Community health centers were born in the atmosphere of hope and possibility prevailing in the mid-1960s. Today, the legislation is nearly 15 years old. With this issue, the Health/PAC Bulletin begins a series of articles addressing the evolution of federal community health center policy and the current dilemmas and future prospects faced by these no-longer fledgling endeavors. As the articles in the next two issues will make clear, the dilemmas are of no small magnitude and the future is—as has seemed all too often true in the past—up for grabs.

Community health centers were not only a product of social reform, they were also to be an agent of it. They were designed to address the unmet health care needs of America's poor; equally important, however, they were to do so in a manner so different and superior
that, if successful, this alternative model might revolutionize the delivery of all primary care. Thus community health centers brought with them a political agenda for the health system.

Instead of rigidly professional and institutional dominance, they offered community control; instead of narrowly medical, illness-oriented services, they proposed a wholistic and preventive approach to the health problems of individuals, fragmented, specialized munities; instead of fragmented, specialized and depersonalized outpatient clinic services, they touted comprehensive and integrated care in single setting; instead of care delivered by a rotating cast of doctors-in-training, community health centers offered a full-time personal physician as well as a staff of culturally and linguistically compatible community residents. Community health centers seemed to offer the ideal blend of personal health services and public health.

Several articles in this series recount, with refreshing specificity, the fate of this alternative model whose economic feasibility in a hostile environment waxed and waned in one-to-one proportion to the strength of the social movement which spawned it. Since the inception of community health centers in 1965, their history has been one in which the federal government has progressively undermined and thrown up obstacles to implementing that original vision of community-controlled, change-oriented, comprehensive care.

The following articles describe how first the base of political support for community health centers was circumscribed and the model tarred with the brush of "poor people's medicine" when OEO and HEW limited the clientele of CHCs to the poor. The articles describe in painful terms the results of the Nixon Administration decision that, if they were to continue, CHCs would have to prove their survivability according to the same reimbursement imperatives that created the very system to which they were to offer an alternative. Without the strength of a social movement to give viability to alternative models, the innovative and unique features of the CHC model were quietly transformed into luxuries and financial liabilities which could no longer be supported.

Whether the CHC experience failed to demonstrate to the unbelieving the success of this particular alternative model, or whether the lagging social movement from which CHCs sprang failed to impress policy makers and funders with the urgency of trying alternatives, the undermining of CHCs was accompanied by a shift in policy. Through a variety of measures detailed in the articles that follow, both HEW and private foundations have clearly decided that hospitals are the more auspicious sponsors of ambulatory care. Not surprisingly hospitals, sniffing clearly "where the money is," are undergoing a renaissance of interest in ambulatory care. Thus the power and resources which flowed away from established institutions during the social turbulence of the 1960s and early 1970s are flowing back to them during the quiescence of the late 1970s and early 1980s.

These developments are described in the general and in the concrete in the articles that follow. The questions they raise, however (or occasionally fail to raise) are more difficult. Among the more important questions still to be answered out of the 15-year experience with CHCs are:

- Is the traditional "us-them" polarization between communities and institutions with regard to ambulatory care still a valid or useful one, particularly in light of the "back-to-the-institutions" flow of federal policy? Can this flow be reversed in the near future with the forces now on hand? If it can, does this struggle warrant the effort and resources? If not, what political agenda should activists pursue with regard to institutions? Is the CHC model of care completely incompatible with institutional sponsorship and delivery of services? If not, what aspects are compatible? Are the unique features worth the struggle necessary to win them?
- Activists have, over the last two decades, come to appreciate the importance of addressing not only the form of health service delivery, but the content of those services as well. What conclusions can be drawn from

**Continued on Page 6**
AGENT ORANGE UPDATE

The Carter Administration's efforts to retain control over scientific studies of those exposed to Agent Orange have suffered several setbacks in recent months. In early May, the National Academy of Sciences published a sharply critical analysis of a plan by the US Air Force to study "Ranchhand" spray personnel. The Academy concluded that the proposed study was too small both in numbers to be studied and duration. Further, it questioned whether the Air Force study would enjoy any credibility—no matter what conclusions it reached. The Pentagon has given no indication of what it will do, but the study seems unlikely to go ahead in the face of such powerful opposition.

Meanwhile, an epidemiological study of veterans being designed by the Veterans Administration "in-house" has also been gathering opponents as its details have become public. Several epidemiologists have criticized this study for its scope and design, concluding that considerations of cost prevailed over scientific integrity. Voices as diverse as Senator Alan Cranston (D-Calif) and the American Legion have begun demanding that the VA's control over such studies be ended.

VITAL SIGNS

Even stockholders of Dow Chemical are beginning to feel the heat for that company's role in manufacturing most of the dioxin-laden 2,4,5-T that was sprayed on Vietnam. A group of stockholders, led by the National Council of Churches, pushed a resolution at Dow's annual meeting in May 1980, calling for an investigation of Dow's handling of potential hazards associated with 2,4,5-T. Dr. Samuel Epstein, well-known scientist/activist and author of The Politics of Cancer, joined their effort, demanding that Dow release the results of studies the company has conducted on the reproductive histories of women married to some 300 dioxin-exposed Dow workers. Predictably, the resolutions were rejected, but not before Dow had received some unwanted publicity for its deceptive and arrogant practices.

Meanwhile, Citizen Soldier recently began the arduous process of hand-coding data from each of the 4,200 medical questionnaires which have been returned to the organization in response to its canvas of ailing veterans. Anyone who can volunteer a few hours for this important work can contact Citizen Soldier at (212) 777-3470. Citizen Soldier, a relatively tiny non-profit group, may represent the only serious attempt to see correlated health data on Vietnam veterans published within the next few years.

MEDICAL MARKETS

The stock market can sometimes tell the astute observer more about the direction of the health care than either patients or workers. The proprietary portion of the US health system, of course, places market success higher on its list of priorities than satisfy patients' or workers' needs. Some bellweather trends in recent market events include:

- Glasrock Products, Inc., has seen its stock shoot up to $40 per share from a low of almost $5 a share in 1979 because the ceramic products company is buying up small home health care companies. National Medical Enterprises, Inc. and National Medical Care, Inc. are two other companies currently gobbling up small home health enterprises as well. The home health care industry may be rapidly moving from cottage industry to major corporate control, and perhaps will end up where much of the rest of the medical-industrial complex has been for some time: highly monopolized by a few giant corporations.

- Merck and Company, maker of Aldomet for high blood pressure and Indocin for arthritis, is being touted as another strong growth prospect. Merck's
new products and growing foreign business are expected to offset the predicted recession-induced drop in doctor's visits in this country. Merck's $227 million in research and development expenditures over the current year — up 21 percent from 1979, and marking Merck's 25th consecutive year of escalating R&D expenditures — is the source of market optimism about its future growth potential.

• Emerson Radio is being recommended as a medical growth stock because of its recent introduction of an FDA approved, portable, battery-powered automatic resuscitator for emergency use on heart attack victims. Stock analysts estimate that Emerson has to sell 250 units to break even. But they are predicting that more than 2,000 Heart-Aids will be sold in fiscal year 1983. Each costs $6,275, about half of which is gross profit. The market includes any place where large numbers of people congregate: industrial plants, offices, buses, planes, transportation terminals, sports stadiums, and auditoriums. Of course, even home sales cannot be ruled out. “Be the first on your block...” — George Lowrey
Sources: Barron's, 4/28/80; Business Week, 7/7/80; and Oppenheimer & Co., Inc.

WHILE SOCIAL CHANGE IS NEGLECTED

William Shockley—who, with his Nobel prize in physics, offers living evidence that “regression” is a social phenomenon, in this case, of the Nobel Foundation—appears to have initiated a new offensive to popularize his "new eugenics" based on racial genetic inferiority and superiority. In the August issue of Playboy, the Stanford professor reveals that he has contributed sperm in an attempt to produce superior children. Superior according to whom, one may ask?

It appears that Shockley's proposed ideas—such as the offering of financial rewards to Black welfare mothers who would get sterilized to prevent "dysgenics" — have not been enthusiastically embraced by enough of the people in power positions to implement them. Shockley evidently does not question the wisdom of these ideas in the face of social and ethical condemnation, however, but proposes a strategy consistent with his own
thinking: "Through genetics, create the 'right' people who will think like I do and adopt and implement my proposals!"
Fortunately, it just doesn’t work that way as Shockley himself suggests in the Playboy article. In it he claims that his children “represent a very significant regression” since they have not reached the academic distinction that he has and one son is a college dropout!

Shockley’s new “contributions” to the creation of a superior stock of people will undoubtedly follow the same course that his existing children did. As they become exposed to other than Shockley-like influences they will develop their own world views, values and social positions. Shockley meanwhile, true to the spirit of racism and eugenics, remains fixed in his positions. As to why his own children are “regressions”, he scientifically explains, “my first wife—their mother — had not as high an academic achievement standing as I had."

Now if this “genius” can only find a way to procreate without Blacks, Latins or women, what a Shockley world we may all look forward to! —Jaime Inclan


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The Health Care Hierarchy
Editorial

Continued from Page 2

the content of the health services delivery attempted in the CHC model? If we had the experience to repeat in light of this new appreciation, would we structure the content of those services any differently? If so, how?

• Similarly, early community-control activists hoped that community residents would espouse a fundamentally different set of values about health and medicine than did health professionals. Put in control of medical resources, the community would allocate things differently, e.g., prevention, education and counseling instead of technology and specialization. To what extent has this proved to be the case? What has this 15-year CHC history taught us about that assumption? Are community control or consumerism a sufficient basis for a radically different health system?

• Is comprehensive care always preferable? In the 1960s and early 1970s, it was assumed anyone who knew better would prefer “comprehensive health care.” Comprehensive services, however, often seemed to make more sense to the providers than to their patients who, in an era of fast food, fast media and rapid transit, were often impatient with visits requiring long, extensive medical histories, thorough diagnostic work-ups, and extensive patient counselling. Moreover, poor health consumers like their more affluent counterparts, proved to be more selective in shopping for their health care than was anticipated — seeking hospital OPDS, health centers, health department clinics and Medicaid mills depending upon the problem and the circumstances.

• What is necessary to overcome the image of CHCs as “poor people’s medicine” and the frequent equation of quality health care with complex technology and prestigious names? If indeed the CHC model of care is superior, what measures are necessary to educate health care consumers?

The editors are convinced that these and similarly major, if knotty, questions underlie the CHC experience. Moreover, whatever else is possible, future activists must have access to, understand and learn lessons from the rich CHC history. The answers to the kind of questions raised here can only result from a process of candid and continuing discussion. We hope the next two issues of the BULLETIN will initiate this discussion. We invite our readers to join in.

Community Health Centers after Fifteen Years

Fедерально funded “Neighborhood Health Centers” began as demonstration projects within the Office of Economic Opportunity (OEO), the lead agency in the Johnson administration’s “War on Poverty.” In some way they have been among the most remarkable survivors of that war. But today, the innovation and reform they symbolized in the 1960s has been largely eroded and their future is unclear.

In 1965 the War on Poverty job training programs were finding then surprising levels of illness and disability among their participants and paying large sums of money to private physicians for their treatment. Sargent Shriver, then director of OEO, found the Public Health Service’s existing programs inadequate to this challenge and called for more innovative approaches (1). The health centers which emerged received a broad mandate from OEO to attack the cycle of poverty and interrelated ill health as they saw fit. As a result, the centers often developed innovations that many observers believed were uniquely successful in integrating preventive and primary care and making both kinds of services more appropriate to the health needs of the poor.

The centers had five initial defining principles: (a) service to and location in a community with a high concentration of poverty; (b) integration of and coordination with existing health and human service agencies; (c) provision of high quality health care; (d) community involvement through participation in governance (i.e., advisory boards and boards of trustees, OEO’s mandated “maximum feasible participation”); and (e) employment opportunities and training for community residents (2).
Neighborhood Health Centers, some 150 in number, grew to provide a wide range of family-oriented health services to approximately 1.5 million residents of low income communities by 1976 (3). With the expansion of the National Health Service Corps and its Rural and Urban Health Initiatives (which combine operating grants with federal personnel) in 1977 approximately 420 centers were serving 3.3 million people. At the same time many have become the focus for social and political action in their surrounding communities, both rural and urban.

Among the unique features of these centers with their wide individual variation were the following:

**Employment and Training of Local Residents as Health Professionals**

Perhaps the best known type of paraprofessional "invented" by the centers is the "Family Health Worker" (or "Community Health Workers"). In many centers the function of the Family Health Worker combined the skills of the more traditional medical assistant inside the center with the public health nurse's preventive outreach and follow-up outside the center, while integrating social work into both spheres.

**A Team Approach to Organizing Primary Care**

Patients visiting many of the pioneer centers related not to just a single physician, but to a team made up of physicians, nurses, technical workers, and paraprofessionals. The team was intended to reduce the traditional professional hierarchy providing care, while emphasizing a more continuous and comprehensive approach to patient and family.

**Community Involvement in Policymaking**

The original OEO centers were started by hospitals or medical schools, or at least had strong ties to such institutions. Each also developed advisory boards that were to promote and gauge the appropriateness of the services provided to their communities. Although there were serious battles over how best to accomplish this aim—some arguing that community control was necessary, others maintaining that advisory functions were sufficient—the consensus which emerged secured channels for maintaining community involvement in and/or control of center policy-making.
The original neighborhood health centers were started by hospitals or medical schools but they all evolved channels for maintaining community involvement in policy-making.

An Emphasis on Prevention

The native wisdom of community boards and local residents working as paraprofessionals, catalyzed by OEO's financial support for reform, contributed to shifting the emphasis from routine medical practice toward interventions which would prevent some of the death and disability associated with poverty. Nutrition, jobs and income, housing, lead paint, and drug and alcohol abuse — what communities knew first-hand was making them sick — became the targets for the centers' intervention.

All of these features, of course, emerged in the social and political context of the late 1960s and early 1970s—a context created by several broad, popular movements raising demands for civil rights, for community control, for service to "the community," and for increased relevance of services from large institutions. As the 1970s progressed, many of these demands were either co-opted by institutionalizing "community involvement" (and thereby removing it from the community) or dampened with the ebbing of social protest in general.

In 1967 the "Partnership for Health" Act had directed the Department of Health, Education, and Welfare (HEW) to expand the neighborhood health center idea. As a result, a steady growth in "Community Health Centers"—the new official name for the centers—progressed, and within the following eight years, the total number of community health centers (CHCs) reached 157, of which 75 percent were in urban areas. With the growth of Medicare and Medicaid programs that offered third-party revenues for services to the poor, the CHCs' future seemed bright.

But the CHCs' troubles were only beginning. Major battles had raged since the beginning — and continue today — over the uneasy relationship between the centers and the hospitals and medical centers affiliated with them. The shift of federal responsibility from OEO to HEW and the growth of Medicaid funding only increased these tensions. HEW has long been closer to the established medical model in outlook than was the more experimental OEO. HEW was also much closer to the hospitals and medical schools. The social reform aspects of the centers could have been predicted to face a troubled future the day HEW took over.

The Case of Boston

Boston offers a unique case study in such conflicts, precisely because of the large numbers of centers that have been developed in the shadows of several powerful teaching hospitals with their own large outpatient services.

In 1965 OEO opened its first neighborhood health center in Boston — the Columbia Point Health Center. Ten years later Boston—with its population of about 640,000 — supported 26 neighborhood health centers within the city. That resulted in the unusually high ratio of one health center for every 25,000 residents. Virtually every neighborhood in the city, and more recently some suburban towns, claimed its own health center (see Table 1).

This proliferation of health centers occurred in the context of a creative use of multiple funding sources. The Economic Opportunity Act of 1964 (the source of OEO funding), the Maternal and Child Health Amendments to the Social Security Act of 1965, and the Demonstration Cities and Metropolitan Development Act of 1965 (Model Cities) all provided federal support for health center development in Boston.

In addition, the city's Department of Health and Hospitals provided "outreach" funds to seven neighborhood health centers and later offered "matching program" funds to several others. Several of the large teaching hospitals and community hospitals extended services and support to neighborhood health centers which affiliated with or were licensed as part of these hospitals.

The availability of so many independent funding sources in Boston generated health centers within blocks of each other in some neighborhoods. Roxbury—North Dorchester, for example, with a 1970 Census population of 145,000, is served by 11 CHCs, a ratio of one health center for every 13,000 residents. Such unplanned growth set the stage for competition for limited resources later, when general
Table 1

**Boston Community Health Centers, 1975**

<table>
<thead>
<tr>
<th>Name</th>
<th>Visits/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allston-Brighton Neighborhood Health Center</td>
<td>8,905</td>
</tr>
<tr>
<td>Bowdoin St. Health Center</td>
<td>7,463</td>
</tr>
<tr>
<td>Brookside Park Family Life Center</td>
<td>63,045</td>
</tr>
<tr>
<td>Bunker Hill Health Center</td>
<td>53,949</td>
</tr>
<tr>
<td>Charles Drew Family Life Center</td>
<td>17,434</td>
</tr>
<tr>
<td>Chelsea Community Health Center</td>
<td>23,460</td>
</tr>
<tr>
<td>Columbia Point Health Center</td>
<td>32,245</td>
</tr>
<tr>
<td>Dimock Community Health Center</td>
<td>32,329</td>
</tr>
<tr>
<td>Dorchester House Health Center</td>
<td>not reported</td>
</tr>
<tr>
<td>East Boston Neighborhood Health Center</td>
<td>53,562</td>
</tr>
<tr>
<td>Fenway Community Health Center</td>
<td>5,000</td>
</tr>
<tr>
<td>Harvard St. Neighborhood Health Center</td>
<td>41,923</td>
</tr>
<tr>
<td>Little House Health Center</td>
<td>7,681</td>
</tr>
<tr>
<td>Martha Eliot Health Center</td>
<td>32,556</td>
</tr>
<tr>
<td>Mattapan Community Health Center</td>
<td>3,213</td>
</tr>
<tr>
<td>Neponset Health Center</td>
<td>13,107</td>
</tr>
<tr>
<td>North End Community Health Center</td>
<td>23,404</td>
</tr>
<tr>
<td>Roslindale Health Center</td>
<td>4,730</td>
</tr>
<tr>
<td>Roxbury Comprehensive Community Health Center</td>
<td>not reported</td>
</tr>
<tr>
<td>Roxbury Dental and Medical Group</td>
<td>12,532</td>
</tr>
<tr>
<td>South Boston Community Health Center</td>
<td>15,685</td>
</tr>
<tr>
<td>South Cove Community Health Center</td>
<td>9,312</td>
</tr>
<tr>
<td>South End Community Health Center</td>
<td>41,594</td>
</tr>
<tr>
<td>Southern Jamaica Plain Health Center</td>
<td>4,657</td>
</tr>
<tr>
<td>Uphams Corner Health Center</td>
<td>18,483</td>
</tr>
<tr>
<td>Whittier St. Health Center</td>
<td>8,817</td>
</tr>
</tbody>
</table>

**Total** 506,095

Source: Massachusetts Department of Public Health, *Health Data Annual 1976*

Operating funds dwindled and funding agencies took other priorities.

Despite their numbers, however, Boston’s CHCs accounted for little more than half a million visits, only eight percent of the city’s total outpatient facility visits, excluding physician encounters in private offices (see Table 2). Since 1975, for which the most recent data is available, many of these CHCs have expanded and moved into new facilities. More recent data would probably show some increase in patient visits.

This utilization pattern reflects a national trend. During the same decade of growth for CHCs, nationally hospital outpatient visits doubled to a high of 250 million in 1975, generating 12 percent of all hospital revenues (4). In 1965 visits to hospital outpatient departments accounted for 14 percent of all physician visits in the country. In 1973, 21 percent of all physician encounters occurred in hospital outpatient settings (5) and by 1979 that proportion had reached about 25 percent. Teaching hospitals—which represent only five percent of all hospitals—accounted for one-quarter of all hospital-based ambulatory care (6).

Hospitals in Boston have traditionally operated large outpatient services, organized as independent specialty clinics for training of residents and conducting research. Faced with the competition offered by group practices and health maintenance organizations as well as by CHCs, the hospitals began to respond to internal and external pressures to improve the quality of primary care in the city.

As early as 1970, Mayor Kevin White had suggested that the tax-exempt status of the city’s hospitals might be jeopardized by their failure to help meet the health needs of the local population. The state’s Determination of Need Program and local health planning agencies repeatedly proposed limitations on hospital expansion. Community groups, meanwhile, became increasingly sophisticated in using the
Determination of Need process to block hospital expansion that occurred at the expense of low-income housing. In order to win approval for their expansion plans, several hospitals made new commitments to primary care services in their surrounding inner-city communities.

Moreover, the hospitals finally began to examine and reorganize their own outpatients departments, long the focus of criticism for fragmentation, long waits, poor record-keeping, and inefficiency. With funding from private foundations such as the Robert Wood Johnson Foundation and later from the federal government, several Boston hospitals established separate primary care centers. Beth Israel Hospital opened the Beth Israel Ambulatory Care Center in 1974. Boston City Hospital opened a modern ambulatory care facility in 1977. Both the Massachusetts General and the new Affiliated Hospitals (a merger of the Peter Bent Brigham, Robert Breck Brigham, and Boston Hospital for Women) have built multi-million dollar ambulatory care centers. Most recently, New England Medical Center was named as a recipient of a large Robert Wood Johnson grant to replace its medical clinics with a group practice.

At the same time that hospitals were exhibiting renewed interest in primary care, federal funding sources for CHCs began tightening. With the expiration of OEO in 1974, its remaining health programs were transferred to HEW. HEW guidelines for CHCs began to reflect concerns with documentation, cost-effectiveness, maximizing third party revenues, and fiscal self sufficiency rather than with community participation in shaping health services or innovative health care delivery. Moreover, the growth of Medicare and Medicaid led federal policy-makers to anticipate some form of national health insurance. Universal coverage would allow patients to purchase their health services from any source they chose, so the days of direct subsidy of CHCs by the public sector were thought to be numbered. Under such a vision of national health insurance the marketplace would attend to the health needs of the poor. This, of course, never materialized, but rather Medicaid and Medicare eligibility and coverage were cut back.

Finally, despite the availability of CHCs, poor people had all along continued to use hospital outpatient facilities for primary care. One year ago, the Massachusetts Department of Public Welfare generated utilization profiles for sample Medicaid recipients who receive care at several CHCs. The profiles revealed a consistent pattern. Medicaid recipients used their health center for about one-third of their ambulatory care and went elsewhere for the rest, most often to a hospital. Health center staff confirm this impression. Patients use different health centers and hospitals for different services, or at different times of the day or night.

Many community residents assume the health center is second-rate just because of its location. "If he were a good doctor, he wouldn’t be working in the ghetto." The best doctors, after all, must be at the big medical centers. Indeed, many physicians and the general public may share this perception of "poor people’s medicine" on the one hand and "Medical Center" on the other. Massachusetts General Hospital, for example, operates two health centers in Chelsea and Charlestown but does not allow the centers’ doctors to admit their patients to the hospital, thus perpetuating two classes of care.

One reason patients “shop around” may well be their perception that CHCs face unstable financial conditions. Community residents hear of such internal struggles because friends, neighbors, and relatives work at the local
center. Such news travels quickly on the grapevine and may be exaggerated in the process. At other times the information may be quite public — a health center goes into receivership or is taken over by an affiliated hospital.

CHCs do reflect the economic instability of the low- and middle-income communities they serve. Many continue to struggle for economic survival long past initial start-up stages, caught between a community with high health care needs and a reimbursement system that does not cover full preventive and ambulatory care services.

Public medical coverage — Medicaid and Medicare—covers hospital costs for similar services at rates that allow the hospitals to recover a greater proportion of their costs than health centers. For example, at the Roxbury Dental and Medical Group, Inc., where the author is Executive Director, a primary care physician who sees a Medicare patient will generate a reimbursement of $10.44. At a hospital outpatient clinic nearby, the institution receives $35 for the same services. At a large private clinic in Boston, a physician performing the same service would generate a $70 consultation. Private health insurance often disallows routine or preventive health care altogether, and most health center patients are not covered by private plans.

As a result, CHCs serving low and moderate income families have never been able to generate sufficient patient reimbursements to cover costs. Annual grant support to subsidize operating deficits has continued to be essential long after HEW policy-makers expected it to "wither away" with the self-sufficiency derived from third party reimbursements.

Meanwhile, actual federal grant support has become increasingly limited. Federal funds that were initially designated for community health programs have shifted since the 1960s toward other priorities. Scarce private philanthropy is being tapped by many other fields of human services. The major national sources of primary care funding—the federal government and the Robert Wood Johnson Foundation—have shifted more and more of their CHC funding from independent community organizations to hospitals.

**Incentives for Hospitals**

The Health Professions Education Assistance Act of 1976 (PL 94-484) tied federal capitation support for medical schools to training for primary care, mandating that an increasing proportion of medical postgraduate training positions be devoted to primary care specialties. The teaching of primary care requires patients who need primary care and the settings in which to provide it. The Act also offers further incentives for teaching hospitals and medical centers to become more involved in primary care. The legislation authorizes special project grants to medical schools and hospitals to develop family medicine departments and residencies and general internal medicine and pediatric residency programs (8).

For the first time in the 1980 Federal Budget, Public Health Service funding was designated for ten Hospital Affiliated Primary Care Centers. In the January 1981 budget request sent to Congress, more than $30 million would be allocated to these centers and other community hospitals for primary care services. The revised budget (March 1981) calls for a $10.1 million reduction for CHCs from the original $374 million requested in January.

The Johnson Foundation, largest single source of health care dollars outside the federal government, has concluded from their experience in funding several autonomous urban and rural health centers that independent CHCs cannot survive without ongoing operational subsidy. Because the Foundation is in-
interested in planting seed money, not indefinite subsidization, they have created an alliance with HEW to identify and jointly fund hospitals to develop community ambulatory care programs. In addition, the Johnson Foundation is funding 15 teaching hospitals to develop group practices within re-organized outpatient departments to provide primary care.

Hospitals need clinical sites for their growing numbers of primary care residents in order to provide patient care experience and respond to increasing demands upon their outpatient facilities. As one alternative they could, of course, send these residents to the health centers under supervision by senior physicians. For their part, health centers can utilize affiliation with teaching hospitals for economic support and to attract well-trained young physicians. But, rather than create and strengthen links between community-based health centers and the hospitals, the new funding incentives are mainly leading to a reorganization of hospital-based ambulatory care.

Thus, the delivery of primary care is becoming consolidated within the hospital sector, both by virtue of patient utilization patterns and the incentives of funding. What difference does this make? Why should primary care not be delivered by hospitals, rather than community-based facilities?

Community Advantages

The differences are important. First, community participation in the organization and delivery of services will be all but lost. Participation of consumers in local, community-based health services has often increased their responsiveness and acceptibility to the community. Although certainly no panacea, at their best the community boards have facilitated a dynamic collaboration between medical professionals and consumers that is rarely repeated in the hospital hierarchy. The providers in a health center are not dependent upon individual patients for their income, as in private practice, but they are dependent upon patient approval. One dentist was dismissed from a health center because, in the director's words, "my Board members told me he hurt when fixing their teeth."

Second, CHCs have been able to document superior performance in providing certain kinds of care, better than either hospital-based or private practice physicians. CHCs, for example, secured better patient compliance in controlling hypertension and ensuring immunization (9). CHCs have reduced infant mortality rates through earlier, more comprehensive prenatal care and reduced the incidence of rheumatic fever through prompt identification and treatment of streptococcal infections in separate studies (10, 11).

Table 2

Outpatient Visits by Type of Facility, 1975

<table>
<thead>
<tr>
<th></th>
<th>No. facilities</th>
<th>No. visits</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boston</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>24</td>
<td>4,280,603</td>
<td>71%</td>
</tr>
<tr>
<td>Free Standing Clinics</td>
<td>38</td>
<td>1,211,353</td>
<td>20%</td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>26</td>
<td>506,095</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88</td>
<td>5,998,051</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Massachusetts</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>109</td>
<td>6,626,247</td>
<td>64%</td>
</tr>
<tr>
<td>Free Standing Clinics</td>
<td>281</td>
<td>2,690,660</td>
<td>26%</td>
</tr>
<tr>
<td>Community Health Centers</td>
<td>48</td>
<td>1,029,352</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td>10,346,259</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Total outpatient visits, including Emergency Room

The reasons for success in treating conditions that require behavior change may well rest on the health center's employment of community residents. The social and personal network of relationships between staff and patients provides information and support that is relatively scarce in hospital settings.

One Boston health center administrator recently recounted the story of a 14 year old pregnant teenager who came with her mother to the family planning counselor. The girl wanted to keep her baby, while the mother insisted that she have an abortion. "Our receptionist knew the family as friends and neighbors," the administrator said. "She confided in the family planning counselor that the mother had her first child at age 14 and wanted desperately to avoid that situation for her daughter. With that history in mind, the counselor could help reconcile mother and daughter in a mutually understanding and supportive relationship, whatever the outcome of the pregnancy."

Third, primary care delivered in a hospital is likely to cost more and use more complex ancillary services than if provided in a community setting. Research has indicated a strikingly higher frequency of diagnostic tests on outpatients in teaching hospitals, even when differences in case mix are taken into account (12). The presence of interns and residents results in both increased use of ancillary services and lower productivity, both of which add to the cost of delivering care. Even those hospitals which have reorganized outpatient services into primary care groups apparently have not reached the productivity or efficiency goals set by HEW for federally-funded CHCs. A recent report on the Community Hospital Program funded by the Johnson Foundation offers data indicating high costs and low productivity in hospital-based programs (13). The average cost per visit in the second grant year of the program was $47.27; the average charge per visit was $19.32. Medical visits at these primary care centers were heavily subsidized — costs were too high to be borne by patient reimbursement alone. The average visits per full-time physician in those hospitals with the longest running programs (25-36 months' operation) was 4,055, still short of the 4200 visits per full-time physician standard set by HEW for CHCs.

More broadly, all levels of patient care—even primary care—in a teaching hospital are likely to be guided by teaching and research goals. Continuity of care cannot be achieved if the availability of any one physician depends upon his or her training rotation. Poor people have traditionally paid their way in such institutions by serving as subjects for teaching and research. A hospital's priority to keep its beds filled, too, would affect the nature of the primary care it provides.

Finally, CHCs have a real track record in innovation and responsiveness to broad environmental and public health issues as opposed to the more medically-oriented hospitals. After all, health centers rose as alternatives to the indignities of the hospital outpatient departments. Health centers have pioneered such innovative approaches as case management, the use of family health workers and other paraprofessionals, and the primary care team approach to patient care. They have also often linked health care with other social and human services. Many have stimulated community organizing to respond to social and political sources of disease in a community. One Boston health center, for example, has just added a staff position of Environmental Health Worker. In others, Family Health Workers have sought out high risk patients and residents who would not ordinarily receive health care at all and provided follow-up for those who would otherwise be forgotten or lost by traditional outpatient care.

Because they are relatively small and tightly knit, CHCs may be more responsive and innovative than hospitals. If innovation is defined as the ability to respond to a changing environment, then small organizations invariably make "mid-course" corrections more easily than large institutions.

For example, emergency room personnel in a large hospital in Massachusetts became
When the Department of Health, Education and Welfare began taking over centers from the Office of Economic Opportunity, the social reform aspects of the centers were threatened. The new concerns became cost-effectiveness, maximizing revenues and fiscal self-sufficiency.

aware that increased community capabilities in cardio-pulmonary resuscitation could improve the condition of presenting cardiac patients. Yet, the ER personnel, knowing they would have to transmit this information to the appropriate management level at the appropriate meeting for the request to be assessed, evaluated, and compared in light of the other demands on organizational resources, never pursued it. A good idea has a poorer chance of becoming reality in a larger, complex, highly differentiated environment than in a small cohesive unit where people naturally come into contact with one another. By the same token, bad ideas can be discarded more easily in a small organization before they become institutionalized.

CHCs offer more than superior primary care services to inner-city neighborhoods, important though that role is. They also continue to serve as testing grounds for innovation in the delivery of ambulatory health care and for implementation of progressive public health programs. Currently, teaching hospitals have developed a sudden interest in the limited primary care funding, awakened by the carrot and stick of federal dollars and aided by sympathetic HEW and private philanthropic policy-makers. If these trends in federal policy become more pronounced, then more and more primary care resources will shift away from community organizations toward the hospital. The result will be a delivery system that is more technologically sophisticated, more expensive, less innovative, less responsive to community needs, and less moved by larger environmental and public health issues.

In Boston, where each year the hospitals assume a greater share of the responsibility for delivering primary care, the trend may be only a harbinger of national trends. If so, in the nation’s poor neighborhoods, it is the community-based health centers themselves that are at risk.

—Rita D. Berkson

(Rita D. Berkson is the executive director of the Roxburg Dental and Medical Group, Inc., a community health center in Boston.)

References

Health planners across the country struggle with the mandate to close hospital beds, but without the authority. In Michigan, a unique and powerful business, labor and health industry coalition has united to put teeth into bed reduction efforts. Concern over mounting health care costs led the Big Three automakers, the United Auto Workers and Michigan Blue Cross/Blue Shield to win passage of landmark legislation in 1978. It specified a quota of beds to be closed in each HSA region, required HSAs within seven months to develop hospital-specific plans for these reductions and created power to enforce these cuts through the Certificate of Need process (2).

A plan for the Detroit area, which bore two-thirds of the state’s bed reduction quota, was completed in late 1979. It calls for closing over 2500 of Detroit’s hospital beds for a projected annual savings of $40,000,000. Although many providers and consumers alike regard it as a progressive and serious attempt to address a grave problem, reaction now threatens to stall the entire statewide effort. Local activists protest that the plan will close many inner city hospitals which are the main source of care for Detroit’s Blacks, and will throw nearly 9000 mostly Black hospital workers out of jobs in an area already plagued by over 26 percent minority unemployment. Meanwhile, small
Although they are no panacea, at their best community boards have facilitated a dynamic collaboration between medical professionals and consumers that is quite rare.

hospitals are incensed that they have been slated to bear the brunt of the cuts and have mobilized their communities to bring the bed reduction effort to at least a temporary halt. Across the country planners, community advocates, union and corporate leaders and civil rights activists are watching the outcome closely for portents of future health cutback plans in their own regions.

Background

The bed reduction effort can only be understood in light of rapidly rising Michigan health costs which have become a major political issue. The Detroit area alone has 77 hospitals, ten of which have more than 500 beds, including four “Galactica Memorials” in the 900-1,100 bed range. Fueled by overbuilding and overinvestment in expensive technology, the use rate of 1,153 patient days per 1,000 residents is among the highest in the nation, and 2.5 times that of many health maintenance organizations (3).

Blue Cross rate hikes exploded into a labor issue in 1976 when the UAW struck Ford Motors for six weeks, primarily to resist demands that the union give up its first-dollar coverage and institute a several-hundred dollar deductible in its insurance plans (4). UAW members now pay more than $1 per hour for health insurance, limiting potential salary or other fringe benefits. With over 300,000 unemployed members, the UAW has become increasingly sensitive to the financial problems of its employers.

In 1975, alarm over the state Medicaid budget led to drastic cuts in such “optional” Medicaid services as optometry and dentistry. A broad-based consumer coalition marched on the Statehouse and successfully restored Medicaid coverage. Medicaid costs have now risen to nearly 10 percent of the entire state budget, cutting into other needed services and increasing tax burdens on the public and to industry.

As a result of these events, state health officials met with business, labor and Blue Cross/Blue Shield representatives to draft a plan that would cut health costs while avoiding labor strikes over private coverage and politically troublesome turmoil over Medicaid cuts. The collective clout of business and labor led the Greater Detroit Area Hospital Council (GDAHC) to throw its weight behind a statewide bed reduction plan, which was enacted into law in 1978.

In accordance with the plan, Michigan’s Office of Health and Medical Affairs (OMHA—Michigan’s SHPDA) assigned reduction quotas to each health service area it deemed overbedded. Once OMHA’s criteria were approved by the Statewide Health Coordinating Committee (SHCC) and a joint committee of the legislature, HSAs were given seven months to prepare a bed reduction plan. Then, when these specific HSA plans were approved by the SHCC, no certificates of need would be approved unless they were consistent with the reduction plan. Hospitals targeted for major cuts would be unable to replace major equipment or make repairs needed to comply with licensing requirements. Thus a war of attrition would force targeted hospitals to consider closing, merging or consolidation.

The Commission

Over two-thirds of the state’s bed reduction quota fell to the Detroit-based Comprehensive Health Planning Council of Southeastern Michigan (CPHC-SEM). Instead of acting on its own, CPHC-SEM chose to establish a “Bed Reduction Commission” to carry out the state’s mandate. HSAs and all their committees are required by law to have consumer majorities and to broadly represent their communities. The Commission, however, was hardly a cross-section of Detroit life. It sported a 62 percent provider majority. Five of the 11 consumer members represented auto manufacturers. One represented a bank and one was a local Assistant District Attorney. Three were union representatives (including a UAW staff member who reported to the UAW national office—not to any of the locals) and only one representative from a community-based consumer group (5).

The Commission assumed an 11 percent

Continued on Page 25
Public hospitals have been suffering a slow death for the last twenty years. Some see our present economic crisis as threatening their existence altogether.

An active and increasingly coordinated resistance to these trends is now emerging, however. During the week of June 16, 1980, representatives from public hospital workers’ unions, community groups, consumer health activists, lawyers representing the poor community, health planners, physicians and public health academics from around the country met in Frederick, Maryland to discuss the plight of these financially troubled public hospitals. The conference was sponsored by the National Health Law Program and the Physicians National Housestaff Association. At the close of the conference, participants formed a new coalition—the National Coalition to Save Public Hospitals.

There was consensus among the conference participants that the future they face is pretty bleak. In the last several years, major public hospitals have been shut down in New York, Philadelphia, St. Louis and San Antonio. Equally serious, large cutbacks in services as well as transfers and outright sales of public facilities to corporate management firms have also become common. Although many of these attacks on the public sector have been accompanied by claims of supposed benefit by local government or public hospital management, the negative impact on access and quality of care for poor communities has been real. But, despite serious challenges by local groups, the severity of the deepening recession and fiscal crises of local governments seem to have conspired to assure that such protests fall on deaf ears.

There were examples of local victories cited at the conference, however. Ironically, one of the major examples involved not a public hospital at all, but a small, inner-city voluntary hospital in East St. Louis, Illinois. There, a broad-based coalition of religious groups, local politicians, legal service and legal aid lawyers, poor people and hospital workers unions successfully fought the planned closure of Christian Welfare Hospital, a voluntary institution serving a primarily Black inner city population.

The hospital management in this case had built a second hospital in the suburbs, allowing the facilities at Christian Welfare to deteriorate. In 1978, management applied to the local HSA to close Christian Welfare claiming that it was no longer financially viable. The community responded with a well coordinated effort to bring up the issue on as many fronts as possible:

- HSA staff were contacted by coalition leaders and educated about the effects of the closure on the community.
- Public hearings were planned and held concerning the closure. These were well attended by local physicians, consumers and hospital workers, largely due to advance work by coalition organizers.
- The Office of Civil Rights was brought in and the hospital management was threatened with a lawsuit over the disparate impact that closing Christian Welfare would have on the Black community. (The suburban hospital’s patient population was entirely white; Christian Welfare’s population was almost exclusively Black.)

The resolution came when management agreed to give the hospital to a group of Black, community physicians and paid $300,000 in damages for civil rights violations. The money has been used to upgrade the facilities and to transfer management.

Another example of successful resistance cited at the conference did involve a public institution—the City of Memphis Hospital (CMH). There, the city had a longstanding affiliation agreement with the University of Tennessee Medical School to staff CMH, which serves Memphis’s inner city. Over the years, the hospital had been chronically underfunded and understaffed. By 1977, the hospital had so deteriorated that the University demanded the city build a new hospital for the University. If Memphis did not agree with this plan, the University threatened to pull
out of the contract altogether, leaving CMH without a medical staff.

Again, a concerted effort was brought to bear on both city and county officials and on the University by a coalition of health and civil rights groups, religious leaders and labor unions. The coalition’s efforts were timed to peak during the process of contract renewal of the affiliation agreement. Recognizing the University’s interest in maintaining its access to a public hospital (source of much of the research and teaching cases it required), coalition representatives on the hospital’s board of trustees worked to write a model contract which would assure the continued existence of the hospital at its present location, staffing by the University and accountability by faculty doctors to their public hospital patients. Provisions of the contract included:

- The University was removed from the management of CMH.
- Invoicing procedures were implemented that would require faculty doctors to directly supervise their public hospital patients’ care before receiving payment for the services. (While it is hoped that this arrangement will improve the quality of care provided, it also essentially reestablished a fee-for-service arrangement between doctor and patient. The coalition fought to require a specific time commitment from the faculty but in the end was forced to compromise on this issue.)
- Transfer procedures were instituted which limit the ability of teaching faculty to move their private-paying patients from CMH to the private University Hospital.

At the same time, city and county officials were lobbied intensively to provide increased funds for the renovation of CMH. With the exception of the invoicing procedures, the coalition won virtually all of its demands. As the conference discussed the above and other possible resistance strategies, several points of agreement emerged. Community coalitions must be broadly based and pursue a wide range of strategies in the political, health planning and legal arenas. Communities struggling to hold on to their hospitals must not depend solely on the courts or HSAs to save the day, but should creatively use every opportunity for publicly airing the testimony of individuals from the affected neighborhoods and work force.

The National Coalition to Save Public Hospitals will meet with US Department of Health and Human Services Undersecretary Nathan Stark to submit testimony for the DHHS Task Force Report on Financially Troubled Hospitals. The following principles were proposed by the Coalition:

1. That the federal government take steps to insure the survival of public hospitals and private hospitals which serve the needs of the poor and minorities.
2. That as part of insuring that survival, there will be an infusion of federal dollars into public hospitals and private hospitals which serve the needs of the poor and minorities.
3. That the United States Department of Health and Human Services not adopt any policy regarding federal assistance to public hospitals and private hospitals which serve the needs of the poor and minorities until after it holds regional public hearings to get national consumer input.
4. That there be a moratorium on the closure of public hospitals and private hospitals which serve the needs of the poor and minorities until such closures can be demonstrated conclusively to have no detrimental impact.

The Coalition is working to form a network of activists around the country to share information and strategies, and to create access for local communities to lobby federal officials. For more information, readers should contact Dorothy Lang at the National Health Law Program, 2639 South La Cienenga Blvd., Los Angeles, California 90034 (213-394-4811).

Perhaps due to the always superior perspective of hindsight, the one issue that seemed not to have been sufficiently explored at the conference was the scope of the Coalition’s concern itself. The Coalition’s title suggests that its only concern is with public hospitals. Yet, as the East St. Louis case demonstrates—and the Coalition’s proposed principles for federal action confirm—the plight of inner city and rural public and small voluntary hospitals are more alike than different. A “National Coalition to Save Hospitals Which Serve the Poor and Minorities” is a strategy whose time is overdue. The approach would indicate both broadening the focus of concern and reaching out to voluntary hospitals’ constituents, workers and unions. Considering the magnitude of the problem and the lateness of the hour, such an opportunity to widen the base of support for those struggling for poor people’s health care ought to be a welcome one.

—Kate Pfordresher
THE SUPREME COURT'S BENZENE DECISION: A TERRIBLE DUTY IS BORNE

The U.S. Supreme Court has rewritten the Occupational Safety and Health Act, inserting the words "significant risk" into the Act where nowhere in the law's 30 pages of fine text did they previously appear.

The Supreme Court's action came as part of its recent landmark decision overturning the new benzene standard set by the Occupational Safety and Health Administration (OSHA) of 1 part per million in air, returning American workers to the old, less protective standard of 10 parts per million (ppm). In so doing the Court's main decision on benzene was actually signed by only a plurality of four of the nine Justices (Stevens—who wrote the decision—Burger, Stewart and Powell), with the fifth and decisive vote cast in support of the plurality's action by Justice Rehnquist. (Living as he does on his own legal moonscape, Rehnquist chose to write his own decision, declaring as a minority of one that the entire Section of the OSHA Act at issue was unconstitutional.)

The Results of This Decision Are Far Worse Than at First Thought

Nevertheless, I believe that this decision to rewrite the standards-setting sections of the Act, while trying to hide from workers and the public the sweeping nature of the change, was a legal and political compromise by the Court which will be with us for many years to come. Thus, for those of us who are actively involved in trying to protect the health and safety of U.S. Workers, the decision and its implications deserve careful attention.

The Secretary of Labor's broad authority to promulgate health and safety standards and the criteria which these standards must satisfy are succinctly stated in Section 6(b) (5) of the Act:

"The Secretary, in promulgating standards dealing with toxic materials or harmful physical agents under this subsection, shall set the standard which most adequately ensures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity even if such employee has regular exposure to the hazard dealt with by such standard for the period of his working life." (My emphasis).

This section sets a high standard for worker health protection. OSHA, through its standards, not only should protect each worker from disease but from loss of functional capacity (such as lung function or kidney function), without necessarily being required to show that the loss of functional capacity represents the onset of a disease or will lead to a disease.

OSHA's use of these standard-setting powers is restrained by the requirement in this Section that the regulated impairment be "material." (The original version of this Section of the OSHA Act said that a standard should protect against "any impairment," but after much debate Congress changed this...
to protection against "material impairment."? It is noteworthy, particularly in light of this Supreme Court decision, that Congress in debating this phrase chose the broader, more encompassing term "material impairment," rather than any of the large number of obvious, but more explicitly value-laden alternatives such as "significant" or "serious."

But the chief restraint on OSHA in this Section is that the standard must be "feasible." This word is not specifically defined anywhere in the Act, so its use obviously leaves OSHA free to consider technical feasibility, economic feasibility or both with setting a standard.

This broad requirement of feasibility, which OSHA has been interpreting in ways unsatisfactory to industry in recent years, must be reconciled, the Supreme Court says, with the definition of a standard given in Section 3(8):

"The term 'occupational safety and health standard' means a standard which requires conditions, or the adoption of practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment." (My emphasis.)

The new means of reconciliation are to be found in the Supreme Court's guideline "significant risk":

"By empowering the Secretary to promulgate standards that are reasonably necessary or appropriate to provide safe or healthful employment and places of employment, the Secretary must make a finding that the workplaces in question are not safe. But 'safe' is not the equivalent of 'risk-free.' There are many activities that we engage in everyday—such as driving a car or even breathing city air—that entail some risk of accident or material health impairment; nevertheless, few people would consider these activities 'unsafe.' Similarly, a workplace can hardly be considered 'unsafe' unless it threatens the workers with a significant risk of harm.

Therefore, before he can promulgate any permanent health or safety standard, the Secretary is required to make a threshold finding that a workplace is unsafe—in the sense that significant risks are present and can be eliminated or lessened by a change in practices." (Emphasis in original).

This was bad enough—but then, in an act unusual in any US court, the Supreme Court delved into the scientific record presented by OSHA and argued that OSHA didn't prove that the original benzene threshold of 10 ppm presented a significant risk. The Court specifically criticized OSHA's cancer policy, especially its "assumption" that human cancer agents have no threshold below which exposure to them is safe.

The Court went on, phrasing its argument in "Nixonian terms,

"In this case the record makes it perfectly clear that the Secretary relied squarely on a special policy for carcinogens that imposed a burden on industry of proving the existence of a safe level of exposure, thereby avoiding the Secretary's threshold responsibility of establishing the need for more stringent standards. In so interpreting his statutory authority, the Secretary exceeded his power."

Since the Secretary of Labor did not show that the old standard presented a "significant risk," the Court was able to avoid the necessity of ruling on the standard's cost-benefit implications.

"Extraordinarily Arrogant and Unfair"

Justice Marshall's minority
opinion, joined by Justices Brennan, White and Blackman, criticizes the Court's decision in unusually harsh and personal terms:

"The plurality's discussion of the record in this case is both extraordinarily arrogant and extraordinarily unfair. It is arrogant because the plurality presumes to make its own factual findings with respect to a variety of disputed issues relating to the carcinogen regulation... It should not be necessary to remind Members of this Court that they were not appointed to undertake review of adequately supported scientific findings made by a technically expert agency. And the plurality's discussion is unfair because its characterization of the Secretary's report bears practically no resemblance to what the Secretary actually did in this case."

Marshall argues that the plurality's decision in reviewing the scientific record ignores extensive evidence in the hearing record of chromosomal damage, aplastic anemia, and other non-cancerous blood disorders at levels of 10 ppm or less, evidence that these changes are early precursors of leukemia, and evidence regarding leukemia incidence itself. In any case, Marshall argues, the Court is not asked to judge whether or not the evidence is true, but whether, in the words of the judicial review of provisions of the Act, they constitute "substantial evidence (of harm) in the record considered as a whole." They obviously do, he concludes.

Marshall is also contemptuous of the plurality's legal scholarship:

"According to the plurality the definition of occupational safety and health standards as those 'reasonably necessary or appropriate to assure safe or healthful working conditions' requires the Secretary to show 'more likely than not' that the risk he seeks to regulate is a 'significant' one. The plurality does not show how this requirement can plausibly be derived from the 'reasonably necessary or appropriate' clause. Indeed the plurality's reasoning is refuted by the Act's language, structure, and legislative history, and it is foreclosed by every applicable guide to statutory construction. In short, the plurality standard is a fabrication bearing no connection with the acts or intentions of Congress. The significant risk approach is particularly embarrassing in this case, for it is contradicted by the plain language of the Act."

Marshall then goes on to show that the Secretary indeed considered and satisfied the requirements of the Act that the standard be necessary or appropriate, the harm material and the remedy feasible.

Why would the Court rewrite the standards-setting section of the Act and then stumblingly try to judge the scientific issues raised in this standard? In part, one suspects, the Court took the unusual action of getting into the scientific issues because it wished to avoid grappling later with the even thornier problems surrounding the standard. Marshall and his colleagues suggest an even broader motive: "The plurality ignores the plain meaning of the Occupational Safety and Health Act of 1970 in order to bring the authority of the Secretary of Labor in line with the plurality's own views of proper regulatory policy." And these views in turn are "based only on the plurality's solicitude for the welfare of regulated industries." (My emphasis)

These are strong and personal judgements by the four minority Justices — and they ring true. For public health people, of course, the decision also represents a sharp break with preventive aspects of occupational safety and health. A standard effectively can not be set until a count of dead or wounded bodies can be made— that is, until after the fact of harm to at least some workers.
Scientists and professionals, in alliance with workers and their unions, can help shape events in health and safety and to a lesser extent in other social and economic areas.

There's a Power

Where does this decision leave us? First of all, despite the sharp words and solid argumentation of Marshall and associates, the benzene ruling stands.

Further, on the basis of the new significant-risk test for standards, we can expect attempts by various industries to re-open appeals contesting earlier OSHA standards, as well as new legal tests of OSHA's authority. OSHA's Cancer Standard, one of the agency's main advances in recent years (see BULLETIN No. 79), appears to be struck down by the Supreme Court even before it has met its first legal test. This legal defeat can be expected even further to weaken Congressional resolve on worker health issues—a weakness reflected in significant new Congressional support for the Schweiker Amendment. The Schweiker Amendment guts the OSHA standards-enforcement process, in complement to the benzene decision which guts the standards-setting process (see BULLETIN, Vol. 11, No. 4).

Let us not forget, while discussing the very real impact of the courts and Congress on health and safety, that the driving force behind the actions in both these arenas is industry's onslaught against OSHA. This is not new. What is new is the intensity with which industry is now peddling its case to the courts, the Congress and the general public—as if OSHA and government regulation in general were the cause of America's economic crisis rather than the cumulative effects of the U.S. industry's pursuit of short-term profits and its weakening grip on the economies of other, smaller countries.

But workers and the labor unions that represent them are not powerless in the face of industry's drive against health and safety (and against whatever else impedes their short-term profitability). By virtue of their organization and their roles in production and in everyday life, workers can and do shape local and national policies to some extent, although more by responding to industry initiatives than by initiating programs of their own.

A measure of this power is the relative strength of the administering agencies, OSHA and NIOSH, in contrast to the agencies administering the Toxic Substances Control Act and other environmental legislation. The environmental movement, with its very large base of support among middle class publics, is not well organized as a movement and hence has a hard time, after getting good laws passed, forcing Congress to appropriate funds to administer these laws.

OSHA, on the other hand, has organized labor movement and its local affiliates to lobby legislators and (successfully, so far) fight against cutbacks in the agency's annual Congressional appropriations. And, as those who have contact with working people on health and safety issues know, workers are quite concerned about their health and safety on the job and will not take serious attacks on OSHA lying down. For example, workers in many shops were and are quite angry at attempts to pass the Schweiker bill. The reason for the bill's defeat so far has been the expression of that anger at demonstrative public meetings and Congressional hearings, which has apparently surprised the so-called Congressional moderates who initially supported it.

Scientists and professionals who work with workers on health and safety (and other social and economic issues) are not doomed to defeat as are, unfortunately, many who work with equally deserving, but weaker and less well organized groups. Despite adverse Supreme Court decisions and weak-willed Congressional allies, workers are capable of defending their interests in health and safety against attacks by Democratic or Republican administrations.

Many professionals like myself who are working with workers and their unions are beginning to understand this more clearly than in the past. We know that in alliance with workers we can help shape events in health and safety and to a lesser extent in other social and economic areas. This of course involves hard, long-term struggles. And success is not assured, although the odds for success are at least reasonable. Then again, who ever said change would come easily?

David Kotchuck
CONSUMERS UNION GROWS IN THE BRONX

In the fall of 1979 a diverse group of health care workers at the Bronx Municipal Hospital Center joined together over the ongoing issue of real and threatened cutbacks of services at the hospital. Over the past few years health care workers in the Bronx have witnessed a dramatic decline in health care services for the elderly, the working poor and the unemployed. It appeared that functioning community health services were being systematically dismantled, and that staff and funds for remaining facilities were becoming impoverished, crowded and marginally effective in meeting the health needs of the Bronx.

General staff reductions at the BMHC created problems at all levels in the hospital, but were particularly felt by the nursing staff. Working conditions had so deteriorated that recruitment of nursing personnel was even more difficult than usual. Nursing shortages led to closing of ward beds, producing a declining census and the inevitable decrease in appropriations for the following year's operating expenses. Thus loomed a vicious cycle of poor conditions generating its own next round of problems.

Erosion of hospital services also affected relations among staff groups at the hospital. As overwork progressed, each overworked group resisted out-of-title labor assignments, which bounced from nurses, to housestaff, to social workers, to ancillary services in an ever-widening spiral of resentment. It became apparent how crucially interdependent all health worker roles are and how, when any one service was restricted, all services suffered.

Combined with the fact that, as further cutbacks occurred, the anonymous anger of patients towards the health care system became more manifest, we were forced to contemplate that the cutbacks and restrictions would mean in terms of our own work and our ability to provide high quality health care to our patients.

It also became apparent that if the BMHC was to maintain its high standards of service and remain an excellent city hospital, the support of the community of users would be essential.

Medicare/Medicaid—which practically affect the actual day-to-day quality of health care services. Through a consumers union, not only would the interests of the users of the health care system be represented, the hospital would also, in some cases, gain an ally in protecting vital health care services for the people of the Bronx.

With the goal of building a BMHC Health Consumers Union, the Consumers Union Support Alliance (CUSA) was formed to raise funds and facilitate the initial development of a consumers union. Membership in the support alliance was drawn from all levels of health care workers at the hospital as well as from faculty and students of the Albert Einstein College of Medicine (the medical school affiliate of BMHO). Funds were
As a political organization, a consumer union could focus on the multiple systems which affect the day-to-day quality of health care services raised, and, in December 1979, the support alliance hired Joyce Dattner, an experienced community organizer working full time for the Association of Better Communities (ABC), to begin the task of organizing a BMHC Consumers Union.

With the support of CUSA, Joyce began a Consumers Union membership drive in February 1980. Leafletting, knocking on doors, follow-up phone calls and visits, meetings in churches, community health centers and other community settings have all met with encouraging responses. To date, 76 families have joined the union and paid the $10 family membership fee ($1 for senior citizens). A goal of 150 family memberships has been set for August of this year.

The first meeting of the Bronx Health Consumers Union (BHCU) was held May 17, 1980, at the Sound-View Presbyterian Church. An organizing committee was formed to take special responsibility for building BHCU by signing up new members, meeting with other organizations and making decisions regarding fundraising.

Major health care issues which individual hospital users and community groups have expressed an interest in confronting so far include transportation services to and from the hospital, ambulance service in the community, and hospital waiting times. When the union reaches this goal of 150 members, it will begin actively negotiating for changes in these areas.

The union has the help of Fran Costa, a full time professional advocate at City Hall employed by ABC, who has begun to explore the political terrain in which the union will be struggling. The Advocate's Office of ABC will help the union in its campaign for recognition and economic representation by pressing politicians to represent the health care interests of the union membership who live in their districts. One of the immediate issues to be taken up involves the possibility of re-routing the bus services in the Bronx to facilitate travel to the hospital. This issue is now being studied with the help of staff from the Bronx Legal Aid Society.

Other union activities include the organization of a package of specific benefits for union members such as dental benefits and discounts at local stores. Joyce has also met with the Patient Relations Office at BMHC in order to clarify the mechanics of patient advocacy as a union benefit. Another area of benefits concerns the exciting possibility of courses in various areas of health care and health sciences offered to BHCU members by CUSA members and supporters.

The support alliance at BMHC has been growing in step with the union, gathering new people, ideas and resources. To date CUSA has raised over $3,000 for the financing of the initial development of the Consumers Union. Fundraising parties, softball games, films and individual pledges have all contributed to this base of support. Currently there are approximately 100 people who have contributed to and/or joined the Support Alliance.

This summer, in conjunction with the Department of Community Medicine at Albert Einstein College of Medicine, the Support Alliance is offering a summer elective course for freshman medical students. The students will work with Joyce Dattner in community organizing activities, while also engaging in research on health care policy-making as it affects consumers and providers in the Bronx. Four students have signed up for the elective, and the medical school has agreed to provide funds for their support.

CUSA has also contacted a number of public and private interests with regard to future help in fundraising and media work. The Committee of Interns and Residents (CIR) has given its support to the union and is considering doing joint work with CUSA and the union.

The building of the BHCU provides an opportunity for health care workers and the consumers of health care services to exchange ideas about what is important in health care and to work together to see that the right to good health care for all is maintained. The experience has been rewarding for the individuals who have participated, and we look forward with optimism to the continued building of the BHCU. If you would like further information the Consumers Union contact Bette Braun at 250 West 104th Street, New York, New York 10025 (212-663-5056).

—Susan Massad, M.D.
(Susan Massad is Director of the Medical Clinic at BMHC.)
The Unkindest Cut of All

Continued from Page 16

reduction in the hospital use rate, down from 1,153 to 1,000 patient days per 1,000 residents. It then made adjustments to account for higher use rates in poor neighborhoods and calculated the number of beds needed by each subarea of the CHPC-SEM region.

The Commission then developed a complex rating system, giving hospitals either positive or negative points depending on how well they scored on over 50 different criteria. Hospitals in each subarea were then assigned to three categories depending on their total score. Each category was assigned a specific percentage of its beds which had to be cut. Some hospitals were assigned reductions of nearly 90 percent, virtually guaranteeing their closure. Other hospitals were assigned reductions of 15-30 percent (which might still force closure in a small hospital). The most successful hospitals

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were slated for token reductions of five percent. By using these very large and small reductions, planners hoped to force hospitals to bargain with one another for consolidations, mergers and shared services.

Reduction Criteria: The Book of Numbers

The fight over review criteria became the first test of power on the Bed Reduction Commission. Consumers initially suggested an entirely different approach, based on hospital occupancy rates. They reasoned that facilities with many empty beds could be cut or closed with the least disruption in services. Moreover, they argued, these hospitals were also the least cost-effective because of the excess capacity they had to support. This approach would have worked against many of the large, politically powerful hospitals which had low occupancy rates, however. Thus the GDAHC and business representatives opposed this strategy and it was dropped.

The Commission instead opted for a scoring system which would target hospitals for cuts. The system used over fifty review criteria to measure hospital performance. Categories of criteria and their relative importance are shown in Table 1 below.

Table 1
Relative Weighting of Measures of Hospital Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of Points on CPHC-SEM's Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization (6)</td>
<td>25.29</td>
</tr>
<tr>
<td>Hospital Size and Physical Plant</td>
<td>16.95</td>
</tr>
<tr>
<td>Financial Management and Operations</td>
<td>12.93</td>
</tr>
<tr>
<td>Medical Staff Qualifications and</td>
<td>12.93</td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Planning and Services</td>
<td>5.75</td>
</tr>
<tr>
<td>Hospital Heavily Used by HMO</td>
<td>4.60</td>
</tr>
<tr>
<td>Access for Poor and Minorities</td>
<td>4.60</td>
</tr>
<tr>
<td>Majority of Medical Staff is Black</td>
<td>3.45</td>
</tr>
<tr>
<td>Governing Board Community-Based</td>
<td>3.16</td>
</tr>
<tr>
<td>Training Program</td>
<td>2.87</td>
</tr>
<tr>
<td>Geographical Access</td>
<td>2.30</td>
</tr>
<tr>
<td>Accreditation</td>
<td>1.72</td>
</tr>
</tbody>
</table>

Although any such scoring system will be controversial, the source of anger among poor and minority groups and small hospitals is immediately apparent upon closer examination of what was included, and excluded, from the hospital performance criteria.

Information key to directly assessing the quality and efficiency of hospital care was omitted from the criteria. Thus the Commission could have demanded outcome (mortality and morbidity) data by casemix, either from the hospitals or from the PSRO. It could have sought other internal measures of quality such as proceedings from hospital tissue, morbidity and mortality and infection control committees. It could have looked at malpractice suits or hospital disciplinary actions against careless or incompetent physicians. Instead, the Commission opted to use a variety of size and utilization measures as surrogates for quality and efficiency.

Similarly the Commission worked without the benefit of patient origin data broken out by race or source of payment, upon which any serious examination of accessibility must be predicated. This could have been obtained from hospitals or from discharge abstracting services which regularly compile it.

When the hospitals adamantly opposed releasing such direct data on quality, efficiency and accessibility, the Commission refused to challenge their resistance. Planners complained they could not handle such complicated issues in the short time allowed them to develop the bed reduction plan. "We're captives of the data," said one leading advocate, voicing the planners' universal plaint.

Although lack of data may prove to be the most serious flaw, biases in many of the hospital performance criteria used support the critics' case.

Utilization

Although a chief objective was achieving an 11 percent decline in patient days, the plan weighted a short average length of stay (15 points) worth less than, for instance, a large parking lot (20 points). Downplaying the length of stay aided the large hospitals with longer average stays (and more complex cases) at the
expense of community hospitals with simpler cases.

The criteria set minimum utilization standards for different services within the hospital such as obstetrics (1500 births per year) and open heart surgery (200 procedures per year). These were generally weighted in favor of high volumes and large services, assuming that size could be used as a proxy measure for high quality and cost efficiency. Not only do large services not assure quality or cost efficiency, however, but this assumption ignores such important issues as the contribution of nursing to quality care, the appropriateness of the setting to the condition being treated and the institution's actual track record in contrast to its level of medical capability. Without considering these, the effect is to increasingly consolidate all care into larger, more intense and expensive medical settings.

There are other serious problems with utilization standards. CHPC-SEM uses the federal standard of 200 or more open heart surgeries per year. This standard is based on the belief that a lesser number of surgeries is insufficient to maintain a high level of care, and is also not cost efficient. Recent reports of death rates for coronary bypass surgery in Chicago highlight the problems with this approach. Although all six hospitals reporting more than 200 procedures per year reported an "acceptable" death rate in the 3-5 percent range, five of the ten hospitals performing fewer than 92 annual bypasses also had acceptable death rates (7). Although many high-volume open heart units are relatively safe, the smaller units can be just as safe. Reliance upon federal dicta is no substitute for specific information about mortality rates at each hospital — information that CHPC-SEM should have demanded from the local PSRO.

Finally, the manner in which the Commission rated utilization permits no distinction between hospitals which barely fail to meet minimum standards and those far below them. Thus a 195-bed hospital is penalized as heavily as a 90-bed facility for failing to meet the standard of 200 beds. A hospital with 1350 births (90 percent of the obstetrical standard of 1,500 births per year) is treated identically with a hospital with 400 annual births.

**Hospital Size and Physical Plant**

Hospitals received credit for having more than 200 beds, for having pediatric units of 30 or more beds, complying with licensing requirements, and having a sound physical plant. Planners also defend these criteria by pointing to economies of scale which allow large hospitals to deliver care more efficiently. Community advocates point to other studies suggesting that economies of scale disappear for hospitals larger than 500 beds because of increased administrative inefficiency. They bitterly note that the flagship hospitals in the 900–1,100 bed range were not penalized for their size.

**Fiscal Management and Operations**

Hospitals received credit for having written conflict-of-interest policies for their directors, for having audited financial statements, and having costs comparable to other hospitals of the same size. Community hospitals objected to this last criteria, pointing out that they received no credit for having costs substantially lower than those of the giant tertiary care facilities. The larger hospitals were burdened with more expensive technology, higher staff-patient ratios, and greater debt services, making them far more costly for even simple care.

**Medical Staff**

Hospitals were rewarded if they could show approval by the Joint Commission on the Accreditation of Hospitals of their utilization review efforts and that the PSRO had delegated utilization reviews to the hospital. Yet the goal of an 11 percent reduction in patient days suggests the inadequacy of current review efforts—certified or not—in preventing needless admissions and surgeries. Rewarding ineffective review efforts seems pointless and contradictory.

The criteria awarded 50 points for each director of a clinical service who is board certified, a measure by which large hospitals with more services piled up many additional points. Because some "directors" provide no supervision whatsoever, there is no proven relationship between this criterion and quality of care. In fact, there is no proven relationship between many such "input measures" and the quality or outcome of care. Yet, as cited above, the Commission was unwilling to wage the battles necessary to truly assess outcome — the only true measure of quality.

Some small community hospitals provide excellent care and may be best suited for treating simpler conditions. Others have alarmingly high death rates, frequent malpractice inci-
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students and permissive standards for high-volume surgeons. The Commission could have used the quality issue to educate the public and put low-quality hospitals on the defensive. It had an invaluable chance to garner community support as the defender of the public's right to decent care—and discarded it.

Health Maintenance Organizations
Hospitals heavily used by an HMO were given eighty points — as much credit as hospitals could get for being totally accessible to the poor. The only hospital eligible for these points was one sponsored by the UAW and the auto industry.
Access for the Poor and Minorities

Accessibility was given little weight in comparison to other criteria. The planners also accepted whatever claims hospitals made at face value, even though they knew many hospitals were not accessible to the poor. Accessibility for the poor and responsiveness to community needs, a non-discrimination policy, a policy to treat patients regardless of ability to pay, and having a reasonable mix of women, minorities, and neighborhood residents on the hospital’s board ranked only as important or slightly more important than the size of a hospital’s parking lot!

A nondiscrimination policy is already required for hospitals to receive Medicaid or Medicare, and is often a meaningless document because of its weak means of enforcement. Commission members freely admitted that hospitals discriminate despite such promises but claimed they could not investigate real compliance (8).

The business-labor interests backing the plan made it difficult to raise access issues. The orientation was so strongly focused on cutbacks that shortly before the plan’s completion, the subcommittee dealing with access problems had only barely grasped the concept that some areas were medically underserved. Two weeks before the final public hearing, one Commissioner earnestly asked, “How do we have so many medically underserved areas in Detroit if we have so many doctors?” (9).

Even the access criteria favored the large hospitals. Hospitals received points if at least 30 percent of their admissions were Medicaid or county-funded patients. Yet they could also receive points merely by being in the top 25
percent of their subarea for total Medicaid admissions. Thus behemoth hospitals with thousands of admissions could admit a high absolute number of Medicaid patients while keeping their percentage of such admissions at a minimum. The five largest central Detroit hospitals averaged 552 beds and 15,183 admissions. The next five hospitals averaged 199 beds and 6,400 admissions. If the largest hospitals admitted one Medicaid patient for every four privately insured patients, the smaller hospitals would have to treat one Medicaid patient for each privately insured patient to receive any points in the rating scheme.

The remaining criteria related to unique treatment programs, presence of Black physicians on medical staff, health professional training programs, accreditation, and geographical accessibility of rural hospitals in the region. The net effect of the criteria was to severely squeeze small and medium-sized hospitals while assigning only token reduction requirements to tertiary facilities, as can be seen in Table 2.

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Hospitals</th>
<th>% Reduction Required</th>
<th>Mean Beds</th>
<th>Median Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
<td>5</td>
<td>5%</td>
<td>582</td>
<td>419</td>
</tr>
<tr>
<td>II</td>
<td>12</td>
<td>30</td>
<td>191</td>
<td>168</td>
</tr>
<tr>
<td>I</td>
<td>3</td>
<td>90</td>
<td>125</td>
<td>128</td>
</tr>
</tbody>
</table>

### A Small Circle of Friends

The reduction plan was written with the guiding hands and steady pressure of Ford, the UAW, and the GDAHC. Of these, the GDAHC certainly faced the most difficult task of all. Although local hospitals accepted the necessity of bed reductions in the abstract, Hospital Council staff members had to work hard to keep facilities from breaking ranks as the plan became more specific. The GDAHC issued its own report on bed reductions in 1977, a report remarkable in its scope and detailed analysis of the political implications of health cuts (3).

Although GDAHC's own efforts are unique in the field of private sector planning, its priorities are not. Despite rhetorical flourishes about access, quality of care, and displaced workers, the report is primarily concerned with money. Only two percent of the document is devoted to access, one percent to job rights and none of it to quality of care. Forty-three percent of the Hospital Council's reduction plan is devoted to finance, the problem of retiring

### Resource

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The standards used to measure hospital care and effectiveness took no note of which institutions had high death rates or quite frequent malpractice incidents

long-term debt and concern over the impact closures may have on future hospital bonding practices.

The Council's commitment to money is equalled only by its commitment to mammoth, technology-intensive hospitals. The Hospital Council's 1977 report announced its own implicit hit list two and a half years prior to the Commission's effort:

"As a purely hypothetical example, therefore, if it were assumed that all twenty-six hospitals with less than 200 beds were closed within a single year..." (Emphasis in the original) (3).

This "example" ceased to be hypothetical as the reduction plan developed. GDAHC Assistant Director Mike Elliott would comment at Commission meetings that "We all know which hospitals should be closed." When CHPC-SEM adopted review criteria closely mirroring GDAHC's bias in favor of larger facilities, several community hospitals felt the deck had been stacked against them.

Those who hoped for countervailing pressure from the UAW were disappointed. Commission insiders report that UAW health chief Mel Glasser never directly involved himself in the Commission and relied on GDAHC Director Sy Gottlieb for progress reports. Glasser was represented on the Commission by a UAW staff member who opposed any real consideration of access problems. Despite expressed personal misgivings, she pressed the UAW's demands for cost containment.

Although the UAW's resolve around cutbacks never wavered in the face of access considerations, reductions did take a backseat to the union's desire to protect Metropolitan Hospital, site of the UAW-auto industry-sponsored HMO. As the Commission considered the final reduction plan, the UAW joined the chorus of advocates from dozens of hospitals crying, "The plan is great...but exempt our hospital!" The UAW ultimately threatened to oppose the plan before the SHCC unless Metropolitan were exempted (10).

Small Is Beautiful

Small hospitals opposed the plan when they found themselves to be the prey. Among these are many osteopathic hospitals which tend to be smaller and which are slated for a 19 percent net reduction compared with a 14 percent for allopathic hospitals. One consumer bitterly defined "community hospitals" as "...any hospital which didn't like its reduction responsibility." Some community hospitals are inefficient, provide poor care, and are no more accessible than other facilities. Others provide a safe, low-cost alternative to the Star Wars medical technology used at tertiary hospitals. Because the plan failed to adequately consider cost, quality or access, the consumers and area politicians cannot distinguish between them.

Several hospitals quickly mobilized neighborhood groups in their defense. Because so much of the bed reduction effort relied on powerful corporate and union elites, CHPC-SEM failed to build community support for the reductions. This failure may prove fatal. Under tremendous community pressure, both houses of the Michigan legislature recently voted to suspend the reduction plan until an investigation is completed.

Black is Beautiful:
Mayor Young in the Middle

Looming over the entire bed reduction effort, although not directly involved in it, was Detroit Mayor Coleman Young. Young has fought to establish a pro-business climate without jeopardizing his political base in the Black community. The cutbacks caught him squarely between corporate demands for reductions and Black physicians who feared they would not get attending privileges at surviving hospitals if their hospitals are closed.

The planners needed federal aid to help pay off the long-term debts of hospitals targeted for closure and they needed Mayor Young to help them get it. Young's influence within the Democratic party and the Carter Administration put even more pressure on him to take a role in the reduction plan.
Young used his leverage to win de facto exemptions from the cutbacks for "historically Black" hospitals. Under his influence the Commission decided that hospitals with a majority of Black directors be considered for exemptions if they merge or affiliate with other hospitals. Moreover, if an institution is considered to be "historically Black" by the (Black) Detroit Medical Society, and the NAACP, Urban League and the Southern Leadership Conference, it will be offered a de facto exemption. This move mollified many of the Black professionals and put community groups in Mayor Young's debt.

It did not, however, solve the access problem. Only two hospitals might be saved by this scheme and they account for only a small proportion of organized outpatient visits. Worse yet, the overtly political tone of the exemptions has triggered a backlash from suburban communities which will bear additional reductions as a result of the redistribution.

**Access: Ford Has A Better Idea**

Planners argue that Central Detroit is receiving less than its share of cuts because of the exemption of the Black hospitals and the allowances the plan made for greater use of inpatient care in poor communities. Nonetheless, activists and union officials who acknowledge the need for reductions are uneasy about the plan. They insist that the question is not \textit{whether} beds should be closed, but \textit{whose}. They point out that empty beds in hospitals with discriminatory admissions policies will do them little good.

Doubts about the reduction plan are hard to dispel. In addition to the plan's uninterest in access-related criteria, the plan suffers from a total absence of patient origin data broken down by race and source of payment. Without such information, those concerned with the problems of minorities, especially uninsured minorities, fear the worst. These grave questions have led some advocates to urge that no reductions take place until more is known about this problem.

All of these concerns prompted HEW's Office for Civil Rights to begin monitoring the effort in the fall of 1979. OCR officials worked with CHPC-SEM to resolve potential access problems. OCR's involvement was partially motivated by CHPC-SEM's refusal to demand that the hospitals release existing patient origin data. OCR hoped to use such information to identify those hospitals used most heavily by minorities and uninsured patients.

Civil rights advocates sought to correct some of the plan's deficiencies by including strict access criteria in all certificate of need reviews, extracting specific binding commitments from surviving hospitals applying for certificates of need to ensure that minorities and poor patients would be able to get medical care. CHPC-SEM staff, strongly backed by the UAW, objected to this approach, fearing that strict access criteria would interfere with the cutbacks by giving hospitals an excuse to resist access criteria as going "too far." Entry of OCR onto the Detroit bed reduction scene strengthened the demands of local advocates concerned about the impact of the cuts on minority communities. Their hopes were quickly shattered, however, when Ford VIP Jack Shelton met privately with HEW Undersecretary Nathan Stark and asked him to interfere with OCR efforts to protect minorities. When Shelton returned to Detroit crowing that Stark had disparaged the civil rights effort, CHPC-SEM cooled its efforts to appease OCR. Although CHPC-SEM refused to make access issues into criteria, they at least agreed to collect a small portion of the data OCR had requested. Clearly CHPC-SEM could be pressured to go much further, but OCR has been relatively silent since Ford's Jack Shelton went to Washington.

**Labor's Love Lost**

The Bed Reduction Commission attempted to provide safeguards to another major group affected by its plan—hospital workers. The plan
states that no closures will occur until retraining
and placement programs are in place and
that surviving hospitals must agree to give top
priority to workers laid off by the closing of
other facilities.

Hospital unions disparage the safeguards.
The provision giving priority to hiring dis­
placed workers is not binding on the hospitals.
Retraining and placement programs will be a
cruel joke for many entry level workers in
Michigan's depressed economy.

Meanwhile, in Washington, as federal aid for
reducing bed capacity was being written into
the 1979 Health Planning Amendments (11),
the American Federation of State, County and
Municipal Employees (AFSCME) which
represents 100,000 hospital workers won cer­
tain safeguards for displaced hospital workers.
Hospitals using federal funds would be re­
quired to supplement unemployment insur­
ance benefits and subsidize health insurance
while their workers undergo retraining and job
placement. This requirement poses a potential
obstacle to the Detroit plan whose advocates are
reluctant to make such a commitment.

CHPC-SEM, OHMA and GDAHC,' seeking
federal aid to pay off the debts of targeted
hospitals, conducted a high-level meeting with
HEW which was virtually chaired by Ford of­
icial Jack Shelton. Ford and GDAHC officials
objected that pending federal requirements
protecting the rights of displaced hospital
workers would make the closures too costly.

Although the Detroit Central Labor Council
testified that it would oppose any reductions oc­
curring until a job placement program was in
full swing, that commitment has not been
translated into action. Neither the UAW nor the
Detroit AFL-CIO officials present at the HEW
meeting objected.

The fight over employee protection will be a
major test of the UAW's commitment to social
justice and progressive domestic policies. It
would be ironic for the UAW, whose members
enjoy a negotiated plan which supplements
their own unemployment insurance benefits, to
oppose such protection for hospital workers
earning less than half the automakers' salaries.

In the meantime, these standards have be­
come mysteriously stalled. Insiders at Detroit
City Hall doubt that a Carter Administration
Labor Department would withdraw its promise
to the hospital workers without Mayor Young's
approval. They speculate that Young may have
demanded exemptions for the Black hospitals
in exchange for his intervention with HEW.

Trouble Ahead, Trouble Behind

The vagaries of politics make it difficult to
predict the final outcome of Detroit’s bed
reduction effort. Even as the original legisla­
tion was under consideration and a hospital
construction moratorium was in effect, the
University of Michigan pushed through approval
of an 1,100 bed replacement facility for the
UM Medical Center. CHPC-SEM opposed the
plan but OHMA collapsed under severe
pressure from UM alumni in the legislature.
Such political interference bodes ill for the
future. Legislators who initially supported
reductions have backed away in the face of
community pressure, suspending the plan until
an investigation by both houses of the Michigan
legislature is completed.

Should the plan be implemented, broad
outlines of its impact are nevertheless clear:

COSTS: The superb irony is that this massive
and disruptive effort may not reduce hospital
costs; it may well increase them. Conventional
planning wisdom favors consolidating care into
regional systems based in large tertiary institu­
tions, where it is assumed the highest quality,
most cost-efficient care is available. There is lit­
tle evidence supporting these assumptions.
Some community advocates cite studies
which argue that these “economies” disappear
in giant, inefficient bureaucracies.

Large tertiary care hospitals, with residency
programs or direct ties to a medical school,
moreover perform more poorly on a wide range
of “efficiency” measures. They are more likely
to have a greater debt structure because of
overinvestment in expensive technology.
Large hospitals also have a higher ratio of full-
Table 3

1978 Average Room and Board Charges by Hospital Group (13)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Type of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical School/Teaching</td>
</tr>
<tr>
<td>Normal Delivery</td>
<td>$196.04</td>
</tr>
<tr>
<td>Chronic Ischemic Heart Disease</td>
<td>234.53</td>
</tr>
<tr>
<td>Inguinal Hernia</td>
<td>193.80</td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Non-malignant Genito-urinary</td>
<td>195.38</td>
</tr>
</tbody>
</table>

time employees per patient (12), perform a greater number of tests, and charge more for them (13). Large hospitals answer that they treat more complicated cases and sicker patients who need more services but their defense does not stand up to scrutiny. When Blue Cross of Greater Philadelphia analyzed the paid claims tapes for 314,000 employees and their dependents for 1978, they found that hospital per diem charges and ancillary charges are often twice as great in tertiary hospitals as they are in community facilities (13). Walter McClure, an authoritative figure in

Table 4

1978 Average Ancillary Charges per Admission (13)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Type of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical School/Teaching</td>
</tr>
<tr>
<td>Normal Delivery</td>
<td>$1,129.99</td>
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<tr>
<td>Chronic Ischemic Heart Disease</td>
<td>4,740.77</td>
</tr>
<tr>
<td>Inguinal Hernia</td>
<td>1,111.42</td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Non-malignant Genito-urinary</td>
<td>1,113.28</td>
</tr>
</tbody>
</table>
Standards used for closing facilities made no note of those most accessible to the poor and minorities. In fact, accessibility ranked just above the size of a hospital's parking lot

excess bed discussions, recently compared metropolitan hospital systems. His findings suggest that:

"Direct capacity reduction could force out the wrong hospitals... the most efficient metropolitan hospital system (may be) comprised of mainly moderate-sized 'front-line' hospitals backed up by a very few 'full service' medical centers offering the more specialized tertiary services... This guideline suggests that, from the standpoint of efficiency consistent with high quality, we should constrain the number and growth of 'full-service' tertiary institutions and emphasize more moderate-sized 'front-line' hospitals" (15).

These two studies raise the troubling thought that after creating access problems for inner city residents and displacing 9,000 hospital workers, the net effect of the reductions may be the opposite of that intended.

ACCESS: There is a real threat of serious access problems. Some of the same crises leading to the reduction plan also make health cuts risky. The closure of city-owned Detroit General Hospital and the threatened sale of the city's DetroitReceiving Hospital to a consortium of private hospitals may deprive Detroit's poor of their most certain sources of care. The most disturbing hint of potential access problems is the disdain planners had for the issue until they were criticized by civil rights groups and community organizations. Four months after promising to study access problems, CHPC-SEM still has not obtained or analyzed patient origin data. The reduction plan has also ignored the effect closures will have on primary care sites such as outpatient departments, emergency room treatments, or the location of physicians' offices. CHPC-SEM Director Terence Carroll went so far as to tell HEW officials that the reductions are solely for inpatient activity, and that "Hospitals don't admit patients... doctors admit patients. This plan has nothing to do with doctors' offices."

Inpatient cuts may also overload long-term care facilities. Some hospitals will react to a limited bed supply by controlling unnecessary admissions and surgeries. Others will work to reduce the present length of stay. There is already a strong financial incentive to discharge patients early since the latter days of a patient's stay generate little revenue beyond the hospital's per diem charge. This encourages rapid discharge of postoperative patients to make room for new, more lucrative surgical patients. Because Medicaid pays less for care than does Medicare or private insurance, Medicaid patients will be discharged most quickly of all. Detroit's long-term care industry is not in a position to care for many postoperative patients. The shortage of long-term care beds is already so severe that some areas nursing homes are illegally demanding substantial private "payments" before admitting Medicaid patients.

As in every other arena, minorities and Medicaid patients will face the greatest barriers in obtaining nursing home care. A recent survey in Philadelphia revealed tremendous discrimination against Blacks and Medicaid patients in nursing homes (16). Similarly, Memphis activists are suing hospitals whose discharge workers regularly refer white patients to skilled nursing facilities while steering Black patients to board and care facilities with little nursing supervision (17).

As one activist summed it up, "The planners behaved as though hospitals existed in a vacuum. They ignored ambulatory care and long-term care. Somewhere, the 'comprehensive' got left out of 'health-planning'."

JOBS: Uncertainty about how many (and which) hospitals will close also complicates projections about unemployment. AFSCME points out that planners' projections of attrition based on historically high turnover among hospital workers may be meaningless in the midst of Depression-like conditions. Hospital workers may well cling to their jobs, leaving displaced employees out in the cold with thousands of other jobless Detroit residents.

Planning and the Dilemma of Community Support

Hospital administrators who support reductions in the abstract become less public-spirited when their own facilities are targeted.
Michigan hospital administrators have suddenly embraced community-based planning. They have not become born-again populists. Their conversion to democratic planning reflects their political judgement that the reduction plan has failed to gain community support. Community participation has long been the "soft underbelly" of health planning. HSAs have allowed questions of community values to become mystified by a series of abstract guidelines and formulae. Because few HSAs are seen as champions of the public good, it is relatively easy for hospital administrators to portray planners as cold-hearted number-crunchers with no respect for community values. Although it may be too late in Detroit, several lessons can be drawn for the future.

As agents of cost control, HSAs are in a difficult position. Consumers complain about the cost of care, but they are also concerned about accessibility, quality and patients' rights. Because few HSAs have worked on these problems, they have failed to garner the support that would see them through controversial reduction plans.

Had CHPC-SEM earned a reputation as a champion of the consumer, it might be harder now for the hospitals to rally consumers against its cost-cutting efforts. Planners who fail to earn the trust of community groups do so at their own peril, for given a choice between a CAT scanner and a planner, many underserved areas will opt for the former however marginal its services may be.

It is equally important that HSAs become champions of quality. The popular sympathy for nursing home reformers, women's health activists, and other consumer advocates suggests this tack will be richly rewarded with increased public support.

CHPC-SEM failed on all of these counts. In this respect it is probably no worse than most HSAs. Yet their failure to address access and quality of care, and to marshal community support may well doom their bed reduction efforts. Ironically, the words of the Hospital Council in its own bed reduction report may frame the issue best should an epitaph be needed:

"...attainment of the cost containment objective without equivalent concern for other health systems objectives revolving around quality, accessibility, organization, management, and comprehensiveness of health services is likely to prove self-defeating in the long run" (3).

**Disaster Planning:**

**Advocate-Planners in a Shrinking System**

As the medical industry's lobbying thwarts cost containment legislation, mounting fiscal pressures are steadily driving federal, state, and local governments to cut costs however they can. New York City, Chicago, St. Louis, and Philadelphia are "solving" this problem with a frontal attack on health care for the poor and through the forced closures of public...
hospitals. Hoping that private hospitals will begin treating the uninsured poor, these cities operate on what Cook County Hospital's Medical Director Quentin Young calls the "Marie Antoinette" theory of health care reform. It is absurd, Young charges, to believe that the poor who have had to scramble for the crumbs of underfunded public medicine will suddenly be allowed to feast on the cake of private sector largesse.

In addition to the direct assault on the poor, HCFA is grimly proceeding with its "omnibus bankruptcy method" of controlling its budget. Unable or unwilling to constrain the massive costs of unnecessary hospitalizations, surgeries, diagnostic tests and drugs, HCFA tries to tighten the screws on the amount Medicare and Medicaid pay for various procedures. These policies have led to a new syndrome of financially distressed hospitals. These hospitals are not facing bankruptcy because of mismanagement or overbuilding. Tragically, their troubles stem from their refusal or inability to close the doors on the poor. Of the twenty-four private hospitals which closed in New York City between 1974 and 1978, 86 percent were in or on the border of medically underserved poverty communities (18). A study of health systems changes in eighteen large cities from 1937 to 1977 found that hospitals in Black neighborhoods were three times more likely to close or relocate than were hospitals in white neighborhoods (19).

The planning arena may offer the least of three evils. The Detroit bed reduction plan was dominated by corporate and political elites indifferent to the poor. Nonetheless, the planning process is more public than private budgetary decisions. This offers advocates freedom to wrest concessions from those planning the cuts. Because advocate planners must prepare for defensive involvement in HSAs, they would do well to develop positive, offensive strategies which seek to translate the pressure to contain costs into efforts to reallocate resources.

One approach is to unite community and labor interests around plans which would reduce tertiary care capacity and reinvest the savings into primary care, prevention and home health efforts. Advocates of such "gain-sharing" programs assert that there is enough fat in the system for consumers to benefit from controlled costs and service improvements (20). The important political element in gain-sharing approaches is that it shifts the debate from fights over proposed public sector cuts to questions of resource reallocation. Residents of underserved areas, senior citizens, women's health groups, and others become a natural constituency for such programs.

Gainsharing approaches are also attractive to hospital workers because the plans concentrate on labor-intensive primary care and public health activities which create jobs for displaced hospital workers. Where planners shirk their obligation to ensure fair treatment for hospitals workers, they are inviting a firestorm of opposition. If unions decide that planning is a code-word for cutbacks, speedups, and lay-offs, trade union support for the planning program will evaporate.

Despite the high potential of gainsharing, advocates should proceed with caution. One planning expert observed that "Promises to substitute free-standing ambulatory centers have proven unreliable in many cases" (19). Even the highest-level HEW official responsible for the planning program has cautioned, "Promises of clinics appearing at some point in the indefinite future or undocumented assertions that there will be no unemployment among hospital workers are not enough" (21).

A gainsharing program in Detroit would require commitments from HCFA, the Michigan Department of Public Health, Blue Cross/Blue Shield, the UAW, and the auto manufacturers. The plan would require that half of the promised $40 million annual savings would be used to establish a comprehensive network of primary care, home health, environmental health and similar programs. Although such a program would be hard to implement, the rewards of broad-based political consensus around capacity reduction would be well worth the effort.

It may well be too late for Detroit, but reduction efforts in other areas will fare better if they include the following steps:

1. Steadily build community support around access, patients' rights, and other issues which will give planning agencies high visibility.
2. As the agency's credibility builds, begin to examine the quality of care. Identify and expose hospitals and physicians practicing dangerous medicine. Concentrate on those hospitals most likely to oppose efforts to reduce tertiary capacity. HSAs must convey to consumers that they are championing the public's right to good health care.
3. Use public support to win approval of a...
The net effect of the criteria measuring hospital care was to severely squeeze small and medium-sized facilities while favoring the large institutions

Regionalization program based on a strengthened network of high-caliber community hospitals and a few large tertiary facilities. Ensure that the savings derived from such a plan will be used to meet health needs of the underserved, provide jobs for displaced hospital workers and emphasize ambulatory care and community treatment of long-term illnesses.

Such a prescription foretells a turbulent future for health planning. Yet there is no way planning agencies can avoid such a role, as fiscal crises, public hospital closures and Medicaid cuts force HSAs to address these problems. Ironically, planning approaches are becoming more attractive at the very moment when the planning program itself may be on the chopping block. The Office for Management and Budget has recommended a 30 percent cut for HSA funding in fiscal year 1981, preferring to strengthen the hands of state planning agencies which are well insulated from community pressures. Planners seeking to build a constituency strong enough to pull HSAs through the budget storm and guarantee their survival would do well to consider these proposals. Planning is down at the crossroads. It's time to flag a ride.

—Mark Allen Kleiman
(Mark Kleiman is executive director of The Consumer Coalition for Health, a national alliance of labor, civil rights, senior citizens, women's, religious and community organizations dedicated to greater consumer control over the health system.)

References

1. The author is indebted to Milt Camhi, Karen Glenn, Ronda Koteichuck, Susan Rourke, Cathy Schoen and Herbert Semmel for their close and patient readings of this paper.
6. Although utilization became the most heavily weighted factor, this does not reflect an emphasis on occupancy rates. Most of the utilization criteria were based on rates for specialized services found only in larger hospitals. Although the small hospitals could not lose points for not having these services, they could not gain points either. The percentage of points given to overall use standards therefore overestimates the importance of this factor.
8. Tape recording of the January 17, 1980 meeting of “Subcommittee A” of the Commission on the Reduction of Excess Hospital Capacity, Comprehensive Health Planning Council of Southeastern Michigan, Detroit, Michigan.
10. Metropolitan was ultimately exempted because the 1979 health planning amendments exempted HMOs or hospitals heavily used by them from the CON process.
11. §1621(b)(1)(C).
14. Among hospitals providing house staff training programs, the degree of teaching intensity has been measured by dividing the number of full-time house staff by the average daily census per hospital. These ratios were listed in descending order and divided into two groups. Hospitals directly affiliated with medical schools, and hospitals which had ratios at or above the mean for all teaching hospitals, were rated as having “intensive” programs.
In Plain English

Dear Health/PAC Bulletin:

I can understand what you’re saying about the exploitation of FNGs (Foreign Nursing Graduates). I understand that many FNGs have problems with English rather than with nursing per se. (Evidence of the fact is that of all four women in my graduating class at UCSF ’79 who did not pass the state Board spoke English as a second language — one at least I know to be a very good nurse.)

But here’s the problem. Some measure of English has to be a requisite for licensure. I’ve worked in mad-house hospitals where I’ve sat through reports not understanding one half of what was being reported to me, where patients (English-speaking) were furious because they couldn’t make FNGs understand their requests, and where FNGs couldn’t understand verbal orders from doctors. It’s dangerous when English-speaking practitioners in this country practice medicine or nursing without being able to understand foreign born patients. It’s also dangerous when FNGs and FMGs can’t understand English.

Sincerely,

Cathie Colwell, RN

Peer Review

Justice for All?

Dear Health/PAC Bulletin:

On Saturday, November 3, five anti-Klan demonstrators were killed and two others seriously wounded by avowed members of the Ku Klux Klan and Nazi Party. Among those murdered were physicians James Waller and Michael Nathan. Paul Bermanzohn, another medical doctor, was seriously injured.

An American Public Health Association resolution passed that same weekend condemned the killings in North Carolina and demanded justice in the full prosecution of the murderers. The resolution went on to state that the APHA “encourages its membership and friends to support in whatever ways possible activities in opposition to the Klan and similar groups.”

The Greensboro Justice Fund has recently been formed to finance a major civil rights suit against the Klan and Nazis and to fight for the widows’ right to a private prosecutor. The directors of the Fund include Philip Berrigan, Reverent Ben Chavis of the Wilmington 10, and Dr. Michio Kaku, physicist and anti-nuclear activist.

Dr. Michael Nathan was a dedicated pediatrician at the Lincoln Community Health Center and was co-founder of the Committee for Medical Aid to Southern Africa. Dr. James Waller had worked as a pediatrician at New York’s Lincoln Hospital, and was active in community organizing there. In North Carolina, Drs. Waller, Nathan, and Bermanzohn all helped to organize screening clinics for respiratory diseases among textile and rubber workers. In the words of the APHA resolution, “these three physicians felt that opposing the Klan was part of their responsibility in serving the interests of the people.”

The ambush of the anti-Klan demonstration and the murders are all recorded on TV videotape. Yet eight of the nine cars in the caravan which attacked the rally were never stopped and their occupants have never been apprehended. Recently, conspiracy charges against all of those who were accused of the murders were dropped and all but one of the 13 accused murderers are free on extremely low bail, ranging from $4,000 to $50,000. One month ago, Dr. Waller’s widow was denied her request for a private prosecutor in the case.

The legal cases in Greensboro have now become a focal point for all those who oppose Klan violence. With the funds for this legal effort, there is a clear and growing danger that most of those responsible for the killings will go free . . . . It would give a green light to all kinds of hate groups and set a frightening precedent for the 1980s

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most of those responsible for the killings will go free.

The acquittal of any of the murderers would give a green light to all kinds of hate groups and set a frightening precedent for the 1980s. The ideology of those killed matters not. Not to fully prosecute the Klan, Nazis and others responsible for the murders both criminally and civilly will cost all progressive people dearly in the years ahead.

The legal cases in Greensboro will cost a tremendous amount of money — more than $250,000 in the first year. We are asking you to make a contribution to the Greensboro Justice Fund to help finance the cases. Your contribution will be used for expenses like depositions, expert witnesses, equipment, xeroxing, and part will be used for attorney, secretarial, investigator, and research fees.

Please donate now to the Greensboro Justice Fund, P.O. Box 2861, Grand Central Station, New York, N.Y. 10017.

Sincerely,

Daniel H. Barco, M.D.
Jill Blacharsh, M.D.
Jean S. Chapman, M.D.
Richard David, M.D.
Barbara Donadio, R.N.
W. LaDell Douglas, M.D.
Joan Drake, M.P.H.
Delores W. Estes, R.N.

Robert Ettinger, M.D.
Arthur Finn, M.D.
Michael Freemark, M.D.
Mary Kane Goldstein, M.D.
Yonkel Goldstein, PhD
Dr. John Hatch
Henry S. Kahn, M.D.
Michio Kaku, PhD
Robert Konrad, Phd
Frank Black Miller, M.D.
Thomas G. Mitchell, PhD
Peter Moyer, M.D.
Martha Nathan, M.D.
Harold Osborne, M.D.
Salvatore Pizzo, M.D.
Neil S. Prose, M.D.
Juanita Saulters, ALPN
Jessica Schorr, M.D.
Michal Schwartz, M.D.
Christiane E. Stahl, M.D.
Alan Woolf, M.D.