IN THE GRIP OF PPS
How Prospective Payment is Transforming Hospital Care

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Notes & Comment

Learning from Las Vegas

We're preparing for our trip to Las Vegas, the September site of the annual convention of the American Public Health Association (APHA). Here at Health/PAC we look forward to these annual meetings, and their rich galaxy of gatherings, as the nearest available thing to a national forum on public health advocacy.

At last year's APHA Convention in Washington, D.C., conveners from across the nation rallied on the Capitol steps to defend public health budgets and programs. This time we plan to demonstrate at Nevada's federally designated nuclear dumping site.

Stop Killing and Torture; Reclaim, Restore and Prevent Poisoned Deserts and Communities; Defend and Reorganize Our Public Health System—these are the messages that would emblazon the schlock casino signs lining the Vegas Strip if Health/PAC's sensibilities ruled.

The person with the top marquee billing at the Vegas convention—no, it's not '76—is keynote speaker Jimmy Carter. For oldies, but goodies, I would prefer the likes of Ralph Nader, Barbara Ehrenreich, or Jesse Jackson. Like Nader, Rev. Jackson's interest in health issues is growing. Just before Ronald Reagan's statue-rape in New York City around July 4, Jackson, speaking at the city's Hotel Martinique (a poor, unhealthy residence for homeless families), said the U.S.'s present and future "huddled masses" are enduring the disgrace of Third World country health status. How many national political leaders are speaking out as clearly and courageously on the painful state of U.S. health and health care?

I'm concerned that health progressives aren't speaking very clearly to each other or to leading constituency representatives—many of whom won't be in Las Vegas—let alone the majority of U.S. health workers and health care seekers. Are we any closer to having a real dialogue among ourselves? Are we any nearer to hitting the progressive's jackpot of a broad-based movement uniting workers and consumers for long-sought health care gains?

There are so many of us representing many diverse, yet intertwined concerns. These include developing state and local "front lines;" advocating a "national health program," health service, or insurance plan; and preparing for corporatization, proprietarization, or privatization.

I'm reminded of the title of the now-classic critique of modern architecture by Robert Venturi, Learning From Las Vegas. Perhaps we can tap our rich diversity as public health advocates, not as Venturi, who celebrates the zig-zagging, neon showcases of Las Vegas as the fragmented mecca of U.S. architecture, but with unity and coherence.

We at Health/PAC want to help forge a stronger and more visible national leadership and network of state and local activists. This involves not only resistance and advocacy in a range of different settings, it requires sharing more analysis and practical experience in reorganizing public and community health services. Through better communication with all of you, we aim to provide the best alternatives to the unhealthy forces that confront us all. We can all learn from Las Vegas—and away from it, too.

Robb Burlage
director of Columbia University's Graduate Program in Urban Planning.

From the Editor

The Bulletin was important reading in my previous work as a labor journalist for the National Hospital Union (1999). Its well-researched articles on vital, under-reported issues often guided me across the rough terrain of the U.S. health care system. In my first months here, I've come to know Health/PAC from within—and it is a lively place.

Flowing in and out of its doors are people who think, read, research, write, report, talk and worry about health care. Some are practitioners, some are academics, some are administrators, but all are activists. Their efforts continue to make this modest, little office on Murray Street the home of the most enduring and valuable experiment in independent health-care journalism. It is a living experiment that expands in importance as the monovocal media grows more superficial in its coverage of health policy issues. The Bulletin's readers play a major role in keeping the publication alive. They do it through sharing their ideas, which arrive here in various ways. They are walked in, phoned in, mailed in, and passed along through friends. We welcome yours.

With this issue, we begin our three-part series on the whys and woes of the three-year-old Prospective Payment System (PPS). Ronda Kotelchuck offers vital data—much of it previously unavailable—and carefully weighs this cost containment system's impact on hospitals and patients. Part one focuses on the system's powerful effects on hospital use and costs. Part two will look deep in the eye of PPS and its wide-ranging impact on patients. The final installment will examine the system's effects on alternative care settings.

In May, we proudly honored Nicaraguan health care leader Dr. Myrna Cunningham with our third annual Samuel Rubin Health and Social Justice Award (see Vital Signs). Health/PAC arranged for Dr. Cunningham to fly to New York City, where she was honored—and interviewed by Hal Strelnick for this issue of the Bulletin. Cunningham is a strong, quiet woman who knows this country well. A Miskito Indian with an English surname, she was raised and still lives on Nicaragua's Atlantic Coast, an area once colonized by the British. She took some of her medical training here in the U.S., but her political education coincided with the Sandinista revolution in her own country. Today she is governor of its Zelaya Norte province. She spoke with us about the struggle for life, health and reconciliation there as one who is on the receiving end of the U.S.A.'s contra war. Amid the terror of this war, there is, as Dr. Cunningham's personal story shows, a genuine effort to provide health care to all within an embattled Nicaragua.

Joe Gordon
Peace and Solidarity

Health/PAC presented its Third Annual Samuel Rubin Awards for Health and Social Justice May 12, in New York City, to Nicaraguan health care leader Dr. Myrna Cunningham, and long-time labor activist Stanley Hill, Associate Director of DC 37, AFSCME, and a leader in labor’s campaign to free South Africa’s black majority.

The evening’s theme was “Peace and Solidarity” and nearly 500 heard Cora Weiss (daughter of the late philanthropist and Health/PAC supporter Samuel Rubin) introduce Dr. Cunningham as “a healer, a physician, a peacemaker and a woman of vision who has faith, that if the U.S. stops making war on her little nation of three million people, they can be counted on to make peace among themselves.”

Dr. Cunningham described the enormous strides in health and human rights that Nicaragua has made, despite continuing attacks by the U.S. government-supported contras. (See her interview elsewhere in this issue.) She told the gathering: “This war cannot destroy the revolution nor the will of the Nicaraguan people to fight for what we know is just.” Her words were met with strong applause from the audience of health-care givers, trade unionists, political activists and a handful of Nicaraguan guests.

Press attache Miriam Hooker, who attended as a representative of the Nicaraguan Embassy, was forced to leave the country by the Reagan Administration May 23, in retaliation for Nicaragua’s earlier identifying two U.S. Embassy employees in Managua as CIA operatives. In the weeks since, the Administration’s military and propaganda war against Nicaragua has escalated, helped along by Congressional approval of President Reagan’s request for $100 million to support the contras.

Vital Signs

City Hospitals: De- or Re-politicize?

The President of the Health and Hospitals Corporation (HHC), a municipal employee trade union leader, a community health activist and a former City Council policy director were the panelists at June 18th’s Health/PAC and Public Interest Health Consortium Forum on the future of New York City’s public hospital system. It was a sober discussion conducted against a background of HHC managerial corruption, public-hospital-baiting by political office-seekers, and the recent resignation of HHC’s appointed Chairman, Victor Botnick, whose fall from power followed newspaper revelations that he had lied about having a college degree.

Led by Health/PAC Board Member Louanne Kennedy, and entitled, “HHC: Market Competitor or Provider of Last Resort?”, no single neat answer emerged from nearly two hours of discussion at City University’s Graduate Center.

HHC President Dr. Jo Ivey Boufford offered a low-key outline of the Corporation’s advances on important fronts: capital bond financing, reimbursement revenues, capitation initiatives, and quality of care. In this last category, she reported that a Joint Council on Accreditation study had found HHC’s hospitals to excel in many key areas in a side-by-side comparison with the city’s voluntary hospitals. She identified the level of state reimbursement as a major issue in charting the Corporation’s future and emphasized that HHC’s hospitals are expending special efforts to retain their insured patients, who might be wooed away by the voluntarism in the city’s increasingly competitive health-care environment.

District Council 37 Associate Director Stan Hill, whose union represents some 25,000 municipal health care employees, called on HHC and its president to work with the union in creating a sound future for the public hospital system. Hill stressed the urgency of responsible planning and coordination at the corporation’s managerial level. He quoted from a copy of his editorial in the union’s newspaper, Public Employee Press, in which he said, “A hospital system…has to be more than the sum of its parts if it is to work successfully.

The extra piece that makes the difference is direction and cohesion from management.”

Marshall England of the Harlem Hospital Community Advisory Board called for a restructuring of the HHC Board to allow better and fuller public and community representation. England also advocated a community-based planning process and challenged the usefulness of HHC’s longstanding affiliation contracts with medical schools and private voluntary hospitals.

Barry Ensminger of the Children’s Defense Fund — and a former director of policy under former City Council President Carol Bellamy — suggested that we “put the politics back into HHC.” Ensminger expanded his point, saying, “If you’re not going to create a stable financing base that will allow [HHC] to meet its needs and force elected officials to take direct accountability,” then, he suggested, a less Mayor-dominated and more publicly influenced Corporation structure may be the best way to go. Ensminger’s progressive “re-politicization” of HHC at the city and state levels involves, among others: labor, public interest advocates and low-income community representatives. He predicted that HHC may soon see an even greater squeeze on its budget from fiscal conservatives at the city and state levels and from directly within the Mayor’s office. He also suggested that an earlier unsuccessful legal challenge be redeveloped to leverage direct fiscal support for HHC’s operations through the State-Chartermandated city tax levy, an initiative opposed earlier by the Mayor-controlled HHC Board and lost in the courts.

Health Organizing — Chicago-Style

Quentin Young, President of the Health and Medicine Policy Research Group (HMPRG), offered a thoughtful appraisal of the possibilities for national health organizing June 6th at a Health/PAC forum in New York City.

On the local level, Young reviewed the nurturing role his five-year-old health advocacy organization has played in bringing together activists and commu-
nity people to organize for solid health gains in Chicago's communities. Its diverse work has included programs for Medicaid reform, infant mortality, environmental health, hunger, and maternal and infant care, as well as plans for an integrated public health system for Cook County.

Dr. Young, the former Chief of Medicine at Cook County Hospital, said that by giving activists support and a "center of gravity," HMPRG has spawned several successful free-standing projects. These include the Healthy Mothers and Babies Coalition and the Health Management Services Center, which provides technical expertise to community groups interested in establishing health ventures as a means of local economic development.

The organization, which played a key role in developing a health policy for Chicago following the election of Mayor Harold Washington, has emerged as a highly visible, city health advocate, whose approach calls for cultivating the media, seizing popular yet vital issues, and organizing carefully thought-out strategies to meet pressing community needs.

Inspired by its own successes, HMPRG is contemplating ways to "export" its methods to health progressives in other cities. In the meantime, says Young, visitors are welcome.

Enormous changes wrought by the corporatization of health care are creating vast opportunities for new organizing, with public perceptions of corporate irresponsibility providing a formidable yet untapped reservoir of opposition, Young said. "At last, progressives have the right enemy: It's corporate America... The American people are good on [understanding] corporations because they've had such awful experiences with them," he said, adding that the decimation of accessible, affordable and personal care will not be lost on U.S. citizens. The corporate health giants, he continued, are "shattering the solidarity of the private medical profession;" "channeling young doctors into employed positions;" and challenging consumer assumptions about "a friendly, personalized health care system." Together, these trends offer a unique opportunity to build a powerful coalition among professionals, patients and the elderly. "The inevitable evolution in this wrenching shift," said Young, "is a national health service." In the meantime, he urges that we push for a nationwide debate on all the attention-getting health issues: patient dumping, corporate domination and its "vampire effect" on voluntary and religious-affiliated hospitals, and the breakdown of quality in the pursuit of profit, to name just a few. "We have to make all this part of the thinking of the American people," said Young.

### The Future of HMOs

The rapidly growing prepaid, managed health care system of the future will continue cost-cutting providers and endanger teaching hospitals, according to the participants in May's Health/PAC forum on HMO (Health Maintenance Organization) trends.

Robert Greifinger, Director of Alternative Delivery Systems at Montefiore Medical Center in the Bronx, and Joseph Lynaugh, currently President of the Sanus Corporation Health Systems, the large national for-profit HMO chain owned by McDonnell-Douglas, were the featured speakers.

Greifinger discussed the transformation of the traditional "doctor-patient dyad" into a triangular relationship between patient, provider, and insurer. The health care system is becoming increasingly integrated as provider and insurance units form networks with one another, and both speakers said that the incentive toward low-cost, more homogenous, minimum levels of health care is the result of the pre-paid trend.

Lynaugh said that insurers are now more powerful than providers since gaining control over price and supply of services -- and in that regard, he said insurers will avoid links with teaching hospitals due to their high costs and high standards of care. Anticipated changes in medical education (due to the doctor surplus), combined with decreasing hospital utilization rates and insurance reimbursement for medical education costs, are placing increased pressure on teaching hospitals to diversify and become cost competitive.

According to Lynaugh and Greifinger, New York City's seven academic medical centers are digging their own graves by ignoring these changes in the finance and delivery system. They predicted that many for-profit HMO chains will quickly invade New York, where they have only recently been allowed to operate.

Both panelists predicted that the prepaid HMO phenomenon will be temporary and that other forms of integrated finance and delivery structures will evolve by the 1990s, because the key role played by the insurers appears here to stay. National health, anyone?

### Vegas Victus

Why, you may be wondering, is the annual meeting of the American Public Health Association (APHA), normally falls in the first or second week of November, being held Sept. 29-Oct. 2 in Las Vegas this year? Before you start thinking poorly of the APHA planners, consider this: The unusual time and place are related to winning one of the great consumer victories of recent years -- the Nestle Boycott.

At the APHA meeting in Detroit in 1980, the low attendance was generally attributed to the convention site. APHA meetings are much more successful when held on the east or west coasts, but APHA policy requires that convention sites rotate through all areas of the country.

APHA policy also provides, however, that if a particular meeting place conflicts with political positions of the Association, the convention site can be moved anywhere.

In Detroit, members of the Nestle Boycott organization INFACT (the Infant Formula Action Coalition) picked up an alarming rumor that APHA planned to meet in Cleveland in 1986. That city is the international headquarters of Stouffer's Hotels which, besides being a notorious union-busting corporation, is also owned by Nestle. It would be impossible to hold the convention in Cleveland without a major portion of the sessions being held at a Stouffer's Hotel.

The INFACT activists quickly contacted APHA Executive Board member and presidential aspirant Stan Matek. He introduced them to Sarah Archer, another Executive Board member. They confirmed the rumor, and listened to the activists' concerns with a great deal of enthusiasm.

Dr. Archer promised to bring up the issue at the next session of the Executive Board, and soon the Board voted to move the annual meeting out of Cleveland. The next year, with the help again of Sarah Archer, APHA endorsed the boycott, and William McBeath, the Executive Di-
When Knowing Where to go is not Enough

As a physician working in the North Central Bronx medical clinics, I have witnessed first hand the untruth of President Reagan's statement, "I don't believe that there is anyone going hungry in America simply by reason of denial or lack of ability to feed them, it is by people not knowing where or how to get help."

I could give dozens of first-hand examples but will relate just one case from today's patients. Mr. P. is a 65-year-old man devastated by diabetes. He has lost both legs from severe vascular disease. He has suffered two heart attacks, has a permanent cardiac pacemaker and congestive heart failure. He and his elderly wife live on his $225-per-month Social Security check. Luckily, his medical expenses are covered by Medicare and Medicaid, but his grocery bill is not. Six months ago, his monthly $40 food stamp allowance was discontinued for reasons that are mysterious to all involved. He cannot afford to buy the proper low-salt, low-fat, dietetic foods he needs. He told me that he has been unable to afford anything but scrambled eggs for supper for the past week. Vegetables, fruits, low-fat cuts of meat, chicken and fish are luxuries reserved for the first week of the month after he receives his Social Security check. It's eggs, hot dogs and bread for the rest of the month. This diet has worsened his congestive heart failure and diabetes prompting two admissions in the past eight weeks.

Is this a problem due to "people not knowing where or how to get help"? Not only have my patient and his family made many attempts to have his food stamps restored, but attempts by our clinic's skilled social workers have been unsuccessful, despite the fact that Mr. P. is eligible. The Harvard University Physicians Task Force on Hunger estimated that 20 million people go hungry in America and that excessive regulations keep as many as 15 million poor people from receiving food stamps.

There is something terribly sick with a nation which spends $300 billion per year—representing 55 percent of our federal tax dollars—on the military, yet will not feed its hungry. President Reagan, we need bread, not bombs. (Lucy Van Hook, M.D.)

continued on page 22
In The Grip of PPS
How Prospective Payment is Transforming Hospital Care
by Ronda Kotelchuck

Rapid and radical changes are transforming the hospital's role in American health care. The single most powerful force in this transformation has been implementation of the Medicare Prospective Payment System (PPS). Why? Because PPS totally reverses the financial incentives by which hospitals have traditionally been managed.

Consider the background: With the inception of third-party insurance dating back to the 1920s, hospitals have been reimbursed for their operating costs, thus creating incentives to spend, rather than to save. By contrast, PPS pays a flat rate or price. (This rate is based on which one of the 471 diagnostic related groups [DRGs] the patient falls into, regardless of the actual costs of treating that patient.) If these costs are less than the rate, the hospital keeps the difference. If the costs exceed the DRG rate, the hospital must suffer the loss. In order to prosper, hospitals for the first time must cut costs and maximize profits like private businesses in a competitive environment. The stakes in many cases are survival or closure.

Acute hospital care is shrinking under PPS.

Now, more than two-and-a-half years after implementation of PPS, we have accumulated evidence to show its dramatic impact. Rarely has such a large sector of the economy undergone such sweeping changes in so short a time—and PPS lies at the center of many of these changes.

Among the most radical changes under PPS is the rapidly shrinking role of hospitals providing acute inpatient care. Patient hospital stays are discernibly shorter: In 1984, the first full year of PPS, the Medicare length of stay dropped nine percent—the single largest drop in its 20-year history. This decrease was three times that of the 1983 drop and over four times the average historical rate of decrease.

PPS's responsibility for reduced inpatient hospital care is clearly demonstrated by data showing a 13.9 percent average drop in lengths of stay within the 46 states under the PPS system, compared to a dramatically lower decrease of just eight percent in the four non-PPS states. The evidence couldn't be more compelling. In 1984, for example, a Medicare patient in a non-PPS state was hospitalized an average of five days longer than a similar patient in a PPS state.

Statistics showing fewer people being admitted to hospitals also vividly demonstrate PPS's role in shrinking acute hospital care. In 1984, Medicare admissions per 1,000 dropped 3.5 percent, marking the first admissions decline in 20 years of Medicare history (there was a negligible 0.6 percent decline in non-PPS states).

This decline in PPS states was surprising. Policymakers assumed that since hospitals were to be paid a flat rate per case, they would actively seek to expand admissions in order to increase their revenues. In fact, the opposite is happening.

One possible explanation for this decrease in admissions may have been a fear among hospitals that Professional Review Organizations—which stringently review hospital practices—might deny Medicare payment for admissions deemed unnecessary under a new, stricter set of criteria. Another is the substantial shifting of many less complicated surgical procedures from inpatient to outpatient settings.

With lengths of stay and hospital admissions down, more and more hospitals are emptying and closing beds. Hospital occupancy fell from 72.6 percent in 1983, to 67.1 percent in 1984, to a low of 63.6 percent in 1985. In 1984 alone, 22,000 hospital beds closed. While these represent only a small fraction of the country's one million beds, they are the bed equivalent of 100 average-sized hospitals. And PPS's final impact is yet to be felt: The Health Care Financing Administration (HCFA), the agency responsible for administering PPS, expects that PPS will eventually close one of every six U.S. hospital beds.

What of PPS's impact on total hospital expenses? Figures show that it slowed expenses' growth markedly. Annual inflationary increases averaged 13.6 percent from 1976 through 1982, but later fell to an average of 5.5 percent from 1983 through 1985. The single greatest drop was in expense per admission (from an average of 15.5 percent to 9.0 percent), while per diem expenses stayed roughly the same.

Labor Force Impact

The drop in hospital labor costs increases was dramatic—falling from 11.3 percent in 1983, to a bare 3.3 percent in 1984, and there was a decrease in the number of hospital workers for the first time in history. While annual increases in full-time-equivalent employees averaged 4.3 percent from 1971 to 1982, they fell in 1984 for the first time, down 2.3 percent that year and 3.5 percent a year later. Hospital unions now predict a 20 percent drop in full time equivalents over the next ten years.

Ronda Kotelchuck is a member of the Health/PAC Board. This is the first in her three-part series on PPS.

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'PPS is expected to close one out of every six hospital beds.'

Under PPS, patients are being admitted to hospitals only after all outpatient procedures have been exhausted—and they are clearly entering the hospital more acutely ill than ever before. Hospitals are treating patients more rapidly and intensively and discharging them to alternate care settings as quickly as possible.

Several facts illustrate this intensification: Length-of-stay rates in 1984 decreased more in routine care units than in intensive, coronary, or other special care units. Ancillary costs including lab, radiology and drug charges, rose in relation to the cost of room and board. There were greater decreases in length of stay and ancillary charges for medical patients than among the more resource-intensive surgical patients. The proportion of surgical patients grew relative to medical patients, and ancillary charges actually increased for surgical patients. Surgical patients entered the hospital one third of a day closer to their date of surgery and left a full day sooner following surgery than they had before PPS.

Despite reductions in the hospital workforce, the ratio of hospital workers to patients has actually increased, reflecting a general environment in which patients are sicker and require more intensive care. And finally, Medicare costs per day skyrocketed from $400 in 1985 to $492 in 1986. A rise to $572 is projected for 1987, which would represent a 43 percent increase over three years.

The steady shrinkage of acute hospital care has greatly expanded the need for pre- and post-hospital care. While inpatient volume and costs have dropped, utilization and costs for outpatient care have ballooned. Medicare outpatient visits, for example, rose 5.8 percent between 1983 and 1984. Expenditures for Medicare Part B, which pays for physician and outpatient services, jumped 14 percent in just the first year following PPS’s implementation.

Surgical procedures performed on an outpatient basis increased from 14 percent in 1980, to 25 percent in 1984. During this same period, the number of hospitals offering outpatient surgery increased from 72 to 91 percent. Responsibility for non-acute care previously provided by the hospital is being shifted to other settings. The largest portion of this non-acute care is “administrative” or “alternate level” care, which is provided to patients who no longer need acute care, but cannot be discharged because required nursing home
Patients are entering the hospital more acutely ill than ever before.

or home care cannot be found.

Medicare patients discharged to skilled nursing care increased 40 percent, and those discharged to home care rose 30 percent, between 1983 and 1984. During this time, nursing homes and home health care agencies reported an influx of sicker patients who required more intensive care.

Hospitals Reorganize

Faced with falling utilization and their ultimate survival, hospitals are seeking a steady source of patients by securing health maintenance organization (HMO) affiliations. They are also offering discounted prices to major purchasers of hospital care, known as preferred provider arrangements. To assure business, some large hospital chains are even offering their own hospitalization insurance or merging with insurance companies. We are also seeing hospitals contracting with existing nursing homes and home care agencies in order to discharge their inpatients sooner. In many cases, hospitals are even going into the nursing home and home health care business. Between 1980 and 1984, the number of hospitals offering nursing home, home health and hospice care nearly doubled.

While we know a lot about the impact of the competitive forces released by PPS on the cost, utilization and rapidly changing roles and responsibilities within the health system, what about PPS’s impact on issues of more immediate concern to consumers? For instance, how have quality of care, accessibility of acute care, and availability and affordability of critical aftercare services been affected under PPS?

The Feds Hold Back

HCFA, which is responsible for administering this system, has not been forthcoming with information on PPS’s impact. In the original legislation, Congress mandated yearly impact reports. The first, due in December 1984, was released a year later, and then only under subpoena by a frustrated Senate Special Committee on Aging. Similarly mandated reports on the impact of PPS on skilled nursing facilities and home care have reportedly been completed but never released.

Cost and utilization data, perhaps because they are financially related, are relatively available. However, information on quality and accessibility has not been systematically collected in the past, allowing HCFA and many providers to argue
that problems just don't exist or that they are few, scattered and anecdotal in nature.

We will examine the problems in the next installment of this series, as well as some of the important questions PPS raises. Are patients being discharged "sicker and quicker" into a "no-

Nursing homes report an influx of patients requiring more intensive care.

care zone," as many critics have charged? Are there actual reductions in the quality of care under PPS? What do professional opinion surveys reveal about quality concerns among health care givers? What are the major quality issues among patients and their families? Has HCFA assumed appropriate responsibility in safeguarding quality? And just what leverage do patients and the public at large have in pressing demands for improved quality?

The answers are fundamental in assessing the radical changes that are transforming the nation's health care system, as well as the challenges facing its health care consumers, particularly the sick elderly.

Resources
1. "HCFA Background Papers," Health Care Financing Administration, Department of Health and Human Services, issued periodically; unpublished.
Local Anesthetics
A look at states’ programs for the uninsured
by Dana Hughes

Sharon Ford was in active labor when she tried to gain admission at two private hospitals in California. Although a fetal heart monitor detected irregularities in her baby’s heartbeat, both hospitals refused Sharon care because she was uninsured. Rather than risk providing uncompensated care, the hospitals “dumped” her on the county hospital where the baby was stillborn.

Sharon Ford was one of millions of Americans unable to obtain needed health care last year. Some were children whose parents couldn’t afford to take off several hours from work to bring them to a publicly funded clinic. Others were elderly Americans who were denied essential medications because they couldn’t afford the Medicare co-payments their physicians charged. And many didn’t even seek care because they feared re-experiencing the degradation of a previous time when they couldn’t pay their fees. And like Ford many were pregnant women who were denied delivery care. Lacking means or alternatives, some of these women waited in the hospital parking lot until their labor reached the critical stage, at which point they were admitted through the emergency room.

For the poor and near-poor in this country, access to health care depends on the altruism of individual providers and the generosity of government programs. The gap between Americans who obtain health care and those who do not has grown deeper and wider in recent years. For the poor, diminishing access to health care is the result of many factors, including federal cutbacks in public health programs and reductions in uncompensated care by hospitals and other private providers. But even more profound than the combined force of these cutbacks is the transformation of the American economy and its growing maldistribution of income. In the early 1980s, patterns of affluence and poverty shifted. Between 1979 and 1983, the incidence of poverty rose by 29 percent, the largest recorded U.S. increase since such data have been collected. As the proportion of people in need of free care rose in the early 1980s, the amount of uncompensated care provided by private hospitals actually declined. Reports of patient dumping have sharply increased. Chicago’s Cook County Hospital reported an increase of private hospital transfers from 1,295 in 1980 to 6,769 in 1983.

Proposed Reforms
As access to health care has become more restricted, substantial resources have been devoted to studying medical indigency and proposing solutions. Numerous alternatives to traditional health care delivery and financing arrangements have emerged. These include initiatives that target funds to providers serving large numbers of the poor, as well as to reform private and public insurance, and regulate providers.

Pending before Congress are several measures designed to alleviate the problem of inaccessibility to care. No fewer than 34 states have established indigent health care programs. These are funded entirely with state funds or a combination of state and local funds.

Despite the level of interest and the intensity of effort, however, virtually no progress has been made towards a true and lasting solution. Rather than reorganize the allocation system to provide care to people based on need, the “reforms” are primarily designed to reimburse providers for uncompensated care. Significantly, a major impetus for “reform” has

Dana Hughes is a Senior Health Specialist for the Children’s Defense Fund.
come from the hospital industry, interested in relief from the growing burden of uncompensated care. Thus, the remedies are limited to two major approaches: providing some insurance coverage to certain categories of people, and directly compensating providers for indigent care. A third, alternative medical indigency initiative—representing a small proportion of the initiatives—requires certain providers to offer a specified amount of uncompensated care.

Will these efforts reverse the trend toward increasing restrictions on access to care? A selected number of initiatives may benefit a limited number of people, but much more is needed to stem the indigent health care tide. While they fail to reckon with the larger, systemic problems, even superficial approaches offer the hope of alleviating some suffering in a nation where so many go without needed care. In the remaining pages I review some of the initiatives that have emerged on the state and local level. They are, in a manner of speaking, topical or local anesthetics—insufficient in the degree to which they can quell the enormity of pain people must endure as critical health needs go unmet.

Insurance for the Uninsured
Several methods of insuring the medically indigent have been devised on the federal and state levels. However, these “insuring initiatives” generally provide select groups with limited coverage for certain services rather than comprehensive coverage to all who need care.

Medicaid Expansion. The Medicaid program is the single largest public health program for women and children. The program pays nearly 55 cents of each inpatient dollar spent on children. Funded jointly by the federal government and the states, the Medicaid program’s eligibility criteria and service plans are set largely by the states.

Since 1981, Medicaid has been drastically cut at the federal level and by many states as well. Yet 30 states have recently expanded their programs by broadening eligibility criteria, covering additional services, or increasing the scope and duration of covered services. It should be pointed out that this approach has enabled these states to take advantage of additional federal Medicaid sharing funds.

In addition, Congress made numerous Medicaid improvements in 1986, including mandating that states cover pregnant women who meet the income test but who would not otherwise be eligible because they live in intact, working households. Nonetheless, Medicaid continues to cover only a fraction of poor pregnant women and children, because they do not meet states’ strict income tests. Today, 32 states set income eligibility below 50 percent of the federal poverty level.

Pending before Congress are several bills that would permit states to increase Medicaid income eligibility to all women with infants and pregnant women with incomes up to the federal poverty level, without necessarily raising eligibility standards for AFDC simultaneously. If approved, this would greatly expand the Medicaid coverage to women and babies who otherwise would have none.

It should be emphasized that Medicaid reforms are inherently limited in ensuring access to care. As long as income and asset tests determine eligibility, many who are poor, uninsured and without income to pay for care will remain ineligible. Others will float in and out of eligibility as their financial circumstances shift. For patients with conditions requiring observation or ongoing attention, floating eligibility can be extremely dangerous. In the end, holding a Medicaid card is no guarantee of access to care. Large and growing numbers of physicians do not accept Medicaid patients; others limit the number of Medicaid patients they treat. 23 percent of all primary care physicians and 36 percent of obstetricians do not accept Medicaid patients. Thus, many who are considered insured because they are enrolled in the Medicaid program are nearly as restricted in their access as those without any coverage.

State-only Health Programs for General Assistance Recipients. Twenty-three states have Medicaid-like programs for people receiving general assistance. These programs are designed to provide medical assistance to poor persons who do not qualify for Medicaid, and are funded and operated exclusively by state governments. State-only Medicaid programs sometimes do provide needed service to populations unlikely to get care otherwise. However, like Medicaid, these state programs provide no coverage for comprehensive health care and they have very restrictive eligibility standards. Most states set qualifying income levels well below the Medicaid eligibility level and none set it above the Medicaid standard. In this way they fail to reach the majority of persons who are poor, uninsured and ineligible for Medicaid. Furthermore, people receiving general assistance in most states are not automatically enrolled in the program and are rarely informed about it. Finally, in some states, these programs do not function as an insuring mechanism at all, but instead serve as provider reimbursement systems. Rather than encouraging providers to give patients complete care by ensuring reimbursement of preventive services under the program, the states tend to reimburse only for costs associated with inpatient services for which they have been billed. This blocks enrollees from availing themselves of primary and preventive care.
Compensating Providers

Among all indigent health “reforms,” the most common are those which are explicitly designed to reimburse providers for uncompensated care. The stated aim of these models is to alleviate the financial burden to providers for uncompensated care and to encourage them to accept uninsured patients. Other provider compensation programs seek to award those that do provide care to the uninsured.

County Responsibility. Ultimate financial responsibility for indigent health care is assigned to counties in nine states (Alabama, Florida, Idaho, Iowa, Michigan, Nevada, New Mexico, Texas, and Utah). Because this approach relies exclusively on county resources, federal and state governments find it appealing. Responsibility is usually confined to reimbursement for inpatient care of county residents. Of the states with county responsibility laws, Alabama, Idaho, Iowa, and New Mexico have no other program or policy regarding indigent health care. Thus, a significant portion of needed health services remains uncovered by county programs. Moreover, because most counties are unable to cover the cost of all uncompensated care for residents (the cost of intensive care for just one newborn can exceed the health budget of many counties), only a portion of uncompensated inpatient care is normally covered by counties.

Resource Pooling. Several states have tried financing indigent health care by creating a trust through pooling funds from various sources. Five states (Arkansas, Florida, New York, South Carolina, and West Virginia) use a variation of the funding pool. Sources of funds include assessments on hospitals and third-party payors and county revenues. States target the funds to hospitals to reimburse uncompensated care, Medicaid expansion (pool resources are used to meet the federal match), and primary care providers serving the uninsured.

Some “all-payor” systems include a variation of the model. In some states where hospitals are paid a predetermined rate (as opposed to retrospective payment based on hospital charges or costs), the rate is determined by considering the cost of providing uncompensated care. Hospitals providing a high proportion of uncompensated care are paid at a higher rate. Because the enhanced rate is charged to all payors—including Blue Cross, commercial insurers and Medicare and Medicaid—all parties contribute to the cost of uncompensated care. To date, eight states (Connecticut, Maine, Maryland, Massachusetts, New Jersey, New York, West Virginia, and Wisconsin) have or will soon establish an all-payor rate setting system.

Pooling resources in these ways has the advantage of sharing the costs of indigent health care among a variety of private and public entities. However, this approach, too, fails to provide any true or lasting relief for the uninsured poor.

Instead of improving people’s access to care, all-payor systems are designed primarily as a hospital cost-containment mechanism. Similarly, unless pooled funds are targeted specifically to provide primary care through community-based sources, they tend to be used to pay providers for care already rendered.

Both models are based on the assumption that if hospitals are assured reimbursement for uncompensated care, they will voluntarily treat the uninsured. To the extent that this is true,
any improvement in access to care would be limited to services only available at hospitals. While offering appropriate inpatient and highly technical care, hospitals are less appropriate and costly for most patients' primary care needs.

Evidence also suggests that hospitals are not necessarily more likely to voluntarily accept uninsured patients under these systems. In a 1986 survey, health officials in New Jersey and New York reported hospitals there continue to require that uninsured pregnant women pay pre-admission deposits. In addition, all-payor rate setting systems can put hospitals with large volumes of uncompensated care at a competitive disadvantage by increasing the hospital's rate, thus making them unappealing for commercial insurers in comparison to hospitals providing smaller amounts of uncompensated care.

Regulating Providers

Requiring providers to serve the uninsured is the least popular of indigent health "reforms." It is not only an uncommon approach, but existing initiatives tend to have little authority and are usually weakly enforced.

Prohibiting Transfers of Women in Labor. Eighteen states have enacted laws prohibiting the transfer of patients in need of emergency care because of their inability to pay. Four other states have established regulations governing hospital licensing to accomplish a similar end. However, because states differ widely in their definition of a "medical emergency," only women in the most advanced stages of labor may qualify for care.

In response to inappropriate transfers of patients in labor, three states (Colorado, Georgia and Texas) have established emergency room laws which explicitly prohibit inappropriate transfers of women in active labor. Many of these laws were superseded by a newly enacted federal law prohibiting any hospital with a Medicare contract from refusing to treat or appropriately transfer emergency patients, including those in active labor. Because Medicare comprises 25 percent of all inpatient hospital revenues, most hospitals are affected by this law.

However, neither the new federal law nor the individual state laws go far enough by prohibiting patient dumping in non-emergency cases. While explicitly prohibiting the denial of services to patients in emergency conditions, they implicitly permit denying care to others.

CON Restrictions. State laws in four jurisdictions (California, the District of Columbia, Georgia, and South Carolina) tie responsibility for indigent health care to the certificate of need (CON) process. In California, health care projects of health facilities which agree to provide free care to indigent patients over a five-year period are CON-exempt. (This law will expire January 1, 1987.) In the District of Columbia and South Carolina, CON applications may be denied to facilities providing too little indigent health care. In order to purchase or lease a Georgia public hospital, applicants must agree to provide three percent of the hospital's gross revenue in indigent care.

Although CON applications have never been used aggressively to force communities to provide uncompensated care, their use is likely to be increasingly less common as federal funds for health planning decline.

Promising Initiatives

While the majority of indigent health initiatives are either designed to reimburse providers or are unenforceable, there are a few efforts with real promise. In 1985, Massachusetts established a program to provide maternity services to pregnant women who are uninsured and ineligible for Medicaid. The Right Start program provides important care to pregnant women residing in the state with an income under 185 percent of the federal poverty level. The Michigan Legislature is considering designating prenatal care as a right of citizenship to all state residents. A Minnesota proposal seeks to provide health services to pregnant women and pre-school children on a prepaid, sliding fee basis for families with incomes up to 200 percent of poverty. These and other maternal and infant health programs in Connecticut, New York, South Carolina, Illinois, California, and Texas ensure access to needed care to many who would otherwise receive none. The obvious shortcomings of these efforts is that they are restricted to specific populations. Once a pregnancy is terminated or a child reaches the age of five, care is no longer available.

In any case, these programs are a preferable model to the more commonly applied approaches, since they allow patients themselves to arrange for care and ensure that they will receive it. As long as health care is available only to those who can purchase it, millions will continue to feel the pain of going without essential care.
Health Care Under Fire:
An Interview With Dr. Myrna Cunningham
by Hal Strelnick

In November and December 1981, Miskito contras launched their Red Christian offensive, killing 60 Nicaraguan soldiers and civilians and expanding the war to the Atlantic Coast. During these attacks, Dr. Myrna Cunningham, Nicaragua’s first Miskito physician and provincial governor, was kidnapped, beaten, and raped. Although she would probably never entertain such a thought, her life and this incident illuminate both the contradictions and the spirit of today’s Nicaragua: its progress in health care; the human toll of the contra war; the struggle to build a new country alongside a struggle for autonomy among its indigenous peoples, sparked by the ideals and errors of the Sandinistas; the volatile chemistry of religion and politics; and the omnipresence of the United States—past and present—for good and evil. Through her story—which is far from over—and in her own words, we can glimpse the heart of the revolution.

“I’m from the northeastern part of Nicaragua, Zelaya Norte. I was born in the village of Bilwasikarma, where the Moravians built a hospital in 1934. Our people had been Christianized by the Moravians for 150 years, a very conservative Protestant church based in the U.S. When I was growing up, my father was a mechanic on a banana company boat. We lived in Wasan, the commercial center of the Rio Coco. Everything we had in our home was purchased at the company store. The companies were managed by Americans, the missionaries were Americans, and the hospitals were run by Americans.

“I’m the eldest of four sisters. When I first went to school, they didn’t admit us to the Catholic high schools because we were half Miskito and half Creole, and we were Moravian. Several families got together and opened a public school. After that the Catholics did a lot to get back these students from the public schools. After graduating from primary school, I was able to go to high school because I got a scholarship through the nuns of the Catholic school.

“I became a Catholic when I was 15 years old. I guess I wanted to be a nun. Today I am something like an ecumenical member of any church. I would say maybe I’m a Christian revolutionary.

“The nuns had a clinic in Wasan. On my vacations I would help at the clinic, something like a midwife. When I came out of high school, I worked for a year as a teacher with the nuns. Because of contact with missionaries and with their vision of life, of helping people, I became interested in studying medicine, to be a missionary doctor, a nun, something. I was lucky and won a scholarship to the medical school in Leon. This was very, very strange in this area because most people didn’t have an opportunity to go to the university.

“I was in Leon at the time that the Sandinista Front (FSLN) was formed in 1966-67, and became more or less involved in the different school activities related with the political movement in the rest of the country. In 1969, the program of the FSLN came out for the first time. They stated that the FSLN would have a special program for the Atlantic Coast. I guess I really didn’t understand much of what was happening until I went to the West Coast and the university.

“When I graduated in 1972, I went back to Rio Coco. I started working with the Moravian mission as a doctor in Bilwasikarma at Taylor Memorial Hospital. First I did my internship and then social service there. Then I did six months of surgery in Fargo, North Dakota. It was very cold.

“I worked from 1972 to 1979 in the Moravian hospital. During those seven years I also worked in the medical extension program. In 1973, I became the first Nicaraguan director of the hospital—the rest had been North American missionary doctors. I was the only doctor along the Rio Coco for a population of about 24,000 people.

This interview with Dr. Cunningham on May 9, 1986, followed her tour of the Montefiore Medical Center in the Bronx. To clarify several of her observations and experiences, I have condensed and reordered the sequence of some of the things she told me. I have also supplemented these with quotations drawn from earlier interviews in Nicaraguan Perspectives (Summer, 1984) and Reed Brody’s Contra Terror in Nicaragua (South End Press, 1985.)

Hal Strelnick, a family physician who teaches social medicine at Montefiore Medical Center in the Bronx, is a member of the Health/PAC Board.
"After 1979, I went and worked two years in Managua. I was the Responsible (person responsible) for the Atlantic Coast at the Ministry of Health in the first year after the Triumph. Then I worked as the Director of Investigation and Research of the Ministry of Health. In 1981, there was a ‘petition’ taken that I should go back and work in Zelaya Norte. It was a year in which we had a lot of problems on the Atlantic Coast with the program of separating the Atlantic Coast from the rest of the country by the MISURASATAs (Miskito, Sumu, Rama, Sandinistas Together; a Miskito contra group.)

"At that time we had a commission responsible for the Atlantic Coast made up of each ministry’s representative. We decided that all the ministry representatives who ‘attended’ the Atlantic Coast would go and work there. Since then, I have been working there.

"I have four children, ages 13, 9, 8 and 6. Two of my children are Catholic, and two are Moravian. They came to Managua in 1979, but it was very difficult for them to actually live there. From 1980, they lived with my parents. My husband still lives in Managua. He is a writer and linguist, Carlos Aleman. Yes, I think it is hard living like this, but it is the situation of a lot of families in Nicaragua. To be able to work, a lot of people are separated. It is one of the problems of the war. So this is just one more case.

"I was kidnapped on December 28, 1981. It happened two days after I went back to work on the Atlantic Coast. As I was leaving the hospital in Bilwaskarma at five in the afternoon with the administrator, a nurse, and a driver, the car in which I was traveling was ambushed by a group of about twenty contras, MISURASATAs. Most were Miskitos, but one was later recognized as an ex-National Guardsman. They started shooting at the car. The driver stopped. When the shooting stopped, the administrator was able to jump out and run into the bush. He got shot in the leg twice. The rest of us were taken out of the car and beaten with rifle butts all over our bodies. They made us get into the car again and forced the driver at knife point to drive to the Rio Coco, where another 100 Miskitos were waiting along with five or six ex-Guardsmen. All the ones that I saw giving orders were ex-Guardsmen. Later they took two of the other doctors at the hospital, dragged them down to the river, tied them up and hit them, too.

"The Guardsmen said, ‘Good, you’re a doctor—you’ll see how we do torture.’ The others were chanting slogans like ‘Christ yesterday, Christ today, Christ forever.’ They tied us up and beat us. When it got dark, the nurse and I were taken into a hut. They started praying and singing religious songs and raped us. Although we would cry or shout, they would hit us and put a knife or a gun to our heads. This went on for almost two hours.

"Then we crossed the river into Honduras and walked for an hour to a training camp. Some of the Miskitos tried to tell us why they attacked the hospital: They said it was run by communists, that anyone who worked with the Nicaraguan government was a communist. They said that Americans flew in provisions and arms and trained them at camps deeper in Honduras; they were proud of the help they were receiving from the U.S. government and showed us a pack of Camel cigarettes as proof.

"The people from the village had seen the contras take us. They organized that same evening and went and talked with the contras and asked for our release. They spent the whole night sending ‘commissions’ from the village to tell them not to kill us. They were my patients, no? They played an important role in saving our lives.

"We were told that we would be executed, but on Nicaraguan soil to leave our bodies as an example to the other people who work with the Nicaraguan government. They made us walk to the river again. On the way we were raped again, and then they made us bathe in the river to remove any evidence. When we got back to Bilwaskarma, they had something like a trial before they let us free.

"When we were released, the contras told us to leave the Atlantic Coast because they did not want doctors there. After we got back to the hospital, we found the administrator in the bush. We were able to save him. The nurse who went through this (also a Miskito) was very disturbed emotionally and still has psychological problems. We had to close the hospital.

"One of the things that really shocked us was that while we were being raped and beaten they would continuously pray in groups. They were from a Christian brigade that was fighting against communism. What became clear that day was the way in which the religion of the people was being used by the contras to get them involved in this war. It helped me a lot to understand the way the people were being manipulated.

"During the first years of the revolution, over 20 clinics were built, immunization campaigns were done, and the hospitals were made free. I returned after the MISURASATAs had made a big campaign saying that people shouldn’t be vaccinated, because through the vaccine they would become communists. We were able to prove to the people that this wasn’t true. We had villages and areas where 98 percent received vaccinations.

"We were able to expand the health programs from the urban areas to the field by continuing the brigadista program and the partera (lay midwife) program in the different villages. In 1982, with the evacuation of the communities from the Rio Coco, we lost a hospital but were able to establish its health program in the new settlements. During the relocation we set up a health program and guaranteed that no one would die during the relocation. In each village the health personnel would go with the people and guarantee that the sick, the old people, the children would go by helicopter and wouldn’t have to walk. Each one of the villagers went with someone from the health program. The people came walking, the health personnel came walking—it was really something. The most important thing was to see how the health personnel really changed. We were able to make them understand that they should be with their patients, no matter where.

"In a poor country like Nicaragua to better the level of life of the people, you can’t talk much about housing. It is too expensive. We are trying to improve transportation, but it is not so easy. A road to Managua was opened in 1982, but because of the war, you cannot travel safely. But health is something you can do easily in every village. It is a way for the revolution to get to everybody, every village, anywhere in Nicaragua. That’s why the health personnel are targets of the contras. A doctor, Domingo Banderas, was kidnapped on a vaccination campaign in April 1985, in Alamicundo, by the MISURASATAs, Brooklyn Riveras’s group. They still have him. We have health workers who have been killed and health centers that have been destroyed. We have had to close nine clinics because of attacks. Now we send out mobile clinics, but it is difficult because they could be ambushed at any time.

"Since 1984, I have been working as the Governor of Zelaya Norte. Zelaya Norte is almost one-quarter of Nicaragua, its population is very dispersed, and we have the presence of three kinds of contras: FDN, MISURASATA and Kisan. So anything can happen. We have ambushes, the roads are mined, so it is a very hard area to work in."
"I'm still learning what a governor does. It is a very different kind of work than health. You start from the beginning to be more global. I think it helped me a lot to be a doctor since doctors sometimes understand things not only in a humanistic way, but in a practical way.

"We are trying to form and build a new state with a lot of the same people from the Somoza regime. That means changing people to become members of a revolutionary state. Most people in Nicaragua are learning that to build a new country, to make a revolution, is very complex. It is easier to fight.

"On the Atlantic Coast, there was no presence of the government before the revolution. Most people from the region didn't have an opportunity to go to school. You have to work with people from the rest of the country who come to the Atlantic Coast to work. Some of them don't understand our problems, our people — so you have to teach them. They were accustomed to a house, a school, a car. You don't have telephones. You don't have television. They are afraid of the war. Sometimes they say, 'Well, I would come if you would guarantee that nothing will happen to me.' I cannot guarantee that there won't be bombings or ambushes or mortars.

"Our highest priority is to maintain the programs that will better the level of life for people. We cannot expect these programs to grow at this time — just maintain them: Health, education, transportation, and food are the basic priorities. The first group that we give priority to are the people who are displaced by the war — the Miskitos along the Rio Coco, the Sumus, the displaced peasants from the mine area. Our biggest priority, as in the rest of the country, is to defend the region.

"All of us (the Miskito leaders including the contras) know one another. We're all from the Atlantic Coast. One of the most cruel things that the U.S. did to the people of the Atlantic Coast has been to put brothers and sisters to fight against one another for no reason — for external reasons, for external interests. We are not enemies because we are the same family. We talk about the reunification of the Miskito family. We always say that things cannot be solved with external people interfering in a family problem. That's why we negotiate with the indigenous people, because we are fighting about family affairs.

"The Miskitos are not fighting to overthrow the Nicaraguan government. They are fighting for the rights of the Miskito people, the same rights that we are talking about. The government has guaranteed for the indigenous people our land, our natural resources. But my point of view and their points of view on how land problems should be settled, we have to discuss. We continue to say that we will negotiate with the people who want peace. If we get the opportunity, I'm sure that there will be some kind of arrangements made, because it is not an irreconcilable conflict.

"The problem is that some of these leaders have become part of the CIA. They are really interested more in dollars than in helping their people. I would say some of them are already lost.

"Practically, we have been invaded already. We have had five years of war. It's an open war — this waste of Nicaraguan people. When you think there have been 26,000 victims already, over 400 air raids, over 300 naval violations of our national waters, you're talking about open aggression against Nicaragua.

"The problem is not to prevent a U.S. invasion but to stop the war."
Yes, I plan to go to the September annual meeting of the American Public Health Association (APHA) in Las Vegas. But why Las Vegas? The town's economy relies on organized gambling, which encourages organized crime. It winks at the sale of young women through street-corner newspaper stands, under the cover of the state's liberal prostitution laws. And it hyps the tawdry downside of the American dream: Strike it rich — by chance, by dumb luck, any way you can, but strike it rich.

Why a public health convention in Las Vegas? Well, the organizers tell us, APHA got stuck at the last moment. So, I decided to go.

While I can put aside my moral scruples (briefly), my public health baggage isn't unloaded so easily, especially at a convention of the American Public Health Association. Setting out for Las Vegas, I ask myself: What are the public consequences of this social and economic environment? Do the gambling, prostitution and crime have a noticeable impact on people's lives there?

Yes. The results of high-roller lifestyles in Las Vegas and Reno are writ large and clear in the state's public health statistics. According to the U.S. Statistical Abstract, death rates are strikingly elevated for the following causes:

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Rank among states</th>
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<tbody>
<tr>
<td>Suicide</td>
<td>1st</td>
</tr>
<tr>
<td>Motor vehicle injuries</td>
<td>3rd</td>
</tr>
<tr>
<td>All unintentional injuries</td>
<td>4th</td>
</tr>
<tr>
<td>Homicide</td>
<td>7th</td>
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These figures from the Injury Fact Book (Baker et al, Lexington Books) are based on death rates per 100,000 residents among 50 U.S. states and the District of Columbia for the years 1977-79. Nevada not only leads the U.S. in rate of suicides, but its 22.2 suicides per 100,000 people is 27 percent greater than the runner-up, Colorado. The list goes on. Nevada leads the U.S. in rate of poisonings by tranquilizers, is second in rate of barbiturate deaths, and third in deaths due to opiates and acute alcohol poisoning.

To be sure, Nevada shares this higher frequency of violent and accidental deaths with many other hard-living western states (except Utah). But Nevada's public health statistics clearly set it apart from its western neighbor states. In categories such as homicide and deaths due to food aspiration or acute alcohol poisoning, where we don't generally find the Rocky Mountain states emerging with the highest death rates — Nevada ranks among the highest 10 states, along with mostly southern and midwestern states.

Nevada is also a high crime state. The FBI rated Nevada third in the U.S. in 1984, behind Florida and the District of Columbia, in its Crime Index Total per 100,000 resident population, based on reports of violent crimes, burglary, larceny, motor vehicle theft and arson.

Can there be any doubt of a clear link between Nevada's gambling, prostitution and crime and its high death rates due to homicide, suicide, accidents and alcohol? I wonder how hardworking Nevadans weigh these public health consequences against the jobs that flow from the grand hotels and glittering casinos. From where I sit, the risks don't even up with the winnings — not by a long shot. But then I drive a 1966 Chevy, and I don't bet hard-earned money, not even in Las Vegas.

David Kotelchuck teaches at the Hunter School of Health Sciences and is a member of the Health/PAC Board.
Credentialing For What?
by Nick Freudenberg

The hottest topic for discussion this fall among health educators is credentialing—the development of a new process to guarantee employers and consumers that they get what they pay for when using a health educator. Organizations like the Society for Public Health Education (SOPHE) and the Association for the Advancement of Health Education (AAHE) have created an alphabet soup of committees, task forces and work groups to explore and debate the issue. By the end of 1986, major health education organizations hope to reach a consensus on a strategy for credentialing.

Several measures are now under consideration. Accreditation refers to the review and approval (or disapproval) of undergraduate and graduate academic programs in health education. Certification is a process whereby individuals are tested by a professional organization and deemed fit (or unfit) for practice. A licensure system employs the state government to determine whether an individual is qualified for practice. Few health educators advocate licensure at this time.

PropONENTS OF CREDENTIALING PLANS promote a yuppie's dream list of benefits, including: increased prestige and professional status, improved quality of education, reduced competition from inadequately trained practitioners, increased pay and greater accountability to the public. But a review of previous efforts to professionalize health personnel provides some grounds for concern.

The professional consolidation of physicians in the last three decades of this century probably improved the scientific training of those doctors who graduated. But the new requirements for the accreditation of medical schools imposed as a result of the Flexner report drove most Black medical schools out of business and dramatically reduced the proportion of physicians who were women or of working class origin. As a result it became more difficult for many Americans to get the medical care they needed.

What is a rigorously trained health educator? And does such a person contribute more to the health of the public than someone less rigorously trained? In the absence of any empirical evidence to answer these questions, the danger of unnecessarily excluding educationally disadvantaged groups from the profession seems high. Moreover, there is some research evidence to suggest that minority practitioners are more likely to practice in underserved communities, providing a public health as well as a moral rationale for affirmative action.

The control that organized medicine wields over that profession illustrates another danger of a strong credentialing process. As a result of creating a professional organization that defined protecting the interests of its members as its primary goal, organized medicine has, for more than 50 years, opposed almost every advance in public health care.

While it is not inevitable that self-interest and public interest conflict, a professional organization dedicated to limiting entry to the field is unlikely to espouse broad reforms. In addition, accreditation and certification pose potential dangers to the educational process itself. The strength of the field of health education is its diversity. Is there really one set of skills that a community organizer, a family planning counselor, a program administrator and a health promotion planner share? Can one devise a fair and reliable test to measure these skills?

Too often, standards of practice become a lowest common denominator and academic programs prepare their students for a test, rather than fostering their creativity or stimulating problem-solving skills. Many college administrators express concern over the escalating curriculum demands imposed by accrediting agencies. Some allied health disciplines already have so many requirements that their students have no time for liberal arts courses. Are these students being adequately prepared either as citizens or professionals?

Any final judgment on credentialing must await a consideration of the alternatives. In closing, I will briefly outline a few options that merit further discussion.

One goal of credentialing proposals is to give health educators greater visibility and to provide the public with greater clarity on what we actually do. To borrow a weapon from our own arsenal, we could instead develop public education campaigns for this purpose. Every health education program, local or national, could include activities designed to help the public understand the process and benefits of health education. This showing-by-doing would help to create new constituencies among citizens, patients and employers who would want additional health education services.

Another goal of credentialing is to create new jobs for health educators. The theory is that if professional organizations can guarantee that health educators can perform certain specific tasks, then employers will be more likely to hire a certified person who can get the job done. An alternative strategy for increasing the number of jobs would be for health educators and their professional organizations to join the coalitions that are fighting for more resources for public health. If health educators are trusted members of such coalitions, then we will be in a position to argue for hiring more health educators, writing job descriptions and specifying their educational requirements. Too often our professional organizations have been on the periphery of such struggles.

It also might be useful for health educators to join the hospital workers' government workers' and other unions now organizing in the health care industry, as many nurses have in recent years. Such an identity challenges traditional notions of professionalism, but more and more highly educated workers are joining unions. It is worth further study to determine which strategies best represent the needs of health educators for decent working conditions and a professional identity.

My intent here is not to reject any form of credentialing for health educators. Rather, I hope to widen the discussion so that the route ultimately chosen will best represent both the needs of health educators and the health of the public.
Health screening: rational or fashionable? by Arthur A. Levin

Many of us appear to approach life, and death, with a bit of the gambler's spirit. How else do public health workers explain those tens of millions who refuse to use seatbelts, or who continue to smoke, or the many who thrill to high-risk sports activities that wager life against individual skill and determination?

Medicine is often raked over the coals for being obsessed with cures while having too little interest in disease prevention and health promotion. But do people want to be "saved from themselves" and their unhealthy habits? Obviously many of us believe we can beat the odds, just as players at the crap table do.

Public health workers, primary care practitioners and others who advocate screening large numbers of well, asymptomatic people bank on such efforts to reduce major health risks as we gamble through life. But do they reduce risks?

The wisdom of the 1960s had been to do everything possible, to as many people as possible, as often as possible. The benchmark of quality in primary care and preventive medicine was the comprehensive annual physical exam. Auto-mated "multiphasic" screening—since it was less labor-intensive—came into vogue because it overcame the manpower constraints of giving annual physicals to everyone.

Reviewing the scientific merits of common screening procedures in the mid-1970s, Doctors Paul Frame and Stephen J. Carlson found no evidence that uncovering asymptomatic medical problems is, by definition, a good thing. They published these findings in a four-part series in The Journal of Family Practice.

Frame and Carlson searched the available scientific evidence and found that the rewards of screening were selective; that is, they made sense for certain people at certain ages, rather than all people at all ages. Their analysis and guidelines have since been described as providing the first rational approach to lifetime health maintenance programs. Subsequent work by Lester Breslow and Ann Somers refined the approach by suggesting that health maintenance goals themselves are age-specific. In 1979, a Canadian Task Force on the Periodic Health Examination issued its final report, reiterating the principles and guidelines of both Frame and Carlson, as well as Breslow and Somers.

Some critics of medicine claim that the "shelf life" of a medical fact is approximately five years.

Some critics of medicine claim that the "shelf life" of a medical fact is approximately five years. Since the critiques of past screening practices and the suggested new guidelines were almost ten years old, Frame felt it was time to take another look.

Frame has recently updated his review of current adult health maintenance guidelines with these conclusions about coronary heart disease and infectious disease: Adults should be screened to determine risk factors, and encouraged to reduce or eliminate those such as smoking, hypertension and high cholesterol levels. (The Canadian Task Force does not recommend screening, but is in favor of treating hypertension.) Frame discounts the utility of routine electrocardiograms (ECG) and maintains that the exercise ECG in asymptomatic people produces more false than true positives. He encourages exercise while cautioning that there is no evidence it will prevent death or disability from coronary heart disease—especially in those with pre-existing disease. The apparent benefit of exercise is in its inverse relationship to excess fat, hypertension, high-serum cholesterol and low ratios of high-density lipoproteins (HDL) to low density lipoproteins (LDL).

Frame encourages testing adults for total serum cholesterol levels every four years until age 70, and measuring blood pressure every two years. While the Canadian Task Force encourages measuring people's blood pressure during practitioner visits, it doesn't recommend cholesterol screening. Both Frame and the Canadians view hypertension detection and treatment as the only worthwhile preventative to reduce incidence of stroke.

Frame suggests that evidence supports using flu vaccine in anyone at high risk for lower respiratory tract infection, regardless of age. He claims the risk is greatest for those suffering chronic diseases such as heart, renal, pulmonary, diabetes, anemia and immune deficiency syndromes. The Canadian Task Force suggests routine vaccination for all people over 65, as well as for those at high risk, regardless of age. Frame finds weak the support for routine vaccination of healthy adults over 65 and believes there is no justification for routine pneumococcal vaccination among other age groups. People at high risk (children and young adults with sickle cell anemia and those who have had their spleens removed) appear to benefit from immunization.

Playing the health game involves lots of risk and the stakes are high. Gamblers at the blackjack table know that how you play a hand is based on many variables: which cards are showing, house rules, the behavior of the other players, etc. The overriding consideration is whether you take more cards or stick with what you've got. In prevention and primary care, as in gambling, taking on more is not always the best choice.

Arthur Aaron Levin is a member of the Health/PAC Board and Director of the Center for Medical Consumers, publishers of the newsletter HealthFacts.

by Tony Bale

The incredible story of the nuclear fallout attack by the United States government on its own citizens, and the continuing search for justice by those injured by the atomic bomb tests, has haunted many of us for more than a generation. The striking images of some of the 96 aboveground bombs detonated at the Nevada Test Site (approximately 70 miles northwest of Las Vegas) between 1951 and 1958 that I saw televised live in my dorm in the 1970s, when stories of governmental negligence and its cover-up began appearing in the media, and the atomic veterans and people living downwind of the blasts—the downwinders—began pressuring their claims for compensation.

In Justice Downwind political scientist Howard Ball, Dean of the College of Social and Behavioral Science at the University of Utah, has crafted a comprehensive and compelling account that puts together all the pieces of the 35 years of mostly injustice experienced by the over 100,000 downwinders living in small desert towns in Utah, Nevada and Arizona.

The book begins by tracing the story of the development of the atomic bomb through to the domestic aboveground testing in the Korean and Cold War atmosphere of the 1950s. Using recently available Atomic Energy Commission documents and other sources, Ball shows how the push to maintain atomic supremacy led to the A.E.C.'s failure to warn the downwinders of the potential risks from the pink clouds that descended on them and its failure to document exposure levels.

Ball describes the growing unease of the downwinders as the atomic testing program progressed, the growing feeling among these patriotic Americans that they had been lied to and abused by their government, and the ways they coped with the leukemias and other illnesses they attributed to the fallout. He reviews the conflicting epidemiological studies and the controversy that surrounds them. In an excellent section, Ball analyzes the progress of the lawsuits filed by the downwinders. The book's hero, U.S. District Court Judge Bruce Jenkins, developed a novel approach to the difficult problem of proving that fallout caused particular injuries. In a ruling awarding compensation to 10 of 24 representative plaintiffs, Judge Jenkins allowed compensation where claimants could show their injuries were possibly caused by radiation exposure—rather than using a more stringent legal test—and shifted the burden of proof onto the government to show why compensation should not be paid.

Jenkins's innovative ruling faces further test on appeal; Ball hopes it will, however, provide impetus to the as-yet unsuccessful attempt to legislate a federal compensation remedy. While his argument that such a program might have passed in 1984 but for Utah Senator Orrin Hatch's incompetence is not completely convincing, his picture of Hatch's incompetence is.

Justice Downwind is essential reading for anyone wanting to understand the continuing litigation and medical controversies around the bomb tests, and the new controversy over the effects of fallout from venting underground tests at the Nevada Test Site into the atmosphere. This book, with its striking graphics and gripping story, is an important tool for building a more comprehensive view of the social relations underlying the corporate-governmental environmental assault on Americans, and the search for justice by the many victimized groups.

Tony Bale is a sociologist and a member of the Health/PAC Board.


by Eric Holtzman

The commercialization of modern biology, especially of recombinant DNA, monoclonal antibodies and the like is the subject of Mark Lappe's Broken Code: the Exploitation of DNA. The outlines of the current situation are already familiar to many reading this review. Biologists are excited by the analytical power conveyed by the ability to manipulate genes directly. Some are also enthusiastic about the potentials for commercial careers and monetary rewards. Physicians and public health officials are drawn to the armory of diagnostic, screening and therapeutic procedures being developed or promised. Industry and agriculture are gearing up to apply the new techniques.

High-rolling investors have created a sometimes giddy investment market in new biotechnology enterprises. The military, interpreting biological warfare treaty obligations with customary flexibility, is also seeking to use modern biology.

Mark Lappe attempts a compact survey of what is happening. He includes historical reviews of the scientific advances and of regulatory efforts; discussions of the major lines of current research and commercialization in agriculture, medicine, waste disposal and other fields; consideration of military research; a brief appendix outlining the new biological techniques; and tables summarizing the products being worked on and the corporate enterprises involved.

Though now a practicing ethicist and policy analyst, Lappe was trained as a biologist. Thus he readily grasps the extraordinary scientific jump that recombinant DNA techniques represent and is also aware of gaps in knowledge that still impede progress—for example, the relatively underdeveloped state of plant molecular biology.

Lappe's approach to risks and benefits is balanced and common-sensical. He appreciates that some of the initial fears have proved overblown. But he is also aware that we still know far too little about organisms and environments to feel confident about manipulating the gene pools of crops too extensively, or to be sanguine about turning loose new live organisms without bending over backwards to be sure we have engineered them so as to be able to use known controlling agents—herbicides, pesticides, etc.—should things go wrong.

His clearly written book reads well and will provide a useful entry point, most immediately accessible to people.
with some background in biology or medicine, but helpful to the uninhibited as well. Although the explanations of techniques are a bit too telegraphic for those with no prior background, the book can be read profitably without a full understanding of the science involved.

Lappe’s most important accomplishment is his sustained focus on the central question: Whose agriculture, whose health and whose economic interests will be served? Most negative public discussion of the new biology has concentrated on potential environmental and occupational hazards, on distortions of academic and scientific life and on relatively abstract ethical problems—often framed in religious terms—that arise with our enhanced abilities to engineer plants, animals and eventually, humans.

Lappe deals with many such issues, but he reemphasizes a more fundamental point: Revolutionary though recombinant DNA technology may be as a set of techniques, its application is being shaped by long-dominant economic and political institutions and forces that are pursuing much the same agenda of research interests, product emphasis and marketing strategies as in the past.

The new technologies arose principally as a result of public investment channeled through government funding of research, but their commercial exploitation is firmly in private hands. The research was carried out by an international network of laboratories, but national or narrow multinational-corporate interests dominate most commercial plans.

A nascent “junk” biotechnology already exists, seeking the cheaper production of sweeteners and potato chips, or new flavorings. In agriculture, most effort is concentrated on the needs of the already well-fed. In medicine, choices of which diagnostic tools or therapeutic agents are to be developed and decisions about the production of vaccines whose primary use would be in the Third World are already enmeshed in the network of conflicting interests waringly familiar to observers of U.S. medicine.

Lappe’s tone and rhetoric are mild. But it is hard to read his book without feeling outraged at the opportunities being lost as still another technology eludes humane and rational application. The solutions he discusses are hardly radical: more public control through regulatory agencies, Congressional oversight and through local democratic institutions; support of international organizations and arrangements that foster public health and economic development in underdeveloped countries; the need for scientists to defend freedom of inquiry and communication, and to be actively aware of the social impact of their work.

But even such a familiar list reminds us that there really is nothing inevitable or mysterious about the misorientation of technology. There is room and reason to change things.

Eric Holtzman is Chairman of the Department of Biological Sciences at Columbia University.

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**Vital Signs**

*continued from page 6*

**Is There a Draft In Your Future?**

A House Armed Services subcommittee took preliminary action this June toward approving legislation which, for the first time, would have required some women to register for the draft. It would also have re instituted the requirement that people as old as 46, who are in some categories of the health care professions, be registered.

In the past, male doctors could be drafted several years past the legal age limit for other men, a special requirement that ended when draft registration was halted for everyone in 1975. When the registration began again in 1980, only men born in 1960 or later were included.

The law would have given the President the power to register nurses, paramedics, veterinarians, or anyone in a health care occupation determined to be “essential to the support and maintenance of the Armed Forces.” The bill would also create a special civil penalty of $5 per day, with a $300 maximum, for late registration by those in any of the designated health care occupations.

Although the proposal didn’t pass the full Armed Services Committee, “it seemed more difficult to defeat this time than when the idea was first raised about three years ago,” says Rick Jahnkow, a representative of Draft Resisters Defense Fund in San Diego. Even with the powerful AMA opposing the bill, he adds, “the chances of its passing seem to get better every year.”

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**Post-Modern Hospital Delight.** This drawing from a 1962 magazine is accompanied by the caption, “Leading hospital designer E. Todd Wheeler foresees this design as the pattern for the hospital of tomorrow. Visitors would drive up the spiral ramp, park, and have direct access to the room or ward of the patient they wanted to visit. Basic advantage of the design is that it keeps visitors off busy hospital elevators…”
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