The Squeeze Is On
Pies and Coins
of Hospital Cost Control

INSIDE

The Medicare Fund "Crisis"  P.21
Merck in Ireland  P.25
The Work Culture of Nursing  P.29
To the Editor:
Your special double issue on "Health Care and Revolution" just arrived in the mail a few days ago and I read it cover to cover—something I don't often do. Wonderful.

It does, however, point up a serious gap in your coverage. Publications discussing the U.S. health care system inevitably tend to analyse the trees, and however well this is done it misses the wood. The strategy for maintaining the status quo is not to pretend that everything here is wonderful—that would, of course, be futile since people's daily reality tells them otherwise—but to persuade the public that any alternative is worse.

In health care this is clearly not the case. We know this practically as well as theoretically. The U.S. is, after all, the only industrialized country in the world apart from South Africa which does not have some form of national health insurance or national health service. The superiority of many of these programs to what we have here—at least as far as serving the needs of the overwhelming majority of the population is concerned—is evident to those who have used or studied them.

A publications such as yours has an obligation to convey this information to its readers. If a progressive alternative is not presented by progressive publications, how can we expect the mass media or political figures to even consider any health care proposals other than their current dreary suggestions for "cost containment" at the expense of the poor?

Mass sentiment for improved health care is evident in the most casual conversation on the street, if not in the current primary campaigns. You should be providing the tools to create it.

Alan Wood
New York

To the Editor:
I received the invitation to your First Annual Awards Dinner, May 7 and really regret that I won't be able to come East to attend, both to see old Health/PAC friends and celebrate the great days of the civil rights movement. It's quite a shock talking to people only ten years younger than I am and discovering that the civil rights movement and the Vietnam War are no more real to them than the Great Depression is to me. I hope you'll have a lot of them at your dinner; this country could use a revival of that spirit, as well as that broad coalition for social justice.

Jay Weinstein, M.D.
San Francisco, CA

To the Editor:
Congratulations on your special issue, "Health Care and Revolution." It's the best argument for ending U.S. intervention in Central America I've found to show people at the hospital where I work. I think that some of them have actually been persuaded by it!

Enclosed is a check for ten copies; I'm not sure that I can sell them all, but I'll certainly try.

Keep up the good work.

Jan Kitzinger
New York
Notes & Comment

A man who attempts to lose weight by putting his dog on a diet might seem amusing. When the federal government, with media encouragement, pretends it can do something similar with the budget it's not so funny.

Hardly a day goes by without articles, editorials, and television news reports declaring that one of the prime targets in proposals to reduce the federal deficit is Medicare, the government's entitlement program for health care for the elderly and the disabled. Most of these proposals concern Part A, the hospitalization coverage which constitutes 70 percent of Medicare outlays. The problem is that Part A could be eliminated entirely and this wouldn't reduce the deficit at all.

Part B, which pays doctor and other ambulatory care bills, is voluntary and funded by recipients (25 percent) and general revenues. But like Social Security, whose finances were often similarly misconstrued before it was cut last year, the rest of Medicare doesn't get a penny out of general revenues. Its funding comes from a payroll tax paid by both employer and employee, currently 1.3 percent of the first $37,500 earned.

Before 1969 Medicare and Social Security were not even included in the regular budget. They were folded in by President Johnson, who wanted to defuse opposition to his Vietnam War allocations; reversing the strategy of fastfood restaurants, he enlarged the bun to make the hamburger look smaller.

As Ohio Senator Howard Metzenbaum pointed out some time ago, David Stockman may be cruel, but he's not stupid. He and other policymakers are well aware that cutting Medicare Part A does not reduce the deficit. They have other reasons for their cutbacks, DRG regulations, higher premiums and other measures. They might see Medicare reductions as a mechanism for braking health care cost inflation in general. They might believe the government has no business running such a program; knowing that a full-scale assault would be political suicide, they could hope to demolish it incrementally. They might want to save corporations the 1.3 percent payroll tax so their owners will have more money to use as they see fit. They might believe that reducing or eliminating this tax would make it easier to obtain greater general revenues for their military buildup.

Most likely it is all these reasons. They are also the hidden motivation when the somewhat more “honest” argument is used that Medicare must be cut to save it from financial disaster (see the article on page 21 of this issue).

Unfortunately none of these reasons are ever discussed, and they would have to be for a public debate on Medicare to have any meaning. If they were, we might begin to look at how we could provide decent medical care for the elderly and all Americans at lower cost. This election year would be as good a time as any.

Jon Steinberg

Letter from the Editor

Readers of our two major articles in this issue on Prospective Payment Systems will notice a difference of opinion about their merits. At least we hope you will, and will be provoked to form your own opinion.

These new systems are already transforming hospital care and therefore American health care in general. Yet they have aroused almost no public debate or even notice. Although health care is of vital concern to all of us it is treated by the mass media as an arcane, complex subject suitable for discussion only by qualified experts.

Campaigns for nuclear disarmament have succeeded in shattering a similar myth about weaponry, and represent our best hope for a durable peace. Two decades, even one decade, ago the disarmament movement in the United States consisted of a small group of dedicated visionaries. In the past three years a nuclear freeze, albeit variously interpreted, has won almost every popular referendum where it has been on the ballot.

Because it affects all of us, health care could become the focus of an analogous upsurge. Perhaps not so passionate— saving the world can arouse stronger emotions than maintaining our health and providing decent care to the ill—but strong enough to achieve a health system designed to meet popular needs.

What we need is a few more dedicated visionaries.

Contents

<table>
<thead>
<tr>
<th>Letters</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs</td>
<td>5</td>
</tr>
<tr>
<td>The New Hospital Reimbursement Programs</td>
<td>7</td>
</tr>
<tr>
<td>Federal: How the DRG System Works</td>
<td>13</td>
</tr>
<tr>
<td>Massachusetts: Terms of Endowment</td>
<td>17</td>
</tr>
<tr>
<td>Rural Health</td>
<td>21</td>
</tr>
<tr>
<td>Care in a troubled economy</td>
<td>25</td>
</tr>
<tr>
<td>Medicare</td>
<td>20</td>
</tr>
<tr>
<td>The truth about the fund “crisis”</td>
<td>27</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>29</td>
</tr>
<tr>
<td>Pain Killers in Ireland</td>
<td>30</td>
</tr>
<tr>
<td>Bulletin Board</td>
<td>33</td>
</tr>
<tr>
<td>Body English</td>
<td>35</td>
</tr>
<tr>
<td>When less care is more</td>
<td>37</td>
</tr>
<tr>
<td>Media Scan</td>
<td>39</td>
</tr>
<tr>
<td>The work culture of nursing</td>
<td>41</td>
</tr>
</tbody>
</table>

Health/PAC Bulletin 3
The Health/PAC Bulletin
isn’t Playboy or Time

You might have noticed this. One of the consequences is that you can’t buy it at most local newsstands. This could mean that if you don’t have a subscription you may miss that key article on medicare or the pharmaceutical industry or nursing homes you really wanted to read.

WHY?

Because when the Bulletin covers a subject you get a perspective on it available nowhere else.

WHY?

Because in health and medicine publishing virtually every magazine depends on glossy industry advertising and/or the medical establishment for financing. If you read a dozen health care publications, you know what we’re talking about. If you only have time for one, check out the competition. If you agree we offer unique, incisive, well-written, and informative health care coverage, why not fill out the form below. Or, if you’re already a subscriber, why not take this opportunity to enlighten a friend.

Health care is this country’s biggest business. Make it your business too.

Please enter ________________ subscription(s) for the Health/PAC Bulletin

Check: • Individuals $17.50 • 2 years $30
• Institutions $35 • 2 years $70
(Foreign subscribers add $8 per year)

Name ____________________________________________________________
Address __________________________________________________________
_________________________________________________________________
City ___________________________ State ___________________________ Zip __________

□ Bill me (plus postage and handling)
□ Charge: □ Visa □ Master Expiration date ____________________
No. __________________________ Signature __________________________

Send your check or money order to Health/PAC Bulletin.
17 Murray St., New York, NY. 10007
Vital Signs

Left Out

The spectrum of public discourse on health care, as on numerous other issues, has lurched to the right in recent years, but a Louis Harris poll published last October shows that there is a substantial popular constituency for national health programs.

The survey, commissioned by the Equitable Life American Insurance Company, found that among the American public as a whole the most commonly suggested changes for improving the health care system (each respondent was asked for one) were

- "control and limit costs" (12 percent)
- "more or better care for the elderly" (11 percent)
- "socialized medicine or national health service" (eight percent)
- "lower hospital costs" (five percent)
- "assure availability of equal quality care for all" (five percent)
- "For those who can't afford it, cut costs or provide financial support" (five percent)

Together, the responses favoring increased government intervention to provide health care total 29 percent, nearly half the 64 percent of respondents who had any suggestions at all.

Among union leaders the poll found even more enthusiasm. Their most common responses were

- "socialized medicine or national health service" (31 percent)
- "control/limit cost" (15 percent)
- "assure availability of equal quality care for all" (12 percent)
- "lower hospital costs" (eight percent)
- "more or better care for the elderly, more inclusive Medicare" (eight percent)

"Socialized medicine/national health insurance" was also the first proposal of five percent of hospital administrators, two percent of insurance executives, and one percent of corporate benefit officers; not one of the physician leaders mentioned it.

Going for the Kill

If members of Congress had a sense of deja vu when they saw the health and social services items in the Reagan administration's proposed 1985 budget it wouldn't be surprising, since they have already rejected many of them in the past. Once again the Administration strategy appears to be to demand the whole store and compromise on half. After pulling this off for three years many of the shelves are already pretty bare.

Rather than get a boost to compensate for inflation, the Public Health Service is slated for a slash of $250 million, from $8,608 billion to $8,387 billion. That still might seem like a lot, but the PHS houses nearly all Department of Health and Human Services health programs, including the Food and Drug Administration; the Center for Disease Control; the National Institutes of Health; the Alcohol, Drug Abuse, and Mental Health Administration; the Office of the Assistant Secretary of Health; and the Health Services Administration.

Another target is the Health Resources Administration, which runs migrant health programs, black lung clinics, the community health center programs, and the family planning programs. The Administration wants to crunch them into a reduced Primary Care Block Grant, which would be shifted to the Office of the Assistant Secretary of Health along with the Maternal and Child Health Block Grant.

Another sacrificial offering to help reduce the budget deficit would be the National Health Service Corps scholarship program, whose recipients agree to work in underserved areas after they graduate. If Reagan has his way, the next allocation will be zero. The rationale is that the projected doctor surplus over the coming decade will spill physicians over from wealthy areas into poor and rural ones.

The Administration also hopes to slice family medicine, physician assistant training, and general dentistry residency programs from $64 million in the current budget to $34.5 million; nurse training programs from $52.1 million to $14.3 million; and the Area Health Education Centers from $17.9 million to $10 million. Health planning is once again on the Administration hit list; only another firm congressional stand will save it—the Administration has hinted that it will agree to some funding in exchange for a drastic, one might even say eviscerating, reorganization. Most health planners agree that the elimination of this program will cost the government money by removing one of the few modest checks on capital expenditures—which the hospitals often fund with tax-exempt bonds and recoup by raising their rates.

The full force of these cutbacks will not shred the social fabric until long after the November elections—in some cases not for many years. Beneficiaries such as children of migrant workers don't do much lobbying in the halls of Congress, nor much voting, so a heavy burden falls on consciences to determine if many programs, and perhaps people, will survive.

The New Freedom of Choice

Limiting the amount of health insurance which employees can receive tax-free is the best way to halt spiralling health care costs, Senator David Durenberger (R-MN) and Ronald Pearlman, Deputy Assistant Treasury Secretary for Tax Policy, told the National Association of Manufacturers' Congress of Industry on March 8.

"When we talk about a tax cap, we're not talking about raising revenues," Sen. Durenberger went on to say, "We're saying that at some point employees don't care [about containing health care costs] if the employer is going to pay for the whole thing."

Everyone, he said, "should be put at risk. If we stay healthy, we ought to be rewarded for it, and if we choose to get sick, we should pay for it."

Perhaps the senator will supply a price list so we could know which diseases are...
the best bargains.

**Saving Lives Saves Money**

New York State has the embarrassing distinction of leading the country in the proportion of nonwhite pregnant women who receive late or no prenatal care, according to a recent study by the Children's Defense Fund. The consequence is an infant mortality rate of 26 per thousand in the black community, more than four times the rate in wealthy white communities.

This gross discrepancy is not only a tragedy, it represents an extraordinary waste of money.

A petition to the State of New York prepared by Charlene Visconti and Judy Wessler of the Downtown Welfare Advocacy Center in New York points out that at the current hospital clinic Medicaid reimbursement rate nine prenatal visits would cost $590; the average daily cost of a neonatal intensive care unit is $1,000-$1,500.

"The average hospitalization is 20 days," they note, "Even if we assume that only half of the low birth weight babies require hospitalization, the cost of providing that care still greatly exceeds the cost of providing the necessary prenatal care." They add that the state spends $35 million a year on the care of children with developmental disabilities from birth to age five; communities and families also spend large sums.

The petition, which calls for aggressive outreach programs and the establishment of new prenatal clinics in high-risk areas, was endorsed by a host of elected officials and over 60 community groups and organizations, including the Associated Medical Schools of New York and Health/PAC.

"I think we're going to get a program," Judy Wessler told the **Bulletin**, "It just had to be laid out clearly."

**Competition Cuts Surgeons**

According to a recent American Medical Association income survey, surgeons slipped to third place among physicians in 1982. Their $130,500 put them behind radiologists ($136,800) and anesthesiologists ($131,800). The net for all physicians was $99,500.

When asked to explain the surgeons' fall from the top spot, Howard V. Stambler, director of the Health Resources and Services Administration's office of data analysis and management, suggested it may be due to "an excess of surgeons, increased competition forcing some into areas where they can't earn as much as before, and the impact of second and third opinions on the need for surgery."

**Thais That Bind**

They call it **ya ma**, "horse pill," in Thailand. Each bears the unicorn symbol of Britain's Wellcome Foundation, the pharmaceutical corporation. Wellcome introduced them but withdrew the pills from the Thai market in the late 1960's. These are counterfeit, made locally and perhaps in Hong Kong.

"The boss, he gives us each one of the pills," a woman working in a Bangkok knitting mill told **New Scientist,** "At about ten o'clock at night. Then after that my hands shake, my head becomes very awake. I work all night. Fast. If you take too much they burn your brains out."

These amphetamines are addictive, as thousands of Thai factory workers, truck drivers, taxi drivers, prostitutes and students are finding out the hard way. Even more common, although only mildly addictive, are tonics with names like **Ktaing-daeng** and Lipovitan-D, sold in small bottles in groceries, bars, pharmacies, and street stands. At ten baht each the bottles drink up one sixth of a Bangkok factory worker's daily wage, continued on page 28
When Congress enacted the Social Security Amendments of 1983, the controversial cutbacks in retirement benefits—the first—held the spotlight. Title VI of the same legislation slipped by virtually unnoticed. Yet this section is imposing the single most radical change in the history of the Medicare program, and of hospital finance in this country in general. Its technical name is the Prospective Payment System (PPS) for hospitals.

Since last October 1, as each hospital has begun its new fiscal year Medicare began paying a single, pre-determined amount for each case based on which of 467 Diagnosis Related Groups (DRG) the patient's illness falls in. If the hospital provides the necessary services for less, it keeps the balance; if its costs exceed the DRG payment, it takes a loss.

Hospitals in New York, New Jersey, Maryland, and Massachusetts, all of which have their own reimbursement demonstration projects, are currently exempt from this system, along with a few types of specialty institutions. Every other hospital in the country which takes Medicare patients—virtually all of them—is engaged in a furious effort to profit from—or, in many cases, survive—the new policy.

The DRG-based Prospective Payment System totally reverses financial incentives under which hospitals have operated for half a century and thus promises a profound transformation of the sector. To appreciate how profound requires understanding how hospitals have traditionally been reimbursed and how this has shaped the nature of American hospital care and the size of the health care dollar.

Historically commercial insurers and patients who pay their entire bill out of pocket have been charged according to prices set by the hospital for each service rendered. Insurers such as Medicare, Medicaid, and Blue Cross, on the other hand, have used what is known as a retrospective and cost-based system. That is, at the end of the year total hospital costs have been divided by patient days to determine the average cost per day per patient, and these insurers have reimbursed the hospital based on how many days their beneficiaries were in, regardless of the particular services they received.

Under this system, a hospital increases its revenue by increasing its costs; financial restraint, careful management, and cost saving measures not only don't help balance the books, they actually cut reimbursement. Hospitals have a strong financial incentive to acquire the latest technology, develop highly specialized modes of treatment (and recruit and train physicians who can provide them), and create vast medical empires with little concern for cost or need. This in turn has subsidized a thriving profit-making sector, including vendors of hospital technology, supplies, medical devices, and pharmaceuticals. For patients, the consequence has often been excessively prolonged hospital stays, especially when the beds would otherwise remain empty (and unreimbursed), as well as excessive tests and other ancillary services.

Not surprisingly, hospital cost inflation has often sped ahead at two and even three times the rate of the consumer price index for the past two decades. Yet this system has persisted since its introduction in the 1930's for two reasons.

First, it has enjoyed the unified support of the most powerful interests in health care delivery. The hospital sector created Blue Cross to fill its beds with paying patients during the Great Depression; for obvious reasons it has been an ideal reimbursement system for hospitals, so much so that its adoption by Medicare and Medicaid became the American Hospital Association's quid pro quo for its crucial support in pushing these programs through Congress in 1965. Until now, the AHA, supported by the American Medical Association and the industries which profit from hospitals, has wielded enough influence to blunt all direct federal efforts to contain or regulate hospital costs, much less to alter the basic reimbursement system. Until PPS no measure, either federal or state, has reversed the basic dynamic of hospitals having to spend in order to get.

Second, establishing another method for reimbursement has foundered on the difficulty of identifying the product which is being purchased. Patients differ in age, medical condition, treatment, and speed and success of recovery. Physicians contend that treatment is individual and often intuitive, defying a "product" definition.

A cataract operation may cost $450 at a small community institution and $2,800 at a vast technology-intensive teaching and research center. The difference is not in the nature of the patient or the services provided, but in the other hospital activities supported by the all-inclusive, average daily rate. Simple, low cost cases subsidize highly complex and intensive care; patient care subsidizes medical education and research; capital reimbursement subsidizes operating expenses; inpa-

Ronda Kotelchuck is a specialist in hospital reimbursement and a member of the Health/PAC Board.
tient services subsidize emergency and outpatient care (although some analysts argue the reverse). As long as costs were reimbursed, hospitals had no incentive to precisely identify either their costs or their product, and many parties benefitted by the covert funding system that blossomed behind the veil of average costs.

The Development of DRG’s

The technical difficulty of identifying the hospital product was overcome in 1975 by Robert Fetter and colleagues at Yale University, aided by a grant from the U.S. government. Fetter’s original goal was not to improve the reimbursement system, but to aid reviews of medical practice. Using data from the medical record, including a patient’s principal diagnosis, secondary diagnosis, major surgical procedure, age, and discharge status, combined with data on hospital services and costs, he constructed a set of 383 patient categories called Diagnosis Related Groups or DRG’s. These groups were designed to be manageable in number, clinically meaningful, and homogeneous in cost or intensity of hospital services required (see illustration).

In 1982 Fetter issued an improved set of 467 DRG’s which are more clinically meaningful than his earlier effort because they are based on body systems. Because this system identifies significant complications and commonly related conditions (co-morbidity), it is more effective in identifying the intensity of resources demanded in treatment. Coupled with more sophisticated programming, it also narrows a hospital’s scope for manipulating categorization to raise its reimbursement.

This is the DRG system now used nationally for Medicare and in New Jersey for all other payors as well. The total cost, or “weight,” of each DRG is determined by identifying the cost of each service required by patients in the group, including x-rays, laboratory tests, operating room minutes, medical supplies and devices, drugs, therapy services, and even nursing hours. Thus the Prospective Payment System, using 1.0 as the average, assigns DRG #106 (coronary bypass with cardiac catheter) a weight of 5.2624; on the average a patient in this group uses over five times the resources required by one in DRG #90 (simple pneumonia and pleurisy, age 18-69, without complications), which has a weight of .9849. This system also makes it possible to construct a weighted average, or “casemix index,” for a hospital, which allows interhospital comparisons.

The New Jersey System

In 1980 New Jersey became the first state to introduce a DRG-based hospital reimbursement system. Concerned about the potential impact on the hospitals, officials proceeded cautiously, first simulating the system, then phasing it in gradually so that problems could be resolved as they arose. Hospitals were brought in over a three year period according to their readiness to make the necessary adaptations.

Hospitals are paid a combination of a statewide standard cost per DRG and their own costs for that DRG, depending on the reliability of the particular DRG. The higher the reliability, the more the hospital is held to statewide cost standards. Another relatively generous aspect of the New Jersey system is that patients who fall beyond the norms in their length of stay or are judged unique in any of several other respects are deemed to be “outliers,” and hospitals are reimbursed for these patients separately, based on their actual itemized charges. Currently 30 percent of all cases fall in this category. Hospitals

| Diseases & Disorders of the Circulatory System (Major Diagnostic Category 5) |
| Operating Room Procedure |
| No |
| To Medical DRG’s |
| Yes |
| Procedure Category |
| Coronary Bypass |
| Yes |
| Cardiac Catheterization |
| DRG104 |
| Wt. 6.853 |
| No |
| Valve with Pump |
| Yes |
| Cardiac Catheterization |
| DRG106 |
| 5.262 |
| No |
| DRG107 |
| 3.989 |
which feel their costs have been unfairly denied can appeal. New Jersey also offered considerable transitional support, including management information, education and consulting services, and additional monies to cover necessary hospital adaptations such as medical records improvements.

But perhaps the most significant difference between the New Jersey system and the federal PPS version is the state’s policy of treating bad debt and charity care as an operating expense which is incorporated into the DRG rate. As a result, in the first year of the program many inner-city hospitals enjoyed sizeable surpluses after suffering years of mounting deficits. Coupled with the transition funds and allowances for working capital and replacement of plant and equipment, this brought a substantial infusion of new funding into the hospital sector during the early years, with the idea that the flow would be reduced gradually in subsequent budgets.

**Medicare’s DRG System**

The PPS legislation aroused little debate or opposition in Congress largely because of its timing. A year earlier the Reagan Administration had ridden a conservative legislative band-wagon to push through the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Among its many drastic provisions were very severe efficiency standards imposed on Medicare costs and a directive to the Department of Health and Human Services (HHS) to devise a DRG-based payment system for Medicare by December of 1982. Cost controls, said TEFRA, had to tighten to generate a total of $15 billion in savings in the next three years. Once TEFRA has passed, not only was DRG-based reimbursement inevitable, it was perceived by hospitals to be preferable to across the board cuts.

The Reagan Administration objective in enacting PPS is to create a competitive environment which will reduce costs and “rationalize” the hospital sector without the burden of regulation. The rationalization envisioned clearly includes the elimination of unprofitable hospitals and hospital services and, although no one will admit it, rejection of unprofitable patients—dumping, to put it bluntly. Reagan partisans consider this long overdue medicine for a bloated and noncompetitive hospital system. Health advocates are less sanguine about many of the consequences.

Unlike the New Jersey system, PPS offered no cautious phase-in. It was proposed in January, passed in March, and implemented in October. Bitter rearguard resistance managed to secure a phase-in of national rates, but when fully implemented there will be only two sets, urban and rural, adjusted...
for labor costs, even though prices differ considerably from region to region. There will be no extra money to ease the transition either. In fact, although the enabling legislation stipulated that the monies under PPS would be equal to what was budgeted under TEFRA during 1984 and 1985, the Reagan Administration has already proposed a further reduction for 1985.

Another fierce battle was necessary to force acceptance of outlier cases. Even now they are limited to a maximum of six percent of all cases and their reimbursement is funded by commensurate reductions in payments for other patients. Nor does PPS allow appeals. The Administration position is that if hospitals don't like the price Medicare is paying, they can find their patients elsewhere.

Consequences for Hospital Management
Cost-based reimbursement offered no incentive for good hospital management. At its best, good management extended to the operation of individual departments. With its imperative for cost savings, DRG-based reimbursement requires integrated, "product line" management.

The first department to be affected is medical records, which generates the information used to assign patients to a DRG. Inaccurate reporting of diagnoses, procedures, age, or discharge status assigns patients to lower-weight DRG's for which the hospital is paid less. This information, which traditionally took weeks to collect, is now necessary before a case can be billed. Thus medical records departments control both the rates a hospital receives and its cash flow. Consonant with their new-found status, they are suddenly being renovated and automated; their staff is being expanded and upgraded.

Like businesses, hospital's must know precisely where their institution makes its profits and losses, why, and whether the losses are remediable. This means recording exactly which supply and service each patient receives — each lab test, x-ray, surgical procedure, therapy service — and calculating exactly what it costs. With this information the administration can establish balance sheets by DRG, by service, and by physician. To do so, however, requires sophisticated accounting and computerized information systems.

Utilization review (whether particular services or continued stay is appropriate and necessary) and discharge planning also take on new importance. Since the hospital gets paid the same amount regardless of how long the patient stays, it becomes eager to develop services that reduce length of stay, including pre-admission testing, post-hospitalization home care, and long term care placement.

More than any other factor, however, hospital survival will depend upon monitoring and modifying the behavior of physicians. They alone decide how hospital resources are to be utilized — whether and when to admit a patient, conduct tests, administer drugs, undertake surgery, utilize special care units and special services, and whether, when, and to whom the patient will be discharged.

DRG's enable a hospital for the first time to identify norms and excesses in physician treatment patterns. Because final treatment decisions are clinical in nature, and because the hospital needs physicians and the patients they bring, it cannot sanction them for overutilization through administrative action alone; the cooperation of physicians themselves must be enlisted to aid in reviewing and taking action. Still, for the first time there will be objective criteria against which to measure physician practice.

Impact on the Quality of Care
The effect of the New Jersey system on the kind of care patients get is still unclear given the gradual phase-in and the original infusion of money. PPS is only seven months old in the hospitals where it was introduced first. Thus little empirical evidence exists to support either advocates or critics.

The incentives to cut costs and boost patient volume are clear, however. Hospitals can be expected to reduce lengths of stay as well as the volume and intensity of the ancillary services they provide and at the same time attempt to increase their total admissions.

This is precisely what the first New Jersey data show. In the earliest group of hospitals to enter the system the average length of stay dropped 1.6 percent in 1980 and another 2.6 percent in 1981 — a very significant decline. Admissions at these hospitals were up 2.6 percent in the first year and another 1.6 percent in the second — also an exceptional change. This effect has aroused fears that patients will be discharged prematurely and suffer increased complications, readmissions, and death as a result. New Jersey has set up stringent review procedures to avert this possibility, and to date there is no evidence that it has occurred.

There are, however, many other potential problems. Physicians, who have largely opposed DRG-based reimbursement, argue that establishing norms and sanctioning excesses will pressure them to deliver cookbook medicine, devoid of the intuitive, patient-specific element of medical judgement they consider to be the soul of their practice.

This argument would be more credible if it wasn't so over-used. Advocates of DRG's have contended that standardization of treatment protocols will actually improve care since it will identify patterns of undertreatment and inappropriate treatment as well as of overtreatment.

Another danger frequently cited is that, in their zeal to save money, hospitals will choose inferior medical procedures and cut-rate devices — not a minor matter in the case of a pacemaker or a lens replacement. The main deterrents to this are the independence of physicians and the threat to both physicians and the hospital of malpractice suits.

Many health activists also fear that rather than risking confrontations with formidable antagonists such as physicians, hospital administrators will extract savings by cutting the number of hospital workers, including nurses. Certainly hospitals are likely to eliminate programs such as social services, patient education, translation services, and patient advocacy which they consider nonessential but which actually increase not only the humanity but the effectiveness of hospital care.

In addition, since the existing DRG systems don't permit reimbursement for simultaneous treatment of unrelated secondary conditions, most hospitals probably won't provide it any more. This will be a serious blow to patients, often poor, who cannot or will not return for a separate hospitalization or who should be treated as soon as possible for multiple ailments.

Even the objective of deterring unnecessary treatment cuts both ways. Because DRG weights will only be revised periodically, the system may retard the development and introduction of improved treatments.
Finally, the imperative to maximize revenues will push hospitals to specialize by expanding profitable services while entirely or partially shutting down money losers. Advocates argue that this will enhance the quality of care by closing underutilized services. Opponents retort that profitability is not the proper criterion for deciding what services should be offered, and if it becomes the determining factor many people may be deprived of access to much-needed care.

The Effect on the Poor

Accessibility of care, particularly for the poor, may be the biggest loser under DRG-based reimbursement, particularly under PPS.

Poor patients, lacking primary and preventive care, are more likely to enter a hospital in a more advanced stage of disease, but their diagnosis and DRG will be the same as those of a less sick patient. Often they are admitted on an emergency basis when their illness is at a crisis stage, without the benefit of pre-admission diagnosis, testing, or records which could shorten their stay. They are also more likely to suffer from general poor health, malnutrition, and multiple, unrelated illnesses which prolong recovery time. They are also less likely to have family support systems or homes which would allow early discharge, and they are unlikely to be considered socially or financially desirable by long term nursing homes or providers of psychiatric care—both of which can be choosy in the current tight market for their services. For all these reasons poor patients are likely to cost a hospital more than their DRG reimbursement will provide.

Refining Diagnosis Groupings

The current DRG system explicitly excludes multiple diagnoses beyond a single secondary one and “system variables” such as socioeconomic status. Public hospital patients have been systematically excluded from most DRG developmental studies, including those Fetter used in establishing his groupings, because necessary cost and billing data for them is unavailable.

This failure to capture the severity of illnesses is not inherent in grouping systems. Susan Horn of John Hopkins has developed a system for determining severity by assessing seven variables: stage of principle diagnosis, interactions, response to therapy, complications, patient dependency, and non-operating room procedures. She demonstrates that each patient can then be assigned to one of four groups, each of which is more homogeneous in total cost, routine cost, laboratory cost, and length of stay than the comparable DRG groupings.

A second methodology called “disease staging,” originally developed by Joseph Gonella in Philadelphia, uses clinical criteria to establish which of three stages a patient is in. Stage

---

Infirmary of the Charity Hospital in an etching, ca. 1635.
I is a disease with no complications (minimal severity). Stage II is a disease with local complications (moderate severity). Stage III is disease with systemic complications (high severity). Like Horn, Gonella has been able to demonstrate a strong correlation between disease stage and cost and length of hospital stays, relationships which are obscured under the DRG system.

Both Horn and Gonella have shown that important variations among hospitals, payors and populations can be related to the general level of severity or disease stage of their patients. Their work presents strong challenges to DRG advocates, and it is exciting considerable interest. Unfortunately neither approach is sufficiently developed to offer a viable alternative to DRG's for reimbursement. Recently Robert Fetter himself, the father of the DRG, declared that he intends to examine the issue of severity.

In the meantime, under the current federal system hospitals serving more severely ill patients will be hurt. Voluntary and for-profit hospitals, which have the option, will shunt these people to public hospitals while marketing themselves to attract the profitable ones. This is known in the industry as “dumping” and “skimming”.

New Jersey has mitigated this threat to public hospital survival through its generous outlier policy and its coverage of the medically indigent. Congress specified in the PPS legislation that Medicare and Medicaid reimbursement must take “the special situation of hospitals serving disproportionate shares of low income people” into account. However despite hard lobbying by the National Association of Public Hospitals for implementation of this clause, the Department of Health and Human Services took the position that “current data do not show that such adjustment is warranted” since they fail to indicate a “significant association between higher Medicare cost per case and either public ownership or the proportion of low income patients.” In effect, the Reagan Administration has thrown the burden of proof as well as of caring for the poor on public hospitals.

Prospects

At the moment Reagan Administration enthusiasm for its program appears unbounded. Other payors such as Blue Cross and commercial insurors, fearful that rather than cut costs hospitals will simply charge them more to make up for any losses on Medicare patients, are giving serious consideration to DRG-based reimbursement themselves.

Ironically, this same fear of cost shifting is propelling moves for regulated all-payor systems in states and even on the national level, although regulation is precisely what the Reagan Administration hoped to eliminate. Such systems existed prior to PPS in New Jersey, New York, Maryland, and Massachusetts.

Connecticut, Washington, and Rhode Island already had systems that regulated all payors except Medicare; in the past year Maine, West Virginia, and Wisconsin have authorized all-payor systems. All six are likely to apply for the exemption from PPS already granted the first four. Many are examining the DRG option.

In Congress, the House Democratic Caucus has called for expanding the prospective payment system to all payors; Representative Richard Gephardt (D-MO) has joined with Senator Edward Kennedy in proposing legislation to do this.

Walter Mondale has advocated a similar plan.

Although these plans are anathema to the Reagan Administration as a gross interference in the private sphere, it is eager to extend the DRG system within Medicare. The PPS legislation mandated the Department of Health and Human Services to develop a DRG-based method for reimbursing hospital capital costs and physician services within the year. HHS is also funding casexim studies in ambulatory and long term care with an eye toward including them.

Whether this enthusiasm will continue unabated once the effects of the program become clearer is a real question. It is certain that the current regulations are so stringent that modification is inevitable unless Reaganism wins an overwhelming mandate in November.

Conclusion

The greatest irony of PPS is that it was the ultra-conservative Reagan Administration that overrode the major special interests in health care, and it did so with a system that addresses many radical criticisms.

Health care radicals frequently argue that the real issue is not how much money is available, but how it is used and by whom. Their criticism focuses on interest groups such as medical empires and the medical-industrial complex who feed at the trough of cost-based reimbursement without a trace of public accountability; who drive up health care costs in the name of providing sorely needed benefits but actually to enhance their own power, profits, and prestige: who distort the health system into a top-heavy, technology-laden, end-stage illness system at the expense of providing unglamorous and unprofitable primary and preventive, community-level care. They also criticize the irresponsibility of those who deposit the hard-earned dollars of workers, consumers, and taxpayers in a blank check funding system without asking what the checks pay for and whether the cost is appropriate.

With all its failings, DRG-based reimbursement addresses many of these issues. DRG's identify the product which is being purchased. They will force the heretofore hidden costs of technology, medical education, and research into the open where forthright decisions will have to be made about their funding. They will compel judicious use of resources where waste and mismanagement once blossomed. And finally, if cost control is inevitable, the hospital sector is a more deserving target than the alternative, which is the eligibility and benefits of Medicare and Medicaid recipients. Presumably DRG's could be improved to truly reflect severity of illness so that no group is penalized. This would seem to offer the fairest system for reimbursing hospitals available.

The fairest available, but far from perfect. It still leaves us with a system predicated on perhaps the ultimate commodification of human suffering, financial competition in providing care, with the possibility that institutions which don't meet its economic efficiency imperatives will go under.

These changes in hospital finance are initiated by conservative forces whose goal is to erode, if not demolish, social programs. Moreover, given the structure of power, any cutbacks eventually bleed the weak and the powerless. The challenge to progressive health care advocates is to address this larger context and the shortcomings of the new reimbursement system without defending what was indefensible in the old.
In August 1982 the Massachusetts Legislature "with no debate and even less understanding of how it all was to work" passed Chapter 372, its experiment in the nationwide trend toward "prospective reimbursement".

The Spirit of the Law
As with similar legislation nationally and in other states, the impetus was the skyrocketing cost of hospital care and insurance premiums, and the concern this has generated among influential businessmen. Health care costs in Massachusetts have risen even faster than the national average, accelerated by competition among Boston's medical school complexes to acquire the latest machines and most luxurious buildings. The average cost of a hospital stay is the highest of any state, 45 percent above the national average. Health care costs amounted to 11.9 percent of the Gross State Product in 1980, considerably more than the national proportion of 9.4 percent.

For businesses, rising health care costs have meant rising costs of employee benefits. Companies such as GM now spend more on health care benefits than on raw materials such as steel. In Massachusetts, Blue Cross premium increases of more than 20 percent were forecast for 1983. New England Telephone, the largest private employer in the state, projected an eightfold increase in the cost of health insurance per employee between 1970 and 1984. Dismayed by rapid cost escalation, the Business Roundtable, a nationwide organization of chief executive officers of large corporations, has urged its members to take an active role in formulating health policy. Its Massachusetts affiliate, MBR, stepped into the health care arena in the spring of 1982 when it appeared that a hospital cost containment bill would die in the state legislature due to opposition from Blue Cross and the hospital industry. Its members voted to support an extremely restrictive cost containment bill unless a compromise could be worked out in negotiations with the Massachusetts Hospital Association, Blue Cross, and the commercial insurance companies. The chairman of the MBR Health Care Task Force, who is also a hospital trustee, a board member of a major insurance company, and president of a firm whose 4500 workers are insured by Blue Cross, met with the governor as part of an intensive lobbying campaign.

"I told [Governor] King that it costs $1200 a year for a family health insurance package at my Tennessee plants and at least $1000 more per employee in Massachusetts," he related, "I said I couldn't continue to do business in Massachusetts if I've got to pay $2400 a year in benefits for somebody who makes $12,000 a year." The compromise, drafted after considerable jockeying, included concessions to the MBR which were likely to limit future increases in health insurance premiums. The insurance companies and Blue Cross got provisions to ensure that their premiums would no longer reflect the rising costs of caring for uninsured patients, and that the hundreds of millions of dollars which they receive yearly for administering health insurance programs would not be jeopardized. Finally, Massachusetts hospitals agreed to support the bill in exchange for defeat of a more stringent cost containment law, and exemption from the federal Medicare DRG system.

"This Medicare waiver was frightfully, frightfully important to hospital administrators around the state," noted a state legislator, since DRG payment rates would have been based on national averages which are much lower than costs in Massachusetts hospitals. The Federal Government also agreed that Medicare would pay for some of the costs of caring for uninsured patients.

Although doctors were not directly party to the negotiations, the proposed law did not attempt to regulate physicians' fees, and quickly won the support of the Massachusetts Medical Society. Labor and consumer groups had little opportunity to either support or oppose the complex compromise bill—written in private and hastily passed into law by a bewildered and compliant state legislature.

The Letter of the Law
Until Chapter 372 went into effect on October 1, 1982 hospitals in Massachusetts, as in most other states, were paid on the basis of "retributive cost-based reimbursement," which offered considerable incentive for hospitals to increase costs and none to curtail them (see previous article, "Baring Costs").

Under the provisions of Chapter 372 the maximum amount that each hospital can collect each year is limited in advance by a complicated prospective reimbursement formula based on the amount which the hospital collected in fiscal 1982 plus...
adjustments for inflation (which are below the previous rate of hospital cost inflation), new capital expenditures, changes in volume of service, and a few other circumstances to be considered by an Exceptions Review Board. If a hospital exceeds its budget, it has to cover the losses from other sources or go out of business. On the other hand, if a hospital spends less than its budget, it gets to keep most of the difference.

For example, in 1982 a hypothetical hospital might have seen 100 patients in its emergency room, charged $100 per visit, and thus collected a total of $10,000. Under the old system, the hospital could raise its rates to, say, $120 per visit if it could convince the Rate Setting Commission that the cost of running the emergency room had increased 20 percent. But Chapter 372 sets the yearly rate increase at 1.25 percent less than the rate of inflation. Thus if the inflation rate were 10 percent, the hospital would receive $108.75 per visit regardless of cost.

The law also provides an incentive for hospitals to decrease the volume of services by limiting the number of visits for which the hospital can charge the full rate. Using the above example, if the hospital had more than the 1982 total of 100 visits in 1983, it would be paid only 60 percent of the $108.75 ($65.25) for each of the additional visits. On the other hand, Chapter 372 specifies that the hospital would receive its full payment of $10,875 even if it had only 98 visits or was able to cut its costs below $108.75 per visit.

The formula for calculating the prospective budget also provides incentives to substitute outpatient services for inpatient care. Hospitals can decrease their volume of inpatient services as much as 7 percent below the base year and still collect their full allocation. In contrast, cutting outpatient services more than 2 percent would trigger a loss of reimbursement dollars. Similarly, hospitals are permitted to step up the volume of some outpatient services without getting their per case reimbursement cut, but they can collect only 50 percent of the normal charges for excess inpatient services.

Another provision of Chapter 372 fixes the variation among payments by different insurance programs for the same service at approximately the 1982 level. Thus a service for which
Blue Cross pays a hospital $1000, a commercial insurance company (e.g., Aetna) will pay $1090, Medicare $940, and Medicaid $830. Finally, the bill provides for limited budget exceptions for hospitals such as Boston City and Cambridge City, which care mainly for uninsured or government insured patients.

The Results of the Law

Hospital administrators appear to be responding to the new financial incentives created by Chapter 372 in three ways.

1. They have tried to decrease operating costs, since reducing the amount spent on patient care means more money for expansion and investment.

Administrators at virtually every major hospital have purchased elaborate computer systems which will enable them to monitor the use of tests and services and eventually to pressure physicians to limit orders of items ineligible for upward budget adjustments. In some cases this will probably result in substandard care, just as the old reimbursement system encouraged excessive interventions.

Private hospitals are also reducing operating costs by limiting admissions of certain “high cost” and/or low reimbursement patients. The uninsured have been particularly hard hit. In the first year under Chapter 372, eight of the nine largest private hospitals in Boston decreased their care of the indigent by between 6 percent and 45 percent. Workers at Boston City Hospital have noted a marked increase in patients transferred from or refused care at private hospitals. Hospitals have also tried to limit the number of Medicaid patients, since their treatment is reimbursed at a lower rate. In the past, when these patients filled an otherwise empty bed, were served largely by personnel who had to be paid anyway, and used a CT scanner which would otherwise lay idle, they boosted revenues. Under Chapter 372, this is no longer true if a hospital has enough privately insured patients. Two Boston hospitals with aggressive programs to market their services to privately insured patients have already reduced their Medicaid populations by over 20 percent.

The hospitals are also attempting to reduce labor costs, which currently account for 57 percent of hospital operating costs (down from 64 percent a decade ago). Unlike reimbursement for capital costs, which is virtually unregulated by Chapter 372, most labor cost increases are not eligible for reimbursement. Few hospitals in Massachusetts are unionized, and the unorganized workforce is largely unable to protect its interests. Nurses and other workers have been laid off at several hospitals and wage freezes and staff reductions through attrition have been announced at others. At the same time one hospital planned a new transplant program and the installation of a computer system costing over $4 million in the first year, it projected operating cuts of more than $10 million requiring the elimination of hundreds of jobs. Another hospital threatened to slash social work and psychiatric services to children while planning a new $71 million building.

2. Hospitals have also exploited adjustments and exceptions allowed by the law, particularly increases allowed for new capital expenditures (buildings, machines, interest costs, and depreciation) and new services (e.g., establishment of a heart transplant program). Prestigious institutions with preferential access to capital markets benefit most; public hospitals are notably absent from the ranks of those planning new capital projects. One of the more perverse effects of Chapter 372 is to encourage the purchase of machines which replace hospital workers, even when they raise the total cost of care; it reimburses the capital costs of the machine, but allows the hospital to keep the money saved by laying off employees.

Massachusetts hospitals proposed $900 million in new capital expenditures in 1983, nearly one third more than in 1982. In Boston, the projected $407 million expenditure for 556 new acute care beds would push excess bed capacity over 1300, and could result in health care cost increases of over $100 million per year. Since the passage of Chapter 372, Boston hospitals have also announced plans for four new liver transplant programs, a new heart transplant program, and six additional nuclear magnetic resonance scanners. Computer systems and automated laboratory equipment which replace clerical and technical workers have been high on administrator's shopping lists. The deluge of new capital projects elicited a state health planning agency call for a statewide limit on capital spending and associated increases in operating costs, but the subsequent guidelines are non-binding and have thus far done more to channel funds to projects with low operating (i.e. labor) costs than to decrease overall capital spending.

In January, 1983, a 63-year old man from Boston was referred to a private Boston teaching hospital by his primary doctor for vascular surgery. The patient went to the admitting office the day prior to his scheduled surgery but was denied admission because he did not have insurance coverage, did not qualify for Medicaid, and was not considered to be an emergency case. His primary care doctor had stated that his condition was "urgent". Efforts by his doctor and administrator at Boston City Hospital to change the decision of the hospital's admitting office failed. Two weeks later the patient was evaluated at the BCH surgical clinic. Three days after that he was admitted to the hospital and right femoral bypass surgery was performed the following week. The patient remained in the hospital for one month, and has had two more admissions to the hospital since that time.


3. Finally, hospitals are shifting costs and services to areas of the health care system not controlled by Chapter 372, particularly outpatient departments. Four hospitals are negotiating with for-profit chains to jointly establish outpatient "surgi-centers". Several hospitals have formed for-profit affiliates to provide home health services. Although it is widely assumed that this substitution of ambulatory for inpatient care encouraged by the law will cut costs, evidence for this is lacking.

Anecdotal accounts suggest that larger hospitals have fared better under the constraints of Chapter 372 because of their access to capital, administrative structures geared to "beating the
system", ability to shift services to un-capped outpatient facilities, and capacity to attract privately insured patients and "dump" the uninsured. Deficits at public hospitals have continued to rise; more than 20 hospitals have applied for the bailout money originally intended solely for Cambridge and Boston City Hospitals, and several community hospitals have encouraged bills in the legislature to increase their budget limit.

Sixteenth century hospital from a cook book for the sick.

Conclusions

While technical details of Chapter 372 differ from those of other states with waivers and the national Medicare DRG programs, they all have much in common. They encourage hospitals to reduce services to hospitalized patients by allowing them to retain unused portions of their budgets. They reward hospitals for cutting labor costs, virtually assuring the loss of thousands of jobs. Most leave intact incentives for capital spending, which have already caused overbedding and the duplication of high cost technologies and services with little or no proven benefit. They do nothing to improve, and, as in Massachusetts, may actually constrict the already grossly inadequate access of the poor to medical care. Finally, they place a premium on administrative control, accelerating the trend toward bureaucratic domination of medical care and the proliferation of hospital administrators and computers enlisted to "beat the system".

The prospective payment scheme established by Chapter 372 does differ from the federal DRG system in two important respects. First, DRG's apply only to Medicare payments, while Chapter 372 regulates all payors. Second, Chapter 372 limits not only the rate of payment for each service, but also the number of times the hospital may collect the full fee for that service. Under the DRG system, while the payment per admission is fixed in advance, the number of admissions, and hence total reimbursement, is unconstrained. Thus, despite its limitations, Chapter 372 is more likely than DRG's to succeed in limiting costs.

Curtailing the extraordinary rate of health care cost inflation while improving quality and equality is certainly an attainable goal, but prospective payment is more detour than step forward. The chief impediments to a humane and effective health care system are big business, the insurance industry, hospital suppliers, and powerful hospitals and doctors. These interests have been catered to rather than confronted by Chapter 372, and whatever cost savings are achieved will be at the expense of health workers, the sick, and the poor. Far from serving as a model to be emulated nationally, Chapter 372 should be a warning of the consequences of health policy made in board rooms and back rooms.

5. ibid.
6. ibid.
9. ibid.
13. ibid.

We wish to thank the members of CommonHealth (a Boston community health organization) who worked collectively to develop much of the analysis of Chapter 372 on which this article is based. The opinions expressed are those of the authors.
Vein Dreams
Rural Health Care in a Troubled Economy
by Richard A. Couto

Although most national attention fixed on health care cutbacks focuses on hospital-based, catastrophic care, the financial crunch squeezes the entire system; primary care is no exception.

In the coalfields of Appalachia, hard times have affected the provision and economics of health care for as long as anyone can remember. People there have a lot of experience in making do with little, attempting first to provide basic health services for a low income population using private cost or profit conscious providers and second to maintain these services for the families of workers recently unemployed and perhaps facing permanent structural unemployment.

Over the years a host of innovative programs have been offered by coal companies, miners, the United Mine Workers of America (UMWA), and local residents. Among them is primary care centers in rural areas to provide accessible low cost services. But now the local economy has slid so far even these low cost efforts are threatened.

In the United States health insurance goes hand in hand with better paying jobs and high employment rates. The Appalachian region bears this out. In active coal mining areas, the miners earn good wages and enjoy extensive health insurance coverage. Clinics serving their communities are generally on much stronger financial footing than the rural clinics in counties without major industries, especially those with few working miners. Inadequate public reimbursement for health services to low income people accentuates the financial bind.

The last recession hit even the relatively prosperous counties hard. The downward spiral, at different stages, is starkly visible in a comparison of rural clinics in the Appalachian areas of Tennessee and West Virginia.

"You've got to make dollar for dollar"

In our survey of four clinics in the Tennessee coalfields we found that a majority of the more than a thousand patients sampled had no form of public or private reimbursement for the services they received (see Table 1). Most of them were children in families below the poverty line.

Serving people with incomes or assets above Medicaid guidelines but living at a poverty level places a severe strain on a clinic budget. Clinics receiving federal support are required to offer these people services at a discount determined by family income; the resulting gap between revenues and costs at the four clinics was substantial (see Table 2). Aside from subsidies, the only major source of income is privately paying patients, who are generally fairly poor themselves.

The White Oak primary care clinic in Campbell County folded under the weight of these deficits in 1976 when the federal government would not provide more funding. The county’s fortunes had changed radically after World War II as its coal mining operations shifted from underground to surface, drastically reducing labor requirements. Union membership, especially in the UMWA, declined precipitously as a result of this and other factors.

In such localities, providing health care services for the entire population is impossible at a break-even budget, much less at a profit.

"If we come up with 50 percent of what we spend, we'd be doing good," one ex-miner and clinic board member recalled, "That's the way I feel about it. That is, if you're going to doctor the people they require you to doctor. That's the people I'm interested in first, you know...the people who can't pay. You see, the thing they tell you is that you've got to make dollar for dollar, and then they turn right around and they tell you you've got to doctor people that can't pay—maybe half that many.

"Well, all right," he continued, "It's like putting legs on a table, and cutting one of them off. You know if you saw it off, it's going to fall over. Well, how're you going to doctor the people that can't pay you, and then pay your bills?"

Balancing the budget, for this board, was just a means to an end.

"There are so very many people in this small part of Appalachia who could never have received the care they so desperately needed had it not been for our clinic," said another community resident who had been a member, "We were providing excellent care with a sliding scale fee so everyone could afford the care he or she needed. Our fondest dreams were fulfilled."

As financial constraints grew tighter, board members decided the best solution was a cutback in services offered.

"I wanted to start out with less, to have a small program to give people good quality health care," explained the board chairperson, "We had more staff than we needed to give people good quality health care; we overdone it. But that's what the funding people said we needed, so what else could we do?"
When they tell you what they'll fund, they'll fund that. And you say, 'Now let's leave this off.' 'No,' they say, 'We want to fund the whole program or no program at all.'"

"The health care system can't be fit to this community and that community," explained a health professional with some resignation. A health planner was blunter: "The clinic has got to be run like—it is—a business!" The deficits mounted, and with them funder demands for more professional control on the board.

"Every day it seemed like it was another step towards someone else running the show," said one local resident, "And I don't know, I really can't put a finger on who or what. There was, it seems, like a conspiracy."

"Don't just take it"

These problems typical of clinics in chronically depressed rural areas of Tennessee have emerged in other parts of the Appalachian coalfields as well since the last recession began.

Gary, West Virginia is one such community. It's a coal town, population 3000, located in McDowell County in the southwest corner of the state. The workers there are UMWA members who had won high wages and excellent health benefits.

Gary had a doctor, initially provided by the company, which also built the infirmary he worked out of. When this doctor died local residents, assisted by the UMWA, established a primary care center similar to others the union was encouraging in the mid-1970's. The clinics were an echo of the UMWA's extensive health care program going back to the close of World War II. Even though it had negotiated its unique comprehensive health fund away in 1978, miners still had health insurance through conventional private insurers and sometimes through health maintenance organizations (HMO's).

The gains achieved by union members lifted the expectations and benefits of other members of the community as well. Gary's clinic served their needs too, and provided physician services with minimum deficits. Many similar communities without a union workforce had to get by without physicians or operate with substantial subsidies, as White Oak's did.

Gary's good times came to an abrupt end in April 1982, when U.S. Steel laid off 1800 miners there. Unemployment shot up to 90 percent in the town and 30 percent in the county. The health benefits of the unemployed ran out within a year; by mid-July of 1983 unemployment benefits were gone as well.

For most Gary residents the "safety net" of social welfare programs was so close to the ground that it didn't break their fall. They found they were ineligible for welfare, excluded by their home ownership or other possessions or the categorical nature of assistance programs—limitations to single parent or disabled wage earner families.

To continue serving these people the primary care clinic had to become essentially a free clinic, providing care without regard to ability to pay. This plunged it from financial self-sufficiency into deep deficits. The federal portion of its budget leaped tenfold, from $25,000 in 1981 to $228,000 in 1983. In May 1982 72 percent of its monthly revenue came from insurance programs; one year late they provided only 32 percent; a month later a bare 20 percent.

The clinic stayed open largely because of the sheer determination of its administrator, Martha Chapman, and the staff.

"We'll see patients till there's nothing to see them with," she said, "You know, it took a lot for us to convince people that they should come in even if they couldn't afford to pay like before. We wouldn't see them till they were deathly ill. They were real reluctant to come. Our patient load fell from 700 a month to 400. In October we were back to 700, but we had to advertise and tell them we were open and they should come. Of course, when people see their city government run out of money so that they can't even turn on the street lights at night, I suppose they think all other services are gone too. That might be part of it.

"You know," she went on, "My job has changed too. When I first started it was fun. I came to work each morning wor-
ried about the patients and how best to care for them. Now I am fighting a bureaucracy about care and costs just to keep the doors open. The saddest thing is that people are not willing to fight any more, to take a stand. Blame the union, blame the government, blame big business but do something, don't just take it! Like I said about this clinic, we'll see patients till there's nothing left to see them with."

The Future
In August 1983 U.S. Steel began calling miners back to work; most had remained in Gary for want of employment opportunities elsewhere. At present 450 of the former 1800 have been rehired. It may be that the recession will turn out to be one more "bust" in an industry and region characterized by a roller-coaster business cycle. However if this downturn is a harbinger of a permanent slump, Gary and similar West Virginia communities may come to resemble the Appalachian Tennessee coalfields.

Some local residents interpret the closing and consequent pressures of unemployment as a major union-busting threat. If the union loses ground in places like Gary, programs dealing with health and safety could be compromised and strip mining, with its attendant depredation of the environment, could increase substantially.

Unless this pattern is reversed, Appalachia may be a sad and ominous microcosm of a growing nationwide crisis in health care for those cast adrift by the changing economy and corporate decisions beyond their control.

Books Received


Champagne, Anthony and Rosemary N. Dawes, *Courts and Modern Medicine* (Springfield, IL: Charles C. Thomas, Publisher, 1983) $29.75

Hartzke, Larry, *Drugs: Concept and Use* (Madison, WI: Institute for Health Planning, 1983)


Neugarten, Bernice L., (Ed.), *Age or Need: Public Policies for Older People* (Beverly Hills: Sage Publications, 1982) $25.00

O'Donnell, Michael P. and Dr. Thomas Ainsworth, (Eds.), *Health Promotion in the Workplace* (New York: John Wiley & Sons, Inc., 1984) $36.00


There He Goes Again

In Poor Health: The Administration’s 1985 Health Budget tells the sad story in the usual concise, informative prose of the National Health Law Program. Copies of this 22-page summary are available from NHeLP, 2639 S. La Cienega Blvd., Los Angeles, CA 90034. Financial contributions are welcomed.

Household Words

The Product Safety Book: The Ultimate Consumer Guide to Product Hazards by Stephen Brobeck and Anne C. Averyt is a comprehensive encyclopedia listing over 1200 potential hazards and 2000 specific models in alphabetical order. Copies are $9.95 including postage and handling from the Consumer Federation of America, 1514 14th St., N.W., Washington, DC 20005. Allow a month for delivery.

Cell Numbers


New Clear Studies

The Proceedings of the New York Academy of Medicine Symposium on the Health Aspects of Nuclear Power Plant Incidents held in April 1983 are now available. Papers cover topics ranging from types of malfunctions to federal, state, and local regulations to care of the radiation exposed and injured. Copies are $7.50 including book rate postage. Write to the Committee on Public Health, New York Academy of Medicine, 2 East 103rd St., New York, NY 10029.

Chemical Reaction

The Secret Agent, a new film directed by Jacki Ochs, was described by the New York Times as “a tough, angry look at the consequences of exposure to Agent Orange . . . . a chilling issue that is effectively addressed here.” Using archival footage, it documents the history of chemical warfare and agricultural herbicides. Rates for non-profit groups are $100 rental, $850 sale for 16mm, $500 sale for 3/4” cassette and $350 for 1/2”. Write Green Mountain Post Films, Box 229, Turners Falls, MA 01376.

A Choice Coalition

The National Campaign to Restore Abortion was launched this February to oppose the Hyde Amendment, publicize its racist and anti-poor character, and contribute to rebuilding the national movement in defense of abortion rights. Endorsing members include New York CARASA, the National Women’s Health Reproductive Network, the San Francisco Action Committee for Abortion Rights, and the Boston Women’s Health Collective. For further information, write NCRAF, P.O. Box 27175, Oakland, CA 94602.

Deducing Reducing

A one-day conference on “Restraining Health Care Costs: Responsibility-Strategies-Solutions” will be held on May 17 in the Cincinnati area at Northern Kentucky University. Sponsored by the University’s Business, Industry, and Labor Institute and the Northern Kentucky Area Development District. Speakers will include Theodore Marmer of Yale University, Judy Waxman of the National Office of Health Law, and representatives of business, the medical profession, and insurers. Topics will include HMO’s, home health care, Physician’s Assistants, Nurse Practitioners, and prevention. For further information call Phyllis J. Jones at (606) 572-5602.

Basic Training

The War Resisters League will be holding its annual training program for organizers July 21-30 in Andover, NJ. Alumni of past sessions hold positions with many local and national organizations. The cost, which covers room and board, is $220. For further information, write Grace Hane Hedemann, WRL, 339 Lafayette St., New York, NY 10012.

Class Consciousness

Cancer, the Worker, and the Workplace: A Teacher’s Guide is the first volume in the new series “Preventing Cancer in the Workplace and Community” edited by Dr. Virginia C. Li. Copies of the Guide are available for $1 (including postage and handling) from Jean McGrane, Empire State College, Center for Labor Studies, 330 W. 42nd St., New York, NY 10036.
Last year, aided by a bipartisan commission of carefully chosen Democrats, Republicans, and labor and business leaders, the Reagan Administration sliced a pound of flesh from Social Security pensions, raising the age for full retirement benefits from 65 to 67 years. Now it is using the same surgical techniques to go after Medicare, the medical insurance plan for the elderly run by Social Security.

This March the new bipartisan Social Security Commission on Medicare officially released its final report—its contents had been widely discussed earlier. Medicare is going bankrupt, it warned in a reprise of the pension fund alarm, and offered a series of changes to save it. Beneath some cosmetics, all of the proposals either slash Medicare eligibility and benefits or increase taxes. The major recommendations are:

- Raise the eligibility age from 65 to 67, beginning in 1990. This would eliminate all coverage for 3.3 million Americans between 65 and 67. For the 100,000 people who die each year between ages 65 and 66, this would mean that they would either have to be among the fortunate minority able to afford private insurance, have families willing and able to pay for their final illness and hospitalization, or die at home. Most black males would never be eligible since their life expectancy at birth is only 65.3 years.
- Push the eligibility age up still further if U.S. life expectancy increases.
- Charge employees federal income tax on company health insurance payments above $70 a month for individuals and $175 a month for families, with the revenue going to Medicare. An estimated 22 percent of all working people would pay the tax now, with more likely to be hit as premiums rise in tandem with soaring health care costs. Employees never see this money in their paychecks. Meanwhile, employers would still be able to deduct all health insurance payments from their taxable revenues.
- Increase federal excise taxes on alcohol and tobacco products, with the money going to Medicare. This regressive tax would be paid by consumers at time of purchase.
- Charge elderly patients $10.68 per day (three percent co-insurance) for every day of hospital care after the first in addition to the current $356 deductible for their first two hospital admissions each year. Now the elderly pay the $356 deductible and nothing else until the 61st to 90th days, for which the charge is $89 a day, followed by a lifetime reserve of 60 days of hospital care at $178 a day.

The elderly have already been hit by heavy increases beginning January 1 of this year, when the deductible was raised $52 and the co-insurance from the 61st to 90th day by $13 a day. At the same time the monthly premium for the optional Part B of Medicare (for doctors' fees and tests) was pushed from $12.20 a month to $14.60.

Under current Medicare regulations, the average hospital stay of ten days for an elderly person would cost him or her $356. The commission proposals would boost this to $452.12, a 27 percent increase. For longer stays, the extra bite becomes ferocious. The cost of a 60 day hospitalization would almost triple from $356 to just under $1000. The median income for Americans over 65 is $6,600, and even with Medicare senior citizens already pay 40 percent of their health care costs out of pocket or through private insurance.

Is Medicare Facing Bankruptcy?

The rationale for these measures, echoed by many Democrats as well as Republicans, is that if current trends continue Medicare will go bankrupt by 1990, according to the Medicare commission's projections, and by 1995 will be running a deficit of $250 billion. Projections, however, are only educated guesses, and they get fuzzier the further into the future they go.

Medicare has taken in more money than it has spent every year since 1973, except for a small deficit in 1977. The fund's reserve has fattened from $6.5 billion at the end of 1973 to $18.7 billion at the end of 1981 (see Table 1), enough to permit a loan of $12.4 billion to the Social Security pension fund at the end of 1982. According to preliminary figures, the fund's reserves again in 1983. Clearly, this is not a system in imminent danger of collapse.

The longer term alarums are based on a number of assumptions. One is the increasing proportion of older Americans, who will use a disproportionate amount of health care resources. Currently, for example, the elderly comprise only ten percent of the population but account for a third of health care expenditures and 38 percent of all hospital days. The commission, which cannot stop this demographic change, wants to do the closest thing by redefining what constitutes old age and postponing Medicare eligibility two years to age 67.

Other Medicare assumptions depend on macroeconomic and social variables such as the projected growth of the Gross Domestic Product.
Medicare Health Insurance
Trust Fund Operations (1973-1983)
(Amounts in billions)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Total Income</th>
<th>Total Disbursements</th>
<th>Net Increase In Fund</th>
<th>Fund Balance at End of Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973</td>
<td>$10.8</td>
<td>$ 7.3</td>
<td>$ 3.5</td>
<td>$ 6.5</td>
</tr>
<tr>
<td>1974</td>
<td>12.0</td>
<td>9.4</td>
<td>2.7</td>
<td>9.1</td>
</tr>
<tr>
<td>1975</td>
<td>13.0</td>
<td>11.6</td>
<td>1.4</td>
<td>10.5</td>
</tr>
<tr>
<td>1976</td>
<td>13.8</td>
<td>13.7</td>
<td>0.1</td>
<td>10.6</td>
</tr>
<tr>
<td>1977</td>
<td>15.9</td>
<td>16.0</td>
<td>-0.2</td>
<td>10.4</td>
</tr>
<tr>
<td>1978</td>
<td>19.2</td>
<td>18.2</td>
<td>1.0</td>
<td>11.5</td>
</tr>
<tr>
<td>1979</td>
<td>22.8</td>
<td>21.1</td>
<td>1.8</td>
<td>13.2</td>
</tr>
<tr>
<td>1980</td>
<td>26.1</td>
<td>25.6</td>
<td>0.5</td>
<td>13.7</td>
</tr>
<tr>
<td>1981</td>
<td>35.7</td>
<td>30.7</td>
<td>5.0</td>
<td>18.7</td>
</tr>
<tr>
<td>1982</td>
<td>38.0</td>
<td>36.1</td>
<td>1.9</td>
<td>20.6*</td>
</tr>
<tr>
<td>1983 (est.)</td>
<td>44.7</td>
<td>41.2</td>
<td>3.5</td>
<td>24.1*</td>
</tr>
</tbody>
</table>

Note: Components may not add to totals due to rounding.
*These balances do not reflect the $12.4 billion loaned to the Old Age and Survivors (OASI) Trust Fund, a sum which by law has to be paid back by 1990.

National Product, estimated unemployment rates, changes in the medical component of the Consumer Price Index, and national mortality and fertility rates.

The commission has chosen to base its projections on unusually dismal economic projections, including unemployment rates of about eight percent through 1985. This may be what conservative economists anticipate, but it is not what the Reagan re-election campaign is promising. His Democratic opponent might note this contradiction, and voters should pay heed to it.

The fragility of futurology into the next decade was manifest in a recent revision of estimated Medicare fund balances by the Congressional Budget Office. Just a year ago CBO predicted a cumulative deficit of $40.7 billion by the end of 1989. When the 1983 economic figures were fed into the computer, the fund came out $30 billion ahead in 1989—a $70.7 billion surplus.

DOES THIS LOOK LIKE A TRUST FUND IN CRISIS?

Current Law Projections of Hospital Insurance Trust Fund
Outlays, Incomes, and Balances*
(by fiscal year, in billions of dollars)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Outlays</td>
<td>44.4</td>
<td>50.8</td>
<td>55.7</td>
<td>62.3</td>
<td>69.9</td>
<td>78.0</td>
</tr>
<tr>
<td>Income**</td>
<td>45.6</td>
<td>51.9</td>
<td>59.3</td>
<td>71.0</td>
<td>75.3</td>
<td>74.3</td>
</tr>
<tr>
<td>Year-End-Balance</td>
<td>14.9</td>
<td>16.0</td>
<td>19.6</td>
<td>28.3</td>
<td>33.7</td>
<td>30.0</td>
</tr>
<tr>
<td>Start of Year Balance as Percent of Outlays***</td>
<td>37.6</td>
<td>35.9</td>
<td>35.4</td>
<td>38.4</td>
<td>47.2</td>
<td>49.6</td>
</tr>
</tbody>
</table>

Source: Based on Congressional Budget Office January 1984 baseline economic assumptions.
Note: Columns might not add to total due to rounding.
* The table shows trust fund balances at the start of year as a percent of total outlays for year. The trust fund balance at the start of the year is higher than the balance at the end of the year by the amount of the normalized revenue transfers. Trust fund balances include any borrowed amounts from the other trust funds. Outlays follow OMB budget accounting methods, which include interest payments for the interfund borrowing and for normalized revenue transfers from the Treasury.
** Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances and certain general fund transfers.
*** Puerto Rico's share of the Old Age, Survivors, and Disability Insurance (OASDI) Trust Fund balances.
The other major variable is hospital costs. They have been shooting up at rates as high as 18 percent a year, and the commission assumes they will continue to outpace the overall rate of inflation. This may be a realistic assumption, but only because government policy permits what many articles in this publication and elsewhere have shown to be wasteful, inefficient, and misguided delivery and reimbursement systems.

Even if the health care system is permitted to continue as is, placing the burden of increased health care costs on the elderly ill is unconscionable. This choice by the Reagan Administration is simply another aspect of the broad policy of redistributing income from the poor and working people to the rich and the corporations; to free more money for the military without requiring any sacrifice by those who can best afford it.

3. ibid. p. 103.
5. National Center, op. cit. p. 36.

---

**Index to Volume 14**

(Note: the cover of Volume 14, Number 6—Volume 15, Number 1 was mislabelled Volume 13, Number 6—Volume 14, Number 1)

<table>
<thead>
<tr>
<th>A</th>
<th>General Accounting Office</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>No. 3</td>
<td>Gersuny, Carl</td>
</tr>
<tr>
<td>American Hospital Supply Co.</td>
<td>No. 2</td>
<td>Gray Panthers</td>
</tr>
<tr>
<td>American Nurses Association</td>
<td>No. 3</td>
<td>Great Britain</td>
</tr>
<tr>
<td>Asbestos</td>
<td>No. 3</td>
<td>Grenada</td>
</tr>
<tr>
<td>Assault on the Worker</td>
<td>No. 5</td>
<td>Hazardous wastes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Health Facts</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berman, Daniel</td>
<td>No. 5</td>
<td>Health &amp; Work Under Capitalism</td>
</tr>
<tr>
<td>Biotechnology</td>
<td>No. 5</td>
<td>Health Research Group</td>
</tr>
<tr>
<td>Black Lung disease</td>
<td>No. 3</td>
<td>HMO's</td>
</tr>
<tr>
<td>Black Women's Health Conference</td>
<td>No. 4</td>
<td>Hoffman-LaRoche</td>
</tr>
<tr>
<td>Brown Lung disease</td>
<td>No. 3</td>
<td>Hospitals</td>
</tr>
<tr>
<td>C</td>
<td>Hospital Corporation of America</td>
<td>I</td>
</tr>
<tr>
<td>Canada</td>
<td>No. 5</td>
<td>Human rights</td>
</tr>
<tr>
<td>Capital budgets</td>
<td>No. 4</td>
<td>Immigration Reform and Control Act</td>
</tr>
<tr>
<td>Carson, W.G.</td>
<td>No. 6</td>
<td>J</td>
</tr>
<tr>
<td>Childbirth</td>
<td>No. 6</td>
<td>Johnson &amp; Johnson</td>
</tr>
<tr>
<td>Childcare</td>
<td>No. 5</td>
<td>Kuhn, Maggie</td>
</tr>
<tr>
<td>Corruption</td>
<td>No. 2</td>
<td>Kuhn, Maggie</td>
</tr>
<tr>
<td>Cost-cutting</td>
<td>No. 6</td>
<td>Maclean Hospital</td>
</tr>
<tr>
<td>Cutbacks</td>
<td>No. 1, 2</td>
<td>McCaffrey, David P.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Medical supply industry</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware Valley Toxics Coalition</td>
<td>No. 4</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Dental care</td>
<td>No. 1, 2, 3</td>
<td>Medicare</td>
</tr>
<tr>
<td>Doctor draft</td>
<td>No. 2</td>
<td>Merck</td>
</tr>
<tr>
<td>DRG's</td>
<td>No. 1</td>
<td>Michigan</td>
</tr>
<tr>
<td>Dumpsite cleanups</td>
<td>No. 4</td>
<td>Military hospitals</td>
</tr>
<tr>
<td>E</td>
<td>Missing Pieces</td>
<td>No. 2</td>
</tr>
<tr>
<td>El Salvador</td>
<td>No. 6</td>
<td>Mississippi</td>
</tr>
<tr>
<td>Environmental Defense Fund</td>
<td>No. 4</td>
<td>Mississipi</td>
</tr>
<tr>
<td>Environmental health</td>
<td>No. 3, 4, 5, 6</td>
<td>Mote</td>
</tr>
<tr>
<td>Eritrea</td>
<td>No. 5</td>
<td>Mote</td>
</tr>
</tbody>
</table>

| F | No. 4 | Mississippi | No. 4 |

---

Health/PAC Bulletin 23
<table>
<thead>
<tr>
<th>N</th>
<th>Napoli, Maryann</th>
<th>No. 3</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National League of Nurses</td>
<td>No. 3</td>
<td>Social Transformation of American Medicine</td>
</tr>
<tr>
<td></td>
<td>Navarro, Vicente</td>
<td>No. 5</td>
<td>Squibb</td>
</tr>
<tr>
<td></td>
<td>Nestle's boycott</td>
<td>No. 6</td>
<td>Starr, Paul</td>
</tr>
<tr>
<td></td>
<td>New York</td>
<td>No. 2,4</td>
<td>Stimtech</td>
</tr>
<tr>
<td></td>
<td>Nicaragua</td>
<td>No. 5,6</td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>No. 3,5</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Occupational safety and health</td>
<td>No. 3,4,5</td>
<td>Tax write-offs</td>
</tr>
<tr>
<td></td>
<td>OSHA and the Politics of Health Regulation</td>
<td>No. 5</td>
<td>Teenage pregnancy</td>
</tr>
<tr>
<td></td>
<td>Oxyphenbutazone</td>
<td>No. 6</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>PAC's</td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paterson, Craig</td>
<td>No. 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pesticides</td>
<td>No. 5,6</td>
<td>Voluntary Hospitals of America</td>
</tr>
<tr>
<td></td>
<td>Pfizer</td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmaceutical Manufacturer's Assoc.</td>
<td>No. 1</td>
<td>Washington, DC</td>
</tr>
<tr>
<td></td>
<td>Phenylbutazone</td>
<td>No. 6</td>
<td>WIC program</td>
</tr>
<tr>
<td></td>
<td>Physician incomes</td>
<td>No. 1</td>
<td>Working Hazards and Industrial Conflict</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td>No. 4</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Reasons, Charles E.</td>
<td>No. 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Right to Know Legislation</td>
<td>No. 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ross, Lois L.</td>
<td>No. 5</td>
<td>Zola, Irving Kenneth</td>
</tr>
<tr>
<td>S</td>
<td></td>
<td>No. 4,5,6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. 2</td>
<td></td>
</tr>
</tbody>
</table>

---

The First Annual Samuel Rubin Health and Social Justice Award
Pain Killers
Merck & Co. Comes to Ireland
by Jon Steinberg

It seems as if people and animals of Ireland's Suir Valley are crying: a stream forms in their eyes and nose and, in truth, there is a good deal to cry about. Milk yields have dropped. Calves have been born with deformed bone structures. Cattle have weakened mysteriously and died. So have rabbits. Bertie Kennedy neither smoked nor drank but he got lung cancer and died last August; the doctor said he had never seen that type of cancer in a farmer before. Bertie Kennedy was 37.

"I'm not blaming Merck Sharp and Dohme for my illness," he told the Irish monthly Magill last spring, "But I think it should definitely be monitored." Others, including his widow, have been ready to blame the Irish division of Merck & Co., the American pharmaceutical giant. The corporation denies it has caused any pollution problem.

Monitors were installed by the County Council of South Tipperary in 1980 when farmers first noticed problems in their plants and animals and raised an outcry. A pollution study commissioned by the council in response to further protests detected some toxins and recommended further monitoring of emissions from the Merck factory. Yet the same year the council disconnected all the monitors, declaring they had detected only "acceptable levels of pollutants."

"Acceptable" is a relative word. South Tipperary and Ireland in general have long suffered levels of unemployment far above U.S. rates; this makes a lot of situations we might find intolerable "acceptable." When Merck proposed building a plant at Ballydine in the Suir Valley which would employ 450 people, local and national government officials were eager to cooperate in any way possible. Their efforts paid off. The plant was built, followed by many more around the country. Ireland now rivals Puerto Rico as the fastest-growing production site for U.S. pharmaceutical manufacturers, with 11 of the top 17

By the 1970's pollution controls accounted for 12 percent of building and operating costs of chemical plants in the U.S. In countries such as Ireland and Puerto Rico, that proportion is halved. Little is required, less is inspected. Local officials in Ireland are not obligated to collect information on pollution-related problems.

The Irish have no occupational health institute. Since 1980 the Chemical Division of their Department of Labor has been effectively dormant for lack of staff and equipment. The only health problems a company is legally obligated to report are deaths, injuries requiring more than three days absence from work, and dangerous occurrences. Workers who refuse to do a job they believe is hazardous to their health can be dismissed. There is no requirement that ex-employers in hazardous occupations be monitored.

Essentially, the state relies on corporate management to police itself. And Merck, before building its Ballydine plant, did distribute leaflets locally promising "air pollution control measures...with the objective of meeting the most stringent demands of any future pollution control legislation." Many residents have since concluded that if their experience with Merck is any guide, future legislation will be quite modest.

There are troubling indications that the corporation doesn't always meet its legal commitments in any case. In the year 1981 alone, it paid a $5,000 fine after being charged with bypassing its pollution control equipment and a $550 fine for alleged release of odors in New Jersey, accepted a settlement obligating it to take all cleanup abatement measures necessary and pay $500 to Pennsylvania's Solid Waste Abatement Fund after two spills of hazardous waste there, and a $4000 payment to the state of Kentucky for violating the operating permit for the carbon reactivation furnace at its plant in Catlettsburg.

Merck's marketing practices have also generated questions and lawsuits. Its promotion of DES, the "wonder drug" prescribed to pregnant women which caused cancer and conception problems in their daughters, has made it a prime target for hundreds of women seeking millions of dollars in damages.

Merck currently markets a product known as amitriptyline under the brand Tryptizol. A powerful antidepressant which has been blamed even in normal doses for deaths from heart failure, blood disease, and liver damage. Tryptizol is recommended by Merck for a variety of ailments including enuresis. Most of us are more familiar with this problem under the name bedwetting, but even with its latin designation few child specialists call it a disease; most commonly, they say it is a

This article was written with the help of Making Their Merck on Ireland, written by the Study Group, and Fear in the Valley, an article by Colm Toibin in the June 1983 issue of Magill magazine, Dublin.)
eliminate bedwetting in children under eight, and the problem usually disappears after that. Worse yet, amitriptyline was the leading cause of fatal poisoning among British children under five in the 1970's.

Osmosin, one of Merck's best-selling drugs internationally, has been withdrawn from the market in eight countries. Essentially a timed-release (through osmosis) version of the anti-arthritis drug indomethacin (sold at three times the price), it was proclaimed "well tolerated" in a massive advertising campaign. Within months of its introduction, Britain's Committee on Safety of Medicines issued a warning to doctors that the high rate of adverse reactions, most commonly severe headaches and gastrointestinal problems such as bleeding and perforation, indicates that Osmosin is no safer than the drugs it replaces and may cause even more damage to certain areas of the bowels.

Indomethacin is sold in the U.S. to treat four ailments, and recommendations for its use are very narrowly drawn. In Latin America it is advertised as valuable for relieving ten problems, including "pain in dental ailments" and "menstrual pain." In Ireland it is also suggested for ten indications, including sprains and strains. "And Merck," Ann Street of the Interfaith Center on Corporate Responsibility told Health/PAC, "is actually one of the better pharmaceuticals companies in its Third World sales policies."

If Ireland is part of Merck's Third World, it is also a recipient of the corporation's largesse, over $300,000 to medical, educational, and community institutions and groups—most of them in South Tipperary. The local county council and district council as well as the national government have given Merck their solid support.

Sometimes this support takes interesting forms. Last summer the county council cut off the water supply to the farm of John Hanrahan, the most vocal critic of the Merck plant, allegedly for non-payment of rates, and only turned it on again when the national Minister for the Environment intervened.

In the most charitable interpretation, these officials appear to have decided that any risk to the property, health, and even lives of a relatively small number of people is far outweighed by the benefits to the general welfare. Understandably the people who feel endangered view the scales differently.

In 1982 public pressure again compelled the county council to commission an environmental study. This was carried out by the Trinity College Department of Botany. The findings were carefully kept from the local citizenry, which finally obtained them after considerable effort. They revealed that "chlorine and bromine in excess of median levels for grass" had been detected on the Hanrahan farm, which lies directly downwind from the Merck plant. In combination, these two substances can be lethal in minute quantities. The report also noted "remarkably high levels of sulphur, chlorine, and bromine over the whole area surveyed," and clear evidence that the sulphur came form sulphur dioxide emissions at the plant.

Merck claims that chlorine and bromine levels in the area are lower now than they were before the plant was built. It also says there are no health problems among its Ballydine employees.

Critics retort that if any workers have complaints, they will probably keep quiet about them. In January 1983 a maintenance worker was fired on the grounds that he had an unacceptable absenteeism record and was medically unfit for work. His ailment was dermatitis, and he had stayed out on the advice of the company doctor.

"Here we would appear to have Merck's policy towards health and safety at work," commented an Irish study group formed to investigate Merck's activities, "when a worker becomes too sick to work because of a disease he contracted at work, sack him."

The maintenance worker's union went out on strike and demanded that he be rehired, but returned when the case was referred to the national Labor Court.

Fighting a multi-billion-dollar corporate giant, multinational in sales and production, American in management and profits, isn't easy for the inhabitants of a small, poor town in a poor country. At a press conference called by Merck last September to announce a $1.7 million laboratory expansion, reporters for all the national dailies pursued the Ballydine pollution issue and filed copy on it; not a word appeared in their papers.

"The people here feel very isolated and helpless," one of their supporters wrote Health/PAC, but to save their breath they have to speak out.

---

**MAKE YOUR COMMUNITY A NUCLEAR FREE ZONE**

Toward a Nuclear Free Future

A comprehensive 44-page guide to designing a Nuclear Free Zone campaign in your community ($5 each, $3 each for 10 or more). Also available: *Uncovering the Nuclear Industry: A Research Guide* ($2 each, $1.50 each for 10 or more) and *Nuclear Free Zone Information Packet* ($3 each, $2.50 each for 10 or more).

**mobilization FOR SURVIVAL**

853 Broadway, 2109B
New York, N.Y. 10003
Body English

When Less Care is More
by Arthur A. Levin

My father died at five minutes after midnight this past October. His last several days were spent in sleep induced by injected morphine—protected from the physical pain and mental disarrangement brought on by widely metastisized prostatic cancer.

Much has been written about fathers and sons, their lives and deaths, and I have no special insights to contribute to that vast literature. No matter how old, or how sick, the death of a parent produces bone-chilling sadness, touching on, as it must, our own perceptions of personal mortality, as well as the realization that a part of one’s life since inception has disappeared.

However, the experience of my father’s illness, given my interest in medical consumerism, did provide interesting insights into medical practice and the behavior of practitioners that I would like to share.

The physicians in charge of my father’s care were board-certified specialists and attendings at the local community hospital. They appeared to be genuinely concerned about his well-being. Because his series of major illnesses had begun (with a major heart attack) some 25 years ago and he had survived them all, my father generally trusted physicians.

Because of my experiences with seriously ill people, particularly those with cancer, I was concerned that my father not be subjected to unnecessary pain and suffering resulting from useless overtreatment, or refusal to provide sufficient pain control. I talked with the rest of the family about the issue in general, and with my father around specifics—such as drugs for pain and chemotherapy. During such discussions I had to temper my belief that all information should be openly shared with the recognition that my father still had hope that something could be done to make him better. We also started discussions with the doctors—trying to make it clear that we wanted them to concentrate on preserving the dignity of a man who had lived a good life and deserved a comfortable departure. We sensed that we were all agreed—intervention would be limited to making my father comfortable.

My father’s remission ended in the late spring. The bone metastasis encroached on his spine so that the back and leg pains increased; they were initially controlled by mild analgesics. As the pain increased in severity, stronger medication was prescribed, as well as two short, very focused courses of palliative radiation. At first the pain seemed to be controlled under these regimens and there were no serious side-effects, but then my father, whose mind had never dulled during his last decades, began to hallucinate, have delusions, and become confused.

The family, which had become adept at dealing with physical illness, now had to adjust to a whole different set of behavioral problems requiring full time attendant care. Despite a commitment to keeping him at home, there unfortunately was little alternative to hospitalization since he had become more disruptive, less ambulatory, and very fragile. The agreement to treat only minimally started to break down as the situation became more complex. Drugs were administered to quiet him; pain medication was continued, as was the second course of radiation. He also continued to receive medication for his heart and high blood pressure as well as to prevent stroke, he had recently had a suspected Transitory Ischemic Attack (a mini-stroke). He was given at least six to eight different drugs, and subjected to both their individual and cumulative risks. When his cognitive abilities deteriorated and his delusions worsened one physician tried to withdraw him from almost all medication to see if the mental difficulties were drug-induced. They may have been, but withdrawal did not remedy the problem and he was put back on some, although not all, of what he had been taking. Then he began to experience terrible diarrhea and gastric cramping, so more medication was prescribed. He weakened quickly and his voice echoed his exhaustion. He could not eat or hold food, so an IV was inserted in a vein. He pulled it out the first night.

On the Wednesday before his death my father told his primary physician that he would not eat nor take any more medicine, that the IV should be disconnected and that he wanted to be made “comfortable.” The family was consulted and supported his decision. The doctor agreed to discontinue all medication, and to administer enough morphine to allow my father to sleep comfortably, which he did until his death several days later.

Despite the understanding to limit treatment to what was necessary for comfort, my father ended up on a multi-drug regimen which may have been the cause of his confused mental state and his rapid decline. With tumors closing in on his spine, radiation was probably necessary to slow their growth, which could have impinged on spinal structure and caused him relentless pain. Otherwise, the only relief might have come from heroic major surgery, which no physician wanted. But what the radiation “cost” in the quality of his life no one can say.

Although none of use would have denied him the pain relief provided by medication—we were always more concerned that he not suffer because of badly managed pain control efforts—that too probably contributed to his decline. Continuing his regular medication seemed an unanalyzed given, yet there is almost no doubt that so much medication must have been harmful given his advanced age, frailty and the inevitable cumulative effects. In short, despite the clearly articulated agreement to provide only palliation, much of what was done represented either a continuation of old curative treatments or the addition of new ones.

What happened? In reflecting on the medical course of the last six weeks of my father’s life I began to realize that my…
father's doctors seemed best able to express their caring by doing something—and that something was medical intervention. My father’s treatments may have been more the result of each physician’s need to act than of any scientific assessment of clinical efficacy. They could accept the abstract notion of minimal treatment, but met each crisis with another invasive action.

Not to treat could be seen as not caring. Physicians need to be convinced that there are many times when not to treat is the ultimate expression of caring. If indeed subject to an imperative to treat those they care about, they must be released from the responsibility of decisions not to treat. Ill people and their families must reassure practitioners that decisions to limit treatment and withhold heroic efforts will not be seen as a callous “writing off,” but as a mutually arrived at expression of concern for comfort and integrity. Practitioners should understand that traditional demonstrations of concern and care—touching, talking and the like—are appropriate physician behavior and will be appreciated by those involved. Just as with many of life’s activities, doing less may be doing more.

Arthur A. Levin is Director of the Center for Medical Consumers, publisher of Healthfacts, and a member of the Health/PAC Board.

continued from page 6

and they are polished off in a few seconds. The national drink is a local whiskey mixed with Ktaing-daeng.

One might think that the government’s failure to act against this expensive, damaging, addictive product must mean powerful interests are involved. This is true. Lipovitan-D is made by a company owned by the Deputy Minister of the Interior and his family.

This family also manufactures Tampai, one of Thailand’s two largest-selling APC’s. A is for aspirin, P is for phenacetin, and C is for codeine. Together they form a powerful, addictive painkiller which Thailand’s eight million farmers drink with water or chew all day the way the hardworking indians of the Andes chew coca leaves.

“Most of our farmers are addicted to them,” a professor at Chulalongkorn University in Bangkok told New Scientist, “Farming is backbreaking business, especially in the rice paddies, and the men need something to dull the pain.” Many spend a sixth of their income or more on APC’s.

The multinational drug companies also profit from the Thai obsession with pills. Shopkeepers create their own mixtures, known as yachud, for a variety of ills. Some, containing vitamins and iron, are harmless though expensive—particularly considering their inefficacy beyond a placebo effect—combinations of vitamins and iron. Others contain phenylbutazone, whose numerous side effects are also ravaging children and others in El Salvador and a host of other countries; steroids, also extremely dangerous; and Valium and Librium, whose negative side effects are well known in the U.S. The Thais who buy them need no prescription, and don’t know the ingredients of the little packets. All they know is they want more.

Thailand’s feefee Food and Drug Administration insists that indiscriminate sales of these packets have been nearly wiped out everywhere but in the most remote villages. “This,” says New Scientist, “is simply not true. . . . Government officials will not discuss frankly the country’s drug problems, let alone acknowledge the existence and extent of, for example, amphetamine and diazepam (Librium) abuse. And the multinational pharmaceutical firms keep their figures and views to themselves.”

Getting the Message

Earlier this year a coalition of 30 public interest groups and unions including the National Audubon Society and the Service Employees International Union sharply criticized the American Cancer Society for its diffidence in opposing carcinogens.

The coalition, led by the Center for Science in the Public Interest, charged that by demanding proof that substances caused cancer in humans, the ACS was creating a virtually impassable hurdle to action. It takes years and vast sums of money to develop strong evidence from human experience, and appropriate animal tests are considered valid by most experts in the field. The ACS position was also disturbingly similar to that of the Reagan Administration’s Environmental Protection Agency, and justified its failure to control many known hazards.

The public denunciation was timed to coincide with the ACS’s triannual board of directors meeting. It followed a letter from 28 noted scientists making a similar point. Whether these criticisms were decisive or the directors themselves reconsidered their position on their own, the resolutions which came out of the meeting represent an amazing turnaround.

The ACS came out in support of safety standards for EDB pesticides and the Superfund to clean up toxic wastes. It also issued statements indicating it will testify on benzene and asbestos at government hearings—something it has been loathe to do in the past when any substance other than cigarettes was under consideration.

Michael Jacobson, director of CSPI, reacted by saying, “We’re delighted,” since the new policies “have changed the ACS from an antismoking society to an anticancer society.”

by Kate Pfordscher

Are nurses professionals or proletarians? This question often resembles asking if a glass is half full or half empty.

The standard histories describe a valiant and largely successful struggle by nursing leadership against doctors and hospitals to win professional autonomy for registered nurses. In contrast, critics on the left emphasize the low pay, poor working conditions, and lack of autonomy which rank and file RN’s well know has not been put behind them.

When these critics measure nursing against a structurally-defined list of criteria such as whether it can strictly limit the entry of new members or fully regulate its practice in society, it is usually found lacking. The conclusion is usually that since working nurses consider themselves to be professionals despite these conditions, they suffer from “false consciousness.”

In her ambitious new history of nursing social historian Barbara Melosh challenges both of these perspectives and reinterprets professionalism as one of several competing traditions nurses have created to control the terms of their employment.

The Physician’s Hand covers the period when the health care industry became centralized as hospitals became the locus of medical practice and health care service work was rationalized. Following an introduction which describes the class origins of early nursing leadership and the strategy it developed to found a women’s profession, Melosh devotes a chapter to each of the dominant forms of nursing work, hospital training schools (1920 to 1950), private duty nursing (1920 to World War II), public health nursing (1920 to 1955), and hospital nursing (1930 to the present).

Placing herself squarely among the revisionist historians, Melosh argues that nursing is not and could never be a true profession. Nurses have always been subordinate to doctors on the job, a relationship reproduced by sex segregation in the labor market, she notes, and “If professions maintain their authority through controlling the division of labor related to their work as Friedson argues, then the doctors’ own professionalism organizes and requires nurses’ subordination.”

Melosh goes on to say that this hierarchical relationship is not absolute and has changed over time. Though cast in the role of “physician’s hand,” working nurses have created ways to resist the pressures of their day to day work lives. This resistance, informally codified in what Melosh terms “work culture,” is the focus of her book.

Drawing on a variety of sources including training manuals, didactic novels, and letters to nursing journals, Melosh attempts to present the voice of rank and file nurses who, she argues, developed their work culture, or ideology, apart from the nursing leadership’s goal of professionalism. She traces this rank and file ideology from the tradition of apprenticeship in hospital training schools and shows how it served as an alternative to the leadership’s elitism.

Melosh defines work culture as the formal and informal social rules, lore, humor, and traditions created by people working together; the means by which workers initiate and school new members of their social grouping. It is also a way to assert control over the work itself.

Occupational culture is not just an elaboration of work; it is the critical link between a job’s official protocol and its actual performance. Without it, most work simply could not be done. Located at this vital juncture, occupational culture at once reveals workers’ central contribution to production and suggests a powerful wedge for claiming and extending workers’ control on the job.

After laying out this notion, she attempts to apply it in attacking a larger issue: What has rationalization meant for women service workers in the twentieth century? In contrast to the conclusions which labor historians such as Harry Braverman, David Montgomery, and Daniel Nelson have drawn about the predominantly male workforce in heavy industries as they were rationalized, Melosh maintains that nurses, though “faced with fundamental reorganization of work that changed the content and experience of nursing...did not suffer a dilution of skill.”

In fact, she argues, these women workers benefited. As relatively stable employment in hospitals replaced the scramble for private duty jobs, nurses became much less dependent on both doctors and individual patients for economic survival. With the growth of technology and an increasingly elaborate hospital bureaucracy after World War II, nurses—now called registered nurses—won a firm place in middle management.

In the late nineteenth century nursing leadership began a campaign to establish their occupation as a women’s profession. Mostly daughters of the middle and upper classes themselves, they attempted to enhance the legitimacy of their demands by attracting “the better sort” and weeding out the lower orders through educational reform.

Since they were founded at the turn of the century, both the American Nursing Association and the National League of Nursing have continued to lobby for educational upgrading and restrictive licensing. The working nurse, coming from less prestigious classes and educational backgrounds and involved in the practical demands of caring for her patients, was threatened by these programs, according to Melosh; it was the shared experience of the work itself, “not the hope of professionalization, that shaped ordinary nurses’ aspirations and ideology.”

Until the 1950’s, most nurses were educated in hospital training schools, where they learned patient care on the hospital ward. Hospitals ran on this student labor and provided free room and board in exchange. Rigidly paternalistic and strictly disciplined, nursing school was an initiation into a vocation which “valued the craft skills of nursing—gentle
hands, a deft injection, careful handling of the patient in pain." Young women quickly learned to deal with the realities of death, disease, and sexuality with appropriate detachment. Perhaps of greater importance, the female community of the hospital school helped justify the right of nurses as working class women to do paid work:

Set apart from the social life of their contemporaries, young women participated in a communal life arranged around work. Theirs was a woman's world: they enjoyed the support and camaraderie of other women as peers, and looked up to female models as they worked with more experienced students and supervisors. Few other institutions in the twentieth century could provide young women with a comparable experience of female autonomy.

Completing their apprenticeship, most nurses took jobs caring for private patients in their homes; fewer went into public health nursing. Those who seek a golden past often portray this period as a time when nurses were truly autonomous craft workers. Though it is true that private duty nurses did work outside direct supervision by medical superiors, most jobs were short-term and nurses rarely enjoyed financial security. Nurses, notes Melosh, were employed directly by their patients and depended on doctors to recommend them for jobs. This was hardly an entrepreneurial paradise; as a nurse complained in a letter to RN, "Many patients seem to think they are 'getting their money's worth' only if they keep the nurse running all the time, regardless of the fact that she is removed from her patient when doing these chores."

Despite these pressures, Melosh says, private duty nurses found ways to limit their patients' demands. She cites evidence that freelance nurses preferred to care for their patients in hospitals where they were much more dependent on the nurse than in their own home.

Public health nursing, on the other hand, offered RN's almost complete independence from physicians and limited patient control. Funded by government and private philanthropy, this field grew to include one fifth of all trained nurses by 1926. In the early years, the public health nurse was a true generalist who would ride out to her poor clients to preach "the gospel of health." Later many joined the ANA and NLN leadership in responding to the growing rationalization of medicine by trying to establish a "scientific basis for nursing methods," and a legitimate public health nursing specialty.

The Depression and the increasing consolidation of health services into hospitals shattered these employment alternatives. The private duty market had all but disappeared by the early 1930's, creating a vast pool of unemployed, trained nurses. Increasingly, those who could still find private duty jobs cared for their patients in the hospital and were subject to the new bureaucratic routine even though they were not yet actually employees. Funding for public health agencies dwindled during the Depression, and their function was also absorbed by the growing hospital sector.

At the same time hospitals began hiring graduate nurses in significant numbers to staff their wards as student enrollments dropped and high unemployment among graduate nurses depressed wages. Studies, many of them sponsored by the nursing leadership, concluded that it did not cost much more to pay a graduate nurse wages than to provide training, room, and board to a student. But what really convinced hospitals to open their doors to graduate nurses, Melosh argues, was their drive to reorganize and apply modern industrial management techniques. The nursing leadership's appeal for professionally trained nurses—now under the rationale of efficiency—found a ready audience among hospital administrators. The number of graduate nurses employed by hospitals jumped from 4,000 to 27,000 between 1929 and 1937.

Rank and file nurses were not so sanguine about these developments. Their argument against the stopwatch was framed in the terms of the older apprenticeship system—nurturance versus scientific medicine. "We surely lose private duty attitude as we must rush everything through in a slam-bang way; checking off of duties assigned to us seems more important than the care of patients," complained a former private duty nurse in a letter to the American Journal of Nursing.

Within the hospital, the nursing leadership used the rhetoric of rationalization to lobby for a better position for graduate nurses in the emerging job hierarchy. Though working nurses vehemently objected to the introduction of auxiliary nursing staff, which they saw as competition, their leadership actively participated in the establishment of licensed practical nursing. The ANA and NLN, Melosh maintains, "yielded to public opinion and to pressure from hospital administrators for cheaper workers in exchange for control of the developing nursing hierarchies." The RN as professional ward foreperson was born.

The technological revolution, beginning in the 1950's, further enhanced the position of RN's generally. Their patients and the public at large were in awe of their growing technical skill, and doctors were now much more dependent on them for careful observation and meticulous record-keeping.

In a most insightful passage, Melosh describes the experience of a nurse during the polio epidemic in the 1940's. While caring for a severely ill patient, the nurse detected a subtle change in her charge's breathing and called for the attending physician. The patient was put into an iron lung and eventually fully recovered:

...The development of new medical technology changed the significance of nursing observation and care in ways that brought nursing and medicine into closer alliance. Twenty-five years before, when iron lungs were not yet in use, the nurse's observation would have signaled the limits of medical care; the physician could only watch helplessly and wait to sign the death certificate. Such a moment had a very different meaning and character as the possibilities for medical intervention expanded.

In the hospital, working RN's also gained a collective workplace, which in combination with increased skill and the status that conferred on nurses as working women, provided a basis for collective action. Rising expectations, Melosh concludes, has encouraged the current growth in unionization.

But this can't be the whole story. Though The Physician's Hand ends on a decidedly upbeat note, it does not carry the logic of its argument into the present. The positive elements of hospital work Melosh describes were present throughout the 1960's (particularly following the passage of Medicaid and Medicare in 1965) yet unionization did not really become a major issue among...
nurses until the mid-1970’s, when the rise in hospital revenues slowed and nurses’ workload “sped up.” This period might be better characterized as one of increased conflict between nurses’ expectations and hospital employers’ declining inclination to meet them.

This does not, I think, do damage to the book’s main argument. The position of registered nurses in the medical division of labor has improved with rationalization, as she argues which explains the success of professionalism as their dominant ideology.

But “professionalism” is not static; it can mean very different things to the leadership and to working RN’s. Faced with the exigencies of work in hospitals—low pay, high skill requirements, enormous workloads, and tremendous responsibility—working RN’s have creatively reshaped the individualism of what might be called “classic” professionalism to justify militant unionism. One striker quoted in The Physician’s Hand says, “I want to feel good about myself as a professional nurse, and the only way I can do that is to be sure the conditions under which I work are good enough for my patient.”

In a similar vein, a nursing organizer for a state nursing association explained to me recently:

“I tell nurses, ‘you have a professional, legal responsibility to give quality care.’ When the hospital is understaffed and a nurse is forced to divide her time between caring for her patients and emptying the garbage, she’s violating her professional duty. It’s like a lawyer who misrepresents his client because he has too much work. The only way to get management to hire more staff is to force them—collectively.

In this statement she has neatly turned the responsibility of a professional as it was traditionally understood on its head to create a justification for strikes; this argument was unheard of even five years ago.

Paradoxically, the new working nurse professionalism is a creative expression of workers’ control within the bureaucratic organization of today’s hospital. It is a strategy which ranks and file RN’s all over the U.S. have forced state nursing associations to adopt and, in my opinion, is a promising development for nursing as a whole.

However, to identify an occupational ideology as a strategy for workers’ control does not in itself make it progressive in all contexts or for all workers. Melosh relates a history which contains losers as well as winners. Although the new ideology, which might be called “unionist” professionalism, is praiseworthy for its militant rank and file perspective, by definition it excludes other hospital workers. Despite their continuing lack of interest in the licensing and accreditation reforms the national leadership lobbies for, most RN’s still do not believe in or ally with other hospital workers to confront their employers.

In the transition to hospital-based nursing, staff RN’s gained authority over other hospital staff but the current trend of cutbacks in both RN and ancillary nursing staff means fewer people to direct and more work to do. And as any nurse—RN, LPN, or aide—will say, the strict distinction between a registered nurse and her subordinates blurs on the ward.

In this context, it is perhaps understandable that RN’s go into collective bargaining demanding that they not be required to perform “non-nursing” functions. But whether this position, which proponents base on the argument that registered nurses have unique skills and other workers often interpret as simply passing the buck, will actually limit registered nurses’ workload remains to be seen.

Kate Pfordresher is on the staff of the American Working Class History Project.

---

**YOU HAVE A BEAUTIFUL FACE BUT YOUR NOSE?**

**IN THIS DAY AND AGE attention to your appearance is an absolute necessity If you expect to make the most out of life, not only should you wish to appear attractive as possible, for your own self satisfaction, which is alone worth your efforts, but you will find the world in general judging you greatly, if not wholly, by your looks, Therefore it pays to “look your best” at all times.

Permits no one to see you looking otherwise: it will injury your welfare! Upon the impression you constantly make rests your future or success of your life. Which is to be your ultimate destiny?

My newest greatly improved superior Nose Shaper, “TRADOS MODEL 25,” U. S. Patent, corrects all ill-shaped noses without operation, quickly, safely, comfortably and permanently. Diseased cases excepted. Model 25 Is the latest in Nose Shapers and surpasses all my previous Models and Nose Shaper Patents by a large margin. It has six adjustable pressure regulators, being worn at night it does not interfere with your daily work. Thousands of unsolicited testimonials on hand, and my fifteen years of studying and manufacturing Nose Shapers is at your disposal, which guarantee you entire satisfaction and a perfect shaped nose. (Above illustration represents my “Trade Mark” and shows my first and oldest Nose Shaper. It is not a replica of my latest superior Model No. 25.)

M. TRILETY, Face Specialist 1959 Ackerman Bldg., Binghamton, N. Y.