SIX Myths of American Medical Care
What the Poor Really Get

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To the Editor:

Congratulations on an excellent issue. I was very impressed with Louanne Kennedy’s cogent and timely analysis of the American Hospital Supply-Hospital Corporation of America merger, and thought I had a good understanding of what it was all about.

Unfortunately, the article proved too timely, since AHS is merging with Baxter Travenol instead. A number of questions come to mind:

Does this mean that rather than following the vertical integration model the health care industry will pursue horizontal integration; that American Hospital Travenol will play U.S. Steel to Charter Hospital Corporation’s General Motors?

Is Monsanto’s takeover of Searle the harbinger of massive entry into the industry by big capital from other, slower-growing industries, and will this preclude full-scale integration within health care, horizontal or vertical? Will Sears become the major force in convenience medical and dental centers?

Will the trend toward bigger and more highly capitalized companies compel health care associations and unions—SEIU, I199(s), UFCW, ANA, the nascent National Federation of House Staff Organizations, and whoever else, to get together in a Hospital Trades Council, if they don’t actually merge? At this point only 20 percent of hospital workers are unionized, and it won’t be easy to bring in many more without organizing entire states, if not entire national corporations. Are unions developing long term workforce projections? Is anybody, outside the corporations?

Is anyone attempting to develop consumer associations to confront health care corporations and HMO’s that have a monopoly or near-monopoly in an area?

I’m sure you could think of another list of questions on this subject; I’m not so sure you could answer them all, but I hope in forthcoming issues you’ll try.

Ira Brooks
Philadelphia, PA
Notes & Comment

Whatever we may have thought five years ago, by now it is clear that the term “Reagan Revolution” is not pure hype. In certain areas, not least ideology, the changes go back far beyond the era of Calvin Coolidge and represent a genuine, radical break with the past, at least the past 2300 years.

One such area is the value of human life. The injunction, “an eye for an eye, a tooth for a tooth,” is often considered an example of Old Testament brutality, but in fact it represents a giant leap forward. The same phrase appears in the Babylonian Code of Hammurabi, written about 600 years earlier circa 2900 B.C., but the specifics of Babylonian law were considerably less egalitarian. The punishment for damage and theft depended not only on the crime, but on the social caste of the victim; if you stole from an aristocrat your compensation payment was far greater than if you stole from a commoner. According to Mosaic law, the punishment was the same whatever the station of the victim.

The Reagan Administration has quietly attempted to reverse this egalitarian trend of the past four millennia in the interests of free enterprise. This great plunge backward is evident in Executive Order 12291, which requires that if Congress does not expressly forbid it, “regulatory action shall not be undertaken unless the potential benefits to society from the regulation outweigh the potential costs to society.”

Superficially it may seem to be merely a crass devaluation of human life in general for the Environmental Protection Agency to arbitrarily set a value somewhere between $400,000 to $7 million on a human life, but the effect is more insidious.

This is very clear in matters concerning occupational health and safety. The system works like this:

Say the known risk of dying from an occupational hazard in a mine is one in a thousand. Grubble is mined in the poorest areas of South Dakota and Utah - areas poor in large part because the mining interests have kept out any other industries and smashed any attempts to organize unions. To feed their families, people in these poverty pockets with holes in them are willing to mine the grubble for only $10,000 a year.

“Well,” say the government regulators, “the pay for a manager at the local Burger King is $9,800 a year. So we know these

Letter from the Editor

As those of you who have read one of our direct mail pieces are aware, we are proud that we analyze the health care system from a progressive perspective which is unique in this country. Although readers of various other health and medicine publications would not be shocked to find some articles that have appeared in the Bulletin in those pages, they would be the political exceptions there, and here they are at home.

Some Bulletin articles, however, would be unlikely to appear in any other U.S. health publication. Not because they are unimportant; on the contrary, because they are very significant, and describe the basis of our health care system, the pursuit of profits at the expense of need.

We are pleased to have major articles on both aspects of this phenomenon in this issue, Geri Dallek’s “Six Myths of American Health Care” and Tony Bale’s “The Great American Health Care Fortunes, 1984.” We hope you find them informative and provocative.

Unlike health care, where the political nature of who gets what is too blatant to be denied, medicine is often presented by its practitioners and their supporters as an objective and apolitical science. This issue of the Bulletin contains four articles, on subjects as diverse as septicemia, tuberculosis, AIDS, and anesthesia, which in different ways show how political considerations enter into medical decisions in a multitude of ways.

The feminist movement achieved a historic cultural victory when it won general American acceptance of the idea that women's medical treatment is a political issue. A great cultural task of a popular medical movement is to expand this realization to all medicine.
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Vital Signs

The News Not Fit to Print

Alumni of the 1968 student strike at Columbia are still rankled that they were (and are) blamed by the New York Times for property destruction during their sit-in although they carefully avoided causing any damage and watched, as they were being dragged off, while the police smashed the rooms to pieces. Striking workers in this country have also often had reason to be angry at the coverage they have received in the media.

Imagine how hospital workers in El Salvador must feel, since they have no way of telling their version of their strike to the American people, and it differs substantially from U.S. media accounts.

The major Times account was published on June 3, the day after the military raided the hospitals. It noted that the hospital workers had struck in May after their demands for salary increases had been rejected. When the government refused to reconsider, the medical personnel took over hospitals.

The report, by Times correspondent Shirley Christian, said that the government charged the hospital workers' union had signed a statement supporting "guerrilla demands" for resumption of talks with the government, and President Duarte had warned that "When unions are infiltrated and used at the altar of war and destabilization, they lose their social function and their credibility with the people." A military judge ruled that the strike was "subversive."

The workers held out, and the government sent troops into the hospitals on June 3, including "over 100" troops at General Hospital in San Salvador. Four police agents who had infiltrated before the raid on the pretext that one of them required emergency care were the only fatalities, "killed, apparently, by other Government forces in the confusion. . . ." according to "several hospital employees." Shirley Christian went on to report that "Military officers said there had been no other violence, though a teenage boy had a bloody nose and several people complained of being mistreated as they were tied up."

The Bulletin has learned a different story from Salvadorean medical personnel who were there.

First, the health workers had a good, non-subversive reason for wanting a raise—they hadn't had one in 20 years.

Second, most people in El Salvador favor a resumption of negotiations between the government and the guerrillas, so calling for this is hardly evidence of leftist infiltration. The "subversive" nature of the Committee of Health Professionals (COPROSAL) lies in its assertion that health workers have the right "to lend assistance to people who are displaced or disadvantaged."

Third, although it is technically correct to write "more than 100" soldiers were involved in the raid, "about 500" would have been more accurate.

Fourth, Shirley Christian didn't have to rely exclusively on secondhand information, because she was one of six journalists invited to come along on the raid.

The government chose their witnesses carefully, since President Duarte and the military are well aware that their survival depends on the support of the U.S. government, and the American public has not been happy with their human rights record. Certainly there has been an improvement in the urban areas. (In the countryside, where the American media rarely go, brutal bombing and shelling have depopulated large areas. On May 17 a doctor, Miguel Angel Orellana, and a priest, Cesar Valle, working at a health center in Guazapa province were arrested by the military and they have not been heard from since.) The members of the COPROSAL know that had they attempted a sit-in strike a year or two ago a lot of them would have been killed, and this time none were.

However there was roughness to be seen, and according to doctors at General Hospital in San Salvador, Shirley Christian not only saw it, she joked with another reporter as she watched doctors being kicked while lying on the floor tied up. A woman in labor died of cardiac arrest after hearing the gunshots; her doctors were unable to attend to her. One surgeon was dragged from the operating room, and the patient might not have survived had not another hospital worker been left behind to sew him up. The medical personnel also insist that Christian was informed that the four men who died weren't killed "in the confusion," but led away despite their protests that they were government agents and shot in cold blood. As it happens, they were government agents, but those who murdered them presumably didn't think so.

Hospital of the Future

Total hospital employment dropped by 73,000, 2.3 percent, in 1984. The cuts go across the board, including doctors and nurses as well as dieticians and aides. The pressures to get patients out faster are probably the major reason, but hospital management has discovered other labor-saving devices as well. One of them is the computer.

Over 100 U.S. hospitals now have multi-million-dollar comprehensive computer systems. One of the most advanced is at University Hospital in Stony Brook, NY. Established under contract by IBM four years ago using a program developed at Duke University, the system has been continually refined at Stony Brook. Employing an easy to use light pen for scanning and registering information, the new system maintains data on the hospital's 25,000 inpatients and 125,000 outpatients served annually as well as on supplies and staff.

Currently it performs functions such as ordering tests, laboratory record-keeping, recording patient diet and nutrition information, keeping patient profiles, tracking medical equipment, and maintaining outpatient appointment files. One innovation enables surgical teams to enter data as they are operating. Right now the hospital is developing a Patient Data Management System that records vital signs such blood pressure, brain pressure, and heart rate continuously, so nurses and doctors don't have to rely on monitoring done every one or two hours for patients in intensive care.

University Hospital has entered into a partnership with Price Waterhouse, the Big Eight accounting firm, to market the system. Buyers will have to pay about half a million dollars to install the system and train personnel and another
but only because their eyes are fixed on
and suggest treatment. The DRG system compares patient information with
patient diagnosis groups it falls in, so hospitals
classify each case according to which of 468
Diagnosis-Related Grief

Reagan Administration officials haven't seen any serious hardship
resulting from Medicare's 20 month old
DRG system of hospital reimbursement,
but only because their eyes are fixed on
Star Wars.

The DRG system pays a flat rate for
each case according to which of 468
diagnosis groups it falls in, so hospitals
have a strong financial incentive to get
people out, sick or well, and this is ex-
actly what they have been doing.

Because the urban poor are concen-
trated in large groups and it is hard for
journalists and politicians to ignore peo-
ple on their sidewalk, the inner city ef-
effects have received some attention, but
the hardship DRG's are wreaking on the
rural poor is largely ignored, and may be
even worse.

Rep. Mike Synar (D-OK), chairper-
son of the House Committee on Aging's
task force on the rural elderly, had his
staff survey nursing home ombudsmen,
appointed in each state and funded by the Administration on Aging, to find out what they see among patients. Most
replied, and their responses were un-
surprisingly depressing. Describing
the period since the DRG system was
instituted,
• 77 percent said patients are being
discharged sicker or much sicker.
• 71 percent said “more or many more”
patients now require skilled nursing
home care.
• 67 percent said nursing homes in rural
areas do not have adequate personnel
(59 percent say this was true before
DRG's).

$450,000 for the software. There is com-
petition for the market, estimated to be
several hundred large hospitals. One
rival, developed by LDS Hospital in Salt
Lake City and sold by Control Data,
compares patient information with
medical knowledge to provide diagnoses
and suggest treatment.

Seek And Ye Shall Find

Although the Reagan Administration
has difficulty seeing hardships on the
lower end of the income scale, even some
corporate leaders are finding them dis-
turbing. The June 24 issue of Fortune
published an essay by William Wood-
side, Chairman and chief executive of-
fer of the American Can Co. on what
he called the “disgrace” of hunger in America.

Woodside, a member of a bipartisan
study group on hunger organized by the
nonprofit Center for National Policy,
called the argument that there is no
hunger “simply wrong.” The study, he
related, “found abundant evidence of in-
creased hunger in America, due partly
to continuing unemployment and infla-
tion and partly to reduced outlays for
programs covering child nutrition, food
stamps, and aid to families with depen-
dent children.”

Noting that “the Commerce Depart-
ment estimates that the number of Amer-
icans living in poverty jumped from 24.5
million in 1978 to 35.3 million in 1983,”
he pointed out that a family of four
just at the poverty line—an income of
$10,200—has only $10 a day to spend on
food.

“Today hunger is a social and public
health problem, and government must do
its share,” declared Woodside. “Other-
wise hunger will exact terrible penalties
in higher health care costs, a higher
death rate, and millions of poorly nour-
ished youngsters growing into poorly
functioning adults.

“Hunger is not the crime of the poor,
it is the shame of the affluent.”

Amen.

Love Is Blind

The American Cancer Society has
given its special Stanley Hayes award for
contributions to the prevention of cancer
to Armand Hammer, head of Occiden-
tal Petroleum. Occidental owns Hooker
Chemical, the company responsible for
Love Canal. As the Bulletin has reported
(Volume 13, No. 2), Hooker workers
have also had reason to complain about
the company’s approach to carcinogenic
toxic hazards.
Mrs. Smith called at 5:45 p.m. on Friday—as I was leaving for my Easter weekend.

Her 13 year old daughter Mary was sick. My first response was, “Why did you wait till closing time to call?” It turned out that they had been to the office on Tuesday. Mary had scabies but her itching was, “Why did you wait till closing time to call?” It turned out that they had been to the office on Tuesday. Mary had scabies and her mother had diagnosed and treated it appropriately.

“What is the problem, then?”

Mrs. Smith replied that she had noticed a little sore with pus in it on Mary’s belly. She had thought it unimportant, but it had become larger and more tender, and now Mary had a fever.

“Apply hot compresses over the skin three or four times a day for the next couple of days and put Neosporin ointment over it,” I said, only to learn that she had already done that.

“Her fever went up to 104° this afternoon,” Mrs. Smith went on. “and after I gave her some aspirin it only came down to 103°. She won’t eat or drink anything. Does scabies act like this?”

It doesn’t, I had to confess. I asked Mrs. Smith to bring Mary in. On the examining table her scabies didn’t look infected except for a single, small pustule on her lower left side. The surrounding skin was red, hardened, and tender.

Pushing more deeply I could feel a tender lump about one inch large underneath the pustule—a small intradermal abscess. Mary lay quietly, moved slowly; she shook from the chills of her fever.

I stuck a thermometer in her mouth and began searching for other causes for her fever. Her temperature was 102.8°. Her urine specimen didn’t show blood or protein, but it was highly concentrated and the ketone test was positive—signs of early dehydration. Yet there was no apparent reason; no cough, sore throat, abnormal respirations, vomiting, or diarrhea to indicate she had an acute viral syndrome.

My best explanation was that the germ in that pustule had invaded deeper into the tissues and entered her blood stream—septicemia. I knew that if Mary did have bacteria in her blood stream, it could be fatal within hours if not treated appropriately. The pustule provided a clue to the cause of the infection—either strept or staph, the usual causes of skin infections. Unfortunately, it would take 48 to 72 hours for the lab to determine which it was.

Strept would probably respond well to long-acting penicillin; I could give Mary the injection and send her home. For staph, however, there is no comparable long-acting antibiotic injection; she would need another dose six hours after the first. If Mary went home, it would have to be taken by mouth, and we could not know whether she would be able to keep it down. In addition, there is a five to ten percent chance that ordinary antibiotics wouldn’t work against staph at all. Thus hospitalization seemed appropriate.

After 48 hours we could know what germ she had. If the clinical response to treatment was good and we knew we had the right antibiotic for the right germ, she could go home. If my diagnosis was wrong, the cost would be only 48 hours of hospitalization. If my diagnosis was right but I sent her home on pills which turned out to be either wrong or unsettling to her stomach, the consequences might be disastrous.

But I had another problem: medical insurance. Patients without medical insurance may make different decisions than patients who have it—even though the physician’s attitude is the same. Mary had health coverage under Medi-Cal, California’s Medicaid program. This meant I didn’t know whether her hospitalization would be covered.

Unlike most conventional insurance plans, Medi-Cal does not allow the patient or the doctor to know in advance what is reimbursable. It decides whether it will pay the provider only after decisions are made, services are rendered, and it becomes clear what illness was treated.

In this situation the possibility of death was too real to worry about payment. I called the hospital, ordered a complete blood count, a chest x-ray, and a urinalysis. For treatment I ordered intravenous fluids and an antibiotic that would cover both strept and staph.

A couple of hours later the blood count and chest x-ray proved to be normal. An examination of the pus with a microscope, however, showed lots of inflammatory cells and lots of small, round germs—which could have been either strept or staph.

In the hospital Mary’s fever went down to 101°. She felt like eating again by lunchtime on Saturday. She even seemed well enough to go home for Easter, but I decided to keep her hospitalized for at least one more day to watch for late-day fever. Besides, the final results of her blood cultures were not ready yet.

By Easter morning she was in excellent spirits and her temperature had not risen. The final culture report was still not ready, but I decided to let her go home if she could continue taking pills that would cover both strept and staph, at least until I knew the culture results.

Two hours later the hospital pharmacy called to tell me that my instructions could not be followed. Under Medi-Cal rules, the hospital was not allowed to send patients home with the antibiotic that I had been using to cover staph. I had to keep Mary in the hospital taking the antibiotic by I.V. until the culture report told us that another option was safe. She would cost Medi-Cal $300 for another day in the hospital just because its rules wouldn’t pay for $15 worth of pills.

What was it worth?

After another two hours the microbiology lab issued its report: the germ in the pustules was staph and it was sensitive to one of the antibiotics that Medi-Cal would cover. Mary was able to go home and take an ordinary antibiotic for the rest of the week.
There was still the question of whether or not Medi-Cal would pay for Mary's hospitalization. Several weeks later the answer was "No"—allegedly because there was insufficient data to justify in-hospital treatment. The hospital asked me to write a letter to Medi-Cal with a further explanation of my decision.

I complied, noting that, one, I had suspected a serious illness and thought that close observation was clinically indicated; two, there was evidence that the child was unable to maintain adequate caloric or liquid intake and needed intravenous hydration; three, if she had been unable to retain oral medication, the result could have been catastrophic; four, if my clinical suspicions were correct, there was no time to wait for answers.

One month later a second Medi-Cal auditor wrote denying payment, on the grounds that I had supplied no "adequate" justification for treating this infection in the hospital.

I was dumbfounded. The California Administrative Code does not define "adequate" documentation. The auditors had all the data there were; if they wanted more, they might have to wait for an autopsy.

The letter denying the appeal suggested that because Mary had responded to intravenous fluids and antibiotics immediately and her fever had never been found to be above 101° in the hospital, she could not have been very sick—a conclusion with absolutely no medical basis. The fever recorded in my office, 102.8°, was sufficiently close to the 103°-104° given by Mary's mother that I accepted her report.

The letter also criticized my description of Mary's "pustule" as a "lesion." This was very disturbing. It meant that the person reviewing the records possessed neither an elementary knowledge of medical terminology nor the industry to consult a medical dictionary, which would have explained that a lesion is "any pathological or traumatic discontinuity of tissue." Thus a pustule is by definition a lesion.

The crowning exasperation was the failure of the reviewer to acknowledge the dilemma of a physician compelled to make a treatment plan with incomplete data that might determine the life or death of a child.

In my second reply I cited some of the current medical literature which clearly describes the life-threatening potential of staph germs in the blood stream to previously-healthy children in Mary's age group.

Sending Mary home when there was a substantial likelihood of a staph infection would have been malpractice. I doubt if it is Medi-Cal's intention to coerce physicians into malpractice, but the clear impact of decisions such as this one will be to establish a substandard level of care for patients like Mary. There is no question that if the child had died the parents would have had a right to bring a malpractice suit against me; they might readily have won from a sympathetic jury.

Two developments seem likely: first, physicians will prefer not to deal with significantly ill Medi-Cal patients because of the increased liability that Medi-Cal rules create; and second, physicians will prefer not to see Medi-Cal patients at all because of the substantial risk that Medi-Cal will not pay them for their services. In the end the poor and the sick, promised health care services by Medi-Cal, will have nowhere to go.

I could have refused to see Mary. It is certainly what I would have preferred at the time. I wouldn't have had to write long, pleading letters to bureaucrats so that a small community hospital could get even minimally reimbursed for its expenses on behalf of a Medi-Cal patient. My life certainly would have been simpler if I had never gotten involved; Mary's just might have been over.

This is not only Mary's problem, or my problem, or the local hospital's problem. Even if Medi-Cal were correct in its blithe assumption that Mary did not have the more serious form of staph infection, one day it will be wrong. And one day—it is only a matter of time—a patient will die.

This is all of California's problem. Most of California's citizens, who do not have the misfortune to be poor and sick, are being taxed to pay for a system that functions inefficiently, uneconomically, and insensitively. For the rest, those who are poor and sick, Medi-Cal is even worse—it is downright dangerous.

It makes us feel better to believe that the United States is the greatest and most generous country on earth. And, indeed, there is a measure of truth in this assertion—witness the outpouring of concern and money for the starving of Ethiopia. Even our rock stars have discovered that the world can be a hungry place.

Yet certain realities undermine this sense of our greatness, our generosity. Confronting one such reality, the millions of Americans without adequate access to medical care, would deflate many of the beliefs we hold about ourselves. Our society has constructed a series of myths to avoid the truth. These may comfort some of us, but those who must do without the services of our health care system would prefer a different reality.

Myth #1: U.S Health Care Programs Provide for the “Truly Needy”

The passage of Medicare and Medicaid was heralded as the beginning of the end of an unequal health care system. Proponents of Medicaid said it would remove the burden of indigent health care from the back of local governments and provide a secure federal and state funding base; open the doors of the private health care sector to the poor; save public hospitals; and eliminate inequalities in the care received by black and white, rural and urban, and rich and poor citizens.

This optimism, shared by government officials and most outside commentators, was expressed in a 1967 pamphlet issued by the Department of Health, Education and Welfare:

The passage of [Medicaid] marks the beginning of a new era in medical care for low-income families. The potential can hardly be overestimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of bills, and states, in order to achieve its high purposes, will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.

While all the poor were not initially covered by Medicaid, nor all services provided, policy makers believed that states would move toward full coverage of the entire poverty population. Indeed, they were mandated to do so. Section 1903(e) of the Medicaid statute required states to continually improve their programs so that they would provide comprehensive coverage for all low-income persons by 1975. However in 1969 Congress postponed the deadline to 1977, and in 1972 it repealed the comprehensive care requirement altogether.

State-imposed eligibility requirements currently restrict Medicaid coverage to less than half of the nation's poor. Only six states cover more than 75 percent of their poverty population, and 13 states cover less than one third of their poor. South Carolina's Medicaid program covers only 23 percent of the state's poor; the cut-off point for a family of four there is $230 a month. In Tennessee, a family of three can earn no more than $1,534 a year to remain eligible; in Mississippi, $1,152.

Katherine Swartz of the Urban Institute estimates that, in 1982, 16 percent of the population under 65, nearly 33 million people, were uninsured. A recent survey by the U.S. Census Bureau put the figure for late 1983 at 15 percent of the entire population, which comes to 35 million people. Even these huge numbers underestimate the problem. A recent Health Care Finance Administration (HCFA) study by Pamela Farley estimates that 27 percent of the nation's population is either uninsured all or part of the year or underinsured—that is, unprotected from the costs of a catastrophic illness.

Many people believe that these uninsured and underinsured Americans are in some way undeserving, not “truly needy.” Nothing could be further from the truth. Over three quarters of the uninsured, 78 percent, work or are dependents of workers. Most are employed at low-paying jobs which do not provide health insurance.

Many of the other uninsured people are newly unemployed workers and their dependents. A study of 1,332 unemployed individuals in the Detroit Tri-County area in late 1983 found that over half had no health insurance; among that group, 78 percent had had coverage until they lost their jobs. A 1984 study of 900 uninsured families in Tennessee found that over 60 percent of those who had previously had health insurance had lost it for a job-related reason.

“We are probably the only country on earth in which employees losing their jobs, already down on their luck in so many material and psychological ways, bear the added anxiety of being without health insurance coverage,” commented Uwe Reinhardt, a Princeton University economist.

Even those who say these people should find a job might have more sympathy for children, who make up a sizable portion of the uninsured. In 1982 two thirds of all poor and near-poor children were either never insured or were insured for only part of the year. A 1983 Colorado study found that 40 percent of the state's poor children were uninsured; a 1981 Texas study found 48 percent were.
Myth #2: Everyone Can Get Health Care When It Is Necessary

“All right,” it is admitted, “some poor don’t get care, but it’s not the system’s fault. Because they’re uneducated, they don’t know (or care) enough to seek attention for such obvious needs as pregnancy care and well baby checkups.”

Of course Tennesseans were shocked by the story of the 18 year old boy with burns over 45 percent of his body who was denied a transfer to Vanderbilt Hospital’s burn unit because he had no insurance—he had to be taken to an Army hospital 1,000 miles away and have his leg amputated. South Carolinians were equally horrified when they read that two children with meningitis were denied transfer to a regional medical center because they were uninsured and resided outside the county. And Californians were angered when they read reports this January that two neurosurgeons on the staff of a private hospital...
had refused to come in to stabilize an uninsured young man with a stab wound in his temple—he died at San Francisco General after two other public hospitals in surrounding counties also refused to accept him.44

Each of these incidents caused some breast pounding and mea culpa promises that it will never happen again. Unfortunately, these lapses in decency and humanity only momentarily catch the public eye, and there is no understanding that they are simply the tip of a very cold, very large iceberg.

Approximately half a million pregnant women are uninsured:15 many of them cannot get any prenatal care. In Escambia County Florida, for example, it costs between $800 and $1000 to obtain physician services for prenatal and delivery care—payable in advance. Hospital delivery costs typically run about $2000 there. According to an October 1984 article in the Pensacola Journal, local pregnant women are regularly denied care because they lack the necessary cash. One pregnancy counseling service "sees many women who are seven or eight months pregnant, yet they have not seen a doctor because they can't afford the fees." During the first nine months of 1984, 130 women in labor who were admitted to one local hospital via the emergency room had had no prenatal care. Of these, 53 had some "significant complicity."16

This is not just a Southern phenomenon. Los Angeles County regularly charges $20-$30 per prenatal visit at its facilities, and women who have received no prenatal care account for 15 percent of all deliveries at County hospitals. Aside from the hardship and dangers stemming from this lack of care, it isn't even a good way to save money: 15 percent of the babies born at these hospitals require treatment in infant care units.17

The problem goes far beyond pregnant women and their offspring. A 1984 study of 900 uninsured families in Tennessee found that 45 percent of those told by a physician that they should be hospitalized did not seek care, and another ten percent were rejected by a hospital.18

A 1983 Michigan study of unemployed and uninsured families found that 40 percent of those surveyed who had a chronic condition reported a decrease in the use of services for it; over 25 percent of those with high blood pressure said they had stopped taking their medication, and another seven percent said they were taking less medication. Of the 675 unemployed and uninsured families studies, 108 reported that one of their members was not hospitalized because of costs, and 27 reported being refused admission to a hospital. Ultimately nine of these families did succeed in getting hospital care, but the other 18 did not, suggesting that "at least for these families, the refusal resulted in foregoing care.19

Finally, a 1983 survey in Seattle's King County discovered that financial reasons prevented 12 percent of food bank users from obtaining care they needed. The study found, "persons with chronic high blood pressure, diabetes, and asthma who were going without care. Children who were not obtaining pediatric care...young people who had gaping holes where teeth had been."20

Minority children are often uninsured, and so receive far less care than they require. Black children average 3.2 physician visits per year and Mexican-American children average 2.8, compared to 4.5 for white children. The proportion of children who have never been to a dentist is 22 percent among blacks and 31 percent among Mexican-Americans, compared to only ten percent among whites.21

The uninsured lack hospital as well as outpatient care. A recent National Center for Health Statistics study found that fewer children are hospitalized here than in Canada. "The possible barrier to hospital care for some U.S. children was financial," the report concludes.

Canadian children were virtually all covered by a national hospital insurance program, but a portion of U.S. children had no health insurance coverage...The lower hospital episode rates of the lower income U.S. children who had no insurance raises the concern that these children may not have been able to obtain hospital care when they needed it because of the cost.22

Not surprisingly, those who lack any or adequate insurance find that if they do get care they have difficulty paying the bill. A 1984 Gallup poll found that 25 percent of the public, including 51 percent of blacks and 69 percent of Hispanics, reported problems in finding enough money to pay for medical care.23 Think of it this way: A person working at a minimum wage job has to work at least a day to pay for a doctor visit and at least 17 days to pay for one day in the hospital.

Myth #3: The Poor Get Better Care Than the Rest of Us

Without question Medicaid has enabled many poor people to get care for the first time or more care; enrollees now see a physician more often than privately insured persons do. However when health status is considered, people with Medicaid still receive less care than they need,24 and people with no insurance at all are even less likely—much less likely—to get either outpatient or hospital care.25 There is a general consensus among health analysts that we have a two-track system, and the tracks are far from parallel.

Health care for many of this nation's poor and minority populations is as fragmented as a shattered glass. Despite the nation's physician glut, rural communities, ghettos, and barrios do not have an adequate supply of physicians. Poor and minority populations must continue to rely heavily on outpatient clinics and emergency rooms of large urban teaching and public hospitals. In 1980 poor people in families with incomes of less than $5,000 were more than twice as likely to receive physician care in a hospital clinic or emergency room than persons in families with incomes over $25,000. When blacks saw a physician in 1980, in over 25 percent of all cases it was at a hospital.26

According to the 1977 National Health Care Expenditures Study, 20 percent of blacks and 19 percent of Hispanics have no regular source of care, compared to 13 percent of whites; 25 percent of the uninsured have no regular source of care, compared with 13 percent of persons with private insurance.27

Poor and minority populations are also forced to spend more time traveling to obtain care than the rest of the population does. Most middle and upper class Americans who have to see a doctor simply hop in a car. How different it is for the poor. A private hospital in Santa Monica, CA, gives the uninsured a hospital. With a car the trip involves three freeways and approximately 45 minutes in light traffic. For the great number of uninsured persons some of them physically and/or mentally disabled, who must rely on public transportation, this trip involves four different buses and two and a half hours of travel time. In the U.S. as a whole, the proportion of those seeking care who must travel more than half an hour is 25 percent among blacks, 24 percent among Hispanics, and 18 percent among whites; of those with family incomes of less than $12,000, 24 percent have to travel more than half an hour to get care, compared to 16 percent of persons with family incomes of $20,000 or more.28

Anyone who believes that the poor and uninsured get better care than the rest of the population need only visit one of

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the nation's large urban public hospitals. These old, overcrowded, and underfunded institutions struggling to survive must shoulder the heaviest burden of care for the uninsured and poor. In 1982 public hospitals in the 100 largest U.S. cities spent 20 percent of their total revenues on uncompensated care, compared to the less than five percent spent by private institutions. California's 31 public hospitals, five percent of all hospitals in the state, provide 45 percent of the state's total uncompensated care; in Texas, one percent of the hospitals provide almost one third of all uncompensated care. Any thoughts that these public institutions are also considered an appropriate place for white, middle class Americans could be dispelled by reading a recent University of Southern California publication, USC Medical School, which trains its students at County-USC Medical Center, the largest public hospital in California, wants a new hospital for its faculty's private patients. It has made arrangements with National Medical Enterprises to build one adjacent to the county hospital, and is now attempting to justify this plan.

The county hospital, the report explains in one argument, "is a marvelous experience for understanding the diseases of the poor and uneducated. Patients from such a population present illnesses of different stages of evolution although frequently these patients have diseases which are past the stage of treatment at the time of presentation." However, the report goes on, "both students and house officers have the need to gain experience with patients whose approach to illness from a cultural and sociologic perspective is different. They need to take a medical history from a college graduate, a businessman or a housewife who has some knowledge of disease and disease prevention."  

Myth #4: The Private Sector Will Pick Up Where the Government Leaves Off

When President Reagan won dramatic cuts in federal domestic spending four years ago he maintained that the voluntary sector would fill any gaps left in the safety net. Corporate analysts agreed, but admit that the past four years have not borne out these predictions. "We had been predicting all along that with the budget cutbacks there would be a drop-off in contributions to the arts and a pickup in health and human services," commented a Senior Research Associate at the Conference Board, a business research organization, "But it's not happening."  

"Higher education and the arts are visible, uncontroversial and closely linked with the class interests of those giving out the money," one analyst explained to the New York Times this February, "But what can a homeless hungry person do for a corporation? He doesn't work at the company, he doesn't buy its products and his good will won't do the corporation much good. That's the real reason why most corporate money doesn't go to poor people."  

Some donors have responded to new needs, but this has been only a drop in what appears to be a bottomless bucket. Take, for example, a program of the Robert Wood Johnson Foundation and the Pew Memorial Trust to provide care for the homeless in 18 U.S. cities. The need is so immense that their generous $25 million funding will provide health care for only a small fraction of the homeless. Even in communities included in the program, care will be limited by lack of funds and environmental circumstances. The Venice Family Clinic, for example, received a small amount of money to provide free medical care for the homeless in its Los Angeles County beach community. It must now decide which of the many in need will get care; where to refer the homeless for eyeglasses and dental care; how to arrange for homeless patients to soak infections; and where the homeless can hold medicines which become pulverized and useless when kept in back pockets.  

The other common expectation was that private health care providers would increase care to the poor and uninsured when the government cut back. This has not happened. Indeed, the opposite seems to have occurred: As the federal government cut health and welfare programs, as more people lost their jobs and health insurance in the 81-82 recession, private hospitals reduced the amount of care they provided to the poor. A June 1984 Urban Institute study by Feder, et al., entitled, "Falling Through the Cracks: Poverty, Insurance Coverage, and Hospital Care to the Poor, 1980 and 1982," found that "despite relatively healthy bottom lines, most private hospitals provided very little free care and did not increase that level in response to growing poverty or uninsurance.

If, as the USC report implies, the uninsured do not get primary care, it might be argued that in times of serious need they at least can get the high-technology care our medical establishment is famous for. A recent Vanderbilt study casts doubt on this, concluding, "Our data imply that most uncompensated care arises from low or mid-level technology care rather than high technology." The authors found that almost no uncompensated care was provided to cover such high-tech procedures as coronary artery bypass, total hip replacement, permanent cardiac pacing, and peripheral vascular surgery.  

Many poor patients who need such services may eventually get them by qualifying for Medicaid or Medicare, but what of the uninsured who for one reason or another can't qualify for public assistance? Although the very idea of rationing medical care on the basis of ability to pay rather than need offends the sense of decency of most Americans, this is an everyday occurrence in our country.
The Omnibus Budget Reconciliation Act (OBRA) of 1981 knocked approximately ten percent of the mothers and children on AFDC rolls off. This reduction came on top of a billion-dollar cut in Medicaid. About 700,000 children lost Medicaid coverage as a direct result of OBRA. We are now beginning to learn what happened to them, and their mothers.

One study of working poor AFDC families who lost their Medicaid found they used physicians 39 percent less often, their hospital admission rate dropped 72 percent, and the amount of prescription drugs they took declined 62 percent.40

Another study found that in Dallas, 24 percent of the people who lost their Medicaid with their AFDC benefits stated they didn't seek care for a medical condition because of the cost.40

Rather than make up for Medicaid cuts by increasing their spending on health care for the poor, states, confronting the worst recession since the 1930's, reduced their own commitment. In Arkansas, for example, between FY 1981 and FY 1983 the number of Medicaid eligibles dropped 14 percent; this followed a six percent decline in the FY 1977-81 period.41

A paper given at the American Public Health Association annual conference last November presented a graphic picture of reductions in health care in Boston. In the communities of Roxbury, the South End, and Jamaica Plain, a comparison of January-June 1980 with January-June 1982 found that 18 percent fewer households were receiving AFDC assistance; Medicaid visits to four health centers in Roxbury were down 25 percent and total children's visits had fallen 20 percent; emergency room use was off by an average of 14 percent in all three communities; the proportion of mothers receiving inadequate prenatal care was up 68 percent; and the infant mortality rate had jumped 53 percent. The study found that infant mortality rose 23 percent in Boston as a whole, from 11.9 per thousand in 1980 to 15.8 in 1982.42

Faced with an unemployment rate which reached 11.2 percent in 1982 and an increase in the number of people living below the poverty line from 11.7 percent in 1979 to 15.2 percent in 1983, state governments felt they were in no position to make up for federal welfare and health cuts. Between 1981 and 1983 rising unemployment should have added 635,000 new Medicaid enrollees; instead the rolls fell by 1,115,000.43 Not only did states cut Medicaid, the number of persons they and local governments served in public health programs also decreased, by five percent from 1981 to 1982 alone.44

**Myth #6: Because of the Price Tag, Nothing Can Be Done To Provide Care for the Uninsured.**

Once myths 1-5 have been debunked, where are we? Up against a yawning $200 billion federal deficit and the continuing perception that taxes, already too high, should not be raised to expand social programs.
Nevertheless, it is absurd to maintain that nothing can be done at the federal level to ameliorate some of the most glaring inequities of our health system. Take, for example, the issue of infant mortality. According to a recent Public Health Service report, nine states have experienced “adverse trends” in the number of infants dying, and the rate of decline of infant mortality has slowed nationwide. Moreover, the proportion of women receiving early prenatal care reached a plateau in 1979 and declined for the first time in 1981 and 1982. The current Administration itself recognizes that these statistics are at least cause for concern. In a letter to state health officials last December, Edward Brandt, Jr., then Assistant Secretary of Health, described the new information as “worrysome.”

Last year Congress, despite the federal deficit, passed legislation requiring states to expand Medicaid coverage to 500,000 poor children and pregnant women. Advocates for mothers and children argue that as a next step Medicaid should mandate state coverage of all poor pregnant women. Our history provides ample precedent for such action. In 1943, despite the massive financial drain of fighting World War II, Congress appropriated funds through the Children's Bureau to provide free maternity and infant care to the wives and babies of servicemen. This emergency program was declared part of our national defense effort.

State and local programs can also make a difference. After significant Medicaid cuts in 1981 and 1982, states have been looking for ways to expand health care programs for the medically indigent. Indeed, several states established task forces in 1983 and 1984 to study the problem and make recommendations for improving care for their uninsured population.

A number of states have adopted or are looking at a range of innovative programs to increase the provision of health care. New York, Maryland, New Jersey, and Massachusetts have hospital rate reimbursement systems which, to varying degrees, cover uncompensated care costs; Florida recently adopted a tax on hospital revenues to expand its Medicaid program; in June South Carolina passed the Medically Indigent Assistance Act, which taxes counties and hospitals to fund indigent health care; several states are considering a cigarette tax to fund new indigent care programs; New York has a new prenatal care program; the governor of Arkansas recently earmarked $12 million for maternal and child health care; the Illinois state legislature is seriously considering the allocation of state funds to help build a new public hospital in Chicago; Wisconsin is studying a program to purchase insurance for its uninsured population; and a tough new certificate of need law for new construction in the District of Columbia requires hospitals to provide indigent care.
Action to improve health care services is also expanding on the local level. A 1983 study by Kentucky Youth Advocates on the rising infant mortality rate and lack of prenatal care for poor women in Fayette County (Lexington) spurred the county to establish a free maternity care program. Community pressure on Cape Cod won a free care program for pregnant women who are on Medicaid or uninsured. Many communities are organizing as never before to expand care to the poor and elderly, reduce the cost of health care, educate health care consumers, and make the system more responsive to their needs.  

New state and local programs provide ample evidence that something can be done to relieve the pain and suffering of those currently unable to obtain health care. But these efforts will not be enough. For example, recent legislation in South Carolina expands the proportion of the state’s poor people eligible for Medicaid from 23 percent to 32 percent, but this still leaves 68 percent outside the program.

It is fairly easy to show that our system for providing medical care relegates millions of people to a separate and unequal place where getting help when ill is difficult and sometimes impossible. It is much harder to overcome the economic and political realities which have long blocked efforts to make this a more decent, humane nation.

In October of 1932 the Committee on the Costs of Medical Care issued perhaps the most famous report on health care delivery in U.S. history. It declared,


20. Testimony by the King County Health Planning Council before the Washington Senate Ways and Means Committee, "Provision of Health Care to Uninsured or Underinsured Persons," May 23, 1984.


25. According to a study by Karen Davis and Diane Rowland of Johns Hopkins University, in 1977 the insured averaged 3.7 physician visits per year compared to 2.4 visits for the uninsured and 1.5 visits for minorities in the South; the insured received 90 percent more hospital care than the uninsured. Davis, K. and Rowland, D., "Uninsured and Underserved: Inequities of Health Care In the United States," paper prepared for the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Sept. 30, 1982.


28. Usual Sources of Medical Care and Their Characteristics, op. cit., p. 11.


31. Statement of Ray S. Newman, Executive Vice President and Chief Operating Officer of the Dallas County Hospital District, before the Subcommittee on Health, Committee on Finance, U.S. Senate, Sept. 28, 1984, p. 22.


35. Feder, J.; Hadley, J.; and Mullner, R., Falling Through the Cracks: Poverty and Insurance Coverage, and Hospital's Care to the Poor, 1980 and 1982, p. 3.


38. Statement of Ray Newman, Executive Vice President and Chief Operating Officer of the Dallas County Hospital District, op. cit.


44. The Association of State and Territorial Health Officers (ASTHO) Foundation, Public Health Agencies 1982: Services and Activities.

Bulletin Board

Birth Illustrated

The Maternity Center Association, founded in 1918, has developed a whole series of publications on topics such as nurse/midwifery and relaxation and breath techniques as well as many teaching aids (including the famous Birth Atlas), all available at low cost. For a free catalogue, write MCA at 48 E. 92nd St., New York, NY 10128.

Baby Food

A new Journal of Pediatric & Perinatal Nutrition to be published by the Haworth Press welcomes manuscripts for consideration. For a copy of the "Instructions for Authors" write Lynn Jacobson, MS, RD, Editor, Journal of Pediatric & Perinatal Nutrition, N-118 Doan Hall, University Hospital, Ohio State University, 410 West 10th Ave., Columbus, OH 43210.

Home Remedies

The Consumer Product Safety Commission has developed an excellent, clearly written and illustrated room-by-room safety checklist for older consumers. Copies (which groups are encouraged to reproduce themselves) are available free of charge by writing "Home Safety Checklist for Older Americans," CPSC, Washington, D.C. 20207.

Post-Hysterectomy

Sudden changes: Post-Hysterectomy Syndrome is a new 29-minute film produced by Barbara Costa and Denise DiLanni using personal testimonies as well as commentary by professionals. It includes interviews with women who have experienced post-surgical problems such as lack of sexual drive, joint pains, and hot flashes. Sudden Changes is available on film and all video formats for $50 rental, $295 purchase, from The Cinema Guild, 1697 Broadway, New York, NY 10019.

Home Study

The American Society of Home Inspectors has warned that its members have found that health hazards from asbestos insulation or heating systems are far greater than those posed by formaldehyde insulation. The Consumer Product Safety Commission is currently sampling levels of asbestos materials in 40 homes around the country to get more precise measurements. Together with the EPA, the CPSC has already produced a 12-page booklet for the public on how to detect asbestos and what to do if you find it. Copies are available from the CPSC at 5401 Westbard Ave., Bethesda, MD 20207.

Cutting Drug Costs

The new AARP Pharmacy Service Catalogue, available free of charge, offers senior citizens savings of up to 50 percent. Orders go to the nonprofit pharmacy established 26 years ago by American Association of Retired Persons and the National Retired Teachers Association. This is now the largest private mail-order pharmacy service in the world. The catalogue contains over 800 brand-name and generic prescription drugs as well as vitamins and other health care products. Copies are available from AARP Pharmacy Service, Department TAG, P.O. Box 19229, Alexandria, VA 22314.

Follow the Money

The Robert Wood Johnson Foundation is offering its third round of fellowships to develop university faculty to teach and conduct research in health care finance. The program has three parts: a four month course at Johns Hopkins; an eight month placement in a major private or public health care financing organization, medical center, or alternative delivery system; and support for related research in the year following. The application deadline is January 20, 1986. For further information, call Carl J. Schramm, Ph.D., J.D., program director, at (301) 955-6891.
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 fledgling 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 millionaires club. The big winners in the health care game constantly 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-Meyers' 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 Richardsons 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 $40 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 $110 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...
14) Товарищи! Бойтесь попасть в такую пасть чтобы с нами никогда не случилось это.
Сплотимся, власть укрепим советов!
ГЛАВПОЛИТПРОСВЕТ № 146.
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 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.

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.

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

Also named in the indictment are his brother, accused of receiving a million dollar fee intended for the Governor after Edwin Edwards took office; HSDC executives; Ronald Falgout, a former Louisiana Health and Human Resources official; and James Wylie Jr., a lawyer and professor at the Tulane School of Public Health and Tropical Medicine. Both Falgout and Wylie 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 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 went 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 renowned 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 Tuyle, 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.

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 the instruments and bandaging for a specified operation, which "would eliminate the handling and assembly of surgical equipment by hospital personnel."

- 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). 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's. This spring rumors were circulating on Wall Street that McDonnell-Douglas, 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 than 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 claimed 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.

"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 grow-
ing 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.


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Grant’s Tomb
Birmingham’s TB Care Goes Private
by Max Michael

In the mid-1960s, Birmingham, Alabama, moved center stage as the nation’s most racially violent city. It was there that three young black girls were killed when a bomb allegedly placed by the Ku Klux Klan shattered their church. Currently this Southern steel town may once again become a bellwether. This time the crisis is in hospital care—less dramatic than the racial tensions tearing at this country’s social fabric two decades ago, but nonetheless an ominous indicator of what could happen across the nation.

Quality Tuberculosis Care

Cooper Green Hospital is the indigent care facility for Jefferson County, Alabama. Virtually from its opening day in 1972 it has been a center of political controversy and budget disputes. Despite these vicissitudes, all too common among municipal facilities, the hospital has won widespread respect for its excellent quality of care, its remarkably low average length of stay (5.1 days), its low cost per illness, and the strong working relationship between its administration and the medical staff.

Among Cooper Green’s various service delivery programs, the care of patients with tuberculosis is perhaps the most unusual. Beginning in 1973, it received a bed allocation grant under the auspices of a state program that partially subsidized inpatient care for patients with tuberculosis. This grant was renewed annually, supporting the only service program at the hospital which operated without losses.

Under the program, any person in a five county area diagnosed as having tuberculosis could be referred to Cooper Green for inpatient care. Reactivation cases referred by the Jefferson County Department of Health’s TB clinics were admitted directly.

During the first decade, approximately 400 patients with newly diagnosed tuberculosis and 90 patients with reactivation or resistant tuberculosis were treated at the hospital. Without exception, those newly diagnosed were admitted through the hospital’s emergency room or clinics. None were referred from other community hospitals.

Because the county has the second highest incidence of TB in the nation, the Cooper Green staff has cared for an amazing array of patients. Eighty percent of them were indigent or medically indigent, as would be expected for a disease of poverty and social isolation. Since the hospital is a public institution and all of the severe active cases initially go there, giving it the state grant seemed to be sound public policy.

The grant has been renegotiated annually based on how many patients had been admitted with confirmed TB. As the number of new cases declined, so did the allocation. On average, the hospital received $130,000 from the State and collected another $60,000 from Medicare, Medicaid, and other third party payors. Since the average annual cost was $180,000, the income provided adequate reimbursement and a modest profit.

Although there has been debate over whether or not it is better to allocate TB care funds to a single institution in a given area or to any local institution which takes care of any patient with tuberculosis, it has been widely agreed that the program developed at Cooper Green was among the nation’s best. Every patient received intense and compassionate medical care to insure his or her future wellbeing and protect the public’s health. Staff physician experts in the management of TB were assisted by the county epidemiologist, TB field representatives from the Health Department, and pulmonary specialists from the University of Alabama Medical Center, located a few blocks away.

Surprise Shift

The recession of 1982-83 and an increasingly competitive medical marketplace in Birmingham severely strained Cooper Green’s budget. Deficits were up to $4 million annually despite strenuous efforts to streamline operations. Newspaper articles about the hospital’s declining financial health further demoralized hospital employees—but did not precipitate a public dialogue about the hospital’s future. In its absence, a strategy of silence and unilateral policy development by the county Commission heightened distress and turmoil.

During this bleak period, three physicians with a total of 25 years of service at Cooper Green announced they were leaving. One, a pulmonary specialist, was the director of the TB program. The remaining staff in the program was then stunned to learn that prior to his departure the Tuberculosis Advisory Board, a committee of the State Committee on Public Health (Alabama’s Board of Health), had promised him that the bed allocation grant would be moved from Cooper Green Hospital to whatever private hospital in Birmingham he decided to join.

Neither county nor hospital officials had been notified of this decision, let alone afforded an opportunity to show that Cooper Green still possessed qualified medical staff supervision for patients admitted with TB. Despite written protests from the hospital’s chief executive officer and the County Commission, the bed allocation was transferred on October 1, 1983, to Baptist Medical Center-Montclair.

The Cooper Green administration and staff decided to fight back. Rather than transfer patients with TB to BMC-Montclair, they elected to continue caring for them, both for medical reasons and, most importantly, because the State Committee

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had slipped this radical change in public health policy through without any public debate, and decisive measures were necessary to provoke one.

Appeal to Reason

From January through June 1984, 65 patients with newly diagnosed tuberculosis were treated in the five county area. Cooper Green Hospital diagnosed and treated 14 of them. BMC-Montclair treated nine, only one of them indigent. The 14 people who went to Cooper Green were 95 percent of the indigent TB patients treated in the County during these months.

The controversy boiled anew during the summer; when the TB Advisory Board announced that it would review its transfer decision without preconceptions. Case reports were scrutinized for all aspects of care and the TB conference at both institutions became a display of expertise and teaching opportunities. In late August, the Board declared unequivocally that the bed allocation grant should be returned to Cooper Green. In a report supporting this recommendation, the county epidemiologist stated:

Since there is no measurable difference in the quality of tuberculosis care at any hospital in Jefferson County, indigent patients should be given the opportunity to have continuity of care and not be transferred from one provider to another when it is medically unnecessary. As a tax-supported institution Cooper Green Hospital should receive tax dollars earmarked for the in-patient care of tuberculosis patients who are indigent. This will facilitate the continued control of tuberculosis in Jefferson County and support the continuity of all needed medical care for the indigent patient.

“Is the transfer of tuberculosis from the public sector the harbinger of an ominous trend?”

In late August the State Committee on Public Health met in Montgomery to make its final decision. Confident that it would accept the Board’s recommendation, as it had every year in the past, Cooper Green sent no representatives. BMC-Montclair did. When asked if there were any comments, they praised themselves, the hospital, and their dedication to the community. When a Committee member noted that their institution seemed interested in the grant primarily as a marketing tool they did not deny this. Nevertheless, the Committee voted 17 to three to ignore the recommendation of the TB Advisory Board.

The staff at Cooper Green was shocked and devastated. In response to the hospital’s formal protest, the State Committee agreed to give it an opportunity to present its arguments publicly. The hospital’s statement to the September meeting of the Committee included the following points:

- Since the grant was transferred fully 87 percent of all new tuberculosis patients have been cared for at institutions other than the contract hospital, but it has earned at least $14,000 on its TB treatment. In this same period Cooper Green lost at least $70,000 providing care to new patients.
- The quality of care for patients with tuberculosis is comparable at all the local institutions diagnosing and treating it. Patients with tuberculosis, particularly socially and economically isolated indigent patients, have other co-morbid conditions requiring regular follow-up and treatment. The clinics at Cooper Green and at the Health Department are their principal source of primary care. The Commissioner has stated publicly that if the allocation were returned to Cooper Green, all tuberculosis patients in the catchment area would without question be hospitalized there.
- The hospital’s statement concluded, “By far most important is the matter of public policy you are to decide. We are not simply discussing whether a relatively small financial allocation for the care of a small group of people is transferred from one institution to another. At issue here is the care of the sick poor of our community and its potential fragmentation into the proprietary sector. The diagnosis and control of tuberculosis has always been a public health matter. . . . To suggest that these patients can be moved about the county like pawns simply because they have some small financial subsidy is to suggest that the current approach to the sick poor in our community has been blatantly wrong all these years. Clearly, we are not here to debate that issue, and therefore I suggest to you that to begin to fragment the care of the poor for reasons of money or ego is morally wrong.”

After a few perfunctory questions, a motion was made, seconded, and unanimously approved to retain the grant at BMC-Montclair. The entire process took little more than five minutes.

Work to Rule

Despite the major setback of losing the grant, the hospital undertook an aggressive strategy. Since October 1, 1984, any uninsured patient who has come to the Cooper Green emergency room with a constellation of signs and symptoms suggestive of tuberculosis has been transported by van or cab to BMC-Montclair. Patients who require hospitalization to rule out TB are put in a bed there. Each referred patient is followed up by representatives of Cooper Green to ensure that appropriate care was rendered. As of February 1985 eight patients had been referred; all of them were hospitalized, but in no case was tuberculosis found. The cost to BMC-Montclair is unknown.

A National Trend?

The recent experience of Cooper Green Hospital raises important concerns about the fate of public institutions in a highly competitive medical care system. Several years ago BMC-Montclair would never have even considered a strategy designed to take a $130,000 grant which provides virtually no profit away from the county hospital. Now it seems to have decided that any patient with a source of funding is important, and the marketing potential in becoming a ‘regional tuberculosis hospital’ is too great to pass up. We have certainly come a long way from sanatorium days.

The real issue here is not whether BMC-Montclair can provide better quality care or whether or not indigent patients should be able to choose among all the local hospitals. Rather, it is whether or not the transfer of tuberculosis patients from the public sector is the harbinger of an ominous trend. Will care for other diseases, if they become wholly or partly subsidized, also be snatched up by proprietary hospitals, reducing public institutions to a frayed ‘safety net’?

If this happens, continuity, access, efficiency, and efficacy of care would all suffer—and with them, certainly, the poor and medically indigent. Inflation, resource limitations, and under-insurance are hurting many health care institutions, however the burden these place on public hospitals is most severe. Undoubtedly, the public sector must change to fulfill the ideal of quality health care for all the poor, but that change must be based on public dialogue and debate.
Health Education and the Politics of AIDS
by Nick Freudenberg

At a meeting with leaders of the gay community this May Dr. James Mason, Director of the U.S. Centers for Disease Control, disclosed that quarantine of those infected with the virus believed to cause acquired immune deficiency syndrome (AIDS) was among the controls the federal government was considering.

In June Life magazine ran a cover story on AIDS under the headline "AIDS: No One Is Safe." The story reported an increase in the number of cases among heterosexuals.

"If you have had multiple sex partners, or your partner has had multiple sex partners, since 1978, you should not be sharing body fluids with anyone," a San Francisco health department official declared.

Rev. Jerry Falwell recently sent out a fundraising letter urging that sexual intercourse by those known to be carrying the virus be made a felony.

By mid-year more than 10,000 people in the United States had been diagnosed as having AIDS; nearly half of them have died. The growing death toll and the anxiety it has created have made AIDS a major public health issue, and a highly charged political issue as well.

AIDS is now the federal government’s number one health priority, according to Health and Human Services Secretary Margaret Heckler. Although the government’s primary AIDS activity has been to sponsor and fund research, recently health education has been proposed as a key strategy for control of the epidemic.

In the past six months the New York State Department of Health and the Centers for Disease Control have awarded grants for education of groups at risk of AIDS. From now on health educators will play an increasingly important role in public health efforts to prevent the syndrome from spreading.

This column and the next will explore some of the controversies that surround AIDS and examine their implications for health educators. In the process, I hope to illuminate the sometimes murky relationships among science, politics, and public policy.

Theories of Causation

The messages that health educators convey to the public are based, of course, on the scientific evidence about a particular problem. In order to tell people how to prevent a disease we must know something about its etiology.

Most AIDS researchers believe that it is caused by a virus that attacks the body’s immune system. This retrovirus, known as lymphadenopathy associated virus (LAV) or human T-cell lymphotropic virus (HTLV-3), is believed to be spread when a person carrying it passes his or her body fluids—blood, semen, and possibly saliva—to someone else. Thus sexual intercourse, blood transfusions, and intravenous injections with contaminated needles are all believed to be modes of transmission. Epidemiological research has identified several risk groups—gay men, intravenous drug users, recipients of transfusions, and hemophiliacs. Of the diagnosed cases, in early 1985 these groups accounted for 73 percent, 17 percent, one percent, and .7 percent respectively. However the number of cases among heterosexuals who do not use drugs intravenously is believed to be increasing. Proponents of the HTLV-3 theory believe that the virus has an incubation period of two to 15 years. They predict a continuing climb in the number of new cases.

In April the U.S. Food and Drug Administration licensed a blood test for the presence of an antibody to the HTLV-3 virus; a positive test is presumed to indicate a greater risk of developing AIDS. Although initially designed as a screening test for blood donations, it is now also being used for research and, in some cases, inappropriately, for diagnosis. The most widely used test has high rates of both false negatives and false positives.

Advocates of the viral theory of AIDS include the CDC and the U.S. Public Health Service, the researchers they fund, and most major medical publications. There is, however, strong dissent from this prevailing view.

Critics raise several questions and objections. First, they point out that most of the evidence for the single viral agent theory is circumstantial. The few animal studies linking HTLV-3 and AIDS have been small and inconclusive. Human studies have often lacked appropriate comparison groups or controls for other possible causal agents.

While it seems clear that there is some link between AIDS and HTLV-3, other explanations of this relationship cannot be ruled out. It is possible, for example, that some unknown Factor X leads to infection with the HTLV-3 virus, which in turn causes AIDS; alternatively, some Factor X might cause both AIDS and HTLV-3 infection. Further research is needed to explore these possibilities, say the critics.

Another puzzle is the existence of populations with antibodies to HTLV-3 but no history of AIDS. Researchers reported in a recent article in the prestigious medical journal Lancet that ten percent of the people in an area in eastern Zaire were HTLV-3 positive but not a single case of AIDS had ever been reported there. Although many infectious agents do not cause disease in all who are infected, there is little precedent for a pathogenic virus which causes no disease in one population and serious illness in others. “The authoritative assertion that HTLV-3 causes AIDS was made in the absence of adequate information about the prevalence of antibodies of the virus in different populations in health and disease,” wrote Dr. Joseph Sornabend, former scientific director of the AIDS Medical Research Foundation.

Until prospective studies on the prevalence of HTLV-3 are done its role will remain uncertain.

John Martin and Carol Vance, two Columbia University School of Public Health researchers, have pointed out that "the dominance of the germ theory model of AIDS has resulted in research that either ignores or only inadequately addresses... life-style factors believed to have direct consequences (though of unknown magnitude or duration) for immunologic functioning." Among the factors Vance and Martin suggest for further investigation are specific sexual practices, previous history of infections, nutritional status, and life stress and social support.

Others challenge the view that AIDS...
is primarily a venereal disease. For two years the CDC promoted the notion that AIDS was almost exclusively a disease of promiscuous gay males; the popular press dubbed it the "gay plague." Dr. John Seale, a British venereal disease specialist, noted the similarity between this characterization and the one given hepatitis B initially.

"The failure to comprehend the mechanisms of its transmission led to the flawed hypothesis that hepatitis B is a venereal disease," he pointed out in the British publication New Scientist, and "The same mistakes continue to be made with AIDS...Once doctors are convinced that a disease is transmitted through sexual contact, many assume that any patient with the disease must have acquired it by promiscuous sexual activity. Those afflicted are assumed to be guilty till they can prove their innocence. This medical attitude is not only arrogant but potentially dangerous, because other means of transmission will inevitably be overlooked."

While critics of the single viral agent theory have yet to present evidence for a coherent alternative theory, they propose that a variety of co-factors must be present in an individual's sexual practices, general health status, medical history, and social environment before an infectious organism—whether HTLV-3 or some other pathogen or variety of pathogens—can cause AIDS. Most chronic diseases follow such a model. Critics further raise the possibility that AIDS may not be a single disease, but rather a spectrum of illnesses that require different control measures in different populations.

The Role of Health Educators

Although debates among virologists, immunologists, and epidemiologists may seem far removed from health education, in fact the answer to the question of what causes AIDS determines what we say to the public. If our understanding is incorrect, we run the risk of developing irrelevant or even dangerous approaches.

If the HTLV-3 virus by itself causes AIDS, if it is spread by any exchange of body fluids, and if it is a lethal and highly infectious agent, then dramatic public health measures are indeed in order. It would make sense to identify those who carry the virus and develop control methods that would prevent sexual contact (including kissing), blood transfusions, and other exchanges of body fluids. It would make sense to isolate infected individuals from the general population and to discourage members of high risk groups from reproducing or even having sex. If the presence of antibodies to HTLV-3 indeed indicated significant risk of AIDS and if a test for it were accurate, it would make sense to screen for it widely and to follow aggressively those who were positive. Health educators would have to convey these messages to the public with urgency. The model of control used for syphilis comes to mind.

But if any of these assumptions is incorrect, the whole model of AIDS control requires drastic revision. If an infectious agent related to AIDS requires a variety of co-factors in order to cause illness, the task of health educators becomes very different. We would need to identify those specific sexual practices that put people at risk and then help individuals work out forms of sexual expression that are both satisfying and safe. We would need to identify patterns of illness and health care utilization that compromise immunologic defenses and develop accessible, affordable health care for gay men, drug addicts, and recipients of transfusions to prevent repeated infections. We would need to look at the specific aspects of illicit drug use that spread AIDS and then develop control measures. We would need to look at the process of stigmatization in our society, examine its health consequences for groups at risk of AIDS, and develop strategies to counter these effects.

The complexity of this approach makes it easier to understand why the single viral agent theory is so attractive—to scientists who want a technological solution, to government agents who want a solution that does not challenge the status quo, and even to risk groups who hope for a quick fix—a vaccine or shot that will wipe out the nightmare of AIDS.

More ominously, the viral theory is attractive to a coalition of the moral forces in our society, from the Moral Majority to the Reagan Administration. For the New Right, AIDS provides a vehicle to advance the social agenda on homosexuality, drugs, poor people, and social control that it developed long before the first case of AIDS was diagnosed.

My next column will examine how the fear of AIDS is being used to attack the advances won by movements of the 1960's, and how public health workers and activists can begin to counter these threats.

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As consumer awareness of the risks inherent in medical encounters has increased, many prospective patients have begun doing research to determine whether a particular operation is necessary and is the treatment of choice. People also want to find out for themselves whether their surgeon is properly trained, experienced, and successful at performing the procedure in question. However consumers have a difficult time making an equally informed selection of their anesthesiologist since the choice is usually made by the hospital or surgeon. Many institutions have a group of physicians under contract to perform all anesthesia services. Most consumers hope—or, more accurately, assume—that the right choice of surgeon and hospital will result in hight quality anesthesia.

Silent Night

People rarely discuss anesthesia with their doctors. The first and often only opportunity to talk with the anesthesiologist is usually the night before surgery. The stress of the immediate pre-surgery period is obviously not conducive to discussion of the merits and risks of the varying methods of administration and the anesthetic substances used. The encounter may be little more than some mumbled questions from a tired physician and terrified replies from the person awaiting surgery.

This pro forma approach is not only unfortunate, it can be dangerous. Textbooks of anesthesiology place great emphasis on the importance of the anesthesiologist obtaining a thorough history of the surgical candidate, both from chart review and from the interview, in order to minimize any risk. People with a known or suspected disease require special care in this assessment and evaluation, as well as in the physical examination. A number of studies also show that a caring anesthesiologist can play an important role in easing the fear and uncertainty common among people about to have an operation.

Drug Interactions

Use of the following drugs is of particular concern because they can cause serious problems, through interaction with anesthesia or other side effects:
- Corticosteroids can cause problems with the adrenal cortex.
- Reserpines can cause problems with the adrenal cortex.
- Some antibiotics can cause cardiovascular problems.
- Levodopa (Inderal) and other beta blocker drugs are myocardial (heart muscle) depressants.

Other Dangers

Another critical concern is satisfactory pulmonary function at the time of surgery. The anesthesiologist should consider the following conditions at least problematic:
- Acute respiratory infection. There should be at least one week between recovery from this and elective surgery.
- Smoking. One more good reason to stop: smoking one or more packs a day is regarded as a presumptive indication of chronic bronchitis. Smoking should be stopped or decreased several weeks before surgery.
Respiratory insufficiency. Extreme cases of this are evident in a thorough physical exam. The problem is borderline cases. They may be the result of obesity, neuromuscular disorder, spinal arthritis, or obstructive lung disease.

Asthma, emphysema, bronchitis, or chronic cough.

Eating six hours or less before surgery. People who do run the risk of pulmonary aspiration and therefore are not good candidates for anesthesia.

Other conditions that should enter into the risk/benefit analysis of elective surgery are severe anemia, bleeding disorders, and low blood volume.

Checkup on the Checkup

In determining the quality of an anesthesiologist it seems appropriate to suggest that the pre-operative physical exam and personal history should at least cover the functions and conditions reviewed above. Anything less may entail unacceptable and easily avoidable risks. A recent study of anesthesia deaths in a large hospital concluded that 75 percent of them could have been avoided. Perhaps consumers who take more interest in both the method of anesthesia and the person delivering it can ensure that many are.

Our next column will discuss the drugs and gases used in anesthesia and their risks and benefits, so that you can make more informed choices.

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Media Scan

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menopausal women are particularly valuable — readers will do well to note that some of the hormone compounds listed include tranquilizers and/or testosterone and progestin. Although Menopause, Naturally would have been stronger if it had offered a political perspective on the medicalization of menopause, as a practical guide it is a welcome addition to the literature designed to help us make more informed choices and take greater control of our health.

(Davi Birnbaum is a member of the Task Force on Older Women of the National Women’s Health Network.)