CLOSING THE DOOR ON NURSES, NEW YORK STYLE: In a strategy to "upgrade" the profession, the NYSNA pushes the BSN degree as a requirement for RNs.

Contracting for Emergencies:
THE SELLING OF EMERGENCY SERVICES IN SAN FRANCISCO. San Francisco's voluntary hospitals turn their emergency services over to proprietary providers.

Columns:
WASHINGTON: What's Healthy for Business?
WOMEN: Abortion: Cash Choice.
NEW YORK: HHC: From Spotlight to Scrapheap.
WORK/ENVIRON: Work, Race and Health.

Media Scan:
Decarceration: Community Treatment of the Deviant—A Radical View, by Andrew T. Scull.

1985:
Nursing is a profession in turmoil. Nurses are tired of subservience and of their role as handmaidsens, and they are seeking new avenues to respect and status. These avenues are as diverse as the trends toward independent nursing prac-
tice, the "laying on of hands," unionization and professional upgrading. For the profession, it is an important time of change which offers both progressive and regressive potentialities.

Leaders of the nursing profession have opted for professional upgrading—requiring more and more education and training for becoming a nurse. The American Nurses' Association (ANA) in 1974 endorsed continuing education as a requirement for the continued licensing of nurses and pressed state affiliates to have such measures passed in state legislatures.

Taking the ANA lead, the New York State Nurses' Association (NYSNA) is sponsoring the most stringent measure to date—a bill that will make a Bachelor of Science in Nursing (BSN) degree a requirement for licensure as a Registered Nurse (RN).

**A History of Upgrading**

For more than fifty years, nurses were trained predominantly in three-year, hospital-based Diploma programs. These programs varied widely in the amounts of formal classroom education they offered, although contemporary programs usually provide at least one full year of such education.

Initially, however, Diploma programs were designed as apprenticeships. Student nurses learned directly under the supervision of instructors on the wards (the only nurses paid by the hospitals at the time). The main beneficiaries of this arrangement were the hospitals, which obtained full nursing services for the mere cost of room and board for the students, and salaries for a handful of instructors.

In the early 1920s, the Goldmark Report indicted hospitals for their labor practices and their failure to provide formal education. Pressures on hospital schools increased during the Depression when the demand for graduate nurses fell sharply. Large numbers of graduate nurses found themselves in competition, for the first time, with virtually free student labor.

Criticism of the Diploma schools resumed soon after the war when a flurry of highly theoretical educational studies were released. The most widely read was the Brown Report, issued in 1948, which called for shifting nursing education from the hospital to the university. Hospitals, however, were still highly dependent on the labor of unpaid and underpaid workers and a successful campaign to change the dominant mode of nursing education would have to wait until the middle 1960s. (For history of nursing, see also September-October 1975 BULLETIN.)

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**Growth of Different Nursing Programs in the US**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of AD Programs</th>
<th>Number of Diploma Programs</th>
<th>Number of BSN Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>330</td>
<td>728</td>
<td>235</td>
</tr>
<tr>
<td>1972</td>
<td>541</td>
<td>543</td>
<td>293</td>
</tr>
</tbody>
</table>


In 1965, the American Nurses' Association, claiming to represent the professional interests of nurses, issued a position paper calling for the division of nursing into two levels: "Professional" nurses were to be educated at the university (BSN) level, and "technical" nurses were to be educated at the community college, Associate Degree (AD) level. Similarly, the National League for Nursing (NLN), which accredits and regulates schools of nursing, passed a resolution, also in 1965, calling for an increased emphasis on Baccalaureate programs.

Subsequently, most programs developed after 1965 have been either university or community college programs, and a war of attrition was launched against the hospital schools. Between 1968 and 1972, the number of hospital diploma programs dropped by 25 percent while community college (AD) programs nearly doubled and university (BSN) programs grew modestly. (See box.)

1984 + 1

A year after the ANA position paper, the NYSNA adopted its stance in a "Blueprint for the Education of Nurses in New York State." It reaffirmed its commitment to a two-tier nursing system again in 1974 and held special conferences in 1975 to work out a formal legislative proposal.

An NYSNA amendment to the State Education Law was submitted to the 1976 legislature. Essentially, it called for a BSN degree as the minimum qualification for licensure to practice "professional" nursing in the state, to take effect in 1985—hence the term "1985 Proposal." An AD degree is to be required for the lower level "prac-
atical" nurse. The measure includes a grandfather clause, ostensibly to protect those nurses licensed before 1985.

The "1985 Proposal" did not pass in 1976, and was reintroduced to the 1977 legislature, where it languished in committee until the expiration of the session. Although the bill is still pending, eventual passage seems certain. One of the only changes the bill has undergone has been to change the term "practical" nurse for the AD graduates to read "registered associate" nurse because it had too blatantly expressed the downgrading effect of the proposal on the majority of working nurses.2

**The Economics of Nursing**

Nurses, like other health workers, have suffered historically from low wages and poor working conditions. Largely due to unionization since the late 1950s, however, salaries have risen dramatically in the last few years, as have wages for most health workers. In New York City voluntary hospitals, wages for general duty nurses now range from $12,920 to $16,201.3

While the supply of nurses relative to demand has remained essentially stable—around 82% of the estimated need for nurses—according to DHETW, there are many indications that what was once considered a nursing shortage exists no longer. For example, the restrictions placed on immigrating RNs have become increasingly stringent. Also, the fact that hospital administrators must now pay nurses the same as other skilled workers with BS or MS degrees undoubtedly impacts on estimates of need.

As might be expected, the American Hospital Association's Assembly of Hospital Schools of Nursing opposes the 1985 Proposal. This opposition, however, probably stems from the sectional interests of those hospitals which still utilize the free labor of in-house students, and does not represent the view of the university-based medical empires built on high technology.

The New York Academy of Medicine recently took a stand opposing the 1985 resolution. It came out strongly in support of Diploma programs, as did the American Medical Association a year ago.

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**At least 24 BSN programs exist that do not accept students who are already RNs!**

What is needed in nursing, these groups say, is better bedside care and less "overeducation." Apparently the Academy feels that doctors' unilateral control of patient care is threatened by nurses with BSNs. Increased education for nurses is progressive as far as it challenges that control, but what would it mean to the nurses that are working now?

**Looking for Differences**

An old adage says that "an LPN is someone who does at night what an RN does during the day." In fact the differences between the roles of RNs, LPNs, aides, orderlies and technicians are often hard to distinguish. Nursing journals rail against this egalitarian practice. To upgrade the role of the RN and to justify the increased education, the ANA and NLN must differentiate the role of a nurse with a BSN from that of a nurse with an AD or Diploma. One of the few unique roles projected for a BSN nurse is the supervision of other RNs.

Under the 1985 Proposal, any Bachelors degree is not sufficient for an RN. He or she must have a Bachelors degree in nursing. Thus a nurse cannot get a BS in Sociology, for instance, and meet the requirements.

Nationally the NLN has engaged in a publicity campaign to warn nurses away from non-nursing major programs. Ironically, the reason given is that, in contrast to social science degrees, for instance, the baccalaureate in nursing will "prepare an independent practitioner who will assume a
leadership role and who is prepared to meet the psychosocial-cultural needs of individuals, families and groups, as well as their physical needs.\textsuperscript{14}

To add insult to injury, BSN programs give working nurses very little credit for experience and acquired knowledge. At best, they receive credit for a few basic introductory courses and are required to fulfill most academic non-nursing requirements. Moreover, since classes are usually scheduled during daytime hours, the working nurse who wishes to get a BSN must work evenings or nights in order to attend classes. Heavy science and humanities loads are required less, it would seem, to benefit the RN than to weed out the "undedicated."

The prospect of large numbers of working nurses getting BSNs apparently threatens the degree with the taint of vocationalism, and some educators believe that too much consideration is given to the problems of the working nurse. "...we seem to be so immersed and almost rabid in our zeal to provide registered nurses with opportunities to obtain a baccalaureate degree... with their taking a minimum amount of course work that we sometimes seem to have lost sight of the four-year generic program... Consider, for instance, the student fresh out of high school who wants a baccalaureate program in nursing because she likes the idea of combining liberal arts, sciences, and nursing in a four-year program, looks forward to experiencing college or university life in the company of classmates and peers who are majoring in other fields, and who has no desire to go through a practical nurse or associate degree program on her way to a baccalaureate degree. Her educational needs and career aspirations are different from those of the practical nurse, the registered nurse, or the student who started her post-secondary education at the community college level.\textsuperscript{15}

NLN consultants proudly announce that 242 out of 266 BSN programs accept RNs as students.\textsuperscript{6} More importantly, however, this means that at least 24 BSN programs exist that do not accept students who are already RNs!

**The Grandfather Myth**

To buy off the opposition of current RNs, the 1985 Proposal provides that, "any individual licensed as a registered professional nurse prior to January first, nineteen-hundred eighty-four need not meet the baccalaureate degree requirements provided..." This clause is necessary because, as of 1972, 80.5 percent of all working nurses, and 84.6 percent of those working in hospitals, had less than a baccalaureate degree.\textsuperscript{7} This clause offers less than meets the eye. It fails, for instance, to assure jobs to or bar discrimination against RNs who do not have a BSN. While a hospital couldn't fire a nurse for not having a BSN, neither can the nurse leave her job and expect to return to the same position later. Furthermore, the Proposal greatly hampers the ability of a nurse to move easily from one job to another. Finally, the

### Chart I

**Black Enrollment in US Nursing Schools**

<table>
<thead>
<tr>
<th>Programs</th>
<th>Year</th>
<th>Number Enrolled</th>
<th>%</th>
<th>Year</th>
<th>Number Graduated</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL PROGRAMS</td>
<td>1963-64</td>
<td>3247</td>
<td>2.7</td>
<td>1963-64</td>
<td>1081</td>
<td>3.4</td>
</tr>
<tr>
<td></td>
<td>1972-73</td>
<td>15210</td>
<td>7.7</td>
<td>1971-72</td>
<td>2735</td>
<td>6.3</td>
</tr>
<tr>
<td>DIPLOMA</td>
<td>1963-64</td>
<td>2024</td>
<td>2.2</td>
<td>1963-64</td>
<td>590</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>1972-73</td>
<td>2330</td>
<td>3.5</td>
<td>1971-72</td>
<td>587</td>
<td>3.3</td>
</tr>
<tr>
<td>AD</td>
<td>1963-64</td>
<td>253</td>
<td>4.2</td>
<td>1963-64</td>
<td>78</td>
<td>5.6</td>
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<tr>
<td></td>
<td>1972-73</td>
<td>7070</td>
<td>11.5</td>
<td>1971-72</td>
<td>1676</td>
<td>10.1</td>
</tr>
<tr>
<td>BSN</td>
<td>1963-64</td>
<td>970</td>
<td>4.2</td>
<td>1963-64</td>
<td>413</td>
<td>9.7</td>
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<tr>
<td></td>
<td>1972-73</td>
<td>5810</td>
<td>8.5</td>
<td>1971-72</td>
<td>472</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Proposal contains an "equivalent education clause" under which students obtaining their BSNs could work as LPNs. This clause could be used to actually demote many present RNs. (For hardships imposed on working nurses by additional educational requirements, see Women's Column, March-April 1977 BULLETIN.)

RNs will always be able to find work as RNs in the less desirable sectors—nursing homes and small community hospitals. Teaching hospitals, however, are expected to hire only BSNs after passage of the 1985 Proposal. The Proposal could also rebound on LPNs. With non-BSN RNs being pushed downward in the workforce, LPNs may have to upgrade themselves to the AD level or be satisfied to work as nurses' aides. At New York University's prestigious University Hospital, the administration has already adopted a de facto policy of hiring only recent BSN graduates and reducing the number of LPNs through attrition. If hospitals cooperate to bypass the grandfather clause, they could save millions in skilled nursing wages, either by forcing non-BSN RNs to work as LPNs, or by setting up wide differential pay scales. For the older nurse, this would further confirm her decaying position in hospital nursing.

The Race Component

Historically, working class women have used nursing as an avenue of advancement. Even though nursing has been considered "women's work" and has been low paid by objective standards, it was still alot better than the sweatshop. The predominance of Irish and Italian nurses in New York is testament to this.

Minorities have played a particularly large role in unskilled hospital work, and a lesser role in the skilled jobs, such as nursing. What effect will the 1985 Proposal have on them?

Figures on the numbers of minority workers in various job categories in the health care system are not readily available. Statistics on the number of Black students in various nursing programs do exist, however. (See Chart I.) Diploma programs have the consistently worst record of Black enrollment. This could be partially due to the fact that many hospital schools of nursing are located in towns and small cities; moreover, many are located in Catholic hospitals.

The greatest change in Black enrollment has occurred in AD programs. These two-year, community college programs now have the largest proportion of Black students of any nursing program. Unfortunately, it is precisely the AD graduate who will be excluded from "professional" nursing if the 1985 Proposal passes.

For BSN programs, the figures are less clear. While there have been large increases in the number of Black students enrolled, the number who have graduated has remained essentially constant. As a percentage, they have actually declined. This phenomena might be partially explained by large numbers of Black students admitted in the last few years. The delayed effect should not be so large, however, and if accurate, it is merely an indication of racist practices that existed in the past.

Nursing journals have recently featured the "problem student," suggesting that Black students may drop out at a disproportionate rate. With setbacks in open admissions and minority recruitment programs since the Bakke decision, the number of Black students and graduates of BSN programs will undoubtedly level off. Even if the number of Black enrollees and graduates of BSN programs were to increase in the future, they would continue to represent a small minority of nurses.

This fact is even more striking when one looks at the percentage of schools with small Black enrollments. (See Chart II.) It would appear that BSN programs have attempted to recruit some Black students...
Other State Efforts to Increase Nursing Requirements

Arizona—Diploma schools are already phased out. The nurses' association is polling its members on the two-level system of licensure.

Idaho—The Idaho Nurses' Association House of Delegates passed a resolution supporting the two-level concept, and has established an ad hoc committee to explore implementation.

Maine—The State Nurses' Association has gone on record as seeking a minimum of BSN for licensure by 1990, but feels it is an unrealistic goal because of the "unwillingness of universities to revise their curricula." 

Ohio—The Ohio Nurses' Association has included a two-level plank, also to take effect in 1985, in their proposal for amendment of the Ohio Nurse Practice Act.

Oklahoma—Forums are being held around the state to evaluate rank-and-file support for a two-level licensure system.

Oregon—The Oregon Nurses' Association has gone on record several times in support of the concept.

Pennsylvania—The State Nurses' Association has passed a resolution in support of the BSN minimum, and is developing a formal legislative proposal, also projected for 1985.

Texas—The Texas Nurses' Association is working on a formal position.

Washington—The issue is under study.


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At the level of nursing practice, the profession has responded to growing pressures by seeking greater professionalism, diversification and exclusivity. On the floor level this has meant an increased emphasis on supervisory and administrative roles; elsewhere, it has meant stressing the uniqueness of that body of knowledge which constitutes the nursing profession, whether it be faith healing or attempts to become independent, free-standing practitioners. These impulses come partly from a healthy reaction to female subjugation in the health care system. Unfortunately, however, they also come from a contempt for the lowly "floor nurse" and other cogs in the hospital workforce.

The President of the NYSNA graphically expressed this contempt for nurses as nurses in an
hysterical letter to the membership recently. In response to a move by the chairman of the Assembly Committee on Higher Education favoring a Physicians Assistant bill over the 1985 Proposal, she suggested that all the nurses in New York give up their licenses and apply for licenses as Physicians Assistants. Physicians Assistants are favored in the hierarchy over nurses, because they can write orders, in spite of having less education. In her anger over status and prerogative, she seemed ready to abandon the value of nursing.

Such issues as professionalism and the 1985 Proposal are not only reactionary, but profoundly diversionary. They do not represent, in any sense, the felt needs of nurses. Nurses are angry over understaffing, shift work, forced and unpaid overtime and poor working conditions. The answer to these woes, however, is not contempt and distancing oneself from fellow workers, but rather the opposite: organization and unification of workers. And nurses are turning in greater numbers to unionization, as indicated by recent successes and the establishment of a nursing division by District 1199 of the National Union of Hospital and Health Care Employees.

Perhaps a positive result of the 1985 Proposal will be a growing awareness that the state nurses' associations represent the nursing bureaucracy, not all nurses. It has been nursing educators, administrators and graduate students who have supplied the bodies for lobbying, rallies and demonstrations. Their impact, if they succeed, will be to demote or at least decrease the earning capacities of tens of thousands of nurses. Nurses constitute half of the health workforce. United, they represent a tremendous force for potential change within the health care system. Creating more divisions, however, will serve only the interests of the latest set of Brahmins.

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REFERENCES
Brookdale:
The Nurses Shift

The economics of hospital administration combined with a somewhat narrow definition of professionalism by established nursing leadership threatens to leave the majority of working Registered Nurses (RNs) out in the cold in the 1970's and 1980's. (See "Closing the Door on Nurses, New York Style," in this issue).

The response from a growing number of nurses themselves, however, has been anything but passive. In larger numbers for each of the last few years, RNs have been developing alternative—and generally more militant—collective answers to both internal and external threats to their status and their ability to perform the work for which they were trained.

To date, RNs have typically sought collective bargaining representation from their State Nurses' Associations (SNAs—state chapters of the American Nurses Association). The SNAs, however, have all too often proven unprepared for the task and generally more militant—collective answers to both internal and external threats to their status and their ability to perform the work for which they were trained.

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The Brookdale Election

Frustration with the SNA approach was made dramatically clear in Brooklyn last February when the RNs at Brookdale Hospital voted to join District 1199, the National Union of Hospital Care Employees. In rejecting the NYSNA by a vote of 279-214, the RNs also took a step away from the SNA strategy for professional autonomy. That strategy seeks to preserve RNs' ability to control their work by narrowly defining their role and clearly separating themselves from other health care employees. The Brookdale RNs, rejecting this approach, chose to cast their lot with some 70,000 other hospital workers in 1199.

Most of the impetus for the 1199 campaign at Brookdale came from an organizing committee of RNs themselves. The committee began meeting over a year prior to the election to discuss common problems and alternatives for representation. They discovered two broad areas of agreement: (1) mounting pressure from Brookdale's administration for increased "productivity" (generally translated as more patients per nurse was making good nursing care impossible; (2) the failure of NYSNA to send organizers in person to Brookdale or to develop adequate grievance machinery or collective bargaining strategies in other institutions made them an unlikely choice to represent Brookdale's nurses.

The committee considered two other alternatives. The first was an independent form of organization for RNs, but this was rejected after investigation and discussion. "An independent organization simply doesn't have the resources or strength to bargain hard and to handle grievances effectively," said Linda Halliday, a committee member from the beginning. "Besides, nurses today are being divided up enough. We wanted to enjoy the strength of being allied with the other workers in the hospital." (All of Brookdale's other employees are members of 1199.)

The committee therefore approached 1199 and began their campaign by handing out union membership cards throughout the hospital. Fewer than 75 nurses signed up. So the committee began the laborious process of personally contacting each nurse in the hospital to discuss the merits of joining. It was a strategy that clearly proved the difference in winning the election, and was to prove crucial several months later.

"I think the success of both the organizing campaign and the strike can be traced to the personal relations we established with every nurse at Brookdale," according to Sondra Clark, another committee member. The strike to which she refers came in late August after over five months of extremely difficult bargaining with the Brookdale administration.

On Strike!

From the beginning, Brookdale's administration reportedly viewed the 1199 bid for nursing representation as a threat not only to the institution itself but to the citywide League of Voluntary Hospitals as well. Brookdale is Brooklyn's largest voluntary and is well represented in the League, which annually negotiates with 1199 for its member hospitals.
The RNs set up a negotiating committee and polled all nurses concerning major demands and grievances. The resulting 27 demands included such bread-and-butter issues as vacations, pay increases, shift and experience differentials, and tuition and in-service training reimbursements. But it also raised broader issues: union security (closed shop) and contract expiration date (the RNs sought an expiration date as close as possible to the expiration date of the other 1199 workers at Brookdale), as well as arbitration of professional grievances and establishment of patient welfare and staff development committees.

Five months of tough—and often angry—bargaining failed to move the hospital on any of the major issues, and by early August the RNs felt action was overdue. A sick-out in June had proven very effective, indicating most RNs were prepared to act. The negotiating committee called a strike vote and a majority of nurses voted in early August to send the hospital a ten-day strike notice.

In the days immediately preceding the strike, the federal mediator assigned to the negotiations called for around-the-clock negotiations. Token concessions were made by the administration on some key issues. Finally, early in the morning of August 22—the strike deadline—the committee had a package offer from the hospital that represented slight concessions on many issues, but was far from initial RN demands. Most members of the negotiating committee were unsatisfied with the package, but all worried about the real support among the majority of RNs for a strike. They decided to postpone the strike for 24 hours, to present the hospital's package to the entire nursing staff with no recommendation for acceptance or rejection, and to reassess the strike following a vote by all the nurses.

When the votes were counted Monday evening, the results were overwhelming even to the committee: by a margin of 272 to 100, the RNs had voted to reject the package and to walk out.

Tuesday morning, August 23 saw picket lines surrounding the hospital, as a strike committee coordinated the work involved and the situation inside. Few nurses reported to work, some units were without RNs altogether except for supervisors and similar personnel. An emergency care committee was established to send an appropriate number of RNs to any unit with a medical emergency on a temporary basis.

Throughout the strike, other 1199 workers resisted pressure to fill in for the absent RNs, and many personnel refused to take over nursing duties. From the first day of the strike, sick-outs by other hospital workers began to occur in various units throughout the hospital. (Other 1199 employees were bound by a no-strike clause in an existing contract. Although many "individually" refused to cross picket lines, the union could not officially call them out). As the strike drug on into the second day, rumors circulated that a hospital-wide sick-out by other workers would occur the following day. The hospital agreed to resume negotiations.

When negotiations resumed on Wednesday afternoon, they involved a negotiating committee newly energized by the support of the majority of Brookdale's RNs. Several hours later, major concessions had been made by the administration, and the negotiating committee emerged with a package they felt could be recommended for acceptance. Most RNs evidently agreed. On Thursday, August 25, Brookdale RNs voted 283 to 35 to accept the new contract.

The Brookdale strike seems notable in two respects:

(1) The viability of a trade union strategy for representing Registered Nurses would seem to have been given a significant boost by the settlement itself—a settlement that leaves Brookdale's RNs with one of the best packages in the region. Gains from their contract include: guaranteed rights with a method of redressing grievances including final recourse to outside arbitration; every third weekend off; significant pay, vacation, shift differential and other benefits increases; a voice in patient welfare and staff development policy within the hospital; and an agency shop, with a possibility of union shop if 75 percent of the RNs join 1199.

(2) It has clearly stimulated similar organizing activity among RNs at regional hospitals. Sondra Clark, since named the Director of 1199's new RN division, reports that organizing committees have formed at a number of regional hospitals and the union now receives numerous inquiries concerning RN membership. The NYSNA conceded in a recent letter to all member nurses that its own organizing efforts had been troubled recently by inadequate staffing and difficult internal problems. If these have left the majority of RNs in a vacuum, it is a vacuum 1199 proposes to fill.
The failure of the American medical care system since World War II to provide low-cost, community-based, accessible primary care has been paralleled by dramatic increases in costly, hospital-based substitutes such as hospital emergency room (ER) services.

"There has been over a 600 percent increase in the number of emergency visits in some hospitals in the last 25 years," estimated Senator Alan Cranston (D-Cal.) in 1973 Senate hearings. Emergency visits increased nationally from 15 million in 1955 to 50 million in 1970, and have since increased at an average of 10 percent each year.

The intrusion of high-technology, hospital-based ER medicine into the vacuum left by disappearing general practice and community medicine is most extreme in the nation's ghettos and low-income neighborhoods. Cranston noted that, "In the critically underserved neighborhoods of densely populated areas, emergency medical services should more accurately be termed health services. Here the distinction between emergency medical care and primary health care is very difficult to determine." One of many reports on emergency rooms stated, "More than one-half of Emergency Room traffic is made up of patients who are not there because their illness or injuries are serious, but because they have nowhere else to go."

But in the nation's middle- as well as low-income areas, the shifting of primary medical services into hospitals has dramatically altered both the cost and quality of care:

- Rather than fulfilling its potential as an alternative to costly hospitalization, primary care via the ER increasingly becomes a form of case-finding and fee-balloonning for the hospitals. In 1973, one of four hospital admissions nationally occurred via ERs. To this are added the substantial costs of the ER visit itself, usually generating additional hospital billing for X-ray, lab, pharmacology and similar ancillary services.
Equally disastrous, however, have been the effects of how ER services are delivered and by whom. Traditionally staffed by interns plus moonlighting residents or housestaff, the hospital ER has become an arena for one of the newest of medical commodities, the contract emergency physician (EP) group.

**Growth of Emergency Medicine**

Emergency medicine emerged as a specialty with the establishment of the American College of Emergency Physicians (ACEP) in 1969. Federal legislation, including such measures as the 1973 Emergency Medical Services Systems (EMSS) Act, provided new economic encouragement for EPs, with Congressional authorizations of $45, $65 and $75 millions for expanded hospital ER care in fiscal years 1974, 1975 and 1976.

As does most federal health legislation, however, the EMSS bill better reflects the interests of private providers than those of private citizens. The bill’s major focus is devoted to sensational, highly technical care for such real emergencies as accidents and heart attacks. But nationally, only a tiny percentage (between two and three percent) of ER patients require such care. The vast majority of America’s ER patients come seeking routine medical care or relatively low-technology treatments for mental, drug and alcohol-related problems.

The major force behind the expansion of higher-priced, less relevant ER care lies within the economics of the voluntary hospital itself. In the words of one San Francisco administrator, “They [ERs] generate the product: patient days.” They can also generate a tremendous increase in ancillary services, whether or not the patient is admitted. According to Dr. Karl Mangold, member of ACEP’s board of directors and head of one of the nation’s largest EP groups, “It is generally acknowledged that in a typical hospital, 50 percent of gross revenue is generated by bed utilization and 50 percent by ancillary service utilization. However, 70 percent to 80 percent of profit is generated by use of ancillary services.”

The profitability of the voluntary hospital ER is virtually guaranteed by the nature of third-party reimbursements (both Medicare/Medicaid and private insurers). Such coverage—generally unavailable for most office or outpatient visits—now extends to over 70 percent of the population. The remaining, uncovered population is typically “dumped” on tax-supported public hospitals.

For the insured population, clear distinctions can be found between those covered by private insurance and those covered by public programs. The former—more often white and middle class—are generally desirable from the hospitals’ viewpoint both on economic and cultural grounds. Medicare and Medicaid patients, however—usually nonwhite and lower or working class—are often treated as patients of last resort. Spurned in times of high occupancy, they are grudgingly received and treated whenever occupancy rates fall low enough to threaten hospital solvency. (The latter may occur seasonally or, under such circumstances as when overexpansion of hospitals in any area leads to surplus beds.) Thus they serve as a reserve source of income for hospitals.

In the words of one San Francisco Emergency Physician, “The purpose [sic] of the Medicare and Medicaid programs was to return the poor patients to the ‘mainstream,’ and that’s what’s happening now. It’s the money... the hospitals couldn’t do it before and now they can. Emergency medicine is no longer indigent medicine.”

Even when covered, however, publicly-supported patients typically receive a level of care that increasingly characterizes the growing contradiction within American medicine: rapidly multiplying, highly technical services in the hands of private providers without any measurable improvement in health.
Mainstreaming in San Francisco

San Francisco provides a kind of case study of how the "mainstreaming" of primary care into the ERs of the private sector has taken place. Leaving little to chance, the city's voluntary hospital administrators have waged a vigorous campaign since the late 1960s to persuade often-dubious private physicians that expanded ER services—and particularly those provided by the contracting EP groups—pose no threat to their practices. Such physicians—virtually all members of the attending staff at these same voluntaries—have been reassured that expanded ER services will yield them new patient referrals and provide reliable off-hours screening for their existing patients. In the words of one major voluntary administrator appealing to his medical staff for cooperation with the newly-contracted Emergency Department Physicians (EDMDs):

"The EDMD is committed to the preservation of the private practice of medicine. His income is derived from the private practice of medicine, too. The EDMD is not competitive with the staff physician and has no private office. He will not refer patients back to the EP except under unusual circumstances."

The major selling point of the EP groups, meanwhile, has been their superior ability to handle emergencies compared with the capacity of traditionally-staffed hospital ERs. The latter have often consisted of hodge-podges of interns and moonlighting residents backed by a few attending staff. EP groups, by contrast, argue that their commitment to emergency care as a full-time career enables accumulation of valuable experience and improves the quality of emergent care available.

Whatever the merits of EP claims to improved care for medical emergencies, the implications for the bulk of emergency room patients is unfortunately clear: contract EP groups, in the context of decreased access to private physicians and other sources of primary care in the community, mean increasingly fragmented, discontinuous and often irrelevant care for those visiting emergency rooms for non-emergency complaints.

Voluntary hospital administrators and EPs alike have managed to find their way onto county commissions that recommend emergency care in and around San Francisco, waging often successful campaigns for ER expansion. One recent public relations pitch focused on the issue of cardiac care—a question certain to appeal to politicians and business people potentially susceptible to cardiac problems.

EPs and administrators used the cardiac care issue as the leading edge of a citywide campaign to break what they characterized as a "monopoly" on emergency services in San Francisco held by the city's public emergency care system. The system—whereby public ambulances transport the vast majority of the city's emergency patients to the Mission Emergency center (affiliated with the city/county public hospital, San Francisco General) and several smaller emergency stations—featured a widely-acclaimed regional trauma center.

Contract EP groups, in the context of decreased access to private physicians and other sources of primary care in the community, mean increasingly fragmented, discontinuous and often irrelevant care for those visiting emergency rooms for non-emergency complaints.

In the words of one EP: "It's just that in San Francisco, the weak spot in the present public care system is the acute cardiac patient. The private hospitals can point out that there is no reason not to take the acute cardiac patient to the nearest hospital. This affords the easiest place to start the attack on the present [public] system. We picked the vulnerable place to break their monopoly. And there's a lot of appeal in the issue. It's a hot item because businessmen get the disease. It's an issue that civic leaders could identify with." The resulting proliferation of ER services in San Francisco since 1970 has been dramatic. Among the city's eight major voluntary hospitals, five have remodeled and expanded their emergency services since 1970.

The EP Contract Group

The key development, however, has been the spreading use of contracts between voluntaries and private emergency physician groups to staff ERs on a 24-hour basis. As the chart on Page 21 shows, six of the eight major voluntaries had signed contracts with emergency physician (Continued on Page 21.)
WHAT'S HEALTHY FOR BUSINESS?

The 1977 Congressional summer recess has ended. The Carter Administration seeks a corporate consensus on its energy and welfare proposals, but its health position hangs in abeyance.

Meanwhile, the corporate community is preparing its class position through a "public interest" front called the Washington Business Group on Health. Aware of what it is paying for health care—with General Motors touting its finding that "unproductive" medical bills are costing it more than auto-body steel—big business has discovered that what's not healthy for GM is not healthy for America.

Three years ago, the Fortune 500-rank, Washington-watching Business Roundtable created, at the urging of Henry Ford III and other corporate executives who sit around it, a special task force to derive a health policy attuned to the needs of the broadly-interested large employers. Out of this came the plan for the Washington Business Group on Health, a membership organization of 145 employers (with 30 million employees) maintaining a strong Washington presence and wielding a lot of clout.

The BizGroup is not simply a right-wing Chamber-of-Commerce sidekick of the AMA. It is hip and in the middle of the latest White House and HEW action. Its bright young Director, Willis Goldbeck, has successfully established entree to the inner circles of the Carter Administration and the top levels of HEW. He attends meetings of Califano's National Health Insurance Advisory Committee and travels with it on its site visits to clinics and health centers.

The Wall Street Journal editorialized early in the 1976 Presidential campaign year that big business must "strip the medical societies of the power to inhibit more efficient methods of delivering medical care." Despite general corporate Administration agreement on this imperative, the BizGroup faces a triple challenge in achieving and implementing such policy in post-Watergate Washington. First, all "special interests" are suspect—so the striving for "public interest" legitimacy has been a key part of the BizGroup's strategy during its formative years. Second, medical care costs continue to rise, so the longer it delays acting, the greater the cost to corporate capital; but consensus about exactly what to do remains very difficult. Third, labor union representatives continue to lobby actively, particularly through the the Committee for National Health Insurance which supports the Kennedy bill.

Director Goldbeck clearly knows his power; he told Congress that "employers represent more muscle than they have even wanted to acknowledge themselves...in the case of medical care, the major employers are also true consumers...the user, the patient, is rarely the consumer from the standpoint of classic economic influences." Though it is the patient whose life and health are at stake, in the corporate world, as in the Kingdom of Id, "He who has the gold makes the rules."

But its [Bizgroup's] very existence shows that, at last, business has become aware of its class interest in how it is all resolved, and it wants Carter and Califano to be aware that it is watching.
rejects the Carter-proposed price controls on hospitals, seeing them as a dangerous precedent for price controls without wage controls. Instead, the BizGroup's program mixes reduction, market incentives, consumer cost-sharing and comprehensive planning, with sophisticated victim-blaming that stresses individual habits, de-emphasizes medical care (especially for the victimized working poor), and ignores corporate-caused social and environmental sources of illness. It strongly supports the PL 93-641 planning process and is urging broader authority for corporately-cooptable Health Systems Agencies.

Unresolved conflicts remain within the corporate class—between the industrial companies that pay the growing fringe benefits and the drug, supply, construction and insurance companies that benefit from them, and between those individual corporate leaders who think the answer is greater state planning and those who strenuously oppose it. All are represented among the members of the BizGroup, explaining the generality, thus far, of its message to the Administration. But its very existence shows that, at last, business has become aware of its class interest in how it is all resolved, and it wants Carter and Califano to be aware that it is watching.

Formation of the Washington Business Group may be the national counterpart to local corporate moves on the problem. It may even represent corporate recognition of the limits of individual companies, the need for collective action and the importance of federal action in solving the health care/cost problem. The BizGroup has been spearheaded by Goodyear, a company whose energetic program for controlling health care costs typifies what "forward looking" companies are beginning to do. Goodyear's Board Chairman heads the Business Roundtable's Health Task Force (which oversees the BizGroup) and is on Califano's NHI Advisory Committee; Goodyear's chief Washington lobbyist heads the Steering Committee of the BizGroup.

Goodyear prides itself on administering its own health benefit plan—it has no insurance carrier. Its Health Services Manager described the advantage to Goodyear: "this "allows us to negotiate directly with providers of health care, just as we would with any other Goodyear suppliers...

Goodyear is using its purchasing power to establish more cost-effective procedures in the communities in which we operate." Goodyear is encouraging the establishment of medical foundations to provide it with a more orderly working relationship with physicians, and it is providing seed money to an offshoot of the medical society in Akron so it can become the area PSRO.

Most significantly, perhaps, Goodyear is urging its management employees to serve on hospital boards and health planning agency boards so they can even more directly control the evolution of health care delivery. Goodyear's Health Service Manager is president of the Akron area Health Systems Agency (which also received start-up financial support from Goodyear).

Willis Goldbeck points out that positions in health planning bodies are "critical entry points for gaining some measure of control over medical care capital investments, operating budgets and administrative procedures... the major employer/purchaser is finding new access to direct involvement in the health delivery system... the providers must realize that the consumer across the table just may be the head of a major corporation."

"Employers represent more muscle than they have even wanted to acknowledge themselves. . . in the case of medical care, the major employers are also true consumers. . . the user, the patient, is rarely the consumer from the standpoint of classic economic influences." —Willis Goldbeck

"Is the direct corporate supervision of health care the wave of the future? Are employers to become what one executive called them—the employee's "health manager?" —Robb Burlage and Len Rodberg
ABORTION: CASH CHOICE

NOT EVEN A Rockefeller can deflect anti-abortion sentiment in this country. In 1972, John D., Ill chaired a commission on overpopulation. It recommended that legal, induced abortion be included in all fertility control policies as a further means of stabilizing the US population. The Supreme Court responded in 1973 with a decision lifting nationwide restrictions on early abortion. The Rockefeller Commission also recommended that abortion "be specifically included in comprehensive health insurance benefits, both public and private." 1

Last year, Congress withdrew support for publicly financed abortions. The Hyde Amendment, tacked onto a fairly innocuous HEW-Labor Appropriations bill, banned Medicaid funds for termination of all but life-threatening pregnancies or those resulting from rape or incest. The House went along with it; the Senate didn't. The Senate supports its own more liberal Brooke Amendment—reimbursement for "medically necessary" abortions. The amendment, locked in furious debate, went to a House-Senate Conference Committee where to date Senate members have done all the compromising and the House has stood firm. At this writing the bill is still deadlocked.

There will be a Hyde Amendment in some form, however. Had the Supreme Court decided differently in June, it might have withered away. Now it will become a permanent part of Social Security Act appropriations for Medicaid-funded health services until it is repealed by both houses. The legislature and the judiciary bolstered each other's outrageous actions and now women's rights and free choice advocates find themselves playing a reformist game—lobbying and demonstrating for the least discriminatory piece of legislation.

The Hyde Amendment and the Supreme Court decision are disincentives for states to provide and pay for abortions. Four-fifths of the $61 million in public funds spent to finance some 261,000 abortions for poor women under federal-state programs last year came from the federal government. Few states will continue payments unless federal financing restrictions are liberalized. Four have already withdrawn support for publicly-funded abortions, 2 while ten which have had traditionally liberal stands on abortion are likely to revert to their former Medicaid reimbursement formula—50 percent state and 50 percent local.

At the state level—if not at the federal—a major criterion is likely to be "medical necessity," a term vague enough to inspire abuse. In the past it has served as a loophole—establishing abortion as a decision made between a patient and her doctor. Its danger, of course, is the ability of providers to apply it selectively and exploit their decision-making power. One New York City voluntary hospital official seemed relieved that abortion would no longer be performed "helter skelter" (on demand) but monitored (read: controlled) through "professional" decisions.

How and why has this cutback happened? The author of the federal amendment, Rep. Henry Hyde (R-Ill.), is a long-time abortion foe. He has said that he would ban abortions for rich and middle class women as well. The poor are an easy target for his
brand of self-righteous opportunism.

Anti-abortion forces have worked long and hard for such a major victory. It is not merely a sop to clear their numbers from the legislative corridors however. A reactionary mood in America embraces a range of issues from US supremacy to male supremacy, i.e., from the Panama Canal to abortion rights. Many people are earnestly against abortion. They don't want to subsidize, with their tax money, a medical procedure they view as a symbol of moral decay.

There exist conditions which have set the tone for an attack on abortion: a workforce no longer dominated by white males; and families increasingly unstable and unsure of their role in American life. There are many citizens—men and women—whose discomfort with their lives and this country is expressed around a highly charged issue like abortion.

Still, the current crisis defies any simple economic analysis; after all, as population controllers point out, it costs the public more to support the unwanted progeny of the poor. Family planning, pregnancy, childbirth, liberalized adoption services, and sterilization—HEW's "alternative to abortion" plan—will continue to be reimbursed by the feds. The majority of Medicaid-eligible women will not be able to pay out-of-pocket for legal abortion. It is more likely that they will attempt to self-abort, seek cheap back-room abortions, carry an unwanted pregnancy to term, or choose sterilization to put a permanent end to the dilemma of unwanted pregnancies or failed/unsafe contraception.

The current attack on Medicaid-funded abortions was not inevitable. In theory, legalized abortion benefitted the poor woman: she could seek a safe one, paid for by Medicaid at a near-by health facility. In practice, abortion services remained inaccessible to a large number of mostly young, black or rural women (some 164,000-245,000 Medicaid-eligible women in 1976, estimates Planned Parenthood). The 1973 decision was supposed to equalize the accessibility of abortion services throughout the country. It didn't. Financing, referral, availability of facilities and access to them has always reflected class structure. Affluent or non-poor women could usually afford the travel expenses to obtain a relatively safe, if illicit, abortion. Anti-abortion groups were immediately hip to the issue of accessibility. After 1973, they began to chip away at the liberalized abortion laws. State laws popped up requiring consent forms, parental consent, and limiting abortion to the first trimester. Anti-abortion riders were tacked to federal legislation: the Health Programs Extension Act; the National Science Foundation Act; the National Research Awards, and so on. Community right-to-life groups began to picket local hospitals, re-zone potential abortion clinic sites and harass physicians who performed the procedure. The women's movement had won an ideological point but the opposition blocked effective implementation of the right to choose.

There is fear among women activists that while the Medicaid crisis may indeed be a response to the anti-abortion, pro-family climate, the master plan is sterilization—sterilization of the poor, orchestrated from the highest places. Critics of sterilization abuse are suspicious of the heightened activity of public and private family planners to expand out-patient sterilization services. Even more alarming is the potential for conditional abortions—abortion only with consent to sterilize.

Population control conspiracy, racism, classism, sexism, or moral climate—no matter what the starting point, abortion is a galvanizing subject. Politicians are not about to relinquish such a hot political touchstone. Safe, legal abortion as a health care service has had a strike against it for the past five years—unequal distribution. Now, the second strike—

**One NYC voluntary hospital official seemed relieved that abortion would no longer be performed "helter skelter" (on demand)...**

**A reactionary mood in America embraces a range of issues from US supremacy to male supremacy...**

...economic inaccessibility. Abortion remains safe and legal only for those women who can afford it. Strike three may outlaw abortion for all women.

— Sharon Lieberman (Sharon Lieberman is a member of HealthRight, a women's health education and advocacy organization. It also publishes a women's health newsletter.)

**REFERENCES**

HHC: OUT OF THE SPOTLIGHT AND ONTO THE SCRAPHEAP?

Proponents of a modified public benefit corporation to operate New York City's municipal hospitals viewed it in 1967 as a mechanism to "get the hospitals out of the gutter of New York City politics." After almost a decade of turmoil, this has seemingly been achieved. Almost none of the candidates in the recent mayoralty primaries mentioned the Health and Hospitals Corporation (HHC) in public.

The candidates' failure to discuss the 17-hospital, $1 billion system might be ascribed to a tacit agreement. A more likely explanation is that no candidate could figure our how to exploit the situation to make it campaign-worthy. Once Dr. John L.S. Holloman was fired in January, 1977, there was no easy target and no publicly-identified spokesman for the system who might answer to a candidate's charges.

Thunderous Silence

The candidates' silence on these HHC moves and the more fundamental issues, however, was thunderous. Mayor Beame, who established a four-year record of opposition to the municipal hospitals, should have found continued opposition to the system—which primarily serves poor people—as politically risky as calling for the end of welfare fraud. But the Mayor apparently blew all his steam when he ousted Holloman and installed his own man at HHC last spring. In any case, Beame's campaign seemed deliberately calculated to bore the populus—a tactic perhaps designed by his chief strategists to help the public to forget his four miserable years of tenancy at City Hall.

Bella Abzug, with a loud voice and an aggressive manner, ran a campaign as timid in substance as Beame's. She never became the lightning rod for discontent that the newspapers and bankers feared. A campaign of much style and little content was hardly suited to deal concretely with the complex problems of the municipal hospital system—and it didn't.

Sitting in an office 150 miles to the north of City Hall, New York's Governor Carey plotted against the incumbency of Beame, a man he reportedly had called an idiot and whose continued presence at City Hall threatened Carey's own re-election plans for 1978. Abzug, a woman whose smoke terrified him, also made the Carey enemies list. Meanwhile, of course, the Governor chose to promote his law school classmate, Secretary Mario Cuomo. Taking his cue from Carey and his strategy from Jimmy Carter's media team, Cuomo fit perfectly into a vacuous campaign. Cuomo did, however, present a lengthy position paper on the city's hospitals which any interested voter could get by calling Cuomo headquarters ten or fifteen times.

Then Came Koch

Ed Koch, the ultimate primary victor, took a slightly different
Abzug never became the lightning rod for discontent that the newspapers and bankers feared.

Koch did point out however, that he wasn’t unclear about the problems. “In general,” Koch said, “I believe that a major reorganization of the health care delivery system in the city is necessary. I believe excess beds must be closed, not just in the municipal hospitals, but also in the voluntary hospitals.”

Like the ill-fated Cuomo campaign, Carey thus seemed to make another political faux pas. Evidently like chickens, counting your czars before they hatch is very dangerous if you don’t want to wind up with egg on your face.

— Barbara Caress

There is really only one conclusion that can be drawn in my judgment from an examination of the morass in which the Health and Hospitals Corporation which spends a billion dollars a year in tax monies finds itself: that is that the purpose behind removing the administration of the city hospitals from Mayoral control has not been served. I would find it hard to believe that with the hospitals as a city agency that the incompetence was greater. It may well not have been less but hardly greater.

“Therefore, in my judgment, two things are required: one is the removal of Dr. John Holloman along with his senior management personnel. And second, a return of the administration of those hospitals to the City of New York with the Mayor to have direct responsibility.”

But with Holloman fired two months later and administrative jurisdiction a very unsexy political issue, Koch eventually joined his campaign mates in stonewalling on the HHC. Aside from boasting about taking on Holloman and the racism charge, which only bolstered Koch’s fashionable “toughness” image, Koch never again confronted problems at HHC during the primaries.

The main issue debated by the candidates during the long campaign was capital punishment. Does Koch’s opposition to city employees and welfare recipients combine with his support of capital punishment to suggest a final role for municipal hospitals, capitalizing on one of their proven strengths? Stay tuned.

Czar Wars

Whatever the outcome of the campaign (Koch is the overwhelming favorite), the multi-billion dollar NYC hospital industry remains a serious threat to the State’s and City’s solvency. For the last six months Governor Carey has been attempting to get the city administration to agree to a joint city-state appointment of a health czar. This strongman will then supposedly knock the hospitals into line. But primary politics interrupted. Cary and Beame weren’t talking.

Barely two weeks after the close of political hostilities with both Beame and Carey’s man, Cuomo, eliminated for the running, the Governor announced his nominee for the post. Morton P. Hyman, a shipping executive whom Rockefeller had appointed to the state’s Public Health Council, was slated for the job. Reportedly, the name had been cleared with Beame’s surrogate, former Deputy Mayor John Zuccotti. But Carey failed to include probable-mayor-elect Koch in his calculations. Koch was quick to object to Carey’s implicit assumption that he would willingly cede power to the czar without prior review.

Municipal hospitals should be returned “to the City of New York with the Mayor to have direct responsibility.”

— Ed Koch, November 1976
Traditionally black workers in the United States have been "the last hired and first fired." The brutal consequences of this policy—e.g., black unemployment rates approaching 50 percent for inner-city youths, or Black median income only 65 percent that of whites—grimly reflect the continued realities of American racism.

Another consequence, not perhaps so obvious but long suspected, is that Black workers, because they are typically hired for the heaviest, most hazardous jobs, experience even greater rates of occupational disease and injury than white workers.

Recently Dr. Morris E. Davis, Associate Director of the Labor Occupational Health Program (LOHP) at the University of California in Berkeley, tried to assess this impact in the August, 1977 issue of Urban Health. The greatest US occupational disaster in this century, Dr. Davis notes parenthetically—the Gauley Bridge scandal in 1930-31—left 1500 workers disabled and nearly 500 dead, most of them black. As workers tunneled through a mountain laced with silica, an estimated 169 black men literally dropped dead on the job and were buried, often two and three deep, in makeshift graves in a nearby field, arranged for by their employer, a subsidiary of Union Carbide. (See also BULLETIN, September, 1972.)

Two key industrial examples cited by Davis of unusually hazardous exposures to Blacks are in the steel and rubber industries.

**Coke is Not a Natural**

In the steel industry, coke ovens have long been a major focus of concern. Recent studies have shown increased rates of lung and other respiratory cancers among coke oven workers. Overall, 22 percent of the workforce in basic steel is Black. But in the coke oven area, 90 percent of the workers are Black—a proportion that has not varied for at least two decades.

Even within this area, Blacks are proportionally more exposed. It is known, Davis notes, that exposure of those working on top of the ovens is more hazardous than for those at the sides. Yet, of all Black coke oven workers, 18 percent were employed at full-time topside jobs compared to only 3.4 percent of whites.

The result is increased lung and other respiratory cancers for all coke oven workers, and even more excessive cancer incidence for Black coke oven workers. Thus Blacks experience eight times more deaths from lung cancer, three times more from other respiratory cancers and a significant excess from causes other than cancer.

**Neither Is Rubber a Natural**

In the rubber industry, Davis reports, a comprehensive study of over 7,000 workers is presently going on. Fourteen percent of these workers are Black. Here again excess mortality from cancer is found at the front end of the production process, in the rubber

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**Table 1**

**Black Representation in Selected Occupations by Sex**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>All occupations</td>
<td>11.7%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Less Hazardous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Professional and technical workers</td>
<td>8.3%</td>
<td>3.5%</td>
</tr>
<tr>
<td>2) Managers and administrators</td>
<td>4.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>3) Sales and clerical workers</td>
<td>6.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>More</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Craft workers</td>
<td>NA</td>
<td>6.2%</td>
</tr>
<tr>
<td>Hazardous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Operatives (gas station attendants, taxi drivers, butchers, welders, etc.)</td>
<td>13.6%</td>
<td>13.0%</td>
</tr>
<tr>
<td>6) Service workers</td>
<td>24.5%</td>
<td>17.0%</td>
</tr>
<tr>
<td>7) Nonfarm laborers</td>
<td>18.0%</td>
<td>20.3%</td>
</tr>
<tr>
<td>8) Farm workers</td>
<td>19.6%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

compounding and mixing areas, where fully 60 percent of the workers are Black.

Additionally, non-manufacturing examples cited by Davis include hazards experienced by sanitation and laundry persons. Sanitation workers, 43 percent of whom are Black, suffer injuries at a rate five times that of underground miners. (What's more, most are government employees and are not covered by the federal OSHA law or by the vast majority of state OSHA laws.)

About 60 percent of all laundry and dry cleaning workers are women, of whom nearly half are Black. Davis cites a study showing that "a higher proportion of female laundry workers, doing heavy lifting while pregnant, had babies with birth defects." Common drycleaning solvents can cause liver problems and are often suspect carcinogens.

Unfortunately Davis' article ends with these examples, presumably because detailed job classification data for individual industries is largely unavailable from government sources, other than a rough national breakdown of individual worker occupations by race, sex and other selected variables. Medical data is also sparse, although perhaps less so in this case than usual. (Davis is interested in collecting and analyzing further data on this subject. Those who might have useful data—from medical studies, legal suits, trade association or labor union data—should contact him at LOHP, 2521 Channing Way, Berkeley, Ca 94720.)

But even a cursory examination of the limited occupational data the government does publish gives further support to the argument that Blacks suffer disproportionately from workplace hazards. For example, the labor force is divided by the Bureau of Census into eight general categories (see Table 1). The first three of these—professional and technical workers, managers and administrators, and sales and clerical workers—are generally considered less physically hazardous than the last five—craft workers, operatives, service workers, nonfarm laborers and farm workers. The percentages both of Black males and Black females in the first three categories are less than their respective percentages in the working population as a whole, whereas Black men exceed their population percentage in three of the last five categories and Black women exceed it in four.

Consider the three relatively less hazardous categories together. (This, by the way, does not at all deny the real hazards present on these jobs—among office workers, for example.) About half of all white workers, male and female, are employed in these job categories to only one-third of all Black workers (see Table 2).

The Census Bureau also breaks down these eight general job categories into separate subcategories—69 for men, excluding the categories "other" and "miscellaneous." (U.S. Statistical Ab-

<table>
<thead>
<tr>
<th>Occupation</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Professional and technical workers</td>
<td>15.5%</td>
<td>11.4%</td>
</tr>
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<td>11.2%</td>
<td>4.4%</td>
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<td>4) Craft workers</td>
<td>13.4%</td>
<td>8.8%</td>
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<td>20.0%</td>
</tr>
<tr>
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</tr>
<tr>
<td>7) Nonfarm laborers</td>
<td>4.4%</td>
<td>8.7%</td>
</tr>
<tr>
<td>8) Farm workers</td>
<td>3.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Emergency Rooms

(Continued from Page 12.)

groups by 1975. The remaining two hope to do so in the near future. These EP groups—operating on a fee-for-service basis—are primarily trained to focus on relatively infrequent major trauma patients (less than 6,000 out of the 80,000 ER visits each year at the San Francisco trauma center at General Hospital). Such patients, of course, are more likely to generate in-patient admissions and utilize high-profit ancillary services while undesirable, low-paying, non-emergent patients can be dumped onto the public system.

Emergency Care and the Poor

In the face of the mushrooming number of emergency rooms, integrating San Francisco’s mix of public and private care becomes ever more difficult. Dr. Francis Curry, former Director of San Francisco’s Department of Public Health, points out that such integration might concede some care—such as cardiac cases—to the private hospitals where there are clear geographic advantages in doing so. But, he adds, the private hospitals appear uninterested in any real inte-

### San Francisco Emergency Services

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Current Status of ER</th>
<th>Date of Contract with ER</th>
<th>Physical Expansion of ER</th>
<th>Previous Set-up</th>
<th>OPD</th>
<th>Future Expansion of ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific Medical Center</td>
<td>24-hr w/ EPs</td>
<td>Early ’73</td>
<td>New ER in ’73</td>
<td>24-hr since 1910 rotating house staff</td>
<td>Medium 30,270/year</td>
<td>Want a trauma center</td>
</tr>
<tr>
<td>Children’s</td>
<td>24-hr w/ EPs</td>
<td>May ’75</td>
<td>?</td>
<td>Treatment area w/ on-call physician</td>
<td>Medium 28,815/yr</td>
<td>No more ED development—but a PHP</td>
</tr>
<tr>
<td>Mt. Zion</td>
<td>24-hr w/EPs</td>
<td>Feb. ’75</td>
<td>?</td>
<td>24-hr w/ moonlighting residents</td>
<td>Big 85,370/yr</td>
<td>None known</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>24-hr w/ EPs</td>
<td>June ’75</td>
<td>New ER in ’75</td>
<td>24-hr w/ rotating house staff</td>
<td>Big 86,976/yr</td>
<td>&quot;Change in the layout&quot;; informally discussing trauma center</td>
</tr>
<tr>
<td>St. Luke’s</td>
<td>24-hr w/ EPs</td>
<td>Dec. ’73</td>
<td>New ER in ’70</td>
<td>24-hr for 20 yrs w/ moonlighting residents</td>
<td>Huge 165,058/yr</td>
<td>No plans for ER New med. office building</td>
</tr>
<tr>
<td>Franklin (R. K. Davies)</td>
<td>24-hr w/ EPs</td>
<td>Summer ’75</td>
<td>New ER end of ’75</td>
<td>Locked mtg. place for use of prut. med staff</td>
<td>Small &amp; exclusive. No figs. reported</td>
<td>Want a trauma center &amp; a heliopad</td>
</tr>
<tr>
<td>St. Joseph’s</td>
<td>“Stand-by” (none)</td>
<td>X</td>
<td>X</td>
<td>Same</td>
<td>Small 17,861/yr</td>
<td>Hope to rebuild facility, including ER—no further comment</td>
</tr>
<tr>
<td>St. Francis</td>
<td>24-hr w/ moonlighting</td>
<td>X</td>
<td>Same</td>
<td>Rebuilding facility including ER &amp; OPD—interested in contract EP group.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: OPD data from 1975 Comprehensive Health Planning Reports and interviews with administrators.
gration, preferring to remain free to attract major trauma patients.

Curry's experience is echoed in the statement of one San Francisco EP that, "You need a critical volume of patients to break even... but you also need the right kind of patients. Now, the high profit patients go to the city, so the private hospitals take the less profitable patients. We need more of the patients who will utilize X-rays and surgery."

Further strengthening Curry's conclusion is the comment of one local voluntary administrator: "The bad debt experience is high with those people. A person walks in who has no known address, and you know it's going to be hard to collect. We do have a free care obligation... But we do send people to General if they have no means and are transportable—that's the system."

Even when they do have access to private hospital ERs, the medically uninsured often receive questionable services. Many back-up specialists refuse to come in as consultants for ER patients who have no insurance, or sometimes even those who have Medi-Cal (California's Medicaid). Such incidents have become frequent enough to force some hospital administrators and Emergency Room Committees to penalize offending physicians. At St. Mary's, for example, a specialist will be taken off the back-up roster if she or he refuses to take an ER case more than three times.

Medi-Cal patients, although they do have third party coverage, are often treated much like indigent patients. In fact, Medi-Cal patients are a focus of dispute between hospital administration and the fee-for-service EPs. Administrators, trying to keep up hospital census, wish to encourage welfare patients to use the ER and now welcome them for admission to the hospital. As Dr. Karl Mangold puts it, "Sure, hospitals have been seeing more lower socio-economic people when they develop ERs, but they're not balk ing at it; you can't be elitist when you have a low occupancy!"

Emergency physicians, on the other hand, tend to mirror the attitudes of their fellow fee-for-service practitioners who avoid Medi-Cal patients and generally try to keep the number of welfare patients they see to a minimum. They justify shunning poor patients by claiming that they are reim-

"The bad debt experience is high with those people. A person walks in who has no known address, and you know it's going to be hard to collect. We do have a free care obligation... But we do send people to General if they have no means and are transportable—that's the system."

...
high that they are prohibitive. More and more private physicians won't see Medi-Cal patients. They say, 'They're the ones who sue me, and I don't even get reimbursed enough for seeing them in the first place.' So there is a high volume of these patients in the ER, because they are denied service by the private practitioners. So, the ERs will have to cut out Medi-Cal eventually, too."

Meanwhile, EPs continue to begrudgingly see Medi-Cal and indigent patients, because the hospital wants welfare patients, and because the legal risks of turning any patients away from the ER prior to an examination remains too great. However, with this attitude, EPs cannot possibly offer the quality of care to Medi-Cal patients that they deserve.

The Market as Mainstream

The rapid expansion of ER services in San Francisco—and particularly the contracting of such services to private EP groups—serves to highlight the damages inherent in the so-called "mainstreaming" strategy in American medical care.

This strategy—which ultimately translates as transferring public responsibility and accountability into the chaotic medical market—invariably generates overutilization of costly hospital services and the distortion of health care priorities around high-technology, specialized care. The consequent neglect of community-based, primary care causes an actual decrease in access to care for many patients, particularly the poor.

As the US health care system increasingly models itself after the "mainstream" voluntary hospital, the example of San Francisco's private EP contractors dramatically underscores the inherent weakness in the entire voluntarization strategy. For, despite their guise as non-profit and community service institutions, voluntary hospitals to date have mainly excelled in proliferating high-cost, high-specialty medical commodities as a substitute for high quality, community oriented health care.

—Robin Baker

REFERENCES

5. ibid.

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The signs are everywhere.
On the corner of 168th and Broadway, every morning, a somewhat disheveled man in his late twenties offers, simultaneously, three games of chess and one of checkers to passers-by. No one takes up the challenge, so he nods off, or lends an unwelcome hand to the men unloading equipment for the hospital. It isn't an isolated incident. Local residents complain that the number of "crazies" on the street has shot up dramatically in recent months.
• A town in Long Island files suit against 40 families for boarding ex-mental patients in "the single most cherished section of our town, the residential neighborhood."1
• "Asylum-bashing" (exposing the horrors of mental institutions), long a standard practice among journalists of all stripes, has become an enthusiastic pursuit of Mental Health Administrators themselves.2
• Other observers turn their gaze on a different target. Not that the hospitalized patient has been forgotten,3 but the presence of another, more visible and foreboding, commands greater attention. These are the ex-patients, those who "panhandle...expose themselves to young children... and defecate in the sidewalk."4 From snake pit to street: the sidewalk psychotic has become as familiar a piece of the urban landscape as the wino.

Such are the external tokens of the latest "revolution" (and the double sense of the word, as we will see, is not out of place) in psychiatry—a revolution publicly proclaimed as the demise of the mental hospital and the dawn of a new era of "community-based treatment." "Deinstitutionalization" it is called, and it has arrived.

Foundations were laid some time ago. Beginning during the post-war years, the still-young profession of psychiatry found the 1950's were boom years, proof positive of how badly its services were needed. The war had helped in two ways. First, as the literature on the "lost divisions" illustrates, it allowed a glimpse of the true dimensions of the mental health problem: one of every eight potential recruits were rejected on psychiatric grounds. Second, the success of combat psychiatry in treating acute stress reactions helped remove the stigma of incurability from psychiatric disorders and conferred a needed measure of technical expertise on the profession.

At the same time, the asylum business was thriving. By 1955, the ranks of mental patients had risen to over 559,000; every other hospital bed in the U.S. was occupied by a mental patient. Fully 98 percent of these were in public hospitals. Average length of stay in the state hospital of 1952 was eight years. Needless to say, costs were rising steadily. Professional groups (notably the American Medical Association and American Psychiatric Association) joined forces with lobbying groups (like the National Mental Health Committee) to draw public and legislative attention to the growing social and economic burden mental illness posed. In 1961, the Joint Commission on Mental Illness ended a six-year study with a report, Action for Mental Health. The report crested a groundswell of criticism aimed at the warehouse model of psychiatric care. The objective of modern treatment, its authors...
held, must be "to enable the patient to maintain himself in the community in a normal manner." In short, if pathologies of place compounded disorders of mind, would not the desiderata of therapeutics as well as the constraints of budget be better served by emptying out the "crockery-bins"? "Aftercare" and "rehabilitation" replaced "asylum" and "custody" as the watchwords of this new and brave mental health policy. The Commission envisioned an extensive network of Community Mental Health Centers to coordinate community-based treatment. A century and a half old tradition of confinement would soon be eclipsed by an untested system of extended care.

But certain preliminary measures were in order. The whole notion of mental illness as an incurable affliction had to be rehabilitated. The Joint Commission urged us to think of it instead as a chronic but controllable malady; as a sort of "arthritis of the mind" was their memorable phrasing. An extensive re-education campaign was mounted, designed to persuade a wary public that the ex-mental patient was not only employable but a suitable matrimonial prospect as well. A carefully monitored regimen of "maintenance therapy"—i.e., regular medication—together with appropriate support services were all that was needed to transform a legacy of neglect and abuse into a working system of humane care.

**Reform Without Change**

If the history of official tampering with penal and asylum policy in this country is one of "reform without change," it is a tradition likely to remain unchallenged by this latest enthusiasm. The lesson of deinstitutionalization is one of uncompromised failure. Or, to put it more accurately, the problem with the community mental health movement, as Chesterton remarked of a somewhat more ambitious enterprise, is not that it has failed but that it has yet to be tried. A brief look at what getting patients "back into the community" has meant in practice will serve to explain what I mean.

The purported cost-effectiveness of the community care scheme—one of two major arguments in its promotion, the other being its alleged therapeutic value—has proven to be more apparent than real. The real financial effect has been to transfer the fiscal burden to federal rather than state coffers. It is the welfare system, heavily subsidized by federal funds, which picks up the largest share of the tab for the maintenance of deinstitutionalized patients. By one calculation, the costs to the federal government of the inpatient program of one community mental health project was 16 times what its contribution to a state hospital would have been. By contrast, state expenditures were one-third of what it would have cost to house those same patients in state facilities.

Still, the savings to the states have not been as large as expected. The reason is simple: hospital closures have not kept pace with patient population declines. Fixed capital expenditures, therefore, have remained high. Since 1955, the inmate population of state mental hospitals has dropped by over a half—the combined effect of shorter lengths of stay, more stringent admittance criteria, and early release of long-
Discharge rates for older patients, many of whom were career inmates with "multiple disabilities," accelerated in the period 1961-1970. In spite of this reduction, only 12 state hospitals in eight states were closed in the period 1970-74. New York State provides an illustrative example: with a 64 percent drop in patient population in the first five years after the implementation of a more selective admittance policy in 1968, and an additional drop of one-third in the next four years, the state has still seen fit to open four new inpatient facilities since 1973, with a total of 1200 beds. (The current Director of Mental Hygiene of the City of New York swears, however, that a complete dismantling of the state hospital system is imminent.)

It is the therapeutic claims, however, that are most disturbing. Against the overblown rhetoric of the "superior quality of community-based care" juts one outstanding fact: the wide range of treatment alternatives and services originally promised—"smaller, better staffed hospitals, halfway houses, sheltered workshops, emergency protective resources, and community treatment centers"—failed to materialize. In the face of this failure—and the evidence in support of it is overwhelming—continued support for community-based care takes on something of the character of a cruel hoax.

Being "in the community" for most released patients has meant the humiliation of welfare, endless empty hours, and no prospect for work. In addition, for the long-term hospitalized patient, the move usually also means residence in a "board-and-care" facility: typically old, dilapidated structures, located in the worst, most victimized sections of the city, with no provisions for inspection, only the laxest of standards, and little if any access to medical, psychiatric or social services. Most are roughcut, small-scale replicas of the institutions they were meant to replace. Internally, the routine is characterized by the same wretched monotony, the same "passivity, isolation and inactivity" that marked the hospital wards. Nor has the lure of this new market gone unheeded: profiteering abounds, with predictable effects on patient care.

Finally, the densely reticulated system of community mental health centers envisioned by the Joint Commission in 1961 never was implemented. Of the 2000 such centers they foresaw, perhaps 450 are providing service. Those that do operate do so for the expressed purpose of crisis intervention, with a heavy emphasis on psychotherapy. Care for the chronic patient—which so often entails assistance with the ruder aspects of livelihood: money, work, food, housing—is viewed as an annoyance, a diverting of needed resources away "from other patients who could be helped."

We have here not an alternative to confinement but its latest embodiment: distributed rather than congregated, somewhat more visible, but no less segregative for that. Reviewing the practical consequences, as distinct from the rhetoric, of community-based care, a recent study concluded that "former patients are just as insulated from community attention and care as they were in the state hospital." It is the form, not the fact, of confinement which has changed.

Put bluntly, what community-based care has demonstrated is that one can, in fact, reap the same debilitating effects without the use of professional overseers. The tidings of stated policy are everywhere overturned by the substance of accomplishment. Deinstitutionalization is a tale told by a trickster, full of sound and promise, but signifying little that is new.

Why the Failure?

Andrew Scull's masterful study, Decarceration: Community Treatment of the Deviant—A Radical View, goes a long way towards explaining why. Closely documented and carefully argued, it is, I think, without parallel in the recent literature on psychiatric and penal institutions. Scull is an able and effective historian, a shrewd critic, and a clear, compelling writer. And he plies his trade well. The book's densely packed 160 pages include moments of anger, but it would be a strangely disembodied work without them. For the most part, he conducts his inquiry with admirable restraint—not easy to accomplish given the nature of the topic.
Scull sets out, he tells us immediately, to provide an alternative to the standard accounts of the origins of the decarceration movement in prisons and correctional institutions as well as in mental health policy. He means to do so through the use of "an historically informed macrosociological perspective on the interrelationship between deviance, control structures, and the nature of the wider social systems of which they are a part and an essential support" (p.11; unless otherwise noted, all page references are to the text). Here, at the outset, in the approach, is located the real advance of Scull's work: a way of contextualizing—historically and structurally—the origins and, given them, the necessary failure of the decarceration movement.

He proceeds in three stages. Part I begins with a sort of theoretic prologue, an attempt to place the inquiry within its proper bounds. Scull first argues the necessity of a macrosociological approach through a demonstration of the theoretic inadequacies of the "labeling" school of analysis. Failing to address the question of the origin of social power, the labeling perspective ultimately reduces to a depiction of social control as arbitrary. Obsessed with the fine-grained structure of the "deviant identity" and the rules of its formation, it ignores the ruder constraints of social and political order, to which such rules owe their operating limits.

What Scull is reaching for in these early pages, it seems to me, is a way of once again disenfranchising deviance, of saving it from too ready an understanding, of returning to it the threat it was robbed of once the pathos of the deviant displaced the fear of the defiant in the hearts and minds of sociologists everywhere. He means to reinvest deviance with the danger it must be seen to represent if the efforts of containing it are to make sense. Without the danger, "outsiders" and refusers are just so many curiosities; confinement a variant of the zoo.

Deinstitutionalization
is a tale told by a trickster, full of sound and promise, but signifying little that is new.

Segregative Control
It is an historically informed tack. Chapter 2 traces the development of the social control apparatus in England and the US in the late 18th and early 19th Centuries. Scull is particularly interested in the emergence of the asylum and prison as centralized and rationalized structures of "segregative control." Their valorization...
emergence in that office, he argues, is unintelligible apart from the simultaneous "growth of a capitalist market system and its impact on economic and social relationships" (p.24). Specifically, the growing role of the state, the sequestering of deviants apart from the community, and the subsequent concern to differentiate among the types of deviance, cannot be understood apart from the necessity of distinguishing, in a market economy, between the able and the disabled poor. Indiscriminant relief would cramp the invisible hand that otherwise smoothly distributes a mobile labor force to where it is most needed. It would remove the threat of starvation and mute the terror of unemployment, that were critical levers in controlling an at-best-recalcitrant workforce. Custody, furthermore, should teach by example: the "well-ordered asylum" of the 19th Century reproduced the routine and discipline of the workplace.

Fixed, centrally-administered structures of social control, Scull is arguing, are crucially of a piece with the emergence of a proletariat and growth of an interventionist state allied with the new capitalist order. From this perspective, if the prisons, reformatories and asylums of last century failed as rehabilitative centers, they succeeded as holding pens: "they remained a convenient way to get rid of inconvenient people" (p.33), consigning them to places where, as one contemporary British observer put it, "they are for the most part harmless because they are kept out of harm's way" (quoted on p. 33).

Control and Community

The third and fourth chapters lay out in some detail the dimensions of the decarceration movement in both the correctional and mental health establishments. The case of the latter we have already reviewed; that of the former, while somewhat murky in its specifics is nonetheless clear as to its scale and direction. A number of instructive examples are offered to illustrate the process.

Part II examines and refutes the two standard accounts of why decarceration is taking place: the advent of psychoactive drugs and the enlightened (if belated) realization, made possible by a spate of sociological studies, of the fundamentally antitherapeutic impact of "total institutions" on their inmates. Here, Scull's arguments, focused on the demise of the asylum, are worth considering in some detail.

With regard to the introduction of tranquilizing drugs, Scull notes that while the conventional account enjoys the twin virtues "of simplicity and of reinforcing the medical model of insanity" (.81), it is empirically flawed in two respects. First, it fails to square with the historical record. The new patterns of early release and selective admittance in both the US and England preceded the introduction of the drugs. At best, their effect was to further expedite an already existing policy. Nor, Scull goes on to note, will simple recourse to a new "technological fix" explain the sudden acceleration of the decline of American inpatient population from the mid-1960s on, when no such change occurred in England. Second, the claims of the therapeutic efficacy of such drugs have been greatly exaggerated, while mounting evidence of their deleterious side-effects has been ignored or slighted. One can therefore conclude that the function of such an explanation is primarily ideological, serving to bolster an invested pattern of control.

On the question of therapeutic efficacy, Scull's case is not as tight as it might be. He contends that recent studies demonstrate that phenothiazines (the most widely used class of heavy tranquilizers) offer only short-term benefits, render patients more susceptible to deterioration once released, and, in fact, increase the likelihood of re-admittance. The weight of evidence, it must be added, appears to be against him: a recent review of twenty-four well-controlled studies, many of which included chronic patients, found that without exception all showed a lower relapse rate among those receiving phenothia-
Scull relies so heavily, while it followed patients for up to three years, made no provisions for insuring that patients out of the hospital were regularly taking their assigned drugs. In addition, that study shows only that young, male, acute schizophrenics, at the onset of their first or (at most) second psychotic break, do better in the long run if treated without drugs. The authors are quite clear that this group "undoubtedly represents a minority of the schizophrenic population."18 More to the point, it is generally not this class of patients which has been most affected by the change in hospitalization policies.

With regard to the contribution of the critique of the asylum, however, Scull is on much firmer ground. The argument is twofold. First, he reviews the follow-up studies which have documented the deplorable state of the community facilities ex-patients are expected to rely upon. The basic lie is exposed clearly: mass hospital releases have never, in practice, depended upon the availability of appropriate aftercare facilities. Nor have the advantages of community-based care been subjected to careful study. It is a dismal story, as we have seen, and Scull tells it well.

It is the second piece of the analysis, though, which displays Scull's gifts at their best. It is an ingenious argument. Reviewing the history of the opposition to the asylum in the last century, Scull reveals remarkable parallels between the modern critique of the mental hospital and the 19th Century critique of the asylum. These early critics well appreciated the double irony of first assigning madness to a place whose circumstances encouraged the very behavior it was meant to correct, and then, of using the pathology so created to justify the asylum's own existence. Little advance is seen in the modern analysis. In fact, noting the power of the 19th century analysis—which stressed the isolation, torpor, artificiality and rigidity of institutional routine—Scull concludes: "It is difficult to see how, in its essentials,

The new patterns of early release and selective admittance in both the US and England preceded the introduction of drugs.

and with respect to either its intellectual cogency or its empirical support, the modern critique elaborated by Goffman and his coworkers is substantially superior" (p. 107). The notion that such criticism by itself constitutes sufficient cause for a reversal of confinement policy is clearly shown to be untenable.

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Warfare to Welfare

Part III concludes the argument, setting forth the alternative perspective that has informed his critical stance throughout. Against the backdrop of the failure of the 19th Century deinstitutionalization movement, Scull shows how the emergence of a new set of priorities—political and economic in nature—can be analyzed to yield a better account of the "success" of the deinstitutionalization effort in the present than either of the rival explanations. The strength of custodiality in the 19th Century was that it provided an effective means of disposing of "the most difficult and troublesome elements of the disreputable poor" (p. 128). Not that the mad themselves posed a threat. Rather, by insuring that the option of legitimate dependency was closed to all but the grossly incapacitated, the asylum kept sharp the "twin spurs of poverty and unemployment" (p. 129) needed to keep an unwilling labor force in harness. It served another function as well. By removing the burden of care from those least able to shoulder it, confinement neutralized a potential source of great discontent.

With the advent of the welfare state and the development of monopoly capitalism, all this changed. Labor was no longer an easily replaceable commodity; skilled labor embodied valuable capital. Legislation, designed in part to safeguard the health of such capital, was less likely to meet opposition from an enlightened capitalist class. Then, too, an increase in the level of the "social wage" in the form of welfare measures represented a far less costly alternative than did more militant forms of class struggle. In the disbursement of such concessions and the mediation of that struggle, the state has assumed an ever-expanding role.

Welfare expenditures, that is, represent both a social investment (directly or indirectly increasing the productivity of a given segment of labor) and a social expense (services rendered to insure social harmony and ward off potential discontent). The population served by such measures has continued to grow in recent years. At the same time, the productivity of the state sector has been unable to keep pace with that of the private sector, an imbalance which results in further costs to the state. The unionization of state employees and the ensuing agitation for wages competitive with those in the private sector places an additional strain on state budgets. In the state hospital system, for example, the introduction of an eight hour shift and forty hour week "virtually doubled unit costs." Under such circumstances, Scull notes, the continuation of an increasingly costly system of segregative control in the face of an apparently cheaper, certainly no more damaging, and possibly more effective alternative, makes very little sense. In a word, rising costs are the hidden variable in the deinstitutionalization debate. It is only in the context of such "structural pressures," Scull concludes, that such therapeutic innovations as the new drugs find their special uses, and that age-old criticisms of the asylum are seized upon as the humanitarian gloss of an essentially cost-effective strategy.

To the extent that such pressures continue or worsen, the argument goes, a policy of deinstitutionalization can be expected to persist, even as public resistance mounts and evidence of the failure of community care accumulates.

If a lesson emerges out of this study, it is an old one. Writing in the pages of the American Journal of Insanity in 1866, George Cook observed: "It is not well to sneer at political economy in its relations to the insane poor. Whether we think it right or not, the question of cost has determined and will continue to determine their fate for weal or woe" (quoted on p. 134). To which should perhaps be added another, older warning: "... all the world will be a hospital and all of us sick nurses tending each other." The words are Goethe's, writing nearly a century before Cook.

Oddly enough, community care is not taken as an antidote to the ever-growing medicalization of deviance or as confirmation of the essentially social nature of the problem.

A policy of deinstitutionalization can be expected to persist, even as public resistance mounts and evidence of the failure of community care accumulates.

Reforms Without Causes

The final irony of deinstitutionalization is an ideological one. In the rush to examine the question of care, in the flurry of activity surrounding the prospect of rehabilitation, the question of cause has been submerged. Nay, subverted. The upshot of a quarter century of
psychiatric epidemiology is that severe psychosis is decidedly a class-related phenomenon: lower class people consistently show higher rates of such disturbances. Rising costs are the hidden variable in the decarceration debate.

In the wake of the new treatment debate, that fact is likely to be lost. For, oddly enough, community care is not taken as an antidote to the ever-growing medicalization of deviance or as confirmation of the essentially social nature of the problem. Far from being a challenge to the medical model, that is, community care appears as the most recent testament to its essential correctness. Madness can be returned to the community because—like diabetes—it can be controlled there. And questions as to its origins become sadly beside the point.

—Kim Hopper

(Kim Hopper is a Teaching Fellow in Sociomedical Sciences at the Columbia School of Public Health. He wishes to thank Ellen Baxter for extensive help in researching background for this review.)

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10. Greenblatt and Glaster, op. cit.
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A benefit concert for the Mud Creek Health Project in Eastern Kentucky will be held in New York City in early December. The Mud Creek Health Project, a community-organized clinic run by and for poor people, has been hurt badly by recent cutbacks in the health care funds by the United Mine Workers and by governmental sources, and proceeds will go to keep the clinic open.

The benefit, entitled "Voices from the Mountains: An Evening With the Mud Creek Coal Miners," will feature a showing of "Harlan County, USA." Barbara Koppel, the filmmaker, and Eula Hall, clinic director, will speak and mountain musicians and singers and invited folk stars will perform. Information concerning date and location will be announced in the Village Voice or can be obtained by writing the Mud Creek Support Project, 332 W. 77th St., New York, N.Y. 10024. Contributions are tax-exempt.

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