Private practicing physicians, after generations of omnipotence in health care delivery matters, are slowly losing ground to institutions and organizations—hospital health care providers, insurance companies, and even government programs and regulations. Fewer and fewer solo practitioners work out of their own offices; they earn less and less of the health dollar.

Less than 50 percent of the nation's 340,000 physicians are presently in solo practice; the rest work in groups, hospitals, teaching administration and research. Only 20 percent of practicing doctors are general practitioners, and with only 2 percent of the medical graduates entering general practice, the number is still dropping. Many specialists are closely tied to hospitals, and their fees are increasingly paid by Blue Shield, commercial insurance companies, Medicare or Medicaid. Only about a quarter of the nation's medical expenditures goes to private practitioners. As their numbers fall, so does their influence. American Medical Association (AMA) membership has declined to less than one-half of the nation's doctors; no longer can the AMA single-handedly stop health care legislation.

There is no need at this time to pity the poor physicians. They are not about to become society's underdogs. Doctors, as a group, still earn more than any other occupational group—an average of $40,000 to $50,000 per year. Furthermore, they are rushing to their own defense with considerable success.

This BULLETIN examines one of the principle defensive maneuvers of doctors: foundations for medical care. Born on the West Coast and attracting nationwide interest, foundations give physicians in local areas as unified bargaining agent for matters related to fees and conditions of medical practice. They give patients nothing new. The foundation was developed to foreclose the pre-paid group practice idea. It is a conservative innovation which advertises itself as a cost-controlling boon to the consumer. Actually it assures top-dog status and income to private practice doctors.

The foundation idea is popular with doctors. It has also been picked up by the Nixon Administration and Congress. Foundations are the model for doctor controlled Health Maintenance Organizations (HMO's), Nixon's on-again, off-again remedy for the health care crisis. Foundations are also central to Professional Standards Review Organizations, Congress' mandate in the new Medicare-Medicaid legislation (HR-1) to doctors to control themselves through peer review. In both roles foundations are principally designed to keep control over fees and medical knowledge in the hands of doctors; they will perform self-regulation to prevent the government from performing real regulation.

Yet another West Coast doctor defense
innovation is the physician union. While conservative doctors are astonished that some of their colleagues would stoop to the commoners' form of organization, the unions are catching on and their real objectives should be cherished by reactionary doctors here and far. The first national meeting was held in San Francisco in October 1972; it was followed in January of this year by a constitutional convention of the American Federation of Physicians and Dentists in Las Vegas. Sanford Marcus, a Bay Area surgeon turned union organizer, makes the traditional equation in an article in January's Medical Dimensions: money=quality. . . . Physicians can and must resist the forces that will reduce their professional effectiveness through a cut in take-home pay." In Las Vegas, physicians on a proprietary hospital utilization committee went on strike. Utilization committees are themselves voluntary peer review mechanisms designed to keep public regulation out of hospital care. It is doubly self-serving and indicative of the direction of physician unions that the first union contract now pays doctors $50 an hour for self-regulation efforts which used to be performed free.

It is too early to tell whether or not the foundations, unions and so forth will succeed in increasing the private physician's leverage in the health care system. One thing is "perfectly clear" at this point: claims and sales pitches to the contrary, these "innovations" are meaningless in terms of improving patient care.

THE VANGUARD
OF THE REARGUARD

A new organization of medical services is rapidly spreading from central California to New York, down to Florida and stretching back to Hawaii. These local affiliations of doctors, known as foundations for medical care, have grown from five in the mid-1960's to 112 in or near operation by the end of 1972. Foundation spokesmen claim the participation of over half the nation's private physicians. California is blanketed with 24 foundations, all set up by county medical societies (local chapters of the AMA). Four are located in New York State; New Mexico, Georgia and Colorado have state-wide foundations; and 16 other states are planning similar statewide groups.

No single definition comfortably fits every foundation. A foundation is an organization created by the private doctors in a given geographical area. It contracts with an insurance company or a government program (such as Medicaid) to review the fees charged by physicians and to determine if the care is appropriate. Occasionally a foundation will act as an insurance company, receiving money from a labor union or a government program and paying doctors and hospitals to provide care to patients covered by that union or government program. The care is provided in the private doctors' offices as well as in the hospitals where these foundation doctors have admitting privileges. The foundation has the right to limit the fees of its doctors, and its physicians' records are open to inspection by the foundation. So a foundation for medical care is not a visible institution that patients go to when they are sick; it is simply a mechanism through which paper and money flows.
While just a few years ago no one had heard of foundations for medical care, now even the “Nixon Administration is showing an increasing interest in the medical foundation movement. . . Indications are that both [foundations and HMO’s] will be advanced by Administration speakers as 'viable alternatives' in the search for improvements in medical care administration” (Washington Report on Medicine and Health, September 11, 1972).

Congress is thinking along the same lines. Health Maintenance Organization (HMO) bills approved by the House Health Subcommittee and by the Senate would also make federal funds available to foundations. And the enormously important new health legislation, the Social Security Amendments of 1972 (HR-1), will create a nationwide network of Professional Standards Review Organizations (PSRO's) modeled directly upon the foundations (see box, page 12).

Why the new emphasis on foundations for medical care? Because the government and insurance companies maintain that the foundations can control the rapid rise in health care costs and physicians see them as buttresses for their own eroding power vis-a-vis health institutions, insurance companies and the government.

**Laying the Foundations**

Foundations originated in the unique social and political environment of California, birthplace of several health care innovations. A brief historical look at health care developments in that state is illuminating. During the '30's Californians were among the most active Americans in the campaign for government health insurance. In 1935 the California Medical Association (CMA) even appeared to endorse compulsory medical insurance; however, the CMA attached more restrictions than the reform-minded legislature could accept, and the State bill was defeated. When in 1938 New Deal candidate C. L. Olson took over the Governor's office, a more rigorous state health insurance plan seemed certain. This time the CMA went to work in earnest against it. By the next year CMA announced its alternative — the California Physician's Service, the first Blue Shield program in the country which successfully supplanted compulsory government insurance with doctor-controlled private insurance. In 1945, California's Governor Earl Warren, proposed yet another state health insurance plan; it was also defeated by the CMA with the help of a public relations firm, Whitaker and Baxter (1).

During that same year a new health care concept, the Kaiser Foundation Health Plan, came into being. An outgrowth of Kaiser Industry's employee health services, the Kaiser plan operates its own hospitals and adjoining clinics (see BULLETIN, November, 1970). Kaiser members pay a monthly premium and receive specific medical services. Frequently a union or employer will arrange for members or employees to join the Kaiser Plan and will pay part of the premiums. From the doctor's point of view, the important feature is that Kaiser hires physicians on a salaried basis, in contrast to the traditional "fee-for-service" method of payment under which doctors charge the going rate every time a patient is seen. (Kaiser doctors rarely have private patients on the side.) Many doctors don't like Kaiser's salary system; fee-for-service allows physicians more control over their income (as well as over working conditions, hours, choice of patients, location of office) than does a fixed salary paid by a corporation. It's the difference between
being your own boss and working for someone else.

In Stockton, California, a small port town on the San Joaquin River in one of the country’s most fertile valleys, Dr. Donald Harrington watched the growth of the Kaiser plan with alarm. An obstetrician in private practice, Harrington feared that Kaiser would take patients away from fee-for-service physicians. As legend has it, Harrington’s brother walked into the union hall one morning to hear that the Longshoremen were about to sign a health care contract with Kaiser. After hearing his brother’s report, Dr. Harrington developed the San Joaquin Foundation for Medical Care. He persuaded the county medical society that the Foundation would keep Kaiser out of the valley. The union and the patients bought it. Nearly twenty years and several small-town foundations later, Kaiser has not moved from the larger metropolitan areas of California.

The First Foundation

The San Joaquin County Medical Society created the San Joaquin Foundation for Medical Care, with a board of trustees elected by the Society’s own Board of Directors. Any Medical Society member was eligible for foundation membership, renewable on an annual basis, and virtually all joined. The foundation and the International Longshoremen’s and Warehousemen’s Union (ILWU) agreed to a group health plan for union members and dependents that offered office and hospital care similar in scope and costs to that of the Kaiser plan. The ILWU plan continues to this day. The union pays the foundation a carefully worked-out amount to cover the estimated cost of caring for its members, who then may seek care from any foundation doctor.

After seeing a member of the Longshoremen, the doctor sends the bill to the Foundation. To keep costs competitive with Kaiser, Foundation physicians have agreed to a ceiling on fees charged for Foundation patients. They also monitor one another to eliminate “overutilization” — too much hospitalization, excessive surgery and unnecessary office procedures — through a mechanism called “peer review” (explained below). After peer review, the bill is paid by the Foundation. The Foundation also pays for hospitalization of ILWU members.

The San Joaquin Foundation has contracted to provide medical care for other groups in the area. Unlike the contract with the ILWU, most of these involve insurance companies. The Foundation, with the strength of the county’s physicians behind it, gets insurance companies to provide expanded benefits for patients; in exchange, the Foundation agrees to process the insurance claims and submit them to peer review. Under insurance company contracts, money does not flow through the Foundation. Rather it passes from the group receiving the care to the insurance companies and from the insurance companies to the doctor or hospital. The doctor does not bill the insurance company or the patient, but sends his bill to the Foundation, which reviews it and sends it to the insurance company for payment. The insurance company then pays the doctor, and also pays the Foundation the administrative costs of peer review.

At the present time the San Joaquin Foundation is involved in the medical care of almost half of the 330,000 residents of its expanded four-county domain. Over 60 groups, including state and county workers and employees in private businesses, have contracts with insurance companies whose claim forms are reviewed by the Foundation. The ILWU, federal employees and the Medicaid program (called Medi-Cal in California) have direct contracts with the Foundation not involving insurance companies.

San Joaquin’s doctors accept the Foundation because it protects them from Kaiser’s incursions while allowing them to continue their private practice virtually unchanged. The compromises—opening their fees and records to peer review—apply only to the fees and records of patients belonging to a foundation plan. Doctors continue to see their private, non-Foundation patients. In contrast to Kaiser, the physicians are paid on a fee-for-

TEAM WORK

This issue of the BULLETIN was written by the staff of the San Francisco office of Health/PAC. Their next BULLETIN will discuss the threatened closure of county hospitals in California and elsewhere.
service basis according to the number of patients seen and the treatment given. There are no salaries and no fixed hours; working conditions are determined by each physician.

The Doctors Determine Their Fees

When Harrington formed the San Joaquin Foundation in 1954, he had to develop a method that would insure the viability of fee-for-service practice while at the same time keeping physician costs within limits that would rival Kaiser's. In order to do this physicians in that area were asked to enumerate their fees for all services; the Foundation staff then chose as the ceiling price the "80th percentile." In other words; suppose that local doctors charge anywhere from $6 to $12 for a regular office visit, with 80 percent of them charging $10 or less. $10 then becomes the limit a Foundation doctor can charge a Foundation patient for an office visit. It should be noted that the 80th percentile is higher than the fees most doctors charge; by definition, more than half charge at or below the 51st percentile. The Foundation, then, only affects the fees of the highest charging doctors.

To aid in determining a "reasonable" fee for a particular service, the Foundation turns to the California Relative Value Study (RVS) which the CMA published in 1956. The RVS book lists in minute detail all possible services performed by a doctor and assigns each one a code number and a unit value. For example, a brief examination of a patient in the office (code 900400, has a unit value of 12; an extended re-examination (code 90070) has a unit value of 30; and an "annual" examination (code 90088) has a unit value of 40. Doctors calculate their fees by multiplying the unit value by a "conversion factor" which turns the number into dollars and cents. If the conversion factor is 75 cents, then the brief exam costs 12 x 75 cents or $9.00.

Each year the Foundation lists a conversion factor that corresponds to the 80th percentile of the doctors' fees in the county. But doctors can disregard the Foundation's conversion factor and charge patients either more or less. Doctors with a lower-income clientele may charge less so that their fees do not scare away patients without insurance. Doctors interested in higher-income patients may charge more, though for Foundation patients they will receive only the 80th percentile fee. Doctors are free to raise their own fees at will. Each year the Foundation recalculates the 80th percentile and, since doctors continue to raise their fees for non-Foundation patients, each year the 80th percentile goes up. So foundations do nothing but slice of a few fees of the highest-priced doctors and do little to slow the rise of doctor's fees in general.

Peer Review

Peer review, not fee ceilings, is the foundation's most important cost-control device. In fact, physician peer review was practically invented by the San Joaquin Foundation. Because it is becoming a controversial issue in medical care delivery, a detailed look at peer review is worthwhile.

Although foundation advocates talk of improving the quality of medical care through peer review, its primary purpose is economic. The idea is that medical costs are too high because fee-for-service doctors—hoping to earn more fees by supplying more services—are providing many unnecessary procedures. Peer review seeks to cut the costs by cutting the gross utilization of services.

How does peer review work? The foundation doctor sends the local foundation office a claim form each time he treats a patient. The form lists the physician's diagnoses, services rendered (including drug prescriptions), charges and additional comments. (This is the same form used by the doctor to bill the foundation or insurance company.) Hospitals follow the same procedure.

At the foundation, row upon row of clerks (or computers, as the case is coming to be) scan the claims forms. The clerks are provided with RVS schedules

"We've actually been called socialistic; the truth is, we're intensely capitalistic."

—Dr. Donald Harrington

Medical World News

October 20, 1972
to see if the fees charged by the doctors are within the 80th percentile limit. The clerks also have a booklet, developed by the foundation, listing local "standard criteria" for care. The booklet has a long list of diagnoses and each diagnosis has certain acceptable criteria of care. For example, a patient with high blood pressure may be allowed only two doctor visits each month; a patient with a minor illness may only be charged for a short office visit rather than for an extended office visit; no more than two vitamin B12 shots per month are allowed, and so forth.

Other foundations have different criteria, though many have adopted the San Joaquin standards. In any event, the criteria of acceptable care are related more to the amount of care and the fees charged than to the quality of the care itself. According to foundation spokesmen, as many as 95 percent of all claims meet the specified criteria and are automatically approved for payment. These claims are then sent to the insurance company which pays the doctor or hospital or else the foundation pays the bill itself as in the case of the San Joaquin contract with the ILWU.

What happens if a doctor has seen a patient with high blood pressure three times in a month rather than the accepted two visits? In that case the clerk or computer rejects the claim and gives it to a reviewing physician, who usually receives $25 an hour for the work. If the doctor feels, after looking at the comments on the claims form, that the extra visit is justified, payment is approved. If the doctor can't approve payment in full, the claim then goes to a physician review committee which meets every two or three weeks over a two-hour lunch. Each specialty has its own review committee; GP's review GP's, orthopedists review orthopedists, etc. These committees make final decisions on doctor payments, although doctors can appeal their decisions back to the same committee.

Peer review is not always objective. In most situations, each foundation doctor knows every other doctor in his specialty. If a reviewer doesn't like a physician for personal or political reasons, he can slash a fee or deny a payment. One foundation doctor in California reports that "the people on the peer review board spend less than two minutes per claim. Often they only read the doctor's name. Someone says, 'Oh, I know him. He's a good doc."

"Medical care foundations have burst out of California to become the fastest spreading phenomenon in U.S. medicine since the coming of the pill."

—Medical Economics September 27, 1971

Let's pay him.' Or, 'He's bad, let's cut his fee.' By controlling the purse strings, a foundation can stop doctors from bad-mouthing the foundation or discourage them from changing local patterns of medical care.

Quality of Care

Does peer review improve the quality of medical care? Clearly it concerns itself with the number of patient visits to a doctor rather than with the quality of care within each visit. It deals with the number of prescriptions given rather than with the correctness of the drug prescribed. The reviewers do not question the diagnosis made.

Supporters of peer review are correct in saying that limiting excessive surgery will improve the quality of care. Ralph Nader has charged that 10,000 Americans die each year as a result of unnecessary operations. This staggering figure is based on a New England Journal of Medicine article (Jan. 15, 1970) by Dr. John Bunker of Stanford Medical School. Bunker argues that the United States has an excess of surgeons and that Americans are operated on twice as much as their English counterparts. Particularly astounding is the enormous volume of hysterectomies, which are four times more common among California Blue Shield patients (not subject to peer review) than among English women.

Dr. Harrington claims that his foundation has reduced excessive surgery. The San Joaquin clerks and computers detect surgeons doing unusually large numbers of tonsillectomies and hysterectomies, and these doctors can be subjected to peer review and denial of payment. However the San Joaquin Foundation has no fig-
ures comparing its surgery rates with non-foundation rates. There is real question whether surgeons reviewing other surgeons will make a significant dent in excessive operations.

The same goes for drug prescriptions. It is estimated that six out of ten prescriptions are unnecessary, and the side effects of drugs make excess prescribing extremely dangerous. On December 7, 1972, Dr. Henry Simmons, a top FDA official, testified that tens of thousands of people die each year from needless use of antibiotics. With the close alliance of doctors and the drug industry, it is unlikely that doctors will truly curb excessive prescribing. Seven out of ten physicians invest in drug companies (Morton Mintz, The Therapeutic Nightmare). One-third of the AMA's operating budget comes from drug company ads in AMA journals. Again, the San Joaquin Foundation does not compare its prescription rates with other patient populations.

Foundation spokesmen say they are powerless to take any action against doctors who refuse to change their practices; fearing lawsuits, they will not publicize the physician's name in the community. To be meaningful, it is clear that review forms complete, hour-long examinations, including preventive care on new patients. Because this is not customary in his county, he is penalized. Instead of receiving $30, the fee for an extended office visit, the foundation peer review committee allows him only $12, the rate for a routine quick exam which is the "standard of care" in the community. Because he could see four patients hastily and collect $48 rather than $12 for an hour's work, he wonders, "Why bother doing a good job? Peer review keeps the quality of care at a static mediocre level."

"CHAPping" the Patient

Since peer review is mainly a device to cut medical costs, its most obvious application is to hospitalization rather than office visits. The reduction of a patient’s stay in the hospital by one day saves unions and insurance companies more money at $100 a day than cutting several office visits at $12 a visit.

Hospitals have traditionally had tissue review committees to check up on surgeons who persistently remove normal organs. Yet unnecessary surgery continues. More recently hospitals have been required to set up utilization review committees, which try to reduce the number of days that patients stay in the hospital. These committees have likewise had only a minor effect on the quantity of hospital care; they show little, if any concern with quality. An inherent problem with review committees is that they look at services after they have already been performed.

In 1969 the Sacramento Foundation for

"Many hospitals don’t like the foundation approach at all. After years of having the last word, they’re uncomfortable about turning leverage over to physicians. So another aspect of the foundation movement is how it bears on the quiet battle for control of doctors between hospitals and doctors themselves."

—Boyd Thompson.
Executive Director San Joaquin Foundation

must go beyond the "peers" who share the same interests, to include trained consumers, nurses, pharmacists and other health workers within each institution where health care is delivered.

One general practitioner in a northern California foundation feels that peer review may actually lower quality. He per-
Medical Care became the first organization to review hospital admissions before the patient is admitted, as a way to cut hospital stays and costs. Known as the Certified Hospital Admission Program (CHAP), the program was originally designed by California-Western States Life Insurance Company, in an attempt to reduce its hospital claims.

Cal-Western took the idea to the fledgling Sacramento Foundation. The Foundation liked the plan and CHAP was incorporated into an experimental group health plan for 2,000 persons insured through the Sacramento printers' union. The Foundation claims that the printers' plan cut hospitalization by 18 percent.

How does CHAP work? If a Sacramento doctor who wants to perform a gall bladder operation must first get the patient "CHAPped," by sending a certification request form to the Foundation office. The form is processed by a registered nurse coordinator employed by the Foundation who sends the physician a form specifying the initial length of stay the patient is allowed. Lengths of stay are based on averages for a particular diagnosis and vary with the patient's age. If the gall bladder patient is 51 years old, for example, the initial length of stay is certified at ten days. CHAP will not authorize payment of funds for longer than that unless the physician explains any complications that require an extension of stay and obtains certification for it. When an extension is requested, physician advisors, who are appointed and paid for their time, take over and make the final decision. Emergency patients are admitted but once in the hospital they too must be "CHAPped."

CHAP administrative costs are high: each hospital admission costs $9.60, which is paid by the insurance company. In 1971 figures were publicized showing that CHAP was cutting hospital costs by 20 percent and saving millions of dollars. However, the Sacramento Foundation's new executive director, George Deubel, implies that many of the early statistics may have been misleading. According to Deubel no new figures on cost cutting or reduced lengths of hospital stay will be available until September, 1974, when CHAP is completely computerized. Meanwhile other studies are underway to determine whether CHAP and similar programs actually have the long-range potential of cutting medical care costs.

Foundation Capitation

In 1970, medical care foundations banded together to form the American Association of Foundations for Medical Care (AAFMC) "a communications organization" for foundations. Donald Harrington, who has served variously as President or Medical Director of the San Joaquin Foundation since its inception, is currently President of the Board of the AAFMC. In mid-1972 it received a Federal grant to turn six foundations into HMO's. Seven other foundations or medical societies have received Federal HMO grants directly.

An HMO is an organization which guarantees medical services from specific hos-
pitals, doctors and clinics to its enrollees, who pay a fixed amount yearly regardless of the amount or cost of the services they may use (see BULLETIN, April and December, 1971). The San Joaquin Foundation has been a model HMO for members of the International Longshoremen's Union since the original 1954 ILWU contract. The contract specified certain medical services which the Foundation as-

sured it would provide to all union members; in exchange, the ILWU paid the Foundation a lump sum based on its total membership.

This kind of financial arrangement is called "capitation:" one fixed payment for each person covered no matter how many services are actually used. Although money comes to the foundation through capitation payments, the foundation pays its doctors on a fee-for-service basis. If the lump sum runs out before the end of the year, the foundation's doctors are bound by the contract to continue providing care anyway; the losses are divided among them and come out of their own pockets. Such a situation is extremely rare because the foundation staff knows enough about health care costs to bargain for more than enough money to cover one year's care. But since losses are a technical possibility, doctors are said to be "on risk" under a capitation contract. (In fact, San Joaquin and other foundations which have capitation contracts sometimes take out their own insurance policies to cover cost overruns. The policy which protects doctors from "risk" is called "re-insurance").

So far, no contracts on a capitation basis have been signed between the foundations and insurance companies. But Boyd Thompson, Executive Director of the AAFMC, speculates that it's only a matter of time. Capitation has too many advantages for the insurance companies to ignore. Primarily, one flat payment allows the insurer to predict its own cash outlay more accurately for a given year and also saves the necessity of claims review, individual payments, and other administrative costs.

But if the HMO model benefits insurance companies and the medical profession, what does it do for patients? The Nixon Administration had supported HMO's with such phrases as "better preventive care," "convenient for patients," and "available at night and on weekends." A look at San Joaquin's 20-year-old ILWU contract shows that there's at least one kind of HMO that brings no changes from the patient's point of view.

The capitation contract brought no new services into the county, no new physicians, no night or emergency clinics; did not make care more easily available for people in the rural areas or in any way distribute specialties throughout the county; and in no way improved the general health of the union members and their families through preventive medicine or public health campaigns. The contract

"I believe that the foundation is the last remaining hope to preserve the freedom of the profession in the United States."

—Dr. George Himmler, President N.Y. State Medical Society

**CORRECTIONS**

Last month's BULLETIN on "The Politics of Mental Retardation" contained two errors:

1) New York State spends $171.6 million on its State Schools. The figure of $111.6 million which appears on page 6 is a typographical error.

2) On page 16 the American Civil Liberties Union was credited with assisting in a class action suit against the State Department of Mental Hygiene over Willowbrook State School. Apologies to the New York Civil Liberties Union which is actually helping in this case.
simply insured them for specified health services.

San Joaquin and other foundation HMO’s provide an illuminating case study of the system Nixon is holding up as the solution to America’s health care crisis.

**Foundations in Action: The Medi-Cal Market**

In 1968 the San Joaquin Foundation sidestepped the customary intermediaries—Blue Cross and Blue Shield—and signed an historic contract with the State of California to provide care for all Medi-Cal (California Medicaid) patients in its area. The State pays a flat fee for each Medi-Cal patient and the Foundation reimburses the doctors on a fee-for-service basis. “In our first year,” Harrington boasts, “we were able to pay our usual customary fees—which were better than other doctors’ in the state.” In their second year, however, the Foundation miscalculated and the doctors’ fees for Medi-Cal patients had to be lowered toward the end of the year. Now that the Foundation knows the program, such an error won’t recur; the State will always give enough to cover all services.

In 1972 the Sacramento Foundation signed a similar HMO-like contract with Medi-Cal officials. But whereas the power-

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**Abortion After**

The recent Supreme Court decision on abortion is an important legal victory for women and the women’s movement. But, like most legal issues, it leaves the real problems of implementation to be decided outside the courtroom.

In its ruling, the Court held that during the first trimester of pregnancy, the state has no “compelling reason” to interfere with a woman’s right to abortion. During the second trimester, the state may only interfere in ways that are “reasonably related to maternal health,” such as licensing or regulating the persons and facilities involved. The Court declared that “reasonably” did not include requiring hospital abortion committees; two physicians certifying that the abortion was necessary to save the woman’s life; residency in the state; and other restrictions suggested by the American Law Institute model abortion code. Only during the last ten weeks of pregnancy, when the fetus could be viable, “may” the state prohibit abortion except when necessary to preserve the mother’s “life and health.”

The Court rejected the position of the women in the suit that a woman’s right to abortion is “absolute and that she may terminate her pregnancy at any time in whatever way and for whatever reasons she alone chooses.” However, Nancy Stearns, staff attorney for the Center for Constitutional Rights who presented an amicus brief on behalf of the New York Women’s Health and Abortion Project and represented Women vs. Connecticut, believes: “The women’s position was absolutely crucial in creating the climate for the decision. Last year, when the case was argued the Court asked narrow legal questions. This year, they asked about a woman’s right to make the decision.” But the crucial factors underlying the decision were that widespread availability of abortion also means lower birth rates, decreasing numbers of children born to welfare mothers and larger numbers of third world women having abortions.

Nevertheless, some women’s groups now believe the time is ripe to push for total repeal of all abortion laws on the statute books. Several New York State legislators have offered a repeal bill; in Congress, Representative Bella Abzug has introduced a bill that “would eliminate any state laws of any nature concerning the regulation of abortion.”

On the state level, differing interpretations of the decision may lead to a variety of restrictions on the conditions under which abortions may be performed or who may receive them. Many institutions and doctors will be very slow in gearing up to provide the services.

While the Court’s decision may take abortion out of the legal arena, crucial health issues remain:
ful San Joaquin Foundation has a monopoly on all Medi-Cal patients in its area, the Sacramento Foundation competes for patients with other Sacramento health providers: an OEO network, a Department of Public Health clinic and the University Medical Center.

Employing 30 salesmen who work in the field, the Foundation uses Madison Avenue gimmicks to enroll patients by advertising "Welcome To The Good Health Community." The Foundation Medi-Cal patients do get more services than those who do not enroll. While ordinary Medi-Cal patients are restricted to two physician visits and two prescriptions per month, the Foundation allows unlimited visits and prescriptions. This is certainly an incentive for patients to join the Foundation. Business is good: since July, 23,000 Medi-Cal patients have enrolled.

The Foundation pays its doctors their customary fees rather than the lower fees that Medi-Cal pays through its usual Blue Shield intermediary. To ease the risk to doctors, the Foundation has arranged for Medi-Cal to pick up the tab on patients with over $10,000 in medical bills per year.

Enormous problems face the Foundation's Medi-Cal patients. The Sacramento Foundation has insufficient general phy-

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**The Court**

- **Quality of Care:** Abortion will now become another medical procedure, regulated by health codes, medical institutions and doctors. Findings of the Joint Program for the Study of Abortion (Population Council, 245 Park Avenue, New York) and studies by Dr. Jean Pakter (New York City Health Department, 125 Worth Street, New York, New York) can be useful in outlining safe procedures and detailing the morbidity and mortality rates that can be expected. But reports and state codes tend to concern themselves with the minutia of how far apart beds should be in recovery rooms, or how many social workers are necessary, rather than more crucial issues like the quality, style and length of counseling, the attitudes of physicians, and speed-ups in the clinics. Many of the New York City clinics, perfectly legal according to the State, are indeed "mills" where the women are pushed through like so many parts on an assembly line.

- **Comprehensive Care:** While in the very short run, separate abortion clinics may seem like a boon to women, they are a re-creation of the fragmentary approach to the delivery of care. Now that abortion is legal, it could become part of comprehensive services for women. Separate facilities take the pressure off the major health institutions to provide comprehensive care.

- **Profiteering:** Free standing abortion clinics are a lucrative business venture for both doctors and entrepreneurs. The opportunity for profiteering is enormous. Several of the New York clinics have already branched out into other cities. Monitoring and publicity from women's group can help bring down the prices, but do not touch the real problem of control over the services.

- **Coercion and Punitive Procedures:** In many states there have been attempts to require welfare mothers with a certain number of children to have abortions. Rumors persist in many communities that welfare allotments will be cut, if such women refuse abortions. In some New York hospitals, both public and private, the number of sterilizations, especially those performed on black and Puerto Rican women, have increased markedly since the liberalization of the abortion law.

Thus, legal abortions mean that the health system rather than the legislatures and courts will have to become the focal point. The New York experience has proven that ambulatory abortion clinics, women counselors and referral groups do not, in and of themselves, guarantee quality of care. Abortion and sterilization can be liberating or repressive procedures depending upon who controls the delivery of the service.

—Susan Reverby
If there were no foundations before October 30, 1972, they would have had to be invented. On that date President Nixon signed the new Social Security Amendments (HR-1) which include the controversial Professional Standards Review Organization (PSRO) amendment for Medicare and Medicaid reimbursement.

A PSRO is a peer review organization which is supposed to oversee the quality and appropriateness of medical services paid for by Medicare and Medicaid. The prototype for PSRO’s is none other than the San Joaquin and Sacramento Foundations. And in all likelihood foundations will now be transformed into PSRO’s.

The amendment, originally inserted by a foundation sympathizer, Utah’s Republican Senator Bennett, was opposed by the American Medical Association, the American Hospital Association and Blue Shield. Bennett, saying “we simply cannot afford to continue down the high costs road we have been travelling,” convinced his colleagues in Congress that PSRO’s would save the Federal government substantial sums of money.

By January 1, 1974, the Secretary of HEW must designate PSRO areas throughout the nation. Areas could be as large as an entire state, but in any case must contain at least three hundred practicing doctors. Organizations representing large numbers of physicians in an area—medical societies, foundations, group practices like Kaiser “would be invited and encouraged to submit plans meeting the requirements of the programs.” The AMA was particularly opposed to the stipulation that allows the HEW Secretary to enter into PSRO agreements “with other agencies or organizations with professional competence as he finds are willing and capable of carrying out PSRO functions,” when medical organizations cannot carry them out. The AMA fears, with some justification, that these organizations will be non-physician dominated, but rather run by large companies such as Blue Cross or consortiums of insurance companies and computer corporations.

PSRO’s will review all Medicare and Medicaid claims, initially for hospitals and nursing homes and in future years for doctors’ offices and pharmacies. PSRO’s can recommend appropriate action against doctors responsible for gross or continued overutilization and even theoretically for inferior quality of services. The HEW Secretary would be authorized to assess a fine related to the significance of the acts or conduct involved—but not to exceed a paltry $5,000—against persons or institutions found to be at fault.

Although one of the stated purposes of the PSRO system is to monitor the quality of care, the amendment, like its foundation prototype, downplays this objective. The real push of PSRO’s will be to monitor the number and costs of the services provided. Congress saw that hospital utilization committees failed to cut Medicare’s costs significantly. With PSRO’s, Congress is going to see if practicing doctors can be better cost cutters through PSRO’s. It is unclear from the foundation experience whether PSRO’s will have a major impact on costs. What is clear is that the government pays for the administrative costs of PSRO’s, so that foundations becoming PSRO’s can look forward to a windfall of government dollars.

Passage of the PSRO legislation insures the spread of Foundations For Medical Care. One of the chief functions of the American Association of Foundations for Medical Care will be to teach Foundations how to set up PSRO’s as quickly as possible. Private doctors now need the Foundations to keep other institutions away from the PSRO function.
referred from specialist to specialist, and are unable to get prompt appointments. Ironically, because of its lack of available doctors, the Foundation has been forced to send some of its enrolled Medi-Cal patients to a competitor, the University Out-Patient Department.

Although many Sacramento Foundation doctors don't like to hear it, the Sacramento Foundation acts as an HMO in its Medi-Cal program. The Foundation through CHAP will probably cut hospital costs—perhaps by up to 15 percent. It can lower the cost to the State by ten percent and still have five percent left for higher doctor fees. Thus, whether doctors realize it or not, foundation HMO's tend to shift money away from hospitals, toward higher physician incomes.

Arresting Change

Whether acting as HMO's or the government's newly-mandated peer review organization (see PSRO's, p. 12) or both, the chief purpose of foundations is to prevent government interference in medical care. This is done by setting up mechanisms for physician self-regulation of the costs of care. And there is some indication that foundations may have an impact on costs. The San Joaquin Foundation, performing the peer review function for insurance companies, says it can save between 8 and 15 percent. The Colorado Foundation claims that peer review of Medicaid patients reduced the average length of hospital stay by one day and decreased hospital admissions by 10 percent. CHAP boasts cuts in hospital stays of 14-18 percent. The most impressive foundation statistics come from San Joaquin's HMO-like plan for federal employees. By carefully reviewing hospital use, the foundation claims to have cut the number of hospital days per 1,000 insured persons per year to 390, compared to 924 for Blue Cross/Blue Shield federal employee plans.

Who benefits from the savings of reduced hospital use? Over the past ten years the federal employees' premium has roughly approximated the Blue Cross/Blue Shield premium. So the savings from decreased hospitalization are not all used to lower patient costs, but appear to go in part to the foundation for overhead and administrative costs and to the doctors. Also, under the Sacramento Medi-Cal plan hospital costs are lower but doctor fees are slightly higher than in the Blue Cross/Blue Shield Medi-Cal mechanism. Only part of lowered hospital costs will be passed on to the government.

The crackdown on hospital and nursing home use may cut costs, although quite possibly at the expense of long-term chronic patients who are the most costly to care for. Cost control which would not harm patients would mean reductions in doctors' fees and the cost of drugs, and elimination of massively-duplicated facilities and equipment that keep hospital rates rising. Foundations can not be expected to touch these matters.

Foundation Futures

Foundations for medical care have established themselves on the American health scene. Foundations started as a response to corporate group practice. Now, fed by Nixon and HR-1, they are spreading due to fear of more thorough-going government intervention. The conservative innovators such as Harrington, who spur the foundations' growth, hope that physicians themselves can act to control the costs of care. PSRO's and doctor-run HMO's will be the mechanisms used by foundations to attempt to cut costs while retaining control over the practice of medicine.

Foundations will mainly take hold in rural and medium-size urban areas, with large medical school and hospital complexes continuing to dominate in large cities. In some localities, foundations loom as threats to Blue Cross, Blue Shield or Kaiser-type plans over issues such as: who will be the Medicare and Medicaid intermediary, and who will take care of desirable populations with ability to pay. But in general the Blues, Kaisers and
Medi-Cal Reformed?

Watch out—here comes another California innovation in health care delivery: HMO's for the poor. Called PHP's (prepaid health plans), these new creatures of California's Medicaid program (Medi-Cal) have already created a storm of protest and controversy.

Under the 1971 Medi-Cal "reform" law the State can contract with PHP—generally corporations or groups of doctors—to provide care to Medi-Cal recipients. The State pays the PHP a flat fee (capitation fee) for each Medi-Cal patient enrolled and the PHP provides out-patient, hospital and nursing home services. If the flat fee is, for example, $300 per patient, a PHP enrolling 10,000 patients will receive $3 million from the State. The State will save money because the capitation fees are set at 10 percent less than the average cost per patient under the present fee-for-service method of Medi-Cal payment. And the PHP will make profits by providing as few services as possible to the patients. Estimates are that PHP's—especially by cutting down patient use of hospitals and nursing homes—can make profits of up to 30 percent.

Thus far the State has signed over 20 contracts covering a potential 40,000 Medi-Cal recipients, and many more contracts are being processed. Most of the PHP's are in the Los Angeles area and many appear to be fly-by-night operations run by investment-hungry doctors. A coalition of community, legal and health provider organizations has already formed to disenroll patients from PHP's and to prepare legal and legislative action against them. According to the Los Angeles Times (December 10, 1972) the Los Angeles County Medical Association received over 500 complaints about PHP's between October and December. For example, a woman came to the clinic of her PHP one night and found it closed even though emergency service was supposed to be available 24 hours a day.

The PHP's will certainly use their profits to expand and enroll non-Medi-Cal patients. So the Medi-Cal program is presently the most potent stimulus in the US for HMO development. The outcome of the struggles against the proprietary PHP's in Los Angeles will affect consumers and health workers across the country, foundations will divide up the money and the paying patients without major battles.

Private doctors are by no means unanimous in supporting foundations. The most conservative will balk at the idea of federally-mandated peer review and some will even refuse to serve Medicare and Medicaid patients to avoid such review. The AMA, though not unfriendly, has not officially welcomed the foundation concept. A growing number of doctors, however, see foundations as the only way to preserve fee-for-service practice. Furthermore, they realize that the fee-limiting function of foundations is so minimal that fees may actually increase by the shifting of government funds from hospitals to doctors.

Foundations help to entrench a system of medical care which leaves people ignorant about their bodies and their health needs and problems. Fee-for-service encourages doctors to see the greatest number of patients in the shortest time to make the most money.

Anyone who wants to change a foundation's approach will have to push from outside, because most foundations exclude patient or health worker representation. In San Joaquin County only the ultimate threat by the Regional Medical Program of loss of funds forced the foundation to allow community members on an advisory board of a foundation-run clinic in the low-income section of Stockton. Dr. Harrington gives lip service to consumers saying that they will have a voice through organizations which have arranged for their group health plans. However these organizations—frequently an employer, a union or government—often lack the power to negotiate with physician monopolies, nor are they known for their responsiveness.

Foundations bring some reforms in health care, but only at the cost of potentially greater reforms. They exist for the benefit of doctors. The health care patients receive—or don't receive—will be virtually indistinguishable from the health care they are presently complaining about.

Footnotes
1. After this success, Whitaker and Baxter was paid $5 million by the AMA to wage a "stop socialism" campaign against the Truman health insurance proposal, and from that victory went on to the payroll of the Eisenhower/Nixon campaign. It continues to manage reactionary political campaigns and in the last two California elections was hired by big business to fight conservationist issues.
2. A second story heard is that local physicians were dissatisfied with the level of Blue Shield payments and wanted a payment system they could control more directly.

—Elinor Blake and Judy Carnoy
San Francisco Beat

For over three years, San Francisco General Hospital has been under pressure from community groups, hospital workers and professionals to improve patient care and working conditions. Strikes in 1970 and 1971 generally failed to bring about improvements (BULLETINS, July-August, 1970 and March, 1971). But in March, 1971 a public hearing before the Joint Commission on Accreditation of Hospitals, organized by hospital workers and community groups, led to a probationary accreditation which required the hospital to make substantial changes.

Using the probationary status as a lever, the Thursday Noon Committee, a group of social workers, doctors, nurses and other workers, prepared a plan for an improved emergency room (BULLETIN, February 1972). With the threat to disaccreditation in the background, the emergency room plan was budgeted in full and is presently being implemented. Thursday Noon Committee also organized another community-worker hearing for the Joint Commission on its repeat inspection tour in June, 1972. In September the new accreditation report was unveiled: another one-year probation.

The conditions that the hospital must meet in order to gain accreditation in 1973 are far-reaching—budget increases not tampered with by City Hall, promise of adequate staffing, more job security for workers and an end to short rotations of University doctors through the hospital. The hospital administration is scurrying about trying to figure out how to make these long overdue changes.

The city government is undertaking a major study of San Francisco General, but until recently the committee performing the study had failed to generate great interest not only in the community but even among its own members. Following the Joint Commission’s new report, the committee leapt into action and is recommending the formation of a hospital corporation for San Francisco General. Hospital workers and community groups must now react to this possibility. Health-PAC is planning an issue of the BULLETIN on significant changes taking place at San Francisco and other county hospitals.

LETTERS

Dear Health-PAC:

I have often been critical of the quality of articles you publish, and have wished for a muck-raking organization which would be more effective. However, if you keep to the standard set in your November 1972 issue, I would have few complaints.

The article on Licensure by Emily Spielner is particularly excellent. I have read a lot in this area, and I think it is a good historical review and a fair analysis. The citing of references is a positive innovation, although I wish that she had attached them by number to specific facts in the text.

Susan Reverby’s article is generally good. However, it suffers from the lack of references, as so many of your articles do. I am particularly disturbed by the last paragraph on p. 10, where the author tries to develop a case that Stead and Estes are sexists. This may be true, but I am not convinced by the quotations, especially when they are out of context and without citation.

Furthermore, the fact that Estes argued something about nurses has no particular bearing on the case. I know a little about the situation in North Carolina, and the two statements quoted seem to me to be fair. Perhaps Estes was sloppy in not confining his remarks to his own situation, but out of context one cannot even tell that. Estes did in fact want to work with the nursing school, but has been rebuffed.

I have other criticisms of the article, but they all could be answered by citing references. I think it is a particular reverse snobbery not to list them.

Sincerely,
H. David Banta,
Assistant Professor
Department of Community Medicine
Mt. Sinai Hospital, New York

The author replies:

The quotations from Estes and Stead were based on my interviews with them. I also stated in the article that one of the reasons for the growth of physician assistant programs has been the attitudes and positions of the nursing schools toward the changes in nursing roles.

The references for my article were unfortunately placed at the end of the first article. As in the current BULLETIN, we will continue to give references and footnotes where appropriate.
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