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It seems as if the twin "M" words—managed care and managed competition—have taken over much of the health care reform debate of the 1990s. "Managing" follows in the footsteps of earlier attempts at controlling health care inflation, such as health maintenance organizations (HMOs) in the 1970s and diagnosis-related groups (DRGs) in the 1980s. These approaches have the apparent strategic advantage of being less politically volatile than those that rely on the "U" word (universal access), the "S" word (single-payer), or the "A" word (accountability).

Managed care and competition proposals have been gaining in popularity among many in politics and health policy as a rational prescription to cure the ills of America's frail health care system. A managed competition approach obviously incorporates a view of health care as a commodity—not as a right or social good. Its proponents argue that the "marketplace" for health care services doesn't work because there is an imbalance of power between the provider industry and its customers (patients). They suggest that the way to redress this imbalance is to put consumers together in large groups that give them more "buying power" and, they say, have their members' best interests at heart.

"Managed care" means different things to different people, but it always is about getting people their medical care in more cost-efficient ways. Even that definition does not do justice to the variety of ways in which the term is used. "Cost-efficient" can be applied to anything from "patient coordinators" who keep people enrolled in managed care facilities to the old-fashioned use of a primary caretaker (see family doctor) to coordinate care for patients and serve as an entry to the health care system. Managed care can be as simple as utilization review; or it can involve voluntary or mandatory enrollment in a health maintenance organization (HMO) or a prepaid set of services offered by an employer; or it can be simply a form of private insurance.

Currently the term "managed," both in the private sector—as in managed competition—and in the public sphere—as in "Medicaid Managed Care"—is meant to be the opposite of waste, fragmentation, and unnecessary costs. Managed competition is meant to convey the notion of rational—as opposed to unbridled—competition among health plans organized by groups of providers for contracts to serve large pools of patients. The inference is that what is managed is provider behavior. Of course, in the context of public-sector programs such as Medicaid Managed Care, the focus is on managing patient behavior rather than that of providers. As in the older HMOs, managed care programs often utilize a "gatekeeper," who may be a physician or patient coordinator. This person is given incentives to "manage" care so as to reduce what she or he judges to be "inappropriate" or "unnecessary" referrals for specialty care, diagnostic tests, hospitalizations, and other services. Usually the gatekeeper is a primary care doctor and, therefore, more likely to incorporate preventive practices that improve health outcomes and are cost-effective.

As managed care becomes more intrusive and limiting in patient choices, the underlying objective behind this approach becomes more explicit—reducing the consumption of health care services. The primary care gatekeeper is the means to achieve professional control and at the same time offer primary care services that have all but disappeared in other settings. The latter is seen by many health advocates as a substantial improvement over the fee-for-service, episodic, specialist-oriented system of ambulatory care that is the present norm. Others are fearful that the adverse effects of a mandated "managed" prescription, which include powerful incentives to do less for patients, a lack of public (Continued on page 39)
Medicaid Managed Care
A Mixed Review
RONDA KOTELCHUCK

Capitalizing on a highly unusual political consensus, the New York State legislature in the spring of 1991 quietly adopted one of the most sweeping changes in the state’s Medicaid program since its inception. This change, if carried out as designed, has the potential to significantly reshape New York State’s health system, either for good or for ill.

The Medicaid Managed Care Act of 1991 requires that within five years, half of the 2.9 million poor New Yorkers who receive Medicaid be enrolled in managed care programs. To achieve this ambitious goal, the counties that administer the program will clearly eventually have to make it mandatory. For these clients, Medicaid will no longer purchase individual medical services on a fee-for-service basis. Instead it will pay a single price for a complete package of services. No longer will it pay physicians, clinics, hospitals, and other providers directly for the services they produce. Instead, it will pay plans—health maintenance organizations or HMO-like organizations—that will be responsible for providing all services to which Medicaid recipients are entitled (with the exception of long-term care, which will remain unchanged).

The Medicaid Managed Care Program is a major departure from previous New York State health policy. It will severely limit freedom for Medicaid recipients to choose their own providers, and it will sanction a fundamentally separate system of care for the poor. It will introduce incentives to reduce not only the cost of care, but the use of services as well. It will inject competition into New York’s largely non-profit, highly regulated health care environment. It will create a major new player in New York’s health system—the plan or HMO—and impose this player between the Medicaid program and medical providers. And, finally, it will create enormous demand for the most precious of commodities in New York—primary care providers willing to serve poor populations.

New York’s Medicaid Managed Care Program offers an ambiguous mix of opportunities for improving care for the poor and threats to its access and quality. The threats and problems are serious enough that, given a choice, few advocates for the poor would have opted for managed care as good social policy. In New York State, and increasingly in other states as well, however, Medicaid Managed Care is no longer a policy choice. It has become a fact. Moreover, it is a fact that is unlikely to be reversed, at least in the near term.

What should people of conscience and of action do in the face of this new reality? Unless one thinks managed care can and should be turned back, the question now becomes, How can the threats that managed care poses be contained, minimized, and eliminated? What new opportunities does managed care offer for building a system that will guarantee accessible, appropriate, and high-quality care for the poor?

Why Managed Care Passed

The consensus to enact New York’s program stemmed from its double promise of reducing costs, while simultaneously improving the quality of care offered to Medicaid recipients, as well as from the growing aura of managed care as a free-market panacea to the entrenched problems of the health system. Its authors also saw managed care as the last and best hope for saving the embattled Medicaid program.

Cost Savings. The promise of cost savings was clearly the strongest motivating force behind passage of the Medicaid Managed Care Program. New York’s $14 billion Medicaid program is enormous, and spending, rising at 20 percent a year over the last two years, is widely perceived to be out of control.

Unlike most states, where the federal and state governments share Medicaid costs, in New York a third party, the county, pays 25 percent of the cost, adding strong local support for cost cutting as well. New York City, for example, which encompasses five counties, pays $2 billion, and many counties pay as much as 30 percent of their tax dollars to support their share of Medicaid.

The problem of Medicaid spending was set in bold relief in the spring of 1991 when steep recession engulfed the entire northeast region of the country. New York City found itself mired in the second year of a major fiscal crisis, and the state for the first time faced a major budget deficit of its own. Calls for “structural reform”—that is, cuts that would permanently reduce spending—joined with an increasingly ugly ideological climate to make the Medicaid program particularly vulnerable. Eleven years of the Reagan-Bush victim-blaming and racial and class polarization set the stage for attacks on social spending.
Moreover, the rapidly declining standard of living and the hardships of recession on the middle and working classes made additional taxation unthinkable. In no way could a social program for the poor, of the size and growing at the speed of Medicaid, be held harmless through a round of major budget cuts. The only issue was how, not whether, the program was to be cut.

Cuts in programs such as Medicaid can be targeted in four ways: tightening eligibility of recipients for the program, eliminating benefits covered by the program, cutting prices paid to the providers, and reducing utilization of services by recipients. Traditionally, New York City, the state Assembly, and the governor, all dominated by the Democratic party, have tended to line up in defense of Medicaid recipients, staunchly opposing reductions in eligibility and benefits and favoring cuts to providers. The conservative, Republican-dominated Senate, on the other hand, siding with the hospital and provider interests, historically has taken the opposite tack, preserving reimbursement to providers at the expense of recipients.

Reimbursement paid to providers in New York State has already been highly controlled, however, removing it and outpatient services Medicaid will cover for each recipient. As cost-cutting pressures intensified, it became clear that MUTS would be extended to include more and more services, and the limits would also be ratcheted down. Managed care offers an attractive alternative to the arbitrary limits of the MUTS program, by using individual case management by a physician or other "gatekeeper" to control and decide what services are needed.

Managed care was the near-perfect political compromise. The program targets reductions in utilization, as the most likely candidate. Physician fees are second lowest in the country, causing the virtual withdrawal of private physicians from the program; outpatient rates have been frozen since 1981 and are now the single largest source of hospital financial losses; and the rate of increase in reimbursement to hospitals for inpatient stays is already among the lowest in the country.

By contrast, utilization of Medicaid services in New York is very high. Those eligible for Medicaid in New York, for example, use 2,600 hospital days per thousand people compared to 760 days for non-Medicaid patients and 15 ambulatory care visits per year, compared to a national average of 5.3 visits. Utilization is particularly high among one group of Medicaid recipients, those on Home Relief (single adults), who use 4,440 hospital days per thousand and average 30 visits per year.

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others. Supporters of managed care articulated a devastating critique of the care Medicaid currently provides. Not only does it spend enormous amounts of money, but Medicaid purchases care that is fragmented, inappropriate, and incapable of meeting the exploding health care needs of New York's poor communities.

While managed care may limit the patient's freedom to choose a provider, under the current system this freedom is an illusory one. Medicaid recipients are free only to choose among Medicaid mills, weeks if not months spent waiting for an outpatient appointment, or an overcrowded emergency room. They cannot choose the kind of care that will address their needs.

The missing ingredient is primary care. Extraordinarily low Medicaid physician rates (currently $11 per visit) have driven private physicians from low-income communities, with the exception of a few who practice in Medicaid mills. Study after study has documented the lack of primary care physicians available to New York's low-income population. The most notable of these, released by the Community Service Society in 1989, surveyed primary care physicians practicing in nine low-income communities. After factoring out those who did not meet basic standards of primary care, the study found a total of only 28 primary care physicians serving 1.7 million people.

The consequences are evident. Hospitalization rates for conditions treatable by primary care, such as asthma, diabetes, and hypertension, are nearly four times higher for Medicaid patients (35.2 admissions per thousand) than they are for others (9.6 admissions per thousand). They constitute nearly 20 percent of all admissions, and the proportion is growing.

Lack of primary and preventive care played an important role in New York City's recent hospital overcrowding crisis, which at its height threatened access to care for everyone, regardless of class or status. During 1989 and 1990, inpatient occupancy soared to over 100 percent in many of New York's major hospitals, and emergency rooms backed up, with patients often waiting days for admission. The gridlock is largely attributable to the urgent and growing health care needs of the poor, many of which could have been addressed at an earlier stage, less expensively, and more appropriately by primary care.

In contrast to the current system, managed care promises to purchase the product most needed by the poor—a comprehensive and coordinated package of services whose centerpiece is primary care.

The Panacea. The final selling point for managed care was its growing aura as a panacea for the ills of the health system. If planning and regulation characterized health policy in the 1970s, and competition dominated the 1980s, the 1990s are fast becoming the decade of managed care.

New York is the first in a rush of financially beleaguered states joining the six that already rely heavily, if not solely, on managed care for the delivery of Medicaid services. Another 27 are experimenting with Medicaid Managed Care demonstrations. Managed care both for Medicaid and for privately insured beneficiaries appears to be the single strongest point of agreement between Republicans and "pay-or-play" Democrats—those who favor a payroll tax on employers who don't provide insurance to cover the uninsured. And the nation's newspaper of record, the New York Times, never misses a chance to lobby for "managed competition," even if its editors are hard put to explain exactly what this is. Managed care is well on its way to taking on an ideological life and becoming a bandwagon of its own.

**Medicaid Managed Care**

**Payment Mechanism.** The boldest departure of the New York State Medicaid Managed Care Program is in its payment mechanism. Instead of paying for individual services as they occur on a fee-for-service basis, under managed care the state will pay a single price per enrollee—or capitation rate—representing the average cost of the entire package of services covered by Medicaid (with the exception of long-term care, which is excluded from managed care and will continue payment on its current basis). While the program allows for two other forms of payment (capitation for primary care services only and continued fee-for-service payment with a monthly case management fee), full capitation is the model heavily favored by the state.

Capitation is paid to a plan, which can be an HMO or a prepaid health service plan (a Medicaid-only, HMO-like organization). The plan either directly provides the required services (primary, specialty, emergency, and inpatient care and a variety of other services) or contracts with a network of other providers to do so. The plan selects these providers based on their availability, convenience, and price.
Managed care reverses the financial incentives of the traditional fee-for-service system. Under the latter, a provider is paid every time a service is rendered, and thus benefits from providing more services. Under managed care, the plan is paid a fixed sum, and must provide all the care required regardless of cost, thus placing it “at risk.” If the cost of providing the required services is less than the capitation rate, the plan profits. If it is more, the plan loses. This creates incentives for plans to reduce the use of expensive services, to compete for healthier enrollees, and to seek low-cost participating providers.

Managed care is both an extension and the culmination of the movement to fixed pricing in health care represented by DRGs (diagnostic related groups) for inpatient care, AVGs (ambulatory visit groups) for outpatient care, and RUGS (resource utilization groups) for long-term care.

**Model of Care.** The New York State program specifies a laudable model of care. Under managed care, each recipient must be assigned his or her own primary care provider. The patient will see the same provider, visit after visit, creating the opportunity to build a meaningful relationship in which the provider gets to know the patient and his or her family and social context. Appointments must be available within a maximum of four weeks for a new patient and within two weeks for follow-up care.

When needed, the provider refers the patient for specialty care, but afterward the patient and the relevant information are returned to the primary care provider for follow-up and ongoing care. The primary care physician also admits the patient to the hospital, follows him or her during the stay, and continues to provide care after discharge. Patients can call their primary care provider or a backup physician 24 hours a day to ask questions and seek advice. Care outside the plan must be authorized, or it will not be reimbursed. Thus, with the exception of genuine emergencies, other providers will generally refer the patient back to his or her plan.

To reinforce this model of care, the state has issued strict standards for who qualifies as a primary care provider. Providers may be physicians, nurse practitioners, or physician’s assistants and must work at least half time in the managed care program. Physicians must be Board certified or, if Board eligible, be certified within five years in a primary care specialty. They must also have admitting privileges and attend their patients when hospitalized. Providers must offer 24-hour telephone access for patients and must also offer evening and/or weekend hours.

**Responsibility for the Program.** Counties are responsible for implementing and monitoring the program. In the case of New York City’s five counties, the city itself is responsible.) In each of the first five years the state will designate 20 counties to participate; each county must then submit its own plan specifying how it will reach the goals of enrolling 10 percent of the Medicaid population in the first year, 25 percent in the third, and 50 percent in the fifth year. Although these targets are extremely ambitious, no penalty or enforcement is built into the legislation if they are not achieved. The state can intervene if a county refuses to participate or does not submit a satisfactory plan.

Counties bear first-line responsibility for assuring the quality and accessibility of care under the managed care program. Together with the state, they approve which plans will be allowed to participate and the particular arrangements these plans propose for providing the care. Counties are also responsible for the enrollment process as well as for monitoring the plan’s operations to ensure that quality, continuity, and access to care are acceptable.

**Patients’ Rights.** While counties may make the program voluntary for recipients, the extremely aggressive enrollment targets ensure that the Medicaid Managed Care Program will eventually be mandatory. Under a mandatory program, recipients must be offered a choice of three plans within a geographically accessible area, and within each plan, a choice of three primary care providers. Recipients can change plans after the first six months and can change their primary care provider at any time for cause.

Managed care is to include all four categories of Medicaid recipients (Aid to Families with Dependent Children; Home Relief; Blind, Aged and Disabled; and Medicaid only). Particular recipients may be exempted from the program, however, including those who can demonstrate a pre-existing relationship with a primary care provider, and those with conditions considered incompatible with managed care. The managed care program guarantees most recipients six months of coverage even if they lose Medicaid eligibility during that period.

**The Plans.** A managed care plan in its essence is an insurer. It can function solely as insurer or it can also deliver services. Plans can be health maintenance organizations (HMOs), which can serve anyone, or prepaid health service plans (Medicaid-only HMOs). They can be profit-making or non-profit. Establishing an HMO or

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PHSP is a lengthy and expensive process, requiring millions of dollars and frequently years of work, guaranteeing that only a limited number of such programs will attempt to participate.

The largest managed care plan currently serving Medicaid recipients in New York City is the Health Insurance Plan of New York (HIP), a non-profit HMO and one of the country’s oldest and largest. Over the last several years, different groups within New York City's
Managed care closes the door on the vision of one system of care.

**Increased Primary Care Resources.** Capitation pays a fixed sum for a package of services and leaves the issue of how and how much the plan will pay for each service to the plan’s discretion. Thus, capitation makes possible a reallocation of tertiary care resources into primary care, which the state, for political reasons, has been unable to achieve. Plans are free to enhance primary care services and pay primary care providers at higher rates as they wish, financing these additional costs from savings in expensive specialty, emergency, and inpatient care. Similarly, plans can finance health prevention, health promotion, and social services not previously reimbursable under Medicaid.

Managed care does this by quietly removing the locus of decision-making about allocation of resources between primary and tertiary care from the level of state policy, where an unorganized and largely low-income constituency for primary care comes up against politically and economically powerful hospital interests supporting tertiary care. It moves these decisions to the invisible hand of the managed care plan and the physician case manager, both of which have incentives to reduce expensive tertiary services. In addition, capitation largely delegates rate-setting responsibility from the public policy apparatus of the state to the privacy of the individual plan. Thus, the Medicaid Managed Care Program could be viewed as an end-run around a historic impasse created by entrenched and powerful hospital forces.

**Mainstream Access.** As a means of expanding primary care capacity, the state intends to “mainstream” Medicaid patients into commercial HMOs, opening up primary care resources that would ordinarily be available only to more affluent patients. The seeds for this policy were planted in 1986 when the state for the first time broke with its historical opposition to all for-profit HMOs by allowing proprietary HMOs to enter the New York market. The quid pro quo, however, was willingness to enroll Medicaid recipients. This provision has remained unenforced while the fledgling industry got its start. Now the state is calling home the industry’s promises. In its 1992 session, the legislature passed a measure heavily penalizing plans that do not enroll a minimum percentage of Medicaid recipients. Overnight, commercial HMO interest in Medicaid recipients skyrocketed.

 Enrollment of Medicaid recipients in commercial HMOs is a mixed blessing, however. First, the financial incentive aside, commercial HMOs—many of them independent practice associations (IPAs), which contract with physicians in private practice—have little experience and even less desire to serve poor patients. Second, Medicaid recipients are quite different than commercial enrollees in their health status and needs, their health-related social problems, and their care-seeking behavior. Medicaid patients require a very different approach in terms of both education and intervention and the resources that must be invested in both.
Primary Care Training. The Medicaid Managed Care Program creates a new opportunity to address the supply of primary care providers. It intensifies pressure on the state's medical schools and academic medical centers to train primary care physicians. Medicaid recipients are the major training resource for both. As the single largest hospital payer, Medicaid is an important revenue source, both for New York's major academic medical centers and for the municipal and community hospitals with which they are affiliated. The threat of losing half of this patient population is a powerful one, offering important leverage for change.

The four medical schools run by the New York State University system should be most subject to pressure. Despite their public funding, they are currently indistinguishable in their mission, their recruitment priorities, their programs, or their product from the state's private medical schools.

Finally, unlike the medical profession, which must be browbeaten against its perceived self-interest into meeting primary care needs, mid-level professions face no such conflicts or obstacles. Nurse practitioners, physician's assistants, and nurse-midwives are dedicated to the delivery of primary care, and they are far quicker and less expensive to train than physicians.

Threats to Care

If managed care offers a number of new opportunities to improve care for the poor, so too does it pose a variety of threats to the future quality and accessibility of that care.

Financial Incentives and Competition. The most pervasive and troubling threat is generic to managed care and goes to the heart of the payment mechanism. Can the natural consequences of an incentive to underservice be corralled and channeled into providing a high-quality and accessible model of care? And will a competitive environment ever be compatible with serving the needs of the poor?

Managed care creates a financial incentive to decrease costs, largely through reduced use of expensive services. While this incentive can support a good model of care (for example, reduced utilization through good primary and preventive care), it can far more easily promote the opposite. Plans can reduce utilization in far cheaper, quicker, and more certain ways, both by design and by default. They can rely on screening and control of utilization to deny authorization for care; long waits for appointments or discourteous service to discourage patients from seeking care; and inadequate telephone lines or insufficient numbers of operators to make it impossible for Medicaid enrollees—many without telephones in their home—to gain access to the system.

Most seriously, however, good care for Medicaid recipients is certain to cost more in the short term, not less. While some Medicaid recipients may overutilize medical services, the vast majority underutilize them, discouraged by the overwhelming obstacles they face. Good managed care plans will reach out to these recipients and, in so doing, will tap into long pent-up health care needs. Bad plans, however, will reap pure profit from such underutilization. While it will be argued that competition among plans for enrollees will discourage these abuses, the freedom of the patient to change plans is highly constrained, and information about available alternatives and how to make the change is complex and forbidding.

All that stands between a dubious incentive and its natural consequences—between a good model of primary and preventive care and a mediocre or scandalous one, between willingness to treat all patients and skimming of healthy patients, between appropriate service and under-service—is the regulatory capacity and disposition of the state and the local county. Not only are these as yet undetermined and untested in the New York program, but the future does not bode well. Additional regulation flies in the face of a new, anti-regulatory environment and will require the commitment of additional resources just when the state and counties are cutting administrative staff and budgets and moving rapidly toward deregulation.

Speed of Implementation. Just as Medicaid Managed Care has the potential in the long run to build primary

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care capacity, so the lack of such capacity in the short run poses a major roadblock to implementation and a major threat to quality of care under the system. Qualified primary care providers do not and will not exist in sufficient numbers to enroll half of the Medicaid population in five years. Nor does this timetable allow for the complex task of reorganizing the massive hospital outpatient clinics upon which the poor overwhelmingly now rely for care.

Rather than investing resources to create the needed capacity or reconsidering the timetable, however, the state is instead crafting a variety of measures that will support or even accelerate the speed with which managed care will be implemented. First, Governor Mario Cuomo is proposing to take over the 25 percent share of Medicaid costs now paid by counties. Savings to localities are tied directly to the number of recipients enrolled in managed care in the first four years of this eight-year proposition. New York City has unrealistically estimated that it could achieve $90 million in savings in the first year, causing some forces to call for an immediate mandatory program.

Second, in exempting Medicaid recipients who enroll in managed care from Medicaid cuts enacted in the 1992 session, the state legislature created a cameo of the compromises that an unreasonable timetable will entail. Because there is little capacity to enroll recipients in actual managed care programs at present, the state instead allowed them to sign up with “medical care coordinators.” These can be either private physicians or outpatient clinics and are not subject to the strict standards of quality and access required of plans.

Under the pressure to enroll patients, will the state and city relax the program’s standards for access and quality? If the state compromises to accept outpatient departments, could Medicaid mills be far behind? Has a tactic strategy decision been made to forcibly reorganize the system first and only then address the problems of quality and access? If this is true, will managed care have a long run? These questions remain as yet disturbingly unanswered.

Less Money for Care. Not only will access to good primary and preventive care for underserved populations cost more, but managed care will actually mean fewer resources available for direct care. First, the state will deduct a guaranteed savings off the capitation it pays to the plans—a discount ranging from 5 to 15 percent of the expected average annual cost of treating the patient. Then the plan must pay for its own administrative expenses, which range anywhere from 15 to 27 percent, including the cost of administration, finance, marketing, patient and provider relations, information systems, reserve funds, reinsurance for high-risk patients, and quality assurance and utilization review programs. Finally, any surpluses or profits also come out of the premium received by the plan.

Beyond the plan, the Medicaid program must finance the cost of additional staff at both the state and local level to implement, administer, and monitor the managed care system, while continuing to operate the fee-for-service system. Thus, managed care typifies and accelerates a disturbing trend in the larger health system in which less and less money goes to the direct provision of care and more and more goes to administration and monitoring.

Two Systems of Care. The original vision was that New York State’s Medicaid program would remove financial barriers to health care for the poor. By offering insurance coverage to the poor, Medicaid was supposed to assure them the same access to services as the more affluent. The actuality fell woefully short of the ideal, particularly for ambulatory care, where physician fees and outpatient rates have been frozen at unrealistic levels. The inpatient rates Medicaid pays to hospitals, however, are equal to those of private insurers as a result of New York State’s “all payer” approach to inpatient reimbursement. Consequently, two-thirds of all Medicaid inpatients are treated by the private sector.

Managed care closes the door on this vision of one system. It undermines the all-payer system and accepts that Medicaid patients will be treated in different settings and systems. The prospects for quality and access are not reassuring, since separate never turns out to be equal.

Reducing Costs

The Medicaid Managed Care Program was sold on its promise to control Medicaid costs. What are the prospects?

Limited Savings, Total Control. Managed care, by establishing a fixed price system, shifts financial risk to the plans and gives the state nearly total control over what it pays out. In addition, the state achieves an immediate and guaranteed savings of 5 to 15 percent, since the capitation rate it pays to plans is based on the average historical cost per Medicaid recipient, less this discount. The state at any time can ratchet down this capitation rate, although it is unlikely to do this in a period in which it wants to encourage program expansion and development.

The largest potential savings—those resulting from reduced utilization—remain within the plan as an incentive and are not available to the state. Plans can achieve substantial savings over the first several years by eliminating excessive and inappropriate utilization through case management and the provision of primary care. These are one-time savings, however, and once excess utilization has been squeezed out, costs will continue to escalate at their previous rate.

The Real Causes of Medicaid Increases. Managed care cannot possibly address the most important causes of increased Medicaid spending in New York State, however, because the real causes lie outside the populations served by managed care.

First, fully half of all Medicaid dollars pay for long-term care patients, many of whom are middle class and either “spend down” or divert their resources to become
eligible for Medicaid. Yet, at the legislative level, no one wants to pit the needs of the poor against the elderly. Concern about cost cutting has cut deeply enough for legislators to bite the bullet with their poor constituents, but not with their elderly or middle-class ones. Second, after 20 years of stability, the number of people on Medicaid has begun to increase notably over the last several years, reflecting increasing poverty and unemployment.

Finally, spending has also ballooned recently because the state has become very adept in exploiting the Medicaid program, with its 50 percent federal matching funds, to pay for programs that previously depended entirely on state or local funding. Thus, Medicaid has assumed the cost of many mental health and mental retardation services, as well as vast portions of bad debt and charity care at the state level and indigent care for New York City’s Health and Hospitals Corporation. But legislators do not make fine distinctions in their zeal to cut spending, and the Medicaid poor take the fall.

Progressive Agenda

Medicaid Managed Care, with all the threats and problems it embodies, might not have been the preferred option for progressive forces. Nevertheless, it appears to be here to stay. The resulting agenda for progressive forces in New York State is clear. Most immediately, we can utilize the formative period in which the program is being shaped and implemented to make sure that protections for patients’ interests are built in. Prevention before the system is in place will be far easier and more effective than cure after the fact.

At the local level, this means lobbying to ensure that marketing practices are honest, that patients truly understand their choices, and that plans do not “cherry-pick” good risks while avoiding the bad; it means making sure that patients know and understand their rights; that programs to monitor quality and accessibility are well funded, rigorous, and meaningful; that standards of care are not compromised; that plans willing to reinvest their surpluses in enhanced quality and expanded primary care are encouraged and predatory plans are excluded from the program; it means translating complex and confusing regulations and plans so that community and advocacy groups understand the issues and can deploy their influence and resources effectively. The program is being implemented by professionals who have the best of intentions. Progressive forces can at least assure that these intentions are supported and institutionalized in the program.

Progressives would be remiss if we did not go beyond a reactive stance, however. New York State’s managed care program has broken through important barriers that blocked the development of primary care to create an enormous new demand for primary care. The urgency of New York State and New York City in implementing the program offers important new leverage in promoting primary care and reshaping the health care system. Progressive forces must also use this opportunity to make sure that managed care is defined to be primary and preventive care, not control and screening systems. We must then lobby to assure that resources are invested in new primary care capacity and that the necessary numbers of primary care physicians, nurse practitioners, and physician’s assistants are trained. If we can pursue this agenda and exploit these opportunities, we will guarantee that, whether it succeeds or fails, New York State’s Medicaid Managed Care Program will leave a legacy much closer to the health system we envision.
about whether full-risk capitation* is the appropriate means of financing providers. Some would argue that that is the only way to guarantee savings. But others believe it places an undue strain on the provider to limit the use of services, and that could be detrimental to people with greater needs.

Padgug: Obviously there currently aren't enough HMOs to take on the whole burden. This process will swamp them in five years. Are there enough hospitals, enough neighborhood health centers to take care of the population, especially in areas like New York City?

Block: No, there aren't enough, which means that there aren't enough to take care of people in the fee-for-service world, either. Again, it's not an inherent deficiency of managed care. It is simply that managed care highlights the degree to which the delivery systems do not currently exist. We have in this state an exemplary record of providing funds to try to encourage the development of community-based providers, through our funding of community health centers and through efforts such as the primary care initiative, which was intended to promote community-based primary care development. Most recently, under our last hospital reimbursement bill, we authorized a program that provides funds directly to hospitals to promote community linkages with either physician groups or community health centers. All of those efforts will contribute to the availability of providers in those communities. Clearly we have not invested enough to solve the problem at this point, but we have some track record. Again, managed care will force us here in the legislature to really look at the resources that we are putting into primary care development. And then, of course, the real political question, which we suspect will come up next year when we do hospital reimbursement again, is how much can we reallocate from the existing streams of funding to promote primary care? Because clearly the taxpayers are not willing to spend a lot more additional dollars to support a health care system that they already think costs too much.

Padgug: What kind of general quality assurance and general state oversight has been built into the program?

Block: It builds on an existing quality assurance system in which all managed care providers currently have to meet certain standards to maintain their certification. This is irrespective of Medicaid. In addition, providers in New York must meet specific federal Medicare and Medicaid requirements with respect to quality assurance. The degree to which they are actually fulfilling those requirements is a matter for the health department administrative jurisdiction. In the big world out there, there is a whole new movement in how we measure quality, and I think we'll benefit from it in starting our managed care initiatives. But we have an existing set of quality assurance requirements in place, and those carry over into this program. We didn't have to reinvent the wheel.

Padgug: Hospitals are used to a particular kind of high-tech inpatient and ambulatory care, and while many do a lot of outpatient basic care for poor and Medicaid populations, they don't do any case coordination. Is the discipline of having to meet a certain budget through capitated rates going to help them solve this problems?

Block: In and of itself, no, a capitated rate won't. Simply tinkering with reimbursement is not sufficient to fundamentally change the way the delivery system is organized and behaves. However, living within a budget through full-risk capitation is a form of economic discipline that some hospitals have openly welcomed and embraced. Managed care capitation can force hospitals to learn to manage their resources more effectively. This is an important lesson, because whether it's Medicaid Managed Care, or New York Health, or any other more broadly based health reform, they're going to have to learn to live within some more limited resources.

This is one of the real tough policy questions that we'll face. Some call it rationing, some think of it in terms of the allocation of resources, but there will ultimately have to be some system in place that satisfies the public that the allocation of resources is fair and appropriate. All the evidence points to the fact that both Medicaid and privately insured patients get more than they need of high-tech services. It would therefore be appropriate to build in financial incentives that would change that behavior for everyone, not just for Medicaid clients.

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Managed care has made us accountable in a way that doesn't exist in the fee-for-service world.

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Padgug: Isn't managed care an attempt to reconstruct a hierarchy in which primary care is at the bottom, and you go into the system through the primary care providers, and only through them do you get to specialists and hospitals?

Block: Yes, the basic idea is to set up a gatekeeper. We think that's an advantage for the Medicaid client, as it would be for any insured person. You have a person who is familiar with your medical history, familiar with your family background, who knows who you are and why you're there and who can then facilitate your access to appropriate specialty services that are outside the scope of that practitioner's competence or setting. The question that always has to be kept out on the table when making comparisons with fee for service is not only how does this approach compare to what the privately insured population currently enjoys, but also how does it compare to what the Medicaid population and the uninsured currently have access to. By either of those measures, we think

* Full-risk capitation is a method of paying providers in which they retain all profits and bear all losses from the "cost-effective" practice of medicine; it is sometimes thought to lead to financial instability and to skimping on care. In partial-risk capitation, providers bear risk for some services only or share the profits and losses with the capitating entity (in the present case, Medicaid).
that this overall gatekeeper approach should represent improvement in access.

**Padgug:** The legislature and the executive branch are the governmental bodies responsible for determining public social policy in New York State. But New York State also has a role as a third-party payer, and because of Medicaid, it’s one of the largest third-party payers. Isn’t there always a danger that the fiscal pressures of being a third-party payer will overwhelm the ability of the state to make proper social policy. That is, to some degree, don’t we run the risk that the cost issue will drive everything else?

**Block:** Well, absent a national program that deals with long-term care and that deals more broadly with acute and primary care financing for the general population, yes. States will no longer be able to sustain the level of commitment that they currently have to programs like Medicaid. The fiscal pressures are clearly not going in the right direction in terms of cost and in terms of their effect on access. What can states do independently to change that dynamic? It is extremely difficult to do anything. Basically, you have to have some kind of systemwide cost control in place that applies to everyone.

**Padgug:** Then that is the next set of steps to be taken—a building block toward a wider reform. Do we have any early preview or prediction of what direction that’s going to take?

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**Irving Selikoff (1915-1992)**

The following is an excerpt from a letter written by Health/PAC board member David Kotelchuck to Dr. Irving Selikoff, world-famous asbestos researcher and Director of the Environmental Sciences Laboratory at Mt. Sinai Medical Center, shortly before Dr. Selikoff’s death from cancer this past summer. It expresses the feelings of many of us on the Health/PAC board and staff.

The years you have been a deep source of inspiration to me, to many, many other health and safety professionals, and of course to asbestos workers and health and safety activists the world over.

We admire you because of your great contributions to the treatment of tuberculosis and to the discovery of the terrible diseases of asbestos dust. But most of all we have been inspired by the tenacity with which you have defended the health, the lives, the interests of working people exposed to this “deadly dust.”

We understand that the asbestos industry and its allies tried at first to silence you through an ugly, covert campaign distorting and maligning your social and political affiliations. But the strength, the soundness of your scientific investigations turned back these critics and won the support of your scientific colleagues and, eventually, peoples and governments.

That storm weathered, you could have turned away from your asbestos worker friends and scientific colleagues by accepting the implicit offers of the asbestos industry to securely fund your laboratory research if you would only soften, ever so slightly, your public criticism of the asbestos industry. But you took the more difficult path of independence of scientific inquiry, social criticism as appropriate of the asbestos industry, and rock-solid support for and concern about asbestos victims—those people who, to paraphrase you, are statistics with tears in their eyes.

Few if any of your colleagues, collaborators, and friends will be able to accomplish in their lifetimes what you have accomplished in yours. But all of us can try and with determination succeed, as you have, in holding fast and true to our deepest commitments to the health and interests of working people and of all people.

You will be long remembered.
Quality and Medicaid Managed Care
Who’s Watching?

ARTHUR A. LEVIN

Concerns about quality loom large in any discussion of Medicaid Managed Care. While such concerns are by no means limited to managed care settings, there are several reasons why health care advocates are anxious as New York State begins its ambitious Medicaid Managed Care Program, particularly in light of the weakened condition of existing state quality assurance programs.

The growing romance with managed care has been largely stimulated by a desire to reduce or at least stabilize inflation in health care costs. Proponents of managed care as the magic bullet of health reform, whether for Medicaid or middle-class populations, often tout other benefits. But it is unlikely that managed care would occupy the reform limelight if it did not at least promise to significantly slow the rise in health care expenditures.

The potential savings from a managed care environment derive from the reversal of the traditional and powerful incentive for health care providers to do more of more things in order to increase revenues. But it is this very feature that makes health advocates worry. Prepayment models create a seductive incentive to provide people with less of fewer things because cutting down on services can significantly increase surplus or profit. There is legitimate cause for concern that providers will be tempted into wholesale denial of appropriate care to those most in need. While most advocates would be hard pressed to find merit in the American fee-for-service tradition, they also know that past experiments of other states with Medicaid prepaid providers have often produced horror stories of terrible quality and outright fraud. But, as proponents of managed care are quick to point out, there is nothing inherently “unhealthy” about a managed care approach, and good quality oversight can prevent abuse.

In New York State, the oversight of Medicaid Managed Care is basically divided between local social service districts and the New York State Department of Health. The local social service agency (either county or city) has responsibility for ensuring that Medicaid enrollees have, among other things, adequate access to care, an appropriate range of primary care services, and a grievance procedure. The Department of Health maintains its traditional responsibility for assessment and assurance of quality of medical care.

Until 1976, prepaid health care plans were treated as just another form of traditional risk insurance and were not subject to certification from the Department of Health. Since then, New York State public health law has required prepaid health services such as health maintenance organizations (HMOs) and “HMO-like” organizations to be specially licensed. Those plans open only to Medicaid beneficiaries receive a limited license or certificate. There are at present 36 HMOs licensed in the state, six of which are open only to Medicaid recipients. Initially, it will be these providers that will enroll Medicaid beneficiaries under Medicaid Managed Care and who, under public health law, are subject to the full range of Department of Health oversight.

(Medicaid Managed Care allows other kinds of plans, such as small groups of physicians, to organize in order to enroll Medicaid beneficiaries. There are half a dozen such physician case management efforts presently underway in the state. But the Department of Health has much less statutory authority to oversee the quality of care in these settings, which are still considered to be the traditionally off-limits “private practice of medicine.”)

Arthur A. Levin is the Director of the Center for Medical Consumers in New York City and President of the Health/PAC Board.
Clouds of Doubt

New York's ambitious new plans for Medicaid will be carried out under a growing cloud of doubt about the Department of Health's ability to meet its regulatory responsibility to assure quality anywhere in the system. The New York State Department of Health has responsibility for a unique, multifaceted program of quality assurance consisting of periodic surveys of hospitals, mandated reporting and investigation of incidents, investigation of complaints and investigation of allegations of physician misconduct.

The "gold standard" of state assurance efforts is the hospital survey program, which is proactive and comprehensive. Survey teams visit hospitals to try to discover and correct problematic practices before the public is harmed. Unfortunately, the gold standard is becoming tarnished because of resource constraints. Originally, the surveys were on a three-year cycle for each hospital; the current time span between visits to a hospital by state surveyors (other than under mandate from the federal Health Care Finance Administration) averages eight years.

The incident reporting system, initiated in 1985, requires that hospitals investigate and report to the Department of Health incidents that cause or contribute to harm to patients or that disrupt patient services. Incident reports serve several functions: they identify serious violations that require immediate action; they reveal patterns or trends of incidents that can help in the design of preventive strategies; and they serve as "flags" to identify potentially serious problems in their early stages. The Department of Health has the responsibility to accumulate and analyze the data submitted and provide feedback to hospitals. This important program, like the others, has been seriously affected by budget cuts and lack of legislative support.

The cumulative effect of recent budget constraints has, at times, seemed so potentially damaging that the Department of Health has contemplated totally abandoning some of its quality assurance responsibilities in order to retain the viability of others. Certain assurance and oversight programs have been brought to a virtual standstill, while others face crippling backlogs. And those programs that continue to function effectively from the standpoint of public protection find themselves facing accusations from providers and their legislative allies ranging from charges of harassment to allegations of "gestapo-like" investigations. Health advocates, particularly those that see the direct human consequences of the political savaging and resource starvation of these programs, characterize the quality assurance programs as being so decimated as to be cause for public alarm.

The clouds over these programs have formed, at least in part, as a result of several years of vigorous provider-led efforts in Albany to encourage "regulatory reform"—which in provider terms means less regulation—in health care. This long-standing provider agenda gathered considerable momentum after illness forced the premature retirement of Health Commissioner David Axelrod, just as many of these quality assurance programs that he fought for were reaching their stride. Axelrod was often criticized and sometimes vilified by both providers and legislators for what was characterized as his "micro-management" of the health care system. While many advocates often found themselves frustrated by Axelrod's dogmatic approach, they at least took comfort in the knowledge that he wanted health care in New York to become more equitable and of high quality, and Axelrod did not shrink from confronting providers in pursuit of these goals. Many advocates worry that the new commissioner, Mark Chassin, was chosen because of his collegial, non-confrontational style and are concerned that he has already indicated openness to the providers' regulatory reform agenda.

In the providers' polemic, quality assurance by government is the enemy, not the protector, of the sick

The state's budget crisis also provided fuel for critics' claims that Department of Health regulations are both costly and ineffective. Government "interference" has been identified as responsible for a good measure of spiraling health care costs and the waste of resources that could be applied to patient care. (The claims that state—as well as federal—regulation is costly and ineffective are anecdotal; there is a paucity of data to support this widely accepted notion.) In the providers' polemic, quality assurance by government is the enemy, not the protector, of the sick.

Many consumer advocates believe that the provider-led "regulatory reform" campaign, which not unexpectedly finds significant support among Republicans and conservative Democrats in the legislature, is a cover for their real agenda—significant deregulation of the health care system. The defunding and consequent curtailment of the Department of Health's quality assurance program has been cynically used by proponents of regulatory reform to bolster their argument that "micro-management" by the state fails to protect the public.

Protecting Whom?

The push for "regulatory reform" at the state level has found some unfortunate resonance with the lingering anti-government public sentiment that views all government oversight as bad. Those who champion this sentiment ignore the reality that most regulations are enacted only when it becomes apparent that without them individuals and communities cannot be protected from harm. The frequent divergence between provider and public interests creates an inherent tension that is exacerbated by the continuing debate over the role, responsibility, and limits of the executive and legislature in protecting the public from harm.

In addition, providers have successfully steered the debate so that it focuses more on protecting their own due-process rights than on protecting the public. Over the years, providers, whether institutions or individuals,
have shown little inclination to put public protection ahead of their self-interest. In fact, self-identified negligence and poor practices are kept hidden from the public and even from government, often in direct violation of the law. Consumer advocates are apt to roll their eyes in disbelief when providers lament that they (hospitals, doctors, etc.) are willing and able to “police” themselves, if only government would stop “interfering.” Those who have suffered harm and their advocates know that protecting the public from negligent, impaired, and fraudulent medical practice requires regulation that makes providers accountable, stipulates acceptable standards of behavior and practice, and grants the state authority to take punitive action.

Although many advocates agree that even in the best of times, the Department of Health’s quality assurance efforts often fell short, they also believe they have never received either the resources or the supportive environment needed to succeed. Because of the providers’ “leave us alone” mentality, quality assurance efforts by the state usually do not have the support of major provider groups such as the Hospital Association of New York State (HANYS) and the Medical Society of New York State. In fact, these powerful organizations regularly challenge the Department of Health’s authority in the courts and lobby the legislature with great zeal and deep pockets. (In 1991, HANYS’s lobbying efforts in Albany were second only to those of New York City in dollars spent). The potential benefits of quality assurance programs are likely to be diminished in such an adversarial and highly politicized context.

New York State has long been a leader in creating regulatory programs to assure the quality of health care. But the confluence of recession, anti-government sentiment, and a well-oiled lobbying effort by the regulated industry may have set back the clock. Medicaid Managed Care will place even greater burdens on the Department of Health as it struggles to meet its regulatory obligations.

**Without adequate surveillance, no one can be certain that Medicaid Managed Care will not result in a repeat of past disasters.**

Without adequate surveillance no one can be certain that Medicaid Managed Care will not result in a repeat of past disasters. What is so frightening, in the end, is that those people living in poor rural and urban communities who depend on Medicaid and whose individual and collective health is increasingly frail may be irrevocably harmed.
Another Kind of Bronx Cheer
Community-Oriented Primary Care at the Montefiore Family Health Center

HAL STRELNICK and RICHARD YOUNGE

Reception area at the Montefiore Family Health Center. Mural of the center's opening day is in the background.

The concept of comprehensive community health centers came into being at the turn of the century with the creation of outpatient dispensaries. The idea then traveled in the 1920s to England with the Peckham Health Center and back to the United States, via South Africa, with the founding of the Mount Bayou Health Center in Mississippi and the Columbia Point Health Center in the Roxbury neighborhood of Boston by Drs. H. Jack Geiger and Count Gibson.

In the 1960s the principal agency of the War on Poverty, the Office of Economic Opportunity, supported about 100 community health centers across the country in impoverished urban and rural communities. These centers provided much more than medical care; they offered job training, legal advocacy, housing development, nutrition education, dental and optometric services, outreach, and home care. Community control was given to health center boards, under the rubric of "maximum feasible participation," to help develop leadership in these communities. At one time, 1,000 such centers were planned to serve 25 million people. In the 1970s, however, community health centers became a categorical grant program in the Public Health Service and lost all but their medical mission. Their numbers grew from 158 in 1971 to 872 in 1982, but, like the Montefiore Family Health Center described in this article, they were of more modest size and goals. The 25 percent across-the-board cuts in funding for community health centers instituted by the Reagan administration in 1981 led to the closure of more than 200 centers nationwide in the early 1980s.

By 1991, approximately 550 public and voluntary organizations, 60 percent of them rural, received $478 million in federal grants, supporting about 1,400 clinics and serving 6 million people, 60 percent of whom have incomes below the federal poverty level. Numerous studies have demonstrated the efficacy of these centers in reducing infant mortality, rheumatic fever, emergency room visits, hospitalizations, and annual health care costs. In 1992, Secretary of Health and Human Services Louis Sullivan proposed expanding their number to 1,700 with a 15 percent increase in funding to serve 7 million people.
Fordham Road is the main east-west commercial strip in the Bronx, passing not only the original Alexander's department store, now defunct, but Dick Gidron Cadillac, the largest black-owned business in New York City; Tremont Savings and Loan, for many years the tallest building in the Bronx; Sears Roebuck and Company; and the Rose Hill campus of Fordham University. Just east of the university, Fordham Road divides the world-famous Bronx Zoo from the equally famous New York Botanical Gardens. During the 1970s and 1980s, Fordham Road also served as the northern boundary, both geographically and sociologically, of the South Bronx and its epidemic of fires and abandoned buildings, the symbol of urban poverty.

Fordham Road also passes the university parking lot where Fordham Hospital once stood and served this community's health care needs. Doomed by an antiquated physical plant, the hospital was closed in 1977 by New York City's Health and Hospitals Corporation. A site for a "new Fordham Hospital" was razed just a few blocks south and east, but the city's fiscal crisis ended those plans. Clinical services from Fordham Hospital in the central Bronx and Morrisania Hospital in the west Bronx were consolidated in a new facility, North Central Bronx Hospital, which stands next door to Montefiore Medical Center on land donated by Montefiore to the city. People in the central Bronx lost access to care in their own community.

In November 1980, the Montefiore Family Health Center, which served this Fordham neighborhood, opened its doors to its first patient—a scene memorialized in a photograph of neighborhood children coming through the entrance, enlarged to decorate the entire wall behind the third-floor reception desk. This scene is reenacted every Christmas when the local kids are treated to a grab bag of gifts and toys. The health center represented new services and jobs in the neighborhood at a time when libraries were being closed, stores were being boarded up, and apartment buildings were being abandoned. In November 1980, Ronald Reagan was also elected president. His first budget in 1981 cut funding for all community health centers by 25 percent.

A Health Center is Born

The Montefiore Family Health Center was created as a new site for the family practice program of Montefiore's Residency Program in Social Medicine. The residency program began in 1970 at the Dr. Martin Luther King, Jr., Health Center (which Montefiore had helped to start in the 1960s), when the center's founders could not find primary care physicians who could work collaboratively in health teams with community activists and family health workers. The residency in family practice was added in 1973, and residents saw patients at the Bathgate Satellite of the Martin Luther King, Jr., Health Center. But as the housing stock in that neighborhood disappeared, so did the patients, and in 1977 most of the family practice residency moved to the new North Central Bronx Hospital. This arrangement was not community based, however, and the health team model conflicted with the hierarchical structures of the hospital. The family practice program began looking for a new home.

Federal grants were then available to start small health centers in medically underserved urban areas through the Carter Administration's Urban Health Initiative. In an attempt to explore how this Urban Health Initiative might meet some of the neighborhood health needs created by the closing of Fordham Hospital, residents and administrators of the Montefiore family practice program began meeting with community organizers from the Northwest Bronx Community and Clergy Coalition. This effective network of church-based neighborhood organizations was formed in the mid-1970s to prevent the spread of the arson and abandonment of the South Bronx to the Fordham Road area. Health care was one of the coalition's priorities, and it had organized demonstrations against neighborhood "Medicaid mills" as well as efforts to "Save Fordham Hospital." The coalition was consulted throughout the development of the new Family Health Center, and activists from the coalition were to provide leadership for its governing community board.

The center's developers sought to learn from more than a decade's previous experience with community health centers in the Bronx in order to prepare for the leaner and meaner 1980s, and many of the staff were recruited from the Dr. Martin Luther King, Jr., Health Center. They developed career ladders for medical assistants and receptionists in lieu of the extensive training program at the Martin Luther King Center. In place of that center's family health workers, ambulatory care assistants (ACAs) were graded to create a career ladder from receptionist to medical assistant to the senior ACA III responsible for triage, outreach, and referrals. Family nurse practitioners, family physicians, and family medicine residents from Montefiore provided the primary care services.

To give a brief picture of the neighborhood that the Family Health Center serves, the population was 106,000 in 1980, 44 percent with incomes of less than $10,000. In 1988, 53 percent of the households earned less than $15,000; 24 percent were African-American, and 59 percent were Latino. The percentage of the Family Health Center's patients receiving Medicaid has grown slightly, from 50 percent to 55 percent, over the 1980s, while a steady 5 percent are on Medicare, and 7 percent are privately insured. The remainder are medically indigent. A total of 49,318 patient visits were made in 1991.

During the 12 years of its existence, the center has developed a number of unusual outreach services and specific programs to fit the needs of the surrounding population—what is now called community-oriented primary care.

Discovering the Refugees

In the summer of 1981, medical students and ambulatory care assistants conducted a door-to-door community survey of hypertension in the six-story apartment buildings that surround the Family Health Center. In the

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building across 193rd Street from the center, a survey team came across an apartment with several children who spoke neither Spanish nor English. When an adult arrived, they discovered that the family was Khmer, recently arrived from Cambodia via refugee camps in Thailand and the Philippines. It turned out that other Khmer families were living in the building as well, the first of what was to become a new wave of immigration. Investigation revealed that in the closing days of the Carter administration, almost 800 Khmer families were resettled in the Bronx. Meanwhile, the resettlement agencies had, of course, arranged for the refugees' health care at hospitals near the agencies' offices in midtown Manhattan!

While looking for hypertension, the Family Health Center outreach team found displaced refugees with a myriad of health problems brought with them from Southeast Asia: intestinal parasites, tuberculosis, post-traumatic stress disorders, and depression. The Cambodian families began to trickle into the Family Health Center. First the Cambodians came for medical care with family members who could translate; then doctors and patients would pass a telephone back and forth while a translator at the resettlement agency interpreted. Soon, the health center hired a couple of English-speaking Cambodians as translators. Then the health center was alerted to Vietnamese refugees in the Bronx; as long-time enemies of the Khmer, their medical care was organized on a separate floor and their own translator hired.

The refugees' problems also reflected the stresses of their new environment clashing with their past: children with lead poisoning and adults with psychosis, the post-traumatic stress disorders of the “killing fields,” and the depression of unresolved grief. At a meeting of angry and confused tenants in the building across 193rd Street where the first Cambodian family had been discovered, a group of family practice residents heard first hand about their problems of heat, hot water, security, and lead poisoning among the children. The mix of Spanish, English, and Khmer created chaos. The family practice residents called in a community organizer from the Northwest Bronx Community and Clergy Coalition, who helped the tenants fight the landlord for heat and hot water, new paint, and a secure front door. The iron gate door with the half moon design at 357 East 193rd Street stands today as a reminder of their organizing success.

The mental health problems of the refugees continued to grow more apparent. One middle-aged Khmer woman who spoke no English had a psychotic break on the subway when she became lost. The Family Health Center's social worker began exploring better ways than medications and hospitalizations to help her patients cope. When she learned that the Khmer people's traditional healing practices relied upon their Buddhist priests, she called in Montefiore's non-profit housing and economic development agency, the Moshulu Preservation Corporation. Working with members of the Cambodian community, they found a house on Marion Avenue and created their first Buddhist temple.

Today, the Family Health Center's first Khmer translator has become a social worker and his successor a registered nurse; the house on Marion Avenue still houses an active Buddhist temple. Grants have been secured to continue mental health services for all Southeast Asian immigrants. The days of collecting used clothing for the refugees is past, as some families have joined the economic mainstream, others the public assistance system, and still others their extended families in the large immigrant communities in Lowell and Boston, Massachusetts. A second wave of Southeast Asian refugees, Amerasian children and their families, has arrived from Vietnam, while a new generation is being born here whose mothers received prenatal care at the Family Health Center.

Prenatal Care Works

In the South Bronx, with its many young families, prenatal care should be among the highest priorities of a community-oriented primary care practice. Despite the fact that prenatal care works, that it is well-described, inexpensive, cost-effective, and supported rhetorically by politicians and opinion polls, clearly not every woman who wants or needs it has access to quality maternity care. In 1980, almost one-third of women in the Family Health Center's neighborhood received late or no prenatal care. This lack of adequate maternity care and the availability of state funds for community health centers inspired the Family Health Center to make prenatal care a central part of its mission in 1983.

In 1982, the New York State Department of Health decided to redirect the funds from the Reagan administration block grant for Maternal and Child Health, which had traditionally gone to the major teaching hospitals, to Children and Youth Programs and to support community health centers. The Montefiore Family Health Center responded with a proposal to establish a low-birthweight-prevention team that would do extensive outreach to encourage early prenatal care, as well as to recruit a staff obstetrician to help increase the quality and intensity of prenatal care at the health center.

The Low Birthweight Prevention Program (now called Perinatal Services) at the Montefiore Family Health Cen-
The Low Birthweight Prevention Program has succeeded. The Family Health Center cared for about 350 pregnant women in 1983 and 650 in 1990. Close to 55 percent of the women entering prenatal care at the Family Health Center now come during their first trimester, compared to only 30 percent in 1984.

The project may have had a more far-reaching effect in improving birth outcomes in the community. In 1987, the Montefiore Family Health Center provided prenatal care for about 14 percent of the 4,383 live births in its target area. Between 1980 and 1987, the low birthweight rate in this neighborhood declined slightly from 10.5 percent of live births to 10.24 percent, a 2.8 percent reduction. During the same period, the low birthweight rate for all of the Bronx increased from 10.3 percent to 10.76 percent of live births—a 4.5 percent increase. Similarly, between 1980 and 1987 infant mortality in the target community declined from 20.6 to 11.86 per 1,000 live births, a 42.5 percent reduction, while the Bronx as a whole experienced only a 22 percent decline, from 17.3 to 13.4 per 1,000 live births. Similar relative improvements can be found in neonatal and post-neonatal mortality for the target community compared to both the Bronx and New York City as a whole. How much of the relatively greater improvement in perinatal outcomes for the Family Health Center’s catchment area compared to the rest of the Bronx is due to the Low Birthweight Prevention Program and how much might be the result of other changes in the community, such as decreased poverty or increased education levels, will be assessed when the 1990 census data are analyzed.

The Montefiore Family Health Center continues to look for ways to improve its maternity care and other community-oriented services. Recently, a number of clinicians at the health center have become concerned about the increasing prevalence of substance abuse among childbearing women due to the crack and cocaine epidemic. Substance use during pregnancy is under-diagnosed, even at the Family Health Center, in spite of the continuity of care and emphasis that is placed on exploring psychosocial issues with patients, as shown by the discrepancy the medical director, Dr. Joseph Lurio, found between medical histories and anonymous urine drug screens in identifying substance use.

When substance use is diagnosed, few drug treatment facilities are willing to treat a pregnant woman with a drug problem. The Family Health Center has developed links with a program that treats addicted pregnant adolescents, and its Health Care for the Homeless Outreach team has provided prenatal care to such women in welfare hotels and shelters. The Family Health Center has begun enhancing its capacity to counsel addicted patients and plans to expand its capacity to serve addicted mothers through grant funding specifically targeted for chemically dependent women.

Prenatal care and services for Southeast Asian refugees are not the Montefiore Family Health Center’s only community-oriented services. Special enhanced services are provided by the outreach team to the homeless and another team dedicated to HIV-related illness. Another grant supports a substance abuse counselor to address drug-related problems on site and a mental health team for HIV-infected patients. The Family Health Center works with adolescent group homes, group homes for the mentally retarded and developmentally disabled, and a residential drug-free treatment program and has conducted employment-based hypertension surveillance and treatment, parenting, and adolescent groups. A self-help network of Latina women in their mid-life transition, based on the principles of Paolo Friere, recently celebrated its tenth anniversary of empowerment and advocacy. A satellite Women, Infants and Children (WIC) nutrition program office was opened on the ground floor in space once occupied by the X-ray viewing office.

**Managed Care Comes to the Bronx**

 Managed care has infused the Family Health Center with badly needed cash, as well as unneeded forms and paperwork. The Montefiore Department of Family Medicine adopted and supported the development of the Bronx Health Plan, one of five experimental Medicaid capitation experiments in New York State (see "Medicaid
Managed Care: A Mixed Review,” p. 4). Since 1986, the Bronx Health Plan has worked closely with a consortium of Bronx community health centers, including Montefiore Family Health Center, to provide accessible and user-friendly primary care with private practice-style specialty services and hospitalization at all major Bronx hospitals.

Clients are voluntarily enrolled at Income Maintenance Centers and give up their regular Medicaid cards for the assurance that they will have 24-hour-a-day, seven-day-a-week access to physicians by appointment or telephone and will have their own personal physician. A team of “patient representatives” recruited from the community, not unlike the family health workers of the 1960s, answer questions, solve problems, and advocate for their clients within the health system.

Bronx Health Plan’s patients rarely miss an appointment with a specialist whom they have been referred; the appointment is made at their convenience while they are in the office with their personal physician. They are seen in private offices, and if they miss an appointment, they are contacted by the patient representative. Other Medicaid patients needing specialty care must wait one to three months for a clinic appointment at Montefiore; only one in five actually see the specialist.

By reducing unnecessary emergency room visits and hospitalizations, the Bronx Health Plan has returned a surplus to its participating health centers every year since its inception. The Bronx Health Plan also administers an experimental managed care insurance program for medically indigent families whose income is too high for them to be eligible for Medicaid, and the Child Plus program, which expands primary care coverage for children up to 12 years of age.

Chair of the Department of Family Medicine Dr. Robert Massad and Executive Director of the Bronx Health Plan Maura Bluestone opposed New York State’s Medicaid Managed Care Program, with its mandatory enrollment of patients, because they believed the success of the Bronx Health Plan came in part from the voluntary decision of informed Medicaid recipients who understood what they were choosing and how to get services when they were needed. Despite this opposition, Governor Mario Cuomo traveled to the Morris Heights Health Center, one of the participating Bronx Health Plan centers, to sign the Medicaid Managed Care legislation into law.

The success of the Bronx Health Plan can be seen in its growth—from 2,000 patients in 1988 to 15,000 today, all voluntarily enrolled. Further growth is limited by the stretched capacity and overcrowding of the health centers. Currently, the Bronx Health Plan is responding to the challenge of the limited physical and personnel capacities of its health centers by building its own small group practices in the building that houses its administrative offices on Fordham Road.

Expanding Against the Tide

The Family Health Center faces the challenges of being at the epicenter of the urban epidemics of poverty, homelessness, HIV, and drugs. Space inside the Family Health Center is at a premium, and outside landlords are speculating on the recovery of the business district based on the success of Fordham Plaza, whose primary tenants are the financial and administrative back-office staff of Montefiore Medical Center, instead of the back offices of Wall Street brokerage houses as originally planned. Recruiting young family physicians to the South Bronx from outside New York City swims against a tide of medical students’ debt and “me-generation” values. Federal and state grant dollars become more precious and knotted in red tape and paperwork every year.

But the need for services in the Bronx continues; the Community Service Society estimated in 1989 that the South Bronx needed 185 primary care physicians. So, with money from the New York State Department of Health’s Primary Care Initiative and the Bronx Health Plan, the Montefiore Ambulatory Care Network is planning to build four new health centers in Kingsbridge, West Farms, Wakefield, and, in October 1992, a five-physician office on the ground floor of Fordham Plaza on Fordham Road.

Last Christmas, despite the recession, the physicians and nurse practitioners at Montefiore Family Health Center were bestowed with more gifts from their patients than any year in memory: ties, cologne, handkerchiefs, souvenirs from Puerto Rico and the Dominican Republic, and home-cooked meals. These gifts were simple, yet elegant ways of demonstrating the important role the Family Health Center plays in the lives of its patients.

Dr. Richard Younge, former medical director of the center, with a patient.
Single Payer—Fifty Players?
Alternative Payers for Universal Health Insurance

THOMAS BODENHEIMER

Over the past two years, the single-payer concept has become a serious contender for the universal health insurance model that can solve the United States’ health crisis. “Single payer” means that one institution in each geographic area receives virtually all money spent on health care and pays hospitals, physicians, health maintenance organizations (HMOs), and other health providers. Business executives, labor leaders, politicians, and health analysts are interested in the single-payer model because of its international track record in solving simultaneously the problems of health access and health cost inflation. A number of single-payer bills have been proposed in Congress and in various state legislatures. Polls taken in 1988 and 1990 indicate that over 60 percent of the American public is sympathetic to the single-payer concept.

Two political drawbacks reduce the attractiveness of the single-payer approach, however: first, the need to raise taxes to finance universal health insurance under a single payer (which has been considered elsewhere), and second, a deep-seated distrust of government. This distrust is manifest in such frequently heard responses to the suggestion of a single-payer system as “Government made a mess of Medicaid, it created a complex and inadequate program for Medicare, and the Veterans Administration hospitals are a disaster. If government has done such a terrible job of running health programs, why do you want to give it even more power? If you like the Post Office, you’ll love the single-payer health system.”

In part, the distrust of government is misguided and promoted by the dominant conservative ideology in the United States. Each governmental program has its own history and its own peculiar failures that should not be attributed to an all-encompassing notion that “whatever government touches is bad.” Moreover, a number of government programs are successful. Social security is highly popular, and Medicare, in spite of its difficulties, in fact commands strong public support as well. The administrative costs of the Medicare and Medicaid programs are far lower than those of private health insurers.

On the other hand, the public’s distrust of government is amply justified by the unethical and illegal activities of some government officials, as in the recent savings and loan scandals, as well as by government coverups of unpopular activities ranging from the Vietnam War to the Watergate scandal to the Iran-contra affair.

For reformers who support the single-payer concept, the response to such public distrust of government must be twofold: on the one hand, the government is not quite as bad as that; but on the other hand, it could be a lot better, and we ought to look for some creative approaches that could minimize governmental ineptitude. Supporters of the single-payer approach must seriously ask themselves: do we want to cede control of the entire health system to the federal or state governments? If so, why? And if not, then who should be the single payer? Before confronting these questions, let us review why we favor a single payer at all.

Why Do We Want a Single Payer, Anyway?

Health care reformers working for universal health insurance have one overriding goal: to efficiently insure everyone in the United States, on an equal basis, for a comprehensive array of health care services of the highest quality, with reasonable control over costs. The single-payer mechanism is seen as the means to this goal; it is not the goal itself.

Thomas Bodenheimer is a practicing physician in San Francisco and a member of Physicians for a National Health Program. An earlier version of this paper was presented at a meeting of the American Public Health Association, Atlanta, Georgia, November 1991.
Four major reasons can be cited to explain why the single-payer structure can best realize this goal: (1) Only with everyone in a single insurance system is there a chance to achieve equality in medical care; (2) international experience demonstrates that only a single payer (or closely coordinated payers acting together, the equivalent of a single payer) can control medical cost inflation; (3) only a single payer can achieve the administrative efficiencies that allow the nation to extend comprehensive health insurance to everyone without incurring burdensome new costs; and (4) a single payer provides the potential for greater public input into major health care decisions—for example, the proportion of the GNP to be dedicated to health care or the priorities given to low-cost preventive and primary care versus high-cost interventions in late or end-stage disease processes.

"If you like the Post Office," people say, "you'll love the single-payer health system."

To best achieve the goal of universal, equitable health insurance, while addressing the widespread distrust of government control, who, then, should be the single payer? Because the United States is far too large for a single payer at the federal level, we will assume that the single payer resides at the state level; to promote equality among states, a proportion of the funds could be collected at the federal level and transferred to states according to formula.

Some Single-Payer Candidates

1. A private company. This option would utilize the public utility model, in which an industry with a natural tendency toward monopoly (such as telephone, gas and electricity, or transportation) is given monopoly status by the government and in return is regulated more tightly than competitive private enterprise. Public utilities are private businesses regarded as "so impressed with peculiar public interest as to justify intensive government regulation of practically every detail of their activities." The public utility model would eliminate the argument that too much control of the single-payer health system resides in government. On the other hand, accountability to the public would be lowered, because the management's primary loyalty would be to the company's stockholders or other financial interests, rather than to the public. Because they are monopolies, public utilities have enormous clout and can often evade strict regulation by government agencies. In health care, the major candidates for public utility status as single payers would be the largest private insurers and HMOs in a given region. Overall, considerable risk is involved in placing so much power in the hands of one private company.

An alternative method for utilizing a private company in the single-payer apparatus is the fiscal intermediary concept currently functioning in the Medicare and Medicaid programs. In the early years of these programs, however, some fiscal intermediaries, who tended to be Blue Cross or Blue Shield plans, engaged in some questionable practices. The use of fiscal intermediaries is also likely to increase administrative costs.

2. A governmental department. The structure farthest removed from the public utility approach is the Canadian method of placing the single payer directly within a government department. Such an option runs directly into the political problem of big government, and means a complex and cumbersome decision-making apparatus involving the governor, the legislature with its committees, plus political and technocratic departmental personnel. It also bogs the single payer down in the quagmires of the state budget, which are increasingly contentious and paralyzing.

3. A government commission. Keeping the single payer within government but separating it from the departmental apparatus of the executive branch is another option. A commission that would include members representing interests involved in health care—both provider and consumer—could be appointed or elected. Depending on how commissioners are chosen, this option could afford some measure of public accountability. But the commission concept does not circumvent the problem of tying health financing to the legislative tax and budgetary process and thereby linking the fiscal fate of health care to the vagaries of government revenue-expenditure-deficit politics. The budgetary difficulty might be overcome by earmarking revenues for the health insurance system and guaranteeing certain revenue increases each year according to formula.

4. A public fund with decentralization of decisions to smaller regions. One mechanism for diffusing the distrust of big government is to decentralize the financing of health care. A statewide fund could be established that would collect all health revenues, but would hold no decision-making authority. The statewide fund would distribute its money to different regions of the state according to a strict formula; these regional funds would become the actual single payer for each geographic area.

The single-payer mechanism is a means to the goal of insuring everyone in the U.S.; it is not the goal itself.

Alternatively, the statewide fund might collect only some of the health revenues, while other funds are collected directly by the regions, in a fashion similar to the process used by Canada's federal and provincial governments. California, for example, has a district hospital law which allows voters in a geographic area to tax themselves in order to operate a hospital for their community. However, any mechanism that allows regional financing all but guarantees inequities, as wealthier regions tend to
Physicians for a National Health Program

Proposed National Health Program Summary

PNHP's proposal would remove all financial barriers to medical care. Every American would be covered for necessary medical care by a public insurance plan administered by state and regional boards. PNHP envisions a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States.

Coverage. Coverage would include standard medical care as well as care for mental health, long-term illness, dental services, occupational health services, and prescription drugs and equipment.

Payment. Patients would receive a National Health Program (NHP) card entitling them to care at any hospital or doctor's office. Patients would not be billed for approved medical care. They would not pay any deductibles, co-payments, or out-of-pocket costs. All approved costs would be paid by the NHP.

Hospitals. Most hospitals and nursing homes would remain privately owned and operated and would receive an annual "global lump sum" from the NHP to cover all operating costs. Global operating budgets would be negotiated with the NHP board. Funds for capital expansion would be distributed separately by regional NHP boards on the basis of health planning goals.

Physicians. Private doctors would continue to practice on a fee-for-service basis, with fee levels set by the NHP board, and would submit bills to the NHP. Physicians could bill patients only for services not covered by the plan. HMOs would receive a yearly lump sum from the NHP for each patient. Neighborhood health centers, clinics, and home care agencies employing salaried doctors and other health providers would be funded directly from the NHP on the basis of a global budget.

Prescription drugs and medical equipment. The NHP would pay pharmacists' wholesale costs plus a reasonable dispensing fee for prescription drugs. Medical equipment would be covered in a similar fashion.

Insurance. Private insurance that duplicates NHP coverage would be eliminated, saving an estimated $44 billion a year in industry profits and overhead, simplifying paperwork for doctors and hospitals, and generating additional billions of dollars of savings on providers' billing and administrative costs.

Cost containment. Costs would be constrained through streamlining of billing and bureaucracy, improved health planning, and the NHP's ability to set and enforce overall spending limits.

Funding. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution. During the transition period, the national health program could be financed from federal funds allocated to Medicare or Medicaid; state and local funds for health care; a payroll tax on employers that takes the place of employer payments to private insurance companies; and taxes on individuals equivalent to the amount now spent on out-of-pocket payments.


tax themselves at a greater rate to obtain a higher level of health resources than do poorer regions. On the other hand, the decentralized model would bring decision-making closer to the people and might be more acceptable than a centralized payer, particularly in more populous states. An additional drawback would be the administrative problem created when people living in one region obtain care in another region.

5. A public enterprise One institution that might be capable of allowing public accountability while separating the health system from state government is the public enterprise or public corporation. The public enterprise is a business that is controlled in full or in part by the government, but exists as an autonomous corporate entity with separate finances. Like any corporation, the public enterprise must be financially viable and must therefore operate as a business. On the other hand, the public enterprise has overriding social goals other than financial viability, such as promoting the health of the public. Whereas the “enterprise” concept in a public enterprise means keeping the institution financially viable, the “public” notion requires public decision making and prohibits profits (net income) from accruing to private individuals.

The synthesis between the public and enterprise concepts is a delicate balance. If it tilts too far in one direction it becomes a non-public enterprise; if it goes too far the
other way, it turns into a public non-enterprise. Public decision-making is often at variance with financial viability.\textsuperscript{12} For example, the enterprise-as-business might wish to raise prices in order to meet costs, but the social goal of access to health care might argue against such price increases. Other issues that might create tension between the public and the enterprise concepts are whether or not to have high copayments and whether to have people with higher incomes subsidize lower income people and the elderly.

In a public enterprise, decision making is diffused among the government agency that created the public enterprise, the board of directors of the enterprise, its management, and its clients. The methods of choosing the board of directors could be any combination of election at-large; election from districts; appointment by the governor, with or without approval by a legislative body; and appointment (or election) by constituent organizations, such as medical societies and business, labor, and consumer groups.

\textbf{SINGLE-PAYER WORKS}

If a public utility model is used, strict government regulation can be evaded.

\textbf{Cost Savings Value $\,?}$

A number of public enterprises exist in the United States, some with positive, some with negative popular ratings. Perhaps the most troublesome in terms of image is the U.S. Postal Service. Given the Postal Service’s proximity to the federal government and its absence of direct public representation, it is not an ideal model for a potentially more democratic, state-level public enterprise that might serve as a single payer of health services. Other examples of public enterprises are the U.S. Government Printing Office, the Tennessee Valley Authority, the Pennsylvania Turnpike Authority (tolls pay for the operating expenses and service the debt), state liquor stores, the New York City Transit Authority and transit systems in about 50 other municipalities, municipal gas and electric power companies throughout the country, and the Port of New York Authority established by the states of New York and New Jersey.\textsuperscript{13}

The public enterprise and the governmental commission are not entirely distinct entities, but can be seen as a spectrum of institutions that are closer to or farther from the parent government. The purest form of public enterprise operates on user fees and does not require a budgetary allocation from the government. Those public enterprises that do rely heavily on fiscal assistance from their parent government—for example, the New York City Health and Hospitals Corporation—are closer to the commission concept in the sense that they are heavily dependent on the legislative budgetary process.

\textbf{6. A cooperative.} A cooperative is a democratic association of persons who voluntarily organize to furnish themselves an economic or social service under a plan that seeks to eliminate entrepreneur profit and that strives for substantial equality in ownership and control. Cooperatives are owned by members who are their users, as distinguished from corporations, whose owners are primarily investors. Cooperatives are organized on democratic principles: boards of directors are elected by the rule of one member, one vote. Membership is voluntary; people can join or leave as they please. Generally, members share the risks, financial obligations, and benefits in proportion to the use they make of the organization. If a cooperative makes a profit, the surplus is distributed to the members according to how much they use the cooperative; in a cooperative food store, for example, the distribution would depend on how much food an individual or family purchased during that year.\textsuperscript{14}

For over 150 years, producer cooperatives have thrived in the field of agriculture, bringing together farmers to market their products. Consumer co-ops also exist as retail stores, and service co-ops provide insurance, banking, transportation, and telephone service. In health care, two prominent co-ops are Group Health in Washington, DC, and Group Health Cooperative of Puget Sound in Washington State.

In order to function as the basis of a single payer of universal health insurance, the cooperative principle would have to be modified to allow compulsory, rather than the usual voluntary, membership; otherwise, the services provided would not be universal.

\textbf{The major difference among single-payer options revolves around the issue of democracy.}
7. A coordinated multiple-payer system. Can multiple payers join together to form the equivalent of a single payer? The most frequently cited model is the payment structure of the West German health system during the 1980s, in which all payers and providers came together in a body called Concerted Action in Health Care to negotiate payments and implement controls on expenditures.\(^{15}\) Although this coordinated multiple payer has slowed the West German rate of health care inflation, it has disadvantages compared with a strict single payer in the areas of administrative efficiency and equity.\(^{16}\) The German example is of questionable relevance to the United States, however, because the multiple payers in Germany (sickness funds) are generally quasi-public institutions without the long history of economic competition that marks the American private health insurance industry. It is unlikely that U.S. health insurance companies and HMOs, with their growing competitive practice of skimming desirable health risks in order to increase profitability, could truly cooperate in a coordinated multipayer system.

We Must Experiment

The single-payer form of organization for universal health insurance has the potential to provide equality, cost control, administrative efficiency, and democracy in health care. All seven single-payer options outlined here have the potential to control health costs. The first six are also capable of ensuring equality and efficiency. The major difference among these options revolves around the issue of democracy. The current image of the government is of an immovable, unfeeling bureaucracy that pays no attention to the people it is designed to serve. How much voice can each of these options offer the health provider community and the general public in such critical decisions as the total size and overall priorities of the health budget?

Can one or another of these single-payer options solve the fundamental American dilemma of an undemocratic democracy? It is difficult to predict which might work the best. Perhaps the most useful approach to the question of who should be the single payer is to try different versions of these options in different states. Only real-life experiments will provide the answer.\(^{17}\)

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9. Woolhandler and Himmelstein, op. cit.
Universal Access in Canada
Questions of Equity Remain

SAMUEL WOLFE and ROBIN F. BADGLEY

Health/PAC readers will remember Samuel Wolfe's previous Bulletin article about Canada's national health care system ("Importing Health Care Reform? Issues in Transposing Canada's Health Care System to the United States," Summer 1990), in which he described the uniqueness of our northern neighbor's experience. At that time, Wolfe expressed doubt that a Canadian-like model could find sufficient political and social momentum to be propelled south. In this latest article, Wolfe is joined by his long-time colleague, Robin Badgley, to discuss the inequity and inequality they believe still exists within the Canadian system.

Wolfe and Badgley's insightful analysis of what they see as shortcomings of the Canadian model and suggestions for their remedy are especially welcome given the questionable validity of most criticism of the Canadian system that Americans hear. Their work helps us understand the real problems that remain in the still-evolving Canadian system.

As Americans discuss the various possibilities for progressive single-payer reform, many envision a state-based system. Wolfe and Badgley point out that demographically rooted inequalities and the lingering health burdens of social class may interfere with truly national universal access. They also alert us to the dangers that federal retreat from adequate levels of support would pose to such a state strategy.

Samuel Wolfe has a unique background as a country doctor, psychiatrist, and public health official who attended the difficult birth of Saskatchewan's provincial health plan—the prototype for Canada's national health insurance. A respected teacher, researcher, and community health activist, Wolfe has taught in the United States for more than 25 years. He will soon move back to Canada and the welcome security of its universal health care system.

Thirty years ago, in May of 1962, one of us, Sam Wolfe, was a commissioner of health insurance in Saskatchewan, and had made plans to fly overseas to try to organize an airlift if the medical profession went ahead with its threat to withdraw all except emergency services if the government went ahead with its plan to pay doctors' bills and certain other bills for the entire population of that province.

We want to talk about the persistence of inequity and inequality in health care in Canada in spite of the universality of national health insurance, which is threatened as never before by Ottawa's abandonment of the federal-provincial cost-sharing formulas.

We have been concerned with the question of equity since day one. In our book on the Saskatchewan doctors' strike, we noted:

There is no direct cause-and-effect relationship between the introduction of medical care legislation and the health of the population. The poor suffer more sickness than those of average or higher income. Public health and welfare programs, as now conceived, do not have their intended or desired impact on the population.

The poor and the poorest were increasing as a proportion of the population, Abel-Smith and Townsend pointed out, saying that this contradicted the commonly held view that a trend toward greater equality accompanied the trend toward greater affluence. Shades of the 1990s!

We went on to quote from the late Richard Titmuss:

Many of us must also now admit that we put too much faith in the nineteen-forties in the concept of universality as applied to social security. Mistakenly, it was linked with economic egalitarianism. Those who have benefitted most are those who have needed it least.

Is there, in fact, reasonable access to uniform health benefits provided on a basis to meet variable individual needs? Have gaps in health status between the poor and other Canadians narrowed as a result of social security programs, including national health insurance? And is
The basic fallacy was the belief that a single program could eliminate problems of access at both the individual and structural levels.

Since the passage of the Medical Care Act of December 1966, the plan’s basic features have remained the same. The financing formula and its administrative conditions have been renegotiated and redefined, however, especially with the Established Programs Financing Act of 1977 and the Canada Health Act of 1984. The doctors’ strike in October 1986 protested the banning of user fees by hospitals and extra billing by doctors. As a consequence of the Canada Health Act, uninsured services such as telephone advice were charged for and fees were levied for missed appointments or special examinations, and the volume of claims increased in number and were more expensive. This of course is an old story. After we established a professional review committee in Saskatchewan in 1964 and we installed the computer as a cop, it was embarrassing to find doctors who charged for house calls on members of their own family.

**Regional Disparities**

Aggregate wealth and standards of living in Canada have shown sharp disparities over the years, with the Maritime provinces lagging behind the rest of the country. National Medicare gave an essential threshold of benefits for all in the country, and there was a substantial leveling of long-standing disparities in the distribution of physicians and hospital beds, even though significant high-low gaps endured. But the poorer provinces spent more of their taxes on health care than did the better-off provinces, spent less on each individual, and provided a narrower range of certain services, especially in new technologies. The Maritimes have spent almost double their provincial revenues in the Maritimes and as little as 12 percent in Alberta. Although disparities remain, the distribution of physicians across the country has markedly improved. In 1986 there was one physician for every 467 residents of British Columbia and one for every 764 residents of New Brunswick. We clearly have a glut of doctors in Canada and too many in the pipeline—though, admittedly, a glut of doctors in Saskatoon or Edmonton or Vancouver provides little satisfaction if you are in one of the many Canadian towns with over 500 population that have no doctors at all. In a way it is a sad commentary on the preparation and training of the new breed of family doctors on which Canada prides itself that there have been such failures to recruit for rural practice.

With respect to social welfare benefits, the Maritimes again lag behind in amount of payments to single-parent families and disabled persons. With respect to computerized axial tomography, diagnostic ultrasound, coronary bypass surgery, hip replacements, and renal dialysis, again the four provinces with the lowest per capita incomes have the lowest rates. Genetic prenatal diagnostic screening in Canada is clearly more readily obtained by women with higher incomes and greater education; for example, although 60 percent of women over age 35 in Manitoba live outside Winnipeg, in that province 85 percent of referrals for genetic diagnostic services come from Winnipeg.

Overall, substantial gains have been made in providing front-line services, and infant mortality and longevity have become more uniform than in the past. But differentials in spending per capita on health care and in the availability of some services serve to perpetuate differential access by individuals, especially to highly specialized services that tend to be located in tertiary-care urban hospitals.

**Class and Access to Medical Care**

During the past 50 years there have been several dozen studies looking at the social and economic backgrounds of individuals and their use of health services. The earlier studies in particular, rather than the more recent ones, clearly recognized the concept of poverty; the relationship of social class to access to care and to the impact on bad health; and the identification of high-risk groups, the unemployed, the disabled, and the needs of poor children.

During the Great Depression of the 1930s, studies were carried out by Marsh and his colleagues in Montreal; they concluded that “if medical care is a contingency left to each individual to secure as best he can, it becomes a function of the distribution of wealth.” The study team cautioned that preventive practices, including improved diets and better housing, rather than the “ambulance work” of medicine alone, were indicated. In 1975, 37 years later, Marsh reiterated that “in every civilized country, no social service is more basic than that of health care...yet it is sad to say that the record reveals every variety of compromise and resistance.” Subsequent pre-Medicare studies, including the Canadian Sickness Survey of 1950-51, confirmed and elaborated on Marsh’s findings. Individuals with higher incomes were more likely to get health care, and there was a strong inverse relationship between income and amount of disability reported.
Inus, before Medicare, the evidence was substantial and consistent in showing sharp class divisions in occurrence of illness, use of services, and expenses incurred in receipt of health care. The needs of high-risk groups—the poor, particularly children, the unemployed, and disabled—were clearly identified. These early studies relied on a broad range of class measures and health status indicators. These studies in general focused on a comprehensive concept of health and encompassed use of a broad range of services and the physical and mental health of individuals, disability, and longevity. Marsh in particular tried to identify the social and economic factors associated with health care inequalities.

After the institution of Medicare, more than two dozen studies have focused on use of health care services by social class. About one-third said that class differences had been eliminated, a quarter that the poor were using more services than before and more than the well-to-do, and the rest said that use was still directly a function of class position. If these studies were to be believed, the national program would have achieved a progressive redistribution by class in the use of health care services.

However, a closer examination reveals little room to be sanguine that the gains are substantial or genuine. Most of these studies were restricted to analysis of a single service; many did not distinguish the nature, level, and quality of care given; and in some cases the research design and methods used were seriously flawed.

The studies most often cited in favor of pro-poor outcome were the before-and-after appraisals done in Montreal between 1969 and 1972. These studies indicate that the overall use of medical services had not risen, but that the number of visits by the poor had increased and the number of visits by the well-off had fallen slightly. For accurate assessments of how services are used, self-reports and official records should be used. When this has been done, the persistence of a positive relationship between social class and use of services has been confirmed.

Several national health surveys were carried out between 1978 and 1985. Insufficient attention has been given to income-related analysis in these studies. Classification has been inconsistent and has precluded analysis of health care use and ill-health among those below the poverty line. Income information was variously assembled for individuals, for families, and for households. A sophisticated knowledge is not needed to know that unless you have family size, class distinctions become meaningless. In Toronto, for example, the poverty cut-off was $10,668 for an individual and $21,708 for a family of four. In the absence of this distinction, the economic situation of a single middle-class person related to use of health services equates with a family of four in poverty, further com-
pounded by the exclusion of children from the analysis. The 1978-79 national health survey, among others, contained a systematic class bias by excluding individuals from the Yukon, the Northwest Territories, the isolated regions, Indian reservations, the homeless, and those in institutions, including the mentally ill, the elderly, and patients in general hospitals. This is not the place to pick holes in the work of others, but sometimes conclusions grounded on analytic assumptions may be more an artifact of the research techniques used rather than a reflection of the real life experience of those being studied. It is hardly surprising, then, that use of multivariate statistical techniques accounts for such a small percentage of the variance, and the researcher concludes that there is no relationship between class and health care use.

Preponderance of Evidence

The preponderance of evidence, we believe, supports a pro-rich outcome. In 1951, the top quintile of Canadian households received 42.8 percent of the income, and the bottom quintile received 4.4 percent. In 1990, the top fifth received 42.1 percent and the bottom quintile got 5.2 percent. The income disparity between the poor and the not-poor has remained almost constant over the past four decades. With full coverage under Medicare in Saskatchewan, people with low incomes generated far fewer dollars of health care costs than those with higher incomes. When hospital user fees were assessed for a period of years, the poor, the elderly and those with larger families were most negatively affected. Other studies have shown the same thing, that benefits received are higher as income increases and, further, that higher income groups use more specialist services, while the poor obtain a significantly higher share of their care at hospital clinics and emergency rooms than do the non-poor.

Beyond coverage by national Medicare, some provinces have had added benefits, but it should be remembered that health care costs include the costs of additional insurance, dental care, drugs, appliances, eyeglasses, and extra bills for services not covered by the provincial plans. Also to be included are the costs of lost pay, transportation, and the provision of follow-up care for services not paid for by the provincial plans.

Equality of opportunity of access did not provide for equality of access in terms of benefits received.

It was flat out wrong for a former deputy minister of health to have said to an international audience that under the Canadian system there is no direct financial burden on the patient, and that the only deterrents to the patient are the time and trouble involved. There is no evidence for the claim made by some researchers that out-of-pocket expenses have been eliminated. High-income families spent 4.5 times as much on health care than low-income families in 1964, and 3.9 times as much in 1982. The proportionate burden on the poor was higher in both years. In fact, the effect on the middle- and upper-income groups of providing coverage for all has been to enable them to get more services, more specialized services, and more sophisticated health benefits than the poor.

Different opportunities, health risks, and life chances exist in Canada for the poor and the non-poor.

Our review of a large number of studies tells us that we should raise the seldom-discussed issue of the effect of political philosophy inherent in the design of health survey research. Since the close association between demographic and socioeconomic variables is well known, the sequential ordering of information in statistical analysis is highly relevant. On the one hand, when social and economic variables are positioned secondarily or as intervening variables, coupled with fuzzy definitions and inadequate controls, their explanatory power tends to be minimal. On the other hand, if distinctive criteria of economic opportunity, such as unemployment, single parenthood, certain handicaps including disability or minority group status, or other clear measures of class are employed, and these are made the lead or primary variables for analysis, this allows for conceptually focused targeting to find out the degree of association with the use of health services. Our review underscores the need to develop more discriminating outcome measures of health care use.

Our central conclusion is that national Medicare in Canada has perpetuated class inequalities that still characterize the way health care is obtained across the country. We think those studies that have shown a pro-poor or no relationship conclusion can be discounted because of defects in analysis, defects in controls, lack of longitudinal baselines, or combinations thereof.

Most Canadians have made extensive use of hospital and medical care benefits. The gain made was the provision of a common denominator of access to services for all the residents of Canada, no mean achievement. But this equality of opportunity of access did not provide for equality of access in terms of benefits received. The amount of care for all has gone up, but this gain has done little to alter existing class differences in getting or providing care. To have expected more of a single measure like national Medicare, as the earlier comments by Titmuss and Abel-Smith and Townsend indicated, was to expect more than the legislation promised, and more than most politicians have claimed.

Health Status and Longevity

The same cautions that we indicated in interpreting the findings of utilization studies apply also to reports of association between class and health status. A volume
between 1972 and 1988, and while improvements in health status, especially for the poor, are clearly attainable, whether they are achievable in the context of existing class divisions in Canada is another matter.

Options for Change
The first issue, of course, is the abandonment by Ottawa of the federal-provincial cost-sharing formulas. Under the original Medical Care Act of 1966, higher equalization transfer payments were made to the poorer provinces to promote interprovincial equalization. Since the Established Programs Financing Act of 1977, which transfers funds to the provinces for their hospital and medical care programs and for support of postsecondary school education, the federal proportion of sharing health care costs with the provinces (which was supposed to be averaged at 50 percent of national per capita costs) has sharply plummeted. Further revisions of the 1977 Act, in 1982, in 1987, and again in 1989, have further restricted federal funding for health care to the provinces. In 1980, Ottawa provided 44.6 percent of provincial health care financing; the estimate for 1990 was 36.7 percent. We estimate that by 1995 at the latest, the federal contributions to the provinces will be down to 30 percent as a proportion of provincial health expenditures, leaving the provinces to make up the difference. It is clearly a fantasy for Ottawa to expect the provinces to adhere to the terms of the original Medical Care Act and the Canada Health Act of 1984 in the face of these cutbacks.

Four interrelated phenomena are operating in Canada at present. First, all over the world there is growing momentum toward greater cost containment and imposition of tighter ceilings on health expenditures. Second is the demography of a falling birth rate and a greater number of elderly. Third, the Canadian constitutional impasse has led to a structure that strongly favors provincial and not federal powers, guaranteeing the further widening of regional and local disparities. Finally, the free trade agreement of late 1988 with the United States will serve to further weaken east-west ties within Canada in favor of north-south ties. It is likely to lead to a taxation policy in Canada that is even more favorable to the rich than at present, with resulting pressures in the direction of privatization and restrictions on universal entitlement programs.

Now is not the time to lose sight of what we started to achieve with the passage of hospital and medical care acts, the centerpieces of the Canadian health care system, the cornerstones of our financing for health services of which we and many others are so proud! There are encouraging harbingers. For example, there is a growing recognition
that reordering the basic features of Canadian society, such as assuring income adequacy, providing a safer ecosystem, and improving political and cultural well-being, are basic prerequisites for the attainment of better health for all Canadians. This sounds like Leonard Marsh of the 1930s and 1940s resurrected for the 21st century!

For better or for worse, Ottawa is the only senior government that Canada has got, and it should not be afraid to act like a senior government on issues that touch the lives of all the residents of Canada. Ottawa should seize upon a number of initiatives that will begin to restore its waning authority in health policy formulation for the Canadian people. The full evolution of these initiatives will take 10 to 20 years, but we must make a start.

This is said in context of the fact that the federal government collected two-thirds of income taxes 20 years ago compared to less than one-third currently; the other two-thirds accrue to the provinces.

The first step is for the federal government to tell the Canadian people in all candor that it is impossible to give everyone everything that the science and art of health care is able to provide without bankrupting the country and robbing other essential programs of their resources. This means that resources have to be allocated on a more equitable, rational basis. Not even 1 percent of provincial health care budgets is now spent on health education or on public education about the cost, quality, and organization of our health services. It is urgent that this type of education begin at both the federal and provincial levels.

By 1971, Canada had already surpassed the doctor-population ratios projected for 1991 by the Royal Commission on Health Services in its 1964 report. Under the fee-for-service system, no province is in a position to put a limit on its number of doctors. Doctors in any province who are licensed can put up their shingles and practice anywhere, at any time, and in any number and immediately be paid by the public purse. In 1973 we proposed the concept of a “medical establishment,” an agreed upon quota of doctors for each province, suggesting that while this posed political and professional dilemmas it was a realistic step. Now, 20 years later, the chickens have come home to roost. Between 1975 and 1981 the number of doctors in Canada increased by 2.7 percent per year; the population increased by 1 percent per year; between 1981 and 1987 the number of doctors increased by 3.5 percent per year. Since the courts have ruled that restricting the number of doctors who can bill is unconstitutional, other severe actions are indicated. The suggestion of Rachlis and Kushner that enrollment be decreased by 30 percent in all Canadian medical schools is sound, and preferable to closing some medical schools. At the same time, in years to come, pressure from other highly trained health professionals will grow to achieve closer income parity with medical doctors; it was not handed down with the tablets on Mount Sinai that physicians in perpetuity ought to be earning four times the income of other taxable workers.

There is a long agenda of other potential reforms in the Canadian health care system waiting to be implemented. Research indicates that between 15 and 30 percent of medical interventions do not benefit the patient; there is an urgent need to assess which technologies work and which do not, and to link this knowledge to increased research on health outcomes. There is an urgent need to reduce sharply the fees paid for procedures of little or no effectiveness. There is an equally urgent need to cut back on the still great incidence of surgical procedures of limited effectiveness (tonsillectomies and hysterectomies, among others). The high incidence of caesarean sections is a national disgrace, as it is in the United States. There is compelling evidence to start to implement on very large
scale the Canadian provincial examples of community health centers.30

Health rights ought to be enshrined in a proposed Social Charter for Canadians.

Our still largely open-ended hospital system in many locations, including metropolitan areas, does not have formal review mechanisms about length of stay, about preadmission diagnostic testing, about pre-discharge planning, and coordination with posthospital services. Across the country, surgical procedures make up about 4 percent of the health services rendered but use about 20 percent of our medical care dollars. Disease prevention, health promotion, and health maintenance are issues still honored often in the breach. We still cling to a biologically oriented medical model, rather than a model that explicitly includes social and environmental factors—a biosociomedical model. Failures in reforming professional governance and regulation, especially in personnel planning, have meant the further significant growth and continuing dominance of the primary health professions and the suppression and retardation of the development of substitute personnel and their training. A massive effort needs to be energized in the years ahead to deal with a variety of community-based alternatives to both short- and long-term care in our institutions.

All these efforts taken together by the provinces could cut their health care costs, we estimate conservatively, by at least 15 percent. The trade-off would be for the federal government to increase transfer payments under the established program financing formulas, coupled with reestablishment of equalization payments to the poorer provinces, in return for federally monitored provincial control of unnecessary procedures in the health care area and steps to assure the safety, effectiveness, and high quality of services of the health care system in all the provinces and the two territories. To move quickly in the direction of a more equitable system, the Canadian tax system has to become fairer. Rooting out poverty among children has to mean ensuring their parents a minimally adequate income, especially for women raising children by themselves. These measures have to be accompanied by community economic development and programs for skills development, adult literacy, and day care for children. Finally, it doesn’t have to happen by tomorrow at noon, but in the not too distant future, health care rights ought to be enshrined in a proposed Social Charter for all Canadians. 

13. Steinmetz, N., and Hoey, J. R., “Hospital Emergency Room Utilization in Montreal before and after Medicare; The Quebec Experience,” Medical Care, 1978:166, pp. 131-139.
29. Some of these issues are discussed in Deber, R. B., and Thompson, G. G., eds., Restructuring Canada’s Health Services System: How Do We Get There From Here? Toronto: University of Toronto Press, 1992.
The story of what happened to our hospitals in their most turbulent decade isn't just about avarice, callousness or stupidity. It’s also about well-intentioned men and women who tried to make an unmanageable situation better. That they failed isn't an indictment of their personal shortcomings. It is an indictment of a health care and hospital system that is not really a system at all but a cobbled-together collection of policies that too often harms rather than heals. Ultimately, it is a system built upon medicine’s great white lie, a myth holding that hospitals and doctors are equally good and deserving of our complete, unquestioning trust. That such a belief should still prevail in this country is as disgraceful as it is dangerous.

So ends the prologue of Walt Bogdanich’s The Great White Lie, a gritty tale of health care horrors guaranteed to change a reader’s perception of hospitals and doctors—and not for the better. This book may affect the nation’s seemingly insatiable appetite for more health care services in a manner reminiscent of what Sinclair Lewis’s revelations about the meat-packing industry did (or didn’t do) to the collective appetite for sausage many decades ago. Bogdanich, who won a Pulitzer Prize for his Wall Street Journal expose of Pap test cytology (labs farming out specimens as take-home piece work by unqualified personnel, and worse) uses compelling, well-detailed stories to illustrate what he sees as the fall from grace of America’s health care providers.

The Great White Lie is an important book because it describes in chilling, human terms the destructive effects of more than a decade of federal policy focusing on provider interests (competition and deregulation) rather than the public interest. Bogdanich occupies a unique place among those journalists whose beat is the U.S. health care system. The depth of his investigative work is second to none, unearthing stories of behavior so venal and outcomes so tragic that they are sometimes almost unbelievable. But with such a sick system, such strong medicine is necessary if we are ever to make it well.

Putting a Face on Suffering

The book is organized into three major sections. The first, “Cutting Corners, Plugging Holes,” chronicles the human consequences of an acute national shortage of nurses, trained pharmacists, and other professionals. It puts a face on the suffering endured by seniors as a result of medically premature and unplanned hospital discharges under the diagnosis-related group (DRG) system of Medicare reimbursement. Included are vivid descriptions of nursing agency scams that end up killing and injuring patients at the same time that they oppress poor and immigrant female employees and defraud the government for tens of millions of dollars.

Part Two, “The New Ethics,” starts by exploring DRG-related fraud and abuse discovered by the General Accounting Office (GAO) during the 1980s. Bogdanich describes in detail the fallout from the federal government’s failure to audit, oversee, and punish providers’ manipulation of Medicare’s DRG reimbursement system (mainly through a process known as DRG “creep”)—resulting in overpayments totaling an estimated $1.5 billion in 1991 alone.

Another story chronicles the tactics large proprietary hospital chains were willing to employ to make up for their bad business decisions. The Hospital Corporation of America (HCA) tried to use its financial muscle to “bribe” a number of providers in Monroe, Louisiana, to send their patients to HCA’s struggling, vastly underutilized new 100-bed facility in nearby North Monroe. As HCA’s hospital continued to experience low occupancy rates, the corporation set out to destroy Monroe’s own community hospital. HCA’s tactics included stealing patient records, illegal computer entry, and financing physician practices to compete directly with those of Monroe doctors who would not play along with HCA or had otherwise had fallen out of its favor.
Bogdanich spotlights the "new ethics" of the Reagan era by telling how hospitals "buy" patients through bounties and kickbacks to doctors to encourage admissions. In one such scheme, hospitals purchased scanners for doctors and then allowed the doctors to pocket profits while holding them harmless from any losses. Another kickback involved appointing a consultant to a do-nothing hospital committee at fees of $1,000 per hour. Although 36 states have laws that prohibit doctors from getting or giving payments for patient referrals, there is almost no monitoring and thus no penalty. The federal government spent more than three years writing guidelines that address patient-buying schemes, but they are too weak and without sufficient enforcement resources to be likely to make any difference.

As the lone defender of those patients (and taxpayers) victimized by unethical and criminal health care providers in the deregulatory Reaganomics wilderness, GAO's aggressive Inspector General Richard Kusserow found himself the subject of the wrath of the American Medical Association, which called for his resignation in September 1990. The AMA was joined by the American Hospital Association in its accusations that Kusserow was unfairly "harassing" providers. Perhaps worn down by the attacks on his integrity and tired of having to fight increasingly stronger provider lobbies and influence in a deregulatory climate, Kusserow resigned in late spring of 1992.

The last part of Great White Lie focuses on the destruction of programs to oversee the quality of medical and hospital care during the 1980s. "Absent Watchdogs" describes the malfeasance of state medical licensing authorities in discovering and punishing negligent and bad doctors and, in a story near and dear to this reviewer's heart, the uselessness and secrecy of the hospital industry's own oversight process. Bogdanich recreates a vivid and prefigurative scene that took place at New York's Waldorf Astoria in 1919: the midnight burning in the hotel furnace of a list of substandard hospitals that had been collected by the American College of Surgeons in its ground-breaking efforts to improve quality. This great fear of public disclosure of bad hospitals remains characteristic of the attitude of doctors and hospitals as well as the Joint Commission on the Accreditation of Health Care Organizations toward public disclosure to this day.

Accountable to No One

In his epilogue, Bogdanich, writes that:

A humane society recognizes that government, too, has a role to play in driving the dishonest, incompetent, or wasteful medical provider from business. Patients need the protection of better laws, better regulation and enforcement, truly independent investigators, and public disclosure of more than just the most flagrant abuses.

But he also notes that the prospects for broad federal reform are not good, in large part because of the growing strength of the health care industry lobby. Unfortunately, this scenario is now also being played out at the state level. (See "Quality and Medicaid Managed Care" in this issue for a description of industry-led attacks on state regulation).

This is a time when a unique confluence of events and perceptions have provided the health care industry with the opportunity to campaign hard to rid itself of "bothersome" regulations and oversight. A faltering national economy, the perceived competitive realities of a "global economy," state budgetary crisis, strong inflation pressure, and a public perception that less government is preferable to more have allowed health care providers to become accountable to no one—and to claim that that is in the public interest. Hopefully, the gripping stories in The Great White Lie will increase public awareness of and opposition to the growth of medical-industrial lobbies in Washington and state capitols. Only a sense of public outrage will give legislators the courage to enact strong oversight regulations with adequate resources to protect the public from harm.

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Infertility and Choice

For many, the popular slogans "reproductive rights" and "pro-choice" mean only the rights of fertile women to control their fertility. Loretta Ross's article ("In Pursuit of Perfect Choice: Feminism and Reproductive Technology," Summer 1992) falls into this same trap. Noting the controversies over high-tech solutions to infertility such as in vitro fertilization, she asks, "Why do infertile people feel they must have children this way?" The obvious answer is because it is the only way that they can bear children. The inability to have a deeply wanted child is a very painful disability.

Supporters of reproductive rights take the position that it is wrong to judge the reasons why women have abortions. How can it be right to judge women who choose fertility treatment to have wanted children?

Ms. Ross suggests that the answer to infertility is to invest in research "to prevent infertility, rather than in risky and questionable solutions after the fact." Some infertility is caused by venereal diseases and pelvic inflammatory diseases which can be prevented (like pregnancy and AIDS) by the use of condoms. The withdrawal of the Dalkon Shield and other IUDs that cause pelvic inflammatory disease and the discontinued use of DES may reduce infertility. However, there is in fact no reason to believe that most infertility is preventable. Infertility is often caused by ovulatory dysfunctions and endometriosis. There are also people who become infertile as a result of cancer treatment who can later become pregnant using previously frozen eggs and sperm. It is a lot easier to prevent pregnancy through consistent use of effective contraception than it is to prevent infertility.
Of course, since fertility does decline with age, particularly after 35, one way to prevent some infertility would be to encourage women to have children in their 20s rather than wait until their 30s. However, even those groups which practice monogamy and youthful childbearing, including Mormons and Orthodox Jews, have significant numbers of women with fertility problems.

The stereotyped fertility patient is an affluent, white woman who is in her mid- to late thirties and delayed childbearing either for professional reasons (first get tenure, get a medical license, or make partner) or because she did not have an available mate. She is in fact a typical feminist who thought she could have it all. Feminists should have compassion for women who followed the advice of the women’s rights movement and built their careers first before trying to have children.

The facts are clear that infertility strikes women and men of every race, ethnic origin, and income level. Fertility treatment is usually not covered by health insurance. Insurance companies don’t consider fertility treatment “medically necessary” on the grounds that people can live without children. Feminists should support Resolve (the national support group for people with fertility impairments) in its efforts to make insurance coverage available so that women of all income levels may have access to fertility treatment.

It is amazing that people who wouldn’t think of adoption as the preferred solution to unwanted pregnancy think that it is the best solution to infertility. While adoption is the first choice for many infertile people, adoption is difficult for others. Adoption is expensive, rarely covered by health insurance, and not tax deductible. Some adoption agencies and lawyers take money from infertile people and never provide a baby.

Many people consider adoption, particularly adoption of children born in Third World countries, to be exploitation of poor women. The latest edition of Our Bodies, Ourselves includes a statement from CUB (Concerned United Birthparents) about the exploitation of birth-

parents; they believe that adoption wrongly breaks up a single-parent family and that birthmothers should receive support, both financial and emotional, that enables them to parent their children.

The children in greatest need of homes are older than 4, members of sibling groups, or have disabilities. While it is wonderful for people to make the choice to parent these children, these children deserve parents who genuinely want them and have the ability to cope with the challenges that such children provide.

Infertile women who want healthy babies who have received good prenatal care are no different from their fertile peers who undergo amniocentesis and other genetic tests to assure themselves of a healthy baby. As many have said, life is not fair. Some 15-year-old crack addicts are pregnant with a second child, some are pregnant with their fourth or fifth child, and some women can’t get pregnant without medical intervention.

While life is not fair, there is no reason why the feminist movement and progressives should not be fair. For the slogan “pro-choice” to mean anything other than “pro-abortion,” reproductive rights advocates should support the right of infertile women to have choices too, including the choice to use modern science as well as the choice to adopt.

ELLEN M. SAIDEMAN
New York, NY

Loretta Ross replies:
First, let me set the record straight. I too am an infertile woman. I lost my ability to have children at the age of 23 and have often considered many options for how to ful-
fill my dream of having a large fami-

ly.
I am also a pro-choice activist who does not agree that pro-choice simply means pro-abortion. For me, as I said in my earlier article, pro-choice means the right to have or not to have children, and the necessary social supports to make these choices meaningful.

Thus, your characterization of the movement and my article was very unfair. I defend that portion of the article that criticizes the use of poor, fertile women to have children for more well-off women. This is nothing more than economic exploitation, and the ends do not justify the means. Secondly, I am not against scientific advancements, as my article also made very clear. I merely point out very important ethical considerations that must be incorporated because our scientific abilities challenge our social inequalities.

And finally, your gratuitous attack on crack-addicted women was both unnecessary and revealing. I don’t judge who should have children—I merely speak against women exploiting other women, no matter how noble the cause. Use all the medical science you choose, but permit me the right to criticize your choices if they involve the exploitation of other women. I’d like to close with a historical reminder. A century ago, white women thought it was okay for their husbands to rape their black slaves if it protected their mistresses from unwanted sex and pregnancies—a form of birth control, if you will. Such a system was not feminism—it was racism.

In sisterhood,

LORETTA J. ROSS
Atlanta, GA
behind-the-scenes view of what the state legislature hopes becomes whether it offers an opportunity to build a Robert Padgug’s interview with Rachel Block provides a managed care as enlightened policy, she argues, now that threat of this new state policy. While few advocates for the poor would have chosen mandatory managed care as enlightened policy, she argues, now that managed care is a reality, the relevant policy question becomes whether it offers an opportunity to build a primary care system responsive to the needs of the poor. Robert Padgug’s interview with Rachel Block provides a behind-the-scenes view of what the state legislature hopes to accomplish in enacting this major shift in Medicaid policy. It also gives us a sense of the desperation of the state’s social policy options in the wake of a 12-year federal policy of withdrawing support from state programs combined with a deep, lingering local and national recession. Hal Strelnick and Richard Younge provide a more positive view of the opportunity Medicaid Managed Care provides for nurturing primary care—as well as a portrait of primary care as it could and should be—as they recount the experience of a community-oriented, primary care center in the Bronx. Finally, I report on the political struggle over state quality assurance policies that will seriously impede the New York State Department of Health’s ability to monitor the quality of care for the hundreds of thousands of new Medicaid Managed Care enrollees.

For many advocates, the history of Medicaid Managed Care does not instill confidence in its chances for success in New York. A number of previous efforts in other states to utilize a similar approach of prepaying a fixed per capita amount for the health services of Medicaid populations have resulted in poor quality and outright fraud. The mandatory aspect of New York’s program runs counter to federal efforts to reverse the isolation of Medicaid beneficiaries who are outside the “mainstream” of health care. It also brings to the fore concerns over the ability of providers to rapidly absorb almost 1.5 million new enrollees and assure a reasonable standard of appropriate and high-quality services. Even those who recognize that Medicaid Managed Care will at least offer primary care to millions who must now go without it worry that this bittersweet benefit is a fragile trade-off. Unaccountable to those it serves, New York’s Medicaid Managed Care program cries out for an aggressive monitoring effort by advocates for the poor so as to minimize further harm to those in our community that can least afford it.

The rest of the Bulletin focuses on the much-maligned alternative in the health care debate: the single-payer insurance system. Thomas Bodenheimer, a physician and active member of Physicians for a National Health Program, postulates that the single-payer approach to reform suffers politically from the country’s deep-seated distrust of government. As a result, he argues, those who support the concept of having one entity responsible for paying all health care bills (and he urges us all to do so) need to do two things: convince people that government isn’t all bad and, more important, devise creative approaches to the single-payer model that could minimize the government’s ineptitude.

Samuel Wolfe’s article on the Canadian experience may provide some answers for the questions Bodenheimer poses. A single-payer system combining federal funding and organized at the state (or provincial) level may not inherently provide adequate remedy for longstanding regional economic and social class inequities. In addition, the level of federal support may not be sufficient to address these inequities, and if it declines may in fact exacerbate them. As Bodenheimer illustrates, such detailed critiques of the Canadian system and other variations on the single-payer approach can only enhance our participation in the health reform debate here in the United States.

—Arthur Levin
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