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22 Vital Signs

The Dynamics of Hospital Expansion

In Orange County, California, fully half the hospital beds are empty on the average day. Annual upkeep on the 2,905 surplus beds costs $58 million. (1)

- The 1,752 surplus beds in Dallas/North Central Texas (average hospital occupancy 60 per cent) will jump to 2,470 in 1976. Unnecessary beds will cost Dallas area residents $180 million between 1975 and 1980, adding $10 a day to each patient's bill. (12)

- Oklahoma City has an average occupancy rate of 65 per cent (3) and a bed sur-
plus of 1,946. Total wasted dollars over the next 30 years will reach $650 million. (4) • The San Francisco Bay Area has an occupancy rate of 60 per cent, with several hospitals able to fill less than 40 per cent of their beds. The regional bed surplus tops 4,000, costing $65 million a year to maintain. (5) • Miami, Florida (Dade County) is yet another urban area with occupancy rates below 60 per cent. Its bed surplus is 2,946. (6) These cities are just the tip of a giant heap of unused beds. On any given day, according to American Hospital Association (AHA) figures, 25 per cent of the nation’s 903,000 short-term hospital beds are empty. (7) With a reasonable occupancy rate assumed to be 85 per cent, 10 per cent of the beds (90,300) are empty because of overbedding. Multiply this figure by the $20,000 a year cost to maintain an unfilled bed (8) and one arrives at $1.9 billion a year in wasted money (See BULLETIN March/April, 1974).

But it’s even worse. According to a well-known public health doctrine, Roemer’s Law, more beds create more hospital admissions, many unnecessary. (9) Barry Ensminger of the Public Citizen Health Research Group estimates that unnecessary stays in the hospital due to unjustified surgery, overly lengthy stays and unneeded admissions fill an equivalent of 250,000 beds. The cost of these unnecessary stays runs at least $6 billion a year, bringing the total cost of overbedding to an astronomical $8 billion a year. (10)

And even these statistics, based on AHA occupancy rates, underestimate the case. A startling gap exists between AHA occupancy rates and those reported locally by comprehensive health planning (CHP) agencies and others. For example, the 1974 AHA Hospital Statistics reports an 81 per cent occupancy rate for Miami (11) while the local CHP places the percentage at 7.03. AHA lists Oklahoma City at 78.1 per cent compared to 65 per cent according to local sources. (12) If those figures are any indication, the number of unnecessarily empty beds may be double the AHA’s estimate.

AHA occupancy rates hide empty beds because the figures are based only on acute beds in use, while the CHP’s include all beds constructed and licensed. According to various local CHP spokesmen, hospitals will actually take beds out of use in order to make their utilization figures look good for the purpose of securing a bank loan. (13) AHA officials admitted in interviews their annual statistics were “soft.”

Recent case studies in Miami (14) and Oklahoma City (see BULLETIN, March/April, 1974) each concluded that local CHP boards ignored their own staff reports predicting overbedding, instead approving a series of major building projects. In late 1972, the federal General Accounting Office released a study warning that each of five cities—Baltimore, Cincinnati, Denver, San Francisco and Seattle—was overbedded or would be overbedded by 1975. (15) Now that 1975 has come, the surplus in those cities exceed even the GAO estimates. In hundreds of cities across the country, hospitals are beginning construction projects with full knowledge that they are contributing to a bed glut. According to the Wall Street Journal (November 2, 1971), “the number of beds in general care hospitals has grown about three times faster than the nation’s population,” rising 33 per cent from 1960-70. Even during the current depression, contrasting markedly to the drastic reduction in housing construction, the number of beds continues to expand, increasing by 4 per cent in 1973 alone.

**Unused Equipment**

The building glut extends beyond beds to specialized service units and equipment. A national study of open-heart surgery units (used for nonemergency operations) showed that 11 percent of the hospitals equipped with such units did not perform a single operation during the study year. Only 175 performed 50 or more procedures. Open-heart surgery units cost $500,000 to build and hundreds of thousands more to maintain. The same study revealed that 30 per cent of the 777 hospitals...
with closed-heart surgery units failed to perform a single operation during the year, while only 6 per cent performed 50 or more.

Supervoltage radiation units cost $500,000. San Francisco has six units, operating at only half their potential capacity. Nationwide statistics on these units are not available.

Even hospitals ten minutes apart duplicate each others' services. Mills Memorial Hospital near San Francisco is adding on a long list of new equipment already functioning at nearby hospitals, including an EMI scanner (which will be outmoded in a year), a coronary angiograph machine and an electron microscope. The San Mateo County Comprehensive Health Planning Council approved Mills' request to add this equipment over CHP staff objections.

Some costs of expansion are not easily measured in dollars and cents. In San Francisco, community groups have battled St. Mary's Hospital over a project that would destroy their neighborhood. The hospital has proposed a medical office building for 144 doctors and a garage for 700 cars. The building would eliminate 48 critically needed low-income and moderate-income homes in a city whose vacancy rate is less than one per cent. In addition the City Planning Department environmental impact report reveals that the project would bring 3,000 more cars and 10,000 more people into the neighborhood each day, doubling pollution, raising the noise level by 25 per cent and increasing congestion. Thus far the neighborhood has blocked the project in court, but the final decision is pending.

Why Hospitals Overbuild—
An Overview

Two sets of social forces shape hospital expansion: 1) powerful interests controlling the hospital—trustees, administrators and doctors—along with the hospital supply, construction and drug companies and banks which together make up the medical-industrial complex; and 2) health beneficiaries such as labor unions, the poor and the elderly who, along with government health bureaucracies, demand an increased flow of money into the health system.

Since World War II these two sets of forces have acted together to spur hospital expansion. Taking advantage of the demand for increased insurance coverage of working people and government coverage of the poor and elderly, hospitals have secured huge construction subsidies through the Hill-Burton Act and the third-party payment mechanisms of Blue Cross and Medicare/Medicaid.

What has developed is a hospital market whose size and shape is determined politically rather than economically. General Motors, for example, does not expand its auto plants without a reasonable expectation of selling more cars. But for hospitals, the flow of economic resources depends far less on direct economic demand or business criteria of efficiency and profitability. Instead, investment in hospitals rests on such political matters as negotiations between labor and management for increased Blue Cross coverage, expansion of governmental health spending, Blue Cross rate increases granted by state insurance commissioners and approvals by local CHP agencies. In the hospital sector, governmental monies account for 53 per cent of all spending, and 90 per cent of hospital income comes through third parties—Blue Cross, com-
mercial insurance, Medicare/Medicaid and other government programs—rather than through the open market (direct patient billing). (17)

This politically driven health market—based on a consensus of expansionary institutional health providers and demanding consumers—has grown vastly during the '50's and '60's, sustained by the global expansion of the US economy. This market is part of a postwar policy of economic Keynesianism in which many political devices were used to artificially stimulate domestic economic demand not only in health but in housing, agriculture, transportation and defense. By what mechanisms, internal and external to the hospital, does the political driven health market create untrammeled hospital expansion?

**FORCES WITHIN THE HOSPITAL**

Within the hospital, three major actors determine the expansion: 1) the doctors who use the hospital as a workshop free of charge and earn one-third to three-fourths of their income there (18); 2) the administrators, whose careers and salaries are bound up in the size and growth of the institution; and 3) businessmen trustees, who may sometimes make money from the expansion process by owning a company that transacts business with the hospital. While occasionally differing over an expansion decision, these three forces controlling the hospital generally act in unison. It is this growth consensus that has made construction crews almost as integral a part of the modern hospital as orderlies and nurses.

**Medical Entrepreneurs**

Stripped of their professional mystique and white robes, most private doctors are highly trained small businessmen who require large capital investments to run their enterprises. They are in the anachronistic position of independent entrepreneurs who require expensive tools but lack the economic resources to buy them. This financial reality underlies doctors' endless stream of demands on hospitals for medical equipment. Historically, doctors have viewed the hospital as their "workshop," a place that offers them free use of the equipment needed to ply their trade profitably. (19) And with medical schools churning out increasing numbers of specialists who are more and more dependent on high technology, the doctors' demands on hospitals are mounting.

Doctors, or rather a select group of doctors, invariably get the facilities and services they demand. Indeed, hospitals compete for doctors and are continually looking out for facilities and equipment that will lure doctors onto their staffs. As the only people who can admit patients to hospitals, doctors can determine whether a hospital thrives or sinks financially. This is particularly true now, with a shortage of doctors yet an excess of hospital beds.

Since most physicians hold staff privileges at more than one hospital, they can choose where to admit their patients based on the resources the hospital has at their disposal. In 1965, doctors at San Francisco's seven largest hospitals held an average of three staff appointments each. Surgical specialists, who use hospitals more than their nonsurgical colleagues, average over four staff appointments. (20) A study of 168 physicians in Omaha, Nebraska concludes, "hospitals that have invested in modern medical technology, and laboratory facilities . . . will better be able to attract and keep practicing physicians." (21)

In each hospital, the powers stemming from the ability to admit patients is concentrated in the small group of doctors who provide the lion's share of the patients. A study of six Boston hospitals found that at each hospital, ten physicians provided 90 per cent of the patients. (22) The administrators of all six hospitals admitted that they had no choice but to respond to the demand for facilities by these "high input physicians." Indeed, the six stated quite pointedly that they purposefully develop facilities to attract particular staff physicians.

One administrator described how the med-
ical staff, in a devastating display of power, vetoed a decision of the hospital trustees to close the hospital pediatric and maternity wards operating with a 20-30 per cent occupancy rate. Not yet satisfied, the doctors forced the board to build a new maternity wing, insisting that the unit was essential for their own practices and for recruiting new staff. At a nearby competing hospital, a staff gynecologist demanded, and the board agreed to build, a similar unit despite equally low utilization. As a result, the two hospitals built 60 new maternity beds in an area where only 10-15 were needed. (23)

For some doctors, power stems not from admitting patients but from the key revenue-producing role they play and their centrality to the functioning of the hospital. These are the physicians heading up the pathology laboratory and X-ray, to whom the administrator must be particularly attentive. Not only are these departments major money makers in themselves, they also provide backup services so vital to other departments that they are a major factor in attracting physicians. For example, a 400-bed teaching hospital in a large Mid-Western city decided to replace its chief radiologist, who had been unable to make the department competitive. The impetus for the decision came from the chiefs of medicine and surgery. Remarkably, the candidate refused the appointment until the hospital board committed $2 million for the department's expansion. (24)

Indicative of their power is the fact that radiologists and pathologists have organized into tight trade associations and forced many hospitals that refused with the threat of a boycott. (25) A 1972 survey of 1,798 hospitals showed that 52 per cent paid their pathologist on a flat percentage basis while 64 per cent paid their radiologist that way. (26) Naturally, this method of payment gives radiologists and pathologists a vested interest in expansion. The bigger the department and the hospital, the more business they can get and the more money they make. The median income for these physicians was $30-40,000 a year. (27) Of the radiologists and pathologists earning over $89,000, the majority were concentrated in hospitals with over 250 beds. (28) On the other hand, 75 percent of those earning $25,000 or less were in hospitals with fewer than 100 beds. (29)
**Health-Care Managers**

Like their managerial counterparts in the giant corporation, (30) the careers of hospital administrators are closely bound to the fate of their hospitals. Generally speaking, competition between hospitals forces individual administrators to support expansion. But bed expansion can be a two-edged sword for administrators; while increasing the size, prestige and long-term survival prospects for the hospital, extra beds—if not filled—are a serious financial drain. For this reason, administrators sometimes balk at bed expansion projects pushed by the medical staff.

On the other hand, administrators are most anxious to expand into areas that will increase their patient census. In fact, it is precisely the cutthroat battles for patients that coerce administrators into duplicating the services of a nearby hospital. In Berkeley, California, the administration of Alta Bates Hospital established an emergency department even though Herrick Hospital, less than 10 minutes away, had an emergency service entirely adequate for the community. The reason? Emergency rooms are a source of patients to fill empty beds. Such duplication of emergency rooms has become commonplace throughout the country, even though a smaller number of well-staffed and equipped emergency rooms would insure a higher quality of care.

Administrators also push for medical office buildings next to their hospitals. The purpose of these office complexes is to tie as many doctors as possible to the hospital and thereby raise occupancy rates. A study of hospital admissions at San Francisco’s St. Francis Hospital confirmed the commonsense notion that doctors working out of office buildings adjacent to hospitals are responsible for a high percentage of a hospital’s patients. The same report showed that the physicians had major complaints about the “obsolete” office building, that the percentage of hospital patients admitted from its medical office building was falling and that young doctors, upon whom St. Francis would have to rely in the future, supported the construction of a new medical office building (31). The administration took the finding to heart and decided to put up a new facility.

Administrators also support medical office buildings because they increase the use of the profitable supportive services—X-ray, laboratories and pharmacy—on an outpa-
tient basis. The concentration of physicians around a hospital shifts business away from independent labs, corner drug stores and office-based radiologists and toward the hospital.

When hospitals succeed in the competitive battle, administrators’ salaries increase. The median salary for hospital administrators is $21-25,000. But administrators in hospitals with budgets over $40 million have a median income of $40,000 (32). Dr. Martin Cherkasky, administrator of Montefiore Hospital in New York City, received a salary of $92,000 in 1972 (up from $82,000 in 1971) and a house near the hospital grounds. Over a ten-year period, Cherkasky has overseen the construction of a 700-bed inpatient facility, a ten-story research building, five apartment buildings for staff and a 676-car garage. Dr. David Porrino, administrator at 1155-bed Mt. Sinai Hospital in New York, received a salary of $100,000 in 1972 (up from $82,000 in 1971) and a 13-room 5th Avenue penthouse easily worth another $100,000. New York’s 935-bed Beth Israel Hospital gave its administrator Dr. Ray E. Trussell $93,000 a year in 1972 and paid for his penthouse apartment (33).

Administrators benefit directly in other ways from hospital growth. At Berkeley’s Herrick Hospital, two former administrators, Andrew Maffly and John F. Wright (belonging to the same family) reportedly made a killing in real estate thanks to their insider positions. They bought up large chunks of land around the hospital and then sold it to the hospital during their terms of office (34).

**Bankers, Builders and Suppliers**

Amongst a city’s many hospital trustees, one can generally find a list of bankers, construction magnates, hospital suppliers or land owners who use hospital expansion to line their pockets. Six major studies prove that businessmen heavily dominate private hospital boards (35), and some use the connection to make a buck. Take Frank W. Burrows, President of Williams and Burrows Construction Company. He used his position as trustee of Mills Memorial Hospital just south of San Francisco to get a $30-million construction contract to rebuild the hospital (36). A small Brooklyn hospital similarly gave a $637,000 project to a local builder sitting on its board (37). In San Francisco, the Bank of America loaned St. Mary’s Hospital a cool (Continued on page 15)
Affirmative Action

When competition gets cut-throat, people seek any advantage they can find to improve their chances. Allan Bakke, a twice-rejected white male applicant to medical school at the University of California at Davis, was doing nothing more than improving his chances for admission when he filed a "reverse discrimination" lawsuit against the special task force program which admitted 16 minority students to a class of 100. In December, 1974, Judge F. L. Manker ruled that the affirmative action program did violate Bakke's rights but did not force the school to admit him. Whether or not Bakke intended it, he is an actor in the political history of American medicine.

The Bakke case is not an isolated incident; it comes at a time when, through layoffs and lawsuits, affirmative action programs are under attack throughout the country. In medical schools, attacks on minority admissions arise from the artificially created scarcity of doctors and the long-standing racism of American medicine. Non-white peoples have always been singled out as scapegoats during the periodic depressions integral to American capitalism. The pattern is repeating itself today.

Scarcity in Medical Education

Battles to limit the number of medical practitioners began as early as 1813. (1) Throughout the 19th Century the followers of "scientific" medicine sought to eliminate competition from homeopaths, midwives, sects and Native American healers. From its origin in 1849, the American Medical Association joined the fight to restrict who could practice.

The limitation of the practice of medicine finally came with the Flexner Report, financed by the Carnegie Foundation. Issued in 1910, it advocated closing many "substandard" medical schools. Over 40 per cent of the nation's medical schools shut down, including six of the eight schools for blacks and the overwhelming majority of schools that accepted women. (2) In addition, educational prerequisites and financial requirements were set so high that only students from well-heeled families could afford medical education. From 1920 through 1970, fewer than 15 per cent of medical students came
from families earning the median family income or less. (3) With exclusive access to medical training, white middle-class and upper-class men commanded the field of medicine.

As Table 1 shows, the physician/population ratio declined sharply in the first two decades of the 20th Century and remained virtually unchanged throughout 1950. Since then the ratio has risen. However, as Table 2 shows, it is the influx of foreign medical graduates that accounts for almost all of the increase. Without them, the physician/population ratio of 1970 would be virtually the same as in 1950.

In the 1960's, the number of places in medical school began to increase, but the competition for those places is greater than ever. The percentage of medical school applicants rejected has risen from 44 per cent in 1962 to 62 per cent in 1972 (see Table 3). In 1960 colleges graduated 56 students with bachelor's degrees for each MD produced; by 1970 colleges graduated 100 students for each MD. At U.C. Davis, Allan Bakke was one of 3,737 applicants for 100 places.

Two facts explain the dramatic increase in medical school applicants: the vastly increased number of college graduates on the one hand and the shortage of jobs for them on the other. After World War II, changing labor requirements of monopoly corporations demanded more technically skilled workers. The "white-collar" proportion of the labor force had to be expanded through broader college education. From 1940 to 1972 the percentage of high school graduates earning a college degree rose from 15 per cent to 31 per cent. But the corporate and educational planners did not concern themselves with the inevitable downward cycle of capitalist economies, and the country produced far more college graduates than the economy could employ.

Moreover, for many students, the available jobs are unappealing. Throughout the 1960's students rebelled against the impersonal, cog-in-a-corporate-machine existence which the "multiversity" trained them for. The war in Vietnam added a further disinclination to work for an inhumane, imperialist government and its defense contractors. Medicine—with its personal freedom, chance to be humanitarian and prospect of a good income besides—became an increasingly popular choice for college graduates. (Bakke, although applying to medical school, is himself an engineer.)

Thus the increased desirability of medical school admission and the long-term scarcity of places have combined with the recent downturn in the economy to make the pressures surrounding medical school admission intense.

**Minority Physicians**

While the physician/population ratio for the United States is 1/700, the ratios of minority physicians to minority populations are
roughly as follows: Black: 1/3,800, Native American: 1/20,000, Chicano: 1/30,000. (4) These figures for minority physicians do not represent improvement over time—the black physician/population has remained around 1/4,000 since the 1930s. (5) The fact that this ratio is no worse cannot be credited to the efforts of white medical schools. Meharry and Howard Universities, the two Black medical schools to survive the Flexner Report, trained over 80 percent of the Black doctors practicing in 1967. (6) As late as 1969 only 2 per cent of the nation’s doctors were Black, compared to a Black population of 11 per cent. The class entering medical school that year had only 1,042 Black students (2.8 percent of the total) and 92 Chicanos (0.2 per cent). (7)

The civil rights movement forced a change. Under political pressure, federal programs were tied to equal-opportunity clauses, and the climate of opinion allowed and required liberals in academia to push schools for more minority admissions. In 1973, 3,041 Blacks entered medical school (6 percent of the total) along with 496 Chicanos (1 per cent). (8) The 1974 class also had an all-time high proportion of minority students: 10 per cent. (9) Even at the rate these gains represent, the National Chicano Health Organization estimates that it will take 38 years for the Chicano physician/population ratio to reach parity with the white ratio. (10)

Statistics and testimony proving the need for more medical care in minority communities already fills volumes. From higher rates of infant mortality, elevated levels of morbidity, to shorter life-expectancy, minority communities suffer from far more health problems than the white population. The major reason for this disparity lies in the basic nature of American society with its lopsided distribution of income and wealth and long history of discrimination against minorities, and the problem will not be corrected simply by producing more minority doctors. But the simple truth is that the white upper-class medical establishment has completely failed to meet the needs of nonwhite peoples in the United States. As an example, “Kenwood-Oakland (Chicago) had 110 physicians serving a population of 28,400 whites in 1930. Today 5 physicians serve 45,000 negroes.” (11)

**Affirmative Action Under Attack**

Allan Bakke’s lawsuit, born out of the growing competition for medical school slots, threatens to halt what minimal progress has been made for racial and national minorities. Bakke argues that the special task force program at U.C. Davis discriminated against him by separating applicants on the basis of race. Superior Court Judge F. L. Manker agreed. The case has been appealed to higher courts.

In a similar case involving University of Washington Law School applicant Mario DeFunis, the court ordered DeFunis’ admission.

“My concern is that some schools will seize upon opinions like DeFunis and Bakke as a cop-out,” said Dr. Andrew Thomas of the National Medical Association, the major organization of black physicians. (12) In fact, the court ruling has already allowed U.C. Davis to weaken its special admissions program.

At the same time that minority admissions programs are under frontal attack, special educational programs to improve the book-learning skills of minority students are quietly being discontinued. Whereas 40 medical schools once participated in such programs, only 15 still do. (13) And many colleges, including the trend-setting Ivy League schools, are cutting back on financial aid to low-income and middle-income students, (14) with the effect that fewer minority students will be able to qualify for medical school.

The genteel termination of educational programs and the stately proceedings of minority admission lawsuits are, however, but a pale reflection of the violent economy-wide attack on minorities and also on women. Massive layoffs are reversing the gains won under affirmative action hiring programs only a few years before. As Business Week puts it, “In a ruling that could stymie employment progress by women and minorities until the recession ends, a U.S. appeals court has held that anti-discrimination goals can-
not take precedence over workers' seniority rights in lay-offs without a specific say-so from Congress." (15)

This is not the first time minorities and women have been forced from their jobs when, in economic crisis, American capitalism rapidly readjusts the size of the labor force:

- During the depression of the 1870's Chinese laborers in California, recruited during boom years, were subjected to massive and violent racial attacks and over half actually fled the US.
- The depression years of the 1890's saw a marked increase in lynchings of Blacks.
- The post-War depression of 1919 led to race riots against Blacks in Chicago and East St. Louis.
- Mexican laborers, brought into California to provide cheap labor for agribusiness in the '20's, were massively deported in the depression of the 1930's.
- The return of millions of men from World War II forced women and many Blacks from their jobs.
- The depression of the 1970's has already seen layoffs of minorities and women far out of proportion to their numbers in the work-force, and the deportation of Mexicans is again on the rise following a decade of recruitment.

Now that times are hard and competition is keen, denying medical training to minorities is but one part of this larger recurring process.

**Resistance**

One of the most significant aspects of the recent gains is that they were won through action from below by minorities and women themselves, and this action continues. At a Continental Can factory in Louisiana, where 48 of 50 Black workers were fired, a lawsuit has won the ruling that the company cannot use a seniority system which makes it impossible for all but two Black workers to hold their jobs. Similar legal action is being taken in California following layoffs of women and minorities at a General Motors plant. In Texas, Black and Chicano students staged a sit-in to rectify discriminatory admissions policies, and students at Brown University in Rhode Island recently seized the administration building over the same issue.

At U.C. Davis, students formed a Coalition for Affirmative Action to defend the program

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"**But, They're Not Qualified...**"

Are affirmative action programs "reverse discrimination"? Do such programs admit less qualified minority people in preference to more qualified whites? The answer, in almost every case, is No.

First, the current standard defining who is qualified makes little sense: "Several investigators have observed that criteria for selecting medical applicants correlate poorly with the students' performance in medical school and not at all with their performance as physicians. In particular, investigators have not been able to predict physician performance by college grade point average, a criterion greatly emphasized by medical school admissions committees."*

At the level of college admission, a study examining the Scholastic Aptitude Tests (SAT) of 17,000 University of California students found the test not valid as an indicator of potential academic performance for Chicanos. "SAT quite strongly exhibits more accuracy for Anglos than for Mexican-Americans." Numerous studies have similarly found IQ tests to show a strong bias in favor of white middle-class and upper-class subjects.*

Second, none of the "objective" measures of quality asks, "Qualified for what?" With regard to meeting the need of minority communities, white doctors have shown themselves entirely unqualified.

Third, it is clear that whatever superior qualifications white applicants may exhibit are the result of unequal opportunity of minorities due to historical racial exclusion. It would be discriminatory to perpetuate such exclusion.

Thus, affirmative action does not discriminate against whites. Since whites have benefited from racism through their primary, secondary and college educations, affirmative action simply attempts to equalize opportunities for minorities. To support a "color-blind" admissions policy, as Judge Manker did, is to deny existing inequality and to perpetuate racism.

against the onslaught of the Bakke case. The Coalition has pointed out that the University used a weak legal argument against Bakke; rather than arguing the necessity of affirmative action in order to redress the prevailing racially based inequality, the University’s lawyers defended the program on the basis of “compelling social need.” This argument was almost guaranteed to lose; it has not been successful since the federal government used to imprison the Japanese during World War II.

**Affirmative Action in Perspective**

The major charge brought against affirmative action by Bakke and others who oppose it is that affirmative action amounts to “reverse discrimination”: White applicants are unfairly shunted aside in favor of minority applicants who are less qualified. This argument fails on many grounds, any one of which is sufficient to destroy it.

The argument requires scrutiny of the criteria that make up “qualifed” to determine whether they select people who become good physicians. Studies have shown that current criteria and the quality of physicians are in fact unrelated (see box page 10). If qualifications now in use function not to selecting the best future doctors, what is their purpose? They serve to maintain the historic class, race and sex composition of the medical profession. Changing that composition means changing the qualifications.

“Reverse discrimination” also completely ignores the long-standing reality of racial discrimination in the United States. White students have received the benefits of years of schooling in an educational system that has been shown to discriminate systematically against minorities. Nonwhite applicants to medical school suffer from the personal prejudices of admissions officers and from economic disadvantages. Affirmative action programs establish admissions criteria that attempt to equalize the unfair advantage held by white students.

The detractors of affirmative action, who view a societal problem only in terms of the individual’s rights, ignore also the neglect and ill treatment minority communities have suffered at the hands of white medical practitioners.

Yet affirmative action is no panacea. While it seeks to equalize individual opportunity, it does not expand opportunity; the scarcity of medical school places, of meaningful jobs, or of any jobs at all, remains. Affirmative action also fails to confront the nature of the physicians being produced; it can be used to broaden opportunities for earning huge income while neglecting the needs of the community. Finally, large numbers of poor working-class people are still unable financially or educationally to compete with middle-class people for medical school spaces.

Despite these limitations, affirmative action is a critical initial step in overturning the present corporate/professional controls over the health system. Antiracist actions are often the breeding ground for political awareness; many of today’s health activists began their political development in the reform efforts of the civil rights movement.

More importantly, affirmative action efforts work to overcome disunity between white and nonwhite health students and health workers. Racism, which gains ascendancy during periods of economic contraction, is the major force dividing working people and preventing a concentrated attack on those who presently wield power. As long as doctors and RN’s are white while LPN’s (LVN’s) and orderlies are Black, racial conflict will exist among people who would benefit from joining together to control their workplace.

So far, this depression has seen the resurgence of job discrimination and race riots over busing. The attack on affirmative action is part of the pattern. Allan Bakke’s lawsuit, upheld by the courts and acquiesced in by the medical schools, preserves privileges which help but a few at the expense of unity which will help us all.

—David Landau and Nancy Green (Nancy is a medical student at U.C. Davis.)

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The Malpractice Blow-up

On May 1, 1975, many northern California anesthesiologists packed up their nitrous oxide tanks and went home. All but the most urgent surgery stopped. Private hospital wards emptied out. Public hospital beds bulged with surgical and obstetric patients. Private hospitals—already financially overextended from their excess building—talked of enormous monetary losses, even of permanently closing. By May 10, over 3,000 lower-paid hospital workers, disproportionately minorities and women, had been laid off. Some of these workers, particularly the nonunionized, may never go back to work.

Argonaut Insurance Company, the nation’s second largest malpractice insurer, had terminated its group coverage of 4,000 northern California doctors, offering individual malpractice insurance at a 384 per cent rate increase. While many doctors swallowed hard and paid up, the anesthesiologists, their premiums zooming from $5,377 to $18,164, resoundingly said no, demanding government intervention to guarantee reasonable malpractice rates.

California doesn’t stand alone. In December, 1974, the New York State Insurance Commission denied Argonaut a 197 per cent rate increase on its malpractice coverage of 20,000 New York State physicians. The company immediately announced cancellation of its insurance coverage as of June 30, 1975.

In Maryland, a judge ordered the St. Paul Fire and Marine Insurance Company to continue its coverage of 85 per cent of the state’s doctors. The company had planned to cancel its insurance by April 30 when a 48 per cent rate increase was denied by the State Insurance Commission.

Doctors in Pennsylvania are suing Argonaut to prevent the company from reneging on its five-year contract with the state medical society.

In February, 1975, Argonaut notified Florida hospitals that malpractice premiums would increase by at least 500 per cent over 1974.

Health providers in 21 states face crises of stupendous rate increases or cancellations of malpractice insurance. Thousands of doctors talk of walking out on their patients. It is a new manifestation of America’s continuing and deepening health-care crisis.

How Malpractice Insurance Works

Malpractice insurance is a subsector of the health-care system with its own peculiar political economy. Last year about $500 million entered this subsector, with payments (premiums) from doctors, dentists and hospitals going principally to ten insurance companies. The money, of course, comes from health consumers as part of hospital daily charges and doctor fees. But a mere 16 per cent of this money ever gets back to the consumer in awards for injuries caused by medical negligence. (1) The rest is siphoned off, mainly to insurance companies and lawyers.

The dynamics of malpractice insurance are rooted in the inherent conflicts among insurance companies, lawyers and health providers (doctors and hospitals) over who will pocket patients’ money. Lawyers, who take a steep percentage of the award or settlement, want more suits with larger awards. Insurance companies want fewer suits and smaller awards as do doctors. But doctors also want insurance companies to keep the premiums low, whereas the companies make their profits by keeping them high. Doctors, hospitals and insurers charge that lawyers cause the malpractice inflation because they are paid by contingent fees: between one-
third and one-half of the settlement, with no payment if the injured person loses. Lawyers reply that the contingent-fee system allows the poor access to malpractice litigation and add that the insurance companies are raising rates to increase their already significant profits.

**Why the Current Crisis?**

The flurry of accusations back and forth obscures the fundamental issue: The malpractice situation exists because Americans are receiving poor quality health care. In the largest malpractice award to date, $4,025,000, a jury found San Francisco's Mt. Zion Hospital and one of its doctors liable in the case of an 11-year-old boy who was not treated following a head injury and is now paralyzed and unable to speak. In another celebrated case, Albert Gonzales, a grocery clerk in constant pain from an unnecessary and bungled back operation, is sharing with his lawyer a $3.7 million award against Dr. John Nork and Mercy Hospital in Sacramento. The judge alluded to Dr. Nork as "an ogre, a monster feeding on human flesh" who "for nine years made a practice of performing unnecessary surgery and performing it badly, simply to line his pockets." Nork himself admitted to needlessly maiming at least 30 patients over the years; many of his colleagues knew but remained silent. The judge assailed the Sacramento County Medical Society, Mercy Hospital and the State Board of Medical Examiners for doing nothing about Nork.

These are the extremes. But poor quality care is not restricted to a tiny minority of incompetent doctors. Two million operations, about 15 percent of all surgery, are entirely unnecessary, performed to profit surgeons: these operations account for the deaths of at least 10,000 people annually. (2) A study of prescribing habits in Ohio revealed that 65.6 per cent of antibiotics were unnecessary or incorrectly administered and that in 92 per cent of cases with adverse drug reactions to antibiotics, the prescription was questionable or clearly faulty. (3) Ninety per cent of antibiotic injections given to a group of patients in New Mexico were unnecessary. (4) Excessive use of antibiotics, pushed by the highly profitable drug industry, has been charged with causing roughly 100,000 deaths per year. (5)

But why have the number of malpractice cases increased 70 per cent from 1973 to 1974? (6) Has the quality of care dropped precipitously in the past year? Probably not, but mass consciousness has risen. The consumer movement, though new and unformed, is having its effect. Between 1966 and 1974, the percent of Americans who have "a great deal of confidence" in their doctors dropped from 72 to 50 per cent. (7) Also, people are conscious of an expensive society that discards its ill and disabled; large malpractice awards are the only economic recourse.

In addition to the number of claims, the average claim size is going up—20 per cent from 1973 to 1974. Though 89 per cent of settlements are less than $10,000, California has seen 16 million-dollar verdicts since 1969. While the lawyer’s fee system feeds the rise in claim size, a more basic factor is the economy and its rising prices.

In fact, malpractice claims themselves influence prices in the health arena since doctors now practice "defensive medicine," going overboard on diagnostic tests that serve only to protect themselves from suits without necessarily improving the quality of care. HEW Secretary Caspar Weinberger estimates that $3 to $5 billion is spent on such unnecessary procedures, including one-third of the $1.4 billion spent annually on X-rays. Thus the profit incentive that creates unnecessary and dangerous care leads to malpractice suits that in turn cause another kind of unnecessary care.

Inflation is only half the linkage between the general economic crisis and the malpractice insurance blowup. Recession completes the chain. Part of the insurance industry’s withdrawal from the malpractice field is related to that crucial determinant of insurance company behavior—investment of their multimillion dollar premium income. 1974 was the worst year ever for casualty insurers, who were hit by a staggering $6-billion drop in their investment portfolios. (8) The conglomerate Teledyne, Inc. ordered its subsidiary...
Argonaut out of the malpractice market when Argonaut's investments fell. Argonaut is continuing its less risky workmen's compensation business. Again, the profit basis of private insurance, disregarding any considerations of health care, determines whether a company will fulfill its needed function or will simply pull out, leaving behind massive disarray.

**Proposed Solutions**

If poor quality care underlies the malpractice crisis, with rising consciousness and the economic crisis more immediate causes, what is the solution? Reading through summaries of state and federal legislative proposals on malpractice, there is an astounding absence of attention to the quality issue. The 1973 HEW Secretary's Commission on Medical malpractice, there is an astounding absence scant 15 out of 1,016 pages dealing directly with quality of care. (9)

The proposals are numerous and complex, with neither the medical profession nor the insurance industry having a unified plan of its own. The only items doctors and insurance companies agree on are those that would penalize the malpractice victims. (10) But aside from these and other tinkerings with the present setup, the broadest reform under discussion is the medical liability compensation system. States would create compensation boards to decide whether a claimant had suffered harm from a medical encounter and to determine a schedule of benefits. The money would come from physicians and go to insurance companies as now. Most importantly, patients would be prohibited from seeking an award through the courts.

This idea comes from the workmen's compensation system. In the early years of this century, workers were increasingly suing industries for corporate-caused industrial accidents, thereby threatening the profits of both the corporations and their insurance companies, identical to the current crisis for doctors and malpractice insurers. The companies, opposed by lawyers and labor unions, lobbied for and won a system of compensation which removed the unpredictability and expense of litigation. Most significantly, big business and the insurance industry have succeeded in structuring a low level of benefit payments. Thus the insurers pay out only a fraction of the costs of injuries to workers while they rake in millions in premiums.

The same can be expected of medical injury compensation boards. Though most victims of malpractice presently receive very little compensation, they cannot look forward to more under the compensation system. And people severely maimed by medical negligence who are now receiving large damages would have to settle for far less and would lose their right to legal redress. Thus while the present setup is dysfunctional for everyone, the compensation board alternative would smooth over the malpractice subsector for doctors and insurance companies while leaving health consumers unsafe and largely uncompensated.

In the current crisis, the chickens have come home to roost for the nation's physicians. Decades of gross malpractice, coupled with physicians' refusal to allow quality controls, have resulted in runaway malpractice insurance premiums. Yet the doctors, in their strikes and legislative demands, are shifting the burden of their crimes onto the backs of patients and hospital workers.

It is macabre to watch the media, the politicians, the health providers and the insurance companies heatedly debate proposals about how and how much money to pay a child whose brain has been damaged or an adult suffering unremitting pain while ignor-
ing the causes of the suffering inflicted by our medical system. But in a capitalist economy, it is not surprising that money, the gateway to obtaining medical care, should be considered adequate compensation for the ravages produced by such care.

—Tom Bodenheimer

References


Expansion

(Continued from page 6)

$16 million for a building project. Bank director Kenneth Larkin sits on the St. Mary’s board (38). A physician trustee at Alta Bates Hospital in Berkeley, California bought up land around the hospital and watched its value soar as the hospital grew (39).

In central cities where redevelopment schemes are always brewing, businessmen trustees may get their hospital to perform the charitable service of booting poor people out of their homes. In Cleveland (see BULLETIN, September, 1971), hospital expansion was so blatantly tied to a local redevelopment strategy that one hospital, St. Vincent, did not even make a pretense of building a medical facility. The hospital, aided by a private redevelopment foundation, bought land for luxury highrise apartments, evicting 1,200 families from their homes. When the hospital could not find developers for the apartment complex they sold the land at below cost to a local junior college, the Boy Scouts and the Salvation Army for new headquarters.

While such conflicts of interest are not rare occurrences, many businessmen trustees have no apparent economic interest in hospital expansion and are not the key initiators of expansion projects. In fact, the commonplace view of hospital trustees has them helping the hospital far more than the hospital helps them. A study of 57 voluntary hospitals in a Mid-Western state showed the trustees to function primarily in political support, fundraising and technical expertise roles. Administrators in the hospitals which registered the fastest growth between 1965 and 1970 acknowledged that they deliberately chose board members for their political connections and fundraising talents. Administrators from hospitals with a large proportion of trustees from manufacturing corporations stated that fundraising was a major board function (40).

But whether businessmen use their hospital trusteeship to give or to receive, their inclination toward hospital expansion remains constant. Hospital board membership lends prestige and a philanthropic cover to the otherwise sordid image of many capitalist enterprises and the larger the hospital the greater the prestige. In addition, large hospitals are major employers in an area, giving their trustees more control over the local workforce. Finally, expansion is a way of life for businessmen, and expansion plans initiated by doctors or administrators generally reach sympathetic ears on the hospital board.

POLITICALLY DRIVEN HEALTH MARKET

There is more to the internal dynamics of hospital expansion than the economic interests of doctors, administrators and trustees. Hospitals as institutions are ruled by the forces of competition. They compete for paying patients just as G.M. and Ford compete for car buyers. Of course, the competition does not show up in cut-rate prices for health consumers or the rapid introduction of cost-saving efficiencies. Indeed, the battle to fill empty beds is hidden because it actually takes place over doctors, not patients. Hospitals compete for patients by vying for doctors, since doctors determine where patients are hospitalized. In this battle, medical fa-
ilities have emerged as a primary competitive weapon which hospitals use to attract doctors.

Competition through facility expansion goes on relatively unchecked by a major force which has traditionally restrained private-sector growth: the threat of failure. In the hospital sector this harsh market force is weak. A few hospitals have closed; others have been purchased by corporate chains or forced into unequal mergers. But these hospitals are relatively few. In the final analysis, while the possibility of failing is real and hospitals must choose to expand or die, it is much easier for a hospital to build than go under. Even with the federal price controls of 1971-74 and now a deep recession piled on top of a massive hospital overexpansion, there have been few hospital failures in the past several years though, as we shall see, this situation is changing due to shifting social tides.

Hospitals' ability to compete by adding onto existing capacity without limit has been made possible by the emergence of a growing hospital market where both demand and investment are determined politically. This politically spurred hospital market is not purely the result of hospital lobbying but of a hospital pro-growth coalition. It has its roots in the immediate post World War II period and the pattern of national politics which grew out of it based on an historic labor-capital compromise. Big business, fearful of a resurgence of the radical labor movement and needing labor's support to stabilize the economy, gave in to union demands for collective bargaining following a dramatic 1946 postwar strike wave. As part of the tradeoff big labor leaders agreed to support foreign economic expansion and gave business a free hand at introducing new highly productive labor-saving machinery, which together helped finance union economic gains (41).

It was out of this basic agreement that labor won billions in employer and employee payments to Blue Cross and commercial insurance companies to cover hospital costs for their workers. Hospitals succeeded in using a portion of the money for expansion. Private hospital insurance and the funds it channels into hospital investment is highly dependent on the collective bargaining process and union and management pressures (42).

The central influence of the hospitals in writing the Medicare bills and regulations allowed vast sums to become available for hospital growth. Helped stimulate employment and consumption, including Hill-Burton and later Medicare. Hill-Burton grew out of the work of the National Commission on Hospital Care, which studied the problem of health facilities between 1942-45. The Commission was initiated by the AHA, funded by the elite Commonwealth Funds and Kellogg Foundation, and included a list of economic notables headed up by Thomas Gates (Commission Chairman), President of the University of Pennsylvania and Edward Ryerson (Commission Vice-Chairman), Chairman of the Board of U.S. Steel. In 1946, a year after the Commission issued its final report, Congress passed the Hill-Burton Act, the major direct-subsidy construction program for hospitals for over a quarter of a century (43).

The labor unions along with elderly organizations were the impetus behind health insurance for older retired workers, or Medicare. It was only in 1962, when congressional approval seemed imminent, that the hospitals jumped on the bandwagon, trying to shape the final act to correspond closely with their economic needs. The central influence of the hospitals in writing the Medicare bills and regulations allowed vast new sums to become available for hospital growth (44).

Giant corporations outside the health sector tacitly supported these developments—private health insurance, Hill-Burton and Medicare—in much the same way they supported mortgage guarantees in housing, the highway trust fund, defense spending and other government spending programs that propped up the private sector. Then, too, the health sector itself was seen as new outlet for private investment and important for
maintaining the labor force. Health insurance "should be considered as part of the normal business expense to take care of temporary and permanent depreciation in the human machine ...," stated a steel industry fact-finding committee.

As a result of these developments 90 per cent of all hospital spending is paid through insurance companies and the government. Hospital demand and investment is ultimately shaped by social forces, expressed at the workplace through the collective bargaining process and in the political arena particularly by Congress and state legislatures and insurance commissioners.

During the 1950's and 1960's hospital spending grew due to the efforts of a hospital pro-growth coalition made up not only hospitals and the medical-industrial complex, but also of labor unions and other health consumers, national business leaders and government health bureaucracies. This coalition and the funds it channeled in hospital investment were sustained by globe-straddling US economy and a domestic political climate favorable to growth.

The politically driven health market functions with two major mechanisms: 1) direct government subsidies and 2) the third-party reimbursement system of Blue Cross and Medicare/Medicaid. These mechanisms were forged by the hospitals, who took advantage of the billions in new dollars streaming into the health-care field.

**Government Subsidy**

Hospitals got their first federal subsidy program for hospital construction in 1946, when Congress passed the Hill-Burton program. Regularly extended until last year (1974), when Congress revamped the program, Hill-Burton has contributed $3.5 billion in health facilities building projects. While this money represents only 11.3 percent of the $30 billion spent in construction between 1946 and 1970, the program stimulated another $9 billion in private and government spending, bringing the total impact of Hill-Burton to $12.5 billion. The program funneled money to 3,800 communities across the nation, directly aiding in the construction of 270,000 nonprofit hospital beds—half the total nonprofit beds in the nation (45). By 1971, 2,267 nonprofit hospitals had received Hill-Burton money.

Nonprofit status, another government subsidy, exempts nonprofit hospitals from paying any taxes, saving them 7 per cent of their revenues per year and making even more funds available for new construction.
The annual property-tax exemption for San Francisco's eight largest hospitals alone runs over $5 million. With the threat of growing tax bills a major impediment to business expansion outside the health sector, tax exemptions assume particular importance for hospitals.

Tax-free status also channels money to nonprofit hospitals by making gifts to hospitals tax-deductible. Contributions at the local level, while a small percentage of hospital construction funds, often provide seed money for purchasing specialized equipment. Out of the over $3 billion spent on construction projects begun in 1973, hospitals netted a total of $162 million from fundraising drives, $81 million from "other contributions" and $11 million from foundations. In all, $256 million came from philanthropy. Tax-exempt bonds for hospital construction, which exempt the purchaser from paying taxes on the interest earned on the bonds, helped send $355 million into the hospitals, while federal loan guarantees accounted for $337.5 million (46).

**Third-Party Reimbursement**

Important as they are, these construction subsidies pale in comparison to the hidden third-party reimbursement subsidies. Medicare, Medicaid, Blue Cross and commercial insurance companies essentially reimburse hospitals for the cost of whatever the hospitals build. Hospitals can add new beds, build new specialized units and send a bill to the third parties which includes much of the costs of constructing and maintaining these beds and units even if they sit unused. In addition, hospitals have wrested a number of other concessions from Medicare and Blue Cross which actively stimulate hospital growth: depreciation payments, interest payments and the plus factor (47).

Depreciation is a complex subject usually discussed among accountants, economists and businessmen. But it is a key to hospital growth and therefore important to demystify. Each year, third parties (insurance companies and the government) make depreciation payments to hospitals to make up for the wearing out of a portion of the hospital's assets (plant and equipment). To determine the annual amount, hospitals may divide the cost of the asset by its useful lifespan. For example, if a new building cost $30 million to construct and is expected to last 30 years, the hospital — using the method of straight-line depreciation — can add $1 million a year to its billings to insurance companies and the government. If, for example, half the patient bills are reimbursed by Medicare and half by Blue Cross, the federal government would pay half a million and Blue Cross the other half. The yearly million dollars can be stored away for future expansion projects or used to cover operating expenses.

Depreciation seems straightforward and lucrative enough until one looks at the sleights-of-hand that hospitals perform to get even more depreciation money for their expansion. Hospitals until recently have secured the right from Medicare and some Blue Cross plans to use accelerated depreciation rather than the straight-line method, thereby receiv-

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**The hidden subsidy paid for capital expansion through depreciation is enormous.**

...ing a larger portion of depreciation money for a given project in the early part of its life. This allows hospitals to accumulate capital more rapidly to speed up the expansion process. Alternatively, certain Blue Cross plans make depreciation payments which are totally arbitrary, based on a percentage of total operating costs and bearing no relation to the capital investments. The percentage ranges from 6 per cent in Cleveland to an incredible 40 per cent in Pittsburgh (48).

A final major concession which hospitals won from Medicare was the right to depreciate assets purchased with government grants or donations. As a result, taxpayers and consumers pay twice for many construction projects. Indeed, some hospitals have collected federal money for the same facility as many as three times: when Medicare began in 1966, the government allowed hospitals to depreciate all assets including those already depreciated on the hospital books. Medicare also allows hospitals to vary depreciation methods from asset to asset depending on which method is more advantageous.

The hidden subsidy paid for capital expansion through depreciation is enormous. With 6 per cent of all Medicare payments to hos-
pitals going for depreciation, annual construction subsidies under Medicare have reached quadruple the amount of annual Hill-Burton grants. In 1969, hospitals received $610 million in Medicare depreciation payments compared to $150 million under Hill-Burton. Blue Cross, using money from health consumers, has made similar contributions to expansion (49).

How many people would go out and buy a house if there were no worry about paying the interest on loans? Thanks to Blue Cross and Medicare, hospitals are in this position. They simply charge the high interest rates to the third parties, thereby removing for hospitals a major barrier inhibiting facility expansion in the nonhospital private sector.

By guaranteeing loan payments through depreciation and by routinely reimbursing interest payments, the third-party system makes it easy for hospitals to secure construction loans in the first place. With the threat of default virtually nonexistent, bankers continue to loan money to hospitals even in areas already plagued by overbedding and duplicated facilities.

And there's more. Another powerful stimulus to hospital expansion is the so-called plus factor—an extra payment to hospitals to cover "hidden" expenses, based on a flat percentage of operating costs. Until 1969, Medicare paid hospitals a 2 per cent plus factor in addition to the depreciation and loan payments. Twenty Blue Cross plans had a plus factor, typically of 5 per cent, but in one case as high as 13 per cent (50). Naturally, larger hospitals with higher operating costs bring in more dollars through the plus factor.

**From Building Boom to Bust?**

For 20 years an expanding, world-dominating US economy sustained hospital over-expansion. Few seriously questioned uncontrolled hospital growth despite the fact that 10 per cent of all beds were unnecessarily empty during most of the period. The main concern of national economic and health policy was in stimulating hospital consumption and investment. The number of beds grew by 223,000 between 1960-73 and assets per bed grew by $20,000, beds per 1,000 population grew from 3.6 to 4.3 (51), and per-capita spending for hospital care increased from $47 to $169 (1973) (52).

Beginning in the mid-'60s, the success of national liberation movements such as that in Vietnam, the rise of European and Japanese economic competition and the need to subdue domestic unrest with huge welfare budgets began to shatter US global economic power. Between 1966 and 1970, total corporate profits dropped from $78.4 billion to $63.5 billion. Profit rates after taxes fell from a high of 10 per cent in 1965 to a low of 5.3 per cent in 1970 (53). Under President Nixon's New Economic Policy, corporate profits made impressive gains, but that temporary boost has now run its course. Today, US corporations and the economy as a whole face an increasingly serious capital squeeze. According to the Wall Street Journal (May 9, 1975), "the root of the problem is a lack of capital, businessmen say. The much publicized energy shortage isn't as serious as the capital shortage, contends General Electric Co. Chairman Reginald H. Jones. Huge sums will be needed in the next decade to modernize aging plants, develop domestic energy resources, protect the environment, expand food output and restore the neglected U.S. infrastructure such as deteriorating railroads and utilities, he says."

In the meantime, hospitals, spurred on by politically driven expenditures, have built themselves out on a limb. It is one thing to have an occupancy rate of 75 per cent on a base of 639,000 beds and $10,684 assets per bed when the economy is growing (1960). It is quite another thing to have an occupancy rate of 75 per cent on a base of 903,000 beds, $30,865 assets per bed and economic stagnation (1974). With the giant investment goods industry—steel, utilities, oil, mining—the cornerstone of the economy, caught in a capital squeeze and inflation taking a giant bite out of real wages, the political coalition which has sustained hospital expansion has begun slowly to fracture. National leaders hitherto silent on hospital policy have begun to speak out (54). Most recently, the Committee on Economic Development, representing the nation's top businessmen, released its report.
Building a National Health Care System (1973), echoing the now common theme summed up succinctly in an October 26, 1974 Business Week editorial, "Hospitals . . . around the country grew up hit or miss. The result is wasteful inefficient health care." Business Week called on the government to "Phase out facilities no longer needed, merge similar facilities and authorize money only where need can be demonstrated."

An anti-growth coalition made up of large corporations, labor unions, other health consumers and budget-conscious governments are beginning to tighten the political noose around the nation's hospitals. Already a number of measures are setting at least minimal limits on hospital access to capital for expansion projects:

- In 1969, the Nixon Administration cancelled the 2 per cent plus factor in the Medicare reimbursement formula (55).
- In 1970 Congress passed the omnibus Social Security Amendments authorizing states to enact certificate-of-need laws forcing hospitals to get approval before expanding. (24 states had enacted such laws by 1974.) HEW also ended accelerated depreciation payments for hospitals under Medicare (56).
- Nixon's Economic Stabilization Program required hospitals to exhaust their reserves before the Cost of Living Council would even consider allowing them to raise their charges more than 7½ per cent. With inflation in hospitals' nonlabor inputs running double and triple that limit, the controls put a severe capital squeeze on the hospitals (57).
- The 1972 Social Security Amendments authorized HEW to withhold reimbursements for new plant assets not approved by local planning agencies (58).
- Mounting resistance by employers and unions to paying higher Blue Cross premiums has forced 35 Blue Cross plans to require planning approval for new building projects. 20 plans have certificate-of-need requirements written into their contracts (59).
- Due to Nixon and congressional budget cuts the Hill-Burton program has gradually been reduced. For example, in 1971, general hospital received $64 million in Hill-Burton funds. From 1947 to 1971 the annual amount averaged $114.6 million (60).
- The 1974 National Health Planning and Development Act requires state-by-state implementation of certificate of need for new construction projects and evaluation of old facilities and services for "continuing appropriateness," so-called "recertification of need." Hospital spokesmen fear this will threaten the ability of institutions to borrow money. The law also states that "not more than 20 per cent of any allotment may go for inpatient facilities (61).

Thus far these measures have done little to limit hospital construction, though they have squeezed hospitals economically. Hospital operating margins (net income divided by total income) declined from 2.8 per cent in 1970 to 1.2 per cent in 1974 (62). Yet in the same period, the number of beds increased 2.2 per cent in 1971, 1.4 per cent in 1972 and up to 4 per cent in 1973 (63). But in all likelihood, hospital construction will slack off within a few years as portions of the politically driven hospital market are driving in opposite directions from the hospitals themselves.

Even within the hospitals, the clouding over of the expansionary political climate is creating conflicts between administrators and doctors. At a time when the pressure is on to tighten third-party reimbursement formulas, the former are concerned with the financial overextension of the hospitals from decades of construction loans.

In sum, the breakup of the hospital growth coalition, in particular business-related efforts to control hospital costs and expenditures, is triggering economic problems in the hospital sector. Indeed the tightening of hospital spending may end up causing the closing or takeover of hospitals with insufficient funds to sustain their overextended investments. "There were more than 70 hospital closures last year...Our guess is that this is only the beginning," predicts Paul Elwood's Interstudy (64). Out of this process larger hospitals will pick up more doctors and patients, and fill their empty beds. The most likely result will be a concentration of power of local health systems into the hands of fewer, larger hospitals. —Dan Feshbach

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Vital Signs

WHERE ARE THE HMO’s?

The past few months have failed to produce any evidence showing that health maintenance organizations are the coming thing in health care. Not only haven’t HMO’s mushroomed with the help of the December, 1973 HMO Act, but from January to March, 1975 they actually declined in number from 183 to 181. The federal government has spent a tiny $10 million in the current fiscal year in grants and loans to develop HMO’s.

The federal law itself didn’t help; standards for becoming an HMO were set so high and premiums for HMO subscribers are so uncompetitive that few corporations or insurance companies are willing to invest their money in the health delivery business. Hospitals, fearing that the emphasis of HMO’s on ambulatory care will further empty their already lonely beds, are not developing HMO’s. Also, big labor has rejected the dual option plan under which all private employees would be offered an HMO plan in addition to the usual Blue Cross or commercial health insurance policy; AFL-CIO President George Meany finds the compulsory dual choice provision to impinge on union rights in collective bargaining.

California’s Medicaid Prepaid Health Plans (PHP’s), a major HMO experiment of the Reagan Administration, have not enhanced the HMO image. Universally condemned for their fraudulent enrollment practices, disastrous quality of care and conflicts of interest by a myriad of state, federal and union investigators, many PHP’s are in danger of being scrapped by the new Brown Administration. Worst of all for HMO advocates, whose major argument is the cost-control potential, the PHP’s have failed to save money (see Health/PAC’s Materials on PHP’s, $1.50).

FIGHTING OVER THE UNEMPLOYED

The recent Congressional charade over health insurance for the unemployed reveals the brutality of our current system of private health insurance. Health insurance for 150 million people is dependent on employment. As layoffs take place, health insurance policies lapse for the 25 million people comprising the unemployed and their families. The families are ineligible for Medicaid because they receive from $50 to $90 a week in unemployment insurance. As the 25 million wait in dread of illness, four Congressional health committees are fighting over which gets the credit for passing the legislation. As one well-paid legislative aide put it, “The political scramble is fascinating.” He apparently failed to comment on the unemployed families’ scramble for health care.

In the words of Sen. Edward Kennedy, “We will be rescuing more than the workers, we are also rescuing the hospitals, the clinics and the doctors.” Favoring the legislation is the unprecedented alliance of the AMA, American Hospital Association, Health Insurance Association of America, Blue Cross, Blue Shield, United Auto Workers and AFL-CIO. Only the fiscal-minded Ford Administration is callous enough to oppose any unemployed health insurance. But clearly the insurance program will not
be able to cover a great deal of medical care since much of its money will go toward protecting the health industry against the depression.

The four key congressional committees in the health field, each vying for eventual jurisdiction over national health insurance through the current battle over who will help the unemployed, are the House Ways and Means Subcommittee on Health, chaired by Rep. Dan Rostenkowski, the Health Subcommittee of the House Commerce Committee (Rep. Paul Rogers), the Senate Finance Committee (Sen. Russell Long) and the Health Subcommittee of the Senate Labor and Public Welfare Committee (Sen. Edward Kennedy).

(As we go to press, it appears that the four committees have tired of their infighting. The result? There will probably be no legislation at all.)

**WHAT IN THE HELL IS P.L. 93-641?**

Perhaps the most significant federal health legislation since Medicare is the National Health Planning and Development Act of 1974, Public Law 93-641, signed by President Ford on January 4, 1975.

Under the planning law, HEW must establish a network of areawide and state health planning agencies consolidating the three previous planning systems of Hill-Burton, Regional Medical Programs and Comprehensive Health Planning. State governors recently suggested to the Secretary of HEW the boundary lines for the areawide planning bodies (called Health Systems Agencies or HSAs). The next step will be designation of who will be the HSAs. Local comprehensive health planning councils, frequently controlled by private hospitals, are fighting hard to become the HSAs and have the clear advantage. While the current widespread maneuverings over boundaries and designations have some impact on health consumers (e.g., consumers could organize more easily around a countywide HSA than a several-county region), they generally consist of infighting among the elites.

The state health planning and development agencies will have the most important power under the planning law: to allow or disallow health facilities construction projects. But their decisions will heavily take into account the recommendations of the HSA’s. A direct power of the HSA’s—without the involvement of the state agencies—will be to approve or disapprove applications for federal health grants within their areas.

In the absence of a significant consumer health movement, the planning law may become a mechanism for large hospitals with political influence to keep their weaker rivals from expanding. Were a strong consumer movement to develop, the HSA’s would be an obvious and key pressure point in determining what kind of health services are provided.

**MINORITY DOCTORS STRIKE**

The second major strike of interns and residents, following the March New York strike, took place at Martin Luther King Hospital in Los Angeles from May 7-14. While the housestaffs at Los Angeles’ other two county hospitals settled for a 5 per cent salary increase and a meager $1.1 million in hospital improvements, the 130 largely minority doctors of MLK voted to reject all salary increases so that all possible county monies would be channeled into improved patient care. The MLK doctors had a seven-page list of demands including more doctors, clerks and interpreters in the emergency room, 24-hour pharmacy coverage and guaranteed blood available in the blood bank. The doctors continued to cover the emergency room and to care for critically ill hospital patients during the walkout.

By the fifth day of the action, which was supported by community groups in the hospital’s largely Black service area, 38 of the strikers had been fired. But two days later the interns and residents returned to work, with their only victory being reinstatement of the fired doctors. The patient care complaints were placed under investigation by a high-level task force.

The progressive nature of the action was in obvious contrast to the concurrent sympathy strike of Los Angeles anesthesiologists for their Northern California colleagues who were demanding a maintenance of their $60,000-plus incomes free from the burden of rising malpractice insurance premiums. Yet the MLK strike failed to place sufficient financial pressure on the hospital and fell short of its aims. Perhaps a strike of all hospital workers rather than simply doctors would have increased the chance of success.

**VIETNAM: HEALING THE WOUNDS OF WAR**

On May 1st the people of South Vietnam won their freedom and independence, a victory which millions of Americans joined in fighting for. At
a mid-May meeting in Vancouver, B.C. with members of the US anti-War movement, representatives of the Provisional Revolutionary Government (PRG) called on the US Government to honor the Paris Peace Treaty, in particular Article 21 in which the United States agreed to "contribute to healing the wounds of war and to postwar reconstruction . . . throughout Indochina." BULLETIN readers may also wish to contribute personally to reconstruction in the health care field. Contact Medical Aid for Vietnam, 65A Winthrop Street, Cambridge, Mass. 02138.

**BACH MAI HOSPITAL FUND**

On May 11 a celebration of the end of the war in Southeast Asia was held in New York City's Central Park and attended by 50,000 people. The Bach Mai Hospital Fund now has available a 45-minute half-inch sound and color videotape of the day's events, showing Congresswomen Bella Abzug and Elizabeth Holtman, David Dellinger, Richie Havens, Phil Ochs, Peter Yarrow and many others. The tape may be rented for a charge of $15.

The tape is perfect for public meetings, private fund-raising events and distribution on local cable (and, if possible, commercial) television. All funds raised will be used to rebuild Bach Mai Hospital and to redevelop Vietnam. The tape may be ordered from the Bach Mai Hospital Fund, 777 United Nations Plaza, 11th Floor, New York, N.Y. 10017. The Fund will also usually be able to provide a speaker should one be desired.

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