THE RUBBLE IN ST. LOUIS
Peter Downs reports on the public impact of privatizing a city health care system

Who's minding PPS? • The Mass. referendum
Catastrophic coverage • Quentin Young on Cook County health
Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and its books, Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a "medical-industrial complex" which has yet to provide decent, affordable care.
Welcome Health & Medicine Readers

The Health and Medicine Policy Research Group (HMPRG), a leading health advocacy organization, recently published the last issue of its fine journal, Health & Medicine. As a result, the small field of progressive health care journals is losing one of its clearest voices in the national debate on health care.

Since 1982, Health & Medicine has offered some of the best writing and analysis of the social and institutional problems confronting Americans in the fight for an equitable and accessible health care system. Speaking in a language that was both understandable and understandable, HMPRG, in its dozen quarterly issues, surveyed the major themes on health care's crowded and confusing landscape.

As it uncovered the structural defects of the status quo, the journal often proposed creative new programs and policies, generated through its forums, conferences and internal brainstorming.

One of its liveliest discussions was prompted by a 1986 radio interview with Studs Terkel, who talked with a handful of the group's members on the occasion of HMPRG's fifth anniversary. Prompted by Terkel's outsized curiosity, the policy-groupers generated what reads like a Socratic primer on what we can do to restore our sick communities to health. "There's a popular phrase that people in the world of medicine and health planning use, and it's health consumer," John McKnight explained. "We believe you can't consume health. You can create health by strong communities and political action that changes the environment that makes you sick. But when you get tricked into believing you can consume health, you will be unhealthy." This is the kind of straightforward and incisive talk that readers of the journal will miss.

While the Chicago group's journalistic activities are ending, its research and advocacy efforts will continue. We're pleased to announce that news of its ongoing work will be reported and discussed here in a regular column by Quentin Young, the physician-activist who co-founded the group and serves as its president. (His column, "Speaking of Health & Medicine," begins in this issue.) In addition, two HMPRG board members will help broaden our coverage of the national health care scene by serving as contributing editors to the Bulletin. We hope that Health & Medicine readers—who are now receiving the Bulletin in place of the remaining issues of their subscriptions—will find the journal's spirit alive and kicking in these pages.

If You Read Us, Join Us
There is other news to report from our office on Murray Street. After long deliberation, Health/PAC has now officially become a membership organization. (We'll be contacting subscribers soon with details.) For years, many of our readers have already considered themselves members. It's a warm inclination that we'd like to encourage among all who find valuable information in these pages. Surveys of over half our subscribers showed strong support for this idea, with the proviso that we maintain our primary function. Rest assured that Health/PAC's basic role will not change. We will still provide incisive reporting and analysis of the critical health care issues that go unreported in the commercial media. And we will continue to organize important forums, conferences and other events which focus attention on the overlooked health needs of the nation, as we've been doing for the past 19 years.

Members will receive Health/PAC's newsletter, featuring reports on local and state-wide advocacy efforts and members' activities. They will also enjoy special discounts on our publications, and other benefits.

Our reason for the change is simple. We believe that these times call for greater organizational efforts to stop the growing assaults on our fragile environment, public health, and civil liberties. The shattering of vital health programs and services continues apace despite recent knocks to the beleagured health-slasher in the White House. His attention may be fading, but his policies are still firmly entrenched and as dangerous as ever.

As a membership organization, Health/PAC will work to support the growth of a revitalized health movement by doing what we've always done best: keeping concerned people informed, involved and in touch around the critical issues affecting all the people's health. If you share these concerns, we hope you'll join Health/PAC soon as a member.

—Joe Gordon, Executive Editor.


Vital Signs
Edited by Tammy Pittman

A Victory for Farmworkers

After 14 years of battle with the United States Department of Labor, farmworkers have finally won the right to have drinking water and sanitation facilities at the worksite.

In February a Federal Appeals court in Washington, D.C., ruled that the Labor Department must issue guidelines requiring farmers to provide fieldworkers proper sanitation facilities. The ruling stated that the court sought to end “this disgraceful chapter of legal neglect.” Farmworkers are the only workers in the United States who do not have a federal guarantee of sanitary facilities in the workplace. Without sanitation facilities, workers have had to work all day with residue-contaminated skin, eating meals and rubbing tired eyes with unwashed hands.

Leaning heavily on such medical advances as the germ theory and the laws of hydration, the court opinion points out that the record “demonstrates beyond dispute that lack of drinking water and toilets causes the spread of contagion, bladder disease and heat prostration among farmworkers.”

Clearly, this decision should have come many years ago, but the fight may not be over. Reagan Administration officials are rumored to be considering an appeal, on the grounds the ruling runs counter to the Administration’s position on states’ rights.

Stay tuned and in the meantime, Boycott Grapes! Cesar Chavez’s United Farm Workers of America is trying to pressure grape farmers to ban five dangerous pesticides and to test grapes in stores for poisonous residues.

Feds De-Fund Key Quality-of-Care Weapon

Last year, Congress dropped funding for the Federal Health Planning initiative and terminated the law requiring states to develop health planning programs. The Congressional move has jeopardized state Certificate of Need (CON) laws, which make it possible for states to regulate the number and placement of hospital beds and health care facilities.

Not only do CON laws prevent all hospital beds from being built in affluent neighborhoods, they have also begun to play an important role in fighting for quality care.

In California, the state health department is using the CON process to revoke the licenses of a nursing home chain charged with providing poor care to patients. In 1985, the state charged Beverly Enterprises with, among other things, the avoidable deaths of nine patients at three of the chain’s facilities. The state chose to penalize the chain operators by threatening not only to revoke the licenses of these three nursing homes, but also to refuse the chain’s CON application for licensure of three other homes already built, for three homes it hoped to buy, and for the expansion of a home health agency.

Beverly protested loudly, charging that, “The Department of Health Services is incorrectly and illegally tying the licensing of new acquisitions and new facilities to the settlement of these cases.”

The State Attorney General’s office responded that the State “may deny approval of any future application for a license if a person named in the application was previously involved with a facility when the license violated the law.” Although this statement is not law, it is a noteworthy opinion and a positive precedent for advocates seeking to safeguard quality care against the venal tendencies of health care empire builders.

The bad news, however, is that California’s CON law expired January 1, 1987, and the legislature will not renew the law without federal support. Advocates in California must now seek other avenues of protection for health care consumers.

Proposed Medicare Cut Imperils Hospitals

The Reagan Administration is seeking to cut advance Medicare
payments to hospitals in a continuing "supply-side" effort to lower costs by unplugging the nation's life support systems.

Medicare's Interim Payment Program, known as PIP, has been slated for termination by the Administration's fiscal 1987 budget package. The PIP-cutters claim it could save as much as $4 billion. Hospital spokespeople charge that ending PIP could lead to hospital closings nationwide and the curtailment of vital services.

Charles Meyer, CEO at Brookdale Hospital in Brooklyn, N.Y., told the new health weekly the Medical Herald, "The potential danger is very great, especially to hospitals in urban areas. We'd need $3 million to carry us through the first 20-day gap. That means going to the bank for a loan. At today's rates that's about $300,000 in interest that we would have to pass on to patients."

PIP's biweekly payments provide revenue to hospitals on projected discharge and payment rates. For many hospitals, PIP's demise means the end of a stable and consistent level of revenue. Financing gaps could lead to intermittent cancellations of surgery, elimination of medical departments, longer waits for care and treatment, and the loss of thousands of jobs. Hospitals most affected by a cutoff would be those financially distressed institutions which serve the medically indigent and the aged who, of course, tend to need care the most.

The House Ways and Means Committee has voted to eliminate PIP—the projected cutoff date is July 1, 1987—but continued debate on the Hill is anticipated.

Three Eggs for Four People

A recent Health/PAC forum studied the problem of hunger in the U.S. and the Federal Government's ludicrously inadequate programs to deal with it.

Of the 35 million poor people in this country, 20 million regularly experience food emergencies. Eighty percent of those who receive food stamps run out by the third week of the month. These startling estimates were presented at the November forum by Sally Guttmacher of the Health/PAC Board.

Guttmacher offered a telling tale of government stupidity as she explained how the U.S. goes about defining poverty. The tale goes like this: In the 1960s, the Social Security Administration (SSA) originally defined the "poverty level" by relying on a Bureau of Labor Statistics study which found that poor people spend about a third of their incomes on food. The SSA took the Department of Agriculture's emergency "thrifty food plan"—which allows a family of four three eggs for breakfast—and multiplied the cost of the plan times three. It is a standard (despite adjustments for inflation) which no urban family could ever live on, yet it was used as the goal for assistance poor families received.

The Reagan Administration has since reduced aid to families to only two-thirds that level. Of those who do receive assistance, the panelists estimated that 35 percent don't get what they are entitled to, due to bureaucratic bungling.

In response to this crisis, the number of food emergency centers in New York City alone has risen from 30 to over 450 during the Reagan years. "We will look back upon the '80s and say, 'What was the great new creation in social services?'—and it's the food pantry and soup kitchen," noted Liz Krueger of the Community Food Resource Center. "And it is no solution." —David Steinhardt

Anti-HCA Battle Continues in Rhode Island

Last year, a broad-based coalition of consumers and unions succeeded in blocking the Hospital Corporation of America (HCA) from gaining a foothold in Rhode Island. Charging the Corporation with a range of misdeeds and mismanagement, the coalition urged state legislators to prohibit for-profit health care conglomerates from entering the state.

As one union member testified before a committee of the State House of Representatives, "These corporations increase the service charges, drastically reduce the staff/patient
rations and increase the burden on voluntary and public hospitals by refusing to treat uninsured and underinsured patients. . . . I don't want to see the same thing happen here that's happened in other states where HCA has moved in."

At least 75 legislators were convinced enough to sign a bill introduced by Rep. Nicholas Tsiongas (D) to block entry of the proprietary giants such as HCA, Beverly Enterprises and Humana. But passage was derailed by an unprecedented resolution requiring the state Supreme Court to rule on the bill's constitutionality.

This February, the Court ruled that the measure was constitutional. The bill will be reintroduced soon and is expected to pass, according to a Tsiongas aide. Meanwhile, the Rhode Island Health Service Council has voted unanimously to recommend denial of HCA's CON application to build a rehabilitative center. HCA is appealing the decision.

Reagan's "Cost Cutting" Misses the Mark

Despite the sometimes draconian measures taken by the Health Care Finance Administration to cut health care costs nationwide, recently released government figures show that medical inflation remains a serious problem.

The cost of medical care last year rose seven times as fast as the Consumer Price Index for all items, with a 77 percent increase, according to the Bureau of Labor Statistics data. The Consumer Price Index rose 1.1 percent in 1986. The disparity between the CPI and medical care costs is the widest since Reagan took office. Despite a developing doctor surplus and a Medicare crackdown on doctors' fees, the physicians charged 78 percent more for their services last year. Hospital room rates were up 77 percent, despite the ceilings imposed under the DRG system.

In those areas where business is given the freest rein, the increases were even more dramatic. Prescription drug prices were up 9 percent, with the biggest increases found in sedatives and tranquilizers, which rose 13.2 percent.

Uwe Reinhardt, the Princeton University economist, told the New York Times the increase in doctors' fees was "remarkable" but consistent with basic principles of economics. "The number of physician visits per capita in the United States fell substantially in the last four or five years," he said. "When their volume fell, the doctors behaved like many American businessmen. They jacked up their prices."

Its Bitsy Amounts of Radiation

Proposed rule changes by the Nuclear Regulatory Commission may permit the disposal of low-level radioactive waste in our landfills with no protective measures or monitoring.

A little-noticed piece of 1985 legislation requires that the NRC find ways to speed action on disposal of nuclear waste deemed "below regulatory concern." According to Kitty Dragonette, senior health physicist at the NRC, the reason for this move is to save rapidly diminishing space at nuclear waste sites.

Scaffolding at a nuclear power plant which is exposed to a leak of radioactive gas, for example, would formerly have been broken down, sealed in drums and disposed of at a nuclear waste site. Under the rules proposed by the NRC in response to the legislative directive, a plant operator may apply to have such a "waste stream," as it is called, declared an insignificant risk to "the human environment," and thus eligible for disposal with non-radioactive garbage.

Particularly troubling is criterion number 12 for the new rules: "The offsite treatment or disposal medium [e.g., sanitary landfill] does not need to be controlled or monitored for radiation protection purposes." In other words, the NRC's new policy for slightly contaminated waste is inspect-no-evil.

The NRC is currently following a case-by-case policy of checking each and every waste stream to be exempted, but significant changes may be in the works. "Generic rule-making" is being considered, which would specify levels under which the NRC could ignore a waste stream.

Urine Testing, Stat!

Now that the green light is on for invasive drug testing in the workplace, manufacturers are rushing to market speedy diagnostic products which make spotting suspicious urine as easy as one, two, three.

One new product, QUIK TEST, promises "to detect the use of cocaine, crack, morphine/heroin, PCP [angel dust], amphetamines, methadone, codeine and Librium, all at the same time," in under five minutes.

With the Justice Department pushing mandatory testing of the nation's 1.5 million federal employees, a lot of private companies are running to join the "national mobilization" against drugs. For too many employers the key question is not whether drug screening is unconstitutional, but whether they can meet the anti-drug litmus test quickly, efficiently and "cost-effectively."

Here comes the answer. "The first practical and cost-effective method for drug screening in the workplace is here," boasts a news release from Keystone Diagnostics, Inc. With it, an experienced operator can screen as many as 175 people in approximately seven hours. And, says the company, on-site screening—which is faster and poses less risk of specimen tampering than sending out urine to a lab—also benefits employees. "From the individual's standpoint, the shorter wait for results usually means less anxiety," the company's president sensitively points out.

Caution is advised, however. "No adverse personnel action should be taken on the basis of a screening result alone," says the promotional piece. "Positive results produced by a drug screen should always be confirmed by . . . definitive laboratory methods." That is to say, be quick but careful. Lawsuits by pissed-off employees could quickly cut into cost-effectiveness.
"Health Care Is Sick in St. Louis"

by Peter Downs

The crumbling of the nation's public health care system is nowhere better illustrated than in St. Louis, Mo., where the city administration recently removed its ailing municipal hospital and clinics from public control in one quick, autocratic stroke. Helping the mayor "rescue" St. Louis "out of the health care business" were the city's business elite and the highly paid managers of National Medical Enterprises, one of the nation's largest for-profit health care corporations. The St. Louis story is just one local chapter of an unfolding tragedy which finds the poor and uninsured increasingly shut out and shunted aside as the nation's public and voluntary health sectors fall prey to what is euphemistically called "privatization."

In 1985, the city of St. Louis closed its last remaining public hospital and gave over the operation of its public health system to a private corporation. It was a drastic action, and Mayor Vincent Schoemehl took it in the hope of ending decades-old problems in the city's health care system.

City officials and the news media had long complained about the inefficiency and rising costs of running St. Louis's public health care system. Reports of unnecessary deaths and poor care at the city's aging acute care hospital had become a yearly newspaper staple by the 1980s.

The mayor, a liberal Democrat, met the city's health care problems the same way he tackled other problems, by contracting with a private corporation to provide vital city services.

Two years ago, the mayor was instrumental in creating the nonprofit Regional Health Care Corporation (RHCC) to take control of the city's health care system, and he hired the nation's third largest for-profit health care firm, National Medical Enterprises (NME), to operate it (see box, "NME: Getting Leaner and Meaner").

So far, the privatization scheme has been a disaster. Costs have continued to rise and, critics charge, the quality of care for the city's poor has been drastically lowered. Critics also charge that the mayor's hasty transfer of public health care out of the public sector, a transfer that was officially completed in under one week, was reckless. Under the transfer, the aging City Hospital, a public institution, was closed and quickly replaced by the new, privately run Regional Medical Center.

On June 25, 1985, the day after Mayor Schoemehl ordered City Hospital closed, Martha Cobb Douglas died of cardiac arrest at the Regional Medical Center. Her family had taken her to the recently opened hospital at 4 a.m. Six hours later, hospital staff decided not to admit her and sent her, via ambulance, to City Hospital. City, however, no longer was admitting patients and sent Douglas back to Regional. She died at 4 p.m.

Insensitivity to Patients

The confusion and chaos that surrounded Douglas's death presaged the problems that continue to plague the new Regional Hospital to this day. Edna Dell Weinell, director of the Family Care Center of Carondelet, a federally funded neighborhood clinic in south St. Louis, charges that city and NME officials "gave no thought to the effects of the transfer on the delivery of health care." Weinell says, "It was irresponsible and demonstrates an insensitivity to patients."

During the next six months, NME hospital administrators continued to demonstrate this insensitivity. They raised patient fees, eliminated sliding scales for the uninsured, harassed patients who couldn't pay their bills and began chopping such community health services as screening for lead poisoning.

NME first entered the city's public health care system in 1984, when the Schoemehl Administration sought its

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Health Care Is a Human Right

Health care professionals organized the Health Care Is A Human Right Coalition in November 1985, in response to the changes being imposed by St. Louis Mayor Vincent Schoemehl and National Medical Enterprises (NME) on the city's ailing health care system.

Paul Kuehnert, co-chairman of the HCHR Coalition, says the group's main accomplishment has been keeping public attention focused on problems of the city's public health care delivery system. HCHR members were the first to alert the public and press about cutbacks in lead poisoning screening and the jump in infant mortality in the black community. Their slogan is "Health Care Is Sick in St. Louis."

One of the coalition's first major decisions was to monitor the quality of care in the city and county's newly privatized public health system. To this end, they established a hotline for patients to call with complaints about how they were treated. Information first obtained over the hotline was instrumental to the testimony the coalition provided to the city's Board of Aldermen. It also provided the basis for public hearings organized by the HCHR Coalition.

The coalition's activities have led to several concrete successes. They brought pressure on the mayor to return lead poisoning screening to the city's health department. They persuaded the hospital administration to reintroduce a sliding fee scale for services, and prompted the county executive to "find" the money to restore some proposed public health cuts. The coalition's work also led to a state investigation of the rising infant mortality rate in the city's black community.

Kuehnert explains, however, that, "There is not going to be a local solution to these problems. There has to be a national solution." For that reason, the HCHR Coalition is working with groups in the American Public Health Association to set up workshops at the October APHA convention in New Orleans.

-- Peter Downs

services to manage City Hospital. The city paid NME over $600,000 that year. The mayor argued that the corporation's national experience, garnered from managing 54 other acute care hospitals, would enable it to improve care and efficiency at City Hospital. NME, for its part, promised that it would save St. Louis $1 million per year more than it charged the city for its services.

Long History of Decline

NME's arrival followed a long history of decline in the city's public health care system. Much of its erosion can be traced to the prolonged prosperity of St. Louis in the fifties, sixties and early seventies. As high levels of employment led to rising real wages and the spread of employee health insurance, workers became less dependent on public hospitals for their medical care. At the same time, many workers were earning enough to leave the city for newly developed suburbs. The figures are dramatic: Between 1950 and 1985, the city's population fell by one half, from 856,000 to 420,000. This loss cut staff needs were chronically neglected. As the hospitals deteriorated, fewer people used them. Prosperity was not evenly distributed, however. Blacks continued to suffer greater unemployment and poverty than whites, and came to make up an ever larger proportion of the public hospital system's clients.

To qualify for Medicare and Medicaid funds, St. Louis formally desegregated its hospitals in 1966. It had two acute care hospitals at that time. City Hospital, on the South Side, was for whites, and Homer G. Phillips Hos-

pital, on the North Side, was for blacks. City officials decided that instead of directing people to hospitals based on their race, they would send them to the hospital nearest their homes. Southsiders would go to City, and Northsiders to Phillips. That change meant very little in practice, however, as city neighborhoods were racially segregated anyway.

At the same time, a bloc of white city politicians began advocating that the city close its hospitals and "get out of the health care business." Health care, they argued, is a federal, not a city, responsibility. The black community rallied to oppose their plans in what amounted to a long series of holding actions.

For the next 15 years, the opponents and supporters of public hospitals reached a stalemate over budgets that essentially kept the hospitals open, while they slowly bled to death. Maintenance, equipment purchases and staff needs were chronically neglected. As the hospitals deteriorated, fewer people used them.

Broken Promises

By 1979, the average daily census for the two hospitals had dropped from about 800 (in 1970) to about 500, or 50 percent occupancy. That year, Mayor James Conway ordered Phillips closed and consolidated hospital services at City, creating an uproar in the black community. The following year, when Vincent Schoemehl began his mayoral campaign as a populist, neighborhood-oriented candidate, he promised to reopen Homer G. Phillips. That promise won him the support of the black commu-

HCHR Coalition co-chair Dr. Herman Blumenthal addresses St. Louis residents about the city's health care problems.
nity and propelled him to an upset victory over Conway in the Democratic primary. But it was a promise that the mayor could not live up to.

During Schoemehl's first year in office, the average daily census at City Hospital fell to 288. Schoemehl urged that the reopening of Homer G. Phillips Hospital be coupled with the closing of City. In 1982, he proposed a $64 million bond issue to renovate and reopen Phillips. He also proposed a city charter amendment that would enable city officials to contract with a private firm to operate the hospital.

Many of the leaders who fought to reopen Phillips felt betrayed by the mayor. They argued that the city still needed two public hospitals. The sharp drop in use of the public hospital between 1979 and 1981, they claimed, reflected City Hospital's inaccessibility to the North Side. Phillips, they said, would be just as inaccessible to the South Side. Critics further contended that by linking the reopening of Phillips to the closing of City, Schoemehl had recast the bond issue question from one of providing accessible health care to one of whether the city's hospital should be "black" or "white."

Bond issues are hard to pass in Missouri, requiring a two-thirds majority vote for approval. Given the strong racist element in St. Louis, the proponents of reopening Phillips thought that Schoemehl's maneuvering had effectively killed any chance of getting the bond issue passed. They opposed it, as well as the charter amendment, since they felt that a privately managed hospital would engender a loss in public accountability and control over the facility.

Fifty-three percent of the voters approved the bond issue, not enough for it to pass. The charter amendment also went down in defeat. Following these defeats Schoemehl said that his pledge to reopen Phillips "was a mistake" and that the hospital was "gone as an acute care hospital."

Contracting Out Becomes Policy

The mayor next sounded the alarm on the city's health care system. "If we continue health care as we are providing it today," he said, "this city is going to go bankrupt within two years." He charged that the hospital was being mismanaged and began to look for private firms to help run it.

Troubles mounted at City Hospital when the Joint Commission on Accreditation of Hospitals decided against reaccrediting it in 1983. Soon after, the mayor announced plans to close City Hospital by the year's end and his intention to sell one of the city's two long-term care facilities which provided care for 428 patients. In the face of heavy city-wide opposition, including resistance from private hospitals, which feared an influx of indigent patients, Schoemehl quickly abandoned his plan to close City. As the pressure mounted he supported efforts to regain accreditation for the hospital. During this period, the city's Board of Estimate and Apportionment—which consists of the mayor, the comptroller, and the
St. Louis Mayor Vincent Schoemehl engineered the transfer of the city's ailing public health system into private hands.

president of the Board of Aldermen — decided to hire a private company to manage the city's remaining long-term care facility. From this point on, the mayor would pursue a policy of contracting with private companies to provide public health services.

Enter NME

By 1984, the Board of Estimate and Apportionment had decided to contract with a private firm to manage City Hospital. The city did not solicit bids for the contract, despite claims from the mayor's press secretary that the mayor's office considered hiring four firms. In August, the city settled on NME to manage the hospital for $400,000 per year (after which NME donated $1,000 to Schoemehl's campaign fund and $1,500 to the incumbent comptroller's campaign fund).

NME claimed that it would save the city $1 million above its contract fee by reducing inventories, rationalizing staffing levels, improving bill collecting, and making use of its national purchasing agreements. But when it took charge of City Hospital, the corporation quickly discovered that it couldn't ignore the mayor's ties with local medical supply firms, which had also contributed funds to Schoemehl's campaign. Nor could NME ignore civil service regulations that protected staff from dismissal. The only area in which it had a free hand to reach for "savings" was in inventory control.

Judy Papian, who was a nurse midwife at City, says that after NME took charge serious supply shortages developed and "we had to turn to some really primitive practices," such as washing and reusing the linen used in deliveries, instead of disposing of them as other hospitals do.

City and NME officials claimed that in the year that NME managed City Hospital, it cut hospital costs by $800,000 and increased revenues by $2.5 million for a net savings of $3.3 million. However, according to the city's audited financial statement, the city subsidy of the hospital actually increased by $4 million that year, to $19.1 million. Clearly the city's contract with NME did not save St. Louis money. Some other action had to be taken to cut costs.

As much as he may have wanted to, there was no politically acceptable way for Schoemehl to get his administration out of the costly and complex business of providing medical care for the indigent. (The city's responsibility is mandated by state law.) Within the bounds of the law, however, Schoemehl was determined to reduce the city's burden for indigent care. For over 20 years, health care experts had been recommending that the city and county merge hospitals to provide indigent care more efficiently. The mayor argued that if such a merger were set up under NME's management, the city could save a lot of money.

The mayor won the backing of area business leaders who agreed to set up a private corporation to assume ownership of the merged hospital. Under the plan, the mayor and the county executive would appoint the board of directors of the new corporation. Schoemehl hoped the plan would put an end to the long history of political battles over health care. A private hospital, he said, would "take public health care out of politics and should make it possible to operate the hospital more efficiently and provide better care for the patients."

A Hasty Plan Is Launched

The ball got rolling on the plan in October 1984, when the Protestant-affiliated St. Luke's Hospital Corp. decided to sell its St. Louis facility. That hospital was ideally located both near the boundary between the city's North and South Sides, and close to the city-county boundary. A for-profit chain, Charter Medical Corp., purchased St. Luke's that month for a reported $10 million. In May 1985, Schoemehl began negotiations with Charter to purchase the hospital. When Charter balked, he threatened to take the hospital by eminent domain if it didn't negotiate. Four months later he reached an agreement on a purchase price: $15 million.

On June 22, 1985, the mayor suddenly and unexpectedly announced that Charter would become the city's new public hospital with ownership vested in a new private, not-for-profit corporation. The new venture was called the St. Louis Regional Health Care Corporation. The hospital purchase was financed by tax-free industrial development bonds issued by the city and the county. The RHCC also took title to the city's five public health clinics. On June 24, City Hospital stopped accepting new patients and began transferring existing patients to Regional. The next day Martha Cobb Douglas died.
The voters had absolutely no say in these sweeping changes. At the time the mayor announced the transfer, many details remained to be worked out. Charter had not yet agreed to an actual sale price, though it had agreed to the sale in principle. Not only was the RHCC not yet incorporated, but the details of how the board of directors would be chosen had yet to be worked out. Nor had the mayor’s office developed a plan for city monitoring of the new facility.

Under the mayor’s plan, NME would manage the hospital and clinics for the RHCC, with the city agreeing to reimburse NME for any and all expenses and liabilities. Two prominent local businessmen would co-chair the Board of Aldermen for $22.7 million for the new hospital. Health workers lost their jobs, the hospital workers’ union was broken, key health services were cut, and patient fees were increased. As all this happened, the city’s subsidy for health care actually rose.

A major disaster was in the making. The move from City to Regional was so sudden that patient files were left in file cabinets auctioned off after the closing of City Hospital. Health workers lost their jobs, the hospital workers’ union was broken, key health services were cut, and patient fees were increased. As all this happened, the city’s subsidy for health care actually rose.

The mayor followed the move with a budget request to the Board of Aldermen for $22.7 million for the new hospital and $5.4 million for the clinics. That compared with the previous year’s expenses of $19.1 million for City Hospital and $2.9 million for the clinics. The subsidy for Regional did not include any amount for debt retirement, although the city is responsible for retiring half of Regional’s $20 million debt. City Budget Director Steve Mullin predicted that Medicare and Medicaid would refund $5 million of the subsidy to the city. Despite the record budget, NME ran out of money in January 1986, three months before the end of the fiscal year.

Patients and Workers Dismissed

In addition, NME cut services drastically. It laid off all City Hospital and clinic employees. Those who wanted to work for Regional had to interview for jobs. In one fell swoop, NME and the City broke the hospital employees’ union and cut nurses’ compensation. (Judy Papian, for example, was offered a wage that was $2 per hour less than her wage at City, and she would have begun with no accrued pension, sick days, or vacation time.) The employees filed suit to stop the transfer and petitioned the city’s Civil Service Commission to hold hearings on their dismissals. They lost the suit. Charles Oldham, the employees’ attorney, says that when the Civil Service Commission agreed to hold hearings, the mayor dismissed the Commission and appointed a new one. The 1,780 employees from City, County and Charter hospitals were left to vie for approximately 1,100 positions at Regional.

### NME: Getting Leaner and Meaner

National Medical Enterprises is the third largest hospital corporation in the U.S. Founded in the late 1960s by three lawyers, Richard K. Eamer, Leonard Cohen and John Bedrosian, NME soared to profitability. By 1984, Cohen and Eamer were the most highly compensated executives of any Los Angeles-based corporation, pulling in close to $97 and $7.9 million, respectively, in salary and exercised stock options.

Much of NME’s money-making strategy is based on the promise of increased efficiency. In reality, the corporation delivers shoddy management, increased charges, and staff cutbacks—which lower employee morale and the quality of patient care.

NME currently operates 544 facilities. It has begun to shed its less lucrative, and potentially unstable, acute care hospitals and is concentrating on more profitable nursing homes. According to recent figures, NME owns 41 acute care hospitals and manages another 43 in the U.S. (plus several others in the U.K., Malaysia and Singapore). The corporation also owns 45 psychiatric and 16 rehabilitation hospitals, 12 alcohol and drug treatment centers and 387 nursing homes. Its operations are concentrated in the South and West, especially California. (According to the corporation’s own plans, it intends to own approximately 32 acute care hospitals by early 1988.)

In 1985, NME turned a handsome profit of $49 million on revenues of $3.3 billion. But 1986 was a year of contraction, with an anticipated 40 percent drop in profits from drastically decreased revenues. It recently laid off 150 employees and reorganized into four operating groups: hospitals, specialty hospitals, long-term care and retail.

St. Louis isn’t the only trouble spot on NME’s map. In New Jersey, where NME was granted a contract in November 1985 to manage Bergen Pines Hospital, county officials hoped NME would increase efficiency there. “Increasing efficiency” has included closing a hospital-run methadone clinic in Hackensack and drastically cutting back staff at the hospital. When NME moved the methadone clinic to the hospital’s psychiatric pavilion (a location much farther from where the clinic’s patients work during the day), it meant increased travel time for many and for others, critics charge, a return to street heroin. NME’s staff reductions have been so severe that they forced the state to temporarily bar new admissions to the hospital’s long-term care facility, for the first time in the hospital’s 70-year history. Bergen Pines nurse and union leader Mabelene Strickland summed up the corporation’s approach to efficiency this way: “NME is for profit, not for patient care.”
At the clinics, NME eliminated virtually all the positions concerned with community health and preventive medicine. Nurse midwives, family planning nurses, family practice nurses, and nutritionists were all cut, says clinic director Dell Weinell. NME, she charges, was changing the clinics’ mission from preventive care to “acting as a pipeline for the hospital.”

A Public Health Disaster
By the end of 1985, black infant mortality had risen 16 percent over a year earlier, to 20 deaths for every 1,000 live births. Dr. Robert Harmon, director of the Missouri Department of Health, charges that in transferring health care operations to Regional, St. Louis officials neglected programs to aid impoverished pregnant women and their infants. The city, he says, lacks “outreach programs such as home visits by nurses to encourage mothers to get adequate prenatal care. There was also a lack of health personnel to give that prenatal care.”

Critics Get Axed
In July 1985, NME introduced a $25 fee for lead poisoning screening and treatment, both of which were free when the lead poisoning clinic was under the city health department. When NME took charge of the hospital, however, the clinic was transferred to the hospital division.

St. Louis has the highest lead poisoning rate of any city in the country. After NME introduced the fee for screening and treatment, the patient load fell by one half, even though clinic staff had been predicting a doubling of the load because of a new, tighter federal definition of lead poisoning.

Paul Kuehnert, the director of the lead poisoning clinic, was fired after he publicly criticized the $25 fee. “Twenty-five dollars is a substantial amount for many people,” he says, “and kids with lead poisoning need a minimum of four or five visits. Some need more.” Only 43 percent of program patients qualified for Medicaid, he adds, but most of the others were only marginally employed, at best, and unable to afford $25 each time they came to the clinic.

The union was broken and health workers lost their jobs.

The new Regional Hospital lacked obstetrics and pediatrics wards, as well. (It was also without a skilled nursing center, which the County Hospital had had.) Lutheran Medical Center, a hospital owned by NME, contracted with NME’s managers at Regional to provide obstetrics care for indigent city patients with uncomplicated pregnancies. Nurses at Lutheran reported that the city’s indigent were treated as second-class patients there. Lutheran’s director openly admitted that city patients had to pay $200 in advance if they wanted any anesthetic during delivery other than pericervical.

During its first year, the Regional Medical Center had space for 250 patients. Its three predecessors had operated a total of 668 beds and maintained a combined average daily census of 330 patients. Regional’s average daily census in its first year was 173 (220 if one includes the obstetrics patients sent to other hospitals). Part of the RHCC’s mission, however, was to attract more privately insured patients to the hospital, so that the city and county had someone sharing the burden of fixed costs. The Health Care Is A Human Right Coalition, a broad coalition of public health care advocates in the St. Louis area (see box), points out that if the RHCC is successful in attracting privately insured patients, it will not have room for the indigent.

Some members of the Coalition, such as Dr. Herman Blumenthal, charge that Regional began billing all patients full treatment costs in order to discourage poor people from using the facility. Hospital staff tried to get patients to agree to monthly payment plans, which, in at least one case, would have stretched out for 18 years. Several medically indigent patients testified at public hearings that they felt they could not return to Regional since they owed the hospital several thousands of dollars, which they were simply unable to pay.

Chaos in the E.R.
Meanwhile, reports of chaos emerged from the emergency room. Emergency medical technicians complained that when they brought patients to the hospital, even in critical condition, hospital personnel were nowhere to be found. The problem continued until one day this chaos led to death.

Ivory Herron died of a ruptured appendix at St. Louis University Hospital at 3:07 p.m. on November 14, 1985, just 12 hours after leaving the emergency room of the Regional Medical Center. He was 20 years old. His brother claimed that they had waited at Regional unattended for over an hour and a half, and then went home.

Herron’s death prompted state and city investigations of the hospital. The major finding was that the emergency room, which was designed to handle 30 patients per day, was handling an average of 150. The state Bureau of Hospital Licensing and Certification also cited the hospital for inadequately staffing the emergency room and for an inaccessibility of supplies. These findings came barely two months after hospital spokesmen
had assured the public that Regional’s emergency room could handle the same load as had City Hospital’s.

Mayor Schoemehl responded that he had known all along that Regional’s emergency room was much smaller than City’s, but, he argued, St. Louis’s need for a new hospital couldn’t wait until an adequate emergency room was built. The RHCC board of directors announced that they would accelerate plans for constructing a new emergency room and obstetrics and pediatrics wards.

NME Gets the Boot
Shortly thereafter, in January 1986, NME exhausted the city budget for health care. As Regional’s financial manager, NME was an abysmal failure. A look into its operations revealed critical errors. Among them was NME’s failure to obtain written contracts from the three hospitals to which Regional contracted out obstetrics and pediatrics. NME also failed to implement accounting procedures to assure that these hospitals were not collecting from both Medicaid-Medicare and Regional for the same patients. To make matters worse, Regional was in arrears to its suppliers, who eventually withdrew credit. According to City Comptroller Paul Berra, NME had cost the city up to $4 million by failing to bill Medicare and Medicaid appropriately.

The RHCC board of directors, which had previously defended NME’s policies, realized that something had to be done to appease the mounting tide of criticism. It hired Robert Johnson, the executive director of the District of Columbia General Hospital, as RHCC’s chief executive officer. Then it axed NME. With the expiration of its consulting contract six months later, NME was completely out of the picture at Regional.

Johnson’s arrival did not bring about any sudden changes in Regional’s policies. However, as the Health Care Is A Human Right Coalition, public health professionals and some aldermen kept up the pressure, Johnson has demonstrated a greater willingness than NME had to talk with the hospital’s critics. He has also slowly agreed to the partial reversal of some of NME’s policies. He ordered the hospital to return to a sliding-scale fee structure and created the office of Patient Service Representative to hear patient complaints. He waived the $25 fee for lead poisoning screening and treatment for those who cannot afford it, and in August 1986, the RHCC board of directors agreed to return lead poisoning screening to the city health department, though the hospital retains control of treatments.

The mayor has also had to respond to public pressures to rein in Regional. He accepted the return of lead poisoning screening duties to the health department. In January 1987, the director of the Department of Health and Hospitals announced that the department would be reorganized, with new managerial staff to be added to enable the department to monitor patient care and finances at Regional on a continuous basis.

Paul Kuehnert, however, claims that the changes in the Department of Health and Hospitals are all “sound and fury signifying nothing.” He points out that the health commissioner was forced out after issuing a report critical of Regional’s handling of the lead poison-
Should We Support Catastrophic Coverage?

by Barbara Berney

Some kind of catastrophic coverage for Medicare beneficiaries will almost assuredly pass Congress this session. It won't protect the elderly from catastrophic medical bills because it won't cover nursing homes or other services not covered by Medicare. The central questions for progressives about any proposed legislation are these: Is it just a feint to cover the five-year $50 billion cut in Medicare and Medicaid the Administration is seeking, or could it be a step along the way to comprehensive coverage for all Americans? Or both?

The Senate Finance Committee and the House Ways and Means Committee are preparing bills. The President has belatedly called on Congress to make catastrophic coverage a priority, in the face of objections from the insurance industry, right-wingers who oppose "intrusion" of the government into the private sector, and some of his own staff. Health care providers including the AMA and the American Hospital Association support it. So do many representatives of the elderly and labor. Catastrophic coverage for Medicare beneficiaries has become as wholesome as apple pie.

Why is catastrophic coverage happening now? Rep. Willis Gradison of Ohio, ranking Republican on the House Ways and Means Health Subcommittee, explained: "Medicare has been subject to a freeze in benefits, retrenchment, cost containment—so there is a backlog of pressure to improve Medicare." The Administration, and perhaps Congress, plans to continue the cuts, thus increasing the political appeal of catastrophic care. Concern about the budget deficit and expanding entitlement programs are keeping the Congress cautious. Catastrophic coverage is about the cheapest thing they can buy and the plan is to make it self-financing and therefore "revenue neutral," at least at the outset. The currently proposed plans will cost about $1.8 billion a year, compared to a total Medicare bill of about $70 billion annually. By contrast, a prescription drug benefit package would cost about $6 billion. Moreover, catastrophic costs are very lumpy; they fall heavily and unevenly on individuals and therefore are a kind of cost traditionally covered by insurance.

Federal legislation for catastrophic coverage has been introduced before by Sens. Dole (R-Kan.), Bentsen (D-Tex.), Durenberger (R-Minn.) and Domenici (D-Ariz.), as well as Reps. Stark (D-Cal.) and Gradison. As Mike Johnson, an assistant to House Minority Leader Michel, commented, "Catastrophic is familiar, people are generally comfortable with it, and there is a need." Also many people on and off Capitol Hill believe that it is the logical next step in expanding Medicare. Many legislators are unwilling to consider additional benefits until the Medicare system has a cap for covered benefits.

The basic content of whatever legislation comes out of Congress has been established. It will pay for 365 days of acute hospital care per year; put a cap on out-of-pocket payments for covered hospital and physician services of somewhere between $1,000 and $2,000; and lower the deductibles for skilled nursing care following hospitalization. But it will not really protect the elderly from catastrophic illness because it will not cover nursing home care, prescription drugs, doctors' fees that are higher than Medicare reimbursement levels, or other categories of services not now covered by Medicare.

Three different methods of financing the additional benefits are being discussed: an increase in the Medicare premium of approximately $5.00 per month, taxing of the actuarial or insurance value of Medicare benefits, and imposing the Medicare payroll tax on now-exempt state and municipal workers, since most of these workers will eventually qualify for Medicare based on other non-public employment.

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Financing the new coverage by increasing premiums is regressive. Nineteen percent of the elderly are below the poverty level and almost 50 percent have incomes of less than $10,000 per year. "These people will be in a public hospital or receiving Medicaid or charity care before they ever cap out," explains Judy Perez of the Villers Foundation. "They'll be paying for something they'll never be able to use." Adding the insurance value of Medicare—about $1,900—to adjusted gross income and taxing it will exempt 50 to 60 percent of seniors from any additional payment while taxing the rest at theoretically progressive rates. Since the financing question is still open, lobbying for the most progressive possibilities may have an impact on the final legislation that emerges.

Broader legislation, including catastrophic coverage for all and mandated health benefits for all employees, will be proposed shortly. Certainly catastrophic coverage, whomever the beneficiaries, neither solves the problems of the poor nor insures access, but because of DRGs and other changes in the health care system, it no longer encourages high-tech or extra care. Progressives should consider: Can it be part of an incremental approach that creates opportunities to push for additional coverage and eventually for a national health program? Or, by closing the gaps that endanger the financial stability of providers and decrease public demand, will catastrophic coverage close off possibilities for further reform?
They Did It in Massachusetts

A Report on the First National Health Referendum

by David Danielson and Susan Abrams

“Shall the Commonwealth of Massachusetts urge the United States Congress to enact a national health program which: provides high quality comprehensive personal health care including preventive, curative and occupational health services; is universal in coverage, community controlled, rationally organized, equitably financed, with no out-of-pocket charges, is sensitive to the particular health needs of all, and is efficient in containing its cost; and whose yearly expenditure does not exceed the proportion of the Gross National Product spent on health care in the immediately preceding fiscal year?”

Massachusetts voters last November approved this progressive national health program referendum by a 2 to 1 margin: 1,045,000 to 510,000 votes. The measure won a majority in 99 percent of the towns and in all 39 cities in the state. The referendum brought together a coalition of 86 groups in support of the campaign. Here are some suggestions which may be of help to others in deciding whether to take on a statewide campaign elsewhere.

The History of the Referendum

In 1979, Rep. Ronald Dellums (D-Ca.) first proposed holding a health referendum in Massachusetts in the hope that a victory would convince then-Sen. Paul Tsongas (D-Ma.) to co-sponsor his Health Service Act. A few Gray Panthers convinced the Cambridge City Council to place a National Health Service question on the city's ballot later that year. To our astonishment, 80 percent of the Cambridge voters approved of the idea, and the city's delegation to the state legislature became the base for a campaign to place the issue before all voters in the state via a legislative initiative.

To get it through the legislature, we finally accepted a "cap on costs" tacked on in the state Senate and abandoned the term service for the less provocative term program. But we still went to the ballot in 1986 with the nation's first statewide referendum on national health care at a time when the Republicans were touting privatization and competition as the solution to the health care crisis.

Massachusetts voters faced 8 ballot questions on such hot issues as abortion and tax limits in 1986. The health referendum, however, sparked little media attention and only pro forma opposition from the Massachusetts Medical Society. Under the FCC's Coleman Doctrine, an underfunded political campaign like ours can obtain radio and television coverage if the opposition buys advertising, but our potential opponents—the insurance companies, profit-making providers, and conservative doctors—didn't really put up much of a fight. As Election Day approached, the last-minute attacks on a national health program by the Boston Herald and Boston's conservative all-news radio station were almost a relief after having been ignored by the media, including the Boston Globe, the state's leading newspaper.

Voter support for health system reform in Massachusetts cuts across age, economic and political party lines. We are well-off medically, with only 10 percent uninsured (versus 16 percent nationally), and have a high density of medical resources, including the most MDs per capita. Opinion polls elsewhere have always demonstrated health program support in the 60-75 percent range. The higher figure was registered in a 1984 Washington Post/ABC News poll. In 1986, an astonishing 93 percent of Wisconsin residents polled by the Gov-

David Danielson ran the state referendum campaign. Susan Abrams is the post-election media coordinator.
Governor's Health Policy Council thought "access to basic health care shouldn't depend on income." It is quite clear that the health care issue is hitting home for many Americans, who are ready for change despite what is often described as a conservative national "mood."

The Canadian "Medicare" system—which covers everybody—started in a single province and became a national program when their Parliament adopted a set of principles that each province had to meet to receive federal funds. Guided by that model, we have proposed a state plan of universal health services—the Massachusetts Health Security Act—to the legislature. Given the success of the referendum, and the strength of the coalition supporting the bill, we expect the plan to be considered seriously. We will also seek federal enabling legislation that would permit states the flexibility needed to combine federal and state funds to establish efficient statewide demonstration programs.

Advice for Others

Should some of the other 26 states with constitutional provisions for advisory ballot questions undertake similar efforts? This may be a way to provide interim victories without compromising the ultimate objective of universal health and medical care for everyone within our borders. One axiom of politics is not to play unless you can afford to lose or are quite sure you'll win; public opinion polling should precede any state health referendum efforts. It proved easy to organize a broad-based coalition of labor, elder groups and progressive health workers, and this should happen early in the game.

We were naive about the required lead time for fund raising and staff recruitment and about the costs of a statewide campaign, and we feel an obligation to caution others to be better prepared. We do not yet know if votes at the state level will translate into Congressional action. The Committee has helpful materials available to assist groups in other states, and we will be available at the New York City Health/PAC National Health Program Conference in June for discussions.
The National Health Care Campaign

A major grassroots effort to improve health care has been launched by the National Health Care Campaign. The campaign is organizing local affiliates around the country to educate the public on major issues in health care and to build support for its three major objectives for 1987. These include: 1) securing legislation to provide access to health care for those without private insurance coverage; 2) winning legislation to cover the cost of long-term care for the elderly and disabled with chronic illnesses; and 3) persuading lawmakers at the state level to implement the recent Congressional authorization allowing states to provide Medicaid coverage for all pregnant women, children under five, and the elderly and disabled with incomes below the poverty level.

At last count, over 25 local affiliates, from Washington State to Rhode Island, were actively involved in the campaign's grassroots organizing. Major support for the campaign is being provided by the Villers Foundation; national groups sponsoring the campaign include the AFL-CIO, several national unions, the U.S. Catholic Conference, Gray Panthers, Children's Defense Fund, National Rainbow Coalition, National Women's Health Network and the American Public Health Association.

While it has adopted the principle that access to quality health care is a right for everyone, the campaign has yet to develop the comprehensive approach to a national health program needed to implement this universal right. Its failure to adopt a comprehensive approach may reflect its broad sponsorship. In any case, there remains a pressing need to develop a unified approach among advocates of universal access to quality care.

Requests for information about the campaign and a summary of its excellent comprehensive report "Facing Facts," a narrative analysis of health care data on access, cost and quality ($10) should be sent to P.O. Box 27434, Washington, D.C. 20038. Telephone: (202) 639-8833.

—Herb Semmel

Herb Semmel is litigation director for New York Lawyers for the Public Interest and a member of the Health/PAC Board.

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Protect your love with condoms. So reads the text accompanying this cartoon from a Planned Parenthood ad promoting condoms. It says, in part, "Sensitivity, strength, security, intelligence. All the qualities women look for in a man can also be found in a foil pack of condoms." Information about the ad campaign is available from Planned Parenthood Federation of America, 810 Seventh Ave., New York, N.Y. 10019.
Watchdog on a Short Chain

How Good Are PPS's Quality-of-Care Reviewers?

by Ronda Kotelchuck

The oversight process for Medicare's Prospective Payment System has overlooked many of its most serious problems. Last year, public pressure finally compelled the Health Care Finance Administration and Congress to take remedial action. In this final installment of her three-part series on the impact of the Prospective Payment System, Ronda Kotelchuck examines both the past failures of Medicare review and the new corrective measures, which will require continued public vigilance if quality of care is to be protected under Medicare.

Professional Review Organizations (PROs) have served as the official watchdogs of the care dispensed to 29 million Americans under Medicare's Prospective Payment System (PPS) since Oct. 1, 1984. Their job is to assure that the care Medicare patients receive in our nation's hospitals is necessary, cost-effective and of high quality. By examining how these Medicare watchdogs have carried out their responsibilities over the last several years, it becomes clear that the Reagan Administration's commitment to the quality-of-care under Medicare has been reluctant at best.

In fact it was only after concerted public pressure over the last two years began to threaten the survival of its Prospective Payment System (PPS)—which the Reagan Administration sees as the first step toward a fully competitive U.S. health care system—that the Health Care Finance Administration (HCFA), which administers both PPS and the PROs, took clear action to safeguard quality.

Because PPS pays a flat price according to DRG (Diagnostic Related Group), rather than the actual cost of treating patients, it provides strong financial incentives for hospitals to cut costs by undertreating patients. It is this particular aspect of the new system which poses a special threat to the quality of care under Medicare.

How PROs Work

PROs receive computerized lists of suspicious cases taken from Medicare bills. The cases fall into a number of different categories, such as patients who have been admitted for unnecessary procedures, patients who could have been treated on an outpatient basis and those who have been readmitted within seven days after their last discharge from the hospital. Then, PRO staff, consisting of nurse and physician reviewers, request the individual medical records from the hospital and look to see what actually happened to the patient. If they find that the care was unnecessary or inappropriate, they deny the hospital payment for the case. For recurring problems, they can intensify their scrutiny by reviewing every case within a category, rather than just a sample. Finally, if infractions are repeated and serious enough, a PRO can request that the Health Care Finance Administration terminate the hospital from the Medicare program.

In several key respects, PROs have proved to be one of the fiercest regulatory programs in Medicare history. Just how fierce becomes clear when we compare them to the earlier Professional Standards Review Organization (PSRO) program which they replaced. Unlike their predecessors, PROs are responsible for all review; they may not "delegate" any part of this monitoring process back to the hospital. Furthermore, unlike PSROs, which received ongoing Medicare support, PROs must seek competitively bid two-year contracts. The contracts specify numerical goals that the PRO must achieve, such as eliminating a given number of unnecessary admissions. If the PRO fails to achieve these goals, HCFA may terminate the contract. And HCFA has not hesitated to demonstrate its displeasure with poor PRO performance. To date, two PROs have been terminated and roughly half of all PROs seeking a second contract were denied automatic renewal.

Old Wine in New Bottles

In one important respect, however, PROs have perpetuated an earlier PSRO tradition by acting primarily as financial watchdogs, rather than watching out for shortfalls in quality of care. In their first two years, PROs specifically focused their concern on all of the ways that hospitals might take financial advantage of the new DRG reimbursement system. (This is known to insiders as "gaming" the system.) Foremost among the prime
PRO "suspects" were those cases in which patients might have been admitted unnecessarily or for procedures which could have been performed on an outpatient basis. HCFA officials set forth specific numerical goals for reducing these types of cases. PROs were also requested to screen cases in all other categories to check for possibly unnecessary admissions.

Various critics, including advocates for the elderly, charged that HCFA's goals for reducing unnecessary admissions became, in effect, rigid quotas for denying hospitals payment. They also charged that PRO zeal in trying to meet these quotas frightened hospitals into denying admission to patients who, in fact, required hospital care. Briefly put, they contended that the agency charged with preventing quality-of-care problems was actually creating them.

What did HCFA do to safeguard quality? The short answer is, not much. To begin with, the agency saw the issue of quality through a lens narrowly focused on stopping unnecessary care. Its vision was distorted by a paranoia about hospital financial manipulations and an obsession with saving money. Thus it rationalized that by reducing unnecessary admissions and unnecessary surgery, it was simultaneously safeguarding quality, since both pose threats to patients' health.

HCFA's narrow focus on unnecessary care was a direct carryover from PSRO review as it operated under the pre-PPS Medicare reimbursement system. By paying hospitals their costs, this system may have given hospitals incentives to do too much, thereby threatening the quality of care. However, HCFA completely overlooked how its new, radically changed PPS system—which pays a flat price per case—threatens the quality of care by creating an incentive for hospitals to do too little.

Discharging Patients Prematurely
HCFA's inadequate approach to safeguarding quality was also demonstrated by the poor way it handled premature discharges—a major concern in a system that creates enormous pressures on hospitals to cut costs by shortening patients' lengths of stay. The one and only PRO tool to identify such cases called for the review of all patients readmitted within seven days after they were discharged. Needless to say, it turned up very few premature discharges. Besides the fact that many patients who are prematurely discharged are not re-hospitalized, seven days is an arbitrary and unreasonably short period in which to expect complications to ensue.

From October 1, 1983, to May 31, 1985, HCFA reported only 4,724 cases of PRO-identified premature or inap-
propriate discharges—an average of less than one per hospital. HCFA, the American Medical Peer Review Association (the PRO trade association) and hospitals offered this finding as proof that patients were not being prematurely discharged. Quality-of-care conclusions were never more clearly in the eye of the beholder.

Critics drew the opposite conclusion. They cited the incredibly small number of premature or inappropriate discharges as proof of PROs’ ineffectiveness in identifying quality issues. Some were quick to note that 14 PROs (30 percent) were not even reporting during this period. The staff of the Senate Special Committee on Aging immediately challenged the accuracy of the other 70 percent, and pointed out that the Missouri PRO alone had reported 4,112 cases of premature or inappropriate discharge. Clearly the other PROs were not on their toes.

If critics were appalled by the small number of premature or inappropriate discharge cases identified by the PROs, they were even more appalled upon learning how these cases were handled. An investigation by Department of Health and Human Services (HHS) Inspector General Richard Kusserow revealed that 43 percent of the records of these cases were lost, warehouse, destroyed, or otherwise unavailable.

"Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 60 percent of the cases,” reported Kusserow. "PRO disposition ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 43 percent of the cases with identified quality issues, the only apparent action taken by the PRO was referral to HCFA. PROs were also cited for failing to identify and act upon repeat violators. Of the 1,158 hospitals involved, 61 percent had between three and ten violations each, according to the Inspector General’s report.

Perhaps the worst flaw standing in the way of a truly responsible quality review program under PPS was HCFA’s limiting the PRO review only to the hospital setting. By narrowing the services performed on an inpatient basis and shortening and intensifying the hospital stay, the PPS system has increased patient reliance on alternative outpatient and aftercare services. Unfortunately, HCFA’s concern did not extend to monitoring the quality of these non-hospital services nor to weighing the consequences to patients when such services were simply unavailable. As a result, PROs were unable to monitor a wide variety of quality problems. These included complications or deaths at home and in nursing homes because patients had been denied hospital admission or were prematurely discharged; refusals by nursing homes to accept more intensely ill or difficult patients; failures by hospitals to prepare patients for home care, or arrange adequate medical or nursing follow-up care in the home; and inappropriately substituting home health services for skilled nursing care in a facility. In limiting PRO purview to the hospital alone, HCFA clearly adopted a see-no-evil, assume-no-responsibility stance.

HCFA Under Fire

With all of these quality-of-care problems slipping through the net, a lot of people got hurt. In late 1985 and early 1986, the spouses and children of Medicare patients appeared repeatedly before television cameras at Congressional hearings to tell of the suffering, anguish and loss of their loved ones under the new Medicare reimbursement system. Their chorus of charges of irresponsibility and indifference against PPS clearly stung HCFA. The agency sensed the growing vulnerability of PPS and the Reagan Administration’s entire competitive health scenario, should its approach be seen as compromising the quality of health care. The agency quickly took a number of actions to address the charges.

At the same time, Congress was also galvanized into action. Prompted by public pressure exerted on behalf of its elderly constituents, it enacted a number of important measures in 1986. It is important to underscore that these belated measures by HCFA and Congress do not significantly alter this system, which encourages the undertreatment of patients, although they do offer advocates important levers in the struggle for quality care. A summary of these changes follows.

HCFA reoriented PRO review to focus primarily on quality issues, rather than issues of unnecessary utilization. In its second round of two-year contracts, HCFA developed 31 criteria (known as generic quality screens) to identify a wide variety of potential quality problems such as inadequate discharge planning, unnecessary deaths, hospital-induced infections, unscheduled returns to surgery within the same admission, and trauma suffered in the hospital. Numeric goals for reducing these problems have been set and HCFA has also required that every case reviewed for any other reason now be screened for potential quality problems as well.
Congress has enhanced PROs' clout to deal with quality-of-care problems. The PROs can now deny payment for quality infractions just as in cases of unnecessary utilization. Thorny issues may block the use of this clout, however. For instance, a charge of substandard care is so serious to hospitals that they are likely to sue a PRO as a result of having been denied payment for poor-quality care. In addition, malpractice suits are sure to proliferate when patients are informed by PROs that they have received substandard care, as the regulations require. These potential problems may make PROs reluctant to use their new clout.

HCFA has strengthened PROs' ability to identify problems resulting from premature discharge. The agency required the review of all cases readmitted to the hospital within 15 days of their original discharge, instead of the previously established seven-day period. Congress has since extended this period to 31 days, creating a far more realistic length of time in which to catch the consequences of premature discharge.

Congress has acted to discourage hospitals from dumping high-cost or unwanted patients on other, usually public, hospitals. Hospitals caught transferring medically unstable patients may now face civil penalties. Institutions with a pattern of these transfers may be terminated from the Medicare program. In addition, the "dumped on" hospital may now sue for damages.

Congress now requires that any Medicare-participating hospital must have a minimum discharge planning program (staffed by registered nurses or social workers) to assure that patients receive proper care after they have been discharged. It has also made it illegal for hospitals and HMOs to offer physicians bonuses for cutting the cost of care. (This has caused considerable consternation among HMOs, which rely heavily on such incentives for financial success.)

HCFA has required that the public have access to PRO-collected data about a hospital's quality of care. These might include a hospital's record of premature discharges, hospital infection rates or avoidable deaths. Such information has been highly confidential in the past; hospitals consider it highly inflammatory and subject to misinterpretation.

PRO boards of directors must now include two consumer representatives. PROs must also conduct a community outreach and education program to inform the public about coverage, patients' rights and appeal options under Medicare. PROs must also assure that hospitals are distributing this information to all new patients. HCFA has also ordered PROs to establish systems for addressing patient complaints.

In addition to these changes, Congress has begun to expand PRO review beyond hospital walls despite HCFA's resolute opposition. For the first time, hospital care offered by Health Maintenance Organizations must also be reviewed. By requiring 100 percent review of certain very frequent surgical procedures, Congress is moving PROs into the outpatient arena, where much of this surgery is now performed.

Finally, HCFA has taken three recent administrative actions to demonstrate its new-found seriousness about quality. First, HCFA used the PROs' poor record on monitoring quality of care as grounds to deny nearly half of the PROs automatic renewals of their two-year contracts. (This could be seen as a form of scapegoating, since it is HCFA, and not the PROs, that establishes how quality-of-care problems are to be identified and treated.) As a result, the PROs which wanted to stay in business were forced to return to the original competitive bidding process.

Second, HCFA created a new national watchdog, the SuperPRO, to watch PRO performance. The SuperPRO will focus special attention on how PROs carry out their quality-of-care responsibilities. In their first round of PRO audits, the SuperPRO found quality problems to be four times more prevalent than had the PROs (involving 4 to 4.5 percent of all cases reviewed, compared to 1 to 1.5 percent found by the PROs).

Third, the Department of Health and Human Services has for the first time excluded a hospital from the Medicare program based on PRO recommendations. The San Diego County Mental Health Facility was terminated in March 1986, for care judged "inappropriate, unnecessary and not meeting recognized standards." The Inspector General has since reportedly approved the termination of 15 to 20 more hospitals from the Medicare program.

Keeping Pressure on the PROs

While HCFA's tougher stance and recent Congressional initiatives aimed at safeguarding quality of care are encouraging, they are nonetheless a rearguard action. And, it should be pointed out, all of these measures depend upon regulation, most of it after the fact. The effectiveness of this regulation depends at all times on political will, funding levels and myriad obscure factors which can wax and wane depending upon the glare of public attention.

By contrast, financial incentives do not depend on after-the-fact regulation, intervention, or monitoring for their effectiveness. The fact remains that the PPS system has strong inherent financial incentives for hospitals to reduce costs by undertreating patients. Our only safeguard is a vigilant and vocal public that keeps the pressure on the system to meet its responsibilities in the crucial area of quality of care.
Greetings! .  .  .  The Cook County Board of Commissioners has generated two major health news events, with at least one of them showing a Chicago-style proclivity for comic absurdity in the face of tragedy.

The Commissioners at long last appear to be moving on the decade-long problem of replacing the moribund 75-year-old Cook County Hospital. Over $60 million has been squandered propping up the aging building, money observers have long pleaded could be better spent shaping a public health system for the 500,000 to 1,000,000 people who rely on the public sector in this city.

While Chicago shares the national “excess bed” phenomenon (even County Hospital’s average census is 740 of a 1,018 capacity, one third of inpatient levels in the 1960s), the gridlock is in ambulatory care, which is up 23 percent over six years ago. More to the point, the wait for a general medicine clinic appointment is nine months, and virtually all of the 700,000 outpatient visits are on the hospital campus. Patients may travel 30 miles to see a clinic physician.

No wonder that a variety of proposals to secure a system of public health care in Cook County have come forth in recent months. They share a consensus on two critical points: Build a new hospital (sizes proposed vary from 300 to 1,000 beds) and create a network of conveniently located clinics to permit earlier care.

The proposal of our Health and Medicine Policy Research Group envisions a much strengthened public sector with community economic development potential. We’re proposing that the various levels of state, county and city government form a common managing agency, emphasizing prevention, early detection and community participation. Both major dailies have praised HMPRG’s plan. Gov. James Thompson has called it the best starting point for intergovernmental planning. However, not everyone spoke with praise. George Dunne, the powerful president of the County Board of Commissioners, had this to say of the plan: “You see all kinds of self-anointed, self-appointed experts in the field of medicine.”

At a minimum, the real issues and potentially good solutions are at last in the public realm and being vigorously debated. A forum is now in place to reach all elements—users of the service, the general public, the health sector—and to assure thereby that the pitfalls of giveaway subsidies to the ailing private hospitals or other privatization schemes are avoided.

They are self-anointed experts. They don’t have to run a hospital.” Thus spake the anointment-obsessed Cook County Board President George Dunne. The “they” he was thrashing was the Centers for Disease Control, whose AIDS guidelines he rejects.

Upon learning that a Cook County Hospital physician had AIDS, Dunne ordered him suspended after the doctor refused Medical Director Agnes Lattimer’s directive forbidding him direct contact with patients. His department chairman and division director both refused to give that order, citing his valued services and the aforementioned CDC guidelines.

Dunne was quoted as denying using an “unfortunate” word to describe homosexuals during the ensuing controversy. “I would never use a word like that,” he said. “I refer to them as ‘cupcakes.’”

The reasons given to justify Dunne’s action were imaginative. One proffered by Lattimer was “perceptions of the community [of the risk of contagion from casual contact].” Another was that informed consent gives a patient the right to know that a physician has AIDS. That the real agenda was as much public hospital staff-bashing as homophobia was clear when Dunne ordered the hospital director to check the records of all 6,500 hospital workers: “I want every category of employee checked, not just doctors and nurses.”

On February 9, the County Board voted 12 to 2 with two abstentions to prohibit the doctor from “touching patients.” The American Civil Liberties Union’s Illinois affiliate, chosen as legal counsel by the suspended physician, will now go to court.

Quentin Young is a physician and the President of Chicago’s Health and Medicine Policy Research Group. He was formerly Chairman of Medicine at Cook County Hospital.
One hopeful note amid the depressing statistics on rising teenage pregnancy and the devastating impact of AIDS is that they create a new opportunity for open public debate on sexuality, morality and health. Progressive health and sex educators can play a critical role in determining whether we return to the sexual morals which predate the women's and gay movements or instead create a new ethic of sexual responsibility and freedom.

Several recent news items reflect the political dimensions of this issue:

- In their recent debate on the role of government in sex education, the Surgeon General and Secretary of Education agreed that “mutually faithful monogamy” should be the Administration’s official line. While the Education Secretary argued that sex education should not begin until eighth grade, the Surgeon General held out for the third grade and also advocated public education and advertising for condoms to prevent AIDS.

- The New York City Board of Education has refused to show its students an acclaimed film on AIDS until its message on abstinence is strengthened.

- The Roman Catholic Archdiocese of New York, after losing a court case, has threatened to terminate its city-financed foster care contract rather than allow adolescents in the program access to contraception services or referrals for abortions.

These events, each with an impact on young people’s right to accurate information on sexuality, have prompted public health workers to criticize the New Right, the Reagan Administration and the Catholic Church for imposing a moral agenda on increasingly critical public health problems. While it is true that conservative political forces are exploiting the fear of AIDS and of teen pregnancy to advance their call for chastity and monogamy within marriage, it is a mistake to deny that sex education raises profound moral questions. By ceding morality to the conservatives, progressives lose an opportunity to articulate a broader vision of sexuality and its connection to the world. We might do better to engage the conservatives in a debate on what constitutes a moral approach to sex education.

What issues do sex educators need to consider to join this debate? To begin with, sexual behavior, and therefore sex education, cannot be divorced from the issue of male-female relationships. In a society where men have more social, political and economic power than women, sexual relationships will inevitably reflect this inequality. A very simple moral criterion for a progressive sex education is whether the curriculum challenges or reinforces inequality.

Sex educators also need to define realistic goals for their education. Too often, they accept the conservatives’ goal of reduced teen pregnancy and less sexual activity. But sex education is only one minor determinant of sexual behavior. Family upbringing, television, advertising that manipulates sexual insecurity and available role models also exert strong influence. It is simply unrealistic to expect one semester or year of sex education to change such deeply rooted attitudes.

The goal of sex education should be to provide students with the knowledge and skills to make decisions about sexual behavior that will promote their mental and physical health. The appropriate measure of the effectiveness of sex education is whether students are, in fact, making intelligent, informed decisions. Those who truly want to lower teenage pregnancy rates will have to address a range of influential factors, including the availability of jobs, the quality of schools, media-promoted images of sexuality, etc. If sex educators accept the conservatives’ goal of reduced sexual activity, we set ourselves up for failure.

In the face of AIDS and high teen pregnancy rates, what do we want for young people coming of sexual age in the late 1980s? Young people must have the right to define for themselves a sexuality that is fulfilling and satisfying and that protects their health.
Pain is the chief reason people seek medical care and take medication. Three out of four Americans have experienced some sort of persistent pain, with headache and backache most prevalent, according to a 1985 Lou Harris survey. Yet until recently, many sufferers have found medicine's interest in alleviating pain to be lacking.

In recent years medical experts have placed an increasing emphasis on educating health professionals to understand and treat pain better. But change has come slowly. Important studies such as Marks and Sacher's 1973 look at post-surgical patients at New York's Montefiore Medical Center showed that almost 75 percent of the patients studied did not get pain relief from the drugs they were given. Their prescribed dosages were often 25 to 50 percent less than what was actually needed to be effective. Another study found that many physicians prescribed inadequate amounts of analgesics for cancer patients. In addition, personnel who administered the drugs often gave only 75 to 80 percent of the already inadequate doses!

The National Institutes of Health has played an important role in focusing public attention on this overlooked problem. At its first conference on pain management in 1979, experts called for a more humanitarian approach in treating pain resulting from terminal disease and for more research aimed at better understanding the mechanisms of pain and the drugs used to treat it.

In 1986, NIH's second conference on pain generated important recommendations. Panelists noted that progress has been made since 1979 in understanding and assessing pain, as well as in developing new and improved pharmacological and nonpharmacological treatment approaches. (Effective nonpharmacological approaches include acupuncture, biofeedback, transcutaneous electrical nerve stimulation [TENS], and physical and behavioral therapy.) Despite these advances, panelists pointed out that, "Many informed observers perceive continuing deficiencies in the clinical management of pain."

One of medicine's major failings cited by the experts is the continuing undermedication of people with acute pain or chronic pain from malignant disease. Incidentally, there is some evidence that inadequately treated acute pain can develop into chronic pain, which is more difficult to resolve. Conversely, panelists found that overmedication is a problem in treating persons with chronic pain not associated with malignancy. NIH conferees concluded that contemporary methods of pain management and assessment as taught to doctors, nurses, dentists and physical therapists have not kept up with research findings. (In 1983, a survey of 17 standard texts on medicine, cancer and surgery found that only 54 pages out of 22,000 contained information about pain.) Conferees also charged that medical professionals have failed to share available knowledge on pain treatment necessary to advancing treatment protocols.

The conference also reaffirmed not only the right but the necessity of those in pain to participate in treatment decisions along with their families and loved ones. Experts on pain have come to understand how important it is to the healing process for an individual to feel a sense of control in the treatment process. One medical advance in this direction actively shifts the locus of pain control to the patient. Known as the patient-controlled analgesia (PCA), the device allows self-administration of intravenous medication within dosage and time parameters established by doctors. Greater compassion and awareness, accompanied by technological advances like this one, hold great promise.

Despite almost two decades of effort to enhance scientific knowledge about pain and its treatment, the quality of clinical care in this area remains wanting. Problems persist in spite of the development of hundreds of pain clinics; the growth of the International Association for the Study of Pain (IASP), which disseminates information; and the training of pain specialists (algologists). In the end, clinicians simply must make more time for the pain.
Smoking Guns for the Asbestos Industry


by David Kotetchuck

During the early 1970s, when the first articles on the asbestos industry disease coverup began appearing in the Health/PAC Bulletin, the authors could only infer from public scientific documents that Johns-Manville and other industry giants must have known for a long time about the dangers of asbestos dust. Now, over a decade later, we finally have the smoking guns: the internal corporate documents which directly and criminally implicate virtually all U.S. companies which manufactured primary asbestos products during the last five decades.

The documents and the legal struggles to get them are examined in these two recent, extraordinary books, which are largely the fruits of two decades of legal discovery by lawyers and consultants representing asbestos victims and their families.

The evidence, summarized in complementary fashion in Barry Castleman's Asbestos: Medical and Legal Aspects and Paul Brodeur's Outrageous Misconduct: The Asbestos Industry on Trial, has helped breach the companies' legal defenses and reveal the fetid core of corporate indifference and greed contained within. As a result, victims and their families have settled or won thousands of lawsuits for compensatory damages against asbestos mining, manufacturing and fabricating companies, over 3,500 of them against Johns-Manville alone. More significantly, in terms both of public policy and corporate ledgers, juries in 1981 began awarding victims and their survivors punitive damages in these cases, to the tune of an average of $600,000 per case during the first half of 1982. Such awards, based on a legal finding of outrageous and reckless misconduct (whence the title of Brodeur's book), can be virtually unlimited in amount and are not covered by insurance. They played a major role in the Manville Corporation's so-far-successful strategy of filing for reorganization under the Federal Bankruptcy Code in August 1982. Through this strategy, Manville has fended off further trials and even stopped payments to victims' families who won their cases before the bankruptcy filing; at the same time, victims continue to die and witnesses' memories fade.

The Brodeur book, based on his excellent series in The New Yorker, chronicles the legal suits and strategies of the victims' lawyers in their dual efforts to win compensation and lay appropriate blame on the offending companies. (It is hard to speak of true justice being done in these cases as long as workers still suffer disability and death, while corporate executives continue to live well, draw hefty salaries and stay out of jail.)

With the solid craft of an experienced writer, Brodeur skillfully traces modern asbestos legal battles. He starts with the precedent-setting
damage suits filed by Ward Stephenson in East Texas in the late 1960s on behalf of Claude Tomplait, a disabled asbestos insulator, and Clarence Borel, another asbestos insulator who subsequently died of mesothelioma. During his own dramatic race against death from cancer in 1973, Stephenson, the book’s hero and the person to whom it is dedicated, argued and won the landmark Borel vs. Fibreboard case in Federal Appeals Court, strongly affirming companies’ “duty to warn” of foreseeable dangers associated with their products. This decision by Judge John Minor Wisdom unleashed “the greatest avalanche of toxic-tort legislation in the history of American jurisprudence,” writes Brodeur. Tragically, Stephenson died just days before this famous decision, but was leaked news of the decision on his deathbed. Borel had died years earlier.

Brodeur then goes chronologically through the tragedy and scandal of PPG Industries’ Tyler, Texas, asbestos plant and the early cases fought by a tenacious group of lawyers including Thomas W. Henderson of Pittsburgh, Paul Gillenwater of Knoxville, Ron Motley of Barnwell, South Carolina, and Stanley Levy of New York City. Throughout, Brodeur brings the courtroom battles to life and explains the significance of the information uncovered in these cases, including that of the so-called Summer Simpson papers.

He also clearly traces the sordid plotting by Manville and other asbestos companies, from concealing information on workers’ health to tailoring scientific reports to their corporate needs. For example, Charles Roemer, a prominent attorney in Paterson, New Jersey, in the 1940s and the local Industrial Commissioner, recalled in a 1984 affidavit what was once said in a meeting he attended with the president of Johns-Manville, Lewis H. Brown, and his brother, Vandiver Brown, J-M’s chief corporate attorney. The men had met in the early 1940s to discuss reports of asbestos disease in the company’s plants. Roemer recalled that Vandiver Brown had told him, “It was foolish for us to be concerned, and that if Johns-Manville’s workers were told, they would stop working and file claims against Johns-Manville, and that it was Johns-Manville’s policy to let them work until they quit work because of asbestosis or died as a result of asbestos-related disease.”

When Roemer asked him, “Mr. Brown, do you mean to tell me you would let them work until they dropped dead?” Brown replied, “Yes, we save a lot of money that way,” according to Roemer.

The book is peppered with similar accounts, many written and documented by the corporate officers themselves. We also learn of the role played by then Senator Gary Hart in sponsoring asbestos industry bailout bills during the early 1980s, which Brodeur comments on and criticizes perceptively. Walter Mondale did not exploit this issue in his 1984 presidential bid, Brodeur goes on to say, in part due to the corporate legal connections of his own campaign staff.

Asbestos: Medical and Legal Aspects, Barry Castleman’s fine book, if perhaps less exciting than Brodeur’s in narrative quality, serves its purpose well. While presumably not written as a work for the general public—its $70 price tag alone precludes that—it is an eminently readable, indispensable reference book for health care professionals who treat asbestos victims and may be called to testify on their behalf, for lawyers and compensation representatives who represent asbestos victims, and for surviving family members who want to know what a particular company knew and when.

Castleman, a consultant to and expert witness on behalf of asbestos victims, has himself played a significant part in uncovering major portions of the scientific, technical and legal data reported in the book. He carefully, methodically and clearly analyzes the medical and technical literature on asbestos hazards, as well as the corporate data uncovered during the last two decades of trials. He begins the book with excellent chapters on the developing medical knowledge of asbestos health hazards, drawn both from European and U.S. sources, and the industry’s early efforts in the 1930s and 40s to suppress and distort it.

Castleman also devotes a chapter to the execrable misconduct of company after company in fighting worker compensation claims and legal suits as well as keeping workers in the dark about their health status. For example, in 1929, a lawyer in New Jersey filed a damage suit for $50,000 against Johns-Manville on behalf of 11 disabled Manville, N.J., employees. Following discussion of
the matter by the full J-M Board of Directors at their April 24, 1933 meeting, the company negotiated a settlement of $30,000 for all the cases—on the condition that the lawyer bringing the case, Samuel Greenstone, also agree that he "would not directly or indirectly participate in the bringing of new actions against the Corporation." Greenstone agreed.

Chapter by chapter, always with extensive, accurate references, Castleman reviews what was known about the hazards of particular asbestos products. In a chapter by Stephen L. Berger, readers are treated to the best discussion I have yet read of the alternatives to asbestos products, including patent numbers and dates of patent. In another chapter is a summary of how much 20 different U.S. companies knew, and when—an invaluable reference for those who need to investigate a particular corporation.

This second edition of the book both updates the first, published in 1984, and presents new and insightful introductions to several chapters, particularly the one in Chapter 4 on the social origins of measures to prevent occupational disease in the U.S.

If you want the full case against U.S. asbestos companies laid out carefully and analyzed in detail, this book is required reading.

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**Shield of Death**


by Judy Lipshutz

Treating the corporation as an individual under the law stimulates the development and perpetuation of corporate irresponsibility, and *At Any Cost*, by Morton Mintz, demonstrates this point dramatically. The author presents a chronological account of the research, development, marketing, distribution and eventual criminal cover-up of the effects of the Dalkon Shield.

The shield was a specific type of intrauterine device, or IUD, developed by the A.H. Robins Company for the purpose of pregnancy prevention. The marketing of the shield in 1971 was, at the least, premature, due to the lack of reliable safety and efficacy studies. An interplay of other factors—greed, sexist attitudes toward women and a massive psychological denial—precipitated a grave injustice against women in particular and consumers in general. Although the FDA finally suspended sales of the Dalkon Shield in 1974, the consequences to women continued to be manifest for over a decade.

The issues in this book are specific to the development of an IUD that would eventually produce serious health hazards for thousands of women in the United States and abroad. Such health hazards included relatively high pregnancy rates, spontaneous abortions, severe cases of pelvic inflammatory disease, septictic abortions, congenital anomalies in fetuses conceived with the Dalkon Shield in situ, infertility, death, and an untoward emotional impact on the women and families so affected.

Throughout the book, the author reminds the reader that the case of the Dalkon Shield is just one example of how corporations can knowingly and willfully profit at the expense of consumers. He systematically presents precise, interesting and accurate information to support his contention.

Judy Lipshutz is a nurse practitioner and social worker at the Door Center of Alternatives in New York, and a member of Health/PAC's Women and Health Work Group.

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**The Feminization of Poverty**


by Patricia Moccia

The widening gap between the rich and poor is one of the most glaring, unhealthy and potentially disruptive divisions within our country today. That we have become a nation in which women and children bear an overwhelming portion of the burdens of the nation's economic ills is among the lessons to be learned from Ruth Sidel's latest book—which won a Book of the Year Award from the *American Journal of Nursing.*

Poor women told their stories to Ruth Sidel, who shares them with us in an artful and scholarly mix of disturbing statistics and unsettling personal accounts. Sidel's findings should be disturbing to women readers of all classes since she reminds us how close all women—especially those with children—are to poverty. By turning abstract statistics into real people, Sidel's work makes the suffering vivid.

Patricia Moccia is the Chair of the Department of Nursing Education at Teacher's College, Columbia University, and a member of the Health/PAC Board.
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Seniors Against Double Billing

The Massachusetts Senior Action Council (MSAC) was pleased to see the article "Docs and Seniors Do Battle Over Double Billing" in the December issue of the Health/PAC Bulletin.

MSAC would like to update Health/PAC on the nationwide battle to ban double billing. You stated that three states are considering action similar to that of Massachusetts. The number is actually much higher. MSAC has received inquiries from twenty-four states on how we organized and won our campaign. Many of these states have filed similar legislation for this year. A few of these state campaigns such as New Jersey, Maryland, Montana, and Connecticut are at a critical point. Connecticut senior groups have mobilized hundreds of seniors on this issue and it promises to be quite a battle. The battle is taking place across the country as seniors are double-billed by as much as $2 to $3 billion.

MSAC is pleased to be a resource to other states as the move for Mandatory Medicare Assignment continues. We are pleased that so many states are filing legislation and wish all of them much success in their efforts.

JESSIE LOGAN
President, MSAC

Apologizing for Reagan?

We were shocked to read what amounts to a defense of the Reagan Administration's 'health care revolution' in your last issue. In his article entitled "More is Not Always Better" (Bulletin, V. 17, #2) Arthur Levin (President of the Health/PAC Board) critiques the state of medicine today as a justification for the increasing denial of health care to millions of Americans.

Contrary to Levin's uncritical acceptance of the notion that cost containment must mean less care and better care, capital's cost containment agenda has little to do with cost containment and nothing to do with exposing or ending harmful or useless medical practices. The Reagan Administration is using 'cost containment' as a veil to obscure a policy of cutting funds that provide basic primary and preventive health services to over 50 million people and transferring those funds to the U.S. war machine. In this manner, a systematic attack is being waged on the health standards of those sectors of the working class that are least useful to capital, namely, the poor, the old and the very young, with a particularly brutal impact on minorities. Medicare, Medicaid, Indian health, food and nutrition, tuberculosis control, immunization programs, AIDS research and prevention, prenatal care, and related programs have suffered massive cuts or been severely under-funded. The problem is not that such programs provide too much care but far too little.

While Levin recognizes that medicine is an imperfect science he fails to grasp the reasons why. It is precisely the commodity nature of U.S. medicine that ensures both the production and distribution of spurious medical practices, as well as the denial of care to those in need. The theory and practice of medicine are primarily determined by the economic system that it is designed to serve, in this case, capitalism.

Until health care in the U.S. is a service provided on the basis of need rather than a business conducted for profit, there is no reason to assume, as Levin does, that cost containment or other ruling class machinations will improve the health of anyone. The only beneficiaries of Reagan's policies have been the military and the private health care sector, both of which have grown by leaps and bounds as a result of financial transmutations while the public health sector has been financially exsanguinated. Nor is there one shred of evidence to support Levin's contention that dangerous medical practices will be disproportionately cut and thus reduce unnecessary morbidity and mortality.

While accepting Reagan's agenda, Levin barely acknowledges the only real possibility for better health care and cost containment, a national health program (NHP). Data from a randomized controlled trial of health insurance options suggests that making all care free at the time of use would save at least 105,000 lives each year. Moreover, an NHP could save $18 billion dollars annually in health sector profits, as well as $78 billion wasted on the billing, marketing and other bureaucratic need to extract those profits. An NHP could eliminate the financial incentives for excessive interven-

Arthur Levin replies:

I do not agree that my column in any way implies that I am in favor of "denial of health care to millions of Americans." I do agree with the authors that the goal should be universal entitlement and a publicly accountable, publicly controlled health care system.

I continue to believe that all Americans will benefit from a more rigorous critique and
stronger regulation of the content of care and diffusion of technology. And, as I hoped to make clear, we must insist that cost-containment technologies themselves should be shown to “first do no harm” before being diffused.

I want to encourage these readers to help expand our ongoing discussion of quality and access issues by submitting articles for publication in the Bulletin.

Finally, my column expresses my opinion and not that of the Health/PAC Board.

Clarifications on PPS

Thank you for Ronda Kotelchuck’s three-part series on PPS. It is an excellent analysis of PPS’s impact.

One point which I think needs clarification is on p. 16 of the Dec. 1986 issue where she states: “...a patient, when no longer acutely ill, may not be discharged if he or she is in need of skilled nursing care and none is available outside the hospital. Until placement can be found, Medicare will continue to pay the hospital as if that patient were acutely ill.” In general, Medicare has never paid hospitals for the days patients awaited skilled nursing care unless that patient be covered under Medicare in the nursing home. Very, very few patients ever qualify for nursing home placement under Medicare. In most cases, the patient goes to a nursing home as a private-pay or Medicaid patient. In the former case, the patient is held responsible for the bill; in the latter, the patient is not.

She also says that: “By Medicare standards, discharging patients who require home or intermediate care is acceptable, regardless of whether such care is available.” While Medicare has many, many flaws, this is not strictly true. The same regulations which govern Medicare stipulate that every patient must be discharged to the appropriate level of post-hospital care. The fact that Medicare does not pay for needed post-hospital care and does not pay for the hospital stay while awaiting post-hospital arrangements does not make it “acceptable” to discharge those patients. In fact, by Medicare standards the hospital can and frequently is cited if it fails to keep patients awaiting post-hospital arrangements, regardless of reimbursement issues.

In my experience of providing hospital discharge planning services, I saw far more patients who suffered from too much hospital care than patients who were prematurely discharged. The case cited as “Premature Discharge, Premature Death” should not be blamed on PPS. It has always been possible for patients to die 14 hours after nursing home admission, even in the ambulance taking them to the nursing home, long before the invention of DRGs.

The most critical concern of patients and their families should be their rights to discharge planning by qualified professionals, regardless of how the institution is being paid. They should recognize that physicians have never been particularly adept at dealing with the social, psychological, and financial impact of illness.

The statement that patients should remember that “only physicians—not hospitals—can discharge them, and...only when deemed medically appropriate” represents a regressive view which brings back horrors of the past when physicians had absolute control over admission and discharge. They regularly discharged medically inappropriate patients whose social, psychological or financial situation could not handle their continuing care needs. Hospitals, with all their faults, have done a great deal to correct that problem by “taking over” discharge planning as an administrative function. It is true that in hospitals where nonprofessionals try to achieve appropriate and timely discharge, abuses take place—but this too existed before PPS.

I believe PPS is encouraging hospitals to develop less costly alternatives to hospital care and that this development is good for patients and their families. The reimbursement system needs to catch up and pay for the services people require so that they can stay out of the hospital.

DEBA FISHER, MSW
Director, Alternative Health Care Services
Presbyterian Health Resources, Inc.

The editors welcome letters from readers. Letters should be typewritten and double-spaced, and are subject to editing for clarity and space.

Professionals Form Network to Promote National Health Program

The Network of Health Professionals for a National Health Program (NHP?) has recently formed to advocate a “universal, comprehensive health care program” for all Americans. It points to the Canadian national health program as one possible model for the U.S. For more information, write to NHP?, Dept. of Medicine, Cambridge Hospital, 1493 Cambridge St., Cambridge, MA 02138.

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