# MONOPOLY CAPITAL AND THE REORGANISATION OF THE HEALTH SECTOR

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*The 'health care crisis' proclaimed by Richard Nixon in 1971 revealed the health sector's interconnections with the overall political economy. These extend simultaneously to problems in the health status of the people; the effectiveness of medicine itself, and the organisation and financing of medical care services. The ruling class has attempted to resolve the present crisis by introducing a structural reorganisation of the health sector. The corporate class has become increasingly active in health policy and programme development at national as well as local levels. This article, reproduced from 'Review of Radical Political Economy' briefly looks at the role of monopoly capital in this reorganisation. What is the capitalist perspective on the crisis in health care ? How are they advancing their class interests by themselves and through the state for a redesigned health care delivery system? The author reviews the discussions, activities and important publications of a few selected capitalist planning bodies, showing their ideological development as they educate the corporate class. These discussions are a key to shaping a class stand to eventually transform health services delivery under monopoly control.*

*" There is a better way to go and that would be to strip the medical societies of the power to inhibit more efficient methods of delivering medical care — corporate organisation, for example — and the various restrictions on competition."*

Editorial, *Wall Street Journal*
January 16, 1976

The present organisation of the health sector, with its excessive use of resources, has come into contradiction with the needs of monopoly capitalism today. A petty-bourgeois mode of health services (structured around solo fee-for-service medical practice and cost-reimbursed hospital care) will yield over the next few decades to a new, qualitatively different stage of development[1]. This emerging delivery system may eventually be dominated by Health Maintenance Organisations (prepaid group medical practices) sponsored by large corporations financed by some form of national health insurance, and regulated by corporate-controlled planning bodies.[2]

Monopoly capital recognizes the health services industry as organisationally backward compared to other sectors of the economy. Although several modes of production coexist, a small scale mode still predominates, principally controlled by petty-bourgeois physicians. This condition entails institutionalised waste, including low productivity of the health labor force, substantial clinically unnecessary care (and its related high hospital utilisation), and the allocation of substantial resources to non-productive segments of the population (e. g., the poor, disabled, aged). From the monopoly capitalist perspective, the health sector diverts a substantial portion of state funds and an increasing amount of variable capital costs (in the form of fringe benefits) from the sphere of monopoly capital. The surplus generated in the delivery of medical care is chiefly appropriated by physicians, hospitals, medical schools, and nursing homes[3].

These conditions contribute to escalating and yet-to-be controlled costs,[4] under the present organisational form and control. There are two aspects of this cost problem.

1) 118.5 billion dollars were spent for health services in 1975, more than a 200 percent rise since 1965. Health expenditures are thus rising more rapidly than the overall rate of inflation in the economy, propelling them to 8.3 percent of the GNP last year.

2) 57.9 billion dollars were spent by government — 42.2 percent of these total expenditures — and is critical in light of the fiscal crisis of the state.[5]

Over the past decade the federal and state governments have instituted increasing cost controls; however, the cumulative effect of these policies has been minimal.[6]

This problem of escalating costs is related to an additional one concerning doubts about the general effectiveness of medical care services in ameliorating disease patterns related to heart, cancer and stroke. The leading mortality indicators for Americans under 45 — accidents, suicide and homicide — are conditions which the medical care system does not, and cannot, address, given its present form.[7] Studies are showing that health levels are not altered significantly now by incremental medical care services[8]. A growing ideological

response may shift attention away from medical care institutions to contain the costs of the health sector.[9]

The drastic decline of U.S. power in the world capitalist system has shaped an international situation which has aggravated the acute domestic stagnation. To cope with these conditions, the capitalist class has been looking more and more at the potential of the health services industry for greater social efficiency. In the present economic crisis, the containment of social consumption expenses can provide funds for private investment in the production sectors. Health policy has been encouraging attempts at general rationalization (cost cutting, profit maximization, forcing higher productivity).

At the same time, various segments of capital are responding to opportunities for greater profits to be derived from both the production of health services[10] and the circulation of commodities through the health sector (e.g. drugs, hospital equipment and supply, construction, systems and communications, legal, accounting and management services, etc).[11] As industrialisation proceeds in the health sector (mass production, elaboration of the division of labour, greater capital intensification, bureaucratisation, etc.), these industries will seek greater capital flows toward the sector.

Renaud has demonstrated how capitalist growth, while giving rise to disease patterns in society, also institutionalises "solutions" to disease which are compatible with capitalism, in the form of a commodification of health services.[12] With alienation and disease creating a greater dependency by the working class on health (and other human) services, these services must function more and more as mechanisms for social control.[13] However, the present structure of health care delivery has not developed sufficiently for monopoly capitalism today. A new organisational form is required, and it will arise under conditions similar to those other sectors where petty-bourgeois or 'pre-capitalist forms historically were smashed or co-opted.[14]

It is surely not new for capitalists to be actively restructuring the health sector. Berliner has detailed how the Carnegie and Rockefeller Foundations in the beginning of the century virtually rebuilt the entire medical care system by endowing research institutes and selected medical schools.[15] This intervention strongly influenced the rise of the presently-dominant organizational form in the health sector, which has served through to the present period.

Stagnation and crises necessitate a growing awareness of monopoly capital's common interests (as well as its conflicts). The coming together of major capital segments to discuss and formulate general policies in itself yields a greater measure of class consciousness.[16] Policy-planning organisations, (such as the Trilateral Commission, Business Council, Comittee for Economic Development, Business Roundtable, etc.) have lately become the arenas for working out programs for the capitalist class as a whole. Their activities provide a system of cooperative interpersonal and interorganisational relationships based upon a commonly-held class perspective. The role of these "consensus-seeking" groups becomes critical, with the mounting contradictions of advanced capitalism and the crescendo of challenges to the American capitalist system on both the international and domestic levels.[17]

Today the "class-conscious corporate directorate"[18] is speaking directly to monopoly capital's needs from the health sector in a number of important publications and conferences. The following sections will review a few of the activities of selected planning bodies, showing their ideological development as they educate the corporate class. As yet, no definitive analysis on the nature and function of the health sector has developed, nor has a comprehensive strategy for the capitalist class as a whole emerged. Nevertheless, a class stand is shaping as the problems for monopoly capital are detailed and potential solutions are discussed.

In contrast to the last decade, *Fortune*, *Forbes*, *Business Week* and the *Wall Street Journal* have been devoting major amounts of space to health care problems and editorializing for a changed structure to favor capitalist interests.[22] The *National Journal* provides frequent indepth analyses of health care issues to apprise business leaders of legislative developments. All of this interest by the business press (coupled with the popular media's attention to health and health care inadequacies)[10] is a marked escalation over their coverage prior to 1970 — a change which parallels the new interest by capitalist planning bodies

### Committee for Economic Development

The Committee for Economic Development (CED) is one of the central educational and policy-making organisations of the corporate class; Domhoff calls it the "major spokesman for the

business viewpoint." Highly influential in state policy formulation, it addresses their societal concerns in lengthy policy statements.[20] It represents a more "progressive" capitalist perspective (generally the longer view of reshaping society) and produces studies that are somewhat broader and less detailed than the issues analysed by the liberal Brookings Institution[21] or the right-wing American Enterprise Institute for Public Policy Research (AEI).[22]

The CED provided a beginning outline of their design for the health sector in a report entitled *Building a National Health Care System* in April 1973. It recommended health maintenance organisations (both profit-making and nonprofit) for restructuring the delivery system. A health maintenance organisation brings together a comprehensive range of medical services into a single organisation, providing services in a benefit package for a fixed contract fee which is paid in advance. A proposal was made for health care providers to be financed through prospective budgeting, with fees and charges fixed in advance. A national health insurance program, providing a basic level of health benefits for all Americans, would be administered by a National Health Insurance Advisory Board. This basic benefit package for *all* Americans, of course, would be a phased and "practical program that does not raise false hopes by promising services that cannot be made available and does not lead to unwarranted increases in costs with little benefit to people."[23] Three categories of financing would be established: 1) employer-based insurance would be phased in for all workers and their dependents; 2) Medicare would be retained for the aged and disabled, 3) care for the poor, nearpoor, unemployed, and others would be provided through federally-sponsored community trusteeships. The policy statement further recommended a control and planning mechanism — which has now been enacted in Public Law 93-641, The National Health Planning and Resources Development Act of 1974.

In short the statement by the Committee for Economic Development essentially endorsed the health policy of the Nixon Administration and countered most of the stands taken by the American Medical Association, which has fought all attempts at restructuring and cost control.

### The Business Roundtable

Perhaps the major capitalist lobbying group on health care has become the Business Roundtable (BR) and its associated Washington Business Group on Health. Made up of the chief executive officers of the 160 largest corporations, BR was formed in the early 1970's to develop class discussions and to formulate corporate policy on labor problems.

In June 1974 the Business Roundtable convened a conference on health care legislation to build a consensus among chief executive officers about what business should be getting from the health sector. In an opening address, the chairman of Eli Lilly Company, the drug manufacturer, noted that "at a recent meeting of the Business Roundtable there was complete agreement that the importance of the health issue to every company should have a very high priority as an issue in future months towards which we should devote our continued and dedicated attention."[24] The panel of speakers was impressive. Chairman of the Business Roundtable's Subcommittee on Health Policy; Chairman of the CED Health Policy Committee; former Congressman William Roy; who authored the Health Maintenace Organisation Act of 1973; a representative from the office of the HEW Assistant Secretary for Health and Scientific Affairs; and Russell Long, Senate Finance Committee Chairman and sponsor of a health insurance bill. While endorsement was encouraged for Senator Paul Fannin's National Health Standards Act (the national health insurance bill of the Chamber of Commerce), what seemed to be emerging was a firm conviction that restructuring the delivery system was a necessity before legislation on the national financing of health care. In the midst of the recession, coupled with the state's fiscal problems, capital was displaying its fear of increased labor costs.

### The Conference Board

The Conference Board based in New York City, is a research organisation concerned with "business economics and business management." Its numerous studies address problems of the firm, which it then relates in its published findings to social policy issues. Their message promotes the common interest of capital in the "efficient operation and sound development of voluntary productive enterprise."

The CB conducted several extensive studies on health care funded by the U.S. Department of Health, Education and Welfare and a consortium of large corporations and foundations. *Top Executives View Health Care Issues* (1972), the first product of this broad CB study in health, surveyed 118 executives about: 1) the nature of the nation's major health problems, the need for new legislation to deal with them, and the particular pending

legislation; 2) the ways in which health costs to business might best be controlled; 3) the desirability of companies creating or expanding their own in-house medical services; 4) a strong business role in community efforts at health services planning, controlling hospital and other health costs, and developing prepaid group practice plans and other new health delivery forms; 5) potential changes over the next decade in corporate health care activities; and 6) the order or priority that business should assign to health care relative to other social issues (e.g. environment, product safety, minority employment and urban redevelopment).

A subsequent study on *Industry Roles in Health Care* surveyed eight hundred large firms to provide a statistical examination of present corporate health care programs. The narrative description of these programs and the suggestions on the "appropriate management response" to the health sector delineate specific policies and activities of corporations in restructuring health care delivery arrangements for their workers and surrounding communities.

Another publication, *National Health Insurance and Corporate Benefit Plans* grew out of two surveys on corporate health programs (a separate one on executive health), which secured the cooperation of 1800 companies for their extensive detail. The national health insurance bills before Congress were analyzed for their effect on industry benefit plans, along with an assessment of labor union attitudes and actions. The report concluded that "a substantive intervention by the Federal Government would have a major impact on the benefit planning, cost sharing, and bargaining, but little direct effect on the benefit coverages to be provided to workers. Benefits to low-wage workers and unemployed would increase greatly."[26]

These reports provided a foundation to the forward and sophisticated thinking presented by the speakers in a CB-sponsored *Health Care Issues for Industry* Conference in April 1974. Over 200 corporate executives and health and government representatives met to discuss the "heavy health-related costs in the form of taxes, employee benefits, workmen's compensation, absenteeism, impaired productivity, and business stake in the allocation of the nation's resources and the health of its economy."[27] Walter Hamilton, former Deputy Assistant Secretary of Commerce under the Nixon Administration and now a CB Vice President, began the conference by observing that health care is "an industry whose methods and structures the business community has both the right and the obligation to study and seek to improve."[28] Dr. Paul M Ellwood, Jr., the chief architect of the Nixon Administration's Health Maintenance Organization Strategy, decried the lack of capitalist leadership in designing national health policy and suggested that:

". . free enterprise solutions that have been effective in solving the problems of conventional business can be applied with similar effect within the health industry, and that you are in the position to apply them. In other words, I am suggesting that you take certain active steps to make the health care market work, by encouraging HMOs to compete with the present system on the basis of prices and benefits."[29]

Dr. G H. Collings, Medical Director of New York Telephone Company, urged corporations to become the "health care manager" for workers through their industrial medicine departments. An executive of Kaiser-Permanente, the largest HMO in the country with over two million subscribers, presented information on a cost-benefit analysis of occupational health measures to aid companies. A corporate officer from Motorola discussed his company's conflicts with hospitals in Phoenix, Arizona and Motorola's attempts in the community to contain their costs. A vicepresident of General Mills spoke of the corporate-sponsored HMO effort being designed and implemented in the Twin Cities area. Equitable, Prudential, Honeywell, General Mills, 3M, Pillsbury, and Mutual of New York are among the twenty corporations there reporting attempts to centralize health services into health maintenance organizations. With the information on the nature and extent of corporate involvement in health care activities from this conference and the CB studies, monopoly capital has positioned itself to initiate a more class-conscious analysis of the health sector and its relation to capital accumulation.

### The Health Manitenance Organisation Strategy

Active state intervention to restructure the health sector was taking place amidst these conferences and publications by capitalist planning bodies and the upsurge in volume of health articles in the business press. The HMO strategy initiated by the Nixon Administration in 1970 had created an awareness among monopoly capital firms of investment possibilities in health care delivery. It was designed for "using the forces of the private sector" to "modify the entire system of health care."[30] Dr.

Paul Ellwood[31] of *Interstudy*, a health policy think-tank, has consulted extensively with large corporations urging them to establish profit-making HMOs, converting their industrial medical departments into HMOs in order to "realize a susbstantial savings over present health expenditures for employee health care benefits..[32]" Through changing the present "sickness-oriented, piece-work basis" of the delivery system, the HMO creates a profit motive "to concentrate on keeping people healthy" and provide "greater efficiency."[33] HMO patients have a markedly lower rate of hospital admissions and a shorter length of stay than those covered by indemnity insurance plans of Blue Cross and the commercial insurance companies. According to Ellwood, HMOs would strengthen the role of competition by introducing economic incentives, and minimize the need for regulation by relying upon market mechanisms. Ellwood's dream of a revamped delivery system envisioned approximately 1000 HMOs across the country, organized similarly to large corporations (possibly as their subsidiaries) to serve up to serveral million persons each. One of his latest suggestions, as an ideological entrepreneur on health for the capitalist class, urges federal government subsidies (up to one million per year) for the nation-wide expansion of the "superclinics" (e.g. Mayo, Cleveland, Palo Alto, Marshfield, Geisinger, etc) as models for a national network of HMOs.[34] The state's role in this redesign of the delivery system would enhance monopolization and assure a rationalized organizational form.

To stimulate corporate-controlled HMOs, HEW under the Nixon Administration designed a program to attract funds from venture capital and investment banking firms, commercial insurance companies, and banks. Capitalist interest in HMO operations, both as commercial ventures and as a more efficient organization of present health care providers, rose as they understood how HMOs could control the runaway costs of the health sector and contain their labour costs.[35] A list of corporations who have been involved in HMO activity reads like the Fortune 500: Westinghouse, Texas Instruments, Sun Oil, North American Rockwell, Zenith, General Foods, DuPont, IBM, Kodak, Xerox, Upjohn, Mobil Oil, Standard Oil of Indiana, and a few dozen others. However, tight money over the past few years and the lack of substantial financing of the Health Maintenance Organization Act of 1973 (P.L. 93-222) by the Ford Administration have temporarily slowed this whole development.

Both profit and non-profit HMO plans have continued to expand, having doubled their enrollment (to approximately 8 million persons) over the past three years in 178 HMOs across the country.[36] However, new HMO projects are dependent on corporate and union support in their "marketing" activity (i. e., acquiring enrollees) to ensure their existence and growth. With the economy on the upswing and several problems resolved in the new HMO law, corporations may reinstitute their involvement in HMO activities and follow the example of R.J. Reynolds, which this year established its own HMO for its workers.[37] The National Association of Employers for HMOs, based in Minneapolis, was just formed this year by several corporations to guide firms in their HMO development.

### Occupational Medicine Developments

While monopoly capital's investment in HMOs has not reached levels predicted by the Nixon Administration, corporate medical directors and employee benefits managers nevertheless have been developing mechanisms within their firms to eventually integrate industrial medicine and occupational health programs with the medical care of workers' families. Writing in a special issue on HMOs of the *Journal of Occupational Medicine*, one corporate medical director evoked the view that: "the scope of proper concern of the occupational physician has expanded quite far beyond his involvement with occupational injuries and disease. It now extends to the non-occupational health problems of the worker and his dependents, and the ways in which the health services they require are organized, delivered, and paid for."[38]

Another corporate medical director has said, in a speech entitled "The Balance Sheet in Employee Health Conservation," that the industrial physician may become the primary care physician of the future for the worker and the family.[39] William Jend, Jr., Medical Director of Michigan Bell Telephone Company, has argued that the "workplace is probably the ideal locale to practice real preventive medicine on a wide and effective scale."[40]

This ideological thrust,[41] coupled with actual program formulation,[42] by industrial medicine physicians, represents a slow but deliberate shift which may lead to a personnel system in which the firm will be able to provide health maintenance services to assure the productivity of the individual worker. This implies a profound change in

the content and control of medicine from that practiced today.[43]

In a larger context, the employer as "health care manager" will deal with worker alienation and disease, contain laborpower reproductive costs, and promote greater social control in an attempt to reduce the level of absenteeism and disability, turnover rates, wildcat strikes, sabotage, and poor quality products. The development of workplace medicine is one more step in the transfer of health services delivery to eventual monopoly capital control.

## Directions and Contradictions

While these conditions are shaped and shape themselves from the outside, rapid change is concurrently happening within the health sector. Concentration and centralization in the production of medical care services have been rearranging patterns of control in the financing and delivery of care. Health industry groups such as the American Hospital Association, Group Health Association of America and Blue Cross are becoming more closely aligned with monopoly capital. Stimulated by increased efforts for bureaucratization and the application of managerial economics, the industrialization process in the health sector is bringing forth fundamental changes in its social relations of production. Meanwhile, regional planning efforts by health systems agencies and the forthcoming passage of some form of national health insurance may help create material conditions for further monopolization and a greater capitalist invasion.

As the rationalization of health services occurs during the present period of economic crisis, monopoly capital's class stand on health policy is being developed. Discussions have been centering around containing cost inflation in health care, redirecting medical dollar flows through the monopoly sphere, and eventual consolidation of health services delivery by large corporations. Recognition of their interest in more rational and precise social investment may lead monopoly capital to mold an organizational reflection of their need for human capital maintenance.

As the larger crisis of accumulation is addressed, the outlook of monopoly capital is becoming more highly developed. How capital can assure stability and predictability in the international and domestic situations is certainly receiving more and more class attention and action. It is crucial for us to analytically grasp this beginning ruling class coordination in the health sector also.

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### Notes and References

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1. See both: Sander Kelman, "Adventure in the Undialectical." Book review of Robert Alford's *Health Care Politics: Ideological and Interest Group Barriers to Reform* in *Journal of Health Politics, Policy and Law*, 1:1 Spring 1976, pp. 122-129; and Sander Kelman, "Toward the Political Economy of Medical Care" *Inquiry* 1:3, 1971, pp. 30-38.

2. A case example of corporate control over health planning may be found in: Health Information and Action Group, *HSA's May Be Dangerous to Your Health* (Philadelphia: Medical Committee for Human Rights, 1975).

3. For details on conflicts between monopoly capital and smaller capitals see: James O'Connor, *The Corporations and the State* (New York: Harper Colophon, 1974).

4. For a capsule analysis of the cost problem, see: Council on Wage and Price Stability, *The Problem of Rising Health Care Costs* (Washington, D.C.:U.S. Government Printing Office, April 1976)

5. James O'Connor, *The Fiscal Crisis of the State* (New York: St. Martin's Press, 1973).

6. The federal government has adopted cost containment measures through the economic stabilization program: utilization review of hospitalizations under Medicare insurance for the aged and Medicaid for the poor; monitoring hospital admissions and length of stay by Professional Standards Review Organization, federally-mandated organizations set up by county medical societies; and authorities for planning construction and equipment purchases given to new regional health systems agencies. Futher, state governments have regulated commercial and non-profit insurance firms, and enacted certificate-of-need legislation for hospital and nurs-

ing home facilities construction, and hospital rate-setting legislation. See: Anthony R. Kover and Edward J. Husk, "State Regulation of Health Care Costs" *Medical Care* 13.8, August, 1975, pp. 619-629.

7. Victor Fuchs, *Who Shall Live? Health, Economics and Social Choice* (New York: Basic Books, Inc., 1974)

8. Lee Benham and Alexandra Benham, 'The Impact of Incremental Medical Services on Health Status, 1963-1970'' in Ronald Anderson, et al. *Equity in Health Services* (Cambridge, Massachusetts: Ballinger Publishing, 1975); and Victor R. Fuchs, *Who Shall Live: Health, Economics and Social Choice* (New York: Basic Books; 1974).

9. By no means has any consensus been reached from outside or within the health sector: nevertheless, the critiques of medicine are being given serious attention. See Howard Berliners "Emerging Ideologies in Medicine." *Review of Radical Political Economics*.

10 For detail on capitalist inroads in health care delivery, see: J. Warren Salmon, "The Health Maintenance Organization Strategy: A Corporate Takeover of Health Services Delivery". *International Journal of Health Services* 5:4, 1975, pp. 605-623.

11. For a detailed description of the functions of the health sector and the production and realization of surplus value in health, see Leonard Rodberg and Gelvin Stevenson, "Health Care Industry in Advanced Capitalism," *Review of Radical Political Economics* (this issue).

12. Marc Renaud, "On The Structural Constraints to State Intervention in Health, *International Journal of Health Services* 5:4, 1975, pp. 559-572.

13. Gelvin Stevenson, "Social Relations of Production and Consumption in Human Service Occupations" *Monthly Review* July-August 1976, pp. 78-87.

14. Maurice Dobb, *Capitalism, Development and planning* (London : Routledge and Kegan Paul, 1967)

15. Howard Berliner, "A Larger Perspective on the Flexner Report," *International Journal of Health Services* 5:4, 1975, pp. 513-592.

16. See the entire issue of: G. William Domhoff (ed). "New Directions in Power Structure Research" *The Insurgent Sociologist* 5:3, Spring 1975.

17. Notwithstanding the instrumentalist overtones here the author is merely stating that *Conditions* are propelling this development. Limitations, both on theoretical and empirical levels, exist in power structure analysis of this sort and obviously the varying theories of the state must be considered. See John Mollenkapf, "Theories of the State and Power Structure Research "*Insurgent Sociologist* 5:3 Spring 1975, pp. 245 - 264.

18. James O'Connor, *The Fiscal Crisis of the State*, p. III

19, Perhaps the first major indictment by monopoly capital against the health sector was the entire January, 1970 issue of *Fortune* 81:1 entitled, "Our Ailing Medical System". The issue strongly advocated health maintenance organizations as did M. Rothfield, "Sensible Surgery for Swelling Medical Costs" *Fortune* 88.4. 1973, pp. 110-119: "Is There an HMO in Your Future?" *Forbes* March 15, 1973, p. 21; "A Revolutionary Plan to Keep People Healthy" *Business Week*, January 12, 1974, p. 58 "Still Waiting for that Revolutionary Health Plan." *Business Week* January 13, 1975, p 53, Dublin. "Unhealthy Start: Prepaid Medical Plans Run Into Difficulties as Enrollment Falters," *Wall Street Journal* February 11, 1975, p. I, plus numerous other articles on aspects of the health care crisis.

20. Every major television network ran specials on the health care crisis. Today newspapers and magazines follow health care developments quite extensively often not missing opportunities to attack the present medical care structure. For example, see the week of front page articles in the *New York Times* January 26-30, 1975.

21. On each of its policy statements the CED writes that "by enabling businessmen to demonstrate constructively their concern for the general welfare, it is helping business to earn and maintain the national and community respect essential to the successful functioning of the free enterprise capitalist system." It is not uncommon for a CED policy statement to precede federal policy or legislation on the issue.

22. The Brookings Institution in Washington, D.C. has published the following studies related to health care: Rashi Fein. *The Doctor Shortage: An Economic Diagnosis*: Herman Miles Somers and Anne Ramsay Somers, *Medicare and the Hospitals: Issues and Prospect*: Karen Davis, *National Health Insurance: Benefits. Costs and Consequences* : among others.

23. In 1973 the AEI established a Centre for Health Policy Research which has published:

C Stewart and C. Siddayao, *Increasing the Supply of Medical Persone! Regulating Health Facilities Construction* proceedings of an AEI Conference; Judith R. Lave and Lester B. Lave. *The Hospital Construction Act*: Sam Petlzman, *Regulation of Pharmaceutical Innovation*. Rita R. Campbell, *Food Safety Regulation*: a legislative analysis. *National Health Insurance Proposals*: David Schwartzman. *The Expected Rate of Return From Pharmaceutical Research*: William M. Wardell and Louis Lasagna. *Regulation and Drug Development*: Alex R. Maurizi, *Public Policy and the Dental Care Market*. Cotton M. Lindsay, *Veteran: Administration Hospitals. An Economic Analysis of Government Enterprise: Drug Development and Marketing. Proceedings of an AEI Conference. Health Insurance What Should Be The Federal Role?* proceedings of an AEI Roundtable television show: and Robert Stewart Smith. *The Occupational Safety and Health Act. Its Goals and its Achievement* Quite an extensive undertaking for only three years work! See also: David Pauly, "Celebration on the Right." *Newsweek*, May 17, 1976. p. 81.

24. Committee for Economic Development. *Building a National Health Care System*, New York, 1974, p,. 66.

25. Business Roundtable, *Washington Health Organization Conference on Health Care Legislation*, June 20 1974, Washington, D.C. pp. 3-4.

26. Commonwealth Fund, which has long been active in health: Rockefeller Brothers Foundation, Andrew Mellon Foundation, as well as New York Life insurance company, Johnson and Johnson Company and medical supply firm and CIBA-Geigy Company and Upjohn Company, both drug manufacturers.

27. David A Weeks, *An Interim Report: National Health Insurance and Corporate Benefit Plans* (New York Conference Board 1974). p. i.

28. Seymour Lustermann (ed.). *Health Care Issues for Industry*. (N.Y. Conference Board, 1974) p.I.

29. Walter A Hamilton, "Conference Aims" in *Ibid* p. 10.

30. Paul M. Ellwood. Jr, "Business and the Changing Health Care Scene." in *Ibid.*, p. 54.

31. U. S. Department of Health, Education and Welfare, *Towards a Comprehensive Health Policy for the 1970s: A White Paper* (Washington, D.C. U.S. Government Printing Office, 1971).

32. See Paul M. Ellwood, et al, "Health Maintenance Strategy" *Medical Care* May-June, 1971, p. 291, Paul M. Ellwood. "Implications of Recent Health Legislation" *American Journal of Public Health* January 1972, p. 20. Paul M Ellwood, "Health Maintenance Organizations: Concept and Strategy," *Journal of American Hospital Association* 45:6 1971., pp. 53-55 Paul M. Ellwood "Big Business Blows the Whistle on Medical Care Costs" *Prism*. December 1974, pp. 13-15; Paul M. Ellwood, "Models for Organizing Health Services and Implications of Legislative Proposals" *Mibank Memorial Fund Quarterly* October 1972, among numerous others.

33. Paul M. Ellwood and Michael Herbert, "Health Care: Should Industry Buy It or Sell It?" *Harvard Business Review* July-August 1973, pp. 99-107

4. Richard Nixon "Building a National Health Strategy: Special Message to Congress." Washington D C. February 18, 1971

35. "Spur 'Superclinics' Expansion to National Scale Ellwood Urges" *Medical Group News* 8:1. March 1976.

For a thorough assessment, see David Gaynor, et al. "Implications of Corporate Involvement in HMOs. HMOs in Historical Perspective" unpublished paper. (Ithaca, New York Cornell University 1974).

36. See ref. 13. For a thorough assessment, see David Gaynor, et al, "Implications of Corporate Involvement in HMOs, HMO in Historical Perspective" unpublished paper. (Ithaca, New York Cornell University 1974)

37. U. S. Department of Health Education and Welfare, Forward Plan For Health F Y 1978-82 (Washington, D.C. U.S. Government Printing Office, 1976). p. 50, and U. S. Department of Health, Education and welfare. *Health Maintenance Organizations. Survey of F. Y. 1975 Annual Report*. DHEW Publication No. (HSA) 76-13036.

38. "R.J. Reynolds to Open New HMO for Employees" *Health Services Information* April 2 , 1976, p. 6-7

39. Dean J. Warshaw, "The Expanding Scope of Occupational Medicine" *Journal of Occupationa Medicine* 17:10, October 1975, p. 624..

40. Miles Colwell, "The Balance Sheet in Employee Health Conservation," presentation to Annual Meeting of the Industrial Health Foundation, October 13, 1970.

41. William Jend, "Where Do we Want To Be in Occupational Medicine." *Journal of Occupational Medicine*, 15:7 ; July 1973, pp. 517-579.

(*Contd. on page 51*)

Census Bureau showed that the number of Americans living in poverty had risen to its highest level in 18 years. As a result of Reagan Administration tax policies, families. earning less than 10,000 dollars annually suffered a net loss of dollars 400 or 4 percent of income, whereas those earning over 80,000 dollars gained 8,270 dollars or about 10 percent. This will further limit the number of blacks who can climb out of the poverty and degradation they are born into. Increasingly large US cities have a black majority population. The white exodus from the cities is matched by a loss in jobs in the manufacturing, wholesale, retail and service industries. In the past 10 years alone New York, Chicago, Philadelphia and Detroit have lost a million jobs with white unemployment levels staying relatively static whilst black unemployment levels have zoomed to nearly 55 percent for teenagers. These trends are likely to continue.

*"Profit has made America what it is" is the proud slogan of American capitalism, which wishes to be known by its new, gleaming, dazzling, forprofit hospitals where the birth of a baby is celebrated by the parents with champagne. In their shadow lies the decay of overstrained public hospitals serving non-white citizens and bearing an uncanny resemblance to large municipal hospitals in India.* Their burden will be greater than before as for-profit hospitals both "cream" off capital and resources and leave to them unprofitable diseases and the care of minorities and poor people.

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42. Two particular issues of the *Journal of Occupational Medicine* detail tasks for corporate medical directors: a special section on "Cost Effectiveness of Occupational Health Programs" In *JOM* 16:3, March 1974: and a special issue on "HMOs and Occupational Medicine" in *JOM* 17:10, October, 1975. See also Jesse Steinfeld. "The Workplace as a Health Care Resource," *JOM* 12 8. August 1970, pp 315-317: Robert O'Connor, "The Role of Industry in the Health of the Nation." *JOM* 10:3, March 1968, p. 379: and J. Williamson and M. van Nieuwenhuzea, "Health Benefit Analysis: An Application in Industrial Absenteeism. "*JOM* 16:4, April 1974. pp. 229-223.

43. For an excellent discussion, see: Sander Kelman "The Social Nature of the Definition problem in Health" *IJHS* 5:4, 1975, pp. 625-642.