1 Oklahoma Crude:  
EVERYTHING'S GUSHING UP HOSPITALS.  
Oklahoma City demonstrates that over-bedding is a good thing—for everyone but patients and taxpayers.

10 CHIP Off the Old Block:  
BUT IS IT NATIONAL HEALTH INSURANCE? Nixon's bill may sound good, but the fine print tells another story.

14 Vital Signs

16 Peer Review

Oklahoma Crude

DURING the past two decades hospitals have sprung up throughout the United States like MacDonald hamburger stands. Now there are too many hospital beds to fill with sick people and the beds stand idle.

In Dade County, Florida about 7,500 beds are needed but within two years the County will have 12,000 beds. This is not an isolated instance; the pattern is being repeated across the country. St. Louis has 714 beds too many, San Francisco 1,130 excess and Honolulu 1,000 empty beds.

Since over-bedding is a national problem (though a few cities like New York are exceptions) one has to conclude that either hospital officials are monumentally inept planners or else that hospital construction serves some purpose other than providing sufficient beds for the infirm. Oklahoma City is a good place to look for some answers because perhaps in no other city are the politics of over-
bedding more transparent.

For a city of 700,000 people, Oklahoma City has a lot of hospitals—18 non-federal hospitals to be exact. Of these, however, only five account for most of the patient admissions. All except the University of Oklahoma-related University Hospital (UH) are private voluntary hospitals: 195-bed Presbyterian, 595-bed Baptist Memorial Hospital, and two Catholic institutions, 181-bed Mercy and 800-bed St. Anthony’s Hospital.

Unlike many cities, Oklahoma City has no municipal or county hospital. However, like other cities, Oklahoma City has many medically indigent patients, perhaps more than ten percent of the city’s census. Up until recently (see below), patients without hospital insurance of any kind were admitted to UH, a state facility related to the state medical school. Indeed, UH served as the “dumping” ground for the other hospitals in the city. Unlike most other cities, UH served more or less the role of a public hospital—it was the hospital of last resort.

Preserving the Last Frontier

Oklahoma City suffers (or thrives) from an untamed frontier mentality or ethos. Mr. E. K. Gaylord, the town’s one-hundred-year-old patriarch and power broker, was one of the illustrious gentlemen who invaded Indian Territory prior to statehood in 1907. At age 100 he is a bit more sedate but no less powerful. He or his minions have membership on almost every key public agency and private board (more later about how those relate to hospitals) and he and his son publish the state’s two leading statewide newspapers, The Daily Oklahoman and the Sunday Oklahoman, as well as Oklahoma City’s evening Oklahoma City Times. The empire also controls WKY Radio-Television. Thus the family molds public opinion for at least one million readers and listeners.

Hospitals are important for the image of men like the Gaylords. They proclaim the idea that the “West has been won” and are a convenient display of the City’s refinement. The truth is, however, that building new hospital pavilions is also good for business.

The hospital building boom started about 20 years ago, just about the time that Oklahoma City hospitals changed their corporate status from profit-making, tax-paying to non-profit, tax-exempt voluntary hospitals. Two events convinced Oklahoma City business-men, who then as now controlled the hospitals, that it was better to switch than fight. In 1947 Congress passed the Hill-Burton Law designating many millions of dollars of federal money for hospital construction. The money had to go, however, only to non-profit hospitals. Then in 1954 the Internal Revenue Service revised its regulations to grant special tax exemptions to voluntary hospitals. For Oklahoma County these rulings save the hospitals some $20 million a year.

While it was said to have been the intent of Congress and the Internal Revenue Service that this money be used for care of the medically indigent, this isn’t how it worked out in Oklahoma City (or, for that matter, anywhere else). Instead the money has been spent building unneeded, in fact, empty hospital beds. A quick look at how hospital bed need is calculated will prove the point.

Build We Must

There are four generally accepted formulae for determining how many short-term beds a community needs, and for projecting bed needs into the future. The community should not have a great deal more or less than these formulae indicate. They are: (1) the Hill-Burton formula; (2) the Hill-Burton adjusted formula; (3) the use/rate formula, a variation of which is utilized below, and (4) the optimum occupancy formula.

A good way to determine about how many short-term acute beds the community should have is to use the locally-accepted ratio of four beds per thousand resident population (4/1000), which assumes an 85 percent occupancy rate. The primary patient origin area of the Oklahoma County area hospitals is the Oklahoma, Canadian, and Cleveland County area. The population of this area is about 674,000 people. This produces a bed need of 2,696 short-term beds.

The expected increase in the population is going to produce a three-county population of 700,000 people in 1975. This creates a need for 2,800 short-term hospital beds.

However, the three-county area will have a projected 4,746 short-term beds in 1975 for a surplus of 1,946 beds. Each one of those excess beds is costing about $50,000 apiece to build and about $20,000 apiece to maintain each year. The surplus will be at least 1,000 beds for 30 years, for a total cost to the community for unneeded facilities of over $650
The local Oklahoma City hospitals that are building the excess beds are borrowing the money to do it, expecting to raise patient fees for the next 30 years in order to recover the cost of construction and of maintaining the empty (non-income-producing) beds. When construction is completed the maintenance costs are figured into the overhead costs of the hospital and tacked onto the bills of the patients occupying some of the beds. One hospital which has completed its construction and is already doing this is St. Anthony’s Hospital.

**St. Anthony’s Hospital**  
**1968 to 1972 percent change**

- Average Daily Census up 1.6%
- Number of Beds up 46%
- Operating Expenses up 51%
- Total Revenue up 62%
- Net Income up 190%

In 1968 the hospital averaged 438 patients a day. By 1972 while the number of beds had increased 46 percent (259 beds) the number of patients had increased only 1.6 percent (seven) per day.

Some of the 51 percent increase in operating costs was passed on to patients in the form of higher per patient day charges. The hospital determines per patient day charges by dividing the number of patient days for the whole year into the cost of operating the facility for a year. The increased cost is then passed on to the government and to private insurance plans and from there on to taxpayers and subscribers. From this perspective it is obvious that everyone, except the hospitals responsible for the costs, pays through the ear. Indeed, over-construction of hospitals and related facilities is the greatest single factor causing national hospital cost inflation (217 percent over the last ten years).

But inflation is only one of the costs which result. In order to keep ahead of the game and maintain their “surplus funds,” hospitals must begin eliminating “unprofitable” services. Some hospital services, such as medicine and surgery, always make money and are used to subsidize money-losing services such as emergency rooms and outpatient departments. To save money Oklahoma City hospitals are cutting back on the number of patients being seen in their emergency rooms and outpatient departments and the number of no-pay and part-pay patients. This has been the major source of care for many of the city’s medically indigent, which the hospitals obligated themselves to serve by acquiring tax exemption. Patients are now charged a pre-admission deposit so that if a family can’t pay the deposit, the patient is refused admittance or service. This allows the hospital to divert the money from patient care to paying construction and operating costs of empty beds. For St. Anthony’s Hospital the data show:

<table>
<thead>
<tr>
<th>St. Anthony’s Hospital</th>
<th>Operating Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1968 to 1972 percent change</strong></td>
<td><strong>1968 to 1972 percent change</strong></td>
</tr>
<tr>
<td>Average Daily Census up 1.6%</td>
<td>Operating Expenses up 51%</td>
</tr>
<tr>
<td>Number of Beds up 46%</td>
<td>Number of Beds up 46%</td>
</tr>
<tr>
<td>Operating Expenses up 51%</td>
<td>Average Daily Census up 1.6%</td>
</tr>
<tr>
<td>Total Revenue up 62%</td>
<td>Occupancy Rate down 31%</td>
</tr>
<tr>
<td>Net Income up 190%</td>
<td>Emergency Room Visits down 32%</td>
</tr>
<tr>
<td></td>
<td>Outpatient Visits down 54%</td>
</tr>
</tbody>
</table>

As the number of emergency room visits and outpatient visits has decreased from 1968 to 1972 the same services at University Hospital have until recently shown a dramatic increase. As working people have been refused at St. Anthony’s Hospital, they have gone to University Hospital in search of medical care for their families.

In Oklahoma City over-expansion is not limited to St. Anthony’s Hospital. Presbyterian Hospital’s capacity will increase from 195 to 412 beds when its new facility, now under construction, opens.
will go from 181 to 400 beds and Baptist Hospital projects an expansion to 800 beds from its present 595.

By 1975 the Oklahoma County area hospitals will have an average occupancy rate of 55 percent because of the added bed-days. But this is not enough to pay the operating costs and mortgages. A minimum of an additional 87,000 income-producing patient days will have to be found somewhere to help the hospitals meet expenses. They are nowhere to be found.

**Choice, Not Chance**

Miscalculations such as these just don’t happen by accident. The fact is that long after it was known that Oklahoma City was fast heading for an excess number of beds, the most powerful business leaders kept relentlessly pushing for further hospital expansion. In 1969 the Community Council of Central Oklahoma, whose members are the wealthiest and most influential business leaders in the community, passed a resolution changing the name of their own Health and Hospital Planning Council to the Areawide Health Planning Organization (AHPO) of Central Oklahoma. The Department of Health, Education and Welfare then cooperated by designating the organization the local Comprehensive Health Planning agency.

By 1970 the AHPO's staff was pitted in opposition to their own Policy Board over the issue of hospital expansion. The Board, composed of hospital administrators and trustees, doctors, government representatives and wealthy “consumers,” was pushing full-steam ahead for more hospital construction. The staff, and anyone else who cared, knew that no more beds were needed. Oklahoma City was being inundated with hospital beds. An independent consultant to the AHPO Board confirmed the staff's judgment. The consultant reported that, “... the community will have 916 excess beds by 1975.” A subsequent report concluded that there would be:

- 35 to 50 million in capital expenses wasted.
- $20,000 per bed per year in operating expenses with no off-setting income.
- Extreme pressure on hospitals to make “use” of the beds to increase income, resulting in unnecessary hospitalization.
- A severe limitation in the hospitals’ ability to explore new forms of health care due to heavy debt burdens incurred for unused beds.
- Increased costs of hospital care, passed on to the patient.
- Increased difficulty in maintaining medical staff rules and regulations due to relative ease of shifting practices from one hospital to another.
- Increased pressure on hospital administration to meet physician demands for duplicative expensive equipment, for fear of losing the medical staff necessary for maintaining the highest occupancy possible.

Naturally, the Policy Board was not persuaded and further hospital expansion was mandated. Since that time the boards of various hospitals with representation on the Policy Board have proposed that an additional 695 short-term hospital beds be built by 1977. This would simply waste another $34 million.

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**The Cost of Excess Hospital Beds**

- By 1975, the population of the Oklahoma City area, from which City hospitals draw their patients, will be 700,000. (It is now 674,500.)
- With hospitals averaging 85 percent occupancy, the recommended level, this size population will require 2,800 hospital beds.
- Present building programs will be completed, and the Oklahoma City area will have 4,746 such beds—a surplus of 1,946 beds!
- At 85 percent occupancy this number of beds would be sufficient to serve a population of 1,186,000. (Official projections do not expect Oklahoma City to reach this population until the year 2019.)
- The cost of maintaining these 1,946 empty beds will be $38,920,000 each year. (An unoccupied bed costs $20,000 a year to maintain—two-thirds as much as a full one.)
- This averages out to a cost of $55.60 each year for every man, woman, and child living in the Oklahoma City area.
- If this weren’t bad enough, hospital administrators are currently planning to build another 554 beds by 1980!

—From an Oklahoma Consumer Protection Agency Fact Sheet
Who Profits

"Profit" is a dirty word in the hospital industry. Yet profit is as important to non-profit hospitals as it is to General Motors.

Some profits in hospitals are obvious—for example, the $100,000 a year salaries garnered by radiologists, anesthesiologists and pathologists. Then there is, at least at the larger medical centers, the $60,000 a year for the administrators. And it isn’t hard to see where the staff doctors profit by being able to use the hospital as their workshop without having to pay anything back in return.

Chances are, however, that the hidden “profit makers” will prove to be of greater importance. Doctors may not profit from over-expansion but other people sure do. Aside from construction companies, which profit directly, lawyers, architects, surveyors, appraisers, management consultants and money lenders—banks and insurance companies—profit handsomely. After all, no hospital can self-finance major construction, so the hospital must borrow money for expansion. The money must, of course, be paid back over a period of 20 to 30 years with interest, which is where the money lenders make their profit.

In Oklahoma City this amounts to big money. The tax-exempt bonds issued by the Oklahoma Industries Authority (OIA) to expand Baptist Memorial, Presbyterian and St. Anthony’s Hospitals total $89.4 million. The OIA is a public-trust State agency established by statute to ensure the economic and industrial growth of Oklahoma. After the OIA funding of the three non-profit hospitals, the hospitals’ anticipated 1973 to 1978 surplus (profit) zoomed to a total of over $56 million (this figure derives from the hospitals’ own bond feasibility reports).

OIA’s chairman is Edward L. Gaylord, son of the 100-year-old Indian raider and Oklahoma City’s leading media baron. OIA does business with Oklahoma City’s First National Bank and Trust Company, whose Chairman of the Board sits as a trustee of OIA. The Bank actually profits in at least three ways: on the interest it receives on loans to the hospitals; on investments it makes on the lump-sum money OIA deposits for hospital construction in the first place; and on the expected investment of the projected $56 million “surplus” of OIA-funded hospitals.

Bank executives are well represented on the boards of all three hospitals as well as other health policy making bodies (see box page 6). The second leading Oklahoma City bank doing hospital business is Liberty National Bank and Trust Company. Liberty handles part of St. Anthony’s money and has its Board Chairman on the OIA. In the last analysis, after including only the money paid on the principal and interest, Oklahoma City health care consumers will have to foot an astronomical $180 million for the hospital over-expansion now in the works. Of course, the consumers’ loss is the banks’ gain.

Flies in the Ointment

Up until now the hospitals and banks have had it all their way. They have been the recipients of generous federal handouts and have been able to depend upon free-flowing reimbursement from Blue Cross which, as is true elsewhere, is controlled by the hospitals.

There are, however, three things wrong with this time-honored, winning strategy: Fed-
### You Scratch My Hospital, I'll Scratch Your Bank

**Members of the Oklahoma Industries Authority**

<table>
<thead>
<tr>
<th>Position</th>
<th>Occupation</th>
<th>Bank Affiliation</th>
<th>Hospital Affiliation</th>
<th>Policy Bodies Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edward L. Gaylord</td>
<td>Chairman</td>
<td>Executive Vice-President and Treasurer, Oklahoma Publishing Company</td>
<td>Board of Directors, Fidelity Bank</td>
<td>Philanthropist, Presbyterian Hospital (1/100,000 personal and $100,000 from Oklahoma Natural Gas)</td>
</tr>
<tr>
<td>Ray A. Young</td>
<td>Secretary</td>
<td>1. Honorary Chairman of the Board, T.G. and Y Stores 2. R.A. Young and Sons (Contractors supplies)</td>
<td>Board of Directors, Liberty Bank</td>
<td>President and Member of the Board, Baptist Foundation (Holds title to Baptist Memorial Hospital)</td>
</tr>
<tr>
<td>Luther T. Dulaney</td>
<td>Member</td>
<td>1. Chairman of the Board, Dulaney's, Inc. (Electrical appliances) 2. Board of Directors, Oklahoma Natural Gas</td>
<td>Lay Advisory Board, St. Anthony's Hospital</td>
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<tr>
<td>Name</td>
<td>Title</td>
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<td>2.</td>
<td>3.</td>
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<tr>
<td>J. W. McLean</td>
<td>Member</td>
<td>1. Chairman of the Board,</td>
<td>Liberty National Bank</td>
<td>1. Same</td>
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<td></td>
<td>2. Liberty National Corp.</td>
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<td>2. (Holding Company)</td>
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<td></td>
<td>3. Board of Directors,</td>
<td>Oklahoma Natural Gas</td>
<td>2. Board of Trustees,</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Mercy Hospital</td>
</tr>
<tr>
<td>Donald Kennedy</td>
<td>Member</td>
<td>1. Chairman of the Board,</td>
<td>Oklahoma Gas and Electric</td>
<td>1. Same</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Board of Directors,</td>
<td>Company</td>
<td>2. Board of Directors,</td>
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<td></td>
<td></td>
<td>3. Board of Directors,</td>
<td>Missouri, Kansas and</td>
<td>3. Board of Directors,</td>
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<td></td>
<td></td>
<td></td>
<td>Texas Railroad</td>
<td>Village Bank</td>
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<tr>
<td>Charles A Vose, Sr.</td>
<td>Member</td>
<td>1. Chairman of the Board,</td>
<td>First National Bank and Trust</td>
<td>1. Same</td>
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<td></td>
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<td>2. Associate Director,</td>
<td>Company</td>
<td>2. Associate Director,</td>
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<td></td>
<td></td>
<td>3. Board of Directors,</td>
<td>Founders Bank and Trust</td>
<td>Founders Bank and Trust</td>
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<td></td>
<td>4. Advisory Director,</td>
<td>Village Bank</td>
<td>Trust Company</td>
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<tr>
<td>George H. Shirk</td>
<td>Attorney and</td>
<td>1. Attorney</td>
<td></td>
<td>Lay Advisory Board,</td>
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<tr>
<td></td>
<td>General Manager</td>
<td>2. Former Mayor of</td>
<td></td>
<td>St. Anthony's Hospital</td>
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<td></td>
<td>Oklahoma City</td>
<td></td>
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<tr>
<td>Harvey P. Everest</td>
<td>Former Member</td>
<td>Honorary Chairman of the</td>
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<td>1. Same</td>
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<tr>
<td></td>
<td></td>
<td>Board, Liberty Bank and</td>
<td></td>
<td>2. Advisory Director,</td>
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<td></td>
<td></td>
<td>Trust Company</td>
<td></td>
<td>May Avenue</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Bank and Trust</td>
</tr>
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<td></td>
<td></td>
<td>1. 1964 Citizen's</td>
<td>Comprehensive Health Survey</td>
<td>1. 1964 Citizen's</td>
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<td></td>
<td></td>
<td>Committee</td>
<td>Committee</td>
<td>Comprehensive Health</td>
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<td></td>
<td>2. Chamber of Commerce's</td>
<td>Medical Education Task Force</td>
<td>Survey Committee</td>
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<td></td>
<td></td>
<td>Executive Committee,</td>
<td>Oklahoma Health Science</td>
<td>Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oklahoma Health Science</td>
<td></td>
<td>1. 1969 Chairman,</td>
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<tr>
<td></td>
<td></td>
<td>Foundation</td>
<td></td>
<td>Health and Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 1970 President of the</td>
<td>Planning Committee of the</td>
<td>Planning Committee</td>
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<td></td>
<td></td>
<td>Community Council</td>
<td>Community Council</td>
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<td></td>
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<td>3. 1972 Community Survey</td>
<td>Services Committee</td>
<td></td>
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<tr>
<td>Oklahoma Industries Authority—A public trust agency established by statute to ensure the economic and industrial growth of Oklahoma. It directly supplies loans to hospitals.</td>
<td></td>
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<tr>
<td>Medical Education Task Force—Created by the Chamber of Commerce to secure long-term financing for major Oklahoma City hospitals.</td>
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</tr>
<tr>
<td>Areawide Health Planning Organization—created by the Community Council of Central Oklahoma (composed of wealthy businessmen) and successor to the Council's Health and Hospital Planning Council. It is the local Comprehensive Health Planning agency.</td>
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<tr>
<td>Oklahoma Health Science Foundation—The health planning entity of the University of Oklahoma Health Science Center. Its major goal is to secure long-term financing for Health Science Center hospitals.</td>
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<tr>
<td>Oklahoma Medical Research Foundation—Supplies part of the funds for the Oklahoma Health Science Foundation. It is mostly concerned with long-term capital financing for major Oklahoma City hospitals, especially Health Science Center Hospitals.</td>
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</tbody>
</table>
eral money is becoming harder to get, and, what's worse, the Nixon Administration is savvy to the rip-off game hospitals have been playing: nobody knows what to do about the medically indigent—those without insurance of any kind or the means to pay a hospital bill; and enraged consumers are suing hospitals to maintain the integrity of hospital money supposedly to be used for the indigent. In theory the Oklahoma ad valorem tax exemption law was supposed to take care of the indigent problem. Hospitals were to use the money saved by not paying taxes for the health and hospital care of the poor. But that is not the way it's worked out. Instead, hospitals in Oklahoma City have done what hospitals everywhere else have done—demand that a prospective patient who doesn't have insurance fork over a deposit ranging from $150 to $500 before they will be admitted to the hospital. In this way poor patients are excluded.

On August 17, 1973 the Oklahoma Consumer Protection Agency (whose members pay property taxes) sued the Oklahoma County tax assessor asking the Oklahoma County District Court to order him to place 12 local hospitals on the ad valorem tax rolls. The Oklahoma ad valorem tax exemption law states: "...such hospital facilities shall be open to the public without discrimination as to race, color or creed and regardless of ability to pay..."

The plaintiffs charged in the complaint that hospitals have violated the law by:

- Requiring a pre-admission deposit of $150 to $300 [since raised to $500 by one hospital] or coverage in that amount by a third-party intermediary, or a combination of both.
- Refusing to admit any individual who is unable to pay a cash pre-admission deposit, or who does not have sufficient third-party intermediary coverage to meet the pre-admission deposit requirements, or who does not possess a suitable occupation and income upon which the hospital may determine the applicant to be a good credit risk.
- Discharging or transferring a patient for whom third-party intermediary coverage has lapsed.

**Hospital Expansion Balance Sheet**

When hospitals need to save money to pay for shiny new unnecessary facilities, they distort the practice of medicine in two ways: they cut back on services which lose money—which are also the ones most heavily relied upon by poor people—and charge illegal pre-admission deposits to exclude those who cannot pay; and they over-treat and over-hospitalize those who can pay (or who are covered by some type of insurance), emphasizing acute hospital care to the exclusion of outpatient clinics, preventive medicine, and other services.

This graph illustrates how St. Anthony's Hospital in Oklahoma City increased profitable operations and cut back severely on money-losing ones.

—from an Oklahoma Consumer Protection Agency Fact Sheet

<table>
<thead>
<tr>
<th>Profitable Services</th>
<th>Unprofitable Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Emergency room</td>
</tr>
<tr>
<td>1962</td>
<td>1972</td>
</tr>
<tr>
<td>up 22%</td>
<td>down 46%</td>
</tr>
<tr>
<td>Radiology</td>
<td>Outpatient</td>
</tr>
<tr>
<td>1962</td>
<td>1972</td>
</tr>
<tr>
<td>up 63%</td>
<td>up 50%</td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td></td>
</tr>
<tr>
<td>up 531%</td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
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<tr>
<td>1972</td>
<td></td>
</tr>
<tr>
<td>Emergency room</td>
<td></td>
</tr>
<tr>
<td>1972</td>
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<tr>
<td>down 46%</td>
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</tr>
</tbody>
</table>

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Refusing to discharge and threatening to refuse to discharge patients until they have made full payment of their accrued hospital bill.

Until 1973 patients refused admittance to Oklahoma City voluntary hospitals were at least assured of getting into UH. As many as 50 percent of UH patients were medically indigent. This arrangement was agreeable to the medical staff who needed the patients for teaching purposes anyway and could admit their own private patients to Presbyterian Hospital a few blocks away.

But in 1973 the State took two actions which threaten to end UH's role as hospital of last resort for the poor. Early in the year the State Legislature (controlled by rural-based representatives with no love for the urban hotshots at the medical school) voted to divorce UH from the State Board of Regents. This had the effect of ending the state subsidy, leaving UH to fend for itself just like any other voluntary hospital. To mitigate the criticism of wipping out the only existing hospital for indigent patients, the Legislature continued a small subsidy for 1974.

Then in mid-December, the State tightened the noose around UH even tighter. The Oklahoma Constitution makes it illegal for a state facility to run in the red, and UH had a $3 million deficit that was still growing. As a result, Governor David Hall (whose own administration is being investigated by a federal grand jury) amended the state's contract with UH to forbid UH doctors from admitting private (read income-producing) patients to any private hospital. The effect was to force the doctors to admit their own patients to UH and this, on top of an earlier cutback on the number of beds, may force non-paying patients out of UH.

There are persistent rumors in Oklahoma City that sooner or later UH will be forced to close. The State Legislature periodically talks of moving it to Tulsa. Meanwhile UH daily becomes less distinguishable from other voluntary hospitals.

Most impressively, UH is beginning to cut its losses by doing what every other private hospital is doing—shafting the poor. For example, emergency room visits fell from about 20,000 for the first three quarters of 1972 to 16,500 for the same period in 1973. More striking was the one-third drop in outpatient visits from the first quarter of 1973 to the third quarter in the same year. It was in this quarter that the economic cuts hit UH. In March 1973 a nine-page memorandum detailing a scheme to charge pre-admission deposits was leaked to the press by the Consumer Protection Agency. Confronted by an angry press and furious public, hospital officials lost no time denying any plan to exclude folks who could not pay. But more recent statements from the hospital cast doubt upon this denial. Robert Snyder, MD, head of the long range planning committee for UH's Department of Medicine, says, "We must compete with the private voluntary hospitals in the City and cannot have Mickey Mouse facilities for people who are paying their way." And another hospital spokesman chimes in, "We are operating as a private hospital with a modest State subsidy. In May when the money runs out we don't expect to admit non-paying patients."

At the receiving end of all these punches are the medically indigent who now have no place to receive medical care. When a State medical official was asked recently, "where will the poor receive care?" he replied, "I don't know." Odds are he doesn't care either, just so long as the State or the City doesn't have to spend money for it.

In the meantime as the poor try not to get sick for fear that they will not be admitted to any hospital, OKC will have a 1,946 bed surplus by 1975. Those with hospital insurance will be paying higher premiums for beds they cannot possibly use. In suburban Northwest Oklahoma City a new hospital—Edmund Memorial Hospital—has only 26 of its 100 beds occupied. It's a dandy situation—hospital administrators polish their image and enhance their stature by building bigger, if not better hospitals; the local and state government saves money by denying care to those who cannot pay; and the bankers rake in the money. Only the people lose—but isn't that the way it's supposed to be?

If you're doing any traveling, Oklahoma City is the place to get sick. You will be sure to find a hospital bed. But don't forget your Blue Cross card. And watch your gall bladder.

—This article was written by Bob Nichols, who is on the staff of the Health Protection Task Force of the Oklahoma Consumer Protection Agency. He was assisted by Eric Johnson, an intern at UH-Presbyterian Hospital, and Deborah Roher, a student intern with the Consumer Protection Agency.
CHIP Off the Old Block

BUT IS IT NATIONAL HEALTH INSURANCE?

"A vastly more liberal bill than the one he introduced in 1971," said the New York Times. "A serious, carefully designed national health insurance proposal," said Senator Edward Kennedy. "An important spur to growing congressional desire to pass a national health insurance bill," said Business Week. These are the assessments coming in on President Nixon's Comprehensive Health Insurance Program (CHIP), introduced in Congress on February 6. Perhaps the most important assessment of all came in the form of sponsorship of the bill in the House by Representative Wilbur Mills, Chairman of the powerful Ways and Means Committee.

Why the stir? Because the bill contains several promises that make it a serious contender in the national health insurance arena. Unlike Nixon's last proposal, it promises nearly comprehensive benefits, universal coverage and a single class of care for all—and all of this at no additional cost to the taxpayer. So tantalizing are its promises that many politicians will find it irresistible. But consumers had better take a long, hard second look, lest the promises turn to dust in their hands.

What the President Promises

Basically the President's proposal would not guarantee anyone health care, but only the ability to purchase a private health insurance policy covering a specific set of services. This would be done under three programs.

- The Employee Health Insurance Plan (EHIP) would require employers to pay 65 percent of the cost of health insurance premiums for their employees; employees would pay the balance. The Department of Health, Education and Welfare (HEW) estimates that insurance companies will charge an average of $600 for an annual premium covering a family of four, meaning that the employer will pay $390 and the employee $210 a year. (After three years, employer-employee proportions would change to 75 percent and 25 percent, respectively.)

- Under the Assisted Health Insurance Plan (AHIP) state and federal governments would subsidize, on a graduated basis according to income, the purchase of premiums for the poor, the unemployed and those considered to be high medical risks.

- Finally, Medicare would subsidize coverage for the elderly, and its benefits would be expanded to match those offered by the other programs.

CHIP offers greatly expanded benefits compared with the 1971 Nixon proposal. Also, CHIP ostensibly offers the same benefits to everyone, unlike the earlier proposal, which would have given much less to the poor. Benefits include (1) unlimited hospital and physician services; (2) prescription and other life-saving drugs; (3) laboratory tests, X-rays, medical devices and ambulance service; (4) limited treatment for mental illness, alcohol-
ism and drug addiction; (5) certain nursing home, convalescent and home health services; and (6) services to children, including preventive care, eye and ear examinations, and dental care to the age of 13.

Persons covered by the President's plan would be issued a "credit card" by their insurance company. The insurance carrier would pay providers in full, presumably making health services free at the point of delivery for the consumer and eliminating the basis on which many providers presently discriminate against the poor. The carrier would then be responsible for collecting from the consumer whatever out-of-pocket expenses he or she may owe.

What the President Didn't Tell You

These are the promises that President Nixon hailed in his health message. What he didn't hail is the fine print in this long, complex bill, which undermines and occasionally negates the promises.

- CHIP is not national. Nixon's proposal does not automatically guarantee everyone health insurance. Instead, it is completely voluntary; only if people join and pay their share of premium costs will they be covered. Hence it promises to leave large numbers of people uncovered. First to fall between the cracks will be the marginally-employed and part-time workers. EHIP does not require employers to offer health insurance until employees have worked 90 days, and does not require coverage of part-time workers at all. Such workers may seek insurance through AHIP, but only by paying much of the $600 premium themselves. This will surely act as an incentive for employers to hire part-time workers and those who do not require health insurance.

In addition, the cost of purchasing health insurance will fall most heavily on lower-income workers, who in a financial pinch may decide to risk not being insured. At incomes above $7,000 a year, premium costs are not graduated and the $7,000-a-year worker must pay the same $210 for a family premium as a $70,000-a-year executive.

Finally, many elderly may actually stand to lose under Nixon's new program. Presently Medicare provides hospitalization automatically, and if elderly persons want coverage for physician cost in addition, they must pay a premium of $6.30 a month. Under CHIP all health insurance coverage for the elderly will be voluntary and will depend upon paying premiums.

- CHIP is not health insurance. It is primarily catastrophic illness insurance. CHIP incorporates a system of out-of-pocket payments that will mean that the ordinary, healthy family will seldom benefit from its health insurance. In addition to the initial $210 a year that a family must pay for its premium, it must also pay the first $150 of medical expenses per family member (called a deductible), up to a total of $450 per year. Thus it could end up spending $660 before receiving any assistance whatever from its health insurance. The same is true of CHIP's drug benefits. Consumers benefit only after paying the first $50 for drugs each year. Once a family has spent $450, it's still not home free. It must still pay 25 percent of the succeeding costs (called coinsurance) up to a maximum of $1,500. Only then does CHIP take over and pay all costs. (Coinsurance and deductibles are graduated according to income for the poor—see accompanying table.)

This system of deductibles and coinsurance is called cost-sharing by the government. It is designed to discourage consumers from misusing or overusing the health system and to create an incentive for them to seek out the least expensive care. This analysis, of course, ignores the fact that a sick person is not like a grocery shopper. A sick person has little to say about when he needs services, what kind, how many and which facilities he uses. These depend on where he lives, what kind of insurance he has, what his doctor decides and where his doctor has admitting privileges.

What Nixon's cost-sharing would do is turn CHIP into catastrophic health insurance—used only when families have a devastating illness that would otherwise result in catastrophic debts. This aid is not insignificant, since illness is the primary cause of individual bankruptcy in this country. But CHIP pretends to much more, including an emphasis on preventive care. Yet a child could only take advantage of CHIP's preventive care after having been sick enough to have spent the first $150 in medical expenses—making a mockery of CHIP's pretensions.

- CHIP would come down hard on the consumer who defaults on his out-of-pocket costs. It would guarantee that he will get no 11
care whatsoever. Presently if a patient has outstanding bills, a particular hospital or doctor may turn him away. But he can still seek services from other providers. Under CHIP all services would be paid for through a medical "credit card" issued by a private health insurance company and all out-of-pocket expenses will be owed that company. CHIP would allow the company to cancel a "credit card" if debts are not paid within 90 days, thus cutting off access to all participating medical services.

CHIP would not be free at the point of delivery, nor would it guarantee one class of care. These promises were undercut by a provision that would certify providers as fully participating, associate participating or non-participating. Associate participating providers (excluding institutions) would be free to charge EHIP patients (wage-earners) direct, individual fees above and beyond those paid for by their "credit card." For EHIP patients, this would make a sham of services being free at the point of delivery or of their having a maximum liability for medical expenses. For the poor and elderly, it would mean discrimination as usual, since they would clearly be less profitable to treat than EHIP patients.

Health-care financing under CHIP would be enormously regressive, particularly for the lower-income worker. The estimated $210 employee share of premium cost would be the same for the $7,000-a-year worker and the $70,000-a-year executive, even though it comprises 3 percent of the worker's salary and 0.3 percent of the executive's salary. Likewise, the maximum out-of-pocket expense of $1,500 would be 21 percent of this worker's income—easily enough to throw a family into bankruptcy—while it would be only 2 percent of the executive's income. Only for the poor (families under $7,000 and individuals under $5,000) would the cost be graduated.

Finally, administration of CHIP would be unspeakably complex. Administration would not be national, since the federal role would be limited to establishing eligibility standards, defining the benefit package and administering Medicare (as the federal government presently does). Left up to individual states would be such crucial issues as the regulation of insurance companies, review of rates received by insurance companies and medical providers, certification of providers and administration of cost-control mechanisms. (With regard to the latter, since the state pays little of the cost under CHIP—only 25 percent of AHIP costs—its incentive to control costs is questionable.) The federal government must approve state plans for doing these things, but short of this, everything is left in the hands of the states. In fact, states apparently have the option of deciding whether or not they even wish to participate in CHIP.

EHIP and AHIP would be administered according to 50 different state plans (assuming all states participate). Medicare would be run by the federal government, although CHIP allows HEW to contract with insurance companies for administration of the program. And as if all this isn't a big enough headache, CHIP's system of graduated costs would mean that both the states and the federal government would be plagued with the complexities of determining the exact income of applicants under AHIP and Medicare. The degree of complexity in CHIP belies Nixon's aversion to big bureaucracy. CHIP's complexity would necessitate an enormous bureaucracy. The difference is that it wouldn't be federal; instead it would be partly at the state level and partly within private insurance companies.

Such complexity is inevitable if Nixon is to satisfy all parties without making basic changes in the health system. States would be free to participate or not in CHIP. Health care providers could choose to participate fully, partially or not at all, and in so doing would be free to accept the rate CHIP would pay or charge more to their wage-earning patients. Insurers would be free, except for small employers (under 50 employees), to charge whatever negotiations will bear for health insurance premiums. The only group whose freedom would be impinged upon is employers, who must cough up 65 percent of employee health premiums. But with the demise of the Economic Stabilization Program, they are free to pass on the increased cost of employee health insurance to the consumer in the form of higher prices.

So it would seem that everyone is free to have his cake and eat it too—everyone, that is, but the consumer. For the consumer, CHIP would not guarantee health care as a human right but only private health insurance—and only catastrophic health insurance at that—as a human right, and then only if the con-
sumer can afford it. And with CHIP’s three programs’ sundry graduated cost scales, Nixon has also decided who can afford to pay how much. But if, after all that, the consumer is still unhappy, of course he has the ultimate freedom not to participate at all.

**What National Health Insurance Can’t Deliver**

But if the needs of the consumer are foremost, any form of national health insurance is the wrong approach. Basically, national health insurance speaks only to the issue of financing. Yet more money is not necessarily what stands between the average American and good health care. America presently spends more per capita on health care than any other country in the world, yet on every significant index, the health of Americans rates below that of other industrialized countries.

This is because the $94 billion that Americans spent on health care last year goes not primarily to protect and enhance their own health, but to support the profits and other priorities of a burgeoning health industry. And more money will not necessarily trickle down into better health care for the consumer, any more than it ever has.

In fact, Americans have already had experience with this approach. For all the fanfare about the advent of national health insurance, America already has two such programs—Medicaid for the poor and Medicare for the elderly. Since their implementation in 1966, the rate of medical inflation has doubled. Doctors’ fees have increased 130 percent and hospital rates have soared 217 percent. The average American now pays $441 a year in health care costs. Medicare and Medicaid have grown to over 80 percent of the federal health budget and now represent over 50 percent of all hospital income. Yet benefits to the poor and elderly have hardly increased proportionately. Indeed, the elderly pay more out-of-pocket medical expenses now than they did in 1966 when Medicare was passed. Where did the money go, if not to patient benefits?

The administration of Medicare and Medicaid was turned over to the health insurance industry, especially to hospital-controlled Blue Cross. And the money went primarily to drive up doctors’ and hospitals’ fees, as well as the profits of the health insurance, drug, hospital supply and equipment and other health-related industries. With this massive influx of money, hospitals in particular were able to build new buildings, add fancy equipment and big-name researchers, pay administrators at rates up to $100,000 a year, hire labor consultants to fight unions and public relations firms to polish up their image afterwards, and charge it all to patient cost. That cost, in turn, was paid for with few questions asked by the health insurance industry, which has no vested interest in controlling health-care costs.

Nixon’s national health insurance plan, or any other for that matter, will surely do the same, so long as it does not change these basic realities of the health industry. "If the Administration’s bill passes . . . two years after implementation starts . . . health in- (Continued on page 20)

### Scale of Graduated Out-of-Pocket Costs Under AHIP (Family of Four)

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Family Share of Premium*</th>
<th>Per Person Deductible</th>
<th>Maximum Liability</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Drugs</td>
<td>Other</td>
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<tr>
<td>$ 0-2,499</td>
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<tr>
<td>2,500-4,999</td>
<td>0</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>5,000-7,499</td>
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<td>100</td>
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<tr>
<td>7,500-9,999</td>
<td>600</td>
<td>50</td>
<td>150</td>
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<tr>
<td>$10,000 +</td>
<td>900</td>
<td>50</td>
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* Based on cost of total premium estimated at $600.
THE HEALTH BILL RISES

The Social Security Administration (SSA) has announced that total spending for health care in the United States was $94.1 billion in fiscal 1973, an 11 percent increase over spending for fiscal 1972. Per capita health expenditures rose from $400 to $441. SSA’s breakdown of fiscal ’73 healthcare expenditures went as follows:

- Hospital care $36.2 billion
- Physicians’ services $18.0 billion
- Dentists’ services $5.4 billion
- Other professional services $1.7 billion
- Drugs and sundries $8.8 billion
- Eyeglasses and appliances $2.1 billion
- Nursing home care $3.7 billion
- Expenses for prepayment and administration $4.2 billion
- Government public health activities $2.8 billion
- Other health services $4.6 billion
- Research and medical facility construction $6.5 billion

That figure of $4.2 billion for prepayment and administration costs includes $3.3 billion in private insurance company retentions, an increase of over $1 billion from the previous fiscal year.

PRE-CERTIFICATION BITES THE DUST

HEW Secretary Caspar Weinberger announced February 8 that HEW was abandoning proposed regulations under the 1972 Medicare and Medicaid amendments that would have required prior approval by a utilization review committee of non-emergency...
admissions of Medicare and Medicaid patients to hospitals and skilled nursing facilities. Touted originally as a means of controlling the rising costs of those programs, the pre-admission certification proposal was withdrawn after the AMA and AHA had threatened to sue and the AMA had sent a top-level delegation to the oval office to meet with the President on the issue. AMA Board Chairman Dr. James H. Sammons had said at a news conference announcing the Association’s readiness to fight the regulation in court: “The Secretary should know better. He’s got some real smart doctors working for him, but apparently he doesn’t listen to a word they tell him.” Perhaps with some presidential assistance, the Secretary is now a better patient.

PRIVATE IS BETTER, OR IS IT?

On February 14 the President dedicated a $75-million addition to Cedars of Lebanon Hospital in Miami with the ringing statement, "When I go to a hospital, or when I have to call a doctor, I want that doctor to be working for the patient and not for the federal government.” The President failed to mention that only the previous day he had received his annual checkup at Bethesda Naval Hospital under the aegis of a team of doctors working for the Navy, which the last we heard was part of the federal government, and whose performance was apparently up to presidential standards.

The new hospital facility example of the United States’ “great private health care system,” which is, of course, “the best in the world.” Again the President did a little editing of the facts: The facility in question was made possible by a $52-million loan guaranteed by the Federal Housing Administration, otherwise known as a government agency. On the other hand, had the facility been built with a federal grant, its patients would not be saddled with an estimated $20 per patient per day in debt service on the loan. And if local health planning officials had had their way, the 500-bed addition would never have been built; these officials estimate that by 1975, the Miami area will have a surplus of 4,000 acute-care hospital beds. That prospect does not augur well for controlling the inflation of hospital-care costs, something about which the President has often expressed his concern.

DO DOCTORS NEED HOSPITALS $500 WORTH?

The medical staff organization at Maimonides Medical Center, a 650-bed voluntary hospital in Brooklyn, New York, has voted to require a $500 contribution to the financially hard-pressed institution from every member of the medical staff as a prerequisite to reappointment. The action has led to cries of “blackmail” from some physicians and a threat to file a complaint with the State Attorney General’s office. An AHA spokesman called the requirement “not the way to run a railroad,” and an AMA official called it “a violation of the principles of medical ethics of the AMA.” The president of the medical staff, Dr. Solomon Ciprut, on the other hand, called it a way to avoid shutting down such hospital services as pediatrics, obstetrics and gynecology and rehabilitation medicine, a move that had been proposed by the hospital.

THE VMA IN THE FOOTSTEPS OF THE AMA

The Montgomery County, Maryland County Council is considering a bill that would create a tax-supported clinic where low-income persons could receive services free or for a fee based on their ability to pay—the services in question being sterilization of their cats and dogs. The County Veterinary Medical Association has attacked the bill as “an infringement of our rights to free enterprise, an unfair competition by the government.” Sound familiar?

TELEPHONE TIME IS MONEY, TOO

Telephone consultations may be going the way of the house call. A time-study expert, R. Alexander Mackenzie, advises doctors that a $50,000-a-year physician who wastes an hour a day on the telephone is lowering his income by $6,250 a year.
Dear Health/PAC:

This is a letter pertaining to the article “As the Nation Goes So Goes Boston,” which appeared in the October 1973 BULLETIN. We decided to write this letter to try to clarify some of the inaccuracies of the article about Boston City Hospital as well as to question the very premise around which this BULLETIN was written.

We were members of the Better Breaks Group and were deeply involved in political work at Boston City Hospital (BCH) for three years prior to these latest struggles concerning the budget cuts and the dismissal of the black administrator Steven Washington.

As people very involved in work at BCH, we disagree with the premise that BCH is a public hospital going private. Previously, BCH had been shared by three medical schools—Harvard, Tufts, and Boston University. The administrator of the hospital was always part of the Health and Hospitals Department of the City of Boston. The Mayor of Boston appoints commissioners and directors of BCH. The medical schools worked together with the city bureaucrats to run the hospital and for years had used the patients of BCH for any research or study they wanted. In fact, Harvard invested millions of dollars of city and federal funds in developing the famous Mallory Institute of Pathology, the Channing Infectious Disease Research Building, and the Thorndike Research Building. The medical schools very often competed or worked together as it suited them.

When the “big” changeover to Boston University Medical School happened, the only important issues were the budget cuts by the city government and the loss of bed space and services as a result of Harvard and Tufts pulling out. It is a real mixture of arrogance and presumption to state, “The Boston City activists might also have better addressed themselves to what in the long run will be an even more serious development at Boston City Hospital—its takeover by Boston University—rather than get caught up in the urgency of the budget crisis.” [See editorial, October, 1973 BULLETIN.]

This may be the correct analysis for the situation in New York City but contrary to the opinion of the Health/PAC editors, New York City is not the center of the nation—it is not the nation. Progressive people in the United States have long been plagued with this New York City chauvinism since the days of Columbia. No thanks!

The changes at BCH have been the loss of many jobs, the curtailment of many services, and the closing of floors. The Board of Trustees, a powerless supposed voice of the community, still exists. The City patronage system is still intact. The only difference is there are two less medical schools training doctors and experimenting on the patients of BCH.

We would like to tell the real story of what happened at BCH. We feel this should be published by Health/PAC because it contains lessons for all people involved in hospital organizing, and we also feel
that this is the type of discussion that should be going on in the BULLETIN. The chain of events at BCH can best be told by talking about the Better Breaks Group and its relation to the struggle. We feel that the meat of the article on BCH was inadequate and inaccurate and we would like to clarify and expand on many of its points.

The Better Breaks Group (BBG) was "... composed primarily of young white transient educated employees in their first year at the hospital." This is a good description of the leadership of BBG, but not a description of the people who came in and out of the group. There were many instances when interested Black hospital employees as well as Black and Spanish-speaking people from the community worked with BBG. There were also old and young white working-class people, nurses, medical students and many other hospital workers.

The great interest in BBG arose when this group became involved in the support of a Black administrator, Steven Washington. Steve Washington, the night administrator on the busy emergency floor, took a personal stand against the brutality of the Boston Police to BCH patients. For his brave efforts he was arrested on a trumped-up rape charge and subsequently fired.

Two grave errors were made by the leadership of BBG in the Steve Washington struggle. For one, Steve and his wife Karen and other Black people interested in Steve's case were never actively incorporated into the BBG. Much of the initiative and leadership exhibited by both Karen and Steve was systematically undermined by the people who ran BBG.

Many groups on the Left talk about Third World leadership being essential in any movement for true social and political change within this country. The struggle for Steve Washington was a perfect opportunity for that leadership to have developed. Who is more qualified to lead a struggle—the people directly involved in that struggle, or as the BBG leadership believed, outside semi-professional organizers—theirseives.

This became the main concern of ours and the main concern of other people working within BBG. We were dealing with a leadership that: (1) was not committed to practice of the idea of Third World leadership; (2) acted as if Third World people were incapable of acting either politically or effectively; (3) did not respect the idea or the fact that the Black community is a separate entity with its own right to self-definition and self-determination.

Points 2 and 3 were best evidenced by the fact that leaders of BBG, without consulting anyone Black or white in the group, felt they could go ahead and offer proposals on community control of police to the Massachusetts Black Congressional Caucus. These proposals came out of a meeting that Steve Washington spoke at. The letter that was written implied that it was speaking for employees at BCH and was made to seem as if it originated from Third World people residing in the area.

The second major error was believing that white counterculture community and media could bring about change at BCH. The roots of the leadership of BBG were the Cambridge based anti-war student movement. To publicize Steve Washington's case, an interview and program was done by the radical newscaster of the counter-culture radio station. This program consisted of a taped interview with Steve which was inter-spliced with statements from a white radical nurse who worked on the accident floor, quotes from Stokely Carmichael, and soul music. The tape made Steve seem like a Black revolutionary hero, when in fact if you knew the man and listened only to what he said on tape, you would realize that Steve was a very sensitive person who possessed a strong sense of justice for all people. (Steve had defended a white youth at the hospital from being shot by the police.) This misrepresentation of Steve as a Black militant was the hip media image of Black people. This is the image that makes good press and is the classical racism of dealing with stereotypes and not real people.

In statements made by the nurse, she said that all security guards at BCH were white. This was erroneous. Almost one-half of the guards at BCH are Third World people. She also stated that all white working-class people at BCH were racists. This helped to polarize and turn-off people who in fact weren't racists. One of these people had worked the previous year in a political group at BCH with a Puerto Rican chairwoman and even though this person was a racist to some degree, she was still able to function in a group that talked about community control of the hospital and had Third World leadership. She was insulted by the tape and did not participate in this important struggle because of it.

17
After Steve's struggle was underway but being stalled in meeting after meeting of the Board of Trustees of the hospital, the issue of the budget cuts mentioned in the BULLETIN article began to arise.

At this point many people in BBG became sick of meetings in which the major topic of discussion was when to hold the next meeting. There was never an official chairperson, just some lucky person given the privilege by the leadership. Minutes were infrequently kept and conveniently lost. (One is reminded of that wonderful paper by Jo Freeman on the "Tyranny of Structurelessness.") Just when people within BBG would attempt to define the group and the group's objectives, the leadership would feel it was being challenged. It would obstruct meetings, not stick to the agenda decided upon at previous meetings, and play personality and power politics with the Progressive Labor Party and other factions within the organization.

Many people in the group were pushing for some direction and structure. Many people wanted BBG to take a position on the budget cuts. People from the Progressive Labor Party (PLP) had a big role in BBG and, along with other people, started the Ad Hoc Committee Against the Budget Cuts—a spin-off group of BBG. PLP and the National Caucus of Labor Committees eroded the budget struggle by telling hospital workers why they should support the Ad Hoc Committee. Since workers at BCH know what PLP is about, many people were turned-off to this struggle. People in BBG could have taken a strong stand on the budget cuts and neutralized the effects of PLP and the National Caucus of Labor Committees. Instead, the leadership of BBG clung to their own sectarian non-position and accelerated the demise of any resistance to the budget cuts at BCH.

Meanwhile Steve Washington and friends got it together and built his own defense relying heavily on the Black community and having to go outside BBG and the hospital completely. He finally won his struggle both in the courts and at BCH.

The opportunity for the Steve Washington struggle to build a bridge between the community and BCH hospital workers was lost. Had Steve and Karen become leaders or even full members of BBG instead of being manipulated by the leadership: (1) many Black hospital workers would have joined BBG; (2) BBG would have developed a direction and purpose so unreachable for white middle-class radicals; (3) because of their strong connection and involvement with an ongoing group of hospital workers, Karen and Steve may have worked on other hospital issues such as the budget cuts.

If we are to have progressive struggles in this country, we must understand that it is a necessity for oppressed Third World people and oppressed white people to work and struggle together to overcome the racism of three hundred years that separates them and to struggle together for social political change in this country. The Better Breaks Group was not only a failure but was a retarding force in that struggle.

The subtle middle-class counter-culture racism of these "political" organizers was in many ways more vicious and divisive than the fearful emotional, often violent, racism of some white working-class people. The racism of working-class whites is based on ignorance and false privilege while the racism of the white radical is based on real privilege and elitism. Therefore, it is more productive to settle the differences between Third World people and working-class whites because the resolution of these differences is the foundation upon which social movements as well as revolutions are built.

—Marshall Blesofsky and Susan Sklar

The authors reply:

We could not respond to every point in the Blesofsky/Sklar letter without writing another whole article, but at the outset we wish to say that we disagree with many of the "facts" and most of their analysis. Certain crucial points bear comment:

1. First and foremost, why all this talk about Steve Washington when we wrote, as individuals, an article about the budget struggle? This letter mainly criticizes work that we didn't write about and the reader cannot legitimately judge the merits of the criticism.

2. We don't believe that racism is best fought by a passive attitude of whites toward Blacks. As far as the whole Steve Washington case, the BBG never took any action without consulting the Washingtons; but making Steve and Karen the leaders of BBG would not have solved either their problems or the organization's. Blesofsky and Sklar criticize others for making Steve Washington a Black hero, then turn around and say that his and Karen's lead-
ership would have solved a whole array of political problems. This is certainly no more sensitive a view than what they criticize, and downright naïve about how to build a mass organization of hospital workers.

3. Still, we freely acknowledge the organization’s limitations, on both the Steve Washington and budget issues. But we believe that anyone, no less “white radicals” such as we and Blesofsky and Sklar are, has the right and responsibility to build a much-needed people’s movement at BCH. Many of our weaknesses stemmed from the distance between us and our co-workers, and their distrust of fly-by-night radical organizations such as besieged the hospital during the budget cuts. Radicals will only be able to see beyond our noses to the real needs of the people when we are willing to drop the rhetoric and style of the sectarian left, such as Blesofsky and Sklar use. To do this we don’t have to deny who we are, but we can’t keep trying to apply simplistically the old formulas such as, “Third-World leadership” or “subtle middle-class counter-culture racism.” The BBG attempted to make the transition to a mass organization; hopefully others can learn from our mistakes as well as our successes.

4. It is off-the-wall for Blesofsky/Sklar to try to throw in guilt by association. We aren’t the media; we didn’t control what went into coverage by the Boston Globe, both Boston anti-establishment weeklies, the Bay State Banner (a local Black weekly), or Challenge, or any of the other coverage, including the radio station they refer to. But we’re proud of having gotten the media interested, because their coverage helped keep the pressure on, and so helped win Steve’s case and make it a lesson for many people.

5. We are open to criticism—our article was itself a criticism of much that we did last year. Through constructive criticism of our practice we hope to learn better and more effective ways of building organizations. If the answers were as obvious as Blesofsky/Sklar imagine, the movement would have been built long ago.

—Jeff Blum, Jerry Feuer, Joan Tighe, Kate Mulhern

Kaiser: The Truth, The Whole Truth?

Dear Health/PAC:

Your issue “The Kaiser Plan” (November, 1973) is a considerable improvement over earlier Health/PAC efforts. On the Kaiser form of prepaid group practice, but still has serious distortions and misstatements of fact. This disturbs me very much, because I see a real need for a group such as yours. But our mutual cause is hurt by sloppy reporting. There are many of us who deal with these issues on a day-to-day basis who would be delighted to have a chance to have input.

To the point: there is much that is right in the issue, and the reporters have presented certain facts not readily available. On the other hand, there are both general and specific flaws. Generally, despite the citing of references, the article is full of value judgments which are not backed up by evidence, and some of these are just wrong. Furthermore, as Dr. Steve Jonas has written recently, the anti-capitalism-in-health position has no validity unless related to a general position, and your Kaiser issue certainly has this flaw. Further, the description clearly deals only with the Northern California Permanente Medical Group, but the findings are generalized to all of Kaiser, when such groups as Hawaii and Portland are quite different. And finally, the emphasis leaves the impression that Kaiser is a bad plan, when the judgment at the beginning, “Kaiser’s not good, but it’s the best around” is much closer to the truth. An anti-Kaiser position has no validity unless related to the fragmented, discontinuous, manipulative and patronizing way in which medical care is usually delivered.

Specifically, I particularly object to the statement that the doctors are salaried, made at the beginning of the article. Later, this is explained more fully, but then is summarized as “physicians are salaried.” Perhaps the staff members of Health/PAC have never been subject to an unreasonable boss, and responsible to him for a salary. I have, and I feel strongly that the medical group structure is completely different, in theory, if not in Northern California. The physicians have a prospective budget, which they draw up, and they pay themselves depending on that budget. Thus, the medical group, ideally at least, and truly in some settings, is a kind of participatory democracy. As in all of the medical system, non-physicians are excluded from participating, which seems wrong.

Secondly, I would like to know the evidence for the statement on page 8, “Clearly, it is more economical for Kaiser to have a continuous
stream of new subscribers who don't know how the system works.” It is not clear to me. It would be interesting to compare physician and hospital utilization of new enrollees to that of enrollees with more tenure. I don't know the result, but I wouldn't be surprised if the finding was the opposite of that so confidently predicted. Kaiser, if anything, is efficient and planned, and unpredictable utilization is not what such a plan thrives on.

One more blatant wrong: on page 8 also, the words of a Kaiser economist are twisted to support the statement, “. . . Kaiser is no different than private insurance companies in skimming lower risk people from the population.” No real evidence is cited to back up such a statement. Demographic characteristics of a population do not fully explain its utilization. In fact, there is evidence to suggest that those who choose Kaiser are sicker than others, or more worried about their health. In the study cited in the article to support other biases of Carnoy et al., Health Insurance Effects by Roemer, but not used on this point, it is concluded: “All in all, the evidence suggests that the commercial plans . . . manage to attract enrollees with the lowest overall risk of illness, the group practice plans get the highest risk enrollees, and the provider plans fall in between.” I find this the worst part of the article, when a statement made is at least partially refuted by facts in a study cited.

I write in this rather harsh tone because I would like to expect more of Health/PAC. I find the medical care literature to be well-cited, with carefully hedged statements, etc., but mostly not the truth. I am convinced that Health/PAC attempts to tell the truth, but articles are too often flawed by sloppy reportage and insufficient regard for facts. If the two methodologies could be put together, it would be powerful.

—David Banta, M.D. 
Assistant Professor 
Department of Community Medicine 
Mount Sinai School of Medicine

Health/PAC replies:

In answer to some of Dr. Banta’s points, first it is true that most of the information was derived from Northern and Southern California. We consider this justified, however, since over 85 percent of Kaiser’s subscribers live in these two regions.

Secondly, Dr. Banta can quibble about how K-P physicians are paid. He may find to his surprise, however, that most Kaiser physicians contend that they are salaried, and they like working at Kaiser for that very reason.

In theory Kaiser claims to have some form of physician “participatory democracy.” Dr. Banta should reread our observations on page 15. We found many physicians in Northern California to be disgruntled with the K-P hierarchy. In fact, many in the past have resigned over this very issue.

To our knowledge there are no statistics available proving that new subscribers utilize Kaiser more than older subscribers as Dr. Banta contends. Our information, which would indicate the opposite, comes from extensive interviewing of Kaiser personnel and is summarized in the statement of one hospital administrator who said he believes that new subscribers use the system far less because “it overwhelms them at first.” He continued, “We have a difficult time getting new enrollees to come in for their first yearly checkup.”

If Dr. Banta had read the article more carefully, he would have noted our evidence that demonstrates that Kaiser skims off lower-risk people. On page 8 we say, “Only 4.2 percent of Kaiser subscribers in Northern California are over 65, whereas 9 percent of the general population are in this high risk age.” Furthermore, Dr. Banta knows Kaiser enrolls primarily working people whose employers or unions pay part or most of the monthly payment. The poor and unemployed, who are known to have more health problems, usually do not have the option of joining Kaiser.

CHIP
(Continued from page 13)

sors could collect double their present annual premium income,” writes Business Week (January 26, 1974). And with Nixon’s CHIP, as with Medicare and Medicaid in the past, there is no assurance that care will be more accessible, of higher quality, more accountable or more geared to patient needs. There is only the assurance that, be it through taxes, insurance premiums or direct payments, the health-care consumer will continue to finance spiralling health-care costs and the health of everyone else in the system except himself.

—Ronda Kotelchuck