

HEALTH PAC BULLETIN

Public Hospitals in Private Hands





Peer Review

To the Editor:

I just read the September/October issue and found it interesting. Why did Arthur Levin wait till the end of his article to talk about "salt" restriction? The docs I respect (and I) try this first if circumstances permit, despite its difficulty; and I can't believe your NYC docs are that far behind the people I trained with in Indiana!

David R. Cundiff, MD
Preventive Medicine resident
Johns Hopkins University
Baltimore, MD

To the Editor:

We need more positive articles! How about something on Nicaragua? Before the revolution the most ever spent there on public health was \$26.4 million in 1979. Infant mortality was 123 per thousand live births. Most of the health care facilities were private, and beyond the means of the majority of the population.

Since the Sandinistas took power they have opened five hospitals and about 80 health stations, most of them in rural areas. This year the health budget is \$46 million. Medical personnel will be increased to 4500 paramedics, 900 nurses, and 1300 doctors (including 200 Cubans).

I realize it's hard to get information about socialist medicine (you won't find it in the *New York Times* or the *New England Journal of Medicine* very often) but that is all the more reason why you should make the effort.

A. Pitkin
New York

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AND SUBSCRIPTION ORDERS should be addressed to
Health/PAC, 17 Murray St., New York, N.Y. 10007.

Subscription rates are \$15 for individuals, \$30 for institutions.

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Articles in the *Bulletin* are indexed in the Health Planning and Administration data base of the National Library of Medicine.

To the Editor:

Your article "Voluntary Compulsions" on the growth and effects of proprietary hospital chains contained many useful insights, but, I think, greatly understated the positive role of for-profit hospitals.

We live in an era of slow economic growth; public funding of hospital construction is virtually non-existent. Small towns with rapidly growing populations are barely able to build sewers fast enough, and large capital outlays for new hospitals are out of the question.

Private firms may not provide care for all, but they do provide quality care, in the community, for many who might have to tra-

vel many miles to get it otherwise.

To put it another way, these private institutions are making a profit because they are filling a real need for health care. With government financing at reasonable rates for services, the medically indigent could also take advantage of these facilities.

As a group which has often (justifiably) criticized voluntary hospitals as accountable to no one, you ought to look more favorably on for-profit hospitals, which are accountable to a broad population through the marketplace.

Stephanie Rogers, Ph.D.
Boston, MA

Notes & Comment

One of the brilliant insights of American public relations is that although a rose is a rose is a rose, if you call it a canteloupe in enough press releases, some people will begin to believe it is a canteloupe.

This observation came to mind when Health/PAC received a news release from VE, "The Voluntary Effort to contain health care costs." VE is a coalition in which the American Medical Association, the American Hospital Association, Blue Cross, Blue Shield, private insurers, and the Health Industry Manufacturers Association play the major role. There may be other interest groups which have contributed to and profited from the incredible escalation of health care costs over the past two decades, but it's hard to think of who they are.

In its new mailing, VE announced that in addition to the coalition's tireless efforts to find "a voluntary approach to resolving the nation's health care cost problem," it will be working on "the demand side of the cost equation, e.g. increased population, more aged persons, expanded health care benefits, and new technology."

After reading this, it seemed wise to put the press release down and take a deep breath before venturing further. Visions of an imaginary VE strategy session were forcing their ominous way to mind.

"Guys," says a brilliant young cost analyst flown in from a prestigious university, "if we want to put medical costs into a descending mode, which is doable, we've got to spin off from the Reagan-Stockman construct and cut to the bone."

A chorus of rational huzzahs runs around the table.

"Wait," says a very ethical drug manufacturer who has just introduced a new remedy for most of the side effects of two other drugs his company sells, "We can't restrain technological innovations just when the Administration is green lighting us to let the buyer beware. That would be stabbing the deregulation program in the back."

"And don't forget," warns a representative from a major health insurance firm, "we can't discourage free enterprise by restraining our profits just when the government is about to say we should assume the whole coverage burden."

"No question," says the young academic, "I'm front-positioning the other two factors, increased population and more aged persons. Over the long term we hope to zero out the surplus by raising entry-level costs for babies and deaccessioning non-productive old people through an accelerated depreciation schedule. But we also have a short term downstream option. Our computer studies show that if you decouple the lower 20 percent of the population from the health care system you can raise per patient capital input and profits 30 percent and still effect significant reductions in the GNP health care component. Not only that, people who do get care will pay market rates so we can be sure service costs will find their true value."

"Terrific," "That's knocking it to the knee-jerk liberals," and other expressions of value-free cost-benefit analysis fill the room.

"An investment incentive for us and raised outlays freed up to buy the Pentagon more arms," cries an ecstatic prosthesis manufacturer."

"Right," says the young analyst, "I've already audience-readied a message President Reagan can offer those who will sacrifice their todays for our better tomorrows: 'Get the government off your back and you can lie on your stomach at home.'"

After fighting off this fantasy, returning to the VE press release seemed a relief. Sure enough, all it promised was "a comprehensive utilization restraint program (spearheaded by the American Medical Association)" and "special attention to Medicare Utilization patterns (led by the Blue Cross and Blue Shield Associations)."

That's completely different. Maybe.

—Jon Steinberg



Excuses Up

In response to an earlier AFL-CIO study, Federal OSHA Director Thorne Auchter claimed that the decline in numbers of inspections and citations was the result of a reduced inspection staff conducting fewer inspections. (Washington Post, Dec. 26, 1981)

In the current study, the AFL-CIO replies that,

"OSHA does have fewer inspections (the number of safety and health inspectors is down to approximately 900-1000). However, in addition to declines in numbers of inspections and citations, there have been significant decreases in the *proportion* of inspections resulting in citations as well as the *proportion* of total citations which are serious, willful and repeat. Total numbers may show a decline due to a reduced inspection staff, but proportion of inspections resulting in citations and the nature of those citations should not be affected."

The union federation particularly noted the steep decline in enforcement in recent months as changes in national OSHA enforcement policy begin to have increasing impact at the local level, among OSHA area directors and inspectors. For example, comparing enforcement activity for October, 1981 with that for October, 1980:

Vital Signs

Total inspections down 45%

Complaint inspections down 49%

Follow-up inspections down 81%

Number of serious citations issued down 40%

Number of willful citations issued down 94%

Number of repeat citations issued down 60%

Number of complaints filed down 40%

Complaint backlog up 208%

—David Kotelchuck

David Kotelchuck is a member of the Health/PAC Editorial Board.

Enforcement Down

Enforcement of the Federal OSHA law continues to decline precipitously, according to a recent study by the Department of Occupational Safety and Health, AFL-CIO.

"For practically all compliance indicators evaluated, the latest analysis shows continuing declines in OSHA enforcement activity under the Reagan Administration, with November, 1981 being the worst month yet for enforcement since the Reagan Administration took office," according to George H.R. Taylor, Department Director.

Comparing figures during the first year of the Reagan Administration (February–November, 1981) with those during the last year of the Carter Administration (January–October, 1980), the study found:

Inspection statistics:

Total inspections down 21%

Complaint inspections down 32%

Follow-up inspections down 72%

Construction inspections down 13%

Citations and Penalties:

Percent of initial inspections with citations down 11%

Number of serious citations down 33%

Number of willful citations down 75%

Number of repeat citations down 48%

Percent of citations which are serious, willful and repeat down 18%

Penalties down 48%

Other indicators:

Number of complaints filed down 26%

Complaint backlog up 105%

Average amount of time spent on health cases down 30%

Average number of employees covered by inspections down 16%

—David Kotelchuck

Unleashing Free Enterprise

After laying off hundreds of inspectors and allowing its budget to be savaged, the Occupational Safety and Health Administration leadership found itself facing a severe occupational hazard: overwork.

With the current number of inspectors, admitted OSHA's deputy assistant secretary, "it would take us 50 years to cover every establishment." To lighten the burden, many previously proposed OSHA regulations have either been eliminated or "indefinitely postponed."

But an overwhelming workload remains and the Reagan Administration appointees, ever

mindful of the needs of their employees, not to say Corporate America, have found a solution.

Some call it deregulation. We like to think of it as a wholesome faith in the basic goodheartedness and responsibility of American free enterprise. Under the proposed plan, OSHA inspections of many companies would be eliminated in exchange for voluntary compliance with health and safety rules. To ensure they follow through, most participating companies would establish management-worker committees to handle health complaints.

Companies with current health and safety plans would not be required to create committees. They are to show their good will by reporting regularly to their employees. Enforcement has been left a little vague.

Trade unionists have expressed doubts that after neglecting their workers' health whenever it was financially beneficial throughout the history of capitalism, companies will suddenly reform. "It is doubtful," com-

mented George Taylor of the AFL-CIO, "that management would allow a committee to make any decision on health and safety that could cost them money."

We hope Mr. Taylor and his ilk are unduly cynical and pessimistic. We've been reading the corporate ads in "opinion-maker" magazines, *Saturday Review*, *Harpers*, the *New Republic*, and so forth, and we know these corporations, at least their public relations departments, realize how despicable it is to sacrifice the health of humans, plants, and animals just to make a little extra cash.

There is, however, some reason for uneasiness. Corporate executives may be a bit confused about what is expected of them since at least one Federal agency appears to be telling them that almost anything goes as long as it's profitable.

According to the February 18 *New York Times*, the Securities and Exchange Commission recently overruled its enforcement staff and decided not to prosecute Citicorp, owner of the

country's second largest bank, for conducting illegal actions to avoid taxes in other countries.

John M. Fedders, a corporate lawyer who just became head of the SEC's enforcement division, joined other top officials in contending that because Citicorp had never represented to stockholders or investors that its senior officials possessed "honesty and integrity," it had no legal duty to disclose its transgressions. Furthermore, Mr. Fedders noted, Citicorp's conduct "does not appear to have resulted in material economic harm to the corporation."

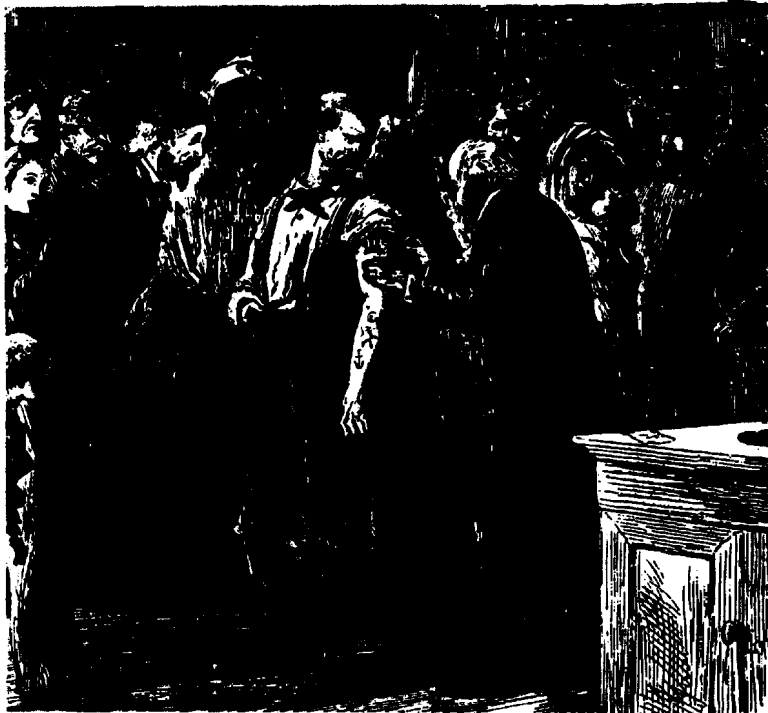
Of course, if workers sued because their health was consciously endangered on the job, it could result in "material economic harm to the corporation." To close this loophole and allow free enterprise free rein, the right to sue employers must be limited. This is exactly the intent of a new piece of legislation written by the legal department of Johns-Mansville Corporation and sponsored by Rep. Millicent Fenwick (R-NJ) and Sen. Gary Hart (D-Colorado). It will prevent asbestos victims or their widows from suing asbestos companies for compensation. The burden would be shifted to the taxpayer.

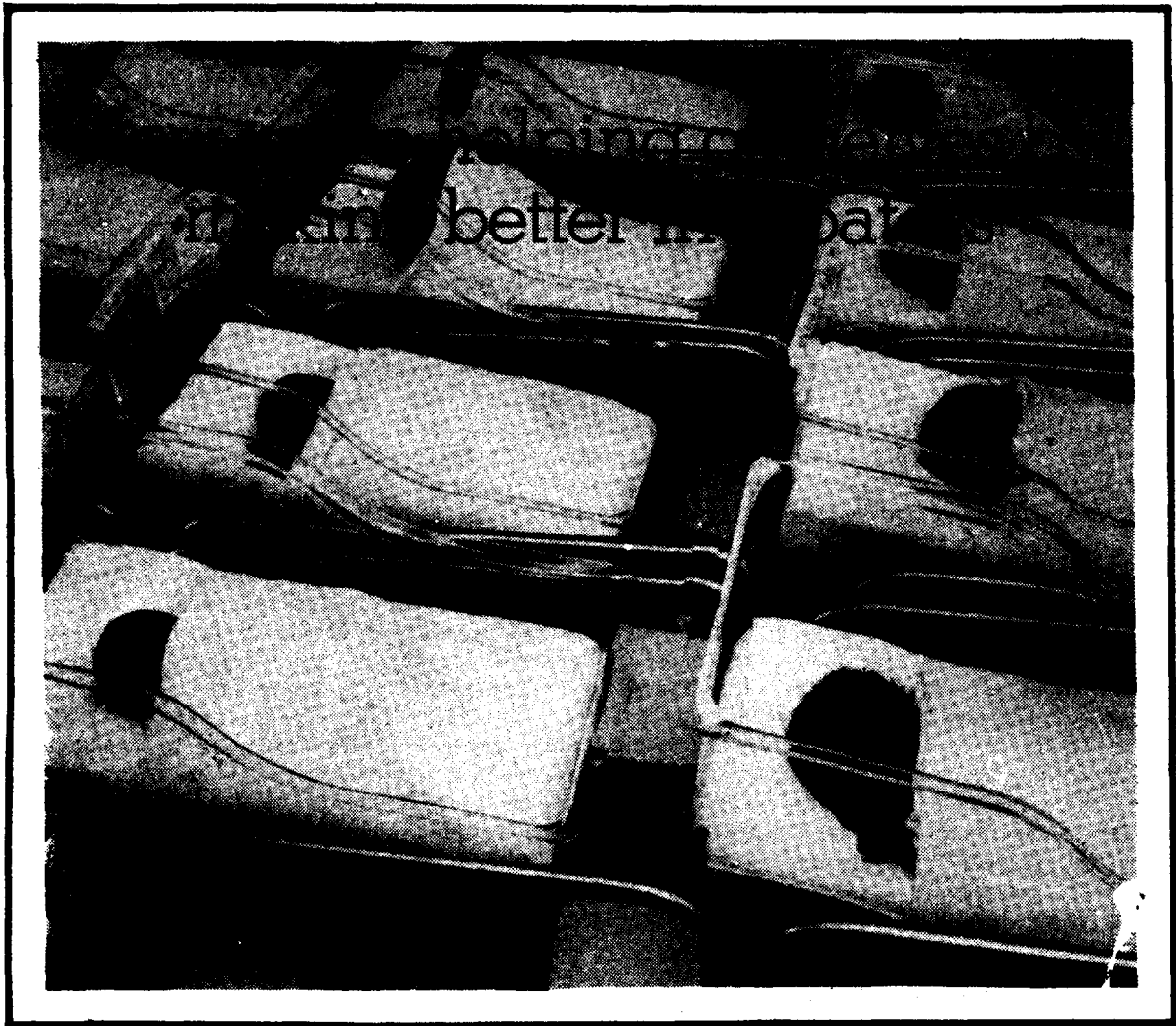
As readers of the *Health/PAC Bulletin* are aware (see Vol. 11, No. 5) there are very good grounds for such suits now, since Johns-Mansville in particular concealed information on hazards from its employees for many years.

Let Poland be Poland could be just a beginning. The Reagan Administration appears to be giving new meanings to freedom every day: let the buyer beware, let the worker be sick; and let them all eat catsup.

—Peter Medoff

(Peter Medoff is a member of the *Health/PAC* staff.)





The socialist government of President Allende in Chile was providing free milk and other food for the poor. This reduced the number of premature babies and lowered infant mortality rates.

But we weren't selling our incubators. On the contrary, our multi-million-dollar investments were threatened. We helped take care of Allende.

Taking care of people is one of our best ideas. And with the unique air compressors we've

come up with for incubators, premature babies can get the pure air, free of all toxic substances, they need to survive.

Or at least preemies whose parents are rich enough to afford our incubators. And they'll grow up to buy bread and insurance from us, rent our cars, and use our telephones.

Dollar for dollar, good nutrition saves many more babies than high technology. But what pioneering medical centers

want to buy is innovative compressors.

And we like to help people. That's why we aided Hitler and Nixon.

Some of the ideas we like to boast about most are the ones that help very little people. Babies are small and helpless. A bit like most Third World countries.

When you see our name, we hope you'll think about how we help some babies.

Our best ideas are the ideas that fool people. WITT

c/o the Health/PAC Bulletin, 17 Murray St., New York, N.Y. 10007

Expanding Contracting

Private Management of Public Hospitals in California

by William Shonick, Ph.D.

Throughout American history we have never stopped debating which publicly mandated functions are better performed directly by a public agency and which should be contracted out to private entrepreneurs. Current practice ranges across the spectrum. Firefighting is almost entirely the province of local government. Military aircraft are manufactured privately with government financing. In between are various combinations of partial public operation and partial contracting out.

Sometimes these hybrids will exist in the same agency. Many local health departments, for example, perform functions such as restaurant inspection directly and contract out programs such as mental health services.

One of the sharpest controversies over contracting publicly mandated services has been in provision of medical services to those unable to pay for it privately. As far back as the late 1800's critics denounced localities that contracted out care of poor populations to the lowest bidder with little or no attention to their capability or performance. These exposures were so devastating that the very term "contracting out" be-

came synonymous with poor care. And yet the policy continued.

Professional services as well as boarding, nursing—and even burials—were "let out" to the lowest bidder on a flat rate basis. In Kern County, California, for instance, in 1877 a contract to "furnish medical and surgical attendance and all medicines and surgical supplies to all patients who might be hospitalized" was awarded to a physician bidding \$116 per month.

Experience soon furnished abundant evidence of the shocking defects inherent in such a system. There was no guarantee that the patients received the care needed. The physicians who waged the necessary battle and those who captured the contract were not necessarily the most respected and competent professional men. At the end of the contract year, the unscrupulous doctor, doing as little as possible for the sick, could record a handsome profit, while the conscientious discovered a deficit. Inevitably many physicians became convinced that a fair deal could never be expected from a governmental agency.

These facts alone, one may be inclined to assume, should have induced public agencies once and for all to discard the practice of "renting the sick out." Yet, such is not the case. In some parts of the country the method is still in use, and here and there it has even remained on the statute books.¹

This commentary was written by a noted public medical care authority in 1945.

Among the solutions used to help remedy the conditions he described was the establishment of public hospitals dedicated to caring for sick

William Shonick is Professor of Public Health at the University of California, Los Angeles. This article is based on research conducted by Ruth Roemer, J.D., who is Adjunct Professor of Public Health at UCLA, SPH, and William Shonick, supported by a grant from the California Policy Seminar 1979#81. Partial support of Ruth Roemer's participation was provided by the University of California, Los Angeles, Health Services Research Center (Charles E. Lewis, M.D., Director). The Center was supported by grant number HS 02015 from the National Center for Health Services Research, U.S. Department of Health and Human Services.

poor people.² These institutions began to increase in many regions in the 1900's. In California, the movement to establish county owned and operated institutions accelerated in the 1920s; by 1950, 50 of the state's 58 counties had at least one, and only the eight that were sparsely populated had none.

Public hospitals serving low income patients were never luxurious, but in the 1930's and 40's many were medically respected and widely used by low income persons, including the working poor. This was particularly true in the major urban centers.³ Among the best known were those in New York City, Cook County (Chicago), Philadelphia, Boston, Baltimore, and Los Angeles County.

Even the poor would be able to abandon inferior public institutions and enter the "mainstream."

Contracting out the management or ownership of these hospitals wasn't an issue then. Almost all private hospitals were sponsored by non-profit entities. Often they provided a considerable amount of free care but even the wealthiest couldn't hope to shoulder the burden of public hospitals. There was no government health insurance and little private. For-profit (proprietary) hospitals were relatively scarce, and certainly had no interest in subsidizing care for those who couldn't pay their bills. Private consulting and management firms eager to run hospitals had yet to appear.

The Postwar Era

After World War II new forces quickly transformed this environment. Private health insurance grew explosively, especially hospital coverage. This increased demand for private hospital care, and passage of the Hill-Burton Hospital Construction Act in 1946 provided the funds for new beds. Rapid expansion of the National Institutes of Health extra-mural research grant programs stimulated a spectacular increase in medical research and high technology medicine. New facilities and equipment quickly became obsolete. Hospitals had to scramble for capital to purchase the "latest developments."⁴

Public hospitals found it increasingly more difficult to compete. Their equipment was often older, their staffing thinner. Private physicians

in the neighborhood followed their privately insured patients to the suburbs.⁵ The inner-city tax base declined, reducing available funds. As the working population drained away, the proportion of non-paying patients increased.⁶

Public hospitals limped through the 1950's and early 60's, sustained politically by the public perception of their position as the sole facility available to a large proportion of the poor and many of the near-poor who lacked hospital coverage. The elderly, mostly low income and on average high users of health care, comprised a major proportion of public hospital patients.

The Medicare and Medicaid Acts of 1965 accelerated⁴ the decline of the public hospital. They did so by helping to drain the pool of patients using the same hospital and by reimbursement mechanisms that disadvantaged the public hospital in comparison to private ones. Theoretically, this didn't have to happen. Direct grants could have been allocated under these programs to expand and improve public hospitals so that they could better care for the poor by themselves or in conjunction with private institutions receiving fee-for-service subsidies.

However public hospitals were in such disfavor in left, right, and center circles that this alternative never had a hearing. The right wanted fee-for-service reimbursement to be the sole form of subsidy since this would enhance the "open marketplace" of "freedom of choice" and "competition." The center and much of the left saw an opportunity to eliminate "second class" medical care: even the poor would be able to abandon inferior public institutions and enter the "mainstream" of privately owned and managed medical establishments. The public hospitals would then be justifiably left to wither away.

Consequently, after Medicaid and Medicare were enacted the abandonment of public hospitals accelerated across the country. Localities that couldn't shed them entirely cut their support. By 1970 the situation was so dire that the American Hospital Association devoted an entire issue of *Hospitals*, its journal, to "the plight of the public hospital." By 1975 the survival of the public hospital was in doubt. An ad hoc Commission on Public Hospitals, set up largely through AHA initiative, began a major inquiry into their condition.⁷

Of the ways in which Medicare and Medicaid weakened the public hospital two were particularly devastating, the reimbursement system and funding for patients to go elsewhere. Their effects were closely linked.

When these programs began, the reimbursement procedures of Blue Cross and commercial insurers were already restructuring private hospital management. Medicare and Medicaid adopted many of the Blue Cross reimbursement methods based on reported hospital costs. Because Blue Cross paid cost, and in many localities charges, the top priority for management became formulating charge structures and reporting procedures that maximized reimbursement from Blue Cross, Medicaid, and Medicare. "True" efficiency, in the sense of lower costs per unit of care, became far less important. A hospital that rejected this principle and kept a tight rein on plant and equipment expenditures to keep costs and charges down risked losing physician referrals to institutions that kept their reimbursement rate up and were able to purchase the latest innovations.

The prominence of reimbursement expertise in these circumstances created new territory for private entrepreneurs. Chains of private hospitals that admit only patients with guaranteed paying ability and structure their services to maximize reimbursement rates have attracted a sizable number of new investors. In sheer self-defense some non-profit hospitals have also banded together in chains, although these are still less significant economically.

Many of these chains have also established hospital management consulting firms. They contract with hospitals other than their own to manage them for a fee. At first these contracts were mostly with other for-profit hospitals, but they now have been signed with many private non-profit and even public hospitals.⁸

As profitable businesses whose repayment of debt is virtually guaranteed by Medicare, Medicaid, and private insurance reimbursement practices, the private chains have little difficulty raising capital for renovation and expansion of their own hospitals. These loans are readily available in the public bond market or from banks. Most voluntary hospitals also keep their plant and equipment up to snuff by following a similar strategy.

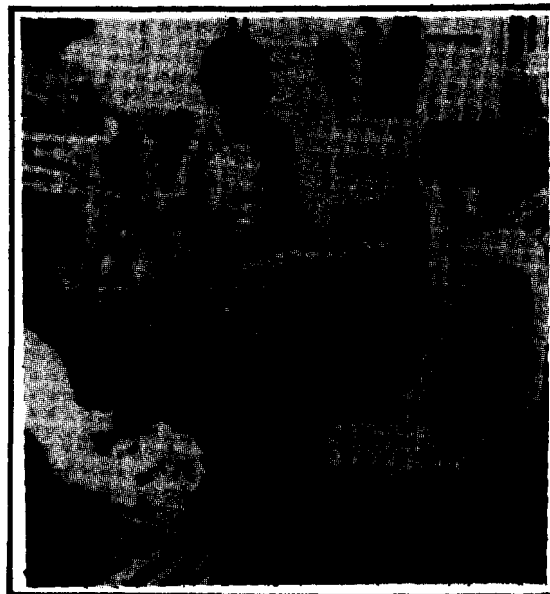
Public hospitals, however, have been unable to obtain capital funds even if there is a reasonable expectation that higher reimbursement rates from Medicaid and Medicare would cover repayment of much of the debt. In California they are effectively blocked because local voter approval is required to float a public bond issue, and in recent years such proposals have been regularly turned down.

As a result, the gap between the condition of

their facilities and those of competitive hospitals has widened rapidly. Patients who can tend to choose the better equipped private facilities; the number who use public hospitals has accordingly steadily declined in many places, further eroding their financial viability. It has also added to the perception of the public and legislators that they are not needed any longer. Dissatisfaction with their deteriorating plant, services, and occupancy has reduced local political support, leaving them vulnerable to demands for further economies and efficiencies.

The mechanism proposed for instituting cost-cutting and efficiency measures has often been contracting out of management. Many of the firms brought in operate their own profitable chains; all have "reimbursement experts" specializing in ferreting out the highest possible insurance payments.

Management contracts are a compromise position for local governments under pressure from those who wish to keep the hospital open and improve it with better public management and those who would like to sell it off or close it. Proponents of private institutions have argued that they have "better" personnel and that the profit motive increases their cost consciousness. Those who favor public management argue that these efficiency claims are largely based on myth. They believe concentration on the "bottom line" is not the best motivation for public service; some would say it is anti-social. By opting for a management contract, officials can claim they are testing a new system without totally abandoning public control.



The California Experience

Nowhere have these trends been clearer than in California. A leader in the establishment of county hospitals, by the late 1950s it had 66, in 49 of its 58 counties. Yet by 1980 the number had dwindled to 37; only half of the state's counties had one.^{10,11} Many of those that remain are under heavy pressure to close. In a belated recognition of these problems, in 1980 the state government appropriated \$50 million for hospital construction and rehabilitation over a two year period.¹²

The attrition in public hospitals has not been accepted without protest in California. Various types of citizen groups have actively opposed closures and service curtailments. Some, such as the citizens coalitions against closing the Yolo County public hospital, have been successful. Others have won partial victories—in Los Angeles, for example, house staff and public advocacy groups have slowed deterioration of patient services.

In some counties members of the elected Board of Supervisors have bucked the trend with varying degrees of success, opposing closures on principle. Probably no county hospital would survive without personnel who work far in excess of what their "contracts" require and then in many cases spend much of their off-duty time working in coalitions with citizen groups and with elected officials to protect and save their hospitals.

Despite this resistance, the intensifying fiscal crisis at the state and local level¹³ and constant attacks in the media and administrative circles on alleged gross mismanagement in the public hospitals have put heavy pressure on supervisors to do "something" in their county.

At one end of the spectrum, that "something" would be a generous increase in financial support, but in a time of severe budgetary constraints and widespread "anti-government" sentiment this is effectively precluded.

A full 180 degrees away lies complete divestiture. In some cases its advocates have been

successful. In others only determined public and official opposition has blocked the way.

Somewhere between these two possibilities officials found the management contract: A commercial firm would be brought in to operate the county hospital for a specified period under well defined terms. At the time it was initiated, this seemed a novel experiment. Although many American private non-profit hospitals had tried this approach, public hospitals had not.^{14,15}

After Merced County signed on with National Medical Enterprises in 1973 other counties soon followed with NME or other firms. Some discontinued the contracts when they came up for renewal (usually after two years). Others signed up again. In all, 15 counties had tried private management by October, 1980. Eight of the contracts were still running, the oldest renewed every two years since 1973 and the newest just initiated in 1980.

The following account is based on a study of the experiences of seven counties. Ruth Roemer and I visited the hospitals in all of them; interviewed numerous people involved; studied the contracts, reports, and documents; and asked an accounting firm to analyse the relevant financial statements.¹⁷

The Findings

Persons interviewed asserted that management contracts had yielded substantial benefits in three major areas—finance, staffing, and management recruitment.

Finance. A number of hospitals reported that the new private management brought in a one-time windfall by collecting on unpaid (and often unsubmitted) bills of prior years from third party insurers—private, MediCal (California's Medicaid), and Medicare. Current collection procedures were also tightened up, according to these accounts.

Continued on Page 22

Important news for 10 million Americans

Health Protection for Operators of VDTs/CRTs

Find out the dangers—eyestrain, muscle pain, indigestion, stress—and some simple ways to minimize them in this booklet produced by the New York Committee for Occupational Safety and Health.

Available from Health/PAC, 17 Murray St., New York, N.Y. 10007, for \$1 plus 25¢ postage for individuals and \$3 plus 25¢ for institutions and corporations.

A Health/PAC Symposium: Is removing the prescription requirement from drugs a menace or a boon?

When Health/PAC received an article on over the counter drugs it stimulated a lively discussion among members of the Editorial Board. We decided that our readers would enjoy sharing our differing opinions. Still other points of view are most welcome for future publication.

A (Non) Prescription for Trouble

By Dana Delibovi

Television viewers may have noticed an increasing number of pitches for diet pills, skin creams, "super-strength" cold formulas, and other nostrums for real and imagined ailments. As medical expenses become a greater headache for consumers, pharmaceutical companies have seized an opportunity to relieve symptoms.

Many Americans have found that a five dollar bottle of cough medicine is considerably easier to swallow than a fifty dollar fee for a throat specialist, and the drug companies are ready and eager to leap over the counter to oblige. So far the risk to profits has been minimal, and the risk to consumers is often forgotten.

Manufacturers report rapid growth in nearly every over-the-counter (OTC) drug category. Cold products brought in a gross of \$400 million last year, up 16 percent over 1979. Sales of laxatives, analgesics, and sinus products were up 10 to 18 percent.

As surely as Madison Avenue executives know that you don't sell laxatives to relieve nasal congestion, they are aware that hype must be targeted to particular groups. Teenage con-

sumers must be convinced that all their friends will drop them if their acne isn't cleared up immediately. The elderly must be taught that a new OTC laxative will solve their problems. And all must be persuaded to believe that neither home remedies nor nutrition supplements will do the job. Druggists and medical practitioners must be drilled, cozened, and free-sampled into prescribing Ezy-Off Pimple Sauce rather than a less expensive substitute.

A recent study by the marketing firm Frost & Sullivan found that pharmaceutical companies spend anywhere from 15 to 35 percent of their OTC revenues on promotion, compared to the three to 12 percent average for all their products combined. Frost & Sullivan predicts this highpowered sales offensive will help win a five percent annual growth rate through 1985, especially if manufacturers can "find special ingredients to trumpet."

The trumpeters are already blasting away, because the ingredients are here. All the companies have to do is convert products previously available only through professionals into something anybody with spending money can buy in a drug-store or supermarket.

"Rx-to-OTC" conversions became more than a gleam in the corporate eye in 1979, when Food and Drug Administration panels reported that the active ingredients of several prescription drugs could be taken without prescription. One drug unleashed by the FDA, low dosage hydrocortisone, has already become a legend in the OTC industry. Upjohn, Schering, Combe, Pfizer, Pharmcraft, and Squibb all introduced OTC versions of hydrocortisone cream in 1979 and 1980. Aided by huge promotion campaigns, they grossed \$54 million from a standing start and sales are expected to reach \$100 million annually before leveling off. Burroughs-

Dana Delibovi has written many articles on the drug industry.

Wellcome is just entering the market, and it probably won't be the last.

The appetite suppressants phenylpropanolamine and benzocaine were also cleared in 1979. Within months, "miracle" diet aids were earning their manufacturers millions, again with the assistance of massive ad blitzes. Sales were over the \$200 million mark in 1980, 43 percent above 1979. This year the gross is expected to rise another 25 percent.

Inevitably, this success has prompted pharmaceutical companies to scour their medicine cabinets for other potential bonanzas. "There are a lot of marketers really watching for opportunities to move from Rx to OTC," noted marketing consultant Letitia Mulcay-Makai in *Drug Topics*, a trade journal. OTC products which have traditionally had "ethical" status, with promotion limited to physicians, pharmacists, and other health care professionals, have also become "proprietary" products pushed in ads directed at the general public. The most famous example of this shift from "ethical" to "proprietary" is Tylenol. Since it was introduced in the mid-1970s, Tylenol has become the best selling internal analgesic, bringing in \$135 million a year. Other profitable shifts are Robitussin cough medicine and Metamucil, which currently corners 77 percent of the OTC bulk-laxative market.

After reading drug company handouts, one might think restrictions on such products have been a perverse policy of government paperpushers determined to stifle free enterprise. Actually there are other reasons for regulation.

Converted and shifted drugs generally have more specific directions and indications and

more significant side effects than other OTCs. Manufacturers are not required to include this information in their advertising, so consumers who fail to read labels and follow instructions diligently may be in for trouble. Schering-Plough's Afrin, for example, induces drowsiness, a side effect not found in other nasal sprays. Users who don't read the fine print may discover this too late while driving or working with potentially dangerous machinery.

Even the best of the OTC products have begun to reveal negative social, political, and economic side effects.

Consumers also could fall victim to deceptive marketing and packaging practices in the sale of the new OTCs. Hydrocortisones fall into this category. Appetite suppressant brand names such as Dexatrim and Dexa Diet II remind consumers of dexadrine, giving the ads a potency which the companies couldn't claim for their products without running into trouble with the Federal Trade Commission for false advertising.

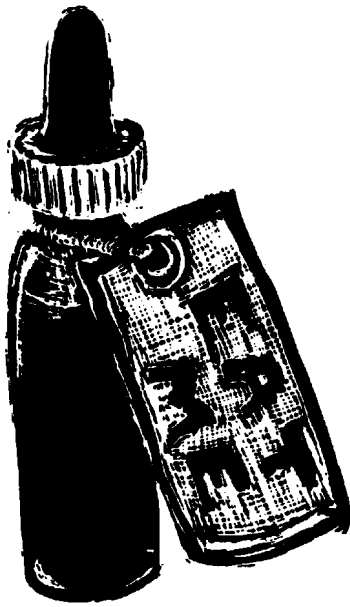
Still more deceiving, even diabolical, is the practice of producing "look-alike" capsules. Thompson Medical Corporation, recently acquired by Revlon, sells Dexatrim in a black capsule with the letters "D-E-X." What this looks like is Pennwalt's prescription-only combination of amphetamine and dextroamphetamine, better known on the street as "black beauties." The result is a secondary market where the naive and inexperienced can boost

the high they get from oregano sold as marijuana with diet pills sold as amphetamines.

This may appear to be a harmless scam; after all, the television program "60 Minutes" has found phenylpropanolamine the only safe and effective OTC diet medication. However National Public Radio recently reported an unusual incidence of strokes among people under 35 in New Mexico, Illinois, and Washington who were found to have "non-toxic" levels of phenylpropanolamine their blood. While not conclusive, this evidence coupled with the drug's previously known tendency to raise blood pressure indicates a need for caution.

Even the best of the OTC products have begun to reveal negative social, political, and economic side effects. Their extensive development and relentless promotion undermine the progressive aspects of self care, such as increasing consumer control of health and lowering medical costs. They whet the appetite of a wealthy and powerful lobby prepared to wave the banner of good health as vociferously as the aerospace industry exploits the theme of national security to press its wares.

If any administration has ever had ears sensitive to the cries of the pharmaceutical industry, it is President Reagan's. Consumer advocates fear that the FDA may cease drug reviews altogether, opening the floodgates to conversion. The Federal Trade Commission may scrap plans to insist on OTC advertising more consistent with labeling requirements. About the only thing which would save the consumer then would be the invention of a greed-suppressant pill—and a popular movement to administer it.



Barbara Ehrenreich:

Let the Patient Decide

At the risk of being labeled a medical anarchist, I would like to propose that *all* drugs be sold over the counter. Consider the savings to the consumer: A chronic user of an anti-hypertensive or cardiac medication may spend \$10 to \$15 a month on it plus another \$40 to \$100 a year on physician visits just to get the prescription renewed. An episode of cystitis may cost \$20 or so in antibiotics and double that in physician and lab fees to entitle the sufferer to buy the drugs. In cases like these, where the problem and the cure are familiar to the patient, why not just eliminate the intermediary?

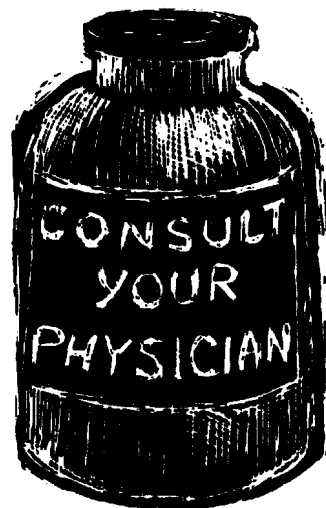
Where the ailment and possible treatments are more mysterious, most people would still want to seek a physician's advice before heading for the drug-

store—assuming, that is, that they can find a physician and afford to pay him or her.

Would de-prescribing drugs lead to an increase in patient "abuse" or drug-related iatrogenesis? I doubt it, especially if the drugs were appropriately and extensively labeled and if we began to utilize the considerable knowledge and skills of pharmacists. An estimated 35 percent of drugs currently prescribed by physicians have no effect (and are not designed to have any effect) on the conditions for which they are prescribed—not exactly a terrific batting average.

How many of us would have thought, on our own, to take antibiotics for routine, viral colds; or DES for spotting in early pregnancy; or chloramphenicol for acne? The medical profession's sycophantic relationship to the pharmaceutical industry is well-known; they have done nothing to justify their continued monopoly over the prescribing of drugs.

(Barbara Ehrenreich is co-author of For Her Own Good: 150 Years of Experts' Advice to Women, and a member of the Health/PAC Editorial Board)



Richard Young:

Let the Doctor Prescribe

I would not support making all medicines over the counter. Eliminating the physician intermediary would have a minimal effect on health care costs. Most of any savings would probably be extracted from the over the counter consumer.

The cost of physician services related to prescription writing is probably very small compared to the cost of all physician services, including high technology diagnostic procedures, radiology, surgery, and hospital care. Any physician in private practice will tell you that his or her money is not made in the office writing prescriptions.

On the other hand, eliminating the physician's role as a prescription writer would be another economic disincentive to primary care practice. Primary care physicians and community health centers derive a greater proportion of their income from prescription-related activities than do specialists.

I'm also constantly surprised at the extent to which my community health center clients can already get medicines without prescriptions. Not uncommonly, a patient will come in with uncontrolled blood pressure who has been taking medicine which a pharmacy has been providing for a year or more without a new prescription. Because they could keep on getting the medicine, they never went back to the primary physician to see if it was having its intended effect. Penicillin can be obtained without prescription fairly easily. One patient told me, "You can get

anything if you have the money." I have treated at least one woman whose male friend inadequately treated himself for gonorrhea.

Physician prescription writing does not protect consumers from incorrect dosage, adverse drug interactions, ineffective drugs, and other therapeutic misadventures. A profit-oriented drug industry selling directly to consumers can hardly be expected to do much better, and could do a lot worse.

(Richard Younge is a family physician at the Council Center for Problems of Living, a Federally-funded community health center, and a member of the Health/PAC Editorial Board.)



Arthur A. Levin:

It Ain't Necessarily So

The concern expressed about drugs that "move" across the line from controlled public access (prescription or ethical drugs) to open public access

(over the counter or OTC) being a danger to the public health deserves comment.

There is considerable evidence that the physician in the role of gatekeeper of the pharmacopia does little to protect the public from harm. Poorly educated in pharmacology and seduced by drug advertisements, detailers and promotions, physicians appear hard pressed to evaluate increasingly complex and constantly proliferating drugs.

Studies show that even in the supposed "best" of all possible medical worlds—the teaching hospital—poor prescribing practices occur with disturbing frequency. Physicians often continue to prescribe drugs whose effectiveness and safety are in question and which present considerable potential harm to patients. DES, for example, was prescribed long after studies indicated it had little or no efficacy; even after evidence appeared that it caused cancer and genital abnormalities in the children of women who had taken the drug during pregnancy.

The battle to discourage physicians from prescribing oral chloraphenicol (Chloromycetin) was waged between the Food and Drug Administration and the manufacturer, who continued to promote it as safe and encouraged physicians to disregard scientific evidence that said otherwise. It took two decades for scientific rationality to prevail over marketing skill. While the number of prescriptions written for chloraphenicol has declined dramatically, too many are still written every year.

Tetracycline is still being prescribed for young children even though the medical world has known for some time that it causes permanent tooth discoloration and effective substitutes are available.

Therefore, the argument that making prescription drugs available to the consumer is potentially more harmful than a restrictive ethical drug distribution system is questionable. I know of no study which has found that the health status of populations abroad who have direct access to drugs restricted in this country is poorer as a result.

Only drugs safe and effective should be available.

People are harmed by irrational prescribing practices using ineffective and toxic drugs. Pharmaceuticals, whether prescription or OTC, should not be marketed unless they have been shown to meet high standards of safety and efficacy. Only drugs proven safe and effective should be available as part of a national drug formulary established and monitored by experts. The system should also include continuing surveillance for evidence of side effects, adverse reactions, and other negative results.

If such a national formulary was in place we then could study the benefits and risks of two distribution systems, one which allows direct access by consumers, the other controlled by physicians. Hopefully such an effort would help us understand what the health benefit or risk is from each system.

(Arthur A. Levin is Executive Director of the Center for Medical Consumers and a member of the Health/PAC Editorial Board.)

JOURNAL OF THE PLAGUE YEARS

The Fiscal Year 1983 Health Budget

by **Mark Kleiman**

If we still had a decent, sane Surgeon General, the nation's top health officer would feel compelled to declare Reagan's Fiscal 1983 budget proposals a danger to the health of the American people. The White House plans an assault on health programs that could well turn the AFL-CIO's charge of "Jonestown economics" into a grim reality for millions of persons.

The proposed budget cuts occur against a leitmotif of blind acquiescence to military profligacy unparalleled in a "peacetime" economy, and a set of giveaways to corporations which has embarrassed even the Republicans and Democrats who shoved these proposals through the last Congress. Barely one year ago, the retiring Comptroller General of the United States cautioned Reagan that there was *at least \$15 billion* in fraud, waste, and abuse in the "defense" budget. The President's response has been to fight fire with gasoline, fueling ever-greater waste at the Pentagon. The give-away has become so notorious that the *Washington Post* reported on February 20 that an unprecedented 40 percent of the people surveyed in a nationwide poll said the government should cut military spending to reduce the Federal deficit. (Just over half opposed tightening the Pentagon's garrison belt.)

The Federal largesse to major corporations is even more shocking. According to the Congressional Budget Office, corporate taxes will drop by a massive \$127 billion through 1986. A February 17 article in the *Washington Post* reports that new tax laws have reduced the effective tax rate for 1982 dramatically—from 32.7 percent to 16.6 percent in agriculture; from 35 percent to 1.1 percent in petroleum refining; from 31 percent to *minus* 2.9 percent in transportation; and from 28.4 percent to *minus* 3.4 percent in mining. These "negative" tax rates mean that corporations in the affected industries will actually show an absolute profit for simply purchasing new plant and equipment.

Mark Kleiman is Executive Director of the Consumer Coalition for Health in Washington, D.C.

Although some politicians facing re-election hope to see a shift from corporate and military spending back into social programs, it is far more likely that minor reforms in the tax subsidies and the Pentagon budget will be used to reduce the staggering Federal deficit.

The drama of the government's self-inflicted budgetary wound may capture congressional concern and national attention, but the Administration has different health problems on its mind. Were Defense Secretary Caspar Weinberger to become a pacifist and the Fortune 500 corporations to come out for sharing tax burdens fairly, health programs would still be an endangered species. Put simply, Reagan and his key domestic advisors stubbornly deny any Federal responsibility for our health care programs. If the budget crunch did not exist, the White House would probably create one as a cover for wiping them out.

The proposal has been greeted with bipartisan derision by Congress and many governors.

The proposed health budget has few surprises. Because the aged vote and are better organized than the poor and minorities, Medicare has escaped with nicks, while Medicaid as well as other low income health programs have been savaged. Even so, the combined outlays for these two major programs continue to dwarf miserly Federal outlays for primary care and prevention.

The only real stunner was the Reagan threat to "swap" Food Stamps and Aid to Families with Dependent Children (AFDC) to the states in exchange for assuming complete responsibility for Medicaid funding. Most stunned of all were Health and Human Services Secretary Richard Schweiker and his top deputies, who only learn-

**SPENDING FOR SELECTED PROGRAMS,
1981-1983 (in millions)**

PROGRAM	1981 spending	1982 (estimate)	1983 Need¹	Reagan Proposal	% cut from '81 Budget
MEDICARE	42,488	49,559	57,951 ¹	55,352	4.5
MEDICAID	16,833	17,823	21,815.57 ¹	17,006	22.0
HEALTH SERVICES ADMINISTRATION					
Primary Care Block ⁴	454	358	625.14	416.8	33.3
Community Health Ctra.	327	248	381.38	*	*
Migrant Health Ctra.	43	38	50.15	*	*
Black Lung Clinics	4	3	4.67	*	*
Family Planning	162	124	188.94	*	*
Nat'l. Health Svc. Corps	92.3	95.5	107.65	103	4.4
NHSC Scholarships	63.4	36.4	86.78 ⁴	11	87.3
"Services to Women, In- fants, & Children—SWIC"	1,381	1,282.08	1,610.66 ⁴	1,000	38.0
MCH Block Grant	454	358	529.50 ⁷	*	*
WIC Program	927	934.08	1,081.16	*	*
CENTER FOR DISEASE CONTROL					
Venereal Disease	48	38	55.98	45	19.6
Immunizations	30	28	36.15 ⁴	29	19.8
Chronic Diseases	22.4	17.3	26.13	19.5	25.4
Environmental Health	9	6	10.50	4	162.0
Nat'l Inst. of Occupational Safety & Health	102.4	60.3	119.43	50.5	57.7

FOOTNOTES TO BUDGET TABLE

1. Unless otherwise noted all estimates of 1983 need are derived by adjusting 1981 spending levels for 9 percent inflation in 1981 and a projected 7 percent inflation in 1982. There will be some error due to the differences in time periods covered by calendar and fiscal years.
2. The 1981 Medicare spending level was multiplied by 29.6 percent to reflect the compounded impact of medical care inflation of 15.2 percent and 12.5 percent, in 1980 and 1981 respectively. This was then multiplied by an additional 3.43 percent to reflect growth in the population of eligible Medicare beneficiaries. Growth estimate made by Alice Rivlin, Director, Congressional Budget Office, in testimony before the House Subcommittee on Health and the Environment, December 15, 1981. Medical care inflator factors derived from Bureau of Labor Statistics for 1981, and *Health Care Financing Review*, 2,3 (Winter: 1981) published by Health Care Financing Administration, DHHS.
3. The 1981 Federal Medicaid spending levels were multi-

plied by 29.6 percent (see fn. 2, supra). The level of 1983 need severely underestimates the actual level of need. Medicaid spends a much higher proportion of its funds for institutional care than do Blue Cross and private insurers. Hospital costs rose 16.8 percent in 1980 and 17.0 percent in 1981, much more rapidly than non-institutional medical costs. More crucially, the 1983 estimation fails to consider the greater need for Medicaid because of millions of workers and their dependents who lost private insurance coverage along with their jobs in the current recession. DHHS very conservatively estimates that over 1.1 million people who would have otherwise been eligible for Medicaid will receive no benefits because of new eligibility restrictions in the 1980 Omnibus Budget Reconciliation Act.

4. Although there was no Primary Care Block Grant in 1981 and 1982 grant, the spending levels for the programs targeted for the block, are included to indicate the overall impact of the proposed cutbacks.
5. 1981 spending levels have been adjusted to reflect a 36.87 percent increase in medical school tuition since that year,

**SPENDING FOR SELECTED PROGRAMS,
1981-1983 (in millions)**

PROGRAM	1981 spending	1982 (estimate)	1983 Need¹	Reagan Proposal	% cut from '81 Budget
INDIAN HEALTH SERVICE	620.5	644.86	723.69	650.88	10.0
HEALTH RESOURCES ADMINISTRATION	381	267.2	444.36	9.68	62.2
Health Planning	126.2	61.7	147.19	2.1	97.7
Health Facilities	9.6	51.2 ²	11.2	8.6	23.3
Primary Care Family Medicine Trng Support	65	51	88.79 ⁴	41	53.9
Disadvantaged Asst. Trng Financially Distressed (mostly black med schls)	20	17	27.37 ⁵	41	53.9
Public Health	10	7	13.69 ⁴	6	57.2
Nursing Education	15	9	17.5	5	71.4
	66	42.1	80.14 ¹⁰	12.5	84.4
OFFICE OF ASST SEC. HEALTH					
Alcohol, Drug, Mental Health Block Grant	540	432	629.80	432	31.4
Prevention Block Grant	92	81.6	107.3	81.6	24.0
Health Services Research	34	15.8	39.65	16.1	58.4
Health Statistics	38	37.3	44.32	40.3	9.1
Health Promotion	2.2	1.1	2.68	2.3	14.2
Adolescent "Family Health" (Chastity Prgm)	*	.7	*	16.0	*

as reported by the American Association of Medical Colleges. Estimates were based on a straightline projection of 1980-1 to 1981-2 (non-resident) tuition fees.

6. Although there is no "SWIC" Block Grant for FY 1981 and 1982, the spending levels for the programs which have been proposed for the block grant are included. It is important to note that if this program were actually block granted states would be confronted with either cutting even deeper into an already weakened MCH program, or drastically reducing food benefits to pregnant women, infants, and young children.
7. The 1983 estimate conservatively uses the CPI inflator rather than a mix of the CPI and Medical Care cost inflators, which would reveal a substantially higher level of need. We cannot quickly disaggregate MCH spending into its medical care, prevention, education, and outreach components, which would presumably inflate at the more general CPI level. Even a 50-50 split between actual medical care and health programs would raise the 1983 need level to \$545.66 million.
8. The Congressional Research Service reports that 29 per-

- cent of these funds were used in 1981 to purchase vaccines which were then distributed to state immunization programs. From 1980-1982 there has been a 30 percent increase in vaccine costs. 1983 need was estimated by adjusting 29 percent of the immunization program to account for the 30 percent increase in vaccine costs. The remainder of the immunization budget was adjusted by the general two-year combined CPI inflator of 16.63 percent.
9. This increase was due to a special one-time expenditure for planned construction costs.
10. The level of 1983 need was estimated by projecting increases in nursing tuition from 1979-80/1980-81 for the period of 1980-81/1982-83, based upon a weighted average of tuition costs for public and private baccalaureate programs. Source: *Nursing Data Book* National League for Nursing, New York, 1981.
11. The Prevention Block included programs receiving \$92 million in FY 1981. The Administration proposal not only cuts it 24 percent, but moves it from the professional control of the Center for Disease Control to domination by a political appointee, the Assistant Secretary for Health.

ed of the Reagan proposal shortly before the President broadcast it to the nation. The next day Reagan gave Schweiker his marching orders: prepare a detailed plan for the mythical "swap" in sixty days.

The proposal has been greeted with bipartisan derision by Congress and many governors, who have no desire to take the heat for the devastating Federal cutbacks Reagan has made and is proposing in these programs.

As California's governor, Reagan mastered the art of shifting costs from state government onto the backs of cities and counties (see the previous *Health/PAC Bulletin* for details). Now as President he practices the same cruel art upon the states. Medicaid and Medicare are prime targets. The budget proposals would not restructure the health system to hold down costs; instead they shift the financial burden onto the backs of the poor, the elderly, the states, insurers, and providers. The Administration does claim its "competition" proposal will save \$5 billion in just a few years. Yet only the truest of his true believers think it even has a chance of being considered seriously in Congress. (See the Health/PAC pamphlet, *Survival of the Fittest, the "Competition" Model for Health Care* for an analysis in depth of what the plan would mean.)

Ten million of the nation's 22 million Medicaid patients are children; another five million are their mothers.

The nearly \$5 billion slash Reagan has proposed for Medicare and Medicaid comes on top of cuts of \$897 million and \$696 million respectively suffered last year. Ironically, for an administration which complains so loudly about welfare costs, this year's Medicaid cuts—and last year's—penalize the working poor most heavily of all. According to a new University of Chicago study, many of them would now be better off financially if they quit their jobs and relied entirely on government assistance, pathetic as it is.

Here is the sorry picture in the major programs:

Medicaid.

The majority of Medicaid beneficiaries qualify because they receive AFDC. Ten million of the nation's 22 million Medicaid patients are children; another five million are their mothers.

When Congress changed the rules for AFDC eligibility, HHS estimated that it also eliminated 1.1 million people who *would* have qualified for Medicaid. A great many of them are marginally above the poverty level, but only a portion of this group has managed to hang on to Medicaid eligibility as "medically needy"—too "well off" for welfare, but too poor to pay medical bills.

The "medically needy" working poor are now right in front of the Reagan buzz saw. Although some states choose not to, currently they can offer a medically needy program and receive partial Federal support for Medicaid coverage (in the same amount as for the "categorically needy" AFDC and other patients). The Reagan budget proposal pares these payments by three percent, which would push states to eliminate the program or drastically curtail benefits.

Reagan wants to lop off another three percent of the Federal payments for "optional" medical services, such as drugs, artificial limbs, dental care, eyeglasses, and intermediate nursing home care. Although the President, who is legally blind without his contact lenses, may believe his visual acuity deserves a government subsidy, he does not feel the same way about the poor. "Savings" from the categorically needy and optional programs alone will cost the states and/or the poor \$600 million.

Another \$329 million in Medicaid "savings" would come from forcing poor people to pay part of the bill. Experience has shown that the \$1 and \$2 payments the Administration describes as nominal deter the poor from seeking medical care they desperately need. California under Reagan is a prime example. When he instituted such a plan there, many people forced to choose between medical care and feeding their children postponed visits to the doctor until their health deteriorated so drastically that care was vital. The eight percent drop in outpatient Medicaid charges was consequently immediately followed by a 17 percent leap in hospitalization expenses for the same population.

Medicare

This is to be cut in the same ugly pattern. The Administration wants the elderly to pay an additional \$65 million—a 25 percent hike—in their deductible for Part B, which even now covers only 38 percent of their physician bills. Other

"savings" would compel the elderly to pay more for home health care and physicians' services. By tightening constraints on Medicare payments to doctors, the government is simply dumping another \$600 million expense onto the elderly, since they will have to make this money up if they want a physician to treat them.

Instead of proposing legislation designed to encourage real cost containment, the Administration has also gone along with a proposal by the Federation of American Hospitals, the trade group of for-profit institutions, to slash Medicare reimbursement by a flat two percent for each facility. "There's not a hospital in the country which can't get around that by simply raising its rates," commented Walter Weinstein, president of American Medical International.

Resistance to these onslaughts will probably follow last year's strategy, with consumer and provider groups banding together to fight for the highest possible authorization level, or "budget mark" for Medicare and Medicaid. Once this mark is established, the real fun begins as hospitals and doctors square off against the poor and the elderly to see who will bear the brunt of the cutbacks and which services or eligibility levels will be slashed. As Woody Allen has observed, "The lion and the lamb may lie down together, but the lamb won't get much sleep."

Public Health Service.

As brutal as the Medicaid cuts have been, private sector providers who rely on Medicaid dollars for their hospitals and nursing homes have been able to stave off worse. Direct service primary care and prevention programs, however, have no "private sector hostages" to hold off the assault. And Reagan has shown no mercy.

Taking inflation into account, Community Health Centers lost 28 percent of their funding last year. They are slated for more of the same in the next budget, for a two-year (inflation adjusted) cut of 33.3 percent. Last year's cuts leave over 2.8 million Americans without their community health centers entirely or dependent on severely curtailed services. In a response to congressional inquiries, HHS has admitted that 71 percent of those harmed will be Black and another 11 percent Hispanic.

The imminent state control over CHCs and the migrant health program is even more alarming. So far 14 states have indicated they want to take up a Federal offer to run their own centers. Most of them are Southern, and health advocates fear the worst. "This problem has

historical roots," explained a clinic administrator in South Carolina, "These people just didn't like giving up their slaves."

Again surprising top officials at HHS, the White House made a last minute decision to fold family planning back into a proposed block grant of primary care programs which the states could control. Although some states would offer

The intensity of the Reagan onslaught has provided new resistance.

better than the anti-choice clique tightening its grip on HHS, citizens in many states would do much worse.

Health advocates contemplating many other block grant programs fear the potential for malicious mischief in states with profound racial or urban/rural splits. Recent health cutbacks in St. Louis illustrate the reasons for their concern. The state of Missouri, which now controls lead paint screening money under the Maternal and Child Health block grant, decided that each of its 80 counties will receive an equal share, some \$6,200. St. Louis thereby loses half its lead paint money and will probably fail to diagnose 500 cases of poisoning this year as a result. Cuts in the St. Louis program for high risk pregnancies will run up at least \$1.8 million in additional costs for neonatal intensive care—over seven times the expense saved.

Other cutbacks will terminate the highly cost-effective vaccination services for 80,000-100,000 children in North Carolina alone. The list is as long as it is appalling.

Small wonder, say Washington watchers, that Reagan's New Federalism is designed to toss this social, fiscal, and administrative time bomb back to the states before it explodes. That might secure the President's political safety, but it does little for the rest of us.

Campfires of Resistance

Local and national groups, still reeling from last year's mauling, feel uncomfortably vulnerable as they brace for the new fiscal assault. Even groups which had congratulated them-



Sweden Now

selves for avoiding dependence on Federal dollars have discovered to their dismay they must compete for small foundation grants with much larger organizations deprived of Federal support. National advocates who had relied on strong grassroots alliances are finding these local bases can barely afford phone calls to Washington. Unions, pressed harder than ever on bread and butter issues for their membership, can't spare resources to fight 30 or 40 cut-back battles at once. The Legal Services network, which had sometimes helped mobilize its clients, is similarly at bay in its own battle for survival.

Nevertheless, a reversal of fortunes may be on its way. The intensity of the Reagan Administration onslaught has provoked new resistance from potentially powerful constituencies. Only days after the budget was released, the American Public Health Association fired back with a major press conference attacking the cuts and denouncing the increase in military spending. The tremendous successes (and excellent media attention) which Physicians for Social Responsibility has achieved in sounding the alarm on nuclear warfare have prodded even the American Medical Association to declare its opposition to the arms buildup. These attacks and the growing impact of the cutbacks are beginning to raise public opposition to unbridled military spending.

On the fiscal front, 75 organizations have banded together in a Fair Budget Action Coalition under the broad banner of opposition to militarism and welfare for the rich and support for social programs. They promise a full-blown grassroots campaign which will galvanize public anger at the Reagan policies. And they just might succeed. The same national poll which found a surge in discontent with the bloated military budget showed nearly two Americans in three think Reagan should abandon his program of cutting taxes and domestic spending. Fully 57 percent expressed disapproval of his handling of the economy.

Such resistance is not without precedent. And neither is the Reagan strategy. As Bertolt Brecht observed in Germany some 50 years ago,

"Those who take meat from the table,
Preach contentment.
Those for whom the taxes are destined,
Demand sacrifice.
Those who lead the nation into the abyss,
Call ruling too difficult for ordinary men."

The Bulletin Board

Consumer Report

Are consumers better off this year than last? The answer is a resounding "no" in energy, health, housing, transportation, product safety, etc. The National Consumers League explains why in *Warning: Reaganomics is Harmful to Consumers*. With the help of Congress Watch, Consumers Union, and other groups, the League has catalogued many of the abuses perpetrated in President Reagan's first year in office. Copies are \$5 from NCL, 1522 K Street, NW, Washington, DC 20005.

Taxing Decisions

It's almost April 15th and with 25,000 nuclear warheads in stock and 17,000 on order, time to read the War Resisters League *Guide to War Tax Resistance*. Contents include mechanics and metaphysics of war tax resistance, the long history of the movement, and its most famous adherents. Send \$6, plus \$1 for postage and handling, to War Resisters League, 339 Lafayette Street, New York, NY 10012.

Gas Pains

One of the main uses of benzene, a carcinogen, is to boost the octane in lead-free gas. So before your next tankful, read CIP Bulletin #19 ("Benzene and Cancer"). For a free copy, send a long self-addressed stamped envelope to Carcinogen Information Program, P.O. Box 6057, St. Louis, MO 63139. CIP's goal is to provide the public with reliable, understandable information about carcinogens.

Metropolitan Death

Hazardous Materials in the Metropolitan Region: Towards a Strategy for Protection is the report of a conference last year at Columbia

University which involved health, environmental, labor and community groups. It includes case histories of chemical dumping, transporting hazardous materials, herbicide spraying, and legislating the "right-to-know" in Love Canal, Newark, New York City, Long Island, Philadelphia and other danger zones. There are also sections on tools and tactics of organizing, with special attention to building new coalitions for health protection in metropolitan regions. For a copy, send \$3 to Washington Heights Health Action Project, 601 West 181st Street, room 22, New York, NY 10033.

Body Language

Like the rest of us, the subjects of medical experiments can now benefit from regulatory relief. Public Responsibility in Medicine and Research will hold a conference, entitled "Institutional Review Boards (IRBs) and Their Institutions," on April 23 and 24 at the University of Texas Health Science Center in Houston. IRBs are the committees in hospitals and universities that are responsible for the conduct of research on humans. The Administration has dramatically changed the rules governing these boards, and the conference will provide the latest instructions on proper behavior for researchers, subjects, and regulators. For more information, contact Joan Rachlin, PRIM&R, 15 Court Square, Boston, MA 02108, (617) 367-4992.

This is Your Life

A new—and vital—62-page pamphlet for workers (and, one would hope, employers) is *Occupational Hazards to Reproduction: An Annotated Bibliography*, by Wendy Chavkin, M.D. with Laurie Welch, M.D. Available for \$5 prepaid (institutions, \$10) from Health/PAC.

Private Management of Public Hospitals

Continued from page 10

In at least one case the new procedures included more rigorous efforts to obtain installment payments from patients not covered by third parties. The amounts demanded were presumably established by ability to pay (a means test). This could conceivably deter some people from seeking care at the public hospital (that is, in all probability, from seeking any care at all), depending on how the means test was administered. Ambulatory care statistics tended to support this suspicion, but were not conclusive. Evidence from our interviews with members of the community and public advocates did not definitively answer this question either because of limitations in the scope of our study.

The hospital must rely on direct county appropriations or replace the poor with a better clientele.

The greatest asserted financial advantage of private management was an ability to recast cost reports to obtain the highest possible MediCal and Medicare reimbursement rates. The MediCal improvements were most important, Medicare second. Blue Cross and commercial insurer fees were also raised (both pay charges in Northern California), but because few patients covered by these plans go to county hospitals, this source of revenue increase is usually not available to them.

Since these revenue enhancement measures involve primarily tax-supported programs, it is clear that money was obtained for the county by *passing on costs* to the state and Federal governments. There was no clear evidence that the overall operating cost per unit of service was substantially decreased or "controlled," which would have been a true cost saving. Indeed, except in the case of Sonoma County Hospital, there was no clearcut evidence of a permanent and sizable reduction in the county contribution to the *net* cost of the hospitals. Sonoma was the only hospital that achieved a "break-even"

budget. It was able to do so because it had sufficient private pay patients to make up for losses on other patients—a very atypical situation.

There appear to be several reasons why management companies, so adept at turning a profit in their own hospitals, were unable to duplicate their success (except in Sonoma) in public institutions:

1. Northern California Blue Cross pays hospital charges. Medicare, however, looks at both charges and costs and pays whichever is less; some costs are not reimbursed at all. Unreimbursed costs, known as "contractual allowances," are even higher with Medicaid.

2. Commercial insurance generally does not pay costs. Hospitals are reimbursed a stipulated amount for each service billed. Charges beyond this fee-for-service schedule are paid by the patient in what is known as "cost-sharing."

3. Therefore, if a private hospital has few if any non-paying patients and most of the patients it does have are covered by Blue Cross and commercial insurers, their fees (charges) can be set high enough to cover the losses on Medicaid and Medicare "contractual allowances," as well as on some patients whose bills are unpaid.

4. Most public hospitals have relatively few Blue Cross or commercially insured patients. Their principal third party payer is Medicaid, which reimburses at the lowest rate. Many of their patients have no coverage at all. Thus improving reimbursement rates can never erase the deficit. The hospital must rely on direct county appropriations or replace the poor with a better insured clientele—even if this were possible, it would remove their reason for existing.

Staffing. Many persons interviewed asserted that the management firm had helped to reduce "overstaffing." The primary technique they mention is "variable staffing" of nurses to cover the service needs ("acuity") of the current patient load as efficiently as possible. County management personnel lauded these changes, but generally no net reduction in county obligations attributable to this feature was visible. Employee unions, not surprisingly, condemned the new measures. Some nurses complained about overly thin staffing, but we could not establish convincing evidence that patients were worse off. However, since nurse recruitment is a problem across the country and county pay scales provide less than optimum attractions, it is hard to determine if management policies were not indeed contributing to hiring difficulties.

Is private contract management then good for public hospitals? In general, I think not. But . . .

Management Recruitment. In most cases the management company brought in a well trained executive director, a controller, and, less often, a director of nurses. The typical contract included a county commitment to pay for at least two of these.

While not all of the new managers were satisfactory, they were generally better than the counties—particularly those with small hospitals—were likely to find locally. As a rule the management advantages were most visible in counties such as Merced, Sonoma, and San Mateo with a modest-sized hospital in a relatively small community where there was little competitive pressure from private hospitals and the doctors that use them.

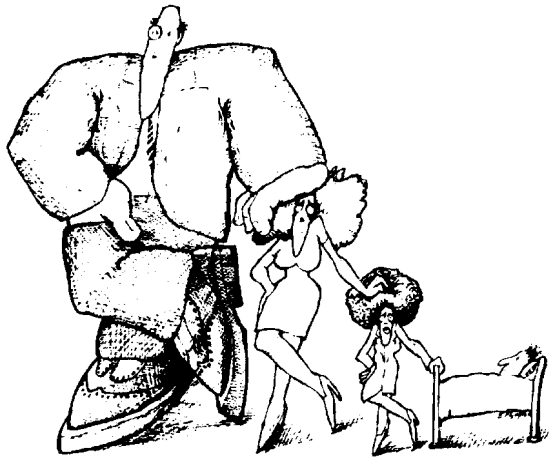
In the large urban centers, including Oakland (Alameda County) and San Jose¹⁸ (Santa Clara County), people interviewed generally agreed that the management firms hadn't helped very much. Big city unions and minority communities blocked personnel manipulation that would have reduced employment. The hospitals already had the expertise to bring in the highest return from collections and reimbursements. If

they were unable to use these techniques, the reasons were political and not managerial.

In two sparsely populated counties, Mendocino and Sutter, the competition of local private hospitals and physicians was pushing the public hospital to the brink and management companies haven't pulled it back. The county hospital in Ukiah (Mendocino) is up against two competitors, one run by a commercial chain and the other by a non-profit religious order chain.¹⁹ The local private physicians use both and want more beds in them. Since the state planning office has declared the area overbedded, they can get them only at the expense of the public hospital.

In Yuba City (Sutter County) some of the public hospital's important services have already been transferred to the competing private hospitals—one for-profit and one non-profit. The county's official emergency room is now in the for-profit institution, and all obstetrics services are in the non-profit. The county hospital hobbles along with an inadequately small number of patients and range of services and its future therefore remains uncertain, de-





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spite improvements obtained in two years of private management. These improvements were primarily in collection and reimbursement procedures and recruitment of a skilled administrator. The administrator was retained by the county after the management contract expired.

Conclusions and Public Welfare Considerations

Is private contract management then good for public hospitals? In general, I think not. But when the other option is complete and irreversible public divestiture through closure or giving the facilities away,²⁰ the experience at the sites Ruth Roemer and I surveyed indicate that contracting can in some instances be an acceptable fallback position for defenders of public services. It is also useful to remember that contracting out of the *management function* of a hospital for a management fee is not the same as contracting out the *total patient care* to a contractor for a fixed total cost. The latter practice, giving the care of a group of poor patients over to the lowest bidder, is the practice referred to at the beginning of this article, and has been for many years totally discredited. It was tried only recently in California on MediCal patients when Ronald Reagan was governor, with disastrous results.

The implementation of the management contracts we observed did not assign the care of patients to the management firm, only the hospital technical management function. The two are not entirely separate of course, and management contracts could in the future lead to turning over all patient care to the firms for a fixed fee, but as of now this has not happened. The contracts are clearly reversible, that is, they can simply be discontinued if the political picture should change.

If the community considers this alternative, it should be aware that success is more likely if several caveats are kept in mind:

1. The contract should be limited to two or three years and spell out the obligations of the firm precisely. We found that the best results were typically with contracts that provided for: a management fee that included an executive director, a controller, and, sometimes, a director of nursing; specified services from the contractor's technical personnel, especially help in preparing reimbursement cost reports and establishing improved data systems; a target date when the hospital would be ready to "stand alone," that is performing the improved pro-

cedures without the aid of the management company. At the end of this period the hospital would at most contract out a few operations ("unbundled services").

2. Smaller communities with relatively smaller public hospitals are likely to find contracting more useful. Larger institutions in the urban centers, if they derive any benefit at all, are probably going to find it in limited contracts for specific narrow tasks, such as doing a cost report. (We all await the results of Cook County's experiment with contract management for Chicago's public hospital. To date we have not seen success in a very large hospital serving a strongly defined "central city" anywhere.)

3. The financial stability and track record of firms bidding for the contract must be carefully checked. If the company owns hospitals, the likelihood that the public institution could become a target for future acquisition must be carefully evaluated.

Medicaid has never covered the entire population, nor is it likely to.

If these precautionary measures are taken, management contracting's worst problems can be avoided and it could be helpful. Still, it remains at best a necessary evil, one which should be avoided if continued direct public operation is feasible.

There are ample historical reasons for this conclusion. The public general hospital,²¹ with its charity stigma inherited from poorhouse antecedents, did not emerge mainly in response to a powerful movement among progressive or radical workers and farmers for a public medical system. The pressures for improved care for working people have typically been directed toward better health insurance, to making the private system more accessible. Public hospitals were established because the private medical system was not providing sufficient services for low income people.

The main impulse for extending the public hospital came from muckraking, reformist sources, people who saw it as an one more of the social services they advocated to lessen the harsher effects of an unchecked entrepreneurial system. They suggested it as part of the same

category as settlement houses, free milk stations for children, and free prenatal care in public health departments. It was, therefore, clearly a philanthropic measure, and not intended to establish *equal* access to medical care for all as a matter of right.

Because they were established only to fill one of the many gaps left by the private medical system and not in response to popular insistence that a public medical service is preferable to a privately run system, public hospitals have always been regarded as the poor track of "two-track medicine." With good reason.

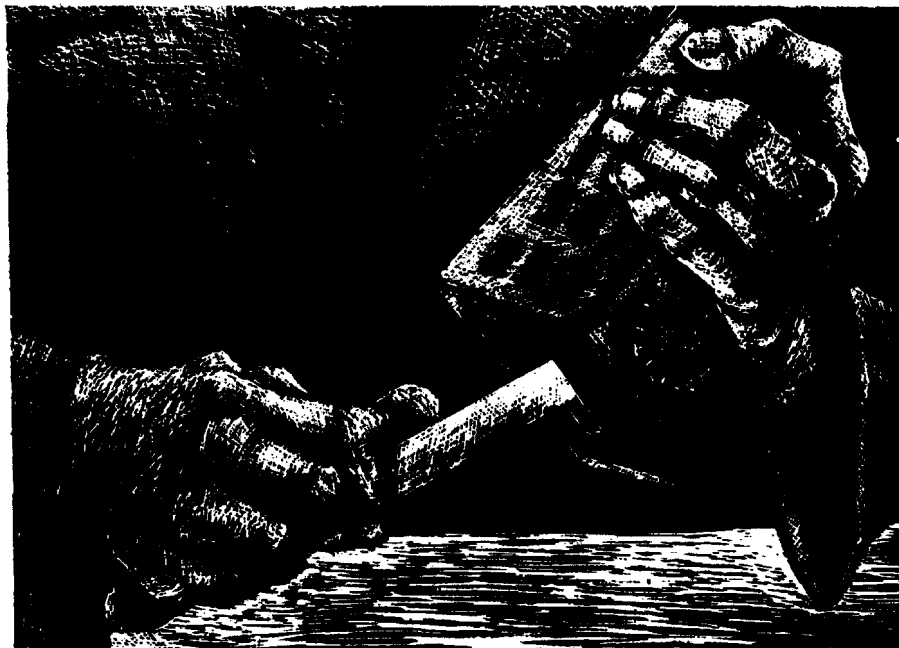
Aware of this history, many philanthropic-liberal reformers and socialist and other radical workers and activists argued in 1965 that the new Medicare and, particularly, Medicaid programs offered a unique opportunity to eliminate two-track medicine. Therefore public hospitals should be permitted to dwindle away or to shrink into emergency trauma centers of some sort. When the day came that Medicaid covered everyone who needed it (by 1975 according to a provision of the original 1965 law repealed in 1972) everyone would have access to the "mainstream" of private hospitals. Public hospitals would no longer be needed.

As we know, this never happened. Medicaid has never covered the entire population, nor is it likely to. Its funding has been slashed and further cuts are slated. Many physicians will not serve Medicaid patients. Many hospitals claim they cannot afford to because reimbursement is "inadequate."

Instead of eliminating the "second track," Medicaid is fully part of it, and perhaps even helping to direct it downhill. Service cutbacks in public facilities and even closures are justified by suggesting that Medicaid allows patients to go elsewhere. The program's reimbursement method cripples the public hospitals until they compare so poorly with private institutions that whatever political base they had is weakened and the local government has an added excuse to close them.

This frontal assault on the health care of millions confronts advocates of an equitable and comprehensive national health plan with a cruel dilemma. On the one hand, supporting the current public provider system seems to entrench two-track medical care. On the other, pressing for extension of market payment programs such as Medicaid and Medicare pumps money into an inequitable system that will not deliver what it is paid for.

With the clarity of 2/20 hindsight gained through observation attempts to rally public support, form successful coalitions, and achieve at least limited expansion of health care accessibility, I believe that advocates of equitably distributed medical services who acquiesced, actively or passively, to the denigration of the public hospital committed a political error. Until we have a national health plan that provides for universal eligibility and de facto universal access to comprehensive medical care services, the idea that the private system will offer the same care for destitute and low income working



Kate Pfordresher

persons that it provides for other patients is a sad delusion.

Middle income persons hard pressed to maintain their own status in a contracting economy historically have favored reducing tax-supported outlays for a medical care system exclusively serving the most powerless members of society. This has certainly been the pattern in periods of Hooverism, Nixonism, and Reaganism.

In more liberal eras, much of the *relatively* more generous funding has been siphoned off in the reimbursement game-playing of the private medical system that is known formally as "optimizing the bottom line." The resulting improvements in services are real, but not at all commensurate with the higher costs.

Therefore religious, liberal, or radical coalitions fighting for *more* equal services for low income people (full equality must await a universal program) have only one effective interim strategy: directing their *primary* energies toward improving the public system while at the same time attempting to hold the line against attacks on Medicaid. Besides offering greater promise of improving health services for low income persons in the short term, this strategy would be most effective in mobilizing popular support for a truly equitable national health plan in the long term.

Had this approach been followed in the past 15 years, we might at least now have a national network of local public hospitals supported by Federal and state funds. Part of the Medicaid and Medicare budget would be flowing directly into this network as institutional grants instead of pouring exclusively into mostly private fee-for-service channels.

As a stay against the wave of cutbacks and a beachhead for future advance, it is more important than ever that our public hospitals not only be maintained but improved and enlarged.

For these reasons private management contracting by public hospitals is a regressive expedient that should be used only as a temporary stopgap measure when the hospital is pushed to the wall. The vital expansion and improvement of *public* system administration must be directed by managers and health workers devoted to *public* service. That is, to the concept that good care, improved access, and *true* cost containment—not manipulating cost reports to pass expenses on to a different level of government—are the criteria of excellence. Their professional training must generally be provided in an educational milieu that shares these goals

and teaches how to evaluate progress in achieving them. The fountainhead of their motivation must be the same we expect of firefighters, teachers, police officers, and forest rangers—not that of business promoters.

At a time when such dedicated and competent public servants are more crucial than ever, finding them is increasingly difficult. As public services are transferred to private, profit-oriented institutions, demand for skills inevitably shifts in the same direction—down toward the bottom line. Hundreds of educational institutions are training administrators for private business; only a relatively few offer rigorous training for future public administrators, especially in the health field. Many public hospitals are forced to rely on managers imbued with a narrow private business outlook that often includes a mythology of evils of public service. In fact, their training commonly entails memorizing the anti-public service rhetoric as a catechism. A public hospital compelled to seek their skills is not likely, in the long run, to find its public goals well served.

Perhaps the most ominous aspect of this threat to the survival of public hospitals is the explosive growth of for-profit hospital chains.²² Many of the firms most aggressive in the post-1975 rush to make acquisitions also have contract management departments. These have won the lion's share of the public hospital management contracts.

The specter of a hospital industry consisting largely of huge private conglomerates that also manage public institutions is not a pleasant one to contemplate. A public hospital under contract for an extended period could become so dependent that it would be easy prey for acquisition if the management firm determined this would be profitable. Something like this has already occurred in at least one case in California, where the Eureka (Humboldt County) public hospital is now leased by the company which originally contracted to manage it; this might well be a transition stage to outright private ownership.

Management firms also operate subsidiaries that provide hospital services such as laundry, laboratory and private physician groups to staff emergency rooms or clinics. A manager brought in under contract could, and in some cases has, routed hospital "business" to these wholly-owned subsidiaries. Abuses which may arise out of this conflict of interest can of course be minimized by close monitoring under appro-

appropriate purchasing procedures of the local government, but then this is likely to arouse cries of "bureaucratic red tape."

Over the long term, the growing concentration of ownership in the hospital industry could wrest principal control of hospital policy from the public. Decisions to improve or maintain public facilities might be pre-empted by a few giant conglomerates that manage them as well as own most of the private institutions.

In summary, over the long run private management is not likely to provide first class public service. We found that under restricted conditions contract firms did aid public hospitals in California, but at best this was, with one exception, limited relief provided in the initial years. History and the current political scene as well as the structure of American health care financing provide strong arguments for vigorously supporting publicly owned hospitals managed by trained administrators dedicated to the public interest.

Readers interested in a more detailed report of the research discussed in this article should write to: California Policy Seminar, Institute of Governmental Studies, University of California, Berkeley, 109 Moses Hall, Berkeley, CA 94720.

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Parasites on the Poor

"If you find a disease, develop a drug or vaccine" is often the response of modern medicine. Or, if the disease is transmitted by insects, "develop a pesticide."

These methods can be successful—witness the eradication of smallpox—but sometimes eliminating a basic factor like poverty will solve the problem and prove more beneficial to its victims as well.

Chagas disease may infect more than 10 percent of the population of Brazil and Argentina. It is caused by a protozoan closely related to the one which causes African sleeping sickness and is transmitted by blood-

sucking bugs. The parasites invade tissues of the victim, who may show no symptoms for years after an initial bout of fever. Then the effects are all too visible—severe damage to the heart, the large bowel, the autonomic nerves. Sometimes the person dies because the heart just can't pump enough blood, particularly after unaccustomed exercise.

According to an article in the October 29 English magazine *New Scientist*, from the time Carlos Chagas first described the disease in 1909 poverty has been identified as its close companion. The poor of the sparsely-vegetated, dry Chaco region live in mud brick huts next to a goat corral—an ideal habitat for one insect carrier.

Under the impetus of a private landowner, reports the *New Scientist*, one part of the Argen-

tine Chaco is now systematically cultivated, allowing the trees and grasses which once covered much of the area to return. The trees provide lumber for sale and modest homes, the cattle provide meat, removing the need for the goats. Since the land can support a higher population density, people can live closer together, sharing safe water and a school.

There is still no known cure for Chagas disease, but in this one area its devastation is declining. The proof is in that. With a fraction of what the Argentine and Brazilian governments are spending annually on arms, millions of their citizens could live happier, more productive lives, free of an "incurable" disease.

—Arthur Levin

(Arthur Levin is a member of the Health/PAC Editorial Board.)



STRESS TEST FAILURES

by Arthur A. Levin

Exercise has become a national obsession in the past decade. A great part of the movement may be spurred by a desire to remain youthful. Many are jogging and touching their toes because they have become convinced that it benefits their heart and lungs. Some may want a longer life, others better quality life when they've got it. And how much of this affair with exercising one's heart is related to affairs of the heart is an interesting question which bears (or bares) study.

We do know that the national interest in fitness and freedom from cardiovascular death and disability has combined with miracles of modern technology to produce the exercise stress test. And in the true American tradition, an industry has grown up around stress testing, and exercise programs for persons with cardiovascular disease.

If you are over 35 years of age and contemplating leaving your sedentary, sugarcoated, overweight, smoke-filled life and entering the promised land of the marathoner's gauntness, rac-

Arthur A. Levin is a member of the Health/PAC Editorial Board and Director of the Center for Medical Consumers and Health Care Information, publisher of HEALTH FACTS.

Body English

quetballer's scars, and swimmer's ear infections, chances are you will be told that you should first have a stress test. In fact, most health clubs and cardiovascular fitness programs will not let you begin without one. Even if you are under 35 years of age, but guilty of a particularly slovenly and slothful recent past, health professionals will most likely encourage you to hook up the wires and get on the treadmill to demonstrate your cardiovascular proclivities.

In fact, if spending money needlessly makes you anxious, if taking a test that is highly inaccurate gets you nervous, and if being put at risk of being told you need coronary angiography (cardiac catheterization) leaves you scared, the stress of stress testing may not be worth it.

A stress test is a graded, cardiogram (ECG) monitored exercise test, in which the subject is placed on an exercise treadmill or bicycle and made to "work" his/her cardiovascular system. "Graded" refers to the gradual increase in the intensity of the exercise load through increasing both speed and incline if a treadmill is used, or the resistance and pedalling speed when a bicycle is used. "Monitored" means the subject's heart activity is constantly observed on the ECG recorder, and an oscilloscope is usually used for continuous monitoring before, during, and after the test. All facilities monitor blood pressure and some oxygen uptake (lung capacity). Test results are considered "positive" if the subject develops any ECG abnormalities. The graded test is designed to duplicate the effects of strenuous aerobic exercise (running, bik-

ing, etc.), which "stresses" the heart, and to reveal any asymptomatic, underlying disease which would make such rigorous activity unwise.

How well it does this is open to question. A 1979 study published in the August 2, 1979, *New England Journal of Medicine* looked at the results obtained in a trial involving over 2000 symptomatic men and women. The subjects all had symptomatic angina pectoris (chest pains), had completed cardiac catheterization and took a stress test within one month of

A more recent study found that significant ST depression was not necessarily associated with poor prognosis.

the angiography. After examining what they called the "classic response to ischemia" on the exercise test—ST segment depression—the researchers concluded that for most of the patients the information obtained from the stress test added little additional that was helpful in predicting coronary artery disease (CAD). They also found that for the patients in whom the prevalence of CAD is high (men with definite symptomatic angina) a negative exercise test was poorly correlated with the absence of disease (false negatives). Although a negative test result was usually accurate in patients with a low prevalence of CAD (women who had "non-ischemic" pain, i.e. not typical of definite angina symptoms), positive test results correlated poorly with presence of CAD (false positives).

A more recent study reported in the same journal in the November 5, 1981, issue found that significant ST depression found on exercise (stress) tests was not necessarily associated with a poor prognosis. The researchers pointed out that it was common practice to refer patients who had positive ST depression readings for cardiac catheterization and possible bypass surgery. They concluded that the evidence they had obtained raised serious questions about this clinical practice policy.

The June 16, 1978, *Medical Letter* noted that as a result of stress testing, "healthy people may be led to think they have serious coronary disease, or asymptomatic people with serious coronary artery disease may feel free to pursue vigorous exercise programs." The authors went on to point out that false positive test results can not only lead down the path to coronary angiography and bypass surgery, they can cause damaging psychological effects and unnecessarily restrict physical exercise.

The normal adult with no symptoms should probably heed trite advice . . .

Another study looked at whether physicians who were athletes practiced what they preached. That is, did they really believe that stress testing was necessary for asymptomatic people prior to starting an exercise program. An attitude survey was sent to 115 primary care physicians who had run in the 1978 Boston Marathon. 69 doctors responded to the questionnaire and only 15-20 percent of this sample indicated that they believed that stress tests prior to

exercise programs were advisable. Reporting on their data in the October 4, 1978, *New England Journal of Medicine*, the physician surveyers concluded that "In our opinion cost containment in medical practice would be better served if the physician applied the same good judgement about his patient's need for pre-exercise examinations as he does in his own life and reserved more costly technological evaluations for those relatively few instances where more extensive investigation is indicated clinically."

Not only does stress testing produce a high percentage of false positives and false negatives, it is very expensive. In the New York City area the cost averages around \$200; some evaluations can run as high as \$500. Enterprising investors have set up a number of proprietary centers that do stress testing and also run "supervised" cardiac exercise programs. Several regularly run full page ads in newspapers such as the *New York Times* and the *Wall Street Journal*.

Much of their marketing appears to be aimed at executives and corporations that employ large numbers of managers. The pitch implies that companies can maximize executive productivity by offering "perks" such as an exercise program, which has the added benefit of lessening the incidence of disability from CAD.

What is the risk of death or disability due to vigorous exercise and is that risk lower in a population that has been "screened" by stress testing? Unfortunately we have been unable to find a study that compared two such groups. There have been numerous reports in the press (and some in the medical literature) of arrhythmias, heart attacks, and sudden

death during or immediately after vigorous exercise such as running. A report in the October 17, 1980, *Journal of the American Medical Association* followed 2,935 adults (mean age, 37) who visited an exercise facility in Dallas. All had been screened with a maximum exercise ECG, another at rest, and a brief cardiovascular exam. The authors concluded that their data suggested a small, although not negligible, risk of cardiovascular events for those adults who participate in strenuous physical exercise. There was some suggestion from this and previous studies that the risk would be increased by factors such as the presence of coronary disease, regularity of exercise, smoking, and competition.

Only 15-20 percent of doctors indicated belief in stress tests.

In the absence of sufficient scientific evidence to suggest otherwise, it appears that the exercise stress test is of limited value in screening healthy, asymptomatic adults for disease. Therefore its prescription as a necessary and prudent prerequisite for adults beginning exercise programs is questionable. Those people who are overweight, smoke, or have any symptoms of disease might reduce their small risk of cardiovascular incidents as a result of exercise by taking a stress test. However, the high number of false positives and negatives makes even this limited recommendation tenuous. The normal asymptomatic adult should probably heed what is seemingly trite advice: start exercising slowly and do not push too hard at the beginning. In other words, test yourself.

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16. See Shonick and Roemer, Note 8 above, Chap. III.
17. For further detail, see Shonick and Roemer, Note 8 above.
18. In San Jose, the contract was for consulting rather than "managing" and the management company withdrew after only 10 months of the 2 year contract had expired. The San Jose experience is, therefore, not a test of management contract expertise that is comparable with the other cases we studied. Nevertheless, the difficulties experienced by the company that prevented it from obtaining a full management contract, and that forced it to withdraw early, are symptomatic of the special difficulties of management contract operation in large urban centers. These difficulties are centered in the social, political and economic factors present in central city life, as sketched in the text.
19. Despite the fact that the latter hospital is run by a religious organization, it is formally listed in American Hospital Association compendia as a voluntary non-profit and not under religious sponsorship classification.
20. For fuller description of methods by which local governments divest themselves of control over their public hospital see: Shonick, William and Walter Price, cited in note 6 above, pp. 236-239.
21. There can be confusion about the meaning of this term. For example, the Report of the Commission on Public-General Hospitals (see note 7 above) lists 1,905 public hospitals out of 5,679 "community" hospitals in the United States as of 1976. These include all hospitals owned by some public authority. Most of them are the only hospital in a county or other local area, and are used by all persons living there. Others are the 45 teaching hospitals attached to State owned medical schools. In this article, I use the term "public hospital" to mean only those publicly owned hospitals that are generally situated in areas that also have other hospitals and that are supported primarily to ensure access for all persons who may not be able to go to other hospitals, primarily poor persons. I refer, in other words, to that public hospital about whose "plight" so much has been written in the last twenty years or so.
22. See notes 14 and 15 above.
23. See note 8 above.

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