Your Money and Your Life, Part II

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> "Horse sense and humanitarianism dictate that we phase out most and probably all municipal hospitals before the end of the century."
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> —New York Commissioner of Health Lowell Benin, speaking to a group of businessmen, March 5, 1976.

> "We're going to have to operate pretty much like a private hospital; if a patient can't pay he won't be admitted. Patients may have to sell their homes for care. We can't deprive a student of his education to finance a patient who can't pay."
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> —Chancellor Elmer Learn of the University of California at Davis, on the occasion of the university's takeover of a public hospital in 1972.

> "Some of you people may have to die."
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> —Boston Mayor Kevin White in answer to public protests against massive budgetary cutbacks at Boston City Hospital, 1973.

The sickness industry in the 'seventies has arrived at something of an historic moment in its development; intense new competitive pressures within it have come together with the competitive pressures already existing and the rampant decline of American cities to bring about the virtual extinction of public health care in America.

No more classic example of the process currently "phasing out" municipal and county hospitals across the country today can be found than right here at Detroit General Hospital, where the confluence of these forces has brought about a crisis which will eventually see its resolution in the hospital's complete removal from the realm of municipal control. And here are the major reasons why:

1) It is inefficient and even more inordinately expensive than other hospitals around it. The people who come to DGH are sicker and poorer than people who go to the private institutions; they require more care and are much less able to pay for it (approximately 25% never pay at all). By dint of being in the inner city it is, like the area it serves, run-down and decrepit; it is also ill-equipped and chronically understaffed and as a consequence must offer higher wage rates just to maintain a working staff. Its doctor staff is largely med students and residents who, since they are not directly responsible to either the hospital or the city, have no incentive to contain costs—in fact, as one med student who went through the hospital put it, "we were never even given any idea of the costs of any of the procedures or tests we were ordering."

2) It is the major "on-the-job" teaching facility of a large, urban university. There is a symbiotic, if somewhat imbalanced, relationship between the med school and the hospital: without the med school the latter would be hard put to find qualified staff, but the med school people in turn would be hard put to find another situation which would allow them the autonomy and "interesting cases" they enjoy at DGH. But, as pointed out above, DGH is aging

and ill-equipped, and the empire builders at Wayne State University want a clean, well-lighted place furnished with the latest in advanced technology in which to train their budding young specialists and in which to conduct their research. Which brings us to the third point.

3) If it stays where it is, doing what it is doing, it will be competing with the people just up the street who happen to be putting together (in the center of depressed Detroit) one of the largest, most comprehensive medical empires in America. There are in Michigan an estimated 3000 more hospital beds than are needed to meet the medical needs of Michiganders, and this is one of the key areas currently targeted by Blue Cross for necessary "cost containment" in the immediate future. It just happens that in the grand plan that the Detroit Medical Center Corp. (DMC) has elaborated for itself—which also coincidentally includes the integration of DGH into the Center in a fine new building, but with fewer beds—there will be, by 1978, an overall reduction of total clinic beds by something in the neighborhood of 300 beds. This will in turn net, in the words of DMC vice-president John Donaher, "a capital savings of $30 million," though to whom he didn't say, "all without any reduction in volume or service." (For some indication of the beneficial results for private hospitals obtained by eliminating "excess" public beds see *Ramparts* magazine, Feb. '74, "Hospitals for Sale" by Elinor Blake and Thomas Bodenheimer.)

4) The city, which presently subsidizes the hospital's annual deficit (estimated at $16 million for the upcoming year) is confronted with a deficit of its own and the aid it has requested from the state comes with some very sturdy strings attached. Plagued, like many major American cities, with middle-class migration to the suburbs and consequent decline of the tax base, Detroit's municipal finances were plunged into crisis by the depression and the huge inflation of operating costs which preceded it. The provisions of the " aid package deal struck by Mayor Coleman Young with Governor Milliken, as described by the latter in a memorandum to the state legislature on April 14, leave little apparent room for argument:

"The mayor and I have agreed that during the 1976–77 fiscal year, during which the city would be terminating its involvement with the hospital, *the city and the state would share equally in subsidizing the operating deficit of the hospital*." (Emphasis added; quoted by Cliff Kashtan in *Synapse*, student publication of the WSU med school.)

The immediate crisis at DGH is one of accreditation, [1] but in the long run it represents merely one aspect of a process which, by 1978, will see the hospital's forced transformation into a private institution unrecognizable, by any reasonable definition of the term, as a general hospital. For all practical purposes, the crucial decisions about the future of DGH have been made; all that remains to be hashed out is the question of control, and all the forces of capitalist history and economic development are on the side of the medical empire.

Before detailing further the situation at DGH/DMC, however, it is instructive to take a look at how the tremendous power of the medical empire came about.

Goodbye Dr. Spock

> "There is no going back for the American Health system, any more than there is for American industry in general. The age of the guild dominated, individual craftsman is over."
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> — Barbara and John Ehrenreich, *The American Health Empire: Power, Profits and Politics*, a report from the Health Policy Advisory Center—Health-PAC.

Within twenty-five years after the close of World War Two, the most striking change in the history of the sickness industry in America had taken place. By 1971 the structural results were already abundantly apparent in the displacement of doctors from the center of power and their replacement by what the Ehrenreichs identified as an enormous and growing "medical-industrial complex." (The social results were apparent in the health care crisis which spurred the publication of their book and which, coming on the tail of the 1969 recession, served as a rehearsal for the even greater crisis confronting us now.)

Today the course Health-PAC charted for the growth of health care five years ago has in large part been run; in the span of three decades the "cottage industry" of individual-doctor-dominated private practice has been transformed into a full-blown corporatized, institutionalized, capitalist industry, based not upon private practice but on medical-school-centered medical empires. Such empires, consisting of interlocked specialty hospitals grouped

around the med school core, are currently the dominant arid future form of health care "delivery" in the U.S., and an analysis of the forces which produced them is, of necessity an analysis of what is wrong with health care—and ultimately, all of industrial society—today.

Evolution of an Industry

The mainspring of capitalism, Adam Smith tells us, is competition; competition forces prices down and keeps quality up, insuring that the wise consumer will always get the best for the least of his or her money (the reasons why competition leads in reality to the qualitative debasement not only of commodities but of productive activity itself—and eventually all of lived human experience—are only touched upon here but will form the center of the discussion in later segments; see also August '75 FE, "The Architecture of Capital—Debasement of Everyday Life").

It appears self-evident (and did to the earliest capitalists) that the "competitive edge" in pricing can be gained by "rationalizing" production to make it most efficient; this means at the most basic level centralizing control over an entire productive process and concentrating the various elements of that process (workers, equipment etc.) under one roof. In turn, centralization and concentration lead to the additional advantage of economies of scale; that is, as a given enterprise grows, its ability to purchase raw materials at reduced per unit costs becomes greater because it is capable of buying in greater bulk, and thus is capable of producing a cheaper commodity.

It was these forces which, at the dawn of industrial capitalism, produced the earliest manufactories, which simply pulled together into one work place the people who had previously done individual "piece work" for the capitalist entrepreneur in their separate homes. Once this course is embarked upon, however, there is, as the Ehrenreichs point out, no going back; the individual entrepreneur soon finds his competitive edge whittled away by the more efficient (rational) production of his competitor (more effective division of labor, etc.) and his temporary monopoly is lost. But though less competitive individual enterprises will fall by the wayside, the forces of competition don't disappear but simply move up to higher levels; eventually a more comprehensive corporate form of organization comes to dominate (as it did in the U.S. in the late 19^{th} century) and the individual entrepreneur is displaced. But competition continues, now even more intense than before, forcing both consolidation of the stronger and disappearance of the weaker until only a few huge conglomerate monopolies control the major industries. But though such monopolies effectively control prices within their industry, they must now compete with other industries for the concomitantly shrinking "consumer" dollar. And this competition now overlaps with competition among the various nation states for their "share" of the world market, just as squabbles (like World Wars One and Two) erupt among them over what is or is not an equitable carving up of the world's "resources."

There is then in capitalism an irresistible tendency toward centralization and concentration, and the tendency manifests itself not only in the physical organization of commodity production but, of necessity, in everything in any way remotely connected with it. Since productive activity of any sort must eventually come under the sway of capitalization, eventually all forms of organization within the society (including most of those which claim to oppose it) come both to serve the ends of commodity production and to emulate its organizational forms and principles.

Thus, for instance, when corporate America began to realize the need for a workforce more attuned to the stultifying regimen of daily wage-labor, education was rationalized in both form and content (i.e., restructured to reproduce both the centralized, hierarchicalized and time-clocked form of the factory and the necessary ideology for the acceptance of daily drudgery, passivity and obedience to authority) and, in the most egalitarian tradition of American democracy, graciously extended to all. By law. Regardless of desire.

The culmination of the concentration and centralization tendency within education today is the huge, sprawling modern state university (the grandest embodiment of commoditized learning) and it contains within it, interestingly enough, the exact point at which the trajectories of the medical-industrial complex and the educational-industrial complex come together: the medical school.

But, to Backtrack for a Moment

Between the World Wars, while America's urban industrialism still remained in tenuous balance with a society previously organized around rural agrarianism, medical enterprise remained largely untouched by these forces and the individual private practitioner was king. But as the concentration and centralization process intensified on the societal level, and migration to cities burgeoned to meet the needs of industrial expansion, the individual doctor's office began to be challenged by the growing institutionalized group practice of hospitals. While this concentration of sickness in urban areas was leading to a parallel concentration of sickness technicians in urban hospitals, the growth of group practice was being further stimulated by (and at the same time was further stimulating) the complementary tendencies within industrial society toward ever-greater division of labor (specialization) and technologization. Specialists need to work in an environment of other specialists and only the greater concentration of capital represented by the hospital can make expensive toys like brainscan machines accessible to individual physicians.

One of the profoundest effects, evident everywhere, of the institutionalization not just of health but of any area of human activity, is the depersonalization of social experience which accompanies it. When the doctor/ patient relationship was reduced to the institution/anonymous patient relationship, this new anonymity had the curious side-effect of making it easier for patients to "neglect" paying their bills, for they were no longer confrontable on a direct one-to-one basis by the lone individual who had provided them with service and toward whom they felt a genuine personal obligation to pay for services rendered. Eventually (specifically, 1929), this "neglecting" of hospital bills spurred a group of Texas hospitals to band together to form a collection agency of their own to insure the continuance of their income.

Adopting the name Blue Cross, the agency hit upon the novel solution of guaranteeing both the hospital's income and health care delivery to patients through a pre-paid protection plan, a plan which would guarantee subscribers a specified number of days hospital care in return for a small monthly payment to the agency. The agency would thereafter reimburse the individual hospitals for the services they performed on a cost-plus basis; that is, they would pay all of the hospital's reported costs plus a small percentage for miscellaneous additional expenses. If costs rose, Blue Cross would simply increase subscribers monthly payments slightly to make up the difference.

Of such innovations are "revolutions" (in the debased language of capital) made. The advent of the third party payers, and most importantly, of the cost-plus provision, was the greatest growth stimulus institutionalized medicine was ever to feel (until the advent of Medicare/Medicaid) because it guaranteed that whatever costs were contained in the final bill (including allowances for expansion, extravagant medical and administrative salaries and a proliferation of new technology which rivals that of the American war industry) would be paid with no questions asked. [2]

Just as the institutionalization of "delivery" had led to a breakdown of personal obligation on the part of the patient, the intervention of yet another institutionalized mediation, this time in payment, had the further curious side-effect of removing on the part of the "deliverers" any sense of the connection between the patient they were servicing and the source of the payment they would receive for their services. Any personal obligation to keep their fees within the reasonable limits of a patient's capacity to pay that they may have had previously rapidly disappeared in the face of this new and seemingly limitless source of funding. In addition, there was now an enormous incentive for subscribers to avoid the doctor's office and to enter the hospital for whatever ailed them.

The net effect within two decades was the emergence of the medical-industrial complex and the effective disappearance of the individual practitioner from the forefront of medical practice. Thereby began a process of unprecedented expansion which eventually hurtled health care into a position as spectacular growth industry which has lasted for more than a quarter century. Only now has it begun to bump up against the limits of that seemingly limitless expansion, and the rest of capitalist society is falling all over itself to begin forcibly reining it in.

The Competition Heats Up

The health care crisis now being splashed over front pages everywhere—as opposed to the real crisis in people's lives—is, as it was in 1971, essentially a crisis of the third party payers (Blue Cross/Blue Shield, private insurers and Medicare/Medicaid). As costs have skyrocketed, the inevitable point has been reached where the inordinate profit-making of the sickness industry has begun to impinge on the profitability of other sectors; most critically, and most visibly, on the auto industry.

As an industry in decline, the auto industry is in a more or less perpetual state of crisis itself (despite glowing reports of record recovery—see "A Big Fat Lie" in this issue, and Emma Rothschild, *Paradise Lost: The Decline and Fall of the Auto-Industrial Age*), and is forced to adopt every cost-cutting measure it can uncover in an effort to remain economically viable. Recent front page stories in the *Free Press* have attested to the impact of spiraling health costs on GM in particular, and the $1,700 a year per worker they are now paying for combined hospital, medical and dental costs ($825 million for model year 1976) has become a "priority issue" for the upcoming contract negotiations. (*FP*, April 8.) As the FP reported in another article only four days before, "their—GM's—problem is the problem of corporations all over the state." Had their story dealt with more than just Michigan's health care crisis it would have undoubtedly read "all over the country.")

The response of the other sectors to their crisis has been to bring pressure to bear on that segment of the sickness industry over which they can exercise some direct economic leverage: Blue Cross and Blue Shield. The goose that laid the golden egg for institutionalized medicine must now be, if not killed, at least contained.

Already Blue Cross has been forced to place an unheard of 10% cap on allowable cost increases to the hospitals this year (even though, curiously enough, it was granted a 28% rate hike for itself by the state commissioner of insurance) and the UAW and big three automakers have unveiled a plan for Blue Cross in which proposed surgery for enrolled workers will be reviewed to determine if it is really necessary and how its costs can be reduced if it is. (Since this procedure requires obtaining a second opinion from another doctor it's difficult to see how it can lead to anything other than more money for doctors and further bureaucratization of health care, but its proponents say it will reduce costs by as much as 25%.)

More than this, however, the medical industry is now forced to turn back in upon itself to weed out the unprofitable segments which have thus far evaded the efficiency expert's axe. As a direct result of the new competitive restraints from without, the competition within for paying customers has intensified enormously, and as is always the case, private enterprise is squeezing out public.

Next issue: liberal and radical reformers—the Detroit Medical Center and the prospects for socialized doctors.

Notes

1. After having been inspected by the independent Joint Committee for Accreditation of Hospitals (JCAH), DGH, as a result of age and chronic shortage of funds, was found to have forty-two areas of deficiency which marked it as ineligible for accreditation. Though insufficient in and of itself to close the hospital, the loss of accreditation, if it is upheld in a re-inspection next month, will eventually lead to a refusal by the third party payers to reimburse the hospital, the removal of Wayne Med School's involvement and then, most assuredly, the closing of the hospital. As a result of much scrambling about to correct the deficiencies, however, the likelihood of this happening seems practically nil.

2. It was the same innovation which many years later turned the defense industry into the most lucrative and inflationary pork-barrel in the history of the U.S.

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