From Them That Hath Not... American Health in the Reagan Era
Peer Review

To the Editor:

I found Tony Bale’s article on Great American Health Fortunes fascinating as well as amusing (I have a macabre sense of humor, I guess), but I would like to correct the statement that none of the new rich in health care come close to the Robin’s family’s $930 million.

The U.S. already has its first health billionaire, H. Ross Perot. Until a couple of months ago he owned 46 percent of the stock in his Electronic Data Systems computer software company, which has just been bought by GM for $2.5 billion.

It is a fitting commentary on the U.S. health care system that it made Perot a billionaire even though he has no direct connection with the provision of care, and his fortune was made through government programs.

In 1966, his EDS was struggling along the road to nowhere. Its president was supplementing his income by moonlighting as the head of the Texas Blue Shield computer department. Then TBS got a contract from the Social Security Administration to develop a computerized system for paying bills in the new Medicare program. After this was done, Perot left Blue Shield to work full time at EDS—with a subcontract from Texas Blue Shield to do its Medicare data processing. As with all administrative costs for the program, the bill was paid by the federal government.

EDS was off and running. Three years later it got an even bigger boost, running the computer operations of California’s Medi-Cal program. This highly lucrative contract was awarded without competitive bidding, under Governor Ronald Reagan. By 1971 EDS was taking in over $100 million a year, most of it from Medicare and Medicaid work.

Certainly since then EDS has used the expertise it developed with government funding to expand its field of operations, but I think Medicare and Medicaid deserve credit for making H. Rose Perot one of the half-dozen richest people in the country.

Phillip Carnow
San Francisco

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What Hath Reagan Wrought?

by Michael Clark

Four years ago progressives quaked as this nation elected its most self-avowedly conservative President in half a century. Today, as Ronald Reagan seeks a second term, Health/PAC is certainly not alone in wondering who is—and isn’t—better off as a result of nearly four years of Reagan’s rule.

For this issue, we tackled the question in our usual style: by looking at the “front lines” of health and health care. We focused particularly on those areas where we expected the damage to be worst: i.e., on the health and health services of the poor and the working class, whose health risks have always been higher and who have always faced the greatest obstacles to getting necessary care.

What we found—and there was far more than we could squeeze in this issue—offers some surprises.

As we talked with health activists in Washington and around the country—about Medicaid and Medicare, about maternal and child health programs, about levels of sickness and death among poor people, about the fate of public hospitals and clinics—the situation was bad but not as catastrophic as some might have suspected. In many areas, severe reductions have occurred in Medicaid, in local hospitals’ willingness to accept the poor, or in categorical programs. Waiting times have increased, benefits and coverage have been weakened or eliminated, and levels of some major, serious illnesses are again on the rise.

In most cases, however, these trends are spotty. Some seem more directly tied to fiscal and political decisions of state and local governments and are only the latest round in a series of cutbacks and crises that began in the mid-1970’s or earlier.

Meanwhile at the national level the Reagan team has largely failed in its own proclaimed mission of slashing Medicaid and other federal health financing or services. This is largely due to the successful counter-offensives of the health industry’s lobbies and to a stubborn Congress. The Medicaid budget has remained relatively intact. What’s more, the nation’s federally funded community health centers survive today in only slightly diminished numbers—remarkable, really, since they were singled out for destruction early on by Reagan strategists who saw them as an “infrastructure for a national health service.”

Indeed, total expenditures for health care—including federal expenditures—have continued to soar throughout the past four years. What’s going on?

For one thing, it’s certainly too early to breathe easy. Reagan’s agenda still includes wiping out decades of progress represented by current federal programs in health service and financing. Emboldened and freed from accountability to the electorate by a second term, this President, if he is re-elected, can be expected to pursue his stalled health agenda with the same draconian flair he has already shown in areas such as low-income housing, food stamps, and employment programs. Further, as several articles in this issue point out, there have been real and far-reaching changes. The contours of Ronald Reagan’s America are already emerging in two distinct areas. On the one hand we are experiencing class polarization, with predictable, mounting health problems for those on the bottom. On the other hand, we see an (already partially successful) ideological and economic offensive designed to bring the bottom line of the marketplace into regions hitherto dominated by less nakedly capitalistic dynamics. To reach these objectives, we see a determined effort to obliterate or transform institutions, programs, and social commitments that stand in the way, and represent decades of struggle and painstaking social progress.

As the class rifts grow wider, as the toe-hold of the working class slips ever further down the ladder, we daily witness a growing population of Americans relegated to a new underclass—of unemployed—or only marginally employable—whose mounting troubles and lack of participation in the new high-tech service economy threaten the very fabric of American society. For health activists, this growing at-risk population represents a new class of refugees from Reagan-era America whose very presence belies the Administration’s claims of new prosperity and good times.

But what of another Reagan legacy—the new entrepreneurialism in health care, to borrow the title from a recent conference at the New York Academy of Medicine? Are the results so bad? If the marketplace can bring us more efficient small cars, no-salt foods, and lower-cost steel, what’s wrong with a little old-fashioned competition for the health care industry?

Orthodox liberal health economists usually point out that one major problem is that health care isn’t automobiles or shoes: people don’t shop for doctors or hospitals quite the way they do for consumer goods. Decisions are more usually made by doctors (what tests to order; which hospital to use) or by “third-party” payors such as Blue Cross (which services to cover and which to exclude). This argument says that competition “won’t work”—i.e., that prices will continue to respond more to marketing efforts by medical suppliers (pharmaceutical and equipment companies, hospitals, etc.) and their

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“captive” professionals (doctors and others) than to any mythical “rational” consumer.

Although the liberal argument contains some truth, all too often it actually represents a kind of rationalization for professional dominance as well. After all, if consumers can't choose rationally, why not leave the real decisions up to government planners and their (professional) staff?

The result—documented by Health/PAC for over 15 years—has been a health system overseen by the professionals and “their” institutions: the large teaching hospital/medical school complexes that we’ve labeled “medical empires.” A health system left in their hands—and those of government regulators “informed” by their wisdom—has produced costly, frequently inappropriate, and inaccessible services with little or no consumer accountability.

Given this history, it is easy to see why Reaganesque, prairie capitalism appeals to some. Particularly during growth periods, private enterprise does have a genuine capacity for seeking out potential customers and finding out what they want. So where’s the beef?

Before handing over our health system lock, stock, and barrel to Wall Street, we need to recall a time, long ago, when issues besides controlling costs mattered in health care. In fact, three broad areas of popular concern about health care have historically affected government policy in the U.S.: assuring access to care, assuring quality of care, and regulating the cost of care.

Runaway military budgets (and “runaway” is the word for Reagan arms spending) and galloping inflation within the health sector itself have combined in recent years to push costs to the fore. Other issues have been swept aside, and virtually no health policy is widely discussed today unless it promises to lower costs.

Will our “new entrepreneurs” bring us lower costs? There is no evidence to date that they will. Profit-making hospitals—including the new corporate “chains”—have generally been found to deliver more expensive care than nonprofits or public institutions. The Reagan Right, of course, is undaunted. Wait, they say. It’s too early. Once the chains get a large enough share of the market, and once competition really permeates the system, then prices will go down and so will overall costs. Traditional capitalist virtues—economies of scale, efficiency of production, price competition—will save the day.

Whether or not the promise of cheaper care through competition materializes, however, it’s important to ask “cheaper for whom?” Price competition only works when there are customers who can pay. For them, even if prices do ultimately fall over the long run (e.g., over a decade), there is no evidence they would drop in the near future (during a second Reagan term).

Meanwhile, the health system this Administration pursues will more and more resemble the society Reagan espouses: a society of “winners” and “losers” where old-fashioned ideas like “equal access” and “entitlements” are banished.

America has long been a land of winners and losers. The “old losers” included those who couldn't get private health insurance or Medicaid; women, minorities, and old people for whom care was often inaccessible and/or inappropriate; most middle class Americans, who couldn't get their doctor to tell them what he was up to. The ranks of the “new losers” are likely to include many more of us. Millions who can't get or stay on Medicaid because funding is static or—as the President wants—actually cut. Millions of Medicare recipients who must spend more and more out-of-pocket each year for the same benefits. Millions of urban poor and working poor who can't find a doctor or hospital that will treat them. Millions of middle-income Americans whose employee health benefits are reduced because of losses at the bargaining table or unilateral reductions by their employers.

And what of the quality of care in Reagan America? Anyone who has bought one of those new $9.95 telephones can tell you that the same wonderful capitalism that offers more for less can often deliver more junk for less. “Junk medicine”—unnecessary or inaccurate tests, duplicative or questionable procedures, inpatient services that ignore complications or needed follow-up care—is no bargain.

So what’s the alternative? Well, we have to be honest and say it’s a hell of a lot more than that other party is promising in this election. For those of us who believe that lower costs, more effective and high quality care, and equal access for all are all attainable, there are a lot of answers we don’t have about how to get there from here. Health activists with a progressive vision need a clearer, more realistic agenda if the simple visions of the Right (“Step right up folks, get it cheaper here!”) are to be successfully confronted.

The Democrats have essentially forgotten or abandoned what once seemed a modest goal—a program of national health insurance. If Reagan can be blamed for that in part, much of the responsibility must also be laid at the feet of health activists. We’ve backed up a long way in four years, and we’re likely to back up a lot further if we don’t put the action back into “activism.”
American Health in the Reagan Era

"Individualism" for the Homeless

by Kim Hopper

"No one is living in the streets,"

Philip Abrams,
Deputy Assistant for Housing,
Department of Housing and Urban
Development (HUD),
June 16, 1982

In the past four years, homelessness has emerged as something of a crise celebre, the subject of three Congressional hearings, lengthy reports by the nation's mayors and governors, and extensive litigation and advocacy efforts. Unsurprisingly, this has been cause for concern in Washington. So much attention concentrated on so wrenching a sign of social dislocation casts an obvious pall of suspicion on the Administration's upbeat pronouncements of recovery. Signs of prosperity lose luster against the backdrop of people sleeping on heating grates two blocks from the White House. Some response was needed.

Simple denial—exemplified by Philip Abrams' remark at the beginning of this piece, and by Ed Meese's observation of Christmastide '83 that people were patronizing soup kitchens because it was cheaper than eating at home—proved unequal to the task. The evidence to the contrary was simply overwhelming. Equally unconvincing were the President's public musings of late January '84 that those on the streets were there, "you might say," by their own choice. Thus abject destitution was converted into an exercise of free will—a late, perhaps perverse, embodiment of the Jacksonian ethic of rugged individualism. Again, the response was mass disbelief. In the wake of these two ill-fated ventures into reality-testing, one option must have seemed especially attractive: commission a study to tell us what really is going on. Hence the origins of the HUD report on the homeless and emergency shelters, about which more later.

To appreciate the anxiety of the Reagan Administration, a brief review of the recent history of homelessness may be of help. As the 1960's drew to a close, students of skid row were confidently predicting its demise. Its population was declining. Many of its old districts had disappeared in the course of urban renewal efforts. Demand in labor pools for casual workers was at an all time low. Social services, unemployment insurance, social security, and health benefits for the indigent had taken the edge off joblessness, sickness, and old age, precipitating causes of homelessness.

But instead of dying, skid row was reborn in the 1970's, although the transformations in its ranks and lifeways rendered its new inhabitants but distant kin of their earlier counterparts. New causes of displacement replaced the old—rising rates of unemployment (especially among minority men), public assistance benefits badly eroded by inflation, deinstitutionalization of state mental hospitals, and the steady loss of low-income housing throughout the decade. Young, jobless men began to crowd out the old veterans of the missions, flophouses, and municipal shelters. Women began appearing on the streets—in the 1960's, their numbers had been negligible—assuming a prominent place in American iconography (the "bag lady") by the decade's end. The burgeoning number of psychiatric casualties, many of them discharged under the mass deinstitutionalization movement of the 1960's and poorly followed outside the hospital (see article on the Mentally Ill), meant that many of the remaining skid row institutions took on the aspect of open asylums. Steadily rising rent-income ratios left thousands of households poised on the brink of homelessness: by 1980, the median rent of half of the 2.7 million households in the U.S. with annual incomes under $3,000 was 72 percent of income, leaving $71 a month to meet all other costs.

It was this legacy, the legacy of a political economy that was slowly marginalizing an ever-growing segment of the American populace, that the Reagan Administration inherited when it took office in 1981.

The new policymakers were immediately put on notice that a nascent crisis was in the making. News of an impending boom in homelessness first hit the national press in the spring of 1981, though at the time the phenomenon seemed to be confined to larger cities. Since then, things have gotten progressively worse. By the Administration's own conservative

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estimates, the ranks of the homeless have grown some 100,000 since 1980; in all probability the numbers are much larger, given the rates of turnover and mobility in the population.

The recent additions include members of those groups which had already appeared in the 1970's, and massive recruits from the "new poor" (a term first used in 1933 to characterize victims of the Depression): individuals and families who have lost jobs, exhausted all other means of support, and are now on the road in search of work or holed up in emergency placements. Among those whose condition could be described as "borderline homeless," are people who are "doubling up" with friends or family in makeshift accommodations under constant threat of unraveling. Some 17,000-20,000 families are thought to be living this way in New York City in public housing units alone, over three times the total the city has placed in emergency shelters and hotels.

Any discussion of homelessness must include what has emerged as the most distinctive feature of the crisis today: the growing scarcity of decent affordable housing. Estimates by the U.S. Department of Housing and Urban Development place the number of people involuntarily displaced from their homes each year at two and a half million—casualties of loss of income and government benefits, neighborhood "revitalization" projects, eviction, economic development, and rent inflation. At the same time, according to the National Housing Law Project, half a million units in low-rent dwellings are lost each year through conversion, abandonment, inflation, arson, and demolition. Obviously, those most vulnerable to displacement and most ill-equipped to recover in its aftermath are the poor. In New York City, over half the families now quartered in emergency accommodations were displaced by primary tenants with whom they had been doubling up. As in the 1970's, rent-income ratios have risen at a rate higher than inflation generally.

The net effect is an inexorably growing pools of households pressing against the outer limits of scraping by. It is this factor more than any other which has given contemporary homelessness its distinctive cast. The loss of single room occupancy (SRO) housing, for example, probably accounts for more of the thousands of psychiatrically impaired people on the streets and in the shelters than personal disability does.

Thus it is somewhat arresting to discover that the new HUD report concludes that homelessness is for the most part a transient state of emergency, a temporary dislocation that most people are able to surmount after but a brief period of stay in shelters, or a difficulty they descend into on an episodic basis.

HUD's assertion—the Administration's premise for any future policy proposals—flies in the face of so much recent evidence that the reasoning behind it must be examined closely. When this is done, a curious sleight of hand emerges. HUD appears to be attributing to the homeless poor a transience that is an artifact of the apparatus that serves them. Most shelters, by the Department's own account, impose limits of stay on their guests, the better to serve more in need. This results in a rapid turnover, but to infer from this that those who are forcibly evicted have somehow "solved" whatever "crisis" made them homeless in the first place, is a blind leap of faith.

To have faced the issue of where such people go would have brought the HUD researchers squarely up against the subject they so studiously ignore; housing. Charged to investigate the plight of those without a roof over their heads by an Administration that has set out to dismantle the paltry federal low-income housing programs that remain, HUD dutifully reports back, in essence, that there is no reason to re-examine the prudence of the 78 percent decrease since 1980 in annual funds it commits to assisted housing. More emergency shelter—not housing to accommodate those now in shelters—is HUD's primary recommendation.

We may thus be witnessing the slow materialization of the covert plan for housing for the poor. Not vouchers but shelters appear to be the wave of the future. Such indeed is the provenance of (in the words of the President's Commission on Housing in 1982) "the genius of the private market, freed of the distortions forced by government housing policies and regulations." If not as Jacksonian individualists, perhaps the homeless will be championed as freedom fighters.
Hunger: No Myth, America
by Joanne Lamphere

The public debate about hunger in the United States took an ugly turn last December when pediatrician George Graham, a member of the President's Task Force on Food Assistance, cited super-star black athletes as evidence that black children "are probably today the best nourished group in the United States." Absence of supportive medical evidence did not deter this public health professor from John Hopkins University, who went on to argue that avoiding sex during pregnancy would address the problems of low birth weight and premature birth, "overwhelmingly a black problem."

The Graham remarks followed (possibly intentionally) on the heels of a comment by White House counselor Edwin Meese III that he had not seen any "authoritative accounts" of hungry children in America and that some people "go to soup kitchens because the food is free and...that's easier than paying for it."

How much hunger and malnutrition is there in the United States? The Reagan Task Force reported early this year that "hunger does persist" but that "allegations of rampant hunger simply cannot be documented." Individual members of the carefully-selected Task Force were blunter. No one "in their right mind believes that there is a massive hunger problem," declared one member, at a time when a Harris poll showed that 80 percent of the American public believed it is a serious problem.

Public debate is hindered by a lack of consensus among "experts" about what constitutes hunger and malnutrition in the United States. However like pornography, it's hard to define but is apparent to most people when they see it. Mounting and diverse evidence, carefully collected under the sponsorship of a variety of institutions and organizations, belies the Task Force position. Among them:

- The New England Commission on Hunger reported last January that hunger in the United States was a "widespread" and growing problem.
- In 1980, the Food and Hunger Hotline in New York City received 2,388 telephone calls from persons seeking emergency assistance. On the basis of early data, the Hotline projects over 6,500 calls this year.
- A 1983 Boston City Hospital clinical survey revealed that 14 percent of young children who used the emergency room were under the 5th percentile for weight for their age and/or height.
- At Cook County Hospital in Chicago, in 1983 pediatricians found a 25 percent increase over 1981 in conditions among children under age two that may be related to malnutrition.
- Last year, the U.S. Conference of Mayors recognized hunger as "the most prevalent and detrimental problem facing American cities today."
- The majority of soup kitchens and food pantries throughout the country continue to report precipitous increases in the number of people requesting emergency food assistance.

Despite this documentation, federal food assistance programs continue to be the target of budget cuts.

In 1981, Congress made the deepest cuts in social programs in the nation's history, adopting about 90 percent of the reductions requested by President Reagan. Although basic programs for low-income Americans (such as food stamps, AFDC, Medicaid, SSI, and school meals) comprise about ten percent of the federal budget, the reduced appropriations for these programs made up the bulk of budget reductions—more than 50 percent, after adjusting for inflation—according to the Center on Budget and Policy Priorities.

In New York City alone, more than 50,000 non-public assistance households have lost their Food Stamp benefits entirely since 1981, and another one million recipients have had their benefits reduced. Of the 21 million people throughout the country who use food stamps, over 85 percent are women and children, the elderly, and the disabled. They received an average food stamp benefit of 47 cents per person per meal.

The cost of the New York City Department of Consumer Affairs market basket to feed a family of four is now $110 per week, but the food allowance for a family of four is $58 a week under the Food Stamp Thrifty Food Plan. (Under this Plan, three scrambled eggs feed four people.) This is for those who are actually in the program; a Montefiore Medical Center study found that over half of those who might be eligible for food stamps were not receiving them.

The National School Lunch Program is the oldest and largest of the child nutrition programs in terms of both participation and federal expenditures. As a result of the Omnibus Budget Reconciliation Act of 1981, stricter income eligibility standards for free and reduced price lunches were promulgated and cash meal subsidies to states were reduced. In all, federal support for the school lunch program was cut $1 billion a year, or

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Cutting the Children

In FY 1982, critical federal children’s programs were cut by $10 billion (See Table 1). The Reagan Administration justified the direct cuts by claiming they would reduce the waste in the programs and thereby reduce the federal deficit. Other cuts were achieved by collapsing the programs into block grants to the states. This was called the “New Federalism”—shifting responsibility onto state and local governments and politely asking the private sector to do its share.

Among the hardest hit were the entitlement programs—Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamps.

**AFDC**

$1 billion was cut, decreasing the absolute number of federal dollars three percent in FY 1982, four percent in FY 1983, and 4.5 percent in FY 1984, at a time when health care costs were soaring.

**Medicaid**

$1 billion was taken from the $7 billion budget by:
1. limiting AFDC eligibility to families whose gross incomes exceed 150 percent of their state’s standard of need;
2. more strictly monitoring expenses and income determining eligibility;
3. counting a step-parent’s income as available to a child in determining eligibility—whether it actually is or not;
4. not allowing AFDC for mothers pregnant for the first time until their sixth month of pregnancy;
5. allowing states to include food stamps and housing subsidies as income in determining eligibility.

**Food Stamps**

The Food Stamp program was cut in both the Reconciliation Act and the farm bill. Total cuts equalled $2.35 billion in FY 1982 and nearly $7 billion over the three-year period from FY 1982 to FY 1984. Over 80 percent of the savings will come from reducing benefits for those with gross incomes below the poverty line, and from reducing or terminating benefits for families slightly above the poverty level who work and pay taxes.

Although the long term effects of these program cuts on health of children are uncertain, evidence on the impact of reductions in benefits and the implications for health status have begun to appear.

Food Stamps

Approximately one million people were dropped from the food stamp program due to the changes in the 1982 budget. Half of them were children. (Another one million children were dropped from the school lunch program, based on cuts of $5.2 billion for FY 1982-1985.)

These cuts have increased concern about the nutritional status of children in this country and the extent of hunger and malnutrition, particularly in families that have lost government assistance. A number of studies have been done and all, including that of President Reagan’s task force on hunger, agree that hunger is a real problem throughout the nation. A few examples:

- In 1983, a study of 413 children who came into the emergency room at Boston City Hospital during one week revealed that nearly 15 percent were below the fifth percentile of growth in weight or height. In an average population of American children, only five percent would be expected to be in this category.

- A Minneapolis Health Department study of low-income women and children enrolling in WIC found that 33 percent of the women, 21 percent of the children, and 13 percent of infants tested were anemic. Overall, 20 percent of the low-income women and children were found to be anemic.

- When staff of Chicago’s Cook County Hospital examined the charts of patients in the pediatric Comprehensive Care Clinic, they discovered that 21 percent were below the tenth percentile for height—approximately twice the expected rate. Concerned about this finding, they began to measure children under age two who came into the clinic. Of 325 screened over a seven day period, 99 (30.5 percent) were under the tenth percentile for height or weight. Some showed signs of acute malnutrition. Clinic staff also reported that hospital admissions for failure-to-thrive, diarrhea, and dehydration—all nutrition related—increased 24 percent from 1981 to 1983.

- A national survey conducted in 1982 by the Centers for Disease Control which looked at 400,000 low-income children around the country found that 8.5 percent of those under age six were stunted and seven percent were anemic. Extrapolating these rates to the population of low-income children nationwide suggests that 500,000 American children under six may be suffering malnutrition.
Medicaid

The cuts in the federal contribution for Medicaid have further stretched state Medicaid budgets. As a result, most states reduced eligibility in 1982, particularly for the medically needy, either through the mandated reductions in AFDC eligibility or by increasing the amount recipients must "spend down" to be eligible for Medicaid. The exact number of children affected is not available. Some children who lost AFDC benefits, thereby automatically eliminating them from Medicaid benefits, were picked up under the states' "medically needy" programs. Overall, the direct cuts in Medicaid benefits to children per se were not drastic, but the cuts in AFDC that led to the loss of Medicaid coverage were.

AFDC

From its survey of state public assistance agencies and an analysis of ten years of program data, the General Accounting Office (GAO) estimated that the 1981 Reconciliation Act decreased the basic monthly caseload of AFDC by 493,000 cases. GAO conducted in-depth evaluations of the effects on individual AFDC families in Boston, Dallas, Memphis, Milwaukee, and Syracuse. These indicate that changes in the food stamp program appear to have resulted in a simultaneous loss of AFDC and food stamps for many families in Boston, Milwaukee, and Syracuse. Although earnings increased for many who remained in the labor force, in general the income of the families studied dropped sharply in all five states; they were unable to make up the loss of income from AFDC and food stamps by working. Additionally, in Dallas and Memphis about half of the families remained without health insurance coverage a year after they lost their Medicaid.

An In-Depth Survey

Over 120 citizen volunteers in 11 Ohio communities conducted a survey to determine the impact of federal cuts on programs for children at the local level. They concluded that although Ohio's high unemployment and the state's budget problems compounded and obscured the effects of federal cutbacks, there remained "striking changes in the types of services provided and the people to whom they were available." Their main findings were:

- One out of five of Ohio's Aid to Dependent Children recipients had their grants reduced or terminated in the first year after the federal ADC changes took effect. Two thirds of them were children.
- The doubling of Ohio's General Relief (GR) caseload since the ADC changes took effect has shifted substantial costs to state and county governments, since it costs them 65 percent more for each child and 26 percent more for each adult who is on GR rather than ADC.
- Ohio's ADC payments are inadequate. A typical family has only $13 left over for living expenses each month once food, rent, and utilities are paid for.
- Fifty thousand Ohio children lost health coverage under Ohio's Medicaid program; unemployment added to the number of families without health insurance. As a result, many children and their families have no place to go for health care.
- As a result of federal budget cuts, there are fewer preventive services to keep mothers and children healthy. And many low-income pregnant women are not able to obtain needed care.
- Over 13,000 children from poor families have lost child care services. The 36 percent reduction in funds for Ohio's Title XX day care program was twice as deep as the reduction in any other Title XX program in the state.
- Budget cuts exacerbated the already serious shortage of infant care, after-school care, and care for handicapped children. They also made it harder for low-income families to pay for child care in order to work.
- One in ten Title XX dollars that support child welfare services in Ohio was cut. Although several of the communities surveyed have replaced some lost federal funds by passing local property tax levies, there is still a net loss in funding for local child welfare services.
- As a result of the federal budget cuts, foster care and adoption services, as well as home-based services that help keep families together, have been reduced at a time when the need is increasing.

—Hila Richardson

Sources


Ohio Children's Defense Fund, Choices: For Ohio, For Children, 190 Stone Avenue, Columbus, OH 43205.

Table 1

Food Programs: Estimated U.S. Spending Levels in 1984, Comparing Projected Expenditures With and Without Legislative Changes Enacted (1981-83)

<table>
<thead>
<tr>
<th>Program</th>
<th>1984 Projected w/out Changes in Law</th>
<th>1984 Projected w/Changes in Law</th>
<th>Cut</th>
</tr>
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<tbody>
<tr>
<td>Food Stamps</td>
<td>$14.3 billion</td>
<td>$12.2 billion</td>
<td>14.6%</td>
</tr>
<tr>
<td>Child Nutrition*</td>
<td>$4.8 billion</td>
<td>$3.4 billion</td>
<td>29%</td>
</tr>
<tr>
<td>WIC</td>
<td>$1.096 billion</td>
<td>$1.019 billion</td>
<td>7%</td>
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*Includes school lunch and breakfast, summer feeding and child care feeding programs.


continued from page 7

nearly 30 percent. As a result, over three million fewer children are in the school lunch program and over one million fewer children from low-income families get free or reduced-price lunches. The potential consequences are severe, since many of these children depend on school meals for one third to one half of their daily nutritional requirements. In addition, the funding reductions have impelled thousands of schools throughout the country to drop out of the lunch program.

The Special Supplemental Food Program for Women, Infants and Children, generally known as WIC, has remained relatively unscathed, despite Reagan proposals to end its categorical status and reduce funding. WIC has strong congressional support among Republicans and Democrats, conservatives and liberals. Even so, WIC's budget has not kept pace with inflation; as a result, thousands of nutritionally "at-risk" pregnant women and young children have been dropped from the program. The majority of those who are nutritionally deficient and eligible for WIC intervention are not being served. Even in New York State, which has aggressively pursued federal funds, only 40 percent of those estimated to be eligible are currently participating.

"More fun than Disneyland" is what people will be saying about the Annual Health/PAC Awards Dinner/Dance at the American Public Health Association Conference Tuesday evening, November 13, at the Hyatt Anaheim. We'll be looking forward to seeing you there.

Maggie Block
American Health in the Reagan Era

Gender Slap

by Joanne E. Lukomnik

Children's songs often have verse after verse requiring prodigious feats of memory. Exhausted from the effort, young singers often wander off in frustration before the last lines have been heard. Trying to catalogue the effect of the Reagan era on women, especially on women's health, is somewhat similar. We add item after item, closer and closer to tears, and fear we'll never finish—because many effects of the cuts won't be clear for years.

While political pundits try to predict how seriously the 1984 election will be affected by the "gender gap" in attitudes, for millions of women in this country the real gender gap is what contributes to their disaffection with the Reagan Administration—the much talked of feminization of poverty, the differential in women's paypackets, and the cutbacks in service programs on the Federal and local levels.

Many of the budget cuts and the collapsing of specific categorical programs into block grants have struck at programs that provided health services for women. In addition, many regulations, proposed regulations, and administrative actions have been designed to decrease access to and utilization of programs which the administration couldn't destroy through legislative action.

Family Planning

The Family Planning Services and Population Research Act, Title X, of the Public Health Service Act (PHSA), enacted by Congress and signed into law by President Nixon in 1970, is the mainstay of the nation's efforts to minimize the incidence of unintended and unwanted pregnancies. During the 1970's, an estimated 2.3 million unintended births were averted through federal support to family planning programs. The Reagan attacks on Title X have been multi-pronged. Since it took office, the Administration has tried to repeal Title X every year and fold family planning services into a proposed "Primary Care" block grant, along with community health centers, migrant health, and black lung programs. Congress has repeatedly rejected this proposed block grant in deference to strong lobbying from affected provider and user groups.

Title X expires on September 30, 1984 and this year's reauthorization battle is expected to be tough and bitter. The Administration has plans to make this another confrontation which wins it New Right support on "family" and "moral" issues. The Senate committee and subcommittee chairs with jurisdiction over the authorizing legislation have fallen into line with the Administration's position and are expected to resist reporting new authorization out of committee.

Congress has already allowed the budget for Title X funding to be slashed by 25 percent (in 1982). Half of all women who wanted family planning services last year were unable to get them because of funding cutbacks. In New York State, for example, there are fewer family planning services and provider agencies than there were in 1975.

The Administration has also attacked with a bureaucratic maneuver. Until January 1983, family planning services were administered in the Bureau of Health Care Delivery and Assistance (BHCDA), along with other primary care programs. Title X was transferred at that time to the office of the Assistant Secretary for Health, a political appointee noted for hostility to the program. Congress responded to this attempt to circumvent its intent by immediately stating its opposition to this transfer through resolutions, and later passed a law (P.L. 98-139) which mandated the return of Title X to BHCDA and the Public Health Service. So far the Administration has refused to comply.

Other attacks on family planning services have included concurrent investigations of the accounting systems and administrative practices of all Title X facilities by the Department of Health and Human Services Office of the Inspector General and by the General Accounting Office. Both concluded that all Title X clinics were operating in full compliance with the law.

The proposed "squeal rule," published in the Federal Register as a regulation, would have required notification of all parents of teenagers seeking family planning information or services. Although the courts have thrown it out (because the Administration failed to follow proper regulatory procedure), the President is trying to amend the law.

While Title X remains the major source of funding for family planning services, a few states use some of the funding available through two of the block grants enacted in 1981, Maternal and Child Health (MCH, Title V of the Social Security Act) and Social Services (Title XX of the Social Security Act) to supplement family planning services. However as these block grants have to be stretched further to cover more programs, and even those states most committed to providing

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family planning services have been forced to reduce service sites and hours.

Medicaid covers contraceptive services and supplies by reimbursing private physicians and clinics for Medicaid-eligible patients. But funding for Medicaid was cut by $3.1 billion in fiscal year 1983-84, following by an additional slice of $1 billion for FY85. These cuts have meant millions of women are no longer ineligible for family planning, along with many other services (see below). Women who remain Medicaid-eligible often find it extremely difficult to locate a private physician willing to provide contraceptive services, since over half of all physicians refuse to provide them to Medicaid recipients.

Abortion

While the Reagan Administration and its allies can claim much of the credit for assaulting family planning through budget cuts and administrative acts, the attack on abortion services has long been one of the major causes of the New Right. The Hyde amendment, cutting off all Medicaid funding for abortions, was passed by Congress in 1977.

Certainly, having a sympathetic administration has helped. Recent legislative attacks on the right of women to choose not to bear an unwanted child include the Beard and Ashbrook Amendments. The Beard Amendment, attached to legislation which specified that all employer-sponsored health plans include coverage for pregnancy disability, excluded insurance coverage for abortion and related services. Thus even women with private health insurance would have been forced to pay out of pocket for abortions. The Ashbrook amendment outlawed reimbursement for abortion and related services for all federal employees, including those in the military.

Beyond the direct legislative attacks on abortion services, the Reagan Administration has helped to create a moral climate in which violent attacks on women seeking abortions and providers of such services have become almost routine in some areas of the country. The failure to encourage rigorous prosecution of those perpetrating this violence and other indications of tacit approval of such methods is a clear message of encouragement to the most extreme foes of abortion.

Despite these pressures, in 1982 approximately 1.6 million abortions were performed for women who had been unable to secure family planning services, or had experienced a contraceptive failure, or had little understanding concerning pregnancy prevention. Fifteen states plus the District of Columbia continue to provide abortion services for eligible women.

Prenatal Care

The Reagan Administration claims to be "pro-family" but just as its policies have savaged family planning and abortion programs, its actions in the area of maternal and child health have hurt pregnant women, now mothers, and babies. While many factors are associated with poor pregnancy outcome, it has been shown repeatedly that prenatal care with adequate nutritional support is the most important factor in preventing pregnancy complications and ensuring healthy babies.

While there were problems—most notably chronic underfunding—with many of the programs before 1980, there was a commitment to provide prenatal care to all women in this country. Three different programs were involved: Medicaid, the Title V Maternal and Child Health and Crippled Children's Program, and the community health centers and preventive health services programs.

The cuts in Medicaid funding have been absorbed through strict eligibility requirements with excessively low income standards, leaving millions of American women without any health coverage. In New York State, 2.9 million people—16 percent of the population—now falls in the medically indigent category, even though New York has retained the highest rate of Medicaid funding of any state in the nation.

The majority of women who are dropped from Medicaid are out of luck if they get pregnant, since cutbacks have left most other programs to provide services for them grossly underfunded and understaffed. In 1980, the Title V Maternal and Child Health and Crippled Children's Program reached nearly 12 million mothers and children. In 1981, Congress adopted the Reagan Administration proposal to create the Title V Maternal and Child Health block grant, with an 18 percent slash in funding. The block grant combined the Title V program with six other specialized programs: Sudden Infant Death, Lead Paint Poisoning Prevention, Genetic Screening, Hemophilia Treatment, Adolescent Pregnancy Services, and Supplemental Security Income Rehabilitation Services for Disabled Children. In each state these programs are now forced to compete with each other for limited funds.

Among the effects:

- In New York State, the elimination of Maternal and Child Health funding for Improved Pregnancy Outcome (IPO) programs.
- In Georgia, 25 percent fewer high-risk pregnant women will be served by special programs each year.
- In New Mexico, 35 percent fewer high-risk pregnant women and 1,000 fewer women in all will get prenatal care.

Every state has had to make similar choices; the effects on the health care of children have been equally devastating.
In FY83, Congress rejected the Administration's proposal
to fold the WIC program (Special Supplemental Food Program
for Women, Infants, and Children, providing baby formula,
diet supplements and checkups for poor pregnant and nurs-
ing women and small children) into the Maternal and Child
Health block grant. Congress did freeze the WIC budget,
which has meant that only one third of the eligible women and
children are receiving necessary services. Before the end of
FY84 another 500,000 people will join the six million left out.

The third area in which the Reagan policies have short-
changed the health of pregnant women (and of newborn in-
fants) is the cuts in community health centers and migrant
health programs.

Community health centers provide comprehensive care in
medically underserved urban and rural areas. The migrant
health centers provide care to migrant and seasonal farm-
workers and their families, a population which has cruelly high
infant mortality rates, and excess morbidity and mortality rates
at all ages. In 1981, five million people received comprehen-
sive care in 827 community health centers and 128 migrant
health centers. Heeding extremely heavy lobbying pressure,
Congress resisted a 1981 attempt to block grant all these
centers, but went along with 13 percent cuts in allocatons for
the community health facilities and 12 percent cuts in the
migrant health budget. In FY83 funding was held constant for
migrant health and the community health center program
received a five percent increase (far below the rate of health
care inflation). As a result of these reductions, in 1982 and 1983
725,000 people lost health services at 239 community health
centers and an additional 70,000 were denied care when seven
migrant health centers lost federal funding. The majority of
health center patients are women and young children; Most
of the women have no other source of care, especially when
pregnant.

Total Abandonment

All of these cutbacks have come at a time when more than
seven million Americans have lost their health insurance due
to unemployment. The consequences for poor pregnant women
have been especially devastating. In the poorest communities
of New York City, one quarter to one third of all pregnant
women are receiving inadequate or no prenatal care. In
Oregon, a survey of poor pregnant women showed that over
ten percent were not receiving prenatal care and more than 13
percent didn't know where they would deliver their babies. In
Detroit, public health officials attribute an "epidemic of infant
mortality" to the lack of prenatal facilities. As a direct result
of Reagan's policies, millions of babies—especially poor,
minority babies—are being born at increased risk of suffer-
ing from a whole host of health problems and, most shock-
ingly, at increased risk of not surviving to celebrate their first
birthday.

The health of women is not only linked to their reproduc-
tive status. As more and more women are thrown into pover-
ty, they are more likely to be afflicted by many physical and
mental health diseases.

The daily stress of trying to cope with too little money, the
occupational hazards of working at low-paying jobs, the in-
ability to see health providers early for primary and preven-
tive services, the fear amid threats to cut Social Security and
Medicare of surviving to an impoverished old age without
resources, all take their toll. It may be years before we fully
understand all the ways in which the Reagan program has
harmed women's health.

Maggie Block
The Health/PAC Bulletin isn’t Playboy or Time

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17 Murray St., New York, N.Y. 10007
Gauging the effects of Reagan-era health care cutbacks on the poor is a massive task which should be undertaken by the federal government. It hasn’t been. With our more modest resources, Health/PAC has done a quick and dirty sample survey of selected states; where relevant, we gathered information on their major cities.

We found that although the cutbacks in services for the poor started under President Carter, the policies of the current Administration have generally accelerated state moves to curtail access. Overall, we found cuts in Medicaid coverage, increased restrictions on eligibility for services, and a continued refusal by many of the states to establish a medically needy category to include individuals who are eligible for neither Aid to Dependent Children nor Supplemental Security Income. What follows are some of the points made by people we interviewed and in reports we read.

**Chicago, Illinois**

Although comparable cities spend five to eight percent of their budgets on health, Chicago allocates barely one percent. Even with progressive leadership on the Chicago Board of Health, such an austerity budget cripples the potential for reform.

**Increase in Hospital Dumping.** The most visible consequence of the past three years of health cuts under President Reagan and Illinois Governor James Thompson has been a more than 500 percent increase in the rate of emergency room transfers from private hospitals to Cook County Hospital, from less than 100 a month to 600-700.

**Restricted Eligibility.** Medicaid covers only 75 percent of those under the poverty level. In the past two-three years there have been drastic cuts in Medicaid, totaling more than $250 million. The most severely affected group is in the General Assistance category. Hospital coverage has been limited to $500 for the entire hospital stay (less than what most hospitals charge for one day of admission), thereby creating a whole class of “untouchables” with a “07” on their green (Medicaid) card. These people are denied hospital care; all outpatient services except renal dialysis, chemotherapy, and burn treatments; and all drugs except those necessary to keep them alive—curative drugs are not available.

**Effects of Cuts in Reimbursement Rates.** Before the $500 ceiling was imposed, Medicaid patients were viewed as financially desirable by private hospitals, which sought them out at the expense of the working poor and other uninsured groups. Now that their “business” is gone, a number of private hospitals in Chicago are facing imminent bankruptcy and hundreds of health workers have been laid off.

**Some Reversals.** A brutal budget-cutting policy of preventing 200,000 people from qualifying for Medicaid until they’ve spent six months paying out of pocket has been successfully challenged in the courts.

At Cook County Hospital, community and housestaff efforts won the addition of 261 new positions for 1984 to begin to offset the increased demands for public hospital services.

**Efforts to Fill the Gap.** Fragmented voluntary efforts have emerged, more a testimony to the great need rather than the systematic solution to problems President Reagan promised would evolve. For example, Basil’s Free Clinic is seeing 25-30 people per night. With considerable effort and ingenuity its staff has scraped together networks for backup lab services, yet it reports numerous instances of being unable to provide needed care—a patient with a probable brain tumor was offered tests to confirm the diagnosis, but informed in advance that follow-up medical and surgical care would not be given.

New coalitions have also been established. Some have brought private hospitals together with advocacy groups for poor people. Others, such as the Healthy Mothers, Healthy Babies Coalition (fighting against infant mortality), have put forward new agendas for the health system.

**Iowa**

**Restricted Eligibility.** Medicaid eligibility in Iowa is tied to ADC and SSI eligibility. Because the Reagan Administration has put a tight lid on the ADC program budget, the income ceiling for eligibility has been lowered and the payment level for a four person household has remained at $419 per month since July 1979 despite a 45 percent increase in consumer prices.

Although the two state-supported hospitals have not suffered much, the cracks in the system are getting larger and more obvious. The state legislature is now considering a medically needy program to cover the substantial number of medically

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*Information for this article was obtained with the assistance of Mardge Cohen, Patrick McClintock, Chuck Spradley, Michael Keys, and Rick Brown.*
indigent in the state who have no Medicaid coverage.

Unmet Needs. In January 1984, the Legal Services Corporation of Iowa conducted a survey of the health care needs of low income individuals in both rural and urban areas. They found: "...Physician and dental services were the most frequently needed medical services that were not obtained because of a lack of medical resources; 36 percent of all respondents indicated that they had needed physician and dental services that they could not afford. Over 41 percent of the elderly and disabled reported needing these services, as did 35 percent of those under age 21.

"Prescription drugs were reported as being needed but not obtained by 33 percent of the elderly/disabled respondents and by 24 percent of the under 21 category. Eye care followed with 34 percent of the elderly/disabled reporting that they needed such services and were forced to do without, while 20 percent of the under 21 reported eye care as an unmet medical need.

"Perhaps most significant, however, is the fact that among all respondents the highest frequency response occurred in relation to the need for multiple medical services. Nearly 49 percent of the elderly/disabled group reported multiple unmet medical needs, while roughly 43 percent of the under 21 category offered a similar response." ("Health Care Needs of Low Income Iowans," Legal Services Corporation of Iowa)

Alabama

Restricted Eligibility. Alabama has no medically needy program. As in Iowa, Medicaid eligibility is contingent upon eligibility for ADC and SSI. Among the cuts in the last three and a half years:

• In 1981 the number of hospital days allowed a Medicaid patient was 30. This was cut to 21 in 1982, and is currently 15 days.
• Prior to 1982 Medicaid recipients were permitted an unlimited number of physician visits. In July 1982 a ceiling was set of 12 per year, including both inpatient and outpatient visits. The number of outpatient visits has been limited to six per year.

The Impact on Children. Clearly such limitations have a severe impact on sick children, especially newborns who require almost continuous care. Until two years ago Alabama permitted exemptions from the ceiling on visits for sick children regardless of whether they were picked up as problematic in EPSDT developmental screening. The federal government strongly disapproved of this policy, so the state has said children must be referred through EPSDT screening, even though it is given only once a year in Alabama after a child's second birthday.

It's not clear where Alabama's poor are going to get care, especially those in rural areas where there is no health department and no public hospital. State legislators allocating block grants have not been sympathetic to preventive health programs. They have generally allocated funds to county health departments rather than to statewide programs. Last year a woman with a sick child was turned away from the Huntsville hospital because she couldn't afford the deposit and she was from out of the county. The child died 24 hours later from meningitis.

The Demise of the HSA. The former Governor, Bob James, terminated the Alabama Health Systems Agency, thereby clearing the way for corporate health chains. The HSA had forced the private hospitals to substitute quasi-Hill-Burton free care for the free care provided by the public hospitals. Since the HSA was eliminated the State Health Planning Agency has been much less aggressive in enforcing this commitment.

South Carolina

Restricted Eligibility. Access to health care has probably been the single greatest problem for low income South Carolinans over the past three years. Due to reductions in Medicaid, Supplemental Social Security Disability Insurance, and other public reimbursement schemes, and to the end of the Hill-Burton 20 year free care obligation for most hospitals (which received these funds in the '50s and '60s), providers have been limiting care for both Medicaid recipients and the medically indigent. Medicaid eligibility in South Carolina is linked to AFDC, hence only single parent families qualify.

Only 11 of the 47 counties have private physicians who will treat the medically indigent. Many hospitals ignore Hill-Burton obligations, knowing that the Department of Health and Human Services does next to nothing to monitor compliance.

In Charleston, the state-run medical school hospital has announced that it will no longer treat people who have no health insurance. In an attempt to limit care provided to the medically indigent, many hospitals have adopted policies which restrict admissions of the poor to those living within their geographic area. This has affected quality of care, since the poor are often denied necessary treatment at the hospitals best equipped to treat them. For example, last year a hospital in Columbia refused to accept the transfer from a smaller hospital of an 11 year old girl with spinal meningitis because she was indigent and from another part of the state.

Unmet Needs: Prenatal Care and Medication. Out of the 458 physicians statewide who treat pregnant women, only 42 will treat those unable to pay. Ten counties have no public clinics or private physicians willing to provide prenatal care to the poor. This in the state with the nation's highest infant mortality rate.

Even when the poor manage to see a physician, they may
be unable to afford necessary medication. Not all prescribed drugs are covered by Medicaid, and copayments are required for those that are.

**Los Angeles County, California**

**Restricted Eligibility.** California passed three laws in 1982 that made significant changes in the Medi-Cal program, ushering in a new era in health care for the poor:

1. Changes in benefits and cuts in reimbursement including: stricter controls on utilization, mandated prior authorization of specific services, limitation of some specialized services (e.g., drugs and vision care), and a change in the definition of medical necessity. Medi-Cal now denies payment for any elective medical or surgical procedure unless such denial will likely result in significant disability or loss of life. Benefits have also been reduced by increasing co-payments and eliminating certain categories of recipients.

2. Changes in eligibility and transfer of responsibility for the 280,000 MIA's (medically indigent adults) from the state to counties.

3. Selective contracting with hospitals and physicians which includes negotiated rates of reimbursement rather than reasonable cost or fee-for-service reimbursement.

**Consequences.** Preliminary consequences largely attributable to these changes have been noted by Christopher Bellavita, one of the authors of a report on Medi-Cal legislation.

1. The number of people eligible for Medi-Cal in Jan. 1983 decreased 12.7 percent from the previous year. Medically needy eligibles decreased 26.5 percent from last year. (Medically indigent eligibles have decreased 72.2 percent from Dec. 1982, reflecting the elimination of MIA's from Medi-Cal.)

2. Many clients are confused and fear for their health.

3. Some clients appear to be delaying care: Community clinic personnel and private practice physicians report that patients are coming in noticeably sicker than in the past. As one physician with a substantial number of Medi-Cal clients put it, “People are sicker, blood pressures are higher, and diabetes is more out of control.” Physicians reported cases of patients waiting before seeking care until abdominal pains, chest pains, skin conditions, cervical disease, ear infections, respiratory infections, and other acute problems were more severe.

4. Clients are not always taking needed medications: Clients are attempting to stretch their medications to make them last. Some pregnant women are not able to pay prenatal vitamins, and several cases were reported of patients with gonorrhea or pelvic inflammatory disease not being able to afford antibiotics. Sometimes the patients are unable to afford the copayments.

5. More physicians are withdrawing from Medi-Cal.

6. It is harder to refer clients to a specialist.

7. There are mixed results about the impact of service restrictions and the new treatment authorization request requirements.

   Women and old people have been hardest hit by the Medi-Cal changes, as they constitute the majority of persons using the program. There have been many reports of TAR denials for acute conditions that pertain to women's health problems.

   The old tend to be heavy users of services that are no long provided by Medi-Cal, such as hearing-aid services, prosthetic devices, non-emergency medical transportation, and certain drugs. Changes in the share of costs and TAR rules have caused a great deal of distress for the aged poor.

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Educat ing for Illness

by Nick Freudenberg and Miriam Kahn

E arly in 1981, just prior to his installation as President Reagan’s Secretary of the Department of Health and Human Services (DHSS), Richard Schweiker was asked what his highest priority in the new job would be. “As a two-milea-day runner,” he replied, “health promotion is going to be my highest priority.” A few weeks later at his Senate confirmation hearings, Schweiker said he wanted to be remembered as the Secretary who turned the emphasis of the Department from disease cure to disease prevention and health promotion.

President Reagan reaffirmed this commitment in a speech to the Health Insurance Association of America on March 13, 1984, noting that “disease prevention and health promotion are in all our interests, not only for people in the insurance business but for employees and employers throughout the wide spectrum of American enterprise... America can only be as strong and healthy as its people.”

How successful has the Reagan Administration been in advancing these aims? To answer this question requires a closer look at how the federal government gets involved in health education.

At the most direct level, Washington funds state and community health education programs. In addition, a variety of government agencies, including DHSS, the U.S. Department of Agriculture (USDA), the Environmental Protection Agency (EPA), the Occupational Safety and Health Administration (OSHA) and the National Highway Traffic Safety Administration (NHTSA) publish pamphlets and other health education materials. Finally, regulatory agencies such as OSHA, the Federal Trade Commission (FTC), and the Food and Drug Administration (FDA) issue regulations mandating what information manufacturers must provide to their employees and consumers. In each of these three activities, the Reagan Administration has significantly reduced federal involvement.

In 1981 the Health Education/Risk Reduction Grant Program, which had been the primary vehicle for funding state and local health education programs was consolidated with seven other programs into the Preventive Health (sic) block grant and funds were cut by 25 percent. In 1980 this program had paid for health education programs in neighborhood and community health programs, mainly smoking and alcohol abuse programs for young people. The active involvement of the Center for Health Promotion and Health Education at the U.S. Centers for Disease Control (CDC) ensured both certain standards of quality and the development of a data base that could be used to develop guidelines for future programs.

No longer able to provide direct funding, the Center for Health Promotion and Health Education has switched its mission to offering training and technical assistance to state and local health departments. While a few states have used the block grant to strengthen their health education efforts, others have used the money to make up for cuts in other health services. The lack of federal data collection and monitoring makes it difficult to estimate the overall reductions in health education services, a ploy frequently used by the Administration to mask its cuts.

While the President’s 1985 health budget calls for a small increase for the Office of Disease Prevention and Health Promotion (up $1 million from 1984), it proposes an overall decline in the resources for prevention. Added on to previous cuts, the 1985 budget is a prescription for unnecessary illness. For example, Bailus Walker, the Commissioner of Public Health of Massachusetts noted in Congressional testimony in early 1984 that federal monies for hypertension control (including health education) in Massachusetts have been cut over 40 percent since 1979.

Similar cuts in family planning, maternal/child health, immunization, tuberculosis, and other federal grant programs have undoubtedly led to reductions in health education in these areas. For example, in the 1985 Budget, the Administration seeks to eliminate 50 federally-funded public health advisers from state venereal disease programs. Public health advisers are the front line educators for VD victims; their counseling often determines whether a patient’s contacts get treatment or not. Reduced funding for the lead poisoning control program has led many local health departments to eliminate outreach workers whose function includes community education. Drastic cuts in allocations for neighborhood and community health centers have forced many clinic administrators to fire “non-essential” staff such as health educators. Increasing caseloads and a declining budget (when corrected for inflation) have cut into nutrition education by the Women, Infant and Children Program.

Direct funding for health education, however, accounts for only a small part of the federal health education effort. The government is a major distributor of pamphlets, films, and other materials. The following examples illustrate the Reagan
Administration's policies regarding getting information on health to the public:

- In 1978 the USDA and the Department of Health, Education and Welfare (forerunner of DHHS) issued a booklet called Dietary Guidelines, which urged people to avoid too much fat, eat foods with adequate fiber, maintain ideal weight, eat a variety of foods, avoid sugar and sodium, and drink alcohol only in moderation. In two years more than seven million copies were distributed free of charge. Another USDA booklet, Food, offered advice on how to follow the guidelines. More than a million free copies were distributed.

Shortly after taking office the Reagan Administration set up a new panel dominated by food industry representatives to rewrite the dietary guidelines. It gave the American Dietetic Association (ADA) the right to re-issue the Food pamphlet, which ADA then sold to the public for $7.50 per copy. Fewer than 20,000 copies were distributed in two years.

- In 1982 Secretary of Agriculture John Block fired five out of seven employees from the Food and Nutrition Information Center. Responses to requests for information dropped from 12,000 a year to 7,000.

- In 1981, Reagan's OSHA director, Thorne Auchter, ordered 100,000 copies of a booklet on brown lung disease destroyed, calling it "offensive" and "biased"; he particularly objected to a photograph of a textile worker suffering from brown lung disease. After a public outcry, Auchter agreed to release the pamphlet, but without the cover photograph—a change which made the publication less likely to attract the attention of workers.

Auchter also stopped distribution of three films commissioned by OSHA on the grounds that they were inflammatory because they advised workers of their rights under the law and showed successful struggles for improved working conditions.

- The OSHA New Directions program, set up in the Carter years to fund worker education on health and safety, had helped many national unions developed innovative health education programs. Between 1981 and 1983 the budget for New Directions was reduced from $13 million to $6.8 million.

- In the last days of the Carter Administration, the National Highway Traffic Safety Administration issued The Car Book, a guide that listed crash test results, defect recalls, and other consumer information by make and model of car, offering car owners a unique opportunity to consider the safety features of the car they planned to buy. More than 1.5 million copies of the first edition were requested by the public. The Reagan Administration refused to reissue the book and has canceled publication of several other safety pamphlets.

What Need Not Be Revealed

Federal regulatory programs also influence what the public learns about health. For example, the FDA regulates drug advertising, the FTC regulates food advertising, and OSHA decides what workers learn about occupational hazards. Again, the record shows that the Reagan Administration has consistently weakened safeguards (see the occupational safety and health survey for the OSHA story).

Since 1968 the FDA has required that patient package inserts (PPI's) be included with a few commonly misused prescription drugs (for example, oral contraceptives and isoproterenol inhalation products). These pamphlets include information on how to use the drug, its side effects, and possible adverse reactions. In 1974 the FDA initiated a study to determine whether to require PPI's for all prescription drugs. Based on its research, the agency decided in 1980 to require inserts for ten drugs that constituted 16 percent of all prescriptions. In 1981, however, after meeting with a delegation from the American Pharmaceutical Association, Secretary Schweiker chose not to enforce the new regulations. In keeping with the President's belief that responsibility for health information should be left in the private sector, the pharmaceutical industry was allowed to prepare its own inserts.

"It appears quite clear that the Bureau has abandoned any effort to deal systematically with food and nutrition advertising."

Michael Pertschuk

The FDA has also ruled that the food industry need not label the sodium content of all foods. Contents must be listed only if a company makes a nutritional claim for a food or provides a nutritional label. Noting that sodium is an important contributor to hypertension, a disease that afflicts 60 million Americans, the Center for Science in the Public Interest, supported by the American Public Health Association, has filed suit against the FDA position, charging the agency is abdicating its responsibility to inform the public of a major health risk.

The Federal Trade Commission (FTC) is the government watchdog over unfair business competition and deceptive trade practices. But after three years under Chairman James Miller, a Reagan appointee, the agency has become more like a lapdog of the food industry. Between January 1981 and October 1982, its staff was cut by 34 percent, significantly reducing its ability to monitor food advertising. "It appears quite clear that the Bureau has largely abandoned any effort to deal systematically with food and nutrition advertising," commented Michael Pertschuk, a dissident FTC Commissioner. FTC consumer protection chief Timothy Muris justified reductions in requirements for consumer information by claiming that "increasing the amount of information in the marketplace is not always beneficial. Because information is expensive to procure, disseminate and use, we can sometimes provide too much information... (making) consumers worse off, not better off."

In the United States today, disease educators, those who seek to convince the public to engage in habits or practices that damage health, are far more powerful and wealthy than health educators. Only the federal government has the resources to challenge them. But rather than strengthening our ability to make better informed choices about health, the Reagan Administration has consistently weakened regulations, reduced access to impartial information, and cut back programs that educate and empower people. Increasingly, the responsibility for health education is being turned over to the private sector, whose primary aim is to convince people to buy its products whatever their health consequences. Four more years of the Reagan Administration will guarantee a growing epidemic of health illiteracy, and a growing burden of preventable diseases.

Health/PAC Bulletin
Ronald Reagan opened the International Olympics for the Disabled on June 17, 1984 in Nassau County by telling the athletes of their courage and commending them for their strength of character in the face of their disabilities. Disabled people, he said, had much to tell the rest of the world about the will to succeed in spite of adversity. Reagan's platitudes are familiar comments by presidents on such occasions, and they merely embody the common stereotype of the successful handicapped person as a hero—contrasted with the more prevalent stereotype of the helpless, hopeless, tragic handicapped person.

For an Administration championing individualism, self-improvement, and Horatio Algerism of rising from rags to riches, people with disabilities conveniently epitomize American capitalist mythology. Any competent, employed disabled adult signifies that people can succeed in spite of odds, for if that "poor cripple" can make it in the world, anyone else can too. Thanks to the Reagan Administration's policies of slashing services and civil rights, any disabled people managing to live dignified, communal, productive lives do testify to the Reagan philosophy—for they cannot thank the Reagan administration for any improvement in their lives and can thank only their collective political efforts from preventing their situations from radically deteriorating.

"Never before... have we have a national government waging a campaign against persons with disabilities," said Gunnar Dybwad, an internationally-recognized professional in work with the disabled.

Before sketching the impact of the Reagan years, however, it is important to provide the context in which to evaluate Reaganism. The decade of the 1970's dramatically changed the situation of people with disabilities, finally giving this minority of 36,000,000 people some recognition of their civil rights, and beginning a consensus in the field of disability that rights precede services and that such services as people need flow from an understanding of and commitment to rights to citizenship, community living, education, employment, and political participation.

It may surprise even health professionals to realize that some 15 percent of the nation is considered to have a substantial impairment of some major life activity such as seeing, hearing, moving, caring for personal needs, thinking, learning, and working; to have a history of such an impairment; or to be regarded by others as having such an impairment. The Rehabilitation Act of 1973 established the foregoing definition of a handicapped person for the purposes of service-provision and civil rights protection.

Although people with disabilities and professionals in the field differentiate among the terms "impairment," "disability," and "handicap," for the purposes of this discussion the terms will generally be used interchangeably. The estimate of 15 percent derives from such sources as the 1979 Health Interview Survey and the 1980 US census. While the percentages differ from survey to survey, there is reason to believe that variations in methodology may account for conflicting estimates, and the 15 percent, or 36,000,000, is an accepted estimate of prevalence.)

It is believed that ten percent of school-age children have a disability, that nine percent of the working-age population aged 16 to 64 reports a work disability, and that nearly half the population over 65 years of age has a handicap. Handicaps include not only the typically understood variety of deafness, blindness, orthopedic impairment, mental retardation, and mental illness, but such less commonly thought-of conditions as heart, lung, respiratory, and back problems, cancer, alcoholism and drug addiction, arthritis, diabetes, epilepsy, emphysema, obesity, and more. Persons with such conditions require medical services to treat and ameliorate their impairments and also use rehabilitation, special education, and other services in order to cope with the residual effects of disability.

Because contemporary medical care is customarily fragmented and specialized, health educators and health workers performing in acute or preventive care settings rarely learn much about the needs, lives, and potential of handicapped people once they leave the acute care phase; rehabilitation workers, medical sociologists, and disabled people themselves all attest to the fact that physicians are often as ignorant as the general public about the situation of people with disabilities.

Typically, handicapped people were thought to epitomize the sick role. They have been seen as perpetual patients,
perpetual users of services, dependent upon charity, unable to participate in customary social or work activity, and grateful for anything doctors, nurses, therapists, counselors, relatives, the government, or private philanthropy did to make their tragic lives more bearable. The growth of a vigorous civil rights movement of disabled people, the passage of legislation guaranteeing rights to treatment, education, and rehabilitation for the most severely disabled, and protections against employment discrimination whenever federal money was involved or whenever the federal government itself was the employer—all have drastically changed the way government looked at disability and the way service-providers and disabled people viewed themselves.

Disabled people have asserted that limitations in one area of life did not affect all areas, and therefore the notion that they were unable to participate in life because they were disabled was inaccurate and discriminatory. As a corollary, disabled people have insisted that health, education, and rehabilitation professionals work with them rather than do for them. They have criticized the paternalist attitudes with which they were met, in much the same manner as women, minority group members, and the general public has criticized the health establishment.

It was at this point that the Reagan Administration entered the lives of people with disabilities, just as they had begun to obtain some respect from the federal government and service-providers and just as they had begun to leave institutions, segregated schools, and sheltered employment to take their places alongside the rest of the nondisabled community. And just as Reagan's policies have harmed all but the upper class of the nation, they have harmed the disabled; in addition, certain services for and rights of disabled people have been particular targets of attack.

Creating Disability
It has been argued that the ghetto and the factory create a substantial portion of U.S. disabilities. By cutting back on such programs as school breakfasts and lunches, by forcing the closing of clinics for pregnant mothers and young children in poor areas, by failing to expand Medicaid, Medicare, and Food Stamp programs to keep pace with inflation, and by failing to vigorously enforce occupational safety and health regulations, Reagan's policies have undoubtedly increased the incidence of disability—especially in the poorest segments of the population. Moreover, the Reagan Administration's inaction on cleaning a polluted environment has aggravated poor health and promises more disabled individuals.

Disability Programs
Those already dependent upon financial benefits and rehabilitation services because of disability have been hurt by Reagan's policies. Many recipients of Supplemental Security Income and Supplemental Security Disability Income were removed from the rolls under orders to cut outlays. The simplest method of reducing expenditures was to determine that thousands of people were really not so disabled as to prevent them from working. Undoubtedly, millions of disabled people are unemployed or underemployed who could work absent discrimination, architectural and transportation barriers, and lack of education and skills. Many SSI and SSDI recipients would welcome the opportunity for productive employment, but withdrawing benefits without providing commensurate education services at a time of the highest rates of unemployment in decades constitutes cruelty and mocks them.

Block grant funding hurt all categorical health and social programs, and Reagan's attempt to place funding for rehabilitation and education for the handicapped in these grants would undoubtedly have ensured that these programs and their beneficiaries would have received far less than their fair share of dwindling federal dollars. Fortunately, disabled people, nonprofit service agencies, and Congress kept their funding separate.
Despite this victory, these programs are further than ever from achieving the goals mandated for them in the 1970's by Congress and presidential administrations. Funding for the National Institute on Handicapped Research has been cut; many of the advocacy programs and demonstration projects begun in the 1970's have lost their federal funding and slashed their staffing and services. Under Reagan, Congress has never seen fit to appropriate mandated funds for services such as post-employment assistance to the handicapped; mandated client assistance programs, which added rehabilitation clients in getting the most out of the system in the same way welfare rights organizations of the '60's and '70's taught the poor to fight through the bureaucratic maze, have been curtailed rather than expanded.

The Berkeley Center for Independent Living, hailed as a model as self-help and advocacy for people with disabilities, had to drop its dynamic deputy director and several other members of its professional staff and close innovative programs such as those training severely disabled people in computer work and placing them in competitive employment. It now retains only a skeleton staff and the rudiments of its advocacy, counseling, wheelchair-repair, attendant, and housing referral services.

Civil Rights

Civil rights is the area where the Reagan Administration has struck its biggest blows. During the past four years, Supreme Court decisions and Justice Department interpretations have narrowed the conceptions of rights to treatment and education which had prevailed since the middle 1970's.

In a Pennsylvania case, the Department of Justice rendered an opinion that the rights of state-institutionalized retarded citizens extended only to maintenance and not to treatment and education. Similarly, the Supreme Court decided that since Amy Rowley, a nine year old deaf student was “passing from grade to grade,” she did not need interpreter services, without which she missed more than half of what transpired in her public school classroom. With these services, she might well have achieved the high grades promised by her tested and undenied intelligence and motivation. These two rulings have told the nation that for Reagan it is enough to house the handicapped and let them sit and pass on from year to year. Nothing mandates a state obligation to provide the treatment and educational services which would mitigate the effects of their disability and assist them in obtaining the skills needed for fulfillment and productivity.

In 1983 Reagan's Task Force on Regulatory Relief tried to decimate the civil rights protection in education, services, and employment won under the Education for All Handicapped Children Act and Section 504 of the Rehabilitation Act of 1973. The proposed less stringent regulations would have permitted the federal government and recipients of federal dollars—such as schools, clinics, social agencies, hospitals, senior citizen centers—to refuse service to disabled people if they could show, among other things, that serving them would distress nondisabled users. In effect this would have meant that the disabled have no entitlements and rights, but only those possibilities of service, education, and employment nondisabled people wish to bestow upon them. The disabled would have lost virtually all they had gained over the past two decades and been reduced once again to charity recipients and not even second-class citizens.

However, Reagan had misjudged the ability of disabled people to mobilize to retain what measures of dignity and citizenship they had achieved. Thousands of letters poured into Congress and the White House and Reagan withdrew his proposal. Disabled people had been victorious.

Reagan and Baby Doe

Reagan's best-known actions on behalf of people with disabilities have been on behalf of newborns who, because of disability, might not receive medical care for their conditions if parents or physicians chose to withhold it. This has won him applause from the Right to Lifers, but as can be seen from the foregoing, the President's interest in people with disabilities stops after they leave the intensive care unit. Unfortunately, this issue has also divided progressive forces. The Left, through opposition to Reagan in general and his encroachments upon the right to abortion in particular; the women's movement, fearing erosion of the right to choose, and convinced that the disabled defective child is a double “burden” to women; and the health care establishment, wary of still more government intrusion upon its methods of practice, have all disparaged the Reagan Administration position and the babies he would save. Disability rights groups, on the other hand, believe that these babies, like all disabled children and adults, deserve access to quality health care, education, and rehabilitation, and equal opportunities with the nondisabled. This is the promise of the '60's and '70's which we must return to and expand.
The Reagan Administration has made its attack on Medicare through a steady and escalating effort to reduce expenditures by directly and indirectly shifting the costs of the program to the beneficiaries, the elderly.

The direct shift has been through increases in what is euphemistically called the “cost-sharing” aspects of Medicare: deductibles, co-insurance for inpatient hospital services, and deductibles, co-insurance plus a premium payment for physician services (Part B).

Indirectly, the Administration has supported measures that have limited Medicare payments to health care providers, particularly hospitals, without offering much protection against policies of restricting access to Medicare patients or passing on to them charges not covered by the Medicare program.

Cost-sharing Changes

Since 1981, there have been two pieces of legislation which have contained the major increases in cost-sharing. The Omnibus Reconciliation Act of 1981 (OBRA) included:

1. an increase in the Part B annual deductible from $60 to $75;
2. elimination of the Part B deductible “carry over” that enabled beneficiaries to apply medical bills in the last three months of a year to the next year’s deductible;
3. an increase in the factor used to calculate Part A deductible and co-insurance increases, thus accelerating their rate of annual increase.

In 1982, the second wave of cost-sharing increases occurred under the Tax Equity and Fiscal Responsibility Act (TEFRA). They included:

1. an increase in the monthly Part B premium from $14 to $15.30, due to the introduction of automatic increases in the premium at a rate sufficient to cover 25 percent of Part B program costs. (Previously, the rate of increase of Part B premiums had been the same as the increase in Social Security payments.)
2. a decrease in the payment to hospital-based radiologists and pathologists from 100 percent to 80 percent of the amount billed, without any limitations on the patient being billed for the amount Medicare no longer pays.

While these changes increased beneficiary costs, TEFRA did add hospice care as a benefit under Medicare. However, the regulations were not published until early 1984 and are very controversial due to the stringent conditions of participation and the low reimbursement rate.

An elderly person covered by Medicare must now “share” the following costs out of his or her own pocket:

1. Physical Services (Part B)
   - $75 annual deductible
   - $184 annual premium payments ($15.30 per month)
   - plus 20 percent of all charges to Medicare, after the deductible
   - plus the amount of all charges above what Medicare pays (about 50 percent of physicians charge patients more than Medicare pays);
2. Inpatient Hospital Services (Part A)
   - $356 deductible for first day of hospitalization
   - $89 deductible for each day from the 61st to 90th day of hospitalization;
3. Nursing Home Care
   - $44.50 for each day from the 21st to 100th day when Medicare coverage ends.

Table 1 shows the steady increase in the out-of-pocket liability for Medicare beneficiaries since 1981.

These costs have to be added to the sizable out-of-pocket payments the elderly make to purchase services and items not covered by Medicare, such as eyeglasses, hearing aids, outpatient drugs, and nursing home care after the 90th day. Right now Medicare pays about 40 percent of the per capita health care costs of the elderly.

In addition, there is the cost of “medi-gap” insurance premiums, for those who can afford to purchase private insurance to partially or fully cover the copayments and deductibles under Medicare. About 65 percent of Medicare beneficiaries purchase very expensive supplementary insurance—currently as much as $600 a year, and the rates increase as the copayments and deductibles increase.

All in all, the elderly are now using about 20 percent of their income to purchase health services, about the same proportion they were paying before Medicare was enacted.

Reagan has more increases on his agenda. For example, in FY1984 the Administration proposed, but did not succeed in getting:

1. increases in Part B premiums so that they will cover 35 percent, instead of the current 25 percent, of Part B program costs;
2. a deductible for the second through the 60th day of hospitalization. After 60 days catastrophic coverage would pay the remainder of the bills. (About one percent

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TABLE 1
Summary of Deductible and Co-insurance Amounts under Medicare's Hospital Insurance Program
1981-1984

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<td>Inpatient Hospital</td>
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<td>Deductible</td>
<td>$204</td>
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<td>Inpatient Hospital</td>
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<td>21st through 100th days</td>
<td>$25.50</td>
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of Medicare patients have more than a 60 day hospital stay.)

3. a voluntary voucher program, enabling beneficiaries to buy private insurance in lieu of Medicare;
4. copayments for home health services.

Another proposal discussed, but not included in the budget, was to make Medicare a means-tested instead of a universal entitlement program.

Changes in Hospital Payment

The most drastic change made in Medicare during the Reagan years has been the restructuring of the Medicare payment to hospitals from a per diem rate based on the reasonable costs of services provided to a prospective payment system (PPS) which sets a specific rate for each discharged patient based on the patient's diagnosis (see Health/PAC Bulletin, March-April 1984).

Paying for hospitalizations at a fixed price per case creates strong incentives for hospitals to:
1. reduce the cost of a hospital stay for a Medicare patient;
2. admit elderly patients that have less complicated medical and nursing problems;
3. increase the number of Medicare admissions while decreasing the number of days each patient stays in the hospital;
4. shift the costs not covered by Medicare to private insurers and private pay patients;
5. avoid admitting patients who cannot pay for their hospital stays.

For hospitals with a high proportion of Medicare patients, there is considerable financial pressure to respond to these incentives. Nationally, 10.4 percent (613) of all community hospitals receive at least 45 percent of their operating revenue from Medicare. These hospitals are primarily not-for-profit institutions with fewer than 200 beds, located in non-metropolitan areas. However, many hospitals heavily reliant on Medicare revenues are located in urban areas where they are major sources of care for the elderly. They are also likely to be primary sources of care for the indigent and, therefore, already feeling considerable financial stress. since PPS does not make any allowances for any individual hospital's needs, reduced Medicare revenue may force them to close.

Changes in Physician Payment

Congress, with the support of the Administration, included in its recent deficit-reduction legislation (HR4170) a freeze on Medicare charges for physicians' services for 15 months beginning July 1, 1984 and ending September 30, 1985. The legislation also contains various incentives for physicians to accept assignment—that is, accept as full payment what Medicare gives for their services. The legislation includes a provision which gives the Secretary of Health and Human Services the authority to impose civil penalties or debarment from the Medicare program on physicians who do not accept assignment if they increase their actual charges during the freeze period.

It had been predicted that the fiscal year '84 would be "the year of the doctor" as FY83 was "the year of hospitals" in terms of cost containment legislation. The temporary freeze on fees may be a way of testing the waters for possible reaction to further and more aggressive efforts to control physicians fees and participation in the Medicare program.

It is hardly a secret that the Reagan Administration's radical restructuring of federal income and expenditure policies and priorities has affected most harshly those with the least political power—women, the aged, children, the poor, ethnic and other minority groups, and the handicapped. They have suffered unemployment, service reductions, and even, according to Johns Hopkins Professor M. Harvey Brenner, increased morbidity and mortality. But perhaps none of these groups has suffered under the present Administration as much as have the mentally ill.

For a long time the mentally disabled have been at the "bottom of the heap" as recipients of services. They have been the last to receive proper care and, in times of budget cuts, the first to be deprived of whatever services were available. All too often they are not even recognized as disabled—after all, their disability is more or less invisible: they use no crutches, wear no dark glasses or hearing aids, and generally bear no physical signs. Yet they are frequently more handicapped in daily functioning than those with these visible cues to disability.

Darinian Self-Help

Among the complex of factors that has helped to make the mentally ill especially at risk and vulnerable to the policies of the Reagan Administration is the argument that aid to business interests will "trickle down" to the benefit of the rest of the society, and that a return to private philanthropy should replace many governmental support services. This ideology has justified the Administration's draconian use of a variety of cost-cutting measures. For example, enforced homelessness has become a major cost-containment device in care—or rather, noncare—of the mentally ill.

In the past a coalition of advocates for the mentally ill has pressed for what has been termed "deinstitutionalization." Among them have been psychiatric reformers, some of whom have envisioned a network of community-based services as replacements for large, remote, mental hospitals where patients were said to be "warehoused" for years. Other advocates have maintained that mental illness is a myth, and/or that the illness is in the society, not in the individual patient; still others regard mental illness as a form of social deviance; still another group was the civil libertarians, who consider psychiatric treatment, especially if involuntary, an infringement of the patient's rights. The "enemy" of all these advocates was the asylum, or mental hospital. Removing the patients from the hospitals, or "deinstitutionalizing" them, was supposed to go a long way toward improving the patients' condition, and little or no preparation was made for giving them the sort of rehabilitative aid and daily care that would eventually enable them to cope once more with life in society, to hold some sort of job and enjoy a decent standard of living.

The reformers were pushing on an open door. Another group was also part of the deinstitutionalization movement: the proponents of cost containment. As early as the Nixon years, they decided that funds could be saved by placing the mentally ill in facilities less costly than mental hospitals, e.g., boarding or nursing homes.

Deinstitutionalization might be said to have "succeeded." The United States has reduced the number of mentally ill in state mental hospitals more than any other industrialized country except Italy, which is a special case. Fewer than 25 percent remain in mental hospitals. In 1955, the year the exit movement began, there were an estimated 559,000 persons in mental hospitals; by 1980, their number had decreased to about 138,000.

Until 1980, the mentally ill leaving the asylums were referred to boarding or nursing homes or to low-income, subsidized housing. Since then, funds for subsidized housing have increased, and the supply of low-cost housing has largely disappeared. Because of a shortage of beds and a reduction in funding, private nursing and boarding homes, about half of whose residents are former mental patients, have become increasingly selective about which of the mentally ill they will accept. These and other factors have resulted in an enormous increase in the number of homeless mentally ill.

Since 1980 a number of policy and legislative changes have also had a tremendous impact on the living conditions of the mentally ill. On assuming office, the Reagan Administration quickly moved to rescind the Mental Health Systems Act of 1980. Passed in the last days of the Carter Administration, it would have mandated a federal-state effort to improve care of seriously mentally ill children and the elderly. Following its rescission, Congress passed the Omnibus Budget Reconciliation Act, which combined previous categorical funds for services in mental health, alcoholism, and alcohol and drug abuse into one block grant.

Despite continuing inflation, funding for mental health has remained at the level budgeted for 1982, and a 25 percent
reduction is scheduled for this year. Under legislation sponsored by the Reagan Administration, mental health centers are no longer required to provide inpatient services, follow-up care, transitional care, or any evaluation of their services. Under the block grant arrangement, states are allowed to choose which services they will provide. In effect, they are receiving less money and are expected to furnish more services.

The results have been predictable: the states have used the available funds to provide services to the groups with the most political clout—and again, the mentally ill have had the lowest priority.

In addition, cuts have been made in staff and programs at the National Institute of Mental Health. This has reduced monitoring of mental health centers for compliance with the service requirements mandated by earlier legislation. Documentation services have also been slashed, making it more difficult to evaluate the effects of the cutbacks.

Cuts in Medicaid have also affected the mentally ill, reducing the care provided during periods of hospitalization in general hospitals. Hospitals have reacted to Medicaid reimbursement cuts by limiting the length of stays to 12-15 days per admission. Since the average length of hospital stay for the major psychoses in 1980 was 15 days, hospitals have been under pressure to discharge patients rapidly or risk providing non-reimbursable care. Premature discharges may, moreover, have substantially increased the risk of homelessness among the mentally ill.

Still another blow was the Reagan Administration's directive, again immediately after taking office, to review payments to recipients of Social Security disability benefits. Despite increased unemployment, the Administration maintained that disability standards had been set too low, and that many of the disabled could and should be working.

The result was massive dumping of the disabled, more than half of whom were people with serious psychosocial disability resulting from mental illness. After more than 470,000 had been removed from the disability rolls, the Administration declared an election year moratorium on further reviews.

Even so, the damage for tens of thousands of formerly mentally ill people will not soon be remedied. Often barred from seeking review of their loss of benefits by the very nature of their disability—their difficulties in, or anxiety about, interpersonal situations—the mentally ill have been forced to seek public assistance at much lower levels. Tens of thousands of them have had to try to find housing that they could afford, but many have not been able to relocate and have swelled the numbers of the homeless, half of whom are mentally ill.

Many of the cost-savings techniques employed by the Reagan policy makers have been used by previous administrations. What is new is that both deinstitutionalization and homelessness are now, in effect, used as cost-saving or cost-containing devices. At an estimated cost for state hospital care of $51,000 per year and $18,000 in a community residence (Goleman, D. "Lawsuits try to force care for the mentally ill," New York Times, Feb. 1984) current "savings" in not providing services to this group exceed $18 billion per year.

No other industrialized nation has reduced its mental hospital census as rapidly or has left such a large proportion of its citizens homeless as the United States. Even in the United Kingdom under Margaret Thatcher, the number of mental hospital beds has been reduced by only one half, and this reduction has been accompanied by a concomitant increase in hostels and rehabilitative facilities.

For most of the mentally ill, the Reagan years have been calamitous. Even if these people wanted to vote against the Reagan policies, many could not since they lack an address, which is a requirement for registration. More than a million are estimated to be homeless, and others have been relegated to cheaper institutional care—boarding or nursing homes or, in some cases, jails. (Interestingly, whereas in 1956 only 120,000 persons were incarcerated in U.S. jails, prisons, and other correctional facilities, there are now over 500,000 inmates—an almost exact reversal of the figures for confinement in mental hospitals.) Moreover, vocational training and other rehabilitative measures for the mentally ill have been sharply reduced, and jobs for them are exceedingly scarce. Among the seriously mentally ill, the unemployment rate may be as high as 90 percent, higher than for any other category of the disabled.

The coalition that once fought to release the mentally ill from antiquated mental hospitals has fragmented. Among the groups that are still pressing for the rights of the mentally ill, however, are the National Alliance for the Mentally Ill, a group composed of members of the families of the mentally ill. This group, as well as the Mental Health Law Project in Washington, and the Coalition for the Homeless in New York, has fought, and is still fighting, to restrain the Reagan Administration from further denying disability benefits and adequate care to the mentally ill. More, many more groups are needed to resist proposed congressional measures to help reduce the Federal deficit by reducing care to the mentally ill.
Since it took office, The Reagan Administration has consistently taken protections away from workers and given management a freer hand to deal with these issues as it wish. Sometimes this has been accomplished by failure to act, in other areas it has involved rescinding measures already in effect.

Standards
In 3 1/2 years, OSHA has issued no final standards for any previously unregulated substance, despite urgent requests that it do so, as in the case of formaldehyde and ethylene dibromide. A majority of the health standards which OSHA had issued on its own since its establishment in 1971 were revoked, withdrawn for review, or postponed for some time or permanently since 1981.

As a result of heavy public pressure, a relatively weak emergency temporary standard for asbestos was promulgated. (This has since been revoked by a U.S. Court of Appeals.) Under direct mandate of a U.S. court imposed deadline, OSHA was also compelled to issue an ethylene oxide standard. An already weak Carter Administration standard for hearing conservation was revoked and replaced during this Administration by an even weaker standard emphasizing use of earplugs and earmuffs for workers rather than noise abatement.

Almost 200 advisory health and safety standards, which recommended rather than mandated improved employer practices in worker training and education and many other areas, have been revoked.

The Right to Know
When it took office, the Reagan Administration promptly revoked one of the most important worker rights measures of recent years, the federal "Right to Know" standard. This required management to tell employees the identities of hazardous workplace materials through labels, posted warning signs, and Material Safety Data Sheets.

The labor, environmental, and public health movements responded by demanding their states, cities, and other local authorities guarantee workers the right to know what they are being exposed to on the job and extend this vital right to other citizens in their communities. As these state and local movements gathered momentum, large corporations became nervous and the Reagan Administration reversed its old hands-off, "leave it to the states" policy. OSHA proposed what it had previously revoked, a (weak) federal "Hazard Communication" standard which repealed all state and local Right to Know laws. The new federal standard is only for manufacturing workers, whereas most state and local laws it pre-empts cover the vast majority of workers and often a large proportion of the general public. This action is being contested in the courts by several state governments.

Enforcement
Soon after taking office, OSHA director Thorne Auchter simply rewrote the enforcement procedures for the OSHA Act, using the vast powers accorded the director under its provisions.

On Oct. 1, 1981 Auchter announced without fanfare the following changes:
• The elimination of all routine safety inspections of plants and businesses with ten employees or less. This category includes more than half of all U.S. manufacturing plants.
• The elimination of routine safety inspections for all larger manufacturing plants if their annual lost-time injury rates are less than or equal to the national average injury rate for all manufacturing industries. This exempted 73 percent of the plants with more than ten employees, according to Auchter's testimony at the time.

The consequence is a new category of "paper chase" inspections: an inspector enters a plant, inspects the company's OSHA logs, compiled by management, and leaves if the reported injury rate is lower than average. According to OSHA records, this now counts as a plant inspection, even though the inspector has never set foot on the shop floor or spoken to a worker.
• A system of authorizing health inspections based on comparisons of an industry-weighted index to a published list of indices for all industries. This system was virtually drawn out of a hat. It was proposed in a study by a single consulting firm and had never been discussed at a public hearing. The data it is based on is very uncertain, and probably could not stand up to public or scientific scrutiny.

These sweeping changes were only the beginning. Five months later OSHA moved to downgrade investigations of worker complaints about possible violations. Previously, OSHA inspectors were required to investigate worker complaints if a "violation or danger" existed. After Feb. 1, 1982 they were under orders not to investigate unless the alleged

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violation “threatened physical harm” or presented an “imminent danger.”

Four months later the Administration introduced yet another set of exemptions from routine safety inspections: If a plant has a lost-time injury rate less than the average for that particular industry, it can apply for a three-year exemption from routine safety inspections. Thus if a particular metal foundry, for example, reports a lower injury rate than the average of all foundries, it may become exempt from inspection even though it is still a very dangerous place to work.

Enforcement Statistics

Along with its cutbacks in enforcement activities, OSHA slashed its staff of inspectors. Between fiscal year 1980, the last full year of the Carter Administration, and FY1983, the number of inspectors dropped 31 percent. OSHA, with its current 880 inspectors, has jurisdiction over approximately four million workplaces.

A comparison of OSHA enforcement activities in the last year of the Carter Administration with FY1983 shows:
• Workplace inspections down 33 percent (paper inspections not included)
• Citations for serious violations down 47 percent
• Worker complaint inspections down 65 percent
• Total fines for violations down 78 percent
• Citations for willful violations down 91 percent

The average fine for an OSHA violation has dropped to $67, less than the price of a round-trip railroad coach ticket between New York and Washington.


Moving?

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One of the most striking (and worrisome) events of this political period has been the abandonment by the leadership of the Democratic Party of its commitment to some form of tax-based, comprehensive, and universal health program. Of the three Democratic candidates, only Jesse Jackson came out for it. Walter Mondale and Gary Hart seem to agree with the argument that the country cannot afford such a program or else, in common with large sectors of the Democratic Party’s leadership, they have bought the idea put forward by the Republicans and most of the media that what we witnessed in the 1980 election was a backlash against government expenditures and regulations: people wanted the government off their backs.

All available evidence, however, shows that the Democratic leadership and the media misread the country’s mood in 1980 and continue to misread it in 1984. A detailed survey of major opinion polls (Gallup, Harris, and others) from 1976 to 1983 shows continuous and undiminished majority support for an expansion, rather than a reduction, of health and social expenditures, and for strengthening rather than weakening government regulations in the health and social sectors. Furthermore, for over ten years now the majority (or a large plurality of Americans, depending on the year) have been in favor of a tax-based comprehensive and universal health program. The evidence is overwhelming that there is no popular mandate for the cuts in health expenditures enacted by the Reagan Administration and Congress. Pollster Louis Harris summarized people’s responses to these policies very well in his remarks to last year’s American Public Health Association conference when he declared that

"people all over the country have been profoundly shocked to find out that the people running the country seem to be in favor of segregation, seem to want to abolish abortion and birth control, seem to want to abandon the poor and the elderly and the minorities... and that the American people [think] that America could well be systematically stripped of all its compassion for decency and humanity... but they are just beginning to get fighting mad about it." 

Agreeing with the need to balance the federal budget, most Americans believe this “should be done by cutting down defense, increasing corporate taxes and not by cutting social (including medical and health) services.”

What Happened in 1980?

It is important to note that (a) at the time Ronald Reagan was elected, the polls were showing the same majority support for government interventions and (b) the majority of eligible voters did not vote for Reagan in 1980: they did not vote, or voted for other candidates.

To believe the victory of Reagan is an indicator of an anti-government wave in the country is (i) to go against all available empirical evidence, and (ii) to believe that Carter lost because he was perceived to be too much in favor of government, or (as it is trendy to say establishment-wide these days) because he was perceived to be too wedded to the old Democratic approach of solving problems by “throwing money at them.”

Carter lost for many reasons, but an important one was disenchantment with his “policies of austerity,” initiated in the middle of his mandate, back in 1978. It was then that he decided to postpone a push for national health insurance, a major component of the Democratic Party platform on which he was elected. Along with most of the media, he misread the success of the California Proposition 13 limiting property taxes as a sign of popular backlash against taxes and government.

This assumed tax revolt was a “media event.” Like most media events, it did not have much substance and merely reproduced the establishment’s perceptions of what then becomes the major components of the conventional wisdom. Professor P. Peretz, after analyzing all the polls from 1972 to 1983 in which people were asked about tax-related issues, concluded that there was no such tax revolt at the time of Proposition 13. Paying taxes has never been popular in the U.S., but a revolt would imply that the level of dissatisfaction had increased. All evidence shows this did not occur. At the same time that Proposition 13 was being passed in California, tax increase proposals were approved by large majorities in other states.

From 1978 on, Carter reduced the growth of social expenditures and began increasing the military budget. This explains why his job rating fell more precipitously from 1977 to midsummer 1979 in the opinion polls than that of any other president since polling on the subject began in 1945.

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didn't win in 1980, Carter lost. Reagan won practically the same percentage of eligible voters that Ford had in 1976. The Democratic percentage, however, dropped from 28 to 22.4

Needless to say, the Republicans, the Reagan Administration, and most of the establishment presented the election as an overwhelming mandate for Reagan "to cut the size of the government," the code term used to justify reductions in social expenditures. There was no such popular mandate. Actually, three years after taking office, Reagan had the lowest popularity rating of any president in the last 15 years. His recovery in the polls since then is in large degree due to the "economic recovery." As to his administration's assumed "anti-government position" the reality is that (1) during his mandate, the share of government expenditures in the GNP has increased (due primarily to the militarization of the federal budget), and (2) the authoritarian features of the U.S. federal government have dramatically increased, with a most substantial reduction of civil, union, women's, and ecological rights.

This expansion of government intervention in people's lives follows a predefined project. Henry Salvatori, a key member of the Reagan transition team, indicated that the purpose of the Reagan Administration should be "to establish a more authoritarian state." Contrary to the terms of the current ideological debate, the real issue in today's United States is not pro- or anti-government, but rather whose government and for what purposes. And the majority of Americans know it. We are witnessing growing tension between the political establishment and popular perceptions that this establishment is not meeting or responding to popular needs.5 This tension is particularly sharp within the Democratic Party, which has traditionally had a broader base than the Republicans.

If it accepts many of the Republican interpretations of the 1980's, the Mondale campaign cannot arouse the mass support and enthusiasm that is required to defeat Reagan. To make "federal deficits" the primary focus in economic discussions and "cost controls" the main issue in health debates is not a winning campaign. These are perceived to be managerial issues, not likely to raise hopes and expectations. The issues have to be seized in ways that affect people in their everyday lives. Cost controls should be put within the context of establishing an effective, humane, compassionate, and comprehensive health care system for all.

The Democratic leadership has to realize that the federal health agenda is still unfinished. Our government contributes the least to total health expenditures of any in the Western developed world. Government outlays represent 91.7 percent of all health expenditures in Sweden, 77 percent in West Germany, 76 percent in France, and so on. In the U.S., they make up only 42.7 percent.6 Not surprisingly, no other developed country faces problems like: 23 million people without any form of insurance coverage whatever; 25 percent of the unemployed (three million people) who have recently lost their insurance; 27 percent of the poor without any insurance including nearly six million children; one million families who have had at least one member refused care for financial reasons, and 88 million people who do not have catastrophic sickness insurance.7

The response of the majority of Americans as expressed in polls is loud and clear. Most think that the benefits of government regulation of medical service costs and charges outweighs the drawbacks; they support federal control of doctors' fees, hospital costs, and prescription drugs; they would be willing to pay even higher taxes if those taxes were spent on health services; and, as noted earlier, a majority or large plurality has supported the establishment of a tax-based comprehensive health program.8

Yet instead of expanding health coverage, the Republicans (assisted by a majority of the Democrats in Congress) are cutting federal health expenditures and strengthening the private sector by fostering the latest fashion, i.e., competitiveness in medicine. Not surprisingly, health care costs rose 50 percent from 1979 to 1983. Never before have health costs increased so rapidly and health coverage been reduced so quickly.

The Need for a Tax Based Comprehensive and Universal Health Program

As to the other argument frequently made in Democratic circles, that the country may not be able to afford a national health program, the international evidence shows that precisely the opposite is true: this may be the only instrument to con-
control costs. Canada’s national health program controlled health costs better while providing comprehensive benefits to the whole population. Waste plus insufficient coverage are indeed the outcomes of the “free market” forces. Recent studies show that active government regulation has kept hospital costs in Canada down far more effectively than the market forces have in the U.S. 4 The same is true of other medical costs. General Motors, for example, pays $322 per month in family insurance premiums for a typical UAW member in Michigan, and only $110 for the same protection just across the border in Ontario.

Public concern about the enormous escalation of costs has motivated Congress, including Republicans, to try to regulate physician fees and hospital charges. While these are positive steps, it is paradoxical, to say the least, that the Reagan Administration continues to maintain that market forces are the best allocators of resources and the mechanism to reduce administrative costs and the size of bureaucracies. All international evidence shows precisely the opposite. The enormous costs of health care in the U.S. are due in large part to the absence of coordination, regionalization, and planning of health services, and to high administrative expenses. Countries such as Great Britain (and to a lesser degree Canada) where there is some form of regionalization and coordination of health services, with a well-defined pattern of patient referrals, have better control of costs and expenditures. No less than 4.7 percent of all medical expenditures in the U.S. go for administrative expenses compared with 0.9 percent in the U.K., 0.4 percent in Sweden, and 1.7 percent in Canada—all countries with medical sectors in which the government plays the major role in the allocation of resources. 5

The answer to the enormous problems of insufficient coverage, costs, and waste that typify U.S. medical care is to expand both government funding and government control over the health care delivery institutions, and to increase their coverage, efficiency, and responsiveness to the public through coordination and regionalization within a comprehensive and universal health program. A majority of the American people are asking for this. But their representatives are not ready for it. Currently the Democrats are running with the hope that some major foreign policy disaster might occur, and that the “recovery” might end. But it is at least plausible that disaster abroad may be temporarily averted, and that the “recovery” may continue into 1985, leaving the Democrats without popular themes. Should this occur, the Democrats stand in danger of losing the election out of terminal timidity, a failure to realize that side by side with peace and jobs, a comprehensive health care program continues to be one of the most popular demands in the United States today. 

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15. R. J. Maxwell, *op. cit.*, Table 4-15, p. 90, and Table 4-12, p. 83.