Poor Diagnosis, Poor Treatment
DRG's & the Poor
To the Editor:

We, who are members of the Filipino and American health community in North America, would like to share with you our deep concern over the serious and deteriorating conditions of health in the Philippines and the non-governmental organizations' response: community-based health programs.

Infant mortality accounts for 25 percent of all deaths in the Philippines. The Philippines has the highest or one of the highest rates of TB, polio, schistosomiasis, whooping cough, diphtheria, rabies, leprosy, and blindness in the world. Most of the causes of mortality and morbidity are communicable but preventable diseases. Fully 70 percent of all Filipinos are malnourished, with children the hardest hit. About 60 percent of all Filipinos die without ever receiving medical attention. Yet for a variety of reasons, including low wages and unemployment, 60 percent of Filipino doctors and 80 percent of Filipino nurses are working abroad — most of them in North America.

In seeking solutions to the health problems of the Philippines, many of our colleagues have chosen to work in the deprived areas. The community-based health program was initiated in 1975 by the Rural Missionaries of the Philippines, a group of Catholic sisters from different congregations, in three pilot areas. In 1978 the National Council of Churches in the Philippines adopted the program and created the National Ecumenical Health Concerns. As of 1984 there are 40 dioceses all over the country, with a CBHP.

The CBHPs are founded on the principles of self-reliance of the community to the extent of their resources in health and development activities; popular participation in all aspects of decision-making which affect the people; and community organizing to solve local problems. Its activities include training volunteer community health workers who are elected by the community in basic primary health care work; launching public health campaigns, e.g., sanitation, immunization, potable water, control of communicable diseases, maternal and child health care; and use of indigenous resources, e.g., traditional/herbal medicine, acupressure, acupuncture.

In May Dr. Mita Pardo de Tavera will arrive for a speaking tour of North America to acquaint the Filipino and American medical community with the present health situation in the Philippines. Dr. de Tavera is a well-known physician in the Philippines, Executive Director of the Primary Health Care/TB program and created the National Ecumenical Health Concerns. As of 1984 there are 40 dioceses all over the country, with a CBHP.

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Letter from the Editor

Longtime readers of the *Bulletin* will recall that some years ago we had quite a few columns, covering subjects such as occupational health, rural health, and urban health. These were initiated both for readers, so that they could expect that certain topics would be covered regularly, and for the members of the Health/PAC Board, so that they would extend themselves to ensure that a breadth of topics was covered in the *Bulletin*. This was an excellent and laudable theory. In practice, we discovered that sometimes the columns had to be omitted, and other times they were filled with material which did not meet our usual standards.

Publications which have columns typically have a paid staff member specifically assigned to that subject who can be depended upon to provide knowledgeable essays on a regular basis. Since the *Bulletin* does not have spare paid staff members, and is unlikely to unless the MacArthur or Ford Foundation puts Health/PAC on its credit card account, we must rely on volunteers with limited time. We are proud to have excellent articles to fill each issue, and try to maintain coverage as comprehensive as possible.

For the past three years we have been fortunate in having one regular volunteer columnist, Arthur A. Levin, Director of the Center for Medical Consumers. Many readers have told us how reassuring it is to read his Body English column and learn what occupies the gap between conflicting certainties purveyed by members of the medical profession. We have long wanted to build on this success with another column of similar caliber, and I am pleased to report that we have found one.

Know News, written by Nick Freudenberg, will explore a subject which should be among the most important in any health care system but receives all too little attention in ours: health education. If we had an endowed column on this subject and could select anyone we wished to write it, we would choose the same person who will be doing it at our usual fee—immense appreciation and gratitude. Nick has been a community activist for many years; he is Director of the Program in Community Health Education at the Hunter College School of Health Sciences, City University of New York; and he is the author of the excellent *Not in Our Backyards: Community Action for Health and the Environment* (Monthly Review, 1984) reviewed in our previous issue.

We welcome Nick's contribution, and are confident that you will too.

Jon Steinberg

Notes & Comment

When the chief executive officers of the American Hospital Supply Corporation and the Hospital Corporation of America announced their agreement to join forces and called it "a good old-fashioned merger," they were saying nothing less than the truth.

If approved by the Justice Department and stockholders—and there is good reason to believe it will be—the formation of this health care conglomerate with combined 1984 revenues of $7.6 billion will not make history, but repeat it.

After Henry Ford developed the assembly line, his next major move was to purchase Ford Motor Company suppliers. He was not able to purchase steel companies, but he was powerful enough to wrest very good contractual arrangements from them. Within the space of a few decades the dozens of tinker-entrepreneurs who today would probably be creating computer companies were gone; the auto industry was dominated by three manufacturers as inefficient and oversized as their cars, vulnerable to the first aggressively innovative foreign competitors to invade their market.

Similarly, the major steel companies ceased to innovate after they drove smaller firms out of the industry or gobbled them up. They stayed with the Bessemer process long after steel manufacturers abroad had introduced more efficient substitute, preferring to invest in unrelated industries rather than their own stable and then shrinking one.

In their youthful, entrepreneurial phase the health care corporations have also innovated. Some of us might not like practices such as convenience "emergicenters", the purchase of buildings for doctors' offices, and the use of temporary nurses to avoid paying for "slack" time and benefits, but these are management changes which have spread throughout the industry. Currently, however, the major focus of hospital corporations is acquisitions. First they began buying hospitals, including smaller chains. Now virtually every week the financial pages carry news of a corporate buyout in the most varied segments of the industry. Humana's Med First is the largest chain of convenience medical centers in the country. With American Hospital Supply HCA will be getting pharmaceutical manufacturing. Av-Met, a National Medical Enterprises subsidiary, is one of a growing number of health maintenance organizations owned by the major chains. Corporate insurance subsidiaries such as Humana Care Plus and Elder Care are already putting pressure on both Blue Cross-Blue Shield and the private health insurers.

HCA currently owns 18 percent of Beverly Enterprises, the largest nursing home chain, and there are suspicions on Wall Street that it may buy the rest. If it does, it will merely be keeping up with other health care corporations. Although Humana Hospital Audubon in Louisville wants to maximize profits under the new flat-fee prospective payment systems by getting patients out of its expensive acute care beds as quickly as possible, it wants to keep those patients, and is quite willing to buy a private nursing home nearby to ensure that it does. The major corporations have found that buying homes is usually cheaper and easier than building them; most new construction today is done by medium-sized firms, which will eventually be acquired by the giants.

If the health care industry is a free, competitive market as its adherents argue, the nursing home business should be an area where this is very evident. The cost of entry is not that

(Louanne Kennedy teaches Hospital Administration at Baruch College, City University of New York, and is a member of the Health/PAC Board.)
of artificial heart surgery shows, they are willing to pay extra-
contracted out services to private firms which are currently
viding both management skills and supplies.

A partnership with a private corporate chain which can pro-
gress a growing number have concluded it makes more sense to form
a hospital is minimal, but if a patient buys the same items out-
and expansion, horizontal and vertical, is a necessity for survival.

The key motivating force in the health care industry's ac-
celerating concentration is not efficiency, despite corporate
claims to the contrary. The proprietary hospitals have higher
costs service for service; their edge comes only from limiting
the services they supply to those which are profitable and
limiting their patients to those with a reasonable reimburse-
ment rate. Five or six corporations will own 75-80 percent of
the entire private $300 billion a year industry within a rela-
tively short period of time because they have better access to
the capital markets. Wall Street has become our national health
planning agency.

The crucial criteria in Moody's rating system for the hospital
bond market are size, debt/liquidity ratio, occupancy rate, and
payor mix—they don't want more than 15 percent Medicaid pa-
tients. Under this system, the proprietary hospital chains win
excellent ratings; community hospitals, particularly the smaller
ones, generally get dismal ones. These institutions are rapidly
disappearing. Even the much better endowed teaching hospitals
frequently find themselves unable to raise the vast amounts of
capital required for construction and new equipment. It isn't
just the smaller, less prestigious ones such as Creighton Med-
ical School in Nebraska which have sold out to private firms;
George Washington Hospital in Washington, DC is very openly
saying it will go to the highest bidder.

This trend will accelerate as word gets out that the new
owners are treating these prestigious institutions well—and
they will. The health care corporations are very eager for
greater legitimacy in the larger culture; as Humana's funding
of artificial heart surgery shows, they are willing to pay extra-
ordinary sums to win it. They have also been weak in tertiary
care, and are eager to prove that they can fill that as well as
every other health care need. The major health care corpora-
tions want to be the owners of the premier medical system, and
the overwhelmingly dominant one.

To get there they are prepared to pursue a new strategy
tailored to the immediate objective. In the Sunbelt the major
chains generally bought up the small, stable institutions first
and worked their way up. In the Northeast, they are wooing
the most prestigious teaching hospitals first, and will work
their way down. Their approach is usually circumspect. Rather
than attempt a total buyout, they offer joint ventures for specific
purposes. The Medicaid reimbursement rate for drugs sold in
a hospital is minimal, but if a patient buys the same items out-
side, Medicaid pays quite well to provide a profit to the entre-
preneur. Hospitals are responding by moving their in-house
pharmacy across the street. They could do this alone, but a
growing number have concluded it makes more sense to form
a partnership with a private corporate chain which can pro-
vide both management skills and supplies.

Throughout the Northeast the major medical centers have
contracted out services to private firms which are currently

Although the workers at New York's Mt. Sinai Hospital are
still members of 1199, the hospital workers union, management
of the laundry, housekeeping, and dietary services is in for-profit
hands.

These contractual arrangements may be profitable, but what
the corporations are most eager for is the access and trust they
bring. They want a foot in the door when a major teaching
hospital needs hundreds of millions of dollars for new facilities
to keep its prestigious physicians, can't sell the necessary
bonds, and is ready to consider acquisition offers.

The nation's major religiously-affiliated institutions are also
under long term capital siege. Many of them have formed
associations for joint purchasing to get bulk rates. A few
religious federations even have joint capital pools to improve
their access to the bond market. Even so, the corporate giants
are beginning to pick them off. The Catholic Hospital Associa-
tion of America asked a member to resign when it was pur-
 chased, but this is at best a holding action. As a whole,
religiously-affiliated hospitals have relatively new facilities,
but like a lot of other voluntary hospitals they are eating up
their endowment to cover operating expenses. Within five years
many of them will require large amounts of capital for im-
provements, and few of them will get it.

The health care conglomerates are well aware that when they
have absorbed these religious institutions and the teaching
hospitals and most of the community hospitals are gone, they
will have to confront the problem of who is going to care for
Medicaid patients and the medically indigent. Probably they
will continue to provide some of this care; at present such ser-
dices make up three percent of their care nationwide, roughly
the same percentage as in the nonprofit institutions. The dif-
ference is that the amount they provide in any given area is
determined by the reimbursement rate there, not by need. The
voluntary teaching hospitals provide ambulatory care to Medi-
caid and medically indigent patients partly out of altruism but
mostly because they need teaching material; their future cor-
porate owners will have similar motivations, and will also be
acutely conscious that their security as custodians of virtually
the entire system demands that they win social acceptability.
Certainly, winning it will be considerably less onerous and
costly if they don't own the entire system, so the corporate
Federation of American Hospitals is currently lobbying for
separate federal reimbursement for public hospitals to ensure
that at least some of these institutions survive to provide care
for the unprofitable.

For the rest of us, the oligopoly era in health care is likely
to mean higher out of pocket expenditures. None of the cor-
porate insurance plans include first dollar coverage; all require
patients to pay a substantial percentage of costs. In their terms,
these plans are designed to make patients cost conscious. The
end result will be to take more of the health care dollar from
the consumer and put it into a half dozen corporate coffers.
It is unclear whether the nation's total health care expenditures
will be higher as a result of corporatization, or whether the
quality of care will be different for most of us. It is certain that
unless there is a radical social upheaval in this country our
grandchildren will be as familiar with the health system we
grew up with as we are with the Packard, the Studebaker, and
the Kaiser-Frazier.

Louanne Kennedy
Make Mine Manhattan?

New York City has a new law which may serve as a model for cities across the country considering similar measures. Many feminists aren't happy about it.

Passed unanimously by the city council, the law requires all vendors of alcoholic beverages to post a conspicuous sign reading, "Warning: Drinking alcoholic beverages during pregnancy can cause birth defects." According to the City's Department of Health, this legislation is intended to "raise the level of awareness of the general public as to the dangers of drinking alcohol during pregnancy."

The law was written by Allan Luks, Executive Director of the Alcoholism Council of Greater New York; his group lobbied hard for its passage. No scientific studies were requested by or presented to the city council while the law was under consideration.

This was a mistake, say feminists, since the required sign's implication that any amount of alcohol may cause birth defects is highly controversial. Although some researchers argue that pregnant women should practice total abstinence, many believe that alcohol in moderation is not harmful to the fetus. In fact, a good number of physicians and other health workers advise women to have an occasional drink.

Particularly given this debate, feminists have asked why alcohol has been singled out; there is no regulation of lead fumes, asbestos, food additives, mercury, and other substances which are part of a pregnant woman's everyday life in New York (and every other American city) and known to be harmful. As in so many other cases, this amounts to blaming the victim.

"It troubles and angers me that we make infant health entirely an individual woman's problem while taking no collective responsibility," commented Barbara Katz Rothman, a sociologist and the author of In Labor: Women and Power in the Birthplace (recently re-released as Giving Birth).

Perhaps the most common objection to the new regulation is that this attempt by the city government to reduce birth defects ultimately involves not education, but intimidation. The mandatory sign does not give pertinent information, but rather blasts a stern warning which is misleading and perhaps untrue.

Anne Cassidy

(Anne Cassidy is a freelance writer on women's health.)

Heads We Win, Tails You Lose

The ruling was for ambiguity, but the message to health care workers and union organizers was clear last August when the National Labor Relations Board decided the case of St. Francis Hospital in Memphis v. Local 474 of the International Brotherhood of Electrical Workers. Reversing earlier decisions and past policies, the NLRB threw out the usual criteria for what constitutes "a community of interests" and "appropriate bargaining units." This left the NLRB regional directors with nothing but vague and imprecise guidelines; they are now making decisions "case by case."

So far, those hit hardest by the decision have been registered nurses and skilled maintenance employees who are deciding whether to organize into bargaining units that are all RN, all skilled maintenance, or mixed. Challenging the number of bargaining units and the mix of employees within the units is one of the most common employer tactics to forestall union recognition. As a result of the August ruling, employees will not know until after they organize whether or not their unit will be found appropriate by the NLRB when there is a challenge—and these days there usually is. Immediately after deciding the St. Francis case the NLRB sent more than 80 cases back to regional directors; the January 1985 issue of the American Journal of Nursing reported that since then at least another 20 cases involving registered nurses were awaiting decisions.

Although Reagan Administration appointees frequently claim that their conservatism is actually strict adherence to the Constitution and the laws of the land, the NLRB has become one of numerous federal institutions and agencies which flagrantly violate the letter and intent of the law. Since the original National Labor Relations Act was passed exactly 50 years ago, a whole string of labor legislation has encouraged and promoted collective bargaining by protecting workers' right to representation. What we see now, according to a recent House-subcommittee report following hearings in both the House and the Senate, is laws "assaulted" by "Heightened employer resistance, intense exploitation of the [National Labor Relations] Act's weaknesses, expert refinements in how to manipulate and circumvent the law, as well as its outright violation [which have] increasingly characterized labor relations over the past twenty years."

The report, appropriately entitled The Failure of Labor Law—A Betrayal of American Workers, also concluded that the NLRB's administrative inefficiency and judicial partiality and bias have "converted [these] serious problems into a veritable crisis."

The status of the National Labor Relations Board is a classic example of the Reagan tactics, also found at Legal Services, the Civil Rights Commission, and many other government agencies with somewhat progressive histories. Since Reagan took office he has appointed three openly anti-union directors to the five-member Board. One of them, current chairperson Donald Dotson, wrote in a 1980 American Bar Association Journal article that "Collective bargaining frequently means labor monopoly, the destruction of individual freedom, and the destruction of the marketplace as the mechanism for determining the value of labor."

Decisions of the Board are often deadlocked two-two, because the President has not filled a vacancy caused by a resignation in 1983. The Board's general counsel, inexperienced and unacceptable to labor, was not approved by the Senate, but Reagan installed him anyway through a recess appointment. Before Reagan took office, the Board met twice weekly; it met a total of four times from the fall of 1983 through the winter of 1984.

"We have reached a point where legal rights given to employees under the NLRA are in jeopardy because of the..."
It appears that since 1975 the worldwide incidence of stomach cancer has been declining, and many experts believe this is related to increased consumption of fresh fruit and vegetables and/or improved food storage. In contrast, it appears that colorectal, prostate, and breast cancer, all much more common in the industrialized nations, are usually related to overconsumption of fats and meat and insufficient fiber intake. Research on human-made carcinogens has been more controversial, but it is likely that a large number of cancers are attributable to them, either alone or in combination with smoking or other hazards.

God may not be a socialist, but it does seem that if the world smoked less, spread its material wealth more evenly, and compelled industry to reduce pollutants from its factories and products, the cancer rate would be drastically reduced.

What 59 cents Buys in Health Care

Women comprised 76 percent of all hospital employees in 1984, according to the Bureau of Labor Statistics. As always, they were most heavily represented in jobs at the lower end of the pay scale, but the number in the higher positions is increasing as well. In 1970 women accounted for only 14 percent of the total enrollment in masters programs in health administration. In 1983, they earned just over half of all the degrees in these programs, according to a survey by the Association of University Programs in Health Administration. One third of all medical students are now women, and 13 percent of all physicians—up from eight percent in 1973.

These statistics could indicate that the status of women is improving, or that the status of these jobs is declining. More likely it is a bit of both. The industry is rapidly becoming more concentrated; most physicians coming out of medical school will find themselves compelled to work as employees rather than be able to pursue the traditional dream of setting up shop as independent practitioners. As this becomes apparent, the status of the profession as a whole is bound to decline, even though there will still be prestigious specialty and administrative roles—and it is a safe bet that the overwhelming majority of these will continue to be held by men.

Although the American Medical Association's projection that 20 percent of all physicians will be women in the year 2000 may be conservative, it will be at least a couple of generations before women comprise the majority of physicians. Until then, doctors will in all likelihood continue to enjoy a far better than average income as well as considerable prestige.

Senior Power

Last year the new Washington-based Villers Foundation financed a National Citizens Board of Inquiry into Health in America. Chaired by Arthur S. Flemming, Secretary of Health, Education, and Welfare under Eisenhower, and including former Secretary of Labor Ray Marshall, former Secretary of HEW Wilbur Cohen, and psychiatrist Alvin Poussaint, it held hearings in ten cities. Medical society and insurance company representatives spoke, but most of the testimony came from elders relying on Medicare and Medicaid. What they had to say wasn't heartening.

The Board's report, issued last October, blamed the Reagan Administration for increasing the deficiencies of the health care system, urged major improvements in Medicare, and concluded that the U.S. needs a health insurance plan like that of Canada at a minimum.

Little news of this appeared in the media, but the Boston office of the Villers Foundation had already ensured that the report would not sit in a pile with others on similar issues published by many groups over the past few years. Villers brought together elder advocacy groups and advocacy-oriented service groups in Massachusetts, where the first three hearings were held, and last summer 18 of them, including two competing state-wide advocacy associations, formed the MassHealth Action Alliance, "a senior-led, intergenerational consumer coalition advocating for improved health care."

The coalition structure did not infringe upon the autonomy of the individual member groups, and guaranteed structural flexibility. The ability of the groups to cooperate was proven in statewide demonstrations September 12-13 for continued on page 31
Poor Diagnosis, Poor Treatment
How the DRG System Affects Hospitals That Serve the Poor
by Ronda Kotelchuck

In October 1983 Medicare became the first payor in the history of hospital finance to pay for care based on price per case. Under this new Prospective Payment System, hospitals are paid a flat rate depending upon the Diagnosis Related Group into which a given patient falls. If a hospital can treat a patient for less, it keeps the difference. If costs exceed the DRG payment, the hospital absorbs the loss. A hospital which sustains consistent losses must make hard choices: cut costs, drop money-losing services, turn away money-losing patients, or go bankrupt.

Although Medicare only introduced this system in 1984, other payors, including many commercial and Blue Cross plans and state Medicaid programs, are following suit, both to cut costs and out of fear that they will otherwise be forced to absorb Medicare losses through cost shifting by hospitals.

Prospective payment will cause enormous changes both within hospitals and throughout the industry (See “Baring Costs: How the DRG System Works,” Bulletin. Vol. 15, No. 2). Yet it is only one of a panoply of Reagan-initiated policies designed to bring competition to the hospital industry and control costs through “the discipline of the free market.” These include competitive bidding and discount pricing arrangements, a variety of measures to place providers at risk for excessive costs, and increased out-of-pocket payments by patients, designed to turn them into “prudent buyers.” The federal government expects one of every six hospitals will close as a result.

Hospitals will respond to this new competitive environment as best they can. Most adaptable will be the proprietary hospitals with the money to undertake expensive systems and plant improvements, the managerial flexibility necessary to reorganize internally, and the freedom from social responsibility which allows them to be highly selective in choosing the services they offer and the patients they treat.

At the opposite end of the spectrum are public hospitals, particularly large urban ones, and a variety of “ghetto voluntaries” and inner city teaching hospitals afflicted, in varying degrees, by most of the same problems. Together these institutions constitute the safety net for those who will fall through the cracks of a competitive health system. Very soon these people may fall very far, since without intervention this same competitive health system will eat away the very fabric of the safety net.

Who Uses the Safety Net
Public hospitals serve a clientele that is overwhelmingly poor and more expensive to treat than the average patient. As cost controls have escalated, so has concern that the poor are more costly to treat and many cost control systems have a built-in bias against hospitals that treat them. This problem was raised in Congress, which responded in 1981 with legislation requiring Medicare and Medicaid to ensure “special consideration for hospitals serving large numbers of the poor and medically indigent.” This concern escalated when DRG-based Medicare reimbursement came up, and Congress incorporated the same provision into that legislation. There were several a priori grounds for believing that this special consideration is necessary. In developing Diagnosis Related Groups, Robert Fetter and his colleagues at Yale specifically excluded “exogenous variables,” i.e., those outside the hospital experience, such as socioeconomic status. Moreover, because public hospitals did not have the necessary data, they were excluded from the original DRG developmental studies and from all subsequent studies undertaken to set the DRG intensity weights—the mechanism for determining reimbursement levels. Thus to the extent that a large proportion of public hospital patients are poor and differ from other patients, and that these differences aren’t taken into account in DRG’s, the reimbursement rates will be disadvantageous to both the poor and the institutions that serve them.

However in implementing the new system the Reagan Administration has chosen to ignore the “special consideration” provision, arguing that there is no evidence that the poor are more costly to treat.

Does Treating Poor Patients Cost More?
In the year and a half since DRG-based reimbursement was implemented, impressive evidence has emerged to prove that the Administration is wrong. A study released last November by the District of Columbia Hospital Association found that overall cost per case rises dramatically as a hospital’s volume of poor patients increases. The researchers compared costs in 257 hospitals in five major metropolitan areas. Controlling for differences in casemix (the proportion of cases of each intensity) and teaching burdens, they found that Medicare costs averaged $568 per case higher among hospitals with a ten percent volume of Medicaid patients than they were in hospitals with no Medicaid patients. When the Medicaid patient proportion was 20 percent, Medicare costs were $964 higher. When the Medicaid patient level was 30 percent, Medicare costs averaged $1,188 higher.  

This confirmed an earlier finding by the Urban Institute that costs per inpatient case were 18 percent higher at institutions providing a great deal of care to the poor than they were at hospitals treating few poor people. Costs at public hospitals were even higher.  

The American Hospital Association added its weight to the
TABLE 1

Patient Characteristics by Payor

<table>
<thead>
<tr>
<th>Casemix Index (measure of overall hospital intensity; 1.0 = average)</th>
<th>Medicaid</th>
<th>Blue Cross</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.82</td>
<td>.91</td>
<td>1.44</td>
</tr>
<tr>
<td>Average Cost Per Case</td>
<td>$1813</td>
<td>$1687</td>
<td>$3380</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>8.3 days</td>
<td>7.2 days</td>
<td>14.8 days</td>
</tr>
<tr>
<td>Age Distribution: Young Middle Old</td>
<td>67% Women, Children 17%</td>
<td>50% Women, Children 34% Ages 45-64</td>
<td>10% 85% Age 64+</td>
</tr>
<tr>
<td>Diversity or Concentration of Caseload (No. DRGs = 50% patient volume)</td>
<td>Highly Concentrated (30 DRGs = 50%)</td>
<td>Diverse (45 DRGs = 50%)</td>
<td>Diverse (46 DRGs = 50%)</td>
</tr>
<tr>
<td>Proportion of Surgical Cases</td>
<td>43%</td>
<td>71%</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of Cases in DRGs with Secondary Diagnoses</td>
<td>23%</td>
<td>13%</td>
<td>37%</td>
</tr>
<tr>
<td>Most Frequent DRGs</td>
<td>Deliveries</td>
<td>Deliveries</td>
<td>Cataract Surgery</td>
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<td></td>
<td>Abortion</td>
<td>Newborns</td>
<td>AMI</td>
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<tr>
<td></td>
<td>Newborns</td>
<td>Gynecology Procedures</td>
<td>Heart Failure,</td>
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<tr>
<td></td>
<td>Gynecology Surgery</td>
<td>Tonsils, Adenoids</td>
<td>No Surgery</td>
</tr>
<tr>
<td></td>
<td>Respiratory and Infectious Disease</td>
<td></td>
<td>Ischemic Heart Disease</td>
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<td></td>
<td>Substance Abuse</td>
<td></td>
<td>Circulatory Disease</td>
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<td>Mental Illness</td>
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<td>Respiratory Disease</td>
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<td>Neoplasms</td>
</tr>
</tbody>
</table>


Note: Study conducted 1978-1980 on 31 NYS Voluntary Hospitals using 383 DRGs.

argument in late November with a study reaching similar conclusions. Medicare's own initial data for the prospective payment era (as yet unreleased) show Medicare costs are averaging $395 higher per case among public hospitals than the costs among nonpublic hospitals in large cities.

Finally, an earlier study of 31 New York State nonpublic hospitals comparing patients covered by different payors, DRG by DRG, concluded that Medicaid patients have longer lengths of stay, are responsible for a disproportionate number of outlier (unusually long term) cases, and cost the hospital more than Blue Cross patients. (Medicare patients, the elderly population, were not surprisingly the group which required the most resources.) This study excluded public hospitals, but its length of stay conclusions were similar to those of a study which compared New York City's public hospitals to a matched set of nonpublic institutions.

A variety of factors may account for these higher costs incurred in treating the poor: their greater severity of illness and more frequent complicating factors; their need for more supplementary services (patient education; drug, alcohol and psychiatric counselling; social work; discharge placement services; transportation; interpreting); a lack of care alternatives which could shorten inpatient convalescence; the greater expense of Medicaid eligibility and fee collection efforts; old, inefficient plants and systems; and/or extra expenses inherent in urban locations (parking, security, higher wage structures, etc.).

Are Poor Patients More Severely Ill?

Although evidence is mounting that poor patients stay in hospitals longer than other patients and their care costs more, existing methodologies have not shown that they are more severely ill. On the basis of their experience, public hospital personnel believe that this is a problem of the methodologies. Lacking primary and preventive care, they argue, poor patients suffer multiple and complicated conditions and do not seek care until their conditions become acute.

Public hospital patients, both Medicare and non-Medicare, consistently fall into less intensive DRG's. Among both the elderly and those below Medicare age, poor patients appear to have considerably less surgery, the single largest contributor...
to DRG intensity. In the non-Medicare group, poor patients are significantly younger, with women of childbearing age and children predominating. They are treated for less intense Diagnosis Related Groups such as childbirth, newborns, drugs, alcohol, psychiatric, asthma, diabetes, and infectious and respiratory diseases.

Casemix indices, the weighted average of patients in all DRGs, are lower for Medicaid patients than they are for those covered by Blue Cross or Medicare. Similarly, the case mix indices for patients in New York City public hospitals, whether considered as a whole or by who (if anyone) pays the fees, are consistently lower than those of patients in nonpublic hospitals.

The DRG system assumes that if hospital costs or lengths of stay exceed the norm, the excess is due to physician practice or operational inefficiencies. Thus how well DRG’s reflect severity and whether or not DRG’s poor patients have more severe problems and/or require more costly treatment are questions of paramount importance.

It is now widely acknowledged that DRG’s do not take severity of illness into account adequately. The DRG category doesn’t distinguish between a patient who has only early or mild symptoms of a given ailment and one who is in a late stage with severe and multiple complications. Even Medicare officials acknowledge this shortcoming and have publicly pledged to incorporate a severity adjustment into the Prospective Payment System when an acceptable measuring method is available.

Two methodologies have been developed. Susan Horn of Johns Hopkins University assigns a severity score of one through four, based on seven indicators, including stage of principle diagnosis, interactions, response to therapy, complications, patient dependency, and nonoperating room procedures. Joseph Gonella of Temple University uses clinical criteria to assign a disease level ranging from Stage 1, uncomplicated illness, to Stage 4, death. Advocates of each of these methodologies believe it can account for large variations in the amount of resources used by different patients in the same DRG.

Until recently only one study has been published which used such methodologies to determine whether poor patients are more severely ill. Done by Rosanna Coffey in 1978, it used disease staging and found public hospital patients were not more severely ill. However it was based on suspect data. More recently, the New York City public hospital system compared its patients to those of nonpublic City hospitals. In 20 of the 25 most frequent diseases with defined stages the public hospital patients fell into a higher stage.

While the severity and disease staging methodologies may ultimately prove sensitive to differences between poor and nonpoor patients, this should not be taken for granted. Nor should severity as they define it be the only stamp of legitimacy for the recognition of unique hospitalization needs among the poor.

How Well Do DRG's “Fit” Poor Patients?

Diagnosis Related Groups utilize only six pieces of information about a patient: principle diagnosis, secondary diagnosis, principle procedure, secondary procedure, age, and (in a few cases) discharge disposition. They are designed to establish categories of cases that use similar hospital resources. Thus a DRG is only as “good” as it is homogeneous. As the evidence cited above suggests, poor and nonpoor patients are not homogeneous: the poor generally cost more to treat, stay longer, and may be more severely ill.

A variety of other differences identified in a study of New York City's public and nonpublic hospitals reveal important variables not included in DRG's which raise serious doubts about how well its groups “fit” the hospitalization experience of poor populations:

Emergency Admissions. DRG’s do not reflect whether a patient comes into the hospital on an emergency or an elective basis. Patients admitted on an emergency basis are in all likelihood more acutely ill; moreover, because they come in without records or preadmission testing, their tests must be conducted while they are hospitalized, thus prolonging their stay.

In addition, handling large volumes of emergency patients makes efficient scheduling difficult for a hospital. In New York City, emergency patients stay in a hospital an average of 11.01 days, compared to an 8.66 average for electively admitted patients. The City’s public hospitals average 60 percent emergency admissions; the average among nonpublic hospitals is 40 percent. By virtue of this alone, these hospitals will be heavily penalized under the DRG system.

Transfers. Fully 25 percent of all nonpublic patients are transferred to another acute care facility, presumably one offering specialty care. By contrast, New York City’s public hospitals transfer virtually no patients to other acute care facilities.

Outliers. Anomalous cases, known as “outliers,” receive additional reimbursement under the Prospective Payment System when their costs or lengths of stay exceed a predefined “trim point.” Outlier cases are considerably more frequent among poor patients. In fact, much of the difference in both cost and length of stay between poor and nonpoor patients is attributable to small numbers of extreme cases, rather than to small excesses among large numbers of patients—which would be more indicative of hospital inefficiency.

However in defining outliers, Medicare set trim points not to achieve DRG homogeneity, but to limit its own financial liability. The outlier ceiling was set at five to six percent of total cases. In 1983 the average in nonpublic hospitals ranged from 1.7 percent to 3.9 percent of total cases; in public hospitals the range was 3.5 to 7.9 percent.

Placement problems. Undoubtedly, part of the reason for extreme lengths of stay is the unique placement problems facing many poor patients. Poor housing conditions, disorganized family situations, and lack of resources often make discharge of poor patients to their home difficult. To make matters worse, it is difficult to find a spot for poor patients in long-term care facilities at a time when any free beds there are easily filled. Compared to nonpublic hospital patients, those in public hospitals are twice as likely to remain hospitalized after they no longer need acute care because no long term-care bed is available, and nearly twice as likely to be transferred to a long-term care facility.

Diagnostic mix within DRG’s. Illnesses uniquely suffered by the poor which demand an expensive array of resources are nevertheless frequently categorized into non-intensive—that is, lower reimbursement—Diagnosis Related Groups. The DRG system compresses some 10,000 individual diagnoses into 467 groups. As a result, it is not surprising that the individual diagnoses which make up a single DRG can vary. TB cases, for example, are categorized into DRG’s 79, 80, and 81 (Respiratory Disease and Inflammation), where average lengths of hospital stay range from six to 11 days. But patients with tuberculosis who are hospitalized (the overwhelming majority are not anymore) tend to have complex and frequently drug-
resistant cases, and require exceptionally long stays, averaging 30 days. New York City public hospitals have over twice as many TB patients in the Respiratory Disease and Inflammation DRG's as the City's nonpublic hospitals do. Similarly, subacute bacterial endocarditis, a heart infection frequently caused by prolonged drug abuse, requires a minimum of six weeks of hospitalization while the patient receives powerful antibiotics. However it is categorized into DRG 124 (Circulatory System Diseases except AMI with Cardiac Catheter and Complex Diagnosis), which is given an average length of stay of only 8.4 days. New York City public hospitals have many times more such cases than nonpublic hospitals do.

Secondary diagnoses such as drug and alcohol abuse, psychiatric problems, malnutrition, diabetes, and hypertension, which prolong hospital stays may also be much more common among public hospital patients. Again, these problems are not reflected in the DRG system.

Disregarding the Law

By failing to take all these factors into account, the DRG system unfairly penalizes poor patients and the hospitals that treat them. Instead of implementing the provision in the DRG legislation requiring special consideration for hospitals treating the poor, the Reagan Administration has shifted the burden onto these institutions; they have to prove that any excessive costs and lengths of stay are legitimate, and not due to their own inefficiency. As we shall see, this won't be easy given their meager data-collecting capabilities.

Systems and Information

To function successfully in the brave new world of health care competition, hospitals need a wealth of information about their internal operations, their patients, and their markets analogous to what any corporation requires. They need to know the mix of DRG's they treat as well as the cost, revenue, and profit or loss coming from each patient, each DRG, each hospital service, each payor group, and each physician. While public hospitals may never function like a traditional manufacturer, their need for this information is just as critical as a steel company's. They need it to improve their efficiency, make strategic decisions, and defend their unique and critical role in the health system. The underdevelopment of systems necessary to produce such information constitutes one of the largest handicaps facing perpetually resource-starved public hospitals.

Patient information. Patient care information comes together in the medical records department. This is where the hospital "product" or DRG is determined through identification and coding of the data. If done accurately, completely, and skillfully, the hospital will obtain the highest DRG rate allowable. If done by untrained and overworked staff, or from inadequate information, the hospital will under-report its cases and be underpaid.

To cope with these new demands, in the short space of a year and a half the medical records department has soared from the status of a mere "library" to that of a critical agency, determining what payment the hospital will receive and how quickly.

In the organization and expertise of their medical records departments, many public hospitals are equal to their nonpublic counterparts. The completeness of information available in the chart to be coded, however, is determined by the degree of cooperation and organization of many parties and systems throughout the hospital. Here the public hospital is at a severe disadvantage.

The admitting office must record the patient's age, admission and discharge dates, and a host of other information. Physicians must write progress and procedure notes, and summarize and sign for the case. The ancillary departments must supply documentation of lab and radiology services, which must be reported back to the nursing unit. They then have to be posted to the chart by ward clerks, and nurses must generally ensure that the chart is returned promptly to the discharge office; one or the other must record the discharge status and disposition. Only then does the chart go to medical records to be coded and filed. Many of these systems do not exist in public hospitals, or function poorly. Frequently public hospitals are so understaffed that this paperwork is put aside in deference to more urgent tasks.

Cost information. In order to determine the cost of treating a patient, a hospital must do two things: identify the cost of each unit of service provided (i.e., each x-ray, lab test, operating room minute, medical supply, etc.), and identify each specific service provided to an individual patient.

Identifying the cost of services is not inherently difficult, and public hospitals aren't particularly behind others in doing it. Although nonpublic hospitals long ago established charges for each good or service, usually these reflected prevailing rates in their area, or were manipulated to maximize revenue from the insurers. Their traditional charges, therefore, have long borne little relation to actual hospital costs. Few hospitals, either public or nonpublic, knew their actual costs per service when the DRG system began.

Nowhere are public hospitals at more of a disadvantage, however, than in recording the specific services rendered to each patient. Nonpublic hospitals have always recorded each individual service, since self-paying and commercially insured patients were billed on this basis. Public hospitals, which have few commercially insured patients, have generally billed at a single, all-inclusive daily rate, precisely because this eliminated the need to record specific services rendered. Keeping such records requires an elaborate system, either computerized or manual, of charge slips. They are issued by the physician, transmitted to the ancillary service department, transmitted back, and posted to both the medical record and the patient bill.

The damage this has caused public hospitals under the Prospective Payment System began before they ever entered it, since their lack of the relevant data led researchers to exclude their patients from the original studies to develop the DRG system as well as from subsequent studies conducted by Medicare and other payors to establish DRG cost weights.

Finally, to identify the sources of profits and losses, a hospital has to integrate cost information on individual patients with medical record and DRG payment data and then aggregate this according to DRG, hospital service, and physician.

Without doing this a hospital has no way of ascertaining whether its losses are due to operational inefficiencies (such as an excessively expensive lab or the inability of the lab to deliver timely results, which leads physicians to order duplicate tests), physician practice patterns (excessive testing or keeping patients in the hospital an excessively long time), or unique characteristics of the patient population (more severely ill, multi-problem, or hard-to-place patients). This information is crucial to a hospital operating under the Prospective Payment System.

Clearly, handling the massive volume of data generated requires sophisticated computerization. But in the hand-to-mouth environment in which public hospitals perpetually find themselves, this has never been a priority. Thus public hos-
physicians must embark upon difficult and costly systems development even before they have data vital to identifying options and developing strategies for survival, protecting their interests, or arguing for equitable treatment by the reimbursement system.

Physicians. On a day-to-day level, physicians make the key economic decisions at a hospital—when and who to admit; what tests, devices, supplies, and drugs to use; when and whether to operate or to put a patient in the recovery room or in the intensive care unit; what therapies to use; when and to whom the patient will be discharged. Their cooperation is pivotal in efforts to utilize hospital resources efficiently.

Public hospitals have historically had difficulty attracting physicians because of their uncompetitive salaries, adverse working conditions, the inferior reputation of the public sector, and the desire of most physicians to go into private, middle and upper class practice. To obtain qualified personnel, most public hospitals rely heavily on housestaff programs and physicians supplied through affiliation agreements with medical schools or academic centers. However these affiliating institutions generally use available funding to advance their own personnel and program interests rather than those of the public hospital. They usually assign physicians to public hospitals on a part-time basis; the loyalty, identification, and priorities of these doctors remain with the affiliate.

Today, the growing supply of physicians makes private practitioners more dependent than ever on hospital admitting privileges. Their self interest lies ultimately in the economic welfare of their hospital and this gives the nonprofit institutions leverage to change physician behavior if necessary.

A public hospital enjoys no similar power over its physicians. Its housestaff, who provide the vast majority of care, are there temporarily to gain experience and education; they have little self-interest in the economic wellbeing of the institution. Judicious use of resources may even conflict with their need to experiment and learn.

To physicians, who have traditionally paid little if any attention to hospital costs anywhere, costs in a public hospital are a matter of even less concern. They have no incentive or reward for efficiency. The energy and frustrations inherent in coping with scarce resources makes them intolerant of what seem like additional and less important demands for paperwork. And finally, they believe that ultimately tax monies will always be available to bail out the hospital.

Beyond the interests of individual housestaff and attending physicians, affiliates' relationships with a public hospital are most often exploitative. They use the public institution as a dumping ground for socially or financially undesirable patients while skimming its profitable or desirable ones; they tap it for expensive services for their own patients; and they follow research, teaching, and experimentation agendas which bear little relation to patient care needs at the public hospital.

For these reasons the affiliate and its staff have little interest in precise documentation of resource utilization, revenues, and the costs incurred in treating each patient at the public hospital. This information, moreover, poses a potential threat to the nature and scope of many exploitative relationships which thrive best in the shadows of ignorance.

Finally, in a nonpublic hospital all patients (with the exception of service patients in teaching hospitals) have a private physician who admits them and is responsible for their care. This makes it easy for the hospital to establish an individual physician's accountability for the treatment of each patient and each resource use.

In urban public hospitals, on the other hand, most patients are not admitted by a private physician, and the heavy reliance on housestaff and part-time attending physicians necessitates a system in which no single physician is responsible for a patient's care. Patients are seen or treated by whomever is in the outpatient department, emergency room, or operating room, or on rounds that day. For purposes of recordkeeping, the case is assigned to the chief of that service. Thus even if it were obstructed by nothing else in a public hospital, the route to physician accountability would be a circuitous one, involving everyone partially and no one totally.

Managerial flexibility Many public hospitals are either

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**TABLE 2**

**Hospital Care for the Poor**

100 Largest Cities

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Total Hospitals</th>
<th>% of Total Beds</th>
<th>Charity Care</th>
<th>Bad Debt</th>
<th>Medicaid</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>100</td>
<td>14%</td>
<td>64%</td>
<td>40%</td>
<td>22%</td>
<td>32%</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>681</td>
<td>77%</td>
<td>36%</td>
<td>53%</td>
<td>73%</td>
<td>63%</td>
</tr>
<tr>
<td>Proprietary</td>
<td>192</td>
<td>9%</td>
<td>0%</td>
<td>7%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>973</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Analysis of Urban Institute data by National Association of Public Hospitals,*
*Testimony to the Senate Finance Subcommittee on Health, September 28, 1984.*
The very raison d’etre of public hospitals guarantees them poor financial prospects in a competitive environment. They exist as providers of last resort, to serve those who, for financial, medical, or social reasons, have no other source of care. In the past patients have sought or been referred to public hospitals primarily because they lacked insurance coverage or could not pay for care elsewhere.

Among the 50 member institutions of the National Association of Public Hospitals, on average 29 percent of all days of inpatient care and 46 percent of all outpatient and emergency room visits are uncompensated. Local tax monies comprise 31 percent of the budget of these hospitals on average. Medicaid covers 22 percent, and Medicare 16 percent. Public hospitals in the nation's 100 largest cities have only five percent of all the hospital beds, but provide 40.3 percent of all charity care, absorb 19 percent of all bad debt, and serve 17 percent of all poor patients, according to data from the Urban Institute. On average they provide 35.8 percent more free care per bed than large-city nonpublic hospitals.

Public hospitals also provide important hospital services not elsewhere available, usually for reasons of cost or social undesirability. These include a disproportionate share of all burn, trauma, and poison control units; emergency psychiatric, drug, alcohol, and child abuse centers; neonatal and pediatric intensive care units; and outpatient and emergency room services. In addition, they host among the largest and most intensive teaching programs.

Nonpublic hospitals have traditionally made up losses on uncompensated patients and unprofitable services with surpluses earned on other patients and from other services. These cushions are vanishing under the pressure to cut costs, legitimizing and in some cases virtually necessitating economic triage, transfers of patients, and the elimination of unprofitable services. These policies increase the burden on public hospitals, which even in the best of times never enjoyed surpluses that could offset losses from offering essential but costly services or treating patients who have no means of payment.

The practice of dumping patients has been spreading for at least a decade. Transfers to public hospitals, which averaged three percent in 1973, had climbed to seven percent by 1983, according to a study by Alan Sager. The numbers already appear to be leaping far higher as Medicare patients whose treatment is unprofitable under the new DRG-based reimbursement system are shunted over. Both Parkland Hospital in Dallas and District of Columbia General Hospital report 400 percent increases over the past two years in the number of transfers they have received from nonpublic hospitals. At Cook County Hospital in Chicago, the number of emergency room patients sent from nonpublic institutions quintupled between 1980 and 1984. The increasing availability of information on profits and losses by DRG by hospital service, by payor, and by population group, combined with competitive financial pressures, will raise dumping and skimming to new levels of sophistication; the unprofitable will join the uncompensated in the forced march to public hospitals. The financial status of these institutions will plummet accordingly.

The Impact To Date

Because the DRG-based reimbursement system was implemented within six months of enactment and at most hospitals
has been in place for less than a year, and because large institutions are inherently slow to adapt to change, the impact is only beginning to be noticeable.

Initial spending limits were set under a formula known as budget neutrality—that is, spending must not exceed what it would have been under the old Medicare reimbursement system. The effect on public hospital budgets has hardly been neutral, however. In 1982, the last year under the old system, public hospitals did better financially than before by treating Medicare patients. Medicare costs among 27 member institutions surveyed by the National Association of Public Hospitals rose an average of $1.01 million, but Medicare revenues were up even more, $1.93 million. In 1983, the first year under the Prospective Payment System, the cash flow reversed. Medicare costs among the same 27 hospitals climbed $1.1 million while Medicare revenues plunged $2.46 million. Since the total allocation for Medicare hospital reimbursement was the same, this means that funds formerly going to the poorest institutions was siphoned off and redistributed to wealthier ones.

The blow to public hospitals has been softened during the past year by the "indirect medical education add-on," a relatively generous supplement to the DRG payment to cover the secondary costs of medical education. These costs appear in forms such as longer hospital stays and above-average amounts of diagnostic testing. The supplementary payments, based on the ratio of house staff to beds, can add as much as 50 percent onto the normal DRG reimbursement rate. Because this provision is generous and public hospitals rely so heavily on interns and residents, they have benefited substantially. However the proposed FY 1986 Reagan budget cuts this add-on by 50 percent; many Reagan Administration policymakers favor its total elimination.

The Hard Choice

Like other Reagan social policies, the Prospective Payment System represents a shift of social and financial responsibilities for the poor to the local level—if not the total abandonment of the poor to the leftover scraps of the marketplace. Large urban public hospitals, along with a few ghetto voluntaries and inner city teaching hospitals, will absorb an impact of yet untold magnitude.

Within the framework of the new system, localities and the public hospitals they finance face a choice. One option is to adopt a passive stance, minimizing current financial liabilities and paying out as little as possible. While conservative in the short term, this course will lead to long term losses so great that they will force an even more drastic choice: either turn away patients in record numbers or close facilities altogether. Since 1970, 13 public hospitals have closed in major cities, and under the Prospective Payment System the casualty list could be far higher in the next few years.

Alternatively, localities can make the large short term investment essential for long term savings. The most critical moves are creating adequate hospital record systems, hiring necessary expertise, and assuring efficient operations. These are crucial to public hospitals in efforts to demonstrate their efficient use of local tax dollars and identify and evaluate innovative strategic options for the future. These options may well include case management, preferred provider or health maintenance organization arrangements under contract to Medicare, Medicaid, or even private insurers or employers; the development of alternatives to inpatient care, including ambulatory, home, long term, and hospice care; and marketing hospital services such as purchasing, laundry, lab, and dietary services to other institutional purchasers at a profit.

Beyond the framework of PPS, localities, public hospitals, and all providers of care to the poor must lobby for state and even federal solutions for providing care to uncompensated patients, funded in as broad and equitable a manner as possible. Localities cannot single-handedly assume this burden, particularly at a time when they are compelled to absorb so many others.

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2. Urban Institute, series of eight studies on hospital care for the poor, 1980-82.
13. Urban Institute, data cited in testimony of Ray G. Newman, Executive Vice President and Chief Operating Officer, Dallas County Hospital District, to the Subcommittee on Health of the Senate Committee on Finance, U.S. Senate, September 28, 1984.
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Speaking off the record to a progressive physician active in health policy issues in December, 1980, a Reagan Administration transition team member specializing in health policy complained of bloated government, of the how vital it was to "let the marketplace solve our health problems," of the superiority of vouchers to a bureaucratic health system. He concluded with a prediction that the coming Reagan economic boom "will be so strong that we will be able to get rid of Medicaid and, if we are really lucky, get rid of Medicare also."

As we now know, this economic boom began with the most severe recession since World War II, and even today the unemployment rate is as high as it was in the 1980 recession. True, inflation is down, but so is the percentage of social spending in the federal budget, and real wages are lower than they were in 1967. The Reagan policies have already left over half the American people worse off economically; when the business cycle brings us into the next recession, they and millions of others will be in even more dire straits.

Stripped of all its rhetoric, the Reagan Administration's program has been to transfer hundreds of billions of dollars to the upper 40 percent of individuals and corporations, increase military spending by 79 percent ($125 billion) in just five years, and finance these policies through deficits equal to those of all previous presidents combined.

These "successes" have not satisfied the Reagan team. It still intends to eliminate poverty by eliminating programs for the poor and other non-market obstacles. They still intend to get the government off our backs and into our bedrooms—and places like Grenada and Nicaragua. They still intend to dismantle the framework of federal social welfare—including Medicare, Medicaid, the Environmental Protection Agency, the Occupational Safety and Health Administration, civil rights enforcement, education, and social legislation—and return to the pre-1948 doctrine of states rights.

If passed, the Administration's proposed Fiscal Year 1986 Budget would be a giant step in this direction. What follows is a brief summary.

Eroding Entitlements

These budget cuts are intended to destroy the public assumption that the federal government has responsibilities in the provision of health services by attacking the concept of entitlements. The Reagan strategists believe that if the 60 million Americans who currently rely upon Washington as the guarantor of their health care are disabused of the notion that they are entitled to these federal programs, the total demolition of these programs will be relatively easy.

The budget is their major vehicle. They have targeted every entitlement program. Medicare, Medicaid, Native American health, and the Veterans Administration would all be cut drastically. The amounts saved would be relatively small in comparison to the total budget or even the deficit, but the effect on the principle of entitlement would be enormous.

I. Medicare. The President who swore to protect Medicare wants to cut its projected expenditures by $3.9 billion. This would be done by giving a nominal $1.5 billion budget increase, far less than what the rate of health care inflation demands just to stay even. These reductions would continue the erosion in the quality of hospital services, which 54 percent of administrators surveyed believe were cause by the earlier cuts. They would accelerate staff cutbacks, already mounting; compel many elderly people to delay necessary care; run up the number of DRG's considered "losers" by hospitals and doctors; and heighten monetary pressures on the battered Medicaid program. Although the Administration has spoken of the need for appropriate, less expensive care, the budget is discouraging it: for the first time the elderly would be compelled to pay part of the cost of home health care after the first 20 visits in a year.

The drive to destroy Medicare as an entitlement program is apparent in the introduction of a voucher option, which would allow beneficiaries to buy private insurance. Many of the affluent and healthy might find this attractive; the poor and sick would be left behind.

The budget would use federal regulatory powers—that is, no specific congressional action would be required—to freeze programs which would require $2.1 billion just to keep up with inflation. This real-dollar cut will come from:

- Hospital DRG payments ($1.8 billion)
- Skilled nursing home facility rates ($5 million)
- Home health care rates ($70 million)
- Medical education & teaching hospital support ($150 million)
- Payments for durable medical equipment ($50 million)
- With congressional action, an additional $1.8 billion would be cut through:
- A one month delay in Medicare eligibility ($225 million)
- The introduction, yet again, of home care co-payments ($65 million)
The changes proposed for 1986 to 1988 would double those from 1981 to 1984. Millions more needy citizens would be shoved off the rolls and into the same plight as the 15 percent of Americans now without any health insurance whatsoever.

In addition, the Reagan budget proposes to cap Medicaid reimbursement to the states with a formula based on proportional expenditures in FY 1984. This would transform Medicaid into a simple block grant program and nullify the new Child Health Assurance Program (see box).

3. Indian Health. The proposed budget eliminates the national programs entirely; President Reagan has already attempted this with a pocket veto last December. In FY 1986 $37 million is needed to maintain both Indian Community Health Representatives and Urban Indian Health Projects and Tribal Management.

4. Veterans Administration Health. The Reagan budget would introduce a means test for veterans health benefits, including hospitals and nursing homes. Veterans would be able to obtain care for non-service-connected health needs only when beds are available and they have exhausted any income above $15,000 per year (for one veteran plus one dependent). If this passed, veterans health benefits would cease to be an entitlement program, and become a vulnerable means-tested benefit program. The next step would be to introduce vouchers and dismantle the VA health system. The budget allots $10 billion, a woefully inadequate sum, particularly given the millions of aging World War II veterans.

5. Block grants. In FY 1981, the Reagan Administration threw 20 separate federal health programs concerning maternal and child health, prevention, alcohol and drug abuse, mental health, and primary care into state-administered block grants and cut their total budget by 25 percent. There is virtually no federal oversight, and some state governments are not noted for their consideration for the poor and vulnerable.

The new budget proposal keeps the appropriations at the FY 1985 level—that is, makes no allowance for inflation—and “expands” the Primary Care Block Grant to include family planning, migrant health, and black lung programs. The family planning programs would be seriously threatened in many states. The migrant health and black lung programs would be considerably diluted by “extending” them to all 50 states—only 14 states have black lung programs and only 34 states plus Puerto Rico have migrant workers.

6. Food and Nutrition. A 3.9 percent increase (to $148 billion) is proposed for the Women, Infants, and Children (WIC) Program for nutrition and health services. In previous years the Reagan Administration

• An increase in Medicare Part B deductibles and premiums ($407 million, including new revenues)
• Continuation of the physician pay freeze ($500 million)
• Reduction of the indirect medical education/severity of illness adjustment ($695 million)
• The shift of insurance coverage of working elderly to private insurers ($293 million)
• A freeze in clinical lab fee schedules ($35 million)

The Reagan Administration also wants to introduce flat rate vouchers, which would not save any money but would signal an all-out assault on the Medicare system itself.

2. Medicaid. The Reagan Administration proposes an actual cut of $1.1 billion in Medicaid for FY 1986. This would mean that since 1981 reductions would total 10.1 percent of spending. Cuts already implemented have brought reduced eligibility (especially for the elderly poor and physically disabled) and curtailments of services (eyeglasses for children, dental care, hospital care, and prescription drugs).

The changes proposed for 1986 to 1988 would double those from 1981 to 1984. Millions more needy citizens would be shoved off the rolls and into the same plight as the 15 percent of Americans now without any health insurance whatsoever.

In addition, the Reagan budget proposes to cap Medicaid reimbursement to the states with a formula based on proportional expenditures in FY 1984. This would transform Medicaid into a simple block grant program and nullify the new Child Health Assurance Program (see box).

Elections have been depressing of late, but election year politics sometimes has surprising results—if people are willing to do enough hard work and persevere. In 1984, in the era of Reagan cutbacks, a bill was enacted that will expand the Medicaid coverage of hundreds of thousands of poor children and pregnant mothers. This legislation is part of the Child Health Assurance Program which the Children's Defense Fund developed, lobbied for vigorously for several years, and finally pushed through with the help of Representative Henry Waxman (D-CA), Chair of the House Subcommittee on Health.

Under the Medicaid law, states were required to cover only children in one-parent families, although they could cover two-parent families as well. Only half did. The new law requires every state to cover all children born after September 30, 1983, until they reach age five, provided their family meets the state's needs test. They must be offered the same Medicaid benefits as other children; the state is mandated to cover. At a minimum, these include hospital care, physician care, laboratories, and testing; some states have exercised their option to cover other services as well—for example, dental care, eyeglasses, or drugs.

The CHAP bill also improved Medicaid coverage in other ways. Previously, some states had required that Medicaid-eligible mothers file a new application for a new-born child, which meant that its coverage was not assured. Now such children are automatically covered at birth. Another provision of CHAP requires coverage of all needy pregnant women—previously seven states had denied first-time mothers coverage until after the child was born. In addition, states must cover pregnant women in two-parent families if both parents have been unemployed for a certain length of time—17 states previously did not cover any pregnant women in two-parent families.

Because CHAP ends the artificial distinction between

A Victory for Children

Kate Pfordresher.
The next move to extend Medicaid coverage will be at the state level. Almost half the states do not cover all two-parent families that meet their own needs test. Some states have set need levels below subsistence, thereby excluding hundreds of thousands of poor people. Health care advocates can work at the state level to win increases in the Medicaid standard of need, and extend coverage to all needy two-parent families. They can also urge coverage of the "medically needy"—people whose income exceeds the state's standard of need but have medical bills high enough to push their income below the standard—in the 20 states which do not provide for them now.

Hospitals will be an uncustomary ally in these efforts. They are loudly complaining that tightened reimbursement policies have transformed the provision of uncompensated care for the medically indigent millions from a heavy burden into a formula for bankruptcy. In the immediate period, however, health advocates will be devoting their efforts to defeating the Reagan budget. If it passes, CHAP would be among the programs to go under.

(Herbert Semmel is a member of the Health/PAC Board and specialist in government programs.)

7. Tuberculosis Control. In FY 1983, Congress undid some of the damage created by cuts in FY 1981-82. However the $5 million per year of FY 1983 to 1985 will be eliminated if the Reagan budget passes. Perhaps if the TB rate were falling, it would be possible to argue that a budget reduction is logical, but the rate is increasing throughout the nation—presumably as a result of the Reagan Administration's war on the poor.

8. NIOSH and OSHA. The proposed FY 1986 budget for the National Institute for Occupational Safety and Health would mean a 13 percent slice (to $58 million) This would eliminate all health professional training and notification to more than 200,000 workers that they are at risk from occupational exposure. The Occupational Safety and Health Administration budget would be reduced 3.5 percent to $213 million, even though OSHA has been citing inadequate staff and resources as a legal defense for its failure to issue a court-ordered safety standard.

9. EPA. The Environmental Protection Agency's operational funding will be down nearly 20 percent (to $1.8 billion) from what it was when Reagan first took office if the proposed budget allocation goes through. Even with the proposed 11 percent increase (to $94 million), funding for the Toxic Substances Program would still be 15 percent below the constant dollar FY 1981 expenditure.

10. Immunization Programs. Despite rapidly escalating vaccine costs (a six-month supply of DPT vaccine costing $900,000 in FY 1982 now costs $27 million) and the large number of unvaccinated children, the Reagan budget proposes a funding freeze at the FY 1985 level ($46 million).

11. Sexually Transmitted Diseases. The American Public Health Association has reported that there is an epidemic of venereal disease affecting one in four Americans between ages 15 and 55. More than 40,000 fetal deaths from ectopic pregnancies are attributable to untreated venereal diseases. The Reagan Administration proposes a freeze at $55 million.

12. AIDS. The Reagan Administration wants to hack 11 percent off funding for Acquired Immune Deficiency Syndrome research, counseling, and alternate testing programs, reducing the allocation to $86 million. The number of cases reported in 1984 was double that of 1983.

13. Health Planning. In FY 1981, the federal government spent $117 million for health planning. This fiscal year the allocation was down more than 50 percent even before inflation, to $58.8 million. The number of health planning agencies has plunged 25 percent, largely due to budget cuts. This year Reagan wants to wipe out the funding entirely.
Gesundheitstag
Lessons From the West German Health Movement
by J. Warren Salmon and Agatha M. Gallo

For us, "gesundheit" is a response to a sneeze; to Germans it means "good health," and has become a political statement as well.

Since 1979 West Germans have periodically held a gesundheitstag, or "good health day" conference. These gatherings now stretch over a week, bringing together a vast number and variety of people to discuss a wide range of health-related topics.

The idea for the conferences originated in West Berlin. When the city was rebuilt after World War II, the ground floor of new apartment dwellings was designed for different kinds of shops, such as "mom and pop" grocery stores, florists, and bakeries. In the 1970's, the economic pressures of the city's isolation within East Germany's borders and the West's long-term economic recession forced many of these shops out of business. Grassroots groups then moved in, creating public spaces where neighborhood residents could come together and organize around common concerns. The new spaces included daycare centers for working women and many "gesundheitsladen"—"shops" or workshops devoted to health-related activities.

When the German Medical Association decided to hold its 1979 annual conference in West Berlin, people involved in these health workshops resolved to sponsor a national meeting right afterward to share their experiences and concerns. This first Gesundheitstag was attended by both conventional health professionals and alternative therapists, as well as political activists from the Green party and the more traditional Socialist and Communist parties.

From this auspicious beginning, the conferences have developed into a broad-based popular health movement and, potentially, an influential political force in health and health care issues. Conference participants now include health academics; representatives of women's organizations; union officials; physicians working in occupational safety and health; and members of Third World support groups. Groups such as Physicians for the Prevention of Nuclear War represent the peace movement—many West Germans argue that peace and people's health are inseparable.

Also present at the most recent conference were persons suffering from various physical ailments who were organized in self-help groups in the late 70's under Helmut Schmidt's Social Democratic administration. Ex-mental patients, prisoners, drug addicts, and members of other special interest consumer groups participated in Gesundheitstag activities and workshops. Gay health workers and staffs from free clinics were well represented.

The energy of the initial Berlin gathering stimulated participants to establish gesundheitsladen in several other major cities, and a second national gathering was organized in Hamburg in 1981.

Gesundheitstag Bremen
The third conference, held last October in Bremen, brought together over 25,000 health workers and consumers to exchange their ideas and experiences.

"Workshops on Eastern philosophies and Native American medicines were also available."

The program agenda was developed through discussions in the gesundheitsladen throughout the country. Reports from each one were disseminated two to three months in advance of a national meeting of delegates. This meeting set four programmatic themes: 1) defining government and public responsibility for health, 2) studying conditions affecting everyday health, 3) establishing linkages between historic left critics of the medical establishment and people in the ecology and natural healing movements, and 4) the "uprising of the marginalized"—those discriminated against by the health care system, including mental patients, the homeless, the disabled, prisoners, drug abusers, gay people, the aged, and migrant workers.

Reaction and Action
Since Bismarck introduced social insurance a century ago in an effort to stem the growth of the powerful socialist move-
government, health care has been regarded as a right in Germany. Consequently, in marked contrast to the United States, in West Germany the social insurance program covers the cost of medical service for about 90 percent of the population. Providers of medical services have long been subordinated to the government and public policymaking bodies.

The conservative Christian Democratic administration of Helmut Kohl is seeking policy changes in health in the same direction as those of the Reagan and Thatcher governments, stressing individual responsibility. As might be expected, many participants at the Gesundheitstag were critical of this. They questioned whether government health expenditures were really excessive, and suggested that a “crisis” mentality was being manufactured to provide a rationale for curtailing health benefits.

Concern was also expressed about proposals by policymakers (and some well-intentioned social scientists) to create central computer data banks to store health information on the entire population of West Germany. Sessions discussed the significant social control implications inherent in this proposal, and how to build safeguards to protect consumers.

One fascinating aspect of the conference was the reports on new research in the archives on Nazi health policies. Aside from describing the well known enlistment of physicians to participate in brutal experiments on humans, instituted even before the establishment of the death camps, and the “racial purification” policies, speakers elaborated on the Nazi Party’s “Aryan” health ideology. They noted that a number of its themes are echoed by some advocates of natural medicine and holistic health. After hearing these talks, many conference participants called for a public education campaign describing this legacy of false science to preclude likeminded practices against the old and disabled today.

Deep fears were expressed about U.S. military and cultural assaults on Third World countries. Several sessions urged concrete support for the Sandinista government in Nicaragua; German health brigaders who had gone there and elsewhere in Latin America related their experiences. Several panels discussed the unhealthful activities of multinational pharmaceutical companies, some of which are based in West Germany, in the Third World; citizen actions to oppose them were described by members of church groups. The existence of hunger in the world while there are food surpluses in the advanced industrial nations was also a frequent topic.

Stress, caused by work and unemployment, evoked widespread interest. There were reports on the “misery” of health provider-inflicted harm. Some sessions examined how behavioral control is exerted by health provider agencies and the federal government. Others looked at new ideas about a “planned life and planned death.”

Many of the conference themes, however, considered the needs of special groups. Sessions on the marginalized were designed to create dialogues among all those considered problem populations by the health care system and usually labelled “deviant.” People in these categories often suffer discrimination, and many of them argue that their particular health needs merit special sensitivities. Representatives from each category described their situation in detail, and presented information on their local responses. These stimulated both theoretical and strategic discussions on how to improve their care.

Parts of the program were devoted to the call by the World Health Organization (WHO) for “Health for All by the Year 2000”—meaning the worldwide elimination of hunger, disease, and oppression.

By far the main topic at Gesundheitstag Bremen was daily health. This had many aspects. There were programs on natural birthing; sexuality, desire, and love; work and personality; death and dying; numerous nutrition topics; pills and herbs; and workshops on massage, bioenergetics, yoga, and other alternative therapeutic. Still other sessions addressed concerns about problems inside health care institutions, including violence against patients, nursing and sexism, and psychosocial aspects of intensive care units in hospitals. Reports from various women’s centers and free clinics suggested ways to handle health worker burnout. Examples of good team work by health professionals and exchanges between conventional practitioners and alternative therapists also received attention.

The ecological concerns articulated by the Green Party have clearly enhanced the importance of health as a political issue. In addition, although previously many activist health professionals did not emphasize affirmative health and well-being, new voices have emerged among alternative practitioners to challenge the “tradition” of only polemicizing against the misery of this life.

As in the United States and elsewhere, this is a difficult discussion. Conference attendees recognized the pitfalls of promoting health merely in terms of lifestyle changes, and there was criticism of those involved in holistic medicine and ecology who ignore the issues of occupational health and safety and other corporate-generated etiologies of disease. It was fascinating to see that the local gesundheitsliden have sought dialogues here, listening to, rather than judging, the conflicting positions. Participants discussed the philosophical basis for their arguments, and then undertook specific examinations of life and health in a polluted and uncontrolled technological environment.

“One fascinating aspect was the reports on Nazi health policies.”

It is not surprising that the birthplace of Wilhelm Reich, Rudolf Steiner, and Samuel Hahnemann has many groups that follow the teachings and practices of various holistic schools. Workshops on topics such as Eastern philosophies and Native American medicines were also available, filling out a range of discussions similar to what is found at a typical holistic health conference in the U.S.

The difference was that although, as in the U.S., the people who attend such conferences rarely interact with traditional left critics of the medical establishment, the Gesundheitstag program offered several opportunities for bringing these two groups together. Such continuing dialogues unite two powerful forces for change in health conditions in West Germany, and the Green party offers a vehicle to advance the discussions to the policy level.

For us, coming from the U.S., Gesundheitstag Bremen was tremendously exciting. We returned home asking ourselves how health activists here can advance en masse to a similar high level of discussion and organization.
Fighting Medicine

Health and the War Against Nicaragua, 1981-1984, by Richard Garfield, RN, Dr. PH, and David Seigel, MD, documents for the first time the goals and results of the U.S.-sponsored contras' efforts to disrupt the health system in Nicaragua as well as the Sandinista government's response of reorganizing health services and training and involving people at the grassroots level. This book should be read by anyone concerned about U.S. policies in Central America and/or what poor people anywhere can accomplish in health care when given the opportunity. Single copies are $3 from LINKS, P.O. Box 407, Audubon Station, New York, NY 10032.

Misconceptions

Abortion: Stories From North and South is a cross-cultural survey filmed in countries throughout the world. It shows how abortion occurs among all types of people in every country—35 million a year, and how differences in practice and perception are mainly in the degree of secrecy and danger surrounding it. Produced by the Canadian Film Board, written and directed by Gail Singer. Rental $100; purchase $895 (16mm), $595 (video). Available from the Cinema Guild, 1697 Broadway, New York, NY 10019.

Bringing It All Back Home

All About Home Care: A Consumer's Guide is a new 30-page booklet with information about the services available under home care and what to do when problems arise. Copies are $2 if you send a stamped, self-addressed business envelope to the National Homecaring Council, 235 Park Ave. S., New York, NY 10003.

Ragtime

The Disability Rag offers the disability rights perspective in analyses of public and not-so-public issues affecting 12 million Americans. Ms. magazine has praised it for its "honest, probing articles," and the Ladies Home Journal has called it "irreverent and feisty." A one year subscription is $9 from The Disability Rag, Box 145, Louisville, KY 40201.

Conference Calls

The Seventh National Lesbian/Gay Health Conference and the Fourth National AIDS Forum will take place June 28 thru July 1 in Washington, D.C. The theme will be "Mainstreaming Lesbian and Gay Health Care," and presentations will include scientific, emotional, social, and organizational issues. The results of the first National Lesbian Health Care Survey will also be presented. For more information, contact the National Lesbian and Gay Health Foundation, Conference '85, P.O. Box 65472, Washington, D.C. 20035.

The 1985 North Carolina Health Promotion—Wellness Institute will be held June 23-28. Participants will learn the principles of wellness and how to promote them in their organization or business. A special wellness program for children will run concurrently. For more information, contact Jacquelin Rollins, Program Assistant, Wake Area Health Education Center, 3000 New Bern Ave., Raleigh, NC 27610.

Bringing Toxics Out of the Closet

Golden Empire Health Planning Center, a non-profit organization working on environmental and public health issues, has just completed a major project on the safe use and disposal of consumer products containing toxic chemicals. The three segments are a colorful poster on reducing home hazards and using safer substitutes, a four-part school curriculum for grades K-12, and a 300-page handbook for communities interested in implementing collection programs for residentially generated hazardous waste. Posters are $3.50 including postage; the handbook is $10, including postage; each curriculum (K-3, 4-6, 7-8, 9-12) is $6.50 with a 3-ring binder, $4 without, plus $3.50 per order for postage and handling (it will be sent to street address only via UPS). Order from GEHPC, 2100 21st St., Sacramento, CA 95818.
When the Guinea Pigs Are Human

by T. Jones

Last May 29th Niall Rush died 15 minutes after being injected with eproxidine. He was participating in a clinical trial of this new drug at the Institute of Clinical Pharmacology, a privately-owned clinic on the grounds of St. James' Hospital, Dublin.

The jury at the inquest found Rush was killed by the interaction of the eproxidine with Depixol, a potent tranquilizer Rush had been prescribed for psychiatric problems. Although he had been a participant in two drug trials a year at ICP for the previous six years, doctors there were unaware that he was receiving psychiatric treatment.

Several other participants in ICP testing who testified at the inquest claimed that marijuana smoking was widespread there, and known to be so by the staff. One spoke of leaving the clinic overnight for a party during a drug test and being so drunk the next morning that staff members were unable to rouse him for a routine blood test.

Dr. Austin Darragh, head of the ICP, denied all the allegations, and claimed that Niall Rush was the first person to suffer an adverse reaction among the 10,000 “volunteers” who had participated in drug trials at the ICP over 17 years.

A public police file on Rush's death was forwarded to the Director of Public Prosecutions for a decision on whether criminal proceedings should be initiated. No action has yet been taken. The inquest jury urged immediate legislation on human drug testing to require those engaged in it to get full medical histories on all subjects from their general practitioner and to ensure that each phase of testing be preceded by a full physical exam. It also called for the establishment of a committee to immediately investigate recruitment, screening, security, and safety procedures at ICP. So far neither legislation nor the investigating committee has appeared. ICP is starting work on a new clinic in Dublin and discussing the possibility of opening drug testing centers in other locations in Ireland.

The clinic was founded in 1969 by Hoffman-La Roche as the Psychoendocrine Unit, one of five the Swiss multinational pharmaceutical giant operated around the world. At that time Roche employed Dr. Darragh to do testing, and provided funding of $250,000 a year. When it decided to close the Unit down Darragh took over, with assistance from the Irish government's Industrial Development Authority—IDA grants to the ICP now total nearly $1 million.

This venture has proven highly successful for Dr. Darragh, who recently declared that “within the strict meaning of the word, ICP is wholly concerned with profits,” because Profits really mean Results, and results of research are what we are in business to produce on time and within budget.” In 1982 ICP formed links with the British-based Huntington Research Centre, which specializes in early tests of drugs on animals. The same year it opened a wholly-owned subsidiary clinic in New Jersey to facilitate contact with its major clients, U.S. pharmaceutical companies. More recently it signed an agreement with New York Medical College to establish a $3 million clinical research center on the school's Westchester campus; Arthur Hull Hayes, dean of the College and a former Food and Drug Administration commissioner, has joined the ICP board of directors. An ICP stock offering in the U.S. was valued at $25 million, and Darragh has become a very wealthy man by Irish standards.

Boasting clients such as Squibb, Pfizer, Warner-Lambert, Bristol-Myers, Schering Plough, and Revlon, Darragh and ICP are among the beneficiaries of the growing export of U.S. drug testing. This movement began after the Thalidomide tragedy spurred public demands for tighter controls on the introduction of new drugs. Congress responded with amendments to the Food and Drug Act requiring human trials to determine their safety and efficacy (Phase I testing). Stricter regulation also delayed introduction to the marketplace, thus shortening the highly profitable patent-protected monopoly sale period; by introducing products abroad while they were still going through the U.S. regulatory system, companies could extend this most lucrative period, and this encouraged more testing abroad. The shift was further accelerated by the loss of the prison testing population due to adverse publicity and prisoner resistance and litigation. In 1975 prisoners were used in 80-90 percent of Phase I testing; by 1979 the proportion had plunged to 15 percent. Lastly, in poor countries eager for foreign investment the likelihood of expensive legal action is much lower than in the U.S. and there is less protection of clinical subjects. In 1970, U.S. drug companies spent 8.7 percent of their research and development budgets abroad; by 1978 they had boosted this proportion to 16.8 percent.

"There was no way as an individual in the U.S. that I could have met the bureaucratic and regulatory problems," remarked Dr. Don Panoz, whose Elan Corporation in Athlone specializes in developing improved dosage forms. “Ireland’s safety standards are as high as in any other country, but the authorities take a more pragmatic approach.”

There is no Irish legislation regulating the clinical testing of drugs on humans or other animals (this has also made Ireland a favorite spot for the introduction of new animal pharmaceuticals). Although a voluntary agreement to submit tests for approval by the National Drugs Advisory Board does exist, at least 20 percent are not brought to it. Even when tests are submitted to the NDAB, the company is under no obligation to accept its advice or to give it the results.

"In carrying out its tasks," the NDAB's guidelines explain, "the Board is concerned to avoid providing a hindrance to the development, clinical trial, and marketing of new drugs of acceptable toxicity." The NDAB and the Department of Health refuse to provide information to the public on which firms test in Ireland, or what they test. The situation is similar in the

T. Jones is a freelance journalist based in Dublin.
United Kingdom, where a dozen such clinics make it possible for manufacturers to test new products on healthy human beings without even notifying the health department.

Criticism of ICP began only a few years ago, but it escalated sharply with Niall Rush's death. The Social Policy Action Group, an organization of doctors, nurses, and social workers who had been monitoring drug testing in Ireland, called for a full independent inquiry and accused the Minister of Health, Barry Desmond of the Labor Party, of criminal negligence. Cutbacks in the departments of Health and Social Welfare have forced disadvantaged people to undergo tests to survive, they charged, and "this makes Mr. Desmond one of the prime recruiters for testing."

Following the Niall Rush disaster and a similar one involving a British student, Philip Jones, the National Union of Students in Britain urged its members not to take part in drug tests. Jones participated in trials of a benzodiazepine tranquilizer produced by Hoffman-La Roche in October 1983 at the Welsh National School of Medicine; he was paid $75. When he volunteered for another trial of the same drug in January 1984 his blood count was found to be seriously off. He is now critically ill with aplastic anemia and his doctor, Gordon Smith of Hammersmith Hospital, London, says "There is a hefty degree of suspicion that the October drug trial caused Philip's illness."

Soon after Niall Rush died, John Donovan, another "volunteer" in the same test, threatened to go on a hunger strike to highlight "inefficiencies" at ICP. He said that he and three others had not been contacted after Rush's death to find out if they were suffering any ill effects from the drug. Donovan also complained that tests prior to the administration of the drug were insufficient, and no doctor checked how the "volunteers" were feeling even though he himself had felt dizzy and faint while the drug was being administered and had informed a nurse; he noticed later that the nurse had not entered this complaint on his chart. In addition, he said, no doctor was available at the clinic after 6 p.m. All these claims were strongly denied by the ICP, which produced files that claimed to show that Mr. Donovan had been asked how he felt at quarter-hourly, then half-hourly, and then hourly intervals for 18 hours after the drug was administered.

The ICP has dismissed other accusations in similar fashion. When another "volunteer" in the same test withdrew after his face swelled up like a balloon and became burning hot, the ICP said his problem was caused by a severe hair perm.

The ICP describes its payments to "volunteers" as "expenses," and presents them with the option (never taken up) of paying these "expenses" to charity. No charity would get rich off the money, which hasn't been increased since 1967 and comes out to less than $1 an hour. When "volunteers" participating in a trial of the cancer drug interferon complained of suffering particularly harsh effects and asked for higher pay, ICP officials said no and warned them that if they walked out they would get no money at all. (When talking to the media, spokespeople from the Institute regularly emphasize the freedom of "volunteers" to withdraw from the tests, but neglect to mention that only those who complete a test receive payment.) Volunteers are inevitably drawn from the student and artist communities and from the ranks of the unemployed, dopers, and other marginals—groups found in abundance in Dublin, where little work is available. The clinic is located in the inner city, which is mired in the worst unemployment in all Ireland.

Low wages make the use of human subjects very attractive to the pharmaceutical industry. Commenting on the heavy failure rate among new drugs, ICP's Darragh declared that "The lesson is unequivocal—perform clinical pharmacological studies in man as safely as possible to establish whether or not the more elaborate, exotic, and sometimes virtually impossible-to-interpret animal studies are worth the money and time." He has also described ICP's business as being "to develop alternative methods for testing drugs which will reduce the growing antagonism of Green parties and animal protection groups to pharmaceutical research."

It is likely, however, that members of these organizations are concerned about human guinea pigs as well as animal ones, and are aware that most tests are performed on pharmaceuticals of dubious value. The U.S. FDA, not noted for its enmity toward the drug industry, has calculated that of new drugs submitted to the FDA, only 5.3 percent were "important therapeutic gains" and only 13.2 percent were "modest therapeutic gains." In other words, 81.5 percent of all new drugs submitted to the FDA represented no great benefit to public health—and only one of every ten drugs tested abroad gets that far.

A great deal of unnecessary health damage could be avoided by legislation which requires the performance of animal tests before human guinea pigs are subjected to clinical trials, and prevents the introduction of new drugs that represent no therapeutic gains over those currently available.
Body English

Testing, Testing, 1,2,3
by Arthur A. Levin

Years ago there wasn't much high-tech diagnostic testing. You went to the doctor and were examined by knowing eyes, ears, and hands. Perhaps someone looked at your chest with a fluoroscope or x-rays, or did a hemoglobin test and a simple litmus paper urine test. Today, as the range and sophistication of diagnostic tests increases, doctors must rely on outside laboratories for both testing and analysis. Physicians have become the intermediaries of diagnostic tests and their offices the collection points for vials of blood and urine.

In New York and some other states, this intermediary status is statutorily enforced; there is no way for a consumer to get any test, even for pregnancy, without a doctor's order. Other states, such as Florida, permit walk-in testing centers at shopping malls, so you can buy your butter and find out your cholesterol level at the same time.

Throughout the country the home medical test market has been booming in the past few years, in both scope and dollar volume. A recent New York Times article estimated that 1984 sales totalled more than $800 million, and predicted that they will climb to almost $2 billion by 1988.

Often the products are repackaged technology that has been employed in labs and doctors' offices for years. This group includes home tests for pregnancy, occult blood (colon cancer), glucose in urine, and blood pressure.

However a growing number of the new home kits are made possible by computer chip technology. A small disposable computer is used in tests for urinary tract infection, ovulation, and strep throat. A non-disposable testing device that measures blood glucose levels used for better control of insulin dosage, costs $150-200. This high-tech digital readout wonder has not replaced the less expensive color-coded urine dip sticks, whose dollar sales are still ten times greater.

Some traditional suppliers of physician and laboratory equipment have cashed in on this expanding market. Well-known consumer product manufacturers such as Timex and Norelco are also offering tests. The day may be approaching when John Cameron Swayze will show us how a blood pressure cuff can survive a 1,000 meter descent into an active volcano.

Tests soon to be on the shelves include a dip stick designed to help hypertensives monitor sodium intake and a thermal foil strip to detect possible breast disease. Since 1976 the Food and Drug Administration has had authority to classify home tests according to their safety and efficacy. It also supervises the content of labeling, with particular attention to whether the use directions help or hinder proficiency.

One problem with some of the tests is that consumers do not trust their own ability to use them properly. Those for pregnancy (the first home test, marketed in 1977) are a prime example. Since this test is a repackaged version of the one used in labs, home versions are very accurate when used correctly. Yet studies show that if the test result contradicts what a woman already believes, she will doubt either the test or her ability to use it correctly. To deal with this problem, some manufacturers have set up hotlines which women can call to discuss their doubts about the test and receive instructions on retesting. Unfortunately many consumers probably end up in a doctor's office for retesting anyway, convinced that they have wasted money and time by purchasing the test because they lack the skill to do home testing correctly.

Critics of some other tests, such as those that screen for early colon cancer, say it is debatable whether early detection of these diseases can be helpful. Furthermore, tests for disease can produce both false positives and false negatives. In the case of life-threatening conditions, this can cause unnecessary anxiety and lead to more invasive tests and procedures.

Some of the new tests do appear to bolster consumer self-reliance. The one for strep throat in children is one example. Although it has long been known that parents do a very good job of taking throat cultures at home, they still had to take the culture to the doctor or a laboratory for analysis. Without a culture there is the risk of unnecessary antibiotics. If no antibiotic is prescribed, there is the risk of not treating the strep infection effectively. The test allows the parent to determine whether or not strep infection is present, so if antibiotics are necessary, they can be prescribed by phone. This eliminates both the cost and frequent delay involved in a doctor visit and reduces inappropriate prescribing.

The new sophisticated home glucose monitor is also widely praised. There is evidence that for some patients these monitors permit tighter control of diabetes through "finer" manipulation of dietary intake, physical activity, and insulin dosage. Many experts believe this can reduce complications that often occur. Supporters of the monitor also argue that it has tremendous motivational potential since the person who uses it is necessarily more actively involved in his or her own treatment.

On the other hand, home glucose monitoring appears to have a serious problem recently identified: some people "lie" about their test results to make them appear lower. The study which noted this drawback suggests that these participants may be afraid that their practitioners would be "angry" if they did not achieve good control.

Aside from glucose monitoring there are few, if any, other situations in which physicians have been willing to pass on treatment responsibility to laypersons. Hypertensives, for example, are not encouraged to adjust medication levels on the basis of their home test results, so the benefits of these tests might be limited. Certain tests seem to benefit consumers by increasing their control over care and reducing their reliance on professionals; some even enable people with a particular medical medical to diagnose and treat it without a physician or laboratory visit. Other tests can be considered valuable only if you believe that getting to a physician earlier will improve outcome—a belief that can be difficult to substantiate scientifically. The ability of the Food and Drug Administration to monitor the safety and efficacy of home testing products is not clear; their over-
Know News

Health Promotion and Class
by Nick Freudenberg

If health promotion hasn’t come to your community or workplace yet, it soon will. President Reagan wants to slash the funding for major public health programs, but raise the allocation for federal health promotion efforts by 40 percent. A 1981 survey of California companies with more than 100 workers found that 78 percent offered their employees health promotion activities. A recent conference on Health Promotion in the Workplace sponsored by the New York Business Group on Health attracted dozens of managers from Fortune 500 companies. Citicorp Chairman Walter Wriston explained why in a special issue of the Health Education Quarterly: “Programs that emphasize prevention and early detection of illness and encourage people to take responsibility for their own health can go a long way towards reducing the health care cost burden for corporations and for society at large.”

The term health promotion can mean one thing to the head of the American Tobacco Company and something else to a public health practitioner. Lawrence Green, former Director of the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine of the U.S. Department of Health and Human Services, has defined it as “any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental changes conducive to health.”

Such a definition could encompass a variety of ideological perspectives. In practice, most health promotion programs have focused on changing individual behavior. The most common corporate programs are concerned with: how to stop smoking, accident prevention, drug abuse control, hypertension screening, and exercise and fitness; the vast majority carefully avoid addressing occupational health problems. Community-based health promotion programs, sometimes partially financed by state governments, are often largely or exclusively designed to lower coronary heart disease mortality by encouraging people to consume less fat, quit smoking, and exercise more. The small but growing number of school-based programs generally address issues such as nutrition, smoking, and interpersonal violence.

Critics of this approach cite several problems. First, it puts the burden of enhancing health on the victims of health damaging social forces and policies, rather than on the perpetrators. The government provides a token amount to help nicotine addicts, but permits cigarette manufacturers—not to say the alcohol, cereal, and automobile industries, among others—to spend billions of dollars on advertising. By defining health promotion as what individuals can do for themselves rather than as what a society does to ensure health for all its people, industry and its protectors in government hope to dissipate public consciousness that persuading consumers to buy dangerous or health damaging products is a virulent form of disease promotion. As such, health promotion can be seen as a backlash to the progressive health movements of the last decade.

Second, health promotion efforts are usually aimed at white, middle-class Americans, the healthiest segment of the population. The shameful customary explanation for the paucity of programs for minorities, older people, or low-income communities is that their costs would exceed their financial benefits. Similarly, some corporations offer a comprehensive health promotion plan to management—membership in a fitness center, health and nutrition classes on company time, elaborate sports facilities on site—and nothing to other employees. The financial consideration here, apparently, is not the cost of poor health to the individual but the replacement value of the employee to the corporation.

Third, few of these programs have been rigorously evaluated. While some assessments affirm changes in health knowledge or behavior, there are no hard data which demonstrate that health promotion saves lives. Until this validation is available, pouring more resources down this channel might be premature.

Despite the justice of these criticisms, it would be a mistake to dismiss health promotion altogether. Media campaigns and organized programs have undoubtedly helped to create a greater awareness of the relationship between health and behavior, and aided some people in asserting greater control over their lives and health. Among them are many critics of the dominant individualistic perspective in health promotion. An informal survey of the members of the Editorial Board of this journal revealed that 88 percent of them do not smoke cigarettes, a similar proportion make conscious efforts to reduce their fat and cholesterol intake, and 65 percent engage in strenuous exercise three or more times a week. (We didn't ask the Board members for their incomes, but if they were tallied, it would probably corroborate the general finding that people with relatively higher incomes and more education are far more likely to engage in preventive health behavior.)

The task for those of us who are committed to a more just and healthful society is to simultaneously help people to change health damaging habits and to organize them into groups that can fight for health promoting policies and programs. It makes sense to buckle your seat belt and to write your legislators to demand that they stand up to the auto industry and support mandatory air bags. Similarly, public health organizations should both set up quit-smoking programs and lobby for stricter controls, if not bans (some countries have them) on tobacco advertising and for more no-smoking zones. Successful efforts are those which educate both consumers and policymakers.

There must also be programs which address the needs of special populations. In an article on health promotion for nursing home residents, Meredith Minkler of the University of California-Berkeley School of Public Health argues that effective programs in long term care facilities must attempt to change both existing institutional arrangements and their dependency-creating environment. “Health promotion,” she notes, “may have a critical role to play in improving the health and quality of life of the institutionalized elderly.”

At its core, health promotion has the potential to be a radical concept: it raises the question of who has responsibility for health. Critics of a narrow definition can continued on page 31

by Mark Kleiman

Although his older sister screamed for days after she received her first pertussis (whooping cough) vaccination, the doctor had never told Nicky's parents that this was a characteristic of severe reaction. When he was four months old, Nicky got his first DPT injections. He went into convulsions so severe he had to be hospitalized. Nearly four years later he was still suffering from convulsions, seriously retarded, partly paralyzed, and unable to talk, to walk, or to stand by himself. He will require lifetime care.

Every week over 50,000 young children get pertussis vaccine as part of their standard diphtheria, pertussis, and tetanus (DPT) shots. Although it is uncertain just how risky pertussis vaccine is, we do know that it is the most dangerous of all the vaccines commonly given young children. Some physicians say that it kills or permanently paralyzes five or six in any given year; others believe the mortality rate is as high as 300 annually, with another 11,000 suffering long term damage. UCLA researchers conducting a government-sponsored study were shocked to discover that at least one child in 1500 suffers from convulsions after receiving a shot.

A Shot in the Dark is more than a call to arms on behalf of thousands of such DPT victims and their families. Its chilling profiles of wasted minds and ruined lives are combined with technical and scientific information that will enable parents to realistically evaluate the risks inherent in DPT inoculation. The authors have done a remarkable job of explaining the basic immunologic and epidemiologic issues in accessible English. This effort to reach lay readers extended to the omission of footnotes, which will frustrate professional readers who want references they cannot easily trace. However there is a 30-page technical bibliography, the most complete listing of the literature available.

The book suffers from this split personality in other ways as well. Fairly technical chapters are interspersed with vignettes from the lives of DPT victims and their families—the kind of horror stories that will keep the anger of lay readers at a fever pitch. However one of the authors' best decisions was to explain what concerned parents can do—about their own children, and about immunization programs which have misled consumers. They describe the relationships between the Food and Drug Administration and the major drug companies, detailing their joint failures to develop a safe vaccine, to identify babies at high risk of severe reaction, and to fully inform American parents of the real risks involved in pertussis vaccination.

FDA scientists have admitted that they are unable to test the safety of any given batch of vaccine before it is sold. However even though the actual cause of severe reactions has never been determined, there is solid evidence that the more potent batches of pertussis vaccine cause the most damage. Because of the way it is made, one batch may be five times stronger than another—and much more dangerous. In 1978-79, 11 babies in Tennessee died within eight days of receiving DPT vaccine; nine of them had been injected with vaccine from the same batch. The odds against this being "coincidental" are more than 30 to one.

Nevertheless, recent Congressional hearings focused on a claimed shortage of DPT vaccine. This represented a victory for the pharmaceutical companies, who temporarily succeeded in creating a "crisis" atmosphere while concealing the underlying political dispute over DPT and the damage it causes. The "shortage" was artificially induced when one of the three drug companies making the vaccine managed to cook up several batches which failed to pass even the minimal FDA tests. Furthermore, nearly all reputable epidemiologists admit that whooping cough is one of the most misunderstood, misdiagnosed, and under-reported diseases in the nation. Because barely one case in five or ten is actually reported, public health officials can easily raise alarams of a "mini-epidemic" by aggressively pushing case-finding and reporting.

Behind the crisis, the real issue is who shall pay for the costly havoc wrought by the vaccine. Health and the Environment Subcommittee Chairman Henry Waxman (D-CA) is supporting a bill which would give parents of DPT victims the option of either receiving guaranteed (albeit inadequate) compensation from the federal government, or of suing the drug companies which continue to make marginally safe, inadequately labeled vaccine. The drug industry is lobbying for a bill which would immunize them from any liability by making government compensation the sole remedy available to DPT victims. Activists point out that if drug companies escape the costs of their negligence, they will have no incentive to develop a safer vaccine, as the Japanese have.

Since 1981 the Japanese have tested millions of doses of a new, safer vaccine. Japanese researchers have not reported a single adverse reaction, much less any deaths or cases of brain damage. Although American drug companies complain that it is too costly to pay for the damage caused by the old vaccines, they have dragged their heels at testing new ones.

The problem is nationwide, but some of the solutions are within reach on a statewide level. Although the federal government measures the actual strength of every batch of DPT, it permits the manufacturers to mislabel the vials as being of single, uniform strength. Laboratory work sheets obtained from the FDA under the Freedom Of Information Act show that the FDA approves vaccines that are three times more toxic than the amount indicated on the label. The true toxicity information is available to the states, and concerned California physicians have urged the state health department to establish a "closed hotline" that could tell them which vaccine batches are more toxic.

Because the Deukmejian administration has ignored this plea for a simple, non-regulatory measure, angry physicians, activist parents, and their lawyers are forcing its hand. Assemblyman Lloyd Connelly has introduced a bill that would require the labeling of all vials of DPT vaccine with the actual toxicity of the pertussis component. This legislation has forced the pertussis controversy onto the public health agenda. Strong lobbying from the parents of a victims group (California DPT—Dissatisfied Parents Together) as well as a barrage of tech-
Technical information from activist physicians have drummed up considerable support, and 18 more legislators have signed on as co-sponsors.

As might be expected, Lederle Pharmaceuticals is pulling out all the stops to oppose the bill. Roderic Cherry has shed his robes as the impartial expert they use for trials and is accompanying their corporate lobbyists. The company has also tried to raise the same "shortage" scare that hit the national press in 1984, and has threatened to end DPT sales in California if the bill is passed. The traditional public health lobby fears that any public debate over DPT vaccine safety will lead to a decrease in all vaccine usage. At the same time, responsible Department of Health officials recognize the problems with DPT and have asked the FDA to release the toxicity data.

The conflict between consumer rights and the public health agencies has blurred many of the traditional left-right political distinctions but the Reagan Administration is doing its best to reestablish them. An Administration-sponsored bill announced in April would bail out the drug companies by drastically limiting the rights of consumers to recover damages for brain damage caused by DPT. The legislation would do nothing at all to warn physicians or consumers, much less push the manufacturers to develop a safer vaccine. Administration spokespersons justify this by raising the spectre of a vaccine shortage. They simply ignore the investigations of Henry Waxman's subcommittee. Last year Waxman exposed the shortage scare as a sham—one of the drug companies which claimed it had halted manufacture of DPT, was actually making more than ever—and selling it through Lederle.

As this indicates, the story is still unfolding, but Shot in the Dark is required reading for anyone interested in the latest wars over mass immunization policy.

Mark Kleiman is a Los Angeles attorney specializing in medical malpractice and products liability law.


by Michael Clark

Many of us have friends who dismiss the 1960's as a hopelessly naive period, laughing off their own former ideals of equal rights, cultural diversity, and popular participation as so much youthful woolly-headedness.

Many of us also have friends for whom the 1960's have never ended. Still caught up in the ideological and real battles of that time (which, as a social period, really extended into the early 1970's), some of my old comrades still speak of "the movement" and "the people" without seeming to notice the intervening decade in which the beliefs of previous allies—no to mention the general public—have become far more conservative.

A cynic, goes the old saw, is a disillusioned idealist; the kind of idealism that most often expresses itself as romanticism in the young all too easily becomes cynicism and false despair in later years.

Between these two extremes lies the commonsensical notion that real social progress is uphill and hard-won, usually in bits and pieces. If Marx is right that all human history is the history of class warfare, it is also observable that long stretches of guerrilla struggle are only occasionally interrupted by grand revolutionary battles.

Many of us were naive in thinking the 1960's was a prerevolutionary period in American history, rather than a series of skirmishes along the borders of class, race, and sexual divisions. Yet, in the process, those borders did move. Our challenge in the quiescent 1980's is to discover how we did it and how we lost momentum somewhere along the way.

The Sidels' book is one of many recent attempts to chart changes in a specific
sector of American society during the turbulent years and beyond (in their case, roughly 1960 through 1984). While it provides little analysis of how the momentum dissipated, it does offer a rich assortment of clues about what we accomplished and merits a detailed summary, even in a relatively brief review.

There is, for example, Jack Geiger's excellent depiction of the movement to establish community health centers in poor neighborhoods throughout the country. Today—in 1984, folks—the vast majority of the more than 900 health centers built since the 1960's still stand. As Geiger notes, the tail has failed to wag the dog. They have not revolutionized all the rest of medicine. But they have brought locally accountable (if not ideally democratic) local control over vital ambulatory care services within reach of literally millions of poor Americans.

Quentin Young presents a similar perspective on the struggles to defend and reform the nation's public hospitals. He traces how urban public hospitals such as Cook County provided the setting in which hundreds if not thousands of doctors, medical students, interns, and residents became activists in the civil rights and antiwar movements. Organizational vehicles such as the Student Health Organization, the Medical Committee for Human Rights, and the hospital workers unions played a key role. He describes in detail how they were crucial in achieving such real victories as expanded access to care and employment for racial minorities, expanded services (particularly in outpatient care), broadened consciousness of the need for consumer involvement, and real gains by hospital workers. Still, he notes, we are far from the thorough transformation we sought and much work obviously lies ahead.

Rick Brown, in a chapter that characterizes the development of the Medicare and Medicaid programs as "bandaids for the old and poor," reminds us that even these limited reimbursement reforms have roots going as far back as the 1920's, although it was not until the 1940's that national health insurance legislation was debated in Congress for the first time—in the form of the Wagner-Murray-Dingell bill supported by President Truman. Brown carefully reconstructs the long and tortured process necessary to create even the limited type of coverage which the Medicare and Medicaid programs offer. When he signed them into law in 1965, President Johnson, speaking in the presence of Truman, commented that the marvel was not "the passage of this bill, but that it took so many years to pass it."

Despite their limitations, Medicare and Medicaid have produced very real health care improvements: greater access for children, better care for the aged, and a certain amount of gap-filling in services for the poor in general. Nevertheless, Brown argues, both programs were fundamentally flawed because they fed patients into the existing market system, inevitably increasing fiscal pressures on state and local governments and driving costs upwards so rapidly that they were bound to produce calls for cutbacks. We can learn from both the failures and the successes, he concludes: the necessity of avoiding programs which serve the poor exclusively; the need for strong and uniform basic coverage at the national level; the need for modifying current market prerogatives within the health care system; and the importance of developing broad political coalitions.

Molly Coye, Mark Smith, and Anthony Mazzocchi, in a chapter on the development of the occupational health and safety movement and related legislative and regulatory victories, note that the Occupational Safety and Health Administration was created in 1970 because
reformers raised a whole constellation of related issues in the late 1960's. They divide these issues into four areas: (1) lack of government regulation of industries, leading to myriad occupational hazards for workers; (2) inadequate compensation for occupationally-related injuries and diseases; (3) insufficient attention to scientific work in areas critical to occupational health, particularly occupational diseases; and (4) little worker awareness and knowledge of job hazards. In addition, they point out, calls for changes in working conditions, such as improved occupational safety and health, were part of a general worker concern in collective bargaining with nonfinancial issues in the late 1960's and early 1970's. The authors stress the crucial role of the leadership of several progressive trade unions and environmental health groups during this period, observing that supporting and expanding such commitments to health and safety issues won't be easy in today's high-unemployment, anti-worker climate.

In a chapter entitled “The Women's Health Movement: Women Take Power,” Dr. Helen Rodriguez-Trias traces the development within the overall women's movement of a particular focus on health. She devotes a good deal of space to a successful New York City fight to secure guidelines for voluntary sterilization within the municipal hospitals; these guidelines have since become national standards.

Rocio Huet-Cox summarizes the history of efforts in the late 1960's and early 1970's to expand access to medical education at a time when the number of physicians was growing rapidly. He rightly traces much of the pressure to expand the supply of physicians and access to medical training for women, minorities, and others formerly virtually excluded to the populist movements of the 1960's. But he laments the response by federal and state officials, who increased the quantity of medical education while disregarding much of the substance behind the original demands. Despite enlarged enrollments, increasing percentages of low-income and minority students, expanded residency training in family practice and other primary care specialties, and wider exposure to relevant topics in medicine, the medical graduate of the 1980's is little better prepared for the complexities of ill health in the modern urban setting than a physician was 30 years earlier; for the most part, old knowledge has simply been rearranged into new categories.
A subsequent chapter by two physicians, Health/PAC Board member Hal Strelnick and former member Richard Younge, "Affirmative Action in Medicine: Money Becomes the Admissions Criterion of the 1980's," is a detailed answer to the question of whether efforts to open the doors of medical schools to minority and female applicants have been successful over the past two decades. Despite some immediate gains following a series of reforms in the 1970's, they conclude, this progress has not been sustained; the rate of increase in enrollment by such groups has trailed off, leaving the percentage far below their proportion of the population at large.

A chapter by Dr. Fitzhugh Mullan, former director of the Federal National Health Service Corps, describes the development of the NHSC and the variety of innovations stimulated by its assignment of doctors to medically underserved areas. He points out that the NHSC strengthened the complementary federal program to create a nationwide network of community health centers, particularly after the election of Jimmy Carter in 1976. Together, he argues, these two programs became a kind of "community health movement." Although he recognizes that this was only an incremental improvement, he concludes that "incrementalism in the development of all social services is an inescapable part of the history and fabric of this country."

In "New Health Professionals: Changing the Hierarchy," Molly Backup and John Molinaro discuss the emergence of new "mid-level practitioners" during the late 1960's and the 1970's. They argue that the explosive growth in these occupations—there are now 11,000 physician assistants and 15,000 nurse practitioners—has had a significant effect on health care.

John W. Hatch and Eugenia Eng re-examine the strategy of community participation and community control in a chapter which looks at early Office of Economic Opportunity (OEO) programs, including community health centers in both urban and rural areas. They cite the limitations of community participation, but conclude that direct involvement of local residents and patients in the control of medical care at the community level has been a generally positive development.

"Holism and Self-Care: Can the Individual Succeed Where Society Fails?" by Larry Sirott and Howard Waitzkin is sharply critical of the individualism inherent in much of the holistic approach. However, the authors welcome this movement as a counterweight to the tendency of high-tech medicine to divide the individual into ever-smaller parts.

In a concluding chapter, Ruth and Victor Sidel take on the ambitious task of bringing all the preceding pieces together into a coherent whole and drawing some broader lessons. They argue that, like Christianity, many of these reforms can't be faulted for what they failed to accomplish since they were never really tried. This category includes minority admissions to medical schools and the whole strategy of affirmative action as well as community participation and control in health care delivery.

Another group they identify is reforms which were implemented but largely coopted into the medical establishment and used to support the existing structure—and perhaps even to make it worse. These include Medicare and Medicaid, reform efforts within urban public hospitals, the creation of new practitioners, and holistic medicine.

The final group in their triad consists of programs which enjoyed considerable success but have been undercut by reductions in funding or administrative attacks. Among them are the National Health Service Corps, community health centers, and the expanded activities of NIOSH and OSHA.

At a broader level of analysis, the Sidels question whether efforts to reform the medical and health care system are worthwhile for progressive activists. They argue that the British "Report of the Working Group on Inequalities in Health" (also known as the Black Report) concluded that even though the National Health Service provides access to health care for every resident, health status in the United Kingdom continues to correlate most closely with class. This and other evidence leads to the conclusion that the most effective treatment for ill health is to improve economic and social conditions and increase social equality.

Does this mean that we should forget about changing the health system? No, say the Sidels, reforms in health care delivery, finance, and organization are themselves a significant factor in broadening the concept of equality, and they do improve health status, even if only marginally.

What is a health progressive to make of these 25 years of efforts at reform, standing as we do in 1985?

Health/PAC itself, of course, was simultaneously a product of, catalyst for, and a reporter of, many of the reforms described in this book. No doubt if we wrote our own history of these efforts it might run slightly differently, but the key question is not so much how to write history as how to make it.
efforts worthwhile, a base to build on, or should we take a long hard look at the entire strategy of reform and try something different?

The Sidels' book is not exactly designed to answer this question. Those who believe that pursuing reform is the only viable strategy—that "We must do something Monday"—will find ample evidence in these chapters to justify their optimism. On the other hand, those who believe that fighting for incremental changes is a bit like shouting into the wind will no doubt finish this book more convinced than ever that the effort was largely wasted.

As I suggested at the outset, both these perspectives flirt with a worldview most properly described as idealist. We did not revolutionize American society or even its health system in the past 25 years, but real changes have occurred; not only in the quantity and quality and financing of care, but in the attitudes and beliefs and practices of those who provide it. Some of this progress continues—sometimes quietly, sometimes loudly and clearly—in the halls and homes and journals of those who practice medicine today and experienced the turbulence and reform struggles we call "the '60s." Anyone who cares about social progress can be justly proud of these achievements. The Sidels' book is valuable not only as their chronicle, but also as a guide for those who would try to defend and expand them in the future.

Michael Clark is a member of the Health/PAC Board.


by Sharon Lieberman

The baby boomlet of the 1980's seems to have set off an explosion of books on birthing, most of them aimed at a tidy vision of the perfect pregnancy and birth "experience." Birth Trap, a consumer guide, is less about "birth styles" and more about how to navigate around the routine meddling technology of American obstetrics. Well-organized and written in succinct, accessible prose, it brings together a decade of research, discovery, and analysis by the authors and others concerning the dehumanizing and often harmful procedures of hospital obstetrics: induced labor, intrapartum drugs, fetal monitoring, surgical birth, and separation of mother and newborn, to name just a few.

A high proportion of childbirth books are marred by a dewy-eyed sentiment for the "traditional" family and a syrupy exaltation of motherhood. Birth Trap is relatively free of these faults, despite the authors' public identification with organizations that refuse to acknowledge that reproductive rights include the right to choose between abortion and maternity. A final caution: this book provides few strategies for the clinic patient who is likely to pass through numerous medical hands in the course of her maternity care. It does assay fairly and accurately the risks and benefits of in-hospital, birth center and home birth. There is no bias toward one type of birth place or attendant over another, just reputable citations.

Most of the studies supporting non-intervention in normal pregnancy and birth have been presented and chewed on for over ten years. Doris Haire's 1973 monograph The Cultural Warping of Childbirth was the first major critique of medicalized childbirth; Haire remains an active advocate of obstetric reform. Suzanne Armont's 1975 book Immaculate Deception is a more popular discussion of the horrors of hospital birth, with an emphasis on the alternatives of birth centers or home birth with midwives. Barbara Katz Rothman's In Labor: Women and Power in the Birthplace, published in 1982, offers a distinctly feminist view of the relationship between women and medicalized childbirth. Birth Trap puts the ideas of these and other studies between two covers, and contributes new ones.

There is a fine chapter on consumer power: how to bring about change in a community's existing maternity facilities. Step-by-step strategies for individual and collective organizing are also provided.

The chapter on legal aspects of childbirth brings a unique perspective on how to lay the groundwork for control by the individual consumer and what to do if something goes wrong. Some critics of American obstetrics believe that litigation is a legitimate strategy for reform. They point out that it opens the field to midwives and their non-intervention philosophy and lower fees. In addition, intrapartum damage to newborns and their mothers will continue to occur as long as obstetricians feel compelled—by training or ego, by personal or hospital economics, or by the insurance carriers that inevitably shape practice standards—to utilize their surgical skills and technological arsenal.

Others respond that although it is useful to understand the legal conditions and vocabulary necessary to plan one's medical care or obtain redress in court for bodily harm, changing institutions and practice through the often expensive, lengthy, and piecemeal route of individual litigation is not the best strategy.

A recent American College of Gynecologists publication reported that ten percent of the nation's OB/GYN's have abandoned obstetrical practice because the malpractice insurance for it had become too burdensome. The majority of American women will, for some time, continue to look to obstetricians and enter their hospitals. And there will always be those high-risk pregnancies, approximately six percent of the total, requiring the skills of an obstetrician.

The 60-page appendix includes a glossary of medical and legal terms, suggested reading and films, resource organizations, sample patient-doctor contracts, and a patient bill of rights and responsibilities. In short, it contains enough information to give prospective parents the confidence needed to control their maternity care, or fire up com-
Vital Signs

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Medicare improvements and state legislation and again in campaign work for the November elections.

The Alliance now has 30 members, and is structured to promote joint action on priority issues recommended by the general membership and to encourage broad support for issues of special concern to individual affiliates. It has a state steering committee and the research assistance of Villers staff members. With the help of a planned computerized command post in Washington, it intends to participate in a nationwide grassroots lobbying network to be known as ASAP (as soon as possible). An ad hoc committee including most national elder organizations (the American Association of Retired Persons is conspicuously absent) is helping to set up the first segment.

Certainly this network has a lot of work to do. Despite Reagan’s frequently stated desires to undermine Social Security and Medicare/Medicaid, as well as social welfare programs in general, a New York Times/CBS exit poll found that voters aged 60 and over favored Reagan over Mondale 63-36 percent, higher than the 58-41 percent margin among all voters.

George F. Markham

(Joseph Regna is a physician in the public health area in Boston.)

Peer Review

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Control Program, and Chairperson of the National Coalition for the Promotion of Breastfeeding and Child Care.

This will be followed by a speaking tour in the fall by Dr. Sylvia de la Paz, Executive Secretary of the Medical Action Group and widow of the popular community physician Dr. Bobby de la Paz, whose murder in April 1982 received international attention.

In addition, two study tours to the Philippines will be organized for Filipino and concerned American health workers.

For more information, contact the Philippine Health and Medical Campaign, c/o APC, P.O. Box 7277, Ann Arbor, MI 48107.
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The Cumulative Impact

The health delivery system in the United States is fraught with problems demanding drastic reform, change, and reorganization. It is too expensive for most people. It is class-biased. It is grossly unfair to workers, the poor, the chronically ill, and women and children. Rather than ameliorating these effects, the proposed Reagan budget proposals exacerbate all of them. In its first four years the Reagan Revolution has already seriously weakened health care delivery. These new assaults will create absolute chaos in many areas. They represent nothing less than an attempt to negate any federal role in health care except subsidization of the private markets which proprietary medical, insurance, financial, and corporate interests are hastily rigging up to catch as many dollars as possible. The Reagan budget is designed to subsidize Medicare for for-profit health maintenance organizations (HMO's), hospital chains, involuntary health insuring organizations (HIO's) for the poor, and voucher systems. Some people will make a great deal of money from this system and a great many people will lose their health because of it. Millions will suffer. Tens of thousands will die from sexually transmitted diseases, industrially caused cancers, heart and lung diseases, malnutrition, and tuberculosis.

What We Can Do

The proposed budget for FY 1986 is only that. The American Public Health Association, 1015 15th St., NW, Washington, DC 20005; and the Coalition on Block Grants and Human Needs, 1000 Wisconsin Ave., NW, Washington, DC 20002, the organizations from which much of the data cited here are taken, are both hard at work building community, political, and health activism to stop these assaults on our nation's health. You can join them, and us.