Confessions of a Health Consumer

As a family physician and advocate for my patients in the health system, I considered myself a well informed consumer when the moment came to enter the health insurance marketplace. Dear reader, with great embarrassment I must admit that I was wrong. Here is my story.

Since I had been awarded a Public Health Service scholarship, I was prepared to enter the National Health Service Corps on completing my residency. Here I made my first mistake: honesty. When

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questioned on my health over the previous decade, I admitted that I had consulted doctors for a knee injury and seen a psychiatrist. Each day I rushed to the mailbox, but that precious letter announcing my appointment to the NHSC never came. At the time I feared the policymakers in Washington suspected that as soon as I joined up I would rush in for knee surgery — which in fact I never intended to have. It was only years later that I found out they were really worried about the psychiatrist.

After several months, I began to think the NHSC didn't want me and I joined the Civil Service, thinking in my innocence that it too provided comprehensive health coverage. Dear reader, I was wrong.

On my first official day as a civil servant, I arrived at the Federal building with 50 other new employees to find myself caught in a blizzard of forms and fingerprint papers. Before I was able to escape, an anonymous hand thrust ten pamphlets and a piece of white paper into my cramped and blackened fingers. On examining them, I found they were a mysterious and complex guide to health insurance options and a form to indicate my choice.

Little did I realize that disaster was stalking me like a shadow. Somehow while moving to Manhattan and starting a new job, I misplaced that form. When it finally reappeared, I called the personnel office. In shocked tones, my fellow civil servant informed me that I had been given 30 days to get the application in. Not only had I missed that initial enrollment period, I had missed the open season in which I could have rectified this lapse. Luck had deserted me. The open season was a year from the time I rushed to the mailbox, but that precious letter announcing my appointment to the NHSC never came. Fortunately, I was saved from this dismal fate by the Health/PAC staff, who learned of my misfortune and invited me to join their Blue Cross/Blue Shield plan. I eagerly accepted and by the Health/PAC staff, who learned of my misfortune and invited me to join their Blue Cross/Blue Shield plan. I eagerly accepted and

Dear reader, I was wrong.

When the first major dental bills arrived six months later, I proudly sat down to complete my portion of the claim kit—only to find my pen paralyzed in mid-air by not-such-small print announcing an age exclusion which meant that our bills were not covered. Confused, I returned to the mysterious and complex pamphlets and found that my careful study had overlooked this, although I had caught the same exclusion in all the other plans and chosen precisely because of this oversight.

My father, recently retired from 32 years as a physical therapist for the Veterans Administration, had warned me never to become a civil servant. In that moment of despair I wished that I had listened to him. He also told me—later—which plan to choose: the Postmasters Benefit Plan.

"It wasn't on the list!" I protested.
"You have to ask," he replied with the logic of a veteran civil servant.

Following his advice, I learned that with wit and determination civil servants in most metropolitan areas can choose among 21 Federal health benefit plans and an HMO option. But it was too late.

The doctoral dissertations which the Reagan Administration will support to compare these plans and determine the best choice among them for all contingencies will do me little good. After receiving my termination date from the Death Valley Days Administration, I went out into the marketplace and found a new job. "What about health insurance?" I inquired with some trepidation.

"There is only one plan and it has everything," replied the physician hiring me. "Including dental?" I asked, stunned by this flagrant violation of the consumer choice, pro-competition ethos.

"Everything."
"Only one?"

Now I live with my embarrassment, shame, guilt, and comprehensive coverage. Maybe the government was right to worry about the psychiatrist.
Vital Signs

time I blinked an eye on the freeway, it seemed there was another of these minor emergency centers,” said investment analyst Michael M. LeCoyne, vice president of Merrill Lynch. “My guess is that in the future they can attract as much as 25 percent of the approximately $45 billion that Americans spent on physician and hospital outpatient services last year. That's more than $10 billion — bigger than the fast-food industry.”

The medical director of MedStop, which operates three emergicenters in Dallas and Houston, is sure that marketing will improve medical care. “Medicine has to change to meet the changing needs of the population,” promises Dr. David Carlyle. “People in medicine will have to recognize that the modes of health care delivery the public wants will survive; the others won't... The secret of success is marketing.

Driving in from the airport to downtown Houston, we were admiring the familiar skyline of McDonald's and Exxon logos and TOPLESS DANCER STRIP HERE neon when — hold on there—a new sign loomed over the Texas plain: “Cut Medical Expenses — Emergency Medi-Clinics, 7 am to 11 pm.”

Pretty soon it was clear these drive-in mini-minute-medi-centers are multiplying faster than jackrabbits. There was MedStop and Medical Networks, Inc., and any number of other medicinal answers to either of Dr. Graham himself or any good but Dr. Graham's famous stomach specialist of New York, has devoted his life to finding a method for reducing obesity naturally without injury to the health of the patient in any way, purely, other wise than by the face of the earth to reduce and public has done no better than Neutroids.” — Constance E. Harris, Brooklyn, N. Y.

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There is great potential in these facilities, but there are safer investments.” Dr. Carlyle was being modest: there aren’t too many industries this side of flying cocaine from Colombia to Miami which offer annual returns on investment of 25-30 percent.

If you bred a Kentucky Fried Chicken franchise, a hospital emergency room, and a doctor’s office and planted it in a shopping center or next to a busy intersection, you’d have yourself an emergicenter. Hours are usually extended into the evening and weekends, although few centers are open 24 hours a day. Patients are expected to deal with cuts and scrapes and other minor problems at home—bandaids don’t yield high profit margins.

“They skim the cream,” complained an Austin family practitioner in a four-doctor group after an emergicenter opened near his office. “All the people we used to sew up, all our bread-and-butter trauma work and minor orthopedics, dried up. Two years ago, in self-defense, we switched our hours and put a sign, adding ‘Minor Emergency Center’ to our practice name... Most of our patients are back.”

Emergi-centers have become so attractive to investors as well as to many patients that Sears Roebuck, the nation’s largest retailer, has opened fee-for-service medical clinics in some of its stores. You can look for them right between sportswear and the denti-center.

The Health/PAC staff is currently considering opening drive-in CAT scans, where customers never need leave the comfort of their car and our technicians will serve them on roller skates. Write us if you have suitable sites or would like to buy your own Health/PAC CAT scan franchise.

Hal Strelnick

RETURN OF THE PRODIGAL SON

In 1976 the National Conservative Political Action Committee (NCPAC) targeted a former aide to Representative John Anderson for defeat in a Michigan congressional election. NCPAC’s dudgeon may have been raised high by David Stockman’s views on Health Services Agencies. Just last year he wrote a constituent that HSAs are “the most effective coordinators of the health planning effort and have done an excellent job involving the community,” and cited their
achievements in Congress when justifying his opposition to the Carter Administration's hospital cost control bill.

This year, however, Director of the Office of Management and Budget David Stockman and his cohorts in the Reagan Administration have proposed ending Federal funding for the HSA program, contending that "it has not proved effective in controlling costs on a national basis."

Detail men at NCPAC can sleep easy. The born again Stockman is ready to cure the pestilence of health care cost inflation with free market faith healing.

—Hal Strelnick

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Attacked from all sides as wasteful, irrational, inefficient, and inequitable, the U.S. health care system—if you can call it a system, rather than a shambles—is in serious need of overhaul. Yet change appears to remain harder than collapse in a structure dominated by institutional and professional monopolies at the local and regional level, encumbered by a regulatory web at the state and national levels, and burdened by rapidly escalating costs in virtually every part of the public and private sectors.

Over the past three decades, as the portion of health care expenditures provided from public funds steadily increased, at least two distinct approaches to controlling or reforming health care delivery emerged.

**Government as Third Party**

In the mid 1960s, the Medicare and Medicaid programs arose as the plight of the poor became impossible to ignore and sectors of the health empire realized that millions of Americans unable to afford the most minimal health care coverage could be transformed into a mother lode of government gold. Conceived as levers of change, both programs cast government in the twin role of payor-regulator. On the one hand, federal, state and some local governments became the payor of health care bills for services delivered by a wide range of providers to those meeting eligibility requirements. On the other hand, in order to avoid writing a blank check, the federal and state governments began to promulgate regulations to control the behavior of consumer and provider alike.

Although these regulations have sometimes succeeded in controlling costs, preventing fraud and abuse, and improving quality, the strategy of pay-then-regulate has proved to be an ineffective instrument for overall change. As in many other spheres of the U.S. economy, the largest and most powerful providers—i.e., those already extracting the highest charges and fueling the most rapidly escalating costs—proved difficult or impossible to contain.

Medical societies have blocked attempts to seriously interfere with “the normal practice of medicine;” state rate-setting and regional planning mechanisms have often functioned under the sway of the largest institutions.

Medical costs have continued to soar at a rate far above overall inflation; inequities have grown, the availability of services has declined for many; and the quality of what we do get is increasingly in question.

**Government as Second Party**

In arguing against the above strategy, many health activists have long advocated direct government involvement in the organization of...
health care delivery. Health care should be a public service, they say, as it is in Great Britain and many East European countries. Such a national health service could be structured to guarantee local accountability, with community, consumer, and worker inputs. It could also follow more sensible priorities, e.g., more emphasis on prevention and primary care, and guarantee universal access.

Health/PAC, like a number of other activist groups such as the Committee for a National Health Service, has long advocated some form of decentralized, public delivery system.

The popularity of this approach has not grown in recent years. In fact, the credibility of the public sector may be at its lowest ebb in decades, with concerted attacks from the Right building upon growing cynicism and alienation among the general population. Nevertheless, the development of a national health service remains an alternative that has yet to be tried, and one that could offer enormous benefits to the health consumer — that is, to most of us — if it were structured in a decentralized and democratic fashion.

Now a third strategy is blossoming with the aid of Reagan Administration fertilizer.

**Government as House Servant**

The right has its own solution to health care delivery problems: let the marketplace solve them. By and large ignoring issues of equity, access, and appropriateness, the competition strategy seems to eliminate the role of government altogether, i.e., existing and new providers would be "left alone" to deliver care as they see fit. But there is clearly more to the strategy than simple-minded laissez-faire. Rather than "getting the government off the backs of the health care system" as they claim, the new advocates of "competition" retain and even strengthen government props for the institutional and professional monopolies dominating the system.

Research and development funds would continue to flow to the major medical empires. Licensure and accreditation policies would continue to shield the top of the health care pyramid from any serious challenge. Tax and financial regulations would continue to support special breaks for monopolies in the proprietary sector such as pharmaceutical companies and hospital construction and supply firms.

Whether or not new government funding proposed for demonstration programs designed to "stimulate competition" will grow into overt subsidies and favoritism for the growing chains of proprietary hospitals and nursing homes remains to be seen. Clearly, Reagan health planners believe this is "where the action is." Government, in short, is to become the Clara Barton of the private providers, offering aid and comfort, following orders, and bowing before the accumulated self-serving wisdom of the health care hierarchy.

Health/PAC readers and other health activists throughout the country are already on the line in the confrontation between these competing ideologies and strategies. In support of this advocacy and activism, we will be publishing a series of articles and pamphlets on the emerging conservative program. Most of this issue is devoted to a powerful and richly documented critique of the "competition"
model by Dan Sigelman. This article is also available from Health/PAC in pamphlet form for mass distribution, along with a growing series on the Reagan cutbacks—write to us for an up-to-date list.

In the coming months, the Bulletin will be publishing a pathbreaking study of the evolving American health care delivery system which will be essential reading for anyone exploring health care policy.

As always, we welcome the thoughts, information, and reactions only you can provide if we are to make the most effective contribution to the struggle.

What's Happening in

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**Survival of the Fittest**

The ‘Competition’ Model for Health Care

By Dan Sigelman

At a time when all Federally funded human services are subject to search and destroy missions, it is only natural that the ascendant Reagan Right is grasping the nettle of soaring health care costs in its Invisible Hand.

Regulation, turned back in 1979 with the overwhelming defeat of President Carter’s hospital cost containment bill, is all but forgotten in the rush to return to marketplace models. Major sponsors of legislation enshrining health care “competition” are now in charge of writing the prescriptions: former Representative David Stockman directs the Office of Management and Budget; Senator Richard Shweiker has become Secretary of Health and Human Services; Orrin Hatch chairs the Senate Labor and Human Resources Committee; David Durenberger, the Senate Finance Committee; and James Jones, the House Budget Committee.

Despite significant variations in scope and design, their “competition” bills share three objectives:

1. Encouraging employees to shop around for the most cost-effective insurance plan through changes in Federal tax policy.
2. Providing catastrophic health insurance protection.
3. Fostering health care delivery systems which compete vigorously in providing the most cost-effective care.

**Altering Tax Incentives**

According to “competition” advocates, current Federal Tax policy accelerates health care inflation. They argue that because employer contributions to employee group health insurance — the predominant private health insurance in the U.S. — are not included as part of wages, workers have no incentive to choose a health plan with low premiums in which they share costs and have reduced coverage rather than an expensive program which pays for virtually everything.

To change this pattern, the “competition” bills generally require employees wanting better coverage with premiums above a fixed ceiling to include any of that excess paid by their employer as part of their taxable income. Conversely, if they select policies costing less than the ceiling, they are entitled to a rebate. Some of the bills even require employers to offer their workers at least one low-option plan.

**Providing Catastrophic Health Insurance**

A system which successfully induces employees to buy substantially less health insurance protection runs the obvious risk of subjecting many workers and their families to major uncovered medical expenses well beyond their financial means. Recognizing this, all of the bills incorporate the catastrophic health insurance concept, guaranteeing full insurance protection beyond a maximum out-of-pocket expenditure or a specified percentage of annual income. Some bills extend this umbrella to individuals outside employee groups.

**Fostering Competing Plans**

As consumer concern with the costs of health insurance intensifies when people start paying more medical fees directly, “competition”
None of the “marketplace” plans calls for an end to licensing, as conservative economist Milton Friedman has advocated. The “pro-competition” plans don’t seem to include competition from midwives and others without an MD.
notes, doctors and hospitals are protected by the reluctance of patients to travel and high entry barriers to potential competitors. It is noteworthy that none of the “marketplace” plans calls for an end to licensing, as conservative economist Milton Friedman has advocated. The “pro-competition” plans don’t seem to include competition from midwives and others without an MD. Using their continued controls, says Roberts, doctors and institutions are likely to arrange an “anticompetitive accommodation” and tacitly cooperate to raise prices for their mutual advantage.”

Many experts, including Enthoven himself, question whether prepaid group practice plans would offer sharp competition as long as a fee-for-service option continues to exist—and ardent “promarket” advocates such as Gephardt and Stockman insist that it must be for those willing to pay for the right to choose their own doctors. As long as fee-for-service does exist, Enthoven and others appear to fear physicians who rely on it will respond “perversely” if the plans take some of their patients: because their services are still in demand, independent medical practitioners could raise their prices to maintain their income instead of lowering them to obtain more clients, and provide more care such as X-rays or operations which may or may not be necessary. To compete, group prepaid plans might have to raise payments to their physicians and offer their members greater convenience and flexibility. The end result would be higher costs all around.

Whose Side are the Insurers On?

The theory that insurers will act as agents of newly cost-conscious consumers to impose cost controls on health care providers also ignores their traditionally cozy relationship with these same people as well as the nature of a medical care marketplace dominated by providers. As Walter McNerney, president of the Blue Cross/Blue Shield Association has suggested, insurers might well prefer to avoid nasty negotiations to lower reimbursement rates and increase provider efficiency; they would find it easier to focus on less confrontational policies such as group experience rating—estimating the likely future incidence of illness on the basis of previous medical needs—and calculating the risk of various treatments.
What they take away with the far right hand they give back with the right, creating a system that requires as much or more regulation.

In health care, as in other areas, conservatives like to assume that the consumer enjoys the advantages of Adam Smith's mythical eighteenth century buyer who knew a good chicken from a turkey and could compel producers of goods and services to compete in price and quality. This is rarely true today, and certainly not in the health care models espoused by the competitive market champions, which perpetuate the current separation between consumers and medical personnel and institutions. People would shop around for health insurance not for individual doctors or other providers, and would have no way of ensuring they will receive the best possible care in time of need.

Consumers who might have to pay more health care expenses out of their own pockets in low-option plans would be especially eager to know how individual prices compare among providers and competing plans. They would also need to know how the utilization patterns—including specific admission rates for diagnosis and procedures, lengths-of-stay, and surgery rates—compare among the doctors and hospitals serving each competing plan. For example, Washington Hospital might remove cartilage from someone who hobbles through the door while Jefferson Hospital in the same plan and Adams Hospital in a different plan would send the same person home with an icepack. Health economist Harold Luft has found the variations in ambulatory practice patterns among physicians within a single health maintenance organization (HMO) to be as great as those among fee-for-service physicians. Consumers joining a plan would want to know how vigilantly it monitors providers to prevent excessive use of resources. Without this information they can't hope to determine whether a low premium reflects the true level of costs or is merely determined by a desire to match the premium in another local plan. Yet instead of encouraging public disclosure of comparative practice patterns “competition” strategists often oppose it. “Free choice of doctor,” declares Enthoven, is inimical to “true economic competition among doctors,” since only groups of doctors in plans can really compete in cost-effectiveness. Not one major “competition” bill sponsor advocates public disclosure of the already existing Professional Standards Review Organization (PSRO) medical quality data which show lengths of stay in different hospitals, and admission, surgery, mortality, and complications rates for
different doctors. In fact, in response to a lawsuit demanding access to such information, Senator Richard Schweiker, a major champion of “competition,” and now Health and Human Services Secretary, introduced the first congressional bill to exempt PSRO data from the disclosure requirements of the Freedom of Information Act. The Reagan Administration wants to go even further and abolish the PSRO program entirely, ostensibly to save money.

There is no question that consumers want comparative medical quality data. Even now, when the comprehensively insured patient has little, if any incentive to shop around for cost-effective care, patients respond immediately to quality comparisons. After disclosure of a technical advisory report on cardiac surgery commissioned by the four Washington, D.C. area Health Systems Agencies in 1979, consumers swiftly cancelled their appointments at unfavorably reviewed hospitals.

Regulating in the Name of Deregulation

The “competition” strategy is often touted as an alternative to regulation of the health care industry. In the words of the Gephardt-Stockman bill, “Competition among qualified plans will be based on market incentives and disciplines, thus permitting natural economic forces to work and making regulation unnecessary.” If not unnecessary, it would certainly become unavailable in its present form, since the bill includes provisions repealing major regulatory programs such as health planning and PSRO.

However what they take away with the far right hand they give back with the right, creating a system that requires as much or more regulation. For example, the health insurance industry has traditionally been regulated by the states—though often with the diligence of a hibernating bear. This policy has become so powerful that in 1980 Congress voted that the Federal Trade Commission should no longer be allowed to study the insurance industry, much less regulate it.

Many of the “competition” bills, however, would restrict entry into the insurance plan market by establishing a highly regulatory Federal “certificate of need” program. Advocates of these bills believe this is necessary because, in the words of Alain Enthoven, “If there are too many third party intermediaries, then none of them will represent a large enough percentage of hospitals’ or physicians’ business to be able to influence the providers’ behavior.” Under many “competition” proposals, the Federal government must determine if a plan complies with Federal minimum benefit standards and provides adequate low-option and catastrophic insurance coverage. But as Enthoven himself warns, government control “would mean susceptibility to all kinds of transient political influences, perhaps the most dangerous of which would be pressure from established health plans to keep out new competitors.” Gephardt-Stockman goes even further in mandating government involvement, requiring Federal certification that insurers meet minimal financial viability standards. Similarly, the requirement in some “competition” proposals that insurers set aside an “open enrollment” period each year in which they generally accept all eligible persons—be they
Even sponsors of "competition" legislation do not always appear confident that employee insurance purchasing habits can be substantially modified.
of the people who use relatively little care, shifting the cost of treating those who require extensive care onto conventional health plans.5

**What If Employees Still Want Comprehensive Coverage?**

Unlike most goods and services, insurance is something people usually buy hoping they won't need it. Workers who forego health insurance protection for themselves and their families in order to obtain a rebate or avoid higher taxes are taking a bet with Fate, and if members of the Federal Employees' Health Benefits plan — the prototype of consumer choice—are any indication, most would prefer incurring a tax penalty. Only 11.6 percent of all federal employees chose low-option plans.6

Even sponsors of “competition” legislation do not always appear confident that employee insurance purchasing habits can be substan-

### The Gephardt-Stockman “Competition” Bill in Brief

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<tr>
<th><strong>Choice-of health plans</strong></th>
<th><strong>Medicaid</strong></th>
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<td>&quot;Qualified health-care plans,&quot; which could be sponsored by any person or agency of government, such as by doctors, hospitals, and insurers.</td>
<td>Medicaid recipients and the near-poor would be eligible for coverage after four years: states could opt at that time to use the Federal system.</td>
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<th><strong>Premiums</strong></th>
<th><strong>Uninsured</strong></th>
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<td>Fixed employer contributions. Tax-free rebate to employees choosing plans costing less than employer contribution; employees make up difference if premiums are higher.</td>
<td>Federal tax credit will apply to those whose employers don't pay for coverage; rebate to individual if excess is greater than his tax liability.</td>
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<th><strong>Maximum non-taxable contribution</strong></th>
<th><strong>Regulation</strong></th>
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<td>The average premium for similar levels of employees in an area.</td>
<td>The Gephardt-Stockman bill would repeal or pre-empt provisions of federal and state law that require review of expenditures, services, or charges by providers, i.e. HSAs, PRSOs, utilization review committees. Requires enrollees in qualified health plans to submit claims of malpractice to arbitration.</td>
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<th><strong>Catastrophic coverage</strong></th>
<th><strong>Medicaid</strong></th>
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<td>Applies after subscriber payments for acute-care services exceed $2,900 in a calendar year.</td>
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<th><strong>Medicare coverage</strong></th>
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<td>A recipient could enroll in a qualified plan at government expense and be reimbursed if the federal contributions for him exceeded premiums. Reasonable cost reimbursement would be phased out.</td>
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Adapted from *Medical Economics*. 
In effect, what this means is income redistribution from the poor, who get sick more often, to the healthier rich.
help is already often scarce in locations and specialties where it is most needed.

Inequities of a "Competitive" System

When a doctor says "You better have that growth removed right away," not many people are willing to say no. Physicians, not consumers, make an overwhelming majority of all major health care expenditure decisions, from whether to hospitalize and when to discharge patients to their homes or other institutions to whether to schedule recontacts for treatment and whether and what kinds of x-rays, tests, and drug regimens to order or prescribe. A system designed to encourage cost-sharing either assumes that patients can know if they really need those little white pills or that operation on their toenail before they see a doctor or simply don't care that they have to submit on faith. Socking it to consumers through increases in their out of pocket costs "without in any way restraining the power of physicians is to blame the victim, not to promote competition," points out a congressional health committee staff member formerly with the legal services corporation.

Contrary to popular belief, most of the astronomical rise in health care costs in the past 20 years has been caused by the huge increase in the amount of labor and equipment concentrated on each patient rather than expansion in medical insurance coverage. Middle class coverage, the major avowed target of the "competition" bills, has increased very little. Proponents of these bills vehemently deny they will reduce Medicaid and Medicare coverage, so one might wonder where the savings are going to come from. On the basis of current conservative enthusiasm for Medicaid spending caps, it's easy to guess which principles (and people) are likely to be sacrificed.

People with lower incomes fare no better on the taxation end. Market reformers correctly observe that the non-taxation of employer-paid health premiums favors high income over low income taxpayers, since workers in higher brackets do get more benefit from anything untaxed. However few low income workers are likely to prefer the "solution" offered in the "competition" bills, which would compel them to pay taxes they could ill afford if they chose high-option coverage. Regardless of their medical need — and low income families as a group have greater health problems—they might well be forced to buy lower option protection with high cost-sharing requirements. In effect, what this means is income redistribution from the poor, who get sick more often and will probably have to share a large proportion of the cost of their care, or pay very high premiums, to the healthier rich.

The exceedingly high out-of-pocket expenditure ceilings established to trigger full catastrophic protection would also hit lower income employees hardest, since paying that first several thousand dollars would itself be catastrophic for all but the relatively affluent. This seems particularly punitive since only five of 100 persons would ever require catastrophic insurance, so it could be financed entirely by a modest monthly increase in premium rates. Group insurance is based on the premise that medical costs will be shared by all employees, thereby releasing higher-risk workers from the full exorbitant cost of insurance they need. But a "competitive" system would encourage those who believe they are likely to require little care—frequently young, healthy employees—to purchase lower-option plans, leaving their high-risk peers with astronomically higher premiums for the protection they feel they require. Substantial adverse selection—inclusion of these people likely to require large payouts of insurance benefits—might by itself sink quite a few health plans.

Workers in high-risk workplaces would suffer the same fate. The premiums for almost all employment-related insurance are experience-related. Thus under the "competition" bills, an asbestos worker whose health care needs virtually demand a plan with extensive benefits could be taxed for the portion above the federal ceiling. This is particularly unfair in a society which often awards the lowest wages to the most hazardous occupations. A study of Chicago found that workers suffering the highest levels of industrial pollution do indeed have the city's lowest median income.

Uniform limits on tax-exempt premiums paid by employers would penalize workers who through no fault of their own live in areas with high medical costs. Environmental hazards, high hospital utilization rates, and steep physician prices all inflate health care costs. A system which makes people pay extra taxes for the privilege of living near a Love Canal has serious problems.

How the Poor Would Fare Under a "Competition" System

The fate of lower income, high-risk persons under a "competitive" system would depend on
whether they can (1) enrol in acceptable plans, (2) find medical personnel and institutions to treat them under the plan, and (3) receive quality treatment if and when they do find help. Meeting these conditions may be difficult. Nearly 27 million Americans had absolutely no health insurance coverage in 1977, the most astounding 47 percent of all U.S. citizens below the poverty line in 1979 did not qualify for Medicaid and the estimated five million undocumented aliens are also left out. Yet the Durenberger bill and several others ignore the uninsured.

The Jones and Martin bills would extend catastrophic coverage to the poor, but only after they have paid a substantial amount of the initial cost. It would also give Medicare and Medicaid patients catastrophic protection some time after their benefits had been exhausted.

The Gephardt-Stockman bill, like Enthoven's 1977 plan, would give the poor—but not undocumented aliens—premium vouchers which they could use at any of their area's competing "qualified" plans. After four years, state Medicaid programs could elect to buy into this program on behalf of their beneficiaries. Any such voucher program should recognize that average treatment costs for low-income persons are substantially higher than costs for the nonpoor. For example, they suffer from long-term disabilities—measured by bed and restricted disability days—far more frequently. Their average lengths-of-stay and admissions rates in institutions are also considerably higher.

Since the poor cost more to treat, it isn't likely that many plans in an individual prepayment system would have any financial incentive to welcome them with open arms, unless the plans were offered higher premium rates or provided inferior care. Without a very generous voucher system, plans forced to enrol disproportionately large numbers of low-income, high-risk individuals may be unable to compete with other plans whose healthier membership permits lower costs.

As proof that a "competitive market system can... work in health care to serve the poor," Enthoven and others usually cite Project Health in Multnomah County, Oregon, which includes the city of Portland. Project Health was established as a broker for medically indigent county enrollees who were allowed to choose among six comprehensive prepaid health plans. The project was to shoulder the cost for
most of the premiums, the small enrollee share depending on the cost of the plan picked and family income.

The launching of the Titanic was also a success; the question is how long it could float. A full 29 percent of Project Health’s enrollees, including many with long illness histories, elected to remain with their personal doctors and so chose to pay the extra fee to join either Portland Metro Health or Oregon Physicians Service, the two individual practice association “free choice of doctor” options. These two IPAs were soon staggering under inpatient rates more than ten times higher than the rate at the competing Kaiser plan — a difference which can’t be entirely ascribed to even the most extraordinary Kaiser efficiency. Oregon Physicians Service eventually withdrew from Project Health and Portland Metro Health agreed to remain only after it was granted a whopping 75 percent rate increase.16 This jump in the premium has apparently prompted PMH’s healthier clients to drop out and join less costly plans, which only adds to the burden of treating the sicker clients who remain. The end result is not beneficial plan competition over enrolling the poor but rather a system in which the healthy pay less and the poor and those who pay on their behalf pay more.

Recognizing that the poor generally have greater medical needs and therefore are costlier to treat, Enthoven recommends that their government vouchers under a “competitive,” consumer choice system be increased to ensure their acceptance into an adequate plan. In a similar vein, Project Health officials have concluded that “with its current high risk population, Project Health must either increase its relative degree of subsidy of the higher cost prepaid plan memberships or face the loss of most prepaid contracts.”17

But this kind of increase is exactly what “competition” bills such as Gephardt-Stockman are designed to avoid, with the aim of preventing the poor from “subscribing to the most costly qualified plan.”18 Gephardt-Stockman, like Enthoven’s Consumer Choice Health Plan, would community-rate — that is, require insurers to charge the same premiums for the same benefits to every area resident in the same demographic category. But although the Gephardt-Stockman rating system would take disabilities, age, marital status, numbers of dependents, and sex into account in settling a premium, income, one of the most important variables in determining health needs, would be ignored.

Even before the rise of Reagan, the Federal government showed little inclination to provide equal, to say nothing of greater, subsidies for low-income Americans; Medicaid reimbursement rates have been chronically inadequate. Budget director David Stockman’s concern can be judged from his unprecedented proposal to cap Federal Medicaid contributions at a flat five percent annual increase even though rising medical costs have been sending Medicaid expenditures up nearly four times as fast in recent years.

The only tool in the Gephardt-Stockman bill to counteract the plan’s economic disincentives to accepting the poor, ironically enough, is regulation — enforced open enrolment. For an uncomfortably brief one month period every year, plans would have to accept all applicants, regardless of health status. Recalcitrant HMOs, however, might not have to worry too much even during that one month. The performance of the Office of HMOs, charged with enforcing open enrolment requirements in existing Federally qualified HMOs has been less than stellar. A study by the government’s General Accounting Office scathingly indicted the Office for “fragmented responsibility and uncoordinated efforts in operating the program, insufficient staff with expertise needed to administer the program effectively, and slow issuance of final regulations and guidelines.”19 Prospects for vigorous enforcement in an increasingly anti-regulatory political climate appear dismal, particularly since there would be hundreds, if not thousands, of times as many plans to monitor.

Worse yet, Gephardt-Stockman would permit plans, with the Secretary’s approval, to limit the number of medically high-risk enrollees if a “disproportionate” number apply. This distressingly vague provision would invite plans to freeze out sickly, low-income patients by seeking exemptions on “financial necessity” grounds.

Those who do get into the plan of their choice may be no better off. “Competition” proponents such as Walter McClure confidently predict that market forces can distribute medical personnel and services, as the Gephardt—Stockman bill puts it, “by making part of the country to purchase health care from Qualified Plans and thus to attract providers.” But as Dr. Edward Martin points out, giving consumers the “purchasing power for health is meaningless if they do not have any available
What exists today is a dual track system, and there is no evidence to indicate that Project Health officials will be successful in their efforts to integrate rich and poor health consumers.

Even if they are successful, actually getting care would be difficult for the poor, as Bruce Spitz has shown. "A basic problem with the Medicaid HMO strategy is that Medicaid clients are not evenly distributed throughout the state," he notes. "Clients tend to be concentrated within the inner cities of large metropolitan regions. If HMOs are to be accessible to this group of recipients, they must locate near or within poverty neighborhoods. At the same time, such a location discourages enrollment of non-Medicaid members." Low-income consumers, including those able to enrol in qualified plans, who had no access to mainstream care would often be forced to continue relying on public hospitals, the only source of ambulatory and emergency as well as inpatient care for many of the inner city poor. Yet trapped in a swamp of sinking urban tax bases and rising costs, public hospitals are closing down across the country as fast as local officials think they can get away with it, and
those that remain are close to going under. Unlike proprietary and private, nonprofit institutions, which can build, expand, and buy the latest equipment, they are generally forced to forget about new capital investments or even replacing deteriorating facilities. Whatever capital depreciation reimbursement they currently receive must be funnelled into covering the huge operating deficits incurred by dispensing vast amounts of mandatory free care as well as inadequately reimbursed care to Medicaid recipients. They also have far less access to capital loan markets than the more affluent, technology-intensive proprietary and private voluntary hospitals. Nothing short of massive infusions of capital will save many of them, but that won't come from any voucher system yet devised. Highly competitive, profit-motivated plans would have little, if any, incentive to make contracts with institutions which predominantly serve high-risk, low-income populations, and none of the "competition" proposals requires it. Closures would be accelerated, because only the poorest and most medically desperate would rely on these facilities and the high cost of serving these people would deter plans from including public hospitals in their network, thus limiting the possibility of reimbursement.

If reimbursement to doctors and hospitals would in any way be based on their plan's ability to control costs, many would be understandably reluctant to join plans with large numbers of high-risk enrollees or with several providers located in and serving high-risk areas. Although a proposal such as Gephardt-Stockman makes it difficult for providers to refuse to treat any of their members, it does not deter them from refusing to contract with any given plan. Increased closures of public hospitals and rejection by doctors and hospitals of plans which serve large numbers of poor people would effectively deprive many of them of any care at all. Compounding the injury, Gephardt-Stockman and other bills contain a "deregulatory" provision which relieves most private hospitals which have received funds under the Hill-Burton Act of their free care and community service obligations.

Access to Quality Treatment

The same logic which argues that fee-for-service and cost-based reimbursement systems create incentives to provide unnecessary treatment would indicate that the prepaid "competitive" systems could create incentives for undertreatment. Because they are permitted to enrol in prepaid plans only so long as they remain eligible for public assistance, the poor tend to leave these plans at a far greater rate than the nonpoor—36 percent of Medicaid patients disenrolled from New York HMOs in one year, twice the rate for other members, according to a 1974 study.24 As a result, plan managers might decide it doesn't pay to provide them with the long term health maintenance services which prevent serious illnesses. Even worse, if there is high membership turnover plans might follow the example of people suffering from both hunger and hepatitis who sell their blood at every opportunity. As Kimbell and Yett put it more delicately in the language of economists, "a short-run profit opportunity" gives the plans "little incentive to produce amounts and quality of service which would attract future demand."25

The California scandals during the administration of Governor Reagan provide a graphic example of the enticements to undertreatment when prepaid health plans serve large numbers of chronically ill, high-risk indigent patients. Enrollees in the Medi-Cal prepaid health plan received only 36 percent as many hospital admissions and hospital days and 15 percent as many nursing home days as people in Medi-Cal's fee-for-service program.26 Similarly, a New York State comptroller audit revealed that the Health Insurance Plan of Greater (HIP), a prepaid group practice plan, violated its Medicaid contract in several critical areas.27

"Undesirables" who belong to competing plans, especially the common "closed panel" type in which consumers are assigned a doctor or choose one from a list provided, might find it very difficult to negotiate the bureaucracy. Access to quality care in a closed panel system assumes an informed and assertive consumer, but as Bruce Spitz points out, the history of Medicaid enrollment in HMOs has not shown the poor to be as "well schooled in institutional confrontations (as in the case of demanding care) as are more affluent middle class consumers." One study found that use of services in the Los Angeles Kaiser program was directly related to enrollee education levels and raised the possibility that low income members with less education obtained inadequate benefits from the HMO because they did not know how to work the bureaucratic system.28 Whatever the reason, as a recently published study comparing a Seattle Blue Cross/Blue Shield fee-for-service plan with an area HMO shows, low income consumers may
If there is high membership turnover, plans might follow the example of people suffering from both hunger and hepatitis who sell their blood at every opportunity have less access to needed care in prepaid systems than they do in more conventional schemes. Poor people with serious illnesses who were in the King County Medical and Blue Cross plan obtained substantially more ambulatory visits and higher hospital admission rates than their counterparts in the prepaid Group Health Cooperative of Puget Sound. When asked if they had gotten the care they needed enrollees in the cooperative suffering poor health said no much more frequently than a similar group from the Blue Cross/Blue Shield Plan.

The High Cost of Artificial Cost Control

The “competition” strategy does not guarantee higher quality, more accessible, or even cheaper medical care. It holds us hostage to parochial, self-serving economic interests. It wipes out the modest government regulation such as quality assurance that currently exists, replacing it with the caress of the Invisible Hand. As Alain Enthoven unabashedly declares, the “consumer choice” policies offer the medical profession “the surest basis for maintaining its autonomy from external, regulatory control.” Consumers, on the other hand, would be “free to choose” only among the options which health care providers have enough incentives to offer.

In the words of Victor Sidel, Chairman of the Department of Social Medicine at Montefiore Hospital in New York City, “By dispersing buying power among the people, [the “consumer choice” plan] weakens consumer choice. The way to get consumer choice in health care and medical care is by organizing consumers in ways that will force a monopolistic, mystifying professional group to give them the services they need. If the providers are organized and the people purposely disorganized, and the power to make the system responsive and responsible is thereby dispersed and divided, the power for choice is effectively lost. In my view, only through a national health service, with effective community control, can real choice be put in the hands of the consumer.”

Consumers have always needed organizations and coalitions with bargaining power, and political visibility and clout, to compel health care providers to deliver community responsive services. The need is even greater now in the effort to defeat “competition” bills. And the need will be greater still if such a bill becomes law.
1. Michael Lesparre, "Stockman sees competition plan as the only way to go" Hospitals, p. 60 (October 1, 1980).
7. W. J. McNerney, Senate Hearings (see above).
12. National Center for Health Services Research, "Who are the Uncovered?" Data Preview 1, National Health Care Expenditure Study, p. 1.
15. Enthoven, op cit., p. 89.
21. Enthoven, op cit., P. 49

Resource

The Carcinogen Information Program, a project of the Center for the Biology Natural Systems, is dedicated to bridging the gap between scientific journals and the public. You can receive The CIP Bulletin, the program's monthly fact sheet, at no cost by sending a long, self-addressed, stamped envelope to:

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Cesarean Birth

The Politics of Consensus Development

By Pamela S. Summey and Marsha Hurst

Susan woke at 6:30 a.m. with a strong contraction. She and her husband, Gary, remained at home timing contractions until 2 p.m., when they went to the birthing center.

Their midwife found Susan was only 3cm. dilated and suggested the couple go home. They returned at 6 p.m. when Susan’s contractions were 4 minutes apart, bringing their four-year-old son and Susan’s mother with them. Adam was born at 9 p.m. with his entire family present. His mother did not require an episiotomy or anesthesia. She nursed Adam minutes after his birth; he slept while Susan and Gary quietly talked. After a few hours sleep and a pediatric check-up for the baby, the family went home.

Marilyn also began having contractions early in the morning and was in telephone contact with her obstetrician during the day. At 6 p.m. she was admitted to a large teaching hospital, put into a labor room and given an enema; then her pubic hair was shaved. The belt of an electronic fetal monitor was strapped around her belly to monitor the baby’s heart rate. She and her husband timed the contractions and did their breathing exercises until Marilyn, exhausted and feeling that she could no longer control the pain, asked for anesthesia. She was given an epidural which blocks all sensation below the waist.

The obstetrician noticed several dips in the fetal heart rate. Fearing the fetus was in distress, he ordered a cesarean. At midnight Michael was born in the operating room while his mother watched. His father was allowed to see Michael for the few minutes it took to transport him to the intensive care nursery for a night of observation. The baby was brought to his mother’s room the next morning to be fed; the two of them left the hospital six days later.

Neither Adam’s nor Michael’s birth is unusual. In the past ten years, while many families were opting for family centered deliveries by midwives with as little technological intervention as possible, the nation-wide rate of cesarean births increased from 5 percent to 15 percent. Childbirth management has become an arena of conflict. Consumers are pulling in one direction, obstetricians in another. “Routine” aspects of birth are in question, including where a delivery takes place, who is present, who assists, what procedures are used, and what happens to the baby and mother afterward.

In an effort to resolve these conflicts, the Federal government has held two “consensus development conferences” on obstetrical practice. In the September 1979 issue of Health/PAC Bulletin we reported some of the

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conclusions of the Consensus Development Conference on Antenatal Diagnosis held in February, the previous March to discuss technologies such as amniocentesis and fetal monitoring which allow physicians to detect potential problems in pregnancy and delivery.

In September 1980 a consensus development conference on cesarean childbirth was sponsored by the National Institute of Child Health and Human Development in conjunction with the National Center for Health Care Technology. Like the previous consensus development conferences held since 1977, the cesarean conference was intended to transfer knowledge into clinical practice, specifically "to evaluate effects on patient wellbeing as influenced by the increase in the number of operative births."

**How the "Consensus" Developed**

The work of forging a consensus is entrusted to a task force which investigates a controversy, device or procedure, puts together a "draft document," report or responds to one written elsewhere, holds a conference to debate the report, and issues recommendations. Consistent with the mood of Washington today, the consensus development program's director carefully refers to these recommendations as guidelines, not regulations: "Our job is to provide the best advice about a given technology and to determine where further information is needed."

The nineteen-member task force appointed in 1979 to study cesarean birth consisted of six obstetricians, one of whom was chairman; two pediatricians; an anesthesiologist; a general practitioner; an epidemiologist; a developmental psychologist; a sociologist; a lawyer; a nurse-midwife; a professor of ethics; a professor of health services administration; a representative of CSEC (a lay group); and a research associate from a federal agency. The members of the Task Force were a largely homogeneous group dominated by physicians, most of whom held powerful positions in large and prestigious institutions. The non-M.D.'s were a less impressive group. Sociologists or psychologists who have made major contributions to medicine or specifically to the area of childbirth were conspicuously absent. The Task Force included no representatives from the home birth movement, birthing centers, child education, or the general public. If the conference organizers argued such representatives were omitted because the primary purpose of the Task Force was to review data and present what is known about cesarean birth, they would have to explain the near-absence of research specialists, epidemiologists, sociologists, and other experts in data analysis and interpretation.

The American College of Obstetricians and Gynecologists (ACOG), the powerful special interest group that dominates the obstetrical specialty has objected to the whole concept of medical policy making by physician and non-physician consensus: "The practice of medicine is not a committee activity... The practice of obstetrics... cannot be enacted by consensus of the populace; it must continue to be a product of professional experience and scientific exploration" [italics ours]. Whether because for only the second time a Task Force served the dual role of providing information and judging it or because of the degree of controversy associated with cesarean birth, the government added a 13-member Panel of Review to the conference to provide "an independent view of the process employed and a judgement on the extent to which the consensus state integrated the data, task force conclusions, and contributions made by the audience. The panel, however, had no access to either the beginning of the process—the year of Task Force work to produce the draft report—or the end of the process.

Furthermore, the Panel of Review could not judge the extent to which audience contributions were incorporated into the Task Force's final report since its own report had to be submitted first.

**Draft Report of the Task Force**

After a year of work, the Task Force submitted a 551-page draft report. This cesarean compendium covered the problem both nationally and internationally, factors related to the increase, effects on the mother and infant, and economic, ethical, and legal aspects. It was distributed to all heads of obstetrics and gynecology departments, 750 individuals and organizations involved in childbirth work, and an equal number of other individuals who requested the draft.

The report's chapter on international statistics—the only input by a sociologist—presents data showing that the cesarean rate is
increasing internationally, but it takes a careful reading to realize that only the Canadian rates even approach those of the United States. Studies of cesarean delivery consistently show that large, Northeastern teaching hospitals have the highest rates. Care in childbirth varies widely according to income: high-income women are much more likely to have cesarians. The question is whether in certain hospitals women with higher incomes receive better care or simply more care.

Most of the discussion at public hearings held in Washington last September 22-24 focussed on the report’s conclusions and recommendations. There was little time for anything else. After lengthy presentations by Task Force members and three “invited reviews” by an obstetrician, a journalist, and a health researcher, others attending the conference were given time for statements. Many, including those of the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists, were uncritical. Some, such as the presentations of the American Academy of Husband Coached Childbirth, were highly rhetorical. Others, including those of the International Childbirth Education Association (ICEA) and the National Foundation/March of Dimes, were thoughtful and constructive. The ICEA speaker noted six important areas not discussed in the draft report; the representative from the National Foundation was quite direct in his criticism of certain aspects: “The committee report underrates the influence of the threat of malpractice suits. . . . Physicians need to be assured that performance of a section is not tantamount to providing perfect care.” Little, if any, of this commentary can be found in the final report.

**Task Force Recommendations**

The Task Force did come up with several important recommendations relating to the four indications for cesarean delivery that account for most of the increase: previous cesarean delivery, dystocia, breech position, and fetal distress.

Probably most significantly, the report urged that women with previous cesareans have a trial of labor and vaginal delivery when possible if the hospital has emergency cesarean delivery back-up and the family is well informed. Repeat cesareans now account for 30 percent of all cesarean deliveries, although the evidence is quite clear that approximately half of all women with previous cesareans could deliver vaginally.

“Dystocia,” a catch-all term that indicates problems in labor, is the most common reason given for cesarean deliveries, accounting for almost one third (30 percent) of the recent increase. Yet when dystocia is diagnosed, cesarean delivery has no proven advantage over vaginal delivery for normal birth weight infants. The Task Force recommended increased efforts to understand factors that influence labor, but clearly it is the category of dystocia that must be critically examined. The use of this vague category now provides a medically acceptable rationale for cesarean delivery in situations where indications are not clear cut.

Over 60 percent of breech deliveries in the United States are surgical, and they account for 10-15 percent of the increase in cesarean births. The Task Force recommended that vaginal delivery be an “acceptable alternative” for term babies under 8 lbs. if the size of the mother’s pelvic structure is normal, the breech position is simple, and the physician has experience with vaginal breech deliveries.

Again, the committee recommends that the family be informed of the risks involved so that decision-making is as consensual as possible.

The final complication of pregnancy the Task Force discussed is fetal distress, the reason given for 5 percent of the increase in cesarean deliveries. Possibly because a previous consensus development conference had focused largely on electronic fetal monitoring, which results in more frequent diagnosis of fetal distress, the Cesarean Childbirth Task Force limited itself to the always reliable recommendation of more studies and new diagnostic techniques. It stayed clear of the controversy surrounding routine use of EFM in low-risk pregnancies.

Many of the recommendations in other areas were even less specific. The Task Force emphasized the need for further data collection and research, and encouraged the use of standard birth and infant death certificates which include type of delivery, complications of pregnancy, and other factors relevant to childbirth management and maternal mortality and morbidity. It also recommended that regional anesthesia be available for cesarean deliveries and that the birthing family be included in decision-making on the type of anesthesia which will be used. Many cesarean
deliveries are scheduled or "elective," particularly for women who have had previous cesareans. Babies delivered by cesarean before the mother has actually gone into labor are more likely to be premature and suffer breathing difficulties. The Task Force recommended that this "iatrogenic," or hospital-induced, prematurity should be avoided.

The report underlined the importance of parent education, including discussion during pregnancy of "available parental choices for care," and during labor of "the indications, procedures and parental options" regarding delivery. Although it encourages hospitals to liberalize their policies and allow fathers or surrogates at cesarean deliveries, the Task Force also recommends that hospitals be part of the decision-making team — a contradiction since a negative hospital policy overrides physician and/or client choice. Similarly, although the committee strongly recommends that the healthy neonate born by cesarean delivery not be routinely separated from its parents, policy made independent of consumer or even obstetrician choice may dictate practice in many hospitals.

Physicians themselves, however, often report that the client's wish for a "perfect baby
recommendation suggest that physicians may need reeducation, and then it was implied rather than stated — in the caveat that vaginal breech deliveries should only be managed by experienced doctors. Although consumer education and information was an important theme of the conference, informed consumer choice regarding physician and institutional practice was not. Never, for example, was it suggested that consumers should be encouraged to interview obstetricians on their cesarean delivery rate. Finally, the Task Force did not challenge the definitions of normal labor and delivery that currently dominate physician practice and education. This is particularly significant in their consideration of dystocia, where the concept of normal labor ought to be reevaluated and redefined.

At the outset, the Task Force members stated their purpose as evaluating the effects of the increase in cesarean delivery on patient wellbeing; the concept of patient wellbeing was confined largely to medical wellbeing. There was no mention of any nonmedical risk other than "disappointment." The recommendations to lower the number of cesarean deliveries imply that cesarean delivery is without medical benefit in many instances, yet the Task Force never directly addressed this, alone or in the broader context of unnecessary surgery.

The overall consensus development conference goal of transferring knowledge to clinical practice is difficult to realize for several reasons. The conference issues guidelines rather than regulations. They are disseminated to all major medical journals, but responsibility for their adoption rests solely with the institutions and professionals. The public is not affected unless the guidelines are adopted as policy by the consumer's hospital and/or physician. In fact, consumers have no direct channel for receiving information on the guidelines.

Furthermore, no followup studies have been done to assess the actual effect of these guidelines on clinical practice. There is no evaluation process to determine whether the cesarean delivery rate has decreased; vaginal deliveries after cesareans have become more common; physicians have changed the way they handle breech deliveries and problem labors; or parents have been able to exert any more choice over the way their children enter the world. Questions about the impact of conference policy on medical practice must be asked and carefully answered before we can judge whether the consensus development program has been of any benefit.

A decade ago a woman had to hunt high and low to find any information on her body and its health status written in language she could understand. The unexpected and overwhelming success of Our Bodies, Ourselves (Simon & Schuster, 1971) by the Boston Women’s Health Book Collective changed all that. A whole new genre of self-help, know-your-body-books can be found at bookstores and even drugstores. It would be nice to find that time and reflection have brought improvements, but the “grandmother of the women’s health movement” remains incomparably the best. The Ms. Guide does not change this situation.

The approach of the authors, a woman doctor and a contributing editor to Ms. magazine, is business-like. They declare two goals at the outset:

“To help women think their way through to a sweeping revision in standards for their own health,”

and “to give them a plan [original emphasis] for staying healthy and coping with illness, so they can survive the crisis that currently seethes in the American health care system.”

To accomplish these purposes, they have chosen an expanded outline format. Each chapter begins with a one or two page narrative followed by a series of bold-face topics—“external signs of puberty;” “a backup method should be used during the first six months on the minipill;” “tooth decay: a preventable epidemic”—discussed in a paragraph or two.

Where Grandmother OBOS presented information affecting all women, deepening its content with personal anecdotes, the Ms. Guide preaches. Not surprisingly, the sermon often has the white, middle-class, heterosexual, bow-to-the-professional intonations of Ms. magazine. For example, long-duration hormonal contraceptives such as depo-provera are described as follows:

“A pill which need be taken only once a month, or a shot which need be given only once in three or six months, is particularly attractive to population planners in underdeveloped countries. . . . The side effects of the long-acting contraceptives, which have thus far kept them off the American market, often are less worrisome to underdeveloped nations, where deaths from childbearing are so frequent.

The discussion of amniocentesis extends from Point 19 to Point 26 in the chapter on Genetics and Prenatal Diagnosis. Tay-Sachs, which affects “one in thirty Ashkenazi Jews. . . in America” rates Point 23, while straggling behind at Point 26 comes “Americans who think that their ancestors may have originated in West Africa should have themselves tested for sickle-cell trait.” The surface message is false; that Tay-Sachs is the most debilitating and widespread genetic disorder in the United States. But the deeper message is all too true: the authors aren’t writing for Black women.

The Ms. Guide isn’t written for lesbians either. They don’t appear in the index, and the only explicit reference to lesbianism is the comforting thought that “Temporary homosexual attachments are normal during adolescence.” The term “he or she” does slip in when sexually transmitted diseases are discussed.

Sadly, the Ms. endorsement, even imprimatur, will impress many women attempting to choose among a dozen books on the shelf. It’s “newer” than OBOS, and therefore presumed to be better. Some white, middle class readers who consider themselves enlightened will find their prejudices reinforced. They would do better to join the rest of us and listen to OBOS.

—Marilyn Norinsky 29
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—R. Alvarez
New York City
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