
Photo shot on the steps of the courthouse at Foley Square for the poster "If Men Could Get Pregnant".

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Health Care: A Buyer's Market?

The quality of mercy has been strained

by Joan Solomon

DURING the first week of April, consumers across the country took a stand on the skyrocketing price of meat: they wouldn't buy that. The price of a different commodity has risen more sharply than almost any other over the past decade but, unlike meat, health care cannot be boycotted. Using an arsenal of alternate techniques, consumer activists hope to do more than bring medical costs into line: they want the treatment of disease to become the promotion of well-being.

The United States spends more money per capita on health than any other country in the world. The nation's health bill exceeded $83.4 billion in 1972 and is expected to hit $100 billion by 1975; since 1960, the cost of a day in the hospital has gone up 204 per cent, doctors' fees 74 per cent. As increasing costs begin to devastate the average pocketbook, middle class people are joining poor ones in demanding that health care be a right, not a privilege.

But what is being done with the money? A statement by Henry Jones, President of Massachusetts Blue Cross, provides a clue: "Probably no activity in the United States today displays more paradoxes than the health industry. On the one hand, it has made incredible advances in human skills and technology; on the other, its actual *delivery system*, except in rare cases, has made little or no progress during the past few decades and, in some cases, has even retrogressed." (*Trial*, March-April, 1973)

Not Rich in Health

Health statistics support his assertion. Compared with other Western countries, the United States shows up poorly in such telling health indices as infant mortality and life expectancy. Even health service deliverers are cognizant of a crisis in care. "The health system fails to meeet the needs of the patient," says a major health insurance plan official, who is also a former hospital administrator. "It is left too much to the medical profession to police themselves, to educate themselves. It is an awesome responsibility and physicians have failed to develop the capacity to meet it. So there are many examples of bad care, of unnecessary care."

Militant consumers point out that the health system is an industry, a profit-making industry. The profits are not in curing disease, but in treating it. Writes Dr. Richard Kunnes, psychiatrist and a founder of the consumer-professional Medical Liberation Front, "It's simpler and more profitable for the doctor to prescribe the wrong treatment, forcing the patient to return, than to take the time to make the right diagnosis. There's no profit in curing, only in treating—and treating—and treating." (*Your Money or Your Life*, Dodd, Mead & Company, 1971)

Very Radical Surgery

One concern of the medical consumer movement: unnecessary surgery. A number of studies indicate that tonsils, uteruses and other assorted organs are often removed needlessly. Pennsylvania Insurance Commissioner Herbert Denenberg recently estimated that only 12 million of the approximately 14 million operations performed each year may really be indicated. In 1960, the Columbia University School of Public Health, studying surgery on the families of 238 Teamsters Union members, found that 20 of 60 hysterectomies were unnecessary and six more were questionable; seven of 13 Caesarian sections were seriously questioned.

Ten years later, anesthesiologist John Bunker compared the number of operations performed per capita in the U.S. with the number performed in England and Wales then related these figures to the number of surgeons practicing in the respective countries. There are about twice as many surgeons for every 100,000 people in this country and about twice as many opera-

tions. Dr. Bunker's conclusion: prepaid group health care in England and Wales, which offers no economic incentive to perform unnecessary operations, reduces their occurrence drastically.

To combat the small number of surgeons whom Commissioner Denenberg calls "knife-happy, incompetent and greedy," some unions have instituted compulsory consultation; the Distributive Workers Union, for example, does not reimburse members fully if they refuse to get a second opinion before surgery. Commissioner Denenberg's diagnosis: "The medical care system is not run for the public's benefit. It is designed by and for hospitals, by and for doctors. Physicians make up one big happy fraternity. Their code of ethics is to keep the truth from the public, and not to tell on one another."

His treatment: holding up rate increases to force medical third parties to set up more stringent standards for insurance-covered health care, publishing and distributing shoppers' guides to health care. This action has won him the enmity of some doctors, lawyers and insurers but, in a recent poll, Pennsylvanians overwhelmingly named Denenberg as the state official doing the best job.

Fraternal Malpractice

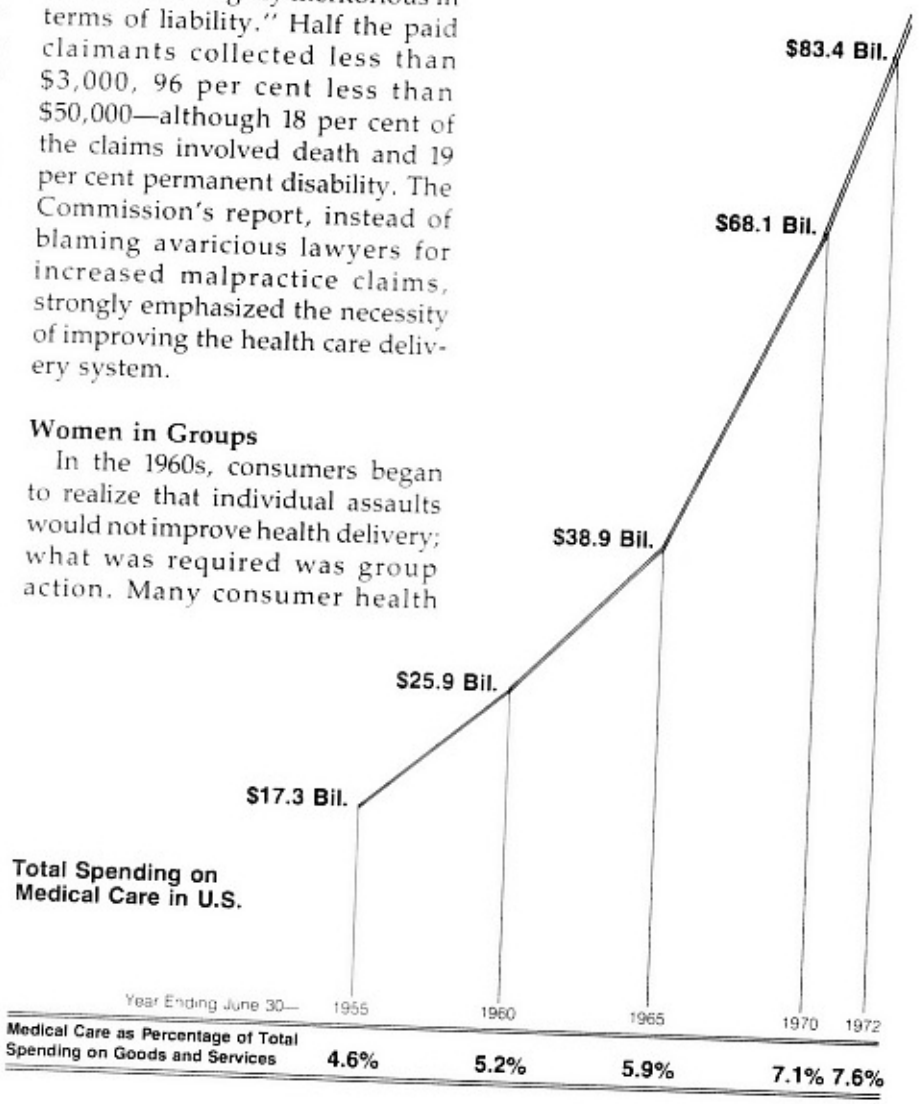
Even before such governmental action was in vogue, consumers had a viable tool in malpractice suits. Melvin Belli, one of the first lawyers to try malpractice cases, has strong opinions about medical men. "Not every physician gives A-1 care," he said in a telephone interview. "But the real problem is the cover-up by the good ones of the bad ones." Although he does not believe in consumer control of medical delivery—"there would be as many and more errors as now" —Belli suggests that medical professionals should be restricted through publicity, legislation and court actions.

However, court action is not invariably effective. According to a recent report of the President's Commission on Medical Malpractice, only 41 per cent of patient-claimants received any payment —although insurers themselves judged that 46 per cent of the claims were "legally meritorious in terms of liability." Half the paid claimants collected less than $3,000, 96 per cent less than $50,000—although 18 per cent of the claims involved death and 19 per cent permanent disability. The Commission's report, instead of blaming avaricious lawyers for increased malpractice claims, strongly emphasized the necessity of improving the health care delivery system.

Women in Groups

In the 1960s, consumers began to realize that individual assaults would not improve health delivery; what was required was group action. Many consumer health groups are also women's groups, not surprising because women make, on the average, 25 per cent more visits to the mostly male doctor population than men do. "The health system is absolutely sexist," contends Pam Booth, a worker at the Women's Medical Center, a New York City health information and counseling organization. "Men run those institutions, whether an office or a hospital or a clinic."

Ms. Booth's interest in health



U. S. health delivery: prices up

care was aroused through the women's liberation movement. "Women are treated as little children," she emphasized. "Doctors will say to you, 'don't worry your little head about that,' in response to a question about the kind of infection you have. In response to 'it hurts,' he'll say 'don't worry, it doesn't hurt.' "

Abortion and Birth Control

The main impetus behind the women's medical movement was the fight for abortion reform. Says Claire Brecher, a British-born feminist active in New York City's Women's Health Organizing Collective and a student at the Columbia University School of Public Health, "What the abortion experience meant for a lot of middle class women was that for the first time they were outside any protected atmosphere, outside the law. The experience was devastating not only because of the pain and the illegality, but because it made women realize if they had more money, they would get better care. In this way, it was a distorted but real reflection of the entire health system."

Before the New York law was liberalized, Ms. Fruchter was a member of the Abortion Project, an organization which conducted demonstrations and an underground referral service. "Most of the women we saw couldn't afford to fly to Puerto Rico or pay $1,000 for a therapeutic abortion. When they had illegal abortions, they were often abused verbally or physically. The polite front typical of medical care faded away. This experience galvanized women because it put them outside the system."

In trading experiences, the women also learned that their physicians were giving them conflicting information, particularly about birth control. "All these opinions were being given to women as fact," Ms. Fruchter said. "We began to realize that this was a subject under debate, and that we should be able to make choices on the basis of much more information."

Because these women felt that their doctors were jealous of their knowledge and unwilling to share it, feminist groups began running discussions and workshops on women and their bodies. Says Susan Reverby, a staff member of the Health Policy Advisory Center (Health-PAC)—research and education center on health politics: "If you refer to your vagina as 'down there,' there's still a basic alienation, so you can't deal with the medical providers. A part of what women's body courses do is demystify all that and make you feel more whole."

Plans of Attack

The current aim of the Women's Health Organizing Collective is to make the health system less fragmented and more responsive to women's needs. Their most impressive project, *A Guide to Women's Health Services in Lower Manhattan, or How to Get Through the Maze with Our Feet in the Stirrups*, outlines the institutions, the services they offer, where they are and how much they cost. Ultimately, the Collective hopes to influence the institutions themselves, but this group's admitted lack of organization and information appears to stand in the way of progress on that front.

To make more of an impact, the Women's Medical Center is trying to go national, unifying women into a powerful health coalition. Their first step will be modest: a newsletter. "In the newsletter we want to talk about what we're doing and what we're thinking and the directions we want to go in, as well as finding out what other women are doing, so we don't duplicate each other's mistakes," Ms. Booth told me. "In this way we can provide a basis for a national direction."

The Women's Health Organizing Collective's plans for expansion include men. Although the group's first objective is comprehensive obstetrics-gynecology clinics with team health delivery and continuity of care, it also envisions total family care health centers—and other basic systemic changes. As their guide to women's health services states: "There are some larger changes we must also fight for—the basic right of patients and health workers to control health services and the right of all people to high quality care."

Health-PAC's Susan Reverby expands on this theme. "What happens to you as a woman is what happens to you as a human being, and so one has to understand the forces affecting people in society in general." In a review of *Our Bodies, Ourselves*, a book by the Boston Women's Health Book Collective, Ms. Reverby wrote, "The speculum may be a weapon to combat bad gynecological care, but it is not a substitute for an army and a battle plan." *(University Review*, April, 1973)

Political battles are what Health-PAC is all about. Founded in New York in 1968 and now also operating in California, it publishes monthly bulletins analyzing vari-

Anatomy and physiology
are taught in a "body" course
at N.Y.C. Women's Medical Center

ous aspects of the health care system. Health-PAC unabashedly calls for the radical restructure of the American medical system, and espouses five principles. Health care is a right and should be free at the point of delivery; health services should be comprehensive, unfragmented and decentralized; medicine should be demystified and health care delivered in an educational manner; health care should be deprofessionalized and skills transferred to worker and patient; community-worker control of health should be instituted.

"The system must be accountable to consumers," says Ms. Reverby. "It's their money and their bodies, and that should give them ultimate control over health institutions." Worker control is also crucial, she maintains. "You need the people on the inside to feed you information, to help you understand, to be part of the policy-making machinery." Because this did not happen during the meat boycott, thousands of industry workers were laid off and prices stayed high.

A Superstructure Grows in The Bronx

A current consumer-provider struggle centers around a 7-year master plan by the N.Y.C. Health and Hospitals Corporation to merge all the health care facilities in the West Bronx, with Montefiore Hospital and Medical Center as its hub. Montefiore is expected to receive a contract from the municipal corporation to staff and operate the North Central Bronx Hospital —a modern $95 million facility being built by the state for the city. For the past two years, Community Planning Board #7 and local health councils have been asking the corporation for information about the new hospital and for the right to participate in decisions about its services. Bronx Borough President Robert Abrams has also attacked the secrecy of the plans, and has demanded a measure of community control.

According to the *New York Post*, the master plan grew out of a private meeting initiated last August by Dr. Martin Cherkasky, Director of Montefiore. Dr. Cherkasky contends that the community will have input into the plan; consumers and providers wil
asked to suggest revisions.
telephone interview, he told
that this was the practical wa
do it: "You can't just set up a t
in the middle of the Grand C
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sumers will have a target. Notl
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companies and banks. "Last,
far from least," says Dr. Kun
of the Medical Liberation Fr
"are major governmental plann
boards, agencies, and dep
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One health administrator ad
the existence of a complex
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But he does not think that the t
"medical-industrial complex
appropriate. "It is not a structu
organized phenomenon with in
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antitrust suits. Everyone is sim
doing their own thing."

Undoubtedly though, gov

ent is trying to gain some control er the private medical system. nsumer participation is being andated by both Federal and ate legislation: the Partnership r Health Act, OEO guidelines for ighborhood health centers, New ork State Ghetto Medicine legis- tion, the Health and Hospitals orporation's requirement for mmunity advisory boards.

Consumer Boards

However, some community oards include as consumers mem- ers of the hospital Board of Trus- ees; some "consumers" are ap- ointed by the hospital, not elected y the community. Zita Fitzgibbon, a member of Brooklyn's Methodist Hospital's Ambulatory Care Ser- ices Advisory Committee, man- dated by New York State's Ghetto Medicine Act, told me of the dif- iculties in influencing hospital pol- cy. "You don't understand half of what they're saying, and every me you bring up something you want to improve, they say there's ot enough money."

But the Methodist board is no ushover, Ms. Fitzgibbon main- ains. "Some hospitals have con- rolled boards, but we try to make hings tough. For everything we want, we hassle, we cajole, we demand, we write letters to the press." Their most potent power: f the board advises the Depart- ment of Health of non-compliance with Ghetto Medicine guidelines, the hospital loses money. Method- ist has lost $100,000 because it didn't have a Director of Ambula- tory Care. "Now, they're really try- ing to get a Director and we're really involved. There's nothing like having money withheld for clout."

Zita Fitzgibbon does see improvements at Methodist: a comprehensive screening program, a primary physician in both the medical and pediatric clinics, an appointments system in the medical clinic, an enlarged role for nurses. But she also sees a lot more work to be done, including the organization of a grass-roots consumer movement. To increase their effectiveness, consumers on both municipal and voluntary city boards have joined in a citywide coalition. They hope to institute internal reforms, improving the boards to make them truly representative, and obtaining a wider perspective for consumer and facility organizing strategies.

Efforts to create coalition on a wider scale—a national consumer health movement—have failed because of factionalization and splitting. Although there is nothing inherently wrong with a lot of little local groups, says Judy Wessler, health advocate at the MFY Legal Services, they may work at cross-purposes simply because they are not in touch with each other. Most community groups are voluntary and the members unpaid. "Without staff to coordinate the effort and keep at it, it's really difficult. When you have to start scrounging around for a Xerox machine, for a telephone, for stamps, there's so much investment of time and energy in that. It's admirable that so many groups have been able to have an adequate process of communication."

Also hampering the consumer movement are the inevitable arguments. "There's a lot of politics inside the consumer movement, and a lot of differences of opinion and a lot of conflicts and infights which probably won't ever be resolved," says Ms. Wessler. A city official in health planning put it more concisely: "When consumer groups are splintered, they become ineffective. Providers won't respond to their demands."

Struggles of a Free Clinic

In opposition to consumers who would challenge existing institutions are those who would set up alternate ones—most often, free clinics. Since the Haight-Ashbury Free Clinic opened in San Francisco in 1967, hundreds more have been formed throughout the country. They aim to give good health care in untraditional ways for little or no money. Most of them are experimenting with community/worker control and stress the transfer of skills as a way to demystify and deprofessionalize medicine.

Emphasizing the split are their detractors in the consumer movement. Says Health-PAC's Ms. Reverby, "They don't provide decent care. They can't, because they're on a tenuous funding basis. Ultimately they fragment care because they can only provide bits and pieces. You're no better off than you were before you walked in, and you still have to deal with the health system."

Advocates of free clinics reply that they are models and instruments for change—and they *do* provide good care. To get an inside look, I visited St. Mark's Free Clinic on New York's lower east side on one of its twice-weekly open evenings. Its 20 or 25 patients a night are usually young adults who have gynecologic, dermatologic or minor medical problems. "They don't want the rigamarole, the red tape, the hassle of a hospital clinic," said a registered nurse from Cornell Medical Center who does volunteer work at the clinic. "Here,

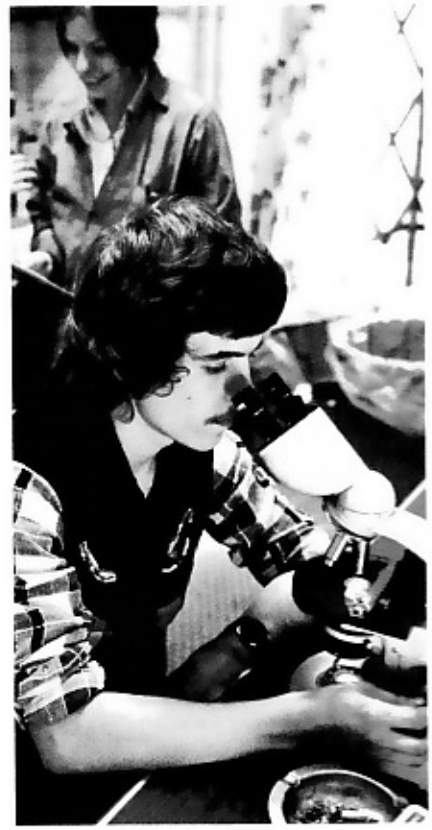
they can get away from the white coats and the high-falutin' language. We give them competent care in an informal setting.

"The best medicine I've ever seen practiced happens here. I was trained in a city hospital. The patients would wait for two hours and then be rushed through in five minutes. Here, if they need a half hour, we give them a half hour. The physicians and other workers are kind and sensitive." Although the Free Clinic is struggling for financial survival, it hopes to add counseling and social services.

Keeping Consumerism under Control

Another medical consumer split is between "radicals," who want a total restructuring of the medical delivery system and a total shift of power, and "reformists," who would be satisfied with consumer input. New York's Comprehensive Health Planning Agency—a coalition of consumers and providers—is a reformist group. Created out of the Federal Partnership for Health Act, a 1966 amendment to the Public Health Law, it is part of New York City government; consumer members, who constitute a one-person majority, were selected from already existing citywide groups.

One member, a union official, thinks it's "healthy" to have a consumer majority. In practice, he says, the consumers are overwhelmed. "When they come to the board meetings they are not knowledgeable enough, so the providers lead the discussions and dominate the meetings." But he would *not* like to see consumer control. "Consumers should be consulted and involved, but they can't direct physicians or hospital



Laboratory of St. Mark's Free Clinic, a medical facility serving New York's lower east side

Boards of Directors. There must be a partnership."

Most health care providers, although they give lip service to consumerism, are quick to point out what they consider its dangers. "All too often, consumers are well-intentioned, but just don't know what it is to take care of patients or to get care delivered," the health insurance official told me. "By working within the existing structure, given the realities of law and tradition, we can best change it."

And although Dr. Cherkasky of Montefiore says that consumers "should control the social institutions that serve them," he qualifies that belief. "For consumers to be effective, when dealing with complex, technically based activities, they need a level of understanding not readily available," he told me. "People want to make social decisions without operational responsibilities, but you must know the instrument to make appropriate solutions." Dr. Cherkasky would like to see a team effort between professional people who know the instrument and lay people who are socially concerned. "The more thoughtful the community leadership, the sooner we'll achieve that day."

The Most Vital Consumer Weapon

One very thoughtful medical consumerist is Edward Gluckmann, executive vice-president of the Consumer Commission on the Accreditation of Health Services, a consumer information service. Just beginning operation, the Consumer Commission has issued its first report on proprietary hospitals in New York City, listing the owners and detailing the level of services. Mr. Gluckmann sees his organization as a countervailing force to the Joint Commission on the Accreditation of Hospitals; the board of *that* Commission is composed only of providers and its accreditation programs are financially supported by the surveyed hospitals.

He hopes to provide consumers with the facts which will help them become a potent pressure group and considers the New York Commission a model. In three to five years, he says, consumer commissions in every major city may be publicizing heretofore secret information, demanding the right to monitor health care delivery, and "making the damn system a little more responsive and accountable to the people who pay the bills." Mr. Gluckmann also wants to form an organization to educate consumers in the politics of health.

Education is now critical to the medical consumer movement. Consumers who want to make their partnership with providers meaningful must counteract Dr. Cherkasky's charges of "ignorance." ■