HOSPITALS AND INSURANCE Rx

There are those who see in our health care delivery system a vast conspiracy against the public, an alliance of greedy physicians, hard-hearted hospitals and profit-hungry insurance corporations. Like many such notions there is enough truth here to render it specious rather than merely spurious; the various elements in our health care puzzle *are* related and do frequently rely upon each other's support. Ultimately, though, they comprise less a conspiracy or even a system than they do a gigantic Rube Goldberg of nonmeshing gears, with the patient caught in the middle.

In all this the hospital is the institution that looms largest and the gear that grinds loudest. It has grown immensely in recent years and now accounts for more than half our total health care bill, but its growth has been without plan or long-range purpose. In the process, therefore, it has absent-mindedly bled the taxpayer, mulcted the patient and come remarkably close to destroying itself as a useful institution.

Over two centuries the hospital has gradually been transformed from a dumping ground for the dying poor into "the heart of our modern medical system," as a 1952 Presidential Health Commission described it. One hundred years ago the nation had at its disposal fewer than 200 hospitals, and a third of those were mental institutions; 50 years later the total had jumped to 6,800. That figure has remained more or less steady, but the size of hospitals has sharply increased. We have 1.7 million hospital beds today, compared to 756,000 in 1923.

Historically, the hospital in America has been fated to cause or exacerbate many of the conflicts that have shocked and shaped our medical system. In pursuit of its natural interests it has promoted specialization over general practice, medical technology over medical artistry and group medicine over solo practice. None of these preferences has endeared the institution to that ever-endangered species, the general practitioner.

Moreover, the hospitals' early custom of dispensing free out-patient care to the poor drew down the wrath of GPs and specialists alike, both groups accusing those charitable institutions of pirating middle-class patients disguised as the poor. The long dispute over "indiscriminate almsgiving" was finally settled in 1926, when New Orleans' Charity Hospital—then the nation's fifth largest—agreed to subject patients to a means test. After that, hospitals slipped reluctantly into the fee-for-service framework—partners, if not blood brothers, of the AMA.

Still, by continuing to pay at least cursory attention to the poor, hospitals kept reminding the public of inequities in our health care arrangements; and as the cost of hospital care started to push upward, more and more citizens began to question those arrangements. These vagrant tendencies converged during the Depression into a full-scale health care emergency, with millions of Americans unable to pay for hospital services and thousands of institutions unable to continue without attracting new forms of support. The solution, a crazyquilt of "voluntary" health insurance schemes, temporarily saved the hospitals, mollified middle-class Americans and postponed the triumph of national health insurance by perhaps half a century. It also gave rise to an enduring interdependence between hospitals and the insurance industry, with Blue Cross—that enigmatic network of nonprofit insurance plans—acting as chief spokesman and chief collection agency for the hospitals.

The spread of hospital insurance programs, in turn, discouraged the practice of preventive medicine and encouraged "crisis" medicine; that is, it became more convenient to treat an illness in the hospital (and bill the insurance company) than to head off an illness in the doctor's office (and bill the patient). In addition, the new economic arrangements appeared to exempt hospitals from such traditional business responsibilities as cost accounting and long-range planning. By the time Medicare arrived, 30 years later,

many hospitals had thrown thrift to the winds; they had become a vast maw ready to receive the Federal program's billions.

In direct outlays, the average patient pays only 8 per cent of the nation's total hospital bill; the rest is currently provided by the health insurance industry (38 per cent) and the government (54 per cent). It is virtually impossible now to be admitted to a hospital without first submitting to a latter-day version of the means test; that is, without producing evidence that an insurance plan or a Federal program such as Medicare is prepared to pay most of the bill.

During a visit to New York City last December, a retired Israeli general and member of Parliament, Avraham Yoffe, suffered a stroke and was rushed to Mount Sinai hospital. He sat in the waiting room for an hour because the admissions office refused him treatment until he had paid $3,080 in advance. (Strokes are expensive.) Even the Israeli Consulate's assurances on the phone guaranteeing the payment of all bills did not help; an Israeli official finally had to send over a check for the full amount. "We would have settled for $1,000," the hospital director said later, by way of apology.

Like the rest of us, hospitals must cope with the shrinking dollar, and at least some of their troubles can be attributed to the rising cost of food, laundry, labor, and other essentials. This is especially true in New York City and in the few other places where unions have succeeded at last in securing decent wages for hospital workers. Only 15 years ago unskilled hospital employes in New York were earning as little as $100 a month; today their minimum pay is $151 per week, and the length of that week has shrunk from 48 to 37.5 hours. Similarly, the recent plethora of technological innovations, such as cardiac monitoring systems, has compelled hospitals to hire more well-paid technicians. At New York City hospitals during the past decade the ratio of staff to patients has risen from 2.5:1 to 5:1.

Nevertheless, even these combined inflationary pressures do not satisfactorily explain why, since 1966, hospital charges have risen four times as fast as the prices of everything else in America. Some of the fault lies in the peculiar way hospitals and other allied institutions conduct their health care business—a way distinguished by a system of payments and subsidies that frequently rewards avarice, punishes sensible management and perpetuates the hospitals' position in U.S. medicine. The system is kept green and growing by the insurance industry and by Federal, state and municipal agencies, all of which have a critical stake in maintaining things as they are.

Unsettling Accounts

Hospitals present us with several depressing paradoxes: slick medical technology tied to labyrinthine bookkeeping, soaring net incomes amid decaying facilities, and increasing dominance of the medical system in the face of rising public discontent. All this has been occurring in the absence of either a workable monitoring system or a strong consumer voice, leaving hospitals accountable to no one but the doctors who use them and the insurance industry that nurtures them. As a result, hospital administrators have been free to raise prices while pretending they are merely victims of inflationary determinism.

The average daily hospital charge has doubled from $53 in 1967 to $107 today, and it is still rising. Last January New York City's voluntary hospitals announced another round of price increases ranging from $5-31 per day. A semiprivate room at Mount Sinai hospital, for example, now costs $160-165; a private room $185-210, depending on the size and view. As hospital charges push upward, so do insurance rates. Accordingly, the New Yorker who paid $15 a year to Blue Cross in 1947 for 21 days of hospital coverage is paying $120 today. And, notes Health-Pac, a reform-minded group in New York, "More and more essential hospital services like radiology and anesthesiology are no longer being covered by Blue Cross." The process appears to be automatic, the consequences inevitable. Gears within gears. Yet the inflationary whirlwind consists of thousands of separate, frequently arbitrary and reversible pricing decisions.

Recently a middle-aged woman in Norwalk, Connecticut, spent 18 days in the community hospital after suffering a slight stroke, and upon discharge she was presented with a bill that included daily levies of $15 for use of a room-humidifier. She refused to pay, pointing out in a series of discussions with hospital officials that the alleged humidifier was really a small vaporizer of the type anyone could purchase at a drugstore for under $10. Convinced, the officials reduced that part of the bill to $2.50 per day, at which point the persistent lady struck a blow for all patients. "I don't want to be the exception," she protested. "*Everybody* ought to be charged $2.50." A few months later she telephoned the hospital's accounting office and without giving her name asked what the daily rate was for use of a room-humidifier. "Two-fifty," was the instant reply.

The story suggests that the hospital's conscience was superior to its original intentions. In the absence of competition, managerial controls and consumer pressures, it could pad its bills without fear of reprisal. Similar overcharges, repeated countless times daily in hospitals across the land, add up to millions of dollars.

In truth, hospitals were and remain quite unprepared, either technically or philosophically, to shoulder the massive management burdens imposed by the ballooning health care business. Until Medicare, the decrepit bookkeeping procedures used by most hospitals were simply sieves through which millions of dollars leaked each year. Then, in a laudable effort to seal the leaks, HEW saddled hospitals doing Medicare business with something called "step-down" cost accounting, a complicated system whereby all hospital expenses, no matter how remote from the patient

—parking lot maintenance, for instance—are ultimately charged to patient-care.

There is, of course, a certain logic to this, but the overall result has been to skyrocket prices for services that in pre-Medicare days were relatively inexpensive, such as out-patient care or laboratory services. Under the old horse-and-buggy accounting method the cost of a blood test was simply the cost of a blood test; under step-down accounting it is that *plus* a percentage of the cost of everything else in the hospital, including the floor wax and toilet paper. That is why it is usually cheaper nowadays for a patient to use independent laboratories and clinics than to rely on hospital facilities.

Part of the problem is that the demands of the system frequently work against the interests of good medical practice. Not long ago an administrator at a big university hospital in the Midwest was eased out of his job because he was not keeping all the beds filled in the psychiatric ward. Most leading psychiatrists think that treating mental patients at home or in out-patient clinics is superior to locking them inside a hospital ward, but in this case the state was giving the hospital a flat sum for every mental patient it admitted. Thus the administrator had to go because he was depriving the hospital of state funds. Bad psychiatry was the price of good grantsmanship.

The big municipal and county hospitals are generally the least efficient. Dean Lewis Thomas of the New York University School of Medicine describes them as "badly run, impoverished, long-neglected fleabags." According to the New York *Times*, a recent study by New York City's Health and Hospital Corporation "found a pattern of financing municipal hospitals that tends to reward inefficiency, giving the less productive more than they should get at the expense of the more productive institutions." Curiously, the results of this study were suppressed for six months out of a concern that they "would create turmoil." As the corporation's acting director explained, "The inevitable reaction is that the underfunded hospitals will insist they are getting a raw deal and the overfunded will say it's destructive of their needs. There's no point in stirring the pot unless a remedy is at hand."

A remedy might begin with full disclosure of hospital finances. HEW's 1972 "Chart Book" reported that the combined net income of all the nation's hospitals soared from $29 million in 1950 to $546 million in 1971. Earnings per patient-day in 1972 among the "for-profit" hospitals exceeded $6; the figure for the nonprofits was $2.63. Since everyone knows that many hospitals operate continuously in the red and are forever on the brink of extinction, the clear implication is that many *other* hospitals—thanks to Medicare and Medicaid—are quietly making a bundle.

In any event, no one in the health field, least of all the hospitals, appears to know where these surplus earnings go. Indeed, few hospital administrators like to mention profits; they prefer to proceed on the assumption that deficits are their destiny. "We wouldn't want to be too visibly in the black," a hospital administrator in New York told me. "It would hurt our fund-raising efforts."

The funds raised go for new equipment, new "wings," new buildings. Since World War II there has been a flurry of hospital construction and modernization, producing 32,000 additional hospital and nursing-home beds from 1946-73. But most of the money flows out of the Hill-Burton Act of 1946, which channels Federal construction funds through the states to nonprofit hospitals. Unfortunately it flows planlessly, with the result that hospitals have grown in ways that do not take into account local and regional needs.

Some hospitals have too many beds (which the administrators must try to fill); others have an excess of special equipment. Hospital boards compete with one another, often duplicating services—especially the glamorous ones—beyond community demand. Cincinnati hospitals, for instance, have five very expensive cobalt therapy units that operate at only 45 per cent capacity. In New York, there are 21 different facilities for open-heart surgery but only seven are regularly used. This is not only bad economics, it is also bad medicine, for any procedure as complex and risky as open-heart surgery requires an experienced, well-rehearsed staff.

In short, most hospitals today behave like private corporations—pursuing gain, undertaking expansion, competing with sister institutions—yet enjoying massive subsidies from Federal programs and guaranteed revenues from insurance plans. Moreover, while reformers call for ways to reduce the hospitals' dominant role in our health care system, the hospitals continue to monopolize much of the action.

Rigged Benefits

Major health insurers have tended to load the dice by peddling narrowly worded policies that penalize a patient for staying out of the hospital and reward him for going in. Over the years Blue Cross has rigged benefits to the hospitals' advantage, giving them a near-monopoly on insured health care. Until recently many Blue Cross plans did not even pay for ambulance service, much less for office visits and other types of ambulatory care. One reason given is fear of fakery, an industry-wide suspicion that claimants who do not rush to the nearest hospital are really malingerers. As an insurance salesman told me, "My company frowns on hypochondria." (Blue Cross officials seem no less suspicious. "Some people," complained one of them, "apply for coverage on their way to the hospital.")

"About the only thing that insurance companies ever pay for outside the hospital," says Dr. Amos Johnson, a past president of the American Academy of General Practice, "is something that carries with it the stigma of pain. They will pay for an out-patient operative procedure, like the removal of moles and skin cancerous lesions,

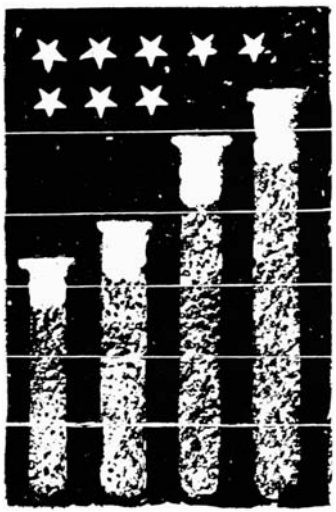
because the patient will not, they think, have a tendency to abuse the benefit." Doctors have been quick to get the message. One physician recently explained to a Senate committee that he could be paid $75 by Blue Shield for administering a shot of cortisone to a patient, provided it occurred in a hospital, whereas the same procedure performed in his office would qualify him for $12.50.

Since the early '50s, studies have shown that insured patients are hospitalized more frequently and for longer stays than are the uninsured. Though such statistics raise questions about comparative quality of care—after all, maybe the uninsured *need* more hospital care—they also suggest a certain amount of needless hospitalization. As the Somers observed in 1961, "It is hardly surprising that, in the general absence of coverage for ambulatory care, both patients and physicians would try to stretch the available hospital expense protection to cover portions of their uninsured costs. A disproportionate supply of one type of insurance can lead, at least temporarily, to a distorted demand for the insured service." Yet the distorted demand has proved to be more than temporary, and it has been further distorted by subsequent Federal policies.

The Federal sin, under Medicare and Medicaid, has been to see no evil and hear no evil while reimbursing hospitals for treatment rendered to the poor and the elderly; to pay first and ask questions later, or not at all. The resulting temptation to take the money and run has been too strong for most to resist. "Seven years of Medicare have taught us one thing," notes Pennsylvania's Denenberg. "Hospitals, doctors and medical care providers are capable of gobbling up every dollar we are willing to throw their way. They are already taking 7.5 per cent of everything our economy produces, and if it were up to Medicare, there would be no end in sight."

Less than a year after the passage of Medicare, Congress had to increase by 25 per cent the Social Security tax budgeted to pay for it. Since then increases have taken on a depressing regularity, both for premium payers and taxpayers. By 1969 it was clear that hospitals, particularly the high-powered ones, were on a Medicare binge. John de Lury, head of New York City's sanitation workers union, observed at the time, "The hospitals with the high . . . costs are the newer ones, those on the make, with brilliant reputations, with teaching affiliations. Above all they are the ones with programs of vast expansions and edifice complexes . . . and they are making us pay through the nose."

Even hospitals with the best



of intentions—and which hospital would deny the compliment?—find it all but impossible to shut off the Federal spigot. A few months ago, for example, officials at the Bronx Municipal Hospital Center in New York announced they might be compelled to abandon a successful presurgical screening program because it was depriving them of essential Federal funds. In the past, they noted, patients had been admitted to the hospital three or four days in advance of surgery, to be given complete physical examinations (a standard presurgery practice). Under the new program the examinations were performed in the hospital's out-patient clinic prior to admission, thereby reducing the hospitalization period and, presumably, saving money.

It turned out, however, that the new program was costing the hospital $7,000 a month, because Medicaid and Medicare paid $120 for each day a patient stayed in the hospital and only $35 for a clinic visit. Furthermore, as the New York *Times* explained, "Since most patients for elective surgery require little attention or services before their operation, these presurgical days are considered 'cheap days' in which the hospital is paid for more than . . . it actually gives." So much for efficiency.

Strangely, the task of holding down Federal costs has been assigned to Blue Cross and the major commercial insurance companies. This is like asking Lockheed to keep an eye on Pentagon spending. For a percentage of the take, the insurers channel Medicare payments to hospitals and other health care providers, and are expected in each instance to act as surrogate auditors, inspectors and comptrollers for the Federal programs. The whole foolish system, in turn, is audited annually by the Department of Health, Education and Welfare; but for some reason, possibly embarrassment, HEW has been reluctant to release these audits. Thanks to researchers at the AFL-CIO office in Washington, I can cite a few tidbits from the 1970-72 audits:

- Billings by physicians to Michigan Blue Cross for Medicare reimbursement were not verified as to reasonableness (as the law requires). Consequently, according to HEW auditors, "there is no assurance that the approximately $6.4 million paid to the providers represents reimbursement for reasonable costs."
- In 70 different audits of Blue Cross-Medicare programs, HEW found millions paid out illegally in duplicate claims and hospital charges for private rooms.
- Aetna, another "fiscal intermediary" for Medicare, made an estimated $3.2 million in duplicate payments in 28 months. (When this became known, both Aetna and HEW announced that the "errors" had been corrected, but as of this

writing no refunds to Medicare have been made.)

• Mutual of Omaha overpaid hospitals and nursing homes by $5 million.

• Occidental Insurance paid $3.2 million to doctors and medical groups who had previously defrauded Medicare, or who were being investigated for possible fraud.

• Over a three-year period Connecticut General Life Insurance is estimated to have squandered $3.2 million in duplicate payments. The company is said to have wasted another $1.3 million in payments that Federal auditors deemed "unreasonable."

It is likely that this modest sampling is merely the tip of the iceberg, and it seems fair to infer that we are squandering billions under the cheerful auspices of Medicare. Which is not to imply criticism of the program's purposes, only of the inexcusable way it is being administered.

Birth of the 'Blues'

The present nightmare is a legacy of too many small and inadequate dreams. The first of these occurred in 1929 when Justin Ford Kimball, an administrator at Baylor University in Dallas, organized a modest health insurance plan for local public school teachers. Each teacher paid 50 cents a month, and in exchange was guaranteed use of a semiprivate room and other services at Baylor University Hospital for up to 21 days. Note that the initiative came not from the teachers but from the university, the idea being less to help patients than to bail out the hospital, then suffering from rising expenses and empty rooms.

Other hospitals around the country, facing similar problems, were quick to see the advantages of an arrangement that guaranteed collection of their bills, and before long dozens of communities were experimenting with Kimball-like plans. Then, in 1933, the Minnesota version hired as its first director a schoolteacher named E. A. van Steenwyk, who started using a blue cross on his stationery. The rest is history, as a drowning citizenry clutched at the Blue Cross straw.

A decade after Kimball's small beginnings there were 3 million Blue Cross subscribers in more than half the states. Today 100 million members of 80 separate plans, all part of the umbrella Blue Cross Association, receive about $5 billion annually in Blue Cross benefits. In addition, acting as a fiscal intermediary for the Federal government, Blue Cross pays out nearly $6 billion a year in Medicare and Medicaid benefits. It also administers the Federal Employees Health Benefits program, covering 5 million government workers.

(A second purveyor of health insurance, Blue Shield, started in California in 1939. Originally organized to provide subscribers with broad, comprehensive health care, it soon retreated to more modest goals, offering limited payments for medical bills incurred in hospitals —mainly for surgery—and thus encouraging the already dangerous drift toward hospital domination of our health care system. Blue Shield and Blue Cross are similar in structure and purpose—together they underwrite nearly 200 million policies every year—but in most communities they have no corporate connection. While the hospitals unofficially control Blue Cross, the local medical societies control Blue Shield. This arrangement was formalized in 1946 when the AMA's house of delegates adopted a set of approval standards for Blue Shield. Henceforth no local Blue Shield could expect to survive without winning the AMA's "Seal of Acceptance.")

For hospitals the key to survival has been their bedfellowship with Blue Cross. Until recently the American Hospital Association (AHA), representing the nation's accredited hospitals, owned the Blue Cross seal and trademark, and it was not possible for the public to distinguish where AHA left off and Blue Cross began. ("Blue Cross has been sponsored and guided since its early days by the American Hospital Association," reads a Blue Cross manual still in use.) That arrangement was officially ended in 1972, when Blue Cross brought out a seal of its own, a signal that it might at last be ready to cut the silver cord. Yet as of this writing, the two associations continue to share an office building in Chicago, two members of the AHA sit on the Blue Cross Association board, and two members of national Blue Cross repay the compliment.

The pattern is repeated among local boards throughout the country. According to a 1971 survey, half the trustees of local Blue Cross organizations were hospital administrators. A few years earlier in Boston, an enterprising group of college students analyzed the local Blue Cross board and found that 11 of 31 directors were directly tied to area hospitals either as trustees or administrators, and that most of the other directors had been chosen to represent large corporations. With the exception of four labor leaders, none represented the subscribers.

Since every Blue Cross plan must periodically negotiate prices with local hospitals, the effect of all this incestuousness has been to undermine each organization's bargaining position and encourage hospitals to charge whatever they think Blue Cross will bear. In theory, Blue Cross has the right to go over the books of cooperating hospitals and insist on a decent minimum of cost and quality control, but in practice few genuinely thorough audits are ventured and fewer still lead to corrections, even in cases of flagrant mismanagement. In a single community, charges for identical services may vary from hospital to hospital by as much as 100 per cent. In New York, Health-Pac found that one teaching hospital charged $274 for delivery room services; another, with virtually identical expenses, charged $143.

Blue Cross has waxed rich over the years, much of the credit going to the Federal government, which supplies the association with one-third of its total revenue. Like all successful enterprises, nonprofit or otherwise, Blue Cross has not hesitated to display the traditional

trappings of corporate wealth—new, glassy office buildings, chartered airplanes for its executives and, on far more than one occasion, lavish entertainment for clients and prospects.

Management of Blue Cross' billions has not always been beyond reproach, either. In Richmond, the local board purchased $1.2 million of furniture from a company that had a Blue Cross director on its staff. Two years after the Virginia "Blues" became fiscal agents for Medicaid, Federal auditors found that staffing was "about 23 percent in excess of requirements" and that money spent on data-processing had jumped 1,409.8 per cent. Nevertheless, said the auditors, the system remained "basically ineffective."

In Washington, D.C., Blue Cross deposited at least $10 million a month in checking accounts at the National Savings and Trust Company, whose chairman was treasurer of the local affiliate (called Group Hospitalization, Inc.). Since the checking accounts were not interest bearing, the program is estimated to have lost $5 million in five years. Three years ago in Massachusetts, while filing for a 33 per cent increase in nongroup policy payments, Blue Cross inadvertently revealed in its supporting evidence that the executive payroll had nearly doubled in two years. The number of executives making $20,000 or more per year had risen from 8 to 15.

When these and similar abuses come to light, Blue Cross responds with a curious mixture of contrition and paranoia. In the view of George Kelley, the association's chief lobbyist in Washington, the unwholesome publicity Blue Cross has endured is a result of a "concerted effort to discredit the private sector" in health care. He blames Senator Edward Kennedy and the labor unions.

In a countermove, Kelley has been distributing thousands of hastily mimeographed yellow "summary sheets" that purport to explain his organization's policies, and he has been holding meetings around the country with subscribers in an effort to "build up citizen loyalty." As is the case with other Operations Candor, Blue Cross would have us forget the past. "We're doing a lot better now" says Joseph S. Nagelschmidt, the program's public information director. "Those stories about overspending have been over-publicized. They're the exceptions, not the rule. Think of us as a great social movement."

Though the hour is rather late, Blue Cross is going to some trouble to bring its attitudes and policies into line with its rhetoric. "We have not been sufficiently self-critical and innovative," Walter McNearney, the association's president, conceded recently. Two years ago he pushed through a revised set of bylaws calling for up to 70 per cent consumer representation on local boards. That paradise is still to be achieved, but half the boards, it is claimed, now have consumer majorities. "We have to make these changes carefully," one official told me. "We don't want to end up with just a bunch of housewives." (But if not housewives, who?)

Policing Policies

A few states are also using their power to persuade Blue Cross to use *its* power. Before Denenberg quit as Pennsylvania's insurance commissioner, Philadelphia's Blue Cross negotiated a near-model contract with local hospitals, including such rare controls as use of generic drugs instead of the more expensive brand names; a salary ceiling for interns and residents; more precise accounting methods; and a hospital safety program to protect patients from needless injury. Most significantly, the contract bears a promise from the hospitals to phase out 12 of their 17 open-heart surgery units.

The Philadelphia story suggests that as an instigator of health reform Blue Cross may be unwilling but far from unable, that it is capable at times of positive response to consumer and government pressures. Yet such pressures seem paltry in contrast to the many counterpressures to which the program must also respond: the Federal cornucopia, the strangely carefree attitude of many hospitals and, by no means least, the increasing competition from commercial insurers, an ironic consequence of Blue Cross' success.

Although a few companies had dabbled in health insurance as early as the 1870s, most shunned the new market as too risky until the Blue Cross experience changed their minds. By 1940 commercial insurers were providing hospital protection to 2.3 million. These totals rose sharply after World War II as labor unions began to demand broader health benefits in their negotiations with management. The 1949 steel strike seems to have been a turning point. Within three months of its settlement there were 236 steel-worker contracts providing for group health insurance and pensions, and the major auto industries soon followed suit. Today the vast majority of union contracts contain provisions for group health coverage, and 90 per cent of the commercial underwriting for these policies is controlled by the largest insurance companies—the approximately 500 members of the Health Insurance Association of America (HIAA).

Health insurance, quite simply, has proven to be extremely profitable. In 1973 the nation's six largest health insurance companies increased their net gain from group health operations to $140 million, a jump of more than $100 million over the previous year. This helps to explain why everyone nowadays seems to be going into the business. Even the Washington (D.C.) Gas & Light Company, not famous for its health concerns, recently sent out a mailing peddling health insurance to 270,000 families.

Blue Cross officials like to draw a sharp distinction between these "for-profit" corporations and their own nonprofit organization. "Damn it," an association spokesman insisted in a recent interview, "we're legitimate. We're a public-interest organization." If we forgive the hyperbole, we can grant the distinction. By and large, Blue Cross'

pursuit of the dollar is less ruthless than that of its private competitors.

Commercial insurance companies, for example, spend millions promoting and selling their policies, and millions more paying commissions to salesmen. As a result, their operating expenses generally run higher than those of Blue Cross, and these expenses are passed on to the consumer. It is a telling fact, too, that whereas Blue Cross pays back in benefits more than 90 per cent of the premiums it collects, the commercials surrender only about half.

In addition, since there is no Federal regulation of health insurance, the states are left with the job, and the states are more lenient with commercial insurers on the whole than they are with Blue Cross. Private companies need not go hat in hand to the state every time they want a rate raise, nor do they have to inquire from the state which persons they must insure and which they can safely ignore. Thus, while the commercials siphon off low-risk subscribers, Blue Cross is often compelled by state regulations to accept the "high risks." Despite the industry's repeated insistence that it is "working for a healthy America," in truth it is working to insure only those Americans who are already healthy and likely to stay that way. The following blunt passage from an Aetna training manual for salesmen fairly typifies the commercial industry's point of view:

"Ever buy a used car?

"It's a risky business. That Super Whizbang gleaming in the sun on Honest Abe's lot may be OK, but it could end up costing you a bundle. If you're careful, you won't just kick the tires and look blankly at the engine under the hood. You'll underwrite it.

". . . If the previous owner has taken the car regularly to the Acme Garage for maintenance, you might check with Acme's mechanic.

"It's sensible, isn't it, to use every available source of information before you accept the risk. . . . And the more reliable your sources of information, the better chance that you won't wind up with a clunker that will bankrupt your bank account.

"You can see what we're getting at. An insurance company is something like a used-car buyer: Before accepting a risk the company underwrites it by using sources that can provide useful information about the risk. . . . Otherwise, the company is bound to wind up with a file full of clunkers."

The insurance industry's position is that the government should insure all the "clunkers," leaving the young and the beautiful to the tender care of the commercials. In effect, the government has already begun this process through Medicare and Medicaid, and many of the health bills now before Congress envision putting the final touches on this peculiar brand of socialism which would have taxpayers subsidize private insurance companies.

It appears therefore that the health care consumer, for all his needs and frustrations, has been as good as forgotten. If the doctors are no longer able to call all the shots, as they were 40 years ago, other powerful groups have risen to take their place. Outside the doctor's office it is the insurance industry that has the power and the profits, and the hospitals that have the revenue. As Senator Kennedy has remarked, "The health system works well for everyone but the patient."

The system we have inherited is largely a pastiche of schemes hatched and cultivated in the wake of past national political failures. The New Deal's surrender to the AMA made something like Blue Cross, the hospitals' boon companion, all but inevitable. Similarly, Congress' careless abandonment of the Wagner-Murray-Dingell bill was an inspiration to the commercial insurance industry. Indeed, every *threat* of national health insurance down through the years has sent the industry scurrying after new business, confirming Mr. Dooley's observation that "Life'd not be worth livin' if we didn't keep our inimies."

Today, thanks in part to Fed-

eral error and institutional arrogance, we are in another of those periods of general discontent verging on reform. And predictably, the threat of reform has galvanized major elements within our health care establishment; both Blue Cross and the commercial insurance companies have lately embarked on a scramble for alternatives, each hoping either to head off or take over whatever new programs Congress may eventually try to institute. It is all very familiar, though it may not be entirely bad.

One of the alternative remedies the establishment is now pursuing is the so-called "health maintenance organization" (HMO), a plan that eschews traditional fee-for-service arrangements, relies upon group practice and puts preventive medicine ahead of conventional, hospital-oriented medicine. This is hardly a new idea, but in recent years it has come into its own, winning the blessings and support of every major health care lobby in America, with the single exception of the AMA. Blue Cross has set up 28 HMOs across the country and the big insurance companies have been close behind. As of last July, according to the HIAA, they have loaned a total of $4.5 million to new HMOs and have put up another $21 million in mortgage financing.

This turn of events, along with the Nixon Administration's erratic backing of the HMO idea, suggests that something new and perhaps fundamental is being added to the health care picture: the beginnings of a network of organizations capable of firming up the flaccid performance of our present system, rendering it less eager to enrich itself and more devoted to serving the public. In theory, HMOs can weaken the links between hospitals and insurers, redirect much of the health care business away from hospitals, and even prune the Federal money-tree. It remains to be seen, however, whether any of this will occur and whether the politics of HMOs—as presently practiced by doctors, hospitals, insurers, and politicians—will be sufficient to the need.