FIGHTING BACK AGAINST THE EMPIRES
Hospital Construction in New York City

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Journalist seeks interviews on experiences with for-profit hospitals.

Dave Lindorff, a New York journalist, is currently working on a book for Bantam Books on the for-profit hospital industry. He is interested in hearing from any health professionals with concrete experience working in (or competing against) hospitals owned by any of the big corporate chains—particularly HCA, Humana, AMI or NME.

Particular areas of interest are such issues as quality of care, access for the poor, relative efficiency and cost, attitude towards labor unions, treatment of physicians and political activities.

All interviews will be confidential if requested.

Write Dave Lindorff at 235 West 102 Street, #11-1, New York, NY 10025 or call (212) 865-0697.

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In the past, "access" has meant the ability of the poor, minorities and other groups to gain entry into the health care system. Increasingly, however, the term can also refer to the ability of health care institutions to gain entry into the capital market. Capital financing, now a major health policy issue, is a major element in the "corporatization" of health care, as the dominant voluntary sector of the hospital system becomes integrally linked with the general economic system.

There are two sides to the capital story: (1) Getting the approval of the regulatory agencies for major capital outlays, and (2) Obtaining the money itself through various financing mechanisms.

Two years ago, the Bulletin described how a major struggle for capital was shaping up in New York State, as four of New York City's "medical empires," the teaching and research centers, were seeking approvals for an exceptionally large total capital expenditure (Volume 14, Number 4).

In this issue, we tell you what happened — and though many of the outcomes were predictable, there are a few surprises here!

The articles on hospital modernization and construction are case studies of the politics of the Certificate of Need process, in a modern climate of competitiveness. They illustrate how the shrewdest medical empires can win the support of both the financiers and regulators in today's health care system, where the battle is for bonds rather than beds.

We see, however, that some "good old-fashioned" ideas still work. Organizing and advocacy were behind some "surprise attacks" by community residents that gained for underserved communities some important concessions from both public planning agencies and medical centers. Although the New York State Health Department is relatively concerned about community access, these concerns were initially subject to behind-the-scenes negotiations with the hospitals, rather than open discussion with the public. It was up to the communities, then, to make clear that the planning agencies' and health care institutions' definitions of needs and how to meet them were not shared by the affected residents.

An upcoming issue of the Bulletin will focus on some of the forces underlying the other side of the capital finance issue. We will discuss why Wall Street has become a major decision-maker in health planning; how competition for capital can affect the future configuration of the health care system, and also access to care; why all the attention given to capital may be a diversion from more fundamental policy issues.

A changing economic environment is inducing new forms of adaptive behavior within health care. As the expensive nucleus of the system, the hospital sector is particularly vulnerable to cost containment efforts, new insurance mechanisms and the growth of less expensive alternatives to hospital care.

More important, for the first time, public and private health policy reflect the view that health care organizations should be judged by the standards of the marketplace. Hospital modernization efforts are one facet of the corporatization of the industry, reflecting internal struggles to beat the competition in the race for patient and financial markets.

Cheryl Merzel

Cheryl Merzel is a member of the Health/PAC Board.
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Learning to Kiss the Blarney Stone

Blarney is skillful flattery, and according to legend, those who kiss the stone in Blarney Castle near Cork, Ireland, acquire a talent for it. And with his Irish blarney showing, Ronald Reagan announced this past fall that his Secretary for Health and Human Services for two short years, Margaret M. Heckler, was to become Ambassador to Ireland.

In the weeks before the announcement, the mainstream press was filled with "malicious gossip," as the President himself once described the allegations leaked by White House staff, and Heckler’s efforts to fight to retain her position. Heckler’s departure was portrayed as the assertion of power of the new chief of staff, Donald T. Regan, within the White House. Regan, who has disliked Heckler since he was Secretary of the Treasury and they were equals in the Cabinet, apparently had her resignation on the top of his list since becoming chief of staff shortly after Reagan’s re-election. He sent her “signals of nuclear proportions” that he wanted her to leave. However, she not only refused to hear the signals, but went to Republican supporters in Congress such as Utah Senator Orrin Hatch, Wyoming Senator Alan K. Simpson, and Mississippi Congressman Trent Lott, and had an aide tell the press that “the chief of staff didn’t hire her, and he doesn’t fire her.”

Before her appointment as Secretary, Heckler had served 16 years in Congress and earned a reputation as a liberal on social issues and women’s rights. She voted against the Reagan Administration 43 percent of the time in 1981 and 56 percent in 1982. Although she maintained that she “faithfully carried the President’s portfolio,” ongoing conflict with the White House and Office of Management and Budget led to many key vacancies in her department and confusion over where domestic policy was to be made. Compared to the ideological conservatives that dominate the Reagan Administration, Heckler supported increased research on AIDS, more effective legislation on child support by absent fathers, and compromise with Congress on Social Security disability. She was accused of being “very individualistic” and a poor administrator.

Actually, she had just outstayed her usefulness. Heckler was appointed in 1983, over the objections of conservatives, to blunt the growing charges of unfairness and insensitivity of the Reagan Administration to the poor. Her job was to create an appearance of compassion, and to reverse the Administration's image on the “fairness” issue. Once Reagan was re-elected, this was no longer necessary. She would have left Washington sooner, had she and the President not undergone surgery at about the same time. She had also gone through a difficult, highly publicized divorce that hurt her standing with the President's closest advisor, Nancy Reagan.

Perhaps the last nail in the coffin was Heckler’s insistence that a damning Report of the Secretary’s Task Force on Black and Minority Health be given extensive press coverage. While she and the Report maintained that the improvements necessary to eliminate inequities in minority health could be achieved without one extra federal dollar, the details and statistics of the Report belied this posturing. While only the first volume of the seven projected has been published, many believe that even this one is a minor (and minority) miracle for this Administration. Of course, since Heckler’s departure, it has almost been
impossible to get a copy of the Report. (See Bulletin Board for details.)

So, Margaret Heckler, whose blond wig had become as much a symbol as Jack Kemp's coiffure around Washington, will now have to learn to kiss the Blarney stone and carry the President's portfolio back to Ireland.

A ‘Country Doctor’ for HHS

Before Margaret Heckler could pack her new shoes for Ireland, a long line had formed to fill the old ones. Health and Human Services, the largest federal agency with more than 120,000 employees and a $330 million budget is quite a plum.

Public speculation included: Michael Novak, a conservative Catholic Democrat who holds a chair in religion and public policy at the American Enterprise Institute; Dr. Tirso del Junco, an Hispanic Los Angeles surgeon and longtime Reagan supporter; Anne L. Armstrong, former Republican National Committee co-chair and Ambassador to Britain; Anne Dore McLaughlin, the Under Secretary of the Interior; Karl D. Bays, chairman and CEO of the American Hospital Supply Corporation, who jilted Hospital Corporation of America for Baxter Travenol in a recent merger; James K. Cavanaugh, a recycled health specialist from the Nixon and Ford Administrations; John A. Svahn, former Under Secretary of HHS who clashed with Heckler there and left for the White House to become domestic policy chief; and David B. Swoap, California's current Health and Welfare secretary.

Washington handicappers had their equivalent of Superbowl Sunday with the speculation. Novak would have played to Catholic ethnics, del Junco to Hispanics, Armstrong and McLaughlin to women, Bays to business, Svahn or Swoap to conservatives. When both Svahn and Swoap removed themselves from consideration, all bets were off.

In the end, Dr. Otis R. Bowen, the country doctor from Bremen, Indiana, walked away with the nod. Dr. Bowen is a family physician who practiced all during his 15 years in the state legislature before becoming Indiana's Governor for two terms in 1973. Bowen chaired the Social Security Advisory Council in 1983, which was charged with making proposals to prevent the Medicare trust fund from bankruptcy. Most opposition came from anti-abortion organizations, who claimed he supported both abortion and euthanasia. Bowen, in fact, opposes abortion on demand, like all members of the Reagan Administration, but supports abortion to save the life of the mother or in cases of rape or incest. He has also supported “living wills,” in which an individual may direct that “heroic measures” not be taken if he or she is hopelessly ill. In 1986, being a moderate in Washington is a radical act.

New York State Wavers

On its Waiver

New York State has given up its Medicare waiver and is joining the national Prospective Payment System. New York State hospitals will now be reimbursed by DRG's (Diagnosis Related Groups) for their Medicare inpatients.

The current progressive system to compensate hospitals for bad debt and charity care and to help financially distressed hospitals will continue for the present, supported as before by a surcharge on hospital revenues. Private, Blue Cross and Medicaid reimbursement will stay under this system, known previously as NYPHRM (New York Prospective Hospital Reimbursement System) and now renamed NYPHRM-II.

The New York State Hospital Association (HANYS) lobbied hard for dropping the DRG waiver. HANYS conducted a computer simulation of what Medicare revenues would have been under the national DRG's and found that New York State hospitals were losing $250 million under the NYPHRM system. Moreover, the hospital industry was unhappy with the power that the State Department of Health could exert through its control of most of their revenues. And since these were federal dollars not coming into New York State, the state legislature was happy to return Medicare cost control back to Washington.

Now, New York hospitals are working under conflicting incentives: The per diem system for private, Blue Cross and Medicaid patients encourages longer lengths of stay, while Medicare's DRG system encourages shorter stays but more frequent admissions. Confusing?

The DRG system remains a serious threat to public hospitals, since the Reagan Administration has been unwavering in its refusal to act on the feature that Congress enacted to protect hospitals caring for a “disproportionate share” of poor patients. New York City, with its 11 acute care public hospitals, will be particularly hard hit.

Meanwhile, across the Hudson River, New Jersey has been arguing for months with the Health Care Finance Administration (which runs the federal Medicare program) for a waiver renewal that would take some of New Jersey's savings from inpatient care and apply them toward ambulatory and primary care. Could this be the reason all New York's professional football teams have moved across the river to the Meadowlands?

Stay tuned.
Early in 1983, the New York State Hospital Review and Planning Council found itself facing a record $5 billion worth of hospital construction plans, despite the fact that the state was considered seriously overbedded. Of that amount, almost $2 billion could be attributed to just four hospitals, major academic centers and "medical empires" in New York City.

At the urging of the Governor's special Health Care Capital Policy Advisory Committee, the state review council imposed a one-year moratorium on approvals, to provide time to evaluate the plans. Concurrently, the advisory committee set forth the following recommendations for making the health care system more responsive to the needs of the entire community:

1. Establish institutional, regional and statewide five-year plans that project capital needs.
2. Develop criteria to rank the "relative need and affordability" of the plans.
3. Broaden the representativeness of public health planning bodies.

Of the medical empires, the State Commissioner of Health, Dr. David Axelrod, would later say: They "have not always dealt with the interests of society, but rather with the interests of the institutions."

Plan for the Poor

During the moratorium, Governor Cuomo and Commissioner Axelrod declared that plans addressing the needs of the poor would be given the most favorable reviews. State regulators announced they would require the major institutions to serve the needy, in return for approving construction.

Since three of the New York City hospitals with expansion plans were near the medically underserved areas of Washington Heights/Inwood and Harlem, health advocates watched hopefully as the state seemed to insist that the tertiary institutions would be accountable to their surrounding communities. At the same time, advocates were well aware of the weaknesses in the regulatory process. Health/PAC's New York City Working Group warned that the moratorium might be "no more than a delay" and limits on capital spending "an idea whose time has not come."

Hospitals Revise, State Buys

The moratorium put on hold the plans of four major Manhattan teaching and research centers.

Mount Sinai Hospital, on Manhattan's upper East Side, had a $450 million plan to consolidate its 1212 beds, which were spread throughout nine buildings, into three new buildings.

New York Hospital-Cornell Medical Center, also on the upper East Side, had a $500 million plan that included construction of an 11-story atrium.

Presbyterian Hospital hoped to spend almost $500 million to renovate its current site in northern Manhattan, and to build a new community hospital.

St. Luke's/Roosevelt Hospital, located on two sites in the quickly gentrifying upper West Side, wanted to spend $400 million reconstructing facilities for 800 beds and renovating space for another 400 beds.

During the moratorium, New York Hospital and St. Luke's/ Roosevelt, which had not yet filed, remained relatively quiet about their own expansion plans, but were told off the record to scale them down.

Presbyterian pressed its case, arguing that it was, indeed, addressing the needs of its community.

Shortly after filing a plan to renovate its main site only, the hospital had modified the proposal, at the urging of state and city planners.

Presbyterian re-presented its Certificate of Need (CON) in a new package — as a "regional plan" for northern Manhattan. The main site would continue as the tertiary institution and a new community hospital would serve as a secondary care center. In addition, Presbyterian would establish an ambulatory care network that would locate additional primary care physicians throughout the community. Presbyterian officials said this three-tier plan would meet the health care needs of the Washington Heights/Inwood community, which had lost a number of health services over the past 10 to 15 years, including four community hospitals.

Apparently convinced, the state overlooked substantial questions raised by the community about access to the new community hospital and the adequacy of the ambulatory care network. Despite protests from segments of the community, Commissioner Axelrod pointed to the new proposal as proof that state and city agencies could, in fact, shape the development plans of tertiary care institutions.

The moratorium ended on December 31, 1983, and within four months, Presbyterian's plans had been praised and approved by both the New York City Health Systems Agency (HSA) and the State Office of Health Systems Management. It would later be up to the North Manhattan Health Action...
Group (NMHAG), a group of eight local residents who had organized to analyze Presbyterian's proposal, to persuade the state to require some changes (see separate story).

Although Mount Sinai also repackaged its plan, the proposal was initially rejected by the HSA, which cited lack of community access as a major problem. Many health advocates believe the rejection resulted in part from the concerns being expressed about Presbyterian by NMHAG, and from a complaint filed by Community Action for Legal Services and the New York Lawyers for the Public Interest (see separate story). The charge: That “New York's health planning agencies have failed to consider, review, analyze or even collect data on access to medical care for low income persons, racial and ethnic minorities, the handicapped, women, the elderly and other underserved groups.”

Nonetheless, in January 1985, the Project Review Subcommittee of the HSA approved a revised Mount Sinai plan on the condition that the hospital promote primary care in East Harlem and also affiliate with that community's financially troubled North General Hospital.

**But The Poor Are Still Missing**

The state's recommendations that Presbyterian build a community hospital and that Mount Sinai serve some of its East Harlem community were worthy attempts to make the system more responsive to community needs. Unfortunately, however, both the Presbyterian and Mount Sinai plans were approved without addressing the needs of the community as seen by the community members themselves. The resulting actions were considerably off-target; despite the apparent attention to community, the most needy were still not being served.

The community of Harlem is one sad example of a constituency overlooked through health planning that is more institution-based than community-based. It is a community surrounded by three of the four New York City hospitals who wanted to spend almost $2 billion for facility construction; yet, none of that spending was aimed at addressing the needs of Harlem residents. The St. Luke's/Roosevelt catchment area excluded most of Harlem, and Mount Sinai excluded it altogether. In addition, despite the fact that between one-fourth and one-half of Presbyterian's emergency room and clinic patients come from the Harlem community, Presbyterian planners defined their service area as stopping right at the Harlem border.

Harlem residents are desperately in need of primary care. In 1982, for example, 35.9 percent of the women having babies in Central Harlem received late prenatal care or none at all, compared with 20 percent citywide; and the low-birthweight rate in Central Harlem was 16.3 percent compared with 8.7 percent citywide. To lower these rates, the residents need accessible primary care that they are not now getting.

The Harlem community has two public hospitals, but both are in need of extensive capital construction. Metropolitan Hospital, threatened with closure just a few years ago, needs $9.5 million for construction to correct code violations. Harlem Hospital, which is affiliated with Columbia University's medical school, needs $26 million to correct code violations and to make some improvements.

Since New York City's public and small voluntary hospitals serve substantial numbers of the poor, it is their capital construction that should be a state priority. But it could take a 21st Century Robin Hood to snatch even a small portion of the diminishing construction dollars still going to the giant medical empires.

The moratorium itself failed to live up to its promise. No systematic means of assuring community access were developed during that period. Further, the multimillion-dollar modernization proposals were approved by the state after the hospitals repackaged them, partially, to include what appeared to be community-oriented provisions. Only persistent community action forced the state to recognize, finally, that most community needs were not being met.

There were some positive outcomes, however. The community eventually won some changes in the proposals that, while not monumental relative to the hospitals' overall plans, were significant to community residents. Even more important: Although the empires still dominate New York City's health care system, they no longer rule unchallenged.
The Presbyterian Story

The People Pull the Strings for a Change

by Peggy Gallagher

In 1984, at a time when the supply of hospital beds throughout the country was being carefully monitored, Presbyterian Hospital, a 1291-bed teaching and research center in northern Manhattan, received approval to spend about $500 million to renovate its current site and to build a new 300-bed community hospital. Its first bond issue to provide funds for the construction was, at $427 million, the largest hospital bond issue in history.

Presbyterian's proposal was approved, only months after New York State had lifted its one-year moratorium on hospital construction, because the hospital had said it would serve the surrounding community of Washington Heights/Inwood. However, the members of that community raised serious questions concerning the hospital's abilities to meet their needs.

Access to comprehensive quality health care has long been a concern of the residents of this community. Four out of five community hospitals have gone bankrupt and closed in the last 15 years. These closings have meant a loss of access to emergency and clinic services, hospital beds, and more than 1000 jobs. In addition, family practitioners were becoming increasingly scarce in the community and the average age of those remaining was 62 years. Consequently, residents were becoming more and more dependent on Presbyterian Hospital, the only major health care provider in the area.

Community Spells Out Needs

When Presbyterian announced its expansion plans—and they went essentially unchallenged—a skeptical group of Washington Heights/Inwood residents decided to conduct their own health needs assessment to determine whether the plans were really relevant and appropriate. In September 1983, they started the North Manhattan Health Action Group (NMHAG), whose eight original members conducted a survey of the community, with technical assistance from the Community Service Society of New York City.

The group describes Washington Heights/Inwood as a diverse community—geographically, ethnically and economically—of about 200,000 people, with six distinct neighborhoods. In general, the neighborhoods to the west have an older population with higher incomes and relatively good medical coverage; by contrast, those to the east are young, poor and medically indigent. All but seven of the community's 32 census tracts are identified as Medically Underserved Areas, and a majority are also designated as Health Manpower Shortage Areas.

According to William Alicea, a NMHAG founder and co-chairman, with Hildamar Ortiz: "Health was not an issue until recently—we had five hospitals—but we have lost all but one of our hospitals and we have seen a tremendous change in demographics in the last 15 years.

“In 1970, 20 percent of the community were from minority groups. In 1984, however, the figure was 72 percent, more than half Hispanic, predominantly Dominican. In 1970, 10 percent of our community lived below the poverty level. Today it is 27 percent, and the number of residents living on public assistance is 60 percent higher than the New York City average. Consistent with this change, there has been an increase in the number of people who do not have health insurance, and who cannot afford to pay the high costs of health care.”

For three months, the eight NMHAG members conducted interviews, in Spanish and English, of some 600 Washington Heights/Inwood residents, to determine their health care experiences and needs. Using a 10-page questionnaire, they found that 25 percent of the community's residents use hospital clinics as their primary source of care, compared with 9 percent citywide. Further, 12 percent of the respondents use an emergency room as their major source of care, compared with only 3 percent citywide. Not surprisingly, residents living in the insured, higher income neighborhoods reported having access to private physicians, while their poorer neighbors tended to rely on the emergency room or clinics for their primary care.

The group also conducted a physician survey in which they identified only 54 full-time-equivalent primary care physicians in the area. According to Alicea, this is fewer than one physician per 3500 residents, at least 25 percent below the state average. Forty percent of the physicians practicing in the area reported having no admitting privileges, and those who did were admitting mostly to hospitals outside the community. After reviewing all sources of care in the community, including the City Department of Health physicians and the Presbyterian Outpatient Department, NMHAG determined that at least 55 additional primary care physicians were needed in the community to meet the needs of its residents.

Health statistics for the area indicated that the most pressing health care concerns in northern Manhattan were distinct from those of the city overall. The average death rate is lower in this community than in the rest of the city for the usual

Peggy Gallagher is a member of the Health/PAC Board.
Map of Upper Manhattan
Showing Sites of Proposed, Existing and Closed Hospitals

Legend
- Washington Heights/Inwood
- East, Central and West Harlem

- Site of proposed new community hospital to be built by Presbyterian Hospital.
- Hospitals closed since 1969.
- Hospitals currently open.
  1. Presbyterian, voluntary, 1291 beds.
  2. Harlem Hospital Center, city, 781 beds.
  5. Mount Sinai, voluntary, 1212 beds.
  6. Metropolitan Hospital Center, city, 621 beds.

Sources: Community Service Society; New York City Health Systems Agency Medical Facilities Plan, August 31, 1983.
leading causes of death: heart disease, cancer and stroke. However, disease rates for Washington Heights/Inwood are higher than those citywide for hepatitis, gonorrhea and lead poisoning: in addition, the birth rate, the percentage of women receiving late or no prenatal care, and the teenage fertility rate are all higher than those citywide.

Hospital Plan Bars Access
The North Manhattan Health Action Group issued a report entitled Washington Heights/Inwood Neighborhoods: Assessment of Health Care Needs. The report reviewed the community's health care resources, socioeconomic and other data, and concluded that community residents needed better access to inexpensive primary and secondary health services. It looked to NMHAG as though Presbyterian's plan was not addressing these needs, and, in fact, would be excluding the community from such services.

Admission to a hospital is generally through one of three avenues: entrance through the emergency room, a referral from a hospital clinic, or admission by an affiliated physician. Plans for the proposed community hospital not only placed it in an area of least need, according to Alicea, but specified an undersized emergency room that could handle only 27 visits a day. Further, there were no clinics planned, thus barring access via that avenue.

The proposed community hospital was to receive most of its patients from private practitioners having admitting privileges. However, this method of entry would also effectively exclude community residents, as only three community physicians reported having admitting privileges at Presbyterian. Moreover, because hospital officials planned to use the same strict requirements for privileges at the new hospital that they use at the teaching institution, it was unlikely that many local physicians would qualify. Thus, local residents who would receive care from community physicians could not be admitted by them to the new community hospital.

According to Presbyterian's plan, the necessary link between local physicians and the new community hospital would be provided by the hospital's proposed Ambulatory Care Network Corporation (ACNC). The ACNC plan had been one of the things that helped to convince state and city planners of the suitability of Presbyterian's proposal overall. Presbyterian's planners had said that, based on a 1981 demonstration project of need, they would "homestead" 50 physicians in the community; that is, loan them capital to start their own practices. However, since the ACNC's inception in 1981, it had not yet produced a single primary care site.

Community Pressure Pays Off
Presbyterian's expansion plans were approved by the state on the basis of proposed service to the surrounding community. The NMHAG investigation showed, however, that the hospital's plans were more focused on the interests of the institution than those of the community. The group determined to make Presbyterian more responsive to community needs and to make state regulators more vigilant in their surveillance of the hospital's contributions to community service.

They conducted an intensive, highly organized "bottom up" campaign that included the following:
• They decided to focus on the issue of primary care rather than the location or services of the community hospital, which they viewed as "after the fact." They wanted to emphasize prevention.
• At first, they met extensively with Presbyterian officials, whose strategy, Alicea says, was "to meet us to death. In response, we not only met with them, but requested more meetings, more documents."
• They also talked with residents wherever they could find them—in community groups and at schools. "We went to all community meetings," Alicea recalls. "We spoke to the interests of each group, and we made the strength and synergism of eight touch hundreds."
• When they felt they were not getting an appropriate response from the hospital, they decided to bypass Presbyterian and went to the State Commissioner of Health, Dr. David Axelrod. "We were encouraged by his response, at first," Alicea says, "but later, when he praised Presbyterian's plans, we felt he still did not understand how little those plans would actually do for Washington Heights/Inwood." They wrote a letter restating their position, but nothing much happened, and they wrote again.
• On May 25, 1985, with a grant from the state they had received after their first meeting with Dr. Axelrod, NMHAG held a public hearing in their poorest neighborhood under a banner that read "Let's Keep Them Honest." The hearing was attended by 300 people including three representatives from the State Department of Health and three from Presbyterian, led by its new president. A report of major aims and demographic statistics was issued, and 62 individuals and community-group representatives testified, over a seven-hour period, to their specific needs for improved health care services. As was true at all major meetings, discussions were bilingual, and day care services were provided.

The proceeds were transcribed and distributed, to repeat the messages again. "We had really 'out-organized' ourselves," Alicea says proudly.
• The hearing helped to get the action they needed. The group met for a second time with Dr. Axelrod, who subsequently directed Presbyterian to work with NMHAG to resolve the issues and to produce a model for primary health care in the community.

"In effect," says Alicea, "Presbyterian wanted to cover the world—to consider its catchment area as global—but the state said 'If you want to use government money, you have to accept responsibility for the community in which you reside.' They even had to revise their mission statement to acknowledge that responsibility."
• A signed agreement was reached early in the fall.

Agreement is a Major Achievement
"After all our research, we had decided to focus on the issue of primary care, and we had two major objectives," Alicea recounts: "To get primary care services consistent with the needs of the neighborhoods, and to get those services placed in areas of greatest need. As basic as those two principles are, they were hard to achieve."

The major points of the document provide for the following:
• Agreement on the general location, size and scope of services for four ACNC sites to be established in 1986.
FIGHTING BACK AGAINST THE EMPIRES

• Agreement on a special-focus geriatric program in a housing development containing a large number of elderly.
• Agreement on the general nature and extent of the shortage of physicians and on collaboration to develop ways to redress that shortage.
• Agreement on the makeup of a steering committee to assure continuing community input into the Ambulatory Care Network Corporation overall; also, agreement to establish a consumer advisory group at each site, and to hold public meetings to obtain additional input.

Additional agreements addressed the composition of the primary care team, access to physicians, admitting privileges, the importance of health education and disease prevention, fee schedules, transportation — and one of the most important provisions, according to Alicea — adequate bilingual staff.

And what now?
"We will continue to serve as a research, planning and advocacy group for the Washington Heights/Inwood community," Alicea reports. "We have now grown to a membership of 300 individuals and organizations, we have just incorporated, and we are already working on our next projects — a birthing center and a comprehensive school health program.

"If more than four or five people are interested in some health issue, we'll listen," Alicea says. "We're not politicians, we're health advocates, and we're about work. We'll lend support, and we'll make it happen."

The Mount Sinai Story
Down From the Mountain and Into the Streets
by Judy Wessler

In November 1981, The New York Times announced that Mount Sinai Hospital was planning a $450 million program of construction and renovation. When the 1983 moratorium on approvals of large hospital construction projects delayed the program, Mount Sinai was undeterred. It pushed forward with its proposal and ultimately gained approval for it, at a new projected cost of $488 million, in March 1985.

But it was not the original proposal that was approved. During the intervening years, this prestigious medical center had to make several changes in its plans, and agree to assume a certain amount of responsibility for the health status of the poor East Harlem community in which it is located.

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Three events influenced the ultimate decision on Mount Sinai's application.

• The first was the moratorium. During that year, the State Health Commissioner, Dr. David Axelrod, and the federally funded Health Systems Agency (HSA) developed regionalized plans that called for major medical centers such as Mount Sinai to take responsibility for the continuing viability of smaller, financially troubled community hospitals. Thus, Mount Sinai was to become the "big brother" for North General Hospital, the only black-run voluntary hospital in Harlem.
• Second, a coalition of community groups and individuals filed a civil rights complaint against the State Department of Health and the HSA in May 1984 (see separate story). The complaint alleged that, during the Certificate of Need review
FIGHTING BACK AGAINST THE EMPIRES

process, these two agencies—contrary to federal laws and regulations—were ignoring the issue of access to medical care for low-income persons, racial and ethnic minorities, the handicapped, women, the elderly, and other underserved groups. The agencies' gradual acceptance of this review responsibility affected the outcome of Mount Sinai's application.

• Third, in 1983, the East Harlem Community Health Committee (EHCHC)—a coalition of community-based primary health care providers and human service organizations—had organized to help fight a city proposal to impose a mandatory case-management system for East Harlem's Medicaid recipients. After the proposal was defeated, the EHCHC continued to monitor public policy and legislation affecting the health services in the community, and got involved in the review of Mount Sinai's application.

Contrary to their usual accommodating behavior when reviewing an application from a politically well-connected hospital, the HSA staff expressed concern and raised some questions about Mount Sinai's proposal. Approval was delayed—ostensibly to get more information, but more than likely to work out a more favorable deal for North General Hospital, which needed financial and other assistance from Mount Sinai.

Mount Sinai was never pressed very hard on its not-terribly-good record of caring for the medically indigent. However, approval of Mount Sinai's application became contingent on its agreement to be more responsive to the needs of the East Harlem community, to reduce its size by 100 beds, and to develop a stronger affiliation agreement with North General. Mount Sinai agreed to work in a consortium with other East Harlem health providers in developing a prenatal care program, an organized health education and promotion program, a plan to increase the availability of ambulatory care, and a proposal to regionalize ambulatory care services for East Harlem. The consortium was to be developed by the Health Systems Agency, but because the staff was busy with other tasks, it accepted an EHCHC proposal that the community group serve as the consortium.

In effect, the HSA allowed Mount Sinai to retain some influence and control over the consortium's planning process when the agency recommended the School of Medicine's Department of Community Medicine as the technical resource in collecting and analyzing data, and making recommendations. It is unclear how committed either the State Health Department or the Health Systems Agency is to guaranteeing that the East Harlem community will benefit from this planning process, and it will be up to the EHCHC to assure that the process is more related to the community's health needs than to Mount Sinai's institutional priorities.

In one sense, then, it may be "business as usual." On the other hand, it was, until recently, highly unusual for the agencies to tell any medical empire what to do. In that respect, the Mount Sinai application stands as a breakthrough in the granting of Certificates of Need in New York City.

Challenging the CON Game
by Cheryl Merzel

A coalition of health advocacy groups in New York City has discovered one way of encouraging public planning agencies to take their legal obligations to the underserved more seriously.

In May 1984, two groups—Community Action for Legal Services and the New York Lawyers for the Public Interest—filed a complaint with the regional Health and Human Services Office of Civil Rights (OCR), on behalf of a number of local organizations and individuals. The complaint charged that New York's Certificate of Need process (CON) was failing to comply with federal anti-discrimination and access regulations. These regulations include rules which state that a federally funded planning agency's Certificate of Need review must include written findings on the accessibility of a health care facility to low income persons, racial and ethnic minorities, the handicapped, women, the elderly, and other underserved groups.

After a year and a half of negotiations and some foot dragging by the OCR, the New York City Health Systems Agency (HSA) and State Department of Health finally settled with the complainants in order to avoid an official investigation by the Office of Civil Rights. That settlement represents a first-step victory in making New York's planning process systematically address access issues.

The Complaint

Encouraged by a successful OCR complaint against the health planning agencies in Tennessee, the New York advocacy organizations decided to challenge the CON process in New York City. In their complaint, they cited violations of Title VI

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of the 1964 Civil Rights Act, which prohibits private institutions that receive federal funds (as most hospitals do, through Medicare, Medicaid and Hill-Burton grants) from discriminating in the provision of services to racial and ethnic minorities. They also cited violations of Title XV of the 1974 Public Health Service Act and Section 504 of the Handicapped Persons Act, which require federally funded state and local planning agencies to consider access issues when approving Certificates of Need.

New York's CON application did not require any information on an institution's past performance regarding access to underserved populations, or on how a proposed project affects future access. Furthermore, the HSA's annual Medical Facilities Plan (the citywide blueprint for capital construction) had not included discussion of accessibility to the underserved even though required to do so by law. Access criteria were framed mainly in terms of general bed-to-population ratios rather than obtainability of care by populations experiencing barriers. The State Department of Health was charged with failing to require the local HSA to correct these deficiencies and for not making state access guidelines conform with federal regulations.

According to Judy Wessler of New York City's Community Action for Legal Services and to Herb Semmel of the New York Lawyers for the Public Interest and a HealthPAC board member, some hospitals' records for serving the poor and minorities are abysmal. For example, in 1984, only 9 percent of New York University Medical Center's inpatients were minorities—in a city with a population that is almost 50 percent minority. NYU's record of service to the poor is even worse. In the two-year period between 1983 and 1985, NYU had only 1.6 percent Medicaid inpatients and one-half of 1 percent Medicaid outpatients. The number of Medicaid patients seen in its emergency room is unknown, due to NYU's practice of billing the patient rather than Medicaid, a practice that can have the effect of discouraging use by people insured through Medicaid.

The Settlement

The main terms of the settlement involve agreement by the state and the HSA to collect more appropriate access data from CON applicants and to consider this information in the review process. Access will be one focus of the HSA's next Medical Facilities Plan.

The state is revising its CON form for certain applications to include questions such as percentage of minorities and Medicaid patients served, the number of community-based physicians with staff privileges (an important route for enabling community residents to gain admission to voluntary hospitals), and percent of Medicaid patients admitted by each staff physician.

The form will ask for the ethnic composition of the facility's physicians; the institution's patient-transfer policy and practices; the availability of foreign-language translators and capacity to communicate with deaf and visually impaired patients. Compliance with Hill-Burton will also be a focus, as well as any requirements for pre-admission deposits.

The HSA is revising its project review manual to incorporate questions about most of these access issues. In addition, the state is conducting a survey on foreign-language and sign-language interpreting needs in New York City health facilities. Although the settlement applies only to CON proposals of at least $15 million, or applications covering three or more functional areas of the facility, negotiations are continuing for an abbreviated form to cover applications involving lesser sums. The complainants retain the right to refile at any time against the planning agencies or individual health facilities.

The biggest question remaining is how the planning agencies will evaluate the new data and implement the access guidelines. Health care advocates will still need to monitor the process; however, now that there will be more critical information in the public domain, the job of prodding the hospitals and public planners will be easier.

Results

Some early returns are already in. Advocacy groups believe that the complaint helped induce the HSA to require Mount Sinai Hospital to include some specific provisions for community health care in its CON proposal (see separate story). New York University Medical Center has agreed to meet with an advocacy organization for the disabled regarding its emergency room modernization plans.

The civil rights approach has proven to be an effective strategy for intervention at the stage where resource allocation decisions are made. Although such efforts don't transform the health care system dramatically, they are meaningful increments in the process of making the system more responsive to the needs of people rather than institutions.

Editor's note: Other cases of using the Certificate of Need process to improve access have been collected by the National Health Law Program, 2639 South La Cienega Boulevard, Los Angeles, CA 90034.
Richland Memorial Hospital is a 611-bed county hospital located in Columbia, the state capital, and affiliated with the University of South Carolina School of Medicine. The hospital accepts all indigents from its own county of Richland, including patients diverted from the two private hospitals in the county. On July 19, 1984, however, it refused to accept a child suffering from meningitis, despite the fact that she had a 104-degree fever and was in a coma, because the child was from another county and no one there would underwrite her care. The child's physician eventually placed her at a hospital in North Carolina.

This widely publicized story is just one of many that illustrate the difficulties indigent people have been facing in getting hospital care, not just in Richland County, but throughout the state.

Hospital administrators have been pushing the state legislature for some time to provide financial relief for unreimbursed hospital care. This pressure paid off in June 1985, when the legislature enacted a Medically Indigent Assistance Program (MIAP), a major expansion of public funding worth $95 million on an annual basis.

The program will add an estimated $55 million to the $300 million currently spent on hospital care for the poor under Medicaid, and $40 million to finance a 25 percent expansion of Aid to Families with Dependent Children (AFDC). Hospitals—and indigent patients in need of acute care—will clearly benefit, as the public funding for such care increases about 20 percent. The added AFDC families will also benefit, with improved nutrition contributing to better health. However, the AFDC expansion will strain an already understaffed social service system and proportionately increase the acute shortage of physicians and clinics willing to treat the poor. Moreover, the program will scarcely begin to close the gap that still exists between the need for and delivery of primary medical services.

Poverty, and Paucity of Care

South Carolina is one of the poorest states in the nation, ranking 48th in personal income per capita. The 1980 census found that one-sixth of the population was living at less than the federal poverty level. And for the poor, access to medical care, especially primary care, can be exceptionally difficult or impossible.

Often the poor simply have no place to go. For example, in 21 of the state's 45 counties, the County Health Department serves less than one-third of the indigent pregnant women. And in nine additional counties, including Horry County, with its booming Myrtle Beach resorts, there is no free prenatal care at all.

As for private physicians, a 1983 report of the Governor's Council of Perinatal Health stated flatly that "Availability of prenatal care in South Carolina almost always is related to an individual's ability to pay. Generally, a pregnant woman must have private funds or third-party reimbursement in order to receive prenatal care on demand."

South Carolina's 1983 infant mortality rate, at 15 per thousand for the total population, and 20 per thousand for blacks alone, was the highest of any state. South Carolina also led the nation that year in low-birthweight babies, at 8.7 percent.

In Columbia, a new charity-supported free clinic, open just two evenings a week, is overcrowded with patients. The clinic is within two miles of three hospitals, and there are 500 practicing physicians in the metropolitan area. Yet, according to the clinic's nurses, all of whom are volunteers, many patients have long-neglected conditions that need treatment beyond that which the clinic can provide. For example, advanced untreated hypertension and diabetes are common, and the patients' needs for prescription drugs far outstrip the clinic's donated supply. Still, as one nurse put it, "If it weren't for this clinic, some of these people wouldn't be walking around next week."

When the poor do become inpatients, they pose serious financial problems for the hospitals treating them, since so many are not covered.

Medicaid is the main reimbursor for medical care for the poor. To be eligible for Medicaid, one must first qualify for either AFDC (for single parents with children) or the Medically Needy Program, enacted in 1984 for children and pregnant women in two-parent families. To qualify for these programs, before MIAP, a family's annual income could be no more than $1728 for a family of two or $2748 for four—the lowest income ceiling of any state, at barely one-fourth the poverty level. Thus, in 1980, according to the U.S. Department of Health and Human Services, only 37 percent of poor children in South Carolina were covered by Medicaid.

County funds for indigent medical care have been severely

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limited, most county hospitals receiving only token subsidies. Fifteen of the 46 counties spend nothing on indigent hospital care: 17 others spend less than $100,000 annually. More than 85 percent of medically indigent hospital care is given in the metropolitan areas of Charleston, Columbia, Florence, Greenville and Spartanburg; yet, even there, county funding has typically been about half what the hospitals say they lose on indigents.

As county hospitals began defending their balance sheets by turning away nonresidents of their counties, the acute shortages of medical personnel in the rural areas left the poor there with nowhere to turn. In 16 counties, there is no obstetrician at all. In Darlington County, the one obstetrician who was treating indigent women—about 130 no-pay deliveries a year—quit abruptly early in 1984 under the tensions he experienced. The “regional” medical center in adjoining Florence competed aggressively for Darlington’s paying patients, but resisted taking no-pays. So for several months, indigent women continued to deliver at Darlington with only nurses attending, backed by on-call physicians who were not obstetricians.

1981 Funding Cuts Reduced Programs

The seriousness of today’s problems can be traced in part to the 1981 Federal Omnibus Budget Reconciliation Act (OBRA), which sharply reduced federal support for social services. In response, the state reduced social service and health care programs rather than make up the lost federal funds. Among the many cutbacks affecting the poor were changes in AFDC eligibility, which reduced the rolls by one-sixth, to 50,000. Since that time, the income eligibility ceiling has been stuck at $2748 for a family of four, despite the inflation that has raised the poverty level to $10,850.

Medical care providers also took cuts. The state changed physician fees from “usual and customary” to a schedule that paid the same office fees to all physicians and lowered specialty fees such as surgery relative to the office visit. Since this change, the general Medicaid physician fee level in South Carolina has been the lowest in the Southeast.

Whether due to fee cuts or other factors, the number of physicians willing to see Medicaid patients has been dropping. Physician practices treating Medicaid patients, including hospital residency programs, fell from 5159 in Fiscal Year 1981-82 to 3382 in 1983-84, and welfare caseworkers are reporting increasing difficulty in placing clients with private physicians. In 1983-84, Medicaid paid for 2 percent fewer family practice and general practice visits, 26 percent fewer internal medicine visits, and 9 percent fewer pediatric visits than the previous year. One hopeful sign is that obstetric and gynecological visits were up 7 percent, perhaps contributing to the drop in the infant mortality rate from more than 16 per thousand in 1981 to about 15 per thousand in 1983 and 1984.

In response to the financial restrictions imposed by OBRA, the state decreed that Medicaid would pay for only 12 inpatient hospital days per person per year. Outpatient, emergency room and physician office visits were limited to 18 per year; prescriptions for drugs, to 3 per month. The reimbursement for drugs was so low that at least one public hospital’s pharmacy would not fill prescriptions for Medicaid clients; these people had to find a pharmacy on their own, with the help of their welfare caseworkers. Overall, after OBRA, the state revised its 1982-83 Medicaid budget downward by $23 million, cutting an originally projected increase in half. For the following fiscal year, the Medicaid budget was actually decreased by 2.6 percent.

The 12-day limit on inpatient stays gave hospitals a strong reason to avoid Medicaid patients with complex conditions, or, according to some staff members, to discharge them prematurely when they had used up their 12 days. The limit particularly affected elderly patients from nursing homes. Medicaid would pay to reserve the patient’s nursing home bed for 12 days only; therefore, if the hospital had not discharged the patient back to the nursing home by the 12th day, it risked being stuck with the patient indefinitely.

Governor Seeks to Raise Standards

It was to be expected that hospitals would be a predominant influence in the development of the Medically Indigent Assistance Program, but as a result, the program emphasizes matters of hospital finance over consumer access.

In 1982, the state funded a study of the medically indigent problem, awarding the contract to a consulting firm headed by Robert Toomey, founder of the Greenville Hospital system, one of the nation’s first multihospital systems. The study centered around a four-week survey of selected South Carolina hospitals to find out what the hospitals said they were losing on indigent care. The study also gathered data on income, family size and other characteristics of indigent patients in those hospitals; however, no attempt was made to assess unmet medical needs or difficulty of access to care.

In 1984, following Toomey’s report, the legislature set up an ad hoc committee to develop the bill that became the Medically Indigent Assistant Program. The chairman was Peter Reibold, vice president for finance of Providence Reibold had been publicly proposing the joint funding of indigent care by counties and hospitals for two years. His concern for the poor was genuine, but he also argued from enlightened self-interest: If the county hospitals were to go broke, the burden of indigent care would be thrown directly on the private hospitals. Reibold conducted a difficult but successful campaign to persuade other private hospital administrators to support the funding of public hospitals with contributions, in part, from their own institutions.

The tertiary care centers were not in imminent danger of going broke, but they were concerned about the future. Health maintenance organizations were just beginning to enter this
most conservative of health care markets. In addition, major employers were showing interest in preferred provider arrangements, under which deductibles and coinsurance would be used to steer employees to less expensive hospitals. If price competition were to break out among the hospitals, those treating no-pays would be at a disadvantage, since they would no longer be able to charge the costs of the no-pays to the paying patients. Aid was needed, said Reibold, to “level the playing field” for hospital competition.

Along with the hospitals, the other major participant in the indigent care funding effort was the state’s Democratic governor, Richard W. Riley. A careful and effective politician, Riley is South Carolina’s first two-term governor since Reconstruction, thanks to a constitutional amendment passed during his first term.

Riley has a strong desire to raise South Carolina above its low ranking, relative to other states, in numerous social indicators. In 1984, he pushed a bill through the legislature to raise the sales tax to expand state funding of education. He also won the Medically Needy Program that extended Medicaid benefits to poor children and pregnant women in two-parent families. For 1985, he made medically indigent assistance a top priority, mounting an impressive legislative and staff effort. Even Republican opponents were afraid to get in the way of what they called “Riley’s train” on this issue. His success impressed Reibold, who said, “It’s surprising how close the legislation mirrors the recommendations of the ad hoc committee.”

New Program’s Provisions

The Medically Indigent Assistance Program expands funding for hospital care three ways:

1. It makes more people eligible for Medicaid, by making more people eligible for AFDC. The income ceiling for AFDC has almost doubled, to $5100 annual income for a family of four (although still only half the federal poverty level). Families with both parents present are now eligible for welfare payments under an Unemployed Parent Program (AFDC-UP). The state’s Department of Social Services estimates that, altogether, up to 42,600 persons will be added to the 119,000 currently on AFDC. Medicaid spending based on the increased enrollment is projected to increase by $22 million per year.

2. It introduces a prospective payment system for Medicaid. As with Medicare’s DRG system, some scheme will be devised under which a hospital’s reimbursement for Medicaid patients will become somewhat independent of how much the hospital actually spends on the patient. The system is now under development.

 Usually, prospective payment is intended to save money. Here, however, it is projected to add $18 million to costs annually, because the system eliminates the 12-day limit on hospital stays. The Toomey report estimated that 18.5 percent of Medicaid patient days were not covered during the period of the study due to the 12-day limit. Getting rid of this limit was a high priority for the hospitals.

3. It establishes a fund of $15 million per year to pay for hospital care for the medically indigent who are not eligible for Medicaid. Half of this money will come from the hospitals, the other half from the counties, both being assessed according to complex formulas intended to produce pro-rated shares for all contributors. For the first time, hospitals that do not take
indigents will be forced to help support the hospitals that do, and counties that have previously contributed little or nothing at all will have to provide something.

Some may see the Medically Indigent Assistance Program as an example of Reagan's new Federalism in action—a state taking over as the federal government cuts back. Ironically, though, the federal government will be the major contributor to this program. Under a long-standing formula for aid to states, the U.S. Treasury pays 73.5% of Medicaid and AFDC benefits in South Carolina. Overall, the federal government will provide $58 million of the MIAP's annual $95 million expenditure.

The MIAP signals more than increased spending on health care. It also has the potential to establish rate regulation in South Carolina for the first time. The annual growth of total hospital inpatient charges across the state (not including unreimbursed care to indigents and education expenditures) will be compared with a target rate of increase. If the charges for the hospital as a group increase less than the target rate, no action will be taken. However, if total charges grow faster than the target rate, a regulatory commission will be established. The individual hospitals whose charges exceeded the target rate will have to justify themselves before the commission or face financial sanctions.

Governor Riley is said to have insisted on this provision. It was intended to appeal to the business community, whose panic about escalating health insurance costs for the work force outweighed its aversion to state regulation. Setting a target rate of increase was supposed to force the hospitals to use the new indigent care funds to increase their charges to other patients less than they otherwise would, a sort of "backward cost shifting."

As a cost containment measure, however, the regulation is remarkably weak. The only sanction for exceeding the target growth rate is that the money from the hospital-county indigent care fund will be cut off. Hospitals avoiding indigents cannot be touched. Furthermore, no matter how flagrantly an individual hospital raises charges, no action will be taken if the total growth of the state's hospitals is less than the target.

The target rate of growth will be the same as the growth rate for the federal index of hospital input prices (the national average of prices hospitals pay for labor, materials and so on) adjusted for "the South Carolina-specific experience."

During the final days before the program passed the legislature, the state hospital association concentrated special attention on this provision, with considerable success. The wording of the law seems to assure that any South Carolina adjustment will only add to the target rate of growth, not subtract. Moreover, the law specifies that, in the first year, the state adjustment shall be the same as the average annual difference over the past 10 years between the growth of South Carolina hospitals and that of the federal index (an addition of 6.6 percent). Thus, the target rate of increase will be 6.6 percent plus the projected increase in the hospital input price index, for a projected total of 11.45 percent for Fiscal Year 1986-87. Since South Carolina hospitals have just moved from a period of rapid inpatient service expansion to one of declining inpatient census, this generous target rate of increase should guarantee that the regulatory commission will not be established.

Staff Shortages a Problem

As the Medically Indigent Assistant program begins to get under way, it is likely to encounter a major bottleneck in the expansion of AFDC enrollment. It is questionable just how smoothly the welfare offices will be able to handle the influx of new clients with the present shortage of staff.

Back in 1981, before the Omnibus Budget Reconciliation Act, Governor Riley fulfilled a first-term campaign promise to reduce the number of state employees by cutting 174 economic service workers. Waits lengthened at welfare offices, despite the subsequent OBRA-inspired caseload reduction of 10,000 families. Visits through the Early Periodic Screening, Detection and Treatment Programs decreased by almost one-third, partly because economic service workers who used to make home visits were now kept in their offices to help handle the workload.

Although the new budget is putting back about 100 positions, total strength will not be up to the 1981 level. The Commissioner of the Department of Social Services had requested 700 positions to handle the 42,600 new cases projected. However, while some officials in some counties are already complaining, they will have to make do with what they have.

All-day waits at the welfare office will be likely to discourage people from signing up. And those that do sign up will face the shortage of physicians who are willing to treat Medicaid patients. Although the state has raised the office visit fee from $9 to $12, it is still less than half the market rate, and may or may not encourage physicians to overcome their aversion to
Medicaid patients. One hope is that the hospitals, who will have a strong financial interest in getting eligible families signed up for AFDC, will bring pressure for continued improvements in the system overall.

Because of the welfare office bottleneck and the physician shortage, it is possible that the Medicaid expenditures for the Medically Indigent Assistance Program will not reach the figure the state projects.

(This would not be the first time that a public aid program had spent less than its budget. Last year's new Medically Needy Program budgeted $19 million for children and pregnant women in 1985-86, but spent only $4 million. While the Department of Social Services had estimated that 5400 pregnant women and 18,500 children would qualify, only 800 women and 3200 children actually did."

The hospital-county indigent care fund for the uninsured will go quickly, however. Asked whether the fund was large enough, Reibold answered, "I doubt it, really. I think we'll find that we've got work to do in future years." And hospitals have not promised to treat all comers after the money runs out; they've made no promises at all.

Primary Care Still a Primary Need

South Carolina's Medically Indigent Assistance Program has some important progressive elements. Those hospitals, mostly public, who treat indigents will get substantial new financial support. Treating the indigent will still not be profitable, but the loss will be less, and the public hospitals' cost disadvantage, relative to private hospitals, will be reduced. Removing the 12-day limit on Medicaid-paid hospital days will mean fewer abrupt discharges, though prospective reimbursement will encourage hospitals to discharge all patients quickly. Welfare rolls will expand, subject to what the overburdened welfare office employees can handle, bringing what has been one of the nation's stingiest AFDC programs more into the mainstream.

The disadvantage of the program is in what it omits—direct measures to expand access to primary care. Those newly eligible for Medicaid will be entitled to a paid office visit, but it is not clear where to find physicians who will accept them and their meager reimbursements. At best, the Medicaid recipients will crowd into hospital outpatient departments, and have longer inpatient stays at the hospitals willing to take them.

For the working poor who do not qualify for AFDC, the hospital-county fund will help to pay for hospital care until the money runs out, but they will still be on their own for physician visits and pharmaceuticals.

Many indigent expectant mothers will still have difficulty finding prenatal care or a qualified professional to assist with the delivery. The Medically Indigent Assistance Program will then be called on to support the state's neonatal intensive care units, helping them to deal with some of the casualties of the state's neglect of primary care.

Expansion of primary care services, with a greater role for nurse practitioners, would be much more humane and cost-effective than throwing so much of the available money at hospitals. But achieving that will require another campaign and additional legislation.

9. South Carolina Department of Social Services, annual reports for the years ended June 30, 1979-1983.
10. Data courtesy of South Carolina Health and Human Services Finance Commission.
12. South Carolina Department of Social Services, annual reports for the years ended June 30, 1979-1983.
Black and Minority Health

In Washington, DC, friends must pledge on their lives that they will return it in 24 hours in order to borrow one. After a full press conference, and media hype, by the former Secretary of Health and Human Services, Margaret Heckler, copies of the Report of the Secretary's Task Force on Black and Minority Health are rarer than Gutenberg Bibles. (This is the first of seven planned volumes, called the executive summary.) Copies may be obtained through the U.S. Government Printing Office (No. 017-090-00078-0) by writing the National Health Information Clearinghouse, Suite 700, 1555 Wilson Boulevard, Rosslyn, VI 22209, or by calling (800) 336-7479 or (202) 522-2590. Enough demand will keep the Report in print.

Boston at Risk

On October 1, 1985, the Boston Foundation released a two-year study of primary health care delivery in Boston. The study examined which groups and communities are at such economic risk that their health is affected, the problems of the uninsured across all income groups, and the limitations of the current primary health care delivery system. The report was a product of the Primary Health Care Seminar Working Group and was authored primarily by Friends of Health/PAC member and Tufts University professor Alonzo Plough. The report found a growing disparity between the health of the disadvantaged and the affluent in Boston, including a dramatic 33 percent rise in infant mortality in 1982. The Boston Foundation will be using the report as a guide in making decisions on its health care grants. The report is entitled Boston at Risk and may be secured through the Boston Foundation, One Boston Place, Room 3005, Boston, MA 02108 (617) 723-7415.

Critical Health and Apartheid

The most recent issue of Critical Health, a journal on health and politics in South Africa, focuses on unrest in the black townships, police violence, unemployment, housing, and child care ("childminding"). The journal is produced by an editorial collective and is published about twice a year. Critical Health aims to "present a critique of health in South Africa, provide ideas for the roles that health workers can play in promoting a healthy society, show that good health is a basic right, and provide insight into the political nature of health." Subscriptions are $8 per year for individuals, $15 for institutions, from Critical Health, P.O. Box 16250, Doornfontein, Union of South Africa 2028.

Defense Measures

The President certainly does not eat kids for breakfast, but he doesn't seem to care if many kids eat nothing for breakfast. The sad details and a lot of other useful information are available from the Children's Defense Fund. Its new list of publications has pamphlets on everything from "Paying Children's Health Bills: Some Dos and Don'ts in Tight Fiscal Times" to an "Adolescent Pregnancy Watch Manual" to help local communities learn more about preventing teenage pregnancy. For a copy of the list, write Children's Defense Fund, 122 C St., N.W., Washington, DC 20001.

Exposure Exposure

The White Lung Association has prepared an excellent four-fold leaflet explaining what to do if you suspect that asbestos fibers are circulating through your office. For copies, write the White Lung Association, P.O. Box 1061, Brooklyn, NY 11202. The WLA has also begun a confidential Registry of Exposed Workers. This will aid in future court cases and provide a list of buildings with asbestos exposure to permit more vigorous pressure on building owners to eliminate asbestos hazards.

No Child's Play

Kidsrights, a privately-run clearinghouse on child abuse, abduction, molestation, teen rape, and suicide, has just published a comprehensive catalogue listing over 500 books, pamphlets, cassettes, games, and visual materials for sale. Producers of the materials include the National Education Association, the National Council for the Prevention of Child Abuse, and many other groups as well as companies. The catalogues are available free of charge from Kidsrights, 120-A West Fifth Ave., P.O. Box 851, Mount Dora, FL 32757.

Mythstakes

Beyond the Myths is concise, well-designed 25-page pamphlet detailing who actually receives Aid to Families with Dependent Children (AFDC), what they get, why, and for how long. This booklet will be a welcome source of information for anyone who has ever had to deal with Reaganesque anecdotes of welfare Cadillacs. It has a wealth of statistics, easy to read text, and clear graphs. Single copies are $2.50 from the Center on Social Welfare Policy and Law, 95 Madison Ave., New York, NY 10016. The Center also publishes an annotated bibliography of reference and statistical sources for legal research on public assistance programs.
Saving Money, Losing Lives
Lead Poisoning and Public Policy

by Maxine Golub

Let's call them Michael and Ivette. Brother and sister, four and three years old, they were referred to a New York hospital in August 1983 with a diagnosis of lead poisoning. Michael was admitted for treatment. Three weeks later, the landlord still hadn't made the necessary repairs in their apartment; the case was referred to the Emergency Repair Program.

After Michael's discharge, he was sent to a relative's home because his apartment still was not clear of lead violations. He stayed there two weeks and then returned to the unsafe home because his mother could no longer care for the family in two locations. The other children had remained home; in late September Ivette also required hospitalization due to her increased lead level.

The Emergency Repair Program crew began work in late November, 66 days after the initial inspection. Three days later the cleanup came to a halt when the landlord refused to allow the ERP contractor into the building. This delayed work for several more days.

In January 1984 the Health Department's inspector returned to the apartment and found peeling paint in the living room. This violation had not been reported the previous September, so the ERP could not repair it. A new citation was issued, but it was not until July that the violations were corrected.1

In May 1985 four families like Michael and Ivette's joined four public health organizations (including Health/PAC) in a class action suit charging the city's Department of Health and Department of Housing Preservation and Development and the state's Department of Social Services with failure to enforce laws designed to prevent lead poisoning.

New Wine in Old Bottles

Michael and Ivette's tragedy is similar to many others far beyond New York City, and far from the 1980's. Historians say that lead was a known source of sickness as far back as ancient Rome, when the ruling class fell ill from wine stored in leaden vessels.2 Some go so far as to blame lead for the fall of the Roman Empire, asserting that lead water pipes caused widespread dementia and sterility.3

During the mid-1700's, the children of lead workers were reported to suffer "retarded growth and development." In 1904 the Australian Medical Gazette documented the first case of lead poisoning caused by "toxicity of habitation."4 Workers and public health officials were well aware of the toxic effects of lead in the United States in the 1920's, when one chemical plant was known as the "House of Butterflies" in recognition of the fate of many intoxicated workers.5

The first cases of lead poisoning in children in the United States were reported in the 1930's, but it was not until the 1950's and 60's that systematic early detection efforts were begun in several large cities.6

These studies found a great deal—at one Baltimore hospital 90 percent of the children seen at the outpatient clinic had elevated lead levels in their blood7—but the breadth of this scourge remained unperceived.

Prior to the 1970's the usual case identified in the United States was symptomatic and dramatic, so-called "frank" lead poisoning. In these cases the child was usually brought to a hospital emergency room, severely ill. Common symptoms included vomiting, convulsions, and seizures, sometimes leading to encephalopathy and coma. The consequences were invariably serious: severe mental retardation, blindness, and/or cerebral palsy—if not death; 28 percent of the children diagnosed with lead poisoning at Chicago's Cook County Hospital between 1959 and 1963 died.8

The widespread incidence of low level lead poisoning has become apparent only since the initiation of mass screening efforts provided for in the 1972 Lead Based Paint Poisoning Prevention Act. The National Health and Nutrition Examination Survey (1976-1980) concluded that undetected lead toxicity afflicts 4 percent of all children between the ages of one and six, including 11.6 percent of low income, inner city children and 18.6 percent of all low income black children.9 Lead poisoning is now considered to be the most widespread preventable pediatric disorder in the United States. Sometimes referred to as the "silent epidemic" due to its asymptomatic nature, this low level toxicity is far from harmless. Pioneering research by Dr. Herbert Needleman has shown that children who have it suffer a range of developmental delays and learning disorders, including intellectual problems such as delayed speech development and verbal processing, poor attention span, and decreased IQ scores—all essential for effective classroom performance and the development of skills necessary for academic success. Needleman's study of dentine lead and neuropsychological deficit in Massachusetts school children inspired the frequently repeated phrase, "No lead is good lead."10 (see Figure 1).

Although there has been some controversy over Needleman's analysis of his data, his conclusions have been confirmed by

Maxine Golub is Chairperson of the New York City Coalition to End Lead Poisoning. For more information about lead poisoning call (212) 920-5016. The author wishes to thank Paul DeBrul, Nicholas Freudenberg, and John F. Rosen for their help with this article.
Figure 1. Distribution of Negative Ratings by Teachers on 11 Classroom Behaviors in Relation to Dentine Lead Concentration. The group boundaries were chosen to obtain symmetrical cell sizes for the median (classes 1 and 6 = 6.8%, classes 2 and 5 = 17.6%, and classes 3 and 4 = 25.6%). (Reprinted with permission from Needleman et al., reference 10; courtesy of *The New England Journal of Medicine.*)

other researchers. In fact, more recent medical research has found that even levels currently considered normal are associated with serious health problems, including impairment of Vitamin D metabolism and neurophysiological functioning. Children who have iron deficiency anemia — another common pediatric problem — face still greater risks because iron deficiency enhances the toxic effects of lead.

Children who require treatment for lead poisoning are often hospitalized for several courses of therapy, each of which may involve five to seven days of painful injections or intravenous medication. Most need regular follow-up visits for two to five years to monitor their blood lead levels, which may change due to redistribution of body lead stores or re-exposure.

Sources of Toxicity

The National Academy of Science estimates that American industry consumes about 1.3 million metric tons of lead annually, and in the process exposes all of us to elevated lead levels in our air, drinking water, and foods. The two major sources are exhaust from cars which burn leaded gasoline, and lead based paint in housing constructed prior to 1960.

Although the popular myth is that low income urban children get lead poisoning by eating paint chips, which they do because they are unsupervised or understimulated, the unfortunate truth is that lead is everywhere. Children may ingest particles which their parents have brought home on work clothes, or from the dirt in urban parks, playgrounds, and backyards, particularly if there is heavy traffic nearby. We are all exposed to lead in our food in the form of vegetables grown in lead-laden soil or canned juices sealed with lead solder (see Figure 2). The apple casually purchased from a street corner vendor may be covered with invisible lead particles, and drinking water may contain lead leached from plumbing.

Recent testimony to the Environmental Protection Agency indicates that as much as 40 percent of the urban dweller's background body lead can be traced to airborne gasoline. It takes only a small quantity from a concentrated source such as paint chips or leaded dust from deteriorating housing to push a child over the threshold into the toxic category (see Figure 3).

Mobilizing the Community

By the late 1950's lead based paint was a well-known hazard to children. Several cities had outlawed its use on interior surfaces, and paint manufacturers had voluntarily reduced the lead content of paint used for toys, furniture, and interior surfaces. Activist efforts to prevent childhood lead poisoning began in the 1960's in the context of the larger social movements of that era—civil rights, community organization, and the decentralization and demystification of health care. The major battles have taken place on the local level, spurred by concerned scientists, physicians, activists, and community groups. Most have focused on one of three arenas—health, housing, and the environment—generally reflecting the area of expertise or primary concern of those involved.

The New York City experience is a prime example of what has and has not been accomplished.

In 1967 four members of the New York Scientists Committee for Public Information learned of the high incidence of lead poisoning in cities around the country when they attended a conference in St. Louis. They came home determined to find out how New York City was affected. Their research led them to the distressing conclusion that lead affected between 9,000 and 18,000 New York City children. Convinced that aggressive prevention measures were in order, they began meeting with health and housing officials, and one sympathetic health official cautiously admitted that their estimates might be too low.

In 1968 they organized Citizens to End Lead Poisoning (CELP), convinced, as Paul Dubrul wrote on behalf of the group, that “No progress will be gained in the battle against lead poisoning without massive mobilization of the ghetto community.

“We have already been told by the Health Department that
no money can be found for a testing program until the black community begins yelling ‘Murder,’” he went on. “Previous experience has shown that existing agencies only respond in the face of crisis. The crisis exists; we have to draw attention to it.”

This marked the beginning of a two-year struggle. The black and Hispanic communities were mobilized on the issue, and Mayor John Lindsay was forced to respond by establishing the Bureau of Lead Poisoning Control in the New York Department of Health in 1970 to oversee community education and screening efforts, medical follow-up and treatment, and to provide housing abatement for identified cases. The Department of Housing Preservation and Development was assigned the task of making repairs in apartments where the landlords failed to comply.

From the outset, housing officials considered the problem virtually insoluble. Disputes flared over resources—and their inadequacy. In one dramatic early 1970s episode the radical Puerto Rican organization the Young Lords focused media attention on the problem by “liberating” a city-owned screening van and bringing it to East Harlem and the South Bronx to test children.

New Legislation

Representative William Fitts Ryan, then representing Manhattan's West Side in Congress and actively involved in the local debates over lead poisoning prevention, pushed for a national effort. With the help of Senator Edward Kennedy, he won passage of the Lead Paint Poisoning Prevention Act, which provided funds for much-needed health education and community awareness campaigns, screening, medical follow-up, and treatment in 60 major cities. Most of the programs also included housing abatement efforts. The act also directed the Department of Housing and Urban Development to establish technical guidelines for the elimination of lead hazards in housing, which had not been mandated by the previous lead paint regulations.

At roughly the same time, environmental groups were gathering strength. Air pollution was becoming a household phrase, and car exhaust was receiving a large share of the blame. This public concern spurred legislation requiring all new cars to have catalytic converters, which can use only unleaded gasoline. In 1971, Environmental Protection Agency administrator William Ruckelshaus announced the government’s intention to ban lead in gasoline.

The Failure of Public Policy

Despite these auspicious legislative measures, efforts to combat lead poisoning soon stalled.

“History,” commented Paul Dubrul recently, “will probably judge America very harshly for the way we’ve handled lead poisoning. It is disgracefully clear that our policymakers have never been committed to eliminating lead poisoning. They have chosen to sacrifice the intellectual potential of some 780,000 American children rather than pay the price of controlling the environment, providing decent housing and adequate primary care for all.”

In 1972, the housing abatement program of the New York City Department of Health averaged 58.56 days from the day a case was reported until the day it was repaired, and only 60 percent of the apartments repaired met the required standards. Ten years later the average was 57 days, with 53 percent considered completely repaired.

The U.S. District Court ruled in 1981 that HUD regulations were not consistent with the goals of the Lead Poisoning Program Prevention Act, but new rules and procedures required for the elimination of lead paint hazards have yet to be established. (Coincidentally, one of the plaintiffs in the current New York City class action suit lives in an apartment subsidized by HUD's Section 8 program.)

This year, the Centers for Disease Control estimated that there are still 30 million households which contain lead based paint. Yet only 10 percent of the federal funds expended on lead research from 1977 to 1979 were used to examine control measures, and HUD’s prevention research was terminated in 1981.

The failure to reckon with environmental, economic, and political aspects of the lead poisoning problem, particularly regarding housing, has ensured that the problem will not be solved. This literally fatal flaw was present on both the national and the local level.

“From the very beginning, the housing abatement program was inadequate...a band-aid solution,” a New York City health official involved from the early period commented confidentially. In New York the support of housing officials, or even of housing advocates, was never enlisted.

The Reagan Years

The never-robust lead poisoning programs were hit with a series of devastating blows by Reagan Administration policies.
In 1981 the categorical funds which had supported prevention programs all over the country for ten years were merged with a host of other preventive care programs into the Maternal and Child Health Block Grant. The states were told they could divide the grant—25 percent less money than the total given its individual components the year before—as they wished. Lead poisoning, asymptomatic, affecting primarily low income, urban children, has not been a strong competitor in the scramble for funding.

The future looks even bleaker. Those local programs which have survived the cutbacks are no longer required to report annual statistics to the Centers for Disease Control. This means, explained one health official, that “we have no way of knowing how many children are screened, or how many are positive. This eliminates our ability to document the problem, and thereby command resources.”

General Motors’ Long Battle

More happily, at long last the opposition appears to be running out of gas in one important area.

Leaded gasoline was invented in the 1920’s to power the larger cars that General Motors wanted to build so it could outsell Ford’s smaller, cheaper models. Gerald Markowitz and David Rosner have recently related in a fascinating study,21 the controversy over the effects of leaded gasoline on public health was so great that the Ethyl Corporation was forced to take it off the market for nine months in 1925, but an alliance between the automobile and gasoline industries and the federal government soon overrode the public clamor. From the late twenties on, say Markowitz and Rosner, “most research into the dangers of leaded gasoline was conducted under the auspices of the oil and auto industries themselves”22—much the same way the EPA’s Ann Gorsuch inappropriately involved herself with the gasoline industry in 1982.23 As a result, the dangers of leaded gasoline had to be rediscovered a half century later—after “unknown numbers of neurologically damaged children,” in the words of Markowitz and Rosner.24

The International Lead-Zinc Research Organization still funds self-serving research, and last year the Lead Industries Association tried to enjoin publication of the Centers for Disease Control’s new guidelines on childhood lead poisoning, but so far even this group has not challenged the announce-ment by Lee Thomas, Administrator of the Environmental Protection Agency, that leaded gasoline can no longer be sold after 1987.

The EPA has documented the dramatic correlation between the drop in leaded gasoline sold and the reduction in blood levels from 1976 to 1980 (see Figure 4). The total ban will not remove the lead paint from 30 million households, but it will cut the background lead levels of children living in them by 25 to 45 percent, significantly reducing vulnerability.25 The EPA’s 1985 study Costs and Benefits of Reducing Lead in Gasoline estimates that “In 1986 alone, the reduction will prevent 172,000 children from developing blood lead levels in excess of 25 micrograms per deciliter.”26 The New York Times praised the EPA for the ban, noting “14 years of delay and obfuscation” since William Ruckelshaus first announced his intention to comply with the relevant provision of the Clean Air Act,27 but the real praise should go to the committed individuals and groups who kept the pressure on. The Natural Resources Defense Council played a critical role; in 1982 it successfully sued the EPA for failing to enforce the Clean Air Act.

Where Do We Go From Here?

Still, the leaded gasoline ban is not the only progress of recent years. The Centers for Disease Control have cut the level at which a child is considered toxic from 30 to 25 micrograms per deciliter, and now urges that all children be screened. The CDC estimates that this will increase the number of children referred for early treatment between three and ten times.

A variety of local groups have remained active around the country, and some have achieved significant reforms. Chicago’s Coalition to Ban the Sale of Lead Gasoline, a broad-based amalgam of environmental and health groups, helped win City Council passage of legislation prohibiting the sale of leaded gas from September 1984. A similar bill was passed in Cook County last November, and these bans were incorporated into the Illinois Clean Air Act implementation plan, currently being reviewed by the EPA.28

In the ten years since a group calling itself LEAD Action initiated a massive public education and awareness campaign in Washington DC, involving people in every walk of life, the case-finding rate there has plummeted from 32 percent to 0.8

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![Figure 2](https://via.placeholder.com/150)

**Figure 2.** From left: a lead-sealed can, a welded can, and a two-piece can, the last two being lead-free. (Courtesy of The Consumers Union Foundation.)
Figure 3. Sources of lead in a child's environment. (Courtesy of The Centers for Disease Control, 1985 statement on "Preventing Lead Poisoning in Children," reference 19.)

*Production of bullets or fishing sinkers
Soldering and stained-glass work
Gasoline sniffing
Pottery glazing
Burning of batteries, colored newsprint, lead-painted objects, and waste oil

**Toys and figures containing lead
Folk remedies
Cosmetics (especially Oriental cosmetics, e.g., Surma, a black eyeliner)
Jewelry (painted with lead to simulate pearl)
Lead-containing dust transmitted on clothing from workplace
The Governor of New Jersey has just signed a mandatory lead screening bill which requires annual testing of all children under six. A group called NYS/Take Lead Out of Children is actively lobbying for the passage of similar legislation in New York.

In New York City, the New York City Coalition to End Lead Poisoning has taken up where CELP left off. A report NYC-CCEL P issued last year, coupled with political pressure, won an additional $300,000 for the City's Lead Poisoning Control Program. More recently, NYC-CCEL P has become one of the more vocal co-plaintiffs in New York's class action suit, and some members hope to keep lead poisoning an issue in city politics.

Health and environmental professionals, often under the aegis of government agencies such as the CDC and the EPA, have produced invaluable documents filled with carefully researched information. These are important tools, but it remains the task of community groups and activists to transform recommendations into policy on the local, state, and federal levels.

There is a tremendous amount to be done: community awareness campaigns, professional education, screening, treatment, home repairs, and the reduction of dietary and environmental lead exposure. Few comprehensive programs address both the health and environmental aspects of the problem. Serious collaborative efforts among the various governmental departments responsible are even rarer.

Activists—health professionals, environmentalists, housing organizations, and educators—must take the lead in demanding the resources to continue and expand this work while insisting on enforcement of existing legislation and challenging ourselves and our legislators to find creative solutions.

4. Lin-Fu, op cit.
8. Lin-Fu, op cit.
16. ibid.
17. ibid.

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17 Murray St., New York, NY. 10007
The Great American Health Fortunes, 1984

by Tony Bale

In 1984 the health care rich and super-rich were still making money the old-fashioned way: having others do most of the work while they reaped large rewards in financial markets. Massive increases in spending, business and financial activity, and new technologies have accelerated the pace of accumulation of personal wealth among those best situated.

The vast wealth made in older pharmaceutical and medical supply ventures and newer entrepreneurial ones inspires the hordes of new fortune seekers hoping to turn fledging companies into the big money. Financially ambitious but less adventurous souls who like a regular paycheck can aspire to the salaries of the top executives in the industry, which provide a yearly ticket to the rapidly growing Reagan Era millionaire club. The big winners in the health care game constantly turn up on the numerous business press lists devoted to various aspects of corporate prowess.

This second annual survey (see Bulletin, May-June 1984, for the first) looks at their stories to create a narrow window into the vast array of interlocking and interacting businesses that make up much of the health care system—and threaten to engulf the rest of it. Knowing something of who these principal beneficiaries are and how they got so rich enables us to trace some of the process by which a corporate health care system transforms the human need to attempt to alleviate suffering into great personal wealth for a fortunate few.

The Largest Fortunes

Starting at the top, the Searle siblings, Daniel, William, and Suzanne, the wealthiest family in the pharmaceutical industry, made a concerted effort to push their net worth, estimated by Forbes at over $700 million, beyond the $1 billion mark. Last September the three heirs to the family fortune announced that G.D. Searle, the Chicago-based pharmaceutical giant, was for sale because they wished to diversify their holdings. At that point, together with their trusts, they owned about 34 percent of the stock. Searle stock immediately began to climb, reaching a peak of nearly $65 by January as speculators bet a company riding high from sales of the highly successful, patent-protected artificial sweetener aspartame (sold under the brand name Nutrasweet) would find many suitors. At this price, the Searles were worth over $1 billion, but they had hoped to receive a bid for the company of at least $75 a share, which would have given them $1.25 billion, and the highest offer they actually received was reported around $62. In April, after this offer was rejected, several Searle family trusts began the diversification process by selling 7.5 million shares back to the company at $51.75 a share, which brought them only $388.1 million but kept control in the family.

In mid-July the chemical giant Monsanto, which has wanted to broaden its drug and health care business, agreed to purchase Searle for $2.7 billion, $65 a share. At this price the Searle family's remaining stock in the company was worth $540 million.

In May Daniel Searle had resigned as chairman of the board. His replacement was the first non-Searle-family chairman, Donald Rumsfeld, Secretary of Defense under Gerald Ford. Rumsfeld, who was previously Searle's President and chief executive officer, is expected to leave before Monsanto's management team moves in. In the words of his replacement as Searle's president, "There is only room for one president, and they have one."

There are other presidencies, however, and Rumsfeld is thought to harbor ambitions to be President of the United States. If he were elected, it would mean a tremendous cut in income. In 1983 his combined salary, bonus, and stock income of $1,485,000 had placed him at the top of the pharmaceutical chief executive list. Last year wasn't quite so good, but his total compensation of $1,062,000 still left him fourth in the industry behind Bristol-Myers' Richard Gelb ($2,205,000), Warner-Lambert's Ward Hagan ($1,535,000), and Eli Lilly's Richard Wood ($1,327,000).

Each of the Searles, of course, collects many times as much simply by staying alive. So do scions of the other old pharmaceutical fortunes, including the Upjohn family (worth $500 million) the Lilly family ($400 million), and the Richarsons of Richardson-Vicks ($250 million). Even the largest fortunes may suffer unanticipated disasters, however. The $150 million Robins family stake in the A.H. Robins Company became a bit shakier when the company posted a $462 million loss in 1984, the largest among the Fortune 500 corporations. Most of the red ink came from a $615 million reserve Robins set up to handle future Dalkon Shield claims. Even this huge fund and profits from Robitussin and other drugs may not be large enough to cover future losses and restore the financial community's confidence; Robins has already paid out more than $300 million in claims resulting from injuries caused by its intrauterine device.

Kansas City's Ewing Kauffman has built the largest new fortune in the pharmaceutical industry. His Marion Laboratories specializes in marketing foreign drugs and doing research necessary to obtain Food and Drug Administration approval. Sales of Cardizem, a Japanese-invented drug for angina, helped triple the value of Kauffman's 24 percent interest in Marion Labs between early 1983 and mid-1985. Cardizem may

Tony Bale is a sociologist and a member of the Health/PAC Board.
soon win FDA approval for treatment of hypertension, opening up an even larger market. *Forbes* estimated that Kauffman’s fortune, worth $160 million in 1983, had grown to at least $200 million in 1984.

The generic drug industry is also generating new fortunes, aided by widespread efforts to cut health care costs through the substitution of generics for brand-name drugs and the Waxman-Hatch bill, which makes it easier to get FDA approval for generic versions of drugs whose patents have expired. Pittsburgh’s Mylan Laboratories, the industry leader, also gets a big boost from its own blood-pressure drug. Between 1979 and 1985 its stock split six times; in mid-1985 it was selling at 40 times earnings, and the holdings of company president Roy McKnight were worth $34 million. Like many new companies, Mylan has rewarded many of its employees with stock options, and 20 of them are now millionaires.

William A. Fickling Jr. of Macon, GA has made the most money in the for-profit hospital business. He owns over 80 percent of Charter Medical Corporation, a firm specializing in the most lucrative end of that industry’s psychiatric hospitals. Fickling began Charter Medical in 1969; in 1984 he increased his net worth $35 million to $175 million.

Patrick Ryan is the biggest recent success story in the health insurance industry. In 1982 he merged his auto insurance company with prominent Nixon-friend and financial backer W. Clement Stone’s Combined International Corporation and became its head. The recently revitalized company, specializing in low-cost health insurance, has raised Ryan’s net worth to at least $140 million.

Surgeon Laszlo Tauber, the wealthiest physician on the *Forbes* 400 list, didn’t accumulate his $250 million removing polyps. Such fortunes can only be made in business. Tauber is a Hungarian Jew who spent time in Nazi labor camps and emigrated to the United States after World War II. His building business sideline grew to the point where he became the U.S. Government’s largest landlord.

Ironically, Tauber’s major breakthrough came in the late 1960’s when he won the contract to build and lease the 1.2 million square foot Parklawn office building of the Department of Health, Education and Welfare in Rockville, MD. Thus this physician started on his way to the world of the super-rich by building a structure where some of the vast bureaucracy concerned with studying and regulating the health care system would be housed. Tauber still does surgery at an Alexandria, VA hospital he built. Among other philanthropies, he tracks down and helps people who aided him during the Holocaust.

**Gifts of Fortunes**

Once amassed, great wealth has been used for widely divergent purposes, and the Johnson & Johnson fortune illustrates some of the extremes. Much of it is the subject of a bitter dispute pitting the third wife of J. Seward Johnson Sr. against his six children. When J. Seward, son and younger brother of the better known Robert Wood Johnson Sr. and Jr., died in May 1983 at the age of 87, he left his wife Barbara the bulk of his estate, valued at between $400 million and $1 billion. Only one of his children received anything—$1 million plus a house—although each had previously been endowed with a trust fund worth $10 million in today’s market. “A cold fish in the face,” is how J. Seward Johnson Jr. described the will.

He and his siblings have decided a billion dollars is worth fighting for, and Barbara thinks the same. Each side in the dispute has amassed huge amounts of documentation in its attempt to discredit the other. Lawyers for Barbara Johnson described the exhibits as “more on the scale of a large antitrust case than of a probate proceeding.” If and when the trial begins as scheduled in New York City this November, the sensational material exposed is likely to tarnish the carefully cultivated
familial image of a company virtually synonymous with baby powder.

When they married in 1971, Johnson and the Polish-born chambermaid, a former art student 42 years his junior, embarked on a spending spree of the sort that may never be equalled by the new health rich. It took four years and $30 million to build their house in Princeton, NJ, which "reportedly came with a $78,000 orchid house, bathrooms with heated marble floors, gold-plated towel racks and an air-conditioned dog house," according to the New York Times.

Since her husband's death, Barbara Johnson has continued to spend lavishly. She recently set records for the most ever paid for a single piece of furniture, $1.5 million for a cabinet from Versailles, and for a drawing, $4.8 million for a Raphael. The Johnsons had been particularly fond of Raphael: one of his murals was to have been the ceiling of the as yet unfinished $5 million mausoleum for them and their two dogs.

Certainly the Johnson & Johnson Company would prefer to be associated with the Robert Wood Johnson Foundation, whose assets of some $1.2 billion also originated in the medical supply fortune. Until this year RWJ was the dominant philanthropic presence in health care, and it derives the bulk of its income from a 13 percent share of Johnson & Johnson's stock.

This giant has now been dwarfed by the June sale of Hughes Aircraft to General Motors for more than $5 billion, all of which goes to the Howard Hughes Medical Institute. At a stroke the Institute has become the largest of all private philanthropies, over $1 billion wealthier than the Ford Foundation. It is expected to support at least $200 million worth of medical research a year, most of it at teaching hospitals and medical schools. This sum is twice what all private foundations put together spent on such research in 1980.

Medical research is not the full beneficiary of the world's richest paranoid hypochondriac. In the eight years since Howard Hughes died, courts attempting to establish the legitimate heirs of another $1.1 billion have been wading through 40 phony wills, the claims of numerous women who say they were secretly married to him, and a vast litigation logjam.

Those who want to dispense their millions while they're still alive can also run into problems. "It's easier to make $100 million than to give it away," declared Edwin Whitehead, who has done both. The giving was difficult because the gift came with strings attached. Students and faculty at MIT undid some of them before the university was able to conclude an agreement to establish his $135-million Whitehead Institute for Biomedical Research, opened in 1984.

Briefly a paper billionaire from his company Technicon, specializing in automated blood analyzers, Whitehead sold out to Revlon in 1979 and became an "enlightened philanthropist." He hopes that as private funding replaces government financing (at least in non-military areas) his MIT model of a privately endowed research center operating in the midst of a university will spread. Still worth over $150 million, Whitehead recently donated a million dollars to the Hastings Center, an institute in Westchester County, NY devoted to biomedical ethics, and has expressed a wish to make the center "a household word."

Going Public

Many of the new multimillionaires of Reagan's Age of the Entrepreneur have realized their wealth by taking a company public. Initial stock offerings raised $10.7 billion in 1983, although plummeting values of new offerings have since made investors wary—at the end of 1984 over half of the companies that have gone public since 1978 were selling at less than their initial offering price. A raft of new high-tech companies were among those which sank after riding high waves of investor enthusiasm. New offerings in 1984 raised only $3.5 billion; the founding entrepreneurs and their financial backers had to settle for prices considerably below what they would have obtained a year earlier.

Among those hard hit was Silicon Valley venture capitalist Arthur Rock. He was worth $160 million at the end of 1983, according to last year's Forbes 400 list, but he didn't even make this year's list because the value of his stock in Diasonics, a troubled maker of diagnostic imaging equipment, plunged $50 million.

Health care has certainly lost some of its glow on Wall Street. The day in 1983 when Diasonics went public Rock's holdings were worth $84 million, and three other stockholders shared another $190 million worth. In 1984 the top single-day moneymaker in the industry was LeRoy Pesch, chairman of the Houston-based Health Resources Corporation of America; his stock was worth only $32.1 million the day his company came on the market. Last year the instant wealth was much greater elsewhere: the stock of toymaker Russell Berrie was valued at $165 million the first day shares were sold, a firm investor vote of confidence in the low-tech stuffed teddy bear industry.

Investor enthusiasm for health maintenance organizations is the one consistently upward trend among health care stocks. Enrollment in HMO's is growing explosively—up a record 22.4 percent in 1984 to 16.7 million members—and since 1980 they have raised over $1 billion in capital by going public. Leonard Abramson, founder of Philadelphia's U.S. Health Care Systems, had stock in his HMO worth $31 million when it went public in early 1983 (see last year's Bulletin article). The price of the company's stock had multiplied six times by mid-April 1985. In the same month, the value of a share in Nashville-based Health America Corporation was triple the initial offering price of July 1983. Shares in several other investor-owned HMO's that went public in 1983 and 1984 had also doubled or tripled by this spring.

Richard Burke, head of the Minnesota health maintenance organization United Health Care Corporation was the 1984 single-day fortune champion for HMO's, with paper worth $18 million.

Here is a list of 1984 single-day recordholders in other branches of health care:

- Austin Darragh ($23.2 million). His Institute for Clinical Pharmacology is an Irish outpost of the American health care system, for which it does drug testing. ICP's scandalous treatment of its human guinea pigs in unregulated and economically depressed Ireland was the subject of a recent Bulletin article (January-February 1985).
- Andrew Miller ($12.5 million). Miller is head of Nashville-based Surgical Care Affiliates, a small chain of freestanding surgery centers.
- Joseph Meringola ($8.3 million). His Medical Action Industries, Inc. of Farmingdale, NY is a dispensary of the new disposable society, manufacturing disposable sponges, surgical masks, and Sure Snip™ suture kits, and distributing surgical apparel and related equipment. Other disposable items in the works include non-sterile surgical apparel, examination gloves, and surgical towels. According to Medical Action's stock prospectus, the company is considering production of pre-packaged sterile surgical kits containing all...
• Ronald Berman ($8.6 million). His New York City-based Cosmopolitan Care Corporation has staked claims in three related growth sectors: temporary office personnel, private contracting of government services, and home health care. It contracts with governmental agencies in the New York-New Jersey area to provide personnel and management for services such as revenue collection and has a rapidly growing Home Care America division.

• John Bradley ($27.1 million) and David Huff ($20.3 million). Bradley is founder and president and Huff is executive vice-president of American Health Care Management, a Dallas-based hospital company.

• Dr. LeRoy Pesch ($32.1 million) and Donna Stone Pesch ($11.3 million). LeRoy is founder and board chairman of Health Resources Corporation of America and married to Donna, who is a director of the company. Their story illustrates some of the interlocks and opportunities which are creating the new rich of health care.

Dr. Pesch founded HRCA in 1981 after holding numerous administrative jobs in voluntary and governmental health, among them President of Michael Reese Hospital in Chicago, Dean of the SUNY/Buffalo School of Medicine, and Assistant Secretary for Health and Scientific Affairs for the U.S. Department of Health, Education, and Welfare.

Donna Stone Pesch is the daughter of W. Clement Stone, the wealthy insurance magnate (see the story of Patrick Ryan above). Stone built his original fortune by having legions of door-to-door salesmen get up in the morning, whip themselves into a positive mental attitude by chanting "I feel happy, I feel healthy, I feel terrific," and then rush out the door to sell low cost accident insurance policies paying approximately ten cents in benefits for each premium dollar. Later his company sold low cost health insurance.

It's certainly possible that Stone gave his son-in-law copies of The Success System That Never Fails and his other inspirational books, but his help was more than spiritual. In 1982, while a director of HRCA, he gave his personal guarantee as collateral for all the company's bank borrowings: in exchange he received 25,000 shares of stock.

When HRCA went public in 1984 LeRoy and Donna Stone Pesch owned over half the stock between them, W. Clement Stone and his wife owned another eight percent, and the most famous member of the board, the eminent surgeon Michael DeBakey, owned 1.2 percent. LeRoy Pesch continued as chief executive officer at a salary of $207,000 a year, subsequently raised to $300,000. In addition he was reimbursed $16,000 a month for expenses connected to his Houston home and automobile.

In late 1984 HRCA merged with the rapidly expanding Republic Health Corporation of Dallas, the fifth largest for-profit hospital chain. The deal gave the Pesch family 22.3 percent of Republic's stock, worth approximately $75 million in June 1985. LeRoy Pesch continued in his job of president of HRCA, and had other income from the merger as well: the agreement stipulated that Republic will obtain business aircraft from Avro, Inc., a company he half owns, and HRCA leases a Lake Forest, IL office building in which the Pesches have a 35 percent interest.

Donna Stone Pesch has devoted her major energies to philanthropy. Since 1969 she has served as president of her parents' foundation, overseeing over $100 million in gifts. It is certainly possible that she will find this experience useful if she and her husband start their own foundation some day.

LeRoy Pesch not only joined a successful management team when he merged his company with Republic, he also linked up with the industry's largest investor-owned hospital chain, Hospital Corporation of America. When HCA sold 18 hospitals to Republic it got 7.5 percent of its stock in partial payment. The purchase agreement also included a proviso that if Republic lost $5 million in a quarter or defaulted in its payments to HCA before July 1985, it would cede control of its board to HCA nominees until its financial condition improved. This clause was never activated. Republic was able to turn the money-losing low occupancy rate HCA hospitals it bought into money makers by revamping them to specialize in a limited number of procedures they could perform at a profit. Despite this success, Republic has decided that buying money-losing hospitals and turning them around is less lucrative than building local networks of physicians, primary care settings, and elective and acute hospitals.

So far this strategy has proven phenomenally successful. In 1984 Republic's net revenues jumped 48 percent and its net income nearly quadrupled over the previous year. This spring rumors were circulating on Wall Street that McDonnellDouglas, already heavily involved in health care, was entering negotiations to acquire 13 percent of Republic.

If Republic does join the military-medical-industrial complex it will be like old times for Mitchell Rogovin. A Washington lawyer, Rogovin's long list of political appointments include the positions of Special Counsel to the CIA and director of the Nuclear Regulatory Commission's investigation of the Three Mile Island accident. As part of the HRCA-Republic merger he is receiving $100,000 on a one-year legal consulting contract. This is considerably less that the $189,000 he earned a year before from HRCA. Rogovin is now a small cog in the wheel of the continual deal making, mergers and acquisitions, network building and elite shuffling that go into making health fortunes.

When deals can be worth so much, some corporations have apparently been willing to step beyond legal bounds to overcome regulatory obstacles, and have found government officials willing to help, in exchange for sufficient compensation. The New Orleans U.S. Attorney claims that while in private legal practice between his second and third terms, Louisiana Governor Edwin Edwards made $3-$4 million as part of a health racketeering scheme that netted the conspirators a total of $10 million. The alleged conspiracy centers around Health Services Development Corporation, a company which obtained certificates of need from the state and resold them to for-profit hospital and nursing home developers. The certificates allowed the new projects to receive Medicare and Medicaid reimbursement.

The indictment charges that Edwards appointed people friendly to the company to supervise the state's certificate of need review process. HSDC has obtained 15 certificates of need, including five which Governor Edwards exempted in August 1984 from a moratorium on new projects. Prospective clients were told that the company enjoyed Edwards' favor, but according to the indictment "the true involvement of Edwin W. Edwards was concealed in order to utilize the power and influence of his position as Governor of the State of Louisiana."

Edwards has admitted receiving $2 million in fees from HSDC while out of office for relatively little work.

"It just waltzed things back and forth," he says.

Also named in the indictment are his brother, accused of
and Wyllie allegedly became health millionaires, receiving $2.6 million each for their parts in the conspiracy. Edwin Edwards took office; HSDC executives; Ronald Falgout, a former Louisiana Health and Human Resources official; and James Wyllie Jr., a lawyer and professor at the Tulane School of Public Health and Tropical Medicine. Both Falgout and Wyllie allegedly became health millionaires, receiving $2.6 million each for their parts in the conspiracy.

Golden Salaries

When money flows from health care providers to political dealmakers, it remains largely outside the public's view. By contrast, the million-dollar salaries of the top executives in the for-profit hospital industry are highly visible symbols of their companies' emergence as one of the great business success stories of the past 20 years. And nobody has been more visibly successful than David Jones, co-founder and chairman of Humana, Inc., of Louisville, KY.

Jones emerged from 1984 as the unquestioned superstar of the health care elite. Evidence of his abilities was everywhere. On the corporate financial side, he could boast that his hospital company was the second largest in the country and had given its investors the second highest return of all the Fortune 500 service companies between 1974 and 1984. A share of Humana stock bought in 1974 for $4 was worth $403 in the spring of 1985. Humana's net income was 9.9 percent of sales in 1984, when its larger rival, Hospital Corporation of America, could only manage 8.5 percent.

Jones' personal finances were even more spectacular last year. His total compensation of $18,116,000, $17 million of it coming from exercising stock options, put him second on the Business Week's list of the highest paid executives, behind only T. Boone Pickens of Mesa Petroleum.

Last year his corporation became one of the most famous in the country. The daily news reports on its artificial heart transplants were a long way toward Jones' goal of making Humana a household word. This free publicity was probably worth considerably more than the millions the company has committed itself to spending on heart transplant experimentation.

Last December Time magazine reconstructed the key recruiting conversation on the porch of the Louisville home of Alan Lansing, director of the Humana Heart Institute, between Jones and the heart transplant surgeon, William DeVries:

Jones asked DeVries: "How many hearts do you need to find out if it works? Would ten be enough?" As a flabbergasted DeVries indicated that ten would be good, Jones added, "If ten's enough, we'll give you 100." That sealed the deal.

Humana and DeVries readily surrendered their $1.4 million worth of stock in Symbion, the maker of the artificial heart used in the transplants, to avoid any appearance of financial impropriety.

Beyond this success in the health care arena, Jones has made Humana a major presence in Louisville. It subsidizes the Louisville Playhouse's reknrowned annual festival of new American plays, now called the Humana Festival. It has also helped bail out a large local hardware distributor that was on the verge of closing down. The local power and national visibility of Humana and Jones is now symbolized and enhanced by the new Humana Building, which opened last year. Designed by noted architect Michael Graves, it was described by New York Times architecture critic Paul Goldberger as "a striking example of a large, prosperous corporation seeking to build a headquarters structure that would stand as a statement against conventional, modernist corporate architecture." Goldberger went on to describe it as "perhaps the first skyscraper of our time to be both serious and visually alive...it is at once a building of great diversity and a building of great energy and passion."

Humana's goal in its recent image-making is the creation of a nationally-recognized marketable name signifying medical benevolence and business. This positive name identification enhances its efforts to build the corporate structure described in its 1984 annual report: "An integrated system of health care services that include hospital care, prepaid health plans, and medical care centers where independent physicians deliver primary care."

It is not surprising that the 53 year old Jones was one of 11 runners-up to General Motors' Roger Smith as Financial World's top chief executive of 1984. Even more significantly, he was the only representative of the health care industry on Business Week's list of the 50 leaders of the new corporate elite. Jones was lauded as one of the "service gurus" who, along with high-tech entrepreneurs, corporate rejuvenators, and financial wizards, are creating a new style of business and financial organization. This new corporate elite, declared Business Week, is beginning to translate its wealth and superior form of business organization into political power, and challenging the older elites.

Other top executives in the investor-owned hospital industry did not do nearly as well as Jones financially, but many were rewarded with sizable increases in total compensation last year, at a time when the government was boasting of a significant drop in health care cost inflation. Among them were Dr. Thomas Frist Jr., co-founder and head of Hospital Corporation of America (up from $1.4 million to $2 million), Richard Eamer of National Medical Enterprises (up from $1.1 million to $6.4 million), and Robert Van Tyule, head of Beverly Enterprises, the largest nursing home chain (up to $1.9 million). Chief executives in the pharmaceutical industry on Forbes' executive compensation list averaged $982,000 in 1984, a jump
of 28 percent from 1983. By contrast, the average chief executive of a large American company got a 22 percent increase last year.

In contrast, the average annual pay hike for workers in 1984 was four percent; this was lower than the six percent raise in 1982 at the height of the last severe recession. Wage increases in contracts signed last year were at record low levels. Hospital workers won wage gains of 11 percent in 1982 and only 4.9 percent in 1984.

“This relatively low rate of wage inflation was purchased at considerable price in terms of labor unrest and, in some cases, strikes,” commented the industry magazine Hospitals. The disparity between the growing incomes of those at the top of the hospital and other industries and the stagnating incomes of their workers could intensify class conflict, as Sylvia Nasar warned in Fortune this April:

Though wage moderation now appears to have become part of the economic landscape, risks remain. Lavish executive pay increases haven’t yet aroused much antagonism from workers, who are still off balance from the shocks of recent years. But the growing spread between management and labor goes against history and could eventually produce a backlash if workers conclude that the burden of adjusting to tougher competition isn’t being shared fairly.

Driving the growing creation of health fortunes is a health system that through various organizational and financial mechanisms transforms personal misfortune into profitable services and personal wealth. At the same time that million dollar a year salaries are becoming commonplace, medical bills in that range are beginning to appear more regularly. Virtually every day the news media proclaim a medical miracle or other gripping episode that involves a massive commitment of medical resources—and a commensurately massive financial outlay.

When Patricia Frustaci gave birth to septuplets this year, she and her husband were very glad they had paid their $111.57 a month half-share for dependent coverage under his New York Life Insurance Co. group policy. After paying the $500 deductible and 20 percent co-payment on the first $2,500 exceeding the deductible, the Frustacis could leave the rest of their anticipated $700,000 bill to New York Life.

At the other end of the life cycle, the day her husband Claus was acquitted of attempting to murder her, Martha "Sunny" von Bulow, a member of the Mellon family, was in the 1631st day of an irreversible coma. Her estate was paying for a $725-a-day room at the Harkness Pavilion of New York’s Presbyterian Hospital and another $350 a day for 24-hour nursing care. Up to that day, the cost had come to $1.7 million, not including doctor bills and other expenses such as the permanent private guard outside her suite. During the next 20 years she is expected to live, even more of her fortune will be transformed into small parts of other fortunes, in the health care industry.

As in these two famous cases, the need for help in coping with bodily suffering is often compelling. The health care system, in its expanding domain, manages this suffering through the financing and provision of health services. This system is becoming more thoroughly penetrated by the financial community and, consequently, is an ever more fertile ground for the pursuit of personal wealth.

As the for-profit medical technology, medical supply, and pharmaceutical industries become more tightly integrated with a delivery system that is increasingly organized on a profit-making basis, the search for profits and for the favor of the financial community increasingly has come to characterize the health care system. Stock prices, not services, have become the bottom line. Mergers, takeovers, deal-making, and stock manipulation are becoming as pervasive here as they are in other sectors of the economy. Big money political fixers are helping to grease the wheels. Health care has become a breeding ground for rising elites of the new service economy. The top executives make huge salaries and have their own lavish stock deals.

Although the near future may bring even more vigorous efforts to cut costs, the prospects for creating and expanding health fortunes are likely to remain bright.
Promoting Disease and Preventing Health: What Role for Health Educators?
by Nick Freudenberg

In their zest to join corporate health promotion campaigns, health educators often ignore the far more significant role many corporations play in disease promotion. Long before quit smoking, stress reduction or exercise programs were even a gleam in some corporate manager’s eye, manufacturers were spending hundreds of millions of dollars annually to oppose public policies that would protect health and to persuade people to engage in habits that would contribute to premature death.

In this column, I will describe some disease promotion campaigns and then discuss how health educators and other health professionals can counter their effects.

Disease Promotion Campaigns

In 1984, the beverage alcohol industry spent more than $900 million persuading people to drink. Recent changes in our population’s demographic profile, combined with modest declines in per capita consumption of alcohol, has led to small population’s demographic profile, combined with modest declines in per capita consumption of alcohol. Long before quit smoking, stress reduction or exercise programs were even a gleam in some corporate manager’s eye, manufacturers were spending hundreds of millions of dollars annually to oppose public policies that would protect health and to persuade people to engage in habits that would contribute to premature death.

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Disease Promotion Campaigns

In 1984, the beverage alcohol industry spent more than $900 million persuading people to drink. Recent changes in our population’s demographic profile, combined with modest declines in per capita consumption of alcohol, has led to small reductions in the total volume of beverages sold. However, 10 percent of the drinking population accounts for 50 to 70 percent of the sales of wine, beer and spirits. These problem drinkers provide the margin of profitability for the industry.

To ensure continued sales and profits, the alcohol industry now seeks to capture the youth market. New products such as wine coolers—mixes of fruit juice and wine—are now on sale in supermarkets and grocery stores. Alcohol advertising seeks to associate drinking with sports, romance, and having a good time. Its goal is to convince young people to start drinking earlier, to drink more and to become lifetime drinkers.

Meanwhile, alcohol-related traffic fatalities are the main cause of death among young people between the ages of 18 and 21. The next two leading causes, homicide and suicide, also have substantial alcohol involvement. In a 1984 survey of New York State high school students, 11 percent reported they were hooked on alcohol; in a national survey, 40 percent of high school seniors claimed they had had five or more drinks on one occasion in the previous two weeks.

In response to the alarming results of the alcohol industry’s marketing strategy, organizations such as the Center for Science in the Public Interest, the National Council on Alcoholism, and the National Parent Teacher Association have begun a campaign to counter the message that alcohol is where it’s at. A bill currently pending in the House of Representatives (HR 2526), the Fairness in Alcohol Advertising Act, would provide for equal time for health and safety messages when alcohol ads are broadcast. Other activists have called for a total ban on advertising alcohol. (Similarly, the American Public Health Association has initiated a campaign to ban the promotion of tobacco products.) Both these efforts provide a refreshing contrast to most alcohol and tobacco health education campaigns, which target only the victims of the legal drug pushers.

Another example of a disease promotion campaign is the automobile industry’s successful efforts to block mandatory installation of air bags in passenger cars.

According to a 1977 study by the National Highway Safety Transportation Board, the installation of passive restraints in all cars would prevent up to 12,000 deaths and 100,000 serious injuries each year. Yet, since the Department of Transportation first proposed mandatory air bags in 1969, the automobile industry has successfully opposed such a standard. Its tactics have ranged from sabotaging a trial of air bags that one manufacturer had agreed to carry out to mounting a public “disinformation” campaign minimizing the benefits of air bags and warning that they could accidently explode.

In early 1985, in response to a court order, Secretary of Transportation Elizabeth Dole issued a ruling that air bags would become mandatory in 1987 unless states with more than two-thirds of the U.S. population passed compulsory seat belt laws. This new ruling spurred the auto industry to begin an unprecedented multimillion-dollar lobbying campaign to persuade state legislatures to pass the seat belt laws that would keep air bags out of American cars.

A coalition of groups including Public Citizen, the American Public Health Association and the insurance industry are now using a variety of tactics to convince the automobile manufacturers that installing air bags may be cheaper than stalling regulations. One of the most promising tactics is a product liability suit charging that failure to install a proven lifesaving technology constitutes negligence.

Lessons for Educators

What can health educators learn from these and other efforts to counter the disease promoters?

• The first lesson is “don’t avoid controversy.” Too often in our effort to win over as many converts as possible we develop a lowest-common-denominator approach. As a result, no one is antagonized, but neither are any passions aroused. Health is political, and solving health problems requires entering the political fray. The campaigns described above and the new anti-tobacco initiative now being discussed within the APHA illustrate that people can be aroused and mobilized when they get angry and when they feel they can support the “right side” in a moral conflict. The history of public health is one of willingness to take on new challenges. Health educators should embrace this history, not renounce it.

• Second, and as part of this willingness to take on the disease promoters, we must combat the disinformation campaigns that industry sponsors to market its policies. The General Motors campaigns against air bags, Reynolds’s full-page ads on politeness as a solution to smoking problems, the petrochemical industry’s multimillion-dollar lobby against right-to-know laws—all demonstrate that disease educators have far more resources than we do. We need to find creative ways to discredit such messages, and to help people analyze critically what they hear.

• A third lesson is that coalitions are critical to success. Consumer groups,
There is growing concern over the long-term dangers for all those exposed, coupled with specific worries about the effects on pregnant women and their fetuses. As the use of this equipment increases and the associated hazards become better known, it is likely that office workers will become more eager for union organization. The need for this protection is certainly the message in all three books.

Our Jobs, Our Health is a simple and straightforward primer for women beginning to consider the potential ill consequences of their work. It is particularly strong in its discussion of reproductive hazards, covering issues ranging from infertility, impotence and loss of sexual desire to the effect of work on a pregnant woman’s health and that of her developing fetus. The authors’ goal is not just to inform readers, but to motivate them to collective advocacy of workplace improvements.

Although it doesn’t discuss housework, this 90-page volume is relatively comprehensive for a book its size in discussing both office and factory work problems. The book concludes with a useful resource list of agencies and organizations involved in workplace issues and a list of books and articles providing greater detail on specific topics.

Jeanne Stellman is the doyenne of the woman’s occupational health movement. Her Work Is Dangerous to Your Health and Women’s Work, Women’s Health are seminal volumes that remain essential reading for all concerned with occupational health. Her new book, co-authored with Mary Sue Henifin, focuses exclusively on office work, with particular emphasis on physical and environmental hazards. Issues the authors cover include VDT’s, indoor air pollution, lighting and the potential for fires in high-rise buildings. They write primarily for those with knowledge of occupational health and the academic training necessary to understand fairly technical discussions of noise and air pollution and VDT radiation levels. One innovative chapter systematically examines the “tools of the office trade”: the angle, size and material of desk chairs; the physical layout of work areas; several office machines, including photocopiers; and chemicals and cleaners commonly used in offices. The authors suggest very specific and carefully researched safeguards and improvements to maximize the efficiency of these tools while reducing any negative effects. They include a thorough discussion of the current controversy over fluorescent lighting, used in most office spaces, and list specific remedies for lighting problems.

This book should prove to be a useful corrective to those who assume that occupational health dangers exist only in mines and industrial factories. The modern office may be more aesthetically pleasing (although some are not), but it can certainly be as dangerous as any other work site if particular hazards are not addressed.

The appendix is extremely useful, especially the checklist survey for office safety. This is a step-by-step guide for concerned workers attempting to document safety deficiencies.

Double Exposure: Women’s Health Hazards on the Job and at Home is a very different book. It is a carefully edited series of papers that is much less a “how-to” and much more a general overview of the issues and concerns that revolve around women’s work and women’s health.

The first section examines the role of women in different work forces, the health hazards to which they are frequently exposed, and the complexities of those work environments that generally act against their abilities to make swift changes.

The second section of the book deals with reproductive risks at work and, since it covers the spectrum of workplace and job types, it may be extremely valuable for women contemplating having children or those who are already pregnant. Increasing its value in this regard is the chapter by Maureen Hatch that discusses the reproductive hazards of the workplace for both men and women.

While each of the essays offers rich insights into a specific aspect of occupational health issues for women, a few in particular stand out. Chavkin’s own chapter on “Walking the Tightrope: Pregnancy, Parenting and Work” is a fascinating discussion of medical and social barriers that confront American working women who become pregnant. The United States is the only industrial-
Body English

What's In A Name?
Generic vs. Brand Name Drugs
by Arthur A. Levin

Controversies over medical practices do not die. Unfortunately, unlike old soldiers, they don't even seem to fade away. It may be pure coincidence, but the latest furor over the safety, efficacy, effectiveness and bioequivalence of generic drugs comes at a time when many brand name best seller drugs are coming off patent. Examples include such heavyweights as Valium (generic name diazepam) and Inderal (generic name propranolol).

Physicians, manufacturers and others embracing the "keep government off the backs of those toiling in the private sector" view of life have always argued that the FDA's approval process was unnecessary. Their argument was based on two hypotheses of the marketplace: first, that no producer would knowingly make an unsafe product because of the liability exposure; and second, that no one would make a product that didn't work because who would buy it? Yet, there is ample evidence that unsafe, ineffective drugs have been knowingly marketed by manufacturers, even with regulatory oversight by the FDA. The mind boggles in imagining what might have occurred without such oversight.

Any questions about the scientific abilities of the FDA have always been focused on the denial or delay in approving a new drug. Now, some professionals are questioning the FDAs scientific integrity in moving too quickly to approve generic drugs.

This new interest comes a year after Congress enacted legislation extending patent protection to brand name products from 17 to 22 years. The bill served also to "facilitate" the approval process for generic versions of previously marketed brand name drugs. This is accomplished by allowing Abbreviated New Drug Ap-

lications (ANDAs) to be used by applicants wanting to market generics of branded products approved after 1962. These products previously required a full new drug application (NDA), which manufacturers claimed was unnecessary, time-consuming and expensive. Use of ANDAs was limited to "grandfathering" generic substitutes for drugs approved prior to 1962. The hope of the bill's sponsors was that it would produce enough benefits for consumers, by making more generics available, to outweigh the costs incurred by granting brand name firms longer periods of exclusivity and higher profits.

The final version of the Drug Price Competition and Patent Term Restoration Act (signed into law in September 1984) was the result of long negotiations between the American Pharmaceutical Association, which represents the big manufacturers of branded products, and the Generic Pharmaceutical Industry Association and the Pharmaceutical Manufacturers Association, both of which represent generic producers. Some observers wondered how long these strange bedfellows would refrain from their usual sparring. The answer seems to be "not very long at all."

The fight for consumer access to safe, effective and less expensive prescription drugs has resulted in some of consumerism's few victories in the health field. Consumers have been advised to insist on the generic equivalent when available. In addition, the willingness of a practitioner to volunteer the generic version when prescribing has become one of the benchmarks for judging the quality of prescribing practice. Many of the attempts both in this country and abroad to rationalize pharmaceutical therapeutics have placed great reliance on the use of generics where available and appropriate.

Years ago, arguments about the lack of safety and inferior performance of generics were used to combat the efforts to change state laws so that consumer access to less expensive generic products was assured. Legislation was necessary because consumers were (and still are) dependent on the physicians as keepers of the keys to the national medicine cabinet. Today, many states do have laws that allow substitution, although the designation of who decides substitution, and to what degree, varies.

The proponents of generic availability claim to be supported by the clinical experiences of large users such as hospitals, whose formularies have long specified the least expensive, comparable version of a drug. The literature has, from time to time, contained discussion of concerns about the effectiveness of some generic products, particularly digoxin (brand name Lanoxin) because of problems with bioavailability (rate and extent of absorption). However, there has also been indication that some generic forms of phentoin are more reliably absorbed than the brand name product Dilantin Kapseal (Medical Letter, May 1980).

Is the advice to insist on generic prescription, where available, good or bad?

There is little evidence from clinical trials available to show whether or not particular generics are equivalent to the brand name product.

On the other hand, the bioequivalence test being used to speed approval of new generic drugs is the same used to monitor reformulations of brand name drugs: This test requires that the tested drug perform within 20 percent of the reference standard drug's rate and extent of absorption (maximum plasma concentrations). Brand name products are often reformulated; that is, they are not the same as when the clinical trials to meet NDA requirements were conducted.

Both generics and branded drugs also vary in bioequivalence from production lot to production lot. The same FDA test is used to monitor and assure that lot variations in absorption characteristics are kept within the 20 percent limits.

There is little other clinical study data available that can be said to prove or disprove the claims that significant problems of bioavailability exist between branded drugs and FDA-approved generic substitutes. Therefore, there is no reason not to continue to encourage consumers to avail themselves of less expensive generic drugs once patent protection expires. Clinical experience seems to indicate that generic products are most likely to be as beneficial as branded ones.

One more fact might help put minds at ease. Brand name manufacturers often imply that they are more competent than generic producers in making safe and ef-

continued on page 39
ized country that does not assure any compensation to working women at childbirth, and Chavkin makes a convincing argument for parental benefits during and after pregnancy so that men and women can care for themselves and their children.

The chapters by Leith Mullings on minority women and by Sonia Jasso and Maria Mazorra on migrant and seasonal workers are both extremely valuable, and cover topics all too often overlooked in discussions of occupational health issues. Health and safety hazards of housework—as well as the stress and isolation of domestic labor—are comprehensively and sensitively reviewed in an essay by Harriet G. Rosenberg.

The closing chapter is by Nick Freudenberg and Ellen Zaltsberg, entitled “From Grassroot Activism to Political Power.” Five case studies present ways in which women have organized to fight against various environmental threats including chemical dumps, pesticide exposure, and asbestos exposure in schools. The authors provide both the rationale and motivation for taking collective action to address health issues. These examples of the successful linkage among the women’s movement and the environmental and labor coalitions serve as models of community or grassroot health advocacy.

All three books are useful addenda to the growing body of knowledge about workplace safety and health. It is a pleasure to read books that reflect in their content, philosophy and readability the growing sophistication of this still relatively young movement.

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*Peggy Clarke is Assistant Commissioner for Health Promotion, New York City Department of Health.*


*by Susan Luck*

We face a crisis in health care; at no time in history has there been a greater need for re-evaluation of the delivery of health care in the United States. Medical care has become America’s leading growth industry, comprising 11 percent of the Gross National Product, nearly $450 billion a year. Spiraling costs—along with a growing dissatisfaction in medical interventions that offer an impersonal, technological approach—have led many consumers, health practitioners and health care analysts to explore alternative therapies that remain outside mainstream medicine.

In Chinese, the word crisis means both “danger” and “opportunity.” In a comprehensive overview of issues, *Alternative Medicines* addresses both the dangers and opportunities in the current medical model and the emerging alternative health movement. The book examines scientific medicine as well as alternative health systems such as homeopathy, chiropractic, traditional Chinese medicine and indigenous healing systems through historical, cultural, socioeconomic and political perspectives. The contributing authors explain the principles and beliefs underlying each system and discuss each in the context of health care planning and policy-making.

*Alternative Medicines* enables health worker and layperson alike to gain a deeper insight into the limitations of the current medical model and the reasons for the popular discontent that has given rise to a growing “holistic” health movement.

The World Health Organization defines health as a state of mental, physical and social well-being, not merely the absence of disease. Analysts of contemporary medicine acknowledge the current medical model as a valuable but incomplete approach to health. Disease-focused, it’s search for the biological determinants of illness ignores the numerous components of health, offering little to enhance health and prevent disease.

The alternative health movement has philosophically set itself in direct opposition to some of the basic beliefs of scientific Western thought. Holistic therapies assume a unity of body, mind and spirit in which illness is seen not as limited to biological causes that occur only in the physical body. Unfortunately, this challenge to modern medicine and its reductionist thinking has prevented many new options and choices in health care from being taken seriously by those in mainstream medicine.

*Alternative Medicines* draws on the empirical and scientific knowledge of other cultural systems for health and practices of healing. The chapter on “Traditional Chinese Medicine” by Effie Chow, PhD, presents clearly the theoretical and philosophical world view that forms the base of Chinese medicine and helps the reader to understand the difficulties in evaluating its efficacy by “scientific” standards. Dr. Chow explains the Chinese holistic view of the universe, concepts of balance (yin, yang), and energy (chi) systems that are integral to diagnosis and treatment in the practice of acupuncture and other therapies.

She also defines the legal issues and difficulties of integrating Chinese medicine into the current Western model.

A critical ingredient in all the alternative modalities in this book is the relationship between the practitioner—whether physician or shaman—and the patient. All cultures appear to acknowledge a dynamic invoked through faith in the practitioner and the influence this has on the healing process itself. One of the failings of our specialized, impersonal technological approach is in this relationship that is believed to be at the heart of healing. In Western medicine, patients often feel neither respected nor listened to. They often feel angry, frustrated, frightened and uninformed, and therefore unable to assume as much responsibility for their health as they otherwise might. Alternative therapies encourage patient participation, respecting the uniqueness of each person.

In his chapter on homeopathy, Harris Coulter explores the uniqueness of the individual and the organism’s own healing powers. Although a Western system of medicine, its theory and practice differ from the medical model. Homeopathy’s gentle approach is based on diagnosis and treatment with minute doses of substances found in nature that are given to stimulate the body’s own defenses. It’s origins, which are pre-industrial, are still recognized throughout the world and practiced today by a majority of physicians in Europe, India, Asia and Latin America. As Dr. Chow does with her discussion of Chinese medicine, this author describes the difficulties in evaluating the efficacy of this alternative system. He also mentions the threat it poses to its pharmaceutical and medical competitors.

Chiropractic is an American system of health care, but has its roots in the writings of Hippocrates, as Ronald Caplan points out in his chapter on this topic. Hippocrates wrote, “Look well to the Spine, for many diseases have their origins in dislocations of the vertebrae column.” Caplan gives a detailed account.
of the legislative battles that chiropractics have fought with the AMA and, finally, their acceptance by licensing boards and health insurance plans. The popularity of chiropractics has posed a threat to the medical profession since the early 20th century. An analysis of both its current status and future prospects is made, with a note of hope for further cooperation within the medical community.

A chapter entitled “Psychic Healing” by Daniel Benor, MD, continues to explore the variety of human experiences and therapies that have influenced and aided the health process within individual and cultural contexts. Today, scientific research has been able to document many claims for psychic healing, therefore offering new possibilities in the realm of health. As anthropologist-psychologist Arthur Klenien emphasizes in his chapter on “Indigenous Systems of Healing,” many of these occurrences are inextricably intertwined with beliefs, attitudes and the expectations of the individual and the community. This implies increased possibilities for healing within our culture, as a new consciousness emerges and the medical model begins to change.

A critical analysis of the rise of modern medicine and the alternative health movement is made by authors Howard Berliner, James Gordon and Rosemary Taylor. Each contributes important perspectives on the implications of health care planning and policymaking for the reformulation of the delivery of health care. In “Holistic Health Centers in the United States,” James Gordon suggests that it is time to create a model of holistic programs in a variety of communities, to assess whether a combination of health promotion and public education about Western and alternative medicine can meet people’s needs more effectively and less expensively than is now the case. In “Scientific Medicine Since Flexner,” Howard Berliner evaluates the shift he sees taking place as mainstream medicine begins to integrate various cultural models and therapies into practice. His concern is that the alternative methods maintain their integrity and not get co-opted by the present system.

In the concluding chapter, “Defining Health and Reorganizing Medicine,” editor Warren Salmon discusses the need to redefine health in order to reorganize medicine and reformulate medical conceptions and theories. He analyzes the political and economic developments in the delivery of health care and the shift in the consciousness of society, and concludes that they will, in time, make the scientific, biological base of Western medicine obsolete.

This book contributes to new ways of understanding health and presents exciting challenges for both consumers and health workers. The issues raised here have no easy answers. However, the authors conclude that the current popular interest in alternative medicines will ultimately provide new health care systems and lead to the reorganization of “scientific” medicine in the decades to come.

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professional organizations, community groups and others must join together to advance a common agenda. Coalitions are, to my mind, the key political development of the 1980s, and effective health educators will have to learn the delicate art of weaving together disparate groups with overlapping interests.

A corollary of this is that we need to use our professional organizations in new and different ways; too often their sole agenda has been to advance the profession. APHA, for one, is moving toward a broader definition of its goals, in which a primary aim is to advance the health of the public. Frequently, we cannot tackle the political and social dimensions of health problems in our roles as practitioners. But by bringing in our professional organizations, we can add an important dimension to our practice.

- Finally, we need to define our desired outcomes appropriately. In the auto safety issue, the behavior we want to encourage involves not only buckling your seat belt but also writing to your Senators and Representatives urging them to make air bags truly mandatory. Good health education programs change the behavior of individuals and institutions. We need to plan both these aspects equally carefully.

Corporate practices that promote disease are a major influence on the health of the American public. By giving people the skills and knowledge they need to thwart disease promotion campaigns, health educators can make an important contribution to well-being.

[Thanks to Christine Lubinski, Washington representative of the National Council on Alcoholism and Joan Claybrook of Public Citizen for the information presented in this column.]

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tive drug products. However, a number of these companies (Smith, Kline & French and Glaxo are two examples) sell generics with their own label, which they have purchased from small generic manufacturers.

The current debate appears to be more about market share than medical care.
CALL FOR PAPERS

Rethinking a National Health Care Program
Health Care in the Post Reagan Era

A national conference being planned for February 1987
sponsored by Health/PAC and other organizations.

With multiple financial, organizational and medical crises facing our current health care system, it is time to re-examine the possibilities for a national health care program.

A number of such concepts—particularly plans for national health insurance and a national health service—were developed and debated in the 1970's. The purposes of this conference are (1) to re-examine those plans from the perspective of the 1980's, (2) to propose new alternatives that might be more appropriate to the coming period in U.S. health care, and (3) to consider the political lessons to be learned from the earlier organizing experiences.

Conference papers will be considered for publication in the Health/PAC Bulletin and in a book to be published after the conference.

Individuals are invited to propose papers for presentation at the conference by sending abstracts or summaries to Herb Semmel, Room 316, 36 West 44th Street, New York, NY 10036.

Deadline for submission of abstracts:
June 15, 1986

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