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HSAs and Cost Control

IN the winter of 1974 the 93rd Congress, combining the fading optimism of the 60s with the emerging regulatory bent of the 70s, passed into law PL93-641, the National Health Planning and Resource Development Act. Its intent was to achieve "equal access to quality health care at
a reasonable cost," by reconstituting the nation's anemic network of state and local health planning agencies.

Now, four years later, that network is largely in place. Yet in those few years since its inception, the political and economic environment has changed dramatically, placing new demands on the nation's health planning effort that it is ill-designed to meet. Foremost among these is the pressure to control spiralling health care costs—now the dominant theme of federal health policy.

The following article chronicles those growing cost control pressures, examines the ways in which the nation's health planning network has been, in part intentionally, ill-equipped for this responsibility, and discusses its likely impact on the future shape of health planning.

**A Legislative Preview**

Congress offered a preview of mounting cost control, anti-regulatory and special interest forces when the original authorization for PL93-641 expired last year. The attempt to renew this authorization and to strengthen the law resulted in a legislative standoff. Congress finally passed a one-year continuing resolution to maintain PL93-641 and fund it as before, postponing until this year resolution of the conflict among these contending forces.

The most powerful of these forces is the pressure to control rising health care costs. National health expenditures have risen inexorably, reaching a total of $163 billion last year, or $737 per capita. A recent HEW study predicts that the tab will reach $1 trillion by the year 2000, consuming over 12 percent of the GNP. The largest and most rapidly rising portion of these are hospital costs, fueled by the generous reimbursement policies of Medicare and Medicaid which now pay over half of all the nation's hospital costs.

The pressure to control these costs is intense, stemming not only from internal budget imperatives, but from such external sources as business and labor as well. Meanwhile, hospital cost control legislation—centerpiece of Carter health care policy—is sitting stalled in Congress for the second year in a row.

Growing cost control pressures coincide, moreover, with an increasingly conservative political climate ushered in by the passage last year of Proposition 13 in California. This climate is marked by concern for a balanced budget and reduced social spending, a desire to turn back the regulatory role of government, and a penchant, unfortunately missing in more expansive times, to examine carefully the effectiveness of tax-supported programs. The result is intense pressure on existing health agencies, particularly regulatory ones, to show their effectiveness, and there can be no doubt in this case about the definition of effectiveness: it is cost control. Evidences of this pressure abound:

Early last year the Administration abruptly announced plans to abolish the Professional Standards Review Organization (PSRO) program because it had proven ineffective in regulating costs. This, in spite of the fact that PSROs were ostensibly created to assure the quality and appropriateness of health care services, not to control costs. Following expressions of shock, the Administration retreated to the position that PSROs must, for the coming year, demonstrate cost savings at least equivalent to their program costs.

Then, in the fall, HEW Secretary Joseph Califano summarily fired Robert Derzon, head of HEW's Health Care Financing Administration (HCFA), for proceeding too slowly with Medicare-Medicaid reform.

HEW's cost control concerns were further manifest by the issuance in August of the National Standards for Health Planning, a major policy edict to the nation's health planning agencies. These standards, which address the minimum size, utilization and need for health facilities, are intended to constitute the basis upon which to begin shrinking the health system. HSAs must now apply these costs.
The heads of this organization provide individual instruction to hospital housekeepers on the most efficient cleaning methods. They work side by side with the cleaning staff, where topics such as the hospital's latest advances in open-heart surgery are discussed—and all during work time. Said Peter K. Read, director of operations at St. Luke's Hospital in Cleveland, "Before, these people looked at their work as the dirtiest job in the hospital. Now they talk about how their work relates to the patient."

The organization responsible for these innovations is not a progressive union, not a radical health collective, not even a company where a liberal personnel manager is interested in humanizing menial labor. It is ServiceMaster Industries Inc., a thoroughly capitalist company that is making a bundle helping hospitals cut their housekeeping costs. Going against the trend of many management consultant firms that contract to run entire hospitals, the Chicago-based ServiceMaster specializes in housekeeping. Its supervisors and instructors manage the hospital's unskilled housekeeping workers. The hospital saves money by using the less expensive supplies and equipment produced by ServiceMaster, and by getting the employees to work more efficiently.

ServiceMaster is growing rapidly, and currently has operations in 742 hospitals which generated revenues of $275 million in 1978—triple the level of five years ago. But, according to the February 19th Business Week, what sets ServiceMaster apart from its rivals is not so much its growth as its explicitly religious orientation. Its corporate goals are “to honor God in all we do, to help people develop, to pursue excellence, to grow profitably.” In a strange place, perhaps, but nevertheless an explicit statement of the capitalist variant of “people before profits” credo.

It should be noted that Business Week quoted no workers in their story so the correlation between promise and performance is not clear. But it definitely appears that ServiceMaster is trying to do something right. According to Alexander Balc, Jr., vice-president for development, “Our willingness to roll up our sleeves and be part of the process communicates to people that they are important and there is value (in their jobs).” This non-élitist approach—superficial though it may be—probably looks a lot better to many workers than the attitudes typically displayed by their hospital bosses. But it may backfire when—and if—hospital employees begin asking why profits are necessary at all.

Source: Business Week, 2/19/79.
It has been over three years since U.S. District Court Judge Aubrey Robinson ordered the federal and District of Columbia governments to work together to devise a plan to place almost half the patients at St. Elizabeths Hospital in more appropriate facilities in the Washington area. In 1975, the hospital's clinical staff agreed with the contention of patients' rights attorneys that 1284 of the hospital's residents were capable of living in less restricted facilities in the community if only such facilities existed. The implementation plan is expected to be submitted to the court for approval later this month.

In October of 1977, the hospital resurveyed the 649 patients still remaining (of the original 1284) using a model designed by the New York State Department of Mental Hygiene. Most were declared no longer acceptable for community placement. The Mental Health Law Project, which filed the original suit, maintains that using the survey to classify patients as ineligible for treatment in the community because of their behavior, rather than because of their need for physical or psychiatric treatment, raises serious legal and constitutional issues. They also oppose the plan to convert vacant buildings at the old Children's Hospital in Washington or on the grounds of St. Elizabeths into "multiservice facilities" for released patients, consisting of residential units and rehabilitative services. "To concentrate former mental patients in large vacant structures of a kind and size not commonly used by other members of the community, and to isolate them from normal contacts that they would otherwise have, may well obstruct their reintegration into the community," the project says in a court brief.

Although Congress recently gave HEW $52 million to renovate inpatient facilities at St. Elizabeths, they seem unwilling to expend the monies necessary to establish community resources which would seem to make much of the hospital's function obsolete. A report on existing community facilities, entitled Community Residences: Alternatives to Institutions, was prepared for the District's Department of Human Resources by the District of Columbia's Municipal Research Bureau, Inc. It stated that the number of community residences in the capital had actually declined since 1975, from 565 to 427, and that the great majority were still concentrated in the central city, with few located in more affluent Washington neighborhoods.

The New York City Department of Health, once perhaps the leading public health department in the country, has recently become another in the growing list of victims of this city’s fiscal crisis. In the following article, some of the dynamics of the recent, rapid decline are outlined against the background of the Department’s long, proud history. The article is condensed from Health/PAC’s recent report, Preventive and Primary Care During the New York City Fiscal Crisis: 1974-1978 (available from Health/PAC). The report is one product of an 18-month study funded in part by the Samuel Rubin Foundation and the New York Community Trust.

The article covers the years 1974-1977. It does not, therefore, cover more recent events which have seen the Department pushed to the brink of extinction. For example, the City’s Health and Hospital Corporation (HHC) (the troubled, quasipublic agency that administers the City’s 17 municipal hospitals) has recently developed a plan to absorb many of the remaining operations of the Department of Health (DOH). Given the desperate search by HHC for inpatients to fill its many empty beds, combined with the mounting shortfalls in HHC revenues, many predict that the public health orientation of these DOH services would be lost should such a transfer materialize.

More recently, DOH officials—under mandate from City Hall to cut even deeper into their city tax levy funding—have begun to plan for the billing of non-Medicaid patients on a sliding fee scale as a means of revenue enhancement. This proposal was denounced by the Public Health Association of New York City (PHANYC) in a letter to Mayor Koch as being “contrary to the public interest.” Such billing, PHANYC pointed out, has been shown to discourage use by the “working poor” (those ineligible for Medicaid and uncovered by private insurance or other means to pay and perhaps total 1.5-million New Yorkers), who, given their marginal incomes, rarely view preventive services as a top priority. A sliding fee scale would thus be counterproductive as it “will surely put these services out of reach for thousands of New York families.”

Such recent moves, and the policies pursued
by DOH during the 1974-1977 period, are indications of a real change in the definition of the role of public health programs as operated by local government. Traditionally, programs such as preventive screening, venereal disease, immunization, child or school health, have been provided on the basis of "need" rather than "demand." Thus, they were generally free and targeted to achieve maximum health impact, rather than to reach those already demanding such services or willing to pay for them.

This "needs based" or epidemiologic principle has long been seen as intrinsic to the effectiveness of public health programming. It is a key difference between most public health and most mainstream medical programs, and it probably represents a key reason why DOH services are so vulnerable in a time of fiscal crisis.

Preventive services are, in general, a low priority, unglamorous part of the medical system. In an era of high-technology, "moon-shot" medicine, taking an immunization history from a preschool child or tracking down a high-risk pregnancy in a ghetto neighborhood may be brushed aside as mundane compared to the expensive, glamorous and dominant specialized medicine of the large teaching and research centers. Further, the interests and the ideology associated with mainstream, marketplace medicine often deny the relevance of such "life enhancing" efforts.

New York's fiscal crisis has pushed such underlying tensions—and the article makes clear they are old tensions—to the point of open conflict. The crisis in the City's budget and the scramble to cut spending and programs has created what Dr. Lowell Bellin, former NYC Commissioner of Health, calls a "lifeboat mentality." While Dr. Bellin is correct in his characterization, it is just such a mentality which allows those who, like Dr. Bellin himself, believe that the public sector is inherently weak and trouble-ridden, an opportunity to advocate their own preference for marketplace medicine. This position then gets promoted as a new, more "rational" criterion for planning. Thus, for example, the answer to screening programs without adequate follow-up is to eliminate the screening program, not to guarantee the follow-up. Services offered by other providers are jettisoned as "duplicative," whether or not the poor and working poor using the programs have access to these other providers.

The accompanying article indicates that the decisions to cut services and/or spending were, at times, "very painful" for those involved. However, it would be a mistake to assume that those who played key policy-making roles during the fiscal crisis were simply following orders. In the case of Dr. Bellin, for example, he indicated in a speech delivered early in his administration, that his own personal preference for the role of health departments was, to quote the title of the speech, "More Quality and Cost Control, Less Direct Delivery of Health Services." Some policy makers, in other words, brought an ideology opposed to public sector services into office with them.

In fairness, this process did not begin nor will it end with Dr. Bellin or any of the other recent DOH Commissioners who share such an approach. The status of DOH and the public health mission it shared with many local departments of health throughout the country have been in trouble since at least the late 1960s, when the glamour of "systems analysis," "modern management skills," and the growth of the hospital-oriented Medicare and Medicaid reimbursement systems (and the revenues they offered) combined to shift virtually all of the City's health policy attention and priorities to HHC and the operation of the municipal hospitals.

Thus it is not surprising that even those functions Bellin and his colleagues actually did defend—the quality control and monitoring functions—have also been taken from DOH and transferred, for the most part, to the New York State Office of Health Systems Management (OHSM).

Whether the loss of even these minimal public health functions by DOH is permanent, is not yet clear. What is however clear is that the conflict between truly public health services and the priorities of the medical marketplace is far from resolved in cities like New York.

If public health sector opponents continue to hold sway, it will not be long before the poor and working poor, and eventually all New Yorkers, will feel the effect. The primary and preventive services traditionally provided by the DOH have had a measurable impact on the health status of many New Yorkers. Without such services, the current "lifeboat mentality" may rapidly transform New York City into a "sinking ship."

The Editorial Board
Since the beginning of the New York City fiscal crisis in 1974, the City's Department of Health (DOH) has undergone drastic reductions in its budget that have severely affected its levels of services and personnel. In order to understand the full impact of these cuts, however, it is necessary to see them against a backdrop of long standing tensions which have marked the Department's history.

The basic question underlying many of these tensions concerns the definition of the proper role of a local health department. To this day, around the country, this question remains a source of real debate.

According to a recent report, one quarter of all reporting local health departments today render "personal health services" (that is, treatments to individual patients) and this proportion has grown steadily in this century. Such services may take the form of well-person care only (child health exams, immunizations, PAP smears), or well-person and sick-person care provided to specific categories of the population (child health or geriatric care), or care for a particular problem (tuberculosis). In some cities, the provision of personal health services extends to the provision of comprehensive ambulatory care—both routine acute care (primary care) and preventive services. (Newark, Boston, part of Atlanta, Denver, and Detroit all have some form of comprehensive ambulatory care system run by their city or county health departments).

In some localities, health departments are the only providers of such services as family planning, maternal and child care, home care, school health and chronic disease programs. In many localities, health departments are the only providers of free personal services for poor people. In 1975, such services accounted to 72 percent of all expenditures (or $2 billion annually) by state health agencies (1).

The New York City DOH has historically been at the forefront of providing these direct personal health services. But the progress in offering them has not been linear. Throughout its long and distinguished history, the expansion of DOH functions to include direct personal services has been a source of tension and controversy concerning the appropriateness of such involvement and the manner in which it was to be achieved.

With the onset of the fiscal crisis, such services have again come under attack. A key element in the conflict is that, since health department services are targeted for poor people, they are often "poor programs"—that is, they receive only marginal support in the best of times. In 1974, less than five percent of the $41.7 billion of tax money expended for health services in the U.S. was allocated to health departments. As a result, health department programs are often the "last funded" and the "first de-funded."

On the other hand, most of today's health care dollar is allocated to the hospital sector. This includes a growing role for hospital-based preventive and primary ambulatory care. There are, however, serious questions about the appropriateness of the hospital as a base for such services. Hospitals, in general, are not oriented toward preventive care or health promotion, but to acute care; their orientation is often to diseases, not whole people; to individual cures rather than community problems; and to keeping beds full of people, not keeping people out of beds.

It has also become increasingly clear that basing services in hospitals is likely to increase overall costs. Hospital costs in particular have driven health costs skyward in recent years. Moreover, it is not clear that hospitals have the capacity to handle increased ambulatory services. Last year in New York City, over a million and a half people used DOH clinics. It is questionable whether hospitals, whose outpatient departments and emergency rooms are already overcrowded, could handle such an increased load.

Health departments are unique among American health providers. Their epidemiologic orientation and statutory mandates to cover whole communities put them in a unique position to monitor not only the quality of services delivered, but also the appropriateness of the mix. Hospitals, in contrast, tend to monitor only the needs of those that use them, rather than the needs of the community as a whole.

According to Dean Myron Wegman, "It might be well to build on the principle used in record keeping in many Child Health Stations, of tabulating not only the immunizations performed, but rather the number of eligible children whose immunization status is not satisfactory. The idea of measuring tasks undone instead of counting
New York’s fiscal crisis has pushed underlying tensions to the point of open conflict. The crisis in the City’s budget and the scramble to cut spending and programs has created what a former City Health Commissioner calls a “lifeboat mentality.”

This kind of health care delivery model is one that approaches the provision of services from the perspective of need. Most other health care providers, including hospitals, approach the question from the perspective of demand. Ideologically, this latter orientation leads to “marketing” services to “consumers” who can “purchase” them if their “effective demand” is improved. But the health problems faced by large, urban, often low-income populations have proved stubbornly immune to this market approach. High infant and maternal mortality rates, for example, rooted in poor nutrition, substandard educational levels and poor housing, have remained alarmingly high despite all the onslaughts of market medicine. Meanwhile, market providers seldom undertake the kinds of programs that could seriously attack such problems—nutritional and prenatal counseling, birth control programs, and an aggressive outreach to find pockets of high risk—because they represent a “poor return” in either direct reimbursements or potential new inpatients.

For many, the only viable solution to the current conflict is an expansion of the public health model of service delivery. However, New York seems firmly headed in the opposite direction—toward strengthening the market model. In recent years, in New York City, those services delivered on the basis of need have been cut first and deepest and this trend seems likely to continue in the coming months.

In the pages that follow, the extent of these cuts and the rationale for them will be explored. The reader will note persistent references to cutting “fat” and to reducing services that were previously “underutilized” or “available elsewhere.” The question remains whether such explanations miss the mark entirely. In the words of one veteran professional in the Department, “I really worry whether anyone realizes what is lost by turning away from the concept of treating health as a public problem, and health care as a public service?”

The Role of District Health Services

In November, 1974, as New York City entered a severe fiscal crisis, the City’s Department of Health began a period of unprecedented reductions in its budget, services, and personnel. From 1974-1977, the Department’s tax levy budget was reduced by 20%, from $50 million to $40 million. Its staff size was reduced by 28%, from 6,000 to 4,300. A hiring freeze, imposed in 1975 and 1976 on all city agencies, made it impossible to replace key professional staff. Over this period, the Department cut programs its policymakers classified as “life-enhancing” (rather than “life-saving”), programs such as dental, school and child health, audiometric and eye testing, chest clinics, public health social work, education, and nutrition.

These reductions took place despite a continuing need for the services by New York City’s poor. In 1974, approximately 938,000 of the City’s total population of 7.8 million were on welfare. For them, for the City’s working poor, and for the City’s estimated one million illegal aliens, the Department of Health was a primary source of free health care.

The DOH has a long history of providing direct personal health services, free of charge, to the City’s poor. As immigrant groups streamed into New York, the DOH responded, sometimes from fear, sometimes compassion, with a number of public health innovations, many generally recognized as “firsts” for a municipal health department.

In the early 1900s, the Department began to offer a wide range of free personal services through its District Health Services program. These neighborhood-based Health Centers were seen at that time as the answer to the special out-of-hospital health problems of the urban poor, chiefly infectious diseases and infant malnutrition. In January of 1915 the City’s first Health District was established on the Lower East Side of Manhattan. This experimental health center quickly proved
itself successful and four similar centers were opened the following year.

In 1917, District Health Officers were appointed on a full-time basis and, in 1918, three more health districts were planned for Brooklyn (3). However, growing opposition from the New York Academy of Medicine and other medical societies halted further progress and by 1918 the newly-created District Health Administration within the Department had already vanished.

The health center movement was catching on nationally, however. C.E.A. Winslow noted in 1919 that “the most striking and typical development of the public health movement of the present day is the health center.” A 1919 Red Cross survey revealed 72 health centers in 49 American communities, with 33 more planned, most under public control. By 1930, a White House conference had obtained data from 1,511 major and minor health centers in the United States (4).

In 1929, a plan for the consolidation of district administration was developed under Health Commissioner Shirley W. Wynne. The plan proposed 30 districts throughout the City, each with a health center serving as headquarters for both the field activities of the Department and private health and welfare agencies. Impressed, Mayor James J. Walker appropriated money the following year for the implementation of this plan. Although this funding was later withdrawn because of the Depression, a persistent Commissioner Wynne managed to procure funds to establish seven centers in the City’s worst “sore spots.” In 1934, Mayor Fiorello LaGuardia endorsed the district health program, declaring, “We are going to have other health centers all over the city because the people have a right to be healthy.”

In spite of such support, the seven functioning districts found themselves continuously embroiled in conflict. Within the Department conflict existed between the Department’s specialized services, centrally-based in Bureaus, and the more general, community-based District services. External attacks were also frequent as the District services seemed to represent the most clearcut challenge to those in private medical practice. Thus, while the district health system continued to grow, its progress was constantly stymied by these built-in conflicts.

Following a 1947 blizzard, in which the district health officers were impaired in their ability to respond to the emergency due to internal conflicts over lines of authority, Commissioner Mustard made them “responsible for all localized activities of DOH in their districts...which heretofore were directed by the respective bureaus in central office, and [gave them the] authority to make any necessary decisions and allocations of personnel.” This gave the district health officers the strongest authority that they ever had, and went a long way toward allowing them to gain control over activities within the districts during the following decade (3).

The early 1960s witnessed a shift toward a new standard of comprehensive care, and the Department, with the help of federal funding, set up new programs for geriatrics, pediatrics and generalized medical care in the districts. Prenatal and tuberculosis clinics were expanded and were affiliated with hospitals. Twenty Child Health Stations, which functioned as satellites of the District Centers, were converted and upgraded to Pediatric Treatment Centers (providing both sick- and well-child services). Nationally, the War on Poverty witnessed legislation creating OEO Neighborhood Health Centers (NHCs), and seven such NHCs were soon created in New York City. The Model Cities and Comprehensive Health Planning programs also facilitated community

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**New York City Department of Health Firsts**

- School nursing service with routine examination of children (1902-1905).
- Employment of public health nurses by the Health Department (1902).
- Well baby clinic, associated with the dispensing of free milk (1908).
- Laboratory for making serologic tests for syphilis and fixation tests for gonorrhea (1912).
- Venereal disease clinics (1913).
- Bureau of Health Education (1914).
- Dental clinics in public schools but under control of Health Department (1921).
- Nutrition education service (1932).
- Cardiac consultation clinics (1948).
organizations to work with district health officers in seeking federal funding for local health programs (5).

Since 1974, however, under the leadership of Commissioners Lowell E. Bellin and Pasquale J. Imperato, this trend has been almost completely reversed. Their belief that the DOH should not deliver direct personal services, coupled with the severe demands of the fiscal crisis, has resulted in the widespread curtailment or elimination of many of the Department’s most vital services.

The Fiscal Crisis

The fiscal crisis first received widespread attention in November, 1974. In response to the City’s severe financial condition, New York State set up the Emergency Financial Control Board in September, 1975 to oversee the City’s financial plans. In one such financial plan that the City was required to submit to the Board, the expense budget was cut by $200 million for the fiscal years ending June 30, 1976, 1977, and 1978 (6).

In 1975, the City’s total expense budget was slightly over $13 billion, of which 31% went into human services. From this $13 billion, DOH received a modest $90 million, of which only $50 million was raised from City tax levy funds. Most of the City’s operating expense budget is controlled by law, funding such entitlement programs as public assistance and Medicaid, or paying past obligations such as debt service and pension contributions. Budget cuts, therefore, had to be implemented in those parts of the budget that the City could control. These “controllable expenses” made up $2.4 billion or 26% of the 1975 total operating expense budget (6). Virtually all of the Department of Health’s budget fell into this category. (See “NYC Public Hospitals,” Health/PAC BULLETIN, No. 69, March/April 1976)(7).

As early as November, 1974, the City’s Office of Management and Budget (OMB) requested that the Department of Health terminate 57 employees for a $1.5 million savings in tax levy money. This request was part of an overall effort by the City to quickly demonstrate its determination to balance the budget in the face of possible default, and the Department was asked to respond within 24 hours.

Commissioner Lowell E. Bellin designated First Deputy Commissioner Pasquale J. Imperato to supervise the requested cuts. Dr. Imperato spent most of the next 13 months doing little else. He immediately began meeting with the Department’s top administrative staff which included Anthony C. Mustalish, Deputy Commissioner for District Health Services, Gerald Flanders, District Health Services Administrator, and various bureau chiefs to formulate a response. It was decided that the reductions would come by virtually eliminating such bureaus as Social Work, Nutrition and Public Health Education, by reducing funding to the Health Research Council, by closing three District Health Centers, and by leaving vacant positions unfilled.

In order to avert an administrative crisis and to anticipate further cuts during the fiscal crisis, Dr. Imperato and his staff formulated a comprehensive policy on future budget reductions.

Since 1974, under a succession of three commissioners, the Department of Health has been virtually destroyed. The District Health Services have been cut back and relegated to the status of an ‘unwanted child’ while the regulatory functions have slowly been ‘adopted’ by the state

Department of Health activities were reclassified into two categories: “life preserving” and “life enhancing.” Infectious disease control was considered to be life preserving; dental public health was considered life enhancing. Life enhancing activities, underutilized services and services for which there were alternative (non-DOH) resources received lowest priority.

For several reasons most of the proposed cuts were in District Services, which then consumed approximately 30% of the Department’s budget, about $15 million of the total tax levy, and about half of the Department’s personnel. One significant reason was that tax revenues could be maximized by cutting the District Services budget since it is matched on a 1:1 ratio by state and federal funding whereas other Depart-
mental programs are matched more favorably. Thus, cutting District Services was thought to be more cost effective and was philosophically

‘Nobody ever died of bad teeth and bad gums. I had to weigh that against diphtheria inoculations. I didn’t have money for both’
—Lowell Bellin
former NYC Commissioner of the Department of Health

in line with Commissioner Bellin’s goal of moving away from personal services.

In May, 1975, Mayor Abraham Beame published his first “crisis budget,” which included a drastic $18 million cut in tax-levy support for DOH. Although these cuts were never implemented, those from an “austerity budget,” published at the same time, were. On May 30, 1975, the Office of Management and Budget requested that 255 specific positions be terminated from DOH’s budget. The Department set its own priorities and proposed the termination of 255 employees in four programs: Ghetto Medicine, Methadone Maintenance, the Health Research Council (eliminated) and the Neighborhood Maternity Center in the Bronx (6).

DOH officials never publicly attacked or questioned the City’s priorities in cutting preventive services. In fact, the criteria of “life enhancing” versus “life preserving” worked to reinforce the medical bias towards treatment as opposed to early intervention. Neither was quality of care the main issue. The Bronx Neighborhood Maternity Center, for example, where the services were well-liked, highly rated for quality and heavily utilized was closed.

In Autumn, 1975, the OMB requested a further $3 million reduction in tax levy funds. The Department of Health eliminated their contributions to the Ghetto Medicine Program; the Board of Education cut $970,000 from its part of the School Health Program; and the Department of Health replaced 50,000 school physician hours with pediatric nurse associates taken from the existing public health nurse corps.

In July, 1976, OMB requested another $4.4 million reduction from the tax levy contribution to the Department of Health’s budget. Some District Health Centers, Chest Clinics and Child Health Stations were closed and dental, laboratory and prison health services were reduced.

The total tax levy-reduction in the Department of Health’s budget during the most intense period of the fiscal crisis totalled a 20% reduction, from $50 million to $40 million. The remainder of the Department’s operating budget of about $90 million in 1975 consisted of matching state and federal funds. These were reduced proportionately with City cuts, so that $1 tax levy savings meant a $2 loss in actual operating funds (6).

From the beginning of the fiscal crisis in November, 1974, to the middle of 1977, the Department of Health lost 28% of its work force. The Department was reduced from 4,400 full-time and 1,600 part-time personnel, to 3,300 and 1,000 respectively. There were approximately 400 full-time terminations. Resignations and retirements accounted for the remainder. A hiring freeze was

### Table 1

<table>
<thead>
<tr>
<th>Services</th>
<th>July, 1974</th>
<th>Jan., 1978</th>
<th>% Change</th>
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<tr>
<td>District Health Centers</td>
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<td>13</td>
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<tr>
<td>Satellite Health Centers</td>
<td>5</td>
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<td>+20</td>
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<tr>
<td>Health Education and Outreach</td>
<td>2</td>
<td>0</td>
<td>-100</td>
</tr>
<tr>
<td>Nutrition</td>
<td>6</td>
<td>0</td>
<td>-100</td>
</tr>
<tr>
<td>Public Health Social Work</td>
<td>3</td>
<td>0</td>
<td>-100</td>
</tr>
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<td>General Immunization Clinics</td>
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<td>-50</td>
</tr>
<tr>
<td>Prenatal, Postpartum and Family Planning</td>
<td>8</td>
<td>7</td>
<td>-13</td>
</tr>
<tr>
<td>Sickle Cell Testing Centers</td>
<td>6</td>
<td>4</td>
<td>-33</td>
</tr>
<tr>
<td>Lead Poisoning Centers</td>
<td>7</td>
<td>5</td>
<td>-29</td>
</tr>
<tr>
<td>Working Paper Clinics</td>
<td>6</td>
<td>5</td>
<td>-17</td>
</tr>
</tbody>
</table>

instituted in early 1975 and no new programs were initiated.

DOH had the highest attrition rate of any City Department. Many of those leaving were young professionals, managers and executives able to obtain attractive jobs elsewhere. Many able supervisors left and the quality and quantity of the Department’s services were seriously compromised.

**Discussion**

New York City’s Department of Health was once unique among local health departments in
Direct Service Cutbacks: 1974-1978

Child Health Stations
Child Health Stations provide such free preventive services as new-born infant care; well-child evaluation; growth and evaluation assessment; child health assurance programs (CHAP); immunizations; screening for treatable disorders; parent counseling and education; and women, infant, and children (WIC) supplemental feeding programs. 22 Child Health Stations which have been upgraded to Pediatric Treatment Centers also provide primary medical care for sick children up to age twelve (8).

During the period between July 1, 1974 and July 1, 1976, 20 of the original 78 Child Health Stations and Pediatric Treatment Centers were closed, a 26% drop. Between FY 73-74 and FY 76-77, there has been approximately an 8% reduction in visits to Child Health Stations. In the same period, there has been a 10% reduction in physician hours, a 13% reduction in public health nursing hours and an 18% drop in public health assistant hours.

Dental Services
Dental services which had included examination, treatment, prevention and education, have been cut significantly since 1974. At that time, there were 27 clinics situated in Health Centers and 164 in schools. In 1978, there were only 18 Health Center clinics and 105 school clinics remaining, about a 33% drop in both instances. Between FY 74-75 and FY 76-77, direct clinic expenditures were reduced by 45%. Dental services suffered a 47% reduction in annual dentist hours, a 56% reduction in annual dental hygienist hours and a 46% drop in public health assistant hours.

Chest Clinics
The Department of Health operates Chest Clinics in both its own District Health Centers and in municipal hospitals. Health Center Clinics provide screening exams, x-rays, sputum induction, case finding and treatment for patients with tuberculosis and associated diseases (8). Between 1974 and 1978, the number of Chest Clinics in District Services have been cut by 35%, from 27 in 1974 to 17 in 1978.

Eye Clinics
Department of Health Eye Clinics primarily provide screening for eye pathology and correction of vision problems, usually refractive errors. The program is for children only. There is little follow-up as patients are referred to local practitioners. The clinics are staffed by Department optometrists and ophthalmologists (8).

Between 1974 and 1978, 12 of an original 22 Eye Clinics were closed, a 55% reduction. Annual hours for physicians and public health assistants have also been reduced by 50%, as have both volume of service and costs ($206,000 in 1973-74 to $104,843 in 1976-77). The complete closure of all DOH Eye Clinics has been proposed and considered at various times since the onset of the fiscal crisis.

Social Hygiene Clinics
DOH operated Venereal Disease Clinics throughout the city, providing free care for screening, contact investigation and case finding. The program involves intake, laboratory, physician diagnosis and treatment (8).

Between FY 73-74 and FY 76-77, two clinics were closed, physician hours were cut by 20%, public health assistants' hours were cut by 25% and public health nurses' hours were cut by 12%. However, total patient visits increased by 3% during this period.

Public Health, Social Work, Nutrition and Education
Since 1974 these three programs have been virtually eliminated. Only a small core of these health professionals is still retained in the Central Office of District Health Services to lend support to the few remaining district programs. Nutrition counseling to low income and disadvantaged mothers and the elderly has been drastically curtailed as have such health education activities as consumer education, participation in health planning and health consumer advisory committees, school health education programs, hospital staff and patients' education programs, maternal and child health and family planning programs. By 1975, there were no social workers left at decentralized service facilities, and referrals
Direct Service Cutbacks: 1974-1978

could be handled only by telephone through the remaining staff in the Central Office.

General Immunization
Between 1974 and 1978, General Immunization Clinics in District Health Centers were cut by 50%, from 10 in 1974 to five as of Spring 1978. These clinics administer shots for travelers, anti-rabies and influenza shots. (Preschool immunizations are provided in the Child Health Stations and in the School Health Programs.)

Sickle Cell Testing
Sickle Cell Testing Clinics offer screening for the sickle cell trait among Black People, but offer no follow-up of genetic counseling services. Since 1974, Sickle Cell Testing Services in District Health Centers have been cut from six to four.

Lead Poisoning Clinics
Two Lead Poisoning Screening Services have been eliminated from District Services Health Centers since 1974, reducing the number from seven to five.

Tropical Disease Clinics
The Tropical Disease Clinics provide complete diagnostic laboratory analysis, treatment and follow-up for tropical diseases—a significant public health problem in a major port city such as New York. Since 1974, the Lower East Side Clinic has been closed and the Bushwick Health Center Clinic has been cut back while the Washington Heights and Morrisania Clinics have been left relatively intact.

School Health
The School Health Program is divided into the Elementary & Junior High School Division and the High School Division. It is a screening and referral system employing public health nurses and paraprofessionals who review school health records and organize work in each school for physicians, nurse practitioners and nurses. The Elementary & Jr. High program includes screening, admissions, follow-up and referral as well as daily inspections, nurse record review and conferences. The High School program is similar, except that more effort is directed towards the specialized needs of High School students, such as working paper and athletic team exams (8).

Between 1974 and 1976, School Health Services have been significantly reduced. Some 50,000 physician hours have been eliminated from an original 80,000 physician hours annually, a 65% drop. Both fourth grade and eighth grade examinations were eliminated. Pediatric nurse associates were introduced into the program to partially offset the reduction in physician hours. This represents a significant change in the program and a marked reduction in cost.

Prison Health
Prison Health services witnessed a 25% reduction in FY 74-75 which resulted in a loss of 7 physicians, 52 nurses (mostly RNs), as well as a 47% drop in dentists and a 50% reduction in dental hours. One third of the pharmacists were dropped and all the program analysts at the Prison Health Services Central Office were eliminated. Mental Health Services were perhaps cut back the most, losing 30% of the part-time psychiatrists, 50% of the social workers (including the psychiatric aftercare program, and 30% of the psychologists. Psychiatric services had to be almost completely eliminated at the two largest institutions—the House of Detention for Men and the Correctional Institution for Men. Remaining staff have had to carry increased patient loads.

Laboratory Services
Between 1975 and 1976, Public Health Laboratory Services witnessed a 26% reduction in staff and a 10% reduction in the number of specimens processed. Free vaccine distribution and the provision of tuberculosis testing material to private physicians have been eliminated.

Environmental Health
The Environmental Health Services budget was cut by 5% for FY 76-77. This resulted in more than a 20% loss in field staff for General Operations. Further losses are projected to include elimination of the drug audit and milk dating programs, and reductions in the number of inspections of pet shops and stables, theatres and cabarets, surveillance of summer feeding programs, in-service training and food, water, fluoride and foreign substances sampling.
the nation. According to former Commissioner Lowell Bellin, the Department "has been cited

In some localities, health departments are the only providers of such services as family planning, maternal and child care, home care, school health and chronic disease programs

in American Schools of Public Health as an Olympus of professional excellence." (9). Historically, it was the nation's largest local health department, and was instrumental in the introduction of many public health innovations, especially in the realm of free personal services.

Because of its distinguished record, the Department has enjoyed wide respect both locally and nationally. Many of its programs and innovations were widely copied and indeed many of its administrators went on to head other health departments throughout the country.

Since 1974, however, a combination of three factors has led to the virtual dismantling of the Department as a major force on New York's health scene:

1. the serious ramifications of the fiscal crisis;
2. the philosophical opposition by the Department's Commissioners to providing direct personal services; and
3. the steady erosion by the New York State Health Department of the City Department's regulatory and standard setting functions.

In Commissioner Bellin's view, a great many public health services are already delivered in the private sector, and this shift toward private care is occurring throughout the country. Similarly, Commissioner Imperato felt that DOH should only provide services where there were no other providers available. They argued that DOH facilities were never meant to be comprehensive, and that a growing number of the poor and indigent were already using hospitals, Neighborhood Health Centers, Neighborhood Family Care Centers and related facilities that provide more comprehensive care.

Both Commissioners saw the fiscal crisis as a result of too many city services. In Dr. Imperato's view, the fiscal crisis resulted from rising costs of services combined with a shrinking tax base (6). As he saw it, the influx of poor people demanding

Table 2

Distribution of Budget Cuts and Their Impact (New York City Department of Health, 1974-1978)

<table>
<thead>
<tr>
<th>Clinics and Personal Health Services</th>
<th>Number of Facilities</th>
<th>% Reduction</th>
<th>Patient Visits</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>July, 1974</td>
<td>Jan., 1978</td>
<td>FY 73-74</td>
<td>FY 77-78</td>
</tr>
<tr>
<td>Child Health Stations and Pediatric Treatment Centers</td>
<td>78</td>
<td>57</td>
<td>-27</td>
<td>330,163</td>
</tr>
<tr>
<td>Dental Health (including school clinics)</td>
<td>191</td>
<td>138</td>
<td>-30</td>
<td>217,470+</td>
</tr>
<tr>
<td>School Health (all levels)</td>
<td>1,537</td>
<td>1,300 (est.)</td>
<td>-15</td>
<td>197,716</td>
</tr>
<tr>
<td>Chest (tuberculosis and Combined)</td>
<td>26</td>
<td>16</td>
<td>-38</td>
<td>193,407+</td>
</tr>
<tr>
<td>Venereal Disease</td>
<td>14</td>
<td>12</td>
<td>-14</td>
<td>174,635</td>
</tr>
<tr>
<td>Eye</td>
<td>21</td>
<td>8</td>
<td>-62</td>
<td>29,047</td>
</tr>
<tr>
<td>Tropical Disease</td>
<td>4</td>
<td>3</td>
<td>-25</td>
<td>24,571+</td>
</tr>
</tbody>
</table>

+Fiscal Year 1974-5
*Fiscal Year 1976-7


Nestlebaum, Z. Review of Department of Health documents.
free services was a major contributing factor to the City's virtual bankruptcy.

This philosophical position was reinforced by the belief that District Health Services contained a great deal of "fat." According to Deputy Commissioner Mustalish, there was a lot of "excess personnel, second rate people, inappropriate activity and ineffectual programs. Many of the cuts were long overdue." He felt that the budget cuts were good overall decisions, giving the Department an opportunity to clean house and to bring the District Services system up to date.

This point of view breaks sharply with the traditional model of public health services delivery. Since 1974, instead of delivery based on need, the DOH has moved toward delivery based on demand. The shift is from a service to a market model. The criteria for reducing services was not declining community need, but utilization statistics and short-run measures of efficiency.

No doubt, this change of focus from what Dean Wegman remembers as "everything that might affect a citizen's health," to what Drs. Bellin and Imperato call a "lifeboat mentality," was partly a consequence of the fiscal crisis. Some cuts were laudable efforts to weed out actual fat from District Services programs. Health officers who were second rate and ineffectual, according to Dr. Mustalish, were dropped or forced into retirement. Physicians who were being paid salaries without ever working, including one earning $25,000 annually as director of a tropical disease clinic who had not had a case in years, were dropped as well.

DOH planners also considered the master plan for District Health Services, drawn up in the 1930s, as hopelessly dated. Demographic shifts had left Health Centers in areas that did not need them, because other providers were available. The Lower East Side Health Center's location on "hospital row," distant from the slums, was cited as one reason for closing it. (Some agencies that formerly occupied the DOH buildings as part of their "in kind contributions to federal and state programs were able to take over the facilities following the removal of DOH programs and personnel.)

Scattered categorical programs often competed with programs offering more comprehensive medical care. In the case of well-baby clinics, for example, their declining registration (without a comparable reduction in services) was used to justify upgrading a few into comprehensive, full-time Pediatric Treatment Centers, while closing many others. Isolated Chest Clinics were closed and chest-tuberculosis clinics, which primarily served drug addicts, alcoholics and the aged, were transferred into hospital settings. Two part-time VD clinics were closed and the rest upgraded to full-time operations.

Decisions to cut services and/or spending were, at times, 'very painful' for those involved. However, it would be a mistake to assume that those who played key policymaking roles during the fiscal crisis were simply following orders. Some brought an ideology opposed to public sector services into office with them.

The DOH officials used several rationales to justify reductions. Eye Clinics, sickle cell screening, lead poisoning case finding and school health examinations were cut back because they lacked follow-up; Immunization Clinics (for adults and travelers), CHAP (Child Health Assurance Program) in day care centers, and school health because they duplicated services; and dental care because, in Dr. Bellin's words, "Nobody ever died of bad teeth and bad gums. I had to weigh that against diphtheria inoculations. I didn't have money for both."

The Commissioners' choices were not easy. In a recent interview, Dr. Bellin noted, "It was a very painful time to be Commissioner. These cuts had to be made. None of us enjoyed it."

While City officials continued to cut back the personal health services of DOH, the Department's regulatory and monitoring functions were coming under attack from another quarter. Beginning in the late 1960s the New York State Health Department began usurping many City DOH functions and asserting increasing control over the City's health activities. The regulation of the Medicaid and Ghetto Medicine programs; inspection of hospitals, nursing homes and supermarkets; and certain environmental activities eventually passed into State hands.
With the creation of the State Office of Health Systems Management in 1977, the State's influence grew markedly. Bellin and Imperato, who felt, as did most local health experts, that the City could do a better job than the "long arm" of the state, went to court, on the basis of home rule, to prevent the loss of DOH's Medicaid functions. But their attempt failed, and the gradual loss of regulatory functions from city to state continues, leaving the DOH, in Dr. Imperato's words, with "what the State Health Department doesn't want."

Before the fiscal crisis began, the DOH, as the major public health institution in New York City, had a long, outstanding tradition. Though not perfect, it played a vital role for the City's poor throughout its 75 year history. However, since 1974, under a succession of three Commissioners, the Department has been virtually destroyed. The District Health Services have been cut back and relegated to the status of an "unwanted child," while the regulatory functions have slowly been "adopted" by the state.

With the cutbacks in personal health services and the loss of most of its regulatory functions, the actual survival of the DOH is in question. What is also in question is the health status of the three million poor and working poor people living in New York City who have relied on the DOH.

New Yorkers who have benefited directly and indirectly from the DOH's public health services.

Attempts to alleviate the fiscal crisis by cutting back on health services may in the long run turn out to have had the opposite effect.

Zamir Nestlebaum

Zamir Nestlebaum is a medical student at the University of Massachusetts.

References

BATTLE OF THE BUDGET

The Congressional budgeting process of 1979, for Fiscal '80, is crawling forward with lowered expectations but some lobbying intentions to, add-on. One thing was clear after this Carter executive budget cycle. HEW Secretary Joseph Califano’s “put-it-up-the-flagpole” advertising agency approach to health budgeting, with a little help from Teddy Kennedy’s midterm Democratic Convention "Memphis Blues," had survived the bigger media campaign in the sky with some lingering programmatic corners.

That bigger ad campaign, of course, has been generated by the chief executive’s personal account executive, Jerry Rafshoon. Rafshoon’s Right-thinking, “shaft-em-with-the-flagpole” approach to federal budgeting had called for across-the-board cuts in all agency requests of at least $30 Billion, with $3 Billion to come from already totally-marginal health expenditures alone.

Many of the $3 Billion cuts officially were reinstated on appeal from Califano. The entire package of “discretionary” federal health expenditures and program “initiatives” (beyond more than $44 Billion for Medicare and Medicaid entitlements) was sold on paper as either immediately cost-cutting or cost-containing or as eventually producing economies through preventive health measures. An asserted $1.7 Billion federal savings during fiscal 1980 is to come from held-over and watered-down hospital cost containment legislation, which has become a rhetorical centerpiece of President Carter’s “anti-inflation strategy.” The only other major program initiative asks $288 million for a held-over and scaled-down Child Health Assurance Program (CHAP), to extend Medicaid eligibility and expand program benefits to two million poor children and 100,000 low-income pregnant women. Otherwise budgeting more savings in the HEW appeal were various Medicare and Medicaid cost control measures. Only Rosalynn Carter’s favorite public charity, mental health, received a net $59 million increase over the current year, but related drug abuse and alcoholism funding was reduced in favor of a state lump formula grant program approach.

Only a few public whimpers were heard from official budget cutters at OMB (the Office of Management and Budget). But until Memphis and revelation of the President’s own vulnerable lines to Kennedy and Labor on health as “their” arena of expenditure, those called-for $3 Billion slashings for federal health were being treated internally at OMB as very real. The cool hands at the White House then treated the HEW Secretary’s National Health (Insurance) Plan, for staged universal coverage and carefully regulated doctor’s reimbursements, like a 1985 priority. The President is into rationed hospital days (the proposed Hospital Cost Containment Act) to match his rationed gallons of gas as highest domestic priorities for 1979.

Carter will have nothing of expanded health insurance entitle-
The People with the responsibility for the health budget do not have clear ideas about making public and community services more effective and reaching the greatest need. They are generally suspicious of government involvement.

Califano likes to package slim ideas with sexy names but he doesn't generally warm to the less glamorous tasks of reorganizing existing federal financing toward the most needed and appropriate services and controls.
containment and fraud and abuse management programs.

Finally, at the Secretary and departmental level there are additional problems of narrow orientation. Despite Califano’s relative reputation as a public expenditure liberal, as the President swings to being a Right-appeasing broker, the HEW Secretary is sometimes stubbornly dense about how to develop any comprehensive and effective federal approach to restructuring health services. His blind impatience about reorganizing and unifying Medicare and Medicaid in the Health Care Financing Administration (HCFA) led to the departure of Robert Derzon, an administrator who at least knew health financing, and his replacement by a generic Califano whiz kid who keeps asking, “Now what is Medicaid?”

The Secretary himself is happiest as a Great Society acronymist, packaging slender items with sexy names for sale on the Hill: (Great! let’s call it the Pregnant Smoking Teenagers’ Program (PSTP)!). Califano doesn’t generally warm to the less glamorous tasks of reorganizing existing federal financing toward the most needed and appropriate services and controls over excess and uneven charges. Nor does he seem terribly interested in interfacing federal resources with state and local governments for stronger community-based services in the underserved areas.

Prevention has been a rising slogan at HEW but it has focused on cigarette smoking and lifestyles, evoking only a single shot at environmental causes of cancer for the political consumption of labor leaders. It has certainly not included a crusade to support the marshaling of scientific evidence or action against the systemic industrial causes of illness, a joint undertaking of HEW’s National Institute for Occupational Safety and Health, under new Director Dr. Anthony Robbins, the Occupational Safety and Health Administration (OSHA) and the Environmental Protection Agency.

The HEW Secretary does continue, almost by default, to haunt this Administration and the unhealthy society as at least a potential advocate of realer steps toward a National Health Plan squeezed through more universal financing, of cost-containment and planning emphasizing community-based alternative levels of health services, and of some prevention that could end up with corporate targets. That is, if a human programmatic presence is tolerated above and demanded popularly as the 1980 Election Year approaches.

However, unless something breaks loose politically in the cities... something with the potential to shake together the now-cowed and fragmented labor, consumer, and environmental citizen lobbies to demand a totally new take on federal health expenditures... the midnight oil-burners within the Carter process won’t be able to hold any budget lines for the unrepresented and underserved neediest infants, children, women, and elderly. Then, forget the working poor and undocumented workers/illegal aliens totally cut out of health entitlement and the moderate-income/working class communities needing new organizational handles for appropriate health services access in weak market areas.

Some of their worst ideological enemies are to be found here within this allegedly Democratic Administration. Richard Nixon had a dream of social privatism that continues to permeate the upper-middle layers of the federal government for health.

—Robb Burlage
ELECTRONIC FETAL MONITORING

The woman’s contractions have been in progress for several hours, serious but not severe, regular but still manageable with the early deep-chest breathing she has learned in her childbirth classes. She and her husband go to the hospital and are escorted to a small bare labor room, where her personal belongings are taken away and she is given a hospital gown. On the bedside at her side is a black box with a blank graph facing forward. She walks slowly around the small room while her husband times her contractions, now getting longer, stronger, and more frequent. Soon the resident comes into the room, asks her to lie down, and proceeds to connect her to the black box through various leads. An external belt holds ultrasound conductors to her abdomen; her membranes are ruptured so that two electronic leads can be placed internally, one—a spiral electrode—into the fetal scalp, and the other between the fetus and the wall of the uterus. A needle connected to a bottle of intravenous solution is inserted in her vein, and she and her husband are left to continue their breathing and timing of contractions.

This woman in labor has been connected to an Electronic Fetal Monitor (EFM). Electronic fetal heart monitoring was developed to help prevent fetal death or damage due to lack of oxygen during birth. By detecting stress in the fetus, it alerts obstetricians to potential problems so that they can intervene in the birth process and deliver the baby quickly if necessary. EFM was first done in “high risk” mothers who, because of problems in this or previous pregnancies, were thought to have the greatest risk of a difficult labor and delivery with possible damage to the infant. It is now done routinely in all births in major urban teaching hospitals, and it has been estimated that at least half of all births nationwide are monitored. One of the most widely used textbooks of Obstetrics and Gynecology states that, “Even though continuous monitoring of all parturients is not now feasible, this is a goal that must be sought” (1).

A recent study of the impact of EFM on cesarean section rates noted the common pattern of EFM acceptance and use in hospitals: “Fetal monitoring was introduced to Evanston Hospital in 1970, and its use was sporadic (less than 5% of patients) until 1974 when use of the monitors greatly increased. By 1975, routine monitoring of patients in labor was standard (85%)” (2).

Risks and Benefits

Proponents of EFM point out that since monitoring was introduced, there has been a dramatic drop in the infant mortality rate in the United States from 20/1000 in 1970 to an estimated 14/1000 in 1977. Obstetricians have attributed this decline in mortality rates to changes in their practice, including electronic fetal monitoring and a more aggressive approach to labor and delivery.
Although the use of electronic monitoring has been a major factor in the drop of infant mortality in the U.S. since 1970, it has increased the risk of death for the mother. Among the complications are cesarian section, uterine perforation, vaginal laceration and fetal distress.

Assuming causality when a coincidence of trends occurs, however, is a common fallacy. A number of other changes in society (including the widespread availability and use of family planning and abortion) have contributed to the decline of infant death rates, and no causal association between the recent trends of more obstetrical intervention and lowered death rates has been established.

The best way to test the benefits of EFM is by randomized controlled trials which compare electronically monitored and humanly (nurse) monitored women in terms of differences in infant health at birth. Only four of these trials have been conducted. These studies have been done on both low and high risk mothers. Neither the randomized controlled studies nor other studies done on larger populations with less rigorous methodology have shown any medical benefit of EFM for low-risk mothers (3,4). For high-risk mothers the evidence is contradictory. In two studies, Haverkamp found no difference between EFM and nurse monitored infants (5), but in an Australian study Renou found that infant outcome was better for the EFM group (6).

One thing however, has been convincingly demonstrated by these studies: fetal monitor leads to more aggressive obstetric management. In every study of EFM, the rate of medical intervention by cesarean section increased dramatically (usually the incidence doubled in five years after introduction of EFM). There is controversy about how much of the rise in the C-section rate is directly due to fetal monitoring. Most authors agree that there has been an increase in the diagnosis of fetal distress leading to cesarean section, although Kelso found that the more than twofold increased rate of C-section in his monitored group could not be attributed to increased fetal distress diagnoses (7).

Although the risk of maternal death from cesarean section is small, it is at least ten times as great as for vaginal delivery. This fact, combined with Haddad’s finding that only half of the monitored women in his study who received a cesarean section actually needed one (8), leads to the disturbing conclusion that there are many unnecessary deaths from cesarean sections as a result of EFM. Cesarean section carries with it other risks to both mother and child such as postoperative infection or anesthesia complications, as well as the many psychological problems of separation of mother and child at birth, difficulty breast feeding, and recovering from major surgery.

Monitoring has other risks for mother and child. An external monitor requires the woman to remain in a supine position, the position which one obstetrician has called the worst conceivable for labor and delivery (9). The monitor not only restricts the movement of the mother, making her uncomfortable, but also may adversely affect uterine activity and the maintenance of normal blood pressure.

Internal monitoring is even more directly harmful to mother and fetus. It requires the artificial rupture of membranes. These membranes, when left intact during the first stage of labor, protect the fetus from damage and distress by equally distributing the pressure of uterine contractions. Thus, because it involves rupturing of the membranes, fetal monitoring can not only detect fetal distress but can also cause it.

Injury or infection of the fetal scalp at the site of the electrode attachment is another not infrequent complication of internal monitoring (10). In addition to this medical complication, no mention has ever been given to the possible psychological trauma to an infant whose first sensation from the outside world is the screwing of an electrode into his or her head.

The major risk of EFM to the mother, other than that of cesarean section, is that of infection from insertion of the electrodes (11). Other infrequent complications such as uterine perforation, bleeding after the vaginal insertion of
The dehumanization of the birth process not only isolates the woman from her childbirth experience but also isolates the birthing family from the physician in what should be a team effort.

the intrauterine catheter, or minor vaginal and cervical lacerations when the scalp electrode is applied have been noted in the literature.

Who benefits from EFM? The infant? The mother? The obstetricians? The hospitals? There is very little evidence to show that infants who have been electronically monitored have less risk of death or damage. Studies which have shown a slight advantage of monitoring for the infant have demonstrated that this advantage is limited to high-risk infants. Aside from a somewhat false sense of security provided by the presence of such awesome technology, there is no medical benefit to the mother. In addition, there are the increased risks to both mother and infant to be weighed against these small, if not nonexistent, benefits.

Physicians and hospitals may indirectly benefit from the use of EFM. The birth rate is declining. Financial and political pressures to regionalize, consolidate, and cut hospital cost and capacity weigh heavily on obstetrical units built and staffed for continual post-war baby booms. Obstetrics has become one of the most frequently sued medical specialties, and defensive medical practice is becoming standard. All these pressures result in increased medical intervention in labor and delivery, even as these interventions are increasingly discovered to be harmful to mother and fetus.

Banta and Thacker estimate the direct costs of EFM to be about $80 million per year (12). This figure does not include costs of unnecessary cesarean sections which may result from EFM, nor does it include the high costs of the resulting morbidity and mortality of EFM and C-section procedures. Given the very limited benefits yet shown, they conclude, “One can only say that EFM does not appear to be a cost-effective procedure.”

Consequences of Increased EFM Use

Routine EFM is part of a number of interrelated though sometimes apparently contradictory trends in obstetrical care and childbearing. One trend, the move toward increasing use of technology in the birth process, has most recently focused on diagnostic technologies—invasive and non-invasive—such as EFM, sonography, oxytocin challenge tests (OCT), and amniocentesis. Previously, technological development concerned methods of extraction—notably forceps and cesarean section—and medications to ease or eliminate the pain of childbirth. Between diagnosis and delivery there is also technology applied to labor—induction and stimulation of labor by oxytocic agents—and the medications required to make induced labor tolerable. The use of these technologies has removed childbirth from the home to the hospital, changed midwife attendance to physician delivery, built a powerful male-dominated obstetrical specialty, and changed a family-centered life-celebrating event to an isolated and alienating medical crisis. The ultimate in medicalized childbirth is the cesarean section. This surgical procedure, apparently closely connected with the use of EFM as a diagnostic tool, is also the ultimate in physician-controlled childbirth.

There are non-medical consequences of routine EFM use that are particularly troubling because they are so little explored. Monitoring has a profound impact on the relationships between people involved in the laboring process. The monitor becomes the subject of conversation, the source of information and expertise, the basis for management decisions, the “protector” of the birth experience and the baby, the voice of the baby, the voice of the health professional, a source of distraction, and a catalyst for communication between mother and father (13).

The physician compounds this dehumanization of the labor experience by dehumanizing the decision-making process. A resident recently commented, with little apparent angst, “When the monitor shows a slow fetal heart rate, we section. If the baby comes out crying and screaming, we wonder what happened, but we have no alternative.” With obstetrical malpractice premiums at $16,000 a year, and the EFM
making a permanent record of the labor process, physician decision-making comes close to being a technocratic exercise, and the skill of being able to humanly auscultate a laboring mother and her child becomes obsolete. Ironically, decreasing the role of the physician as primary source of information and skilled decision-maker distances the physician from the patient, leaving her/him vulnerable to lawsuit if something goes wrong with the delivery. The de-humanization of the birth process not only isolates the woman from her childbirth experience, but isolates the birthing family from the physician in what is ideally a team effort. Frequently, use of EFM prolongs this isolation and intensifies its effects by leading to cesarean delivery and routine separation of child from the mother after cesarean birth. It is yet another unfortunate irony that as we begin to understand the severe effects of maternal-infant separation on both mother and child (14), the incidence of routine mother-infant separation is increasing.

The irony of a cesarean section rate which may be approaching one in four or five births is that at the same time families are becoming increasingly involved in efforts to control their own childbirth experiences. And it is precisely among the educated, middle-class families who are most involved in regaining control over their own childbirth experiences that the increase in the rate of technological interventions has been the greatest.

Two studies which have reviewed scientific findings regarding the medical risks and benefits of EFM have reached virtually the same conclusion. Ettner states decisively, “It is apparent that the benefits of EFM do not outweigh the risks” (15). Banta and Thacker similarly conclude, “The diffusion of EFM is an example of a widely used technology of uncertain benefit associated with definite risks and financial costs” (16).

Women seeking obstetrical care should realize, however, that today’s physicians are being trained to use EFM, without regard for the growing evidence showing little benefit and possible harm. To again quote one of the most widely used textbook of obstetrics and Gynecology in its discussion of EFM, “It seems clear that the returns are great and that the art and science of FHR monitoring have advanced to the point where this capability should not be limited to the larger medical centers” (17). In deciding on obstetrical care, women should find out whether routine EFM will be part of that care, and if so, should consider the implications of this for their labor and delivery.

New regulations for the use of EFM are being developed by the National Institute of Child Health and Human Development. (In the September issue of Health/PAC BULLETIN, we will take a look at them.

—Marsha Hurst and Pamela S. Summey

References


16. Banta and Thacker, op. cit., p. 16.

This year a new buzz word will come of age in the lexicon of occupational health. It is “white lung,” a code name for the profound damage asbestos dust causes to lung tissue.

There is nothing new about “white lung” or the diseases it encompasses; asbestosis, lung cancer and mesothelioma, a previously rare tumor which turns the lining of the chest or abdominal cavity into a cancerous form of concrete. But for the first time compensation for the estimated 5,000 to 10,000 people who die each year from asbestos related disease is a realistic prospect.

There have been a number of developments; the most significant is that product liability lawyers have declared open season on big asbestos manufacturers, firms like Johns-Manville, Raybestos-Manhattan Inc. and Owens Corning. The argument is simple. The manufacturers knew asbestos fibers could kill as early as the 1930's when the nonflammable silicate mineral came into widespread use. But warnings and protection either for asbestos workers or others who used asbestos products in insulation, textile or paints were inadequate to nonexistent.

The health evidence incriminating asbestos is very solid. Even HEW Secretary Joseph Califano has officially warned workers of its dangers. But hard evidence of an industrial cover-up was scant, until Congressional hearings in San Francisco in October, 1978. Within a week, lawyers for Local 9 of the Marine & Shipbuilders Workers, AFL-CIO, based in Los Angeles, filed a $1 billion action on behalf of more than 5,000 workers. “I tend to be rather cynical but I have never seen anything like this,” said David Epstein, an attorney for the plaintiffs. “You might go home at night and fantasize about how great it would be for our case if so and so wrote a letter to their medical chief and said don't tell your workers about the health hazards of asbestos. The next day, lo and behold, you find out that it is true.

The largest settlement in an asbestos-related suit to date has involved 400 former workers at a Pittsburgh Corning Corporation plant near Tyler, Texas who reached a $20 million agreement last year with defendants including asbestos suppliers and the federal government. All told, more than 2,000 actions are now pending nationwide, involving the Groton, Conn. shipyard, the Philadelphia Naval Shipyard and Raybestos-Manhattan's Passaic, N.J. plant among others.

Third party suits are not without major drawbacks. The most obvious is that they do nothing to reverse the debility of those who file actions. Indeed, Clarence Borel, a Texas insulation worker who brought a landmark case in the early 1970's, died long before the U.S. Court of Appeals for the Fifth Circuit awarded his widow $79,000 in 1973.

On the other hand, as an economic incentive for strong preventive medicine programs, torts law has a chance to succeed where workmen's compensation and fed-
eral health standards have often failed. One might argue that workers' struggles are best fought through trade unions or the political process, not in court rooms, where the workers role is minor and cases take years to decide. But there is no denying that product liability suits can be an effective tool.

Consider for example some of the safety debacles that have been publicized in recent years. Velsicol Chemical Corp. has about 80 civil damage suits pending against it in Michigan for its role in the Michigan PCB disaster. The total, according to the Wall Street Journal, for settling 650 other claims, mostly for loss of cattle that ate the tainted food, is $40 million.

Just as interesting are suits steaming from Allied Chemical's kepone disaster in Hopewell, Va. Richmond attorney Edward W. Taylor has filed 100 lawsuits on behalf of workers and their families, with total claims exceeding $100 million. Fifty-seven have been settled but the dollar amounts are being kept secret. "My guess is all the cases will be settled before they go to trial," Taylor said. "I don't imagine (Allied) wants any more bad publicity and they don't want to set a precedent."

One alternative to third-party suits are workmen's compensation laws, which now cover better than 85 per cent of the labor force. Under most state statutes, workers forfeit the right to sue their employers over injuries and illness on the job in return for guaranteed payments, no matter who was at fault for the incidents. A major problem with these laws was illustrated by the kepone case, where Allied's lawyers have tried to prove the company was in fact the employer of the injured workers—and thus immune from suit—and not just a supplier of chemicals to Life Sciences, Inc. This illustrates what Purdue professor James Robert Chelius calls the "potentially perverse incentives of workers' compensation." In a 1977 American Enterprise Institute study, he argues that a worker's right to sue should be restored in just such instances of "serious employer negligence."

Asbestos cases have taken the lead in product liability suits because the diseases are so widespread and the dangers so clear cut. Their ultimate success is anybody's guess. High priced legal and medical talent used by the asbestos industry have helped keep settlements down. The average per case is less than $25,000—and that is covered by insurance—according to a report Jons-Manville filed with the Securities & Exchange Commission last March.

On the other hand, firms like Manville, Pittsburgh-Corning, Armstrong, Raybestos-Manhattan, Owens-Corning, Certain-Teed and UNARCO have an overwhelming advantage. Just such instances of "serious employer negligence." In a 1977 American Enterprise Institute study, he argues that a worker's right to sue should be restored in just such instances of "serious employer negligence."

BRINGING THE CHEMICAL WARFARE BACK HOME

While the U.S. no longer rains death on Vietnam from the skies, some of the chemicals created for that purpose have become part of the American way of death. The avowed purposes are no longer defoliation for military purposes but the end result is just as deadly. Business as usual produces deadly toxic substances: the victims are workers and, increasingly, citizens in the community. Few persons or places are immune to the attack. American society increasingly resembles a combat zone where the people are under assault from the products and wastes of industrial production.

On March 1, the Environmental Protection Agency banned most uses of the herbicides—2, 4, 5-T and Silvex. Both contain dioxin, one of the deadliest poisons known. 2, 4, 5-T and dioxin were ingredients of Agent Orange, over 11 million gallons of which were sprayed on South Vietnam between 1965 and 1970. Findings of birth defects and stillbirths in mice, coupled with public outcry, led to cessation of its use. But its ingredient, 2, 4, 5-T, continued to be widely used in U.S. forests by timber companies, utilities, and agribusiness until a study showing increased miscarriages in Alsea, Oregon led to a ban. Once again, it took a human tragedy to stimulate action when heeding warnings from animal studies could have prevented widespread diffusion into the environment. Silvex, homeowners may know, is a widely used home garden weed killer.

If you're not being sprayed with dioxin, or using it in your
garden, you may be living on it.
At least that's what some residents of Niagara Falls, New York have discovered. Over 80 toxic chemicals from the Hooker Chemical Company dump at Love Canal have been found in samples taken from nearby houses and backyards. It's estimated there may be 130 pounds of dioxin in the Love Canal dump and another 2,000 pounds in the Hyde Park dump in Niagara Falls. Studies of health effects are just beginning, but already there are clear suggestions of increases in birth defects, miscarriages, liver cancers, hyperactive children, and seizures. The Love Canal neighborhood has been declared a federal disaster area.

Public outrage at the Love Canal disaster has finally spurred EPA to get on with its tasks mandated under the Resource Recovery Act of 1976. Reports of toxic dumps have begun to come in from around the country raising the specter of further "Love Canals." EPA reversed its earlier policy of trying not to publicize the dangers and actually sought to count and identify possible hazardous waste sites. A quick check by EPA regional offices identified over 32,000 waste sites with potential adverse public health consequences.

EPA's first estimate of cleanup costs for existing chemical waste dumps is a nice round $50 billion. But the sum will only clean up past messes. An additional 35 million tons of hazardous waste are produced every year—most of which is disposed of inadequately. Safe waste management costs from 10 to 40 times as much as the methods most commonly used.

EPA had a Congressional mandate to promulgate regulations for a cradle-to-grave waste disposal system by April 1978. Now EPA talks about January 1980—almost two years beyond the statutory deadline.

While EPA fiddles with its regulations, more and more hot spots ignite. Employees of the Robinson Brick & Tile Company in Denver, learned in February for example, that their factory is built on an old uranium waste dump emitting dangerous levels of radiation. Twenty-two such radioactive dumps have been found in Colorado alone. Large numbers of the 70 million Americans dependent on groundwater for drinking water are finding their sources polluted by toxic chemicals. Such damage can occur almost anywhere. "Midnight dumpers" have deposited their massive toxic loads along the roads, streams and vacant land of America. Many unknown toxic hot spots sit like unexploded bombs waiting to do their damage to the unsuspecting humans who come into contact with them.

**America Explodes**

Sometimes, whole towns come under attack. Three years ago, a Hooker chlorine tank car exploded killing four Niagara Falls residents and hospitalizing 90 others, some of them exposed while shopping three miles away. As the rate of train derailments has doubled in the last decade, deaths have risen faster. One weekend last February, 23 people were killed in two separate tank car accidents involving tank car leaks and explosions. Between January 1, 1976 and June 30, 1978, the Louisville & Nashville Railroad had 121 accidents involving hazardous cargo: damage included 19 deaths, 71 serious injuries, and evacuation of 7,280 people from towns in seven states. Such explosions and evacuations, complete with armed forces in gas masks, evoke familiar war imagery.

Communities are fighting back: The Love Canal Homeowners Association, led by its women, are pressing for evacuation, cleanup, and compensation. Arrests occurred after pickets blocked traffic. In Warrenton, North Carolina, fearing "another Love Canal," large numbers have militantly protested using their county as a dump site for PCB contaminated soil which the state proposed to bury close to the water table, in violation of Federal regulations, rather than pay the cost of shipment to a secure site in Alabama. North Carolina has no adequate hazardous waste disposal site.

All the recent publicity, including an explosion at a New Jersey disposal site which took 6 lives, has helped fuel local opposition around the country. Existing dumps have been closed and proposed new waste disposal sites blocked. Communities are demanding that existing dumps be found and cleaned-up. A big question remains whether taxpayers or industry and insurance companies will foot the bill. People around the country no longer trust industry and government's ability to safely handle toxic wastes.

Industry public relations campaigns argue that the risks are a small price to pay for the great benefits derived from chemicals. Dow, makers of 2, 4, 5-T and napalm, now tells us that natural dioxins are a bigger hazard than theirs and that the decision to ban 2, 4, 5-T is based on irrational fears. Industry appraisals of risks and benefits increasingly resemble the "destroy the village in order to save it" logic used in Vietnam.

The discovery of a vast poisoning of America through toxic wastes is the latest in a chain of shocks from the pervasive harmful effects of toxic substances in our society. How was it possible for so
much lethal material to be lost only to resurface virtually everywhere or anywhere? The proliferation of lawsuits by GIs exposed to dioxin in Vietnam, Love Canal residents and others may provide some compensation to victims, but little protection for the rest of us. Regulation comes too little and too late. The lawmakers fight last year's war even as new threats continue to make themselves known.

Increasingly, the ways of organizing production cannot safely contain the hazardous substances that threaten us. The potent hazards produced in our industrial processes have outgrown the social relations in which these processes are embedded. The result is death, destruction and growing insecurity at the lethal threats posed by toxic substances.

Only a system of community-worker surveillance and control and a massive shifting of priorities towards a safe society and away from short term profits can produce a country at peace with its own potential chemical weapons. Either we begin to reorganize the way industrial production is conducted in this country or we'll continue to inhabit a perpetual war zone.

—Tony Bale
NYC's Hospitals: Beyond CARING

In September, 1978, New York City's Mayor Koch got some rather unsettling news. The Emergency Financial Control Board (EFCB) completed its audit of the city budget projections for the coming years. The EFCB concluded that the city would be at least $450 million in the red during FY 1981; and if spending continued at the present rate the city would be more than $1 billion behind by FY 1983—that magic year during which the Koch Administration and the preceding Beame Administration promised the Congress and U.S. Treasury Department that the city's books would be balanced.

It took only a few months for the mayor to announce that the city's financial condition dictated drastic cuts in public hospital spending. By mid-November, the New York Times predicted that the so-called "big cuts" would undoubtedly center first on the Health and Hospitals Corporation (HHC). According to the Mayor's health advisors, the figure is probably close to $80 million.

Meanwhile, in the face of protests from defenders of the public hospital system, the Mayor turned to Governor Carey for help in closing some 5,000 public and private hospital beds in the city. Rumors about a state-compiled "hit list" for hospital closings have led to speculation about the Governor's willingness to close private hospitals. New York's three major newspapers have called for joint city-state action even in the face of public outcry.

What looked initially like a story of racist budget cutting of public hospitals is rapidly turning into a case of medical abandonment by and of our health care system. The crisis not only threatens a large component of the public hospital system, but is moving right into the board rooms of the city's major voluntary (private, non-profit) medical centers. And in its wake, our ability to get and pay for care is rapidly being undermined.

Koch's predilection to take his pound of flesh from the HHC budget was encouraged by his new and dear friend, Dr. Martin Cherkasky, president of Montefiore Hospital in the North Bronx. The good doctor is reported to have told Koch that something in the order of half a billion dollars could be carved out of the HHC's hide, if only some courageous politician were willing to take on those with vested interests. Koch named Cherkasky his special assistant for health, an ambassador without portfolio, whose task was to help get the city solvent by turning the Corporation into a corpse.

Running through all of the public comment on the HHC is the oft-cited waste and mismanagement of the public system. The clear, not unstated implication is that under other auspices the job could be done and better. But the facts are otherwise.

It costs about $245 a day to keep a patient in an HHC hospital. This is an all inclusive rate; it covers the costs of physician services as well as the traditional nursing
and hotel components of hospital care. The value of physician services already figured into the HHC’s costs is $47.50 a day. Subtracting the cost of doctors from the HHC rate means that the Corporation spends about $200 a day. Compared to the costs in voluntary hospitals of comparable size, $200 a day is one of the best buys in town. Montefiore, Dr. Cherkasky’s home base, for example, bills Medicaid for $325 a day.

There probably is a good deal of waste and mismanagement in the municipal hospitals. Certainly there have been legions of reports by funding agencies, task forces, panels and accounting firms which have detailed numerous instances of potential savings. But thinking that inefficiency is the source of the system’s woes is like believing that a monthly welfare grant of $543 for a family of four is excessive.

Managerial reform of the HHC will not save much money. The only way to substantially reduce the city’s tax levy support of the Corporation is to close or get rid of hospitals. But it will take a lot of hospital closings to save $80 million.

For example, if Metropolitan Hospital, the 788-bed East Harlem municipal hospital which has been targeted for possible closing or transfer to NY Medical College, were no longer run by the city the total tax levy savings from its $79.1 million budget would be $18.3 million. But on-going expenditures for debt-service, pensions, allocated city overhead, mothballing, unrecovered HHC overhead costs, medical record maintenance and transfer costs would take a $10.8 million bite out of the tax levy savings. Closing Metropolitan would result in only a $7.5 million savings in the first year. Since some of the costs, mothballing, pensions, etc., would eventually disappear as city obligations, the savings would be increased in a couple of years.

In order to make up $80 million, the HHC would have to close a minimum of six municipal hospitals. Saving this tax levy money means a reduction of about $450 million in total Corporation spending since a closed hospital cannot receive Medicaid, Medicare or any other reimbursements.

An analysis of where the city tax levy money is spent pinpoints both the sources of the problems and the difficulty with all the proposed solutions. The HHC calculates that about half of the $408 million tax levy money it is receiving this year from the city pays for the services to the medically indigent. Most of the HHC’s expenditures for the medically indigent are incurred through outpatient services because almost anyone without adequate coverage would become eligible for Medicaid after paying the costs of a day or two in the hospital.

Using hospitals for primary care, as many people do, is a very expensive way to get medical services. Medicaid, for example, reimburses up to $50 a visit (which most hospitals claim is inadequate) whereas a non-Medicaid visit to a private doctor probably wouldn’t cost more than $25 or $30. But most people don’t have a choice. If they don’t feel well, there aren’t any doctors’ offices for them to go to even if they had the money to pay.

Despite the fact that the Upper East Side has one of the highest concentrations of doctors anywhere in the world, most neighborhoods in the city have been virtually abandoned by private doctors. Morrisania, Mott Haven, Pelham Bay, Brownsville and Bushwick have less than one practicing physician per thousand population. And the situation is getting worse. Between 1966 and 1976, there was a decline of 2,800 office-based physicians in the city.

The HHC’s statistics bear out the hypothesis that people are using the hospital clinics as they previously used doctors’ offices. In just six years, between 1970 and 1976, the number of outpatient visits to HHC institutions increased by 53 percent.

If a significant part of the HHC’s capacity is reduced through the closing or selling of hospitals, its patients would have two alternatives. They can go without care, particularly ambulatory care or they can turn to the voluntary hospitals. But the cost of care in the voluntaries is, more often than not, higher than the cost of care in the city hospitals.
To take half of the city hospital's inpatient load in voluntary hospitals would cost the system nearly $100 million more.

Even if the private hospitals could increase their capacity to handle more patients, who is going to pay? According to Joe Hoffman, the new president of the HHC, fully one-third of the patients seen in the municipal outpatient departments are so-called "self-pay." These people are billed on a sliding scale of from $2 to $46 for each visit. Few can pay the whole cost of their care. Even the most elaborate billing system in the world won't get money from someone who doesn't have it.

Perhaps sometime in the past, the voluntary hospitals would have been able to absorb some of the cost of care for the unsponsored patients in their generally fat budgets. Not anymore. Since 1975, the State of NY has been trying to hold a tight lid on both Medicaid and Blue Cross reimbursement rates. (The state is caught in a terrible bind. It has guaranteed most of the half a billion dollars in mortgage commitments of the voluntary hospitals. The primary source of income the hospitals have to pay off this debt is their reimbursement income. The tighter the state holds reimbursement, the more likely it is that some hospitals will face bankruptcy and thus default on their mortgages and force the state to make good on the loans, thus jeopardizing the state's fiscal solvency.)

Medicaid expenditures in the city, to private providers, both doctors and hospitals, have increased by only 6.6 percent between 1976 and 1978. This rate of increase looks even smaller when viewed in the context of a national medical care inflation rate of about fifteen percent a year.

Nineteen private hospitals have closed their doors since New Year's day, 1976. Seventy-eight of the 87 voluntary and proprietary (profit-making) hospitals in the city reported operating losses in 1977. But hospitals have always claimed poverty. More telling is the fact that 33 institutions were technically bankrupt, meaning that they lacked the assets to pay their debts if three or more creditors decided to call them in. And with one large, recently closed voluntary hospital, Flower Fifth Avenue, paying only 60 cents on the dollar, suppliers just might be frightened enough to call in their money.

The list of hospitals in serious financial disarray includes both small marginal institutions and some of the city's major medical centers. The big five superhospitals—Montefiore, Mount Sinai, New York, Presbyterian and NYU—reported in early 1978 combined operating deficits of more than $50 million. Montefiore and NYU are still probably crying wolf, but the situation at Sinai, Presbyterian and New York is quite serious. Each is facing increased competition for paying patients from suburban hospitals and an increasingly tough rate-setting commission which is less easily swayed than in the past by the influence and power of the voluntary hospital trustees. Although the gross sum of public funds being spent for health care is growing very slowly, the more powerful institutions are seeking a redistribution of the $4 billion pot. An obvious target is the HHC's $1 billion.

Perhaps in pursuit of this redistribution, 60 board members of voluntary hospitals contributed a total of $162,250 to Koch's campaign. Even if fewer patients can be served for the money saved from the private hospitals' point of view, it would be far better to have it invested in their prestigious and in many cases debt-ridden institutions.

Regardless of how the voluntaries manipulate to increase their reimbursement and their share of paying patients, none is in a position to absorb an increase in non-paying or part-paying patients. The few hospitals in poor neighborhoods which have extended their services to surrounding communities find themselves in desperate straits. Brooklyn Jewish Hospital in Bedford-Stuyvesant filed for a Chapter 11 bankruptcy on February 8. Following on the heels of this action came the public announcement that in order to restore solvency, Brooklyn Jewish would have to begin denying services to non-paying patients.

Another case in point is Bronx Lebanon Hospital located in the depressed mid-Bronx. The hospital is reporting an annual deficit of $4 million a year. Both Bronx Lebanon and its more solvent...
neighbor to the north, Montefiore, see more than 200,000 ambulatory care (outpatient and emergency room) patients a year. Both report they spend about $80 for each patient encounter. Both receive about $50 as reimbursement for each covered patient. But Bronx Lebanon nets only about $30 to cover the cost of a visit and Montefiore makes about $60. Montefiore is thriving; Bronx Lebanon is on the verge of bankruptcy.

Were Montefiore to absorb some of the patients denied care because of the closing of city hospitals, it too might find itself on the brink. Montefiore is unlikely to step over into that abyss. More likely, patients will find it harder and harder to get medical care until they are sick enough to need hospitalization and thereby become financially desperate enough to qualify for Medicaid.

The health care system has very little impact on the rate at which people get sick and die. But when it functions, it is able to relieve suffering. The closing of city hospitals will probably show up in increased incidence of TB and venereal disease, more premature births and perhaps a higher infant death rate. But it won't appear on any vital statistics tables—suffering cannot be quantified.

Reducing the city's tax levy commitment helps to solve Koch's budget problems. The transfer of reimbursed patients to the voluntary hospitals begins to ameliorate some of their fiscal problems. But it can only be done at the expense of uninsured patients.

The alternative is a total reorganization of the way health care services are organized and delivered. There is too much expensive hospital care and too little affordable ambulatory care. There are too few primary care physicians and too many specialists. $7 billion is a lot of money for New York and New Yorkers to spend on health care, but it won't buy what we need until the system is reorganized. Reorganization requires disenfranchising the priorities of the big, private teaching hospitals. We do not know any politician currently in or seeking office willing to take them on.

—Barbara Caress and Pam Brier
NURSES' NETWORK FORMED

Nurses today are faced with a host of problems with strong political roots. Ideas and proposals for change are legion, and inseparable from the problems of the health care system. The Nurses' Network has been established to serve as the focus of the discussion toward a political agenda for activist nurses and students.

The question of organization is crucial. We must grapple with the question of which organizations are best for us—independent unions, union with other health workers, or the state associations. The historical organizations of nurses, the ANA and NLN, with their aggressively provincial view of professionalism, seem incapable of fully meeting the needs of rank-and-file, working nurses. A new voice is needed.

Around the country there are individuals and small groups of activist nurses who are trying to address the problems of nursing. Up until now, they have usually acted independently and in isolation from one another. The Nurses' Network would like to try to end that isolation, and be part of the struggle to build responsive groups.

Starting with nurses who are friends of Health/PAC, we have developed a mailing list with heavy concentrations on both coasts, and contacts with small groups of working nurses in Boston, Philadelphia, and New York. The Nurses' Network would like to serve as an information exchange between activist nurses in different parts of the country—a sort of "bulletin board" for the rank-and-file movement. It is hoped that such an information exchange will lay the basis for concerted action in the future.

Through periodic mailings, we will try to keep our readers a-

Poll

Organized nursing leadership seems to be heading in a different direction than its membership with regard to baccalaureate nursing. A poll conducted by RN magazine finds that 72% of the RNs surveyed opposed the division of nursing into technical and professional levels—a policy called for by the ANA with a target date of 1985. Furthermore, 91% of the 10,000 polled favor the concept of a career ladder that would allow several basic training options for entering the profession and mobility within the profession.

Source: Health Planning and Manpower Reports, 1/3/79
A Fifth Column

For over ten years, Health/PAC has been providing a critical analysis of the health care system, with special emphasis on the issues of priorities in planning and delivery, politics and economics. While providing an overview analysis for the information of progressive workers within the system, Health/PAC has only devoted sporadic attention to the aspirations and experiences of the planners, policy-makers, and hospital workers working for change in their respective roles. Characterized by rising expectations and a steady growth in numbers, health care workers can be a potent force for change.

In the tradition of keeping our readers informed of new developments in the health care field, and in the spirit of encouraging activity among health care workers and professionals, Health/PAC Bulletin introduces “The Fifth Column.”

“The Fifth Column” will attempt to reflect the experiences and organizing efforts of health care workers. Rather than analyzing policy as a distinct entity, we hope to explore how policy impacts on the workforce, and how health care workers can ultimately influence policy.

One developing area is the growing interest of health care workers in their organization as workers. Considerable organizing efforts have been spurred by the legalization of collective bargaining in voluntary hospitals beginning in 1974. While setbacks are bound to occur, union organizing efforts should continue for the foreseeable future and may affect the balance of forces in large institutions.

While the ideology of professionalism enjoys continued popularity, it remains to be seen if it will be used to justify further hierarchical isolation between professionals and workers, or be used as a focus for asserting pride and demanding a measure of control over the work environment. The policy-maker and the lowest paid hospital worker alike are concerned with the humane delivery of health care. When political and economic policies stand between health care workers and their goals, frustration and alienation increase. Consequently, there is a natural tendency toward a recognition of common problems—a community of interests.

“The Fifth Column” will be used as a forum for expressing this community of interests, for exploring causes of discontent and pointing to possible solutions. Letters from activists and extended news items on manpower policies and organizing efforts will be the medium. The Editorial Board invites comments and contributions from activist health care workers among our readers.

The Editorial Board

breast of new publications of interest, upcoming meetings, and samples of the work of active groups of nurses. Introduction to the work of other nurses around the country should help end the isolation felt by many concerned working nurses. Toward this end, the Nurses' Network has already co-sponsored a lively meeting of activist nurses in the New York City area.

Articles and comments on nursing will be appearing regularly in the pages of Health/PAC BULLETIN. Other contributions will be offered to such magazines as Ms., where appropriate. Additional material will be distributed separately in the Nurses' Network newsletter as the situation demands and funds permit.

We ask you to send the Nurses' Network news about what's going on in your area. Announcements of meetings, suggestions for reading, and additions to the mailing list are most welcomed. If you or your group issues a leaflet or writes an article, send us a copy. Perhaps the most valuable practical benefit of an information exchange is the opportunity for working nurses to learn from the experiences of others. Finally, send letters, news items and other written contributions for consideration for Health/PAC BULLETIN, or other publications. We would like to see the real issues in nursing presented to the large progressive health care movement.

Only by working together can we hope to lift the stifling hand of conservative tradition from nursing, and begin to solve the real problems of today's working nurses.

For further information write: Nurses' Network, c/o Health/PAC, 17 Murray Street, New York, N.Y. 10007.
to their local areas, incorporate them into their plans and then set about the task of implementing them.

Finally, in October HEW, with the concurrence of the Office of Management and Budget (OMB), moved to assess the cost savings attributable to the nation's planning effort. Frightened, the American Health Planning Association (AHPA), trade association of health planners, leapt into action with its own survey, the results of which were out long before OMB and HEW could even agree on the forms.

The growing pressures on health planning are not limited to cost control, however. A variety of other special interest groups have also made themselves heard. HSAs are mandated to address measures which would improve the health status of their populations in their plans. Although they have pitifully little power to implement their proposals, many plans include strong sections on prevention and environmental and occupational health, raising such issues as auto safety, smoking in public places, gun control, pollution and workplace hazards. Such stances have triggered reaction by those special interests who saw renewal of the legislation as the occasion to seek redress.

An example of this process occurred when the Northern Virginia HSA took a strong public stand on the right of Medicaid recipients to publicly-funded abortion and also recommended passage of a county law against smoking in public buildings. The result was a furor which eventually led Fairfax County to withdraw its financial support of the HSA and Senator Richard Schweiker (R-Pa.), ranking Republican on the HEW Appropriations Subcommittee, to attempt to trim the HSA's wings with regard to "controversial" health issues.

The auto and tobacco lobbies' expressed concern over efforts to renew the health planning law and the threat of Right-to-Lifers to tie up the bill with an anti-abortion amendment may have thrown it into its final, lethal stall. Rather than fighting issue by issue, however, these groups settled for a single compromise amendment, fashioned by Senator Schweiker, limiting the scope of HSAs primarily to "health care delivery and the elimination of duplication and waste," rather than wider-ranging and potentially more controversial areas. Even this position was a considerable step back from a more stringent stand which would have limited HSAs exclusively, not just primarily, to health care delivery.

Finally, attempts to strengthen PL93-641 enraged the AMA, whose early opposition was critical in scuttling the bill. The original law had left a large loophole in the authority of health planning agencies to regulate health system expansion. Planning authority is currently limited to institutional health care providers only, leaving private physicians and others free to purchase major medical equipment and sell their services at will. Thus when the application of a Miami hospital to purchase a scanner was denied, a group of physicians rented space in the medical office building across the street and installed a scanner. The same thing happened in Cincinnati when Bethesda North Hospital ran into problems in getting HSA approval for a brain scanner. The fact that Cincinnati was already over-supplied with scanners was irrelevant.

The proposed amendments to PL93-641 would have closed this loophole, extending planning authority to the purchase of all major equipment, regardless of its location. Raising the specter of big brother horning in on private practice, the AMA fought this reform bitterly and succeeded during the final days in having it withdrawn.

By the time the bill reached the floor of the House, three days before Congress adjourned, the AMA, the AHA, and the AHPA—groups frequently at odds—had finally come to terms on a single issue: all wanted this bill passed this year. Each group felt it had secured the best possible compromises and each feared the erosion of its position under the intensifying pressures of the coming year. For HSAs the stakes were particularly high. Rep. Paul Rogers, (D-Fla.), architect of PL93-641 and chief proponent of health planning, was retiring and would not be present in the next session.

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Because of the failure of all other cost control efforts, the mantle of cost control is now being thrust on planning agencies. To the extent that Congress and the Administration insist on cost control as the measure of HSA effectiveness, their failure is preordained.

Pa.), ranking Republican on the HEW Appropriations Subcommittee, to attempt to trim the HSA's wings with regard to "controversial" health issues.
to defend planning interests. Nevertheless, the various parties had simply gotten their act together too late and the clock ran out.

What will happen to the planning bill when it is reintroduced this year is unclear. Speculation is rife, although the strongest rumor has it that lawmakers will quickly submit a bill identical to last year's, hoping that the final momentum and consensus will endure long enough to allow its passage.

Whatever the vagaries of Congress, however, the pressures which manifest themselves last year are clear and their implications for health planning grim. Because of the failure of all other cost control efforts, the mantle of cost control is now being thrust on planning agencies. While cost control was clearly a motivating factor in the bill's passage, PL93-641 failed to provide the new planning agencies with the tools to effect it. By virtue of their lack of power, the primitive state of the art and contradictions in their composition and functions, planning agencies are pitifully ill-equipped to inherit that mantle. To the extent that Congress and the Administration insist on cost control as the measure of HSA effectiveness, their failure is preordained.

Background

PL93-641 replaced three previous federal programs: Comprehensive Health Planning, the Regional Medical Program and the Hill-Burton Hospital Construction Program. It created a network of local agencies called Health Systems Agencies (HSAs), a network of two-part state-level agencies called State Health Coordinating Councils (SHCCs), and State Health Planning and Development Agencies (SHPDAs), and six regional health planning centers.

HSAs are governed by independent, consumer-dominated boards of directors. Elaborate rules govern their composition to assure that they are broadly representative of consumer, provider and other interests in their communities. Each agency is responsible for a "health service area" with a population ranging from 500,000 to 3 million, and each has at least one "sub-area" or community level advisory council.

At the state level, SHPDAs carry out planning, resource allocation and regulatory functions with the advice of Statewide Health Coordinating Councils, which are unpaid, governor-appointed bodies, similarly representative of the state. The SHPDA in many ways serves as staff to the SHCC and the two roughly parallel at the state level the roles and responsibilities of HSAs at the local level.

One of the first tasks faced by state and local planning agencies is the development of five-year plans (Health Systems Plans or HSPs, in the case of HSAs, and State Health Plans in the case of state agencies). These plans examine the health status of the population and inventory existing health resources, identifying resource needs and surpluses. On the basis of its plan, the HSA establishes priority problems to be addressed and frames these into a one-year, Annual Implementation Plan, which largely constitutes the basis of its implementation activities.

(Hereafter planning will be discussed largely in terms of HSAs, although most of the arguments apply equally to state health planning agencies.)

Power—Or Lack of It

What was to distinguish PL93-641 from previous health planning efforts was that, rather than simply planning, HSAs were to be given power to implement their plans. As originally conceived, these powers were impressive. They were to include: (1) rate setting power over Medicare and Medicaid reimbursements; (2) the power to approve and disapprove the use of HEW-Public Health Service monies coming into a local area; (3) distribution of Area Health Services Development Funds to aid in establishing needed health services; (4) the power to certify and decertify health facilities and services on the basis of need; and (5) the power to approve and disapprove expansion or changes in health services.

The actuality of these powers, however, is far from impressive. It reflects a long-standing ambivalence on the part of Congress and HEW toward health care cost control. The rhetoric is good and the intent is no doubt genuine. But the political power of the interests that would suffer from serious cost control measures—large hospitals and medical schools, medical equipment, supply and drug manufacturers, banks, etc.—is such that HEW and Congress always end up sidestepping the real issues at the critical moment (1).

Thus the very creation of HSAs sidestepped the primary cause of rising costs: Medicaid and Medicare reimbursement practices enacted by Congress and administered by HEW. Again, while talking
a good line, HEW and Congress sidestepped the issue of equipping HSAs to achieve cost control. The result is that now, under increasing pressure, HSAs are being sent forth to do proxy battle with the monster of rising costs—armed with a table-knife. And in the new-found atmosphere of program effectiveness, the word is, that if they fail, they can also be expected to take the rap.

The first proposed HSA power—that of setting Medicare and Medicaid reimbursement rates as a means of enforcing HSA decisions—was quickly withdrawn and dispatched into near-oblivion. It remains only in a vestigial state in the law, as funding for six demonstration rate setting projects nationwide.

The power to approve and disapprove HEW/PHS monies has not been granted to HSAs, nor does it seem to be in the offing.

Area Health Services Development Funds have never been appropriated and, in the atmosphere of cost control, it is inconceivable that they ever will be.

All that remains of the power of certification in PL93-641 is an atrophied anomaly known as “appropriateness review.” Every five years HSAs are required to review health care facilities and services in their areas, evaluating their appropriateness to the area’s health needs. While implementation was a major concern at many other junctures in PL93-641, it was curiously absent in the case of appropriateness review. Presumably a finding of appropriateness or inappropriateness by an HSA will be a self-implementing truth, powerful enough in its mere statement to bring about a more appropriate and rational health system. Very curious, indeed.

Yet parody of the original that it is, appropriateness review is still controversial enough to keep HEW scraping and shuffling. The first appropriateness review was to be completed within three years of an HSA’s official designation. Yet HEW has stalled for over two years in issuing regulations. And, lest appropriateness review prove an item too hot to handle, HEW announced in May that HSAs are not to name names. Their first reviews are to be area-wide, applying only to services in the aggregate, rather than being “institution specific.” This latest masterpiece of compromise was delivered by the American Hospital Association over the objections of HSAs, rate setting commissions and Blue Cross (2).

This leaves the core of HSA “power” in their Certificate of Need (CON) review. To receive Medicaid or Medicare reimbursement for the depreciation of any capital expense over $150,000, institutional providers of health care must first receive CON approval. HSAs review CON applications, assessing them on the basis of the area’s need for the service or facility. Although HSA findings are advisory and final decisions are made at the state level, they still have significant impact. Disapproval of a project carries with it the certainty of careful public scrutiny and many facilities would rather withdraw or modify their applications than risk such disapproval.

Noticeably absent from the HSA arsenal, however, is any generic linkage with agencies or organizations which do have power in the health system, including third-party payers, rate setting commissions, state licensing and certification bodies, and even PSROs. An HSA, therefore, has little, if anything, to offer as an incentive to institutions to open, close or alter services. Nor do they have authority over basic elements of the health system, such as private physicians, home care and domiciliary services, health manpower or federal hospitals such as those operated by the VA and the Public Health Service.

“Thus the Act carried on the by-now venerable Congressional tradition of calling grandly for changes in the health care system without being willing to touch its principle actors,” concludes noted expert, Katherine Bauer, in a recent study (3). Again she states, “the Planning Act excludes from the purview of the agencies it creates most of the key elements that currently determine the way the U.S. health system actually operates” (4). “Physicians and other health professionals continue to function just as autonomously as before, the basic way the system is financed continues
unchanged and the new review and regulatory functions prescribed by the Act are simply superimposed on the existing, complicated regulatory structure, not integrated with it" (5).

HSAs are reduced to piggybacking on other programs for hard clout. Voluntary as such cooperation is, the clout is nevertheless growing, fed perhaps by the confidence among those who would control costs that there is safety in numbers. Thus rate setting programs, (of which there are now ten independent state programs, 25 Blue Cross and two state hospital association-administered programs) have pulled in behind HSAs, at least to the extent of frequently refusing to reimburse hospitals for capital improvements that have not received prior CON approval.

HEW has also sought the cooperation of other federal agencies funding hospital construction. HUD, which has helped to fund 139 projects worth $1.655 billion, has recently agreed to abide by the National Standards for Health Planning in granting loan insurance to hospitals. HEW is trying to work out similar agreements with the Department of Agriculture, Interior and Commerce, the Farmers Home Administration, the Veteran's Administration and the Appalachian Regional Commission. Finally, private financiers are increasingly reluctant to loan money for projects lacking CON approval.

The sole exception to this hat-in-hand approach to planning agency power has been New York State, pioneer of both CON regulation and hospital cost control programs. There the planning apparatus is integrated into the State Department of Health which is also responsible for setting Medicaid rates, advising on Blue Cross rates and setting prospective rates for hospitals under the New York Hospital Cost Control Act. New York's Commissioner of Health, moreover, has the power to decertify institutions on the basis of appropriateness. New York is the sole state where hospital interests do not dominate the structure and decision-making process of the CON agency (6).

**The State of the Art**

The lack of HSA power to achieve cost control is rivalled only by the lack of data to guide a policy for achieving such ends. No data exist on the systemwide or long-term impact of different cost-cutting policies. The ability to assess community health needs is exceedingly primitive. The clinical effectiveness of health services in treating specific maladies or in influencing general health status has presented itself as a policy or research issue only in the last few years.

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**If cost control pressures threaten to consign planning to the back seat, resource development is likely to wind up in the fifth balcony**

No means exist to evaluate the lifetime costs, including income loss and welfare costs, of patients with avoidable illnesses or conditions. Comparative costs of comparable care in alternative settings is unknown. Comparisons of direct treatment costs of patients with identical conditions in different hospitals have not been conducted. Comparable risks and benefits of different levels of diagnosis and treatment services according to outcome have not been assessed. There are no data on institutional costs that would identify targets of excess costs (7).

Lack of such information means that HSAs are reduced to making many important policies and decisions by guess and by gosh—a poor basis on which to defend these decisions to the public or to the courts where every HSA can expect to land if it bucks the providers too hard.

**Regionalization a.k.a. Monopolization**

Data are so poor that they cast doubt, if not discredit, on the central, cost-controlling thrust of the planning program: reduction and regionalization of the health care system.

Low occupancies and utilization rates have led HEW to conclude that the nation suffers a serious excess of health facilities—particularly hospitals. Estimates of unnecessary beds range as high as 250,000. These empty beds cost nearly as much as filled beds, but do not generate patient revenues. Furthermore, the little research data in existence suggests that the supply of health services creates its own demand (dubbed "Roemer's Law"). Finally, researchers are finding that the availability of services and frequency of medical procedures bears little, if any, relation to the health status of populations.

Combined, these three emergent and poorly-understood facts form the basis of HEW's major planning and cost control policy: elimination of unneeded facilities and services and control of the growth of new ones. HEW has begun to codi-
fy this policy in the form of the National Standards for Health Planning. These Standards, which now exist only for acute care facilities, call for a 10 percent reduction in hospital beds during the next five years, from 4.4 beds per 1000 population to 4.0, to be followed by a further reduction to 3.7 in the following five years. Occupancy rates are to increase from an average of 75 percent to 80 percent; obstetrical units should have a minimum of 1,500 births annually; pediatric units should have at least 20 beds; open heart surgery units should conduct 200 procedures a year, etc. Facilities or services not meeting these standards should consolidate, convert or close.

The effect of this thrust will be the regionalization of health services, an ostensibly more rational basis for distributing health care resources. The real effect is more likely to be the merger or elimination of smaller institutions and services and consolidation of the system around fewer, larger and, not coincidentally, more expensive institutions. In less mystified industries this process is known as monopolization. Its motive force is the giants of the industry in question and its means are government regulation. Moreover, it rarely, if ever, serves consumer interests in the cost, quality or variety of the product.

The parallels of monopolization to recent developments in the health system are striking. The American Hospital Association has been in the forefront of support for CON legislation since 1968 (8), just as the large voluntary hospitals in New York State actively promoted passage of that state’s CON law—the first in the nation—in 1964. Until the advent of PL93-641, representatives of these influential hospitals controlled New York’s local health planning councils, administered the CON program, and thus effectively orchestrated the development of the health system.

Regulation generally serves to block the entry of new providers into the market, but rarely is it able or willing to stem the flow of resources into the industry, argues Mark Chassin, in a monograph on cost control strategies (9). Drawing parallels from the airline industry, Chassin states, “Regulation in these oligopolistic industries has led to price increases as the regulators allowed the producers to reach cartel-like agreements and enforce them where it had not previously been possible” (10).

Since regulation prevents the carriers (airlines) from utilizing price rivalry to obtain larger market shares, they turn to service quality rivalry in their endeavors to obtain increased shares of the cartel benefits available to each market. This causes them to buy more and newer equipment and facilities, and to utilize more personnel and provide the superior service” (11).

Recently, planning officials have become concerned that regionalization, or monopolization, may violate the law. Last February officials of the Central Virginia HSA, challenged by the local hospital association, sought an advisory opinion from the FTC on whether voluntary merger or collaboration among providers to reduce facilities and services violates the Sherman Anti-Trust Act. Preliminary FTC staff opinion holds that it does, and a final decision from the Justice Department is expected shortly. “If Justice determines that these cooperative arrangements constitute restraint of trade, HEW officials fear the entire planning program will be undermined,” particularly in light of its reliance on cooperation by providers in lieu of serious enforcement power, states the Health Finance Letter (12). Lawmakers are hastily attempting to write into the new HSA bill a clarification of legislative intent that might exempt HSAs from such consideration.

**Conflicts of Purpose**

Finally, the pressures of cost control exacerbate latent conflicts built into the basic purposes, structures and functions of PL93-641.

The Preamble to PL93-641 states “the achievement of equal access to quality health care at a reasonable cost is a priority of the federal government. Lawmakers in 1974 may not have foreseen—or perhaps did not care to specify—what should happen if these three stated priorities—equal access, quality care and reasonable cost—came into conflict.’

Now reasonable cost has clearly become the dominant federal priority, while HSA staffs, boards and constituencies have come together largely around equal access and quality care. Providers participate in HSAs for defensive reasons—to protect their own self interests—interests which seldom coincide with cost control. Consumers are more frequently health activists from their local communities or from special need groups such as the elderly, the handicapped, etc., who have no wish to preside over cost cutting, especially if it is aimed at their own communities. Together, these two
groups are more likely to act as advocates for the local health system than they are as its regulators, particularly if cost control pressures from Washington become more stringent.

This conflict in priorities underscores a serious predicament for achieving cost control: while in the abstract, everyone agrees with its importance, in reality, cost control has little or no constituency. The convoluted structure of health care financing insulates the consumer and thus leaves state and federal budgeters alone as its only avid constituency.

**Conflicts in Function**

Cost control pressure also creates a tension between the basic functions of HSAs: planning, regulation and resource development. Planning took precedence in the initial period after passage of PL93-641. Production of state and local health systems plans was necessary, not only for agencies

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**Scorecard for HSAs**

In the four years that have elapsed since passage of PL93-641, much of the nation’s network of state and local agencies has been put into place.

As of September, 1978, 213 health service areas had been established and 205 Health Systems Agencies (HSAs) had been designated. Of these, 147 had received final, or official, designation by HEW, while the remaining 57 operated in a status of “conditional” designation, meaning that they were still in the organizational stage and had not yet met all HEW conditions for final designation.

Approximately 60 percent of these HSAs evolved from the old Comprehensive Health Planning “B” (local) agencies, while the balance have been created anew. Of the total, 180 HSAs are private, nonprofit agencies; four are units of local government and 21 are regional planning boards.

HSA governing boards vary in size from a low of 15 members to a high of 137. Nationwide, consumers comprise 53 percent of all HSA board members. “Subarea” or community-level advisory boards vary in number and size from Arizona Area I, with a single subarea council of 15 members, to New York Area VII with 33 councils numbering a total of 1,800 members. Across the country, subarea councils total 500 with a total membership of 15,000.

HSAs are funded mainly by grants from the federal government, calculated on a per capita basis according to the population in a health service area. Funding started in 1976 at $.28 per capita and has risen to $.44 per capita in 1978. Federal grants to HSAs averaged $473,000 each in 1977. Total funding of HSAs has risen from $64 million in 1976 to $107 million in 1978.

As of September, all 50 State Health Coordinating Councils (SHCCs) had been established. These voluntary, governor-appointed bodies ranged in membership from a low of 13 in Wyoming to a high of 83 in Massachusetts. Consumers comprised 53 percent of SHCC members; 60 percent of these must represent local HSAs.

As of September, all 50 State Health Planning and Development Agencies (SHPDAs) had also been established. Their operation is contracted by HEW to state governments; HEW provides 75 percent of SHPDA funding. Currently, 26 SHPDAs are located in state health departments; 20 are in state health and welfare departments; six are in governor’s offices and three exist by some other arrangement. Federal SHPDA appropriations have risen from $19 million in 1976 to $29.5 million in 1978.

A major priority of HEW in the current year is to complete the final designation of all HSAs.

(Data taken from presentation made by Henry A. Foley, Health Resources Administration Director, to the National Council on Health Planning and Development, Sept. 8, 1978.)
to receive official HEW designation, but to create a credible basis on which to implement regulation. Now, under pressure of cost control, the emphasis will necessarily shift to regulation, specifically, to CON review.

The two approaches harbor inherent conflicts. Planning attempts to take a long-range, system-wide view while CON review is necessarily conducted on a narrow case-by-case, short-term reactive basis. CON review is exceedingly concrete; it must be completed on a rigorous schedule; its outcome is tangible as is its impact on the system. Planning, beyond the gestures minimally necessary to please HEW, is often far from concrete and its outcome not necessarily tangible. In spite of HEW's emphasis on a good plan, the HSP is only one of 12 factors which must be taken into account in a CON review. Moreover, actions which will realize tangible savings in the short-run often conflict with those which are most rational and cost-efficient in the long-term.

The ability of systemwide, long-term planning considerations to stand up against short-term, immediate cost factors is hurt badly by the primitive state of the art described earlier. Until recently, no target goals for capital spending existed to provide HSAs with a context for making specific review decisions. Secretary Califano has just suggested a nationwide maximum of $3 billion to be adopted by HSAs as a voluntary guideline.

If cost control pressures threaten to consign planning to the back seat, resource development is likely to wind up in the fifth balcony. It is unlikely in a period of economic contraction, when the problem is defined as having a surplus of health resources, that funds will be available for creating new ones. Developing alternatives to a system based on expensive, crisis-oriented, high technology care, however, is the only route to long-term cost effectiveness. Unfortunately, this requires increased investment in the short-term.

Primary and preventive care, public health and education, which might comprise this alternative, receive unanimous lip service in times of plenty; in times of contraction, the consensus evaporates and they are the first programs to go. Economic adversity rarely begets greater cost effectiveness. Rather the opposite: it causes retrenchment around the vested interests of the status quo. In this climate, such programs will be viewed as suspect, as new spending programs, untried experiments and amenities compared with the life-saving basics offered by the acute care system. Such services offer a ripe and expedient target for pre-emptive cutbacks. Moreover, little constituency exists to fight for as yet non-existent programs, no matter how sensible their rationale, while established programs have developed a dependence among both workers and users, and therefore a constituency to guard against cost cutting.

The Cost Savings Tally

The effectiveness of programs such as HSAs has only recently become an issue of public, professional and political concern, and HEW-OMB and AHPA studies no doubt are the first of many. To date, the results of the cost impact of HSAs, or more specifically of the CON programs, is mixed.

The most careful study was conducted before the passage of PL93-641 by Salkever and Bice who carefully analyzed the cost impact of CON programs from 1968 to 1972, comparing them to costs in states having no CON programs (13). The results suggest that while CON programs may have held down increased in the total number of hospital beds, they had no impact whatsoever on total hospital investment. Clearly, surplus income was invested in hospital assets which were exempt from CON approval (14). This is known as the feather-pillow principle of hospital cost control. Another study conducted by Hellinger confirms this conclusion. It shows CON having no effect on total hospital investment, although it does not distinguish hospital beds from plant assets (15).

On the other side of the ledger is a recent study by the Congressional Budget Office showing that some state CON programs have reduced the rate of bed expansion by as much as four percent and slowed the acquisition of plant assets per bed by 10 percent in a period when plants assets increased an average of 40 percent (16).

Not surprisingly, the AHPA study found CON programs to be marvelously effective (17). Of 205 HSAs, 139 reported an aggregate of 5,717 short-
ter hospital beds disapproved, converted or eliminated for an aggregate savings of $553 million; another $457 million that would have been spent on unnecessary renovations was also saved, for a total saving in in-hospital capital expenditures of over $1 billion. If all facilities (not just hospitals) are considered, $1.8 billion out of a total $7 billion was saved, or approximately 25 percent of all proposed capital investment.

Operating the 139 HSAs and related state agencies meanwhile, cost a total of $215 billion, for a rate of return of $8 saved for every $1 spent on CON programs. It should be noted, however, that the AHPA study was a quick-and-dirty one conducted for the purpose of arguing the HSA cause before an increasingly skeptical Congress and Administration. The results may only prove that effectiveness is in the eye of the beholder.

**Conclusion: What Terms Effectiveness?**

HSAs in their regulatory role may achieve some modest preemptive cost savings. These are quite unlikely to dent the spiral of health care costs, however.

It is in their planning role that HSAs perhaps have the most important contribution to make, although it may not earn them the necessary brownie points in Washington. It is the task of HSAs to constantly hold up the systemwide, long-term view of what cost-effective health care is. They must create a professional community and a public that understand the difference between short-term expediency and long-term rationality; that understand that the causes of inflation lie largely in the increasing reliance on a high-cost, high-technology curative approach to the health problems of individuals; that understand that effectiveness and cost savings will be achieved in a system that begins with a concern for the health status of the population and measures which affect it, a system which places public health, health promotion, prevention and primary care at its heart and not at its periphery; that understands that such a change will require a new model of what effective health care is, as well as a shift in resources and in political power within the health system.

Defined in this manner, HSAs need not shrink from the task of cost control. There need not be a polarity between that which will ultimately save money and that which will prove most effective in meeting the health needs of the country. The key is in keeping the long-run, systemwide view.

Defined in this manner, HSAs also have reasonable tools with which to tackle the job. While they have pitifully little ability to exercise raw power, they have considerable ability to influence the climate of opinion within which health institutions operate. Their power lies not in nose-to-nose regulatory confrontations, but in their ability to educate, organize, and catalyze. Their fate clearly depends on the speed and skill with which they can accomplish these tasks.

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**References**

1. For a legislative history with an excellent discussion of different lobbies and compromises involved in PL93-641, see Lander, L., If At First You Don't Succeed..., *Health/PAC BULLETIN*, No. 70, 1976.
4. Ibid., p. 221.
10. Ibid., p. 22.
In December, 1977, the U.S. Comptroller General’s Office reported to the Congress on a broad review of needs for and costs of providing home health care for older people. Although noting that the current maze of home health care agencies and programs contain serious problems, the Report nevertheless concluded that: “Until older people become greatly or extremely impaired, the cost for home health services, including the large portion provided by families and friends, is less than the cost of putting these people in institutions” (1).

This statement says a lot about the growing attention being paid to one of the oldest approaches to health care, home-based services. In order to understand where home health care is “at” in 1978, however, some background is necessary.

**History and Potential**

In the most general terms, home health care has come to mean those health and medical services delivered to patients in their homes by professional and allied health personnel under the direction of a physician. The optimum goal is to fully restore the patient to health and/or obtain maximum rehabilitation while causing the least possible disruption to daily living patterns.

In fact, home care is undoubtedly the first and oldest form of health care. Until the dawn of the twentieth century the home was the setting for illness and health care, and the family, assisted from time to time by midwives and healers, was the provider of health care. While hospitals entered the scene some two hundred years before, it has only been in the last 60 years that they were seen as anything but last resorts for the poor and those too unfortunate to have a family care for them. Not surprisingly early medical institutions understood and respected the roles of home and family in health care.

In this country in 1796, the Boston Dispensary, an out-patient clinic that also provided home visits, was founded so that, “The sick, without being pained by separation from their families, may be attended and relieved in their own homes”(2). Ideals of service for the welfare of the poor were expounded. But, in fact, the Boston Dispensary home care programs provided practice for its resident physicians, setting a precedent that was to prevail for many years to follow: home care as
an extension of hospital medical care.

Visiting resident physicians, however, were eventually displaced by the organized public health Visiting Nurse Associations. First established in 1842, these organizations began to appear throughout the U.S. in the latter 19th century, often reflecting a religious/philanthropic philosophy that paralleled that of the nation’s proliferating hospitals.

First established in 1842, Visiting Nurse Associations began to appear throughout the U.S. in the latter 19th century, often reflecting a religious/philanthropic philosophy...

Throughout the following century, home care operated quite separately from hospitals, translating services and equipment, ordinarily appropriate to the hospitals, into the home. In the last three decades, however, as hospitals have emerged as a dominant force in the health system, so too have they come to dominate that which was to be their alternative. This trend was first marked in 1947 by Dr. E.M. Bluestone, then director of New York’s Montefiore Hospital, who started a home health service based in the hospital itself. As hospitals became more crowded during this period, home care became increasingly hospital-linked.

The theme song became, “get them out of the hospital.” Dr. Bluestone referred to home care as a “hospital without walls,” an extension of the hospital’s overall medical program. “If you have a 500-bed hospital, and 50 patients on home care, you have a 550-bed hospital,” he concluded.

Indeed, the priorities of the mainstream medical system have come to play an increasingly large role in modern home care. Some feel that the real antecedents to today’s programs are the desire to keep the poor and/or uninteresting patients out of the hospital. Others see the trend toward hospital-based programs as a move by hospitals, ever worried about occupancy, to keep tabs on potential patients and the potential income they represent. Meanwhile, many point to the potential of home care as a full-fledged alternative to institutional care. Where is the reality today?

Theoretically, anyone who needs health care which can safely be delivered in the home may receive home care services. It is possible to purchase home health services privately and some health insurance policies include home care coverage. Public funds pay for home care for the elderly who are eligible for Medicare or poor who meet the Medi-caid requirements. In fact, most home health care consumers in the U.S. today suffer chronic or long-term disability. This includes some younger persons, but the majority are among the group 65 and older.

Home care encompasses a wide range of services and personnel. All skilled medical services, including those of the nurse, aide, and therapist, are provided under the direction of the patient’s physician, who draws up a treatment plan and evaluates and renews it according to program reports from the home health care professionals.

Registered nurses may visit weekly, or even daily for a limited time to perform such broad nursing functions as: supervision, evaluation, teaching, and prevention; or more direct ones such as treatments, dressing changes, injections, blood pressure readings, enemas, urinary catheter changes or treatment of bed sores.

. . . but as hospitals became more crowded in the 20th century, home care became increasingly hospital-linked with the idea being ‘get them out of the hospital’

Usually through the home care agency, the nurse has access to necessary equipment (e.g., syringes, catheters, bedpans, bandages, walkers, chair lifts).

Further, the nurse may assign a nurses’ aide to assist the patient with personal care—bathing, shampoo, etc. The home care agency often hires home health aides directly or may subcontract these services from other agencies as we will discuss later.

Home care agencies may also provide occupational, physical, and speech therapy as part of their services. Often, such rehabilitation requires direct services of the therapist. In many cases, however, family members or friends can be taught by the therapist to eventually carry out the rehabilitative therapy themselves.
In addition to medical home health services as provided through VNAs, hospitals, etc., there are social service agencies which provide those non-medical services essential to maintaining chronically ill and disabled patients in their homes. Homemaker services are the most popular of these. The homemaker may assist with light housekeeping, chores and meal preparation (usually not exceeding 12 hours a week). In addition, transportation services for groceries and physician appointments are sometimes available. The most comprehensive programs include “Meals-on-Wheels,” group meal sites and client advocacy programs.

While a patient, or a patient’s family may purchase these “social” services, just as they may purchase medical services, privately, federal funds are also available for these services under Title XX of the Social Security Act and Title III and VII of the Older Americans Act. Because medical services are funded separately under Title XVIII and XIX of the Social Security Act (more commonly known as Medicare and Medicaid), the effect is often a serious fragmentation of services.

Based on an artificial and often detrimental distinction between “medical” and “social” services, for example, the “homemaker” (a “social services” worker) is not allowed to touch the patient, whereas the “home health aide” (a “medical” worker) is not allowed to perform any services except direct patient care.

While home care is as old as human history, today it enjoys an innovative status based on its potential for responding to two pressing problems in the current health care system: spiralling costs and increasingly impersonal and ineffective institutionalization. This cost factor and the recognized importance of flexible support systems to the healing process point to home care as a real alternative to institutional care.

As the U.S. experiences the rapid growth of the population aged 65 years and older, the need to develop home health care as an alternative to institutionalization has pushed its way to the top of the priority list in terms of sheer numbers. According to the U.S. Dept. of Health, Education and Welfare (1976), older persons now comprise 10.5 percent of the total U.S. population. By the year 2030, the percentage of persons over 65 years in the population is expected to reach 17 percent. Already, the population of those aged 45 and above account for almost one-third of our total population. As a result, there is an increase in the population at risk medically. The U.S. Senate Committee on Aging estimates that nearly “80 percent of those who are 65 and older are afflicted with one or more chronic and degenerative health problem” (4).

Cost Effectiveness: Much of the excitement about home health care centers on its cost-reducing potential and this comes primarily from government officials assigned the task of trying to contain today’s $180 billion health system (5).

The 1977 Comptroller General’s “Report to Congress on Home Health Care” calls for liberalizing home health benefits under Medicare, such as eliminating the requirements that beneficiaries be confined to their homes and be in need of skilled care, and limitations on the number of home visits. In GAO’s view, the costs associated with these changes would not be prohibitive and could provide disincentives to institutionalization (6).

Human Growth and Health Promotion: Home health care also appeals to many as a more humane approach to care for those requiring some form of care other than the alternatives represented by institutionalization. By contrast with the nursing home resident or hospital inpatient, the recipient of home health services, it is argued, can maintain interpersonal ties with family and friends, can pre-
serve a greater measure of independence and self-worth, and can even, in many cases, continue the personal growth and creative activity that would be impossible within institutional walls.

Further, it is increasingly recognized that institutionalization, when mandated by the absence of alternatives, is frequently harmful. The iatrogenesis (treatment induced illness) and psychological trauma of institutionalization are suggested in the sharp rise in mortality for persons in the first few months after entering nursing homes.

New HEW regulations allow public and nonprofit home health agencies to subcontract services from proprietary agencies. This was done ostensibly to increase the availability of home health services . . .

The Current Problems

There is growing evidence, however, that the actual development of home care services in the U.S. may proceed to deny the potential that it intuitively offers. Among the problems that plague the actual delivery of home care are:

1. Medicalization: The focus of home care services is generally only upon that segment of the population that is virtually on the brink of institutionalization. By the time a person meets these criteria of course, he or she is quite likely to suffer from a number of serious medical problems and/or to be largely incapacitated. To develop its potential as an alternative—and deterrent—to institutional care, home care services would need to be made available to a much broader range of persons. At the same time these services should be geared to encourage already existing informal/community support relationships. Rather than assuming that the home care services recipient is totally dependent, such an approach would assume that he or she is part of a set of ongoing family and community relationships that, with perhaps some outside help or resources, could allow the older person to continue to play an active role in many ways. Potential beneficiaries, under this approach, would also be assumed to be competent and intelligent human beings capable of helping to define which services or parts of services are needed. The focus exclusively on the frail and incapacitated who are one step away from institutionalization allows all decisions to be made by the professional or provider. It also creates dependency in many cases.

2. Narrow concern with costs: Funding for home care is generally compared with expenditures for hospital or nursing home care over relatively short periods of time—typically, one year. Reimbursements for home care services, furthermore, have generally been held quite low. Much of the interest seems to be to provide a cheaper short run alternative to the patient-day. Unfortunately, there is some evidence that the unwillingness to devote adequate resources to home care, however, robs the services of their health promotion potential, reducing home care for many recipients to the status of custodial care. Unable to prevent deterioration and mounting illness, such home care “services” may simply become an “add-on” to institutional care thus resulting in higher overall costs.

3. Commodification and Fragmentation: Like much of the mainstream medical system in the U.S., home care has been seriously distorted by the underlying financial dynamics that pervade the industry. Stimulated by a reimbursement system that pays for the delivery of certain categorical service “packages” (e.g., reimbursements are for “visits” or “shifts”, not for health maintenance on a caseload basis or for treatment outcomes), services have become quite fragmented. Whereas once, a single nurse may have provided all the home care required by a given individual, today that same individual may receive separate (and separately reimbursable) visits from a case manager, a visiting
nurse, a home health aide, a physical therapist, a social worker, etc.

Proprietary home health agencies are essentially private, profit-making businesses. Probably the largest and most widely known is Upjohn Health Care Services. Business Week reports, "like other proprietary firms, Upjohn wants to compete for...

...but the fact is, the supply of home health aides has not increased in proportion to the number of services currently being delivered

the Medicare and Medicaid dollar in all states." Homemakers Home and Health Care Services, Inc., a subsidiary of Upjohn Co. of Kalamazoo, Michigan, reports that it supplied 20 million hours of service in a recent year. Assuming an average price of $5 or $6 per hour, sales would produce at least $100 million a year—a small bite out of the home health dollar (9).

The reason for this somewhat limited role is that up until January, 1976, only voluntary or public home health agencies could be certified under Medicare and Medicaid regulations. Proprietary agencies could only receive Medicare or Medicaid reimbursements in those few states having their own licensing laws.

However, new HEW regulations, promulgated in 1976, allow public and non-profit home health agencies—e.g., the local Department of Health or local Visiting Nurse Association—to subcontract services from proprietary agencies—e.g., Homemaker Upjohn. The responsibility for supervision and control remains with the contracting agency. This was done ostensibly to increase the availability of home care services but it promises to be a boon to the proprietary sector of the industry—who can now expect to increase their "relatively small portion" of available home health funding.

In New York City, another form of subcontracting called "vendorization" (switching from direct provision of services to paying other agents or "vendors" to perform them) has been seen more recently as the City's Department of Social Services has begun to sub-contract the provision of homemakers and home health services to private providers. A general cynicism on the part of community and consumer activists accompanied this change. They pointed by way of warning to the recent scandals in New York's nursing home industry, which represents an already "vendorized" sector. This concern was echoed by the New York Secretary of State who recently concluded that "the basic problems in home health care involve the concept of 'vendorization' of these programs" (10).

In addition to the entry of an increasing number of private providers into home care, some observers have also pointed to the direct interests of hospitals that manage to exert substantial influence over the industry as well. Recently, a growing number of hospitals have developed a home health care department of their own. From the hospital's standpoint, there are at least two advantages in becoming directly involved as a provider:

1. The hospital may directly recover a portion of the reimbursements available for home care. Generally, hospitals sub-contract most of the direct services provision to a "community agency" (e.g., Visiting Nurses' Associations—VNAs). However, the hospital may be reimbursed for providing the case management or service coordination services that the hospitals would ordinarily provide.

...but one home health agency official said that the subcontracting process is 'labor busting, no question about it. Two-thirds of them are paid 10¢ above minimum wage and receive no benefits, not even Social Security or unemployment insurance. The new process is aimed at preserving the exploitation'

...at least partially, anyway. Thus by becoming the contractor that hires the contractor (ordinarily a VNA or similar "community agency" provider), the hospital inserts itself directly into the home care continuum and recovers an extra layer of revenues in the process.

2. By developing a direct link with the home care population, hospitals and their medical staffs may more directly market the services they normally provide. By functioning as the "back up" institutions, in other words, hospitals and physicians stand ready to increase their own revenues
from direct patient care. The home care case load becomes part of the population “base” from which the hospital can routinely “recruit” inpatient admissions.

One trend, then, beginning to emerge in the home care industry is a multi-tiered, fragmented system of subcontracting and sub-subcontracting of services stimulated by the provisions of third party payers.

For a given patient, home care services may be provided by a hospital home health agency which subcontracts nursing care and supervision to a VNA association which, in turn, subcontracts the provision of home health attendant services to Upjohn Home Health Services.

Obviously the maintenance of quality and insuring appropriateness of services becomes a monumental task under such conditions. Current mechanisms for maintaining quality—case management by professional nurses or social workers, and certification of agencies by accrediting bodies—are rather meager resources in the face of such severe fragmentation.

**The Home Care Worker**

One serious repercussion—and, some say, the real motivation—of the vendorization and subcontracting phenomena in home health care services is the generally degrading impact on the home health care labor force. Most home health attendants and homemakers have traditionally been underpaid and generally overworked. Some union representatives have characterized home health attendants as “the most exploited of service workers” (11). One home health agency official recently conceded that the vendorization and subcontracting process, in fact, is aimed at preserving that exploitation. “It’s labor busting, no question about it,” the official noted. The vendor providers can often “deliver” a labor force made up of largely part-time workers, with minimal training and less likely to organize for better wages and working conditions than if these workers were employed directly by the public or “community” home health agency.

Most homemakers and home health aides are Black and Latin women. A profile of a typical homemaker/home health aide is a middle-aged woman with several children who wants to work part time while her children are in school. “Two thirds of them are considered ‘independent contractors’ by the city, and are paid $2.75 an hour, 10 cents above the minimum wage . . . and receive absolutely no benefits—not even Social Security or unemployment insurance...Because of their low wages . . . these workers are themselves eligible for welfare benefits. Ironically, many workers I spoke to are ‘too proud’ to apply for these benefits. Some are illegal aliens who are afraid . . . of applying. Others were unaware of their rights” (12).

Home health workers carry out extremely difficult work in isolation; often caring for chronically ill patients for indefinite periods of time, with no opportunities for advancement.

Adding insult to injury is the fact that the supply of home health aides has not increased in proportion to the increase in the number of services currently being delivered. The White House Conference on Aging has estimated that while the total number of homemaker-home health aides employed in public and voluntary agencies is currently 30,000 - there is a “total estimated need of 300,000”(13). As a result, home health workers face increased case loads, chronic overwork, and frequent speed-ups; clients face harried workers with less and less time available to provide the quantity or quality of services which they may require.

Not surprisingly, the turnover rate is quite high among home health workers resulting, of course, in a loss of continuity of care for clients.

Such working conditions have recently led a number of unions to begin organizing home care workers in New York. To date, however, such organizing remains at the embryonic level. And it is likely to be some time before home care workers or their clients see substantial improvements.

**Conclusion**

From a service with a potential for humane and cost effective care, the current home health industry has so far developed a fragmented, discontinuous, and often inappropriate maze of services whose priorities are increasingly influenced by financial incentives and institutionalized medicine.

Without substantial changes in the emerging patterns, home care will not “work” as a progressive alternative to institutional health care. What are the chances for such changes? What are the characteristics of home health services systems that do “work”?

One way home care might “work” is suggested by the important role home health care serves within the British health care system.

In Britain, the widespread use of home health care and the more generous funding devoted to
“domiciliary services” (as the British call them) reflects a general national policy commitment to base health care and social services in the local community. Extensive experience in that country has led to the general belief that health care can be provided with greater quality and greater cost-effectiveness if it concentrates as many resources as possible in the home and in the community, relative to those concentrated in institutions.

The British medical system, for example, pioneered home treatment programs (e.g., for heart attack treatments) for illnesses that are ordinarily treated only in hospitals in this country. Institutionalization is seen as a solution of last resort in Britain, and home care services are integrated within the local community health centers that are the infrastructure of the National Health Service.

In this country, of course, the immediate question is more that of how to address problems within the current system. This process must involve a willingness to move beyond a medical model of care. This means redirecting resources toward supporting the increasing number of older people in our population in their attempts to live creative, active lives as first class citizens of their community and their society.

The implications for the emerging home care system in this country include:

1. Shifting provider control away from large voluntary agencies and hospitals and toward community-based sponsors. In those countries where home care seems to “work” best it is tightly integrated with a truly community-based preventive and primary health care network. (In the jargon of U.S. home care, the term “community agency” is quite misleadingly used to refer to private, nonprofit providers that are neither hospitals nor government agencies. We use the term “community” here to refer, instead, to services that are actually provided for and accountable to a discrete community or neighborhood.)

The current dual control of home care services by institutional medical providers and institutionalized social service agencies is at the heart of many problems described above. The rigid separation between “hands on” and “hands off” services seems to be more a product of warfare for “turf” between social work and health professionals in this country than the result of any needs-based planning.

2. Integration of the currently fragmented and discontinuous pattern of services. The varied and poorly coordinated array of professional and para-professional roles that make up the current pattern of delivery can best be understood as a response to the poor reimbursement that has been provided for home care services in the past. As home care receives increased attention and funding from state and local governments, however, the answer to upgrading quality of care is unlikely to be as simple as replacing non-professional with professional. Rather, some serious rethinking and integration of current functions such as visiting nurse, home attendant, homemaker, home health aide, and housekeeper services, is long overdue. Again, it must be remembered that in the main, older people could often remain healthy and active longer without direct care if the services they received were geared to maintaining health and facilitating personal growth. A professionalism that all-too-often creates dependency may not be part of such a solution.

3. Upgrading reimbursement and broadening eligibility for services. This requires a serious commitment of resources and funding to allow expansion of services to include a broader range of the population. As long as the approach remains a “last-ditch” funding to prevent hospitalization, home care will remain an “add-on” expense in the overall spiral of health care inflation.

4. Fuller recognition of the rights and needs of older people for active, creative lives and services which they may take an active role in defining. Home care services would not be seen as merely services administered to “dependent” patients, but as providing tools and skills which contribute to the individual’s needs and supplement personal competence. The focus of this approach would be to develop and recognize individual and group strengths.

Most home care recipients in this country are older people, and the general state of home care services is not separable, in the final analysis, from the overall conditions of their lives. To be old in America is frequently to know chronic poverty, substandard housing, ill health and a sense of abandonment by the broader society and its services. No home care “industry” that generates standardized and narrowly defined “packages” of services will wholly redress this abandonment. What is called for, instead, is a wholly new and broader look at the requirements for life-sustaining and health-promoting networks of “kith and kin” for older people in their communities.
This means adequate incomes, housing, nutrition, medical care and social services. It means putting maximum emphasis on allowing persons of older age to continue to work, play and love as active community members and, whenever possible, in their own homes. Home care approached in this way grows out of concern for the quality of life rather than the narrow economics of beating health care inflation.

There are, here and there around the country, groups and programs beginning to attempt to approach home care in this way. If readers would like additional information, inquiries—and other comments—are welcome.

-Cynthia R. Driver

(Cynthia Driver is a Registered Nurse who worked as a visiting nurse in Indiana and is currently coordinator of The Nurses' Network. The author wishes to acknowledge the interviewing assistance and collaboration of Michael E. Clark of Health/PAC and Richard Surpin and Doug Dornan of the Mutual Aid Project for Older People, New York.)

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PROGNOSIS NEGATIVE: CRISIS IN THE HEALTH CARE SYSTEM
edited by David Kotelchuck

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Selma Fraiberg's book, *Every Child's Birthright: In Defense of Mothering*, has been appropriated by many as the final proof that working mothers jeopardize the healthy development of their children. One wonders how the same woman who wrote *The Magic Years* could write a book on mothering which, since its publication a year ago, has become the theoretical backbone of reactionary movements among women. Overall the book has been taken to mean, as one *New York Times* reviewer wrote, "simply ... that mothers are going to have to look after their children."

Actually, Fraiberg has not written such a reactionary book, but one that reads like two separate polemics. The first argues that a child who has formed no personal human bonds during the first year of life will show a marked impairment in the capacity to form relationships later in life. In tone, and largely in substance, this part of the book constitutes an attack on working women which is simply not substantiated by Fraiberg's evidence, but which has been quickly accepted by the right. The second part of the book, an excellent critique of social policy as it relates to mothers and children, is generally less known, even by those advocating mothers' and children's rights.

In place of solid evidence Fraiberg begins the first section with a pseudoanthropological description of four tribes of women who convene to discuss birth and child-rearing. Tribes A, B, and C have their origins in rural Mexico, Africa, and India. Tribe D mothers live in North America and clearly represent American mothers. Tribes A, B, and C share many beliefs—that breastfeeding and certain methods of carrying children are best for insuring physical contact with a child, small children should be included in the care of siblings, childcare wisdom should be transmitted from one generation to the next, birth itself should occur in the presence of loving relatives and other women, and finally, women should be highly valued as mothers. Tribe D mothers are different. They feed their babies scientific formula in plastic bottles and argue that this is good for mothers who do not want to be tied down. Tribe D mothers exclude other children from childcare for fear of "sibling rivalry." They learn about babies from books, doctors, and other new mothers, not from their own mothers and grandmothers who are busy playing tennis, studying pottery, and relaxing in the sun every winter. Finally, Tribe D mothers give birth in isolated hospital settings. Once their child is born, they feel a loss of self-esteem because they feel they are just mothers.

Unfortunately, this opening parable is difficult to read as anything but a condemnation of American women who, according to Fraiberg, have much to learn from the exemplary women of imaginary tribes. A comparison of childcare in the United States with that of other industrial countries might have been of more value. Fraiberg's criticism, here, applies principally to those middle
and upper class women who have a choice about working. Unfortunately, this criticism can be used as well against the poor, middle and working class women whose choices about work and childcare are not free of economic and social constraints.

Weak Argument

In the absence of adequate data to support her thesis that working mothers jeopardize the health of their children, Fraiberg argues by analogy with imaginary primitive tribes, with romanticized grandmothers of bygone days and finally, with other species.

It is true that most women have not totally succeeded in wresting control of their lives from doctors who dictate sterile, isolated births, from experts who offer the wisdom of "scientific study," and from a market which mass produces baby strollers and carriers. Nor have women always succeeded in creating new forms of community in the absence of available relatives or in gaining respect for their motherhood apart from whatever they produce for the society. But women do not deserve all the blame in a society whose priorities preclude quality day care, flexible work hours and situations, and the freedom to choose to work while still assuring the care of children. Fraiberg makes no claim to understand the constraints on women. She states that as the child's advocate she is "not mindful of the needs of those employed or seeking employment." Were she mindful of those needs—and their effects on children, her criticisms might be more helpful.

These analogies cover up for her lack of evidence to support the connection she makes between maternal employment and "diseases of non-attachment."

Fraiberg's analogies, then, cover up for her lack of evidence to support the connection she makes between maternal employment and the "diseases of non-attachment." Her discussion of children who fail to thrive is based on studies done on children who lived in institutions or a series of foster homes, whose mothers either died or gave up their children. The anaclytic depression of these children is far different from the reactions of children whose mothers work. Yet Fraiberg makes the false connection between maternal employment and such pathology.

Instead of presenting analogies of bonding in other species, Fraiberg might have looked at actual studies of the children of working mothers.

Reduced presence of a mother often correlates with lack of money, poor housing, nutrition,
and health care. Yet she chooses to isolate poor mothering as the factor which determines deviance. This failure to integrate a political and social analysis into her argument leaves the book open to use as ideology by the right.

Ultimately, then, Fraiberg’s argument cannot stand on its own. Had she actually looked at the studies done on the children of working mothers, she would not have found support for her argument. In fact, as Robert Coles has pointed out, “research suggests that children of mothers who freely choose to work outside the home are better off, other things being equal, than the children of mothers who stay home but are discontented with full time mothering and homemaking” (3). In an extensive review of all the studies which “bear on the question of the family life of employed mothers” (280 in all, including those cited by Fraiberg), Mary C. Howell noted that the marked bias of researchers such as Fraiberg in this field cannot be supported by the facts. The family’s attitude toward and the actual conditions of employment, as they bear on the mother’s self-esteem and energy resources, were the factors which most affected children. Howell concluded,

Children are likely to be positively affected by maternal employment, and attendant changes in family function, if the mother finds satisfaction in work outside the home and if she is supported by family members.

It is impressive that a number of studies report that the families of nonemployed mothers (husbands, children, and the mothers themselves) are strongly opposed to maternal employment, principally on the grounds that the family may be harmed. When mothers are successfully and enthusiastically employed, however, the changes reported by their families, if anything, tend to be in a

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positive direction. The myth dies hard. (4)

In the second part of the book Fraiberg moves to her discussion of policy. There she argues in defense of the rights of children with real understanding of the limited options available to women in our society. In this broader context, where all the blame does not fall on individual women, one can appreciate her argument for consistency in childcare, for greater attention to what we can all accept as sound psychological principles—that children need to feel secure and loved, attached to particular people, and not arbitrarily shifted from caretaker to caretaker, from foster home to foster home. We are, in fact, not outraged enough at the way children are treated in this society. For this reason we can welcome Fraiberg’s second argument—because here she criticizes the social and economic policies which make good mothering so difficult for women in America.

In the second half of the book Fraiberg carefully delineates the limitations of childcare as a result of legislative failure to allocate sufficient funds for quality services. She uses her thesis that children need a consistent care-taker to criticize a court system that decides custody and placement of children on the basis of funding and a notion of children as property. Finally, Fraiberg makes an excellent critique of AFDC policy. She points out that the WIN program has continued to cost more than the original AFDC payments and that, while compulsory work requirements have not been broadly enforced, the WIN program still allows for pressuring welfare mothers to work. She acknowledges that economic incentives, as slight as they might be, encourage welfare mothers to work and leave their young children to the poor care available to them. She makes a convincing case that AFDC payments guarantee malnutrition, poor health care, and substandard living conditions for large numbers of children.

Again, the problem with the book is that Fraiberg’s criticism of mothers in the first half of the book remains to be used against the very women and children she defends in her policy analysis later. For example, children who do not work out in foster and adoptive homes are now returned to agencies where there is an attempt to determine if some early trauma or lack of consistent caretaker means that the child is incapable of forming relationships. If that determination is made, he or she may be left in an institution. The situation for many foster and adoptive children is hopeless if our psychological understanding of their problems is used against them. The same misuses of Fraiberg’s findings is possible in regard to AFDC mothers. Her defense of the welfare mother’s right to care for her children without compulsory employment, can be turned to equate working mothers with the unstable homes that produce “non-attached” criminals and deviants. Her views on day care argue for the allocation of greater funds for quality services that provide consistent caretakers, yet even she sometimes stresses the hopelessness of day care, and by implication, the inadequacies of those who choose it.

Reactionary movements among women have used Fraiberg’s book to support an ideology that extols the nuclear family while condemning working mothers, that opposes day care, the ERA, and quality of work laws. In responding to this, the left must avoid being forced into the false position of opposing the family and motherhood. Instead, the left can shift the blame from individual women to focus on the failure of American society to create economic and social structures which allow women work and childcare choices which will not jeopardize the mental health of their children.

The left must be clear that the issues about child-rearing go beyond raising children capable of forming relationships, as important as that is. We must concern ourselves with raising children with a social conscience, a commitment to equality, and a respect for people from other ethnic and cultural groups than their own. We must think of how childcare can involve fathers and other adults. We must demand that our work include childcare provisions. We must bring the issues related to adoption and foster care into the open. We must, somehow, take responsibility for all children.

—Kathy Conway

References


The heart of this report is the review of 17 widely practiced medical interventions (1). These procedures were selected to illustrate the main issues in the assessment of efficacy and safety in medicine, and the enactment of policy on this basis; they were not meant to be representative of medicine as a whole. The results of the 17 cases are also enlightening in their own right; as it happens, however, the situation in medicine is even worse.

The largest group of procedures reviewed—10 out of 17—have little or no efficacy, pose definite hazards to health, are already widely used at great cost, and are fully reimbursed by third party payers. These 10 procedures account for about $6 billion of the roughly $10 billion total cost of the 17 taken together. The most costly and striking of these 10 are hysterectomy, coronary artery bypass grafting, chemotherapy for lung cancer, tonsillectomy and appendectomy, which combined account for $4.7 billion in annual costs.

If the current rate continues into the future, more than half of all US women will have had hysterectomies by age 65. The evidence reviewed by the Office of Technology Assessment (OTA) clearly implies that the risks of surgery, of postoperative complications, of increases of other diseases influenced by ovarian hormones and of negative psychosocial impacts considerably outweigh the health benefits when hysterectomy is this widely applied. For the removal of uterine cancer or the correction of certain obstetric catastrophes, there are very clearcut net benefits from hysterectomy, but the subgroup to which this benefit applies is small (2).

The situation for coronary artery bypass grafting to relieve angina is similar. Several studies show no gain in either relief of angina or life expectancy for bypass grafted patients compared with matched patients treated by the usual drug regimens. In only one study is there a subgroup of less than ten percent for whom there is a small but statistically significant increases in life expectancy (3).

In addition, the evidence collected allows comparison not only with drug treatment, but with a placebo—a sham operation in which the chest is opened and an irrelevant procedure carried out on patients with a similar distribution of chronic angina and history of heart attack. The interesting
finding in this, as well as most other placebo-controlled scientific studies of medicine, is that a properly administered placebo does very well in producing the im-

The wide and random use of antibiotics represents a substantial threat which may outweigh the benefits of their proper use in a much smaller population

provement ordinarily attributed to the specific surgery or drug treatment. For both coronary artery bypass grafting and the sham operation, over 70 percent of the patients experience relief of angina and some extension of life expectancy (4).

The efficacy of a specific technique cannot be measured merely by recording the improvement of treated versus untreated patients, since a placebo, properly administered, can in most cases produce the same improvement without the hazards of the so-called technically designed intervention. In the case of angina, it is also possible to cure the condition with a pill placebo or other noninvasive methods (5); in contrast, the reported direct mortality from coronary artery bypass surgery varies in these studies from 0.3 percent to 8 percent (6).

The risks of invasive mechanical interventions, as compared with psychosocial suggestion as a method of treatment, are highlighted by the evidence cited for appendectomy (7). Although no controlled clinical trials have been carried out, the death rate for appendicitis and the prevalence of appendectomy rise and fall together in epidemiological comparisons. This and other evidence clearly implies that, throughout its history in the Twentieth Century, appendectomy has increased—rather than decreased—mortality risks associated with inflamed appendices. The incidence of appendectomy has been declining since the 1930s and since the mid-1960s a policy of bed rest under thoughtful watch in hospital has developed, allowing rest and care to promote the body's own mechanisms for decreasing the inflammation.

Excessive and irrational prescribing of drugs adds to the growing problem of adverse reactions. In one year, between 100 and 200 Americans a day were believed to have died as a result of adverse reactions

There is a very similar story, not covered in the report, for ulcer therapies, none of which until recently* produced any greater improvement than simply hospitalizing the patient (9). Both ulcer and inflammation of the appendix have important causes in social stress, and the temporary relief of stress which is possible by extricating a person from the tension-ridden primary network is probably

*Long-duration, double-blind, controlled trials of Tagamet, the latest chemical nostrum in ulcer treatment, have not yet been conducted. Ulcers do heal rapidly during treatment, but reappear when the drug is withdrawn (8).

The most commonly prescribed drugs, Valium and Librium, do not work any better than a placebo. In fact, the placebo may cure more

From 1960 to 1970, 75 percent of such patients were treated. Yet the five-year survival rate among lung cancer victims (8 percent for
males, 10 percent for females) did not change between 1950 and 1970. These survival rates apply to patients treated by all methods, including surgery, immunotherapy, radiation and chemotherapy (13). Clearly, current therapy for lung cancer has very little net benefit. Total current lung cancer treatment absorbs at least $5 billion yearly (14).

Two more technologies reviewed in the report—electronic fetal monitoring and its consequent increase in rates of Cesarian section, and routine diagnostic use of skull X-rays—together account for almost $500 million in costs and raise wider questions about other similar technologies not covered in this particular report.

As with many other new diagnostic technologies, electronic fetal monitoring seems to be based on a solid, scientific rationale: among low birth weight infants fetal distress occurs at higher rates than in normal infants and contributes fundamentally to the elevated risk of low birth weight. Fetal distress can be detected by electronic fetal monitoring of the fetal heart rate and blood chemistry, making possible prompt C-section to deliver the baby before brain damage or other irreversible injury can occur. Exactly the same sort of rationale underlies the massive development of coronary intensive care units since about 1960, and the massive push in the 1970s to get people into such units as quickly as possible after heart attack by improved networks of ambulance and emergency services.

For both coronary care units and electronic fetal monitoring, controlled trials and epidemiological comparisons show no net benefit in survival or health associated with the new procedures despite large and escalating costs (15, 16). The current cost of electronic fetal monitoring and its associated multiplication of the rate of C-section is about $300 million, and there is a clear pressure to equip all institutional childbirth environments with fetal monitoring equipment (17). The costs of CCUs are much larger—at least $6 billion yearly (18), and more if all the diversified delivery services are included.

In both cases it is apparent that the introduction of monitoring technology and the more restricted, disruptive and impersonal routine of the new units impose psychosocial stresses which negate any possible benefits of more prompt medical intervention. In the case of electronic fetal monitoring there is the additional problem of determining whether the

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**Much of technical medicine is relatively worthless and risky, and it really hasn’t reduced death rates or improved people’s health. More important for these have been and continue to be good food, rest and humane care**

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In the late 18th Century, it occurred to a number of Viennese doctors that bed rest, good food and humane, caring attention was far superior therapy for more diseases than the various nostrums of the day. We are discovering much the same thing 200 years later.
loped and widely applied, regardless of the therapeutic usefulness of this development. This is a point now well understood by the medical and public health community for chest X-ray. In a previous report, the OTA summarized the evidence supporting this description of computerized axial tomography, or CAT scanners (21).

The OTA report also reviews the evidence that prophylactic antibiotics in intestinal surgery yield little net benefit (22), that antihistamines and decongestants routinely prescribed by doctors in treatment of otitis media are ineffective (23), and that hyperbaric oxygen treatment for cognitive deficits in the elderly is worthless (24). These are all examples of the medical tendency to bring a treatment into routine use on the basis of a simple theory of what should work, not on the basis of direct experimental knowledge.

The appalling situation described for this large group of therapies is in fact an understatement, as the OTA report briefly explains (25). The effectiveness and risk measures emerging from the controlled trials of the procedures are usually the work of the most competent and scientific of the specialist practitioners in a given area. These measures do not reflect, therefore, the average efficacy or safety in the general medical use of these procedures, which is worse than that reported in controlled studies.

Properly used antibiotics, for example, are highly effective and relatively safe against a wide variety of bacterial infections. The same cannot be said for the average medical use of antibiotics. The most common kind of antibiotic misuse is prescription of a drug to which the patient is allergic, the result of thoughtless overprescription of antibiotics in general (26). In one study, 14 percent of patients treated with antimicrobials experienced adverse reactions and 90 percent of these adverse reactions were associated with unnecessary or inappropriate therapy (27). Patients also die unnecessarily because antibiotics are given without checking for the presence of resistant organisms (28), and because toxic antibiotics, such as chloramphenicol, are too widely used despite warnings (29).

Such irrational prescribing contributes to the growing problem of adverse drug reactions (30), which have come to be a significant cause of illness and even death. Between 100 and 200 Americans a day are believed to have died as a result of adverse reactions to prescribed drugs in 1971 (31). Thus adverse drug reactions cause about as many deaths as motor vehicle accidents (140 deaths a day in 1971).

As with the case of hysterectomy described above, antibiotics this widely and randomly used represent a substantial threat which may outweigh the benefits of their proper use in a much smaller population. This is especially true in a country like the United States for which improved nutrition, environmental sanitation and immunization play the fundamental roles in the reduction of infectious disease prevalence. On the grounds of the average medical use of antibiotics today, one might well seek to eliminate the technology altogether, despite the clearcut efficacy and relative safety in controlled trials. Clearly, the appropriate use of antibiotics in the restricted group for which there is benefit is the proper policy, but this discussion illustrates the gulf which separates average medical practice from the results reported in controlled trials.

At the other end of the spectrum from the ten procedures just described are a smaller group of preventively-oriented technologies which are demonstrably effective and safe, but which are generally not fully funded by third party payers. The report reviews the history of the struggle to establish the usefulness of the Pap smear for preventing the progression of cervical cancer from its earliest stages (32), and the difficulties surrounding the effective population use of drug treatment for essential hypertension (33). The risks and benefits of mammography (34) and the sociopolitical questions surrounding amniocentesis studied until after the second World War. The sciences of medicine, as opposed to basic biological science, is quite recent and the (36) and multimodal therapy for Hodgkin's disease (37).

Although the cases selected for the report were based on the knowledge of panel specialists in particular areas, the picture that emerges is not unrepresentative of medicine as a whole. By and large, modern medicine spends a great deal of money and effort on ineffective and risky attempts to cure the endstages of diseases that have developed over decades prior to treatment. Attempts to prevent these diseases are underfunded and almost always contested by the medical establishment.

Science and Scientism in Medicine

These results seem striking and even iconoclastic; part of the reason for this impression is that most people, doctors included, believe that medicine has been a science at least since the mid-19th Century. In fact, the procedures of medicine were not scientifically
Causal understanding in science can only be based on direct experimentation involving control of all relevant variables. Until recently, medical treatments were derived from the various theories that unified and explained the descriptive and sometimes experimental data of basic biological and physical science. In the late 18th Century, for example, analogies to Newton's theory of gravitation and physical mechanics derived from it were developed in medicine. In the 19th Century, analogies to chemistry and microbiology prevailed, and the early 20th Century was marked by the mass overuse (39) of unseen radiation to reveal hidden structure, on analogy to developing atomic and nuclear physics. Today, the trendy thing is microminiaturization of electronics and computers, reflecting the enormous advances in solid-state physics in the 1960s. As the overall theories of "basic" science sometimes changed drastically from one period to another, so did the vogue of "scientific" medical treatment (40).

This general tendency to justify medical procedures solely by analogy to basic scientific theory can be termed scientism, to distinguish it from the real practice of science in medicine. Scientism converts knowledge gained in other areas of thoughtful experience into symbols used in the psychosocial practice of interpersonal healing. These symbols are important to medicine, not because they work "technically," but because they reinforce the world-view of society by use of its apparently most powerful forces.

As the OTA report points out, a situation favorable to scientism still prevails in medicine. Possibly as much as 90 percent of current medical procedures have been brought into wide practice on the basis on qualitative impressions of clinical practitioners, without use of control groups, on very small numbers of studied patients. These procedures are transmitted from generation to generation in medicine by clinical and classroom experience in medical school, residency and special courses, environments in which students naturally assume that because a procedure is used it is therefore scientifically valid. Physicians do not base their practice on a critical reading of the literature of controlled trials or animal experimentation, much less experimental thought within their own experience.

Experimental science in medicine has a prehistory, the period in which the practice of deliberate experimentation and control gradually developed. In the late 18th Century, for example, the Vienna clinic under van Swieten and de Haen produced the first large corpus of exact case histories of patients, including not only the symptoms, course and postmortem anatomy of diseases, but also every treatment applied and the results.

From cross-comparisons in this systematic and comprehensive record of every person treated, the leaders of the Vienna clinic gradually became convinced that bed rest, good food, and humane, caring attention were the best therapy for most diseases. They called this "expectant" or waiting treatment, and viewed it as nonintervention. So far did the Vienna clinic go in the elimination of the specific nostrums of the various scientific schools that they were widely accused of "therapeutic nihilism" (41). The systematic cross-comparisons of case histories underwent a further wave of development in the late 19th Century. In this period, simple comparisons again demonstrated the worthlessness of the great mass of scientific medical treatments (42).

The comparative evaluation of treatments from the 18th Century onward really constitutes the pre-history of scientific method in medicine, largely because of the lack of deliberate control. Additional precursors of medical science in the United States occurred in the 1938 and 1961 legislative changes which resulted in the pre-market experimental testing of drugs, and to some extent equipment, for both safety and efficiency. These tests are conducted largely on lower animals, involve small numbers and short periods of high-dosage use to determine immediate toxicity, as opposed, for example, to long-range carcinogenicity, and are generally inadequately controlled, as explained below. Yet these changes resulted in the elimination of the majority of drugs in the medical compendia prior to 1938 (43).

The first fully developed examples of scientific method in medicine and psychiatry came in the 1950s with the first blind, randomized, controlled trials in humans. The importance of conducting the studies on humans and of having a thoroughly blind methodology is nicely illustrated by an example from psychiatry (44). In this experiment, chronic hospita-
lized schizophrenics receiving normal doses of phenothiazine were switched to placebo by the experimenters, without the patients, treatment staff, or patient assessors being aware that a study was even being conducted. Thus, this was a “triple blind” study. In the first few weeks after placement on placebo, the placebo group did better than the matched group of patients who remained under phenothiazine as before in various social learning tasks that were part of the hospital’s normal social therapy program. Subsequently, the two groups did equally well in learning performance and in clinical appraisal of psychiatric status. Clearly, the bottle believed by nurses and patients to contain a potent drug worked wonders regardless of its chemical content.

The Placebo Effect and Healing

Perhaps the largest causal effect in scientific medical studies is the interpersonal healing impact which appears in these studies most often as the effect of the placebo control. In all scientific medical evaluation studies, the theoretically inactive substance, instrument or procedure, given in the same setting and in the same way as the technically designed procedure, will always improve or cure a fraction of the patients. In the VA study of antihypertensive drugs, for example, all prospective patients were first placed on placebo for two to four months, and the large fraction whose diastolic blood pressure dropped below 90 mm Hg, during this time were excluded from the study. In the main study that followed this weeding out of placebo responders, 40-50 percent of the men on placebo still showed significant declines in blood pressure (45).

If such a study is done so as to optimize the placebo effect, the placebo will in most cases cure or improve as large a percentage as the supposedly efficacious intervention. The studies of coronary bypass surgery reviewed above, for example, show that a theoretically useless operation, sham operation as a control for mammary artery ligation, cures angina in over 70 percent of the sufferers, a percentage comparable to that found in the coronary artery bypass graft surgery studies (3, 4). And again, the first and fourth most commonly prescribed drugs, Valium and Librium, work little better for their specific indications than placebo in double-blind controlled trials (26).

In the OTA report, as in the deliberations of the FDA, or any ordinary medical discussion of the efficacy and safety of drugs, equipment or procedures, the significance of the placebo effect is usually misunderstood. A procedure is usually considered efficacious if it improves or cures a greater percentage of matched patients than the placebo. It is considered relatively safe if impairments or death in the treated group occur at a lower rate than among untreated people. If, however, a properly administered placebo can cure or improve the same or even a considerably lesser fraction, while involving no technical increment of risk compared to the untreated, the placebo will in many cases be the treatment of choice, a possibility excluded in the routine way of thinking of this issue.

Or, to put the issue in its real setting, nontechnical interpersonal healing interactions are the method of choice indicated from most scientific medical evaluation studies. Rather than “therapeutic nihilism,” the true harvest of science in medicine is a substantial body of worthwhile treatments: extrication from stressful social situations, empathetic care, rest, good food, and symbolic interactions which may costlessly maximize the interpersonal healing impact.

The Possible Political Impact of the OTA Report

These considerations, especially concerning the placebo effect, are very relevant to the political substance of the OTA report. The message of the report is really very simple and could have been put in a much shorter space: scientific medical evaluation studies show that much of technical medicine is relatively worthless and risky, and third party payers should not reimburse the performance of this part of medicine. This substance is couched very cautiously; it is written as though by summarizing facts, the authors were thereby committing religious transgressions, as indeed they are.

The summaries of the review of each technique, for example, are written in the most favorable possible terms to the medical profession, and in some cases almost ignore the facts recounted in the immediately preceding paragraphs. The studies are surrounded fore and aft by tens of pages of rigid bureaucratese, which give the appearance of carefulness and order while creating a jungle of analytical points and policy recommendations.

This timidity becomes even more evident in a comparison of a draft of the original report written in 1977 with the published version. In the original, many issues are squarely confronted in terse prose, that are here eliminated from consideration. In the evidence for each procedure, as much selected “recent evidence”
favorable to the procedures is added, though this evidence is most often not scientifically comparable to that from controlled studies. Overall, the report obviously reflects a political situation in the government and in medicine in which the appearance of science holds sway and frowns upon the policy use of real science.

Hidden in the complex bureaucratic proposals for how to use the information from scientific studies of medicine are comments very revealing of this situation. The most direct way to use this information would be to have the FDA base regulatory decisions upon it, as it already does for drugs and to some extent for instruments. This alternative is not taken seriously by the report, however, since the "FDA is basically a regulatory agency and may not be able to attract the scientists necessary for regulating procedures. Furthermore, FDA's negative image with the practicing community would hamper its work (p. 102)....Physicians would undoubtedly resist such regulation. The process would be expensive and could retard innovation" (p. 104).

The information must be gathered and synthesized from historical and ongoing controlled clinical trials, and NIH currently funds the greatest number of such trials. According to the OTA report, however, "a system for identifying technologies that need assessment could be developed in a number of agencies at various levels....NIH has exhibited a stronger interest in developing medical technologies than in assessing them (p. 99)....NIH could assume a larger role in testing both new and existing technologies for efficacy and safety. Not only has NIH been reluctant to assume such an expanded role without new funding, but also NIH has resisted becoming deeply involved in existing medical practice (p. 101)....NIH could undertake the task of synthesizing efficacy and safety information; however, NIH has shown little inclination to make judgements that could be used by regulatory agencies (p. 102)....NIH could refine and expand its (information) dissemination efforts....However, NIH is reluctant to expand its role in this area, particularly in regard to practicing physicians" (p. 103).

These comments about the FDA, NIH and other government bodies assume added significance when we realize that they are practically quotations of what the heads of these agencies said to the OTA panel in interviews, as the first draft of the report notes.

With the obvious ways of solving the problem politically excluded, the report focuses on a number of government agencies which have been legally established to control reimbursement depending on the quality, efficacy and safety of procedures; but, according to the report, all such agencies have either lacked the expertise or the political clout to carry out the task, or, like the PSROs, have been dominated by the medical profession and therefore rendered ineffective. In response to the OTA report, Congress has just passed a bill, which President Carter is expected to sign, establishing yet another such agency in the government at $25 million a year (46).

A careful reading of the OTA report therefore raises a curious and troubling question: Now that science is finally possible in medicine, who will bell the cat? One might think that conservative middle-class government cost cutters would see this as a way of lightening their own tax and insurance burdens, and indeed they have been an important political force in the closing down of public hospitals and clinics. But these closings, far from limiting the useless and dangerous parts of medicine, have instead had the greatest impact on the preventive and primary care end, and have done nothing to slow the avalanche of new high technology treatments of dubious merit. This result is really not surprising, since this constituency is composed in part of doctors, researchers, statisticians, accountants, construction company managers, drug company personnel, admen, banking executives and a myriad of others whose personal self-interest is bound up with the triumph of the leading growth industry.

Corporate planners interested in cutting benefit costs of controlling worker unrest on occupational health issues might be possible candidates, through corporate-sponsored HMOs of Nixonian design (47). While it is true that HMOs generally have lower rates of hysterectomy or other dubious medical procedures than fee-for-service institutions (48) and that important evaluation studies have been done in England under the pressure of enforced budget ceilings or outright reductions, the economies in these organizations are not necessarily related to efficacy. Further, these organizations still show great excesses of unnecessary curative medicine, and are little better at preventing the social causes of disease, despite the putative financial incentive in this direction (49). Perhaps in estimating their future one should be reminded that scientific medicine was legally established and massively funded by the corporate foundations not be-
cause it was medically effective, but because it was necessary for political and social control (50). As this necessity has not disappeared, neither will scientism.

Reflection on the history of what actually has reduced death rates and improved people's health demonstrates the effectiveness of procedures long advocated by nonestablishment forms of medicine—nutrition and environmental health (51)—while the evidence of controlled trials in scientific medicine points to the importance of interpersonal healing and stress reduction in cure. A popular health movement practicing these measures is growing in the United States and other developed countries today.

A bridge needs to be built between this movement and the practice of scientific evaluation in medicine. This is particularly true in the scientific study of interpersonal healing phenomena. It will not be an easy bridge to build, since nonestablishment forms of medicine have for so long been arrogantly suppressed by scientism that they have often rejected the scientific habit of thought and inquiry in reaction.

Beyond this bridge lies the possibility of challenging the political, social and economic authority which scientism defends. The 1980s promise to be a decade of great social unrest and instability, so this challenge may be possible (52). If not, we shall be back to the surrealistic situation in which genuine science challenges the mirage of science, and loses. Like the situation of the nonscience of nuclear waste handling and storage, this situation in medicine is a premonition of the nightmare of the mind which lies ahead in the world order constructed by rampant scientific Progress.

—Joe Eyer

References

1. Pages 26-56 in the OTA report. For each controversial point below, I will cite the relevant pages in the report and the documentation which the OTA has marshalled in this area. If the point is not contained in the OTA report, I include my own reference material.
6. OTA page 43.


17. O.T.A page 41.


25. O.T.A page 16.


32. O.T.A pages 26-29; Pap smear has been validated by epidemiological comparisons of uterine cancer rates between screened and unscreened populations, not by controlled blind trials: Christopherson, W. et al. Cervical cancer control, Cancer 38: 1357, 1976; Cramer, D. The role of cervical cytology in the de-
OTA, page 49. The main reason for the small return is that coronary heart disease is untouched and may be increased by antihypertensive medication.

OTA, page 52-53. The critique of the overuse of X-rays is well known in medical literature. For yet another recently emergent example, see Favus, M. et al. Thyroid cancer occurring as a late consequence of head-and-neck irradiation. N. Engl. J. Med. 294 (19): 1019, 1025, 1976. This story is particularly interesting because of its possible wide consequences, beyond thyroid cancer alone. Since the beginning of the 20th century, an enlarged thymus in children was baselessly considered pathological by many scientific doctors. At first this condition was treated by surgical removal of the thymus, and from the 1920's through the 1950's, millions of infants and children were treated by high-intensity X-ray irradiation to shrink the thymus. In light of the present knowledge on the essential role of the thymus in cell mediated immunity, it can be anticipated that these children should develop immune-deficiency diseases in later life. The very high risk of thyroid cancers reported by Favus et al. in previously irradiated persons is perhaps only the tip of the iceberg.


See VA study, cited in reference 33. The exact fraction excluded by preselection against "placebo responders" was not reported in these studies.


INTRODUCING

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