1 Kennedy Mills:
A FUNNY THING HAPPENED ON THE WAY TO THE WHITE HOUSE. Kennedy beats a retreat on national health insurance.

6 Patient Dumping:
PRIVATES PICK PUBLIC PATIENTS. California’s private hospitals select profitable patients.

11 Medicaid Mills:
PING PONG REBOUNDS. Bronx Medicaid patients organize.

15 Media Scan
Marcus Welby et al.

17 Peer Review

19 Vital Signs

Kennedy-Mills

Many supporters were shocked and dismayed in early April when Senator Edward Kennedy retreated from his cradle-to-grave Health Security Act and, with Representative Wilbur Mills, introduced into Congress a more limited, compromise measure—the National Health Insurance Program (NHIP).
While Senator Kennedy’s retreat may have been disappointing, it should not have been a surprise. For the economic and political climate has shifted dramatically since the introduction of the Health Security Act in 1971. And if the earlier measure ever had political viability, in the last year it has run up against a three-way roadblock which has rendered it a virtual dead letter.

First, the introduction of the Health Security Act followed on the heels of a decade of economic prosperity. By 1972, the beginning of President Nixon’s second administration, however, it was clear that the American economy was in serious trouble. And one of Nixon’s answers was cuts in the federal budget, particularly the domestic budget, and most particularly, the largest and most inflationary sector of the domestic budget: health care spending (see BULLETIN, May 1973). Although the expected hue and cry followed, and Watergate has since moderated the President’s original heavy-handedness, there is now a widespread acceptance of the necessity of tightening the government spending belt—hardly the friendliest environment for a bill which would have added over $100 billion to the public purse.

Secondly, the public, while it may not understand the causes and solutions to the economic crisis, intimately understands its impact. While once the consumer worried that health care would exceed his economic grasp, now he has begun to worry about food, clothing, shelter and his standard of living as well. And if it comes down to choosing among these, he wants to make the decision himself, and not have it made for him by the federal government. Consequently, whatever consumer base the Health Security Act may have had has been seriously eroded.

Finally, introduction of the Health Security Act also followed on the heels of a decade of social unrest—urban riots, student protest, marches on Washington—which seemed to call not only for a change in foreign policy, but for significant domestic reform as well. Although it was hardly an organized constituency, these social forces created an environment for domestic reform programs—OEO, Model Cities, Urban Renewal, not to speak of Medicare, Medicaid and Neighborhood Health Centers. Yet by 1974 this movement had virtually disappeared, and with it the reform environment as well.

Facing severe economic obstacles, faltering consumer support and the absence of any social movement, it is hardly a mystery why Kennedy pulled back from the Health Security Act. The only mystery is why there is any momentum whatsoever for national health insurance at the present time. The answer has more to do with the internal maneuverings of Congress and with political opportunism than it does with the needs, sentiments or organization of the health constituency.

While the base may not exist for a more thoroughgoing national health insurance, there is still a felt need, particularly among the middle class, for protection against catastrophic illness. And, of course, this is the narrowest, least expensive need to meet. When the 93rd Congress convened, the Long-Ribicoff catastrophic health insurance measure, sponsored by the powerful Senate Finance Committee chairman, had built up a head of steam. Seeing this, and possibly seeing also an opportunity to deflect Watergate criticism, President Nixon added his weight to national health insurance’s momentum by sponsoring an apparently liberalized, more politically viable version of his former bill. Either sincerely fearing the passage of one of these bills, or seeking a legislative coup prior to the 1976 presidential campaign, or both, Senator Kennedy then withdrew his support for the Health Security Act, sponsoring instead the National Health Insurance Program.

Senator Kennedy clearly felt uncomfortable with the compromises involved, but proclaimed that NHIP “represents a practical embodiment of these principles that can be enacted into law in the next year or two.” NHIP retains two important principles of the Health Security Act which distinguish it from other bills: financing of the bill is entirely public and the measure is compulsory. But it made three probably more important concessions:

- Acceptance of out-of-pocket costs: NHIP incorporates a set of deductibles and coinsurance very similar to, if slightly less than, those in the Nixon bill. Each individual must pay $150 in medical expenses annually before receiving health insurance benefits. Families pay a total deductible of $300 a year (compared with Nixon’s $450). After that, they must pay 25 percent of succeeding costs up to a maximum of $1,000 a year.
For the poor, these out-of-pocket costs are graduated according to income. For this concession, Kennedy reaps for the government several of the assets of the Nixon bill. Out-of-pocket payments (plus a few other measures) will significantly reduce the cost of the bill—both in direct government outlays and in the indirect cost saving stemming from the deterrent effect of out-of-pocket costs on utilization. Consequently, the Kennedy-Mills bill has the same public price tag as the Nixon bill: $40 billion.

The consumer, of course, reaps the flip side of this out-of-pocket coin: These costs will transform the Kennedy bill into one of primarily catastrophic illness insurance, discouraging early diagnosis and treatment (except for children). But more than this, if health care costs continue to rise, as they surely will, these out-of-pocket costs may come to overshadow the benefits of the bill, as has happened under Medicare. (Medicare recipients pay more out-of-pocket costs today than they did in 1966 when Medicare was established.)

- More regressive financing: In a serious step back from the earlier bill, NHIP will be financed entirely by payroll taxes, 1 percent for employees up to $20,000 and 3 percent by employers. There are no additional taxes on income above $20,000, so an executive making $100,000 per year will pay the same amount as a colleague making $20,000. At least in the earlier Kennedy bill 50 percent of all costs came from general revenues (graduated income taxes, industrial tax, etc.), although the rest also came from Social Security-type payroll taxes. In the new Kennedy-Mills bill, the concept of "cost-sharing" is carried to the obscene length that even recipients of welfare and unemployment must pay a 1 percent tax on their income.

- Role of insurance companies: The old Kennedy bill would have eliminated the insurance industry from the national health insurance scene altogether, and this was, no doubt, the source of some of the bill's most serious opposition. NHIP will allow private insurers to act as fiscal intermediaries, receiving the money from the federal government and reimbursing providers, as they presently do under Medicare. Also, Kennedy says, NHIP will allow the insurance industry a profitable business in supplementary insurance—covering initial and other medical expenses not covered under NHIP.

In their role as fiscal intermediaries, the health insurance industry has been primarily responsible for the runaway inflation which took place under Medicare and Medicaid. Not only does it have no vested interest in controlling costs, since it can always turn around and charge the government or the consumer more, but there is reason to think that the health insurance industry may have a positive interest in rising costs. Its profits are not simply related to the surplus of income over expenses, but also to the absolute size of cash flow, since the large sums of money passing through insurance company hands can yield considerable interest even on short-term investments. More than that, Blue Cross, the giant of health insurers (40 percent of the market), has had until recently such strong links to hospitals that many have claimed they constituted a conflict of interest. Under recent public pressure, and probably as a cosmetic job in anticipation of national health insurance, Blue Cross has sought to sanitize, if not break those ties, and has begun to make motions toward cost control and innovations in health care delivery.

But even these criticisms, which pertain to all the bills currently under consideration in Congress, pale beside the chief shortcoming of all national health insurance measures, including the old Health Security Act: failure (Continued on page 10)
<table>
<thead>
<tr>
<th>CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT (Long-Ribicoff)</th>
<th>COMPREHENSIVE HEALTH INSURANCE PLAN (Nixon)</th>
<th>NATIONAL HEALTH INSURANCE PROGRAM (Kennedy-Mills)</th>
<th>HEALTH SECURITY ACT (Kennedy) (For comparison only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUT-OF-POCKET COSTS</strong></td>
<td><strong>ELIGIBILITY</strong></td>
<td><strong>BENEFITS</strong></td>
<td><strong>FINANCING</strong></td>
</tr>
<tr>
<td><strong>Title I</strong></td>
<td>1. Physicians services. 2. Physicians psychiatric services. Title I limited as in Medicare: <strong>Title II</strong>: 5 private visits for crisis intervention; unlimited community mental health center services. 3. Dental services—none. 4. Hospital services. 5. Home health services, unlimited. 6. Inpatient psychiatric care, active treatment, 90 day lifetime maximum. 7. Post-hospital extended care, 100 days/benefit period. 8. Drugs—none.</td>
<td>3. Dental services to age 13. 4. Hospital services, unlimited. 5. Home health services, 100 visits/yr. 6. Inpatient psychiatric care, 30 full days or 60 partial. 7. Post-hospital extended care, 100 days/year. 8. Prescription drugs.</td>
<td>3. Dental services to age 15, to be extended annually. 4. Hospital care, unlimited. 5. Home health services.</td>
</tr>
<tr>
<td><strong>Title II</strong></td>
<td>Uniform benefits for all groups.</td>
<td>Uniform benefits for all groups.</td>
<td>Uniform benefits for all groups.</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET COSTS</strong></td>
<td><strong>BENEFITS</strong></td>
<td><strong>FINANCING</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Title I</strong>: Hospitalization: 60 day deductible, $21/day co-insurance thereafter. <strong>Title II</strong>: No deductible; co-insurance of $3 for first 10 physician visits per year.</td>
<td><strong>Title I</strong>: Deductible: $150/person. $450/family per year; pertains to all services. $50 deductible on drugs. <strong>Title II</strong>: Deductible: $150/person. <strong>Title I</strong>: Co-insurance: 25% (1% employees' payroll tax up to income of $20,000, also 1% of unearned income). <strong>Title II</strong>: 1% employees' payroll tax up to income of $20,000, also 1% of unearned income. 3% employers' payroll tax. 2.5% self employment earnings.</td>
<td><strong>Title I</strong>: Deductible: $150/person. <strong>Title II</strong>: Deductible: $200/person. <strong>Title I</strong>: Co-insurance: 25% (1% employees' payroll tax up to income of $20,000, also 1% of unearned income). <strong>Title II</strong>: 1% employees' payroll tax up to income of $20,000, also 1% of unearned income. 3% employers' payroll tax. 2.5% self employment earnings. <strong>Title I</strong>: Premium share graduated according to income. <strong>Title II</strong>: 50% of total from general revenues. <strong>Title I</strong>: 2.5% self employment earnings. <strong>Title II</strong>: 50% of total from general revenues.</td>
<td></td>
</tr>
<tr>
<td><strong>FINANCING</strong></td>
<td><strong>COINSURANCE</strong></td>
<td><strong>FINANCING</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Title I</strong>: 3% tax on payroll up to annual income of $9,599 paid by both employer &amp; employee. <strong>Title II</strong>: 75% federal through general revenues, 25% state.</td>
<td><strong>Title I</strong>: EHIP; paid for entirely by employer and employee. <strong>Title II</strong>: AHIP; 75% federal from general revenues; 25% state.</td>
<td><strong>Title I</strong>: Medicaid contributions to offset money lost on graduated deductibles, co-insurance maximum liability for poor.</td>
<td><strong>Title I</strong>: Medicare contributions to offset money lost on graduated deductibles, co-insurance maximum liability for poor.</td>
</tr>
<tr>
<td>CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT (Long-Ribicoff)</td>
<td>COMPREHENSIVE HEALTH INSURANCE PLAN (Nixon)</td>
<td>NATIONAL HEALTH INSURANCE PROGRAM (Kennedy-Mills)</td>
<td>HEALTH SECURITY ACT (Kennedy) (For comparison only)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Both programs administered same as Medicare. —Administration by Social Security Administration.</td>
<td>Federal role: administer Medicare, establish benefits &amp; eligibility, approve state plans. State role: administer Govt. Assisted Plan, regulate cost &amp; quality controls, provider reimbursements, insurance company profits.</td>
<td>Will be part of new independent Social Security agency, directly under President.</td>
<td>—5-member natl. board, appointed by the President &amp; confirmed by Senate, under Sec’y of HEW. Duties: general administration, policy, regulation, control of reimbursement, quality &amp; cost. Natl. Advisory Council, 20 members appointed by Sec’y of HEW; consumer majority. Basic administration through regional &amp; local offices. Regional &amp; local advisory councils set up like Natl. Advisory Council. Commission on Quality of Health Care set up in HEW. —Health Resources Development Board will eventually be funded at 5% of national health insurance revenues. Miscellaneous. —Commission on Quality of Health Resources Development Board will eventually be funded at 2% of national health insurance revenues. —Miscellaneous. 1. No role for insurance companies.</td>
</tr>
<tr>
<td><strong>ADMINISTRATION</strong></td>
<td><strong>PAYMENTS TO PROVIDERS</strong></td>
<td><strong>COST AND QUALITY CONTROLS</strong></td>
<td><strong>IMPACT ON OTHER PROGRAMS</strong></td>
</tr>
<tr>
<td>—Miscellaneous 1. Insurance companies will serve as fiscal intermediaries. 2. No provision for consumer input.</td>
<td>—Miscellaneous 1. Insurance companies will serve as fiscal intermediaries for Medicare &amp; probably Govt. Assisted Plan. Will handle Employee Plan entirely. 2. No provision for consumer input. 3. No grievance or appeals provision.</td>
<td>—Health Resources Development Board, will eventually be funded at 2% of national health insurance revenues. —Miscellaneous. 1. Insurance companies will serve as fiscal intermediaries as they do presently with Medicare.</td>
<td>—5-member natl. board, appointed by the President &amp; confirmed by Senate, under Sec’y of HEW; consumer majority. Basic administration through regional &amp; local offices. Regional &amp; local advisory councils set up like Natl. Advisory Council. Commission on Quality of Health Care set up in HEW. —Health Resources Development Board will eventually be funded at 5% of national health insurance revenues. Miscellaneous. —Commission on Quality of Health Resources Development Board will eventually be funded at 2% of national health insurance revenues. —Miscellaneous. 1. No role for insurance companies.</td>
</tr>
<tr>
<td>Title II: must be accepted as payment in full.</td>
<td>Providers paid in full by credit card issued to consumer by govt. or insurance company. Out-of-pocket expenses collected from consumers by agency. Physicians allowed to charge patients under Employee Plan direct fees in addition to what natl. health insurance pays.</td>
<td>Providers paid in full by credit card issued to consumer by govt. or intermediary. Cost sharing collected from consumer by agency.</td>
<td>—Providers must accept national health insurance as payment in full. —Natl. Board determines annual budget, allocates it to regions on per capita basis. —Regional boards subdivide it among categories of services.</td>
</tr>
<tr>
<td>1. Institutions paid on basis of reasonable costs. 2. Individual providers paid on basis of reasonable charges.</td>
<td>1. Institutions paid by prospective reimbursement. 2. Individual providers reimbursed according to fee schedule established by profession, approved by govt. HMO incentive.</td>
<td>1. Institutions paid by prospective reimbursement with incentive for efficiency. 2. Individual providers reimbursed according to fee schedule established by profession, approved by govt. HMO incentive.</td>
<td>1. Institutions paid by prospective budget based on reasonable costs. 2. Individual providers can choose fee-for-service, salary, capitation; incentives provided in underserved areas. HMO incentive.</td>
</tr>
<tr>
<td>Payment subject to same quality, safety, utilization controls as Medicare.</td>
<td>Physician-controlled PSRO review.</td>
<td>Physician-controlled PSRO review.</td>
<td>Establishes Quality Control Commission which sets standards for individual &amp; institutional providers. 1. Hospitals: a) Must have planning agency approval of character &amp; quantity of services for reimbursement. b) Standards similar to Medicare, monitored by states. 2. Physicians: Present MD’s must be state-licensed &amp; meet continuing education requirements; new ones must meet new national standards.</td>
</tr>
</tbody>
</table>
Patient Dumping

The two-class health system usually operates smoothly: people unable to pay for their health care go to public hospitals and stay away from the private sector where they know they are often considered "undesirable." But occasionally these "undesirables" ruffle the waters by showing up at the emergency room of a private hospital. Then the grossest manifestation of the two-class health system is witnessed: patient dumping. This means loading the poor, sick victim into an ambulance or car (or even pointing out the nearest bus stop) and shipping him to a public hospital.

In Chicago, 18,000 persons were turned away from private emergency rooms in 1970; at least 50 died in the course of transfer to Cook County Hospital. (1) The Director of Washington's D.C. General Hospital emergency room testified before a Senate committee in 1970 that 20 patients die each year as a result of transfers from private hospitals. (2) Extrapolating from these figures, 4,000 people can be expected to die each year from patient dumping.

Though patient dumping is well recognized by everyone, few have documented it in detail. This study was done by surveying patient records of every emergency room visit and acute hospital admission at Alameda County's public hospitals for a two-week period in January, 1974. Data were collected on patients who had been transferred (dumped) from other hospitals. These data were analyzed in the context of hospital statistics provided by the County.

Who Gets Dumped?

Alameda County, across the bay from San Francisco, is an urban and suburban area of one million population, with most poverty areas concentrated in Oakland, a city of 400,000. The county has two public hospitals: Highland General Hospital, a typical large urban public hospital in Oakland, and Fairmont Alameda County Hospital, a chronic-care hospital with some acute services such as the emergency room. The rest of the county's 24 short-term hospitals are private, chiefly non-profit.

Transfers constituted 2.4 percent of Highland's emergency room visits and 5.4 percent of Fairmont's, a rate that yields 1,500 transfers annually. The transfers came from 12 hospitals, with two—Herrick Memorial and Washington—accounting for 40 percent of the transfers to Highland, and Washington the source of 35 percent of the transfers to Fairmont.

The vast majority of transfers are medically indigent of Medi-Cal (Medicaid) patients. At Highland, 80 percent were medically indigent and 20 percent Medi-Cal. At Fairmont, 45 percent were medically indigent, 28 percent Medi-Cal, 16 percent private insurance, 9 percent Kaiser, and 2 percent Medicare. Almost all the private insurance transfers had psychiatric, drug or alcohol related problems, and all the patients transferred from Kaiser had psychiatric problems. (Kaiser seldom offers its enrollees mental health care.) The percentage of medically indigent people transferred is far higher than the county hospitals' overall medically indigent load.

Transferred patients are far sicker than the average county hospital patient. Although only 12 to 16 percent of emergency room patients are generally admitted to the county hospitals, 64 percent of the dumped patients required admission. Whereas overall 12 percent of Highland admissions go to the intensive care unit, 25 percent of transferred patients went to intensive care. Among the transferred patients were many with life-threatening diagnoses: a brain hemorrhage, a stroke, a possible heart attack, low blood sugar, three serious head traumas, a drug overdose, a skull fracture, a gunshot wound to the chest, two serious intestinal hemorrhages, three broken legs and a fractured pelvis combined with severe head trauma.

In their paper on patient dumping, Roemer and Mera note that one California county hospital keeps an "Atrocity Book" of patients dumped from private hospitals. (3) The characteristics of the transferred patients seem to be similar to those in Alameda County.

Although the total number of transfers is not large, the impact on the functioning of the county hospitals is enormous. 74 percent of the transfers arrived between 6 p.m. and 2:30 a.m., a time when hospitals are short staffed. The transfers were sicker than the average patient, thus requiring more staff time; fully 20 percent of all Highland intensive care unit patients are private hospital transfers. And most of the transferred patients have no Medicare, Medicaid or hos-
pital insurance at all, thereby constituting a financial drain on the hospital.

Who Dumps?

Why are patients transferred? The 1973 written policy of Samuel Merritt Hospital, a typical Oakland non-teaching private hospital, provides an answer: “Certain categories of patients should be transferred to other facilities for emergency or hospital care when possible or appropriate . . . these categories include . . . Medically indigent [and] . . . Patients for whom Merritt Hospital does not have the facilities and/or staff for proper and safe care of their particular problems, or whose admission to the Hospital would predictably jeopardize the care of other patients in the Hospital.”

At Merritt’s emergency room, a clerk asks patients upon arrival whether they have Medicare, Medi-Cal or health insurance. If not, they are told that a certain amount of cash is required before leaving the premises. Some leave at once; others stay, get treatment and pay. A bill is sent for any outstanding amount, and if not paid, it goes to a collection agency. Except in real emergencies, patients on Medi-Cal must have a Medi-Cal card with a valid sticker (each Medi-Cal patient receives a new card each month with two removable stickers for the two doctor visits to which they are entitled); otherwise they are sent away.

One emergency room (ER) physician at Merritt—a hospital with declining occupancy—says that hospital admissions have increased four percent since the ER opened in 1972. “That’s why they opened it,” he added. The hospital makes money on laboratory tests, X-rays, pharmacy and inpatient services but loses on the ER itself. The hospital bills the ER patients for both hospital and doctor services, then pays the ER doctors $15 an hour plus part of any fees collected over that amount. Thus it is in both the doctors’ and the hospital’s interest that patients pay.

At the point that a patient needs to be admitted, stricter financial screening is done. But the patient seeking admission faces another, equally serious problem: a private doctor must be found to care for him. The Merritt ER regulations state: “Every effort must be made to preserve and protect existing relationships between the private physician and the private patient. Thus every effort must also be made to refer patients to private physicians only when it is appropriate to do so . . . inquiry will be made of every patient presenting at the Emergency Department as to whether or not he has a private primary physician . . . Patients will be considered then as either private or other.”

Private patients are treated only after getting permission from their doctor; it is considered improper to interfere with a doctor’s clientele. But it is equally improper to burden the private doctors who make up the hospital staff with non-private patients. Doctors on hospital staffs are often reluctant to care for the poor, the uninsured, the very sick or anyone who is not their own patient. So both the hospital and doctor conspire to transfer precisely these categories of patients to the public hospital.
Patient Tracking

Patient dumping is only the tip of the iceberg. Most poor, sick and uninsured people are channeled to the county hospital directly, without the benefit of a side trip to the private emergency room. For example, the majority of Highland’s patients (60 percent) come from “poor Oakland,” the core ghetto area of Alameda County. (Poor Oakland has 85 percent of Oakland’s Blacks, 80 percent of its Latinos, 79 percent of its poverty families and 77 percent of its Medi-Cal households. It also has a rate of infant deaths 1.9 times that of the rest of the City and similar statistics pertain for other illnesses.) About ten percent of households in Oakland are medically indigent and 25 percent receive Medi-Cal; yet 25 percent of Highland’s patients are medically indigent and 50 percent are on Medi-Cal. Only eight percent of Highland patients have private insurance and four percent have Medicare; these are the programs that reimburse most lucrative and finance the vast majority of private hospital patients.

One of the key mechanisms for channeling patients is referral. For example, in contrast to legal authorities (police, courts, etc.), which deal largely with individuals unable to pay hospital bills, private employers refer their sick employees to private hospitals. Specifically, in Alameda County, referrals from legal authorities account for 40 percent of Fairmont’s emergency room patients and 22 percent of Highland’s. On the other hand, workplaces refer ten times as many patients to private hospitals as they do to public ones. Not unexpectedly, private doctors refer most of their patients to private ER’s. Private physician referrals make up 30 percent of private ER patients, but only two percent of public ER patients. Public hospitals also tend to get a disproportionate share of psychiatric, drug and alcohol cases. For example, Highland, which only gets 28 percent of all emergency room visits in the northern half of Alameda County, receives 53 percent of all psychiatric referrals, 84 percent of all alcoholic patients and 50 percent of all drug abuse patients in that area. In the southern half of the County, Fairmont, which gets six percent of the emergency room visits, sees 40 percent, 83 percent and 38 percent of these respectively.

Ambulances are another way of routing patients to their “proper” destinations. Alameda County has a private system of ambulances with the ambulance stewards making the decision about ambulance destination 80 percent of the time. The case of Providence Hospital demonstrates how it works. Providence recently opened a 24-hour emergency room to bolster its sagging inpatient occupancy rate. Soon patients who before would have gone to Highland were being shipped to Providence. Whereas nine percent of Highland ER patients were covered by private insurance in 1972 before the opening of the Providence ER, by 1974 these patients had dwindled to three percent. The patients which Highland now gets from ambulances are 33 percent medically indigent, 53 percent Medi-Cal, five percent Medicare, three percent private insurance, two percent police hold and four percent dead on arrival. According to an 18-month study by a University of California anthropologist, Stephen Frankel, “There is an informal system of ambulance triage which is based on a variety of non-medical factors which include patients’ insurance coverage.” The ambulance stewards are treated well by the Providence emergency room; they have a room for coffee, whereas at Highland there are no such amenities. Clearly the stewards play an important role in patient channeling.

In obstetrics, where occupancy rates are particularly low and Medi-Cal reimbursements are high, the creaming off of paying patients by private hospitals is even more glaring. For example, while most pregnant women living in Oakland’s poverty areas went to private hospitals (87 percent), those without health insurance of any kind are forced to utilize Highland’s obstetrics service. Thus Highland receives only the poorest and sickest expectant mothers. About 50 percent are medically indigent or Medi-Cal pending (eligibility uncertain) so that they constitute a financial risk to the hospital—a far higher percentage than that for the rest of the hospital. The workload this entails is considerable.

During a one-week period in April, 1974, seven out of 13 Highland deliveries involved complications, showing the enormously high risk group of mothers that Highland sees. Some of these deliveries were complicated in multiple ways, including three breeches, two markedly premature infants, several cases of fetal distress, one Caesarian birth
and three infants requiring intensive care units.

Of course all of this shuffling of patients is shaped by the amalgam of different needs and interests of the particular private hospitals involved. Hospitals such as private Samuel Merritt, which are staffed predominately by private doctors, have neither the need nor the interest to hospitalize patients without a private doctor (or at least not until their occupancy rates tailspin). On the other hand, hospitals with housestaff teaching programs (only 16 percent of all hospitals, but the largest and most important hospitals), like Children's or Herrick, require patients as "teaching material." And the best "teaching patients" are those who can pay but whose bill is financed by public monies. These patients (e.g., Medi-Cal) are not a financial drag on the hospital, and because they must be grateful for being admitted to a hospital, even with public health insurance, they are in no position to decry their exploitation. Thus 62 and 30 percent of Children's and Herrick's ER patients are on Medi-Cal, whereas only six percent of private Alta Bates Hospital's ER patients are on Medi-Cal.

The rejection and exploitation of poor patients by both private doctors and hospitals is old and well documented. Nor has Medicaid, which was supposed to give the poor access to private sector medicine, remedied the situation. (See article on Medicaid, page 11 this issue, and BULLETIN, July/Aug. '72).

In New York City, four percent of the doctors collect 85 percent of Medicaid fees. (4) A 10-year survey of welfare recipients in New York, entitled "Medicaid Benefits Mainly the Younger and Less Sick," reveals that the aged and disabled receive less care after Medicaid than before its enactment, concluding, "There are considerable limitations to the extent to which money alone will cure the health care ills of the urban poor." (5)

In Washington, D.C. less than one of three private doctors participate in Medicaid. (6) In Rochester, a study showed that declines in Medicaid reimbursement "led many private practitioners to withdraw from the program" (7), and similar observations have been made in other states. In Chicago, 100 of 9,000 physicians care for over one-half of the 275,000 Medicaid patients, with Cook County Hospital treating half of the County's Black people. (8) The same discrimination is practiced by hospitals, unless Medicaid reimbursements are unusually lucrative or the hospital is in unusually desperate financial straits. In New Orleans, seven out of nine hospitals were sued for denying access to Medicaid patients. (9) In Ohio, 45 percent of Medicaid payments go to 15 hospitals, a mere four percent of the total hospitals in the state.(10)

In Cook County (Chicago) 14 out of 95 hospitals account for 67 percent of the Medicaid payments to hospitals; most of these 14 hospitals are major teaching institutions. Cook County Hospital receives fully 22 percent of the county's payments. In one low-income neighborhood of Chicago 55 percent of Medicaid patients have to travel outside the area for hospital care because six of the seven neighborhood hospitals see few Medicaid patients. The administrators of the seven hospitals report that "Even if a person were able to demonstrate Medicaid eligibility at the time he sought service, the hospital may not have enough house physicians to provide the needed care if the patient had no private physician of his own." (11)

If Medicaid patients have few options, medically indigent patients have even fewer. Anne Somers, nationally recognized spokesperson for private hospitals, states, "The provision of free care is a disappearing phenomenon." (12) The Wall Street Journal (August 8, 1972) asks, "Does tender loving care end at the cashier's window?" and answers, "Nearly all hospitals require evidence from patients as to their ability to pay the bill."

Perhaps the most revealing case study of private hospital behavior is the response to the 1946 federal law requiring that hospitals receiving Hill-Burton construction funds (about half the nonprofit hospitals in the country) must provide a "reasonable volume" of free or below-cost service to people unable to pay. (13) For years the hospitals did not comply at all. Following a recent series of law suits, they fought tooth and nail to minimize the amount of free care by weakening federal and state regulations. At present, most state Hill-Burton agencies have either failed to promulgate regulations on the matter or have issued illegal provisions favoring the hospitals. (14)

In late 1973, the US District Court in Washington, D.C. declared that the Internal Rev-
The suit was filed on behalf of a number of organizations across the country and charged that nonprofit hospitals are dumping poor patients into overcrowded and underfinanced public hospitals. One example cited occurred in Prestonburg, Kentucky, where a 21-year-old woman in labor was denied admission to Prestonburg General Hospital because she couldn’t pay a $250 deposit. The woman died shortly after childbirth. Immediately following the 1973 court decision, the American Hospital Association petitioned for a rehearing of the case. Though the court has just denied the petition, the plaintiffs expect further maneuvering by the AHA to annul or limit the effects of the decision.

Patient dumping and patient channeling are but blatant and subtle aspects of the same phenomenon—the channeling of patients by private hospitals so that the profitable ones come to them (profitable financially or in terms of teaching potential), while those who are unfunded or socially undesirable get shunted to public hospitals. The existence of this phenomenon means that financing mechanisms, a la national health insurance, are not enough to guarantee care for everyone in the private sector. As long as private doctors and hospitals are allowed to pick and choose their clients (which after all is one characteristic of being private), a significant minority of Americans will be denied access to care.

—Barry Roth (Dr. Roth is an intern at Highland General Hospital in Oakland, California.)

References
7. Roghmann, K.J. “Use of Medicaid Payment Files for Medical Care Research” Medical Care, February, 1974.
15. Schwarts and Rose, op. cit.

Kennedy-Mills
(Continued from page 3)

to at least recognize the need for the restructuring of the health system. For as long as the bulk of every health care dollar goes not for the delivery of health services, but for the profits of drug, insurance and hospital supply companies and the academic, teaching, expansion and other non-patient priorities of health care providers, consumers cannot expect their health care to improve with any national health insurance measure. Indeed, to the extent that national health insurance bills beef up financing without speaking to these issues, they result in the redistribution of income—from workers and the American public to those who profit financially and professionally from the delivery of health care. Maybe some inkling of this perception accounts for why the present interest in national health insurance is coming primarily from the latter group and not from workers and consumers.

—Ronda Kotelchuck

More on National Health Insurance

WHO WILL PAY YOUR BILLS?

A detailed analysis and an overview of the issues—includes supplement on Kennedy-Mills, Long-Ribicoff, and new Nixon Bills. 30 pp. $.50 apiece; $.30 apiece for ten or more.

A CONSUMER CRITIQUE OF NATIONAL HEALTH INSURANCE

A quick way of getting a grasp on key issues, updated to include new versions of all major bills. 8 pp. $.10 apiece.

Write: Health/PAC 17 Murray St. New York, N.Y. 10007

Add 20% for postage ($0.10 minimum)
Medicaid Mills

What is exhilaratingly revolutionary about Medicaid is neither the program's more generous enrollment of the medically indigent, nor even its delightful smorgasbord of comprehensive health services. No, Medicaid's critical innovation lurks elsewhere—in its exclusively assigning to the Health Department the heady tasks of standard setting, surveillance, and enforcement of quality in every aspect and every locus of publicly funded, personal health care.

—Dr. Lowell E. Bellin
Former Executive Medical Director, Medicaid
New York City Department of Health
At American Public Health Association convention, Nov. 1968

Mrs. Gloria King went to the Davidson Medicaid Building for treatment of migraine headaches. She saw a doctor. "He told me to stop taking the birth control pill I was using. Then he referred me to a podiatrist." The podiatrist took X-rays of her feet and diagnosed the cause of her headaches as ingrown toenails. He removed the toenails from both her big toes and Mrs. King has been in pain ever since. Nine years after the inception of the Medicaid program, Mrs. King and other patients in the Bronx have tired of waiting for Dr. Bellin's 'exhilarating revolution.' They have joined the Morris Heights Ad Hoc Committee for Better Health Care.

Since the beginning of the Medicaid program in 1966, newspaper reports documenting instances of malpractice and outright fraud at neighborhood Medicaid clinics have made headlines. From time to time, local health and welfare officials have announced new programs to curb abuses. But the Morris Heights Committee is the first to attempt to organize patients to challenge such abuses.

Medicaid Financing

The problems of neighborhood Medicaid clinics stem from the way New York City finances medical care for the poor. Last year the City reimbursed providers $1.3 billion. Three-quarters of this impressive sum went to hospitals and nursing homes. Only eleven percent, $145 million, was paid to private doctors, dentists, podiatrists and optometrists.

Most Medicaid payments for ambulatory care are on a fee-for-service basis—the more patients seen, the more money received. In New York City Medicaid pays private doctors $7.40 for the patient's first visit and $6.00 for every visit thereafter. In contrast, outpatient clinics (OPD) at voluntary hospitals are typically reimbursed at more than five times this rate (see chart). For example, Montefiore Hospital in the Bronx is paid $40.24 for each visit and Mount Sinai in Manhattan $46.66. True to form, the municipal hospitals receive a lower rate than most voluntaries ($33.71), although much more than the private doctors. Thus Medicaid's ambulatory program is primarily a funding mechanism for hospital outpatient departments, helping them to cut their losses on outpatient care. At the same time, though, it does provide a way for a few doctors willing to practice bad medicine in poor neighborhoods to reap a financial windfall.

Medicaid Mills

These inequities in reimbursement schedules when combined with a fee-for-service system produce Medicaid mills—privately owned, profit-making neighborhood health facilities. The system puts a premium on quantity, not quality. A solo practitioner who must pay all of his costs from Medicaid payments—rent, equipment, salaries, etc.—can hardly be expected to deliver decent care at the rates currently in effect. A Medicaid doctor would have to see over 10,000 patients a year to earn a salary of $40,000 per year.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Israel Medical Center</td>
<td>$44.69</td>
</tr>
<tr>
<td>Flower and Fifth Ave. Hospital</td>
<td>63.38</td>
</tr>
<tr>
<td>Mount Sinai Hospital</td>
<td>46.66</td>
</tr>
<tr>
<td>Montefiore Hospital</td>
<td>40.24</td>
</tr>
<tr>
<td>Roosevelt Hospital</td>
<td>50.41</td>
</tr>
<tr>
<td>St. Vincent's Hospital</td>
<td>41.64</td>
</tr>
<tr>
<td>Presbyterian Hospital</td>
<td>30.89</td>
</tr>
<tr>
<td>New York City Municipal Hospitals</td>
<td>33.71</td>
</tr>
<tr>
<td>Medicaid Clinics</td>
<td>7.40</td>
</tr>
</tbody>
</table>

State of New York—Dept. of Health Memorandum
Series 72-10

11
the average for a US doctor. As a result, doctors cut costs by turning to group practices in poor neighborhoods, which in turn become Medicaid mills (see BULLETIN, July-August 1972).

Medicaid mills are usually organized by one or two enterprising individuals who buy or lease a building, often a storefront, and rent space to other practitioners. In some cases the tenants pay a fixed monthly rent, as is customary in New York City. But, typical of the spirit which permeates these operations, many landlord-doctors charge rents on a sliding scale based on the number of patients their tenant-doctors see. The more patients seen or recruited, the lower the rent.

Another way Medicaid doctors increase their income is through a practice graphically called "ping-ponging." One doctor in a clinic refers a patient to another, whether the referral is medically necessary or not; the second doctor then sends the patient back and so on. This practice of I’ll scratch your back, you scratch mine drives up the volume of patient visits, resulting in Medicaid money for the doctors and many unnecessary appointments for the patient. For example, in the Bronx, nearly every patient entering the Davidson building, regardless of complaint, was sent to the podiatrist.

Medicaid patients use these facilities because they are all that is available to them. Only 2,000 of the 19,000 practicing physicians in New York City earned any appreciable amount of income from Medicaid (see chart). Nearly all of these doctors practice out of one of the 362 profit-making neighborhood clinics. Of these doctors, 280 (about 10 percent) made over $50,000 last year from Medicaid alone.

**Physicians in N.Y.C. Receiving Substantial Amounts From Medicaid, 1973**

<table>
<thead>
<tr>
<th>Number</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>580</td>
<td>$ 5,000-$ 10,000</td>
</tr>
<tr>
<td>560</td>
<td>10,000- 20,000</td>
</tr>
<tr>
<td>567</td>
<td>20,000- 50,000</td>
</tr>
<tr>
<td>220</td>
<td>50,000-100,000</td>
</tr>
<tr>
<td>60</td>
<td>over $100,000</td>
</tr>
</tbody>
</table>

New York Medicine March, 1974, page 96

cult to reach. Thus, because the neighborhood falls between the cracks of the City’s public hospital system, it is ideally situated for the establishment of private Medicaid clinics. Twelve have now sprung up.

In March 1973, the Morris Heights Improvement Association, a coalition of block associations and tenants groups, formed an Ad Hoc Committee to investigate the practices of Medicaid offices. The group was composed of eight people, four of whom were Medicaid patients. One full-time paid organizer from the Improvement Association, Roger Hayes, was assigned to work with them. Surprisingly, their first task was to identify the clinics in their area, a difficult chore because storefront offices are not licensed as group practices (they are called "shared facilities" by the Health Department) and practitioners often have separate billing addresses elsewhere. Even the Health Department does not have a complete list of these facilities.

The Ad Hoc Committee, after locating the eight clinics then in operation, finding out the doctors' names and specialties, their hours and equipment, began interviewing patients: "Do you know what you are being treated for? What drugs were you given? Why? Did you see more than one doctor? Do you know why? Does the clinic keep a record of your health status?" Within two months, the Committee had generated enough community interest to hold a public meeting.

**Patients Testify**

Two of the local clinic doctors/administrators were invited to the meeting to hear the testimony of their patients. They hesitated, but when the Committee threatened to picket their storefronts, they came. The complaints they heard included:

- Unnecessary referral from one doctor to

---

**The Morris Heights Ad Hoc Committee**

Within the last half dozen years Morris Heights, a neighborhood in the Bronx, has changed from middle-class Irish and Jewish to predominantly Third World—45 percent Puerto Rican and 45 percent Black. A substantial minority of the residents are welfare recipients and slightly more are covered by publicly-funded health programs (Medicaid and Medicare). The 45,000 people of Morris Heights are served poorly by two municipal hospitals, Fordham and Morrisania. Both hospitals are badly deteriorated and diffi-
another (ping-ponging). Mrs. Peggy Pierson went to the Davidson Avenue Center for a backache. "They suggested plastic surgery for my nose. Then they wanted to check my feet, my eyes, the whole works."

- Endless visits for specious medical problems. Mrs. Rose Ann Frey was told to come back every three weeks to have her "tilted uterus" examined.

- Patients poorly examined and given inappropriate drugs. Mrs. Angie Reyes took her son to the University Avenue Medical Group. Dr. Malba examined the child quickly, diagnosed a bad cold and prescribed ampicillin. Since he did not get better, Mrs. Reyes took Daniel to Columbia-Presbyterian Hospital. After a spinal tap, he was found to have spinal meningitis. He was admitted to the hospital and stayed ten days.

- Incomplete or nonexistent medical records. Mrs. Sally Williams was being treated at the Davidson Avenue clinic for asthma. The same drug was given to her a second time although she had gone into anaphylactic shock after the first administration. "The next thing I knew, I woke up in the Fordham Hospital emergency room."

- Non-Medicaid patients charged high fees for non-service. Mr. Henry Leisin went to the University Avenue Medical Group to take care of a mole on his face. The clinic manager collected $15 from Mr. Leisin before he saw a doctor. The visit with the doctor lasted less than one minute. He was referred to Bronx-Lebanon Hospital. On his way out Mr. Leisin asked for a receipt. The manager resisted, saying, "You don't want a receipt." Mr. Leisin left in disgust.

The two doctors present at the meeting were asked to sign an agreement which specifically prohibited the above practices, most of which in any case violate Medicaid regulations. They balked and agreed to sign only if the other clinics in the neighborhood did likewise. By mid-July, the Committee had coerced and cajoled seven of the eight clinics into signing. The one recalcitrant clinic was picketed.

Fundamental to the Committee's strategy was the notion that the clinics were basically business ventures and vulnerable to the same tactics used to influence other neighborhood businesses. Because there were so many clinics in close proximity in Morris Heights, the Committee could exploit competition between them for the patients' benefit. Picketing was viewed as a way of putting economic pressure on the non-complying clinic. People entering the storefront were asked to boycott it and take their Medicaid business elsewhere. This strategy is, of course, of limited value if none of the available facilities are delivering decent care.

The New York City Department of Health, which had initially encouraged the Ad Hoc Committee, sent medical auditors to check out the clinics. This was pursuant to their responsibility "to develop and maintain a sys-
tem of continuing review of the quality and extent of care provided Medical Assistance [Medicaid] recipients" (New York State Medical Handbook). The City Health Department, however, does not have the capacity to audit Medicaid facilities on a regular basis. In fact, it can only perform two audits a week on New York's 362 Medicaid clinics. So, teams are sent out only in response to specific complaints, such as those from Morris Heights.

The auditors found the services in Morris Heights to be about average for such facilities—a devastating comment on the quality of such clinics. Copies of the audits were turned over to the Committee. The Health Department report cited such violations as cockroach infestation, "prescribing in small amounts so as to increase the number of patient visits," illegible and incomplete medical records and "unnecessary referrals."

With the Health Department audits in hand, the Ad Hoc Committee went to see the administrators of several of the clinics. They accused the doctors of violating the agreements signed with the Committee since the audits clearly documented the continuation of abuses. They threatened these clinics with picket lines if the violations were not corrected. Only one of the clinic administrators refused to see the delegation. All of the others cleaned up their clinics and eliminated some of the more glaring conditions. The storefront which refused to discuss the situation with the Committee was picketed every Saturday for several months. In addition, the suburban homes of two of the doctors were picketed and leafletted.

Later on, the Committee investigated collusion between some of the storefronts and local pharmacies. First they surveyed drug prices. They found enormous discrepancies in prices which seemed related to the location of Medicaid mills. For example, forty 250 mg. tablets of ampicillin cost $16.95 in a drug store adjacent to a Medicaid office and $3.50 at a store further away.

The drug price survey and other informational leaflets were distributed to people entering and leaving Medicaid offices. One entitled "How Good A Patient Are You" encourages patients to ask for comprehensive and continuous care. For example it questions, "Do you ask to see the same doctor on every visit? If the doctor tells you to return to the clinic, do you know why? Do you make sure that the doctor knows your complete medical history?" Other leaflets were information and evaluation sheets for patients to use as a basis for judging the quality of care they were receiving.

One Year Later

By March, 1974 the Morris Heights Committee concluded that their strategy of patient education and pressuring clinics with Health Department audits and picket lines was not enough. They felt they had made some inroads into the Medicaid situation and that community people looked to them as a watchdog and complaint bureau. One of the organizers commented that "At least the people identified with the Committee are getting better care. They think twice now about ripping off patients." But, they felt services delivered in storefront clinics were still not very good and could not be made better without the intervention of other forces. They called another public meeting to chart their future course. The group demanded that the Health Department, which had sent representatives to the meeting, follow up its audits and impose sanctions on clinics found in violation of standards of good medical practice.

Dr. Lowell E. Bellin, New York City's recently appointed Health Commissioner, contends that he does not have the statutory authority to enforce standards of care. He tempers this legal assessment with political hesitancy. "We want to put pressure on sufficiently so we can reform them, if we put too much pressure we can drive them out completely." It is difficult to tell if Dr. Bellin is more concerned about his legal limitations or considerations of political realities. His recent action ordering the Bureau of Standards and Evaluations to stop distributing audit reports to community groups leads one to believe that the "problem" is a political one.

Paul Brandt, chairman of Bronx Community Planning Board 5 and an active supporter of the Ad Hoc Committee, feels Bellin is side-stepping the issue. "The Health Department has a statutory responsibility as administrator of the Medicaid program to assure that the services are of good quality. Besides being a public health menace, the Medicaid mills are a tremendous drain on the taxpayer." The Ad Hoc Committee does not believe that the Health Department has brought all of the authority it currently pos-
sesses to bear. Bellin’s argument might or might not be accurate, but the City has never behaved in a way to test it out. Despite its rhetoric of good intentions, the Health Department has had only minimal impact on Medicaid mills—witness the audit which found the Morris Heights clinics on a par with other Medicaid practices.

The Ad Hoc Committee does agree with Bellin that some new and strengthened regulations are needed, and they have joined him in lobbying in the State Legislature and City Council. They see this as a major focus of their current program. Some of the changes proposed included expanding the legal definition of group practices so Medicaid mills fall under customary licensing requirements, limiting the number of patients a doctor can bill (currently the City will reimburse for up to 50 patients a day), prohibiting rent agreements based on the number of patients seen, requiring facilities to maintain central records and increasing the penalties for non-compliance.

Of course, all of these changes may be fine, but they are dependent upon the ability and willingness of the Health Department to enforce standards and penalize violators. Dr. Bellin before becoming Health Commissioner was Executive Medical Director of New York City’s Medicaid program from 1967 to 1972. A few practitioners were prosecuted for fraud and some claims were disallowed. But for the most part his track record in that job does not inspire confidence in the idea that if a few laws are changed, giving the Health Department more power, Medicaid patients would get better care.

For the time being the Ad Hoc Committee has hitched its star to Bellin’s legislative program. Their experience with the Health Department before Bellin’s installation was one of close cooperation. But under Bellin, the Department seems to have a different agenda and is responding to political pressures often inimical to consumer interests. The reform of Medicaid mills is not high on the agenda of the Health Department. Of course, public agencies have never been adverse to using community struggles to their own ends. And Bellin has openly advocated this position. In speaking of community boards he said: “In the 1970’s one can hardly begrudge the poor the indulgence of serving on boards. . . . The experienced administrator should theoretically be able to work quite comfortably within the mandates of the board’s broad policy and claim quite accurately that he is responsive to the will of the community.”

—Barbara Caress

Media Scan

MARCUS WELBY ET AL

Television medical shows reach more people than any other source of health care information. TV medical miracle workers show up on three prime-time shows, two daytime soap operas and three non-prime time evening shows. Like their companion video shows their primary function is not to inform, or even to entertain, but to provide America’s businesses with convenient access in a supportive setting to a large number of consumers.

The supportive setting goes beyond the use of medications on a medical show to reinforce the message of commercials for over-the-counter drugs. Advertisers, and therefore producers and networks, need to present viewers with programs that idealize the economic and social systems from which they profit. In the medical arena this means that television’s version of medical care is intensely personal, of high quality and readily available to all who need it. The doctor—invariably white and male—is deified, while other health workers—mostly female and Third World—are relegated to trivial and subservient roles.

The oldest and most popular of the prime-time doctor shows is ABC’s “Marcus Welby, M.D.” Welby is a greying, paternal family physician, who, with his young assistant,
Stephen Kiley, runs a lucrative practice out of their shared home-office. Most family doctors are largely occupied with administering physical examinations and vaccinations and treating sore throats and broken bones. The Welby-Kiley team, on the other hand, spends most of its time treating an enormously diverse range of rare medical maladies—Hodgkin's disease, an exotic heart ailment caused by an African insect and a rare fatal disease found only in Jewish children, to name a few.

Treating this range of medical problems takes up most of the doctors’ waking—and even sleeping—hours. In one episode, Welby spends the night in his patient's hospital room just to be on hand should a complication develop. Young Kiley is constantly standing up his current girlfriend for the sake of a patient, smiling and shrugging it off as the price a doctor must pay in the service of his patients. In their rare leisure hours Welby and Kiley are usually found reading medical journals in their living room.

Working and socializing flow together in the shows. Most of the patients are personal friends of the doctors or become so by the end of the hour. Many episodes deal with the medical problems of Welby’s neighbors in his plush suburban neighborhood, thus giving Welby the opportunity to be a good friend and neighbor while being a good doctor.

“Medical Center” is the CBS version of hospital-centered health care. Although 90 percent of hospital workers are not physicians, most of the program’s footage centers on a doctor star, Dr. Joe Gannon, a young athletic surgeon sporting skin-tight scrub clothes. Dr. Gannon emerges as the Renaissance man of modern medicine—an accomplished cardiovascular surgeon, neurosurgeon, thoracic surgeon, internist, gynecologist, pediatrician and head of the Student Health Service as well.

Much of Gannon’s clientele, like Welby’s, consists of personal friends in need of special hospital treatment. Also like Welby, Gannon thinks nothing of giving his patients unique personal attention. In one episode the patient is a poverty-stricken elderly woman, suffering from a fatal disease, who wants to conceal her downtrodden status from her visiting daughter. Nothing beyond the call of duty for Dr. Gannon, he cheerfully pays for a new wardrobe and the services of a beautician and then puts up the patient in his apartment for a week, while he camps out on the couch in his hospital office.

One would never guess from watching “Medical Center” that 10,000 Americans died each year from unnecessary surgery. Surgery is frequently and expertly performed. The patient never suffers complications and is always cured. The fallacious idea that surgery is frequently necessary and always a life-saving grace is thus perpetuated and reinforced.

Fees and hospital bills, in fact, are rarely mentioned on TV medical shows, even when the treatment being portrayed is a kidney transplant which in the real world costs about $16,000. What mention there is of the cost of medical care—which is the leading cause of bankruptcy in the United States—is vague and cursory.

When a young woman asked Marcus Welby about how she
Dear Health/PAC:

Advocacy journalism performs a worthwhile function for the public. However, when such journalism relies mainly on conjecture rather than facts, readers can be confused and misled. The October article "As the National Goes, So Goes Boston," concludes that Boston would like to join other American cities in pulling out of the hospital business completely. This conclusion is drawn from three decisions made by the Board of Health and Hospitals in early 1973: (1) reduce the capacity of Boston City Hospital (BCH) to 500 beds; (2) give Boston University Medical School (BU) sole responsibility for medical staffing; and (3) reduce the hospital employment level consistent with the expected number of patient days under the new arrangement.

Since the advent of Medicare and Medicaid, BCH has been under-utilized. As the data in Table 1 indicate, bed capacity had been lowered several times prior to the 1973 decision. Moreover, the table shows that occupancy has remained around 76 percent of capacity even as that capacity was being reduced. In 1972, though BCH had a count of 817 beds, it utilized only 572 on the average. Thus, the reduction in beds to 500 combined with efforts to better utilize those beds has resulted in a relatively small effect on the number of patients admitted to the hospital. To survive, BCH must operate at 85 percent of capacity or higher. We feel that at 500 beds this is now possible.

Tighter bed limitations have resulted in the transfer of some patients to other hospitals when occupancy limits have been reached, primarily in the medical service. On 60 occasions in the past 8 months, transfers have been made with no risk to the patients involved. The article incorrectly states that "A majority of admissions are on the danger list and cannot be transferred out." Of course, danger list patients are not transferred, but the fact is that only about 12 of the 50 admissions per day are danger list. Beds are always left open for possible danger list patients.

The BCH policy in relation to medically indigent patients has not changed. The City still accepts the responsibility of caring for patients who are unable to pay. This does not mean, however, that the other Boston hospitals have no responsibility at all. They must also provide reasonable levels of free care.

Hospital staffing must relate directly to utilization. As the accompanying table indicates, utilization has been declining steadily since 1968. During the same time, the number of hospital employees had been increasing. Controls on employment levels are now required if for no other reason than the tight economic squeeze in which the City finds itself. Hence, the Board had no choice but to push for a reasonable staffing pattern and greater efficiency.

Increased efficiency was also a major factor in the decision to give BU sole responsibility for medical staffing. Boston University was chosen over Tufts and Harvard for several reasons. Boston Uni-
University shares with BCH a strong commitment to the community served by Boston City Hospital. Boston University already had medical responsibility for more than 50 percent of BCH's beds. And BU was the logical choice geographically.

The article also contained the implication that Boston's Mayor is insensitive to the problems the poor have in getting medical care. Nothing could be further from the truth. Since Mayor White's first election in 1968, his administration has taken leadership responsibility for developing a city-wide system of neighborhood health centers with strong hospital back-up. A community dental program has been developed. Many other community health projects have been initiated to improve the health of Boston's poor and non-poor alike. Mayor White and all other big city Mayors are worried about where they are going to continue to get the money to pay for health care that is rightfully the Federal Government's responsibility. But until the President and Congress act, we will meet our health responsibilities in Boston to the best of our ability.

—Leon S. White, Ph.D.
Commissioner of Health and Hospitals
City of Boston

### Media Scan
(Continued from page 16)

was to pay for his care of her son, he ended the discussion with "We can work something out." When a script had one of Welby's associates commenting, "I'm sorry to say that many of those who need insurance most don't have it," the line was censored by the network's AMA consultants before the episode reached the air. The present health care delivery system is thus legitimized by the implication that television-quality health care is readily available regardless of social class.

Third World people rarely appear on the medical shows, either as doctors, a fact that does bear a relation to reality, or as supportive health workers—an omission that is grossly misrepresentative of reality. Black patients occasionally appear, almost invariably suffering from sickle cell anemia, as if more common medical inflictions are only visited upon whites.

Women, when they appear, are typically portrayed in a manner that denigrates their role in the provision of health care. (Some 70 percent of all health workers are women, and nurses are frequently the workers most directly involved with on-going patient care.) Dr. Welby's nurse, Consuelo, for example, spends most of her time on camera doing paperwork and engaging the patients in small talk. Women doctors, when their existence is acknowledged, are characterized in ways that make their gender more important than their profession. In one "Medical Center" episode, a female surgeon is forced to leave her profession because it does not allow her enough time with her husband and family. A male surgeon in a later episode, on the other hand, divorces his wife rather than sacrifice his profession. Men, in other words, are justified in being totally dedicated to their profession, while women must ultimately be loyal to their marriage and family.

Fantasy may make for good entertainment. It may even sell deodorants. But the contradictions between health care on television and health care in the real world are too great for the TV medium to successfully sell the proposition that all is well with American medicine.

—Written collectively by students at Theme House in Community Health at the University of California, Berkeley

<table>
<thead>
<tr>
<th>Year</th>
<th>Personnel</th>
<th>Beds</th>
<th>Census</th>
<th>Personnel/Bed Ratio</th>
<th>Personnel/Census Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>3569</td>
<td>1132</td>
<td>750</td>
<td>3.15</td>
<td>4.70</td>
</tr>
<tr>
<td>1969</td>
<td>3697</td>
<td>998</td>
<td>691</td>
<td>3.70</td>
<td>5.35</td>
</tr>
<tr>
<td>1970</td>
<td>4145</td>
<td>835</td>
<td>644</td>
<td>4.96</td>
<td>6.43</td>
</tr>
<tr>
<td>1971</td>
<td>3880</td>
<td>757</td>
<td>625</td>
<td>5.12</td>
<td>6.20</td>
</tr>
<tr>
<td>1972</td>
<td>4157</td>
<td>817</td>
<td>572</td>
<td>5.08</td>
<td>7.26</td>
</tr>
<tr>
<td>1973*</td>
<td>3644</td>
<td>658</td>
<td>480</td>
<td>5.18</td>
<td>7.53</td>
</tr>
<tr>
<td>1974</td>
<td>3287</td>
<td>500</td>
<td>420</td>
<td>6.57</td>
<td>7.82</td>
</tr>
</tbody>
</table>

(*) Personnel and bed figures are averaged for greater accuracy at beginning and end of year.)
Vital Signs

MIDAS TOUCH IN REVERSE

Nothing ever seems to go right for President Nixon. Remember the Cedars of Lebanon Hospital in Miami, that paragon of the nation’s “great private health care system” whose $75 million new wing President Nixon dedicated in February?

What hospital officials didn’t say in the dedication ceremony was that on that very day, the hospital was two weeks late on mortgage payments of some $98,000 and had sustained operating losses of over $600,000 in the previous year.

In early April the hospital’s director and board chairman were both fired for financial mismanagement and the hospital went into federal bankruptcy court to have its debts frozen. The hospital’s debts total more than $9 million, including over $500,000 owed the Internal Revenue Service for employee withholding tax.

Miami officials never thought the Cedars of Lebanon was a paragon of anything except runaway expansionism. They opposed its expansion from the beginning, arguing that by 1975 Miami is expected to have a surplus of 4,000 hospital beds (out of a total of 12,000). The hospital went over their heads to the regional Federal Housing Authority (FHA) office and to Washington, and now connections with Nixon aides Bryce Harlow and James Cavanaugh are being mentioned. The head of the regional FHA office is now in jail for accepting bribes in another case, and a Senate investigating committee is about to descend on the Cedars of Lebanon, looking, among other things, for links between the hospital and Presidential confidant Bebe Rebozo’s Key Biscayne Bank. Maybe the Cedars of Lebanon is a paragon of more than we at first thought.

SEXUAL DISCRIMINATION IN HEALTH INSURANCE

Women get sick at an equal, if not lower, rate than men, yet they pay more for health insurance benefits, and suffer job discrimination as a result. So says a recent report of New York’s Temporary State Commission on Living Costs and the Economy.

Labor Department statistics show that men lost an average of 5.1 days of work due to sickness and injury in 1971, compared to 5.2 days for women, which included time off for childbirth and complications of pregnancy. Women’s illnesses kept them away from work for shorter periods than did men’s. These findings are confirmed by a study Metropolitan Life Insurance Company did of its own workforce. It found 88.7 of every 1,000 men were hospitalized during 1972 compared to 76 of every 1,000 women. Furthermore, hospital stays averaged 9.5 days for men and 9 days for women.

Yet women pay substantially more for the same health insurance policies than men. For example, a five-year accident and sickness plan for men costs $496.70. Women of the same age and occupation pay $762.80. Similarly, a one-year sickness and accident plan costs men $320 and women $496. These inequalities were found in plan after plan, and are even more striking in the case of low-income wo-
men. The result is employer discrimination against the hiring of women, the report finds.

Much of this discrimination lies in the attitude that women work by choice and out of personal convenience, rather than out of necessity as do men, states the report. Yet it finds that 41 percent of the women who work are single, widowed, divorced or separated, and another 21 percent have husbands who earn less than $7,000 a year.

The New York Civil Liberties Union is filing a class action suit against the New York Insurance Commissioner Benjamin Schenck to halt such discrimination.

GETTING PATIENTS WHOLESALE

Southern California, that cradle of the new capitalism, has pioneered a new solution to the problem of empty hospital beds, reports New Times Magazine. It’s called patient buying. The going rate is apparently $50 to $100 per patient, although there are reports of hospitals offering doctors stocks, vacations, cars and free lab and X-ray work.

The source of the practice lies in Los Angeles County’s 32,230 hospital beds—10,400 of which are vacant. Many of these are in newly-built proprietary institutions which lack the reputation, staff or facilities to attract doctors voluntarily.

There are no statistics on exactly the number of patients bought and sold each year, but everyone involved admits the practice is widespread, not only in Southern California, but across the country. Said one patient “seller,” “Name me a major city with proprietary hospitals that have overbuilt, and I’ll guarantee you it’s a place where patients are bought and sold. In New York City doctors get cash, autos, vacations and other gratuities from proprietary hospitals in exchange for regular deliveries. In Miami I know of physicians who deliver all their patients to one hospital in exchange for $3,000.”

The practice is also sophisticated. Many doctors work through brokers who search among hospitals for the highest bidder. Most patients come from private practice, but some of the biggest suppliers own or operate private emergency rooms. Hospitals often employ publicists or consultants who work on a retainer or commission basis. Named in the article are some of the nation’s largest proprietary hospital chains—American Medical International, the Los Angeles-based Century Medical, Inc. and the Seattle-based chain, Centennial Villas.

“As long as these profit-oriented firms persist in overbuilding, hospitals will continue buying patients. It’s strictly a matter of survival. The doctors involved couldn’t be happier. They’ve found a recession-proof business that just happens to be tax free,” says one broker.

CHARITABLE INSTITUTIONS MUST BE CHARITABLE?

Poor people may have won a potentially significant court victory recently. A federal district court in Washington in December ruled that to continue to qualify for tax exemption (under IRS Code, Section 501 (c) (3)), hospitals must give free care to “patients in need of hospital care who cannot pay.” In January, the court extended this ruling to require hospitals to post such a notice “conspicuously” within the hospital so all patients can read it. It also ruled that the provision of free care cannot be limited to emergency services, although additional guidelines are as yet unclear. The suit was brought by the Kentucky Welfare Rights Organization, the Association of Disabled Miners and Widows, the National Tenants Organization and individuals against the IRS.

PUBLIC PROGRAMS MUST BE PUBLIC?

Hospital cost data filed under Medicare must be made available to the public upon specific request after May 1, according to James Cardwell, head of the Social Security Administration. He reports an increasing demand for this information and has ruled that it must be made public under the Freedom of Information Act. Hospitals are asking for a delay while they study the legal issues.

WHAT THE DOCTOR DIDN’T TELL YOU

Presuming you can find it and pay for it, have you ever wondered exactly what you’re getting when you seek health care? Several recent studies and congressional testimony suggest perhaps you should. For example:

• 30,000 people die each year, most needlessly, from adverse reactions to antibiotics, charges Senator Edward Kennedy, chairman of the Senate Subcommittee on Health. Kennedy bases his charges on testimony from highly diverse and respected witnesses appearing at a recent hearing on drugs and the pharmaceutical industry.