LOSSES IN PROFITS

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To the Editor:

I have decided not to sign up to “participate” in Medicare and thereby accept “assignment” of all fees on all Medicare visits for the year under the new legislation. I want to explain why.

I have a solo private practice in a rather poor rural area in Columbia County of upstate New York. I like it here. I came to try to put into effect some ideas and ideals I held after many years in community medicine in hospitals, health centers, academic life, and medical-political activism and writing in New York and New Haven. My practice tilts toward geriatric care because that is an area where I have interest and skill. I practice largely in the office and rather little in the hospital. I do more house calls in a week than most doctors do in six months. My fees are among the lowest in this county. I charge $20 for a first short visit, $18 for a follow-up, $45 for a first complete history and physical, $30 for a weekday house call, and $40 for a first complete history and physical, $30 for a weekday house call, and $40 for a required at nights or on weekends. I do a lot of “cognitive medicine,” that is, I listen to my patients and I talk with them. I do very few procedures for which a lot of money can be made in a very short time. At a time when other doctors feel forced to cut back on it, I see a very large proportion of Medicaid and other low income patients from whom the return in fees is never even worth the time and expense of billing.

I net a little over $30,000 a year.

Generally I have taken assignment from Medicare on hospital cases because the sums are larger than on office bills, and they, without assignment, also represent a burden for the patient. And I have taken assignment on other bills when requested to do so. The result of all this is that my Medicare feel profile over recent years is so low as to make city doctors laugh. I must add that the amount authorized by Medicare is the lowest of the present actual charge, the past pattern of charges for similar visits, and a weighted percentage of the prevailing community pattern for such visits. If I were forced to take assignment across the board I would get about $15 for a 30 minute house call plus about 20 minute’s drive each way. And I would suffer a major cut in income from work in the office because that is where most of patient visits occur.

My medical income is certainly in the lowest tenth percentile of medical incomes across the country. It is in no sense higher than that of many professional, business, and even many retired people in my community. Hence I cannot take a major reduction in that by way of forced Medicare assignment. And I do not seek now to raise my fees.

This legislation makes no attack on the massive profiteering by many physicians who charge high fees, let alone the for-profit hospital chains and equipment manufacturers. Under the current Medicare fee structure hospital, surgical and technical fees far surpass those of any country in the world. It pays doctors according to their past profile, so that the highest chargers keep on getting high rates and the lowest chargers keep on getting low rates for the same work. The impact this has on primary care medicine is obvious.

In essence, this means Medicare reinforces class medicine, in which there is one system of medical care for the rich and another for the poor, with the doctor...
Notes & Comment

Virtually all of us know of at least one elderly person who has been hospitalized or placed in a nursing home for lack of adequate home care—or, more accurately, for lack of insurance or other means to pay for adequate home care. The result is often not only emotional trauma and even premature death, but a substantial waste of money.

At a recent meeting sponsored by the Hospital Research and Educational Fund Trust, Patrice Feinstein of the Health Care Financing Administration (HCFA) seemed to agree. She suggested that Medicaid might change its policies to permit social and support services such as home care, adding, “We don't know how cost effective these approaches would be. If they turn out to be cost effective, what a marvelous breakthrough.”

The problem is, this formulation is more ambiguous than it seems. If paying someone to clean house and bring a hot meal for an enfeebled person every day or two turns out be cheaper than placing that person in an institution, this would seem more a vindication of common sense than a remarkable breakthrough. For the Reagan Administration, however, “cost effective” really means cheaper, and in this case the two may be on opposite sides of the bottom line.

It is very possible that if home care were provided under Medicare and Medicaid, the number of people who requested it would not be limited to those who would go into an institution without it. If the government paid for this care for everyone who needed it—that is, for everyone who would suffer severe hardship without it—the number of people qualifying would probably number in the tens of millions. Providing them with this modicum of comfort would certainly far outweigh savings from the reduced cost of care for those spared unnecessary entry into a hospital or nursing home.

But here it is important to add that the only costs considered are the government’s. (We can leave aside the vast unquantifiable suffering hidden behind millions of doors, since this has no financial value and could not be assimilated by HCFA’s computers, or David Stockman.) It might well be that in terms of the financial outlay of society as a whole, the current policy of benign neglect is not cost effective.

By not providing reimbursement for home care, the government throws the incapacitated into the marketplace. This is hardly their most secure environment, since the governing principle there is survival of the fittest. What they find is hospitals and hospital chains vertically integrating to provide (for those who can pay) services ranging from skilled nursing homes to residential communities for the elderly to home care assistance and emergency medical backup. Individuals are shifted from one to the other on the basis of what the parent health care organization—perhaps known as a “Health Care Campus” or “Social Health Maintenance Organization”—finds most profitable.

Looking Back and Looking Ahead

Looking back at the results of the 1984 elections many of us may feel like folding our arms over our heads in despair. For those of us who are health care providers and professionals, there is always the urge to slip back from our day to day work for justice and equality into the fragmented flurry of everyday life—working hard as individuals to deliver the best medical services we can, then just living for ourselves and our families, voting for “good folks” at election times and maybe giving a little money from time to time to groups such as Health/PAC.

Our readers, like many other Americans, know that Reaganomics is a disaster which will not preserve, much less enhance, our national economic wealth; a clumsy, bear-like swipe by the wealthy for a bigger piece of our shrinking national pie.

These policies will fail, but we don't intend to await their demise passively. We can’t. Single mothers with children, people on welfare, blue-collar manufacturing workers, minority peoples are all suffering too much. They need jobs, access to decent health care, and other improved human services now.

If Washington and state capitals aren't listening to these needs, we have to make them listen by organizing local grassroots movements to assure health care for the poor, the unemployed and senior citizens. We must develop local agendas which reaffirm health care as a human right, not as a privilege for those who can afford it and a favor for those who can't.

What we do now can have a far greater impact on whether the U.S. turns left or right after the failure of Reaganomics than almost anything we will be able to do after the failure is manifest. Let's go on with it—together, now.

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Health/PAC Bulletin 3
Roeing and Wadeing in Hot Water

President Reagan has finally condemned violent attacks on abortion clinics, but as many supporters of abortion have pointed out, the tone the Administration has set is more important than a single statement. It would be easy to suspect that policy makers are more worried that the use of violence by the unauthorized could spread from attacks on abortion clinics and black teenagers in the New York subways to other, less worthy targets—it was, after all, Christian Crusaders who sacked Christian Byzantium. Worse, it could stimulate violence from quarters less congenial to the Administration.

From this perspective, the state seems to have developed at least one method of having its cake and eating it too, at least in Tallahassee, Florida. The Christian Action Council of Tallahassee, local branch of a national organization of the same name, declares that it "concentrates its efforts on the lobbying of our national leaders to change the current liberal laws concerning abortion and seeks the reversal of the 1973 Supreme Court decision Roe v. Wade, which has since facilitated the abortion of more than 15 million babies in America. [It] is also actively involved in the establishment of counseling centers around the country to serve the pregnant woman in her time of need and to inform her about the facts of what an abortion really is."

What it "really is," being, of course, the murder of babies. If murder is involved, it is logical to conclude that law enforcement officials should be—and they are. Among the four co-chairs of the Tallahassee Christian Action Council are William Scott, Jr., the city's Assistant Chief of Police, and William Meggs, State Attorney.

Their involvement serves multiple purposes. It provides an aura of authority and legitimacy. It might intimidate women, often young and feeling alone, who want an abortion; it could even intimidate members of a clinic's staff. It also provides at least a possibility of sanction for a potential arsonist or bomber. He—it always seems to be a man; if a woman is involved it is only as an accessory—could well reason, "Well, the Assistant Chief of Police thinks abortion is murder, just like I do, but he can't do anything because some point-headed, black-robed sissies in Washington said he can't. But we can't allow these people to kill babies, and whatever they might say in public, I think President Reagan, Bill Scott and Bill Meggs would be happy if I put a stop to it." He might well be mistaken, but he and everyone else might find that out too late.

Poor Vision

Predictions of future trends in health care are as reliable as weather forecasts for next week, but they are interesting indicators of what current thinking is. One recent one comes from 1000 "health care experts," representing hospitals, suppliers, legislators, regulators, payors, and physicians surveyed in a Delphi study co-sponsored by Arthur Andersen & Co. and the American College of Hospital Administrators. Among the conclusions of the study, entitled Health Care in the 1990's: Trends and Strategies:

continued on page 28

continued from page 3

The result will be a replication of our overall medical—and economic—system carried to extremes. Health care costs will increase rapidly, with at best a marginal improvement in health status. Totally captive patients will find themselves treated less and less like vulnerable consumers and more and more like products going through a manufacturing process. Just as many manufacturers of sophisticated computers send their products out for assembly in countries where the daily wage is a fraction of the hourly wage in the U.S., health care corporations will make every effort to shunt their patients between the highest-tech care his or her reimbursement system will cover and the lowest-tech, lowest-wage facility in their enterprise. Health care will be provided largely by a low-paid, alienated workforce—nursing home workers are often the cousins of computer assembly workers in their home country; even with five or more years' experience they very commonly earn under $10,000 a year, putting their families far below the poverty line.

It could be argued—is, by those who earn substantial incomes from this system and some academics who have never had the misfortune to experience it at first hand—that health consumers who find themselves in one of these all-care arrangements are not like chickens in an automated henhouse; they are free individuals in a free market, able to move elsewhere at the first twinge of dissatisfaction. Although this may be true in theory, our experience with nursing homes shows that it is rarely the case in practice, particularly at a time of capacity enrollment. And the same social trends that are filling the beds are increasing the vulnerability of those who must lie in them.

Family ties are breaking down. It is hard for Texans who have two sets of children and three ex-spouses in as many states to think about taking full responsibility for the care of elderly parents in Akron. The proportion of people living into their seventies and eighties is increasing. As people postpone childbearing to pursue their careers, the material pleasures afforded by limited financial responsibilities, and the best possible mate, the age and social gap between parents and children is bound to increase. And hard though it is to believe, the postwar baby boom will begin to pour into retirement in only 25 years. Right now this cohort is in its prime; let us hope that the millions in it will attend to the current need and their own future, rather than leave their health and welfare in the hands of people unlikely to be alive when they will need help.

Jon Steinberg
The Losses in Profits

*How Proprietaries Affect Public and Voluntary Hospitals*

by Louanne Kennedy

At no time since their establishment have the nation's nonprofit, voluntary, and public hospitals been swept by such radical change. Hospital care has entered a new stage, and these old actors must either adapt to it or disappear.

The impact of for-profit corporate chains on hospital care has been measured primarily in terms of the number of hospitals or beds they control. And, indeed, these chains have been growing rapidly. Arnold Relman, editor of the *New England Journal of Medicine*, has noted with alarm that if their expansion continues at the current rate, by 1990 they will own 30 percent of all hospitals.¹ The American College of Hospital Administrators has projected an even more remarkable figure of 60 percent market share by the year 1995.²

Whether or not either of these forecasts is accurate, the growth and consolidation of for-profit chains is of concern not solely because it is changing the ownership pattern of hospital beds, but because it is quickly causing what can be termed the proprietarization of voluntary hospitals, which means a fundamental change in their historic mission and function. The nation's public hospitals, meanwhile, are continuing to disappear, hurried into oblivion by the declining local government commitment to the provision of health care.

Although acute-care hospitals are most affected right now, the movement toward for-profit centralized ownership has progressed in nursing homes, psychiatric hospitals, home health care, health maintenance organizations (HMO's), and freestanding surgi-centers, and emergi-centers; this process has recently spread to alcoholism and drug dependency clinics, primary care centers and medical equipment suppliers. (See Table 1.)

The Impact on the Voluntary Hospital Sector

The historic claim of voluntary hospitals has been that they provide necessary community health services. In reality they have offered has often been determined by research and teaching priorities, particularly in major metropolitan areas dominated by medical schools and large teaching hospitals. However even if community service was only a byproduct in such institutions, at least it existed. In many localities throughout the country where academic medicine was absent, community service was minimal. In others, nonprofit institutions did provide care otherwise unavailable to those with limited insurance coverage or ability to pay. Today the new corporate chains are taking over voluntary hospitals in even the smallest cities, and where they do remain independent, non-profit institutions—and some public hospitals—are increasingly adopting the practices of proprietary hospitals, eschewing community responsibility in their pursuit of solvency.

This phenomenon has an impact far greater than the proprietary hospitals themselves do because voluntary and public institutions still provide most hospital care; the voluntary institutions alone account for two thirds. In 1982, the for-profit institutions accounted for only nine percent of all non-federal acute care beds, a share up only 1.2 percent from 1975.³ This apparent stability is, however, deceptive. The proprietary sector is now dominated by chains rather than individually owned facilities, corporate giants with far greater ability to distribute costs, gain access to capital markets, and diversify into other health care ventures.

Currently 475 centrally managed corporate chains own, lease, or manage 7,602 hospitals, nursing homes, lifecare centers, home healthcare agency offices, and physicians' offices. Another 58 organizations, mostly Catholic orders, sponsor 244 hospitals.⁴

Of these, 179 manage acute-care hospitals. (Table 2 describes the ten largest corporate, secular non-profit, and religiously-affiliated chains.) Between 1979 and 1983, the secular non-profit chains have added the most beds, followed by the investor-owned chains; the number of beds in religious and public hospitals have dropped.

When proprietaries alone placed primary emphasis on profit and fiscal management, there were safety valves in the voluntary and public sector to assure minimum care levels. Now that voluntary are following their lead, whatever possibility many people had of finding accessible, high quality, accountable care is fast disappearing.

Historically, their care was arranged through cross-subsidization, both between individual institutions and at the community level. Premiums paid by subscribers to Blue Cross and private insurors have subsidized care for the medically indigent to some extent. Indigent care also tended to be distributed: implicitly or explicitly, patients were sorted so that no single voluntary hospital was responsible for all the non-paying or low paying patients. Certainly this balance was an uneasy one; some hospitals shouldered much greater burdens than others. Particularly in areas with sizable numbers of public hospital beds, some voluntary were able to more nearly sidestep the responsibility. Nevertheless, even in the current period of intensifying cost containment pressures, volun-

Louanne Kennedy teaches Hospital Administration at Baruch College, CUNY, and is a member of the Health/PAC Board.

TABLE 1
Multi-Unit Providers

<table>
<thead>
<tr>
<th></th>
<th>Chains</th>
<th>Units/Offices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals (U.S.)</td>
<td>179</td>
<td>1,926</td>
</tr>
<tr>
<td>Shared services organizations</td>
<td>106</td>
<td>9,562</td>
</tr>
<tr>
<td>Alliances</td>
<td>6</td>
<td>500</td>
</tr>
<tr>
<td>Department control managers</td>
<td>74</td>
<td>6,411</td>
</tr>
<tr>
<td>Psychiatric hospitals</td>
<td>25</td>
<td>154</td>
</tr>
<tr>
<td>Alternative services*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run by hospital chains</td>
<td>90</td>
<td>758</td>
</tr>
<tr>
<td>Run by other chains</td>
<td>31</td>
<td>226</td>
</tr>
<tr>
<td>Nursing homes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run by hospital chains</td>
<td>30</td>
<td>239</td>
</tr>
<tr>
<td>Run by other chains</td>
<td>24</td>
<td>2,079</td>
</tr>
<tr>
<td>Lifecare centers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run by hospital chains</td>
<td>21</td>
<td>47</td>
</tr>
<tr>
<td>Run by nursing home chains</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Home healthcare agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full service</td>
<td>11</td>
<td>1,261</td>
</tr>
<tr>
<td>I.V. therapy</td>
<td>4</td>
<td>175</td>
</tr>
<tr>
<td>Health maintenance organizations (U.S.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run by hospital chains</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Run by other chains</td>
<td>13</td>
<td>134</td>
</tr>
<tr>
<td>Renal dialysis centers</td>
<td>6</td>
<td>267</td>
</tr>
<tr>
<td>Surgery centers</td>
<td>8</td>
<td>82</td>
</tr>
<tr>
<td>Dental clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In retail stores</td>
<td>6</td>
<td>73</td>
</tr>
<tr>
<td>Franchisers</td>
<td>7</td>
<td>140</td>
</tr>
<tr>
<td>Sub-total</td>
<td>663</td>
<td>24,075</td>
</tr>
<tr>
<td>Groups sponsoring hospitals</td>
<td>58</td>
<td>244</td>
</tr>
<tr>
<td>Total</td>
<td>721</td>
<td>24,319</td>
</tr>
</tbody>
</table>

*Freestanding centers other than surgery centers.

Tertiary hospitals could reasonably have been expected to maintain a significant role in providing care for the uninsured, and voluntary hospital lobbies have continued to support some form of national health insurance as a way of socializing the cost of this care. However, the tide among voluntary hospitals has shifted towards proprietarization, instituting the classic business strategy of seeking a more and more selective market of patients at the expense of community services.

Public Hospitals Disappear

In some cases, proprietarization involves an actual takeover of a public or voluntary institution; in others, it is indirect, effecting a fundamental realignment of values.

When the Coweta County, Georgia public hospital was suffering from internal problems and inadequate funding, public officials chose to abandon this county hospital rather than raise taxes to cover the need. Despite opposition from a group of Georgia Legal Services clients and initial Health Systems Agency opposition, the state approved the county’s application to sell the hospital to the Humana Corporation. The effects of this transfer were soon clear:

- Under an agreement with the county, a dollar amount was established to provide indigent care. This sum immediately proved to be far less than was needed, but when it is exhausted the uninsured are given only emergency care—as defined, narrowly, by the Humana staff.
- As a hospital which had received funding under the Hill-Burton Act, Coweta County was obligated to provide care to the medically indigent until 1997; this obligation ceased within the sale.
- Far from enhancing cost-effectiveness, the sale has increased the cost of care. One new expense is interest payments. Humana borrowed $9 million at 17 percent interest to purchase the hospital. Interest payments now ac-
count for 15.8 percent of operation expenses, or $52 per patient day, compared to 2.2 percent, or $5.92 per patient day, under public ownership. Some of the capital outlay has gone for new facilities and equipment, but access to these services is limited.5

Although Coweta County's experience is not unique, proprietarization more commonly takes less overt forms. Tampa General, the public hospital in Tampa, Florida, is one example. In 1983, hard hit by loss of paying patients to the new Humana Women's Hospital and voluntary institutions which had adopted aggressive marketing tactics, it developed a two-track strategy. First, it has adopted a policy of turning away medically indigent and Medicaid patients whose cases are not urgent. (Florida Medicaid rates are below those of other third-party payors such as Blue Cross.) Second, it has embarked on a major construction program to provide new beds for well-insured patients.6

A Voluntary Diversifies

In 1981 Dayton Hospital, a voluntary non-profit facility in Dayton, Ohio, was in serious straits. Its occupancy rate was low; its assets were declining; it had difficulty borrowing money; it didn't have the funds to purchase equipment its physicians deemed absolutely necessary; and its physicians who also had attending privileges at other institutions often sent their well insured patients to them.

To reverse this downward spiral, the Board of Trustees established a Marketing Department to seek out better insured Daytonians and identify new services that would be attractive to patients and physicians. The new department developed an ambitious plan, which included a new hospital with new technology. Three years later, Dayton Hospital had:

- Developed a for-profit subsidiary which purchased a nearby proprietary nursing home and an alcoholism clinic.
- Formed a group to sell management services to other hospitals in trouble. Dayton Hospital is considering the purchase of one of its management contract clients, a voluntary hospital in Gainesville, Florida.
- Achieved an AA rating from a major brokerage house, which has enhanced its ability to borrow for capital expenditures and lowered the interest rates it must pay.
- Boosted physician morale. Delighted with the new patient population, new equipment and new physical plant, most now believe they are attached to the “best” hospital in Dayton.7

The Seven Choices

These three cases indicate some of the responses to the growing concerns about fiscal accountability in a competitive, cost containment environment. In the decade ahead, public and independent voluntary hospitals will face the following choices:

1) seek acquisition by a for-profit or non-profit chain; 2) diversify and expand vertically; 3) merge; 4) hire contract management; 5) take forceful measures to maintain current market share; 6) convert into another type of institution; 7) close.

Not all of these strategies are available to every type of institution. For example, public hospitals are unlikely to be in a position to diversify and expand and are more likely to seek acquisition or contract management. Moreover, as the three cases described above demonstrate, none of these potential strategies are based upon providing low-cost care to the poor and uninsured.

Why Is Proprietarization Occurring?

The accelerating trend toward proprietarization is encouraged by a number of factors, including changing ideologies, the unequal mobility of hospitals, and changes in reimbursement policies.

The role of ideology. The commitment to the public delivery of services has historically been limited in the U.S. In the 1930's, the New Deal programs to solve the problems of the Great Depression included public sector financing of delivery of education and health as well as construction projects. Once again in the 1960's the public sector was expanded to deliver health, employment, and community services. In both the 1930's and the 1960's public financing of services was the result of powerful social movements among the poor demanding them. However these periods of expansion are aberrations, running counter to the dominant ideological premise that public delivery of services is worse, i.e., inefficient, plagued by incompetent workers, and costly, while services provided by the private sector are efficient, cost-effective, and responsive to the demands of the market.

Since the election of President Reagan, assertions of the superiority of private ownership have become even more consistent. Pressures to contract with private firms for delivery of services ranging from garbage collection to social programs have intensified. Behind the rhetoric of “public v. private” lies the real issue: whether poor and working people get care.

The provision of health services has always been marked by an uneasy balance between public, voluntary, and proprietary interests, with the voluntary non-profit hospitals dominant. However in the 1970's and the 80's mounting pressure to control costs has shaken their dominance and further marginalized the public institutions. Both government and industry have seized upon marketplace competition as the answer to rising costs.

Unequal mobility. Voluntary hospitals are usually associated with a particular community. Private hospital chains—actually large, national corporations—are in the business of buying and building facilities in areas where market analysis indicates the presence of a substantial insured population. They have almost complete freedom to go into places with a favorable state regulatory climate and high population growth. As a result, they are heavily concentrated in the South and the West, regions where population and economic growth has been rapid in recent years: 73 percent of the beds owned by the nation's five largest private firms are located in the South and another 20 percent in California. This has given these companies a steadily increasing patient base and made them essentially recession proof.8 David Jones, Chairman and Chief Executive Officer of Humana, is one of many corporate officials who expect investor-owned chains to continue to expand most vigorously in the Sunbelt, where population growth runs ahead of the national rate. Although many executives are predicting an increase in private management of urban public hospitals in the North and the Northeast, they do not foresee any dramatic growth in their ownership of northern urban hospitals.9 Jones points out that the high cost Eastern states such as Massachusetts, New York, and Maryland also have the most “oppressive” regulations and cites their tightened planning restrictions as further reasons for staying out.

David Williamson, Executive Vice President for domestic development at Hospital Corporation of America agrees that "By and large, the future growth of the industry will be in dynamic states where the population is growing...and in those states that decide to modify punitive state regulations."
### TABLE 2
Top 10 Hospital Operators by Type, in 1983*

<table>
<thead>
<tr>
<th>Investor-Owned</th>
<th>Beds 1983</th>
<th>Beds 1982</th>
<th>Units 1983</th>
<th>Units 1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Corp. of America</td>
<td>52,913</td>
<td>47,415</td>
<td>363</td>
<td>325</td>
</tr>
<tr>
<td>Humana Inc.</td>
<td>17,704</td>
<td>16,786</td>
<td>89</td>
<td>90</td>
</tr>
<tr>
<td>American Medical International Inc.</td>
<td>14,274</td>
<td>12,623</td>
<td>104</td>
<td>95</td>
</tr>
<tr>
<td>National Medical Enterprises Inc.</td>
<td>9,576</td>
<td>8,919</td>
<td>63</td>
<td>64</td>
</tr>
<tr>
<td>Nu-Med Inc.</td>
<td>5,696</td>
<td>5,403</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>Lifemark Corp.</td>
<td>5,074</td>
<td>4,334</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Republic Health Corp.</td>
<td>3,335</td>
<td>895</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>Universal Health Service Inc.</td>
<td>2,732</td>
<td>1,573</td>
<td>23</td>
<td>12</td>
</tr>
<tr>
<td>American Healthcare Mgmt. Inc.</td>
<td>2,704</td>
<td>1,857</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Hospital Mgmt. Professional Inc.</td>
<td>2,654</td>
<td>1,799</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116,662</strong></td>
<td><strong>101,604</strong></td>
<td><strong>768</strong></td>
<td><strong>663</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secular Nonprofit</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation</td>
<td>6,576</td>
<td>6,538</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Fairview Community Hospitals</td>
<td>3,842</td>
<td>3,536</td>
<td>46</td>
<td>42</td>
</tr>
<tr>
<td>Intermountain Health Care Inc.</td>
<td>2,953</td>
<td>2,887</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Health Central System</td>
<td>2,769</td>
<td>2,689</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>SunHealth</td>
<td>2,685</td>
<td>2,143</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Health Frontiers Inc.</td>
<td>2,611</td>
<td>2,662</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Lutheran Hospitals &amp; Home Society of America</td>
<td>2,451</td>
<td>2,232</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Affiliated Hospital Systems</td>
<td>2,179</td>
<td>1,960</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>SamCor</td>
<td>1,604</td>
<td>1,564</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>HealthOne Corp.</td>
<td>1,455</td>
<td>880</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29,125</strong></td>
<td><strong>28,226</strong></td>
<td><strong>261</strong></td>
<td><strong>249</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Catholic</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sisters of Mercy Health Corp.</td>
<td>5,889</td>
<td>5,760</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Sisters of Mercy of the Union</td>
<td>4,356</td>
<td>4,166</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Sisters of Charity Health Care System</td>
<td>4,306</td>
<td>4,336</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Hospital Sisters Health System</td>
<td>3,719</td>
<td>3,731</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Sisters of Providence Health Care System</td>
<td>3,428</td>
<td>3,218</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Catholic Health Corp.</td>
<td>3,335</td>
<td>3,003</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Holy Cross Health System Corp.</td>
<td>3,089</td>
<td>3,062</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Franciscan Health System</td>
<td>3,012</td>
<td>2,877</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Anellia Domini Health Services Inc.</td>
<td>2,933</td>
<td>2,923</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Sisters of Charity of Leavenworth Health Services</td>
<td>2,454</td>
<td>2,397</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36,491</strong></td>
<td><strong>35,483</strong></td>
<td><strong>147</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

*added that HCA's pursuit of growth opportunities will continue to be "principally in the hospital sector of the health care field and not in diversification. HCA, he elaborated, expects to replace and/or build 2,500 to 3,500 hospital beds per year, and it is currently targeting public hospitals "whose life cycles have ended, and that are without the resources to finance the replacement of their facilities."*

As the easier markets in the Sunbelt are saturated, the industry is likely to pursue management contracting and acquisition more aggressively, because Certificate of Need laws make construction of new hospitals difficult in heavily bedded areas. Another possibility is accelerated diversification. National Medical Enterprises, for example, is acquiring and building nursing homes, psychiatric hospitals, and homecare agencies. Voluntary hospitals generally lack mobility, although some have moved to more well-to-do suburbs—creating serious problems for the patients left behind. Many institutions that remain in areas of declining population and income are adopting restrictive access policies in the name of financial solvency. Others that continue to serve everyone in their commun-
### TABLE 2

Top 10 Hospital Operators by Type, in 1983* (continued)

<table>
<thead>
<tr>
<th>Type</th>
<th>Beds 1983</th>
<th>Beds 1982</th>
<th>Units 1983</th>
<th>Units 1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Religious</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adventist Health System/U.S.</td>
<td>10,633</td>
<td>10,536</td>
<td>74</td>
<td>76</td>
</tr>
<tr>
<td>2. Methodist Health Systems Inc.</td>
<td>3,692</td>
<td>3,275</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>3. Lutheran Hospital Society of Southern California</td>
<td>2,373</td>
<td>2,615</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>4. Evangelical Health Systems</td>
<td>1,634</td>
<td>1,634</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>5. Harris Methodist Health System</td>
<td>1,603</td>
<td>1,221</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>6. Baylor Health Care System</td>
<td>1,497</td>
<td>1,425</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7. Baptist Medical Center</td>
<td>1,351</td>
<td>1,152</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>8. St. Luke's-Roosevelt Hospital Ctr.</td>
<td>1,315</td>
<td>1,316</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>9. Southwest Community Health Services</td>
<td>1,201</td>
<td>1,269</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>10. Methodist Hospital of Indiana</td>
<td>1,190</td>
<td>1,190</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. NYC Health &amp; Hospital Corp.</td>
<td>7,778</td>
<td>7,919</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>2. Los Angeles County - Dept. of Health Services</td>
<td>4,506</td>
<td>4,902</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. North Broward Hospital District</td>
<td>1,262</td>
<td>1,253</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. Peoples Community Hospital Authority</td>
<td>1,236</td>
<td>1,236</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>5. Fulton-DeKalb Hospital Authority</td>
<td>1,204</td>
<td>1,204</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6. Harris County Hospital District</td>
<td>804</td>
<td>774</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>7. Hospital Commission of Prince George County</td>
<td>791</td>
<td>791</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>8. Wake County Hospital System</td>
<td>656</td>
<td>656</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9. Spartanburg General Hospital System</td>
<td>617</td>
<td>617</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>10. Alameda County Health Care Services Agency</td>
<td>600</td>
<td>600</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>19,454</td>
<td>19,952</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Contract Managers**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Hospital Corp. of America</td>
<td>22,642</td>
<td>18,828</td>
<td>169</td>
<td>144</td>
</tr>
<tr>
<td>2. Nu-Med Inc.</td>
<td>4,815</td>
<td>5,291</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>3. Catholic Health Corp.</td>
<td>3,335</td>
<td>3,003</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>4. National Medical Enterprises Inc.</td>
<td>3,269</td>
<td>2,691</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>5. SunHealth</td>
<td>2,685</td>
<td>2,143</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>6. Hospital Management Professionals Inc.</td>
<td>2,654</td>
<td>1,799</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>7. Fairview Community Hospitals</td>
<td>2,606</td>
<td>2,300</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>8. American Medical International Inc.</td>
<td>2,137</td>
<td>2,119</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>9. Lutheran Hospital Society of Southern California</td>
<td>2,124</td>
<td>1,960</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>10. Geisinger Medical Mgmt. Corp.</td>
<td>1,123</td>
<td>1,039</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>47,915</td>
<td>41,004</td>
<td>342</td>
<td>294</td>
</tr>
</tbody>
</table>

*Largest systems based on number of U.S. and foreign acute care hospital beds operated in 1983.

**Largest managers of U.S. and foreign acute care hospitals based on number of beds-managed facilities in 1983.

...ity regardless of ability to pay face bankruptcy. Most of the 25 hospital closures in New York City since 1975 are due to bankruptcies, caused in large part by their willingness to serve increased numbers of uninsured patients.

Changes in reimbursement policies. For many years hospitals were cushioned by cost-based reimbursement, under which they were reimbursed for whatever they spent on patient care. Those days are clearly over. As controls on reimbursement have tightened, mostly through government efforts, voluntary hospitals have been acting more like proprietary...
### TABLE 3
Hospitals in Multi-Institutional Systems

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of System:</th>
<th>1979 Beds</th>
<th>1983 Beds</th>
<th>% Change</th>
<th>1979 Hospitals</th>
<th>1983 Hospitals</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Investor-owned</td>
<td>90,580</td>
<td>123,810</td>
<td>36.7</td>
<td>695</td>
<td>869</td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td>Secular nonprofit</td>
<td>56,398</td>
<td>86,266</td>
<td>52.9</td>
<td>301</td>
<td>583</td>
<td>93.7</td>
</tr>
<tr>
<td></td>
<td>Religious</td>
<td>106,062</td>
<td>87,826</td>
<td>-17.2%</td>
<td>455</td>
<td>415</td>
<td>-8.8%</td>
</tr>
<tr>
<td></td>
<td>Public</td>
<td>21,718</td>
<td>20,646</td>
<td>-4.9</td>
<td>59</td>
<td>49</td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td><strong>274,758</strong></td>
<td><strong>318,548</strong></td>
<td></td>
<td><strong>1,510</strong></td>
<td><strong>1,916</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of System:</th>
<th>1979 Beds</th>
<th>1983 Beds</th>
<th>% Change</th>
<th>1979 Hospitals</th>
<th>1983 Hospitals</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Investor-owned</td>
<td>58,000</td>
<td>86,128</td>
<td>48.5</td>
<td>395</td>
<td>595</td>
<td>50.6</td>
</tr>
<tr>
<td></td>
<td>Secular nonprofit</td>
<td>50,775</td>
<td>69,886</td>
<td>37.6</td>
<td>245</td>
<td>374</td>
<td>52.6</td>
</tr>
<tr>
<td></td>
<td>Religious</td>
<td>100,389</td>
<td>78,319</td>
<td>-21.9%</td>
<td>391</td>
<td>327</td>
<td>-16.4%</td>
</tr>
<tr>
<td></td>
<td>Public</td>
<td>21,619</td>
<td>20,646</td>
<td>-4.5</td>
<td>57</td>
<td>49</td>
<td>14.0</td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td><strong>230,783</strong></td>
<td><strong>254,979</strong></td>
<td></td>
<td><strong>1,088</strong></td>
<td><strong>1,345</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of System:</th>
<th>1979 Beds</th>
<th>1983 Beds</th>
<th>% Change</th>
<th>1979 Hospitals</th>
<th>1983 Hospitals</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Investor-owned</td>
<td>32,580</td>
<td>37,682</td>
<td>15.6</td>
<td>300</td>
<td>274</td>
<td>-8.7</td>
</tr>
<tr>
<td></td>
<td>Secular nonprofit</td>
<td>5,623</td>
<td>16,380</td>
<td>191.3</td>
<td>56</td>
<td>209</td>
<td>273.2</td>
</tr>
<tr>
<td></td>
<td>Religious</td>
<td>5,673</td>
<td>9,508</td>
<td>67.6%</td>
<td>64</td>
<td>88</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>Public</td>
<td>99</td>
<td>0</td>
<td>-100.0%</td>
<td>2</td>
<td>0</td>
<td>-100.0%</td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td><strong>43,975</strong></td>
<td><strong>63,570</strong></td>
<td></td>
<td><strong>422</strong></td>
<td><strong>571</strong></td>
<td>35.3%</td>
</tr>
</tbody>
</table>


hospitals than ever before. For the proprietary sector, prospective payment systems such as Diagnosis Related Groups (DRG's) have been a boon. According to John Hindelong, Director of Research at the brokerage firm Becker Paribas and a leading health care analyst, DRG's are "now seen as a system that does what it's supposed to do—that is, increase profits to the efficient provider of health-care services."

Non-profit Chains and Subsidiaries

As competitive pressures mount, many non-profit hospitals are setting up for-profit subsidiaries and/or multihospital systems and chains of their own, which then often initiate diversification schemes "to work out of the corner they've been pushed into by government constraints and increased competition." Typically, they form for-profit subsidiaries to supplement the revenues from their non-profit hospital operations. Some non-profit systems are even considering offering stock in these subsidiaries, a move that would further blur the once clear-cut line between for-profits and non-profits.

Intermountain Healthcare Inc., a voluntary chain in Salt Lake City, now has three for-profit subsidiaries. One offers insurance; another provides shared services; the third, a professional services corporation, will manage operations such as clinics, outpatient surgical centers, and occupational medicine programs.

The Health Central System in Minneapolis is also in the midst of corporate restructuring. Like Intermountain, this 23-hospital group is diversifying into the insurance business. It also plans to manage three housing centers for the elderly. Research Health Services in Kansas City completed a reorganization in 1982 and is moving into the commercial laboratory business. The Alexian Brothers of America, Inc., in Elk Grove Village, Illinois is also restructuring. According to Sam Torres, Vice President of Alexian Brothers Health Management, the religious systems now "understand that being competitive and being growth oriented is compatible with being church oriented... We can't afford to sit quietly and allow the proprieters to take over health care—including us."

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In the coming years consolidation of the voluntary hospital industry is likely to continue through the demise of the weaker institutions, or their absorption in the expanding non-profit and for-profit chains. Their growth, in turn, is certain to be accompanied by diversification into non-hospital based services, including surgi-centers, emergi-centers, and alcoholism, drug, obesity, and wellness clinics.

The Impact on Health Care Services

A judgement as to whether this trend toward proprietarization should be encouraged or discouraged ought not to depend on an uncritical ideologically-based belief, but on a pragmatic assessment of its consequences for health care services—in particular on access, costs, quality, and accountability.

Access. The proprietary sector has made it clear that it feels little or no obligation to serve the medically indigent and only limited obligation to serve Medicaid patients. Nationally, the for-profit chains have a much smaller proportion of Medicaid patients than the average hospital. In states such as Texas, Tennessee, and Florida which have low Medicaid reimbursement, less than three percent of their patients are covered by it, while in California, which reimburses for the care of Medi-Cal patients at a rate close to that offered by other third party payors, 11.45 percent of their patients qualify. Similar practices are now followed by voluntaries, who rationalize them as good management practices necessary for economic survival.

Quality of care. Little is known about the quality of care in proprietary hospitals. In general it appears to be adequate. The problem arises at the system-wide level and is related to the proprietary policy of "skimming the cream"—attracting patients with the easiest diagnoses, and leaving more complicated, poorly insured cases to the public hospitals and those voluntaries still willing to take them. There is also some evidence that for-profits retain certain complicated but financially rewarding patients who may be more appropriately treated elsewhere.

Another problem arises when a hospital company acts to improve the profitability of the mix of services at a particular hospital it owns or manages. This may entail emphasizing the profitable services (e.g. surgical as opposed to medical, ancillary as opposed to routine, simple operations as opposed to complicated, etc.), increasing the intensity of care with new services and technology, and adapting the services offered to the demographics of the market area. These practices reflect a conscious decision to focus on profitability of services rather than medical necessity. There is also pressure to curtail or eliminate services that may be required in the community but not at a level sufficient to yield a profit. For example, certain ophthalmology services and therapeutic radiology.

The new DRG method of Medicare reimbursement will probably exacerbate these trends. It is also evident that physicians will be pressured to make their practices fit the demands of the market or the reimbursement system rather than a professional standard as, however, imperfectly, they have in the past.

In all community hospitals, both profit and non-profit, overall length of stay is declining, along with ratios of full-time equivalent personnel and staffed beds. This is a direct result of efficiency demands that may well bode ill for quality of care. The decline in length of stay poses particular hardship for the elderly. However to the for-profit sector, this decline is a measure of increased efficiency and profitability. Declining length of stay increases profitability because, when you think about a hospital visit most of the actual business occurs in the first couple of days—surgery, intensive care, diagnostic testing, etc. The last part of the stay, convalescence.
Although it cannot be argued that proprietarization give birth to profit consciousness by doctors, what is new is the systemic incentives that encourage such behavior in these institutions and the direct conflict they pose between professional principles and business ideology.

Conclusions

Considerable evidence indicates that the growth of the for-profit sector has reduced access, raised costs somewhat, and lessened physician accountability to professional standards. Whether the quality of care, for those who get it, has been affected remains undetermined.

As we have seen, the expansion of the private chains is also negatively affecting the performance of voluntary and public hospitals. What can be done to reverse these trends and to encourage hospitals to respond to community health needs rather than immediate fiscal pressure?

To begin developing solutions, we must consider the roots of the problem. First, between 25 and 40 million Americans have no health insurance. Universal health care coverage is not only just and ethical, it may also be essential to the preservation of the nation's voluntary and public hospitals, which serve the broad health needs of the public.

Second, differences in rates of reimbursement encourage skimming of more lucrative patients and dumping of poorly insured patients on the dwindling number of hospitals willing to serve them. This inequitable pattern could be alleviated by all-payor, uniform systems of reimbursement—which have already been enacted in some states and proposed nationally.

Third, insurance coverage must be sufficiently comprehensive to ensure that patients are likely to receive appropriate care rather than a treatment, often more expensive, which happens to be the only one covered by insurance. All-payor systems, now in place in a few states, that reimburse hospitals for uncompensated care are a progressive move toward universal coverage, but affect in-patient care only. These programs should be expanded to include more states and outpatient care—for the medically indigent as well as others.

Fourth, we ought to have a National Hospital Policy similar to the National Blood Policy of 1974, one which defines minimum standards of access, quality and cost and is monitored to guarantee that low cost is not the sole criteria of excellence.

Universal coverage, uniform reimbursement rates, and comprehensive services are the characteristics of a planned, national health care system. The United States is the only industrialized nation aside from South African without a program embodying these fundamental characteristics. Although currently far from the top of the American political agenda, such a national program for financing and planning health care services represents the best hope of preventing the complete transformation of our health care institutions into businesses that court and serve only the wealthy and well-insured.

This is not the costly approach it is often depicted to be. In the long term, by relieving the financial pressure on those hospitals that serve everyone, and distributing the costs of caring for the uninsured equitably, a national program offers the best prospect for reducing the costs of care—and for providing quality care for all.

**Bulletin Board**

**Art for Disarmament’s Sake**

The Bread and Roses Program of 1999 has been justly famous as the most ambitious trade union cultural program in the country. Its art exhibition, “Disarming Images: Art for Disarmament,” is currently touring the country (this spring it will be at Baxter Art Gallery, Caltech; and Yellowstone Art Center in Billings, MT), and is now available in a book with beautiful full-color graphics. The artists represented include Laurie Anderson, Rudolf Baranik, Mary Frank, Red Grooms, Claes Oldenburg, and Robert Rauschenberg. Copies of the book are $14.95 from Art for Nuclear Disarmament, 330 West 42nd St., New York, NY 10036.

**Does VDT Mean Very Dangerous Technology?**

The Office Technology Education Project, an independent organization funded by the Massachusetts State Health Department, has prepared a series of four hard-hitting, eye-catching posters on the health and social effects of office automation. Their titles are “Common Office Health Problems… and How to Avoid Them,” “A Stress Epidemic in the Office,” “A Model VDT Workstation,” and “Job Content: More than Meets the Eye.” It would be great if these were up in every office; your boss isn’t likely to order them. You can, by sending $1.50 per set to OTEP, 6 Newsome Park, Jamaica Plain, MA 02130.

**Far from Hollywood**

“All healthcare workers, patients, and communities stand to benefit from this,” says Robb Burlage about From Bedside to Bargaining Table. In this new 20-minute color video nurses talk about their concerns and what they can do about them. The sale price is $60; rental $30 from Tamerik Productions, 237 Second St., Jersey City, NJ 07302.

Women Make Movies is distributing a series of videotapes on health subjects, including menopause, feminist health practices, and midwifery in Nicaragua. For a catalogue, write WMM, Inc., 19 W. 21st St., New York, NY 10011.

**Revolution on Wheels**

About 400 of the thousands of Nicaraguans seriously maimed or incapacitated in the war against Somoza and the contras have formed the Organization of Disabled Revolutionaries to integrate themselves and others into the socio-economic life of the new Nicaragua. ORD members are designing, manufacturing, and repairing wheelchairs for themselves and others, but they need supplies. The Reagan Administration’s economic strangulation strategy has made it impossible for them to import the 24” and 8” diameter inflatable rubber tire wheels. If you can help supply them, they’ll be able to put people in complete, very maneuverable wheelchairs. Your contributions made out to NICMAC/HAND are tax-deductible. You can mail your check to Nicaragua Medical/Material Aid Campaign, 1239 Broadway, Rm. 802, New York, NY 10001.

**Help Wanted**

The Frieda Wolff National Health Service Fund, organized in memory of the late president of the California Gray Panthers, is inviting health professionals and activists to join its advisory board. The fund was established to compile and disseminate information promoting a national health service. Interested persons should write the Fund at PO Box 7369, Berkeley, CA 94707.

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5. Linda Lowe, “Sales of Strapped Public Hospitals Bode Ill For Poor,” Atlanta Constitution, October 1, 1982. See also “Consumer Testimony Opposing the Sale of a Public Hospital in Georgia to a For-Profit Corporation,” Georgia Legal Services, Atlanta, Georgia, 1982.
7. Ibid.
10. Ibid.
12. Lavisollete, op. cit.
13. Ibid.
15. Ibid.
19. Ibid.
20. Ibid.
22. Ibid.
The pattern is familiar, dismal, and now well-known. Cook County, Chicago's only public general hospital, receives a call from a private institution: a patient with a condition requiring immediate hospitalization is being placed in an ambulance and will be arriving shortly. There were six thousand of these transfers from an Emergency Room at a private hospital to C.C.H. in 1984, a fivefold increase in just four years. The extent of this private hospital policy, often referred to as inpatient dumping, as well as the problems associated with it have been well documented and widely reported in the medical and popular press. However it is not generally realized that these direct, emergency-room-to-emergency-room transfers represent only the tip of the iceberg, a small fraction of the overall dumping problem. The overwhelming majority of dumping cases involve outpatients previously cared for in private sector institutions or community clinics who are shunted to public hospitals. Because these transfers are indirect, they are both less visible and more difficult to pinpoint, so as yet there is little data on them.

A Survey at Cook County Hospital
To estimate the magnitude of this problem, we surveyed 500 patients waiting to be seen in the Adult Emergency Room at C.C.H. during November 1984.

Within this group, precisely defining an "outpatient dump" posed methodological problems. A patient who arrived with a new onset of jaundice, seizures, and bleeding in his urine and stools carrying a note on his discharge papers from Englewood Hospital reading "to Cook County Hospital" is an obvious "dump." (That he was sent home at all illustrates another feature of the dumping problem, the extent to which institutional financial considerations bias and override medical judgements.)

Other patients may have a less urgent need for follow-up care, but are referred to C.C.H. routinely or are told to come there for additional tests and treatment for problems identified by the private hospitals or clinics. Often they are told that they are in need of C.C.H.'s specialized services, although on examination it becomes apparent that they have fairly uncomplicated problems—for example, the woman who was told by Billings (the University of Chicago teaching and research hospital) to go to C.C.H. because they "had the best doctors for skin problems." Others are referred to C.C.H. for tests even though the private hospital has the requisite equipment—for example, the man with early gangrene of the toe who was told at Jackson Hospital that they "couldn't handle the problem" because they lacked the proper "instruments." Out of our sample, 12 percent of the patients fell into one of our three blatantly dumped groups (see Figure 1).

A larger group of "dumped" patients consisted of those who had been receiving care elsewhere in the past two years but are now coming to C.C.H. because they can no longer afford to pay for that care or were dissatisfied with it. (Of those expressing dissatisfaction with their private sector care, most mentioned that they could not afford to pay for it any longer.)

Patients of special interest to us were the one in five who had never come to Cook County Hospital before. Half of them fell into one of the "dumped" categories. The proportion of this group which had lost their jobs during the previous 12 months (33 percent) was twice the rate we found among the "veteran" C.C.H. patients.

Ambiguities
It must be said that there is no absolute division between those who get public care and those who get private. More than 40 percent of the patients in our sample who had previously received care at C.C.H. had also been treated elsewhere in the past three years. However, unlike other Chicago hospitals, Cook County cannot refer a patient elsewhere or refuse care due to inability to pay. Since free care and medications are unavailable anywhere else, statements by 73 percent of the patients that they could not afford to go elsewhere suggest that the magnitude of any reverse flow from public to private must be considerably less than the flow to C.C.H. Declining census in the private sector and a rising patient census at C.C.H. strengthen this conclusion.

A second limitation of our data relates to difficulties in assigning patients to the "dumping" categories (groups A-E). Many of the patients had overlapping features (i.e. most of the patients in the Refused Care group were also explicitly told to go to C.C.H.). Also, a substantial number of the "dumped" patients (87 of 185) also mentioned positive reasons for coming to C.C.H. (its "good reputation"); it might be argued that this disqualifies them from being labeled as "dumps." However when the issue is defined broadly as the shifting of financially unrewarding care from private and neighborhood sources onto the Public Hospital, it is evident this has indeed occurred. Finally, the "attraction" of C.C.H. to such patients must

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Gordon Schiff is an attending physician in the Department of Medicine at Cook County Hospital. Kari Angus and Saholy Razafinarivo were interns in the Associated Colleges of the Midwest Urban Studies Program.
be viewed in its proper context. At C.C.H.'s Emergency Room, these patients generally must wait six to eight hours to be seen by a moonlighting resident or a nurse practitioner, and another one to two hours at the Pharmacy. It is unlikely that any private or voluntary facility genuinely attempting to attract this population would find it difficult to improve upon this.

As distinguished from "inpatient dumping" statistics, in which virtually every patient referred is counted (except those who expire in the ambulance en route), our method of quantifying the magnitude of outpatient dumping in all probability significantly underestimates the numbers of patients referred. We have no way of knowing what fraction of the patients told to go to C.C.H. actually do. These "lost" patients, unable or unwilling to beat a path to C.C.H., are in some respects of even greater concern than the huge numbers who do arrive.

Even excluding these people, the survey clearly reveals massive dumping. Extrapolating from the sample results, the 208,000 Adult Emergency Room visits in 1984 included more than 75,000 "dumps"; even using the narrowest definitions of dumping (groups A-C), there were 25,380. Although Illinois Governor Thompson and President Reagan claim that their health cuts have not disrupted health care for people in need, this survey is powerful evidence that tens of thousands of people in Chicago have been uprooted from their previous channels of care, and have no alternative save a public institution whose resources were already overtaxed.

Cumulative Effect
The cumulative impact of this shift is also devastating. Many of the patients initially seen in the Emergency Room require follow-up care. For example, during the past two years approximately 400 patients per week were referred to C.C.H.'s General Medical Clinic, which can accommodate only 120 new patients per week. No one knows what has happened to those who could not be given an appointment. At this point the Clinic, a public resource that had previously been available to a broad range of working, insured people as well as the unemployed and poor, is so full that it cannot accept any new patients at all. The one continuous source of care for persons living in one of Chicago's 33 (out of a total of 77) communities officially designated as "severe physician shortage" areas by Chicago's Health Systems Agency.

Distinctions between "dumped" and "nondumped" patients should not be taken too literally. The major difference between "dumped" and "nondumped" outpatients is really that dumped patients have not learned their "place" in the system. Those patients who "naturally" report to C.C.H. have internalized the rules of the game. For the others, dumping serves a policing function, disciplining people whose access to alternate channels of care had been expanded during the '60's and '70's and is now being taken away.

It would be difficult to argue that transferring care to C.C.H.'s Emergency Room is more cost-efficient than a system of more continuous care by a primary provider in the community. Fragmentation of care and duplication of tests and records is inevitable. Without an established relationship with the patient, the health care provider's ability to assess a problem, develop mutual trust, or give advice on the telephone, etc. is very limited. The two major active parties responsible for this epidemic of dumping, governmental policy makers and the private institutions, are pursuing this wasteful course in the name of controlling costs and increasing efficiency. What they

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### Definitions and Rates of Outpatient Dumping

<table>
<thead>
<tr>
<th>Dumping Category</th>
<th>Definition (why are you here now)</th>
<th>Numbers of Patients</th>
<th>% of 500 Pts. Surveyed</th>
<th># of pts translates to per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Refused Care Elsewhere (&amp; usually told to go to C.C.H.)</td>
<td>23</td>
<td>4.6</td>
<td>9,570</td>
</tr>
<tr>
<td>B</td>
<td>Sought Care Elsewhere but Left Without Being Seen (for financial reasons)</td>
<td>3</td>
<td>0.6</td>
<td>1,250</td>
</tr>
<tr>
<td>C</td>
<td>Explicitly Told to Go to C.C.H. by previous source of Care</td>
<td>35</td>
<td>7.0</td>
<td>14,560</td>
</tr>
<tr>
<td>D</td>
<td>Coming to C.C.H. now because Can No Longer Afford Previous Source of Care</td>
<td>78</td>
<td>15.6</td>
<td>32,450</td>
</tr>
<tr>
<td>E</td>
<td>Dissatisfied with Care Elsewhere and Unable to Afford it any longer</td>
<td>38</td>
<td>7.6</td>
<td>15,810</td>
</tr>
<tr>
<td>F</td>
<td>Dissatisfied with Care Elsewhere for Other Reasons</td>
<td>8</td>
<td>1.6</td>
<td>3,330</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td></td>
<td><strong>185</strong></td>
<td><strong>37.0</strong></td>
<td><strong>76,960</strong></td>
</tr>
</tbody>
</table>

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are really doing is shifting the burden onto the public hospital and the tens of the thousands of patients in Chicago alone who have been dumped.

**Private Hospitals Unload**

Seventy-two percent (133/185) of the "dumped" patients came from private voluntary hospitals, which are restricting access to their outpatient clinics through closures and policies such as increased fees. "Our picture is not as bright as previously," explained the Executive Director of Illinois Masonic Hospital. "We find ourselves being forced to choose between our heritage of caring for the indigent or fiscal viability. This is certainly an unpleasant choice, but of course it is really not a choice." He described how Illinois Masonic "began to set specific monthly targets for Medicaid days by Department or service. While we have yet to achieve many of these targets, the trend continues in the right direction."

**Who Was Surveyed**

The survey group of 500 left out 34 patients who declined to be interviewed or were non-English-speaking. Of the 500, 69 percent were ambulatory patients triaged by staff nurses to the "nonurgent screening" area; 20 percent had been classified non-critically ill "emergency" cases; the remaining 11 percent were obstetric/gynecology patients. This distribution is similar to that of all ambulatory patients at Cook County Hospital.

The sample excludes patients who arrived by ambulance (some of whom would be "inpatient dumps") and those who had life-threatening illnesses that may have caused them to have been recently treated at another hospital.

This path was first beaten by another institution. In 1975-77 Rush-Presbyterian St. Lukes Medical Center phased out its outpatient clinic, which had been serving the poor for over 100 years, in part to reduce Medicaid admissions which it claimed could no longer afford. During the same three year period the Medical Center was increasing its total assets from $125 million to $285 million.

During the past fifteen years hundreds of millions of Medicaid dollars have gone towards the purchase of the latest equipment and new hospital wings for private hospitals such as these. It is bitterly ironic that Medicaid patients are now finding themselves excluded from them. Meanwhile, Cook County Hospital, where they are sent, is a 70 year old antiquated and unsafe structure. The J.C.A.H. has threatened it with disaccreditation for fire safety violations. A recent spate of power failures included one on December 20th which knocked out all electrical power and backup systems for more than one hour. Fourteen people in the Intensive Care Unit were on ventilators at the time.

**Where Now?**

Will this trend continue unabated? Legal and community organizations in Chicago have distributed over 100,000 cards spelling out patients' rights to emergency treatment. A coalition of groups has recently succeeded in overturning a $500 per admission cap on Medicaid re-embursement for General Assistance patients in Illinois, which had been in effect for the past two years. This promises to bring some relief. Proposals are being consider to use County monies to bail out community hospitals hard hit by the Medicaid cuts in return for their agreement to accept re-routed transfer referrals. It remains to be seen whether this would merely facilitate dumping, or actually relieve C.C.H.'s overcrowding and increase the public accessibility and accountability of these institutions.

What is certain is that the window dressing is off of the system. Dumping practices which in the past were viewed as shameful, which hospitals vigorously denied engaging in, have become the accepted norm. Rather than "What, me dump?" we are now hearing "Of course we dump; we have no choice." The corruption of the mission of these "caring institutions," and the dehumanizing effects on the values of those who work and train within them, will have a lasting impact. More tangibly, the human suffering is epitomized by the words of a patient who said, "I'm afraid to let my kids go out and play for fear that they'll get hurt, because I couldn't afford care for them." It gives sobering insights into a health system which by the care it refuses, treats people like refuse, to be dumped onto the doorstep of the Public Hospital.


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Psychiatrist needed to serve as Director of our new program of Mental Health Services for the New York City Department of Correction. This program will have a professional staff of approximately fifty. Our goal is to create a model program of mental health care for this special population.

The Director must be Board Certified in Psychiatry and should have significant experience in the practice and administration of community, social, emergency, or administrative psychiatry.

Excellent salary and benefits as well as an academic appointment at the Albert Einstein College of Medicine are available to the successful candidate. We seek an individual with a strong commitment to social justice to develop and run this program. We take affirmative action to equal opportunity. Send CV to: Personnel Manager

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16 Health/PAC Bulletin
The recent Ninth Annual Illinois Blue Cross-Blue Shield Symposium offered a lot of abstract concepts, but it was more than an academic exercise. The standing room only crowd of several thousand well-heeled health care executives, administrators, consultants, professors, and political operatives makes decisions about how to manage the nation’s health care bill which affect the cost and coverage of our health insurance, how often our kids can see a dentist or afford new eyeglasses, the availability of care for our elderly relatives who may no longer be able to live at home, whether our neighborhood hospital or clinic will stay open, or even how our doctors examine and treat us for different illnesses.

These policy makers packed the Hyatt Regency Chicago’s Grand Ballroom expecting to hear an all-star lineup of pundits and senior politicians diagnose the problems in the politics and economics of U.S. health. What they got was a prospectus on the new era of health care competition.

The speakers had little or nothing to say about once traditional issues such as improving access to care for the disadvantaged, the need to protect all Americans from financial ruin while sick, or the need to reduce the indignities and regional disparities of health care facilities. (One exception was Illinois Senator Paul Simon’s call for extending Medicare coverage to dentures, eyeglasses, and hearing aids, all vital needs of millions of elderly low-income Americans.) And despite the participants’ obsession with health care costs, virtually nothing was said about public health or the preventable causes of illness and injury. Instead, almost everyone tended to accept and reinforce all the implicit assumptions underlying the transformation of health care from a public community service to a private consumer good available to those able to pay for it.

Cutting into the Future

The introductory panel featured Illinois Congressman Bob Michel, House Republican leader, and Dan Rostenkowski, Chairman of the House Ways and Means Committee. These two powers in health care legislation joined together to proclaim the need for budgetary encouragement for private initiatives, particularly health maintenance organizations (HMO’s). Rostenkowski stressed that Medicare, “which has no comparision amongst entitlement programs,” has to be cut.

Michel congratulated the private sector for helping to lower the annual number of doctor visits and hospital admissions, and praised the growing number of companies which now require employees to pay a portion of their health insurance premiums.

This bipartisan sentiment is not limited to the Illinois congressional delegation. For the first time in over a decade, the Democratic Party platform relegated national health insurance to a “long-term goal,” rather than a legislative proposal. The Republican platform bowed to election year pressures by excluding any reference to President Reagan’s proposed voucher system for Medicare beneficiaries. (In theory, this would save money by converting Medicare insurance benefits to lump sum payments and permit the elderly to shop around for the best health care buy; for the reality, see “Survival of the Fittest,” Bulletin, May-June 1981.)

Lauding Competition

At the conference, those endorsing the new era included Paul Starr, the author of the bestselling Social Transformation of American Medicine. He offered the good news that health care for profit is already driving down costs. Competition, he argued, is the inevitable consequence of past expansionary policies such as more medical school admissions, overbuilt hospital capacity, and extended insurance coverage. The current cost containment effort is part of the general disillusionment with 1960’s concerns about redistribution and growth, he suggested, and the 1970’s “nothing works” syndrome has undermined the legitimacy of increased health care spending.

Starr applauded corporate consolidation and vertical integration of facilities (hospitals acquiring satellite clinics, HMO’s buying hospitals, etc.), saying it has the potential to produce savings while maintaining quality care. Competing hospitals will have to slash prices and provide unique services to win contracts from prepaid plans. Hospital administrators will no longer be able to expect automatic reimbursement for ever-higher hospital charges; they will be bargaining with an “MBA with 10,000 patients in his briefcase.”

Most importantly, Starr noted, HMO’s and corporate medicine will produce dramatically more efficient physician practice habits. In their decisions to admit patients to the hospital, order laboratory tests, and prescribe drugs, therapy, or surgery, physicians generate about 70 percent of all health care costs. He cited a study demonstrating that an HMO physician serves 100 patients, while private fee-for-service physicians in the surrounding area serve only 250; each HMO surgeon performs nine procedures a week, as opposed to an
average of three per week for fee-for-service surgeons.

Only in passing did Starr comment on the potential downside of health care competition, which goes quite far down. When doctors have to process long lines of waiting patients quickly, doctor-patient intimacy is bound to decline. When doctors are constantly monitored by hospital administrators bent on cutting costs to a minimum, professional quality standards will certainly suffer. There will also be new limits to medical care for the very sick, the poor, and the less fortunate elderly, all of whom are unattractive to HMO's since caring for them costs more than "competitively" set premiums provide.

Another perspective was offered by Henry Aaron of the Brookings Institution, a relatively liberal think-tank, who co-authored the recent book Painful Prescription: Rationing Health Care. Like most other health care economists, Aaron sees the rapid growth in medical care costs as an inevitable consequence of the lack of a free market, since widespread insurance coverage naturally means health care consumers are not concerned about the actual cost of services and physicians and hospitals are only too happy to provide as much care, necessary or not, as insurance will reimburse them for. Aaron argued that thinking this momentum can be slowed significantly by increasing efficiency is a delusion, "the hospital version of eliminating waste, fraud, and abuse in government."

Forcing consumers to pay more out-of-pocket deductibles won't have much effect either, he asserted: "no country has done it— at times of illness people are spared most cost."

Aaron also expressed skepticism about the effect of HMO's on costs, noting that even if every U.S. hospital were to match the alleged 30 percent lower HMO admission rate (HMO's currently cover only seven percent of the U.S. population), the savings would still equal only about 10-15 percent of the current hospital care budget, and cut the soaring health care inflation rate by only one or two percent.

Our best hope, he suggested, is to learn from Great Britain, which has achieved a higher life expectancy and lower infant mortality than the U.S. He believes this is in large measure the result of state guaranteed social services and a much lower poverty rate. He then noted that even though the U.S. and Britain train physicians similarly and share common medical journals as well as standards for medical research, the cost of hospital care per person there is one half ours. The primary reason, according to Aaron, is the British willingness to accept rationing of scarce and costly medical resources.

He reported that the British generally apply the same standards of care to most illnesses, including costly treatments such as chemotherapy and bone marrow transplants — when a positive effect has been demonstrated. The biggest differentials between U.S. and British medicine, he said, come in cases where treatments have little or no proven effects, particularly expensive procedures for the elderly and terminally ill. For instance, the British use the first third less hemodialysis for renal failure, and generally none for patients over 55. They use one quarter less x-rays per patient; British hospitals have one sixth as many coronary artery operations as ours do.

This rationing generally occurs in a subtle, impersonal way, Aaron said. Often British physicians will refer to the limited technological capacity of their facilities as a method of discouraging further care. They may also attempt to reconcile older patients to the reality of an inevitable outcome. Here, said Aaron, different cultural traits are crucial: "While the British patient tends toward the stiff upper lip, the American patient typically demands that something, anything, be done."

The rationing that Aaron proposed obviously raises difficult moral and ethical problems. In the words of another conference participant, physician and author Stanley Wohl, "Rationing is obscene when 20 percent of our hospital system is earning enormous profits for private shareholders." Furthermore, as Aaron himself noted, those likely to be rationed are the poor and the uninsured, "an old American tradition."

Hopes for DRG's

Not surprisingly, the new Diagnosis-Related Groups system for Medicare hospital patient reimbursement (see Bulletin, March-April 1984) was a prime topic of discussion. Stuart Altman, Dean of the Heller Graduate School of Brandeis University and a member of the Institute of Medicine's Prospective Payment Commission, raised the key question of whether strict DRG rates will actually be enforced. He recounted his own experience years ago as a naive young health planner who thought he was going to block duplicate hospital purchases of high-tech equipment—"We thought we were going to eat CT scanners for breakfast."

Despite what he had thought were the strict cost containment measures of the 1974 Health Planning Act (known as the "hospital caviar" amendments), it turned out that hospital accountants could always create ingenious methods to exploit loopholes in the legislation.

A similar process is already underway with DRG's, Altman declared. Consultants are rushing to sell hospitals new medical records software packages designed to maximize DRG reimbursement. He asserted that it is often not very difficult for a doctor or hospital medical record staff to alter a patient's primary diagnosis to obtain a higher DRG reimbursement rate. "DRG creep," the extraordinary ability of hospitals to find secondary complications invisible under other reimbursement systems, "is now approaching DRG gallop," according to Altman. He estimated that creative recordkeeping could raise reimbursement rates as much as 12-15 percent, and predicted a "computer star wars" as the government's Health Care Financing Administration increases the sophistication of its anti-creep software system.

Reinhardt's Rebuttal

If audience reaction is any indication, the prize address of the conference was given by Professor Uwe Reinhardt of Princeton. Widely known in industry circles for his sarcastic health care jokes (a recent essay he wrote on regulation was entitled "Table Manners at the Health Care Feast"), he loves to rub the faces of health care executives into their affluence, and they love him for doing it.

In his customary maverick manner, Reinhardt rebutted the common wisdom answers to a series of basic questions.

Could the government be bankrupted by spiraling health care costs? Not likely, he said, pointing out that the U.S. has the smallest public health sector of any industrial nation. Furthermore, he noted, the government can squeeze providers: most have high fixed overhead costs and low marginal or variable costs per patient; so long as reimbursement covers these variable costs, the government can "make Humana eat it—if squished to the wall." He sees the DRG system as just the beginning, "a two by four to hit the donkey over the head to get his attention."

Are HMO's the future of health care delivery? Reinhardt doubts it: "If the Yuppies won't send their kids to public schools they aren't going to buy HMO's:"

Are corporate profits and the international competitiveness of American business endangered by hugh health care costs?
Outlays would do better to spend their time studying his that American companies seeking ways to cut their health of a burden than business taxes are in Europe. He suggested “Business bellyaching,” snorted Reinhardt, arguing that the five “oversupply”? “The medical school graduate today is a young doctor increase includes a growing number of female doctors, who see only 60-70 percent as many patients as their male counterparts.

Reinhardt does foresee continuing rapid growth in the health care industry. He also agrees that competition will win out over regulation in the near term. He believes this will happen in part because government rate regulation, advocated by Senator Ted Kennedy and private insurance company executives among others, invokes the subjective principle of a fair profit, or a regulated return to equity. This has been controversial when applied to utilities, he observed, and would be even more so for health care: “Consultants like me would be called in to advise that anywhere from eight percent to 24 percent is a fair rate of return.” Once a comprehensive regulatory process begins, providers would quickly have to submit to political pressure for regulated operating costs, he suggested, and such global budgeting, characteristic of European socialized medicine, would be fiercely resisted by virtually every industry interest group.

The professor concluded by calling attention to a great irony in health care competition: it’s first victim would be the practice of charging paying customers for charity care for the poor and the indigent; with the “fig leaf of cost shifting gone, the poor and uninsured will have to come begging on their knees.” This, Reinhardt commented, is just one more example of our low valuation of social peace. We pay daily for massive “internal defense expenditures” such as police, guards, locks, barbed wire, and prisons—and, of course, for the crime and vandalism these measures don’t prevent—which in the long run will prove far more expensive than the alternative course of “joining the ranks of civilized nations.”

Unfortunately health care policymakers, including those at this symposium, seem to pay more attention to profits than to prophets such as Professor Reinhardt.

“Business bellyaching,” snorted Reinhardt, arguing that the five percent of payroll expenses going for health insurance is less of a burden than business taxes are in Europe. He suggested that American companies seeking ways to cut their health outlays would do better to spend their time studying his Mercedes so they would learn how to make superior products.

Are doctors going to be squeezed by the much-discussed “oversupply”? “The medical school graduate today is a young man with a champagne class in his hand who looks into the mirror and smiles,” declared Reinhardt, adding that physicians may have “frittered away much of their prestige,” but they remain “the traffic cops of the system—they direct the flow of money anywhere they please.” He also noted that the physician increase includes a growing number of female doctors, who see only 60-70 percent as many patients as their male counterparts.

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by Tony Bale and Robb Burlage

Waterwagons have appeared in wealthy suburbs of Southern California and Long Island, supplying safe public water just as they did in 19th century inner city tenement rows. Shocking in itself, this is also an ecological parable of our times, an indication that the post-World War II "effluent society" has invaded wealthy neighborhoods as well as working class communities such as Love Canal in New York and Times Beach in Missouri.

Dangers lurk everywhere in this paranoid's nightmare come true. Toxic materials turn up inside the home, schools, and workplaces as well as in the air and ground. Toxic wastes which nobody kept track of in communities reappear in home basements, gardens, playgrounds, and water supplies; property values plummet. People fear for their lives and those of their children.

Those responsible have, at best, shown little foresight. Public warnings have been rare or nonexistent. There is evidence some corporate perpetrators and their company physicians and scientists have actually suppressed what knowledge there was. When confronted with preliminary evidence of disasters in the making, the regulatory arms of the state which allow risks to develop have responded slowly.

Compelled to rely on their own resources, people in communities throughout the country have created premonitory, do-it-yourself science which has all too often confirmed their fears that there is more disease around them than there should be. Their leaders, often women, have emerged as adept organizers and advocates, challenging corporations and agencies of the state. They and their local groups are now reaching out to others as they begin to realize that solutions to the menaces they face often lie far beyond their communities.

Combating toxic waste hazards in the community has become a cross-class "new public health" concern, extending beneath and beyond the remarkably broad support for government intervention to protect the environment. Its power, part of the phenomenon of what Harry Boyte has called "The Backyard Revolution," is already sufficient to alter the rhetoric, and sometimes the policies, of the state.

This is all the more impressive because the opposition remains strong. Despite prodding from congressional liberals, the Environmental Protection Administration is reluctant to move beyond the previous Federal "Superfund" appropriations for clean-up; fiscal constraints are often cited as an obstacle. Deference to industrial prerogatives is often as strong on the state level as it is in Washington, or stronger.

Nicholas Freudenberg's Not in Our Backyards is the first book to pull together the diverse strands of this movement, which burst into national visibility in 1978 when residents of the Love Canal community near Niagara Falls found out that they were living atop a massive dump for toxic chemicals.

Freudenberg integrates experiences from around the country into a complex picture of where the movement comes from, what lessons it has learned, and where it might go. Combining his experience as an organizer in this movement with an academic background as a professor of community health education, he asks and attempts to answer the basic questions the issue raises: Why are we facing this continual assault on our health? What can we do to stop it?

His book is an excellent primer for reviewing the major environmental hazards facing communities in the U.S. and globally, and the adverse health effects of each stage of the production process—in petrochemical production, power generation, agribusiness, mining, and manufacturing; from the initial extraction of raw materials to waste disposal.

After laying this groundwork Freudenberg presents a variety of case studies to show the breadth of the movement in this country, using published sources and his own extensive interviews and questionnaires. Failures are candidly discussed, although, perhaps partly due to self-selection in the response to this national survey, small but locally significant victories predominate.

There is, for example, the description of how a New York City couple who became concerned about a proposed storage facility for highly explosive liquefied natural gas initiated a group called BLAST and, through trial and error, learned important lessons about how to research a toxic waste problem. The efforts of a rural, largely Black-populated county in North Carolina to avoid becoming the home of a dump for PCB's provide valuable lessons in organizing and gaining national attention through the media.

One of the most noteworthy points in the book, buttressed by many examples, is that the general perception that environmental concerns are middle class
issues is inaccurate; there is a strong current of working class, low and moderate income leadership in these grassroots organizations which, Freudenberg urges, should be recognized and supported. Many of these leaders are women describing themselves as housewives; others are industrial workers and small farmers.

Freudenberg also explores the potential for links with racial and ethnic minority communities and organized labor, again citing examples, such as community support for an Oil, Chemical, and Atomic Workers strike against Shell Oil over occupational and environmental health protection issues.

Such explorations are particularly important now, when splits among environmentalists along class and consciousness lines are a real danger. Witness the June 1984 call for international “free trade” solutions to environmental problems.

Some groups such as Environmentalists for Full Employment voiced vigorous opposition. However the report, which bluntly ignores U.S. labor movement concerns about imports—including those from overseas operations of U.S. multinationals set up in part to escape environmental regulation here—was signed by major environmental organizations such as the Natural Resources Defense Council and the Sierra Club.

Another important point Freudenberg makes, again supported by his national survey, is that community residents and industrial workers can be very knowledgeable about complex issues of health impacts and links to specific processes, and can be very responsive to cooperative offers of scientific and professional education and supportive advocacy. In many cases, the book notes, community groups achieve their expertise despite the inadequacy of established scientific research and government regulation—not to say the inadequacy of communication with the affected communities.

The Role of Professionals

Professionals whose work concerns community health and quality of life protection may find this aspect of the book most challenging. Combining the views of the community groups he surveyed with his own thinking, Freudenberg suggests guidelines for effective educational, developmental, and advocacy activity which include the need for positive and open responses by public officials, at least in an “early warning system.” He also stresses the potential for political alliances offered by these organizations and uprisings.

The May 1984 Journal of the American Public Health Association report of Freudenberg’s national survey findings, which noted the widespread community organization perception of official obstruction and even cover-ups, was paired with a lead guest editorial by Dr. David Harris, Commissioner of the Department of Health Services of Suffolk County, New York. Headlined “Health Department: Enemy or Champion of the People?, this editorial lamented the “scientific illiteracy” of most citizens and the “anti-science” attitudes and “environmental paranoia” of community groups—in Harris’ Long Island area, over pesticides in ground water. “Public health workers,” he concluded, “must somehow rise above the clamor...in the face of criticism and false accusations.”

The debate surfaced again in an editorial in the September issue entitled “The Environment Returns to the Health Department.” The writer, Dr. Lloyd Novick, now Director of the State of Arizona Department of Health Services, cites an agency survey in the same issue as evidence that the sharply increased health department activity...will continue to expand as the number of toxic chemicals in our environment grows and more information about their adverse health effects becomes available. The historical role of health departments in the protection of the community, epidemiological investigation, and public education uniquely fits them to this expanded, if not fundamentally new, role in the environmental quandaries that lie ahead.

Another editorial in the same issue on COSH groups (area-wide committees or coalitions for occupational safety and health), entitled “A Grass-roots Public Health Movement,” notes that “important links have been forged between occupational and environmental health activists through community fights for right-to-know laws and attempts to deal with hazardous waste effects.”

Freudenberg’s work, therefore, may be salutary in challenging public health professionals and assisting them in reasserting an “historical role” of appreciating both the need for community action and the corporate and political nature of the problem.

“The primary causes of pollution in this country are the social and political imperatives of modern capitalism,” he declares, “and so the real solution to environmental problems is to transform a system that puts profit ahead of human needs.”

The question is how to develop the broad coalition this will require. Freudenberg briefly discusses the Japanese environmental movement and the West German Greens, but he has no illusions that a national movement is about to coalesce in the United States able to move the grassroots groups much beyond their own backyards. He is, however, optimistic, foreseeing a movement in the decade to come that battles for two rights articulated by the local groups: “The right to live in an environment that does not damage health and the right to participate in making the decisions about the environment in which one lives.”

He proposes that these rights be an integral part of popular movements for a national and internationalist politics of industrial conversion and control which goes beyond established frameworks of “industrial policy” or environmental negotiation. The book ends with a preliminary program for moving towards a socialist-environmentalist transformation.

Freudenberg’s conception also provides a strong potential link, analytically and practically, between the politicized community development and organizing activities he describes and the “new public health” movement whose activists, most prominently women’s groups and health workers, challenge and provide alternatives to costly, limited, and dangerous aspects of our high-technology-dominated medical care system. Ostensibly local health and sectoral health care issues can then become the basis for a national work-and-community-based democratic movement for health protection and quality-of-life promotion. This would require advancing beyond the often reactive community rebellions to a more comprehensive health and political movement that builds on and links itself consciously with, for example, insurgent labor movements and broader, often minority-led, social movements.

Obviously this will require more than creative community education outreach and advocacy about environmental and occupational health. And it must be remembered that this movement will be up against the world’s most advanced and complex technological forces, including global nuclear weaponry and the “medical-industrial complex.” But the surprising organizational seeds which Not in Our Backyards so well describes and analyzes will give its readers hope that
there is much to grow from.

Tony Bale and Robb Burlage are members of the Health/PAC Board.


by David Kotchuck

In occupational health and safety, to borrow a phrase from Rev. Martin Luther King, Jr., "We've come a long, long way, but we've still got a long, long way to go."

In this book of interviews conducted and edited by two Cornell researchers, 75 people, from chemical and electronics factory workers to lab technicians, firefighters, railroad workers, and gardeners, explain why.

Joe, a chemical worker (last names are not used to protect the workers) describes the time when he spent 30 days in a hospital: "We had the phosgene in 2000-pound cylinders and ran it in through hoses. There was a leak in the cylinder one day so I notified the supervisor, who said I should go out and tighten it up. But when I twisted the wrench, the whole fitting fell off and phosgene hit me. I got a pretty good dose of it. I went into convulsions and couldn't breathe. They had me in an oxygen tent. Then, for months after I got out of the hospital, every once in a while I wouldn't be able to breathe. That's happened two or three different times in the last eight or ten years. The day after the accident I was given a written warning from the company because I didn't have the proper safety equipment when I went over to the phosgene tank. You know, they covered their ass."

Many workers describe their fear: "At 30 I didn't worry. At 46 I worry a lot," and, often eloquently, their anger: "The company cares nothing about its employees, or even its supervisors. It's just a board of directors who only care about profits for their stockholders. They will put up the facade of being safety-conscious, but the reality of working conditions—that is of little concern, because fixing them would reduce profits. I personally believe that the rich, the powerful, the large corporations, take advantage of the workers. We've become dehumanized, subject to machine-speed theories, as if we're mice in a maze. We've been toyed with, played with, and symbolically given compensation in the form of paychecks every Wednesday, with little or no regard for how long we'll enjoy the paycheck or for the economic hardship on our wives and our children if we were to die of an occupational disease. It's of little concern to them, it's of great concern to us."

They also describe their resistance: "Why am I active in safety? Partly because I kept getting hassled. You can't wear your safety glasses because they're all steamed up, but if you take them off a piece of the pipe may blow in your eyes and they'll blame you for not having your safety glasses on... ."

How Companies Cover Up

One of the real insights in the book is how many different ways companies cover up their inaction and lack of concern. Together, the workers from different jobs and industries, about half of them in unions, describe almost enough to fill a corporate manual on "How to Save Money At the Expense of Health and Safety." Here are some of their ploys:

"When we complain the reply is, 'Engineering is looking at it.' After a few years, Engineering does look at it, but then it requires parts and these can be on order for a year and a half. When they get the parts in, it takes them six months to get it together, and when they do get it together they have to take it apart and do it again because they don't do it right. The company can see no reason why anything should be shut down if we need that product: A piece of tape will fix the leak until we can get it done. Just be careful. Don't walk under it, walk around it: That's pretty much the way they run the plant."

"There was a problem with the disposal and storage of chemicals. It was especially bad for people who smoked. So instead of trying to solve the problem, they eliminated the smoking, which was more or less a form of punishment. That's a blame-the-worker approach; it's a way of saying 'O.K., you bad people, this is what you get for speaking up.' To this day, there is still no smoking allowed in the press room."

"I wore a mask when I worked directly with toxics. It's so uncomfortable to wear this thing. After hours of wearing it, I'd get these really tight indentations in my face. It was totally inconvenient. I couldn't communicate, I was wearing goggles, respirator, lab coat, surgical gloves, because that's what we were supposed to do. But how long can you wear that without feeling like you're inside of a clam shell filled with marshmallows?"

"Anything that goes wrong—machine breaks down, box of film gets fogged—in their view it's never the machine's fault, it's always human error. They couldn't care less if you died, except that if you die you should die outside so they don't have to have an ambulance come with a stretcher."

"You never balance the wage against the risk," says Arnie, a worker in a food processing plant, "You balance the wage against the alternative. And the alternative is starving when you're put in this situation. That's what's so phony about this cost/benefit analysis. A worker in the plant doesn't say, 'Well, I'm getting $6.50 an hour so I'm gonna take this risk.' The worker in the plant says, 'I'm getting $6.50 an hour. If I open my mouth I might get nothing an hour, or I might get minimum wage. In that case, I can't afford to live.' So, what's the difference? There's no difference for a person in that position. Either way they're trapped."

Others have found a way out of this trap—through a militant union.

"We sat down to look at the injury and illness reports of the company, and we found seven lost-time accidents all related to the steps," explained one worker, "We decided that fixing the steps was the first issue to take on, because it affected the biggest number of people. We found that every set of steps in the plant except for the two that came down from the offices failed to meet OSHA standards. We confronted management and said we wanted the stairs changed.

"They weren't very sophisticated on how to handle a grievance. They told us, 'Those steps only have to meet OSHA standards if you carry things up the stairs. So we're issuing a memo effective today, that no one will carry anything up the stairs.' We called an emergency union meeting and got everyone to work to rule: They say don't carry anything up these steps, we won't carry nothing up. Nothing! When we had to load a still, we didn't carry a pipe wrench up those steps. If we had to use a pipe wrench, we'd go and find a lift truck. Then we'd go and find a flat, put our pipe wrench in the middle, bring it over to the still, and haul it up. That all took 45 minutes. After a week the company caved in. We got what we wanted."

Easy to read and well worth the time,
this book has one major problem: It costs $20. It would be nice if the University of Chicago press put out soft cover editions—so workers like those whose story this is can afford to read it.

David Kotelchuck teaches at the Hunter College School of Health Science and is a member of the Health/PAC Board.


by Judith Sackoff

In recent years, volume after volume has been written on pregnancy and childbirth, but hardly a word about the health concerns of older women. No More Hot Flashes and Other Good News by Dr. Penny Wise Budoff fills at least a portion of this lacuna. Her focus is the biomedical aspects of concerns such as osteoporosis, breast and uterine cancer, urinary incontinence, and the hot flashes that sometimes accompany menopause. The presentation of these difficult subjects is intellectually honest and, at the same time, accessible to a nonmedical audience.

The chapter on Hormone Replacement Therapy (HRT), for example, should be useful in helping women sort through the medical controversies surrounding its use. Dr. Budoff recommends HRT as a cure for the hot flashes that plague some women during menopause, showing how it works in the chemistry of the menstrual cycle and the changes that occur during menopause. She carefully distinguishes between HRT and Estrogen Replacement Therapy (ERT) —widely prescribed as a therapy for hot flashes until it was linked to uterine cancer. (HRT uses a trial of progesterone to counteract the potentially cancerous buildup of cells caused by taking estrogen alone.)

The book, however, has two shortcomings, one in content and the other in tone. First, Dr. Budoff makes only a very superficial attempt to put the medical dimensions of older women’s health in their appropriate cultural context. The potential abuse of HRT in the search for eternal youth, for example, is not touched on.

Second, at least in the early sections of the book, Dr. Budoff has the unfortunate habit of lionizing her own contributions to women’s health. At a professional meeting at which she spoke on HRT, she tells us, a colleague “grabbed the microphone... and said, ‘Penny Budoff, I love you. . . You have said everything that I have always believed and written about, but you have said it ever so much more eloquently.’ Now really!

Still, for its attention to the medical aspects of older women’s health, this is a book worth reading.

Judith Sackoff is a member of Health/PAC’s Women and Health Working Group.


by Eric Holtzman

Not In Our Genes, subtitled Biology, Ideology and Human Nature, has two intertwined themes. It attacks, vigorously, the “biologically determinist” view that humans are significantly constrained in their social and intellectual activities by inherent biological limitations. And, it sets forth the outlines of a “dialectical” biology, stemming from the Marxist tradition, that gives central place to the mutual interlacing of biology, society and physical environment.

The authors are outstanding and world-recognized scientists whose specialities are complementary: Lewontin is a population geneticist; Rose a neurobiologist; Kamin a psychologist. All three have long histories of outspoken participation in the controversies on which they comment. They ably elucidate the political connections of the scientific issues they discuss; in the first pages they state their “commitment to the prospect of the creation both of a more socially just—a socialist—society” and of a corresponding critical science, whose instincts are to look for possibilities rather than limits. Partly as a consequence of such forthrightness, Not In Our Genes rapidly evoked public praise or attack, with predictable emphases, by major figures along the “left-right” spectrum in modern biology such as Stephen Jay Gould, P.B. Medawar, and Bernard Davis.

The heart of the book, occupying its middle sections, covers familiar terrain,
dealing with questions such as: Is IQ inherited? To what extent are human social structures, such as patriarchy, expressions of biological imperatives? Is schizophrenia a genetic disorder? Should "conditions" such as hyperactivity among school children be treated as medical problems, appropriately dealt with by pharmacological means? The authors readily demolish the views of the more extreme of their opponents. They demonstrate the paucity and weakness of the data upon which leading theories have been built, and identify the biases that are often manifest in the underlying research.

For some tastes, there may be a certain amount of overkill or imbalance here. I think the authors could give more credit to those areas of work in the sociobiology of non-human species that are moving in constructive directions. Nonetheless the book will be very useful for its concise, detailed marshalling of the crucial arguments against those who seek to skew our educational systems, hiring practices, and self-images on the basis of pessimistic assumptions about human potential and social possibilities. Even readers with only a minimal background in the sciences will come away inoculated against taking studies of the IQ's or mental disorders of twins too seriously, or accepting too rapidly the psychiatric labeling of behavior. These authors know their stuff and know how to present it. They cannot readily be dismissed as childish know-nothings or wishful thinkers.

The beginning and the end of the book will be less familiar to those who have not previously encountered "radical science." The book opens with an analysis of science as a social and historical construct; it is designed to demonstrate that the sciences inextricably join, in dialectical tension, the intellectual search for "the truth" with service to ideological needs of socially dominant classes. Biological determinism, from this vantage point, provides legitimation for key elements of bourgeois society such as the inequalities among classes. The incorporation of such arguments in this book arises, I believe, from the authors' conviction that it is misoriented to seek to obtain "objective" and meaningful information about important biological constraints on human social and intellectual capacities and activities (other than such obvious ones as the need to eat or the inability to fly).

Defenders of the opposing view readily admit that there are flaws in the information and procedures used to support, for example, the belief that IQ is inheritable; they call for redoubling our efforts to improve the data and refine the analyses (see, e.g., the lead editorial in *Nature* 309:579, 1984). Lewontin, Rose and Kamin, in contrast, assert that in most crucial areas there is no realistic way to determine what limits biology may actually impose. For them, analyses of the type, now popular, that attempt to ascribe X percent of a characteristic to biological influences and Y percent to environmental ones are highly suspect in principle when the subject is evolution or social structure or intellectual and emotional development. In fact, the book implies strongly that the very effort to decide how much biology there is in our social and intellectual lives is irremediably flawed and politicized at birth, since it involves decisions about which elements to emphasize and which tools to use that are themselves products of social influences and as such strongly color or even preordain the outcome. These arguments are important ones to make; they get at deep-seated discomforts experienced by many people, scientists and nonscientists, who share the authors' distaste for racism and sexism but think of science as occupying a special insulated niche. Their argument puts them in direct opposition to the view expressed in the *Nature* editorial to which I referred above, that we should go ahead full blast with studies of the hereditability of IQ, confident that irrespective of the outcome there will be little social effect—or at least that the science itself will not be to blame for the effects. Such a call for more information is always a difficult one to resist, since it resonates strongly with our commitments to openmindedness and freedom of inquiry. Lewontin, Rose, and Kamin's response is that social impacts of such studies and on such studies are near the center of the scientific attempt, and that the social and the scientific can never really be disentangled.

The book ends with an effort to sketch features of a dialectical biology designed to avoid reductionism and determinism, both cultural and biological. The authors consider this a very important project, lamenting that too much of their own energy has been consumed with fighting the ever-recurring fires of determinism and too little with "drawing plans for a truly fireproof" biology. An effective biology, they believe, treats organism and environment not simply as interact-
Imagine your brain as the executive branch of a big business. It is divided, as you see here, into many departments. Seated at the big desk in the headquarters office is the General Manager—your Conscious Self—with telephone lines running to all departments. Around you are your chief assistants—the Superintendents of Outgoing Messages, which control Speech and the movement of Arms, Legs, and all other parts of the body. Of course, only the most important messages ever reach your office. Routine tasks, such as running the heart, lungs, and stomach, and supervising the minor details of muscular movements, are dealt with by the Manager of Automatic Actions in the Medulla Oblongata and the Manager of Reflex Actions in the Cerebellum. A third group of departments form what the scientists call the Cerebrum. Such work is done in the Camera Room. "Watch out!" came the signal to your desk, and at the same instant both messages were laid in front of you. As you say "Hullo!" and shake hands, it all seems very simple, but let's see what happened during that time in your brain. The instant you called your name, your Hearing Manager reported the sound, and your Camera Man flashed a picture of him to the Face and Lip Superintendents. All your orders were faithfully carried out. Think how much work we do in our brain every 24 hours!

During the 1980's nuclear war has come out of the closet. Millions of Americans have entered the struggle to end the nuclear arms race, and dozens of new books have come out on the subject. Certainly the reasons for popular concern are obvious. In the Fate of the Earth Jonathan Schell provides a wealth of information on the impact of nuclear war as it was understood at the time he wrote. Within a day, he explained, a single bomb explosion would create an electromagnetic pulse which would knock out an area's electricity, a massive heat wave and a shock wave with winds up to the speed of sound, and intense but local radioactivity.

In the following weeks and months the major health effects would be acute radiation sickness, burns, blast-induced injuries, increased birth defects, and sterility. Serious indirect effects would include additional radiation sickness caused by fallout and contaminated food and water, epidemics of communicable diseases, desperate shortages of food, and emotional traumas such as the feeling that the entire world was dying. Lifton and Falk provide many details on this in Indefensible Weapons. Numerous toxic chemicals such as dioxin and nitric oxides would be released into the air; some of these chemicals would react with the ozone layer in the stratosphere, quite possibly halving it for 30 years. If this occurred, numerous animals, insects, and birds would be blinded; the growth of many plants would be stunted.

This is not all. Catastrophes developing in the ensuing years are harder to predict in detail. Additional ones will probably come to light as new research is completed; many are likely to come from interactions between individual effects. One major recent study has

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predicted a "nuclear winter," in which a huge cloud of smoke and dust thrown up by a major nuclear war would cut sunlight by 95 percent for several weeks, knocking world average temperatures down between five and 40 degrees centigrade. These sudden and drastic changes would be fatal, in any season, to many crops and animals; for several years famine would be horrendous, and the study's authors do not rule out the extinction of the human race.

Given such frightening consequences of nuclear war, we might well wonder what causes the nuclear arms race. If you ask the American nuclear establishment, you will be told that the U.S. has built up its nuclear arsenal only because of its stated, reasonable military and political objectives. The Harvard group that wrote Living with Nuclear Weapons provides a good statement of this conventional wisdom—hardly surprising, since four of this all-male group's six members have advised presidents from Franklin Roosevelt through Jimmy Carter.

The Harvard group surveys the causes of the arms race, and concludes that the most important is the superpower political rivalry. When the analysts examine the opposing side, they stress the great difficulties of understanding Soviet behavior, but clearly imply that its roots lie in expansionism and militarism (an "evil empire" a bit less evil than Reagan's). The authors argue that faced with such an adversary the U.S. has no choice but to build up its nuclear forces, since only they can make deterrence credible and ensure that the East-West conflict does not escalate into a nuclear war.

Freeman Dyson offers a very different view of Soviet motivations in Weapons and Hope. In a lucid and profound essay, he suggests that the Soviets' military and foreign policy is primarily shaped by a grim determination to defend their borders, and to avoid the surprise attack their country has experienced so often through the centuries. While the Soviets are determined to win a nuclear war, he says, they know that victory will only emerge out of the fog of war, in a highly unpredictable way.

If we assume that Dyson and many others who have made similar points are correct, and American policy makers share their analysis, we must then explain why the U.S. continues to build more bombs and missiles. The reasons are complex, involving a whole range of causes that reinforce each other.

First, on the level of international politics, the U.S. has developed nuclear weapons to deter not so much the Soviet Union as Third World threats to its empire. This is documented in Eiltsberg's introduction to Protest and Survive, where he demonstrates that Washington's nuclear threats have almost all been directed at Third World countries. This pattern has remained hidden from the American public largely, Lifton and Falk point out in their book, as a result of the government's strategy of stifling criticism of American nuclear weapons policies ever since the first atomic bomb was exploded in 1945.

A related cause, highlighted by Schell, is the persistence of the sovereign nation-state. Sovereign nations, he says, are prepared to defend their independence by any means, and members of the nuclear club have acted in this way since 1945 no less than before.

The second set of causes of America's nuclear buildup is to be found in our country's political economy. The Thompson and Smith volume contains thoughtful analyses (especially those of Rothschild and Kaldor) on the massive and self-sustaining power wielded by American military contractors and by their friends among politicians, bureaucrats, and scientists. This power has a great impact on the weapons that get developed and on the public justifications for them.

The personal side of the military-industrial complex is vividly portrayed in Nash's article in Thompson and Smith. He states that in his experience as a Pentagon analyst, he and his colleagues "never experienced guilt or self-criticism." They could do technically excellent work, partly because their jobs never allowed them to look at the "big picture." They objectified and quantified their potential victims, and they enjoyed the prestige of doing classified work.

This mind-set is related to the third group of causes—the ideological. Lifton and Falk discuss the phenomenon of "nuclearism," the belief held by most Americans that nuclear weapons are an effective, controllable, and morally acceptable way to protect national security.

Several writers, especially Thompson in his opening essay, refer to the distortions of language that reinforce nuclearism by employing what he calls "nukespeak"—a mixture of euphemisms and jargon.

Closely related to these causes is a fourth set—the psychological. Both Lifton and Schell place great emphasis on the psychic numbing that results from Americans' denial of their feelings about nuclear war. When they are acknowledged, Lifton implies, those feelings are often contradictory. On the one hand, Americans are scared of nuclear war. On the other, many of them sense the absurdity and duality of life (which combines business-as-usual with the possibility of instant extinction). Lifton-Falk and Schell seem to suggest (quite correctly, I think) that these psychological undercurrents make millions of Americans cling more tightly to nuclearist ideologies.

As Schell puts it, two kinds of answers have been offered in this country to the question of what to do. The realists say we must learn to live with nuclear weapons; the idealists say we must ultimately abolish them. (I ignore extreme hawks who say we can and should use nuclear weapons to defeat Communism.)

Not surprisingly, the Harvard group endorses the realist position. It places higher priority on arms control than the Reagan Administration and is more willing to take risks of Soviet violations of arms control agreements, but its report endorses most of the Reagan nuclear buildup.

The Harvard group acknowledges some of the paradoxes involved in the arms race, noting, for example, that "nuclear weapons can prevent aggression only if there is the possibility that they will be used, but we do not want to make them so usable that anyone is tempted to use them." However their report pays little attention to the simple fact, crucial to Dyson's argument, that any reasonably humane person who tries to prevent nuclear war by building any kind of nuclear weapon would be shocked by the realization of the massive destruction its use would inflict.

The Harvard analysts say we will always have at least the knowledge of making nuclear weapons, and the sovereign state is here to stay. Schell, in contrast, argues that if humanity is to respond adequately to its fear of extinction, it must abolish all weapons and build a system of non-violent national defense. He was justly criticized for not providing sufficient detail on this point, but in his latest book, The Abolition, he has insightfully answered his critics.

Dyson's Weapons and Hope is the only book reviewed here that offers specific suggestions on how to move the international system and the military towards the abolition of nuclear weapons. Dyson searches for an overarching perspec-
tive—what he calls a “concept”—to guide the construction and deployment of all weapons so that a nation's enemies are deterred yet progress is made towards nuclear disarmament. He reviews a range of such concepts, from nuclear war-fighting to unilateral disarmament, and the only one he finds acceptable is “live and let live”—which means that higher priority is assigned to keeping our nation’s people alive than to killing our enemies.

The details are fascinating, but there is a serious inconsistency in Dyson’s approach. Although he would have us sympathize with the victims of wars, not with those whom he calls “the warriors,” he frequently slips into an elitism which blinds him to the non-nuclear atrocities committed by modern nation-states. He calls on soldiers, scientists, and diplomats (humane ones, of course) to put his ideas into practice, not ordinary men and women.

If we really want to avoid this kind of elitism and blindness to mass destruction, we must look once again at Schell’s proposal to drastically curtail national sovereignty and replace all weapons with non-violence as the basis of national defense. Dyson examines some historical cases of non-violent defense, and concludes that it works only when the defender is well organized beforehand. He is probably right, given the history of non-violence so far.

Unfortunately, none of the books reviewed here come to grips with the question of what it means to have a well-organized non-violent defense. There is no space to go into that question here, other than to say that if we weaken the grip of the nation-state on its citizens, we strengthen the possibilities for non-violence. Anti-war activists throughout the world are teaching us some political lessons on this.

But there are other ways of tugging at the economic and ideological roots of militarism and national sovereignty that are less dramatic, although still potent in the long run. One is Kaldor’s proposal (in Thompson and Smith) that we reverse the arms-making process by bringing together workers from diverse (if possible, hostile?) countries to collaborate on converting weapons-making plants to ones meeting human needs. Another interesting idea is Dyson’s suggestion that “the elimination of nuclear weapons must be presented to the public as a response to the demands of military honor and self-respect, not as a response to fear.”

Finally, prominent in Schell and Lifton-Falk is the call on humanity to “imagine the real,” as Lifton puts it. We must face up to the horrors of Armageddon and throw off nuclearism. And then, they urge, we must go further: develop a new sense of empowerment, a new understanding of security, and a new awareness that we all share one fate.

Other significant writings on nuclear weapons


On American weapons and strategy, a powerful and detailed critique of the official position is First Strike (Boston: South End Press, 1983) by Robert C. Aldridge; The Nuclear Question (New York: Cambridge University Press, 1979) by Michael Mandelbaum is a history close to the Harvard Group’s perspective; a very detailed survey is The Evolution of Nuclear Strategy (New York: St. Martin’s Press, 1981), by Lawrence Freedman.

On the Soviet Union, see The Nuclear Delusion (New York: Pantheon, 1983), by George F. Kennan, an authoritative set of essays; The Soviet Union and the Arms Race (New Haven: Yale University Press, 1983), by David Holloway is a detailed and fair-minded analysis; The Soviet Union Today (Chicago: Bulletin of the Atomic Scientists) is an informative general reader.


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**Peer Review**

continued from page 2

From each locked into their respective rungs on the ladder.

Desmond Callen, M.D. Copake, New York

P.S. Last fall the politicians announced a 30 percent increase in New York Medicaid fees for physicians. In January 1985 the new fee schedule came in the mail. It cuts the basic office fee from $9 to $7, a 22 percent reduction. So much for state support of out-of-hospital care for the poor.

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**Vital Signs**

continued from page 4

* The quality of health services for the poor will decline significantly by 1995.
* Medicare beneficiaries will pay more for their care, but there will be coverage for catastrophic illness.
* Congress will limit malpractice awards by 1990, which will lower malpractice insurance rates and reduce defensive medicine.
* HMO's and PPO's will quintuple their share of hospital revenues to ten percent by 1995.
* Physician income and job satisfaction will decline.
* Health care costs will continue to rise rapidly, up from the current 10.8 percent of the GNP to 12 percent by 1990, but will remain at that level for the rest of the century.

Most of those surveyed also believe that the best ways to reduce health care cost inflation are alternative delivery systems, increased emphasis on ambulatory care, and increasing the share patients must pay.

**Medicine as an Art, Not a Science**

Senate Appropriations Committee hearings last November chaired by William Proxmire (D-WI) found overwhelming agreement that the government could save itself and others a great deal of money, not to say trouble, by funding some basic studies of how patient groups respond to different treatments.

Dr. John Wennberg of Dartmouth Medical School, a specialist in physician practice patterns, noted that when we have situations such as that in Maine, where seven out of ten 70 year old women in one part of the state have undergone a hysterectomy while in another part only two in ten have, the variations cannot be explained by demographics or case mix. Wennberg and others suggest that whether the surgeons in the one region are overtreating or those in the other are undertreating requires long term, expensive outcome studies—but these would cost only a fraction of what the government spends pours into the health care industry.

**Computer Medicine**

We recently received a letter from Comp Doc, Inc., a Colorado firm specializing in home health care software, announcing its new Home Doc computer program. Its contents include an "educational portion" and medical record-keeping system as well as "a quick access summary menu...to obtain guidelines of what to do when faced with common problems like fever, diarrhea, vomiting, etc."

Comp Doc is not the first in the compu-med field. Dow Jones News Retrieval offers an on-line medical database to subscribers which provides similar medical advice. More will no doubt be in your computer store soon, followed by videotapes—"Your Favorite Hollywood Stars Exhibit Your Favorite Disease Symptoms and Tell You What to Do About Them."

These services create interesting problems and possibilities. Can the software manufacturer be sued for medical malpractice? Could a non-M.D. who developed a sophisticated medical program be sued for practicing without a license? Could other health workers using a computer examine and treat patients who would formerly have seen a doctor? How soon will we have interactive systems, which suggest testing what a patient can do in the home (with a kit conveniently sold by the conglomerate which distributes the software) and then suggest further measures based on the results?

The potential for improving consumer medical knowledge and the ability of non-physicians to treat themselves in many cases is enormous. It is unfortunate that the very health consumers who could use these systems most—those who are unable to obtain medical treatment or must wait long hours for an often-cursory examination—are least likely to benefit, since they can’t afford a computer. We may hope that the day will soon come when these people do have access to medical programming, so that practitioners who treat them like assembly line parts will themselves be automated out of existence.

**My Enemy’s Enemy**

When California’s ultra-right politicians mounted their latest anti-welfare initiative they thought they had the perfect formula for a subtly racist campaign. By touting Proposition 41 as an attack on the AFDC program and its many minority beneficiaries, they hoped to convey the impression that its passage would affect only them and not wreak hardship on the handicapped and the elderly.

Not true. Had it passed, Proposition 41 would have slashed AFDC and Medical (California’s Medicaid program) by approximately 30-40 percent. Nevertheless, early surveys commissioned by Prop. 41 opponents showed the conservative ploy had been successful. A substantial majority supported the measure.

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Body English

Continuing Affairs Of The Heart
by Arthur A. Levin

Along with the controversy over the role of sodium and other dietary constituents in causing and/or controlling high blood pressure, there is heated debate over both new drugs and older ones about which we have new information.

Since 1976 "stepped care" guidelines for the diagnosis and treatment of high blood pressure developed by a committee of experts assembled by the National Heart, Lung and Blood Institute have been generally accepted. A third revision was published by the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure (JNC) in 1984.

One bit of dogma has been that once a person has been diagnosed as requiring treatment, he or she should remain on a drug regimen for life. Behavioral and life-style alterations such as diet and exercise were seen as possibly helpful adjuncts, but not alternatives.

The 1984 JNC protocols address this controversy for the first time, discussing treatment of so-called "mild" or "borderline" hypertension, defined as a diastolic blood pressure of 90 to 94 mm mercury. They suggest that it is appropriate to try the following non-drug approaches:

- Advising obese people to lose weight.
- Advising smokers to stop.
- Urging people to restrict sodium intake to two grams per day (the report does not discuss the sodium controversy).
- Suggesting that alcohol consumption be limited to two ounces per day.
- Recommending regular cardiovascular exercise.

- Reducing "abnormally" high serum cholesterol levels.

None of the above recommendations are news to most of those interested in heart disease issues, but official medicine has never before suggested that a behavioral approach alone might suffice for even this subset of hypertensives. While this is a welcome change, with all we know about how difficult it is to change behaviors, it seems simplistic to suggest that advice from a doctor is sufficient. The physician humility we all know and admire would be welcome here.

Perhaps even more startling than the behavioral recommendations, particularly for those who have marveled for years at establishment medicine's resistance to admitting the value of non-invasive techniques, are the recommendations of relaxation techniques and biofeedback. The committee also declares that even if the non-invasive approach should fail, drugs may be unnecessary if the patient is closely monitored.

For persons with moderate and severe high blood pressure (a diastolic of 95 mm mercury or higher) drug treatment is still affirmed to be imperative. However, the steps in the "stepped care" approach have been modified to reflect the greater clinical experience and new drug families developed in the past decade.

The older guidelines held that the most appropriate first step was treatment with a diuretic. The new JNC advice is that a beta-blocker may be an appropriate first intervention instead. As a second step, the report says, angiotensin-converting enzymes (e.g., captopril) and calcium channel blockers (nifedipine, verapamil, or diltiazem) may be substituted for, or added to, previously recommended drugs—although channel blockers are not approved by the FDA for treatment of high blood pressure. The guidelines also recommend both enzymes and channel blockers for new third steps.

As could be expected, these new guidelines have not been universally accepted as good advice. Dr. McCarron, whose studies were described in the last column, criticizes the JNC's sodium restriction recommendation. Dr. Laragh joins McCarron in raising questions about recommending reduced sodium intake for all hypertensives, since only 30 percent are sodium dependent. He also criticizes the rigidity of the guidelines in general, taking issue, for example, with the advice that diuretics are appropriate for all hypertensives, when the MRFFIT and other research trials indicate they may actually be harmful for some people with high blood pressure.

For those tens of millions of people who have mild or borderline high blood pressure all this controversy may be unsettling. On the other hand, by highlighting the fallability of medical scientists and practitioners, it serves to remind the public that it is up to each of us to evaluate the varied therapeutic approaches to determine which is the most appropriate in our own individual case.

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

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Vital Signs

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based on their understanding that it would cut benefits only to the "able-bodied" poor. However when survey takers explained that passage would cut the Medi-Cal benefits of nearly one million children and hundreds of thousands of elderly and disabled persons, support for Prop. 41 plunged to barely 50 percent.

Community and grassroots organizations were the first to sound the alarm and begin to build on this base, but the scope of the proposed cuts extended the opposition far across the political spectrum to include the California Hospital Association, the California Medical Association, the Chamber of Commerce, and Republican Governor George Deukmejian.

The hospitals poured millions into an anti-Prop. 41 war chest. Much of this money went for a massive PR campaign developed by professional media and political consultants. Taking their cue from the survey results, they used video interviews with real Medi-Cal beneficiaries (all disabled or elderly, almost all white) who would lose their benefits if Prop. 41 passed. Although community groups were deeply disturbed by this focus on "acceptable" white beneficiaries, the threat posed by the measure was so great that very few were willing to risk losing the election by waging a more "principled" campaign.

Activists were soon chagrined to find themselves labelled mouthpieces for the moneyed health provider interests by Prop. 41 supporters. They nevertheless held their collective tongue to maintain the alliance; they refrained from pointing out that the profligacy of the health care system affects all payors and the solution lies in greater public control, not in cutbacks inflicted on those most in need.

Despite these compromises, the left went all out. What it lacked in money it made up in moxie and peoplepower. A grassroots voter registration and mobilization campaign brought vast numbers of poor voters to the polls. In combination with industry cash, this popular movement carried the day: Prop. 41 was crushed by a margin of nearly 20 points.

Unfortunately, this victory may be short-lived. Learning from his setback, the original sponsor of Prop. 41 has promised to revise it so that only AFDC is eviscerated, while Medi-Cal is spared. This will almost certainly pacify the hospitals and permit a campaign with far more ugly racial overtones.

—Mark Allen Kleiman

Mark Allen Kleiman is an attorney practicing in Los Angeles.

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