Swine Flu

The swine flu vaccine program is the most recent chapter in the larger story of the failure to provide adequate health care for the American people. The main theme is a familiar one: the federal government’s inability to intelligently consider and reasonably implement an effective public health program against a backdrop of massive expenditures for hospital-oriented acute care and minimal expenditures on preventive and outpatient care.
At the center of the action are the nation’s medical scientists and their role in the development and implementation of government policy. Based on real fears of a world-wide “killer” flu outbreak, these scientists, with their activist medical orientation, prematurely recommended a massive program whose implications they barely comprehended. In so doing they took an active role in the decision-making process, despite assertions by many of them that they are “just scientists” and technical advisors, outside the political process. Their presentation of the facts and their inability or unwillingness to explore the ambiguities and uncertainties in their knowledge led the Executive branch to rush into a program that is ill-considered, mistargeted and largely ineffective.

Marching in close step behind these scientists came the various private interests—especially large drug companies—who had played a smaller role in initiating the program but stood to gain substantially from its implementation. Once these interests had thrown their full corporate weight behind a mass inoculation program, it became virtually impossible to reconsider it. This latter point is all the more poignant since many of the growing doubts about the effectiveness of the program have been voiced by the very scientists who initially championed it.

The current federal strategy for protecting Americans against the swine flu is: (a) vaccination of “high-risk” people with a bivalent (two-virus) vaccine that seeks to protect them against both swine flu and ordinary Victoria flu viruses and (b) vaccination of all other Americans eighteen years and older against swine flu virus alone.

On the basis of the available evidence there is no reason to dispute the vaccination of high-risk people. High-risk persons are those who would have a significant chance of dying if they contracted influenza. They fall into two categories: those over 65 years of age and those with serious, chronic diseases, including: pulmonary disorders, such as emphysema and severe asthma; heart disorders, especially mitral stenosis; metabolic disorders, like diabetes and cystic fibrosis; certain kidney disorders; and deficiencies of the immune systems. Forty million Americans, one-fifth of the population, fall into these two categories and account for well over 80 percent of all deaths associated with recent influenza epidemics.

While the Federal government’s strategy of vaccinating high-risk persons may be
sensible, there is considerable reason to oppose the decision to vaccinate non-high-risk people. Vaccination of the entire US population represents a huge expenditure of public health resources which at best could prevent non-fatal illness in some. More likely, however, the program will divert scarce public health resources with no significant effect at all. The vaccination of non-high-risk people was premised on similarities between the new swine flu virus and the virus that many scientists believe caused the great flu pandemic (world-wide epidemic) of 1918, an association that is now largely discredited.

The plan for mass vaccination of the entire population has come under such intensive public attack that some states are already effectively giving it up. Massachusetts, for example, has publicly stated that the vaccination of high-risk persons is their first priority and only after this has substantially been accomplished will they begin to vaccinate others. Given the slowness of the implementation of the mass vaccination program nationally, few non-high-risk persons are likely to be vaccinated in Massachusetts this year.

INFLUENZA AT FORT DIX

When, in January, 1976, soldiers returned to Fort Dix from their Christmas holidays, they brought with them the usual assortment of sniffles, sneezes, runny noses and coughs. Army doctors assumed they were seeing the usual adenoviruses (common cold viruses), some of which were severe enough to require hospitalization. They gave little thought to influenza because every Army recruit receives a heavy dose of influenza vaccine upon beginning basic training and is revaccinated each year with whatever influenza strains are prevalent that year.

Colonel Joseph Bartley, chief of preventive medicine at Fort Dix, called the local county health officer to warn him that the adenoviruses might spread to the nearby civilian population. The county health officer in turn contacted Dr. Martin Goldfield, director of public health laboratories for New

1918

The influenza pandemic of 1918 occurred in two major waves. The first was in the winter and spring of 1917-18 and was characterized by high morbidity (50% of the people in the world got it) and low fatality rates. The second wave started at Fort Devens, Massachusetts on September 12, 1918 and involved almost the entire world in a very short time. Its spread was bizarre: it was detected on the same day in Boston and Bombay but it did not occur in New York until three weeks later. It did not affect those who had been ill the previous winter and spring but its effect on everyone else was devastating. It may well have killed more people in a short space of time than any other disaster in the history of the world.

In all, about 20 million people died, including 500,000 Americans, in six to eight weeks. A total of 500 million people are estimated to have been stricken by the disease in the same period. "The number of fatalities at the height of the outbreak in Boston were 175; in New York City, 600 to 700; and in Philadelphia, 1,700 per day. . . . The impact of this pandemic was as great as that of the plague in London, which killed about 2 percent of the population per month."(1)

Much of the 1918 mortality occurred among young adults, who rarely die from flu, rather than such typical victims of flu epidemics as the elderly and chronically ill. In many cases, young persons became ill in the morning and died that night, often without any chance to get medical attention.(2)

See References pages 19, 20
Jersey, who said that the outbreak sounded more like influenza than an adenovirus. He suggested that cultures from the affected soldiers be checked by the state lab for the influenza type predominant at the moment, A/Victoria/75 (so named because it is a Type A influenza strain that was first identified in Victoria, Australia in 1975).

Goldfield was right: Fort Dix was having a flu epidemic. Most of the nineteen cases for which samples were sent to the New Jersey labs on January 29 contained the Victoria flu, but four samples were unusual strains of Type A influenza that could not be identified. The unknowns were sent to Atlanta, Georgia to the Center for Disease Control (CDC), a branch of the Public Health Service of the US Department of Health, Education and Welfare (DHEW). To the amazement of the CDC staff, they discovered, on February 13, that this unusual Fort Dix virus was similar to one of the first viruses that had ever been isolated, in the 1930s.

This virus had early been identified as very similar to a virus common in pigs (hence the name "swine flu" virus). What is more, in most locations investigated throughout the world, survivors of the 1918 flu pandemic had antibodies to this virus, leading scientists to conclude that the 1918 pandemic had been caused by swine flu virus. CDC labelled this new virus strain A/New Jersey/76 (Type A virus strain discovered in New Jersey in 1976) and alerted Army doctors to the possibilities of a "killer" virus outbreak like that of 1918.

CDC was particularly concerned because the swine flu virus at Fort Dix had been spread from one person to another, apparently because of a recent genetic mutation of the virus. Virologists had seen swine flu in people in direct contact with pigs, but they had never before seen swine flu spread from person to person. Their assumption that 1918 was caused by a swine flu that spread from person to person raised the specter of an epidemic of major proportions.

**A SOLDIER DIES**

On February 4, the same day CDC received initial samples from Fort Dix, Private David Lewis died of viral pneumonia at Fort Dix. Lewis had had a moderately severe flu-like illness and was told by Army doctors to stay in bed for 48 hours. He knew that if he missed more than three days of basic training, however, he would have to repeat it all, so he joined his company on a seven mile "forced march" in the snow. Lewis collapsed before the end of the march and was dead on arrival at the base hospital. Most experts, including Colonel Bartley, think Lewis would have lived if he had stayed in bed instead of going on the march.

Immediately a large-scale screening was implemented at Fort Dix and in the surrounding community. A/New Jersey/76 was isolated in five cases, including that of Lewis. In another eight cases there was clear evidence of infection by A/New Jersey/76 as determined by an increase in antibody levels following the second of two blood tests several weeks apart. In another 500 cases high levels of antibodies to swine flu virus were found after a single blood test; these cases were concentrated in the same companies as the positively identified cases, although many of these soldiers had not been sick.

**CDC ORCHESTRATES A RESPONSE**

The discovery of swine flu virus at Fort Dix and Lewis' death prompted CDC to call an urgent meeting on February 14. Representatives attended from the Army, the State of New Jersey and three involved branches of the Public Health Service: CDC; the Food and Drug Administration (FDA), represented by its Bureau of Biologics; and the National Institutes of Health (NIH), represented by the National Institute of Allergy and Infectious Diseases. All parties agreed to a serious investigation of the swine flu situation at Fort Dix and a search for cases elsewhere.

On February 19, CDC made the first public announcement that a new flu virus had been
discovered. The official press release said nothing about 1918; under questioning, however, Dr. H. Bruce Dull, Assistant Director of CDC, noted the similarity between the flu strains. The next day media reports throughout the United States featured stories about Fort Dix and the "specter of 1918." Reporters quickly sought out survivors of the 1918 pandemic and recorded their reminiscences in numerous media features. The predictable rise in public fears paved the way for federal action.

Was 1918 Swine Flu?

In recent years the theory that the 1918 pandemic was caused by the swine influenza virus has also come under attack. Three NIH scientists, including Dr. J. Anthony Morris and 1976 Nobel prize winner D. Carleton Gajdusek, reported in a 1969 Science article the details of a study of an isolated Pacific island which had been exposed to only one twentieth century flu epidemic, a late outbreak of the 1918 pandemic. They measured antibodies in the inhabitants' blood and found much higher antibody levels to PR/8 influenza virus than to swine flu virus. PR/8 is an A-type virus that has very different surface antigens (protein subunits) than swine flu. The study concludes, "Our results indicate that the virus circulating in the 1918 pandemic era was more closely related to human type A strains circulating in the middle 1930s than to other known influenza virus strains, including the virus of swine influenza." (1)

One reason scientists have so long accepted findings that the 1918 pandemic was swine flu, according to the same article, is that almost all data were gathered from urban populations. "Although antibody to swine influenza occurs very infrequently after a single infection by the PR/8 strain of influenza virus, antibody develops against both swine and human strains of influenza after repeated immunization with the PR/8 strain." Antibodies to swine flu virus may have developed simply because of "the broadening effect of cumulative infections with human type A strains." (2)

The day after the CDC announcement, the Bureau of Biologics, the primary FDA agency responsible for checking the safety and efficacy of vaccines, sponsored a workshop for university, government and industry scientists in preparation for a possible crash mass vaccination campaign. They set April 1 as the date by which a decision would have to be made if a mass campaign were to be carried out in time to prepare for a possible autumn outbreak.

Rushing against this deadline, medical scientists and public health officials searched aggressively for new evidence of the disease. They found none. No new cases were found at Fort Dix or anywhere else in the US or the rest of the world. Nevertheless, in a March 13 "action memo," Dr. David Sencer, Director of CDC, recommended a mass vaccination program for all Americans at a total cost of $135 million. He noted that "the Administration can tolerate unnecessary health expenditures better than it can tolerate unnecessary death and illness, particularly if a flu pandemic should occur."

Sencer's memo was issued on his own initiative. He failed even to consult members of the CDC's own Advisory Committee of Immunization Practices before sending the memo to higher-ups in the Ford Administration (perhaps because the Committee at its March 10 meeting had refrained from calling for such a program, recommending only that planning for such an eventuality begin).

AN EPIDEMIC IS CREATED

On March 22, DHEW officials took the memo to the President. Ford, never known for quick, decisive action, except for the deadly Mayaguez incident, called a meeting with thirty prominent medical scientists within 48 hours. The scientists, led by Jonas Salk and Albert Sabin, both of polio-vaccine fame, and vaccine researchers Edwin Kilbourne of Mount Sinai Medical School and Fred Davenport of the University of Michigan, recommended a nationwide vaccination program.

Literally within minutes of the panel's recommendation, President Ford called a press conference to announce the program. "This virus is very similar to the one that caused a widespread and very deadly epidemic late in the First World War," the President said. "Some older Americans
today will remember that 548,000 people died in this country during that tragic period.” The only way to prevent a recurrence, he concluded, was to vaccinate “every man, woman and child” in America.

In the aftermath of President Ford’s dramatic announcement, with little serious debate, Congress enacted the program. Symbolically, the date was April 12, thirty-first anniversary of Franklin Roosevelt’s death and the day, exactly ten years later, that successful results of the polio vaccine trials were first announced publicly. Congress appropriated the entire $135 million requested for the program:

- $100 million for purchase of 200 million doses of flu vaccine from four drug companies (Merck, Sharp and Dohme; Merrell-National; Wyeth; and Parke-Davis);
- $26 million in project grants as seed money to state and local governments to develop mass immunization programs;
- $4 million to the National Institute of Allergy and Infectious Diseases to expand research on flu;
- $3.2 million to the FDA to certify the vaccine;
- $1.08 million to CDC to coordinate the national program.

Thus three-quarters of the money went to private, profit-making drug companies. The companies were reimbursed at about 50 cents per dose, roughly the same cost per dose as in earlier flu vaccination programs. In contrast, administrative expenses were underfunded: only $26 million—13 cents per dose—was budgeted for state and local administrative costs. These costs averaged 60 cents per dose during earlier vaccination programs, however—more than four times the budgeted amount.

State and local health officials had earlier protested the inadequacy of the proposed administrative funding, but to no avail. They argued that already hard-pressed states could not allocate additional funds for this new program but would be forced to divert money and resources from already underfunded preventive and public health programs like family planning, maternal and child care and tuberculosis and venereal disease surveillance.

**THE BUBBLE BURSTS**

Initially the decision to launch the mass vaccination program seemed sensible given the little data available. A new flu strain had been detected, which could be expected to lead to a worldwide outbreak (all previous strains since 1930 had done so). Its virulence was apparently confirmed by Private Lewis’ death and by the virus’ resemblance to the strain usually blamed for the 1918 pandemic.

Medical scientists believed that they had the capability of preventing an epidemic, given their unprecedented lead time in detecting the virus—perhaps six to twelve months earlier than any previous strain. For such a vaccination program to be effective, they felt, it must include healthy young adults—the group particularly hard hit by the 1918 pandemic—as well as more traditional victims of the flu—the elderly and the chronically ill.

The basic medical assumptions behind the program, however—that the flu strain threatened a worldwide outbreak and that it was a “killer” virus—were not borne out. During the spring and early summer the fearsome projections of the program’s supporters were undermined by an increasing accumulation of negative evidence pouring in from many sources and discounting the medical rationale for the program. This evidence was persistently discounted or ignored.

**THE DISEASE DOES NOT SPREAD**

Despite an intensive search for A/New Jersey/76, not a single case has been found anywhere in the world since the Fort Dix outbreak. After the first week in which swine flu was detected at Fort Dix, repeated throat washings at the Army base have turned up only the common A/Victoria/75. The winter flu season has now passed in the Southern Hemisphere and flu centers there have detected no A/New Jersey/76. (1) Nor have

(Continued on page 10.)
Notes From NYC's Fiscal Crisis

North Central Bronx Hospital Fiasco

In the midst of fiscal crisis, New York City's Health and Hospitals Corporation (HHC—the quasi-public parent agency of NYC's public hospitals) has narrowly avoided forfeiting $800,000 to a private hospital.

It all began seven years ago when the Bronx's private Montefiore Hospital deeded 73,000 square feet of prime real estate to the City of New York. There was one major hitch: the City was obligated to construct a 412-bed public hospital on the land, located adjacent to Montefiore. The City agreed to the obligation and further committed itself to a formula whereby Montefiore would receive $400,000 (the land's appraised value) if no hospital were built plus $400,000 if the city decided not to contract with Montefiore to manage and staff the facility (see BULLETIN Jan./Feb. 1974).

Construction of the new facility—to be known as North Central Bronx (NCB) Hospital went according to formula until 1973 when public outcries were heard from Bronx community groups protesting the "giveaway" nature of the arrangement. They argued that giving Montefiore effective control and a guaranteed income from NCB amounted to giving public property to a private institution. They were further angered that NCB's North Bronx location made it all but inaccessible to much of the South Bronx's population.

Montefiore and HHC agreed to restudy their plans. Ultimately, however, this re-examination was lost in the shuffle of administrations at both City Hall and the HHC.

NCB construction was completed in 1976. Meanwhile, fiscal crisis loomed over the City and the HHC. The future of municipal hospitals in New York was in serious doubt, and by now NCB was seen as a replacement facility for two antiquated Bronx municipal hospitals—Morrisania and Fordham.

The fiscal crisis also called into question the financial arrangements between HHC
and Montefiore concerning operation of NCB. The HHC, for example, backed off its previous commitment to cover any debts incurred by Montefiore for patients without third-party coverage (Medicaid, Medicare or private insurance).

A battle of nerves ensued between HHC and Montefiore. In July, NCB opened its doors to everyone but patients; fully staffed and operational, the hospital "functioned" at a cost of $2.5 million a month for over three months without admitting anyone.

NCB could not admit patients without an operating certificate from the New York State Department of Health. State officials refused to grant such a certificate until the following issues could be resolved:

- Where would HHC find the anticipated $41.6 million needed to operate NCB annually? The question was a biting one since HHC's expenditures were already running $75 million over its budget.
- How could the state allow HHC to add 412 hospital beds in a city already thought to contain 5,000 excess beds? Specifically which Bronx hospitals would be eliminated?
- Should the HHC sell NCB to Montefiore, thus escaping any operating cost or responsibility at all? Such a suggestion seemed perfectly rational, to those who sympathized with the call by financial leaders for drastic cutbacks in all city services.

Resolving these and lesser issues involved weeks of backroom bargaining among City, State and Montefiore representatives. None seemed especially worried that the entire municipal hospital system was sinking; rather it was as if the officers on the Titanic had fallen into a poker game with the ship and fittings as stakes.

Meanwhile aboveboard, the public on the one hand and the worker's unions on the other demanded the hospital's opening. As the media focused on the costs of delay, community groups protested the lack of health care and the largest municipal workers union—DC 37—threatened citywide action, the HHC filed suit in State Supreme Court to force State officials to issue the operating certificate. On October 14, State Supreme Court Judge Edward Greenfield finally ordered the certificate released and on October 22, with Montefiore agreeing to a trimmed-down affiliation contract, North Central Bronx Hospital admitted its first patient.

Disposable Hospital

At least two patients are reported to have bled to death in recent weeks at the South Bronx's Lincoln Hospital as a result of cuts in services and battles over its affiliation contracts and administration.

*The New York Times* (November 5, 1976) reported that State Health Department investigators clearly linked the two deaths to inadequate facilities and a shortage of nurses. "Others may have died" as well, according to Robert Whalen, State Health Commissioner.

Constructed at a cost of $260 million, the 700-bed Lincoln Hospital has virtually ceased to function as a health care facility—a victim of New York City's byzantine health politics, compounded by severe fiscal crisis.

Lincoln's administration was for many years controlled by Ramon Velez, czar of the South Bronx anti-poverty empire. Velez hand-picked Lincoln's administrator, J. Cesar Galarce, as well as numerous other administrative and service personnel. Charges of Galarce's gross incompetence were overlooked by Mayor Beame since Lincoln, cornerstone of the Velez empire, served as bastion against the influence by Herman Badillo, another Puerto Rican politician. Badillo was a Beame opponent in the last mayoral Democratic primary and is a probable opponent in the next.
When Badillo defeated Velez in September's primary for the South Bronx congressional seat, pressure mounted for Galarce's dismissal. The Health and Hospitals Corporation (HHC) felt obligated to get rid of Galarce. But, like virtually every other recent event involving the public hospitals, firing Galarce became an ugly and complicated matter.

Following a perfunctory and obviously preordained investigation, HHC accused Galarce of mismanagement and summarily fired him in late October. Galarce refused to leave. Reports of suspicious fires, gangs running through corridors, and takeover of the administrative offices by Velez's henchmen began to circulate. Badillo called for "the National Guard to stop the reign of terror". After more than a week of utter chaos, Galarce was finally removed; Lincoln has since been administered from the HHC's downtown Manhattan offices.

Despite its obvious problems, however, the new Lincoln remains a plum to the medical schools and voluntary hospitals whose affiliation agreements provide much of the professional staffs in public hospitals. These private affiliates, feeling the fiscal pinch as well, since where there were four public hospitals in the Bronx, there are now three. Montefiore Hospital is now securely installed at NCB (see above) and Albert Einstein College of Medicine continues its affiliation with the Bronx Municipal Hospital Center. With the closing of Fordham Hospital, however, Einstein has been forced to share affiliation at Lincoln with Fordham's old affiliate, Misericordia Hospital.

The only Catholic institution in the mix, Misericordia had actively campaigned for the NCB affiliation but lost out to Montefiore. It then insisted on being given Lincoln as a kind of consolation prize. Einstein balked. Governor Carey and Deputy Mayor John Zuccotti came down on Misericordia's side. HHC's own Board of Directors voted for continuation of the joint affiliation. Finally, Mayor Beame and Governor Carey overruled them and Einstein will be phased out of Lincoln by June, 1977.

Amidst all this jockeying, the two deaths reported in the emergency room were avoidable according to Lincoln's Director of Surgery, Dr. Francisco Suarez. "There is an excellent chance [of more deaths] unless the real gut problems are resolved," he said. Despite the deaths—not to mention its investment of $260 million—the City seems to regard Lincoln, the only public hospital in the south Bronx, as a disposable item to be used for ammunition in the increasingly heated wars over fiscal politics.

PROGNOSIS NEGATIVE:
CRISIS IN THE HEALTH CARE SYSTEM
edited by David Kotelchuck

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Swine Flu
(Continued from page 9.)

any of the World Health Organization's 96 monitoring stations all over the world ever found A/New Jersey/76.

(A recent case of swine flu in Missouri was documented by increased swine flu antibody level. The lack of spread despite extensive searches among contacts makes it likely that this man's illness was due to the classical pig-to-man swine flu, not the Fort Dix swine flu, which spread from person to person. This was not an example of seeding but another variety of swine flu. This variety's virulence appears to be low judging from the man's relatively mild symptoms.)

This absence has important implications because no pandemic of flu has ever occurred without being preceded by at least several local outbreaks in various parts of the world, according to British flu expert Dr. David Tyrell. Tyrell's statement is supported by Dr. W. Charles Cockburn, Director of the Communicable Disease Division of the World Health Organization. Currently none of this 'seeding process' is evident. The failure of A/New Jersey/76 to spread led two researchers to state, in the lead article in Lancet, one of Britain's most respected medical journals, "It seems possible that the outbreak in the U.S.A. was an isolated event and that the virus will not become established in man."(4)

There is a possibility that A/New Jersey/76 has been detected early in its natural cycle compared to previous strains and that it will "seed" later and strike with full force in the winter of 1977-78. If so, however, a vaccination program this year will have little impact on the seeding process and the whole vaccination program will have to be repeated next autumn, since flu vaccinations give immunity for only six to eight months.

NOT A KILLER VIRUS

Mounting evidence also casts doubt on whether A/New Jersey/76 is a killer virus. Six British volunteers were infected with A/New Jersey/76 and the mildness of their symptoms led the researchers to conclude that A/New Jersey/76 is less virulent in man than A/Victoria/75. A similar result was reported by CDC, comparing ten men hospitalized with A/New Jersey/76 during the Fort Dix outbreak with ten men hospitalized with A/Victoria/75. It concluded that "their illnesses were similar but that A/New Jersey influenza may have been a somewhat milder illness."(6) In a review article in the July 3 Lancet, the renowned Charles Stuart-Harris summarizes the influenza epidemics of the last forty years and concludes: "This experience of pandemic influenza due to a virus of antigenic composition completely different from its precursors thus gives no ground for a belief that the Swine-like virus will behave in an unusually virulent way. Nor can the human population of 1976 be regarded as analogous to that of the Western World of 1918 after 4 years of an exhausting war."(7)

Even the apparent resemblance of A/New Jersey/76 to the earlier swine flu strain in laboratory tests is weak evidence for its virulence. A/New Jersey/76 was identified and typed because it produced the same antibodies as the original swine flu virus—i.e., it has very similar surface antigens. But this similarity sheds no light on the internal antigens, which determine a flu strain's virulence. Many scientists noted, for example, that flu strains with surface antigens similar to the 1918 flu virus continued to be common around the world until 1928 but during those ten years they rarely killed healthy adults or even produced particularly severe symptoms.

Throughout the swine flu controversy much public confusion has arisen from the assumption that a pandemic implies great virulence. This, of course, is not necessarily true: there can be world-wide spread of low-virulence influenzas. So far there is neither evidence of a world-wide swine flu outbreak nor any solid evidence of swine flu virulence.

THE VACCINE ITSELF: HOW EFFECTIVE?

In recent months another major line of criticism of the mass vaccination program has developed: that flu vaccines in general are not very effective and that they have significant side effects. Those in government who have been responsible for carrying out the program, not surprisingly, have been optimistic about the new vaccine's effectiveness. Dr. Theodore
Non-Side-Effects Side Effects

When three elderly heart patients died on October 11, hours after receiving the flu vaccine in a Pittsburgh clinic, it produced headlines throughout the country and vaccinations dropped precipitously. Headlines featured daily body counts. The total who died within a few days of receiving bivalent (swine and Victoria) vaccine reached 38 within the first week.

Although later investigation showed the deaths to be coincidental, as government officials initially asserted, the credibility of the mass vaccination program had been seriously weakened by trying to pass off this initial educated guess as fact. When 2½ million high-risk persons are vaccinated in one week (only bivalent vaccine was being given at that time) a certain number can be expected to die suddenly of other causes. CDC analysis of the 38 reported cases showed that the number of deaths probably reflected the extent to which physicians connected deaths of their patients with vaccination. Over half of the deaths were autopsied, showing causes of death within the normal range for old people who die suddenly: a lot of heart attacks and one ruptured aneurysm. The absence of deaths in the first hour after vaccination indicates that none was due to allergic reactions, which would occur within minutes of vaccination. (1) One cardiologist hypothesized that the stress of waiting in line, getting the injection or any other stress might cause a person already on the verge of having a heart attack to do so a few hours earlier. Fever is a classic type of stress that produces such a response, but the deaths do not correlate with the time when fever side-effects of the vaccine should occur.

The most important effect of the hysteria has been to decrease the number of people who will get vaccinated this year, a serious problem for high-risk people who really do need the vaccine—especially against A/Victoria/75.

Cooper, DHEW Assistant Secretary for Health, says that government experts "agree that, in recent years, flu vaccine has been up to 90 percent effective when the infecting virus matches the virus used in the vaccine. They anticipate similar performance from the swine flu vaccine." (9) Similarly, CDC has estimated that "at least 70% of the individuals receiving the A/New Jersey influenza vaccine will be fully protected against that strain for the coming fall and winter influenza season." (10)

Governmental optimism was boosted by an extensive study sponsored by the Public Health Service and reported in a June 21 conference. 5,200 volunteers were injected with the flu vaccine, mostly A/New Jersey/76 and/or A/Victoria/75, in the dosages being recommended. Antibody levels to the vaccine before and two weeks after the vaccination were measured. About 90 percent of the subjects over 25 showed a large antibody response, although only 28 to 58 percent (depending on which company's vaccine) of the subjects between 18 and 24 had adequate antibody responses. (11)

Government reports and many scientists have equated antibody response with vaccine effectiveness, that is, the extent to which the vaccine will prevent a person from becoming ill after exposure to the naturally occurring flu virus. This equation, however, has been questioned by some scientists.

Dr. J. Anthony Morris, a former section director of FDA's Bureau of Biologics, argues that "Flu vaccine made from inactivated particles, like the one now being manufactured, produces 'the wrong kind of immunity.' It elicits systemic antibody [immune globulin G] that can be measured in the blood, but does not produce the local antibody [immune globulin A], in the lungs and nose, which is needed to protect against infection by the flu virus." Morris estimated the effectiveness of the flu vaccine against A/New Jersey/76 to be only about 20 percent. When the Government Accounting Office, a watchdog agency of the US
Congress, asked other scientists to assess the vaccine's effectiveness, the estimates ranged from 25 to 73 percent. (12)

Public criticism from within the government infuriated Morris' superiors. In the early 1970s, Morris and his attorney, James S. Turner, had been key figures in instigating Congressional hearings on the management of federally coordinated vaccination programs. (13) The result of the hearings was a transfer of responsibility for regulation of vaccine safety and efficacy to the FDA and the creation within FDA of the Bureau of Biologics. In July, 1976, Morris was fired from his position in the FDA. FDA Commissioner Alexander Schmidt claimed that he was fired for "inefficiency and insubordination," and that the timing was "coincidental." (14)

Morris' arguments about the efficacy of vaccines are controversial. He argues that in some cases flu vaccination may increase susceptibility to the flu; in his Congressional testimony he cites two unpublished 1968 studies in which vaccinated sailors and industrial workers had rates of flu that were more than twice that of their unvaccinated peers (54 to 55 percent vs. 25 to 26 percent). (15)

Morris' arguments are buttressed by an NIH workshop on the long-term consequences of killed (formaldehyde-inactivated) viral vaccines. It described two such viral vaccines (against measles and respiratory syncytial virus) in which prior immunization with killed vaccine caused vaccine recipients to become more ill than non-vaccine recipients when exposed to the natural virus. (16)

Government experts admit that their evidence about field efficacy is woefully inadequate. There are many experiments in which subjects were vaccinated against an influenza strain and then given a "challenge dose" of that influenza virus; the efficacy under these circumstances is often over 70 percent. But there have been very few adequate studies of the protective value of vaccination against a real epidemic. One of the few good prospective studies on the actual efficacy of flu vaccines was done in 1968-69 in Tokyo. Initial doses of vaccine comparable to those being used this year were followed by a booster of the same dose. Researchers found no statistically significant correlation between vaccination and the presence of symptoms (fevers and respiratory symptoms) but an 80 percent efficacy rate when they defined influenza by blood antibody levels. (17) Another study done during the Hong Kong flu epidemic of 1968 concluded that: "The results indicated that the optimally constituted influenza vaccines at standard dosage levels have little, if any, effectiveness." (18) In the last analysis, it is clear that there is simply not enough data to evaluate the efficacy of influenza vaccines, especially those developed during the past few years, which have not been field-tested at all.

**SIDE EFFECTS**

In essence, flu vaccines induce a mild version of the flu in order to prevent a much more serious illness later. Generally, the most serious symptoms of this milder illness are low fever, headache, muscular aches and generalized weakness. The June 21 PHS
Conference reported that only about two percent of those over 24 years old had such symptoms, although it is reasonable to assume that a much larger number of people experienced milder symptoms.

The Conference also reported an unacceptably high rate of side effects in children aged three to ten (they did no testing of children under three). A two-dose regimen for children was more recently approved, but the matter is of no great concern, since children do not get particularly sick from flu. The high level of side effects was a setback, however, for those scientists who had hoped to actually prevent an epidemic from occurring by vaccinating "every man, woman and child," since children are major carriers of epidemics like the flu. Meanwhile, young adults (18 to 24) had side effect rates intermediate between children and older adults.(19)

The flu virus is routinely grown in fertilized eggs. Because the purification process is imperfect, some egg proteins remain in the final product. For this reason public health officials have routinely alerted egg-allergic people not to be vaccinated. Although there have never been any reported deaths from allergic reactions to earlier influenza vaccines, the report of the June 21 PHS Conference lists five separate individuals whose reactions to the vaccine were considered to be allergic.(20)

THE SABIN SWITCH

Perhaps the most telling blow was struck by Dr. Albert Sabin, who publicly abandoned the program in early November. Sabin, like so many others, went along with David Sencer's initial memo to President on the basis of available evidence at the time. He has sufficient stature, due to his pioneering work in developing the polio vaccine, that his opposition to Sencer's plan would have cast a shadow over the program at its inception. Sabin's support certainly cannot be attributed to dependency on federal research monies, since his prestige has guaranteed funding from numerous sources.

Sabin began to rethink his position as negative information on the mass vaccination program began to accumulate. His doubts grew after the June 21 meeting, when the poor antibody response of those under 25 led him to seriously question vaccinating young people. He also began to challenge the use of vaccine on non-high-risk people in general.

Then, on November 5, he stated publicly that the possibility of a swine flu epidemic is "now practically negligible."(21)

ALTERNATIVES

The speed with which the federal government had to make a go or no-go decision on the mass vaccination program seemed to preclude the possibility of public discussion of alternative programs. As noted earlier, CDC identified A/New Jersey/76 on February 13 and made the first public announcement of its discovery on February 19. Very soon thereafter the Bureau of Biologics set April 1 as the target date by which a decision had to be made. Five or six weeks hardly allowed time for the government to crank up administrative machinery for a major public health decision, let alone for public discussion.
Swine Flu Insurers: Legion Heirs

The mass vaccination program had scarcely been announced before the drug industry began voicing fears about obtaining insurance coverage for the production of vaccine. The fact that such coverage is necessary has a history in the 20-year-old tension among government, drug companies and insurance companies over vaccine safety and liability for public protection in their use:

• In 1955 a batch of polio vaccine made by Cutter Laboratories and contained inadequately inactivated polio virus caused ten deaths and 192 cases of paralytic polio. (1)
• In 1961, Dr. Bernice Eddy, Division of Biologic Standards (predecessor of the FDA’s Bureau of Biologies), showed that some of the polio vaccine being used was heavily contaminated with “SV-40,” a virus that had been shown to produce cancer in several animals. (2)
• Finally, last year, a federal court found (Reyes vs. Wyeth, 1975) a drug company liable when a child got polio from polio vaccine. Since no “doctor-patient” relationship existed, thus making “informed consent” impossible in the public clinic where the vaccine was administered, the company was held responsible for informing the child’s parents that one possible complication of polio vaccination is the development of polio.

This landmark decision had its greatest impact on the insurance companies, now faced with coverage of a large, potentially open-ended liability. Since 1975, these insurance companies have been threatening to get out of the vaccination insurance business, in what seems to be part of a long-term strategy to abandon the medical malpractice field altogether. Argonaut, for one, has openly stated its interest in getting out of the malpractice field; in late 1974-75, the whole industry began pressuring for huge increases in malpractice rates. Despite variable success, the industry as a whole was disappointed and continued to express its disillusionment with malpractice coverage.

On April 12, the day the House of Representatives passed the $135 million funding bill for mass flu vaccination, Merck & Co. requested relief from claims arising from adverse reactions to the vaccine. Over the next few months drug companies repeatedly told DHEW, CDC and the press that their insurance carriers were not offering coverage for liability claims arising from swine flu vaccine production. The most frequent excuse was the fear that anyone who got as much as a cold after vaccination would file a “nuisance” suit, costing a lot of money to defend in court even if the company won. At no time did drug or insurance firms publicly state qualms about any dangerous side-

Further limiting policy alternatives is the lack of an extensive, coordinated public health system in the US to quickly implement such a vaccination program. In European industrial countries, for instance, the start-up time would be shorter because neighborhood and workplace health delivery mechanisms are generally already in place.

The only alternative extensively discussed since President Ford’s announcement of the program has been production of the vaccine and stockpiling it until a possible reappearance of A/New Jersey/76—at which time a mass vaccination program might be implemented. The stockpiling strategy is a questionable one, however, since the main delay in any future vaccination program would stem from the bureaucratic bottleneck of administration rather than from delays in vaccine production. The 1918 flu spread rapidly and erratically; even the less virulent Asian and Hong Kong flus spread worldwide within a few weeks. Since it takes about two weeks after vaccination for the vaccine to become fully effective, the disease could therefore spread throughout the population before a mass program could be implemented.
The real alternative, a high-risk-only program, would save the amount of money that was going into production of vaccine for non-high-risk people. The cost of the 40 million doses to vaccinate all high-risk Americans would be about $20 million, compared to the $100 million now being spent for 200 million doses. The $80 million saving could have been spent on finding and vaccinating high-risk people—in recent years, an average of only 10 million people (one-fourth) of all high risk people have actually received flu vaccine. Or it could have been spent on any of a dozen other public health projects that are desperately needed and seriously underfunded. The real benefactors of the $80 million now are the drug companies.

**RESISTANCE TO CHANGE**

If the decision to vaccinate all Americans were simply a medical decision, no doubt the mass program would have been abandoned long ago in favor of a reasonable alternative, such as vaccinating only high-risk people. Medical decisions never occur outside a social context, however, especially when they affect entire populations.
Once the Ford Administration, following recommendations of public health officials and prominent medical scientists, decided to proceed with the program, a whole series of interests were unleashed which stood to benefit from it. These, combined with the Administration's election year imperatives, were so powerful in stabilizing the program that it continues despite a preponderance of medical evidence against it. Among these interests are middle-level public health officials, drug companies and private physicians, and large employers in general.

- Public Health Officials: Emerging from the often routine and thankless world of public health administration, many officials are still wide-eyed at the sudden glare of publicity produced by the swine flu program. Dr. Harry Meyer, Director of the Bureau of Biologics, put it clearly: "In the world I deal with every day, there are so many things you do that are not terribly interesting, but which are called 'real chores.' To have a challenge of something that is a real public health interest is really stimulating."(22) From a more mundane perspective, public health officials have a vested interest in pursuing a program which at least prevents them from looking bad. "It's a lot better to do something and be wrong than to do nothing and be faced with a terrible epidemic."(23) As a result, support for the program among public health officials has remained strong.

- Drug Companies: Drug companies were delighted at the prospect of a federal financial injection of $100 million for producing the vaccine. The amount seems to have been derived from a 50 cents-per-dose cost for the smaller lots manufactured in the past. Since economies of scale were inevitable for the mass program, they stood to profit enormously. The $100 million was to be divided among four drug companies (two of which have sordid histories, in the marketing of thalidomide and chloramphenicol), apparently irrespective of how the program itself fared. The appropriation came long before anyone knew how many inactivated virus particles would be needed per dose (the first test results were not reported until three months later) or how many doses would actually be needed and hence produced.

- Private Physicians: Private, fee-for-service physicians obviously derive benefit from the program from the large number of patients they will see in their practices. Some are volunteering in free public vaccination programs; most, however, will simply collect routine office fees. Although not permitted to charge patients for the cost of the vaccine, which comes free from the government, fees will be charged for other nominal services.

- Large Employers: American businessmen, especially those from large corporations, generally favor the mass vaccination program. Their most obvious interest lies with non-high-risk Americans, for whom the program is the most questionable, since virtually all productive workers fall into that category. The program, from their vantage point, can be counted on to reduce absenteeism during the winter, thus enhancing company productivity and profits. The Hong Kong pandemic of 1968-69 was estimated to have cost $3.9 billion in medical care, industrial absenteeism and future earnings of those who died. Corporate executives are all too happy to have the government (with a tax base that disproportionately takes from the working classes)
give them a $135 million insurance policy against potential damage to their earnings.

- The Ford Administration: The key decision to go ahead with the mass program, and the later necessity to defend it against all criticism, came, of course, from the Ford Administration. Noted for having taken no initiative on any major health program (see BULLETIN, September/October, 1976), the swine flu program might take the edge off criticism that might arise during the campaign.

At first blush, it was a no-lose program for President Ford: if there was an outbreak of swine flu, he had acted to protect the American people; if no outbreak materialized, he could still say that he had protected them. The program became a no-win one, however, with few benefits, many rip-offs, growing cynicism and several deaths apparently caused by the vaccine a few weeks before the Presidential election.

WHAT IS AN EPIDEMIC?

If there are any lasting benefits from Ford’s swine flu extravaganza, it may come from the questions it raises about the limitations of modern clinical medicine. The failures of the mass vaccination effort, along with the unsolved mystery of the Legionnaires’ disease, bring unprecedented public attention to a growing controversy about those limitations.

Based on a medical model that seeks a technical answer to every problem, modern clinical medicine largely ignores the social and emotional stresses so critical in producing major killer diseases such as heart disease, stroke(24) and cancer.(25)

An unanswered question about influenza is the extent to which illness is caused by the virulence of the virus versus the health of the victim (usually spoken of as "host resistance"). Medicine recognizes the role of host resistance in susceptibility to many diseases, including infectious ones like herpes, but very little work has been done from this perspective on influenza. At the most obvious level, the flu is much like the common cold: some people who are exposed to the virus become ill and others do not and the extent of illness is not simply proportional to the number of germs that have entered the body. In the most extreme cases, malnourished and other debilitated persons will become far more ill from the same exposure than healthy persons.

In 1918 the world was well into its fourth year of the worst war it had ever experienced. There is no way to know what would happen if the identical virus were to reappear today, but it is highly unlikely that it would wreak such destruction as it did then. In 1918, world nutrition levels were lower, housing conditions everywhere were worse, and the effects of war, stress and fatigue are incalculable. Incredibly, however, scientists and public health officials have generally failed to consider the question of host resistance in the case of A/New Jersey/76.

CONCLUSION: MEDICAL OVERKILL

If the US economy were reasonably healthy and there existed a real national commitment to meet the health care needs of all the people, the medical overkill associated with the swine flu program and its millions of dollars in wasted resources would be no great tragedy. With government budgets tight and health care programs being cut back, however, especially preventive and primary care programs, misallocation of resources on such a scale is tragic.

In Fiscal 1975, the total federal outlay for prevention and control of health problems was about $1 billion, just three percent of the federal health budget.(26) Thus the $135 million associated with the swine flu program represents about thirteen percent of all federal expenditures for prevention and control. It rivals the $170 million spent annually for all occupational health activities, and far exceeds the $30 million yearly budget of the National Institute for Occupational Safety and Health, the chief agency for

The Hong Kong pandemic of 1968-69 was estimated to have cost $3.9 billion in medical care, industrial absenteeism and future earnings of those who died.
Epidemic: Germs or Social Factors?

There is a long history of conflict between those medical people who feel that diseases and epidemics are caused solely by germs and those who feel they are caused by economic, social and psychological factors that make the host less resistant to germs around them. "In 1847 Virchow was sent by the Prussian government to investigate a typhus epidemic. . . . Virchow's recommendations . . . called for full employment, better nutrition and sanitation, raise in wages, separation of church and state, restoration of native language, public education, self-government, shifting of tax burden from poor to rich, creation of agricultural cooperatives, etc."(1)

Virchow's suggestions represented the thinking of the anti-contagionists, who said that disease came from local conditions and opposed quarantines (hence obtaining support from commercial interests "who did not want ports tied up."). They were opposed by the contagionists, "who took the position that disease comes from the outside, needs quarantine and related bureaucracy. . . . When the germ theory was developed, it would seem natural . . . that germs were also a necessary but not sufficient condition for disease production — but . . . germs became heralded as . . . the sole cause of disease production to the total exclusion of social factors."(2)

See References pages 19, 20

occupational health research in the US government. It is about twice the total spent on noise control and abatement (27) and dwarfs the few million dollars spent yearly by the government on its anti-smoking efforts.

The swine flu program is a diversion in another way, as well. Touted by its supporters as a major preventive health program, it was in fact a narrowly defined preventive health program, within a traditional medical model that seeks a technical fix for every health problem—a drug, a shot, a surgical procedure. For many years the preventive health field has put its major, almost exclusive, emphasis on infectious disease control, a strategy firmly situated within this medical model.

Recently, under the impact of efforts to prevent heart disease, cancer and stroke, there has been increased emphasis on improved nutrition, physical conditioning, anti-smoking efforts, and control of environmental and occupational hazards. Some are even seeking a relation between the onset of disease and the physical and emotional stresses of late twentieth-century US capitalism (e.g. see 28). The focus of the swine flu program emphasizes that which is most traditional in preventive health, although renewed emphasis on traditional childhood vaccination programs is still needed in inner cities and rural areas. It also diverts attention and resources from those aspects of the field vitally important in the effort to bring under control such present epidemics as heart disease, cancer and stroke. The tragedy of the swine flu program, then, is not so much in what it does as in what urgent tasks it diverts us from.

—Kenneth D. Rosenberg

References

5. Idem.
Consumer Reports, "Swine Flu: Did Uncle Sam Buy a Pig in a Poke?" September, 1976, pages 495-498.


Swine Flu Insurers: Legion Heirs (page 14)

Epidemics: Germs or Social Factors? (page 18)
1 Howard Berliner, "Notes on Historical Precursors of Materialist Epidemiology," Health Marxist Organization Packet #1, April, 1975; available from Health/PAC.
2 Ibid.

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HMO PACKET No. 2
Materialist Epidemiology

Articles discussing the socio-economic aspects of the major causes of death including:
- hypertension
- coronary-artery disease
- cancer
- drug addiction
- mental illness
- occupational diseases
- rheumatoid arthritis

Available for $3 (Student) or $5 from: HMO
c/o Health/PAC
17 Murray Street
New York, New York 10007
Vital Signs

THE MEDICAID BITE

An HEW-sponsored Rand Corporation study in New York City suggests that medical care may be a major cause of families moving onto the welfare rolls. Short-term welfare families (on welfare for less than three years) use 50 percent more Medicaid services than do long-term welfare families, according to the study. The study shows Medicaid to be the second largest welfare expense, accounting for one-quarter of all welfare expenditures. Each year, the typical welfare family (3.3 persons) receives an average of $1900 in direct welfare assistance, $1600 in Medicaid financed health care, $1500 in shelter allowances, $500 in food stamps, $460 in non-welfare earnings and $128 in social services.

(American Medical News, October 4, 1976)

MEDICAID REFORM:
 PENALIZING THE PATIENT

In response to the growing storm over Medicaid fraud, HEW has acted to ban factoring, a widespread practice in the Medicaid program. Factoring firms immediately advance a physician money owed in Medicaid claims less a fee (often substantial). These claims are held until they are paid by Medicaid and the firm pockets the full amount. The practice has spread because of extensive delays by many states in paying Medicaid claims—delays exceeding a year in some instances. Because many doctors cannot or will not wait this length of time to be paid, the factoring ban will result in more doctors refusing to take Medicaid patients. Thus by dealing with the symptom rather than the cause of the problem, Medicaid reform penalizes the recipients.

(Modern Healthcare, October 1976)

NATIONAL HEALTH
INSURANCE COSTS

If recent months have failed to produce legislative activity on the national health insurance issue, they have produced studies, some of them influential. One of these, a Rand Corporation study conducted by Bridger M. Mitchell and William B. Schwartz, was published in Science on May 14. It found the cost impact of four major bills (Long-Ribicoff, Kennedy-Labor, Nixon, and Kennedy-Mills) to be surprisingly similar in many respects. Costs to middle and upper income families, for instance, were similar for all four measures with the exception of the Kennedy-Labor bill, which costs substantially more for upper income families. Similarly, the cost to families with incomes under $15,000 was very similar for all four bills with the exception of the old Nixon-CHIP bill, which cost substantially more for low income families. Policy makers hope this study will form the basis for a new compromise measure.

More recently, a study conducted by Gordon R. Trapnell, consulting actuary for HEW, finds Kennedy-Labor not the most expensive bill. Topping the list in expense is...
the American Hospital Association plan, spearheaded by Al Ullman, chairman of the House Ways and Means Committee, at a cost of $200.4 billion. Following it in cost are Kennedy-Labor, $200.2 billion; the American Medical Association bill, $196.6 billion; the old Nixon-CHIP plan, $189.3 billion; the health insurance industry bill, $189.1 billion; and Long-Ribicoff, $188.1 billion. Even without passage of a national health insurance measure, health costs are expected to reach $180.2 billion by 1980, the year for which costs are projected. Trapnell found benefits of the Kennedy bill to be by far the broadest. 


HILL-BURTON AND FREE CARE

Hospitals required to provide free care under the Hill-Burton program must now post multilingual signs or distribute written notices stating whether the hospitals' free care obligations have been met and, if not, when free care is available. This results from new HEW regulations which also require that decisions concerning free care be made before a patient is treated. In the past hospitals were allowed to write off bad debts to meet free care obligations. Hospitals which have received Hill-Burton construction grants must provide 10 percent of the grant monies in free care; those receiving Hill-Burton loans must provide three percent of operating costs over a 20 year period in free care. (Medical World News, October 17, 1975)

ABRITRATION BINDS HOSPITAL WORKERS

The bitter eleven-day strike of 40,000 nonprofessional health workers represented by District 1199, National Union of Hospital & Health Care Employees, against 57 New York City voluntary hospitals and nursing homes last July has resulted in an equally bitter settlement brought about by binding arbitration accepted to finally settle the strike. Retroactive to July, present wages were frozen for six months. Subsequently workers will receive a 4% percent wage increase which will not become part of base pay, now a minimum of $9,412 a year. The union had asked for a $9.95 a week wage increase, a one-year contract, larger pensions and vacations, increased sick leave and other fringe benefits. The settlement, far below that recommended in the preceding months by a federal mediation commission, was characterized by Mel Foner, 1199 executive secretary, as "a bitter disappointment to our members and a major setback for future labor peace in the voluntary hospitals."


SCIENCE BY THE PEOPLE

Last year high levels of asbestos were found in the air throughout the Washington, D.C., metropolitan area; residents have been understandably upset ever since. At the time, Dr. Irving Selikoff of Mt. Sinai Medical Center, a nationally known expert on asbestos hazards, suggested that the high levels might be caused by wear-and-tear on auto brake linings and clutch plates from local cars. Two amateur rockhounds, Don Maxey and Raymond Kent, school teachers in suburban Maryland, were skeptical. They thought that the cause was natural asbestos in the serpentine rock used widely on D.C. roads and driveways and mined at a large quarry in Rockville, Md. As cars rode over the rock, they believed, it disintegrated and released asbestos fibers into the air. To check their theory, they took samples from the quarry and, under the largest magnification of a student's microscope, saw asbestos fibers. The two contacted Dr. Arthur Rohl, an associate of Selikoff at Mt. Sinai, who confirmed their findings. In August the four announced their finding to D.C. officials for local action.

(The Washington Post, August 11, 1976)
of," commented the Committee head. The Committee was disbanded two years ago.

OLD COSTS, NEW FORMS

To counter criticism of hospital cost increases, the American Hospital Association has just devised its own indices which separate cost increases due to increased services from those due to price inflation. Using these, the AHA finds, "The reason hospital expenditures are seemingly rising faster than others is due directly to improvement in the product—hospitals care."

The Hospital Intensity Index, measuring the frequency and complexity of hospital services, indicates that intensity of hospital services has increased at an annual rate of 4.8 percent in the last six years. This accounts for 28.5 percent of hospital cost increases between 1972 and 1974.

The Hospital Input Price Index, measuring increases due to inflation in the labor and products the hospital must purchase, accounted for 71.5 percent of cost increases in the same period. Cost increases are standardly measured by the Hospital Service Charge component of the Consumer Price Index, which measure increases in what patients pay. Excluding increased intensity, hospital cost increases paralleled others in the CPI, states the AHA.

(American Hospital Association Press Release, September 21, 1976)

LEGISLATION OF NOTE:

The $56.6 billion Labor-HEW Appropriations bill for fiscal year 1977 was enacted into law September 30 when Congress overrode a Ford veto. The bill exceeded the Ford Administration request by about $4 billion. Attached to the bill was an amendment banning Medicaid payment for abortions except when the life of the mother is endangered. Women's and civil rights groups immediately went to court and won a temporary restraining order, and a final decision regarding the legality of the amendment promises to take years in the federal courts.


After four years of controversy, a compromise version of the Toxic Substances Control Act was passed and signed by President Ford on October 12. As originally conceived, the bill required testing all chemical products for health hazards before marketing. Dropping this provision, the Act as finally passed simply requires that companies notify the Environmental Protection Agency (EPA) of all new products at least 90 days before they are introduced commercially. If EPA decides the materials are potentially dangerous, they can require testing. Thus the responsibility to assure testing falls not on industry but on the government, whose Environmental Protection Agency is already overworked and under heavy industry attack. An industry displeased with EPA's order to test a chemical can appeal the order in the federal courts and stay the decision until the court acts, which may take years. The final bill is very similar to the version originally passed by the House, which the chemical industry was reported earlier to have considered "the best deal possible."

(New York Times, September 7 and October 13, 1976)
Cumulative Index (December 31, 1976)

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Asn. for Voluntary Sterilization—Jan.-Feb. 75; July-Aug. 75.

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B

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Beryllium Poisoning—Sept. ’72.


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Cleveland—Sept. ’71.

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Community Medical School Proposal (Lincoln)—Oct. ’72.

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Committee on Health Insurance (NYC)—Apr. ’74.

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Cook County Hospital—Apr. ’73.

Cornell/New York Hospital—Sept. ’69.

D

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Downstate Medical Center—Sept. ’69; Oct. ’70.

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ERRATA

The three tables published in the September/October 1976 Bulletin (Number 72) are incorrectly labelled. The correct titles are: "Table 1 US Health Expenditures 1962-75 (in 000,000's)," "Table 2 Profit-Making Components of US Health Expenditures 1962-75 (in 000,000's)." The previous title showed the amounts 'in 000's.'
N
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NENA (Northeast Neighborhood Assn.)—Jul. '68; Aug. '68; Oct. 70; June '72.
New Orleans—Sept.-Oct. '75.
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New York City Prisons—Sept. '73.
New York Infirmary—June '72.
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North Central Bronx Hospital—May '72; Jan.-Feb. '74; Nov.-Dec. '76*.
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Nursing Homes—Nov. '69; July-Aug. '76*; Nov.-Dec. '76*.


O
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P
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Prisons—May '70; Nov. '71; Sept. '73.
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R
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Ritalin—Nov.-Dec. '74.
Roe, Felix—Mar.-Apr. '76.

S
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Smith, David—Oct. '71; Feb. '72.
Social Workers—Sept. '70.
Stahl, Dr. William—Oct. '72.
Sterilization—Jan.-Feb. '75; Mar.-Apr. '75 (letter); July-Aug. '75; Jan.-Feb. '76.
Sterling Drug Co.—Sept. '71.
Student AMA—Mar. '70; Sept. '70.
Student Health Organization (SHO)—Aug. '68; Mar. '70; Sept. '70; Mar.-Apr. '75.
St. Vincent's Hospital—Jan. '70; Mar. '71; Jul.-Aug. '72.
Swine Flu—Nov.-Dec. '76.
Sydenham Hospital—Nov.-Dec. '68.

T
Taylor, Frederick—Sept.-Oct. '75.
Technicon Corp.—July-Aug. '74.
Therapeutic Communities—June '70; July-Aug. '75.
Think-Lincoln—Sept. '70; Oct. '70; Jan. '71.
Thursday Noon Committee—Feb. '72; Apr. '73.
Tulane Medical Center—Sept.-Oct. '75.
Tunnel Workers—Oct. '70.
Trussel, Dr. Ray—Nov.-Dec. '68; Apr. '70; July-Aug. '72; Jan.-Feb. '74.

U
UCLA Medical Center—Jul.-Aug. '70; Sept. '73.
United Harlem Drug Fighters—Oct. '70; Dec. '70.

V
Valentine Medical Center—Apr. '73.
Vanderbilt Clinic—May '70.
Veterans Administration Hospitals—Apr. '70; May '71.
Virchow, Dr. Rudolph—Nov.-Dec. '75.

W
Walsh-Healy Act—Sept. '72.
Washington Heights-Inwood Community Mental Health Center—
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