To the Editor:
Your Body English column is wonderful! Articles on health written in plain English with scientific references and without condescension are as welcome as they are rare.
Rachel Holcombe
Seattle, Washington

To the Editor:
I want to congratulate the Health/PAC Bulletin for being the only magazine I know aside from Road & Track which has not had an article on herpes.

This alone justifies renewing my subscription.
Will Grant
Holyoke, Massachusetts

(continued from page 4) provide people with firm but subtle hints that they aren't welcome. For those who need a stronger prod, the techniques she mentioned include lengthy waiting times, a cash deposit requirement, elimination of parking facilities, and unlisted phone numbers for hospital emergency departments. If non-payers are still desperate enough to keep coming, she noted that the hospital can move its ambulatory care programs out into "satellite" facilities, and "services disproportionately used by Medicaid and non-paying patients should be eliminated." To avoid any liability for the consequences, she advises, hospitals may want to alter their corporate structure.

Even so, she warns, "No doubt some hospitals will be criticized for abandoning the poor."

Not by us. We're gratified to know that although the War on Poverty may be over, the American Hospital Association is still doing its part to eliminate the poor, not only from the hospitals, but from the face of the earth.
**Health/PAC Bulletin**

**November-December, 1982**

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**Notes & Comment**

More over Adam and Eve. There's a new conflict in town, and it isn't on cassette.

This classic conflict pits public against private health and medical information systems. Although its outcome may be years away, it has already inspired articles and editorials in publications such as *New England Journal of Medicine* and *Annals of Internal Medicine* as well as somewhat less reliable but very important book-length technical memoranda. A prominent figure from the Congressional Office of Technology Assessment notes that: "Government-run health and medicine information services have a long history in the U.S. The forerunner of today's National Library of Medicine began in 1879. The NL's index to biomedical literature was a pioneer in the computer era, morning or night in 1964. By 1981 almost 2,000 institutions had hooked up to its MEDLARS data retrieval system, which logged over two million queries. Volume has doubled in the past four years alone as thousands of users—primarily researchers, clinicians, and health science students— learn the joy of saving hours of time in the library at a relatively low cost. Natural... the resounding success and growing popularity of a public sector institution has aroused considerable hostility from the rapidly expanding private information industry. And the major firms have chortled. Among the information retrieval services:

"Data Retrieval Information Service (DCS), a subsidiary of Lockheed..." System Development Corporation, a subsidiary of Burroughs..." Bibliographic Retrieval Services (BRS), a subsidiary of the Dutch multinational Thysen-Bornemisza... Among the information retrieval services:

"Excerpta Medica, a subsidiary of the Dutch publishing giant Elsevier, EM has hired a Washington law firm to lobby as an American Association for the Advancement of Science and the National Academy of Sciences..." Information Retrieval Ltd. (IRL), a British-owned company specializing in biological and medical sciences, has just announced a new line of literature announcements, unpublished reports, etc."

"Researchers, a bibliographic database database service based in the private, profit-oriented firm for Scientific Information, a Philadelphia-based firm..." Through this company, the government is involved in the industry's business. They are charging that the "provision of subsidized information services by government at low prices (or no cost at all) is blocking and delaying the ability of the market economy in information to deliver low priced information to everyone..." IIA president P. Zumbrowski has gone on to accuse the government of taking unfair competitive advantage of its prestige and the perception that "Government-sponsored information goods and services are reliable."

Even under the Carter Administration, the Office of Management and Budget echoed this theme with a 1979 Circular 36 around the same time. It noted that the "Government should not compete with its citizens..." Ronald Reagan, in his January 1981 address to Congress, made the following declaration: "The government's business is not to be in business."

"...but not in the industry..." However, as we mentioned earlier, this is the public sector role in creating the private services. BIOSIS received its early support from the National Science Foundation... Excerpta Medica was helped along by grants and contracts from the U.S. Public Health Service..."
case is not for the most part servicing the same market as the private firms. According to the Office of Technology Assessment memorandum, almost 60 percent of the online hookups to the NLM's MEDLINE data base are in hospitals and academic institutions, and only 10 percent in commercial organizations. In contrast, only 28 percent of DIALOG is in academic and other non-profit institutions (as percentage of commercial users is proprietary information); for SLIC, the figures are 65 percent private and 20 percent academic. After a careful examination, the OTA concluded that the NLM was not in competition with either of these two firms although a third, BRS, does find in majority of its clients in academia.

The study went on to note that all of the private search services can sell access to the NLM's MEDLINE data base, setting the rates their own way. In November, 1982, for example, DIALOG was charging $55 an hour for a MEDLINE search, which was then charged $45 an hour for a MEDLINE search, which was then enjoyed direct access purchased for only $22.

However, the opposition to public information services is not purely ideological. Like all well-run corporations, those offering health and medical data are concerned about the future as well as the present. They realize, as the radio and television industries have shown so well, that the most effective way to eliminate the government's distribution and providing access to information is in the initial stages of the medium.

By the time this Center Administration's ORB report came out urging emphasis on public sector computer information services, the medical data base industry already had annual revenues of $8 billion, and growth of 30 percent a year was predicted for 1980 and 1981. New entries are appearing for a piece of the pie, including a disease-related information system launched by the American Medical Association and General Telephone and Electronics. The private firms could not have a stronger ally than the Reagan Administration, which is committed to curtailment of government services, and eliminating of any public competition with private enterprise. Already the National Center for Health Care Technologies has been eliminated. Statistics gathered by the Bureau of Labor Statistics have been manipulated and in some cases no longer tabulated. Prices on almost all government publications have been raised, and the number of new ones has dropped precipitously—some, such as the brown lung patient, were actually withdrawn to remove material offensive to management.

DIALOG. Lockheed's entry in the computer wars, used the sales slogan 'How to turn knowing into winning.' The problem is, winning is not what health and disease prevention require. It is conceivable that Lockheed et al., could win and the public lose.

Hal Steinberg

Vital Signs

Cancer Wards

Idiopathic diseases have long been a concern, but it seems that patients are not the only ones at risk in hospitals.

In the first study of this kind, covering almost the entire spectrum of hospital jobs, medical researchers at Columbia University have found elevated risks of cancer among men and women workers, both black and white.

Using records kept by Dist. of Det. 1986, National Union of Hospital and Health Care Employees, Dr. Jeanne Stellman and Teresia Schrump of the Women's Occupational Health Resource Center at Columbia examined the cause of death for all hospital members who died between 1973 and 1979. They found higher than expected death rates for cancers of the stomach and large intestine among black workers, and for cancer of the pancreas among white workers, male and female. Also elevated rates of liver cancer were found among black men, breast cancer among black women, and leukemia among both black and white women.

The researchers are currently studying the distribution of these cancers among different job categories. So far, they have detected excess liver cancer among service workers, many of whom are black men. This is of particular concern, they noted, because this type of cancer has been associated with Hepatitis B viral infection, to which many service workers are exposed while caring for patients and washing their bedding clothes and linen.

Further information is available from the WHRC News, a bimonthly publication of the Women's Occupational Health Resource Center, Columbia School of Public Health, 60 Haven Avenue, B-21, NY, NY 10027. (Subscription rates are $12 annually for individuals and $8 for students.)

David Koteichuck (David Koteichuck is an occupational safety and health specialist and a member of the Health/PAC Board.)

Unlucky Strikes Again

U.S. tobacco industry cigarette advertising was up 13 percent in 1980 to a record $1.24 billion, according to a recent Federal Trade Commission report to Congress, with another $17 million put up sponsoring special events such as musical programs and sports events.

This massive outlay of cigarette companies have been cost effective. Perhaps aided by reversion-induced stress, the border sale reduced the average 1980 smoker to light up 11,633 times, an unhealthy increase over the previous year's 11,500.

The good news is that the number of cigarette smokers declined, as it usually has since the Surgeon General's Report on Smoking was released 18 years ago. But for those who do succumb, an ad announcing 'More is you' carries a deadly message.

This Issue's OSHA Disaster Report

Occupational Safety and Health Director Thorne Aucther has been presenting a lower and more benign profile in the media but, as President Nixon was fond of saying, we have to watch what officials do, not what they say. Once again, this is a depressing task.

At the end of 1982 OSHA had proposed or already begun:

- Requiring 194 advisory health and safety standards, many of considerable significance. Among occupational health specialists it is widely agreed that, far from making elimination, some of them as such the standard on respirator use should be made mandatory.
- Replacing monthly reports on OSHA inspection activities with quarterly releases.
- Demoting half a million employees in white collar industries from keeping health and safety records.
- Forbidding states from adopting standards to be lighter than Federal OSHA law contains. (So much for the New Federalism.)

These and other policies prompted the Occupational Health section of the American Public Health Association at the recent APHA convention to call for Thorne Aucther's resignation.

David Koteichuck
Bankrupt Policies

Usually companies filing for bankruptcy begin selling off assets, but the Manville Corporation has been breaking new ground in its pursuit of asbestos and cash (see Notes & Comment in the previous issue). Recently, therefore, Wall Street was surprised but not shocked when the giant of the American asbestos industry turned around after filing under Chapter 11 and announced plans to buy a plywood and sawmill plant from Crown Zellerbach. Any criticism of the proposed purchase, a corporate spokesperson explained to the Wall Street Journal, was a result of misunderstanding the purposes of Chapter 11.

Manville hopes to persuade the Federal Trade Commission and the Federal bank regulators in New York to approve the acquisition. If consummated, it might succeed in the only financial obligations the corporation faces: to avoid default on credit lines. They're part to present employees and their families suffering from redness of the eyes caused by decades of company neglect and heartlessness in pursuit of profits.

David Kateshuck

What They Don't Know Can Hurt You

Aside from the makers of aspirin and ibuprofen, few people know that the pharmaceutical industry is a major cause of death in the U.S. Two leaders pour millions into television and radio commercials, while the drug companies spend their billions on media and political campaigns in an attempt to keep the public uninformed about the possible effects of their products.

Herb Semmel is director of the Consumer Coalition for Health and Dean of the Antioch School.

Report from Washington

The Reagans Show was back for another year, once again attempting its magic act of reducing taxes and increasing military spending while controlling the skyrocketing Federal deficit. The idea is to perform the latter without the former, in the traditional fashion of the drug companies concerning themselves with the safety of the public.

Although a vast majority of people are aware of the problem, few are aware of the extent of the problem. The problem is not just in the price of drugs, but in the way they are advertised. The advertising is done by pharmaceutical companies, who have a vested interest in keeping people informed about the dangers of their products.

The research conducted by the Consumer Coalition for Health and Dean of the Antioch School revealed that the advertising is done by pharmaceutical companies, who have a vested interest in keeping people informed about the dangers of their products. The research also showed that the advertising is done by pharmaceutical companies, who have a vested interest in keeping people informed about the dangers of their products.

Medicare

Last year, Medicare took the worst beating, administered in a way designed to portray the benefits and thereby the political power of those who will suffer. There are basically three ways to limit Medicare spending. One is to compel beneficiaries to pay more by increasing co-payments or other such fees. Another is to limit Federal payments to physicians. This is actually another form of cost-sharing to beneficiaries, since most doctors require Medicare patients to pay any difference between their fee and what Medicare pays. The third option is to limit reimbursement to hospitals.

The first approach is widely regarded as unfair. The opposition is divided, the premium for Part B benefits, primarily for physicians fees, was increased by
The major Medicare cuts came in new cost limits on hospital reimbursement. Hospitals had become adept at maximizing their reimbursement through accounting methods which shifted costs to services not subject to cost ceilings. The 1982 changes attempt to close this loophole by broadening the old ceilings on routine services ("room charges") to include ancillary services such as x-rays, lab tests, and operating room use over a three-year phase-in period. The resultant savings may not reach Washington expectations, however, since the impact of hospital cost-accounting has thus far proved overcapitalization at cost control.

In addition, Congress imposed new annual limit increases in total Medicare reimbursement for each individual case. As in the case of the new service ceilings, the effectiveness of these new cost controls will depend on large measures on the implementation and enforcement of the Department of Health and Human Services and the effectiveness of the audits by the insurance companies that act as "fiscal intermediaries" between hospitals and the Federal government. One of the more bizarre political deals cut to obtain passage of the original Medicare law in 1965 allows hospitals to choose their own auditor.

Even if the cost controls work, they are only a short-term expedient. So long as health care costs continue to rise faster than Federal spending limits, hospitals will have to find the difference elsewhere. The most immediate hospital response will be to increase charges for patients covered by private insurance, since the Federal controls apply only to the 40 percent of hospital revenues coming from Medicare and Medicaid. However, state cost control programs as well as market resistance to increased insurance premiums by employers, who pay most of the cost, may limit the ability of the hospitals to do this. The insurers themselves have begun a major public relations campaign to develop opposition to this cost-shifting.

Hospitals have some cushion provided by accounting techniques, such as accelerated depreciation and duplicate billing, which overstate costs, but these hidden over-charges also have their limits.

Eventually, Congress will either have to face up to the built-in inflation in a true-for-service system or reduce benefits. If past experience is a guide, the elderly are likely to be the losers, not the hospitals, unless a broad-based coalition develops similar to that which has thus far at least kept the social security system intact.

Medicaid

Considering the Reagan Administration had asked for $8.6 billion in Medicaid "savings" for Fiscal Years 1983-85, Medicaid did fairly well for itself, with only $1 billion lopped off. Federal matching payments for cash and major reductions beyond the 1981 cuts.

Some beneficiaries may actually do better than in the past under the law, states the note of imposing nominal co-payments on all services to the "medically needy"—those not receiving welfare payments only because their income is slightly above the state's ceiling. These co-payments were as small as $5 per service for a family with sick children or chronically ill adult, co-payments sometimes reached $30 or more a month—a substantial amount for a family with a monthly income of $300-$400. Even persons actually receiving welfare could be charged co-payments for "optional" services—basically almost everything other than hospitalization, physicians, laboratories, and x-rays.

The new law permits nominal co-payments for all services, but bars "sharps" for care given to patients under 18 and for any pregnancy-related services to either women or welfare or those designated "medically needy.

This is a significant improvement, particularly since children are the largest group among Medicaid recipients. However, getting this free care may not be easy; in Arkansas, for example, women reported have to wait four to six months for a prenatal care visit.

In addition, although no co-payments can be charged for emergency services and family planning services and supplies, Medicaid recipients enrolled in an HMO, or to anyone institutionalized on a long-term basis (most nursing home residents) are the exception.

As this brief summary of changes indicates, co-payment provisions have become extremely complex. At least one state, Georgia, has decided that it makes sense to drop them entirely, since any revenue gained is not worth the administrative trouble and expense involved in determining and collecting the fees.

The major Medicaid cuts came through the back door with changes in eligibility for Aid to Families with Dependent Children. Tightening the AFDC rules knocked ten percent of the recipients off the rolls. These families, usually headed by low-income working mothers, thereby lost their Medicaid coverage, a much greater "savings" for the government than the relatively small expense of welfare grants involved.

Some of those dropped will qualify for Medicaid in states which have elected to cover the medically needy, but they have to dip into their meager savings first, and hard-pressed states are finding these people a politically easy target for budget-cutting. Five states dropped coverage for the medically needy in 1982; six will no longer give benefits to young parents even when both are unemployed; six dropped coverage for 18-21 year olds who are still in school; seven imposed lower limits on hospital days, physician visits or prescription drugs (even to critically ill patients available under Medicaid).

Those recipients fortunate enough to be untouched by these cuts are also in danger. A provision of the 1982 legislation allows the Secretary of Health and Human Services to waive "freedom of choice" provisions of the Medicaid law.

Under the current statute, a patient may choose any provider eligible to receive Medicare reimbursement. In practice this has included almost all hospitals and physicians, although many of the latter have chosen to remain outside the program and those who refused have often been compelled to spend hours sifting through the clinics.

The 1982 amendment means states can request the right to limit Medicare reimbursement to a limited number of providers—those willing to offer services at the lowest fees. The result may well be a bargain basement HMO's that cut costs at the expense of the patient. This exactly what happened in California when Governor Reagan used this "experiment" a decade ago. Not only did the Medicaid mills provide low-quality care, they drained federal out of millions of dollars. California is the first state to receive a waiver under the 1982 provision.

Miscellaneous Programs

The buzz word for health programs at the
start of the Reagan Administration was competition, but so far all of the major competition proposals have been blocked by powerful opponents. Health insurers and physicians oppose any effective stimulants to competition-as do many liberals, although for different reasons. The major medical and dental society is backing legislation to deny the Federal Trade Commission authority to enforce the anti-trust laws against doctors and dentists. This bill failed in the rush to adjourn but will be back again. The only so-called pro-legislation effort to pass was a provision decreasing the tax deduction for medical expenses.

In health planning, a bill passed the House which removed even the facade of democratic participation in planning. The bill prohibits any state which accepts federal health planning funds from currently do from instituting the Health Systems Agencies in the Certificate of Need process. HSA's are currently required by law to be governed by a board containing a majority of consumers broadly representative of the public. Certificate of Need, which licenses capital expenditures for health care, is the real teeth of the planning law. The House bill did not make it through the Senate, and health planning continues unchanged for 1983.

There will be also a renewed effort to pass a bill, which got through the House in 1982, that would remove even the facade of democratic participation in health planning. This legislation prohibits any state which accepts Federal health planning funds (all currently do) from including the local Health Systems Agency in the Certificate of Need process, which is related to new capital expenditures. By law HSA's must be governed by a board with a consumer majority broadly representative of the public, and cutting them out effectively ends any direct health consumer involvement.

In a situation when curtailing a health consumer defeat counts as a victory, two more were won. Hospitals failed in their attempts to have the enforcement provisions of the free care and community service obligations which bind institutions that have received Federal grants or loans under the Hill-Burton Act. And Professional Standards Review Organizations (PSRO's) are now effectively ended, although with less funding. Only six years ago Jimmy Carter came to office with a promise to enact a national health insurance program. Only three years ago, Senator Kennedy unveiled the most recent of his many proposals for NHL. Today, such thoughts are so distant from the political scene that the labor funded Committee for National Health Insurance is fighting backouts rather than promoting its own program and the Coalition for a National Health Service is hibernating. The Reagan Administration began 1983 with high hopes of dismantling the Federal Hill-Burton programs but succeeded only in delivering a sharp kick in the ribs. From such a perspective, 1982 was not such a bad year.

AND NOW FOR 1984

The President's budget message for 1984 was simple—raise military spending $30 billion, freeze domestic spending and the salaries of federal employees, impose additional but more or less hidden taxes on the public, and accept a $50 billion deficit.

In the health area, the budget message states that a major problem in meeting health care needs is the rapid inflation in costs. Indeed, in 1983, health care costs jumped another 11 percent, almost three times the increase in the general cost of living index. Hospital room rates soared 13.3 percent and health insurance 15.9 percent. Despite their loud cries of distress, neither the Reagan Administration nor Congress has offered any serious program to curtail costs. Instead, the 1984 budget simply proposes to shift some of the expenses from the Federal government onto the backs of the public and state governments. Dr. Karen Davis, speaking for the American Public Health Association, aptly described the Reagan proposals as 'reducing the deficit with the unlikeliest tax of all—a tax on the sick and vulnerable.' Even the New York Times forbade the administration's proposals as 'callousness if not callousness to the poor.'

The most insidious proposed taxes are on the elderly. The largest is an increase in the Medicare co-insurance payment for the first 30 days of hospitalization. Currently, Medicare pays all basic hospital charges after the first day of hospitalization through the 18th day. Reagan proposes to charge Medicare patients $85 to $130 a day which could reach $1,529 for a sixty day stay—this the already existing deductible of $350. The seven million elderly who are hospitalized each year would bear this cost.

In exchange, the budget offers catastrophic coverage not currently covered under Medicare to patients who spend more than $2500 annually on Medicare-covered services. This tradeoff would save the government a lot of money, since under 60,000 persons will come under the new benefit plan, less than 2 percent of those eligible for Medicare, and many of them already get Medicaid coverage for their catastrophic expenses.

The second tax on the elderly is a proposal to freeze the levels of Medicare payments to physicians in 1984, hike the deductible Medicare patients pay doctors 12.5 percent, and increase the amount the government pays for 'private sector' doctors already must pay the government to be covered for physician services. The increased premiums alone will cost the patients $9.3 billion over five years. Additional patient costs will come from increases in the number of physicians who refuse to accept Medicare assignment and charge patients in excess of the government's reimbursement figure. More than half of all doctors already refuse Medicare assignment.

The poor are also singled out for a drubbing. Medicaid payments would be required to pay $1 to $1.50 for visits to physicians and up to $3 daily for hospital care. Both these 'budget-transmitting' charges may mean cutting the Federal government a great deal. Many poor people might spend their meager funds on moccasins or shoes and defer physician visits and early usage of relatively low cost care until their condition deteriorates into more serious illness that costs a lot more to treat. The children are the largest group of Medicaid recipients, their health will suffer most.

Middle income groups will also pay a substantial price for the MX missiles. The Administration is proposing a tax on health insurance premiums paid by employers in excess of $70 per month for a single individual and $175 per month for a family. The theory is that many people are "overinsured" and therefore use more health care, more than is necessary. Taking insurance benefits is supposed to discourage employees from signing up for comprehensive coverage and consequently reduce their utilization of services no longer covered in their plan.

This might sound effective on paper, but there is no clear evidence to support either the premise or the result. On the contrary, the elderly are purchasing "Medi-Gap" insurance even though their payments are fully taxed. They do so, often in excessive amounts and at great expense, primarily because the tax benefits they may otherwise be hit with medical bills they cannot meet.

Furthermore, any reductions in coverage which do occur may drop services virtually no one needed. In the area where universal coverage, for example, will probably be the first program to go, it employers cut their benefit levels to the new tax-free ceilings.

If passed, taxation of health insurance benefits is expected to produce $3.3 billion for the Federal treasury in 1984 and $6 billion by 1986. The revenues will come from the pockets of employees. The average tax will be $141 in 1984, the heaviest burden will fall on those who have comprehensive coverage paid for by employers, predominantly unionized employees in large industry and workers in the Northeast and on the West Coast.
Firms with aging workforces would be hard hit because premiums in many areas are now "community-rated" and are therefore higher for a group of older insured persons, who use more health care services.

This is like the alphabet soup being served up as a quick remedy for the staggering rise in health care costs. It stands for diagnostic related group, a recently developed method for hospital reimbursement, and the most important procedure used if there is surgery, the age of the patient, and his or her discharge status from the hospital. For example, is an appendectomy, without complicated principal diagnosis complications, or associated illness in a patient under 70.

This in turn would mean higher insurance premiums and higher out of pocket payments for the tens of millions of people who do not have full hospitalization coverage.

Under the Reagan Administration proposal, whether the patient remains in one of its beds one day or ten, the hospital would receive the same payment for DRG 167, with adjustments for regional wage rates, medical education costs (for teaching hospitals), and capital costs. Payment would be prospective—that is, given in advance periodically, based on the hospital's patient mix for the same period in the prior year. This would ease hospital cash flow problems; later adjustments would cover any differentials from the previous year.

Like most quick fixes, this one looks best on paper. The first problem with DRG is that the Reagan Administration proposal applies it only to Medicare. This means it doesn't necessarily restrain costs, it only limits the annual increase in the federal government will pay for Medicare patients—currently their care brings in 40 percent of all hospital revenue. The result: labor, business, and private health insurers may, will, be forced to charge other insured patients as hospitals rush to compensate for lost Medicare revenue. This in turn would mean higher private insurance premiums and higher out of pocket payments for the tens of millions of people who do not have full hospitalization coverage.

Past experience supports these fears. In one recent study, the California Health Facilities Commission reported that in 1983 the state's hospitals boosted average daily charges a stunning 22.4 percent to $498 while patient days were declining 2.9 percent. Instead of supplying the Federal Health Facilities Commission, the commission's director, there we was a direct connection: the increasing increased stemmed partly from hospital efforts to cover their costs with fewer patients. There is also no assurance that even a DRG program applicable to all patients will save money. In New Jersey, the only state where the system is fully operative, after two years the evidence is mixed. This is hardly surprising, since hospital administrators and accountants have long demonstrated a genius for outwitting regulations designed to contain costs.

Their most obvious trick under a DRG plan would be to encourage physicians to practice in their hospital to "overdiagnose," or, pushing the patient up into a higher payment category. This would be unlikely to detect more than a fraction of such schemes. The Reagan version of DRG leaves one anxious loophole by allowing capital costs to be figured into the reimbursement rates. This reemphasizes the current incentive to pour money into construction, equipment, modernization, technology, and other capital outlays. The incentive to purchase labor-saving equipment is particularly great. If the DRG payment will not be cut if labor costs are reduced and a premium will be added to pay for the new equipment. The workers most likely to be replaced are nurses, technicians, and housekeeping staff, all low-wage positions in which minorities and women predominate.

These groups will also be hard hit as patients, since public hospitals and the dependant minority of non-profits which serve large populations of elderly and low income populations have few if any well insured patients to whom they can shift costs. These hospitals also assert that the patients who come to them have a higher incidence of multiple diagnosis and severe illness than the national average, and the DRG categorization is not sensitive to all these differences. The result will probably be accelerated closings among these institutions, and declining care in most of the rest. The consequences for their patient population, which is predominantly comprised of people who have no where else to go, will be devastating.

Despite all these double dangers, and dissent, Congress is likely to approve this form of DRG reimbursement for Medicare patients, if only because advocates who desire to appear to be doing something about hospital cost inflation.

If past experience is any guide, bad as they are the Reagan proposals are likely to be better than what finally emerges. The American Hospital Association has already come up with its own so-called DRG plan which includes a new twist tightening the screws on the sick elderly. Under current law, the hospital must accept Medicare payment from the government as full payment; the patient cannot be charged beyond the first day deductible. The AHA wants to change the law to allow hospitals to charge Medicare patients over and above what the government pays. They are proposing this as a cost containment measure. If this doesn't make sense to you, don't think you're the problem.

The sad fact is that the Democratic opposition has yet to produce an alternative.

Finally, the Reagan plan proposes a one year freeze on Medicare hospital reimbursement rate in 1984. If implemented, the plan would further accelerate cost shifting to privately insured patients, pushing their premium up even higher. Some hospitals may limit admissions of Medicare patients. Financial advisors, particularly at proprietary, are already urging clients to improve their "patient mix," meaning more Freedom of the best insured patients. The result is the dumping of Medicare and Medicaid patients not to receive high costs onto the public hospitals and those voluntary which have traditionally served one.

Quality may also suffer. Hospital management experts have identified the essential ingredient of patient care, nursing services, as the prime target for cost saving measures. Although these budget proposals should have little appeal to anyone since they don't accomplish their stated aim and hurt millions of people, the sad fact is that the Democratic opposition has yet to produce an alternative. Congressional liberals are aware that no piecemeal approach is likely to check soaring costs, but the Democrats lack the political courage to be nonviolent and undertake the basic structural changes in the health care system needed to bring this monster under control. Medical industry PAC's were by far the largest contributors to members of Congress in the 1982 election campaign, and every dollar given a patient ends up in their hands. And as we shall all pay, and pay, and pay.
First Easter

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A Private Revolt
The Rise of Agency Nursing

by Kate Pfordresher

Strolling into a recent nursing job fair at the Venetian Hotel in mid-town Manhattan, you could easily forget that within this same city there are broad lines of the unemployer-forming. Inside this brightly-lit convention hall, about 150 hospitals, temporary nursing agencies and national hospital chains tried to for the attention of nurses ambling by their booths. Free T-shirts, toys, chance to win theater tickets or dinner-for-two-and lots of pens, pencils and date-books were offered just for picking up a brochure.

"Please, don't pass us by," cried an especially lonely recruiter leaning over her table at the Venetian Administration's booth. "We have openings for a career-minded nurse in any of our hospitals across the United States."

She had few takers. The hundreds of nurses passed by the VA, the public hospitals, and the out-of-state voluntary hospitals. Even nationally known giants such as Baylor University Medical Center, which tent recruitment all the way from Texas, drew very few. Among institutions, only the local elite, the medical empires such as Mount Sinai and Columbia Presbyterian, enjoyed any success.

Nurses clustered in small knots around the booths of the local temporary agencies that offer per diem assignments in New York area hospitals. The sales pitch explained their popularity. "If you want flexibility in your schedule, say you are just returning to work after having a child, or want to shop around before taking a full-time position, we are just the place for you," promised the representative of a local agency. "You can pursue your professional and personal goals at the same time."

But the most popular booths belonged to the national temporary agencies and the for-profit hospital chains. Though they are diffe-
rent types of businesses—an agency is a kind of temporary employment service providing shift nurses to hospitals with shortages and the hospital chains employ nurses for tem-
porary assignments in their own hospitals across the U.S.—the offer is pretty much the same.

Imagine for a minute what it would be like to pursue your career in an area that's world
famous for its beaches and sunshine," suggested the recruitment literature for National
Medical Enterprises, a national hospital chain. "Forget the dreary days at cloudy
skies, sleath and snow. Polish up your sun-
glasses, pack up your play clothes and . . . C'mon down!" Added an NME re-
cruiter standing at the booth. "If you take a six-
week job at one of our Florida hospitals, we
will cover your travel and housing expenses.
and, while you are employed at our hospital, pay
you as a regular full-time employee."

National agency inducements were simi-
lar. "You're looking for more excitement than
your present job can provide. And Traveling
Nurse Corps can help you find it. We'll fly you
to a good full-time hospital job in a place
where you've always dreamed of playing. Southern
California. The Colorado Rockies. The
You'll get free round-trip airfare, free or sub-
sidized housing, and a full salary. Each
assignment lasts a minimum of four weeks.
At the end of your assignment, you may
choose to stay in the new location, move on
to another assignment elsewhere, or return
home."

Despite the best efforts of their hospital em-
ployers to recruit them for permanent staff
positions, nurses are increasingly choosing temporary agency work. Supercificially this
would appear strange in the midst of a se-
vere recession when jobs—any jobs—are
scarce. The standard answers don't satisfy.
Nursing shortages were identified at least as
far back as the early 1980's. Discontent and
high turnover rates among nurses are not new,
and part-time work—even part-time
work through an agency—was not invented
in the last five years. What is new is that
nurses are using temporary agency work as
a way to change their individual working
conditions.

Agency nursing in hospitals has brought into
focus conflicts that have been evolving for
some time, between nurses and their em-
ployers, among hospitals in a new and in-
creasingly competitive health care market,
and among nurses themselves over whether
to work individually or in a collective setting. This
article, the second in Health PAC's two-part
series on agency nursing, will explore this
complex trend further.

Why agencies came into being is not
mysterious. Business entrepreneurs realized
shortages of staff nurses cost hospitals money, especially if they were forced to close
beds, so they would pay for a service offering
nurses on demand. Overhead expenses are

small, the expertise required is minimal, and
profits are enormous. It is not surprising that
in the space of a few years the industry has
expanded to include an estimated 3000
agencies nationwide, ranging from "mom-
and-pop" businesses operating out of a
spare bedroom to huge national firms, such
as Staff Builders, which has nurses across
the country, and the elite, "mobile nurse corps" of
the giant, for-profit hospital chains like
Humana and National Medical Enterprises, Inc.

"We are stuck with shortages we just can't
fill," declared the director of nursing at a
small community hospital. "Agency nurses
cost us more than regular staff nurses—at
least 50 percent more. I would much rather
have nurses who know the hospital, who I
can understand our procedures, and who I
have confidence in. But I'm stuck. If I use my
nursing budget on agency nurses, how can I
develop programs for my regular staff so
they'll want to stay?"

Though little data exists on the whole sub-
ject of agency nursing, what is known sup-
ports this claim. Patricia Prosect, RN, is cur-
rently directing a major study for the Federal
government on the use of temporary agency
nurses. In a survey of 163 hospitals that
use agency nurses, she and her colleagues
found that hospitals spend between 29 and
52 percent more for extra hours and nights
performed by an agency nurse than they would
use a staff nurse with one year's experi-
ence. Salary figures in the study included the
cost of fringe benefits so this expense cannot
explain the differential. Although this dif-
ferential varies by region and the size of the
institution, it is clear that hospitals are not
using agency nurses simply because they
are cheaper.

"When a facility is placed in the position of
having to use agency nurses, it is an unwise
financial ground. It is hard to calculate the
exact dollar amount, but I can say that a shift
paid to an agency nurse is much more than
what is paid to a staff nurse—in hard cash," said Laura Nichols (not her real
name), RN, the director of staff development
at a New York voluntary hospital. "That's
how the agencies make their money. They
charge the hospital a lot because they are
giving you someone on the day you need
her," she added. "But it's only a stopgap
measure. As a nursing director, I know that I
can only afford to pay for one shift from an
agency nurse for every two nursing shifts I
need to cover. That means that I still can't
cover all the positions I minimally need to
cover to keep the hospital running. I can't cor-
rect the underlying problem either because I
have used up a significant portion of my
nursing budget. My budget is being spent on
someone who has very little stake in this insti-
tution and likely will not return instead of
joining to improve the wages and benefits
of our own nurses. The impact is devastating."

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Temporary agency nurses are employed by private, profit-making companies and are assigned to hospitals on a day or shift basis to fill vacancies in the hospital’s regular staff. Pay arrangements vary and depend on the area and the particular company. The nurses are usually paid by the agency as subcontractors; typically no employment benefits are withheld. In the past, many charged the nurse a fee, few offered fringe benefits. In a survey of its readers on the question of part-time versus full-time nursing, Nursing ‘80 found that only 25 percent of agency nurses responding received any contribution toward health insurance and just 23 percent received increased pay for working on holidays. However, in the last three years, as competition for nurses has increased, agencies have begun treating their nurses more like regular employees. In the New York area, they have given up less entirely and may now offer some fringe benefits for nurses who work a certain minimum number of hours.

“So imagine—you are supposed to prepare medications, change dressings, bathe patients—and you don’t even know where anything is kept.”

Even if they lose some benefit coverage, agency nurses enjoy higher cash wages. In Southern California, Nursing ’80 reported, agency nurses were able to earn $300 dollars per month more than regular staff nurses. “I can’t afford to work full time for a hospital,” claimed one respondent from Georgia. “Salaries and benefits are terrible. Staff shortages are getting so bad that they are advertising as a generous benefits package. They claim one respondent from Georgia.”

“The bodies are in place but nothing has been done to lighten the burden of the regular staff.”

...
rationalize hospital care along an industrial model.

This plan included replacing doctors with nurses, who in 1945 earned about one third what physicians did, without significant change in the work itself. This new form of work and technological skill was not imposed upon nurses. Melosh notes, "Nurses adjusted to the idea that these new, specialized technological positions be defined as nurs- ing jobs. Taking up skilled tasks from doctors, nurses gained a kind of borrowed prestige and a unique role for nursing in the eye of the public."

The irony from the hospital industry's point of view is that though hospitals reduced their costs relatively easily by using nurses instead of doctors, their labor costs soared even higher. From the time Medicaid and Medicare were enacted, hospitals enjoyed an almost limitless expense account to purchase fancy new machinery, because they were reimbursed on the basis of their expenditures. In most industries increased capital investment reduces labor costs. In hospital care, it had the opposite effect. Cheap, skill- ed workers were subsidized by government through grants to nursing schools and deferred reimbursement for patient care; so there was little pressure for labor efficiency.

The technology kept expanding so rapidly that even though the division of labor also changed dramatically, everyone was doing many of the same kinds of things. In 1966, the number of nurses rose to 2,375; that year it was 1,975. It is hard to say what is more attributable to the shortage of nurses or the surge of new technology. Whatever causes, the shortage is a reality, and as a result, nurses have more control over their work than they did in the past. They are able to demand more for the greater skill and education they bring to the job demanded, but that for nursing, rationalization at this time did not result in dehumanizing.

Whatever gains in labor efficiency hospitals can claim have come from the introduction of low-tech items such as pre-packaged, disposable medical kits. These innovations do not reduce the number of skilled nurses needed, although they do allow hospitals to cut their staff of less-skilled workers such as inventory clerks and equipment sterilizers. Thus the ratio of skilled to less-skilled workers grows steadily.

The number of technical occupations increased dramatically during this period (see Health/PAC Bulletin, November 1972). The new job descriptions took away from nurses existing responsibilities (the single exception may be the introduction of respiratory therapy). More important, nurses retained chief responsibility for man- aging the actual delivery of care to patients. The old adage still holds true: the doctor makes rounds just once a day, but the nurses are there around the clock.

"Nurses aren't trained just to operate the machinery," said Laura Nichols. "The tech- nology of the I.C.U. is amazingly complex and requires a great deal of skill. But techni- cal medical skill is not all. I have to have enough medical knowledge to know that I need the machine in the first place, then I need to know how to use it. But before I can get to that I need to know how to get the machine. Nurses have to be expert at more or less ways of getting around hospital bureaucracy."

Then, it doesn't work. I have to tell them, "I can't find the chart." I need to find someone who does, or find some way to do it before I can even think about the patient. Let me tell you, it can be nerve wracking.

"Nurses have to be experts in overt or covert ways of getting around hospital bureaucracy."

"Familiarity with the hospital means knowing what to do when it doesn't work," commented an emergency room nurse from a large teaching hospital. "On top of everything else, we are expected to be mechanics."

It is the nurse who calls in the technicians, oversees the delivery of care, monitors the patient, and keeps the clock. In 1966, nurses were paid more for the greater skill and education they bring to the job demanded, but that for nursing, rationalization at this time did not result in dehumanizing.

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ing shortage have also contributed to a new militancy among nurses. "I've been in nursing a long time," said the nursing director of a large voluntary hospital. "I've seen in the 1950's. They are highly skilled and conditioned at that last. And they know what they want. They want to work with health care professionals—not some doctor's handmaid. The desire for proper recognition brought them to their own agency work. Others have taken advantage of the growing opportunities to practice nursing outside the hospital. This exodus has become so massive that in recent years hospitals in many areas can no longer staff their own institutions. They have to contract with agencies and other hospitals for nurses. This has driven wages up—nurses find that they have risen 13.5 percent in both 1980 and 1981. In the Chicago area, however, 68 percent of the hospitals reported using agencies, double the national percentage.1

Hospitals are dealing with this new variety of ways some have decided to live with temporary agencies and limit the costs they can. Others have created their own in-house programs to offer their staff nurses some of the advantages of agency care. Still others, usually the well-endowed medical centers, have decided not to use agency nurses at all. Agency nurses become a regular feature at the Illinois Masonical Center in Brooklyn, New York. Initially they were used only to fill in on the night shift; soon they were regularly found on all shifts in the hospital. There is such a hospital in the hospital's own staff. Ellen McHugh, a critical care nurse who worked at the hospital until last month, attributes it to this happening. Nurses refused to work overtime because after taxes and benefits were subtracted they were making only $30 or $40 for that second shift. Agency work was a much better deal if you wanted to work extra hours. The hospital then decided asking the agency for its own staff nurses, it seemed to work. The nurses were paid better and are familiar with the hospital. The hospital likes it becaused it's better for the patients. The nurses problem, it seemed, was the profit margin skinned off by the agency, so the hospital has moved to set up its own agency. Many hospitals have revised the old in-house pool to offer their own employees the flexibility of agency work and cut the cost of agency as intermediate. These programs differ from their predecessors in that nurses are usually given the choice of foregoing benefits in exchange for a higher wage rate and the ability to refuse an assignment. The most successful programs, not surprisingly, seem to be those that pay premium wages for shorter hours.

The National Health Care Management Center at the Wharton School of Business reports that one such program at a California hospital reduced overtime by 98 percent and turnover by 14 percent one year after introducing the in-house pool.1 St. Joseph Medical Center in Burbank, California, has set up a special pool to fill a for night duty where the nurses work 72 hours and are paid for 80. The hospital has the lowest turnover rate of RN's in California, so that they have a waiting list for the night shift. The Illinois Hospital Association has organized the region's hospital association to give the state, which provides temporary nurses to its member hospitals without a fee.1

Hospitals such as Beth Israel and Mount Sinai in New York have chosen not to use temporary agency nurses at all. "We found that the agencies we're not as reliable as our nurses," said a nurse at an area hospital. We have seen in the past that the agency nurses have not always been able to fill our turnover rate of RN's in California, so that they have a waiting list for the night shift. The Illinois Hospital Association has organized the region's hospital association to give the state, which provides temporary nurses to its member hospitals without a fee.1

But for-profit chains don't provide emergency rooms or critical care services. They don't take responsibility for complex illnesses or those that require longer-term care—especially those people who are suffering or completely disabled. They are not organized to treat the most lucrative paying patients, the whole financial structure on which community, voluntary, and public hospitals depend on to raise. Others, one-third of all hospitals belong to voluntary or proprietary chains. As the industry consolidates, the struggle over who does what tasks in the hospital increasingly will shift from the legislature to the workplace itself.

For nurses, this development will close off some avenues for gaining control over their work and their work settings. Fighting to maintain legal restrictions on nursing practice may become obsolete if hospital management is able to recognize nursing work such that it...
no longer needs registered nurses. And this is clearly on the agenda. In an oft the record conversation, the vice president for planning at a prestigious teaching hospital in New York City pointed out that, "Unless nursing schools can turn out less than 2,400 new nurses, we will have to find some way to do without them."

Politically, this conflict is likely to spur unionization among registered nurses. Writing in the industry journal Hospitals, Clinton L. Elster, a Kansas City attorney specializing in activating hospitals on labor matters, warns that "By taking hospital costs out of the arena of Federal regulation and putting them into the workplace, the [Reagan pro-competitiveness] bill would kill hospitals' argument that the wages and benefits they provide are substantially increased by collective bargaining. In order to compete effectively on a cost basis, hospitals may decide to operate with lower staffing ratios, and this decision would exacerbate existing employee frustration and stress that are attributable to staffing shortages."14 In other words, non-profit hospitals will no longer be able to present themselves as financial wards of the state, mere charity institutions and beneficiaries of the needy, in their efforts to rebut workers' demands. Even so, to win their wage and non-wage demands, staff nurses will require unprecedented organization and militancy among nurses. Unless staff nurses are able to force their employer to recognize their unions, they will continue to face incentives for inadequate recruitment and retention to stem the flow of nurses, and hospita!/the will become even more vulnerable to increased workloads, deteriorating working conditions, and the not too distant future find themselves targets for reorganization and de-skilling.

As an individual's response to worsening working conditions, temporary agency nursing is consistent with nurses' ideal of professional autonomy. If you don't like your job, you can quit. And this private outrage for frustration dissipates nurses' collective ability to actually change the workplace. As one nurse, who attended the national conference on the role of the professional organization at the conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' organizational structure, who attended the national conference on the role of nurses' 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Bouncing Back

A Rubber Workers' Guide to Occupational Health has just been published by the Waterloo Public Interest Research Group. Available from the authors for $1.00 plus 25 cents postage and handling (discounts for bulk orders). They can be reached at WPIRG, University of Waterloo, Waterloo, Ontario, Canada, Tel. 519 886-4020.

Meet the Folks

"Traditional Healing and Contemporary Medicine" will be the theme of the annual conference of the National Council for International Health this June 13-15 in Washington, D.C. For further information, contact NCICH Conference Coordinator, 2121 Virginia Avenue, N.W., Suite 303, Washington, D.C. 20037.

Amazing Medical Recovery

California's Consumer Health Coalition is back after two years of relative inactivity. Its quarterly or thereabouts newsletter is available for $2.00 from 369 Pine St., Suite 800, San Francisco, CA 94104 (Tel. 415) 784-2430.

Nine Out of Ten

A Food and Drug Administration advisory panel has recommended approval of a new drug, disposable contraceptive sponge at least as effective as the diaphragm (ten percent failure rate). For more information contact: FDA Office of Consumer Affairs, 5600 Fishers Lane, Rockville, MD 20857.

In Women's Sano

The International Women's Health Coalition, a non-profit, non-governmental coalition of groups here and abroad supports local efforts to provide better reproductive care for women. For information write: IWHC, 1424 16 St., N.W., Suite 501, Washington, D.C. 20036.

Learn While Earning

Interested in getting a master's degree in public health without leaving your job? Students in this program, whose eight year begins next fall, attend four-day sessions every four or five weeks in Ann Arbor for a total of 25. For more information, write: David Perlman, M.F.H., On Job On Campus Program, Department of Medical Care Organization, School of Public Health, The University of Michigan, Ann Arbor, MI 48109.

Plant Care

The New York Academy of Medicine is holding a symposium on Health Aspects of Nuclear Power Plant Incidents on April 7 & 8 at the Academy for physicians and other health professionals. Topics range from the rationale for government regulation to the prophylactic value of potassium iodide. Pre-registration is required by March 31. For further information, write the Academy at 2 East 103rd St., New York, NY 10029.

Good Work on Bad Work

"A bunch of hogswash" is the rare review from CSHRA director Thomas Auer for the newest pamphlet of the Job Action Program released by the Labor Coalition. Jointly produced and distributed by the Service Club, the Urban Environment Conference, and the National Resource Defense Council. Inside it is a brief and readable summary of the Reagan Administration's gulfed federal budget and safety enforcement. Single copies are $2.00 from the Urban Environment Conference, 1314 14th St., N.W., 3rd Floor, Washington, D.C. 20005.

A Better Mousetrap

Many physical problems on jobs are avoidable, an innovative new booklet from the United Auto Workers shows how. Strains and Sprains, A Worker's Guide to Job Design, explains cohesively and graphically how everything from tendonitis to back ache can be eliminated or at least mitigated by very simple changes. Copies are $1 from UAW Purchasing and Supply Department, 8800 E. Jefferson, Detroit, MI 48214.

The WIC and The Wicked

Readers interested in what's happening to the special Supplemental Food Program for Women, Infants, and Children can get full details from a newsletter published every four to six weeks at the Children's Foundation from 1972 to 1982. Subscriptions are $50 for agencies, $15 for non-profit groups (not administering WIC program). Write for a subscription issue write Center on Budget and Policy Priorities, 258 Massachusetts Ave., N.E., Suite 303, Washington, D.C. 20002.

The Dope on the Zap

Radiation on the Job, a manual written by and for health workers, will answer your questions on what ionizing radiation is, whether you're getting it, and what you're doing to reduce it. For a copy send a check for $5.00 to the Coalition for the Medical Rights of Women, 1058 B Haight St., San Francisco, CA 94117.

Our Bodies, Our Cells

The Melpomene Institute, named for the first woman Olympic marathoner (1896) has recently been formed to study the effects of radiation on an area in which little research has been done. They can be reached at 316 University Ave., St. Paul, MN. 55103.

Dirty Movie

What Price Clean Air?, a documentary broadcast nationally on PBS, is now available on VHS film. This 57-minute show focuses on the congressional battle over revising the Clean Air Act and the arguments pro and con, discussing the long-term effect legislation. Rental fee is $100, Sale price $350 cassette, $850 film. From Robert Richter Production, 330 West 42nd St., New York, NY 10036.

Thought For Food

Food First Comics is a simple but very readable and far from simple-minded critique of what it calls "The Myth of Scarcity" in food in the world. The argument is based on the book Food First Beyond the Myth of Scarcity, by Frances Moore Lappe and Joseph Collins with Cary Fowler. Single copies are $1 plus 15 percent postage and handling ($1 minimum) from the Institute for Food and Development Policy, 1885 Mission St., San Francisco, CA 94103.

Do-It-Yourself KIt

Informed Homebirth, a non-profit organization, will be offering a series of Midwifery Skills Workshops in workshops from April 1 to 4 in Los Angeles, San Francisco, Portland, OR, and Boulder, CO. For details, and information on the group's programs, tape series, and books, write P.O. Box 788, Boulder, CO 80306.

Home Remedies

Friends and Relatives of the Institutionalized, an independent working group in New York, has just published a Consumer's Guide to Nursing Home Care in New York City. Although there are details on Big Apple nursing homes, the booklet contains a guide which other Americans will also find valuable, explaining how to choose the right facility, what to look for and ask about, when visiting, and how to pay for care. Copies are $5.50 from FRIA, 425 East 25th St., New York, NY 10010.

Biodegradable Subjects

Public Responsibility in Medicine & Research (PRIM&R), a non-profit group concerned with protecting human subjects in biomedical and behavioral research, will be holding two meetings this March. On March 4, at the Sidney Farber Cancer Institute in Boston the topic will be "Making Your Institutional Review Board Work." March 31-April 1 at the Philadelphia Hilton the topic will be "Current Challenges and Practical Problems in Drug and Device Research." Further information is available from PRIM&R at 132 Boylston St., Boston, MA 02116.
Books Received


O'Carroll, Tom, Paedophilia: The Radical Case (Boston, Alyson Publications, 1982).


Rommer, David, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn (New York: Cambridge University Press, 1982).

Body English

Points on Weakpoints

In the previous Bulletin we discussed some general approaches to the damage suffered by many patients of cardiovascular, mental, and cosmetic benefits of active lifestyle. What follows is a discussion of some of the specific physical ailments.

Tennis Elbow

Despite its name, tennis elbow strikes beyond the racquet set. Victims include carpenters, gardeners, cellists, domestic workers, and politicians, and any one else who strains the mus- cles of the forearm which attach to the elbow.

It should come as no sur- prise that those of you firmly im- planted in, or about to join, the spreading ranks of the middle- aged, that you are four times as likely to suffer from this malady as those under 25.

Experts have described two kinds of tennis elbow, forehand and backhand. Which you get depends on what you do. Among tennis players, the forehand variety more com- monly afflicts professionals and serious amateurs and is attributed to the wrist snap used in power serves. The pain occurs on the inner side of the elbow.

This is a pain that can probably be relieved by success on the pro circuit bringing several Marl million dollars in income, but this remedy is not readily available.

Backhand tennis elbow is the mark of the new or weekend tennis enthusiast, whose backhand form is often incorrect and whose income is usually adversely affected by the game, even without medi- cal bills. The pain occurs on the outer side of the elbow, conditioned primarily by the muscles of the shoulder that straighten the wrist.

Some authorities recommend a two-handled backhand as a preventive measure. They also caution players not to use a heavy racquet or balls: to avoid an overall grip, and to watch out for high- strung racquet strings, which can transmit rather than absorb shock, increasing the strength and flexibility of the muscles on the upper side of the fore- arm is helpful—simple ways to try after a tennis ball frequently.

Tennis lessons to improve backhand may be the best precaution. They'll have the extra benefit of improving your game, and may help you graduate to forehand tennis elbow.

First aid for both varieties of tennis elbow is the same and described in the previous Bul- letin for all muscle strains—RICE: rest, ice, compression, and elevation. Some experts recommend that if you are not sure you should not try to play tennis until you can swing the rac- quest without pain. Others sug- gest moderate play after the initial recuperative period even if some pain persists, since the condition will go away over time.

Eye Injuries

The upsizing in racquet sports has been accompanied by a similar rise in the number of people carried off the courts. The most common se- rious injuries, surprisingly enough, are to eyes. Most occur in a head-on collision with a ball. In squashes, a signifi- cant number are caused by a racquet smash.

The resulting trauma can range from laceration and hemorrhage of the eye lid to full-thickness corneal surgery, such as nasal detachment. Players who normally wear prescription glasses risk partic- ularly alarming injury. Although many feel confident when they put on so-called "shatterproof" (fracture-resistant) prescription lenses, a number of studies have shown that they do indeed break when hit by squash or racquet balls. The result can be serious in- jury from pieces of glass im- bedded in the eye and/or the eyelid. Plastic prescription lenses are similarly unable to withstand the incredible velocity and force of a ball fired at full strength by the average player. Obviously non-hardened glass lenses are even less safe.

The only true protection is specially made eye guards. These are available both with and without prescription lenses and should be worn by all players, whether they normally use glasses or not. The lenses are made from polycarbonate plastic.

Open (lenses) eye guards are also available, but they are not adequate protection from a "direct hit" travelling at up to 90 miles an hour.
Knees

The knee has been described as fundamentally important, containing as it does, the major part of our weight-bearing capacity, and thus affecting the body's posture, gait, and overall balance. It is a complex joint, consisting of three bones: the femur, tibia, and patella. The knee is a hinge joint, allowing only flexion and extension. The knee is also a pivot joint, allowing rotation and axial rotation. The knee is a weight-bearing joint, and is therefore subject to a variety of injuries, including tears, sprains, and fractures.

Injury to the knee can be caused by a variety of factors, including direct trauma, such as a fall or slip, or indirect trauma, such as a blow to the knee. The knee is also susceptible to overuse injuries, such as those caused by repetitive activities, such as running or jumping.

Injury to the knee can cause pain, swelling, and loss of function. It can also lead to long-term disability, such as arthritis, which can cause pain, stiffness, and limited mobility.

Treatment for knee injuries depends on the specific injury and its severity. It may involve rest, ice, compression, and elevation (RICE), as well as pain medication and physical therapy. In some cases, surgery may be necessary.

Living With Death

In No Immediate Danger. A video created by Gerald Saldo and Joan Engel, 30 min, black and white. Presented by the producers, 250 Mulberry St., New York, N.Y.

The decline of the steel industry has been traumatic enough for the residents of western Pennsylvania, but one town just 20 miles from Pittsburgh is reeling from a new, longer-term disaster, one which has so many already been terminal. Strabane's tragedy and the response is the focus of this documentary. One of its producers, Joan Engel, is a former resident of the town.

In the early 1960s Strabane was settled by Slovenians who came to work in the mines and mills of Pennsylvania. By the 1920s the town had a radium processing plant which produced uranium ore for medical, technical, and experimental use. The "tailings" left over after processing were casually dumped in sites immediately adjacent to the plant. Subsequently, a heavy industrial pollution of the town's air, soil, and waterways, and the town's families, to consistent low-level radiation. In addition, workers and children, and their families, to consistent low-level radiation. The town's environment was contaminated, and the community's health was at risk.

For many decades high incidences of lung cancer among elderly men who had worked in the plant, leukemia, hysteroscopes, allergies, and many other signs that something was seriously wrong were accepted as part of the town's life. However, in the early 1970s, perhaps because of the growing awareness of environmental concerns and occupationally induced illness, some residents of Strabane began to grow more concerned. Their informal community surveys revealed 53 cases of thyroid problems among 15 families and 67 cases of cancer in the 15 homes bordering the radioactive site. These findings spurred efforts to obtain a government grant. What the residents got was a blinding of that there was no "immediate danger"—the Engel-Saldo videotape's title. The residents persisted. They
formed United Citizens Awareness of Radioactive Exposure (UCARE), began intensive lobbying in Washington, and interested epidemiologists at the University of Pittsburgh School of Public Health in the issue.

At the time the videotape was completed UCARE still had not obtained any government commitment to a cleanup. In fact, the group was floundering, its members frustrated by their inability to enlist their neighbors for what admittedly seemed to be endless negotiations with a stonewalling public bureaucracy. Many people, the tape shows, were unwilling to question the government's honesty, and preferred to ignore the problem in general.

"No one knows how to fight it," comments one resident in the tape, "they'd rather push it to the back of their mind."

The tape makers don't sub- sidize the problems of organizing against long-term health hazards whose significance is only vaguely understood.

Their honesty has created a fine videotape more valuable as a teaching tool than many more "upbeat" productions. Let's hope that the citizens of St. Albans are among those who benefit.

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