Politics Makes Strange Beds

NEW YORK AS A LABORATORY FOR COST CONTROLS. After a 13-year war employing every other cost control ploy, New York State now turns to cutting excess hospital beds.

In August, 1976 New York State Commissioner of Health, Dr. Robert Whalen, having just been granted extraordinary powers by the state legislature to close hospital beds, issued a "hit list" of 13 New York City hospitals he deemed to be "unnecessary."

Targeting unnecessary beds and institutions for closing is the latest battle in a 13-year,
increasingly serious war on hospital costs in New York State. This war is of particular interest because it offers a preview, at the state level, of virtually every existing or prospective cost control weapon—from certification of need and massive Medicaid eligibility cuts, to prospective reimbursements and hospital revenue caps—in the federal arsenal.

**Certification of Need**

New York State enacted the first certificate of need legislation in the country following release of the findings of the 1963 Governor’s Committee on Hospital Costs (Folsom Commission) warning that “If costs continue to rise as they have in the recent past, by 1973 the average day in New York hospitals will cost nearly $100.” The law required that all hospital capital expenditures in excess of $100,000 receive prior approval from the appropriate planning body.

Certificate of need requirements, however, appear to have been an ineffectual means of controlling costs. The rate of increase in hospital costs which had so alarmed the Folsom Commission continued unabated. (In fact, the Folsom Commission had underestimated the rise by 43 percent; by 1973, an average day in a New York hospital cost not $100, but $143.) New York State found its cost per patient day rising faster than that in the rest of the country where no such regulation existed. Between 1960 and 1965 New York’s annual increase in the cost per patient day averaged 7.5 percent compared to 6.5 percent nationally. In retrospect, according to a report cited by Walter McClure in his comprehensive review of the literature, “Certificate of Need controls did indeed slow the growth in hospital beds but accelerated the growth in intensity per bed, so that capital cost increases (and hospital operating cost increases) remained unaffected.”

While the certificate of need program failed to dampen the state’s rate of health care inflation, the introduction of Medicare and Medicaid in 1967 simply opened the floodgates. New York State established the most generous eligibility standards in the country—an income ceiling of $6,000 for a family of four compared with that of $3,900 in California, New York’s closest competitor. The federal government funds half of the New York State Medicaid program, matched by 25 percent local and 25 percent state monies. Health care providers were quick to recognize a bonanza. During its first full year of operation, New York’s Medicaid program cost the federal government $277 million, more than had been anticipated for the entire country. The reaction of Congress was to impose more stringent eligibility criteria forcing the state to severely limit Medicaid enrollment.

But even dumping over one million people from the Medicaid rolls, which was done in 1969, failed to take the steam out of the inflationary engine of New York’s health care system. Costs per patient day increased by 14.2 percent per year between 1965 and 1970—nearly 14 percent above the national average. Between 1966 and 1971 the state’s own contribution to health care expenditures in New York City more than doubled, from $292.3 million to $678.1 million.

**Prospective Reimbursement**

By early 1969 state lawmakers began to focus on hospital reimbursement policies as the main culprit of cost inflation. As a temporary measure, Medicaid reimbursement was frozen for a period
overbedding suggests that the more appropriate concept should be "hospital intensity capacity." While no studies take on this more ambitious concept in toto, studies of particular services suggest the magnitude of the problem. It has been established, for instance, that to maintain optimal skills, an open heart surgery unit must perform at least 100 procedures a year; 200-300 are preferable. In 1969 only 16 percent of all hospitals with cardiac surgery units performed over 100 procedures a year, and only seven percent performed over 200. How many other services such as CAT scanners and radiation therapy units are similarly underutilized is not addressed by traditional estimates of overbedding and can only be imagined.

It maintaining unused or underutilized beds and services is expensive, however, overutilization is even more expensive—a concept totally overlooked by traditional estimates of overbedding. These accept current patterns of hospital utilization as appropriate and pinpoint only empty beds, while unnecessarily utilized beds may prove more serious in both number and cost, if not also in their impact on health care.

The most concrete evidence for hospital overutilization lies in the "Roemer Effect" which shows that, instead of the number of patients generating the need for hospital beds, the reverse seems to occur: bed supply seems to generate patients. Roemer found in 1959 that hospital utilization was most strongly correlated with the number of hospital beds available and not with population characteristics or rates of illness in the community. His finding has since been substantiated by several studies and is widely accepted. The second most important factor in hospital utilization rates appears to be the number of specialists in the community.

No one can say precisely how much of this hospital usage is unnecessary, but a number of different studies provide an inkling. Hospital utilization among matched patient populations enrolled in HMO's, for example, runs 30 to 50 percent less than that of the same patients dependent on fee-for-service care. Per capita hospital admissions and lengths of stay for the same procedures vary up to 50 percent among different regions of the U.S. Variation in the frequency of particular hospital procedures such as tonsillectomies, appendectomies and hysterectomies is even better documented. Although no one can pinpoint precisely the amount of unnecessary hospital use, what Roemer's and related studies show is that current utilization patterns are a totally improper basis upon which to project hospital bed need. Ignoring the Roemer Effect puts the projection of bed need on a continuous upward escalator: additional beds promote additional usage which, of course, points to the need for even more beds.

The state hoped that prospective reimbursement would force hospitals out of their spendthrift habits. According to Ralph Berry, a Harvard economist, "the legislated rate reimbursement was specifically intended to contain costs by discouraging the expansion of new services, by encouraging the phasing out of excess capacity, and constraining hospital cost inflation to the rate of input cost inflation." New services were discouraged by permitting no inflation or adjustment for new capital expenditure.

ditures. Thus, while increases, based on an index of hospital input prices, were granted each year for operating costs, capital costs were calculated on a fixed basis.

- The state forced hospitals to withdraw unused beds from service by building an automatic penalty for low occupancy rates into the formula. Consequently, some 6,000 general, acute care hospital beds in New York State have been shut down since 1972.9 Yet neither gross expenditures nor net bed complement has diminished since the 1969 adoption of prospective reimbursement. Even while some hospitals reduced their bed counts, others were adding beds (and most of the reduction has taken place in the public hospital sector). Thus, the number of general care beds in the New York metropolitan area increased by 3.5 percent between 1966 and 1976.10 Voluntary hospital general care beds increased by over four times that amount—by 15.3 percent.11

The reimbursement system failed to cut gross expenditures because the hospitals appear to have compensated for reduced reimbursement rates by increasing their volume. Thus while the length-of-stay and occupancy rates in the nation have fallen, New York’s have remained constant or actually increased. Between 1970 and 1974 the occupancy rate for general care hospitals across the country dipped from 80.1 percent to 77.8 percent.14 Yet the occupancy rate in the state remained constant at 85.2 percent13 while New York City’s actually rose from 85.4 percent in 1970 to 86.5 percent in 1974.14

Even more dramatic is what happened to New York’s length-of-stay. As the length of stay fell nationally by 3.7 percent (from 8.2 to 7.9 days) it increased in New York State by 1.0 percent (from 9.7 to 9.8 days).17 “The industry tries to make up through volume,” commented Joseph Giglio, Deputy New York State Health Commission for Finances, “anything we save by curtailing costs.”18

The reimbursement system did seem to dampen the unit, or per diem, costs of care in New York. Between 1970 and 1973 New York state, with an average annual increase of 11.5 percent in the cost per patient day, fell below the national increase of 11.8 percent. By 1974 the results were more conclusive; the average cost per patient day increased by only 9.4 percent in New York compared with 11.3 percent in the nation.19 A recent study by William Dowling of the effects of prospective reimbursement in southern New York State estimate that the reimbursement system

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
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<tbody>
<tr>
<td>1960</td>
<td>$31.08 (100%)</td>
</tr>
<tr>
<td>1965</td>
<td>47.08 (151%)</td>
</tr>
<tr>
<td>1970</td>
<td>95.46 (307%)</td>
</tr>
<tr>
<td>1974</td>
<td>154.56 (497%)</td>
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</tbody>
</table>

Source: Hospitals, J.A.H.A. Guide Issue, August, 1975

**Table II**

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>$31.08 (100%)</td>
</tr>
<tr>
<td>1965</td>
<td>47.08 (151%)</td>
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<tr>
<td>1970</td>
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<tr>
<td>1974</td>
<td>154.56 (497%)</td>
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</tbody>
</table>

Source: Hospitals, J.A.H.A. Guide Issue, August, 1975

saved Blue Cross and Medicaid a total of $204 million between 1970 and 1974.

The Reimbursement Game Gets Rough

State officials undoubtedly welcomed the relative reduction in health care inflation in the state. But the improvement became less and less adequate as the state’s fiscal problems worsened. By 1974, New York State was spending 21.4 percent of its entire expense budget on health and hospitals.21 The whopping total of nearly $3 billion in state funds was 140 percent greater than it had been in 1968.

Governor Carey responded by promulgating the Emergency Medicaid Law of 1976, giving the state budget director veto power over total health expenditures. All reimbursement rates thus became subject to prior approval by the budget director who was instructed to “take into consideration economic factors within the state which effect the economic resources available to meet the cost of government funded medical services.”22 If the budget director finds that “economic conditions will have a serious adverse effect on

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**Table I**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Beds</th>
<th>Beds/1000 Persons</th>
<th>Hospital Occupancy Rate</th>
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<tbody>
<tr>
<td>1960</td>
<td>640,000</td>
<td>3.6</td>
<td>74.7%</td>
</tr>
<tr>
<td>1965</td>
<td>742,000</td>
<td>3.8</td>
<td>76.0%</td>
</tr>
<tr>
<td>1970</td>
<td>848,000</td>
<td>4.2</td>
<td>78.0%</td>
</tr>
<tr>
<td>1974</td>
<td>931,000</td>
<td>4.4</td>
<td>75.3%</td>
</tr>
</tbody>
</table>

Source: Institute of Medicine, “Controlling the Supply of Hospital Beds,” 1976; Hospitals J.A.H.A. Guide Issue, August, 1975
the ability of the state government to pay for medical care at the proposed rates," he can order the rate setting bodies to revise the rates.  

With this law in effect, the state can effectively cap its yearly health expenditures, regardless of what any reimbursement formulas might indicate. At the height of the fiscal crisis, 1975-76, the state virtually froze its total expenditures. With little or no adjustment for inflation, hospitals took cuts in revenue. The average statewide Medicaid reimbursement rate in 1977 actually fell slightly below that of 1976—$181.40 a patient day in 1977 compared with $181.90 for 1976.  

Such revenue cuts appear to have taken their toll. Roosevelt Hospital, a 595-bed voluntary in Manhattan, claims a $9 million deficit for 1974, a net loss of $7.5 million in 1975 and, after the layoff of about 100 employees, a 1976 operating deficit of $1.3 million. This rather dismal situation caused the firing of Roosevelt’s chief administrator and his replacement by Hospital Affiliates, a large outside management company. Columbia-Presbyterian Hospital and Mount Sinai Hospital have also reportedly hired outside management consultants to help them adjust to the new fiscal realities.  

St. Luke’s Hospital, another Manhattan voluntary, estimates that its costs will rise by 7.5 percent during 1977 but its Medicaid reimbursement rate has fallen by 8.5 percent. During 1976 the hospital fired 400 employees in order to keep its operating budget out of the red. “We wonder if the state knows the difference between a squeeze and a stranglehold,” commented St. Luke’s vice-president for administration.  

The state’s 1976 move against rising hospital reimbursement rates produced not only a pained outcry from the hospitals but a rash of lawsuits challenging the legality of the action as well. “We have to be prepared to defend, in a lawsuit, every action we take these days,” commented one state health official.  

### Shrinking the System, a.k.a. Hospital Rubouts  

Responding to the pinch of heavy reimbursement controls, a special task force of the now-defunct Health and Hospitals Planning Council (HHPC), a publicly-authorized but privately-constituted planning body dominated by powerful voluntary interests, posed an alternative strategy: “It is the feeling of the Task Force that this approach to reducing costs (across-the-board-cuts) is not in the public interest, since it adversely affects the ability of all providers of health care to meet the needs of those seeking health care services. The Task Force believes that a sounder approach to decreasing expenditures is to eliminate entirely expenditures for services in institutions which are not needed to meet the public’s requirements for services.”  

The HHPC then proceeded to list 27 hospitals it thought should be sacrificed for the greater good of the remaining institutions. The bulk of the beds so generously offered up were from the city’s municipal system. Of the remaining 21 hospitals, 12 were small proprietary hospitals and the other nine, with one exception—a hospital already in bankruptcy court—were very small voluntary hospitals. The big medical empires—Columbia, Mt. Sinai, and NYU—went untouched.  

This strategy of shrinking the system had also occurred to the state, and in a second, major legislative move, the State Health Commissioner was given power to close down those institutions considered unnecessary. Prior to this the Commissioner could only decertify a hospital on the grounds that the institution was in flagrant vio-

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions/1000 Persons</th>
<th>Average Length of Stay (days)</th>
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<tbody>
<tr>
<td>1960</td>
<td>127.1 (100%)</td>
<td>7.60 (100%)</td>
</tr>
<tr>
<td>1965</td>
<td>136.6 (107%)</td>
<td>7.77 (102%)</td>
</tr>
<tr>
<td>1970</td>
<td>142.8 (112%)</td>
<td>8.26 (109%)</td>
</tr>
<tr>
<td>1974</td>
<td>155.5 (122%)</td>
<td>7.77 (102%)</td>
</tr>
</tbody>
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Source: Hospitals J.A.H.A. Guide Issue, August, 1975

<table>
<thead>
<tr>
<th>Year</th>
<th>Beds/1000 Persons</th>
<th>Hospital Employees/1000 Persons</th>
<th>Hospital Assets/1000 Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>3.53 (100%)</td>
<td>6.0 (100%)</td>
<td>$65 (100%)</td>
</tr>
<tr>
<td>1965</td>
<td>3.81 (108%)</td>
<td>7.1 (118%)</td>
<td>84 (129%)</td>
</tr>
<tr>
<td>1970</td>
<td>4.14 (117%)</td>
<td>9.4 (157%)</td>
<td>130 (200%)</td>
</tr>
<tr>
<td>1974</td>
<td>4.39 (124%)</td>
<td>N/A</td>
<td>197 (303%)</td>
</tr>
</tbody>
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Source: Hospitals J.A.H.A. Guide Issue, August, 1975
lation of the state hospital code, an event that occurred rarely, if ever, in the past. Now, the Health Commissioner may decertify beds simply on the grounds of excess capacity. It was on the heels of this legislation that Commissioner Whalen proclaimed the list of 13 unnecessary hospitals in New York City.

Whalen's list looked suspiciously like an abbreviated version of the HHPC list. All 13 hospitals cited by Whalen had also been named by the HHPC. The major difference was the significant omission of public hospitals from the Health Commissioner's log. But then, in the interim between publication of the HHPC and Whalen lists, four acute care municipal hospitals bit the dust.

Of the 13 hospitals fingered by Whalen, only one—French Polyclinic, a voluntary with a long history of financial woes—was of significant size. Although proprietary beds number less than five percent of the city's total, six of Whalen's 13 hospitals were proprietary. It would also seem that the chosen hospitals were among the city's least expensive. While reimbursement rates in the city average about $190 a day, the average among the unlucky 13 was under $140. Clearly Whalen's hit list was not representative of New York City's hospital system.

Curiously, in November, 1976, three months after the Whalen announcement, the New York State Health Planning Commission issued a new estimate of the need for acute care beds in New York State. By revising the beds-to-population standard downward, from 4.1/1000 to 3.75/1,000, New York City suddenly, by fiat, went from being underbedded to having a bed surplus.

As the president of Long Island Jewish-Hillside Medical Center, Dr. Robert K. Match, complained, "Counties which were underbedded in September became overbedded in November, e.g., Queens County, which was underbedded by 638 beds in September became overbedded by 938 beds in November—a total differential of over 1,500 beds in two months time." On the basis of the new calculations, the State Health Planning Commission announced that New York City was suddenly overbedded.

Why Is There An Excess?

The most significant factor in construction of hospital beds has been the growth of health insurance programs, both public and private. These have ended the dependence of hospitals on philanthropy and on the federal Hill Burton program and have built the funding of construction into the mainstream of hospital financing by creating surpluses and guaranteeing equity for bank loans. There is a growing consensus that these programs—Blue Cross, Medicare, Medicaid and commercial insurers—are responsible not only for the overbuilding of hospitals, but for runaway hospital costs in general.

Health insurance has come to constitute over 90 percent of all hospital income and its effect has been to insulate the health system from virtually any cost control constraints. Thus the patient, having paid his premium, wants the best the health system can offer. Neither he nor, more to the point, the doctor who decides what treatment is appropriate, need consider its cost, since that cost is paid largely by the insuror. For the hospital, insurance coverage offers a virtual blank check, paying on the basis of costs incurred. Higher costs thus generate higher revenues.

Consequently the hospital system operates largely outside any market system and is virtually free of cost restraints. Health care costs, while they eat tangibly into the consumer dollar, do so in a largely invisible way. They often bypass the individual entirely, and are paid instead by his employer or union to an insurance carrier or through taxes. Thus the whole process is insulated.

The reimbursement system feeds at least two other generators of health care cost, both well outlined by McClure in his comprehensive study of overbedding, "Reducing Excess Hospital Capacity." (1) The indefinitely expansible style of modern medicine: "The nature of a system's product is one of the most important structural elements. The quality, quantity and style of medical care are indefinitely expansible. The medical care system can legitimately absorb every dollar society will make available to it.... Providers can always try to provide ever greater safety margins for treatable patients, treat more and more hopeless patients, and screen for
Commission announced that there were 5,000 excess beds in New York City.

To the state, closing beds offered yet another strategy for reducing state health expenditures—a strategy it seemed prepared to pursue both directly and indirectly. Dr. Roger Herdman, Deputy Commissioner of Health, expressed this most bluntly: "All the strategies imposed by the state are directed at shrinking the supply. We will do this frontally or by trying the whistle them away by making the climate unbearable." According to Herdman, the state is looking for a total reduction of 20 percent in its bed complement.

If the Health Commissioner's newly-granted, if somewhat raw, power represented the direct route to closing unneeded institutions, reimbursement policy offered an indirect attack. By reducing or holding constant an institution's reimbursement rate, the state anticipated that a number of financially marginal institutions would be forced into bankruptcy. This was a reasonable hypothesis, considering that more than 60 percent of the hospitals in New York City were reporting operating deficits by 1975 and only the large, more established voluntaries had considerable reserves to fall back on.

The major voluntaries themselves subscribed to the hospital closure strategy. They reasoned that, if a famine was in the offing, it was better to have fewer mouths to feed. So long as the state concentrated its fire on the smaller hospitals, representatives of the major institutions were not unhappy to see the fiscal crisis take its toll on their weak sisters.

The City Joins the Chorus

By late 1975, New York City added its stamp of approval to the bed closing strategy. For nearly two years Mayor Beame waged a massive campaign to close a substantial piece of the city's public hospital system. Critics constantly charged that the campaign was one-sided, however: "What about the voluntaries and proprietaries? It isn't fair to just close public hospitals." Thus in December 1975, just as the public hospital crisis was coming to a head, Beame announced his intention to have nine small, non-public hospitals closed. He instructed the newly created Health Systems Agency (HSA) to produce a hospital closing plan.

In May, 1976 the HSA prepared to make its report. The draft was published with a singular disclaimer: "This report is obviously not a final and definitive document but a vehicle to focus on the problem and stimulate the discussion and debate needed to arrive at a decision point and agree on a course of action. Clearly any implementation which will occur must take place in a phased manner or time." This disclaimer is testimony to the intense struggle which must have taken place inside the agency while the document was produced.

The report itself is a tedious and tentative rendition of the problem. It cites the uneven historical development of New York City's tripartite public, voluntary and proprietary hospital system as reason for the maldistribution of beds among the city's five boroughs (Staten Island and Queens each have 3.0 beds per thousand residents, the Bronx and Brooklyn 4.0 per thousand residents and Manhattan has 10.9 beds per thousand residents). Next, it reviews demographic trends, projecting a population decline in the City of about 5 percent between 1975 and 1985. By cataloging the supply of beds, reviewing both length-of-stay and occupancy data, the HSA concluded that New York City will have a surplus of 6,500 general care beds by 1985.
Savings from the Closing of Beds

Hospital utilization increases with the availability of beds, according to Roemer's Law. Will it decrease as hospital beds are reduced? Several studies indicate that it will. One study estimates that a ten percent reduction in beds per thousand population results in approximately a four percent decrease in utilization (patient days per thousand population).

But how much money is saved by closing beds? This is more difficult to answer and depends largely on the type of closing. What kind of closings are possible and the resultant savings are both in turn highly dependent on the nature of the community and its facilities. The following very tentative estimates are based on a national average.

(1) Closing of entire hospitals effects the greatest savings. A ten percent reduction due to entire hospital closings will bring a savings of approximately eight percent of the annual per capita hospital expenditures. McClure estimates that if hospitals must be purchased in order to be closed, the investment would constitute approximately 22 percent of annual per capita hospital cost, and would be repaid by the resulting savings in three to four years. Entire hospitals are also most suitable for conversion to alternate uses which can help to offset the purchase cost.

(2) Individual bed closings are least effective in cost savings since many specialized assets and personnel must be retained. A ten percent bed reduction attained by closing individual beds saves roughly from .5 to 2.5 percent in annual per capita hospital expenditures. McClure estimates the purchase cost of these beds to be 15 percent of annual per capita expenditures, recoverable in five to 15 years from the resultant savings. Individual beds are most difficult to convert to alternate use.

(3) Closing of service departments such as X-ray, laboratory, and food service may result in a moderate saving (approx. 3 percent), but the relative cost of conversion to alternate use is high. McClure estimates that half of the closure investment of these departments would be repaid over a period of 10 to 15 years. Conversion to alternate use is severely limited.

Three major voluntary hospitals that were recommended for closure in the HSA study—Brooklyn Jewish (751 beds), Flower Fifth Avenue (332 beds), and Montefiore (close to 332 beds)—would account for 22 percent of the annual per capita hospital expenditures. McClure estimates that if these hospitals must be purchased in order to be closed, the investment would constitute approximately 22 percent of annual per capita hospital cost, and would be repaid by the resulting savings in three to four years. Entire hospitals are also most suitable for conversion to alternate uses which can help to offset the purchase cost.

As a consequence of the outcry, the HSA draft report was never finalized. As a matter of fact, the final version of the agency's Health Services Plan for New York City—the comprehensive plan required before the agency receives final designation—contained not a single mention of the issue of excess beds.

An Imperial Buffer

Due largely to stagnation on the hospital closure front the Governor in January, 1977 strongarmed the Mayor into announcing their intention to jointly appoint a health "czar" for New York City. According to press reports, a chief role of the "czar" would be to close "excess institutions."

With the mayor facing a tough primary this year and the governor up for re-election next year, bed closing was too volatile an issue for either to view with equanimity. The appointment of a czar for this purpose would add a protective buffer for both. According to Stephen Berger, Director of the Emergency Financial Control Board, the state's agency for controlling New York City finances, the czar "would take the heat and both public officeholders would be in a position to step back." The ideal candidate according to Berger is someone "equally well liked and disliked by both the municipal hospitals and the voluntaries,"
as obstetrics or pediatrics results in cost savings intermediate between closing entire hospitals and individual beds. McClure estimates the savings from a ten percent bed reduction by closing entire service departments to be two to four percent of annual per capita expenditures; the purchase cost is estimated to be 18 percent of annual per capita expenditures, recoverable from savings in five to ten years.

(4) Moratorium on new beds. The savings from a moratorium on the building of new beds accrue as the population grows and the number of beds to population falls. Savings are thus negligible in the early years, but increase with population growth. Because it does not require the closing of existing facilities, a moratorium is by far the most politically feasible way of reducing the number of beds to population, although it freezes existing distribution of beds in place.

Reductions in utilization and costs stemming from reductions in hospital beds rest on the assumption that hospital administrators will be forced to manage patient flow more efficiently and that physicians will exercise more stringent judgment in deciding who should be hospitalized and how long they should stay. These judgments are also constrained, however, by the availability of alternatives to hospitalization—e.g., day surgery and home care—not to mention insurance coverage for alternative forms of care.

Better management of patients, while it may result in a community-wide savings, will increase the unit cost of the remaining hospital care, since those patients who are hospitalized will be, on the average, sicker and will require more intensive care than is now the case. Also, of hospitals chosen for closing, the most vulnerable will be small hospitals considered marginal medically and/or economically. These hospitals invariably have the lowest costs and reimbursement rates, and in their absence patients will depend on the larger, high-unit-cost facilities.

In spite of the hoopla, no czar has been named to date. The buffer itself may have proven politically too hot to handle, or perhaps no suitable candidate has emerged for this kamikaze post. In either case, the idea of a czar seems to be in hibernation. It has, however, accomplished one important thing already. Like Jimmy Carter's hospital cost control program, it has put the hospitals on notice that if they will not yield an inch, the state may embark on a course that will force them a mile.

Extortion as a Tool of Public Policy

The latest episode in the state's campaign surfaced in March, 1977 when the State Health Department ordered a review of all previously-approved hospital expansion or renovation projects not yet actually under construction (called "pipeline projects"). The Health Department's Special Subcommittee for the Re-evaluation of Acute Care Projects, chaired by Joseph Terenzio, president of the United Hospital Fund, looking over renovation plans of several large hospitals decided it could demand tit-for-tat—no renovation or construction approvals from the state until the hospitals—this time some major ones including New York University Medical Center, Columbia-Presbyterian Medical Center and Terrace Heights Hospital—agreed to give up beds. This included withdrawal of approvals already given, providing the project had not reached construction stage.

The affected institutions responded with unmitigated fury. "It smacks of blackmail, clear and simple," said Irving Wilmot, executive vice-president of NYU Medical Center. "The idea that they are going to stop everything to cut beds is just crazy at worst and naive at best," Wilmot continued. "I guess we're going to have to have it out with them." The negotiations between the state and the hospitals has now moved into a less public arena with the exchange of documents and letters. As of July 1, 1977, no hospital had announced any bed closings.

Losing the Battle; No Bets on the War

New York State's war on hospital expenditures has had a limited success; its frontal attack on excess hospital capacity, however, has for the moment produced more flack than results:
Key National Studies of Hospital Overbedding

"A Statistical Profile of Short-Term Hospitals in the United States as of 1973." by Fredric Sattler and Max D. Bennett (Minneapolis: Interstudy, 1973). Issued in 1974 by Interstudy, health policy think-tank headed by Nixon advisor and HMO-promoter Paul Elwood, this study was the first to carefully assess the problem. The report estimated a national surplus of 69,000 beds—7.5 percent of the nation's existing 914,787 hospital beds. This surplus, Interstudy claimed, cost the public some $1 billion a year.

"The $8 Billion Hospital Bed Overrun," by Barry Ensminger (Public Citizen's Health Research Group, 2000 P Street, N.W., Washington, D.C., 1975). This 1975 report by Ralph Nader's Health Research Group found an excess of 100,000 hospital beds. In addition, they estimated that another 250,000 beds were unnecessarily utilized, and together the tab came to $8 billion a year in unnecessary costs.

"Controlling the Supply of Hospital Beds." Institute of Medicine (Washington, D.C., October 1976). This prestigious group put the stamp of officialdom on the issue in a special task force report calling for a 10 percent reduction in hospital beds within five years to be followed by additional reductions.


- No hospital has been closed by Commissioner Whalen despite his expanded powers.
- No hospital closing plan has been adopted by New York City's HSA.
- No health "czar," to reign over hospital closings, has been appointed.
- No beds have been closed in exchange for renovation approvals.

This notable lack of results to date, if not this entire saga, points to the difficulty with which serious regulation comes to the health system. With the exception of government budgeteers, little constituency exists for closing hospitals. Institutions are understandably reluctant to volunteer themselves for extinction. Hospitals workers are hardly enthusiastic about sacrificing their jobs. Similarly, users and the immediate community surrounding a hospital rarely wish to see it closed. Although the public will certainly benefit in general from attempts to control costs, measured against the loss of an institution, these benefits appear abstract indeed. In the context of a contracting economy, the public rightly suspects it is being asked to give up something—however dubious its quality or efficiency—for nothing.

HSA's, comprised of these consumer and provider representatives, are not an ideal setting for achieving a consensus on the issue. Recently created, HSA's are anxious to establish their community-wide legitimacy and calling for closings is hardly the best strategy. All of this adds up to an enormous political headache for elected officials who must balance their obeisance to budget directors against public reaction.

New York State has, theoretically, just granted its Health Commissioner the power to cut through all of these parochial and political interests and to close institutions solely on the basis of their being unnecessary. The problem with this power, however, is a bit akin to that of the atom bomb—the price of using it is so enormous that it may prove largely unusable, at least until the state reaches a new level of desperation. It is no wonder, then, that the state has more often turned to subtler means of reducing bed supply in New York:

- Reductions in reimbursement rates severe enough to push marginal institutions into bankruptcy.
- Penalties for low occupancy which encourage hospitals to take under-utilized beds out of service.
- Utilization review teams, now deployed in more than 50 hospitals, which are establishing the procedures and baseline data necessary to penalize hospitals for overutilization.

(Continued on Page 19.)
NHI: EXPANDING THE HORIZONS

What ever happened to national health insurance? The people, polls show, are to the "left"; they want more than federal underwriting; they want comprehensive, cost-controlled services as a right for everyone. The Carter Administration is to the "right"; it is backing off from more government spending, preoccupied with cost, emphasizing that more medicine won't lead to health as they cut back services to those who already have the least access.

Carter's unwillingness to confront the dominant interests in this highly inflationary, high-technology system—now openly called "too fat" by HEW Secretary Califano—has led the Administration to be more conservative about comprehensive restructuring through public financing. Although the President told the United Auto Workers at an impressive national forum for the "under-served and over-charged" in mid-June that he would have a proposal by 1978 and Califano's NHI Task Force is flying around the country visiting progressive community health centers, a fog still hangs over prospects for a comprehensive program surfacing from this Administration.

In this frozen setting, a progressive Congressman has challenged the Administration's health planners, asserting that the problems they are attempting to solve by cost containment and fiscal incentives are inherent in the privately-controlled, piecework-financed health care institutions that dominate this country's health industry. He has brought forward a radically different but straightforward plan for addressing these now federally-acknowledged ills of the health system.

Ronald V. Dellums (D., Ca.), a leader of the Congressional Black Caucus, introduced on May 4 his long-awaited Health Service Act (H.R. 6894), providing for comprehensive, community-based health services with progressive national financing. Dellums' proposal puts on the national agenda the issue of whether to proceed with more and more stringent controls from the "top," imposed on an essentially uncontrollable and chaotic private system, or to move toward a democratically-planned, community-controlled, nationally-financed health service. In sharp contrast with the various proposals for national health insurance—which would only prop up with federal and/or employer-employee money an inadequate, maldistributed, and inflationary private system—a health service such as Dellums is proposing would guarantee that high quality health services be available in every community and accountable to the residents of those communities.

The Dellums proposal would guarantee high quality health services available in every community and accountable to those communities.

Model bills were prepared by the Community Health Alternatives Project (originally at the Institute for Policy Studies but now located at the newly-created Public Resource Center in Washington, DC) and by the Committee for a National Health Service.

The Health Service Act that emerged from this lengthy process hews remarkably closely to the original MCHR principles. It would establish the United States Health Service Organiza-
tions, a non-profit corporation mandated to provide, without charge, comprehensive health services (including, notably, occupational health advocacy services) to everyone within the boundaries of the United States.

The governance of the Organization parallels the organization of health care delivery. It would be controlled from "below" through a process of "community federalism" that begins with elected community health boards ("communities" are defined as geographic areas containing about 25,000 people, less for isolated rural areas). These oversee the provision of primary, outpatient health care as well as any nursing homes and multi-service facilities located in the community. General hospitals would serve "districts" of about 250,000 people and would be governed by district health boards elected by communities. These district boards, in turn, choose members of regional boards which oversee specialized ("tertiary") medical centers.

When asked why the health service is set up as a private corporation rather than the expected government agency, Dellung's office explains that by current interpretations of the US Constitution, such a democratic, "bottom-up" structure cannot be part of the Executive Branch; it is unconstitutional.

This necessitated the adoption of a corporate form for the Health Service Organization.

Under the bill, health care facilities will be operated on a day-to-day basis through democratic worker self-management appropriate to each facility. Health workers would, in addition, be able to organize collectively. Patients would be assured extensive rights and access to a grievance and advocacy system.

Under the Dellungen proposal, the Health Service Organization would be funded by a special progressive federal income tax that would impose a much smaller financial burden on low-income and working Americans than they now bear for health care. Funds would be distributed on a capitation basis to the various levels of the health services. It is in this pre-paid, community-based budgeting and financing, and the provision of services through an organization that employs salaried health workers, that makes the Dellungen Bill such a departure from any of the national health insurance proposals now extant. All others would, in essence, provide varying degrees of federal funding and planning for the existing private, fee-for-service system.

When confronted with the charge that his plan is utopian and "can't pass," Dellungen replies: "I realize it is unlikely that this Congress—or, in fact, the next several Congresses—will adopt this legislation, but I firmly believe that a health service will increasingly be seen as the real alternative. The United States must move towards a health care delivery system based on the principles enunciated in this bill. It is imperative that the debate begin now."

Even before the bill was introduced, the American Public Health Association (APHA) went on record, at its most recent annual meeting, in favor of the principles embodied in the Dellungen Bill. The United Electrical Workers (UE) favors it; and the Gray Panthers, the activist senior citizens organization, has declared its support for the Bill.

However, left health critics and organizers have debated the "reformist" character of this approach (see, for instance, Sander Kelman in review of Health Care Politics (Health/PAC BULLETIN, No. 70, May/June 1976) or Louise Lander, "National Health Insurance", Health/PAC Special Report, 1975.) Some left-liberal ranks have expressed nervousness about whether it will detract from a united national health insurance movement or from the most effective local organizing (see, for instance, S. Axelrod and M. Roemer, American Journal of Public Health, May, 1977). Interestingly, top Kennedy-Corman Bill advocates continue to express keen interest in the introduction of such a bill to expand the breadth of national debate—in fact, to relieve Kennedy of holding up the lonely left flank.

The Dellungen-backed political education effort, on the other hand, will emphasize such immediate community-based actions as defending community health center budgets, democratizing health planning, and organizing health workers through such media as regional hearings and local action-study groups.

The important question, of course, is whether the Dellungen Bill will succeed in raising the consciousness and activating health service users and workers. Obviously this will take more than the introduction of a piece of legislation. Will they demand that politicians get off the dime and support the right to health care through a comprehensive community-based health service?

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Dellungen is supporting the creation of Health Service Action as a vehicle to conduct educational activities in support of the concepts embodied in the Health Service Act, in cooperation with community, labor and health worker groups across the country, and to gather comments and suggestions on the Bill. For information or copies of the Bill, write Health Service Action, PO Box 6586, T Street Station, Washington, DC 20009.

—Len Rodberg and Robb Burlage
WOMEN

WOMB-BOOM

While the sky seems to be the limit for American physicians performing hysterectomies, the province of Saskatchewan has found that public education and simple scrutiny has sent the hysterectomy rate in the province plummeting.

Hysterectomy (surgical removal of the uterus) may be acceptable as a treatment for anxiety, states Dr. James Sammons, the AMA's senior staff physician. Sammons, testifying before a recent subcommittee hearing of the House Commerce Committee, advocated use of this major surgical procedure as the treatment of choice for "pregnaphobia."

Judging from available statistics, there are many American doctors who share Sammons' opinion. The National Center for Health Statistics estimated that 794,000 women underwent hysterectomies in 1976. This operation—up 15 percent in just three years—is performed at a higher rate than any other surgical procedure as the treatment of choice for "pregnaphobia."

Hysterectomy has long been an accepted medical procedure for treating cancer of the cervix, uterus and ovaries and other serious gynecological problems, but its use as a birth control method and as a preventive measure accounts for the enormous variations in rates. (In the mid-1800s hysterectomies were performed for symptoms ranging from "troublesomeness" and "erotic tendencies" to such problems as "eating like a ploughman" and "simple cussedness." ) Dr. R. C. Wright, writing in Obstetrics and Gynecology, journal of the American College of Obstetrics and Gynecology, in 1969 promoted what have come to be called "birthday hysterectomies." "The uterus has but one function: reproduction. After the last planned pregnancy the uterus becomes a useless, cancer-bearing, symptom-producing, potentially cancer-bearing organ and therefore should be removed."

Risks and Benefits

Removing the uteri of all women at age 35—about one million a year—would prevent 34,800 cases of uterine cancer (a disease easily detected by Pap smear). This would save some 13,000 women who would otherwise have died of cancer, a gain in life expectancy for the entire group of 0.2 years. At the mortality rates for the operation (estimates range from 0.06 to 0.2 percent) some 600 to 2,000 women would have died from the operation itself and another 300,000 to 450,000 would have suffered such complications as infection, bleeding and blood clots (complication rates run 30-45 percent). The monetary cost would be $2.9 billion.

These figures do not reflect the psychological costs of a hysterectomy. There are many reports of women experiencing severe depression after surgery. A 1973 English study, for example, found that one-third of the women within three years of undergoing surgery were treated for depression. Other potentially harmful side effects may result. Hysterectomy appears to affect ovarian function and, if estrogen levels are thus impaired, higher rates of coronary artery disease could result. Even a one percent increase in death rates from heart
disease would offset any possible gain from cancer prevention.

Outrageous as elective hysterectomy sounds for relief of anxiety, sterilization, or the general prevention of cancer, such uses were informally endorsed at the 1971 meeting of the American College of Obstetrics and Gynecology. Following debate on prophylactic hysterectomy, the assembled doctors were asked to register approval or disapproval by their applause. An audiometer registered 25 seconds of applause from those in favor of prophylactic hysterectomy and 10 seconds from those against.

Hysterectomy solely for the purpose of sterilization—hystero-sterilization—is now performed routinely in many hospitals. At the Los Angeles County-University of Southern California Medical Center, for example, the number of elective hysterectomies increased 742 percent between July, 1968 and December, 1970.

The Saskatchewan Solution

In 1972 the Saskatchewan Department of Health noticed an alarming increase in the number of hysterectomies performed in the province. The number jumped 72.1 percent between 1964 and 1971 while the number of women over 15 years increased by only 7.6 percent. This rise occurred despite the presence of required second opinions for all major surgery. Obviously, most doctors simply rubber-stamped their colleagues' recommendations.

The Provincial College of Physicians and Surgeons organized a committee comprised of both medical and nonmedical personnel to study the problem. The Committee drafted a list of acceptable indications for hysterectomy (see box). According to a report by participants which appeared in the July 9, 1977 New England Journal of Medicine: "The so-called sterilizing, prophylactic or birthday hysterectomy was not accepted as a justified hysterectomy when not associated with other factors since, in our opinion, hysterectomy solely for the purpose of sterilization does not conform to good gynecological practice."

Based on these criteria the Committee found that the number of unnecessary hysterectomies performed in five major provincial hospitals ranged from a high of 59 percent to a still-unacceptable low of 17 percent. Although no penalties were invoked against doctors operating for reasons other than those listed, the Committee considered its activities very effective. By 1974 the number of unjustified hysterectomies had dropped to 7.8 percent. In those hospitals where unjustified operations were still being performed, the College of Physicians and Surgeons met with administrators and medical staffs and "recommended that unnecessary operations should cease."

The authors of the report noted in conclusion that: "It is also of interest that the start of the decline in hysterectomy rate was coincident with the publicity given to the high rate of hysterectomies in Saskatchewan in the news media in 1972 and the announcement of the formation of the Committee."

—Barbara Caress

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**Medical Indications for Hysterectomy**

The following is the list of medical conditions the Saskatchewan Study identified as acceptable indications for hysterectomy:

- Malignant and premalignant lesions of the female reproductive tract.
- Endometriosis: the appearance of uterine lining tissue in the abdominal cavity where it does not belong.
- Adenomyosis: ingrowth of the endometrium (lining) into the uterine musculature.
- Leiomyosis with a uterine weight of 200 grams or more (fibroid tumors).
- Salpingitis and oophoritis: infections, generally chronic, of the tubes and ovaries.
- Hysterectomy associated with complications of pregnancy.
- Benign ovarian neoplasms: tumors which are not cancerous and will not metastasize.
- Cervical dysplasia: thought by some to be premalignant cellular changes.
- Hyperplasia of the endometrium: an overgrowth of the uterine lining.
- Dysfunctional uterine bleeding: bleeding not related to normal menses.
- Pelvic congestion syndrome: a disputed category including such symptoms as low back pain and extreme menstrual pain.
CHILDREN BEWARE

On March 22 and 26 of this year, two New York City children, ages 5 and 6 respectively, died needlessly from a serious but easily preventable disease.

At the time the two children were stricken, both press and medical attention focused on two key facts, each alarming in its own right:

First, the disease was diphtheria, an often fatal condition that attacks the throat membranes and is highly infectious. When the five-year-old was diagnosed by physicians at Columbia-Presbyterian Medical Center's Babies Hospital, health officials hospitalized her three sisters immediately, realizing the public health hazard that a new outbreak of diptheria would mean. (The city's last outbreak had been in 1963.) One of the children had already been immunized and, fortunately, another simply never got the disease. But the five-year-old daughter of Dominican immigrant parents died on March 22, and her six-year-old sister survived only four days longer. When it was determined that none of the children attended day care centers or schools, and no further cases appeared (19 known contacts were checked), the potential nightmare of a diphtheria epidemic subsided.

Meanwhile the second major focus of attention—and the highlight of press coverage—concerned the circumstances whereby the two girls had not been immunized.

According to early news stories—based on a statement by the dead girls' mother taken by a NYC Department of Health official—the trouble lay with one of those notorious "Medicaid mills." According to the mother—although obviously distraught and despite some translation difficulties—she had sought immunizations from a Medicaid facility when the children were young but was turned away when one became too unruly.

This account apparently satisfied everyone concerned at the time. Unfortunately, it contained only a fragment of the truth.

There is no reason to disbelieve the mother's statement about the Medicaid mill. What was left out of the statement, however—and has been ignored publicly to date—was hinted in the March 1977, "Disease Control News-
letter at the New York State Department of Health:

"The younger of these two children had been seen in an outpatient department of a major medical center eight times in two years but had received no immunizations. During one visit there, she had a scalp laceration sutured, but no tetanus immunization was given. [Childhood tetanus immunizations routinely include diphtheria immunizations—ed.] In addition she had been hospitalized there at age three for twenty-four hours for another problem. The older child had also been seen previously in this clinic and she also lacked immunizations."

"The younger of these two children had been seen in an outpatient department of a major medical center eight times in two years but had received no immunizations."

New York State Department of Health

Medical Center's Babies Hospital, health officials hospitalized her three sisters immediately, realizing the public health hazard that
At Columbia-Presbyterian, the "major medical center" referred to in the State newsletter, one physician admitted, "most of the children coming through here—sadly enough—just don't get asked [for immunization histories]. These two girls just slipped through."

Were lessons learned from two young girls' needless deaths?

New York City Department of Health officials report they have initiated several new attempts to encourage voluntary taking of immunization histories in outpatient departments of the city's voluntary and municipal hospitals. Laminated cards have been prepared instructing physicians on the necessary vaccinations, booster schedules, etc.

Efforts are reportedly also underway to convince the New York State Medicaid office to use the taking of immunization histories as an indicator of quality of care, thus potentially affecting the eligibility for reimbursement of any physician treating any child.

Of the 81 child health stations that once served the children of the city, 24 have been closed in recent months.

However, these otherwise laudable efforts come in the midst of a major curtailment of child health services by this same New York City Department of Health. To cite a single indicator, of the 81 child health stations that once served the children of the city (providing immunizations and boosters free of charge), 24 have been closed in recent months. Could it be fewer preventive services are needed for the city's children? Hardly.

A recent study by the Department reveals that in many New York neighborhoods, as many as one-third of all children entering school lack one or more of the major immunizations mandated by law (P.H. Law 2164). In summary: large numbers of children lack necessary immunizations in New York. Voluntary hospitals cannot be relied upon to provide them. The Department of Health is curtailing its own provision of immunizations.

The lesson seems crystal clear. New York City children should live somewhere else.

**HEALTH AND HOSPITALS CIRCUS**

Mayor Beame's spring offensive against the NYC Health and Hospitals Corporation (HHC) was temporarily ambushed in early June be a single, well-aimed shot fired by a group known as the Coalition to Preserve the Municipal Hospital System.

The Coalition—a citizens group formed following the ouster of HHC President, Dr. John L. S. Holloman, Jr., in January—filed suit in State Supreme Court in June against Beame and the interim operating committee he named last April to replace Holloman. The grant of executive power to such a committee, the suit charges, violated the HHC enabling legislation, which intended a semi-autonomous, public benefit agency free of control by City Hall.

City Hall responded quickly to the suit, instructing the majority of HHC board members who are Beame loyalists to abolish the interim operating group and replace it with a "transition committee" holding considerably less power. At the same meeting, Joseph T. Lynaugh was upgraded from first executive vice president to acting HHC president. The Coalition still argues in its suit, however, that HHC executive powers continue to be wielded, in reality and illegally, from Beame's office.

Lynaugh himself has plunged headlong into managing the HHC's circus-like affairs, although some predicted he will have trouble wielding an iron fist with one hand tied to city hall. So far, he has begun moving in his own new management team while making himself inaccessible to the press. This latter "initiative" reportedly extends to the Executive Directors of the individual municipal hospitals.

Lynaugh's style may be better suited to the current political climate than that of his relatively open, press-conscious predecessor. It will certainly minimize embarrassment during Beame's re-election campaign. Unfortunately, it augurs poorly for even the limited public accountability of the municipal hospitals in the past, and it allows every Mayoral candidate the luxury of treating HHC policy as a non-issue in this campaign. In a city with the fastest-disappearing public health and hospitals services in the country, this is good news for only that handful of vested interests who have always felt the public's business should be conducted in private.

—Michael E. Clark
CARTER'S LITTLE BUSINESS PILLS

The Carter Administration has finally shaped its own thrust in occupational safety and health—a thrust that signals a major retreat from OSHA monitoring of small business.

In a widely reported press conference on May 19, President Carter's Secretary of Labor, F. Ray Marshall, and the Assistant Secretary of Labor for OSHA, Eula Bingham, announced an end to "nitpicking" regulations and enforcement of the federal Occupational Safety and Health Act (OSHA) and a return to a "common sense approach" to health and safety.

These goals seem reasonable enough. Who would favor nitpicking regulations or argue against common sense? What they mask, however, is an effort to placate small business while leaving millions of workers unprotected.

Four major actions characterize the thrust of the Administration program:

• Increased inspection of high-hazard industries accompanied by decreased inspection of low-hazard industries.

• An expanded educational effort to encourage "self-compliance" with OSHA standards by small business.

• Appointment of a special assistant to Bingham for small business matters.

• Revision of all OSHA standards and elimination of those having "no direct relationship" to safety and health.

With All Deliberate Delay

This shift in emphasis will mean the concentration of OSHA inspection efforts on large establishments, since 40 percent of these are considered high-risk compared with 20 percent of small industry. Moreover, OSHA policy already favors inspection of large plants in order to broaden the total number of workers covered. This allocation of resources to large, high-hazard industries makes sense only so long as an adequate inspection rate is maintained for workers in low-priority industries.

Even the present rate of inspections for small, low-risk industries, however, is appalling. According to OSHA figures, a small, low-risk industry such as a wholesale and retail business or service establishment, stands only one chance in 500 of being inspected in any given year. Put less charitably, a small, low-risk firm can expect an inspection about once every 500 years (Think for a moment of the situation an OSHA inspector might have encountered on tour of a typical supermarket during his or her last semi-millennial visit.) Due to its new policy of concentrating on high-hazard industries, OSHA will now slow this dizzying pace of inspections for small, low-risk firms to one visit every 1,300 years. The present owners should live so long!

The need to take inspectors from low hazard industries in order to more frequently inspect high-hazard industries stems directly from President Carter's attempt to hold the line on government expenditures. In his Labor Department memo Marshall states clearly, "We have been told not to expect any significant increase in the Department's outlay for controllable programs or in employment ceilings." He goes on to say, in a revealing comment on the role of zero-base budgeting:

"Zero-base budgeting requires you to rank your proposals in order of priority. We believe that this ranking is the most critical...

At the present rate, a small, low-risk industry stands only one chance in 500 of being inspected in any given year.
job you as a manager will perform in this budget cycle. Particular attention will be given to your ranking since, in order to allocate resources to the high priority objectives discussed here, and other possible new alternatives, we must cut back on lower priority ongoing programs." (Emphasis added.)

So instead of adding new personnel to target high-hazard industries, OSHA must take them from already depleted resources in the low-hazard industries. For those concerned with worker protection, this is nothing more than robbing Peter to pay Paul.

**Small Business Fatalities**

This attempt to modify OSHA through Executive action must be seen, of course, in the context of strong legislative and judicial attacks on OSHA. Small business organizations, abetted by right-wing political and big business groups, have aggressively lobbied against OSHA in the US Congress, where they traditionally have had political strength. Bills to exempt small businesses from OSHA coverage have repeatedly been introduced in recent sessions of Congress and failed by the narrowest of margins—and new attempts are now in the works. These attempts would have an even more serious impact on OSHA than the Carter Administration cutbacks.

A recent report by the Industrial Union Department, AFL-CIO makes clear the heavy cost in worker protection that will result if small establishments are exempted from OSHA coverage. The report notes that workplaces with 25 or fewer employees constitute 90 percent of all US firms, employ 30 percent of all workers and are responsible for almost half (45 percent) of all job-related fatalities reported by employers.  

Due to its new policy of concentrating on high hazard industries, OSHA will now slow its pace of inspections for small, low-risk firms to one visit every 1300 years.

"To exempt workplaces with three or fewer employees, for example, exempts 3.9 million workers. In the logging industry such an exemption deprives from protection 59 percent of workers. Among these workers, according to employer reports, one of four will be injured this year."

"In small foundries with less than 20 employees, the employers report double the rate of new cases of illness than is found in the industry as a whole."

"OSHA hygienists have found illegal levels of leukemia-causing benzene ten times more often in workplaces with 25 or fewer employees than in larger shops."

The impact of the Carter Administration’s retreat from OSHA coverage of small firms will be less severe than an across-the-board Congressional exemption. Time will tell whether the Carter actions reflect a basic Administration attitude or a strategic retreat in the face of imminent Congressional action. In either case, for an Administration supposedly friendly to labor, this one now looks suspiciously similar to its immediate predecessors.

—David Kotchuck
Reimbursement is frequently counterposed to planning as a strategy for reducing hospital bed supply, and it has many things—both good and bad—going for it. Many experts agree that reimbursement practices lie at the source of the problem and are therefore a key to its solution. (See box.) Compared with the unilateral power of the Health Commissioner or the political liabilities facing a governor or mayor, use of reimbursement to achieve bed closings seems impersonal, invisible

An Outline of Federal Policy Regarding Bed Supply

Hill Burton—Since its beginning in 1948, the Hill Burton Hospital Construction Program has channeled over $3 billion of federal funds into the building and modernizing of health facilities—15 percent of annual hospital construction costs. The program was originally designed to address regional and urban-rural imbalances in the supply of hospital beds—a goal it has largely accomplished. In its last decade Hill Burton shifted priorities from new construction to the modernization of existing facilities, and from rural to poverty areas; it also began to make money available for ambulatory care.

Medicaid and Medicare reimbursement for depreciation costs, as well as federal loans and loan guarantees (not to mention private insurers) have largely replaced private philanthropy and Hill Burton as the major source of hospital construction funds in the last decade. These sources have also made it possible for hospitals to finance their own construction through bank loans and the sale of bonds.

The Comprehensive Health Planning Act, enacted in 1966, provided funding for the establishment of a network of state and local planning agencies. These agencies were changed with drawing up a comprehensive plan for each state and local area and with making non-binding reviews of proposed capital expenditures. In the late 1960s, individual Blue Cross plans began adopting “conformance clauses,” penalizing hospitals that proceeded with building plans without CHP approval.

Section 1122, Social Security Amendments, enacted in 1972, required that states adopt certificate of need programs, requiring states to certify that all capital investments of $100,000 or more are, in fact, needed. Several states had already adopted such programs prior to these amendments; New York State has had such a program since 1964. HEW may deny Medicare and Medicaid reimbursement for depreciation or interest costs if a facility builds without prior state approval. Section 1122 was the first attempt to directly link planning with reimbursement policy. By 1975 all but one state had such programs and, increasingly, commercial lenders and governmental loan programs have begun to require certificate of need approvals before financing a project.

The National Health Planning and Resources Development Act of 1974 (PL93-641), supplanted the old CHP network with a new network of planning agencies endowed with expanded powers. Most significant, perhaps, is that HSAs, the local planning bodies, are mandated to review the appropriateness of existing facilities every five years, although they are not empowered to act upon their findings.
About Your Health,” the ad called upon Governor Carey “to promptly close those institutions designated by the State Department of Health” instead of trying to save money by cutting back further on Medicaid and Blue Cross rates.”

Since state officials have not yet settled on an effective strategy for closing excess hospital capacity, it is doubtful they have resolved some of the more difficult questions that may arise should they succeed. For example: since it is clear for reasons of political and economic power that small institutions will be squeezed out, how will the state deal with the consequent impact of further monopolization? What cost saving will result if patients formerly using low-cost, small hospitals now shift into large, expensive teaching hospitals? As the cost of this high-intensity medicine increases and the state becomes more desperate about cutting costs, what will be the alternative to severely limited access? With increasing monopoly power, who will deal with the increased ability of the large institutions to pick and choose the patients they prefer and to set their own prices? Do these problems portend snowballing, piecemeal and equally-ineffective intervention of the state into the internal affairs of the hospital industry, each step to correct the unforeseen exigencies of the last? Must hospital costs then join death and taxes as unresolvable problems?

Hardly. The only effective and humane means of reducing hospital utilization on the one hand and excess supply on the other lies not in cutting back, consolidating around, and then attempting after-the-fact to regulate high-cost, high-technology medical centers. It lies instead in providing the alternative—low cost, badly-needed, preventive and primary services—on the community level so that patients will not be forced to inappropriately seek these from the only institutions to which they have access at a stage in their illness when human and monetary costs can no longer be controlled.

Control of unnecessary expansion of costly and medically marginal services will remain an unreachable goal only for those public officials unwilling or unable to challenge the dominance of this kind of medicine.

—Barbara Caress and Ronda Kotelchuck

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Even as the regulatory and fiscal net tightens over hospitals, the story of Lahey Clinic’s attempt to relocate from downtown Boston to suburban Burlington illustrates how difficult effective regulation will be. This story underscores the power of special interests, while even themselves desperately threatened, to win their way on an issue of vital concern, however dubious that concern may be for the public interest. It also points to the paucity of groups whose interest is cost control when the issue is a concrete, local one. Finally, it also portends the fierce competition and subsequent monopolization that is likely to result from an era of contracting resources available to the health system.

The prestigious Lahey Clinic is an organized group practice located in Boston, Massachusetts. The physicians around which it is organized are salaried, highly specialized and attract many patients from areas well outside the Boston Metropolitan area. In fact, 40 percent of their patients come from outside Massachusetts.

Back in the 1960s, Lahey decided it needed its own full-sized hospital. The Clinic presently uses 300 beds in various teaching hospitals in the area. It also owns a small 60-bed hospital in neighboring Brookline. Lahey first explored several sites within the city and even bought acreage in the Mission Hill community of Boston. Low income housing occupied most of the land purchased. In the spirit of hospital expansion of the day, Lahey cleared the land of housing before even finalizing its plans.

Those plans were never finalized. Sometime after clearing the site, Lahey selected a new one in Burlington, a suburb of Boston. Ideally situated at the junction of two major arteries, the Burlington site rests in the heart of an established suburban community.

In the early 1970s Lahey completed plans for the new site. The new facility would include a new 250-bed hospital and a complete replacement of the institution’s clinical facilities in Boston. It would be half hospital, half clinic—staffed by member physicians of the Lahey group.

Just as Lahey was completing its new plans, however, the Massachusetts Legislature passed a Certificate of Need statute, creating what it called
a "Determination of Need Program" under the jurisdiction of the Department of Public Health (see box). The basic function of the program is to review major capital expenditures for health facilities to determine if these expenditures are, in fact, necessary. The staff reviews applications and submits recommendations to the Public Health Council which, acting as the Department, makes the final decisions.

Lahey's planned construction thus became one of the first expenditures to be reviewed by the program. In 1972 Lahey informed the Determination of Need Program that it intended to build a facility which would be 400,000 square feet in size and cost $43.1 million. With virtually no analysis of Lahey's plans (basic schematic drawings had yet to be drawn up) and over the objections of the local planning agency, the Department approved a 200-bed hospital—all private rooms—and the clinic component at an associated capital cost of $43.1 million. It was only after the approval that Lahey instructed its architects to begin designing the facility. The Clinic apparently did not inform the architect of any size or dollar limit on the construction.

**An Empire Doubles While No One Notices**

From the start, Lahey was beset with financing problems. Since Lahey had little of its own equity, almost the whole cost of the facility would have to be borrowed. Also, during this period, the bond market—Lahey's hoped-for source of financing—suffered severe jolts from the failure of New York State's bonds among other assorted financial troubles stemming from the general economic crisis being experienced throughout the country.

At this point, Lahey sought out the lender of last resort. In general, whenever the money market fails to provide financing because a project is considered too risky for conventional lenders, industry turns to the federal government, and the hospital industry is no exception. Because of unpredictable reimbursement policies, private money lenders have become reluctant to finance hospital construction; instead, the industry has turned to the Federal Housing Authority for assistance in the form of loan guarantees approved by the Department of Housing and Urban Development. If the project should fail and the hospital go into bankruptcy, the taxpayer, not only the institution, bears the financial penalty for the error. Lahey filed its application and was informed that approval would be forthcoming as long as the Determination of Need was clear of any and all appeals.

Meanwhile, Lahey's architects proceeded with a free hand. The facility first grew to 510,000 square feet, then on to 610,000 square feet. During this time, the Department of Public Health sent out a questionnaire asking all Certificate of Need holders to inform the Department if the costs of their projects had increased and why. Lahey dutifully responded that, yes, its costs had risen to $67,000,000 and claimed that inflation was the major factor in the increase. There was no mention of the change in size in this submission to the Department. (Lahey had been submitting architectural drawings indicating the size changes to another arm of the Department. That bureau, however, was unaware of any size limitations on the project.)

In March, 1975 the Department, in an unprecedented and incomprehensible attempt to "clear the decks" of a backlog of requests to approve cost overruns, decided that any hospital whose cost overrun ran less than 386 percent of the approved cost would be granted automatic approval without the increases receiving any scrutiny by the Department.

Lahey, however, had not finished growing. Nor had the cost of building the facility. In August, 1976, Lahey submitted another cost overrun request. In the request, the Clinic stated that the costs had risen to $79,000,000 while the facility had grown to 674,000 square feet. In four years, the costs had risen nearly 100 percent, and the size was two-thirds greater than the original proposal approved in 1972.
Initail Skirmishes

At this point, Lahey's hassle-free voyage through the bureaucracy ended. The Department balked at approving a cost overrun of such magnitude. They had been stung by previous mistakes. The Department had earlier approved a request by Faulkner Hospital agreeing that personnel would be cut in half as a result of an expensive, mechanized hospital design. The number of employees doubled, however, and were it not for emergency aid from the federal government, the hospital would have been bankrupt the day it opened.) The Council requested more information before it voted on the cost overrun request. The Public Health Council ordered the Determination of Need Program Director to investigate why the facility was costing so much and whether the project changed so substantially that it could no longer be considered the same project that was approved in 1972.

During the investigation, a division developed within the Department. Some staff members concluded that the project had changed substantially. They further believed that the project would result in such a high daily hospital cost that third party reimbursers, especially Medicare, would be unwilling to pay the full costs. The State Rate Setting Commission stated that the all-inclusive daily rate would be $380 while a single outpatient visit would cost $70. These staff members felt that the project would prove financially unfeasible and that the hospital would face bankruptcy the moment it opened. It also became clear that the

Determination of Need Program in Massachusetts

The Determination of Need process is a program of the State Department of Public Health. It reviews any capital expenditure for a health care facility which falls within the following categories:

1. The capital expenditure is over $100,000.
2. A substantial change in service is involved. For example, changing beds from a medical/surgical use to intensive care use.
3. The capital expenditure involves the approval of an original clinic license, alcohol detoxification facility or halfway house.

The applicant submits a description of the project with associated capital expenditure to the Determination of Need Program, the

The stakes are high. The regulatory and economic climate make it clear that the entry of Lahey into the community will drive out one or more of the existing hospitals.

Department had never adequately analyzed the project from the beginning. This group therefore reasoned that the Determination of Need should be revoked. If Lahey still wished to proceed, its plans would then be opened to public scrutiny via a new Determination of Need application.

Opposing the staff findings were those in the Department who believed that revocation would not stand up in court, that Lahey had not intended to deceive the Department (since Lahey had indeed filed drawings indicating the change in size) and that the Determination of Need Program might not survive the political repercussions that would result from a revocation decision. This group included two assistant commissioners and, as it turned out, the Secretary of Human Services—a cabinet officer to whom the Public Health Commissioner reports.

In an unusual meeting on the Lahey matter, the Secretary of Human Services informed the staff that he had received calls from many politicians, including Senator Edward Kennedy, all urging that the project be allowed to proceed. He agreed with the assistant commissioners and recommended the staff permit Lahey to construct the facility as designed with no further investigation.

The staff finally conceded and recommended to the Public Health Council that, although the proj-
local HSA, to other State Agencies as appropriate and to the Department of Elder Affairs, Mental Health, or Environmental Affairs—whichever is appropriate.

Once an application has been submitted, any ten or more taxpayers may petition the Department of Public Health for recognition as a "Ten Taxpayer Group." Once recognized, they may then receive all correspondence transmitted among the parties of record. A Ten Taxpayer Group can call for a public hearing and submit comments concerning the application to the Department of Public Health.

Once all parties have submitted comments to the Determination of Need Program, a staff summary is drawn up which includes the Determination of Need Program recommendations and the recommendations and comments of all the other parties of record, including those of any "Ten Taxpayer Group." This staff summary is submitted to the State Public Health Council which makes the final decision concerning approval or denial of the project.

The Public Health Council is made up of nine members appointed by the Governor; the Commissioner of Public Health serves as chairperson. (Numbers are specified for seats for doctors, other providers and consumers.)

After the Public Health Council reaches a final decision, any party can appeal it to the Health Facilities Appeals Board, which reviews procedural questions. This Board is also appointed by the Governor and made up mostly of lawyers. The Health Facilities Appeals Board can remand a decision back to the Public Health Council for reconsideration. If upon reconsideration any party still believes itself to be aggrieved, it can go to court to seek an overruling of the decision.

Several hospitals in Massachusetts have also sought legislative relief. That is, upon denial by the Public Health Council, they submitted a special exemption bill to the legislature. To date, all significant special exemption bills have been either voted down or vetoed.

ect had changed, no punitive action should be taken. The Public Health Council voted on December 14, 1976, with one dissenting vote, to support the staff recommendation.

Two staff members later wrote a memo to the file revealing the internal dissension within the Department. A UPI reporter subsequently gained access to the memo. When interviewed, the Secretary of Human Services claimed it did not accurately reflect the meeting. Senator Kennedy's office denied that the calls made were intended to influence the decision; rather he simply wished to ascertain the progress of the investigation. The Kennedy aide further claimed the calls were unrelated to Kennedy's status as a long time trustee of Lahey Clinic.

**Full Scale War**

Lahey successfully hurdled one obstacle only to find a host of others. Just as its officials thought they had cleared the bureaucratic woods, and the long-simmering turf battle between Lahey and its suburban competition boiled over into full scale war. In January, 1977 four area hospitals filed suit to prevent construction of the facility, and the Battle of Burlington commenced in earnest.

The opponents of Lahey charged the move would have an adverse economic effect on their hospitals. In addition, a group of physicians from the Burlington area constituted itself as a "Ten Taxpayer Group," and filed an appeal with the Health Facilities Appeals Board stating that the Department's action was improper and that it should have revoked the Determination of Need. This group also argued that the construction of the Lahey facility would have an adverse economic effect on the health care system. (The Health Facilities Appeals Board decides whether the Public Health Council actions are within its regulations and all parties have been accorded proper due process. The "Ten Taxpayer Group" is a mechanism for public participation in the Determination of Need Process. See box.)

The stakes in the fight are high. The regulatory and economic climate in the health industry make it clear that the entry of Lahey into the community will drive out one or more of the existing hospitals. On a less dramatic scale one community hospital has already been denied the acquisition of a brain scanner on the grounds that the Lahey scanner will be sufficient to serve the area and they recognize this as a portent of the future.
Lahey would become the logical locus for the regionalization of many different services. The stakes for Lahey, however, were equally high. It had already invested $11 million in the project. With this investment as outstanding debt, a decision to stop the project might create a financial crisis the Clinic could not survive. Regardless of the risks and expense, Lahey officials were determined to proceed.

Lahey quickly enlisted the aid of the Executive Director of the Boston HSA, who assumed the role of moderator between Lahey and its opponents. When the opponents held firm, Lahey decided to pull out its big guns. The Clinic threatened to file a $40 million countersuit against the hospitals and doctors on the grounds of malicious prosecution, restraint of trade or both. Faced with virtually unlimited legal expenses for their defense plus the possible jeopardy of their own building programs (since no bank will lend to an institution with a multi-million dollar suit pending against it), the doctors and hospitals capitulated and signed a memorandum of agreement dropping all suits and appeals.

In resulting newspaper articles, one of Lahey’s opponents characterized the memorandum as a “whitewash.” One of the defeated hospital administrators said that the experience confirmed his belief that “in spite of what they say about planning and grass roots, there are three or four people up there who make the decisions.”

One Down, How Many to Go?

And so it appeared that Lahey had succeeded in crushing its critics once and for all, were it not for the Health Facilities Appeals Board. The Board reluctantly accepted the withdrawal of the doctors’ and hospitals’ ten taxpayer groups from the appeals process and invited the parties of record of the original Determination of Need to submit appeals. The Health Facilities Appeals Board also made it clear that it felt the Department had erred and that it might rule against Lahey if anyone appealed.

Three of these parties of record were area HSAs (then CHP “B” agencies) which had participated in the original 1972 approval. This development threw the three into a two-week paroxysm of special Board meetings to decide whether they should get involved or not. By this time, the affair had garnered an unusual amount of public attention, including headlines, editorials, and even letters to the area’s major newspapers. Over 450 Burlington residents met to register their support of the project. The HSAs were thus forced to make their decisions in the glare of public scrutiny. Until this point these agencies, responsible for planning in the area, had been conspicuous by their silence on the issue.

The first agency to meet, the North Shore Health Planning Council, voted to file an appeal. The second, the Merrimack Valley Health Planning Council, voted not to appeal primarily on the grounds that it could not afford the legal expenses involved in an appeals fight. Finally, the Health Planning Council for Greater Boston voted against appealing largely due to efforts of its Executive Director, who earlier mediated the conflict for Lahey.

All the classic tools have been used—from political arm-twisting to the extensive use of public money to pay the legal costs involved in avoiding full public disclosure.

Perhaps more significantly, however, a new, much larger physician/consumer ten taxpayer group formed and also submitted an appeal. This group has allegedly stockpiled $100,000 to carry
on the case. The war had grown in intensity. Lahey was now faced with a determined, well-financed opposition which was not easy to intimidate.

Lahey made the next move. Its lawyers filed a brief with the Suffolk Superior Court requesting an injunction against the Health Facility Appeals Board from hearing the case. They argued that the Board no longer had jurisdiction since the other appellants had withdrawn. The Chief Justice heard two weeks of arguments. He separated the case into two questions: (1) Did the Board still have jurisdiction in the case? and (2) Had the Department erred in its decision? On the first question the judge issued a permanent injunction against the Board from ever hearing the appeals; he continued the other questions and after hearing weeks more of evidence will decide shortly.

Although that question is still open, it is likely the judge will rule in Lahey's favor. The language of the injunction indicated his conviction that the fault lay with the bumbling of the Department of Public Health and not with Lahey.

Some time later, after intensive negotiations with HUD, Lahey received approval of the FHA loan guarantee in spite of the fact that appeal is still pending. If a final determination is not made in Lahey's favor by the end of the year, however, Lahey must repay HUD whatever amount has been used from the $70 million bond issue.

**Conclusion**

It appears then that Lahey will finally win the war. But many valuable questions have been raised for public discussion and some lessons can be learned from the struggle. Lahey has pulled out every stop in its effort to avoid full public disclosure of its plans and intentions. All the classic tools have been used—from political arm-twisting within a supposedly non-political planning process to the extensive use of public money to pay the legal costs involved in avoiding full public disclosure. The state government and the courts have become the battleground upon which Lahey fought its way into Burlington's health market. One can only conclude that serious regulation will require massive public support.

This story may also provide a glimpse into the future when major hospitals in the inner city decide to follow their doctors and middle-class clientele to the suburbs, rather than rebuilding in the cities. This is especially true where fiscal contraction forces inner city residents back to the municipal hospitals, as has happened in both Atlanta and New York City as well as in Boston.

The Lahey affair also portends a fierce struggle for survival among hospitals engendered by the tightening flow of federal and state dollars—a struggle that will force decisions out into the open in a manner unprecedented in the health system, and that will give birth to alliances even stranger than that of Burlington's doctors and community hospitals.

### One can only conclude that serious regulation will require massive public support.

And finally, the Burlington story illustrates that the health system does provide mechanisms for citizen involvement—such as HSAs and Massachusetts' Ten Taxpayer Groups—which used skillfully can influence the priorities of health expenditures and programs. Ten Taxpayer Groups, for instance, have successfully increased the primary care in an area, reached agreements on the limits of a hospital's expansion and even negotiated no-strings-attached financial assistance from major teaching institutions.

To the extent that the health system will always reflect the irrationalities of the American economic system, health care allocation decisions will also reflect those irrationalities. But vigorous public scrutiny and involvement will allow for public influence on the decision-making process so that some of these decisions may be more rational and in the public interest.

### Postscript

A final postscript on the Lahey affair aptly illustrates the irrationality of the present order of federal priorities. It is tragically ironic that HUD gave its approval to a Federal Housing Authority guarantee of Lahey's $70 million bond issue, in spite of the fact that Lahey needlessly destroyed inner-city low income housing and to this day allows the land to become an overgrown, vacant lot. Thus a housing guarantee goes to assist an overpriced, oversized, financially unfeasible hospital instead of providing decent, low-cost housing for those who, in the final analysis, will end up paying for both the government's and Lahey's mistakes, not only with their money but with their health as well.

—David Gaynor

(The author is a health planner working in Boston.)
Announcements

SPECIAL URPE HEALTH ISSUE

The Political Economy of Health, a special issue of the Review of Radical Political Economics, has just been published and is available from Health/PAC. Contents include: "Stress-Related Mortality and Social Organization" by Joseph Eyer and Peter Sterling, "The Political Ecology of Disease" by Meredith Turshen, "Political Power, the State and Their Implications in Medicine" by Vicente Navarro, "Malaria, the Politics of Public Health and the International Crisis" by Harry Cleaver, "The Health Care Industry in Advanced Capitalism" by Leonard Rodberg and Gelvin Stevenson, "Emerging Ideologies in Medicine" by Howard S. Berliner, "Monopoly Capital and the Reorganization of the Health Sector" by J. Warren Salmon and "The Political Economy of Rural Health Care in China" by Robert C. Hsu. Copies cost $3.00 plus $.30 for postage and must be prepaid.

NYC MAYORAL CANDIDATES: SEE THEM RUN

Perhaps the best hope for preventing all New York City's mayoral candidates from ignoring health and hospitals lies with a task force of community and health worker organizations formed by the New York City Coalition for Community Health, Inc., for the purpose of conducting a "Mayoral Forum on Health Care."

The forum—scheduled for 7-10 p.m., Tuesday, August 23, at the G.H.I. Building, 326 West 42 St.—will feature all the candidates responding to questions from community groups on city health issues.

HEALTH AND HEALTH CARE IN THE SOUTH

In order to present the problems of obtaining and providing health care in the South and suggest directions for change in the future, Southern Exposure, the quarterly journal of the Institute for Southern Studies, is preparing an issue devoted to health. "A history steeped in self-reliant traditions of healing enables us in the South to try bold experiments in community-controlled health care delivery. At the same time, it makes our region a woefully underserved "market," ripe for exploitation by the burgeoning health corporations and medical/educational complexes. We invite health workers, community people, organizers, students and others interested in Southern health care to submit articles, photographs and suggestions."


CONFERENCE ON HEALTH POLICY AND RESOURCE ALLOCATION

The National Legal Center for Bioethics is presenting a conference in Washington, D.C., on October 20-22, 1977, on "Policy Making and Health Resource Allocation." Experts in law, medicine, ethics and economics will examine public policy and life-prolonging technology, concepts of distributive justice, relationships between definitions of health and societal responsibility, and the constitutional parameters of the policy making process. Special attention will be given to the underlying rationale of policy making methodologies. For further information, contact: Joseph F. Siedlik, Conference Coordinator, PO Box 24021, Washington, DC 20024, (310) 649-4421.

HEALTH/PAC TO REQUIRE PREPAYMENT

Health/PAC has just adopted a system whereby orders for literature, packets, BULLETIN, and subscriptions will have to be prepaid. This was necessitated by the inordinate staff time invested in billing and trying to collect bills, and by Health/PAC's general financial plight. We regret the inconvenience.

SACCHARIN CONFERENCE

The Society for Occupational and Environmental Health will hold a public conference on the scientific and public policy issues surrounding the proposed ban of saccharin as a food additive at The Mayflower Hotel, Washington, DC on September 16-17, 1977. For more information contact: Sandy Zimmerman, SOEH, 1714 Massachusetts Avenue, NW, Washington, DC 20036; (202) 785-8177.