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MR REAGAN

IN THE RUINS OF REAGANISM
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S
ince its inception in 1968, the Health Policy Advisory Center—also known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and the books Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a “medical-industrial complex” which has yet to provide decent, affordable care.

ASSESSING THE REAGAN YEARS

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These Rotten Reagan Years

When Ronald Reagan leaves the White House, he will leave behind a bitter legacy of impoverished, embattled lives and shattered dreams. One cannot overestimate the disastrous impact his administration has had on working people, the environment, and our most vulnerable citizens — and a great many people living in Central America and elsewhere who have suffered the terror of the Reagan foreign policy. Clearly, no matter who wins in November, it will take years to recover the monumental losses we've experienced since 1980, even under the best political circumstances.

In these times of people living under cardboard roofs, of epidemic hunger and medical indigency, of heightened racial tensions, and the continuing lack of federal commitment to battling AIDS, the need for progressive health policy solutions has never been greater. The centerpiece of this Bulletin is a detailed look by Geraldine Dallek at the impact of Reagan's policies on health care. Dallek, a California health policy analyst, reported on Reagan's health care cuts for the Bulletin during his first two years in the White House (Vol. 14, No. 1). Now, five years later, after considerably more damage has been done, she presents a detailed survey of the causes and effects of his policies to help us comprehend the enormity of our health care losses. We also include our own reporting on the destruction Reagan has wrought on health care labor organizing — no other recent president has more ruthlessly violated workers' rights to organize or protect their unions.

What conclusions can we draw from this decade's struggles and defeats? Here Dallek moves onto more controversial grounds, particularly in her advocacy of incremental change. "The job before us," she contends, "is to shore up what we have and build from there." In another article, David U. Himmelstein and Steffie Woolhandler take direct aim at this conclusion. They argue that "some progressive health activists, demoralized by the long winter of Reaganism, are setting their sights too low." According to these Boston physicians, nothing short of a full-fledged national health program, assuring universal comprehensive coverage, is what we should be advocating; the piecemeal approach of the incrementalists, they charge, is self-defeating.

On the subject of achieving a national health program, Vicente Navarro, one of this country's leading Marxist social analysts and a health care advisor to the Jackson presidential campaign, refutes two key arguments favored by the detractors of a national health program. We offer these articles in the hope of stimulating the debate over future directions and strategies. There's much to do — and look forward to — as we take stock of our gains and losses and continue working to build a health and civil rights coalition that assures the health care rights of all our citizens.

—The Editors
Frozen in Ice
Federal Health Policy During the Reagan Years
GERALDINE DALLEK

Government can err, presidents do make mistakes, but the immortal Dante tells us that divine justice weighs the sins of the cold-blooded and the sins of the warm-hearted in different scales. Better the occasional faults of a government that lives in a spirit of charity than the constant omission of a government frozen in the ice of its own indifference.

— President Franklin Roosevelt
Acceptance Speech, June 1936

President Reagan came to office in 1981 with a specific health care agenda. He claimed he would cut federal programs without harming the “truly needy,” transfer responsibility to the states and voluntary sector, control health care costs, and eviscerate federal regulations while giving competition free rein. After seven and a half years of the Reagan presidency, it is time to look back and assess how well he succeeded; the changes wrought because of, or despite, the Reagan agenda; and where we stand today as we look forward to the post-Reagan era.

The Reagan years have been marked by a government that cared little about the basic needs of its people, one “frozen in the ice of its own indifference.” As a consequence, the nation has lost ground in its efforts to build a more decent health care system. Yet, despite the losses under Reagan, the people of the United States continue to believe in the idea of health care as a right. The goal for the post-Reagan years will be to make that idea a reality.

FEDERAL PROGRAMS

The Poor

In the first flush of its perceived mandate to cut government fat, the Reagan administration successfully slashed health care programs for the poor. The Omnibus Budget Reconciliation Act of 1981 cut 25 percent from the budgets of most categorical health programs. It also set in place a rolling reduction of federal Medicaid matching funds — 3 percent in 1982, 4 percent in 1983, and 4½ percent in 1984. Moreover, a 10 percent decrease in AFDC (Aid to Families with Dependent Children) coverage for the working poor in 1982 led some 700,000 children to lose their Medicaid coverage. States, hard pressed by the 1982 recession, responded to federal Medicaid cuts with cuts of their own. As a result, large numbers of Americans lost access to medical care.

After the early Reagan years, Congress and the states lost their appetite for more Medicaid cuts. Nevertheless, today state Medicaid programs cannot adequately meet the needs of the poor for medical care. When the Washington-based Health Research Group of Public Citizen released a report in December 1987 ranking the performance of the 50 state Medicaid programs in terms of eligibility, services, and reimbursement policies, no one was more surprised than advocates in California to learn that their state had one of the best Medicaid programs in the nation. After all, they had just sued the state for inadequate services. If best is inadequate, then worst (Mississippi) is dismal indeed.

State Medicaid programs ration care for the poor in subtle and not-so-subtle ways. Historically, rationing is hidden behind low reimbursement rates or utilization controls. At least one state — Oregon — though, has a written policy of denying transplants to Medicaid beneficiaries and using the money saved to increase prenatal care. This tradeoff makes sense from a Medicaid perspective. However, by making explicit what had been implicit, this policy brought the rationing of care to public attention as a serious ethical issue.

Geraldine Dallek is a health policy consultant in Los Angeles who writes widely on the problems of the poor and the elderly.
these Medicaid recipients, privately insured children and adults are not denied life-saving operations; nor, as has happened in Oregon, are they forced to launch media campaigns — become television beggars — to raise thousands of dollars, or to leave their homes in search of a state with a more generous Medicaid program.5

After the 1981 budget cuts in Medicaid and categorical health programs, Reagan hit a solid brick wall of congressional and state opposition to further reductions in health programs for the poor. Remember the Medicaid "cap" — the proposed 3 percent reduction in states' federal Medicaid reimbursement — and attempts to make Medicaid co-payments mandatory? Probably not (how quickly we forget our victories), as Reagan's later efforts to slash federal health care programs arrived in Congress with small chance of survival. As Medicaid celebrated its 20th anniversary in 1985, the program seemed to have become sacrosanct — off limits to both Gramm-Rudman and budget cuts.

Moreover, Medicaid underwent a dramatic broadening of its base when Congress, in the Omnibus Budget Reconciliation Acts of 1986 and 1987, severed the proportion of welfare recipients who are on Medicaid from 63 percent in 1975. Over 37 million citizens (17 percent) have no health insurance and little access to health care — the poor among us have been harmed. "Die Rea­
gan administration has watched passively as the health care fortunes of this group plummet. Today, Medicaid covers significantly less than half the nation's poor, down from 63 percent in 1975. Over 37 million citizens (17 percent) have no health insurance and little access to care.8 A survey by the Robert Wood Johnson Foundation documents the dramatic decline in access to care among poor and minority populations between 1982 and 1986 — years during which Reagan promised no harm would come to the "truly needy."3

The United States does not provide for even the simplest and most fundamental health care need — prenatal care. A recent study by the General Accounting Office found that 59 percent of women on Medicaid and 67 percent of uninsured women get insufficient prenatal care.9 Since 1979, the number of babies born to mothers who received inadequate prenatal care grew by nearly 10 percent.10 As a result, the nation's high infant mortality rate continues to haunt us.

The number of underinsured individuals who lack adequate protection from catastrophic illness is also growing11 and, in all likelihood, will continue to grow in the years to come. According to a survey by the Bureau of National Affairs, 27 percent of employers plan to eliminate or reduce employee health insurance coverage during 1988.12

Some programs and providers serving the poor — community and migrant health centers, maternal and child health programs, and WIC agencies — have done fairly well, given federal budget limits. Other major sources of care — notably inner-city and rural public and private hospitals — are in serious financial trouble, often unable to provide their patients with a minimal level of services.13 Thus, the poor and the health care institutions on which they depend fared badly during the Rea­gan years.

The Elderly

No federal health program underwent a more dramatic change during the Reagan years than Medicare. PPS, DRG's, "participating physicians," and CMP's were all added to the Medicare lexicon as the federal government experimented with ways to control Medicare costs. The jury is still out on what the various changes in Medi­care reimbursement will ultimately mean for the elderly and those who care for them. Although anecdotal evidence suggests that at least some elderly patients were discharged "quick and sicker," studies have failed to find systematic evidence of inappropriate discharges. Moreover, given past overutilization of hospital care it is also likely that the prospective payment system resulted in less unnecessary care.

There is no question, however, that the elderly lost ground on a number of other fronts during Reagan's term of office. Twenty-five percent of the elderly population have incomes below 150 percent of the poverty level.14 According to the Commonwealth Fund's Commission on Elderly People Living Alone, two-thirds of poor elderly Americans are not covered by Medicaid and are spending nearly a quarter of their income on health care.15

Although policymakers have finally recognized that lack of long-term care insurance posed a financial catastrophe for the elderly, they did little but talk about the problem. As out-of-pocket costs increased both for services covered by Medicare as well as those not covered, the administration and Congress came close to passing a catastrophic insurance program. However, the proposal, awaiting likely enactment at the time of this writing, may not give enough bang for the buck; it ignores coverage for long-term care and contains a funding mechanism based on a means test that could ultimately undermine the program's broad political support.

The truly needy have been hurt and hurt badly.
Perhaps the most troubling feature of Reagan's Medicare proposal, a voucher system, never got off the ground. Medicare HMO's and competitive medical plans (CMP's), however, made a shaky and, in one instance, criminal debut; and a new program of MIG's (no, not Soviet fighter planes, but Medicare Insured Groups) holds as many pitfalls as promises.

Overall, the government seemed to have tread the Medicare waters, obsessing about expenditures and recognizing unmet need, but unable to deal effectively with either.

AIDS

Sometimes individuals and governments can make up for past mistakes. The AIDS epidemic is not one of those instances. The $1.3 billion federal budget for AIDS proposed for fiscal year 1989 cannot buy back the years lost while the federal government did precious little to address the worst epidemic of our time. An unwillingness to spend federal dollars, coupled with homophobia, stupidity, and denial, has left us with an estimated one and a half million individuals infected with the AIDS virus, continued ignorance and misconceptions about the disease, and inestimable pain and suffering. The Reagan administration's apathy and inaction during the early years of the epidemic only fanned the flames of the contagion. [See "Ignoring the Epidemic: How the Reagan Administration Failed on AIDS," Vol. 17, No. 2.]

The Budget Deficit and Public Opinion

Along with the early indifference to the AIDS epidemic, the Reagan budget deficit will haunt us for years to come. Ronald Reagan is the biggest, freest spender we have ever had in the White House. His tax cuts and military expansion leave us with a debt that future generations will struggle to repay.

With 20 percent of total federal spending going for interest payments on the $2.2 trillion national debt, and with a budget deficit sure to exceed the Office of Management and Budget's projected $128 billion for 1988, the Reagan years have changed the way we think about new entitlement programs. Now it's strictly pay as you go, and general revenues are off limits.

Although Congress is still willing to respond, albeit inadequately, to the most dramatic of domestic needs (research and education on AIDS and support for the homeless), any new entitlement program must rest on a specific funding source if it is to have a chance of success. Thus, no matter how great the need or desire for change, the nation will find it harder than ever to enact a national health insurance program. Moreover, the budget deficit will further limit the government's spending options when the next recession comes, as it surely will.

A counterweight to the negative effect of the budget deficit is the overwhelming and widespread support expressed by the American people for a more equitable health care system. That support is found not just in liberal places like Massachusetts, where a statewide poll in April 1987 found that 89 percent of those surveyed believed that access to health care is a basic human right and 79 percent were willing to pay higher state taxes to guarantee that right. It is also found in Orange County, California, one of the most conservative, bedrock Republican communities in the nation. A September 1987 poll found that 75 percent of those surveyed supported national health insurance, and 72 percent were willing to pay higher taxes to insure that the poor get necessary care.

No matter who does the polls, the results are consistent. A nationwide poll sponsored by Hospitals magazine found that 69 percent of the population would pay higher taxes to provide health care for the indigent, while 70 percent of Californians polled in a 1988 survey regard access to health care as a right. And, in the guns-and-butter debate, military spending is now on the defensive; 71 percent of the public would rather see a reduction in the nation's defense outlays than cuts in federal expenditures for health.

Cost-containment efforts during the Reagan years largely failed.

Americans' support for an expanded health care system may not be as solid as these polls indicate. The public continues to view Medicaid at least partially as a welfare program, making it vulnerable to future cutbacks in economic hard times. In addition, U.S. citizens do not consider health care among the most important problems facing the nation, and so may not be willing to put their money where their mouth is when it comes to increased taxes. Nevertheless, the American people
remain committed to providing health care for those in need, and the administration’s efforts to undermine support for government involvement in the financing of health care have failed miserably.

TRANSFER OF FEDERAL RESPONSIBILITY

The States

Along with reducing federal health care programs, the Reagan administration repeatedly proposed giving more responsibility and flexibility in administering these programs to the states. Generally, efforts to transfer responsibility — labeled the “new federalism” — failed when states realized that they were a ploy to cut federal spending.

Yet, acting on their own, states assumed increased responsibility and used it well. After 1981 and 1982, the states’ flexibility in administering Medicaid was used almost exclusively to expand rather than reduce coverage. Fears over how the states would use and misuse the 1981 block grants were also unfounded.

During the Reagan years, as the aftermath of the 1981 federal budget cuts and 1982 recession became visible, over 25 states studied the problems of the uninsured, and many enacted small but significant expansions of state programs. States increased medical services for low-income pregnant women, taxed insurers to pay for uncompensated hospital care, and established high-risk pools for the “uninsurable” population. Massachusetts passed “health care for all” legislation in April 1988, and the state of Washington is soon to pilot a state-subsidized program for the uninsured working poor.

States, of course, did not operate in a monolithic fashion. Some states, most notably California, cut back on programs for the poor, especially in the early part of the decade. Others misused the new flexibility and adopted Medicaid case management programs helter-skelter, without adequately protecting access to care and quality of services. But, looking back over the years, it is fair to conclude that Reagan was at least partly right in this regard. States used their new flexibility well. Within the limited confines of their budgets, they attempted to fill the void left by the federal government’s inaction.

Moreover, in a number of instances when states were unwilling or incapable of addressing a major problem, Congress stepped in. A case in point is the 1986 Omnibus Budget Reconciliation Act. By acting to regulate hospitals through tough anti-dumping penalties in the Medicare Act, Congress further advanced on territory traditionally left to the states. Likewise, federal requirements that employers offer continuation and conversion insurance policies encroached on what had heretofore been an area of state authority.

The Voluntary Sector

Reagan claimed that the voluntary sector — that is, private charitable organizations — would fill in any holes left in the safety net by federal and state governments. The president was partly correct in his assessment. Although it was specious to maintain, as he did, that private money and effort could replace the federal government’s role in providing care for the needy, it was nonetheless true that the voluntary sector mobilized to serve those in greatest need. Activities of organizations serving the homeless or people with AIDS are only two cases in point.

Even the more traditional charitable organizations took on new projects to meet new problems. For example, the Robert Wood Johnson Foundation moved from its seemingly knee-jerk funding of large teaching hospitals and medical schools to support innovative community organizations serving the homeless and experimental programs to insure the uninsured.

The Massachusetts Health Action Alliance was a major force in the passage of the state’s new health care legislation. Health Access in California and the Health Care For All Campaign in New York have also set their sights on statewide health care coverage. And new programs for uninsured pregnant women in a number of states (Massachusetts, Minnesota, South Carolina), were enacted only after long and arduous community campaigns.
Foxes in the Henhouse
Health Care Organizing under Reagan

On May 1, 1967, the professional employees at Fountain Valley Hospital in Fountain Valley, Ca., voted in favor of joining a union (the United Nurses Association of California). To this day, thanks to the National Labor Relations Board, there is still no union at Fountain Valley. “When we filed for an NLRB election,” says Chris Majors, a registered nurse at the hospital, “little did we know we were handing our employers a loaded gun to turn against us.”

When Ronald Reagan came to power, he was faced with a dilemma. Health care workers were making impressive gains in improving their low wages and poor working conditions through unionization. So the Reagan administration did what comes naturally for them: they used a federal agency to attack the very rights it had been created to protect, in this case the NLRB.

Reagan appointees achieved a majority on the board by 1982, and that year pushed through a crucial change in its definition of an “appropriate bargaining unit” — that group of workers in a hospital or other health care facility permitted to negotiate on its own behalf. The old standard, which required that such a group constitute a “community of interest,” kept the units fairly narrow — nurses with nurses, clerical workers with clerical workers, and so forth.

But in the infamous St. Francis II decision, the Reagan-rulled board stood the old standard on its head, requiring health care workers to bargain in one of two ponderous categories, professionals and non-professionals, unless they could prove a “disparity of interest.” The pro-management board put itself in the position of telling health care workers whom they may unionize with, explains Bob Muehlenkamp, director of organizing for the National Union of Hospital and Health Care Employees/1199.

In the age of Reagan, organizing drives now involve a separate legal struggle, as management, armed with the new standard, challenges the bargaining units workers put forward. Julie Fry Gibson of the American Nurses’ Association tells how efforts typically involve years of litigation, forcing delays that sap the energy that drove the initial push to organize. The NLRB, faced with the chaos St. Francis II created, reopened the matter for review, this year. A final ruling should be handed down within a year.

The impact of organizing, however, was immediate. Gerry Shaw, head of the Health Care division of the Service Employees International Union, describes how health care professionals, a work force that’s normally reluctant to unionize, will often lose their appetite for collective bargaining entirely if forced to undertake it with others who don’t share their specific professional concerns.

With the NLRB on their side, hospitals have effectively stymied unionization. No single union has the resources to take on the “big four” for-profit chains, and a combined effort is unlikely in the foreseeable future. When organizing has been successful in the voluntary sector, it has almost always occurred in hospitals where some workers were already unionized — “breakthrough” contracts are rare. The voluntaries have also excelled at union busting.

In the few cases where breakthroughs occurred, nurses led the way. The nursing shortage is largely responsible for this, creating intolerable working conditions on the one hand, and, on the other, forcing management to become more receptive to nurses’ demands. The shortage is also an important example of how changes in the way care is delivered affect health care workers first and most. Another is the rise of cost controls. As Medicare’s DRG system empties hospitals, jobs are shifting to nursing homes and clinics. Unions have organized hundreds of the former, and prospects for future victories look good. Efforts in clinics, dialysis centers, drug-rehabilitation programs, and the like have been much scarcer. With one health care job in eight now found in such settings, Muehlenkamp says, the unions will have to do better.

The changes sweeping the industry have gotten more doctors talking about organizing. “There’s enormous potential and a lot more interest among salaried physicians for unionization,” according to Janet Friedman, president of the Committee of Interns and Residents, a union in the Northeast. But, again, the NLRB saves the day for management: while interns and residents in public hospitals are defined as employees and may unionize, those in voluntary hospitals are considered students — voluntaries need not recognize them.

What does the future hold for the millions of non-unionized nurses, clerical and maintenance workers, nurse’s aides, physicians, and others? The answer largely depends on the outcome of the struggle over bargaining units. Whatever the decision, organizing should become easier with the curtailling of management’s opportunity to cause delays through litigation. A return to the old standard, of course, would be a tremendous boon to health care workers, allowing them to resume closing the gap in wages that separates them from the rest of the nation’s work force, and to improve working conditions that have steadily deteriorated during the Reagan years.

— Bill Dersiewicz
Local advocacy organizations such as Staying Alive in Boston and the Committee to Save Cook County Hospi­tal in Chicago have survived the 1980's, maybe not stronger, but as committed as ever to saving their public hospitals. Legal services, against all odds, also made it through the Reagan years. And, finally, progressive health advocacy organizations remain a symbol for advocates who have kept the faith that this nation will have a more just, equitable health care system.

COST CONTAINMENT

Only one item on the Reagan agenda garnered widespread support — the need to control health care costs. Unfortunately, cost-containment efforts during the Reagan years largely failed. In 1981, we spent 9.4 percent of the gross national budget — $287 billion — on health care. By 1987, spending had reached half a trillion dollars ($499 billion), 11.2 percent of the GNP. In each year of the Reagan administration, health care inflation far exceeded inflation in other areas of the economy.

The most dramatic of the president's efforts to control costs was Medicare's prospective payment system. Alan Sager of Boston University calls these jerking lurches to reform our health care system "policy by spasm." In 1984, we suddenly found ourselves inundat­ed by a plethora of new acronyms and a basically un­tested scheme for reimbursing hospitals in the Medicare program.

Prospective payment systems (PPS's) and diagnosis related groups (DRG's) may have kept Medicare expenditures below what they otherwise would have been. Not even this is certain, though, as early DRG payments were excessive, and outpatient and ambulatory care costs went through the roof. Moreover, Medicare Part B physician payments continued to increase at a 17 percent annual rate. And hospital and physician costs show few signs of abating: a recent survey of 1,863 hospitals found that hospital charges increased 19 percent in 1986. During that same year, physicians' incomes jumped 6.5 percent.

Insurance rates, too, are increasing at a phenomenal rate. At the beginning of 1988, insurance companies generally raised their premiums between 12 and 25 percent. As we began the decade with a "crisis" in health care costs, so will we end it. We are today spending more money than ever, yet providing care to fewer Americans.

We may have controlled payments to some providers, but we haven't controlled costs. Today, we spend approximately 6 percent of our GNP on defense and 5 percent on hospital care. Efforts during the Reagan years,
planted in infertile soil, have borne little fruit. Without doubt, the vertiginous heights to which health care spending has risen since 1981 are a major failure of the Reagan administration.

COMPETITION AND DEREGULATION

Reaganites who came to power in 1981 believed there was only one way to control health care costs — marketplace competition. An early spokesman for this view, David Stockman, wrote that the "liberal national health care policy" was built on a number of erroneous assumptions, including beliefs that the health care sector "can be efficiently and effectively regulated by government agencies and by bureaucratic mechanisms" and that "health care is unique" — a "sort of spiritual or social or collective good." Rather, Stockman argued, health care should be treated as an economic good "so that we can bring into play those self-regulatory, economizing, efficiency-producing mechanisms that we rely on in all other sectors." Stockman offered a simple prescription for the ills afflicting our health care system: "Enfranchise consumers" through cost-sharing, provide fixed rather than open-ended federal subsidies, encourage "at-risk" for-profit enterprise, promote a competitive "retail market" for health care, and build the entire health care system on a "laissez-faire" foundation "where government specifies nothing."28

Certainly, the Stockman cure has not worked. A growing number of HMO's and new preferred provider organizations (PPO's) did begin to compete with each other, but without any discernible overall savings in the health care system.29

For-profit hospital chains were the darlings of Wall Street in the first part of the decade, only to see their fortunes plummet after 1986. Today, few would argue that the growth of for-profit health care led to greater efficiency and lower costs.30 Hospitals did compete, but not on the basis of price. Facilities, not-for-profit and for-profit alike, continued to expand and purchase the latest, most technologically advanced and expensive equipment, resulting in gross overcapacity.31 Predictions by the likes of Stockman that such anti-competitive behavior would lead to bankruptcy now seem simplistic. The hospitals that closed in the 1980's were generally small, undercapitalized, inner-city and rural hospitals that served the poor, not the overcapitalized giants.32

Moreover, to the extent that hospitals did compete for business during the 1980's, this competition had a number of negative by-products: first, private insurers were less willing to subsidize the costs of caring for the indigent; second, the amount of money spent on advertising and marketing instead of patient care was vastly expanded; and, finally, hospital-controlled inpatient services and procedures were moved to the less regulated outpatient sector to make up for lost inpatient revenues through higher outpatient profits. As one economist put it, "The competitive market is an opponent, not an ally, of cost containment. When capacity increases, advertising and marketing increase, the boundaries of the system are expanded, duplication of costly services is encouraged, and the public is pushed to consume more health care services than it needs."33

The unwillingness of Medicare and private insurers to continue to subsidize hospital care for the poor has had particularly negative consequences. In Los Angeles, for example, the lack of reimbursement for emergency care provided to the uninsured poor has led a number of hospitals to opt out of the city's trauma system and close or limit their emergency rooms, resulting in a crisis for the entire community.34

Despite the failure of Reagan's broad agenda to increase free market competition, the way health care is organized has changed. The rapid growth of prepayment and managed care has transformed the health care landscape in ways that could not have been predicted in 1981. HMO's and their brethren hold promise for curbing overutilization and perhaps controlling costs. Further, the move away from the open-ended fee-for-service reimbursement system, with its incentives to provide unnecessary services, can only be viewed as positive. Although prospective payment and capitation have their own set of problems, the existing situation was no longer tenable.

The deregulators had some successes during the Reagan years, but these were few and far between. Early in the Reagan reign, 22 categorical health programs were combined into four block grants, and over 300 pages of regulation were eliminated from the Federal Register. However, Congress strongly resisted other efforts to slow down the regulatory machine, making almost yearly admonitions to a reluctant Department of Health and Human Services to issue congressionally mandated regulations. The administration simply got around these mandates by shoddy enforcement of regulations that did exist.

Reaganites became regulatory hypocrites.

A second major success of the anti-regulators was the final elimination of federal health planning, with the failure to reauthorize funding for the Health Planning and Development Act of 1974. Although the program was not always successful in controlling the proliferation of the high-tech medical armamentarium, its demise has resulted in an orgy of hospital and nursing home expansion in a number of states. Health planning was also a useful tool to obtain concessions from providers to serve the poor.

Despite the anti-regulation rhetoric, the administration has not been averse to using federal regulation to suit its own purposes. Its attempts at price fixing of hospitals, and, lately, physicians' fees in the Medicare program are a far cry from the laissez-faire medical care system where "government specifies nothing," envisioned by Stockman.35 If anything, Reaganites became regulatory hypocrites with their repeated attempts to use regulations to implement their own social agenda, especially in the matters of abortion, family planning, and pro-
tection of newborns with serious birth defects.
The most ardent of free-market advocates might argue that competition was not given a fair chance during the Reagan years. They would be right. Congress, and by extension, the American people, were not willing to go the competition route. Reagan proposed a revolutionary restructuring in our health care system. Americans, generally happy with their health care (although not the costs of that care), were not willing to support this revolution. It appears that the American people do not believe that medical care should be a commodity and are unwilling to eliminate many of the anti-competitive underpinnings of our health care system. David Kinzer of the Harvard University School of Public Health makes this point: "If and when our nation's political establishment responds to public sentiment about universal access to medical care, it should be obvious that more law and regulation are the inescapable corollary. Where citizens' rights are involved, only government can guarantee them." 

QUALITY OF CARE
Although the anti-regulatory, pro-marketplace approach of the Reagan agenda was rejected, its emphasis led to a new interest in quality of care. Advocates of competition argued that if consumers were to make informed and rational decisions in the medical care marketplace, they would need information on quality as well as price. This competition-driven move to inform the medical care consumer, combined with a concern that capitated systems have incentives to skimp on needed care, a hope of saving money by reducing inappropriate care, and an awareness of the recurring medical malpractice crisis, sparked a new interest at the federal level in quality of care.
During the 1980's we made some progress in figuring out how to define and measure quality. Peer review organizations (PRO's) replaced their weaker brothers, professional standards review organizations (PSRO's) as the government's lead agencies to monitor the quality of care for the elderly. The Health Care Finance Administration (HCFA) released data on mortality rates of Medicare patients, despite furious opposition from the hospital industry and others who argued that the data did not adequately adjust for the varying types and severity of cases handled by the different hospitals.
Although still in their infancy, research attempts to measure quality and government efforts to use information about quality of care hold promise of a more rational and safer medical care system.

THE REAGAN BALANCE SHEET
Where have seven and a half years of Reagan's efforts to transform the health care system left us? The nation's health care system provides less for the poor and elderly today than it did when Reagan became president. The truly needy have been hurt and hurt badly. To the extent that they were tried, competition, deregulation, and
for-profit medicine failed to control costs. State and voluntary efforts are not viable substitutes for federal health care programs and money. And Reagan’s budget deficit may well slam the door to an expanded, more equitable health care system.

Yet, as we look forward to the post-Reagan years, there is cause for hope. Perhaps more than ever, Americans favor expanding health care to the poor and near poor; the elderly are mobilizing to fill in the substantial gaps in insurance coverage left by Medicare; insurers are moving away from an open-ended funding system that clearly did not control costs to, we can hope, something better; health care advocacy by states and community organizations is paying off in more care to the uninsured; and the nation has finally recognized the AIDS epidemic for what it is — a plague that threatens us all.

Unfortunately, the Reagan administration has also left us without a workable plan for the future. The nation is without a clear vision of where it wants the health care system to go, and, just as important, how to get there.

The Reagan administration has left us without a workable plan for the future.

Thus, with the post-Reagan years upon us, we must take cognizance of the lessons of the Reagan era. First, a health care revolution is not in our future. Policy in this country changes slowly, step by incremental step. As the American people rejected the Reagan health care revolution, so will they reject any proposal that does not build on foundations previously laid, weak as they may be. The job before us is to shore up what we have and build from there.

Second, we must face the issue of health care rationing. If we hadn’t realized it before Reagan, we certainly know it now: rationing of health care exists in its most insidious and inequitable form — based on income and race. Yet, we cannot afford to provide all that medical science is capable of. As ethicist James Callahan posits in his 1987 book, Setting Limits: Medical Goals in An Aging Society, it is time to begin the soul-searching process of deciding how much and for whom.

A continued emphasis on quality assessment will make that search much less difficult. This is the third lesson from the Reagan years. We must find a way to control the explosive growth of expensive high-tech machines and procedures that are of questionable value. A recent RAND Corporation study showed that 32 percent of carotid endarterectomies, an extremely high-risk and very expensive procedure, were inappropriate. Such findings again underscore the need to regulate the introduction of new medical and surgical procedures and technology, much as we do drugs.

We also need quality assessment to prevent underutilization of medical resources. The increase in prepayment and managed care systems during the Reagan years raises new ethical dilemmas for physicians and hospitals by allowing them to make more by doing less. We now have the worst of all worlds for quality of care — where incentives to do too much and too little exist side by side.

Fourth, we must control costs if we are to expand care. It may be that, as HCFA predicts, Americans by 1990 will spend not 11 percent but 15 percent of our GNP on health care. If for that extra 4 percent and $200 billion dollars we get better care for more people, the expense will be worth it. If, however, the nation spends those extra billions only to end up with the same system we have today, the American people will have been cheated. Although many of us may disagree with how the Reagan administration proposed to control costs, one could well argue that its emphasis on the issue was well placed.

Fifth, even as we turn our attention to federal efforts to expand health care, we must continue to pursue advocacy at the state level. Fears that granting states greater flexibility in setting health care policy would prove disastrous were not realized. The states have become our laboratories for experiments on the best way to provide health care for the most people. Only a few of these experiments need to be successful for us to learn the best approaches to reforming the federal system.

Finally, it’s important to remember that individuals and organizations working for a more humane and decent health care system make a difference. There would be far less care for the poor and elderly today had advocates not fought hard against the worst excesses of Reagan policy.

We have survived the Reagan years. Unfortunately, the next few years do not look promising for reshaping our health care system. Costs are out of control, the number of uninsured seems likely to grow, the graying of America will make it even harder to address the needs of the elderly, and the specter of death and disease from AIDS haunts the nation. Yet, as we look to the 1988 election and a new presidency, anything is possible. If we keep working at it, America will have one day a “government that lives in the spirit of charity” and a health care system for all.

3. For example, Alabama will pay for only 12 hospital days per year, three outpatient hospital visits per year, 12 physician days per year, and eight well-child screenings from birth through age 21, including only one visit during the first year of life.


17. Under the MIG program, employer-based plans are paid a capitallized rate to provide health care benefits to Medicare beneficiaries affiliated with the employer’s retirement plan. HCFA has contracted for several MIG demonstration projects.


23. While polls show significant support for health care spending for the poor, they also show very limited support for welfare. Forty-one percent of the public believes that the nation spends too much on welfare. Thus, to the extent that Medicaid is tied to the welfare system, it remains vulnerable to the anti-welfare bias and to cutbacks. See ibid.


31. Although generally we have far too many hospital beds, in a number of communities, most notably New York City, as well as in large
urban public hospitals, there are too few resources to meet community needs. See Lambert, Bruce, "Hospital Shortages Hurt Patient Care in New York," New York Times, March 22, 1968, p. 1.
32. Richards, Bill, op. cit.
37. For a description of microeconomic theory applied to the economics of health care, see Newhouse, Joseph, The Economics of Medical Care, Addison-Wesley, 1978.
Refuting Arguments Against a National Health Program

VICENTE NAVARRO

The tenor of the debate on a national health policy in this country has undergone a dramatic change during the last 15 years. While the theme of the 1970's was the expansion of the federal role in health care through a national health program — a nationwide federal system that would be universal, comprehensive, and funded primarily with general tax revenues and/or payroll taxes¹ — the discussion in the present decade has concentrated on devising ways to reduce that role.

The possibility of a national health program has all but disappeared from discussion, not only in Congress, but also in political circles, academia, and the media. Moreover, when voices are raised in support of that solution, as they are by only a few groups, they are drowned out by a huge wave of messages and counterarguments, all presented as scientific and reasonable, against the advisability and feasibility of such a plan. In attempting to reframe the debate to include, once again, serious and wide consideration of a national health program, this article will analyze two of these counterarguments, and the evidence that supports them, to see whether they are really scientific or just plain ideological.

Spending on health care in this country is much higher than it should be. A national health program would push it even higher.

The first part of this argument is true. The United States spends more per capita on health services than any other country — nearly 11 percent of our GNP. This is expected to increase to 14 percent by the year 2000.

Despite these huge expenditures, the United States still faces problems without parallel among other industrialized countries. Although the amount of money we spend on health care has grown unchecked during the 1980's, people are receiving less and poorer health care than in the past. The number of visits to physicians and the number of hospitalizations recorded in this country have declined, while the percentage of people who had not visited a physician during the preceding year jumped from 19 percent in 1982 to 33 percent in 1986. The proportion of the population without a regular source of care has also increased. Moreover, the segment of the population lacking health insurance has also grown. In 1986, 16 percent of the population (38 million people) had no form of coverage whatsoever, and another 6 percent (13.5 million people) did not receive medical care for financial reasons. Among the uninsured, 13 percent did not receive needed care because they could not pay for it.²

In no other developed nation, furthermore, do people still pay such a high percentage of health costs out of their own pockets. Patients absorb 27 percent of the cost of health care in the United States, compared with 5 percent in Great Britain, 8 percent in Sweden, 12 percent in West Germany, and 20 percent in Canada.³

The campaign to reduce the deficit is really a campaign to reduce social spending.

Why do we see this diminishing return on increased costs? Another look at the international picture provides the answer. The United States is the only major industrialized nation (besides South Africa) where most of the money for health care is drawn from and most of it spent through the private sector. The overwhelming majority of industrialized nations fund their health services with public revenues. In 1983, the U.S. government spent 4.5 percent of the nation's GNP on health, while the Swedish government spent 8.8 percent; the British, 5.5 percent; the West German, 6.6 percent; and the Canadian, 6.2 percent.⁴

At the same time, no other country has a larger for-profit health sector than we do. Forty-four percent of all spending for health care here went to private, for-profit institutions and contractors, compared with 17 percent in Sweden, 26 percent in the United Kingdom, and 42 percent in Canada.⁵ No other country spends such a staggering amount on profits and administration, either in absolute numbers or as percentages of health expenditure,⁶ and these figures have increased during the Reagan years. The profit margin for hospitals has bal-

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loomed 19 percent in this period, for example, far larger than the 7 percent growth in profits for the economy as a whole.\textsuperscript{7}

**Look to the North**

We can look to Canada for a relevant comparison to the United States' approach to funding health care. The countries had similar rates of growth for health expenditures until 1968, when Canada established a national health program. Since then, the percentage of GNP going to health has remained almost constant in Canada; we already know what's happened here. Furthermore, Canada now provides more comprehensive and universal health benefits than were offered before 1968.\textsuperscript{8} Canada covers hospital and ambulatory care for the country's entire population, while public programs in the United States cover only 40 percent of the population for hospital care and 25 percent for ambulatory care.\textsuperscript{9}

In the course of the Reagan administration, as we have seen, market forces and profit interests have expanded their influence on the management of health care. Free-market competition has failed to reduce costs, broaden coverage, or improve access to care. People are increasingly dissatisfied with the delivery of health care services. Seventy-five percent of those polled in one survey — an all-time high — said they want to see fundamental changes in our system of funding and delivering health care.\textsuperscript{10} The strategy of unlimited competition has been successful only in increasing the profits of the corporations that dominate the health care industry. The solution to these problems of growing costs and limited coverage lies in a larger, not smaller, role for government, and in a concomitant reduction of the private sector's role in the funding and organization of health services. Now on to the second argument.

**The large federal deficit is one of the major reasons for the economy's poor performance. A national health program would require larger expenditures that would increase the deficit.**

This is one of the arguments most frequently used against the establishment of a national health program. The size of the deficit needs to be reduced, according to this line of thinking, before we can consider enlarging the federal role in health. Otherwise, the economy is going to get worse, and we will all suffer. Over and over, leading figures in the political and medical establishments reiterate these beliefs. People as unlikely as the national leadership of the AFL-CIO and Senator Edward Kennedy have also embraced this argument to explain why they backed away from supporting a national health program in favor of mandated employer-paid coverage.\textsuperscript{11}

The argument hinges on a misrepresentation of the federal deficit. Contrary to public perception, today's budget deficit was created by the current administration with the support of Congress, primarily through the federal tax cuts of 1981 and by the unprecedented growth of military spending during the Reagan administration.\textsuperscript{12} It was, moreover, deliberately created to force reductions in social expenditures, including spending on health, now and in the future. As David Stockman put it, "The plan was to have a strategic deficit that would give us an argument for cutting back the programs that weren't desired."\textsuperscript{13}
The administration's proposed budget cuts for the years 1981-84 showed clearly what those undesired programs were. The proposals included reductions of 60 percent in non-means-tested programs, 27.7 percent in means-tested programs, and 11.4 percent in social insurance entitlements. Health programs were among those federal initiatives that would have suffered the greatest reductions. Medicare, for example, which represents 7 percent of all federal expenditures, accounted for 12 percent of proposed reductions during this period. In Reagan's budget for 1987, 36 percent of the proposed cuts were to have been made in health programs.

The huge campaign orchestrated by the Reagan administration to reduce the deficit has actually been a campaign to reduce spending for social and health programs. As J. Peter Grace and other leading business people who support and finance this anti-deficit advertising campaign recognize, "We are not concerned about the deficit, we are concerned about the level of government spending." And "government spending" is a code name for social expenditures.

Security Means Strength
The origins of our economic problems cannot be reduced to the federal deficit or rapidly growing social expenditures. If this were the case, we would expect those countries with larger deficits, greater public spend-

Health expenditures continue to grow while people get less services.

ing for social programs, and higher rates of growth in these areas to do worse economically than the United States. They don't — they do much better.

In 1986, the federal deficit constituted 4.8 percent of the GNP in the United States. Sweden's deficit in the late 1970's was three times higher (15 percent of the GNP), and remains higher even today (7 percent). The rate of growth of social spending, including spending on health, in Sweden from 1975 to 1982 was also higher than that in the United States. During these years Sweden had lower unemployment, lower inflation, and faster economic growth than the United States.

Japan, Austria, and Norway have deficits comparable to ours, and the rate of growth of their social expenditures is larger than that here. Again, these countries have lower unemployment, higher economic growth, and lower inflation than we do. Not coincidentally, all
these nations have well-established and growing national health programs. And all of them have greater public expenditures for health, and a higher rate of growth of these expenditures, than the United States.

No other country has a larger for-profit health sector than the U.S.

Thus, a national health program is not the economic drain that its detractors portray. In fact, the evidence shows that unless a country's working population has the social supports, including health and social services, needed to cushion the impact of changes in the economic structure, it is unlikely to cooperate with the technological and social changes that may be required for the successful development of the economy. For example, no other country has as many robots per capita — a sign of technological advance — or more labor flexibility than Sweden, in part because of the economic security that grows out of its universal social and health benefits. In contrast, one of the major reasons workers in the United States resist changing jobs is their fear of losing health benefits. The expansion of coverage, comprehensiveness, and universality of social and health supports is a condition of, rather than a handicap to, the successful economic performance of our country.

In the last eight years, a conservative ideological avalanche has all but buried the country by transforming political issues into economic ones. The issue of a national health program, however, is clearly political, and the arguments brought to bear against it are not logical, but ideological. Once they are dissected, it becomes clear not only that the country will benefit from a national approach to health care, but that its citizens have wanted such a program for some time. As the Reagan era draws to a close, we have the opportunity to reverse the deterioration in health services experienced by large segments of our nation and to rescue the issue of a national health program from obscurity. Despite the attempts of the Reagan administration and its supporters to bury the idea of a national health program, reports of its death are greatly exaggerated.


Aiming So Low
We Hit Our Own Feet
The Limits of Incrementalism
DAVID U. HIMMELSTEIN AND STEFFIE WOOLHANDLER

This article is a response to remarks made by Ron Pollack of the Villers Foundation at Health/PAC’s June 1987 conference, “Rethinking a National Health Program in the Post-Reagan Era.” Pollack advocated an incrementalist strategy for health policy reform, through such measures as extending Medicaid, and warned against more radical approaches.

— D.U.H. and S.W.

Some progressive health activists, demoralized by the long winter of Reaganism (following the none-too-hospitable autumn of Carter’s reign), are setting their sights far too low. They advise us to mute our fight for fundamental reform of the U.S. health care system, and instead to pursue more “realistic” goals such as the extension of coverage under Medicaid, “catastrophic” coverage, mandated employee coverage, and the like. To the contrary, we think the time is right to vigorously advocate a national health program assuring universal comprehensive coverage in a unified public system.

In the past year, debate on health policy has moved markedly to the left. The issues of social justice and access to care have again appeared on the mainstream policy agenda after a decade of debate and legislation dominated by cost containment. The people of Massachusetts overwhelmingly approved a referendum endorsing a national health program, and Governor Dukakis and the legislature have taken steps, if mainly rhetorical ones, toward universal health insurance. The rhetoric of access will play prominently in Dukakis’ presidential bid. Legislatures in more than half the states are considering measures to extend access to care, in some cases dramatically. Even President Reagan has been forced to endorse “catastrophic” health care protection, though the proposals behind his rhetoric are, as usual, useless or worse. The next few years offer exciting opportunities for progress. How can we best take advantage of these opportunities?

First, extending access without fundamentally altering the health care system would recreate the problems that led to Reagan’s successful assault on access to care. Costs would skyrocket as private insurers and providers scrambled to enrich themselves by “serving” the newly insured, while avoiding the restraints on profit and irrational behavior that a universal public system could impose. The oppressed would continue to be ghettoized in separate programs such as Medicaid, ripe for attack when the political pendulum next swings back. The fundamental causes of the crisis in health care would remain untouched, and when the cost crisis reemerges in a few years, reactionaries will again successfully blame the programs of the left — forcing us once more to defend Medicaid, the worst health program for the poor in the developed world.

In contrast, a national health program could solve the crisis — provide universal access and contain costs. Only a universal, comprehensive public system can put teeth into health planning and eliminate the excess administrative expense — $70 billion annually — needed to enforce inequality and insure profitability. The Canadian national health program, which assures universal and comprehensive care at only 75 percent of the per-capita cost of U.S. health care, provides proof of the feasibility and long-term economic stability of a national health program. Moreover, in such a universal system the oppressed cannot so easily be singled out for cutbacks — as shown in the United States, as well, by the relative immunity to cuts in funding of universal entitlement programs such as Social Security.

Want a Slice? Demand the Whole Pie
Indeed, advocating for narrow reform is not even the

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best way to win narrow reform. The best way to get a slice is to forcefully demand the whole pie — particularly when two-thirds of the populace supports us. Thus Medicaid was not the result of agitation for a limited program to cover some of the poor, but a response to the threat of national health insurance. The then Secretary of Health, Education and Welfare, Wilbur Cohen, has since described the process:

The inclusion of Medicaid in the 1965 law evolved when Wilbur Mills asked me what his answer would be to the inevitable question..."Isn't Medicare an 'entering wedge' to a broader program of nationwide 'compulsory' insurance coverage of everyone?" I suggested that if he included some plan to cover the key groups of poor people, he would have a possible answer to this criticism. Medicaid evolved from this problem and discussion.3

The recent Massachusetts experience again shows the wisdom of honestly advocating what we know to be the best, indeed the only, real solution. The national health program referendum, placed on the ballot against the urgings of ''incrementalist'' friends, was instrumental in creating a climate for change. In this climate Dukakis has been only too happy to offer inadequate compromise measures. There will always be plenty of politicians prepared to make compromises for us; we needn't make them ourselves in advance.

Third, there is much broader support for basic reform of health care than for minor tinkering that would simply extend coverage to some, or even all, of those currently uninsured. Extending coverage does nothing for the vast majority who have insurance but are dissatisfied with our current system — because of gaps in coverage, inadequate preventive care, horrible long-term care, or its many other deficiencies. The narrower our demands the narrower our constituency.

What is to Be Done

Whatever reforms we propose we will undoubtedly face many generations of continuing struggle to achieve a just health care system and a healthful society. The question is which reforms move us forward and open up new space for struggle, and which leave the fundamental problems untouched, condemning us to fight old battles repeatedly. There is an element of self-fulfilling prophecy to the claim that more radical demands are untenable. Obviously we will not get more than we demand. The following measures are realistically achievable in the next decade, and are the minimum necessary for a viable and stable solution to the current crisis in health care:

Coverage must be universal and comprehensive under a single program. This would assure access, avoid a “two-class” system of care, minimize administrative expense, and provide a firm political base of support. Allowing competing private insurance programs or balanced billing negates this advantage.

Out-of-pocket payments should be eliminated. They are unpopular, unnecessary, administratively unwieldy, and unfair to the sick and the poor.

Hospitals must be paid on a lump-sum basis for operating expenses, with capital spending budgeted separately — as is done in Canada. This minimizes the economic incentives for providing too little care inherent in per-case prospective payment systems like DRG’s or HMO’s, since money not spent on patient care cannot be used for institutional expansion. Similarly, the incentives for providing too much care inherent in fee-for-service hospital reimbursement are eliminated. Lump-sum payment for operating expenses eliminates billing and greatly simplifies administration. Separate budgeting of capital facilitates rational health planning.

The system should be administered by a public or quasi-public body. Private insurance firms have an incentive to increase costs and bureaucracy since these result in higher income. The cost of insurance overhead and administration in private plans is three times higher than in public programs in both the United States and Canada.

Health activists should advocate a realistic solution to the health care crisis. That solution is a national health program. By aiming lower we risk shooting ourselves in the feet.□

American Indians are one of the few groups in the United States who have the legislated right to receive health care from the U.S. government. The right is based on the Snyder Act of 1921, which guarantees health care services to Indian people. It is ironic that one of the few groups entitled to health care in the United States has allotted to it a smaller proportion of health care resources than any other group in the country.

Such a disproportionate allotment may be traced to the nineteenth century view of the Indians as an obstacle to white economic development in Indian territories. Indians were not considered people — they were barriers to the expansion of American frontiers. Indigenous Indian communities could not withstand the onslaught of white colonization backed by the U.S. Army. In this century, poverty and ignorance created by the destruction of traditional Indian societies have left the Indians disenfranchised and ineffective in advocating for themselves at the federal level.

The Indian Health Service (IHS) is the federal agency charged with providing health care services to Indian people. It is divided for administrative purposes into a number of regional areas. The Aberdeen Area consists of 12 reservations, termed “service units,” in the upper Midwest. The largest of the Aberdeen Area service units by far is Pine Ridge, home of the Oglala Lakota or Sioux Indians. The reservation, about the size of the state of Connecticut, is the second largest in the United States.

Approximately 18,500 people (no accurate census figures are available) receive services at Pine Ridge Hospital (originally constructed in 1928) and at five outlying clinics. Historically, the quality of care delivered in Pine Ridge has been inadequate. A few good providers (doctors and others) were always present, though most physicians at Pine Ridge, until recently, were uncommitted to the people. Some came newly out of medical school with little if any advanced training or experience, forced to serve in a remote area not of their choosing to pay back scholarships or loans. Some were physicians between jobs or retired physicians, with little interest in long-term solutions to the health problems of the Sioux. All worked long hours and many suffered from burnout.

The undersupply of experienced and motivated doctors is attributable to the remoteness of Pine Ridge, two hours (or more, if the snow is bad) to the nearest town of 50,000. Work on an Indian reservation in South Dakota is not attractive to physicians used to conventional amenities in their communities. Eight of the 25 poorest counties in the nation are on or near South Dakota reservations according to a 1987 United Methodist Church study on poverty. The poorest county in the United States is Shannon, on the Pine Ridge reservation. Another factor is the frustrating nature of the health problems of the Sioux. The century-long legacy of poverty and ignorance has left the Indians plagued by alcoholism, violence, self-neglect, and other “social” diseases that the average physician is inexperienced in treating.

As an employer, the IHS is not appealing to many physicians. It does not provide the psychological incentives that might attract physicians who would be interested in assignment to the reservation despite the absence of material rewards. Always limited in funds, the IHS can hardly meet its obligation even to provide services for the Indians.

The IHS receives $800 to $900 per capita for health, water, sewer, and sanitation. The national average for all Americans is twice that for health alone. The national physician-to-patient ratio is 1 to 1,000. In the IHS it is 1 to 1,300. At Pine Ridge, the physician-to-patient ratio is 1 to 2,000.

New Leadership, New Hope

The Aberdeen Area office made efforts to substantially improve the quality of care at Pine Ridge from 1984 to early 1987. In January 1985, a new service unit director began making important changes, from the cleaning up of the hospital to the more complex task of increasing Medicare and Medicaid collections from the U.S.
government.

Indian people are eligible to receive benefits from Medicare and Medicaid if they meet age or economic criteria (as most do), and the IHS may increase its revenues by billing the programs. Before 1984, less than half a million dollars were collected annually because requests for reimbursement were not made consistently.

Aberdeen deliberately recruited better-trained physicians to Pine Ridge. In 1985, at any given time there were half a dozen physicians at Pine Ridge, of whom, with staff turnover, one or two usually were board-certified or board-eligible specialists. In 1987, there were a dozen physicians all but one or two of whom were specialists. Many of the physicians were attracted to Pine Ridge by the variety of professional colleagues available, by the increase in support services that came with the increased collections, and by the deliberate efforts of the service unit director to create a receptive environment. Though the majority of the physicians are still "payback," they are better trained, more experienced, and more willing to serve the disadvantaged population.

It is the brief and dramatic improvement at Pine Ridge from 1985 to 1987 that is at the heart of the current crisis. With the rise in the number of support staff and physicians came an expectation, a vision, of a critical mass of people and resources able to make a lasting and positive impact on the health of the Sioux. We would be able to prevent illness and make keeping people well a priority over treating them after they become sick. In fact, patient visits rose 40 percent over three years, an example of demand for services rising to meet supply. The dream is rapidly fading with the budget crisis of 1987.

Cuts that Draw Blood

President Ronald Reagan has no reputation as a friend of the poor. Numerous examples have been documented elsewhere of human suffering occurring as a result of the failure of Reagan's "safety net" to provide for the disadvantaged. Indian people are not excluded from the effects of cutbacks, though Reagan's cutbacks cannot be blamed completely for the budget crisis at Pine Ridge. No public report is available, but it is said that Aberdeen mismanaged several million dollars in fiscal year 1986, and service units are being made to pay for dollars lost at the area level. The good intentions of the area office from several years ago fell victim to a serious lack of management expertise, aggravated by the Reagan administration's diversion of essential funds away from human-needs programs.

Figures and statistics for the Pine Ridge Service Unit are hard to tie down. They vary depending on which administrator you ask, and when. Due to an inability at the area level to manage large amounts of money, a firm budget for the service unit may not be set until the latter part of the fiscal year. Budget figures may represent reconciliation of projections with ultimate outcomes.

There appear to be two major sources of funds for the hospital and clinics. The smaller source is the Medicare
Pharmacist Cynthia Roach examines hands of patient James Pourier.

and Medicaid collections. Those totaled $560,000 in 1984, peaked at $2.9 million in 1986 (which included back collections), and stabilized at $1.8 million for each of 1987 and 1988 (expected). The larger source of funds is the IHS line item "Hospitals and Clinics," which rose from $3.9 million in 1984 to $5.5 million in 1987. The figure has been reduced to $4.3 million for 1988.

The budget picture is made confusing by allegations from Pine Ridge that hundreds of thousands of dollars have been taken inappropriately by Aberdeen for administrative purposes, and by allegations from the area of poor local budgeting, requiring a bail-out of the service unit of at least a million dollars. It is true that Pine Ridge was not prepared for the drop in Medicare and Medicaid collections after the peak in fiscal year 1986, though that alone cannot account for the severity of the current crisis. Area mismanagement is a major factor.

In 1987, the number of staff positions at Pine Ridge fell precipitously because of the budget crisis. The process was mostly by attrition, by a few lay-offs, and by the slashing of the majority of temporary positions to half or three-quarters time. The number of physicians and physician assistants providing general medical and pediatric care fell from 20 providers to 13, a drop of 40 percent, at a time when visits were up 14 percent.

In July of 1987, there were 236 employee positions at Pine Ridge, all-time high, of which 101 were temporary, most of those full-time. As of October 22, 1987, there were 181 employee positions, though the figure is misleading, since of the remaining temporary positions, only a small number are full-time. A more accurate number of full-time equivalent positions in October would be 164, a loss of 72 full-time positions, representing a 30 percent reduction in hospital staff in three months.

Pine Ridge has lost 30 percent of its staff.

The effect of the cuts on hospital and clinical services is considerable. A staff pediatrician, after spending his day seeing patients in the clinic, went to make rounds on children hospitalized for lung infections. He found that because of a nursing shortage the children were not getting the breathing treatments they needed. The hospital did not have enough nurses available to look after the children. On 23 days in December 1987, hospital nurse-to-inpatient ratios did not meet even IHS standards. The radiology department has gone from five and one-half technicians to two and one-half. Those two and one-half technicians are supposed to provide 24-hour X-ray coverage for 85,000 expected patient visits in 1988. The laboratory has gone from ten technologists to five.

The Pine Ridge optometrist cites IHS (and professional) standards that recommend one optometrist and two
assistants per 5,000 patient population. As he and his two assistants are the only providers of eye care on the reservation, he finds a 75 percent unmet need for eye care. The eye clinic opens its books for appointments every two weeks on Friday at 8 a.m. The clinic is usually booked for the following two weeks in 20 minutes.

The optometrist says that it is not uncommon for him to find a patient who can hardly see two fingers wiggled in front of his face. When such a patient is asked how he arrived at the clinic that day, he says “I drove myself.” The optometrist writes, “I honestly feel that poor vision, from lack of glasses, represents a significant handicap that [bears] on economics and productivity on the reservation.” The single optometrist was added in 1986, before which there was none.

Pine Ridge Fights Back

The budget crisis is particularly stressful, aside from the actual cuts, because of frequent miscommunication between Aberdeen and local administration and hospital staff. Employees feel disenfranchised, and experience a decline in job satisfaction. One nursing administrator says, “I’m going to resign. These are my people. I can’t watch them be sacrificed to a bottom line of dollars and cents.” A number of staff have left Pine Ridge out of frustration and disappointment.

Rumors abound of cronyism and misappropriation of funds at all levels. It is said that additional administrators are being hired in Aberdeen while people who provide direct patient care are let go at Pine Ridge. One assistant department head says, “I’m furious that they’re hiring more GS 13’s and 14’s [high-paying positions] in Aberdeen, while the GS 3’s in my department, making $5.39 an hour, are cut back to half-time. How can they feed their kids on that?” Some of those GS 3’s went without heat this winter because they could not afford it.

The reaction to the budget crisis at Pine Ridge has varied. Most employees are unwilling to speak out, many because they are from the community. With a reservation-wide unemployment rate of 85 percent, they need to be careful about protecting their jobs. The physicians are less vulnerable. On November 20, 1987, they held a press conference — a highly unusual move for federal employees — to publicize the crisis at Pine Ridge. At a meeting in response to the press conference, the area director offered little hope for a satisfactory resolution. He said that no more funds are available and that the staff will have to scale back its expectations.

A press release from the administration promises a

We must bring needed resources to this most needy population.
new hospital to start construction in 1989 or 1990, and a new free-standing clinic to be built beginning in the spring of 1988. These projects, which have been promised for some time, will hardly help the people who need services now.

Tribal officials and other community members have condemned the cuts publicly and called for IHS accountability. A tribal representative said, "It is ridiculous for the Aberdeen Area office to call for cuts. There isn't one hospital bed in the federal building in Aberdeen. They don't take one blood pressure or one temperature measurement, yet they require us to cut staff."

The administrations locally and at the area level have said that despite the cuts, the service unit is better off than it was before. It is true that in the past few years there have been major additions in optometry, surgery, obstetrics, kidney dialysis, maternal and child health, and communicable disease control. An experienced obstetrician and a surgeon have saved health care dollars by providing services at Pine Ridge that previously were

There is a shortage of experienced and motivated doctors.

The Poor State

The expansion of white settlement across North America did more than deprive American Indians of their land. It disturbed native cultures in a profound and permanent way, and with them the patterns of behavior that kept Indians healthy. Today's American Indians, impoverished, desperate, are in poorer health than nearly any other group in the United States.

In 1985, the Office of Technology Assessment published *Indian Health*, the most comprehensive study to date of the health status of American Indians. (Indian people prefer to use this term, as opposed to 'Native American.') Although the study covers only those Indians who live on reservations and presents figures for mortality alone, it has much to tell us. Perhaps its most disturbing statistic is that 37 percent of reservation Indians die before age 45, compared to 12 percent of the total U.S. population. In all, the mortality rate on reservations is 40 percent higher than among Americans as a whole.

Most of the leading causes of death among American Indians — liver disease, digestive cancer, accident, homicide, suicide — are related in great measure to alcohol abuse. While Indian people have lower-than-average mortality rates for heart disease, stroke, and most forms of cancer, their rates of death from alcohol-related causes are several times higher than for the country as a whole: four times higher for liver disease, twice as high for homicide. The poverty of the Indian diet results in high mortality rates for diabetes and renal failure, both almost three times the national average. Tobacco abuse is also widespread on reservations.

According to Tom Welty, an epidemiologist with the Indian Health Service, health problems typical of the Third World — tuberculosis, high infant mortality — have been successfully addressed by the IHS since the mid-1950's. American Indians are now plagued by health problems stemming from the changes in their lifestyles brought on by contact with Europeans.

"Socioeconomic conditions among American Indians create the kind of despair that drives people to anesthetize their pain through alcohol," says Ron Rowell, head of the National Native American Prevention Center in San Francisco. On some reservations, unemployment runs as high as 85 percent. Median family income among American Indians is 30 percent below that for the nation as a whole. And alcoholism isn't simply an unintended by-product of the displacement of native societies, but one of its causes. "The Europeans used alcohol," Rowell says, "as a weapon of conquest."

Before contact with Europeans, Indian nations lived off the land, the majority of them as farmers. "The whole idea of the reservation system," Rowell says, "was to get Indians off the best farmland and give it to the white settlers." By no means do reservation Indians live in a state of nature, he points out. The Navajo, for instance, were originally farmers, not the shepherds they have been forced to become. The Indian diet, once high in fiber and low in fat, has been turned upside down. "There's little knowledge among Indian people about nutrition," Rowell says. "They buy their food at Safeway, like everyone else." Chronic unemployment and high-fat diets have led to obesity, triggering what public health officials believe to be a genetic predisposition to diabetes among American Indians. The disease, with its related renal disorders, has reached unheard-of proportions in many areas (30-40 percent of adults on reservations in the northern plains have diabetes, 50 percent of Arizona's Pima have kidney disease) and its incidence is growing.
purchased outside the IHS (the savings were absorbed by Aberdeen). An interdisciplinary maternal and child health committee has brought WIC (a federal food supplement program) to the reservation and is addressing the problem of infant mortality. The tuberculosis control program has doubled the number of people on chemoprophylaxis. Quality assurance efforts contributed to hospital re-accreditation in 1987.

Those programs are becoming skeleton services with the current round of cuts. The availability of resources is returning to the unacceptable level of three years ago. What had been quietly moving ahead is falling back at an alarming rate. We are losing the resources to provide the preventive programs needed to improve the health of the Sioux. Our programs will not succeed in accomplishing their objectives because of inadequate staffing and funding.

Last year, the dream of quality care began to fade rapidly.

The issue clearly is not how to maintain the status quo. The issue is the most effective means to bring needed resources to this most needy population of Native Ameri-
can people. U.S. Senator Tom Daschle of South Dakota, who sits on the Indian Affairs Committee, has visited Pine Ridge and met with physicians and tribal leaders to discuss the health care crisis. On his most recent visit in early May, he accompanied Senator Daniel Inouye, chairman of the committee, who appeared responsive to our concerns.

Letters to those officials are needed to thank them for their attention and to encourage their efforts to improve conditions at Pine Ridge. Individuals should write their congresspeople, as well as Senators Daschle and Inouye, to protest the cuts at Pine Ridge and to demand that health care resources be made available to bring the health status of Pine Ridge up to national standards.
The Candidates and AIDS

Ronald Reagan has been dangerously negligent in his response to AIDS. Can we expect any change from the new president in January? Probably not.

In a speech at the annual meeting of the American Association for the Advancement of Science last February, Dr. David Baltimore, Nobel laureate in medicine and physiology, criticized the presidential candidates for their lack of leadership against AIDS. "Echoing the silence from Washington, there have been no bold or comprehensive AIDS programs presented by the candidates," he said. "We need political leadership, but we are given silence."

In the months since Baltimore's speech, the field of candidates has narrowed considerably, yet none of them has emerged as a leader on this issue. Jesse Jackson and Michael Dukakis both address the obvious need for improvements in AIDS education and research, in civil rights for HIV-positive people, and in treatment for drug users, but their promises are vague. Dukakis speaks of committing "will" and "resources" to the problem.

According to Vicente Navarro, Jackson's health policy advisor, Jackson is "sympathetic" to the $3 billion research proposal recommended by the Rainbow Coalition, but he has not expressly adopted it. Although he has not spoken specifically about funding, Jackson, unlike Dukakis, is specific about where money for AIDS would come from; it would come from the military budget.

George Bush thrusts the responsibility for leadership and spending onto local government and the private sector. Furthermore, he is particularly silent on the problems of drug abuse and AIDS. His "plan" calls for a "change of behavior" motivated by education. "Those at risk will not change unless they know of the terrible dangers they face," he preaches.

Several government groups have developed specific budgetary proposals for the fight against AIDS. The president's AIDS commission has drawn up a comprehensive plan with a $10 billion budget, $2 billion of which would support treatment on demand for IV drug users. The National Academy of Sciences' research and education programs would require $2 billion a year in new expenditures by 1991. None of the candidates, however, has endorsed either of these plans or has stated how much funding he would allocate for AIDS in 1989.

Perhaps political motives have silenced the candidates. Campaign pressures prevent them from committing themselves to expensive funding proposals. Whatever the reason, the candidates will keep silent until we force them to talk.

— Anne McDonough

AIDS and the Needle Debate

A year and a half is about all we have left before the AIDS epidemic will be unstoppable among intravenous drug users, their sexual partners, and children, according to New York City Health Commissioner Stephen Joseph. With drug users now accounting for the majority of new AIDS cases in New York City, Joseph has had to battle law enforcement officials and resistant community groups to institute even a small-scale pilot needle-exchange program that will reach only a tiny fraction of the city's 250,000 addicts. He spoke at a recent forum organized by the Community Service Society (CSS) and the Association for Drug Abuse Prevention and Treatment (ADAPT) to debate New York City's controversial program to exchange clean needles for used "works."

While supporting the program, fellow panelist Yolanda Serrano, executive director of ADAPT, favored a much more activist approach, one that would bring education along with needles into the drug users' own communities. ADAPT, a nonprofit educational and outreach organization, has called for needle distribution in defiance of the law if necessary. New York is one of 11 states that outlaw possession of hypodermic needles without a prescription.

Dr. Joseph admitted that the proposed program might be "too little,
too late, too timid," and "set up to fail," but he defended it as "all we can get in the current climate." With inadequate federal funds available for drug treatment or education and community groups pressuring law enforcement officials to crack down on drug use in their neighborhoods, what's a health commissioner to do?

Sparks flew as the vocal audience of several hundred, many of them former addicts with HIV-positive diagnoses, criticized the city and state's long delays in approving the needle-exchange program, while at the same time deriding it as being much ado about little. Quoting Joseph's year-and-a-half target date, one former drug user and ADAPT volunteer commented, "It might be more convenient to time yourself with the amount of people that are dying and how fast they're dying." Another cited a proposed target of 300 needles for 300 users in five boroughs and exclaimed, "There's that many addicts on my block!"

But audience and panelists alike saved their greatest scorn for panelist Arthur Diamond, Deputy Chief Assistant for the city's Special Narcotics Prosecutor, the only speaker to condemn the program outright. "We do not believe that it's in the best interests of society in general to have the government supplying or encouraging drug users," he said. Faced with evidence of success from similar programs in Europe, Diamond argued that needle-exchange programs are doomed to fail here because addicts would continue to share needles even if clean ones were available.

Panelist Robert Bixler, Deputy Director for AIDS Education and Training for the Narcotic and Drug Research Training Institute (an affiliate of the New York State Division of Substance Abuse Services) reminded Diamond that we're "fighting the battle of HIV infection, not the battle of drug abuse." The needle exchange program will "buy time" while we work to provide treatment and education for addicts, he argued.

For more information about the fight against AIDS among drug users, contact ADAPT, 85 Bergen Street, Brooklyn, NY 11201 (718) 834-9585. — Ellen Bilofsky

Is the Dukakis Bill Any Good?

Last April, Governor Michael Dukakis signed Massachusetts' new Medical Securities Act, hailing it as the first universal health care law in the nation. The final version was drafted largely along the lines of a bill designed last December by State Senator Patricia McGovern after a Dukakis proposal was nearly killed in the House. While hardly the kind of program that health care progressives would design, we in the Health Care For All Campaign, a coalition of consumer groups and other health care activists in Massachusetts, view it as a major step forward.

Numerous provisions will kick in between now and 1992. These include a requirement that all insurance policies in the state provide well-child care; a Medicaid buy-in program for disabled adults who wish to return to work and for parents of disabled children; and, beginning in 1990, a surcharge on small employers (less than $17 per employee per year) to insure the unemployed. The program's lack of cost-containment measures for hospitals is troubling, as is the uncertainty of adequate funding for the proposed benefits. But the political reality is that systemic reform — such as moving toward a program like that in Canada — is not even on the agenda of any of the interest groups that determine health policy. Understanding this, Massachusetts activists view the new law as a platform on which to build. — Larry Bresslour
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