NEW WAYS TO KEEP OLD PROMISES IN HEALTH CARE

by David L. Rosenbloom

Prologue: The American health care system is an amalgam of resources, private and public, that have evolved over time to meet a wide-ranging and ever-changing set of needs. The ninety urban public hospitals located in the nation's largest cities represent the cornerstone of the local role in personal health services. These institutions are large physical facilities, symbols of a continuing commitment on the part of government that no one shall be denied care because of an inability to pay. But public hospitals face a staggering array of problems. As Boston's former commissioner of health and hospitals (1975-1983), David Rosenbloom is intimately familiar with the problems of public hospitals. A political scientist by training (Ph.D., Massachusetts Institute of Technology), Rosenbloom was a close confidant of Mayor Kevin White and an articulate spokesman for the poor during his tenure as health commissioner. He also was known to do battle with Boston's medical establishment, an array of medical schools, teaching hospitals, and research facilities that make health care one of the city's largest employers. As this article strongly suggests, Rosenbloom is far from satisfied with the configuration of local health departments, in Boston or elsewhere. He points to their ownership of teaching hospitals as a primary source of their financial problems. Rosenbloom, one of the founding fathers of the National Association of Public Hospitals, argues that the delivery of medical care through teaching hospitals is the most expensive way to go; moreover, he says, most of the people treated in public hospitals do not need tertiary care.

Rosenbloom, who now teaches at the Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University, believes that state and local governments must maintain a commitment to providing access to medical care to those without means, but he argues for new approaches. He points to Arizona and California as two states that have sought to balance through new approaches access to care and moderation of its cost.
The idea that government can play a positive role in the protection and enhancement of human life is under attack. We are told that we cannot afford to meet the promises that have been made to the elderly and the poor, that we must retrench. In health care, we are told, the problem is that Medicare and Medicaid costs are rising astronomically. The solution is to cut eligibility and benefits and to make the poor and the elderly pay more for their care. Built into most attempts to define the appropriate roles of state and local governments in health care delivery, finance, and regulation is the phrase “in an era of restraint.” This rhetoric presumes further reductions and a minimalist approach to the provision of health care services.

The assumptions behind our current policy and actions have undergone little public analysis or debate. I believe that all these assumptions are wrong.

The Assumptions Underlying Current Policy

1. Paying for medical costs is the principal health responsibility of state and local governments. In recent years, on this assumption, state and local expenditures for medical care have grown enormously while public health programs have grown less rapidly (they now represent only 13 percent of state and local health expenditures). The traditional tasks of state and local governments—preventing disease, providing safety for the public, and giving refuge to the homeless—have been overwhelmed by the growth of medical expenses for the acutely ill and custodial expenses in medically oriented nursing homes for some of the elderly.

2. The way we now provide medical care to the poor and the elderly is the only method available to state and local governments. Providers with vested interests have convinced public policymakers that any change will mean less service to the elderly and the poor. This assumption is being challenged in some states, but, for the moment, it prevails.

3. Since the providers cannot be blamed, the poor and the elderly must be held responsible. “They use the system too much—abuse it—because it is ‘free.’ The greed of doctors and hospitals could not operate if the poor and the elderly stayed away or were forced to be ‘price conscious.’”

4. Government intervention and financial support through Medicare and Medicaid have proven, in part, to be inflationary and wasteful interference with the private market. “They have raised expectations to levels that cannot be met. We must cut back as quickly as we can to limit the damage.”

5. Medical care equals health care. Contrary to this assumption, medical care is only one component of health, and not necessarily the most important.

A disturbing feature of the current rhetoric about government’s role in health is its silence about the steady and dramatic progress toward a...
healthier population made throughout the century. This success has many “fathers”: increases in economic well-being, improved sanitation in water and sewage, preventive advances against childhood diseases, improved medical care outcomes, healthier lifestyles, safer cars and workplaces.

To be sure, important gaps remain. Poor people and racial minorities still have shorter lives and poorer health than rich and white people. Preventive and curative success with some diseases that killed quickly have uncovered new medical, social, and financial problems of chronic care for a much older population. Many of us know sixty-five-year-olds who have responsibility for caring for their ninety-year-old mothers.

Today, state and local governments may well need to provide access to medical care for special populations, but their primary obligation to the entire population remains providing access to health. The traditional basic health goal of state and local governments was the prevention of disease. A return to that formulation may place medical care in an appropriate context and help us to redefine our role in medical care delivery in a way that is both affordable and just.

More Reasonable Assumptions

1. Medical care is a redistributive good. Those of us who are healthier, younger, and richer are going to pay for the care of those of us who are older, sicker, and poorer. The validity of this assumption does not depend on the vagaries of government policy and reimbursement. We can control the amount and method of redistribution, but we cannot stop it from occurring unless we enforce policies that let the poor and the elderly die in the streets.

If the current sense of national poverty persists, then we should at least resist retreat from the progress made to date and insist on maintaining the population at its current level of health. Sadly, evidence from some states indicates that we are not even meeting this limited objective. For example, a rise in the infant death rate was reported in Michigan in 1982, and malnutrition and failure to develop were reported to be increasing among some inner-city children.6

Government remains the most efficient, effective, and equitable method of redistributing society’s resources. Therefore, government must continue to play a major role in direct delivery of care. State and local governments are not as well equipped as the federal government, but they continue to be responsible for a large part of the burden for medical services.

If government funding is inadequate to support the amount of redistribution that is actually taking place through the delivery system, other mechanisms such as cost shifting will be created to make up the difference, at least in the short term. The political reaction from organized
business to the cost shifting now occurring may spark a new national
debate on how to pay for care of the poor.

2. For the population as a whole, at least some of our efforts in health are a common good. That is, the benefit of a particular activity is shared by all the members of the community. Providing common goods is the reason we have governments. For example, the control of environmentally spread disease has always been an important function of local government, and local governments enjoy extraordinary powers to perform this function.

3. State and local governments cannot really be lumped together as if they were one and the same. There is almost continuous political rivalry and competition between elected state and local officials and bureaucracies. In periods of expansion, elected state and local officials compete for credit for delivering the goods. In periods of retrenchment, they work hard to make sure the others get the blame.

In the past, big city health departments have often been far ahead of their states in public health innovations and have had far better records than their states in administering health care institutions. In more rural and poor areas, the states have often led. State and local capacities vary considerably across the country, but the trend is for state governments to assume more power and responsibility as a result of tax-limiting laws and assumption by the states of costs for such items as education and welfare.

4. State and local governments are sources of innovation and social invention. Many policies, ideas, programs, and roles initiated by a single state or community have subsequently been adopted nationwide. People with contrary political philosophies may disagree about the merits of particular innovations, but they all agree about the value of the state and local system as a “laboratory.”

5. Government intervention in health can have a beneficial effect on the population as a whole and on individuals. The leadership of state and local governments in establishing safe and sanitary water systems alone is responsible for eliminating major health problems. Mandatory vaccination programs have virtually eliminated childhood diseases, from measles to polio. Water fluoridation has reduced dental cavities. In recent years, advanced emergency medical systems have reduced death and morbidity from accidents.

6. “Doing the right thing” will not cost more. Fifteen percent annual inflation in medical care expenditures is neither necessary nor desirable to achieve the goal of access to health. The country may well be able to continue its progress toward this goal while devoting a constant or reduced percentage of the Gross National Product to medical care. States can play an active role in helping to attack the medical cost inflation that affects all citizens. To do so, they must be able to distinguish saving money for the state from cutting medical inflation. At the moment, almost all state cost-cutting policy, in fact, shifts costs to somebody else.
Roles For State And Local Government:
Direct Delivery Or Financing Medical Care For The Poor

States, by and large, spend their medical care money for the purchase of medical care for covered populations, while cities and counties, by and large, spend theirs on direct delivery through their own institutions. The critical task for both state and local governments is to remove the financial, geographic, social, cultural, and racial barriers to medical care for their populations—either through direct delivery by publicly owned systems, or indirectly through some form of sponsorship and payment for care. The importance and moral imperative of providing access to medical care to those who have no means cannot be understated. It is tragic, therefore, that we are abandoning the poor because we have done such a bad job of conceptualizing and operating our Medicaid programs.

The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has stated the challenge very well:

Although local, state, and federal efforts have done much to improve access, they have not yet succeeded in making equitable access to health care a reality for all Americans. . . . Further movement toward that goal is now in doubt because of mounting concern with the growing share of national resources, and particularly of public funds, being spent on health care. Americans are asking—with good reason—whether increased expenditures are matched by increased benefits. . . . Until effective steps are taken to control the escalation in health care costs, policymakers are likely to remain reluctant to focus attention on improving access. Second, wasteful practices siphon off precious resources that could be used to provide adequate care for all and to promote the vigorous research efforts on which future triumphs over illness depend.7

State and local government expenditures are large and growing faster than the rate of inflation. Between 1979 and 1981, state and local government expenditures for medical care increased by 35 percent. In almost every state, medical care represented an increasing share of the total state and local expenditures for the period. In fact, state and local governments continue to spend a higher percentage of their total budgets for medical care than the federal government. Despite the rhetoric about cost containment and the pressure to slow things down, in 1983, inflation will be more than 12 percent for medical care, much higher than for the rest of the economy.

Almost all state Medicaid programs are more restrictive and less generous now than they were two years ago, no matter how broad or narrow they were then. In 1981 and 1982, more than thirty states took actions that resulted in limitations in eligibility, benefits, or reimbursement to
providers. For example, in 1982, eleven states put restrictions on inpatient hospital use, and fourteen put in new copayments on optional services. On the other hand, thirteen states added new services, seven of them adding coverage for community-based alternatives to institutional care.

Arizona adopted a Medicaid program for the first time and organized it along very different lines from existing programs. In each county, the state solicited bids from providers who had to compete for the right to serve Medicaid patients. The California state legislature also authorized price competitive bidding by hospitals for Medicaid business.

Local government health delivery systems continue to care for very large numbers of people, about 20 percent of their populations, almost all of them substantially poorer, with more minority representation, and more likely to have a combination of social and medical problems than the community as a whole.

Public hospitals provide important and humane social medicine services to people in desperate conditions, but they are people much of the rest of the society does not want to hear about or see. Street people, battered children, and chronic schizophrenics make their fellow citizens uncomfortable. Public hospitals provide excellent trauma care, but more fortunate members of the community appear to associate public hospital emergency rooms and hospitals with violence and avoid them where possible.

Despite their reputations for shoddy patronage-ridden management, the public hospitals appear to be well managed. For example, public hospitals have somewhat lower costs per diagnosis-related group (DRG) than the average hospital. The rate of inflation in public hospitals is substantially lower than in the industry as a whole. And yet, public hospital officials are absolutely terrified about the next five years. Public hospitals are caught between the privatization of public services and the cutbacks in public entitlements. In almost every state, patient “dumping” from the private and so-called charitable sectors is a fact of life and on the rise. Some patients are even “dumped” from other government agencies, such as state mental health systems, or are people without places to live, whom the housing authorities cannot or will not accommodate. Patient loads at city and county hospitals are actually increasing after many years of decline or stability, even though the populations of many of our central cities continue to decline.

As administrators of large public systems, public hospital officials are on the receiving end of two broad-based attacks: one on the cost of health care and one on all governments. As managers they also feel trapped. They have the overhead and financial burden of huge hospitals. They run these hospitals in partnership with academic medical centers that have an insatiable appetite for money and a real resistance to change. In
most large public hospitals, substantial amounts of the care are provided by residents and medical students. The physician staffs prefer to think of themselves as faculty members. The physical plants are much better than they were before Medicaid started and the clinical faculty provides more supervision—which hospitals pay a lot to get—but care is still provided through teaching-oriented clinics and wards. Before Medicare and Medicaid, providing medical care for the poor through teaching models was probably very cheap. Now; it is enormously expensive and wasteful. The voluntary teaching hospitals and the medical schools have become overdependent on the cash produced by the inflated Medicare and Medicaid fee-for-service system. With these funds, they have built huge medical centers and become major employers in all our big cities.

This dilemma has no simple solution. However, the problem of providing access to health and problems of medical education, employment, and the social needs of the medically indigent must be separated and analyzed before they can be solved. Today, the medical centers are avoiding the need to control their own high costs by invoking the care they provide for the poor and the elderly. When properly analyzed, the real problem of health care costs may be located at fewer than two hundred hospitals in about fifty cities.

Local Delivery Systems

The teaching hospital is the most expensive health care facility known; almost any alternative is cheaper. Moreover, most of the people local public hospitals serve do not need tertiary care. Rather, they have social problems that complicate their medical care. But the orientation of the academic medical community on which patients in public hospitals now rely is toward physical disease; they neither know nor care very much about those other problems.

Local medical care officials have supported the hospitals and their teaching programs by using Medicare and Medicaid patients to keep the beds full. But the real needs of many of the people in those beds can only be met outside the hospital. Public hospital officials must divert the people who come to the emergency rooms and clinics to more appropriate facilities. For example, many public hospital admissions come from other institutions, particularly nursing homes. Patients with minor medical problems are often sent to the public hospital because nursing homes have no medical capacity. Once in a hospital bed, they tend to remain there. Improving the care available in nursing homes could prevent many of these admissions.

A substantial number of children in public hospital pediatric beds are there for social reasons. They have been abused and the staff is appropriately afraid to send them home. Medicaid usually pays very high bills to
keep these children in the hospital. Similarly, repeat admissions for lead paint poisoning occur more frequently than we like to acknowledge, and the children stay longer than is medically necessary because local governments cannot find a way or money to delead the houses they live in.

Many public hospital orthopedic or surgery patients stay longer than is medically necessary because they live in single room walk-ups with no social or family support system or because they are street alcoholics with no homes at all. Much other surgery could be done on an outpatient basis if hospitals planned better preadmission work and after-surgery home support. But teaching programs are oriented to inpatient care and the present financial imperative is to keep beds full.

Public hospitals are the unwilling and perhaps unknowing participants in a great cover-up. By taking care of so many social-medical problems, they help the rest of society ignore real but soluble problems. When Boston’s mayor and city council asked for help in getting the homeless off the streets, Boston City Hospital responded quickly and effectively. Today, the hospital is providing housing to almost two hundred people, including some families. By responding to the immediate need, the hospital is helping the rest of the society avoid the problem of the homeless. Public hospitals are doing the same thing with battered children, alcoholics, drug addicts, and the victims of violence. Public hospitals must treat these conditions of social failure and neglect, but they should not do so quietly. I believe they must help their patients politically as well as medically. As they do, proposed changes in the delivery system may gain the support of the poor and their spokesmen rather than generate fear that change will leave them worse off.

Public delivery systems also must learn, again, to help prevent disease and to keep people healthy. They have fallen behind private industry in developing and implementing programs of risk factor intervention and modification. The people public hospitals serve are more at risk for hypertension, obesity, stress, smoking, and accidental injury than the population at large. Since we literally cannot afford to take care of them when they get sick, we should logically be investing larger rather than smaller percentages in prevention each year.

Public medical care systems also must begin to build a medical staff that is dependent for its success and compensation on treating patient populations. The base of the medical staff organization must be outside the hospital, just as it is for most of the people in the country, although, of course, some patients will need to use the hospital from time to time.

Compensation for the staff must be competitive, but the glut of doctors may make it easier now than it has been in the past for big city systems to compete against private fee-for-service practice for medical talent. Some local governments can start by capitating the care of people now using outpatient departments through practice groups created and
hired by neighborhood health centers. The centers and their physicians should control all care, even care given in the hospital.

In addition, community groups can recruit independent practitioners back to the neighborhoods and ensure them an adequate income by paying them a capitation fee for taking care of a panel of patients. The capitation should be large enough to let the participating physicians buy whatever speciality care they need for their patients, and they should be at risk if they fail to keep the cost within the capitation amount. If they spend less than the capitation, they should be able to keep the difference.

Practicing physicians working under this model would try hard to keep their patients out of public hospital clinics. They would want to use office-based specialists and would try to avoid hospitalizations in teaching centers. They would favor ambulatory surgery and home care. Above all, they would look to risk intervention and prevention to keep their patients healthier and out of their offices entirely.

**States As Purchasers**

Because, by and large, they pay retail for Medicaid services provided to individuals, states are virtually helpless when it comes to controlling the total cost of care for Medicaid recipients.

The cost of care in the fee-for-service system equals the total units of care times the price per unit. States that have tried to control the price per unit have usually been beaten by providers who increased the volume of services by administering extra tests or keeping the Medicaid patient in the hospital an extra day or two, practices that not only are not intended for the patient's benefit, but also place the patient at unnecessary risk of injury or disease.

California and Arizona are experimenting with alternatives to these cuts. This year, California established a competitive bidding system among hospitals to provide specified days of care to medical recipients at negotiated prices. Many observers believe that the total price for hospitalization of medical patients in California in 1983 will either stay the same as or fall below 1982 levels. Unit cost inflation will continue above 12 percent for the rest of the country. Arizona has gone further. It wrote specifications and took bids for the management and provision of care to the Medicaid-eligible (AFDC) population in each of its counties. In each county, competitive fixed price bids were received and contracts with a sole provider were signed.

Whatever results from these dramatic innovations, Arizona and California have shown that states are not powerless. Other states may learn from observing California and Arizona and develop systems of their own to provide access to medical care to those who really need it, at prices that are affordable. If they design their ‘purchase or insurance programs.
properly, states can make real progress in providing access to health as well as medical care for those whose care they sponsor. Aggressive health promotion and disease prevention should be a substantive requirement for all bidders.

Regulation And Licensure

A second major role for state and local governments is the preservation of safety for consumers and providers of health care. This concern has been exercised through regulation and licensing of facilities and providers. A government policy of *caveat emptor* (let the buyer beware) has no place in situations where the buyer has substantially limited options and where the “product” being purchased is so complex that the occasional user cannot be expected to be knowledgeable enough to make a prudent choice. Government intervention is particularly appropriate in the health field because the government itself is a major purchaser of health services.

Before the twentieth century, medical interventions had little effect, and most hospitals were largely custodial institutions for the poor or for sick itinerants. As such medical advances as complex surgical procedures and the introduction of asepsis led to greater risks and benefits, private and public agencies began to regulate health care facilities and providers.

The American Medical Association began its regulatory activities in 1904 with the development of standards for the conduct of medical education within hospitals. Since then, the medical community has established and enforced national standards for training programs in virtually every field of medicine. In 1914, the American College of Surgeons began a voluntary accreditation program to encourage institutions to meet at least minimum standards of sanitation and recordkeeping. The list of standards was one page long, but accreditation was a major step in helping to define the modern hospital, as opposed to the home or barber shops or doctors’ private offices, as a place for surgery. This activity led in 1951 to the creation of the Joint Commission on the Accreditation of Hospitals, whose national inspection and accreditation program was given a basis in law in the Medicare and Medicaid Act of 1965. Today, any hospital receiving Medicare or Medicaid money must be accredited by the joint commission or directly by the federal government (usually acting through a state department of public health).

During the first decade of the twentieth century, the states began regulation and licensure of hospitals, emphasizing compliance with relevant building codes. But by 1931, only nineteen states had legislated standards for hospitals and maternity homes. During and after World War II, detailed state regulation and licensure became common. But actual state licensure procedures vary widely. A comparative study of state inspec-
tion and joint commission inspection conducted by the General Accounting Office found that, by and large, the joint commission was more thorough.

The medical care industry is highly regulated. In fact, if one listens to the complaints of the providers, they spend more time with the regulators than with their patients. The number and variety of hospital regulatory programs is astounding. The hospitals complain of enormous duplication, overlap, contradiction, and confusion associated with all the regulations they face.

Undoubtedly, they are correct. Agencies promulgate regulations to meet different social objectives. Regulatory attempts to meet these conflicting objectives may well leave the affected industries confused. The process is part of the way in which our political system absorbs conflict. Neither the existence of conflicting regulations nor the complaints of the regulated justifies panic or retreat. Like most other institutions, hospitals use broad attacks on the regulatory process to mask politically unacceptable objections to the substantive purposes behind some regulations; in fact, hospitals generally favor regulation that prevents competition.

Either the state governments or the joint commission should get out of the business of licensing hospitals. Some states have done so, and others are considering such a step.

The original purpose of hospital licensure regulation was assurance of minimal safety standards to protect the public from harm. This goal has been transformed into the goal of maximum achievable quality. A standard has been developed for virtually every activity and process in a hospital. The assumption behind the regulations is that if the standard is met, quality care will result. Setting maximum standards may have been appropriate in an era of scarce hospital management resources and poorly informed hospital governing boards. But in the next few years, governing boards will either exercise sound stewardship or see their hospitals go broke.

Returning to a simpler approach toward licensure may help contain some of the rising costs of health care. Much of the capital construction now under way and planned will replace adequate facilities with newer and more expensive ones in the name of “meeting standards.” If a hospital is reasonably safe, a licensure standard seems a poor excuse for building replacement beds that will cost an additional $100 per day per patient for the next twenty years.

Professional Licensure

Every state regulates health care through professional licensing. The public purpose is to protect individual consumers from quacks and unqualified practitioners. The practical effect is to protect practitioners from
Before the latter part of the nineteenth century, government imposed no licensing requirements or standards for medical training. Medical doctors competed with other types of healers, and medical schools ranged from fraudulent diploma mills and one-year classroom programs to the institutions that have become today’s university-based medical research and teaching centers.

In *The Social Transformation of American Medicine*, Paul Starr tells the story of this open competition and the gradual development of organized medicine. By 1900, there were 160 medical schools in the United States. Competition from both newly “trained” doctors and new movements like Christian Science healers galvanized state and local medical societies into actively supporting licensing. As Starr found, virtually all the new laws grandfathered existing practitioners. They affected only people trying to enter the field: “The occupations that pursued their interests through licensing were distinguished less by their political power than by their distinctive structural position within the economy. Predominantly self-employed, most of their members worked out of small shops requiring little capital to establish. Their trades and profession were easy to enter and consequently beset by competition.”

In its support for professional licensing today, organized medicine still seeks to maintain control over diagnosis, prescription, and treatment. Physicians generally oppose expanding roles for independent nurse practitioners (but favor physicians’ assistants working under their control) as dentists oppose denturists, and ophthalmologists oppose expanding the scope of the work optometrists are allowed to do.

Today, this special interest licensing uses the power of the states to maintain monopolies, forcing the public to pay the resulting monopoly prices. And yet, state governments could use licensure to promote public safety by identifying and weeding out incompetents, whether new or established in practice. In Massachusetts, the staff of the Board of Registration for Medicine is tiny and has almost no capacity to initiate or conduct investigations. If similar conditions prevail in other states, perhaps the malpractice insurers should assume responsibility for ensuring the qualifications of health care professionals. At least the insurers have an explicit interest in the matter.

Ineffective regulation and licensing may be worse than none at all. If the medical marketplace were open to new practitioners, we might or might not be worse off. At least we would know that we were up against *caveat emptor*.

**Rate-Setting Regulations**

Some states have tried to regulate the price of health care for all in the
face of the enormous inflation that has occurred in recent years. By the close of 1982, seventeen states had adopted hospital cost control regulations of some kind. The programs vary and have met with different results. Such experiments are sure to continue, but many state and federal attempts to regulate hospital prices are failing because the sides are unevenly matched. Financial regulation is enormously complex. Without the most sophisticated design and implementation, it can create incentives that lead in wholly undesired directions.

The state and even the federal governments have not developed the necessary skills. The hospitals on the other hand have invested heavily in learning how to manipulate financial regulations to their own benefit. In Massachusetts, for example, the State Rate Setting Commission has only a few professionally trained people in the bureau that sets rates for each of the 140 acute care hospitals in the state. The staff of virtually every major hospital in the state is larger than the state’s, and most make use of professional consultants in formulating hospital reimbursement strategies. The computer simulation tools available to hospitals are substantially more sophisticated than those available to their state regulators. Thus, despite strict rate setting, Massachusetts hospital costs continue to be among the highest in the country and total revenues to the hospitals continue to grow dramatically each year.

If states are to use their regulatory power to control costs successfully, they cannot rely on low-paid, modestly trained employees working with rudimentary tools. They must acquire the skills and pay for the kind of talent the hospitals employ to make the programs work.

Conclusion

The roles that state and local governments play in health finance, delivery, and regulation derive from tradition and from policymakers’ assumptions. Constructive roles, including those described in this paper and others, are available for state and local governments. But to perform them successfully, we must avoid panic. The cost projections in medical care are staggering, but they need not come true if we keep our wits and our willingness to experiment. This country can afford to meet the promises it has made to its people if it sorts out its problems and does not leave matters other than health care in the hands of health care providers.
NOTES

1. I am grateful to Bruce C. Vladeck and Alan Sager for their criticism of an early draft of this paper.
3. For example, the first set of recommendations for “solving” the Medicare funding problem by the Advisory Council on Social Security includes raising the age of eligibility to sixty-seven and charging recipients more. See Betty Ann Williams, “Medicare Bankruptcy Called Avoidable,” Boston Globe, 26 June 1983.
4. Ibid.
6. The Boston City Hospital Pediatrics Department reported increases in the number of children who were “failing to thrive” after AFDC and WIC programs were ended for their mothers.
9. Projections based on data provided by the American Hospital Association.
10. Through 1981 and 1982, the cutbacks were monitored and reported on a monthly basis in a newsletter entitled State Health Notes.
11. Ibid.
12. Ibid.
13. Ibid.
14. Ibid.
15. For example, polling done for Boston City Hospital showed that a majority of city residents had a high opinion of Boston City Hospital’s trauma care, but were reluctant to use the hospital except in a dire emergency.
18. Approximately twenty of the patients in the two chronic disease hospitals run by the city of Boston are former patients at state mental health systems. A substantial number of walk-in patients at the Boston City Hospital Emergency Room are people who have been discharged from, or refused admission to, state mental hospitals without adequate treatment plans.
21. At Boston City Hospital, for example, almost 20 percent of the adult medical and surgical admissions were from nursing homes. A program to provide more primary care in nursing homes led to a reduction in short-stay admission.
23. Ibid.
24. Hospital Regulation, 8.
27. Ibid., 103.