1 HSAs:

IF AT FIRST YOU DON'T SUCCEED... The National Health Planning and Resources Development Act of 1974 tries to plan for national health insurance, but falls victim to special interests.

16 Media Scan:

Health Care Politics: Ideological and Interest Group Barriers to Reform, by Robert R. Alford

22 Peer Review

24 Vital Signs

HSAs

If the early days of Medicare and Medicaid represented the honeymoon period in the marriage between the federal government and health-care providers, particularly hospitals, the current period represents a midlife crisis, in which the terms of the marriage contract are up for grabs and the future nature of the relationship is in doubt. One important reflection of that shift can be seen in the politics of the enactment and implementation of the new federal health-planning legislation, formally titled the National Health Planning and Resources Development Act of 1974, more commonly known as PL 93-641.

Passed during the closing days of the 93rd Congress and signed into law January 4, 1975, during the early months of the Ford Administration, PL 93-641 represents an attempt by federal policymakers to create a health-planning mechanism capable of containing health-care costs before national health insurance becomes a reality. The law
replaced the comprehensive health planning program (CHP), which had expired, unmourned, six months earlier. It also revamped the Hill-Burton program for medical facilities construction and killed off the regional medical program (RMP). (See BULLETINS, May 1973, May/June 1975, p. 23.)

The complexity of the Act's provisions—it takes 33 pages to set forth what the CHP law had covered in five—has been the despair of many observers and has led to widely varied interpretations of its meaning. The niceties of its language, however, are appreciably less important than the legislative and bureaucratic happenings it has inspired, which are indices of the dynamic of forces working to shape the future of the health-care system. And the legislative language is, in critical instances, sufficiently ambiguous to permit widely differing effects, depending on political realities at a given time and place.

The legislative process saw the cost-cutting, rationalizing interests of the federal government being confronted, not surprisingly, by the interests of the hospital lobby. The hospital lobby supported a health-planning process which buttressed existing institutions and it otherwise sought to minimize governmental interference with hospitals' freedom of action. (The AMA persisted in seeing federal health legislation as an unmitigated evil and thereby continued to make an ass of itself; see box page 2.) The planning legislation also brought to the halls of Congress another complex of interests not typically concerned with health legislation, namely state and local governments, which came out of the woodwork to maximize control over what they saw as the present and potential pork barrel of federal health resources.

The interests of monopoly capital have been aligned with federal bureaucratic interests in seeking to contain the costs of health care. Health-care costs, after all, are subsidized to a large extent by taxes and fringe benefits which, directly or indirectly, are costs of doing business. This sector also sees cost containment as necessary to ward off a crisis which might lead to nationalization of the health system.

The interest of health-care consumers in accessible, comprehensive health care at a reasonable cost has not in itself been of concern to these appreciably more powerful forces. At best, consumers have been the incidental beneficiaries of the federal bureaucrats' efforts to undermine the power of health-care providers to break the federal bank.

In summary, the legislative process that coughed up PL 93-641 saw Congress and the White House become the battleground for a complex struggle with many combatants, in which shifting alliances developed around particular issues. What got coughed up was a description of a monumentally complicated structure, in which planning and limited forms of regulation are to take place at three levels—local, state and federal—and in which the relations among the respective functions of the three levels are simultaneously tangled and ambiguous.

At the local level about 200 health systems agencies (HSAs) will spin out health plans of various descriptions, review and approve or disapprove applications by local providers for federal funding and take part in certificate-of-need programs applying to institutional health services. At the state level state health planning and development agencies and statewide health coordinating coun-

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**AMA Strikes Out**

The lobbying strategy of the American Medical Association (AMA) vis-a-vis the health-planning legislation was totally determined by its fear that the law might encroach on the domain of its private-practitioner constituency. As a result, the AMA's approach to the legislative and administrative process can best described as ineffectual political action followed by ineffectual legal action. The AMA credits its lobbying with winning deletion from the House bill of any reference to rate regulation, but others say it bargained away most of its chips on that effort and that a faux pas by its Illinois affiliate created momentum that defeated a number of diluting amendments offered in committee. The executive director of the Illinois State Medical Society sent a memo to 14 other state societies observing that "if we get lucky, we may create sufficient disarray within the [House Commerce] Committee to delay the whole bill." The memo somehow got to Commod...
mittee Chairman Harley Staggers, who was not amused.

As the legislative process progressed, the AMA tried to get the entire bill scuttled in favor of a simple one-year extension of the comprehensive health planning (CHP) program and, failing that, urged President Ford to veto the legislation. After enactment, the AMA took a hands-off position—issuing potshots (“the single, most potentially destructive piece of medical legislation ever enacted,” said Dr. James H. Sammons, AMA executive vice-president) but not even bothering to assign a staff person to keep track of the Act’s implementation.

In line with its newly militant posture, however, the AMA did threaten a lawsuit. It started threatening a lawsuit in January, 1975, shortly after the law was signed, when its Executive Committee directed its legal staff to draw up the papers. (“The courts are our last resort to prevent saddling the nation’s patients and physicians with this bad legislation,” declared Board Chairman Dr. Richard E. Palmer.) It continued to threaten a lawsuit in June, 1975, when the House of Delegates voted its support of legal action. By the fall, trade press reports of an “imminent lawsuit” had yielded to press speculation that the AMA had decided to concentrate its energies on getting rid of then-HEW planning chief Eugene J. Rubel (see text) rather than file a suit that appeared to have little prospect of success.

In February, 1976 the rumor mill reported that imminent HEW regulations on the certificate-of-need provision of the legislation would exclude from that program’s purview “organized ambulatory health care facilities;” that exclusion was intended as a means of warding off an AMA lawsuit. Sure enough, the proposed regulations appeared March 19 with that exclusion. (Ambulatory surgical facilities were included, but with the explanation that that term “does not include the offices of private physicians or dentists, whether for individual or group practice.”) In April, however, it was rumored that the AMA would join the state of North Carolina in a suit against the law, presumably as a means of maintaining some credibility without risking failure alone.

cils, not to mention governors, will jointly develop guidelines governing national health-planning policy and further plan and administer the certificate-of-need program. HEW has broad supervisory functions over every-thing in the structure below it and serves as an appeals agency for the review-and-approval process. A national council on health planning and development gives advice to HEW.

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This grossly oversimplified version of the statute is fleshed out somewhat in the box appearing on page 8. Any description of the legislative program based solely on the language of the law, however, bears roughly the same relation to the emerging reality as a pattern bears to the finished garment.

**CHP: Rejecting the Past**

The new planning legislation grew out of a widely shared consensus that CHP had been an abysmal failure at rationalizing the health-care system and that it was unthinkable to unleash the inflationary imperatives of national health insurance without creating a new planning mechanism capable of bringing health-care cost inflation under control.

The comprehensive health planning legislation had been enacted in an offhanded way in 1966 by the same Congress that gave us Medicare and Medicaid and was amended three times thereafter to patch up some of the holes. It spawned a network of state CHP agencies (A agencies), which were units of state government, and areawide agencies (B agencies), which were mostly private, nonprofit corporations. (The letter designations of the agencies came from their having been authorized by subsections (a) and (b) of the legislation.)

The A and B agencies were given a vague mandate to develop state and areawide comprehensive health plans, which they were given inadequate resources to develop (the average size of the B agencies’ staff was three) and, in any event, no authority to implement. The closest thing to a sanction existing in the program was the power given the B agencies to review and comment on applications for federal categorical health grants filed by providers in their area. The problem was that these comments could be disregarded by the federal granting agency, not to mention the underlying problem that this function was limited to that narrow range of provider activity represented by such federal grants.

The B agencies were required to match their own federal operating grants with local funds, funds that frequently turned out to be contributions from provider groups. That fact, needless to say, made it awkward at best for the B agencies to take a hard line against the institutional plans of local providers.

A significant structural feature of the program, reflecting its genesis in the era of “maximum feasible participation,” was its requirement that areawide agencies be governed by councils with a majority of health-care consumers. The result was an inordinate preoccupation with the niceties of the consumer-provider distinction. That preoccupation in turn disguised two underlying problems: first, the federal definition of “provider” was so narrow that a hospital trustee or a doctor’s wife would be classified as a consumer; second, even an individual who was a consumer in the strictest sense was not necessarily an advocate for consumer interests (or, even if such an advocate, did not necessarily represent a constituency that would require such advocacy to be taken seriously). The net effect, as explained to those who read *Health Care Management Review*, is that: “... in business, a 51 percent majority means full control... However, this is not so in the health planning business.” (1)

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**The CHP program had no significant effect on the behavior of health-care providers.**

Constrained by its lack of resources, lack of power and the ineffectuality of its consumer input, the CHP program had no significant effect on the behavior of health-care providers. This worried federal policymakers. The Senate Committee Report on PL 93-641, after noting that CHP has been “only marginally successful,” opines in the next paragraph that “effective comprehensive health planning activities are an absolute prerequisite to the successful implementation of a national health insurance program.” (2)

**NHI: Postponing the Future**

This statement reflects a concern engendered by the roaring inflation in health-care costs that came in the wake of the enactment of Medicare and Medicaid. In particular, a significant part of the increase in expenditures on Medicare and Medicaid since their
inception in 1966 represents the increase in the cost of a day of inpatient hospital care—an increase from an average of $49.22 in fiscal 1967 to $110.77 in fiscal 1974. (3) In turn, many in both the legislative and executive branches came to perceive that an excess of hospital beds had developed, spurred by the availability of Medicare and Medicaid reimbursements, and had created an incentive to overutilize this inordinately expensive form of health care. (The Senate Committee Report cites estimates of unnecessary beds ranging from 67,000 to 110,000, or 5 to 7 percent of the US total; then-HEW Secretary Caspar Weinberger threw around the figure of 70,000.)

Thus effective health planning, as a means of reining in and rationalizing a system dangerously out of control, came to be seen by federal health managerial types as an essential prerequisite to any expansion of Medicare and Medicaid in the direction of national health insurance. One month after the enactment of PL 93-641, in February, 1975, the then-director of health planning at HEW, Eugene J. Rubel said: “This law is attempting to provide a better management focus for the health industry. It is clearly a step in the direction of national health insurance, and it is an attempt to avoid the mistakes made with Medicare and Medicaid.” (4) Back in November, 1974, when neither house of Congress had acted on the legislation, HEW Undersecretary Frank C. Carlucci had spoken of the Administration’s intention “to work very hard to enact legislation this year. It’s a high priority. It’s important that we have a planning structure in place before the enactment of a national health insurance program.” (5)

An early attempt to rationalize the health system was a federal certificate-of-need law, known in the trade as section 1122 (of the 1972 Social Security Amendments). It provided that the depreciation and interest portion of Medicare and Medicaid reimbursements to institutions would be disallowed if the capital expenditures in question had not received prior review and approval by a designated state agency, usually the CHP A agency. (Implementation of the provision in a particular state, however, was subject to its governor’s willingness to designate a state agency and enter into an agreement with HEW. It should be noted that depreciation and interest comprise but a small percentage
of a hospital's reimbursement rate and that the appropriateness of recognizing such items as costs of operation for nonprofit entities has been frequently questioned.)

Both the applicability and the sanction of section 1122 were severely limited. Nonetheless, HEW saw the provision as an important precedent in linking planning and regulation and as the first stage in a strategy of controlling hospital costs by boosting state authority to halt overbedding.

The next stage of that strategy was to be the projected overhaul of the CHP legislation. That overhaul, spurred on by the lapse of the CHP legislation on June 30, 1974, took over a year's worth of the legislative process and became part of PL 93-641. Much of what resulted has more to do with form than substance, in particular with correcting some of the formal deficiencies of the CHP program.

On matters of substance, the managerial inclinations of federal bureaucrats have been distorted by hospitals and state and local politicos.

Thus the legislators' concern with the inadequate resources available to CHP B agencies is reflected in provisions prescribing minimal staffing standards for their successors, the HSAs, and requiring HEW to provide HSAs with various forms of technical assistance. Their concern with lackadaisical HEW administration of the CHP program is seen in exhaustive provisions for HEW oversight of the HSAs and the state health planning and development agencies. Their concern with provider domination of the B agencies is translated into an excruciatingly complex definition of "provider" and a prohibition against HSAs receiving money from provider sources.

However, on matters of substance, and, to some extent, structure, the managerial inclinations of federal bureaucrats have been distorted by special-interest lobbying by the hospitals and state and local politicos. While the hospitals were determined to protect their position of control over the health-care system, the politicos were seeking to gain leverage over what they saw as a source of patronage and local power.

The County Commissioners Muscle In

One expects to find lobbyists for the American Hospital Association (AHA) on the scene when Congress is making moves in the direction of enacting health legislation. What is less expected but what was very much in evidence as the health-planning legislation struggled through the legislative mill was the vocal presence of a complex of interests not identified with the health-care system, represented by the National Association of Counties (NACO) and the National Governors' Conference.

Supporters of the legislation first collided with these narrow political interests over the issue of the proposed structure of the HSAs. NACO was determined that local government would control the HSAs. It wanted HSAs to cover more territory, have larger budgets and be granted more power than their predecessors. It also expected the HSAs eventually to allocate federal health resources including national health insurance funds. (Back in 1967, city and county governments had staged a forerunner of this struggle when they had lobbied successfully for an amendment to the CHP legislation requiring representation of local government on the governing boards of B agencies, most of which were private nonprofit corporations rather than governmental entities.)

NACO's position was diametrically opposed by the Health Subcommittee of the House Commerce Committee, which had drafted a bill requiring that HSAs be private nonprofit corporations. This requirement largely reflected a fear that the purpose of curbing unnecessary hospital construction would be thwarted if politicians took over the health-planning business. In the words of Rep. William Roy (D., Kan.), then an influential member of the Health Subcommittee, "It's almost impossible for a local government unit to be a health service agency without becoming a total advocate for additional
services. It's extremely important that we separate health planning from local government, so we don't get right back into the soup of 'anything that's bigger is better.'" (6)

The House Subcommittee's stance was also a measure of deference to the hospital lobby: it represented a view of health, in the words of the Committee's report on the bill, as "basically a private industry" in which "there are some private providers of health care who are reluctant to submit to planning done by public government." (7)

Of course neither the pork-barreling interests of the local politicos nor the cost-containment interests of the government had anything to do with decent health care per se. Consumers might plausibly feel that their voices as voters would count for more with a government agency like an HSA than with a private corporation. But the staff of such an agency might well be loaded with recipients of patronage or civil servants who are not the most effective advocates for a patient-centered health-care system.

But despite the House Committee's position and HEW's support of that position, NACO's lobbyists rounded up enough votes to pass an amendment in the House permitting HSAs to be private nonprofit corporations, public benefit corporations, public regional planning bodies or single units of local government. The provision survived the House-Senate Conference Committee (the Senate bill had permitted HSAs to be either private or public), albeit with a provision taken from the Senate bill requiring public HSAs to have a separate governing body for health planning.

If the meantime, the National Governors' Conference focused on the precise division of functions among the governors, the HSAs beneath them and HEW above them. (The statute assigns certain functions to governors, as distinct from the state health planning agencies and the statewide health coordinating councils (see box page 8).) It succeeded in nudging the House Health Subcommittee to increase the governors' power in the delineation of the boundaries of health service areas and in persuading the Senate Labor and Public Welfare Committee to increase their power to determine the composition of the statewide health coordinating councils. Ultimately, however, the legislators rebuffed the gubernatorial onslaught by leaving in place provisions that would enable HEW to play a strong, presumably nonpolitical, supervisory role, supervising both state planning functions themselves and the functions of the HSAs. Whether the federal administrators will choose to exercise their managerial prerogatives is of course another question.

Watering Down: The Hospital Lobby

While governors and county commissioners expressed their concern over who would control the planning structures, the hospital lobby concerned itself with the far more compelling issue of what sanctions were available as forms of control.

Neither the pork-barreling interests of the local politicos nor the cost-containment interests of the government had anything to do with decent health care per se.

One weak sanction that survived the legislative process is the power of HSAs to "review and approve or disapprove" funding proposals. This escalates the previous powers of CHP B agencies to "review and comment" on providers' applications for categorical health grants, for example, under the Public Health Service Act or the Community Mental Health Centers Act. The catch, however, is that, in the event of an HSA disapproval, the provider in question may appeal to HEW, which may fund the application despite HSA disapproval.

Of more interest than the review-and-comment or review-and-approval function, federal policymakers projected a scenario for locating at the state level a complex of regulatory, as opposed to planning, functions aimed at containing the quantity and cost of institutional health services. This on the theory that while private bodies may engage in planning (private, nonprofit corporations usually comprise local planning structures), regulation is properly a function of government.

(Continued on page 10)
Perhaps the most striking feature of PL 93-641 is the complex hierarchy it creates. From bottom to top, the structure and functions of the various layers of that hierarchy, as set forth in the statute, look like this:

- **HEALTH SYSTEMS AGENCY (HSA).**
  
  **Structure:** May be either private nonprofit or public benefit corporation, public regional planning body or single unit of general local government. In any case the HSA must have a governing body of 10 or more members with an executive committee of no more than 25. The governing body must include 51 to 60 percent health-care consumers who are not providers and who represent the social, economic, linguistic and racial populations and geographical areas of the health service area and major health-care purchasers. Of provider members at least one-third must be direct, as opposed to indirect, providers. (Definition of "provider" in the statute is worthy of the Internal Revenue Code and is designed to prevent, e.g., the wife of a hospital trustee from being classified as a consumer.) Representatives of local government must be on the governing body, either as consumers or providers. If the area includes a Veterans' Administration facility or a federally recognized Health Maintenance Organization, they must be represented on the governing body.
  
  **Functions:** Establish, review annually and amend as necessary a long-range health systems plan. Establish, review annually and amend as necessary an annual implementation plan. Once an HSA has developed these plans it is eligible to receive from HEW, subject to congressional appropriations, a grant to establish an Area Health Services Development Fund. It may use this money to make grants and enter into contracts with public and private nonprofit entities for planning and development projects, but not to cover the cost of delivering health services or constructing or modernizing health facilities. The HSA is also mandated to review and approve or disapprove applications for various federal health grants, not including Medicare and Medicaid (subject to reversal by HEW in the case of a disapproval). At least every five years it must review institutional health services in its area for continued "appropriateness" and make recommendations to the state health planning and development agency. As part of the state certificate-of-need programs, the HSA reviews and makes recommendations to the state agency concerning the need for any proposed new institutional health services.

- **STATEWIDE HEALTH COORDINATING COUNCIL (SHCC).**
  
  **Structure:** At least 16 representatives of HSAs within the state, appointed by the governor from lists of at least five nominees each, of which at least one-half are to be health-care consumers. These plus other gubernatorial appointments may not exceed 40 percent of the total SHCC membership, of which a majority must be consumers. At least one-third of all providers must be direct providers.
  
  **Functions:** Annually reviews and coordinates the plans of each HSA and sends their comments to HEW. At least annually prepares state health plans made up of the HSAs' health systems plans, based on preliminary plans submitted by the State Health Planning and Development Agency (with revisions as necessary to achieve coordination or meet statewide needs). Reviews and sends comments to HEW on each HSA's annual budget and applications for development fund grants. Reviews and approves or disapproves applications submitted by the state for funds under various federal health programs, not including Medicaid (also subject to reversal by HEW in the case of a disapproval).

- **STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.**
  
  **Structure:** An agency of state government designated by governor; any of its functions may be performed by another state agency at the governor's initiative and with HEW's approval.
  
  **Functions:** Prepares a preliminary state health plan for submission to the SHCC. Administers a state certificate-of-need program applicable to proposed new institutional health services. At least every five years re-
views institutional health services in the state and, after considering the recommendations of the relevant HSA, makes public its findings as to their continued "appropriateness."

**GOVERNOR.**

Designates the boundaries of health service areas within the state, subject to revision by HEW. Is consulted by HEW about the HSA applicant. Selects an agency of state government to serve as the State Health Planning and Development Agency. Appoints the members of the SHCC.

**HEW.**

Issues and periodically revises guidelines concerning national health planning policy, including standards of "the appropriate supply, distribution, and organization of health resources" and a statement of health planning goals developed from the priorities specified in the statute, after considering comments from all other levels of the structure and from provider organizations. Designates health service area boundaries, based on gubernatorial designations unless they fail to meet the requirements of the statute. Designates HSAs, after consultation with governors. Makes operating grants to HSAs and state agencies, and health services development grants to HSAs that have a health systems plan and an annual implementation plan and are performing satisfactorily. Provides technical assistance to HSAs and state agencies. Establishes a national health planning information center and grants federal funds for the establishment of at least five centers for health planning. Establishes a uniform system for calculating the aggregate cost and aggregate volume of institutional health services, a uniform cost accounting system for health services institutions, a uniform system for calculating reimbursement rates for health institutions, and a classification system for health-services institutions. Annually reviews and approves or disapproves the budget of each HSA and state agency. At least every three years reviews in detail the structure, operation and performance of the functions of each HSA and state agency. Prescribes performance standards for each HSA and state agency and establishes a reporting system to permit continuous review of their structure, operation and performance. Reviews funding applications disapproved by local HSAs upon request of the applicant and may make federal funds available notwithstanding HSA disapproval, giving a statement of reasons to the HSA and state agency. Reviews disapprovals of state applications for federal funds by SHCCs at the governor's request and may make federal funds available, giving a statement of reasons to the SHCC. Makes grants for demonstration programs of rate-regulation to no more than six state agencies. Appoints members of the National Council on Health Planning and Development, except for the three ex officio members.

**NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT.**

*Structure:* Fifteen members, of which three are nonvoting ex-officio members (the Veterans Administration's Chief Medical Officer, the Assistant Secretary of Defense for Health and Environment and the Assistant HEW Secretary for Health). The remaining members are appointed by the HEW Secretary for six-year terms. At least five of them are not providers of health services, three are members of HSA governing bodies, more than three are federal officers or employees and three are members of SHCCs. The two major political parties are to have equal representation.

*Functions:* Advises and makes recommendations to the HEW Secretary concerning the development of national health planning guidelines, the implementation of the law and the implications of new medical technology for health-care organization and delivery.
Of the three state regulatory mechanisms considered, the only one to emerge without maiming from the legislative process is a requirement that state agencies administer a certificate-of-need program applying to proposed new institutional health services, that is, a program prohibiting the construction or expansion of health-care institutions without prior approval of the state agency. The statute gives HEW approval power over the details of the state program and requires that recommendations of the relevant HSAs be considered in administering it.

The reason for the smooth legislative sailing of the certificate-of-need provision is simply that the AHA and its state affiliates have since 1968 been supporters of state certificate-of-need legislation. Prior to 1968 only one state, New York, had such legislation on its books; by January, 1975, when PL 93-641 was enacted, 29 states and the District of Columbia had passed certificate-of-need laws. Many state laws hooked up with the federal CHP legislation by designating the CHP A agency as the administering agency of the certificate-of-need mechanism.

The AHA position reflects the realization that a franchise to exist in perpetuity is ultimately a protection against competition. In other words, an existing hospital, by virtue of having a certificate or being exempted from the need for one because of its prior existence, is at least to some extent protected against the danger of a competing hospital opening nearby and stealing its patients. As observed by the authors of a survey of state certificate-of-need laws, “Control of facilities expansion is currently in accordance with the goal of both the health planners and the dominant, established health care institutions in most states and communities.” (8)

HEW has touted the certificate-of-need provision of PL 93-641 as an enormous improvement over the earlier version contained in section 1122 of the 1972 Social Security Amendments since preventing unnecessary facilities construction is preferable to applying a financial sanction to such construction after it’s taken place. Still, the device remains a reactive mechanism—the regulatory agency may only bring its planning function to bear in the context of scrutinizing someone else’s proposal to create new facilities or services. Its planning function remains unimplementable to the extent that it either identifies areas of need that no provider desires to fill or identifies already existing services or facilities that should be eliminated.

The problem of superfluous real estate or services (whether reflecting initial overbedding or subsequent population shifts) could logically be met by a regulatory mechanism if existing facilities were subject to periodic reexamination of their continued usefulness, and provision made for their being phased out if they were judged no longer needed. Such recertification, however, would undermine the hospital lobby’s rationale for supporting certificate-of-need programs, namely their assurance of monopoly status to approved institutions.

Thus in the context of the legislative process, the recertification-of-need idea was no match for the organized onslaughts of an entrenched interest group. Both Senate and House bills began the process with a provision for periodic review by state planning agencies (with HSA input) of the continued need for institutional services and facilities and for their improvement, restructuring or elimination if not needed. The AHA’s predictable attack on those provisions was couched not in terms of hospitals’ fears of losing their monopoly status but in terms of the difficulty of borrowing for capital construction in the private money market if one’s lenders could not be assured of one’s continued existence.

In the Senate the AHA onslaught won a floor amendment shooting the recertification provision full of holes in the form of major exceptions to its applicability. In the House, AHA allies secured passage of a two-part floor amendment: the first part substituted “appropriateness” for “need” as the standard against which facilities and services would
be reviewed, and the second eliminated any sanction for “inappropriateness” and reduced the state agency merely to making public its findings. The House provision emerged from Conference Committee, and the Conference report went so far as to note the conferees’ desire “to stress that the purpose of the findings by the State Agency is to inform the public and providers of health services as to the appropriateness of particular services and what, if any, voluntary remedial actions are advisable.” (9) The AHA then announced that the House-passed provision had been its preference (10), probably because it eliminated any possibility of a meaningful sanction.

Of course even the combination of certification and recertification of need would at best be an indirect strategy for bringing health-care costs under control—which is, in the end, what most legislators and bureaucrats see as the point of the whole exercise. Regulation of institutional reimbursement rates would presumably be a lot more direct as a cost-controlling strategy. The AHA calculated that its constituents would benefit in some states and suffer in others at the hands of rate-setting agencies and was thus unhappy at the prospect of their creation nationwide. It proposed that rate regulation should not be included in federal legislation unless that legislation also provided for comprehensive health-care financing (i.e., was national health insurance). In its opposition to a rate-setting provision in the planning law the AHA was joined by the Blue Cross Association, but for the opposite reason. Blue Cross plans in many localities pay hospitals at discounted reimbursement rates—justified on the theory that Blue Cross pays more promptly than commercial insurers and government agencies—and BCA feared that rate-setting agencies would establish a single reimbursement rate for all third-party payers.

The strongest position on rate regulation taken at any point in the legislative process was a provision reported out by the Senate Labor and Public Welfare Committee, with HEW support, and passed by the Senate. It would have made federal grants available to states that chose to establish programs regulating reimbursement rates. After much wavering during the drafting and redrafting process, the House Health Subcommittee caved in and deleted any reference to rate regulation in its bill, including even a compromise that would have required publication of reimbursement rates by state planning agencies. The House-Senate Conference Committee took the Senate’s provision for optional rate-setting and the House’s lack of any provision for rate-setting and came up with a provision for HEW to award grants for demonstration programs of rate-setting in no more than six states.

Managing Thin Air

In the end, the hospital lobby’s focus on the issue of sanctions and its relative unconcern with the issue of structure paid off: whoever is warming the chairs in the conference rooms under the new law, their power to encroach on institutional interests is severely limited. Not that the hospital lobby plans to stay away from those deliberations; one of the AHA’s publications has advised its constituents that “If the HSAs are to be responsive to local needs, local hospitals must play a major role in the selection of the HSA board, in the formation of the HSA itself, and in the development of adequate HSA staffing.” (11)

The managerial, cost-containment thrust that provided the original impetus for the legislation ended up being reflected in provisions that appear to be wholly symbolic. Many commentators have made much of the unprecedented mandate to establish a set of national health priorities to be considered in the formulation of national health planning policy guidelines, a task another provision assigns to HEW. Of the ten priorities enumerated, however, seven concern themselves with cost-containment and/or efficiency—including the development of health maintenance organizations (HMOs), the increased utilization of physician assistants, the sharing of institutional support services and the education of the public in personal preventive health care. In part this provision reflects
congressional dissatisfaction with HEW's limited policy-making role in the past; the report of the House Commerce Committee accompanying the planning bill noted that the Committee "has often felt the lack of a single coherent statement of national health policy and a concrete plan by the Department [of HEW] for achieving that policy. Thus, the proposed legislation specifies national health priorities . . ." (12)

Cost accounting based on "true cost" may ultimately prove to be the sleeper of the statute.

Another such managerial, but apparently only symbolic, provision, sandwiched in the middle of a section on technical assistance to state and local agencies, instructs HEW to develop a uniform system of cost accounting for health-care institutions and a uniform system for calculating reimbursement rates, to be based on the "true cost" of services to a particular category of patients. This provision is a survivor of the Senate bill's provision for optional state rate-regulation programs. It has no apparent purpose in the legislation as enacted, but some commentators claim it will ultimately prove to be the sleeper of the statute and some hospital administrators have expressed anxiety that someone might try to do something with that cost information.

Guerrilla Warfare in the Bureaucracy

The federal health-planning bureaucracy, where one might expect a managerial approach to the law's implementation, instead has been a battleground where state and local politicos have taken up arms, with considerable success, against federal managers. The leader of the managerial side and arch-enemy of the politicos has been Eugene J. Rubel, who was named acting director of HEW's Bureau of Health Planning and Resource Development when the bureau was created in May, 1975. Rubel is a Harvard MBA in his 30s who used to enjoy giving out statements about the landmark significance of the new planning legislation ("We are now very definitely intervening in the private practice of medicine and in the organization and operation of health care institutions." (13)) and who has always been an advocate of the private nonprofit form of local planning agency.

Rubel's brash, full-steam-ahead approach to the law's implementation made him a target of many governors, who were unhappy with how their interests emerged from the legislative process and were looking to the implementation process to improve their standing. A letter in August from the Human Resources Committee of the National Governors' Conference to Rubel's boss, Dr. Kenneth M. Endicott, Administrator of HEW's Health Resources Administration, forecast "little hope of any cooperation between the Governors and the department in implementing this law" if Rubel retained his post. (14)

Rubel declined to go quietly, and the battleground then shifted to a search committee created by Endicott to come up with a permanent health planning chief. An unnamed member of the search committee was quoted as explaining: "Two thirds of the anti-Rubel sentiment is anti the law. Those interests who resist the development of a coherent national health strategy are also anti-Rubel." (15) As one might expect, Rubel's backers included Chairpersons Kennedy of the Senate Health Subcommittee and Rogers of the House Health Subcommittee.

The search committee submitted the names of four candidates for Rubel's job—including Rubel himself—to Endicott in December. The impasse continued, however, until March, when Rubel finally threw in the towel and informed Dr. Theodore Cooper, HEW Assistant Secretary for Health, that he was bowing out. Cooper made Rubel a special assistant and gave Rubel's post to Harry P. Cain II, PhD, director of the Office of Policy Development and Planning.

In the meantime, another victory for state and local politicos emerged in the very fine print of the Federal Register, when the first proposed regulations implementing the statute were published on October 1, 1975 (three months late). These reflected the lobbying efforts of NACO, the National Governors' Conference and the National Association of Regional Councils (NARC), efforts fo-
cussed on the interpretation of the statutory provision permitting HSAs to be public regional planning bodies or units of local government. HEW required public HSAs to separate the governing body for health planning from its regular governing body (the latter being a county board of supervisors, for example, or a regional council of governments). The health-planning board was required to have the same composition as private, nonprofit HSAs, a delicately balanced mix of consumers (between 51 and 60 percent), direct providers and indirect providers. (The mix is also supposed to represent elected public officials, residents of nonmetropolitan areas and the social, economic, linguistic and racial populations of the health service area.) The more powers given the governing body for health planning, the less influential would be the regular governing body.

As helpfully explained in the preamble (its language being the product of negotiations between Endicott and a governors' delegation), the proposed regulation would "permit (but not require) the regular public governing board of a public health systems agency to exercise considerable authority over its health planning and resources development program." (16) That "considerable authority" would include selecting and removing members of the health-planning board, establishing the agency's personnel policies, budget and operating procedures and reviewing and commenting on proposed agency actions.

Both the AHA and members of the House Health Subcommittee made loud noises about the disparity between the proposed regulatory language and the statutory language. A "briefing" on the proposed regulations held later in October by HEW and the National Health Council was the scene of a heated argument between the representatives of the AHA and NACO. Five months later, when its second set of proposed regulations appeared on March 19, the most HEW could announce was that comments received on the proposed October regulations, which reportedly numbered about 700, "are currently being evaluated within the Department." (17)

**Boundary Disputes: Carving up the Cities**

Washington, DC has not been the only setting for the expression of conflict between national planners and parochial politicos. One decentralized manifestation of that conflict has been the struggle around setting the boundaries over which HSAs will have jurisdiction—the issue being whether those areas will conform to relatively smaller political jurisdictions or to broader economic regions. The boundary-designation function is shared between governors and HEW. Here as elsewhere, parochial political interests have been scoring over regional economic interests.

In the Philadelphia area, for example, the issue was whether there would be one health service area encompassing the five-county Philadelphia area or whether those five coun-
ties would be split up into three HSAs, one of which would limit itself to the city of Philadelphia. The larger area was favored by such regional economic interests as the Sun Oil Company and Rohm and Haas Corporation, joined by the area's medical schools and their medical empires. The smaller was backed by Philadelphia Mayor Frank Rizzo, the county governments and the county medical societies. After originally designating the five counties as one area, HEW yielded to local political pressure and changed the designation to three.

A comparable scenario was enacted in Chicago. Mayor Richard Daley, via Illinois Representative Dan Rostenkowski, chairman of the Health Subcommittee of the House Ways and Means Committee, got the city rather than the metropolitan area designated as a health service area, despite a contrary recommendation by an HEW area-designation task force. In the San Francisco Bay Area, pressure from county governments on Governor Edmund Brown Jr. persuaded him to recommend to HEW that the nine-county Bay Area be carved up into four health service areas.

**Sabotage from Above**

All these skirmishes of course have been motivated by the assumption that federal support for the health-planning process, financial and otherwise, would make control of that process worth fighting over. Evidence that this logical assumption might in the short run, at least, prove unwarranted first surfaced last December when HEW lost a budget battle with the White House. HEW had asked for about $140 million for health-planning activities in fiscal 1977 (the law authorizes $176 million), which the Office of Management and Budget (OMB) had recommended cutting to $66 million. At a meeting with the President, HEW's advocacy of speedy implementation of the law lost out to OMB's go-slow approach at a reduced funding level.

President Ford added insult to injury in January, when he included the health-planning program as one of many federal health programs to be consolidated into a health revenue-sharing scheme (see BULLETINS, March/April 1976, May 1973). This maneuver was bound to slow down its implementation even if the revenue-sharing proposal was ultimately rejected by Congress. Both the consolidation and the reduced funding were predictably attacked by the AHA and NACO, which on this issue found their interests to be congruent. By March, Dr. Paul Ellwood, one of the health scene's major market-reformers and cost-containment strategists, was citing, as an example of the Ford Administration's lack of a strategy to contain medical inflation, the fact that "Its proposals on the administration and financing of health planning are effectively destroying that program." (18) (Ellwood is best known as the originator of the Nixon HMO strategy, see BULLETIN, July/August 1972.)

Ford's dilemma of course is that the traditional Republican alliance with small-town and small-business interests has him calling in this election year both for reduced government intervention in the private sector and reduced government spending. But the only way to slow the growth of government spending on health care, most of which goes to the private sector via Medicare and Medicaid reimbursements, is to increase government intervention, which would at least involve funding of a health planning structure that might eventually develop into a cost-containment mechanism. Because Ford is apparently unwilling to acknowledge the possibility of additional but cost-effective government expenditures, he is emerging as the superpolitico of them all.

**Regulation As a Last-Ditch Rescue**

The supermanager of them all then becomes a progressive, monopolist Republican expatriate from the Nixon Administration, former Assistant HEW Secretary for Health Dr. Charles Edwards. Currently senior vice-president of Becton, Dickinson and Company, a major manufacturer of hospital supplies, Edwards presented his scenario for "Rational Change in the Health Care System" (19) at a forum sponsored by Arthur D. Little, Inc. in March.

After arguing that the cost of health care "is becoming prohibitive" and that that fact made inevitable the occurrence of "fundamental change in the structure and regula-
tion of the health care system," Edwards laid out what he sees as the only two options for national health policy. One is to let the health-care system remain on its current economic course, which he predicted would lead to its collapse and subsequent nationalization. The other is to impose strong central regulation, which he advocated for the form of a national health authority, comparable to the Federal Reserve Board. That authority would be empowered by Congress "to establish rate and fee schedules on a regional basis, to approve or reject regional plans for the allocation of health resources, to determine health manpower requirements and see that they are being met, to regulate all public and private health insurance programs, and to advise the Congress and the Executive Branch on budget and policy issues."

Such an apparently comprehensive regulatory scheme would not represent a federal takeover of the health-care system, Edwards reassured his audience, but rather a means for preventing such a takeover. Nor would it necessarily represent an economic threat to the system: "Some of the best examples of highly successful and profitable segments of American industry are to be found among those subject to federal regulation." Conversely, he argued, "without regulation the health-care system and the industrial groups that serve it will shortly see the end of profitability because the US economy will not be able to sustain them." And strong central regulation is an absolute prerequisite to the enactment of national health insurance; otherwise, he predicted, "the adoption of national health insurance would hasten, rather than prevent, the collapse of the system."

The Republican monopolist Edwards may find a growing natural alliance among those liberal Democrats who are learning managerial techniques under the aegis of the Congressional Budget and Impoundment Control Act of 1974. That experience is apparently providing a sober antidote to their bigger-is-better inclinations and making liberals such as Senator Edmund Muskie, chairman of the new Senate Budget Committee, sound like fiscal conservatives. Thus Muskie criticized Ford's block-grant proposal because it did not inspire "confidence that the government can hold down spiraling health care costs" and would "simply shift the cost of federal programs to the states and cities."

On the House side, liberal Budget Committee Chairman Brock Adams, in an address to an AHA seminar on federal relations, recently warned that "We must be realistic and admit we cannot enact a new and comprehensive national health insurance program unless and until we also enact successful measures to bring in new budget revenues or to attain significant savings." The Congressional Budget Office, a new economic think tank, recently reported to Congress that primarily because of medical inflation, current federal health programs will increase in cost from about $33 billion in fiscal 1976 to about $38 billion during fiscal 1977 and $58 billion in fiscal 1981. "Only government regulation of the health industry," the report observed, "would seem to permit improving individual protection without adding significantly to inflation."

Whatever the short-term vagaries of election-year politics, the national government and monopoly capital agree that aggressive health-care regulation is necessary to their own preservation. While such regulation may have some beneficial effects for those who use or work in the health-care delivery system, these effects will be purely coincidental.

—Louise Lander

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3. Louise Landor, National Health Insurance, He Who Pays the Piper Lets the Piper Call the Tune, Health/PAC, 1975, Table 1, p. 24. (Available from Health/PAC for $1.00 plus 21c postage.)
13. Downey, op. cit., p. 32.
15. Ibid.
HEALTH CARE POLITICS: IDEOLOGICAL AND INTEREST GROUP BARRIERS TO REFORM
By Robert R. Alford
(New York: Pantheon, 1976)

Until the late 1960s the major criticism of American health care was that it was not available to enough people. Among a precocious few the private practicing medical profession and the drug industry were seen as self-serving mercenaries who dominated the politics.

For academic social scientists medical care was merely one more instance of the natural social harmony inherent in pluralist, free enterprise society. (1) By the late 1960s, however, that facade of harmony began to crumble throughout American and Western society.

The critique of medical care in the US, transcending that of organized medicine and the drug industry, and moving on to a recognition of the imperial designs of the medical schools, the technological expansionism of the voluntary hospitals and the complicity of the Blues, developed first out of a report on the municipal hospitals of New York City by Robb Burlage, appearing in 1967. This critique, dubbed the “empire model,” developed, notably, outside the university, became the basis for the formation of Health/PAC, and was followed quickly by the development of several academic critiques of American medical care. This review is an interpretation and evaluation of one of those—the work of Robert Alford.

The Intellectual Location of Health Care Politics

To his credit Alford’s earlier versions of the argument under review, appearing in 1971 and 1972, were among the first substantial academic broadsides leveled at the medical care system and developed at a time when virtually all health care academics were still engaged either in apologetics or professionally sanitary tests of statistical significance. At the time his work had a substantial impact in challenging many more timid social scientists in the health field to face some of the larger issues.

The present volume is a further elaboration of those articles with two intensive case studies of aspects of the New York City health care system. Briefly, his argument is that the (change-free) health care dynamics can best be understood by focussing on the mutual relationships among three unequal categories of interest groups formulated as structural interests: professional monopolists (doctors and voluntary hospitals) who dominate the decision making and are thus labelled the “dominant structural interests”; market and bureaucratic reformers who challenge the hegemony of the previous group, but whose challenge and proposals for reform never alter the structural nature of the interests which the former seek to preserve; and the community-oriented, equal-health advocates who are generally marginal to the outcome of the political dynamics over the struggle for control of health care.

In his own words:

The proposals for change . . . do not challenge any of the institutional roots from which the power of structural interests derives. None of the decisions called for by the market reformers . . . or . . . by the bureaucratic reformers . . . will challenge the effective institutionalized and legal control of the system as a whole by the dominant structural interests which benefit from its continuance in its present form. (page 6)

The bulk of the empirical analysis focuses on the use by the dominant structural interests of political mirrors and shadows (Edelman’s symbolic political action (2)) to deflect from themselves the potentially undesirable effects of the proposed market and bureaucratic reforms.

This brings us a long way beyond the standard academic fare of the 1960s: the interest group pluralism of the political scientists, the consumer sovereignty of economists, and the functionalism, sick role, and patient-doctor relationship of the sociologists—each
suggesting in positivist fashion that what was observed was merely the acting out of universal and harmonious patterns of human social behavior. By focusing instead on the warts of the health care system Alford helped bring to the attention of the health care academic world not only their importance and, perhaps, their centrality, but also that their existence may be rooted in the very structure of organization, rather than merely historical oddities to be relegated to footnotes. In short, power and conflict substitute for order and harmony as the lenses through which health care is thus viewed.

Still, despite the advances which Alford’s analysis provided, it suffers from many of the same defects of other analyses of the same period and genre. Mills (3), Marcuse (4), and Baran and Sweezy (5) represent the forward wing of the rude break with the smug social science which developed in the Post-War period. Though the above represent an important shift in the perceptions and uses of social science, they do not represent a noticeable shift in method: they remain mechanistic, but progressive, versions of the respective extant disciplinary methods; they use the existing methods to challenge the metaphysically derived, normative conclusions of their consensus colleagues.

Mills analyzes interest group dynamics to dispell the dominant normative perception of pluralism; Baran and Sweezy use an essentially Keynesian analysis to suggest that advanced capitalist societies are those of recurrent waste and underconsumption rather than the Samuelsonian view of a “grand neoclassical synthetic” image of full-employment and consumer sovereignty; and Marcuse intellectually transforms Rostow’s ideal of the mass-consumption society into one of commodity fetishism serving to secure ruling-class hegemony through repressive tolerance. What is progressive about these shifts is that they indicate the possibility of antipodal conclusions derived from pre-existing methods, with only modest alterations in the behavioral and empirical assumptions.

In each case, and this is also true for Alford, the organizational structure of what is being analyzed is viewed as both perverse—generally stacked in the direction of the wealthy and powerful—and unchanging. This is debilitating both intellectually and politically: intellectually because it lacks any historical sensitivity and politically because it can never lead to a strategy for change. Significantly, Mills and Baran and Sweezy during the 1960s see the only possibilities for progress in the United States growing out of Third World revolution, whereas Marcuse, prior to 1968, sees the developed social systems as totally locked up and incapable of significant change.

This is not to minimize or condemn their contribution. Their work provided, if not the appropriate method, at least the appropriate lenses through which to view the social landscape. To the extent that the social analysis of the mid-1970s transcends their work it is, no doubt, because of them, not despite them. Similarly, but later, Alford, rather than surpassing them methodologically, merely reproduced their analytical metaphor and embroiders in Edelman’s symbolic politics for the case of health care. In the end, Health Care Politics must be seen as a “period piece.”

In the end, Health Care Politics must be seen as a “period piece.”

Dynamics of the Structural Interests

The twenty-year period from 1950 to 1970, in which Alford claims to see “dynamics without change,” is actually bounded at both ends by programs, policies, and events which distinguish that period from what precedes it and what will follow it. As a result, the health care behavior which Alford depicts as historically invariant turns out to be historically specific. (And this argument could be made for the empire model of Health/PAC, as well.)

The period in question is, if nothing else, precisely the period in which the United States is economically unrivalled in the Western world. Whereas in the immediate post-War period the European and Japanese economies are preoccupied with industrial reconstruction, the United States is preoccupied with the avoidance of possibly endemic
depression, specifically, how to absorb enough of the surplus generated in production to keep the labor force "fully" employed. (6) With this as temporary backdrop, then, three immediate postwar health care developments become understandable and suggestive of the historical origins of Alford's structural interests. Not in chronological order, the establishment of the National Institutes of Health and congressionally-backed increases in bio-medical research step up expenditures for research, and especially medical-technological development; the Hill-Burton program provides federal money for the construction of hospitals (rural at first, but later urban as well); and the expansion of voluntary and commercial health insurance through industrial-union-bargained fringe benefits not only substantially increases the access to increasingly costly health care but, equivalently, provides the continuing financial basis for the capital expansion developed in the medical school research centers and promoted by their graduates.

Starting from specific (individual) defect, anti-epidemiologic medical theory and fee-for-service provider payment, and unobstructed by any planning or popular control over the delivery system, the super-imposition of these policies and programs merely stepped up the pace of accumulation and simultaneously provided the financial means by which the internally generated technological imperatives could be realized. With the force of law, technological sanctimony, and much public and private money, Alford's dominant structural interests are, in the early part of this period, largely as he describes them.

Such a structure, however, at the same time contains its own negation. In particular, the uncollectable accounts receivable, unnecessary care and redundant accumulation inherent in this new structure, were to lead to policies which eventually and inevitably would lead to the demise of the dominant structural interests.

As the unit expense of health care began to increase in response to the new dynamics set in motion, the uncollectables from the poor and the long and expensive stays of the old brought the private hospitals and insurance plans together, in opposition to the AMA, to champion the passage of some federal program to pick up the medical expenses of these two groups. And this alliance began quite some time before the arrival of the Kennedy administration in Washington (1957). (7)

In response to the social dynamics set in motion within the medical profession, hospitals felt increasingly compelled to accumulate expensive service units even if they could be expected to be used rarely: the penalty for not doing so was (and is) the fear of losing members of the medical staff, the marketing officers of the nation's hospitals. And given the fee-for-service (piecework) mode of reimbursing providers, much care was provided because it was revenue-generating, rather than clinically justifiable.

A recent public estimate of the extent of wasteful expenditures in health care put the figure conservatively at $20 billion in 1974 or roughly 25% of personal health care expenditures for that year. The principal components of that estimate include unnecessary hospital construction, unnecessary hospitalization, and unnecessary surgery (8) all, for the most part, a consequence of the structure laid in place by the early 1950s.
In response to the first contradiction came the Medicare and Medicaid laws over the strident objections of the granddaddy of all the dominant structural interests—the AMA. And in response to the latter two contradictions have come a series of planning and regulatory acts, which despite their severe cooptation in early stages, have had their effect in curtailting the autonomy of the previously unbridled interests. Among these are Comprehensive Health Planning, Regional Medical Programs, Peer and Utilization Review (enacted through the Medicare law), Prospective Reimbursement, Certificate of Need, and the yet-to-be-tested Professional Standards Review Organizations, Health Maintenance Organizations, and Health Systems Agencies.

The extent to which (or whether or not) these have been or will be progressively effective is not the main issue. For, to return to the opening of this review, in the end Alford’s structural interests all reside within the petit-bourgeois (middle class) layer of the society (9); their ability to control their own territory rests ultimately on the continued satisfaction or lack of political interest of the other major groups in the political economy—the corporate bourgeoisie and organized labor. Yet, the former have since 1970 strongly indicated in many different media and study reports (Forbes, Fortune, Business Week, the U.S. Chamber of Commerce, Committee on Economic Development, Conference Board, and all three Nixon administration Secretaries of Health, Education and Welfare in congressional testimony (10)) the conclusion that the fee-for-service system is no longer effective in rationally delivering health care and recommended the reconstitution of the system on a prepayment, HMO basis. Many explicitly corporate models are already in the process of software development or actual formation. (10) The latter, labor, will either respond in kind or suffer the consequences of corporate-dominated health care, and social democrats will likely move for the adoption of a National Health Service, one version of which is already close to Congressional introduction. (“The National Community Health Services (Dellums) Bill,” Community Health Alternatives Project, Institute for Policy Studies, Washington, D.C.)

Still, the present context is not simply one of interest group politics writ large, for the situation of the American economy is now quite different from what it was at the beginning of this period. The American economy is now challenged from several of its “trading partners” and, domestically, chronic stagnation is the general condition. The corporate view of the crisis argues that it has resulted from the diversion of too much of the social surplus from direct private investment to (non-productive) social and public expenditures. This, it is argued, has resulted in the lowered competitive edge of the American economy internationally, and the lowered rate of return to capital investment, since, it is argued, taxes, capital costs (interest rates), wages (including fringes) and the debt (-to-asset) structure are so high. The

Alford’s structural interests all reside within the petit-bourgeoisie; their ability to control their own territory rests ultimately on the continued satisfaction or lack of political interest of...the corporate bourgeoisie and organized labor.
basis. In either case "the effective institutionalized and legal control of the system as a whole by the dominant structural interests which benefit from its continuance in its present form" will be broken. And this without to any significant degree altering the larger political-economic system of power and wealth.

There is no apparent recognition of the pathogenic effects of a society based on accumulation through insecurity (competition).

One can see these shifting sands today in the medical care politics of New York City, the empirical basis of the studies of both Alford and Health/PAC. With hospital utilization rates declining, the voluntary hospitals are now more interested in closing, rather than exploiting, the municipals. Indeed, there is now substantial pressure coming from within their own trade association, the Health and Hospitals Planning Council, to close some voluntary hospitals. Even the medical schools are on the defensive, unable to maintain the levels of activity made possible by funding no longer available.

Beyond the Health Care System

But even this is only to argue with Alford on his own terms: the political sociology of health care organization, broadly conceived. A major limitation of this approach is the corollary implicit in Health Care Politics that all that stands between universal access to quality health care and the present circumstances is the retrograde, dominant structural interests. There is no apparent recognition of the pathogenic effects of a society based on accumulation through insecurity (competition), resulting directly in pollution and stress and ultimately in heart disease, stroke, kidney damage, mental disorders, drug addiction, cirrhosis, cancer, and other pulmonary disorders.

There is a further oversight implicit in the book—its assumption that there is nothing awry with medical science, if only it were not applied under such mercenary circumstances. Yet we are now beginning to find how inaccurate that assumption has been. The sociology of knowledge in (the ideological nature of) medical science is quickly becoming a fruitful area of intellectual investigation, particularly in the specialty areas of obstetrics, hypertension, oncology, and psychiatry.

Naturally it would be too much to expect these last two issues to be systematically dealt with in a single book which also investigates the political sociology of health care organization to the length which this one does. Yet it is rather late in the day to let such fundamental issues go unmentioned in a book entitled Health Care Politics. Moreover, to the extent that these two defects are empirically significant, the analysis of health care providers becomes that much less crucial.

Beyond Analysis

Finally, though it is not incumbent upon intellectuals in bourgeois society to root their investigations in strategic considerations, criticism of Health Care Politics along these lines would seem in order, given its polemical thrust.

As stated toward the beginning of this review, a static and mechanistic model of social behavior has, at best, no strategic implications, since, by inference, nothing can be done. The present distribution of power, according to such theories, does not rest on some delicate equilibrium of social contradictions, but rather on "the effective institutionalized and legal control of the system as a whole..." The historical origins and specificity of that control are never investigated, and, as a consequence, cynicism substitutes for program in the politics of the reader. Surely, this is not Alford's end and, in fairness, it should be pointed out that in the final paragraphs of the book he suggests that a class or institutional perspective may be superior to the pluralist or bureaucratic. According to that perspective health care is but a metaphor of the larger society and can only be significantly altered through a social movement, yet invisible, capable of reconstituting our entire present society on a new basis. However hortatory the intent, it still
leaves us with nothing. It does not point out the contradictions of the present, both in the health care system and out, which portend the possibilities of the future—both progressive and retrograde—on the knowledge of which we can begin to build a program—both in the health care system and out. We must move beyond the nihilism of Ivan Illich (11), the victim-blaming of Victor Fuchs (12), and yes, the cynicism of Health Care Politics. "Philosophers have only interpreted the world in various ways; the point, however, is to change it." (13)

― Sander Kelman

(The author teaches in the Sloan School of Hospital Administration at Cornell University. This review was adapted from an article appearing in the Journal of Health Politics, Policy and Law, Vol. 1, No. 1.)

Footnotes and References
6. Ironically, this is also the precise period and the sense in which the conclusions of Baran and Sweezy are accurate—but also historically specific.
9. Elements of the middle class (defined as a class, rather than as a status group) neither own the means of production nor are directly employed by them. Instead their principal activity, as doctors, lawyers, clergy, teachers, etc., is to reproduce the social relations of the society.
13. From a scene in the movie, "Morgan."

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Dear Health/PAC:

I read your malpractice article in the January/February BULLETIN. I found it timely and informative. I liked the general setting of the article in that you state that this situation only becomes a crisis when it becomes an economic threat to professionals and institutions. Your first section, on the triumph of economics, was good but could have been stronger with the addition of specifics regarding insurance company investments and losses. I agree with your analysis of the contradictions medical professionals find themselves in, for example, claiming of insurance companies following free market incentives while defending them for themselves.

I like your development of the internal conflict in medical practice between those who defend no limitation on practice and no reexamination and those other professionals who want limitation of practice and frequent reexamination. I think that this split does generally break down between office-based generalists and primarily hospital-based specialists. I would add that I think that the move toward reexamination and more efficient medical recordkeeping came from the so-called family practice movement, which indeed does have its base in institutions (and roots in the liberal wing of internal medicine) but is increas-
ums, drive them to group situations where they will receive "free malpractice," wages and benefits like other workers.

The fact that hospitals are becoming legally liable for the practice of those professionals in them fits in here also, in that as institutions (in the future controlled and operated by interests wanting only profit) they will try to closely supervise their workers for maximum efficiency.

Your next section on "A Healing Relationship or a Market Transaction" rings true, especially the conflict between the professionals' quest for profit and its supposed altruistic motives. I would like to add the example of fetal monitors as an instance of technology developed basically for profit. They provide some information to professionals about the status of the fetus during the labor process but may actually create the same problems that they detect. They have added tremendously to the cost of labor and delivery.

I agree with you that the evasiveness of the malpractice issue is a case of the "foam rubber pillow syndrome." Here in Chico, California the biggest hue and cry has come from physicians, mostly anesthesiologists and GPs practicing surgery. A neurosurgeon, 3 anesthetists and 5-7 GPs have stopped practice altogether and more have limited their practice. The "crisis" was used as an excuse:

1) by GPs and OB/gyns to restrict their practice to include only private fee-paying patients and to exclude Medi-Cal (welfare) patients. All GPs have dropped OB.

2) by the medical society and hospital accreditation committees to deny hospital privileges for an OB/gyn who had agreed to take welfare patients, worked part-time for the local Feminist Woman's Health Center and was sympathetic to home births.

3) by the medical society to publicly blame insurance companies and attorneys for the increased rates.

4) by all local MDs to raise their fees—e.g., from $450 to $1000 for a normal delivery.

I enjoyed your article. I hope that you can use some of these undeveloped ideas to improve your analysis. I imply that corporate interests have "motives" in "raising the malpractice ante" against organized medicine. Perhaps this is not literally true but I feel that the effect is the same. I would appreciate a reply. I work in a neighborhood health center in Chico, California and information such as the BULLETIN is invaluable to us.

—Mark Murray

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Alabama Blue Cross may have been a little overzealous in its attempt to cut costs. Seeking to block a union organizing campaign among its employees; it prohibited "... employees from discussing their wages among themselves." Unmoved by Blue Cross' argument that it did not strongly enforce the measure, a National Labor Relations Board judge ruled the tactic illegal.

(Wall Street Journal, May 25, 1976)

CHLOROFORM CAUSES CANCER?

Chloroform, long used as an anesthetic in hospital operating rooms, has recently been found by the National Cancer Institute (NCI) to cause liver, kidney and thyroid cancers in mice and rats. In a report released on June 10, 1976, NCI scientists called the findings "definitive for animal studies" and "a warning of possible carcinogenicity in humans."

These results may help explain the unusually high rates of cancer found among operating room workers (see BULLETIN, November/December, 1974).

Chloroform, also known as trichloromethane, is used in extracting and purifying antibiotics, in manufacturing dyes, drugs and pesticides, and in some toothpastes, cough medicines, liniments and salves. It is a widely-used industrial solvent. These studies are part of a continuing NCI screening program for possible carcinogens. (Chloroform is one of a class of chemicals called chlorinated hydrocarbons, many of which have been found to be carcinogens—for example trichloroethylene and polyvinyl chloride.) Copies of the chloroform report and additional information are available free of charge from the Office of Cancer Communications, National Cancer Institute, Bethesda, Maryland 20014.

BONANZA FOR PUSHERS

The ban on TV advertising of cigarettes, enacted in 1970, has proved to be a bonanza for other media. Newspaper and magazine advertising by cigarette makers has increased by over 300 percent since 1970. Advertising expenditures by makers of the top 20 brands, which had reached $241 million by 1970, dropped for a couple of years after the ban, but overtook the previous high in 1974, totalling $243 million. Advertising for 1975, when the totals are calculated, is expected to be even higher. The only major publications which refuse cigarette advertising are the New Yorker and Readers Digest.

(Health Law Newsletter, March 1976; Washington Monthly, February 1976.)

HEALTH COSTS PUT CRUNCH ON EMPLOYERS

American industry, which will pay $3.18 billion in employee health and safety costs this year, is becoming increasingly unhappy with the rising cost of health care. General Motors, which claims it spends far more for Blue Cross-Blue Shield ($1,700 per employee) than it does for steel (a cost it won't reveal), is calling for workers to pay for their own health insurance in contract negotiations with the United Auto Workers. Increasing numbers of companies are turning to self-insurance of employees,
in-house claims monitoring, and involvement in local health planning in an attempt to control health costs, according to Business Week.


DES SIDE EFFECTS: EQUALITY BETWEEN THE SEXES

Researchers at the University of Chicago recently found sterility among one-third of the sons born of mothers who used the drug diethylstilbestrol (DES) during pregnancy. The finding follows by four years discovery of the occurrence of a rare form of vaginal cancer among daughters whose mothers used the drug during pregnancy. DES was widely used to prevent miscarriages between the 1940s and the early 1970s. More recently it has been used as a "morning after" contraceptive pill.

(American Medical News, April 26, 1976.)

MARKETING INFANTICIDE

Increased reliance on bottle feeding is one of the prime contributors to high infant mortality rates in developing countries, a recent nutrition study by Cornell University has found. The study adds fuel to a growing controversy.

Manufacturers of infant formula, facing declining birth rates at home, have stepped up marketing efforts in developing countries where birth rates remain high. These bottle-fed infants suffer high rates of malnutrition and diarrhea, particularly among poor families who may lack clean water for diluting the powdered formula, facilities for sterilization and refrigeration, and/or income to purchase sufficient amounts of formula. Studies in some Caribbean islands found 82 percent of the mothers over-diluting formula, in some cases stretching a four-day supply to make it last as long as three weeks. Use of the formula also deprives infants of the immunological protection of breast milk, making them less able to fight infections.

But powerful advertising techniques associate bottle feeding with sophistication and development. In addition formula makers employ "milk nurses" who, working out of maternity wards and clinics, give away free samples and encourage mothers to bottle feed. Their identification as medical personnel (most are not) greatly enhances their credibility with poor mothers.

Thus mothers are convinced to give up breast feeding, which is free and nutritionally and immunologically ideal for the infant. "In many instances, placing an infant on a bottle is tantamount to signing the death certificate of the child," says Michael Latham, author of the study.

Protests against the manufacturers of infant formula, chief among which are Nestle, Abbott Laboratories, Bristol-Myers and American Home Products, are mounting in Europe and the US. Here they are spearheaded by the Interfaith Center for Corporate Responsibility (ICCR) which also distributes a widely-acclaimed film entitled, "Bottle Babies." ICCR may be reached at Room 566, 475 Riverside Drive, New York, New York 10027; phone (212) 870-2294.


DEPARTMENT OF INTERESTING FACTS

- The health care bill of a person 65 or older averaged $1,360 in the fiscal year ending in June 1975, three times that of a person 19 to 64 years old, according to a recent report issued by the Social Security Administration. Not only are their bills large, but they are increasing rapidly—expenditures by the elderly rose 18 percent in fiscal 1975 compared to 11.4 percent in fiscal 1974.

(American Medical News, May 24, 1976)

- The nation's health care bill will reach $133 billion for fiscal 1976--double the amount spent in 1970, according to the Congressional Budget Office (CBO). Under current policies, health care spending will reach $252 billion by 1981—a 113.5 percent increase in the next five years, predicts the CBO.

- Family budget estimates show that the amount spent on health care by an urban family of four is virtually identical for low, intermediate and high budget families. These families with average budgets of $9,588, $15,318 and $22,294 spent $818, $822 and $857, respectively, on health care. In contrast, expenditures for every other item in the budget were graduated by income level. Estimates of family budgets are conducted annually by the Bureau of Labor Statistics.


- Worklife expectancy for men has fallen 1.4 years—from 41.5 years in 1950 to 40.1 years in 1970. In the same period, worklife expectancy of women 25
has increased from 15.1 to 22.9 years.

(Monthly Labor Review, February 1976.)

Women physicians earn a median income of $33,000 compared to $54,000 for all doctors, reports a recent survey by Medical Economics. The reasons? Women physicians average only 55 hours a week, compared to 60 for all doctors (a difference which in private practice, at an average of $12 per patient visit, translates into $21,000 per year). More importantly, however, there are relatively few women physicians in high-paying surgical specialties. 84 percent of women physicians are in nonsurgical specialties (especially general practice, anesthesiology and pediatrics) compared to 58 percent of all physicians.

(New Physicians, June 1976)

BREAKTHROUGH FOR HEART ATTACKS: HOME CARE
The British have made a major breakthrough in the treatment of heart attack victims; they have discovered home care. A four-year British study found that the death rate within 28 days after the attack was 12 percent for those treated at home and 14 percent for those treated in the hospital. After a year, rates were 20 and 27 percent respectively. The subjects were men between the ages of 60 and 70 who had not suffered medical complications during the first few hours after the attack.

(New York Times, May 18, 1976.)

WHAT YOU PAY FOR

What should a doctor do when a patient can't pay the bill? Incredible as it may seem, "Take back the services," was the answer of Dr. Bobby Merkle of Uniontown, Alabama, who immediately removed stitches from the arm of 14-year-old Melvin Armstrong upon finding that Armstrong didn't have the full $25 fee. Merkle, the only physician in Uniontown, is white. Armstrong, like 65 percent of the county residents, is Black.

The Armstrong family, in a $50,000 damage suit, was granted $20 by an all-white jury—the cost of having the wound restitched by a physician in a neighboring community. The case is being appealed. Merkle was merely censured by the Alabama State Board of Medical Examiners.

(New York Times, May 20, 1976.)

RULING: HOUSESTAFF ARE STUDENTS

Interns and residents are "students rather than employees" according to a March 19, 1976 ruling of the National Labor Relations Board (NLRB). In a 4-1 decision, the NLRB rejected the contention of housestaff at Cedars-Sinai Medical Center, Los Angeles, that they are entitled to the protection of the National Labor Relations Act.

By its ruling the NLRB threw a monkey wrench into the organizing efforts of the Physicians National Housestaff Association (PNHA). Housestaff unions, except in states where existing labor laws cover them, may now be forced to strike for recognition, even if every intern, resident and fellow at an institution is enrolled in a collective bargaining unit. Housestaff associations are now in the same position as other hospital workers before federal legal protection was extended to employees of non-profit hospitals in 1974.

The Board's ruling was based on its conclusion that housestaff are "primarily engaged in graduate educational training" and thus provide patient care merely as a byproduct of the schooling.

The single dissenting board member, John Fanning, vociferously argued against the majority. "Certainly," he wrote, "there is a didactic component to the work of any initiate, but simply because an individual is 'learning' while performing this service cannot possibly be said to mark that individual as 'primarily a student and therefore, not an employee' " Fanning charged his fellow Board members with using a meaningless "semantic distinction. One does not necessarily exclude the other."

RULING: PNHA REACTS

PNHA President Dr. Robert G. Harmon denounced the NLRB decision: "Saturday night," Harmon said, "60,000 doctors went to bed as doctors and Monday morning they woke up to find they were students. This was brought to you by the same Administration that brought Watergate, Spiro Agnew and the Nixon pardon." Harmon promised to appeal the Board's decision, and, if unsuccessful, to fight for Congressional action explicitly including housestaff under the federal labor law.

The American Association of Medical Colleges (AAMC), on the other hand, was delighted with the decision. Its president, Dr. John A. D. Cooper, reiterated the AAMC's stance in its "friend of the court" brief before the Board, commenting, "This decision will further strengthen the traditional student-teacher rela-
tionship, which is largely re-
sponsible for the superior train-
ing American physicians re-
ceive.”

Like many other Washing-
ton actions these days, the 
NLRB ruling was tinged with a 
conflict-of-interest. Board mem-
ber Peter Walther was, before 
joining the board, a member 
of a Philadelphia law firm 
which represents St. Chris-
opher’s Hospital, whose house-
staff was also petitioning for 
NLRB recognition. Although 
Walther did not take part in 
the decision against the Phila-
delphia housestaff, he did join 
the majority in the landmark 
Los Angeles case.

ANNOUNCEMENTS

A manual on community 
health organizing, published 
in three booklets, has just been 
completed by Terry Mizrahi 
Madison. *Booklet I: The Amer-
ican Health System: A Consu-
mer Information and Action 
Guide* offers an analysis of 
major actors in the health sys-
tem and a guide to help local 
groups analyze parts of the 
system most relevant to them. 
*Booklet II: The People’s Guide 
to Good Health* discusses rights 
of consumers not only to get 
health care, but also to partici-
pate in making health care 
policy. *Booklet III: Organizing 
for Better Health: Strategies for 
Consumer Health Groups* ana-
lyzes various community 
health struggles and discusses 
different strategies.

The three booklets are avail-
able from the Appalachian Re-
search and Defense Fund, Inc., 
1116-B Kanawha Boulevard 
East, Charleston, West Vir-
ginia 25301. For a limited time, 
sets of all three booklets will 
be available for $5 plus $1 for 
postage.

A Berlitz guide to bureau-
cratese spoken in health policy 
discussions has just been pub-
lished by the House Commerce 
Committee Subcommittee on 
Health. *A Discursive Dictionary 
of Health Care* serves as a 
handy guide to medical, legal 
and governmental terms and 
acronyms, providing not only 
definitions and explanations, 
but a touch of whimsy as well. 
National health insurance, for 
instance, is defined as “a term 
not yet defined in the United 
States.” The Discursive Dictio-


Rutstein, David, Blueprint for Medical Care (Cambridge: MIT Press, 1974). $8.95.


Young, James Harvey, American Self-Dosage Medicines: An Historical Perspective (Lawrence: Coronado Press, 1974).

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