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On Feb. 7, Walter J. McNerney, president of the Blue Cross-Blue Shield Association, declared that payment will be phased out for 31 surgical and 10 diagnostic services unless ordered by a physician in writing on an individual basis. This would eliminate routine blood counts, urine analyses, chest X-rays, and electrocardiograms—tests that often catch the irregularities signaling serious disease. This would deny health care particularly to the elderly and also those 21 million citizens who are referred by group plans and therefore have no individual doctors.

In summary, by placing strict ceilings on expenditures and adding millions to an already overburdened system, the Kennedy bill would legislate many hospitals out of existence through bankruptcy. By tightening requirements for hospital entry, the Kennedy bill would deny care to those who need it. By enacting strict fee schedules for the treatment of disease to those who are permitted entry and by holding a ceiling on allowed expenditures, the Kennedy bill would guarantee that the hospitals could no longer supply the kind of improved care that has greatly lowered the nation's mortality rate in the last decade.

'Alternatives' to hospital care

The logic behind the Kennedy bill was stated simply by David Rogers, M.D., president of the Robert Wood Johnson Foundation, who has prepared the provisions in the bill for medical education and wrote in *Daedalus* magazine in 1977: "While we can probably make hospitals more efficient, the continuing technological advances of medicine dictate that the costs of a day in a hospital bed will continue to rise. But there is good evidence to show that a well-organized ambulatory-care system for certain groups can significantly reduce the amount of hospital care needed per person. A program that would cut hospitalization for each patient now admitted to a hospital in the United States each year by just one day would save $2 billion. Obviously, logic suggests that we strive toward a system in which less hospitalization is required, if we are to contain the costs of medical care within tolerable limits."

Rogers suggests, and the Kennedy bill provides for, the reversal of the increased specialization of medicine and a new stress on "primary care"; reliance on Health Maintenance Systems in lieu of hospitals for service; the elimination of "unnecessary" surgery; the creation of neighborhood clinics to replace closed hospitals especially in cities; accelerated creation of hospices for the elderly and dying; and stress on "preventive medicine."

Under the Kennedy bill:

Fee schedules will be designed ... to encourage more primary care physicians, particularly in medically underserved areas.

The increased ability through vaccines and advanced methods to treat disease since the late 19th century and particularly in the last two decades has produced an increased specialization in the medical field. No longer is the ordinary doctor a general practitioner who is limited in his knowledge and experience of many diseases. The increased division of labor in the medical field, like the development of high technologies to detect disease and treat patients, has increased the *intensity* of health care delivered. It has saved lives.

The Kennedy bill, does not propose an interdisciplinary approach to solve coordination problems among specializations, but seeks to lower the level of medical skill to the lowest common denominator.

Proposed OSHA regulation to hit

The traditionally private relationship between corporations and insurance companies that has kept health benefit reimbursement standards high in the corporate sector will be jeopardized if Senate Bill 3450 with its regulations pertaining to employee medical records is passed.

Most corporations negotiate directly wiih the 20 major group health insurance companies in the United States for their employee benefit plans and often use this as a bargaining chip in labor negotiations. These insurance companies, with the exception of Blue Cross and the Prudential Insurance Company of New Jersey, have in the past joined with the American Medical Association to oppose the Kennedy Health Security Act.

But under Senate Bill 3450, proposed by Javits (R-N.Y.), Muskie (D-Me.), and Ribicoff (D-Ct.), the Occupational Safety and Health Administration will be handed vastly expanded powers to prosecute businesses and management for allegedly not providing their employees with "adequate and proper health care." The bill would give a special commission of "qualified personnel" within OSHA access to health records in order to determine if employees have been "unable to protect themselves from occupational diseases and exposure to toxic substances because their claims have been ignored by industry."

Patient access to medical records, presently forbidden except in cases deemed exceptional and in certain court suits, will also be allowed. This opens the way to litigation against occupational physicians, most of whom are attached to corporations, threatening millions of dollars in losses from suits brought by employees who claim exposure to toxic substances or occupational diseases.

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corporate health benefit standards

Patient access would tie in closely with the proposed expansion of OSHA's role as a center for data-bank information providing evidence against major corporations that the introduction of new technologies into their plants and factories is harmful to workers. This indeed was the intention of the Occupational and Safety Hazards Administration Act of 1970. In the health-care sector specifically these guidelines will force government intervention into the benefit structure of private insurance carriers on the grounds that coverage is "inadequate."

For example, the data files could be used to prove that corporate white-collar employees are "treated favorably" by hospitals since they have corporate group health plans and are admitted for "unwarranted surgery and excessive hospitalization." This would provide the rationale to force insurance companies to lower their benefits structures as their corporate clients come under pressure from the expert OSHA committee.

Who is reportedly being proposed for this expert review committee?

• Anthony Mazzocchi, vice president of the Oil, Chemical, and Atomic Workers International Union and an ardent supporter of the Kennedy health bill.

• Alan F. Westin, a professor of law at Columbia University, a board member of the American Civil Liberties Union, and an advocate of the antitrust legislation that Senator Kennedy has sponsored in Congress.

• Alan A. McLean, M.D., the New York area medical director for IBM, a company with a massive electronic data base and surveillance capability, and president of the American Occupational Medical Association.

Dr. Rogers even goes so far as to suggest the "use of nonphysicians to deliver most primary medical care. ... Such a system would probably be, at least initially, most acceptable to the two areas that currently have the most serious problems in general medical care—rural areas of low patient density and heavily congested, inner-city areas now deprived of physicians."

A lowering of the standards of health care is not only projected for low income areas. The Kennedy bill mandates:

National licensure standards and requirements for continuing education.

The Kennedy bill would mandate priorities in medical education toward primary care and less specialization. Already, Secretary of Health, Education and Welfare Joseph Califano has proposed that federal grants to medical schools be predicated on an "incentive system" that would reward schools which admit a higher percentage of students for tracking in primary care. Many of the country's 114 medical schools currently operate on the financial margin afforded by government grants and would thus have to change their orientation toward primary care or close.

The U.S. health system does need more family practitioner specialists—a designation that requires three years of hospital residency. Dr. Rogers, however, suggests the training of two types of physicians—"first class" physicians would be trained like those today; "second class" doctors would be "rapidly trained practitioners."

The Kennedy bill further mandates:

Regulation of major surgery and other specialist services.

It is the contention of many backers and supporters of the Kennedy bill that since the number of types of operations varies from region to region, then some of this surgery must have been "unnecessary." Califano has established an HEW program "to get a second opinion free" if a doctor should order surgery. But, it has been shown that in cases in which surgery has been delayed—for example, removal of the gall bladder—the problem has recurred, making surgery necessary when the patient is older and less able to withstand it.

It might be argued that some surgery could be eliminated through the development of new drugs. However, the Kennedy-Javits bill for Pharmaceutical Revision Reform Code introduced in 1978 acts to deprive pharmaceutical companies of their research and development capabilities through divestiture of drug patent rights after a 60-month period.

Harvard's Dr. John Knowles, a likely candidate until his recent death to sit on the bill's national Public Authority, has claimed: "Ten billion dollars could be saved and made available for such (preventive) programs, if by miracle all unnecessary surgery were abolished." The claim that $10 billion a year is spent on "unnecessary" surgery is a ruse to rationalize the closing of the country's hospitals and pave the way for the "ambulatory" service that the bill's backers say will do just as well.

Under the Kennedy bill:

Health Maintenance Organizations and other nontraditional forms of health care delivery, such as neighborhood health centers, will be fully supported and their development encouraged through incentives.

As originally conceived, Health Maintenance Organizations were designed to provide a group of people—through business, school, or union—with