Your Health Care in Crisis:
A HEATH/PAC Special Report

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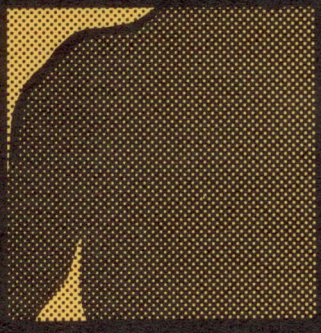

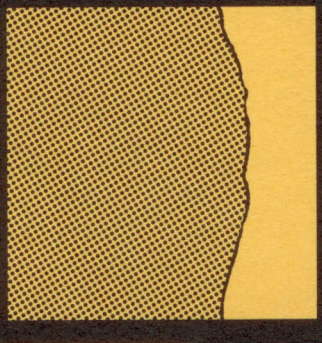

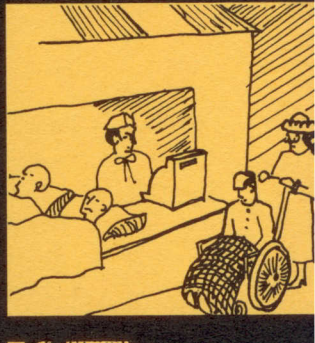

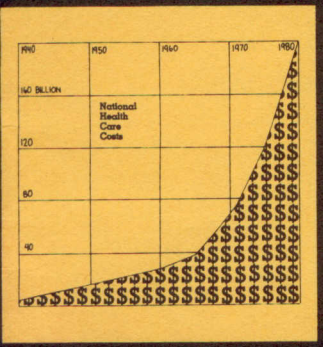

Your Health Care In Crisis

A HEALTH/PAC Special Report

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This is the first in a series of pamphlets published by the Health Policy Advisory Center (Health-PAC). It analyzes the forces in the health system that prevent most Americans from getting good health care.

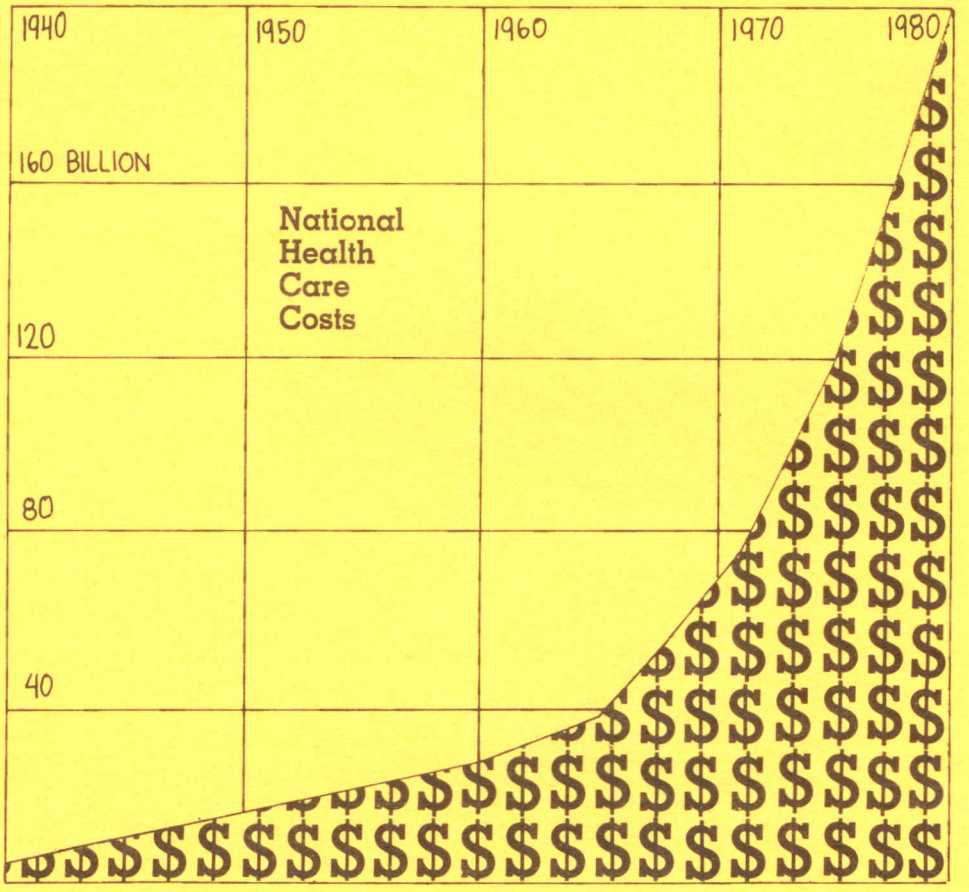
How can that system be changed so that good health care is a right for all? Around the country emerging community and worker groups are working to transform the present health system into one that will provide high quality, low-cost, accessible health care for all. Health-PAC, an independent, non-profit research and education organization, works with and services these groups. Health-PAC has information available on patient's rights; health worker issues; community and worker struggles to change health institutions; the organization and financing of health care; Blue Cross; national health insurance proposals; and many other health care topics.

Health-PAC also conducts workshops and supplies technical assistance and speakers for community, worker and student groups. Health-PAC publishes a monthly Bulletin focusing on news and analysis of health issues. Subscriptions to the Health-PAC Bulletin are $7 a year and $5 for students.

In addition, Health-PAC publishes occasional papers on various topics. Health-PAC's first book, *The American Health Empire*, can be obtained at local book stores in paperback (Vintage, 1970) or directly from Random House Publishers.

For more information, contact Health-PAC, 17 Murray Street, New York, New York 10007, (212) 267-8890.

Illustrations: Bob Rosenthal, David Bragin

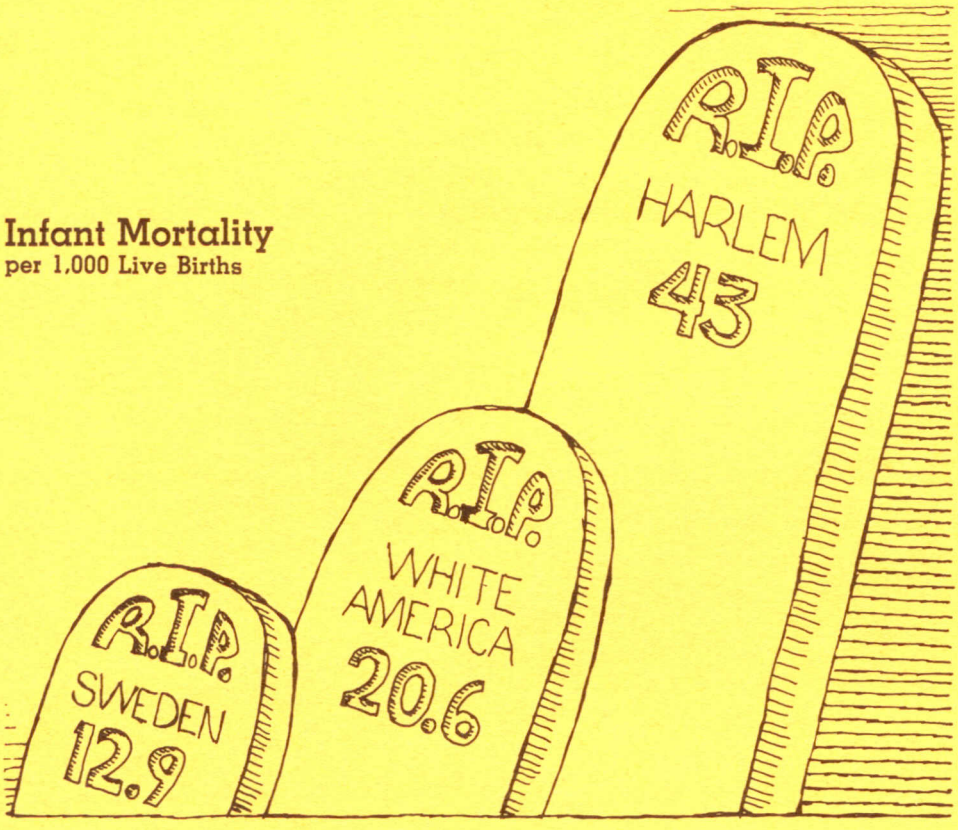


The Health Care Crisis

Everyone who watches television, reads a newspaper, or needs a doctor knows by now that there is a "health crisis." The surest sign is that the cost of medical care has soared out of sight. Doctors' bills have risen 130% in the last ten years and hospital costs have shot even higher—217% in the same period. In most cities the average hospital patient can now expect to pay at least $100 a day, and charges as high as $175 a day are not uncommon. Since, of course, no one except the very rich can afford these prices, people must buy health insurance policies from Blue Cross or commercial companies such as Metropolitan and Aetna. But the cost of health insurance is skyrocketing, too. New York City's Blue Cross plan has raised its rates 71% in the last two years, and the story is the same across the country.

Health care is certainly expensive. But if we were getting really good care for all that money, we probably wouldn't complain. The trouble is, American health care isn't all that good.

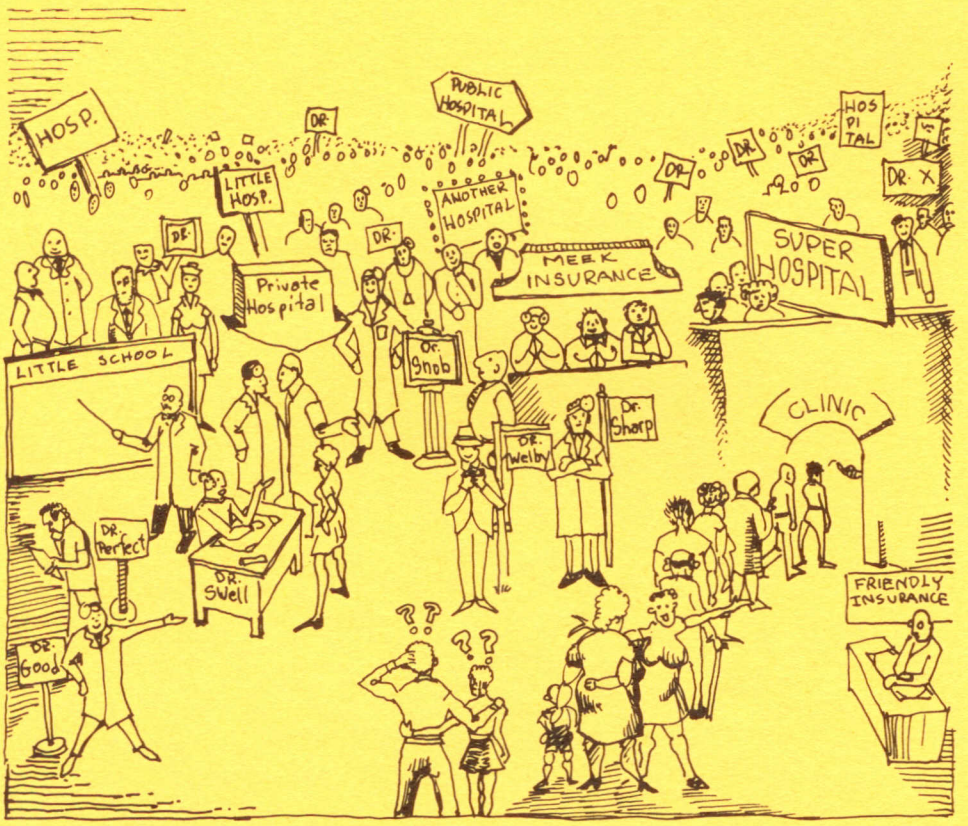
The statistics tell the story: In the United States, 22.1 out of every thousand babies born alive will die before they are one year old. By contrast, in Sweden (which has the best record of medical care in the world) only 12.9 babies per thousand die. That means that some 35,000 American babies die needlessly each year. In at least 12 other nations, a newborn baby has a



better chance of living than it does in the United States. And, of course, Blacks, Puerto Ricans, and other poor people fare much worse than middle-class whites. In white America, 20.6 babies per thousand die; in Harlem more than 43 babies per thousand die. Many blacks think that a medical system which permits so many more of their children to die can only be called "genocidal."

Adults come in for a bad time in the medical statistics too. The average American man can expect to live five years less than his Swedish counterpart and 1.5 years less than an East German. He is twice as likely to die between the ages of 40 and 50 as a Swede. Not too good for a country that spent $75 billion on health care in 1971—more money per person than any other country in the history of the world! Something is very wrong.

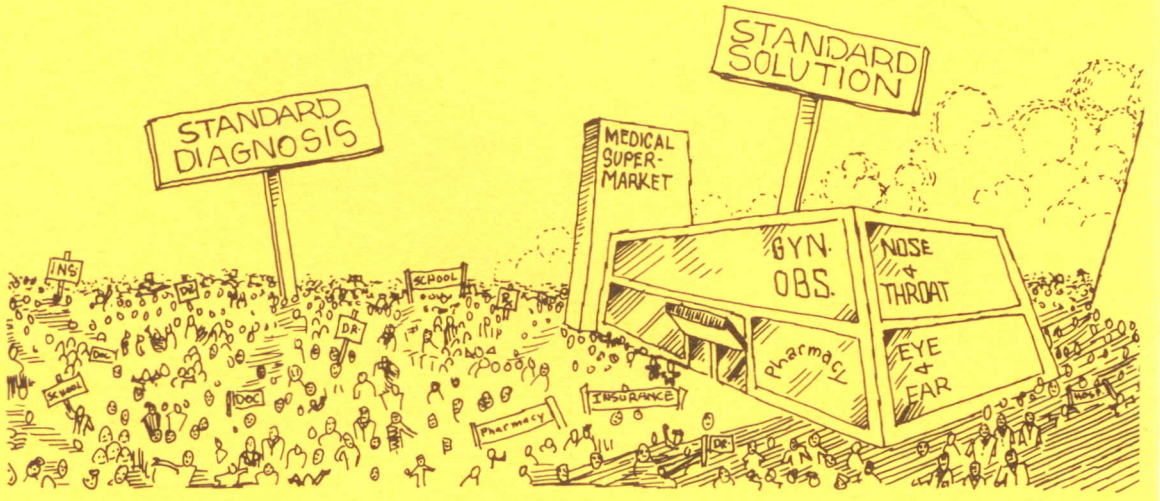
American health care is expensive and mediocre; it is also a humiliating hassle to get it. People who use clinics complain of waiting there three, four, and five hours to see a doctor who is rude and can only spare them five minutes. Those who can afford a private doctor often fare no better. Often just finding a doctor, especially at night or on weekends, is all but impossible; and the pediatrician who makes house calls is remembered only in legend. Even when you get to the doctor, he's likely to examine you briefly, then send you off to see a long string of specialists, each at high fees, or to order a long series of lab tests, each of which adds to your bill.



The Standard Diagnosis

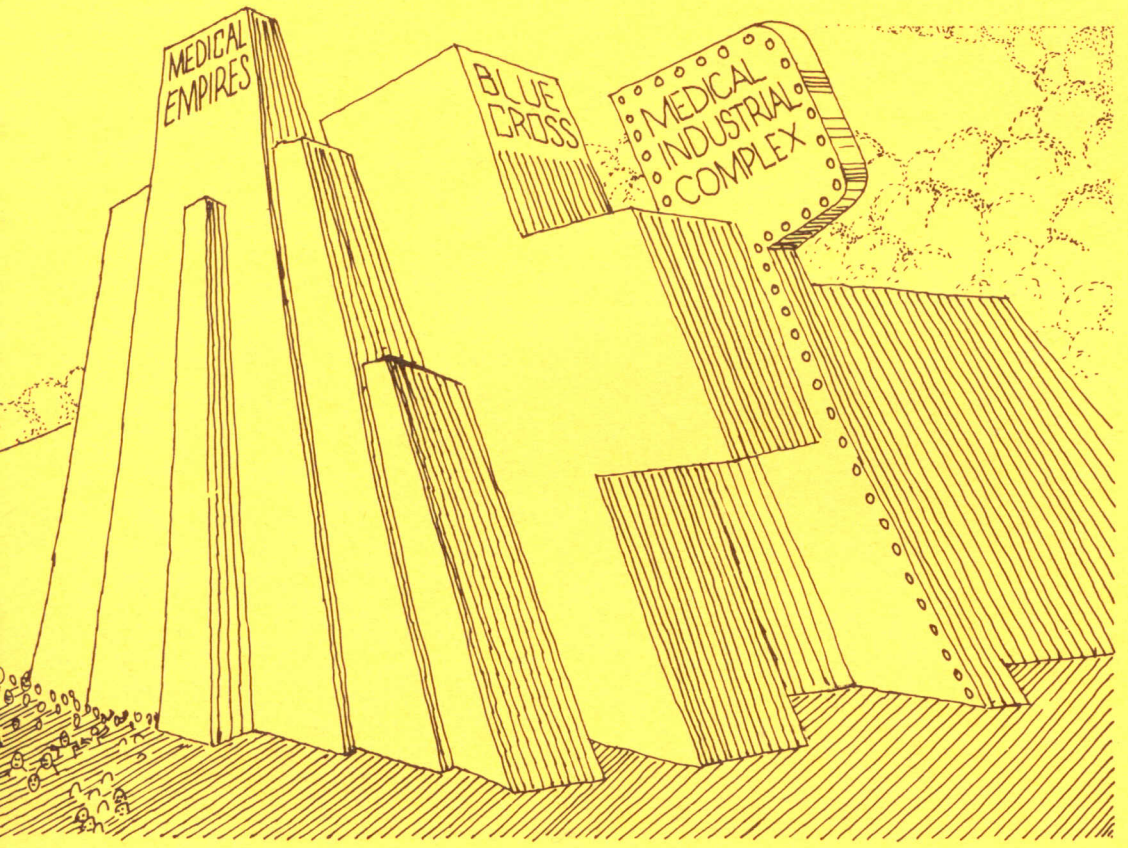
Everybody, from the man on the street to the President of the United States, knows that the health system is sick. And a lot of experts claim they know why. Health care, they say, is the only major American industry which is still run by a lot of small businessmen (the doctors). Most people no longer buy food from a corner grocery, the experts point out. They buy it at a giant supermarket, which is much more efficient and can offer a wider selection at lower prices. But health care, with its tens of thousands of private doctors, is still in the corner grocery store era. Not only does this make the health care system inefficient and expensive, but it leaves it uncoordinated and chaotic as well. For instance, some areas have too many hospitals and doctors, while others have too few. In the suburbs where there is one doctor for every 500 people, surgeons complain they can't find enough patients to keep them busy. Meanwhile, in the inner cities and in many rural areas there is only one doctor for every 2000 people; and many small towns have no doctor at all.

The health care system seems so chaotic, so unplanned, so uncoordinated, that many people call it a "non-system." To cure the health care crisis, they conclude, we must turn it into a system. Specifically, they argue, some form of national health insurance would provide financially-shaky hospitals with a stable income. Doctors should be encouraged to form group prac-



tices to increase efficiency (the equivalent of corner grocers banding together to open a supermarket). And hospitals and medical schools should be linked together into regional networks which would be able to efficiently and rationally plan to provide for the medical needs of an entire region. More money, more planning, more coordination—that is the standard prescription for the ailing American health system.

But careful examination of the health care system indicates that, in fact, there *is* a health care system; it is not totally chaotic and unplanned. It seems chaotic only if it is described in terms of private doctors. Years ago, the doctors did dominate and control health care; but now health care is dominated by institutions—hospitals, medical schools, research laboratories, drug companies, health insurance companies, health planning agencies, and many others. Many people don't even have a private doctor any more; the hospital clinic and emergency room have become their doctor. Less than 20 percent of the nation's health expenditures now go for private doctors; most of the rest goes to institutions. And nine out of ten health workers these days are not doctors at all, but workers employed by health care institutions —nurses, dieticians, X-ray technicians, orderlies, laboratory technicians, etc. The health institutions are big and rapidly growing; and as they grow, they are becoming more and more interconnected to form a system.



Medical Empires

There are three major parts to the system. First, there are "medical empires"—medical schools, medical centers and large hospitals which control the medical resources of a wide geographical area through vast networks of affiliations. For example, through affiliations (contracts to provide professional personnel) Einstein Medical College and its close ally, Montifiore Hospital, have come to control the majority of medical resources in the Bronx—city hospitals, private hospitals, state mental hospitals, neighborhood comprehensive care clinics, and experimental projects to provide health care in ghetto areas. 2000 of the 2400 hospital beds in the Bronx are controlled by Einstein; 2000 of the 2700 doctors practicing in the Bronx are affiliated to Einstein.

What has this network meant for health care in the Bronx? Einstein, with its priorities on teaching and research, has actually acted to strengthen the dual system of healh care that provides fairly good care for wealthy patients and mediocre to poor care for everyone else. For example, if you are a poor person living in the Bronx and you get sick, you will go to the City-owned, rundown Lincoln Hospital. If, on the other hand, you are wealthy and have a private doctor on the Montifiore or Einstein staff, you will be admitted to the advanced, luxurious Einstein College or Montefiore Hospital.

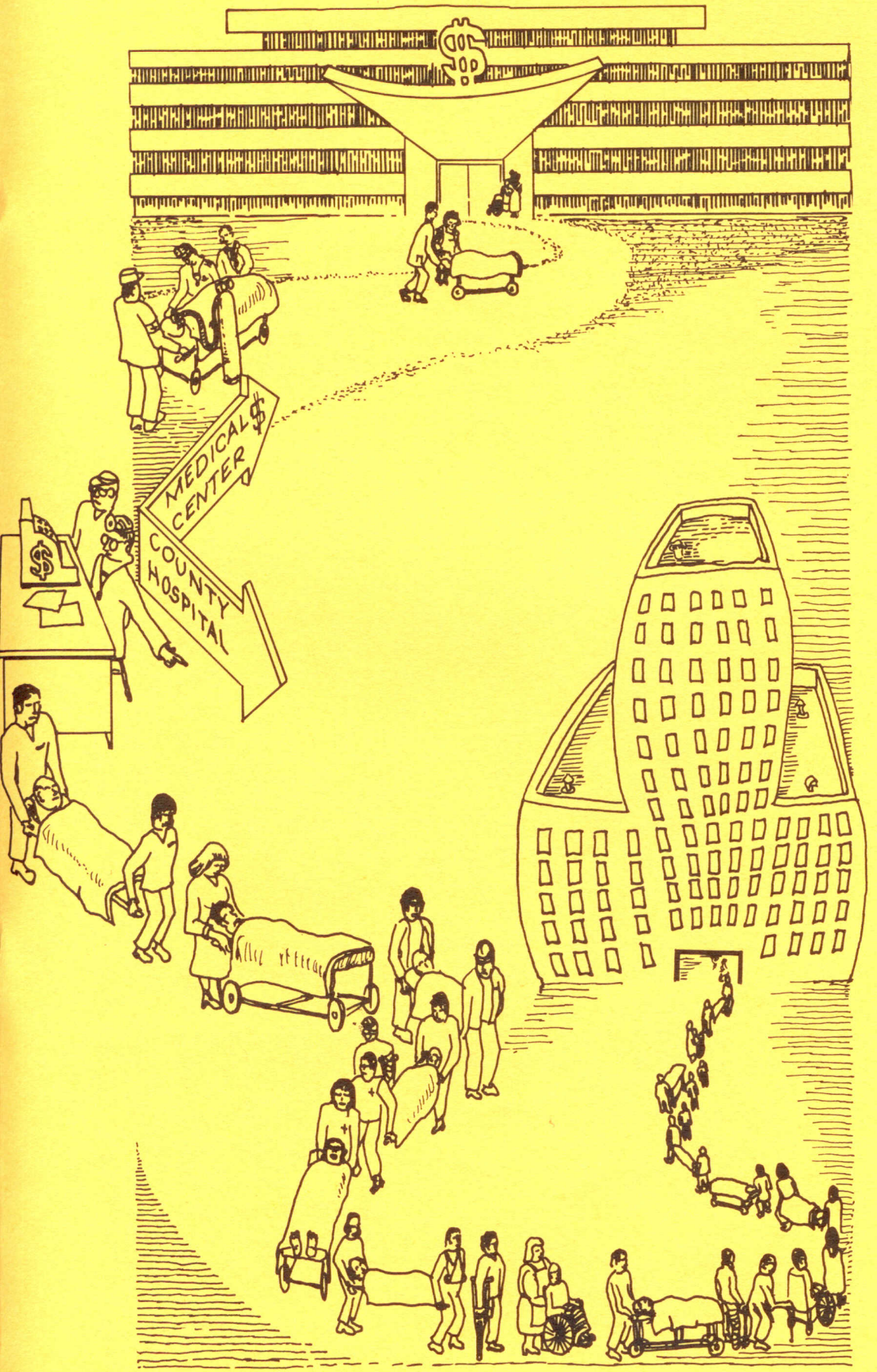
There is one way the poor patient can make it to Einstein,

and that's by having a rare or interesting disease. If he can be used for teaching or research, a poor patient may be transferred to Montifiore, and may in fact, get excellent care. Conversely, Einstein uses its poorer affiliates as "dumping grounds" to which it transfers the "uninteresting" cases which turn up in its own emergency rooms.

Patients who are used for teaching and research frequently find themselves subjected to unnecessary and occasionally painful tests and medications. They are sometimes "practiced" on. For instance, dental students report not using novacaine on clinic patients because the patient's pain is an excellent guide for the inexperienced student. And, of course, the patient's dignity is at the mercy of peering and probing medical students, professors and classes.

The teaching and research priorities of the empires affect the community as a whole as well as the individual patient. Outpatient departments, upon which increasing numbers of poorer patients depend, are fragmented into hundreds of sub-specialty clinics. If you have infectious hepititis, you must come one day at one time; if you have serum hepititis, you must appear another day at another time. This provides the doctor with a convenient source of similar cases; but the patient finds himself trudging from clinic to clinic with no one looking after or caring about his needs as a whole person. Many poor communities feel they are dying from "mundane" medical problems—drug addiction, alcoholism, lead poisoning, TB, trauma, and lack of "mundane" health care, while the medical schools are generally interested in pursuing esoteric medical problems which will "advance the frontiers of science" and, not incidentally, their own reputations.

Medical "empires" have sprung up in many places across the country. In Boston, Harvard Medical School controls many of the medical resources; in Baltimore it's Johns Hopkins; in Cleveland it's Western Reserve; and in Seattle the University of Washington Medical School rules the turf. And everywhere the results are the same: the system works to provide reasonably good, often luxurious care for the wealthy; mediocre or bad, and always uncomfortable care for poor and working people.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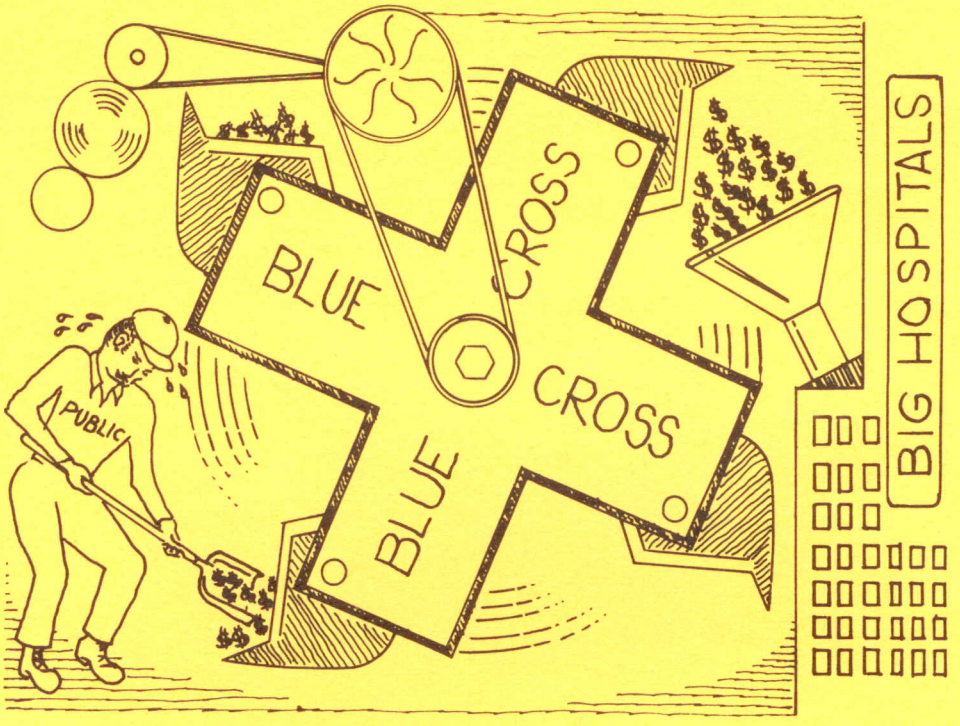
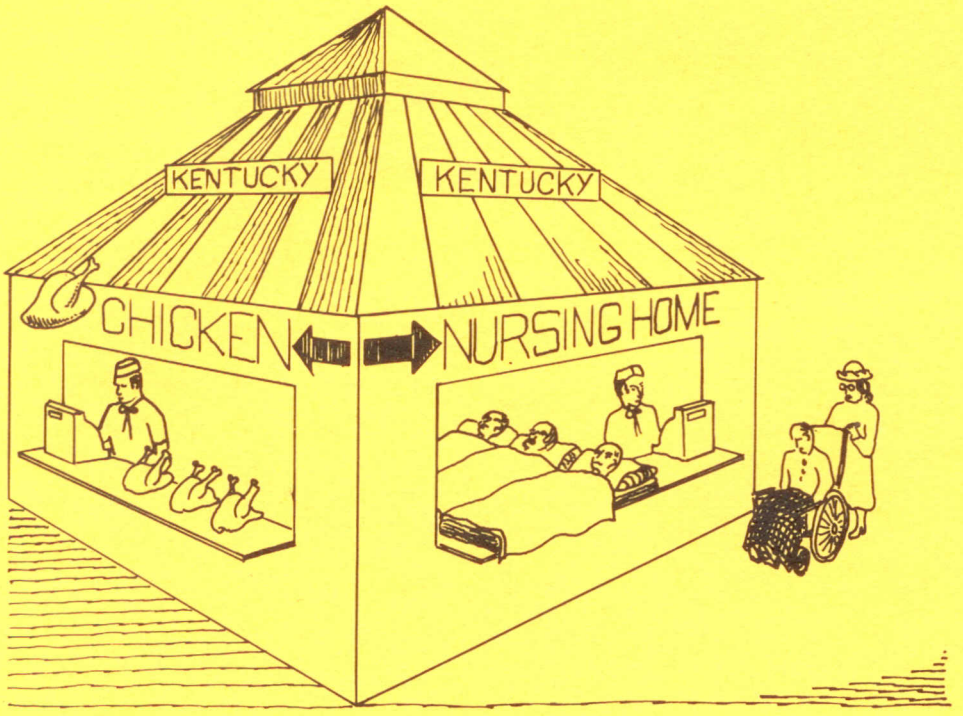


The Financing-Planning Complex

The second main part of the health care system is the financing-planning complex. The most important part of this is the multi-billion dollar Blue Cross operation through which 45 percent of all Americans receive hospital benefits. Blue Cross pays half of all hospital income in the U.S. and in New York City it pays 75 percent of all hospital bills.

Because it holds a near monopoly on health insurance, Blue Cross plays a very important role in setting health policy; its board of directors and top officers sit on governmental advisory committees, advise Congressional committees, and, together with representatives of the big private hospitals, set up and run area-wide comprehensive health planning agencies.

Blue Cross is closely allied with the big hospitals. It was set up during the Depression by financially-starved hospitals to provide them a guaranteed income, and it continues to be dominated by the major hospitals. Half of all regional directors of Blue Cross (Blue Cross operates in 71 nearly-autonomous regions) are hospital administrators. Needless to say, hospitals and health consumers often have very different interests. Consumers want high-quality, low-cost, relavant health care; hospitals, on the other hand, are often more interested in institutional expansion and the prestige gained through the acquisition of well-known researchers, fancy medical equipment and new and larger buildings. This is why the hospital-dominated Blue Cross has consistently failed to support consumer concerns such as cost and quality control.

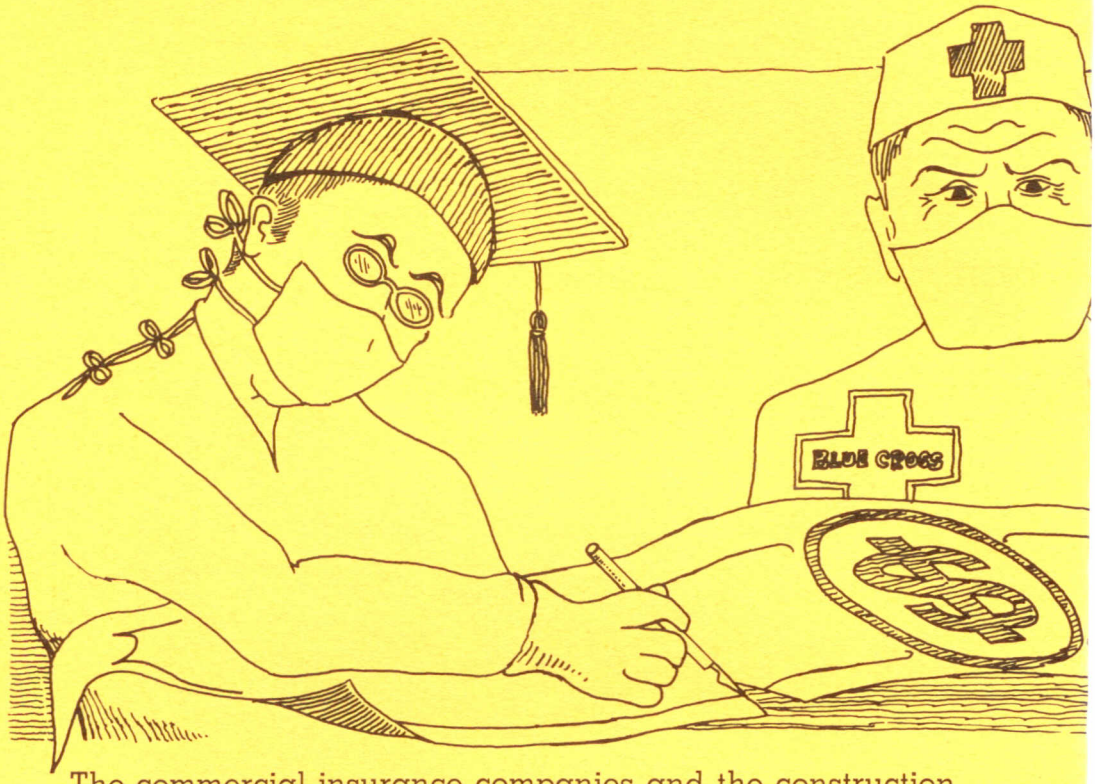


The Insurance Companies

The third part of the health system is the "medical-industrial complex." An alliance exists between the providers of health care (doctors, hospitals, medical schools and the like) and the companies that make money from people's sickness (drug companies, hospital supply companies, hospital construction companies, commercial insurance companies, and even companies that provide medical services for profit—profit-making "proprietary" hospitals, chains of nursing homes for old people, laboratories, etc.). Health care is one of the biggest businesses around, and one of the fastest-growing. Check any stockbroker—he'll tell you that health stocks are the hottest things on Wall Street.

The magnitude of the medical-industrial complex is hard to believe. For example, in 1969 drug companies (Abbott, Upjohn, Merck, etc.) had after-tax profits of about $600 million. The drug industry has rated first, second, or third in profitability among all U.S. industries during the last ten years, causing *Forbes Magazine*, a financial journal, to call it "one of the biggest crap games in U.S. industry."

Hospital supply companies (Becton-Dickinson, American Hospital Supply, etc.), which sell hospitals and doctors everything from sheets and towels and bedpans to surgical instruments, X-ray machines and heart-lung machines, had after-tax profits of $400 million. Proprietary (profit-making) hospitals and nursing homes earned nearly $200 million. (There are now even nationwide chains of hospitals and nursing homes run by such businesses as Holiday Inns and Minnie Pearl Fried Chicken.)

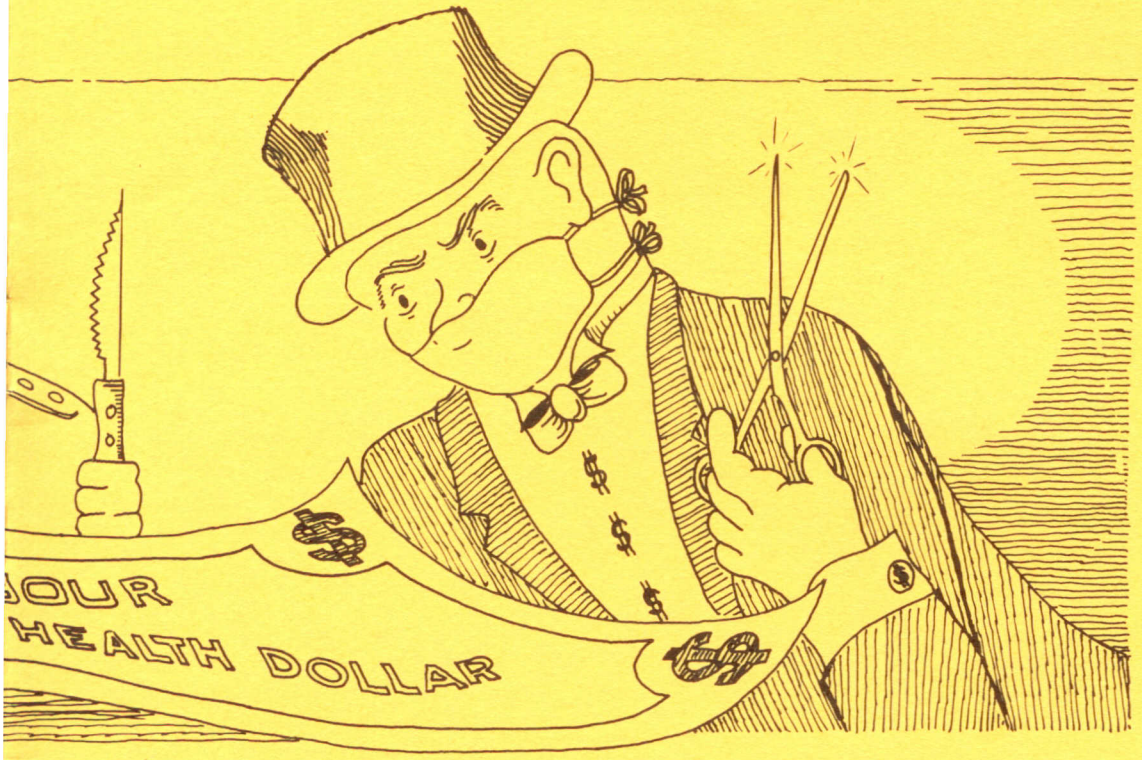


The commercial insurance companies and the construction firms which build hospitals make additional millions, and, of course, the doctors themselves are still the highest paid people around. Even the banks are getting in on the act, with loans to hospitals both for building and for operating expenses. The patient at one of New York's prestigious hospitals, for example, finds that $3 a day of his hospital bill doesn't go for services at all; it goes to the banks for interest payments.

The "System" in Health

And not only do all of these empires, insurancemen, financiers, businessmen and doctors make a lot of money from people's bad health, they do it with togetherness. Their mutual needs coincide so that prestigious medical empires require the manufacture of expensive equipment and the presence of large construction companies; and, of course, *only* large institutions can afford the expensive products of the medical equipment and drug manufacturers. And all of these groups require the stable, lenient financing of Blue Cross and other medical insurers. Their growing interdependence is evident in the fact that drug company executives sit on hospital boards of trustees. Increasingly drug and medical equipment executives are joining the boards of large medical schools and centers. Doctors own shares in profit-making hospitals and hospital supply companies. Hospital and medical school professionals "moonlight" as consultants to hospital supply companies and even sit on their boards of trustees.

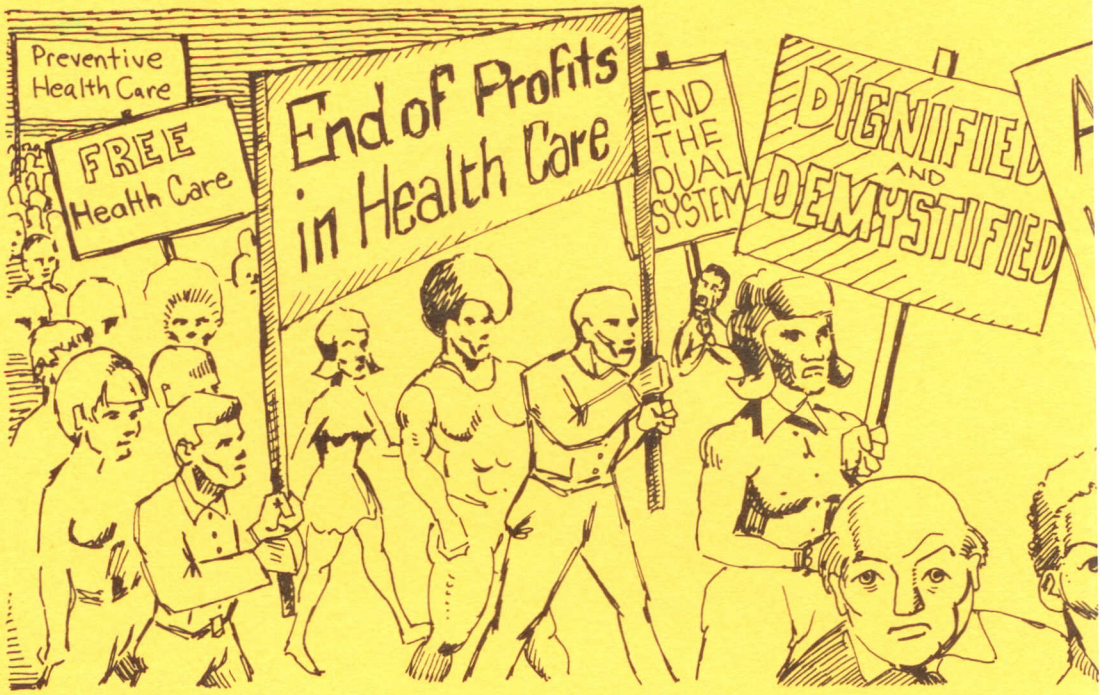
The best thing about the health business is that the profits are sure (as long as you're not a patient or taxpayer, that is). Blue Cross and the government's Medicare and Medicaid pro-



grams hand the doctors and hospitals a virtual blank check. The hospital, in effect, simply tells Blue Cross how much its expenses are, and Blue Cross pays the bill. There are not cost controls. The hospital's costs may, of course, be necessary for the patient's welfare. But they also may be "necessary" for the purchase of seldom-used and expensive equipment that was available in another hospital across the street; for plush offices and high salaries for doctors and hospital administrators; for expenses incurred in fighting off attempts by unions to organize hospital workers; or for hiring public relations firms to clean up the hospital's poor image in the community. The health companies and doctors get rich; the consumer and the taxpayer pay the bill.

Even the so-called "non-profit" hospitals get in on the fun. All that "non-profit" means is that they don't have to pay out their excess income to stockholders. They also don't have to pay it back to their patients in the form of cheaper rates. Instead, they use it to grow; to buy more fancy (even if unnecessary) equipment, more plush offices, more public relations; to pay staff doctors ever higher salaries; to buy up real estate, tear down poor people's housing, and build new pavilions for private patients.

There is, then, a health care *system*. It's components are, in addition to the doctors, the vast network of health care resources —"medical empires;" the financing and planning complex of agencies dominated by Blue Cross; and the "medical-industrial complex." But if American health care is provided by such a big, well-organized, interconnected, business-like system, why is it so poor? The answer is that *health care is not the aim of the health care system*. The health care system exists to serve its own ends.



The aims of big medical centers are teaching and research. The hospitals and medical schools seek to expand their real estate and financial holdings. And everyone, from hospitals and doctors to drug companies and insurance companies, wants to make profits. Health care for patients is a means to these ends, but it is not the sole end in itself. And so the patient sees a system which is expensive, which is fragmented into dozens of specialties, which has no time to treat him in a dignified way, and which doesn't even take care of him very well.

Rx for the Health System

The health crisis has reached such proportions that every big politician is offering his solution, be it national health insurance, health maintenance organizations, group practices, or the like. However, it is now more important than ever to ask, "*Who* will benefit from these reforms? Will it be primarily the providers and those who profit on health care? Or will it be those who use it?"

National health insurance is a good example. What happened when Medicare and Medicaid, which were, in effect, national health insurance for the elderly and the poor, were introduced in 1966? For millions of people, the economic burden of medical care was lightened. But since the programs included no cost controls, the doctors and hospitals went wild. Doctors raised their fees; hospitals bought up every expensive piece of equipment they could think of. The income of hospital supply companies and drug companies skyrocketed. The price Americans paid for hospital care almost doubled. Did the quality of medical

care double? Hardly. The taxpayers and patients paid the bill; the doctors, hospitals, drug and hospital supply companies reaped the profit.

Is there reason to think that the outcome of the present national health insurance or other reform proposals will be different? No, not so long as these powers still dominate and control the health system. More money, more planning and more coordination will make little difference as long as control of the health system is left in the hands of those who make their fortunes and reputations from it. Those who use and pay for health care must begin to have a say in the priorities of the health system. Only then can we hope for low-cost, high-quality, easily-accessible and relevant health care.

But across the country people are beginning to take things into their own hands. In New York and Pennsylvania subscribers are challenging Blue Cross rate increases; in Cincinnati poor and working class communities are demanding that the Health Department provide decentralized, community-controlled neighborhood health centers; in San Francisco, Chicago and Washington, D.C., hospital workers allied with community groups are challenging the accreditation of overcrowded, under-staffed, run-down public hospitals; in New York community residents are challenging hospitals who would force them out of their homes to build doctor's offices, parking lots and professional staff housing. The beginnings are modest; but a movement is afoot to take control of the medical system and to reshape it to meet the needs of the vast majority of those who work in and use the health system.