PARENTS/CHILDREN

Staggering Expenses of Having a Baby

By RICHARD FLASTE

Forget, for a moment, the buzzing confusion that greets infants at birth, and consider instead the rude awakening some parents experience—when they learn what childbirth costs.

Joan Weiss, who recently gave birth at New York-Cornell, had in her mind that the charges would run, oh, maybe $1,000 from start to finish, and when her doctor told her the fee would be $350, she thought that was the total. But that was *his* bill. Then came the hospital's which routinely is in the vicinity of $1,200.

Insurance Inadequate

"I just didn't realize it would be up in the $2,000 range," she said, "and that my insurance would only cover about $300 of it."

For Kathy Lesser, "the biggest shock" came after she notified the hospital, Beth Israel, that she was three months' pregnant.

"By the end of the week we had a bill for $650," she said. The Lessers were requested to pay that deposit six months in advance to guarantee that they would be charged room rates prevailing at the time. They could wait a while before paying but, the request clearly implied, who knew what the rooms would cost then?

Hospital rates have indeed been rising rapidly. The United Hospital Fund says that in the last four years daily maternity room rates in all New York City hospitals have gone up from an average of $108 to $161 for private accommodations and $86 to $122 for rooms with more than one bed (the averages would be higher than that for Manhattan, which is the most expensive borough, and lower for Staten Island). The average hospital stay is four or five days.

Physicians' Fees Up

Representative Manhattan physicians' rates, according to Blue Cross-Blue Shield, have gone from $500 to $700 in the last four years. But many obstetricians charge as high as $1,000.

Various reasons are offered for the increase in hospital costs. Hospitals have faced sharply rising employment costs; they have invested heavily in technological development, and they are large users of fuel. Maternity costs at hospitals have climbed because each birth pays in part for all that technology and manpower, regardless of whether the birth was routine, requiring relatively little attention.

That realization led Dr. Philip Lee, director of the health policy program at the University of California in San Francisco and a former assistant secretary for health at the United States Department of Health, Education and Welfare, to question in a recent speech here why childbirth so frequently took place in such highly sophisticated hospitals.

He noted that only 10 to 20 percent of pregnancies presented "serious problems" and these "can be identified if the mother is under professional care." He urged the study of other childbirth settings.

Donald Rubin of the Consumer Commission on the Accreditation of Health Services, a watchdog group, attributes the high cost not so much to the nature of hospitals, but to what he sees as inefficient management.

He points to statistics indicating that some hospitals regularly operate at 50 percent of capacity or less. "There are hundreds and hundreds of empty beds," he said.

He recommends the shutting of more maternity departments, a trend that has already begun as maternity proves itself to be an unprofitable business. Mr. Rubin says that each empty bed, without providing any income, still costs the hospital about two-thirds of what it would cost if in use.

Meanwhile, as prices rise, the insurance coverage most commonly purchased pays little of the cost. Nine million Blue Cross-Blue Shield customers in southern New York State have only hospital coverage, which, in the most popular plan among many, has gone from $100 paid toward the cost in 1972 to $200 now. The 5.4 million customers who also have physicians' coverage received an additional $250 in the most popular plan, a sum that has not changed in several years.

That leaves the consumer with a considerable burden, often totaling $1,500 to $1,800. And yet the consumer frequently feels that there's no chance to shop around.

"It's not a consumer's market," one mother said. "You're stuck with whatever hospital your doctor is affiliated with." And another likened childbirth to funerals, when cost seems no object and "you just want to be sure it's perfect."

But the fact is that there are a number of options. Doctors are often affiliated with more than one hospital. And it is also possible to choose a hospital first and then ask for a list of doctors associated with it.

The hospital might be chosen because you do want every technological advancement, just in case, and do want a commodious room with a view of the river.

On the other hand, if cost is a major factor, older, smaller hospitals can be several hundred dollars less expensive. New York Infirmary has a semiprivate rate (with four in a room) that is $90 a day and thus $78 a day below the four-in-a-room rate at St. Luke's. And the nursery charge of $35 a day is $79 a day less.

Clinics Open to All

At French & Polyclinic, which has been struggling financially and trying hard to attract patients to its sparsely populated maternity section, the four-day rate, including nursery and delivery room, totals $475.

Moreover, a number of hospitals have maternity clinics that are open to anyone and used by middle-income patients as well as the poor.

At New York-Cornell's clinic, one stays in the same semiprivate room that might be used by a nonclinic patient and pays the same rates —the only difference is that there is no physician's charge. A staff resident or midwife handles the prenatal care, delivery and postpartum visit, all services included at no extra charge.

Other hospitals with clinic programs are Columbia-Presbyterian, Flower & Fifth Avenue, New York Infirmary, St. Luke's and French & Polyclinic.

Backup Hospital

At Roosevelt Hospital, the midwife program costs $459.

And at the new Maternity Center Association facility at 48 East 92d Street, the program run by teams of obstetricians and nurse-midwives totals $575 for all costs in a normal delivery. The program is geared for normal births only, but the facility is said to be 11 minutes away, by ambulance, from Lenox Hill Hospital in an emergency.

A common misapprehension is that natural childbirth at hospitals is necessarily less expensive, because it attempts to limit or eliminate the use of anesthesia. But hospitals add an anesthesia charge to their bills in any case on the ground that the doctor and equipment should be on hand if needed immediately.

Joan Weiss, who thought it would be a "ridiculous" extra charge of $50 if she turned out not to need an anesthesiologist, did end up requiring anesthesia.

The only thing that puzzles her now is why it took the anesthesiologist a half hour to arrive.

U.S. Is Cutting Off Funds To Wadsworth Hospital

By DAVID BIRD

Four years after inspectors found a wide range of serious violations at Wadsworth Hospital, a 50-bed private institution in Washington Heights, the Federal Government has moved to withhold the Government funds that are the institution's major source of support.

Wadsworth, which many health officials say is one of the city's worst hospitals, was told in a letter dated last Monday from the Department of Health, Education and Welfare that the institution's Medicare and Medicaid claims would not be honored for patients admitted after March 26.

A year ago an investigation by The New York Times of State Health Department records showed Wadsworth, where the most-frequent procedure was abortion, had one of the most-extensive lists of deficiencies, ranging from a lack of protection against fire to little or no protection against the spread of infection.

State Did Not Act

Although the deficiencies had long been in the State Health Department files, health officials said they had not been able to close Wadsworth because of a lack of staff to press the case and because of a feeling that it would be difficult to win a case if the hospital challenged the closing in court.

Yesterday, Dr. J. Warren Toff, the State Health Department's associate commissioner for New York City affairs, called the Federal action on withholding funds to Wadsworth a breakthrough that could lead to the closing of others like it.

"While Wadsworth is one of the worst hospitals in the city," Dr. Toff said, "there are many other inadequate and unneeded private hospitals that also could be closed."

Dr. Toff did not name any institutions specifically, but he cited the report issued last month by the Health and Hospital Planning Council of Southern, the quasipublic advisory agency, which called for the elimination of 27 general-care hospitals in the city because they were unneeded for the city's health care.

Of those 27, 15 were private hospitals operated for a profit.

The State Health Department had recommended to Federal officials last Aug. 28 that the Medicare and Medicaid funds be withheld from Wadsworth. Medicare pays health costs for the aged, and Medicaid covers the poor.

For a time there had been a dispute over who should act first, the state in withholding the license to operate or the Federal Government in cutting off funds. Recently, there has been agreement that the cutting off of funds is the most effective means.

But if the state and Federal Governments have agreed on what seems to be a viable course, their actions are still viewed with some skepticism by consumer health groups, which say the process is taking much too long.

Donald Rubin, the president of the Consumer Commission on the Accreditation of Health Services, who has charged that "there has been a total breakdown in the inspection process," said yesterday that the length of time it took to close a seriously deficient hospital was still much too long.

Letter to Hospital

The administrator of Wadsworth, which is at 629 West 185th Street, was told this week in a letter from Joseph Godfrey, the regional director of the Federal Bureau of Health Insurance, that the Government payments would end because the hospital's condition "jeopardizes the health and safety of its patients."

Mr. Godfrey's letter said that repeated inspections in December 1974, April and June 1975 and last month had shown uncorrected violations ranging from the lack of fireproof doors and adequate exits to the lack of a medical library.

Wadsworth officials have in the past said that it would be too costly to make the corrections and that in any case it would be difficult to get the necessary money if the hospital were listed as unneeded.

THE NEW YORK TIMES, WEDNESDAY, MAY 26, 1976

CONSUMER NOTES

Surveys Uncover Hospital Hazards

By FRANCES CERRA

When people check into a hospital for surgery or other treatment that carries risk, they generally assume that the hospital is equipped and staffed so that the inherent dangers of the surgical procedures are not compounded.

But random surveys of accredited hospitals ordered by the Federal Government from January 1974 through October 1975 showed that 64 percent of the hospitals inspected failed to meet one or more of the Federal standards.

These standards, among other things, concern the cleanliness of a hospital, its protection against fire and explosion, the adequacy of its nursing staff and equipment and its record-keeping.

Accreditation by the Joint Commission on the Accreditation of Hospitals, an independent, nongovernmental organization, is supposed to mean that these standards are met. Indeed, the Federal legislation that established Medicare makes accreditation the basis for Medicare eligibility, and under that law, no regular, periodic inspections of a hospital are necessary as long as a hospital is accredited.

However, doubts about the completeness of accreditation surveys led the Federal Government to order its own random surveys. According to Donald Rubin, president of the Consumer Commission on the Accreditation of Health Services, the 64 percent failure rate shows that consumers must act themselves to force improvement of hospital conditions.

261 Hospitals Checked

The random surveys have, so far, covered only 261 hospitals nationwide, and the Federal agencies involved have temporarily suspended further surveys while they consider the implications of their findings.

How can a consumer force a hospital to improve conditions? By taking advantage, Mr. Rubin points out, of a procedure that results in a Federal inspection of a hospital. If that inspection finds violations that the hospital cannot or will not correct, the hospital can lose its Medicare and Medicaid eligibility. Without these funds, hospitals today cannot operate.

The procedure is simple. A consumer who has evidence that a hospital is not meeting proper standards directs a complaint to the Department of Health, Education and Welfare, Social Security Administration, Bureau of Health Insurance at 26 Federal Plaza, New York, N.Y. 10007, and requests that an inspection survey of the hospital be conducted.

The evidence could be a condition that the person has seen himself, possibly an inadequate nursing staff, or dirty or crowded conditions. This agency has no jurisdiction over physicians, and complaints about doctors should not be directed to it.

Another piece of evidence that could be used is a copy of the New York State Health Department's Article 28 inspection report on a hospital. The Health Department is supposed to make these inspections regularly as the basis for issuing operating certificates to hospitals. However, spokesmen for the department admit that inspections are backlogged, particularly for proprietary, or profit-making hospitals.

However, if an Article 28 inspection has been done recently, the report makes good evidence for the Federal Government. So far, three hospitals in New York City that were the target of complaints filed by Mr. Rubin based on the Article 28 reports have lost their Medicare eligibility.

In New York City, these records can be obtained from the State Health Department's Office of New York City Affairs at 2 World Trade Center. Outside the city they can be obtained from the local health department office. There is a charge of 15 cents a page to cover the cost of reproduction.

THE NEW YORK TIMES, THURSDAY, OCTOBER 14, 1976

Controversy Rages on Whether Municipalities Should Run Own Hospitals

By DAVID BIRD

The battle over whether New York City's deficit-ridden government has enough money to run its new North Central Bronx Hospital has raised a much larger question of whether municipalities should be in the hospital business at all.

New York has been running municipal hospitals to take care of the poor ever since Bellevue opened in 1736, but in the last decade new legislation and the economic pinch have combined to create a force that could make municipal hospitals obsolete.

Traditionally, the municipal hospitals took care of the poor because the poor had no other place to go.

The rich could pay their own way in the more comfortable and prestigious proprietary (private, profit-making) and in the voluntary (private, nonprofit hospitals.

But in 1966, in a surge of social legislation, Washington brought Medicaid and Medicare into existence that was to pay bills for the poor and the aged no matter where they were treated.

A Trend Is Started

The Government programs started a trend away from municipal hospitals. In 1965, public hospitals cared for 25 percent of the total number of patients. By 1974, the public share had dropped to 19 percent.

The slow erosion of the public system was markedly speeded by the fiscal crisis.

"It was the two factors in combination that really made a difference," says Dr. Lowell E. Bellin, the city's Health Commissioner. "The poor had a chance to go someplace else and the city was forced to think of economies that would never have been thought of before."

With a $1 billion annual budget the city's Health and Hospitals Corporation, which oversees the municipal hospital system, loomed as a large target for budget cutters.

City officials reasoned that if the required budget savings were not taken out of the municipal hospitals they would have to be taken out of vital services like the Fire and Police Departments.

With Medicare and Medicaid many of the indigent could get treatment someplace else, the reasoning went, but fire and police protection could not easily be obtained elsewhere.

But the future of the municipal hospital system could determine the whole future of health-care delivery.

For Municipals

Defenders of the municipal system say it is important to keep the system if government is going to pay more and more of the hospital bills—assuming national health insurance is not far over the horizon—and it is important for government to run the hospitals too so there will be strict accountability.

Among other issues that defenders of the municipal system are raising now is the specter of the recent Medicaid scandals that have come to the surface as a result of the Government's channeling money to private doctors without adequate control over the funds.

Dr. John L. S. Holloman Jr., the president of the Health and Hospitals Corporation, says that "the fundamental advantage of municipal hospitals is that they spend public money in public and consequently are accountable in a way that voluntary hospitals are not."

Medicaid pays bills only for the very poor. Those earning over about $5,000 a year still must pay their own way, if they can, or do without care.

'Skimming the Cream' Seen

Dr. Holloman says the voluntary hospitals "have gotten rich by skimming the cream, by cutting losses" through not treating the poor who are not covered by programs to pay their bills.

Dr. Holloman doubts that a poor person really gets the same treatment even when he can get into a voluntary hospital.

"A Medicaid patient legally must be treated in the same way as a private patient paying for service," Dr. Holloman says, but he adds: "It seems to be somewhat naive that this in fact is true, especially when a Medicaid patient doesn't have a private physician."

Another strong defender of the municipal system is Donald Rubin, president of the Consumer Commission on the Accreditation of Health Services, a private activist group.

"We've got to have government-operated hospitals," Mr. Rubin says, "so the fee-for-service physicians will not rip us off."

He contends that physicians who are remunerated on the basis of each service perform unnecessary operations and other procedures just to raise their incomes.

In a government-operated hospital where the physician is paid a straight salary, he says, there would be no temptation to perform unnecessary procedures than can harm rather than help a patient.

Mr. Rubin says that municipal hospital systems have deteriorated because they have been bled by politicians favoring the private sector. He says that government hospitals can be good.

"After all," Mr. Rubin says, "when the President gets sick he goes to a Government hospital not a private hospital." He was referring to Bethesda Naval Hospital, which takes care of Presidents and other oGvernment officials.

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Against Municipals

"There is no point in hanging on to a system that no longer has any use," says Dr. Bellin, the Health Commissioner, who refers to the municipals as an "anachronism."

He says that "for the most part there never has been a tradition in this country of excellence under public auspices" and the municipals have the stigma of being second-class places for the poor.

Dr. Belin says that once there is national health insurance for everyone, there will be no need for municipals.

"If you have the choice of going to the local greasy spoon or the place that serves squab under glass you'll use the greasy spoon only if you don't have money," says Dr. Bellin. "But if I give you a free credit card you're going to go for the squab under glass."

Dr. Bellin denies that the poor receive less than the best care in voluntaries. You now have different classes cheek by jowl in the same rooms," he says. "It's a degree of integration that is taking place no place else."

The Impact of Civil Service

Dr. Ray E. Trussell, who once ran the municipal system here as Hospial Commissioner and is now general director of Beth Israel, a leading voluntary institution, says "the inflexibility of civil service is man's worst enemy when it comes to providing medical care." He says it is almost impossible to get the right person in the right place because of rigid seniority rules that dictate who goes where.

Dr. Trussell denies charges that the voluntaries are for the rich. "Beth Israel was founded to serve the poor of the Lower East Side and that is what we do now."

He agrees that some municipal hospitals would still be needed to take care of the poor who did not have government programs to pay their bills but that eventually national health insurance will enable everyone to go to the voluntaries.

The Outlook

Another former Hospital Commissioner, Joseph V. Terenzio, who is now president of the United Hospital Fund, which raises money for the voluntaries, sees the future as one in which municipal hospitals and voluntary hospitals will become somewhat the same with the institutions run by voluntary corporations under strict legal controls of accountability on the use of government funds.

Dr. J. Warren Toff, the associate commissioner for New York City affairs of the State Health Department, says the fight among the proprietaries, voluntaries and municipals is not going to be settled easily.

"Each of the three sectors is going for the jugular and the result is mass chaos," Dr. Toff says, emphasizing that he is speaking of his own observations in 36 years in public health here and not necessarily reflecting the official view.

"Each hospital is worried about its own prestige, its own status and there is no concern for the health delivery system as a whole."

He says there is duplication that wastes money because each institution had to have its own equipment and its own staff for every department. Dr. Toff says the health-care system should be regionalized so that there would be only enough pediatrics or obstetrics department, for example, to serve the area's needs rather than one in almost every hospital.

"I see a need for all three types of hospitals if we can avoid duplication," Dr. Toff says, "but in the current battle one type may get knocked out "and the municipal system seems to be the weakest of the three."

N.Y.T. Thurs. Oct. 14, 1976

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50% CUT IS WEIGHED IN CITY'S HOSPITALS

Koch Assails System as Wasteful — Plans Reductions by 1982

By RONALD SULLIVAN

Mayor Koch will seek to reduce the number of municipal hospitals the city operates by as many as half by 1982, according to the Mayor's top health adviser, Dr. Martin Cherkasky.

The projection, given in an interview Wednesday, was the first public disclosure that the city hoped to achieve a major dismantling of the largest and most costly municipal-hospital system in the country.

City officials, including Philip L. Toia, the Deputy Mayor for Financial Management, had suggested previously that the Mayor would seek to cut the current $1.2-billion-a-year budget of the New York City Health and Hospitals Corporation, the semiautonomous city agency that operates the city's 17 municipal hospitals, by as much as 10 percent for the fiscal year beginning next July. Such a cutback would almost certainly force the closing of some hospitals and the layoffs of hundreds of hospital workers.

The deeper cutback described by Dr. Cherkasky drew a bitter reaction from a leader of municipal-hospital employees and strong criticism from advocates of the municipal hospitals. The latter charged the Mayor with seeking to abdicate a responsibility to provide free hospital care to the working poor, aliens and other patients who cannot afford hospital care and are not covered by Medicaid or other forms of hospital insurance.

Asked what kind of municipal system he envisioned when the reductions were completed, Dr. Cherkasky said, "I think we're talking about something in the neighborhood of half." He emphasized, however, that the figure was only an estimate.

He said there were some hospitals in the system that the city could not do without, and he cited Lincoln Hospital in the South Bronx as an example.

Later, a top city health official said Dr. Cherkasky envisioned a vastly reduced municipal system that would have only about seven or eight existing general-care hospitals remaining open under city auspices.

The official, who asked not to be identified, said that the Bronx should probably have two, Lincoln and Bronx Municipal; Manhattan two, Bellevue and Harlem Hospitals; Queens one, City Hospital at Elmhurst, and Brooklyn two, the new Woodhull and a vastly reduced Kings County Hospital Center.

The remaining hospitals could be closed, given away or converted to ambulatory-care centers where possible.

All told, the 17 municipal hospitals, which also include several long-term-care institutions that do not figure in the city's projected cutbacks, account for 7,761 beds, or 22 percent, of the 35,000 general-care hospital beds in the city. Private voluntary hospitals have a total of 24,651 beds, or 70 percent of the total. The 2,836 beds in proprietary hospitals account for the remaining 8 percent.

Political Battle Is Expected

Varying city, state and Federal calculations estimate that there are 3,000 to 5,000 unnecessary hospital beds in the city, a surplus that they regard as prohibitively wasteful. And since the city must pay for a major share of that waste in its own hospitals, Mr. Koch is said to be determined to cut his own losses regardless of the almost certain political battle it promises with local political interests, community organizations, municipal workers and leaders of the city's black and Puerto Rican constituencies, which account for most patients and employees in the municipal hospitals.

In a private meeting with city labor leaders last Monday, Mr. Koch said that the municipal-hospital system was riddled with waste and redundant medical services that had the "potential for bankrupting the city."

The leaders said later that they had been most alarmed by the Mayor's statement that the city could no longer afford the cost of providing its own "national health insurance" with city tax funds to the more than one million municipal-hospital patients who have neither Medicaid nor funds of their own to pay for hospital bills. It is estimated that their care is costing the city $422 million this year.

System Termed Unmanageable

Consequently, the Mayor and Dr. Cherkasky, who is also president of the prestigious Montefiore Hospital and Medical Center in the Bronx, are determined to force drastic cutbacks on a system that City Hall regards as "monstrous and unmanageable," and shift the financial burden for providing free care for the working poor and aliens somewhere else — presumably to the state and Federal governments.

Dr. Cherkasky also said he believed that many private voluntary hospitals should be cut back or closed. They contend that only the state — not the city — has the power to do it.

However, critics of the projected dismantling offered a far different perspective.

Donald Rubin, the head of the Consumer Commission on the Accreditation of Health Services, a nonprofit, public-interest organization, said Mr. Koch and Dr. Cherkasky "are simply trying to fill up the empty beds in the voluntary and proprietary hospitals at the expense of the public system."

"It's a power struggle for the health-care dollar, and it seems the Mayor has sided with the private sector," Mr. Rubin said. "Our national health priority is to foster health services for the poor, and that's what the municipals try to do — not the voluntaries."

Mr. Rubin also said that the major voluntary hospitals in the city were already filled and that displaced municipal patients would be "funneled into second-rate voluntary institutions that should be forced to close."

The Committee of Interns and Residents, an organization that bargains for most of the physicians in municipal hospitals, said the "Mayor's hospital closing and giveaway plan" would mean the "almost complete destruction of city health services for the poor and uninsured."

The group organized a strike committee on Thursday and a spokesman said job actions to protest against the Mayor's plan would begin at municipal hospitals on Jan. 15 and then grow toward a complete walkout by physicians by early February if the cutback plans were not abandoned.

'Would Not Save a Penny'

Lillian Roberts, an associate director of District 37, American Federation of State, County and Municipal Employees, which represents the city's 37,000 hospital workers, said that "any tampering with the municipal hospitals would only compound the city's fiscal problems," presumably by forcing hospital workers on welfare.

"It would not save a penny and it would cost the lives of poor patients," she said. "The city has got to decide whether it is going to turn its back on the poor by trying to save money on their backs."

John Gardner, a spokesman for the Coalition to Save the Public Hospitals and the chairman of the citywide Council of Municipal Hospital Community Advisory Boards, said his organizations "have no intention of allowing the Mayor or Dr. Cherkasky to dump public funds into private hospitals." He predicted that there would be "bitter public protests in demonstration form, just like the 60's."