Lincoln Hospital

- Lincoln is losing a $160,000 child-screening program in which 350 nurses' aides would have been trained by Model Cities.
- The Lincoln Community Mental Health Center has also lost a two-year training program for 40 para-professionals.
- With the future of both the Martin Luther King, Jr. Health Center and the Hunts Point Multi-Service Center also in jeopardy, Lincoln could receive up to 65,000 patients.

Morrisania

- A $132,000 ambulatory drug detoxification program funded by Model Cities is in jeopardy.
- A $1.22 million children and youth project run by Montefiore at Morrisania is being terminated.

It is not surprising, then, to discover that the Corporation has not made an assessment of the effects of the Nixon health budget on its hospitals. Even though it directed the hospital directors to submit their own surveys of the effects on individual hospital operations, the Corporation after many months has still not heard from two of its four Bronx hospitals. Furthermore, most of the cuts they've reported refer to programs which are administered by Montefiore and Einstein, and from which the Corporation receives no income or remuneration.

No one doubts that the City hospitals will be called upon to serve more patients. However, the hospitals are completely unprepared for this new stress, not only because of their leadership void, but also because of the Corporation's employment policies over the last several years. For many months the Corporation pursued an attrition policy. Hospital staff were not replaced as they retired or quit, unless they were RN's or doctors. Not only did this not save the Corporation from fiscal disaster, it resulted in employee speed-ups and staff shortages which jeopardized patient care throughout the municipal system.

The attrition policy was lifted in September, 1972 and by November the Corporation was publicly assuring that, "The effects of attrition have been wiped out." This hasn't fooled many people, especially hospital staff and patients. Although naturally many jobs have been refilled, many others were simply "wiped out." Wards have been closed down and "job lines" have been removed so that on paper at least, it appears that the hospitals are going full steam ahead with a full complement of staff. The Corporation also claims to have made significant progress in hiring a complete nursing staff, but since nurses assume so many non-patient duties in municipal hospitals due to the shortage of other health workers, little time is left for actual patient care. All this has resulted in a pathetic situation at Lincoln Hospital where one general medicine ward has been labeled a "Self Help Ward." As soon as patients are able to be minimally self-sufficient, they are put together on an unstaffed ward to take care of themselves and each other. Few are deceived by the hospital's promotion of the ward as a progressive concept in patient care.

Into this desperate situation come the Nixon budget cuts and the anti-inflation health budget. How could things be worse? The Corporation has long been preoccu-
plied with its third-party collections (reimbursements from Medicare and Medicaid), which have been inefficient and wasteful. The prospect of further changes in Medicaid and Medicare, in addition to those already accomplished through HR 1 (see previous article, page 12), presents a dismal future for the municipals.

Nixon proposes that Medicare patients pay the total cost of their first day in the hospital plus ten percent of each successive day. While Caspar Weinberger, Nixon’s chief of HEW, says that the elderly would pay $192 for an average hospitalization, in New York average costs can run almost that high per day! At Montefiore Hospital, administrators have figured that elderly patients would pay $360 for an average 15-day visit, if Nixon’s proposals are approved.

Obviously, many older people simply cannot afford to pay $360 for care which now only costs them the $72 deductible fee. Private voluntary hospitals are aware of this and will be looking closely into an older person’s ability to pay before admission. Some, if not many, will be forced to go to the municipal hospitals, where ability to pay is not a requirement for admission.

The municipal hospitals, for their part, have plenty of room. Occupancy rates have been so low that 1,000 beds have been closed down over the last year. Normally an increase in patient load would mean that municipal hospitals could operate more efficiently. However, very little is normal in municipal hospitals. They do not have the personnel for even their present low patient load, as the “Self Help Ward” at Lincoln indicates. In addition, these new patients coming to the municipals will not be bringing more money. In fact, they will bring less money, decreased Medicare income and more unpaid hospital bills.

The Nixon proposals would not only throw the public hospitals into an immediate fiscal crisis greater than their present one, but would also undermine these public hospitals over the long haul. Paul Kerz, powerful and controversial Senior Vice President for Fiscal Affairs at the Corporation, points out that if municipal hospitals do not receive a proportional increase in income to match the larger patient load, then the hospitals will actually be spending less per patient than they are now. If they spend even less per patient, their rates (determined in part by Blue Cross, friend of the voluntaries) will drop further.

It is questionable whether Nixon’s proposed Medicare changes will get their needed Congressional approval. Last year, however, many changes were approved in Medicare and Medicaid by HR 1. While no one knows for sure how the states will implement HR 1’s co-insurance provisions, there is no doubt that these provisions will make Medicaid more restrictive. This means that Medicaid will pay for less and perhaps will cover even fewer people. The municipal hospitals, as well as the Medicaid patients, will be hurt. Nixon calls this “sharing the responsibility for one’s medical care.”

Not only will voluntary hospitals shuttle their more expensive patients to municipal hospitals, nursing homes will also join in the patient passing routine. Under changes enacted in HR 1, the federal government is refusing to reimburse nursing homes at more than 105 percent of last year’s rates—an obvious way to curb nursing home rates which have risen astronomically on Medicare reimbursements. Now the patients will be penalized for nursing homes’ runaway costs. For example, Montefiore Hospital owns a nursing home in the Bronx. Beth Abraham claims a seven percent inflationary increase over last year’s budget. It also claims that it cannot limit its costs and will incur three-quarters of a million dollar deficit as a result of the changed reimbursement policies. It has already laid off 20 employees.

Nursing homes will take the natural steps to avoid losses. They will not take the sicker and poorer patients. These chronic care patients will be forced to remain in the acute care hospitals. For Nix-

**Correction:** Please note the following corrections in the key to map on page 9 of last month’s BULLETIN (“Dismantling California’s County Hospitals,” No. 51, April 1973). San Mateo’s county hospital is closing. “Contracting out” at Los Angeles County is only under discussion at the present time. Nothing has happened to the private takeover plans for Merced County Hospital. Fresno is not closing down but may opt for tighter billing, and Orange County’s university takeover is still only in the discussion stage.

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on's own purposes this will be extremely inefficient, because it is far more costly to care for a chronic patient in an acute care facility than it is in a nursing home. Voluntary hospitals do not wish to maintain chronic patients and will attempt to discharge them whether or not adequate arrangements for their care have been made. They will also be more cautious about admitting patients who may become "disposition problems" later on—stroke victims, for example.

These patients will end up at municipal hospitals. If the new Medicare changes go through, even more chronic care patients will be dumped on municipal wards. Ironically, this comes at a time when the municipal hospitals have managed to finally get most of the chronic patients they've been carrying for years transferred out to nursing homes.

No one can determine with confidence exactly how much these Medicare-Medicaid changes will cost the municipal hospitals. However, the impact of the cuts and terminations in other delivery programs can be estimated in three of the four City hospitals in the Bronx. (No information is available on Fordham.) While it is difficult to judge the actual value of these programs, there is no question that the recipients of their services will now go to the municipal hospitals.

Not only do the municipal hospitals provide poor service in their OPD's, in many instances the programs that are being cut or completely dismantled provided services that the City health system didn't provide. Many of the programs weren't merely alternatives to already existing city-run programs. They were the only place to get the kind of care they provided.

As a result, the City health care system will be under pressure not only to expand the services it already provides but also to fill the vacuum left by the Nixon cuts. However, it will not be able to fill the vacuum.

In New York, the municipal hospitals are being backed up against the wall. Their disastrous fiscal predicament has already prompted the Health and Hospitals Corporation to sue the City for $78 million. Even if the Corporation wins the suit, the City isn't rolling in clover itself. While Richard Nixon succeeds in cutting the federal health budget, his policies will put even greater strains on state and local health budgets.

—Constance Bloomfield and A. Sandra Abramson

News Briefs

Another We Told You So

Comprehensive health care is certainly not where it's at, according to the administrators of university medical centers. In a survey of the administrators on the topic, "The 1980 University Medical Center: Its Missions and Administration," the respondents were asked to rank the missions of their centers. The top two missions are:

1. Train physicians and dentists to meet the needs of a given area.
2. Deliver patient care of the types needed in the teaching programs of the University Medical Center's (UMC) schools.

The administrators also agreed that the missions of their centers did not include:

1. Maintain a balance of racial, ethnic and socio-economic backgrounds in the student populations of UMC schools, representative of the area served by the UMC.
2. Deliver comprehensive health care to meet the needs of the community immediately surrounding the UMC.
3. Perform general social service not directly related to health care to meet the needs of the community immediately surrounding the UMC.

Owen C. Elder, Jr.
from "The 1980 University Medical Center: Its Missions and Administration."
Journal of Medical Education
March 1973

Boston Loses Control

If New York and California are doing it, can Boston be far behind? No. So Mayor Kevin White of Boston has transferred control of all medical services at Boston City Hospital (BCH), the only full-service municipal hospital in the city, to Boston University and its medical school. To make BCH, in the words of the agreement, a "community hospital focused on provision of high-quality family care," the City has cut the BCH budget by $12 million this year and is cutting the number of patient beds from 850 to 500. There have been scattered community and worker protests, but so far the half dozen unions representing the hospital workers and the various community groups have been pulling in separate directions. A fall BULLETIN will examine this development in detail.