Profits in Medicine:

THE BUSINESS OF HEALTH IS BUSINESS. The structure and dynamics of private, profit-making companies explains much about how thirty-four cents of every health dollar is spent.

10 Ford-Carter Checklist on Health Issues:

NEW FACES, OLD DEBATE. The candidate's stances on health issues reflects the on-going national debate, as well as the muddiness of the entire campaign.

20 Vital Signs

Profits in Medicine

The US is one of the few countries in which profit-making industries are significant organizational components of the health system. About one-third of the $120 billion pouring into the health system passes through private, profit-making corporations. Two basic economic tendencies describe much about the underlying dynamics of these corporations. First, economic activity is increasingly concentrated in fewer and fewer big companies. Secondly, these corporations are in turn producing a more diversified line of health-related goods and services.

Profits, net income after expenses of private corporations, are a relatively small percentage of health dollars. As shown in Table III, it is possible to identify $1.7 billion of profit made in the US health industry in 1972. This represents approximately two
percent of total health expenditures for that year, although this is, in all probability, an underestimate. Applying the same conservative figure to 1975 health expenditures yields an estimated $2.4 billion of profit realized in 1975.

However the influence of the profit sector is considerably greater than this figure would imply. A better estimate of the magnitude and influence of profit making in the health sector is the fact that approximately 35 percent of all health expenditures pass through the profit sector. In other words, 35 cents of every health care dollar spent in the US went to a profit-making enterprise. (see Table II)

Profit-making industries have been major beneficiaries of the enormous growth of the health system in recent decades. Total US expenditures increased 277 percent between 1962 and 1975. The biggest spurt took place after the enactment of Medicare/Medicaid in 1966. Between 1967 and 1975, health expenditures more than doubled. At its current rate of growth, the Congressional Budget Office predicts that by 1980, health care will consume 12 percent of the gross national product.

While the profit component has remained a relatively constant percent of the health care dollar, 34.2 in 1962 and 35.5 in 1975, some industries expanded far faster, while others lagged significantly behind. For example, the pharmaceutical industry grew by 159 percent between 1962 and 1975, while proprietary (for-profit) nursing homes increased more than ten times during the same period. As shown on Graph I, the largest increases were registered by profit-making nursing homes and hospitals. The biggest losers were pharmaceuticals.

Predicting Ups and Downs

Uneven growth can best be understood in terms of the relationship between what economists call the product cycle and the market structure cycle. The product cycle describes the life history of a product from invention or discovery, through distribution and sales to eventual market saturation. This cycle forces firms to continually diversify into other product lines. "If a particular firm were tied to only one product," writes one economist, "its growth would follow the same life-cycle pattern (growing more rapidly when they first introduced and more

### Table 1

**US Health Expenditures 1962-75 (in 000's)**

<table>
<thead>
<tr>
<th></th>
<th>1962(a)</th>
<th>1967(b)</th>
<th>1962-67</th>
<th>1972(b)</th>
<th>1967-72</th>
<th>1975(c)</th>
<th>1973-75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$31,404</td>
<td>$47,879</td>
<td>52.5%</td>
<td>$86,687</td>
<td>81.1%</td>
<td>$118,500</td>
<td>36.7%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>10,598</td>
<td>16,921</td>
<td>69.7%</td>
<td>32,720</td>
<td>93.4%</td>
<td>46,600</td>
<td>42.4%</td>
</tr>
<tr>
<td>Physicians</td>
<td>6,498</td>
<td>9,738</td>
<td>49.9%</td>
<td>16,527</td>
<td>70.0%</td>
<td>22,100</td>
<td>33.7%</td>
</tr>
<tr>
<td>Dentists</td>
<td>2,234</td>
<td>3,158</td>
<td>41.4%</td>
<td>5,364</td>
<td>69.9%</td>
<td>7,500</td>
<td>39.8%</td>
</tr>
<tr>
<td>Other prof. services</td>
<td>902</td>
<td>1,139</td>
<td>26.3%</td>
<td>1,634</td>
<td>43.5%</td>
<td>2,100</td>
<td>28.5%</td>
</tr>
<tr>
<td>Drug &amp; drug sund.</td>
<td>4,095</td>
<td>5,480</td>
<td>33.8%</td>
<td>8,239</td>
<td>50.3%</td>
<td>10,600</td>
<td>28.7%</td>
</tr>
<tr>
<td>Eyeglasses &amp; appliances</td>
<td>908</td>
<td>1,514</td>
<td>66.7%</td>
<td>1,878</td>
<td>24.0%</td>
<td>2,300</td>
<td>22.5%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>695</td>
<td>1,751</td>
<td>151.9%</td>
<td>5,860</td>
<td>234.7%</td>
<td>9,000</td>
<td>53.6%</td>
</tr>
<tr>
<td>Prepayment expenses</td>
<td>1,088</td>
<td>1,818</td>
<td>67.1%</td>
<td>3,845</td>
<td>100.5%</td>
<td>4,593</td>
<td>26.0%</td>
</tr>
<tr>
<td>Govt. public health exp.</td>
<td>503</td>
<td>884</td>
<td>75.7%</td>
<td>2,075</td>
<td>134.7%</td>
<td>3,457</td>
<td>66.6%</td>
</tr>
<tr>
<td>Other health services</td>
<td>1,445</td>
<td>1,940</td>
<td>34.3%</td>
<td>2,606</td>
<td>34.3%</td>
<td>3,000</td>
<td>15.1%</td>
</tr>
<tr>
<td>Research</td>
<td>1,032</td>
<td>1,606</td>
<td>55.6%</td>
<td>2,058</td>
<td>28.1%</td>
<td>2,750</td>
<td>33.6%</td>
</tr>
<tr>
<td>Construction</td>
<td>1,406</td>
<td>1,930</td>
<td>37.3%</td>
<td>4,081</td>
<td>111.5%</td>
<td>4,500</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

(see note on methodology and references, p. 19)
Table 2
Profit-Making Components of US Health Expenditures 1962-75 (in 000's)

<table>
<thead>
<tr>
<th></th>
<th>1962</th>
<th>1967</th>
<th>1972</th>
<th>1975</th>
<th>% Increase 1962-75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total US health expenditures (a,b,c)</td>
<td>$31,404</td>
<td>47,879</td>
<td>86,687</td>
<td>118,500</td>
<td>277.3</td>
</tr>
<tr>
<td>Drugs &amp; drug sundries (a,b,c)</td>
<td>4,095</td>
<td>5,480</td>
<td>8,239</td>
<td>10,600</td>
<td>158.9</td>
</tr>
<tr>
<td>Non-profit hosp. expenses for food, supplies, drugs, etc. (d)</td>
<td>3,333</td>
<td>5,310</td>
<td>10,193</td>
<td>14,524</td>
<td>335.2</td>
</tr>
<tr>
<td>Construction (a,b,c)</td>
<td>1,406</td>
<td>1,930</td>
<td>4,081</td>
<td>4,500</td>
<td>220.1</td>
</tr>
<tr>
<td>Eyeglasses &amp; appliances (a,b,c)</td>
<td>908</td>
<td>1,514</td>
<td>1,878</td>
<td>2,300</td>
<td>153.3</td>
</tr>
<tr>
<td>For-profit hospitals (e)</td>
<td>498</td>
<td>829</td>
<td>1,632</td>
<td>3,076</td>
<td>517.7</td>
</tr>
<tr>
<td>For-profit nursing homes (f)</td>
<td>419</td>
<td>1,133</td>
<td>3,932</td>
<td>6,093</td>
<td>1,354.2</td>
</tr>
<tr>
<td>Non-profit nursing homes expenses for supplies, etc. (g)</td>
<td>82</td>
<td>184</td>
<td>627</td>
<td>1,035</td>
<td>1,162.2</td>
</tr>
<tr>
<td>Total for-profit component</td>
<td>$10,741</td>
<td>16,381</td>
<td>30,782</td>
<td>42,128</td>
<td>292.2</td>
</tr>
<tr>
<td>Profit component as % of US health expenditures</td>
<td>34.2</td>
<td>34.2</td>
<td>35.5</td>
<td>35.5</td>
<td></td>
</tr>
</tbody>
</table>

(see note on methodology and references, p45)

slowly later) and would eventually slow down and perhaps even come to a halt. If the corporation was to grow steadily at a rapid rate, it had continuously to introduce new products.‘‘(1) The process of diversification through merger and acquisition is described by the market structure cycle shown in Chart I.

The product cycle begins with the invention or discovery of a new product. Then it must be patented, tested, and the process of gaining user approval begun. During this stage, the market is generally crowded with small companies as well as some large corporations determining the probable risks and rewards of participating in that particular market. If the product passes through these steps successfully, it will be aggressively marketed, leading either to rapid sales growth or failure. In this second stage of the market structure cycle, the market becomes more predictable. Here competitive pressures, financial strength, marketing expertise, and other advantages of size begin to be felt, and small companies either fail or are taken over by larger ones. These fewer companies then compete for their share of a particular product’s market. The far-sighted ones take advantage of the large cash flows and profits generated during periods of rapid growth to develop new products.

The final stage in the product cycle occurs when the market gets “filled up” and sales growth slows or even stops. It is at this stage that mature corporations combine—through merger or acquisition—to increase their strength, expand into other areas, and
accelerate their expansion through sales outlets abroad and later through manufacturing by foreign subsidiaries. In their foreign ventures corporations attempt to expand the life of the rapid sales growth stage of the product cycle. (Keep in mind that the market structure does not move with the product cycle in as simple a way as described here, because modern multinational corporations have numerous product lines. The relationship between the two cycles is one of forces and tendencies. In addition, outside forces, particularly government, can intervene in these developmental stages.)

Corporations in the health arena are at various stages in the product and market structure cycles. For example, drug companies following their post World War II boom period (Stage 2) are adjusting and adapting to some rapidly changing conditions, with one leg in Stage 3 and another in Stage 4. The medical instrument and supply sector is characterized by many small companies and large scientific companies edging into the business (Stage 1); while traditional X-ray operations have reached Stage 2. There have always been privately owned hospitals and nursing homes, but chains which only began developing in the 1960s are moving into Stage 2.

**DRUGS AND PHARMACEUTICALS**

After three decades of enormous expansion, created by the antibiotics boom of the late 1940s and fed by the development of psychotropic drugs in the 1950s and birth control pills in the 1960s, the pharmaceutical industry is finally settled into a less hectic, but still extremely profitable existence. As the industry grows, it has become more concentrated as the dominant firms increased their domination. Yet drug firms are also becoming more diversified as drug companies move into other products and non-drug companies, like Greyhound, diversify in. Prospects for growth abroad have never been better, and drug markets are becoming more and more international in scope.

The last decade has not been without problems for pharmaceutical corporations. But with little competition from fledgling companies, the central position of drugs in clinical medicine, and the rapid expansion in health expenditures the drug industry has, for many years, been one of the most—if not the most—profitable in the US.*

**Concentration of Companies, Diversification of Products**

This is a highly concentrated industry. In 1972, the last year for which government data is available, the eight largest drug companies accounted for approximately 50 percent of the value of total industry shipments; the largest 50 companies for more than 90 percent.

Concentration does not always take the traditional form of large companies swallowing up smaller ones. There has been much more diversification into related or not-so-related product lines, through merger or acquisition. US Census data shows that the industry lost 358 companies between 1954 and 1972, a decline from 1321 to 963. A total of 189 mergers occurred between 1952 and 1957, an average of 32 per year. This sped up between 1963 and 1968, with larger corporations having a higher merger rate, to an average of 97 per year, or 581 total. (2) Mergers and acquisition activity derive from a corporation’s need to grow in order to survive. The 17-year patent on a drug makes a secure profit shelter, but they must find a

*Whether it is the most profitable industry or merely the second or third most profitable depends on the measure used. Net profits as a percent of net worth (return on stockholder’s equity) has been around 18 percent during the past two years, ranking it numero uno in the profit sweepstakes. Pharmaceutical pessimists, however, focus on profits as a percent of sales, which have fluctuated between nine and a half and twelve percent over the last few years, placing it second behind mining, or third behind mining and petroleum. (US Industrial Outlook, p. 108)
## Chart 1

### Product Cycle and Market Structure Cycle

<table>
<thead>
<tr>
<th>Product Cycle</th>
<th>Example</th>
<th>Market Structure Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invention and discovery</td>
<td>Spinal Cord implants</td>
<td>Stage 1&lt;br&gt;Many small companies. Large companies testing the waters.</td>
</tr>
<tr>
<td>Testing, patenting, and approval by government and consumers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction and marketing</td>
<td>3-dimensional X-ray scanners</td>
<td>Stage 2&lt;br&gt;Fewer and larger companies. Boom period.</td>
</tr>
<tr>
<td>Rapid sales growth or failure</td>
<td>Proprietary hospital chains, hypertensive drugs</td>
<td>Stage 3&lt;br&gt;Fewer and larger companies. Competition over market share, expansion into other product lines, development of new products.</td>
</tr>
<tr>
<td>Sales growth slowing and possibly halting</td>
<td>Birth control pills</td>
<td>Stage 4&lt;br&gt;Mature corporations merge or combine to increase strength. Expand abroad.</td>
</tr>
</tbody>
</table>

(see note on methodology and references, p.19)

Profit-generating replacement after that time. Increased public attention and regulation, the impending expiration of many patents on high volume and high profit drugs, and the decline in the introduction of newly synthesized drugs (18 in 1974, down from the 1959 peak of 63) have made the pharmaceutical industry a somewhat less promising growth area than it was over the last couple of decades. This has caused drug firms to diversify into other health-related areas (see box on Abbott Labs).

Mergers have also occurred from the outside in. The reputation of the health industry as a growth area and the high profit margins of the drug industry have led several non-health companies to acquire drug companies. Chemical giants, such as Dow and American Cyanamid have integrated vertically through purchase of pharmaceutical companies which use their chemicals (vertical integration). Also, non-related firms, e.g. Greyhound—now the second largest insulin supplier in the US—have bought their way in.

### Bigger MAC

In the Department of Health, Education and Welfare, MAC (which is neither a hamburger nor a political hatchet group from...
New York City) stands for Maximum Allowable Costs, the new HEW program whose purpose is to control drug costs under Medicare and Medicaid. Under the MAC program, pharmacies will be reimbursed at the lowest price for which chemically identical drugs are available from two or more producers—essentially generic (non-brand name) prescribing. The price will be calculated and set by HEW, based on acquisition costs plus a fee for filling the prescription. The program also requires that comparative price information be made available to physicians and pharmacists.

Currently, generic drugs, which are already more competitively priced than brand name drugs, account for about 10 to 12 percent of prescription drug volume. Most drug producers feel that the MAC program will have little effect on their sales and earnings. Merck predicted a minimal impact on sales and earnings in its 1974 annual report. Searle predicts a four percent decline in total company sales after MAC implementation. However, the effects could be larger in the next decade as patents expire on many widely used brand name drugs. Generic drugs are expected to increase their share of prescription drug sales to 45 or 50 percent. To counter this trend and the threat it poses to drug profits, companies are expected to invest more money in research and development programs surpassing the high $1 billion peak in 1975. The impact of MAC may fall heaviest on the small generic drug producers who are unable to spread marketing and distribution costs over a large volume of drug shipments. Therefore their drugs often have higher costs than those of big companies and they may be forced out of business as big pharmaceutical houses move into the generic line.

**Drugs and National Health Insurance**

Whether or not the MAC program cuts into total sales volume, the predicted advent of some form of national health insurance...
enhances the prospects of drug companies. Everyone expects greater drug sales under national health insurance. As one stock analyst put it: "In the United States, the average person spends about $20 a year on drugs, while in other countries with more comprehensive health insurance, the figure goes up to $35 per capita. We could go to $40 to $50 a year with national health insurance."(6)

The Federal government estimates that, under a national health insurance program, total industry shipments could rise from their 1975 level of $10.4 billion to about $16 billion by 1980 and to nearly $23 billion by 1985. Maintaining current profit rates (12.1 percent of sales in 1974), the industry will generate $1.94 billion in profits in 1980, and $2.78 billion by 1985.

MAC is important not only as a new form of government regulation, but it is also being watched closely as an indication of what cost regulation might be like under a national health insurance. The end result may be a marginal reduction in drug costs, and a strengthening of the economic position of dominant firms at the expense of the smaller drug companies.

The Imperial Connection

More so than any other health-related industry, the drug industry is multinational. The foreign trade of drug companies generates increased sales and profits, and provides an arena for relatively unregulated, wide-open testing of new drugs. The pharmaceutical industry has long passed the stage of only exporting drugs. Today they export capital, buying up local companies and building their own production facilities.

Foreign sales of prescription drugs are faster growing, and relatively more profitable than domestic sales. At a growth rate one and a half times greater than the US market the 18 largest US drug companies sell between 29 percent (Smith, Kline and French) and 53 percent (Pfizer) of their products abroad.(7)

The icing on the cake is that foreign earnings are taxed at a lower rate than are domestic earnings. Probably the best tax deal abroad occurs in the US colony of Puerto Rico, where earnings are exempted from US income for 15 years after a plant is opened. They have had a heyday from this tax break.

Pulling the Abbott Out of the Hat

Capitalism isn’t always easy, even for the capitalist, as illustrated by the story of Abbott Laboratories.

Abbott Labs had begun to diversify in 1964, because in the words of its hard-driving Board Chairman, Edward J. Ledder, "our new drug research was not coming along." It acquired health-equipment manufacturers and suppliers and a number of other laboratories in the next five years. So even before its problems had begun, Abbott had insulated itself from bad times.

1969 began a staggering period for the firm. It was rocked by three problems of major proportions:

—1969. Cyclamate was banned from the US market.
—1971. Contaminated Abbott intravenous solutions infected thousands of patients, resulting in the recall of all Abbott IV solutions.

Abbott’s caution in the mid-sixties was rewarded in its sales record in the seventies. Despite serious setbacks it did not experience a sales decline in any of these years. Due to unusual expenses between 1969 and 1971, the company’s net income after expenses fell sharply during these years. However, it was able to maintain a dividend of $1.10 per share in 1970 and 1971, raising it from $1.07Vi in 1969.

In 1974, according to Standard and Poor’s, Puerto Rican operations allowed Eli Lilly to increase its profits by $18.1 million, Smith, Kline and French by $16 million, and Baxter Laboratories by over $10 million.(8)

Pharmaceutical corporations also use foreign markets to sell drugs for use in ways that have been found to be unsafe or ineffective here. One example, cited in Congressional testimony by Dr. Milton Silverman, is chloramphenicol, an antibiotic that can lead to irreversible and fatal
anemia. In the US the label indicates it only for typhoid fever or other life-threatening infections. But Latin American physicians are encouraged to “prescribe it for relatively minor illnesses ranging from diarrhea, sore throats and urinary infections to whooping cough.”(9)

Only two US drug companies—Merck and Syntex—make public to the rest of the world the same scientific information about their products as they do in the US. This malignant situation is exacerbated by the often extreme overdependence on drugs evidenced in many underdeveloped countries. In these areas drugs often absorb 15 to 20 percent of all health care expenditures.(10)

The honeymoon is over for the drug industry. Their control of approximately 10 percent of US health expenditures will guarantee their survival. It is the pharmaceutical companies’ ability to diversify at home and expand abroad which is the underpinning of their continuing profitability.

MEDICAL AND DENTAL INSTRUMENTS AND SUPPLIES

This industry is about half the size of the drug industry but is growing fast. Industry shipments in 1976 are expected to reach $4.9 billion, an increase of 10 percent over 1975. It is in an earlier stage of development than pharmaceuticals—where they were perhaps two decades ago. While several products have been successfully marketed for some time, for example X-ray equipment, much of the industry is engaged in the earliest stage of product development—investing or discovering, testing, securing government approval, or introducing and marketing (Stage 1). Only a few are in the position of having rapid sales growth. Reflecting this, the industry is characterized by large numbers of highly competitive small firms with a few large scientific firms, well established in other markets, testing the waters. The first major attempt at government regulation, the Medical Device Act, was signed into law in June, 1976.

The supply and equipment industry will benefit greatly from rapid market expansion brought about by health care providers attempt to substitute equipment and material expenses for variable labor costs; increasing desires for ever more advanced equipment to perform clinical medicine; and pressure to "rationalize" the system and make it more cost-effective, through the use of automated diagnostic and multi-phasic screening equipment.

Profit margins are lower in this industry than in pharmaceuticals, running about six percent of sales for the largest companies, compared to nearly 11 percent for drug companies. Profits totaled about $308 million in 1974, less than a third the profits of drug companies.

Competition and Growth

The industry manufactures a wide variety of products ranging from disposable surgical dressings to heart pacemakers to computerized 3-D X-ray equipment. The considerable economic risk in this field—particularly instrument manufacturing where obsoles-
ience is rapid—makes product research and development and marketing crucial to company growth.

Distribution is another vital component of this industry. But because of the higher profit margins in manufacturing than distribution, other major hospital supply firms such as American Hospital Supply are attempting to increase their manufacturing component.

Growth and profit prospects are drawing many companies into the field, creating a highly competitive atmosphere in which many companies will be unable to survive. However, there is already substantial concentration, as nearly 50 percent of industry shipments is accounted for by the eight largest companies.

A focus on the product cycle in bioengineering well illustrates the dynamics involved in a highly technical field where the market is relatively new and still uncertain. The 1971 study, "An Assessment of Industrial Activity in the Field of Biomedical Engineering," sponsored by the National Academy of Engineering, provides unique insight into the early development of this industry. Despite considerable expansion since then, the basic dynamics are still the same.

The first item of business for a corporation entering this industry is to decide what to produce. They do not carry on massive or expensive research efforts on their own; instead they look to the journals and magazines of the medical profession, research reports, and meetings of medical professionals. These sources, in addition to being much cheaper than in-house research, have the important advantage of emanating from the medical profession. The corporation can therefore expect less resistance by physicians when they try to sell the product.

Estimating the size of the market is an important but difficult aspect of product determination. Accurate market estimation is possible for only a few products in common use, for example standard X-ray equipment. Even where need is obvious and the equipment literally life-saving, such as kidney dialysis equipment, market estimation is difficult because it depends on extra-industry decisions concerning reimbursement. Further complicating market estimation are physicians, who ultimately make most purchasing decisions, and have their own personal styles of treatment—often medically conservative.

These factors make clinical evaluation and product endorsement vital components of the sales effort. "Endorsements by opinion leaders through professional papers and personal recommendations," writes the National Academy of Engineering, "are the most effective means of generating confidence among the medical community."(11)

This process does not always work as planned. For example, a piece of EKG (electrocardiogram) equipment which met minimal federal standards and had a reputable name was widely purchased, even though it was "less capable of producing high quality data than older equipment that had been discarded by all those who either [could not] afford the new and shiny equipment or who [had], in fact, measured and compared the capabilities of each."(12)

In other cases, it can be very difficult to get physicians to purchase their products. For instance, physicians accept products embodying new technology based on conventional knowledge, like patient monitoring equipment, much more easily than they can (Continued on page 13)
If there is anything believable in campaign rhetoric then voters can believe that the presidential candidates will offer them a choice, at least on the issue of health, when they go to the polls in November. In fact, national health insurance, which, in spite of numerous predictions to the contrary, has never emerged as a campaign issue, may even become a major point of contention between Jimmy Carter and Gerald Ford. The stated positions of the two candidates, as of press time, are summarized below.

**Ford**

- **National health insurance**: Ford's chief domestic thrust has been controlling inflation; his health policies have been subordinated to this goal. Reflecting this, Ford opposes passage of any national health insurance bill whatsoever at the present time. The economy permitting, he would probably support a bill similar to the old Nixon Comprehensive Health Insurance bill, which he backed in his first months in office (see BULLETIN, March/April, 1974). The only measure Ford does support is the extension of Medicare to offer catastrophic coverage to the elderly, while increasing their share of non-catastrophic costs.

  On national health insurance, Ford appears to differ with the Republican national platform, which supports catastrophic insurance for "all who cannot obtain it," and encourages utilization of the private health insurance system. The platform "opposes any form of compulsory national health insurance," however.

- **Cost Control**: This has been a major concern of Ford, and has been effected mostly through vetoes of additional spending measures and passive support of regulatory measures. The Republican platform more explicitly calls for a coordinated effort to control costs, using "all available means" including (1) encouraging healthier lifestyles through education, (2) improved preventive care, (3) emphasis on out-of-hospital services, (4) improved distribution of health manpower and (5) elimination of wasteful duplication of medical services. The platform opposes "excessive intrusions from Washington" to achieve these, however.

- **Federal health programs**: Ford favors consolidating existing categorical programs by giving block grants to states under a revenue-sharing arrangement, where possible. This would allow states to distribute the monies according to their own priorities.
Ford’s health stands, except for his opposition to Democratic national health insurance proposals, are far from explicit, and are probably most accurately gleaned from his actions while in office. His chief concern has been budget-watching, reflected not only in his vetoes, but by the widespread impression among Washington officials that health policy is made in the President’s Office of Management and Budget, not by HEW. Frustration stemming from this fact was largely responsible for the recent departure of Charles Edwards, former HEW Secretary for Health. "Health has not been a high priority item for President Ford," states Stuart Altman, departing HEW Deputy Assistant Secretary for Health Planning. These sentiments are reiterated by Spencer Johnson, health staff member of the President’s Domestic Council, who said, "There is no health policy as such in this administration... there are principles. One of these is that categorical programs offer no consistency, no rational way to solve problems." Another is that the federal government should support activities that are best handled at the national level—such as research and development—but that other problems are best handled at the state and community levels. (Medical World News, September 6, 1976)

**Carter**

In contrast to Ford, who proposes little, Jimmy Carter, Democratic presidential candidate, promises much.

- National Health Insurance: "I say we need a national health insurance program. I mean to do it," says Jimmy Carter. (Washington Post, June 16, 1976) Specific provisions he supports include:
  - Coverage—universal and mandatory.
  - Financing—public financing through a combination of payroll taxes shared by employers and employees and general tax revenues.
  - Benefits—comprehensive, but to be phased in gradually according to need and feasibility.
  - Administration—to include use of private health insurance companies as financial intermediaries on a "trial" basis.
  - Cost and Quality Controls—to be "clear, strong and built-in." Mentioned specifically are (1) prospective reimbursement for institutions and physicians, (2) emphasis on preventive care, early detection and low-cost treatment rather than acute care, hospitalization and reliance on technology-intensive services and (3) additional costs to be minimized by reorganization of the present system to cut waste and inefficiency.

Community emphasis—community participation in policy-making, local emphasis in administration, concentration on development of community health centers.

- Geographic and specialty maldistribution of doctors: Better utilization of available health personnel, particularly physicians' assistants, nurse practitioners and para-professionals and redirection of medical education toward primary care.

- Research funding: Increased aid to find cures for heart disease, cancer, sickle cell anemia, drug addiction and other diseases.

Unlike Ford, who has a record to examine, but little stated policy, Carter has little record and much stated policy. Carter’s vagueness in many instances leaves him a host of different options. Thus some gossip on his predilections, experience and associations in health may prove more illuminating.

Carter’s nation health insurance position parallels the labor-backed Kennedy-Corman bill in almost every respect except that he envisions a role for private insurance companies and gradual phasing in of the bill’s provisions. Apparently Carter wasn’t always so chummy with labor on health issues, however. Rumor has it that early in the primaries he formulated a national health insurance position designed to embrace all camps except labor. When UAW President Leonard Woodcock, who had just endorsed Carter against Wallace in the Florida primary, heard this, he exploded. Carter
quickly reshaped his position and went on to win critical labor support in subsequent primaries. (*Modern Healthcare*, July, 1976)

Now the word on health issues in the Carter camp is "clear it with Woodcock," whose name is bandied about as the prospective Secretary of HEW. Carter reaffirmed his affinity for labor when he selected Walter Mondale, sponsor and long-time supporter of the Kennedy-Corman bill, to be his vice presidential running-mate.

Partisans cite Carter's Georgia health record as evidence of his administrative abilities. When in 1972 the Georgia Board of Health, then appointed by the Georgia Medical Association (a medieval arrangement, to say the least), proved intractible on a Carter-proposed drug abuse program, Carter announced plans to abolish the Board. He coupled this with a reorganization plan for the State Health Department, pushed it through the State legislature, fired the old physician-dominated board and appointed an entirely new cast to the newly-constituted Human Resources Board (the first appointment of which was his mother), snubbing the Georgia Medical Association and winning their ever-lasting enmity in the process. Carter later reflected on organized medicine, "[Doctors] collectively have done more to block adequate medical care for people of this country than any other single group." (*Medical World News*, August 9, 1976) The effect his reorganization had on the adequacy of medical care for Georgians is unclear.

Finally, Carter's health team may provide some hints for the future. Co-captains have been the husband-and-wife team of liberal Washington movers Peter Bourne and Mary King, once close friends and advisors of Carter who are now alternately reported to be in and out of favor. Peter Bourne is an English-born psychiatrist who served with the Green Berets in Vietnam. He headed drug abuse programs in Georgia under Carter and later came to Washington to be second in command of Nixon's Special Task Force on Drug Abuse. Bourne accepts the characterization of his politics as "very liberal" and many believe he will get a top policy job if Carter is elected. Mary King worked with SNCC in the early 1960s and then with health programs for OEO. She has recently been working as a private consultant in health.

Others seen around the Carter camp are Dr. William Roy, former Congressman and healthnik from Kansas, former HEW Assistant Secretaries for Health Dr. Philip Lee, Dr. Merlin DuVal and Dr. Charles Edwards, as well as Dr. Thomas Bryant, former OEO chief, and Dr. Harvey Sloane, mayor of Louisville. The list also includes Ruth Hanft, formerly of the Institute of Medicine and chief author of Nixon's Family Health Insurance Plan national health insurance proposal, now teaching at Dartmouth; Dr. Joseph English, former OEO and HEW health official and former head of New York City's Health and Hospitals Corporation, now head of psychiatry at New York's St. Vincent's Hospital; and Dr. David Kindig, former HEW manpower director, now executive director of the Montefiore empire in the Bronx.

**Conclusions**

With the economy in dubious shape, health-care inflation running 50 percent above the consumer price index and health care expenditures doubling every five years, the rising cost and resulting decrease in access to care are likely to be the health issue of the next four years. Ford acknowledges this, although his policy for dealing with it has been limited to a calculated refusal to spend more federal money with its punitive impact on the poor and elderly. Carter, following in the liberal-labor Democratic tradition, verges on not acknowledging any economic constraints whatsoever. And, campaign platitudes to the contrary, neither candidate acknowledges that behind every evil of the health system—be it skyrocketing costs, poor quality, duplication, waste, lack of preventive and ambulatory care, mal-distribution of health personnel or over-concentration on high technology medicine—lies one or several vested interests who benefit from the status quo and who have carefully engineered the system to work the way it does. But then political candidates do not announce in advance of election which, if any, interests they plan to alienate after taking office.

—Ronda Kotelchuck
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Profits

(Continued from page 9)

accept products embodying new physiological knowledge with new technology, such as nuclear medicine devices. Thus growth is likely to occur more rapidly in the new technology-old physiology market. However, while the new physiology market is less certain, there will be less competition there.

Medical Device Safety Legislation

Corporations throughout the industry understand the contradiction involved in federal regulation like the Medical Device Act of 1976. On the negative side they fear "excessive" government controls, which might slow the evolution of the product cycle. On the positive side, they understand that the development of realistic product safety and performance standards and controls are necessary to protect the user from unsafe or ineffective equipment. This would ease and speed product acceptance by increasing user confidence in the minimum quality level of products on the market. By rationalizing and standardizing the market, regulation gives a boost to large corporations who can plan marketing and distribution campaigns. As a result, Standard and Poor's predicts that federal medical device regulation will not have a material impact on "most of the major producers in the field . . . [but] . . . some smaller firms could have difficulty and may have to leave the field or be absorbed by a larger firm."(14) This parallels the effect of government regulation in the drug industry.

Foreign Markets

Foreign sales are just becoming important to health equipment corporations.
percent of industry shipments were exported in 1975 ($715 million out of $4.9 billion). Exports are expected to grow by 15 percent yearly, greater than the 10 percent annual growth predicted for the total industry. However, in contrast to the drug industry, imports of medical equipment are significant and are creating a bilateral international market.

INVESTOR-OWNED HOSPITALS AND HOSPITAL CHAINS

Investor-owned hospital chains are a phenomenon of the sixties, although individual proprietary (for-profit) hospitals have existed since colonial times. They grew rapidly during the late sixties and early seventies due to soaring medical costs, gaps in the medical-care market, the introduction of modern management and administrative techniques into hospitals, and their ready access to financial markets for both equity and debt. Today they control approximately one-third of all general care proprietary hospitals (378 of 1100 total proprietaries), about five percent of all US general care hospitals, and approximately three percent of all general care beds in the US.

In the context of general care hospitals they are a relatively small component, and cannot replace non-profit hospitals as the core of the US health system, in part because they want no involvement in teaching or in other nonprofitable areas. But the proportion of proprietary hospitals will probably increase. In certain geographic areas the proprietary presence is already quite large. In the Houston area, for instance, proprietary hospitals make up a third of all hospitals, and nearly all have been purchased by chains in recent years.(15) The Federation of American Hospitals, the trade association of the investor-owned hospitals, "estimated that of the 90,000 new hospital beds this country may need by 1977, at least 37 percent will be built by for-profit hospital companies."(16)

Hospital Chains and Management Contracts

Proprietary hospitals, whether or not they are part of a chain, tend to be smaller than other hospitals, located in more affluent areas, offer a limited range of services and be concentrated in a few states.(17)

There are over a dozen investor-owned hospital chains listed on major stock exchanges involved in general hospital ownership. Others specialize in nursing homes or psychiatric hospitals, such as Gericenters and Community Psychiatric Centers, Inc., respectively. In most cases these chains engage in much more than operating the hospitals they own. They have

Passing the Bucks I

US drug companies are so anxious for a piece of the rich European market that, according to a New York Times report, they have engaged in bribery, "questionable testing procedures, false accounting, patent piracy and other forms of abnormal competition." Eleven drug companies have reported making more than $12.5 million in "extraordinary overseas payments," generally to lower and middle level employees in government or regulatory agencies. These payments are peanuts compared to a market expected to reach $12 billion by 1980, about the size of the current US market. (New York Times, March 21, 1976)

Passing the Bucks II

Although the importance of foreign trade is much less than in the pharmaceutical industry, the trend is toward an equivalent importance in the future. The similarities even extend to the area of questionable marketing practices, as indicated by the example of the American Hospital Supply Corporation, which reported on July 1, in documents filed with the Securities and Exchange Commission, that "its overseas subsidiaries spend $1.2 million in bribes, kickbacks and other improper payments in the last five years." (New York Times, July 1, 1976, Section 3, p. 2)
diversified into many related and not so related businesses. Related businesses include automated data systems for hospitals, medical and dental laboratories, management and development services for health maintenance organizations, medical facilities construction, optical companies and the development and marketing of various prepaid health and dental plans. Probably the most distantly related subsidiary activity is recreational land development.

The role of subsidiaries distinguishes the operation of chains and single proprietary hospitals. The other principal differences are the chains' aggressive commitment to growth and their sophisticated business practices.

During the late sixties, chains grew through both the acquisition of other hospitals—proprietaries, voluntaries and even government—and the construction of new ones. New construction slowed in the early seventies because of record high interest rates, capital shortages and escalating construction costs. Acquisitions slowed as the stock prices of the chains tumbled. When stock prices were high, acquisition was relatively "cheap" for the company. A one million dollar acquisition costs only 10,000 shares when the stock is selling at $100 per share. But when the price is $10, they have to dish out 100,000 shares to make the same acquisition. The mid-seventies has renewed favorable prospects. Currently one cannot read any of the major financial publications—Barrons, Business Week, Forbes, Fortune, and the Wall Street Journal—for any length of time without coming across favorable forecasts on the profitability of hospital chains. This favorable press is important, for the availability of finance capital is necessary to enable the for-profit sector to grow and allows the shifting of resources from other sectors of the economy into the health market.

The latest growth strategy of investor-owned hospital chains is management contracts, under which they contract to run a health care institution or some component of it. A typical management contract runs for three to five years, and the fee generally amounts to six or seven percent of the hospital's gross revenues. In some cases, an incentive fee is included. The hospital under contract gives up a great deal of authority in exchange for the promise of financial health. Under this arrangement, the chains tend to break even the first year, "then profits range from one-third to two-thirds of the annual fee."(18) Thus chain operators receive income without tying up large amounts of capital.

The chains institute several revenue-enhancing and cost-saving measures:

- Bulk buying. Since they already buy in large quantities for their own hospitals, they can save the contracting hospitals 10 to 30 percent on the purchase of drugs, supplies, and even insurance.
- Increased collections. They bring in a team of experts to process and collect bills from private patients and third parties. Striking increases in the rate of bill collections are made. Sometimes they institute new accounting procedures in order to have the bills accepted by third parties.
- Increased rates. In many cases they aggressively seek higher reimbursement rates from third parties.
- Smaller staffs. Not atypically, they will lay off employees, occasionally amounting to one-fourth to one-half an employee per bed.
- Management efficiencies. For example, the management consultants replaced an unnecessarily expensive computer with a much cheaper model, and lowered the average computer costs per patient from $12 to $2.25.

A favorable report in Barrons went even further: "Chain operators not only run hospitals more efficiently, but also do a better job from a therapeutic standpoint. They spend money liberally on all kinds of...
diagnostic equipment, intensive care units and radiation therapy machines which will improve health care standards in the community and at the same time hypo revenues. Out-patient departments reduce health care costs but still turn into profit centers. If the community lacks doctors, they import some.”(19)

**Imperial Connection**

Investor-owned hospital corporations are actively expanding abroad, partly through ownership of hospitals—the export of capital—but mostly through management contracts—the export of expertise. American corporations manage hospitals in Saudi Arabia, Mexico and Panama (Hospital Corporation of America), Iran (American Medicorp) and London (American Medical International)—and own them in Paris and Guam (Hospital Affiliates International).

**Trends and Prospects**

Several important issues are raised by the existence and growth of proprietary hospitals. Are they really efficient? If so, how do they achieve savings? And perhaps most important, what happens to the quality of care when profit enters the picture in such a blatant way?

Investor-owned hospitals don’t exhibit overwhelmingly greater efficiencies than voluntary hospitals, it appears. In particular, they do not appear to have lower costs for similar services. Chains have introduced strong management controls into their hospitals through their managment contracts. It could be that most cost savings are absorbed in profits and in taxes, which only for-profit hospitals pay, instead of being passed on to the consumer through lower charges.

Care must be taken not to confuse profitability with efficiency. A hospital can be profitable and inefficient or efficient and unprofitable. For example, centralized buying of supplies can bring substantial discounts, which are unavailable to a single, small hospital. This creates profits through bargaining power, not efficient operations. Financial manipulations are another possible source of profits which are unrelated to efficient hospital operations. For example, in the early 1970s a hospital chain issued $1000 bonds, with a certain interest yield. In 1974 and 1975, as interest rates rose, bond prices fell. The firm bought back its own bonds in 1975 at the lower market price. They thereby made a handsome profit which was completely unrelated to patient care.

Construction is one area where proprietary chains are more economical than most
hospitals. Because of the volume of work, they are able to establish ongoing relationships with design and construction concerns, in some cases absorbing them as subsidiaries. By using similar designs and blueprints for several hospitals they save on design costs directly and are able to do construction more rapidly and efficiently. Humana, Inc.'s estimated construction cost per bed is $34,000, about half the national average of $67,000 per bed.

Quality of care is a difficult concept to measure. A recent assessment of quality care by Neuhauser indicates that quality in single proprietary hospitals is lower than that provided in voluntary teaching hospitals but that chain hospitals provide better care than independent proprietaries. (20)

The major hospital chains grew consistently over the past decade, increasing in size 10 to 14 times from 1967 to 1974. (21) Such growth rates are expected to continue in the next few years, and would get a shot in the arm if a national health insurance plan is enacted. Expansion will probably proceed in four directions: building or buying hospitals, managing hospitals, expanding abroad, and diversifying into related fields, for instance, by acquiring nursing homes or through the acquisition of medical supply companies or laboratories (i.e., by integrating backwards).

In broader perspective, the chains should have a considerable impact on the larger medical care system. Both directly and indirectly they will influence the system toward lower staffing ratios and more cost-effective administrative procedures.

The chains will undoubtedly survive as corporate forms, and tend toward concentration, merger and diversification. Over the long run, there may occur a convergence between non-profit and for-profit hospitals, possibly ending in the disappearance of the "for-profit/not-for-profit dichotomy" as "complex corporate structures evolve which contain both." (22) This will depend crucially on possible new reimbursement arrangements and the form and extent of the struggle over quality and humane health care in the years ahead.

A final implication of these trends is their contradictory impact on health care costs. It is possible that the heightened cost-consciousness of profit-making institutions will work to lower health care costs. In fact, proprietary hospital chains can construct a hospital at a considerably lower cost per bed than individual hospitals. But, more likely, any increasing "profitization" of the health sector will tend to increase the rate of health care inflation. Their drive for continued growth induces chains to provide new products as quickly as possible and to charge as high a price as the market will bear. As the for-profit companies drive to take over the "profitable" aspects of health care, they leave less profitable activities to the non-profit sector. This is especially noticeable in the case of proprietary hospital chains taking over profitable patients and procedures from non-profit institutions, leaving them with high-risk, low-income, unhealthy patients and high-cost, high-loss procedures.

TRENDS IN THE PROFIT SECTOR

The study of profits in medicine shows several important trends:

• Increased concentration of health-related corporations;
• Diversification of product lines;
• Entry of non-health companies into the health business;
• The growing importance of international markets; and
• Expanded government regulation.

Larger conglomerates moving into health bring with them management tools and methods well tested in the ways of monopoly profit maximization—price rises, restriction of output and the manipulation of consumers (or physicians) through advertising and other sales techniques—all geared toward stimulating both the level and composition of final demand.

More government regulation will establish needed standards and keep blatantly unsafe products off the market. Initially it will also raise the cost of these standardized products, but as large companies produce them on a mass scale, unit costs will probably decrease. Also sales of regulated products will be easier when they have been tested against minimum standards.

It is not immediately obvious whether a restricted number of products available on the market is a bad thing. The difficulty involved in judging the quality of a highly technical product, such as testing equipment or a drug, means that a physician or some other person with buying authority must spend a considerable amount of time deciding between products—unless, of
course, there is sufficient pre-marketing testing certified by a governmental or other regulatory agency. The existence of a large number of products means more freedom of choice theoretically, but in fact choice is limited mainly by the time required to test the various products. Since selection is usually made between a small number of products anyway, the smaller number produced under monopolistic market conditions may not effectively limit their choice. The real problem is that under either competitive or monopolistic market conditions the decisions as to what to research and what to produce are made on the basis of market conditions as perceived by profit-minded corporate executives, not on the basis of health care needs.

—Gelvin Stevenson

(Gelvin Stevenson, a member of the Union for Radical Political Economics (URPE) works with community groups in New York City.)

Note on Methodology

Tables 1, 2, and 3 show the breakdown in total health care expenditures provided annually by the Social Security Administration, data published every five years by the Census Bureau in the Census of Manufacturing, and other data gathered from various sources. The definition used for profits in this Table, profits as a percent of total sales, allows for an estimate of profits from all the relevant sectors which is consistent among all expenditure categories. It was practically impossible to calculate profits as a percent of net equity from the available data.

The Standard Industrial Classification (SIC) data from the Census of Manufacturing was included in order to show another angle of the profit-making sectors of the health industry. Although the SIC data is far from comprehensive—hospitals are not included in SIC data, for instance—it is nevertheless "pure" in the sense that it includes total industry shipments. Thus the data for pharmaceuticals provides an accurate picture of that industry, as compared with the Social Security data which is classified according to the institution funds originally flowed to. Therefore profit estimates based on SIC data tend to be more accurate than those based on Social Security data and these were used for profit estimated where possible. The Census data also serves as the basis for concentration ratios, which indicate the degree of concentration or monopolization in an industry.

There are innumerable difficulties in calculating profits from the available data. One problem occurs because most of the Social Security Administration categories combine expenditures going to both profit and non-profit institutions. For example, they do not distinguish between expenditures for hospital care going to profit or to non-profit hospitals. Therefore expenditures going to profit institutions were separated out from those going to non-profit institutions in the cases of hospitals and nursing homes.

Some expenditure categories are exclusively profit. These are drug and drug sundries; eyeglasses and appliances; expenses for prepayment and administration; and medical facilities construction. Categories of physicians', dentists', and other professional services may be profit or non-profit depending on how they are incorporated. Gross receipts of group practices (including dentists' clinics) are included here.

Another difficulty in estimating profits is created by the inclusion of expenditures for profit items, e.g. drugs and bandages, in the non-profit categories. For example, expenditures for drugs that are included on hospital bills are included in hospital expenditures. However, since all production of material goods is done by for-profit companies, it is safe to assume that these expenditures went predominantly to profit-making enterprises. About one-third of hospital expenditures were for supplies, food and drugs. Approximately 58% of the total was for workers' salaries and benefits, while the rest was accounted for by interest payments, depreciation, rent and net income after all expenses.

References

5. Ibid.
7. Standard & Poor's, op. cit.
8. Ibid.
12. Ibid., p. 76.
13. Ibid., p. 77.
21. Standard & Poor’s, op. cit.

Table References

d. Calculated by multiplying the expenditures of non-profit hospitals by the average ratio of expenditure for supplies, food and drugs to total expenditures for all US hospitals for the appropriate year.
e. Beds in proprietary hospitals as a percent of total (non-psychiatric) hospital beds was equal to 4.7 percent in 1962, 4.9 percent in 1967, 5.6 percent in 1972 and 6.6 percent in 1974. This data was calculated from Hospital Statistics, 1975 Edition (American Hospital Association), Table 1, by dividing the number of beds in “Investor-owned (for-profit) short-term general and other special” by the sum of the number of beds for “Total nonfederal short-term general and other special” plus the number of beds in “Federal” hospitals.
f. Data for proprietary nursing homes prior to 1967 is spotty. The percent estimated for 1975 Master Facility Inventory Survey, (National Center for Health Statistics, Division of Health Manpower and Facilities, Department of HEW) did not always break out nursing homes by ownership prior to 1967. However the Resident-Places Survey #2, made estimates based on ownership from a sample survey for 1964. Beginning with the total number of homes and beds in 1963 and the 1964 ratio of proprietary to total beds, I extrapolated back to 1962, assuming the same relationship between proprietary and total held in those two years. Proprietary as a percent of total beds equalled 60.3 percent in 1964 (and, by assumption, 1962); 64.7 percent in 1967, 67.1 percent estimated in 1972; 67.3 percent in 1973 and 67.7 percent estimated in 1975.
g. Calculated by multiplying the expenditures going to non-profit nursing home care (“non-federal long-term general and other special”, Hospital Statistics, 1975 edition) by the ratio of non-payroll to total expenditures for all US nursing homes. (Hospital Statistics) The ratios are 33.5 percent for 1962; 29.7 percent for 1967; 32.5 percent for 1972, 34.8 percent for 1974; and 36.5 percent estimated for 1975.
h. Calculated from 1972 for the five largest chains; American Medical International, Inc; American Medicorp, Inc; Hospital Affiliates International, Inc. Hospital Corporation of America; and Humana, Inc.
i. When no other estimates are available, I used the very conservative estimate of a five percent rate of profit. The use of such a conservative figure undoubtedly underestimates the actual profit rate in these areas.
k. 10.2 percent is the figure for 1973 from the US Industrial Outlook, p. 157.
l. 7.2 percent represents net income as a percent of sales for the Damon Corporation, 1972. This was one of the largest clinical laboratory companies.
m. Standard & Poor’s, H21.
Vital Signs

MEDICAID ON THE ROCKS

The first experiment in letting a private company entirely take over a Medicaid program, at its own risk, has failed.

In April, 1975 Health Application Systems (HAS) signed a two-year contract with the state of North Carolina to run its $405 million Medicaid program, excluding drug payments. (HAS is owned by the Bergen Brunswig Corporation, a health products wholesaling company.) Savings, which were anticipated through increased efficiency and tighter claims control, were to be split, with the state receiving 75 percent and HAS 25 percent.

By late spring HAS was in trouble. It claimed the state underestimated by 15 percent the number of people eligible and likely to apply for Medicaid. Moreover, the state legislature increased nursing home reimbursement in the meantime, resulting in greater nursing home utilization and increased expenditures.

As a result HAS terminated its contract with the state. It will continue to act as fiscal intermediary, however, (at no risk) until other arrangements are made. In the termination agreement the state agreed to assume all nursing home losses and HAS agreed to assume losses due to unexpected enrollment.

Although this experiment ended in failure, the takeover of Medicaid by private companies is a growing trend. Ross Perot’s giant Electronic Data Systems has just signed a similar contract taking over the Texas Medicaid program (costs will be renegotiated yearly, however), and has itself just won a contract to administer (at no risk) the Department of Defense’s civilian health program in the Southwest.


EXPERIMENTING WITH CUTBACKS

A Georgia “experiment” to cut Medicaid expenditures by requiring recipients to share the cost of medical services has been halted by the courts.

Federal Medicaid legislation specifically prohibits such arrangements, except in the case of an experiment or demonstration project especially approved by the Secretary of HEW. The State of Georgia got such approval for a statewide “experiment” designed to control Medicaid costs. By charging recipients a share of the cost of medical services, the State hoped to cut unnecessary utilization.

The State was challenged by several Medicaid recipients (represented by Georgia Legal Services, the Center for Social Welfare Policy and Law and the National Health Law Program) who argued that if the co-payment program was indeed an experiment, then recipients are entitled to protection afforded subjects of human experimentation under federal regulations, e.g., review of the experiment by an Institutional Review Board (IRB) and informed consent by the recipients. The court ruled in their favor and the subsequent IRB review found that
the risks of the experiment outweighed its potential benefits.

(Health Law Newsletter, August, 1976)

BUY FIRST, THINK LATER

Hospitals routinely purchase prestigious, sophisticated technology with little regard for its need, how it will be utilized, or its impact on patient care. This is the conclusion of a study of fifteen Boston hospitals undertaken by ABT Associates, a private research firm for HEW's National Center for Health Services Research and Development.

ABT zeroed in on purchasing decisions concerning five types of equipment—cardiac catheter laboratory equipment, automated blood analyzers, patient monitors, computers and diagnostic X-ray machines. It found that, by and large, hospitals made no attempt to quantify the impact of these devices on patient care and consulted with no other institutions about the estimated operating costs or utilization rates—rather they relied almost exclusively on the advice of department chiefs. ABT found that utilization rates of the new equipment averaged no more than 50-60 percent—prima facie evidence of overpurchasing. It further found that additional costs stemmed from the personnel required to operate the equipment not from the cost of the equipment itself. Obsolescence of the equipment, they found, could be expected within six to eight years.

(Medical World News, August 9, 1976)

LIFE EXPECTANCY RISES

Life expectancy in the US has reached the highest level ever, exceeding 72 years in 1975, reports the National Center for Health Statistics (68.5 years for men and 76.4 years for women). The increase above 1974 was due largely to two factors: (1) a drop of 2.9 percent in accidents, heart disease and stroke, and (2) a 3.6 percent drop in infant mortality. Countering the increase was a 2.3 percent rise in deaths from cancer.

The gap in life expectancy between men and women continued to widen, reaching 7.9 years, compared with 5.6 years in 1964.

(Medical World News, August 9, 1976)

BIG BROTHER EYES YOUR MEDICAL RECORDS

The confidentiality of medical records is an issue of increasing concern. Representatives from the Blue Cross-Blue Shield Federal Employees Program recently revealed that they occasionally give the FBI access to their records on psychiatric claims by policy holders. (Washington Report on Medicine and Health, June 12, 1976).

In a hearing the U.S. Privacy Protection Study Commission heard the Denver District Attorney detail how insurance companies get medical information: "Investigators posed falsely as doctors and nurses.... Sometimes they dressed in a cleric's attire. Sometimes persons within a hospital would walk in wearing a white jacket. Bogus letters were used..... Nobody has to break into an office. They can call in and claim they're a doctor. It's amazing what people will give over the phone." The Denver D.A. also described "a pattern of selling that information to insurance companies and their counsel because that information is very valuable to the insurance companies defending personal-injury claims."

(U.S. News and World Report, June 21, 1976)

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THE HEALTH OF THE AMA

The AMA's 125th annual meeting held in Dallas in June addressed many issues. But perhaps the most important went unaddressed—the health of the AMA itself. Only 3,800 doctors turned out—perhaps the smallest number in recent AMA history, notes Medical World News (June 26, 1976). Attendance at the 1965 meeting was 24,300.

While the prospect of Dallas in the summer may have discouraged some, Medical World News notes that AMA convention attendance has fallen steadily as that of sub-specialty conventions has risen.

Dues-paying membership has fallen from 151,000 last year to 138,000—largely as a result of a steep increase in dues from $110 to $250 a year. The AMA is anticipating the loss of another 10,000 members when the California Medical Association drops its rule requiring members to join the AMA.

CLEANING UP THE HUDSON

In a precedent-setting move, General Electric Company recently concluded an agreement with the State of New York to pay three million dollars toward the cost of cleaning up the Hudson River, which GE had been polluting for over 25 years by dumping PCBs (polychlorinated biphenyls) from its two capacitor plants in Ft. Edward and Hudson Falls, New York. GE also agreed to pay one million dollars for research on methods of cleaning up the river.

The State backed off assessing the entire cleanup costs to GE, however. Asserting that it shared responsibility for the pollution by issuing GE permits to dump the chemicals, the State agreed to put up
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another three million dollars for the cleanup. In doing this the State did not pursue the argument that its early information that PCBs were not dangerous came largely from studies conducted by the companies that profitted from its use.

Nevertheless the agreement is an important one. In the past companies have rarely, if ever, even contributed to cleaning up the pollution they caused.


HOSPITAL ACCREDITATION:
COVERING THE TRACKS

HEW has just proposed that documents relating to accreditation of hospitals by the Joint Commission for the Accreditation of Hospitals (JCAH) be exempted from public disclosure under the Freedom of Information Act.

HEW deems that hospitals meet conditions to receive Medicare (and usually Medicaid as well) on the basis of the JCAH accreditation, rather than conducting its own inspections of hospitals. (See BULLETIN, July/August, 1975, p. 31) When HEW did its own spot check of 100 hospitals recently accredited by the JCAH, a private, industry-dominated group, 68 failed to meet standards. For a brief period the public had access to accreditation information which JCAH turned over to HEW. Under the proposed new regulation, not only will this information be confidential, but JCAH will only furnish it to HEW with the specific authorization of each hospital.

(American Medical News, June 7, 1976) 23