

THE
AMERICAN
HEALTH
EMPIRE:

Power, Profits, and Politics

*A HEALTH-PAC BOOK Prepared by
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I

INTRODUCTION:

THE SYSTEM BEHIND THE CHAOS

The American health crisis became official in 1969. President Nixon announced it in a special message in July. Liberal academic observers of the health scene, from Harvard's John Knowles to Einstein College of Medicine's Martin Cherkasky, hastened to verify the existence of the crisis. Now the media is rushing in with details and documentation. *Time*, *Fortune*, *Business Week*, CBS, and NBC, are on the medical scene, and finding it "chaotic," "archaic," and "unmanageable."

For the great majority of Americans, the "health care crisis" is not a TV show or a presidential address; it is an on-going crisis of survival. Every day three million Americans go out in search of medical care. Some find it; others do not. Some are helped by it; others are not. Another twenty million Americans probably ought to enter the daily search for medical help, but are not healthy enough, rich enough, or enterprising enough to try. The obstacles are enormous. Health care is scarce and expensive to begin with. It is dangerously fragmented, and usually offered in an atmosphere of mystery and unaccountability. For many, it is obtained only at the price of humiliation, dependence, or bodily insult. The stakes are high—health,

life, beauty, sanity—and getting higher all the time. But the odds of winning are low and getting lower.

For the person in search of medical help, the illness or possibility of illness which prompted the search is quickly overshadowed by the difficulties of the medical experience itself:

Problem One: Finding a place where the appropriate care is offered at a reasonable price

For the poor and for many working-class people, this can be all but impossible. Not long ago it was commonly believed that sheer distance from doctors or hospitals was a problem only in rural areas. But today's resident of slums like Brooklyn's Bedford-Stuyvesant, or Chicago's south side, is as effectively removed from health services as his relatives who stayed behind in Mississippi. One region of Bedford-Stuyvesant contains only one practicing physician for a population of one hundred thousand. Milwaukee County Hospital, the sole source of medical care for tens of thousands of poor and working-class people, is sixteen miles outside the city, an hour and a half bus ride for many. A few years ago, a social science graduate student was able to carry out her thesis work on rural health problems in a densely populated Chicago slum.

After getting to the building or office where medical care is offered, the next problem which affects both poor and middle-class people is paying for the care. Except at a diminishing number of charitable facilities, health care is not free; it is a commodity which consumers purchase from providers at unregulated, steadily increasing prices. Insurance plans like Medicaid, Medicare, and Blue Cross help soften the blow for many, but many other people are

too rich for Medicaid, too poor for Blue Cross, and too young for Medicare. A total of twenty-four million Americans have no health insurance of any variety. Even for those who are insured, costs remain a major problem: first there is the cost of the insurance itself, then there is the cost of all those services which are not covered by insurance. 102 million Americans have no insurance coverage for visits to the doctor, as opposed to hospital stays. They spend about ten dollars just to see a doctor; more, if laboratory tests or specialists are needed. Otherwise, they wait for an illness to become serious enough to warrant hospitalization. Hardly anyone, of course, has insurance for such everyday needs as dental care or prenatal care.

Supposing that one can afford the cost of the care itself, there remains the problem of paying for the time spent getting it. Working people must plan on losing a full work-day for a simple doctor's appointment, whether with a private physician or at a hospital clinic. First, there is a long wait to see the doctor. Middle-class people may enjoy comfortable chairs, magazines, and even coffee, while waiting in their doctor's anteroom, but they wait just the same. As busy private doctors try to squeeze more and more customers into their day, their patients are finding that upwards of an hour's wait is part of the price for a five- or ten-minute face-to-face encounter with a harried physician.

Not all kinds of care are as available, or unavailable, as others. In a city studded with major hospitals the person with multiple bullet wounds or a rare and fatal blood disease stands a far better chance of making a successful medical "connection," than the person with stomach pains, or the parents of a feverish child. Hospitals, at all times, and physicians, after 7:00 P.M. (if they can be located) are geared to handling the dramatic and exotic cases which

excite professional interest. The more mundane, or less obviously catastrophic, case can wait—and wait. For psychiatric problems, which are probably the nation's single greatest source of disability, there are almost no outpatient facilities, much less sympathetic attention when one finds them. Those of the mentally ill who venture forth in search of help are usually rewarded with imprisonment in a state institution, except for the few who are able to make the investment required for private psychiatric care. Even for the wealthy, borderline problems, like alcoholism and addiction may as well be lived with—there are vanishingly few facilities of any kind to deal with them.

Problem Two: Finding one's way amidst the many available types of medical care

Most of us know what buildings or other locations are possible sources of medical help. Many of us can even arrange to get to these buildings in a reasonable amount of time. But, having arrived at the right spot, the patient finds that his safari has just begun. He must now chop through the tangled morass of medical specialization. The only system to American health services, the patient discovers, is the system used in preparing the tables of contents of medical textbooks. Everything is arranged according to the various specialties and subspecialties doctors study, not according to the symptoms and problems which patients perceive.

The middle-class patient is relatively lucky. He has a private doctor who can serve as a kind of guide. After an initial examination, which may cost as little as five dollars or as much as fifty dollars, the patient's personal doctor sends him to visit a long list of his specialist colleagues—

a hematologist, allergist, cardiologist, endocrinologist, and maybe a urologist. Each of these examines his organ of interest, collects twenty dollars and up, and passes the patient along to the next specialist in line. If the patient is lucky, his illness will be claimed by one of the specialists fairly early in the process. If he is not so lucky, none of them will claim it, or—worse yet—several of them will. Only the very wealthy patient can afford the expense of visiting and retaining two medical specialists.

The hospital clinic patient wanders about in the same jungle, but without a guide. The hospital may screen him for his ills and point him in the right direction, but, from then on, he's on his own. There's nobody to take overall responsibility for his illness. He can only hope that at some point in time and space, one of the many specialty clinics to which he has been sent (each at the cost of a day off from work) will coincide with his disease of the moment.

Just as exasperating as the fragmentation of medical care is the fragmentation of medical care financing. Seymour Thaler, a New York state senator from Queens, likes to tell the story of one of his constituents who came to Thaler's office, pulled out his wallet, and emptied out a stack of cards. "Here's my Medicaid card, my Medicare card, my Blue Cross supplementary card, my workmen's compensation card, and my union retirement health plan card." "So what are you complaining about?" Thaler asked. "I've got a stomach ache," the old man answered, "so what do I do?"

A family makes matters even more complicated and confusing. Grandparents have Medicare, children have Medicaid, the parents may have one or several union hospitalization insurance plans. No one is covered for everything, and no mother is sure just who is covered for what.

If three members of the family came down with the same illness, they would more than likely end up seeing three different doctors, paying for it in three (or more) different ways, and staying in separate hospitals. In 1968, a New York father of six quit his job and applied for welfare, claiming he couldn't work and see to his children's health care. One child, diagnosed as retarded, had to be taken to and from a special school each day. All required dental care, which was free at a Health Department clinic on Manhattan's lower east side. For dental surgery, however, they went to a clinic a bus ride away, at Bellevue. The youngest children went to a neighborhood pediatrician who accepted Medicaid patients. An older child, with a rare metabolic defect, required weekly visits to a private hospital clinic a half hour's trip uptown. The father himself, the victim of a chronic back problem, qualified for care at a union health center on the west side. For him, family health maintenance was a full-time job, not, as it is for most parents, just a busy sideline.

Doctors like to tell us that fragmentation is the price of quality. We should be happy to be seeing a specialist, twice as happy to be seeing two of them, and fully gratified to have everyone in the family seeing a special one of his own. In many difficult cases, specialization does pay off. But evidence is accumulating that care which is targeted at a particular organ often completely misses the mark. Take the case of the Cleveland woman who had both a neurological disease and a damaged kidney. Since the neurologist had no time to chat, and since she assumed that doctors know a good deal more than their patients, she never mentioned her kidney to her neurologist. Over a period of time, her urologist noted a steady deterioration of her kidney problem. Only after the kidney had been removed did

the urologist discover that his colleague, the neurologist, had been prescribing a drug which is known to put an extra strain on the kidney.

The patient may have only one problem—as far as his doctors are concerned—and still succumb to medical fragmentation. Recently, an elderly man with a heart condition was discharged from a prestigious private medical center, assured he was good for another decade or two. Four weeks later he died of heart failure. Cause? Overexertion. He lived on the fifth floor of a walk-up apartment—a detail which was obviously out of the purview of his team of hospital physicians, for all the time and technology they had brought to bear on his heart. Until human physiology adapts itself to the fragmentation of modern medical practice, it is up to the patient himself to integrate his medical problems, and to integrate them with the rest of his life.

Problem Three: Figuring out what they are doing to you

Many people are not satisfied to have found the correct doctor or clinic. They also want to know what is being done to their bodies, and why. For most, this is not just idle curiosity. If the patient has to pay all or some of the bill, he wants to know whether a cheaper treatment would be just as efficacious, or whether he should really be paying for something much fancier. The doctors' magazine *Medical Economics* tells the story of the family whose infant developed bronchopneumonia. The physician who visited the home judged from the furnishings that the family could not afford hospitalization. With little or no explanation, he prescribed an antibiotic and left. The baby died six hours later. The parents were enraged when they learned the diagnosis and realized that hospitalization might have

helped. They wanted to know the risks, and make the decision themselves.

More commonly, the patients fear they will be over-treated, hence overbilled, for a medical problem. A twenty-five-year-old graduate student, a victim of hayfever, was told by an allergist at prestigious New York Hospital that his case would require several years of multiple, weekly, antiallergy injections. When he asked to know the probability that this treatment would actually cure his hayfever, the allergist told him, "I'm the doctor, not you, and if you don't want to trust my judgment you can find another doctor—or be sick forever for all I care!" Following this advice, the patient did, indeed, find a new doctor. And when the limitations of the treatment were explained to him, he decided the treatment was probably worth the trouble after all. The important thing is that *he* decided.

Some people, perhaps more trusting of doctors, never ask for an explanation until they have to in sheer self-defense. Residents of Manhattan's lower east side tell the story of the woman who was admitted to a ward at Bellevue for a stomach operation. The operation was scheduled for Thursday. On Wednesday a nurse told her she was to be operated on that day. The patient asked why the change. "Never mind," said the nurse, "give me your glasses." The patient could not see why she should give up her glasses, but finally handed them over at the nurse's insistence. Inside the operating room, the patient was surprised when she was not given general anesthesia. Although her English was poor, she noticed that the doctors were talking about eye cancer, and looking at her eyes. She sat up and said there was nothing wrong with her eyes—her stomach was the problem. She was pushed back on the operating table. With the strength of panic, she leapt up

and ran into the hall. A security guard caught her, running sobbing down the hall in an operating gown. She was summarily placed in the psychiatric ward for a week's observation.

Even when confronted with what seems to be irrational therapy, most patients feel helpless to question or complain. A new folklore of medicine has emerged, rivaling that of the old witch doctors. Medical technology, from all that the patient has read in the newspapers, is as complex and mystifying as space technology. Physicians, from all he has seen on TV serials or heard thirdhand from other patients, are steely-nerved, omniscient, medical astronauts. The patient himself is usually sick-feeling, often undressed, a nameless observer in a process which he can never hope to understand. He has been schooled by all the news of medical "space shots"—heart transplants, renal dialysis, wonder drugs, nuclear therapy, etc.—to expect some small miracle in his own case—a magical new prescription drug or an operation. And miracles, by their very nature, are not explainable or understandable. Whether it's a "miracle detergent," a "miracle mouth wash," or a "miracle medical treatment," the customer can only pay the price and hope the product works.

Problem Four: Getting a bearing if things don't go right

Everything about the American medical system seems calculated to maintain the childlike, dependent, and depersonalized condition of the patient. It is bad enough that modern medical technology has been infused by its practitioners with all the mystery and unaccountability of primitive shamanism. What is worse is that the patient is given absolutely no means of judging what care he should get or

evaluating what he has gotten. As one Washington, D.C. taxi driver put it, "When I buy a used car, I know it might be a gyp. But I go over it, test it, try to figure out if it's O.K. for the price. Then take last year when I got started getting some stomach problem. The doctor says I need an operation. How do I know I need an operation? But what can I do—I have an operation. Later I get the bill—\$1700—and Blue Cross left over \$850 for me to pay. How should I know whether the operation should cost \$50 or \$1700? Now I think my stomach problem is coming back. Do I get my money back?"

Doctors and hospitals have turned patients into "consumers," but patients have none of the rights or protections which consumers of other goods and services expect. People in search of medical care cannot very easily do comparative shopping. When they're sick, they take help wherever they can get it. Besides, patients who switch doctors more than once are viewed by other doctors as possible neurotics. Health consumers know what they'd like—good health—but they have no way of knowing what this should entail in terms of services—a new diet, a prescription, or a thousand-dollar operation. Once they've received the service, the doctor, not their own perception, tells them whether it did any good. And if they suspect that the price was unduly high, the treatment unnecessarily complicated or drastic, there is no one to turn to—no Better Business Bureau or Department of Consumer Protection.

When something goes really wrong—a person is killed or maimed in the course of medical treatment—there is still no formal avenue of recourse for the patient or his survivors. Middle-class people, who know the ropes and have some money to spend, can embark on a long and

costly malpractice suit, and win, at best, a cash compensation for the damage done. But this process, like everything else in a person's encounter with doctors and hospitals, is highly individualistic, and has no pay-off in terms of the general health and safety of the community. For the poor, there is usually no resource at all short of open resistance. A Manhattan man, infuriated by his wife's treatment in the emergency room of New York's Beth Israel Medical Center, beat up the intern on duty. Another man, whose child died inexplicably at a big city public hospital, solitarily pickets City Hall summer after summer.

Problem Five: Overcoming the built-in racism and male chauvinism of doctors and hospitals

In the ways that it irritates, exhausts, and occasionally injures patients, the American medical system is not egalitarian. Everything that is bad about American medicine is especially so for Americans who are not male or white. Blacks, and in some areas Indians, Puerto Ricans, or Mexicans, face unique problems of access to medical care, and not just because they are poor. Many hospitals in the south are still unofficially segregated, or at least highly selective. For instance, in towns outside of Orangeburg, South Carolina, blacks claim they are admitted to the hospital only on the recommendation of a (white) employer or other white "reference."

In the big cities of the north, health facilities are available on a more equal footing to blacks, browns, and poor whites. But for the nonwhite patient, the medical experience is more likely to be something he will not look forward to repeating. The first thing he notices about the large hospital—he is more likely to be at a hospital clinic:

than at a private doctor's office—is that the doctors are almost uniformly white; the nonskilled workers are almost entirely brown or black. Thus the nonwhite patient enters the hospital at the bottom end of its social scale, quite aside from any personal racial prejudices the staff may harbor. And, in medicine, these prejudices take a particularly insulting form. Black and Puerto Rican patients complain again and again of literally being “treated like animals” by everyone from the clerks to the M.D.'s. Since blacks are assumed to be less sensitive than white patients, they get less privacy. Since blacks are assumed to be more ignorant than whites, they get less by way of explanation of what is happening to them. And since they are assumed to be irresponsible and forgetful, they are more likely to be given a drastic, one-shot treatment, instead of a prolonged regimen of drugs, or a restricted diet.

Only a part of this medical racism is due to the racist attitudes of individual medical personnel. The rest is “institutional racism,” a built-in feature of the way medicine is learned and practiced in the United States. As interns and residents, young doctors get their training by practicing on the hospital ward and clinic patients—generally nonwhite. Later they make their money by practicing for a paying clientele—generally white. White patients are “customers”; black patients are “teaching material.” White patients pay for care with their money; black patients pay with their dignity and their comfort. Clinic patients at the hospital affiliated with Columbia University's medical school recently learned this distinction in a particularly painful way. They had complained that anesthesia was never available in the dental clinic. Finally, a leak from one of the dental interns showed that this was an official policy: the patient's pain is a good guide to the

dentist-in-training—it teaches him not to drill too deep. Anesthesia would deaden the pain and dull the intern's learning experience.

Hospitals' institutional racism clearly serves the needs of the medical system, but it is also an instrument of the racist, repressive impulses of the society at large. Black community organizations in New York have charged hospitals with “genocidal” policies towards the black community. Harlem residents tell of medical atrocities—cases where patients have unwittingly given their lives or their organs in the cause of medical research. A more common charge is that, to public hospital doctors, “the birth control method of choice for black women is the hysterectomy.” Even some doctors admit that hysterectomies are often performed with pretty slim justification in ghetto hospitals. (After all, they can't be expected to take a pill every day, can they? And one less black baby is one less baby on welfare, isn't it?) If deaths from sloppy abortions run highest in the ghetto, it is partly because black women are afraid to go to the hospital for an abortion or for treatment following a sloppy abortion, fearing that an involuntary sterilization—all for “medical” reasons—will be the likely result. Aside from their medical policies, ghetto hospitals have a reputation as racist because they serve as police strongholds in the community. In the emergency room, cops often outnumber doctors. They interrogate the wounded—often before the doctor does, and pick up any vagrants, police brutality victims, drunks or addicts who have mistakenly come in for help. In fact, during the 1964 riots in New York, the police used Harlem Hospital as a launching pad for their pacification measures.

Women are the other major group of Americans singled out for special treatment by the medical system. Just as

blacks face a medical hierarchy dominated by whites, women entering a hospital or doctor's office encounter a hierarchy headed by men, with women as nurses and aides playing subservient, hand-maid roles. And in the medical system, women face all the male supremacist attitudes and superstitions that characterize American society in general—they are the victims of sexism, as blacks are of racism. Women are assumed to be incapable of understanding complex technological explanations, so they are not given any. Women are assumed to be emotional and "difficult," so they are often classified as neurotic well before physical illness has been ruled out. (Note how many tranquilizer ads in medical journals depict women, rather than men, as likely customers.) And women are assumed to be vain, so they are the special prey of the paramedical dieting, cosmetics, and plastic surgery businesses.

Everyone who enters the medical system in search of care quickly finds himself transformed into an object, a mass of organs and pathology. Women have a special handicap—they start out as "objects." Physicians, despite their supposed objectivity and clinical impersonality, share all the sexual hangups of other American men. The sick person who enters the gynecology clinic is the same sex as the sexual "object" who sells cars in the magazine ads. What makes matters worse is that a high proportion of routine medical care for women centers on the most superstitious and fantasy-ridden aspect of female physiology—the reproductive system. Women of all classes almost uniformly hate or fear their gynecologists. The gynecologist plays a controlling role in that aspect of their lives society values most, the sexual aspect—and he knows it. Middle-class women find a man who is either patronizingly jolly, or cold and condescending. Poorer women, using clinics, are

more likely to encounter outright brutality and sadism. Of course, black women have it worst of all. A shy teenager from a New York ghetto reports going to the clinic for her first prenatal check-up, and being used as teaching material for an entire class of young, male medical students learning to give pelvic examinations.

Doctors and hospitals treat pregnancy and childbirth, which are probably among the healthier things that women experience, as diseases—to be supervised by doctors and confined to hospitals. Women in other economically advanced countries, such as Holland, receive their prenatal care at home, from nurses, and, if all goes well, are delivered at home by trained midwives. (The Netherlands rank third lowest in infant mortality rate; the U.S. ranks fourteenth!) But for American women, pregnancy and childbirth are just another harrowing, expensive medical procedure. The doctor does it; the woman is essentially passive. Even in large cities, women often have to go from one obstetrician to another before they find one who approves of natural childbirth. Otherwise, childbirth is handled as if it were a surgical operation, even to the point of "scheduling" the event to suit the obstetrician's convenience through the use of possibly dangerous labor-inducing drugs.

Most people who have set out to look for medical care eventually have to conclude that there *is* no American medical system—at least there is no systematic way in America of getting medical help when you need it, without being financially ruined, humiliated, or injured in the process. What system there is—the three hundred thousand doctors, seven thousand hospitals and supporting insurance plans—was clearly not designed to deal with the sick. In fact the one thing you need most in order to qualify

for care financially and to survive the process of obtaining it is *health*, plus, of course, a good deal of cunning and resourcefulness. The trouble is that it's almost impossible to stay healthy and strong enough to be able to tackle the medical system. Preventive health care (regular check-ups, chest X-rays, pap tests, etc.) is not a specialty or even an interest of the American medical system.

The price of this double bind—having to be healthy just to stay healthy—is not just consumer frustration and discomfort. The price is lives. The United States ranks fourteenth among the nations of the world in infant mortality, which means that approximately 33,000 American babies under one year old die unnecessarily every year. (Our infant mortality statistics are not, as often asserted, so high because they are “spoiled” by the death rates for blacks. The statistics for white America alone compare unfavorably to those for countries such as Sweden, the Netherlands, Norway, etc.) Mothers also stand a better chance of dying in the United States, where the maternal mortality rate ranks twelfth among the world's nations. The average American man lives five years less than the Swedish man, and his life expectancy is shorter than for males in seventeen other nations. Many American men never live out their already relatively short lifetime, since the chance of dying between ages forty and fifty is twice as high for an American as it is for a Scandinavian. What is perhaps most alarming about these statistics is that they are, in a relative sense, getting worse. The statistics improve a little each year, but at a rate far slower than that for other advanced countries. Gradually, the United States is slipping behind most of the European nations, and even some non-European nations, in its ability to keep its citizens alive.

* * *

These are the symptoms: unhealthy statistics, soaring costs and mounting consumer frustration over the quality and even the quantity of medical care. Practically everyone but the A.M.A. agrees that something is drastically wrong. The roster of public figures actively concerned about the health care crisis is beginning to read like *Who's Who in America*: Labor leaders Walter Reuther of the Auto Workers and Harold Gibbons of the Teamsters, businessmen like General James Gavin of Arthur D. Little, Inc., politicians like New York's Mayor John Lindsay and Cleveland's Mayor Carl Stokes, doctors like Michael DeBakey of Baylor College of Medicine, and civil rights leaders like Mrs. Martin Luther King, Jr. and Whitney Young, Jr. With the help of eminent medical economists like Harvard's Rashi Fein and Princeton's Ann Somers, these liberal leaders have come up with a common diagnosis of the problem: the medical care system is in a state of near-chaos. There is no one to blame—medical care is simply adrift, with the winds rising in all directions. In the words of the official pamphlet of the Committee for National Health Insurance (a coalition of one hundred well-known liberals): “The fact is that we do not have a health care system at all. We have a ‘nonsystem.’” According to this diagnosis, the health care industry is, in the words of the January, 1970, *Fortune* magazine, a “cottage industry.” It is dominated by small, inefficient and uncoordinated enterprises (private doctors, small hospitals, and nursing homes), which add up to a fragmented and wasteful whole—a nonsystem.

Proponents of the nonsystem theory trace the problem to the fact that health care, as a commodity, does not obey the orderly, businesslike laws of economics. With a commodity like bacon, demand reflects people's desire to eat

bacon and ability to pay for bacon. Since the supply gracefully adjusts itself to demand, things never get out of hand—there is a *system* of bacon production and sales. No such invisible hand of economic law operates in the health market. First, people buy medical care when they have to, not when they want to or can afford to. Then, when he does go to purchase care, the consumer is not the one who decides what and how much to buy—the doctor or hospital does. In other words, in the medical market place, it is the supplier who controls the demand. Finally, medical care suppliers have none of the usual economic incentives to lower their prices or rationalize their services. Most hospitals receive a large part of their income on a cost-plus basis from insurance organizations, and couldn't care less about cost or efficiency. Doctors do not compete on the basis of price. In fact, given the shortage of doctors (which is maintained by the doctors themselves through the A.M.A.'s prevention of medical school expansion), they don't have to compete at all.

Solutions offered by the liberal viewers of the medical nonsystem are all along the lines of putting the health industry on a more "rational," i.e., businesslike basis. First, the consumer should not have to fish in his pocket each time the need for care arises; he should have some sort of all-purpose medical credit card. With some form of National Health Insurance, all consumers, rich or poor, would have the same amount of medical credit, paid for by the government, by the consumer, or both through payroll taxes (see chapter XII). Second, the delivery of health services must be made more efficient. Just as supermarkets are more efficient than corner groceries, and shopping centers are more efficient than isolated supermarkets, the

medical system ought to be more efficient if it were bigger and more integrated at all levels. Doctors should be encouraged to come together into group practices, and group practices, hospitals and medical schools should be gradually knitted together into coordinated regional medical care systems. Since they are the centers of medical technology, the medical schools should be the centers and leaders of these regional systems—regulating quality in the "outposts," training professional and paraprofessional personnel, and planning to meet changing needs(see chapters II-VI).

There is only one thing wrong with this analysis of the health care crisis: it's based on a false assumption. The medical reformers have assumed, understandably enough, that the function of the American health industry is to provide adequate health care to the American people. From this it is easy enough to conclude that there is no American health *system*. But this is like assuming that the function of the TV networks is to give comprehensive, penetrating, and meaningful information to the viewers—a premise which would quickly lead us to believe that the networks have fallen into wild disorganization and confusion. Like the mass media, the American medical industry has many items on its agenda other than service to the consumers. Analyzed in terms of all of its functions, the medical industry emerges as a coherent, highly organized system. One particular function—patient care—may be getting slighted, and there may be some problems in other areas as well, but it remains a *system*, and can only be analyzed as such.

The most obvious function of the American medical system, other than patient care, is profit-making. When it

comes to making money, the health industry is an extraordinarily well-organized and efficient machine. The most profitable small business around is the private practice of medicine, with aggregate profits running into the billions. The most profitable big business in America is the manufacture and sale of drugs. Rivaling the drug industry for Wall Street attention is the burgeoning hospital supply and equipment industry, with products ranging from chicken soup to catheters and heart-lung machines. The fledgling nursing home (for profit) industry was a speculator's dream in 1968 and 1969, and even the stolid insurance companies gross over ten billion dollars a year in health insurance premiums. In fact, the health business is so profitable that even the "nonprofit" hospitals make profits. All that "nonprofit" means is that the hospital's profit, i.e., the difference between its income and its expenditures, is not distributed to shareholders. These nonprofits are used to finance the expansion of medical empires—to buy real estate, stocks, plush new buildings, and expensively salaried professional employees. The medical system may not be doing too well at fighting disease, but, as any broker will testify, it's one of the healthiest businesses around.

Next in the medical system's list of priorities is research. Again, if this undertaking is measured in terms of its dividends for patient care, it comes out looking pretty unsystematic and disorganized. Although the vast federal appropriations for biomedical research are primarily motivated by the hope of improving health care, only a small fraction (much smaller than need be) of the work done in the name of medical research leaks out to the general public as improved medical care. But medical research has a *raison d'être* wholly independent of the delivery of health services, as an indispensable part of the nation's giant re-

search and development enterprise. Since the Second World War, the United States has developed a vast machinery for R.&D. in all areas—physics, electronics, aerospace as well as biomedical sciences—financed largely by the government and carried out in universities and private industry. It has generated military and aerospace technology, and all the many little innovations which fuel the expansion of private industry.

For the purposes of this growing R.&D. effort, the medical system is important because it happens to be the place where R.&D. in general comes into contact with human material. Medical research is the link. The nation's major biomedical research institutes are affiliated to hospitals to a significant extent because they require human material to carry out their own, usually abstract, investigations. For instance, a sophisticated (and possible patentable) technique for investigating protein structure was recently developed through the use of the blood of several dozen victims of a rare and fatal bone marrow disease. Even the research carried out inside hospitals has implications for the entire R.&D. enterprise. Investigations of the pulmonary disorders of patients in Harlem Hospital may provide insights for designing space suits, or it may contribute to the technology of aerosol dissemination of nerve gas. Or, of course, it may simply lead to yet another investigation.

Human bodies are not all that the medical care system offers up to R.&D. The sociological and psychological research carried out in hospitals and ghetto health centers may have pay-offs in the form of new counterinsurgency techniques for use at home and abroad. And who knows what sinister—or benignly academic—ends are met by the routine neurological and drug research carried out on the nation's millions of mental hospital inmates?

Finally, an important function of the medical care system is the reproduction of its key personnel—physicians. Here, again, there seems to be no system if patient care is the ultimate goal. The medical schools graduate each year just a few more doctors than are needed to replace the ones who retire, and far too few doctors to keep up with the growth of population. Of those who graduate, a growing proportion go straight into academic government, or industrial biomedical research, and never see a patient. The rest, according to some dissatisfied medical students, aren't trained to take care of patients anyway—having been educated chiefly in academic medicine (a mixture of basic sciences and “interesting” pathology). But all this is not as irrational as it seems. The limited size of medical school classes has been maintained through the diligent, and entirely systematic, efforts of the A.M.A. Too many—or even enough—doctors would mean lower profits for those already in practice. And the research orientation of medical education simply reflects the medical schools' own consuming preoccupation with research.

Profits, research and teaching, then, are independent functions of the medical system, not just adjuncts to patient care. But they do not go on along separate tracks, removed from patient care. Patients are the indispensable ingredient of medical profit-making, research, and education. In order that the medical industry serve these functions, patient care must be twisted to meet the needs of these other “medical” enterprises.

Different groups of patients serve the ends of profit-making, research and education in different ways. The rich, of course, do much to keep medical care profitable. They can afford luxury, so, for them, the medical system produces a luxury commodity—the most painstaking,

supertechnological treatment possible; special cosmetic care to preserve youth, or to add or subtract fatty tissue; even sumptuous private hospital rooms with carpeting and a selection of wines at meals. The poor, on the other hand, serve chiefly to subsidize medical research and education—with their bodies. City and county hospitals and the wards and clinics of private hospitals provide free care for the poor, who, in turn, provide their bodies for young doctors to practice on and for researchers to experiment with. The lucky poor patient with a rare or interesting disease may qualify for someone's research project, and end up receiving the technically most advanced care. But most of the poor are no more interesting than they are profitable, and receive minimal, low-quality care from bored young interns.

The majority of Americans have enough money to buy their way out of being used for research, but not enough to buy luxury care. Medical care for the middle class is, like any other commodity, aimed at a mass market: the profits are based on volume, not on high quality. The rich man may have his steak dinners catered to him individually; the middle-class consumer waits for his hamburger in the check-out line at the A&P. Similarly, the middle-class patient waits in crowded waiting rooms, receives five minutes of brusque, impersonal attention from a doctor who is quicker to farm him out to a specialist than to take the time to treat him himself, and finally is charged all that the market will bear. Preventive care is out of the question: it is neither very profitable nor interesting to the modern, science-oriented M.D.

The crisis experienced by the poor and middle-class consumer of health care can be traced directly to the fact that patient care is not the only, or even the primary, aim

of the medical care system. But what has turned the consumer's private nightmare into a great public debate about the health care crisis is that the other functions of the system are also in trouble. Profit-making, research, and education are all increasingly suffering from financial shortage on the one hand and institutional inadequacies on the other. The solutions offered by the growing chorus of medical reformers are, in large measure, aimed at salvaging profits, research, and education as much as they are aimed at improving patient care. They are simple survival measures, aimed at preserving and strengthening the medical system as it now operates.

No one, so far, has seen through the proposed reforms. Union and management groups, who have moved into the forefront of the medical reform movement, seem happy to go along with the prescription that the medical system is writing for itself. The alternative—to marshal all the force of public power to take medical care out of the arena of private enterprise and recreate it as a public system, a community service, is rarely mentioned, and never considered seriously. To do this would be to challenge some of the underlying tenets of the American free enterprise system. If physicians were to become community employees, if the drug companies were to be nationalized—then why not expropriate the oil and coal industries, or the automobile industry? There is an even more direct antipathy to nationalizing the health industry: a host of industries, including the aerospace industry, the electronic industry, the chemical industry, and the insurance industry, all have a direct stake in the profitability of the medical care system. (And a much larger sector of American industry stands to profit from the human technology spun off by the medical research enterprise.) Of course, the argument

never takes this form. Both business and unions assert, in their public pronouncements, that only a private enterprise system is capable of managing medical services in an efficient, nonbureaucratic, and flexible manner. (The obvious extrapolation, that all medical services, including voluntary and city hospitals, would be in better shape if run as profit-making enterprises, is already being advanced by a few of the more visionary medical reformers.)

For all these reasons, business and unions (and, as a result, government) are not interested in restructuring the medical care system in ways contrary to those already put forth by the doctors, hospitals, and medical industry companies. Their only remaining choice is to go along with the reforms which have been proposed, in the hope that lower costs, and possibly even more effective care, will somehow fall out as by-products.

For the health care consumer, this is a slim hope. What he is up against now, what he will be up against even after the best-intentioned reform measures, is a system in which health care is itself only a by-product, secondary to the priorities of profits, research, and training. The danger is that, when all the current reforms are said and done, the system as a whole will be tighter, more efficient, and harder to crack, while health services, from the consumer's point of view, will be no less chaotic and inadequate. Health care will remain a commodity, to be purchased at great effort and expense, and not a right to be freely exercised.

But there are already the beginnings of a consumer rebellion against the reformer-managers of the medical care system (see chapter XVI). The demand is to turn the medical system upside down, putting human care on top, placing research and education at its service, and putting

profit-making aside. Ultimately, the growing movement of health care consumers *does not want to “consume”* health care at all, on any terms. They want to take it—because they have to have it—even if this means creating a wholly new American health care system.