No Golden Door
The Health Care and Non-Care of the Undocumented
To the Editor:

Per your March/April 1982 issue, here’s a preliminary survey report completed in November 1982 on the impact of budget cuts from United Community Services of Metropolitan Detroit.

(What follows is an edited version—ed.)

Surveys were sent to approximately 175 programs in Southeast Michigan known or believed to deliver health services to adolescents; 68 were returned, representing 48 out of 60 possible service area "cells," defined by 15 service categories in four geographic areas.

Almost nine out of ten respondents (60 out of 68) reported that they had reduced operating budgets in the past year in real dollars. Cuts in Federal funding were greatest in non-health categories, where the deep slashes in the CETA program, legal services, and social services reduced funding by 60 percent. By comparison, traditional health services for teens (family planning, VD control, pre-natal care) funded by the Federal government were cut by about 22 percent, corresponding to the average cuts made through the block grants. Michigan just barely maintained funding for mental health services from FY81 to FY82, but made reductions in health (five percent) and social services (18 percent).

The most common reaction (70 percent of all agencies) to budget cuts was to reduce staff either through layoffs or through attrition. Slightly more private than public agencies cut staff (72 percent vs. 64 percent). The next belt-tightening measure, indicated by 41 percent of respondents, was to reduce or eliminate money for staff development and training. Again this was more common among private agencies (47 percent) than public agencies (32 percent). Service reductions and less outreach and education were the next two commonly named responses, each in almost one third of the agencies.

Some service reductions were only in the amount offered. In other cases, entire programs were eliminated, such as the CETA funded school health workers program in Detroit; a short term counseling program in an Oakland agency; free birth control services for previously pregnant teens throughout the Detroit area; three maternal and child health centers in Wayne County, and an adolescent day treatment program.

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The scene is familiar. Entering a government office is a step into winter. The secretary's voice is cool as she says, "I'm sorry, X is busy now." "I have to see X," the visitor persists. "Do you have an appointment?" "Your telephone is out of order." "Ah," she agrees, adding, "I'm afraid he has a very heavy schedule."

"I have something for X," the visitor says, removing the fat envelope from a bag and putting it on her desk. The secretary takes it briskly but carefully; none of the cash falls out. "Since it is urgent. . ." she accedes with a sympathetic smile, rising and disappearing into the inner office. This baksheesh ritual is common enough in many parts of the world. We find it unfortunate, if not reprehensible. Bribes subvert equality. X is available to those who pay rather than to those who need. He inevitably begins to think of himself as someone who works for those who give him money more than for the public which pays what has become his base salary. If he has a conscience, X might argue with some justice that he needs the extra cash in order to survive or even to keep his job; there are many people, less competent and honest, who would be willing to put out substantial sums to win it.

Baksheesh is a violation of, a threat to, predictability. Is the bribe necessary? Is it sufficient? Is it treated with contempt or gratitude? None of these concerns can be assuaged with certainty.

Wresting order from the whims of nature and individuals was one of the greatest triumphs of the bourgeois revolution. You cannot run a complex economy efficiently without knowing that events will follow certain patterns. The sun must rise at an identifiable hour, the check clear in a requisite number of days, the bureaucracy issue the permit in a specified number of weeks.

This necessity was recognized in the United States as the economy reached maturity. It is exactly 100 years since the merit system was introduced in the civil service following the assassination of President Garfield by a disgruntled office-seeker. Killing the President can focus attention on an issue, but the need for predictability mandated the new system in any case.

Political Action Committees are letterhead baksheesh. Elected representatives have always been responsive to special interests, but the pressure of friends, associates, and the powerful is broad, an embrace; PAC contributions are a firm handshake.

Politicians are understandably reluctant to announce that they have sold their votes; the few known recent instances of lobbyists announcing purchase come in the form of "He said that, and I kicked him out of my office" anecdotes from the righteous and aggrieved recipients of the contributions. Still, no one takes the trouble to spread so much seed unless they expect to cultivate something or someone, and the universally agreed harvest is "access." Put crudely—it has been, not surprisingly, by a close friend and advisor of President Reagan, in this case Justin Dart—access means "Talking to politicians is fine, but with a little money they hear you better."

The term "little money" is not inaccurate, even though 3,149 PAC's spent a total of $83 million during the 1982 congressional campaign. The current Washington wisdom is that $500 almost always buys access; as little as $200 generally does. The value, however, may not be that a politician hears you better, but that he or she hears you at all.

Each member of Congress has sessions and committees to attend; offices to run; constituents to aid in personal matters; reporters to accommodate; dinners; caucuses; events back home; bills to read, write, and vote on; often a family which can only be ignored so long; and every two or six years a campaign with fundraising, speaking, handshaking, and responsiveness to questions on a multitude of issues.

In the House of Representatives public health legislation comes before the Subcommittee on Health and the Environment of the Energy and Commerce Committee. The amount of time that its 18 members can devote to health is limited by their other responsi-
sibilities on the committee and in general. The attention they can give to any legislation that comes before the subcommittee, or that they might initiate, is limited as well.

But for a lobbyist, there might well be one bill which is the focus of attention for the entire year, a bill which means millions of dollars for his or her employer. And this lobbyist, highly paid as an articulate, knowledgeable, persuasive advocate, has bought access.

If a piece of legislation is of particular concern to the pharmaceutical industry, its lobbyists would want to talk to Representative Edward R. Madigan, a member of the Health and Environment subcommittee. Those who contributed to his 1982 campaign include Ciba-Geigy ($1000), Abbott Laboratories ($750), Johnson & Johnson ($750), Smith Kline ($750), Eli Lilly ($500), Merck ($500), Richardson-Vicks ($500), Walgreen Co. ($500), Bristol Myers ($400), Hoffman-La Roche ($250), Pfizer ($250), Sandoz ($250), Schering-Plough ($250), G.D. Searle ($250), Sterling Drug ($250), and Upjohn ($250).

Conceivably all of these lobbyists could hire a bus and come to Representative Madigan's office together, but if the companies wanted to say the same thing at the same time they could have made their contributions through the Pharmaceutical Manufacturers Association PAC and saved themselves the considerable expense of hiring a lobbyist. Pfizer and Abbott may think there are nuances in their positions which must be heard separately from the Smith Kline presentation. They might also believe that after Representative Madigan has heard their cogent discussion of the issues 15 times he will not only be persuaded, he will be able to repeat the arguments forcefully in a committee as if they were his own.

Representative Madigan and his colleagues might well hear differing views. Some groups which have contributed would probably want to make their opinions known on this legislation even though it is not their most vital concern. In the case of Representative Madigan, other health-related PACs which have bought access include the American Health Care Association ($2,500), the Illinois State Medical Association ($2,250), the American Dental Association ($1,000), the American Hospital Association ($1,000), the American Podiatry Association ($1,000), the National Association of Casualty and Surety Agents ($800), Family Health Program, Inc. ($750), the Health Industry Manufacturers Association ($750), the National Association of Private Psychiatric Hospitals ($600), the Independent Insurance Agents of America ($500), the National Association of Life Underwriters ($500), the National Council of Health Centers ($500), the Prudential Insurance Company ($500), and the Surgical Trade Association ($500).

These groups don't always agree. The American Hospital Association and the American Medical Association were at odds this year on prospective payments to hospitals, for example. But while public expenditures for health care are expanding by billions of dollars annually these organizations have usually been able to find room for accommodations. This year the American Hospital Association presented an Honorary Member Award, "bestowed on persons who have made noteworthy contributions to the health care field," to Joe D. Miller, the first director of the AMA's political action committee.

The people whom not too many representatives have much time for are those who don't have the money to hire high-powered lobbyists and dole out a few hundred dollars to large numbers of candidates the way drug companies like Abbott did—it spread $89,000 among 192 candidates in the 1982 congressional elections—or the way the AMA did—it gave $1.68 million to 463 candidates. The people who might not be heard could be the very ones whose health and welfare are at stake. You and me, for example. So far, the only way of offsetting the financial weight of PAC's which the American system has come up with is establishing an oligarchy. According to Senator Alan Cranston (D-CA), at least 55 of the current members of the Senate are millionaires.

The rise of de facto oligarchy and the PAC's, troubling in themselves, are deeply ominous. The history of Athens in the fifth century B.C. shows dramatically how overextension in imperial adventures can shatter the most brilliant, prosperous, and powerful state.

On a more mundane level, a decade ago in the Koreagate scandal we were shaken to find that investing a few million dollars in the entertainment of food-, sex- and fun-starved congresspersons brought a return of hundreds of millions of dollars for some astute, well-connected, and corrupt South Koreans. continued to p. 24
Vital Signs

America on the Mend

Ronald Reagan came to Washington with a promise to root out Federal waste and fraud as firm as a matinee marshal’s pledge to clean up Dodge City. There have been problems, however.

For one, the President and his corporate posse have been surrounded—by disclosures of conflicts of interest, insider trading, influence peddling, extortion-scale consulting fees, violations of international law, astronomical decorating bills, and the use of public sector secretaries by an expert on the superiority of the private sector to prepare his book on the subject.

And now Sewergate has sloshed into town, soiling the President’s reputation, if not his boots.

But we’re not going to cower behind the bar waiting for this media ambush to end. We’re here to set the record straight by publicizing at least some of the profound progress conservatives have made in uncovering scandalous abuses of the commonwealth largely ignored by the Liberal Establishment Press Editor and Reporter (LEPER) cabal.

In a major victory for justice, efficiency, and the American Way, upon discovering two California cases in which children who murdered their parents managed to collect $29,500 between them in Social Security survivor benefits (as the saying goes, they threw themselves on the mercy of the court as orphans), the Department of Health and Human Services took swift action. Past administrations had foolishly issued regulations merely prohibiting anyone convicted of killing his or her parents from collecting survivor benefits, but in many states juveniles cannot be convicted of felonies. HHS has now closed this gaping loophole.

Moving from strength to strength, the Reagan team has been cutting off monthly checks from a still lower form of parasite, the legally dead. By comparing computer tapes of death records from the Veterans Administration, 11 states, and New York City with Social Security rolls, these watchdogs found 718 deceased individuals receiving checks among the 6.7 million individuals screened. The average post mortem overpayment was nearly $15,000.

Perhaps it is just as well that the LEPER cabal hasn’t picked up on this scandal, though, since almost 75 percent of the money the SSA has recovered has been in uncashed checks; in most cases the families duly reported the death, but clerical or computer errors kept the payments coming to their mailboxes. Furthermore, nearly ten percent of the supposedly deceased recipients have been found very much alive.

The Administration is not commenting on rumors that the names of the 90 percent which are in their graves were largely provided by the voter registries of the Cook County Democratic machine in Chicago.

One-upping the Administration, the Republican-controlled Senate Special Committee on Aging decided to go after living adults. Just as the President predicted, in examining the Medicare system they uncovered unreasonable costs, kickbacks, bribery, stock manipulation, unnecessary procedures, and overutilization. The only problem is, the chief culprit is not the elderly but the private sector pacemaker industry.

It seems manufacturers were charging three to five times their production costs to hospitals, which then marked the price up another 50 to 150 percent and passed the bills to Medicare and other insurers. Demand for pacemakers was kept at more than double the rate in any other Western nation by physicians wooed with kickbacks, stock options, expensive Las Vegas and Caribbean vacations, lucrative "consulting fees," goldplated shotguns, gold watches, and special "rebates." Pacemaker salespersons have been happy to assist at operations, train inexperienced physicians eager to get in on the action, and even teach doctors how to meet and manipulate Medicare guidelines. A dozen stellar sellers take in more than $1 million annually in commissions.

Medical Corpse

Not satisfied with their almost all volunteer (only the employees are drafted) Civilian-Military Contingency Hospital System, the Department continued to p. 26
continued from p. 2
program for mentally ill teens in Detroit.

Public agencies cited service reductions three times more than private agencies. This difference may be explained by the fifth most popular reaction to budget cuts: almost half of all private agencies report increased efforts to raise funds from private sources. Public agencies are prohibited from this activity, though some report stepped up grant writing for government funds.

Other coping methods include fee scale implementation or an increase in client fees (cited by one out of five agencies, public and private); a growing tendency to accept clients with health insurance or who can pay for treatment; and long waiting lists (one agency in six)."

An open-ended question on the survey asked if the respondent could cite examples of teenagers whose health or well-being was adversely affected by the results of governmental budget cuts. There were specific and general responses. Of the first type:

- "A male client age fifteen was recently shot by police during an alleged attempted murder. For several months, the worker and the family had been trying to have the teenager evaluated for the possibility of residential care. Because of a clinic no longer providing service and long waiting lists elsewhere, the evaluation process was delayed and the youth was shot."

- "Two babies died of Sudden Infant Death Syndrome. Their teen mothers had been counseled by Project Redirection, before this program ended. They might have known what to do to prevent such deaths if the service had not been cut.

Respondents expressed a general impression that teen pregnancy, suicidal youth, and the incidence of runaways had all increased. Says one worker in an adolescent pregnancy program, "Patients have expressed increasing anxiety regarding their ability to provide basic necessities for themselves and their children, i.e. food, shelter, clothing, and medical care. There has been an increase in withdrawal of family support in finances, so as to increase depression, family disruption, and psychological problems."

A worker in a rural counseling service agency reports that "Youth of (families affected by unemployment) are experiencing or have become victims of a variety of problems, i.e. substance abuse, domestic violence, child abuse, stress/anxiety, inadequate nutrition, and dislocation. Unfortunately services which in the past would have assisted those in need have also been drastically cut or eliminated."

Nevertheless, three of every four agencies responding to the survey predicted that the quantity of health or human services for adolescents will increase or stay the same in 1982. How do the respondents expect to serve more clients with fewer resources?

Many of the private agencies expect to succeed in their fundraising campaigns. Theoretically these private funds will replace lost public revenues. But one would have to determine on a case by case basis if the private dollars are supporting the same services or new programs. It would also be interesting to know if these funds are expected to be stable after the next year or so.

Predictions of increased service levels in the face of budget cuts may also be explained by plans to increase staff caseloads to accommodate the anticipated high demand for services. This could be accomplished by reducing outreach or follow-up care, devoting less time per client, or otherwise streamlining service. Some would call this "cutting the "fat" in the system. Conversely, agencies could strive to maintain the same intensity and range of services by increasing worker productivity. The result may be increased staff "burnout" and stress.

One of the first sets of services to be deleted in budget-cutting times is outreach, education, and counselling services. As the survey showed, one third of the agencies have taken this step, which frees up time for the community outreach and liaison person to deliver direct service. This trend is disheartening since outreach and education are often the only prevention-oriented services available in a community, particularly when a school district does not offer health education classes. Though agencies may be making very pragmatic decisions to provide treatment rather than prevention services in times of increased demand for care, the result may be increased prevalence and costs of more severe illness in the long run.

Debra Lipson
Director, Adolescent Health Project
United Community Services
Detroit, Michigan
Aiming to be Number One, and getting there, is as American as Horatio Alger. Underdogs trying harder may win hearts at the Saturday matinee or in Avis commercials, but second-best does not impress Wall Street. The ticker tape, of course, does not register ethics or quality, and getting to the winner's circle may mean bending or breaking the rules.

Once upon a time 'ethical' manufacturers may have held themselves to higher standards since patients' lives depended upon the quality of their products, but such scruples seem to have disappeared with snake oil and patent medicines. Despite much rhetoric and advertising to the contrary, the industry today hews as closely to the bottom line as any other. And the price is paid by patients and consumers.

Few companies fit this model better than American Hospital Supply Corporation. Just a decade ago American stood a humble sixth in what was once called the "no technology" business of distributing hospital and medical supplies, left in the dust of Brunswick, Whitaker's General Medical Corporation, and Searle's Will Ross, Inc.

However American's sales climbed from $510 million in 1970 to $2.9 billion in 1981, capturing the hallowed Number One position with a 20 percent share of the chaotic and fragmented hospital supply market. Net income has grown an average of 16 percent a year, and stock analysts predict 20 percent annual growth in earnings-per-share for the next five years. Its ten percent pre-tax profit margins are four times the industry average. American currently distributes 120,000 health care products and services to 7,000 hospitals around the world, everything from surgeon's masks and latex gloves to TV rentals for hospital patients.

According to Fortune, this rags-to-riches story was accomplished "with an aggressive high-tech marketing drive that has propelled hospital-supply purchasing and inventory control into the 20th century."

The only problem is, what American did to become Number One is illegal.

American Hospital Supply was founded in 1922 by Foster G. McGaw. Its growth and profits have made McGaw a philanthropist worth $75 million whose name now adorns both the fieldhouse and the medical center of Northwestern University.

When McGaw began, most hospital equipment was owned by private physicians, and supply salesmen stopped by their client hospitals twice a year on cross-country treks. Salesmen literally wrote their own orders.

Under McGaw's leadership American began to manufacture the supplies it sold; he reasoned that offering exclusive products would boost profits and distinguish American from its rivals. Acquisitions of small companies soon followed—and they haven't stopped since.

In 1966 American bought Edwards Labora-

Hal Strelnick teaches in the Residency Pro-
gram in Social Medicine at Montefiore Hospi-
tal in the Bronx and is a member of the Health/PAC Board.
tories in Irvine, California, the developers of the first successful artificial heart valve and to this day the leader in the field. Edwards keeps American in the high profit, high-tech market with such new products as its widely used intracardiac catheter that measures blood flow and pressure inside the heart and sometimes obviates the need for surgery. As in many high-tech fields, inexpensive Asian labor is a key component. Edwards has capitalized on the recent influx of Vietnamese refugees in Southern California, hiring many for the fine needlework required for stitching Teflon to pig heart valves, the most common implanted today. Of the 50,000 heart valves implanted annually, two-thirds are Edwards made, and only American sells them. American refuses to let its rivals distribute Edwards catheters or heart valves.

These and the 28,000 other products American makes account for more than 40 percent of its sales and more than half of its profits. American boasts that it can sell a hospital 60 percent of all the items it needs, from plastic syringes to plastic intraocular lenses. In addition, other acquisitions enable American to offer a wide variety of operating services, including pre-architectural planning, equipment leasing, data processing, and housekeeping.

American's real push toward industry leadership began in 1970 when McGaw appointed Karl Bays as president. The then-36-year-old former Marine took a couple of large individual hospitals. In 1979 American signed its biggest contract—more than twice the size of any to date—with Voluntary Hospitals of America (VHA), a consortium of 29 prestigious, non-profit hospitals in 22 states, including Baylor University Medical Center in Houston and Henry Ford Hospital in Detroit. VHA is a for-profit corporation, founded in 1977 to provide its members management services, economies of scale, and political clout. Their contract called for "competitive" prices, specified ceilings on price increases, and rebates based upon the hospitals' annual per-bed purchases. American was to be shown competitors' prices so it could "match" them or "walk away" from low profit business. Both sides referred to the arrangement as a "partnership" for cost-containment, which VHA extended to other major suppliers. Administrators and purchasing agents unsettled by this transformation of the traditional adversarial relations between buyer and seller were told in writing by American that their com-
pliance "boils down to a matter of trust." 

Sales or Marketing Management magazine honored American for signing VHA with its Distinguished "Winner's Circle" Award for "winning new customers by making a major change in industry buying patterns." 

These new patterns had a few flaws. For one, no hospital could qualify for a rebate unless all the hospitals achieved their quotas; Tallahassee Memorial's rebate depended upon purchasing by Riverside Methodist Hospital in Columbus, Ohio, creating a collective pressure to "buy American." At one VHA board meeting the American group marketing president, who attended all their meetings to "scoreboard" their progress and keep the pressure on, told the hospitals' chief executive officers, "Some of you have joined the church but still haven't gotten religion!" To meet its quota, Henry Ford Hospital knowingly bought faulty needles and miscalibrated syringes from American's Pharmaseal division but did not use them on patients. In three years, VHA hospitals quadrupled their purchases from American.

Although the contract called for "competitive" prices, American pushed its rebates, price caps, and consulting as the major sources of savings. In fact, American could not boast of low prices because on many standard items its prices were not only uncompetitive, they were outrageous. A Becton-Dickinson surgical clip that some distributors sell for a penny was sold by American for as much as $6.55. Yet when ordering supplies on the American ASAP computer terminal, no prices appear at all* so the purchaser does not necessarily realize the costs. With this little trick, accord-
According to a study by a Wall Street brokerage house, American improved its profit margin from one to three percent because "prices are not even actively considered by the purchaser at the moment the order is placed." In the fall of 1979 four tiny local hospital supply distributors decided to fight back. They filed a six-count anti-trust suit against American, citing the VHA members as conspirators but not defendants. American's defense, as summarized in its post-trial brief, was that it had "not done anything that is 'wrong' or predatory or even controversial. (It) is in the business of selling hospital supplies for a profit. It wanted to sell more. ... It is what salesmen do for a living." In other words, this was business as usual.

In April 1982 after 81 days, 43 witnesses, and 15,000 pages of testimony, District Judge Douglas W. Hillman in Grand Rapids, Michigan, found American guilty of restraint of trade, anti-competitive practices, and attempts to monopolize the market in seven Midwestern cities. He enjoined the corporation from enforcing its VHA contract in those cities and awarded treble damages of $430,600. Hillman noted that VHA and American had agreed to work to "preclude formal bidding" by American's competitors, to disclose competitor's bids so American could match them and assume new VHA business, and to standardize along American's product specifications. According to Michigan State's Martin, a specialist in industrial organization who advised the plaintiff's attorney and testified at the trial, the court's ruling "accepted the argument that the VHA-American contract interfered with price competition by obscuring prices at the point of purchase . . ., so that in its ideal form, price is not even considered when an item is purchased."

As for cost-containment, economies of scale, and rebates, the hospitals seem to be left holding the bag. After one hospital bought more than $3 million in supplies from American in 1981, it received a measly $13,000 rebate (about 0.4 percent), the largest American has yet to pay. When VHA and American announced the savings of their "partnership," Charleston Area Medical Center (CAMC) in Western Virginia was shown to have saved $1.2 million that its purchasing agent, Robert Dietz, is still waiting for American to explain. Before the VHA contract Dietz "had no complaints" about American's competitor, one of the suit's plaintiffs, while American had several serious backorder problems. CAMC increased its American orders 3000 percent. At Christ Hospital in Cincinnati, American's prices usually were well beyond its bidding range, but the VHA contract led them to shift $500,000 worth of business to American. Miami Valley Hospital in Dayton, Ohio, and Norton Children's Hospital in Louisville began giving business to American without allowing their existing suppliers to rebid—despite American's previous poor service to each.

As for American's consulting on materials-management, this consisted of having the VHA Materials Management Committee junket to American plants in California and Illinois and recommend standardization exclusively for American products. According to economist Martin, American consultants almost invariably recommended that American take complete charge of the hospital's purchasing, "letting the fox into the chicken coop."

American has renegotiated the VHA contract but is appealing the decision in Cincinnati's Sixth Circuit Court. President Bays told the New York Times, "We don't believe we have lost any business as a result of the suit." Legal hurdles, however, are nothing new for American. In 1974 the Federal Trade Commission subpoenaed American records in an anti-trust probe into its "acquisition and trade practices" that was dropped four years later. In 1975 American had to recall ten million bottles of intravenous fluids when some were found contaminated with mold in its Georgia production plant.
This adversity at home may have spurred American to expand its research and development in its high-tech Edwards division and to invest in its international and export divisions. Its international operations, both manufacturing and distribution, have grown exponentially from $10 million a year in 1966 to $410 million last year, contributing 18 percent of total earnings and yielding a 16 percent return on investment.

Of course, not all growth is earned by honest competition. In 1976 the Security and Exchange Commission (SEC) accused American of covering up $4.6 million in payoffs involving the construction of King Faisal Specialty Hospital in Saudi Arabia and in 1978 of $1.3 million paid to associates of South Korean President Park in return for the contract to build Seoul National University Hospital. Since 1976 the company has been under a Federal court injunction to take steps against these payments and ones in Mexico and two other countries, as well.

**Other Companies, Same Policies**

While it has often been observed that preserving a fortune does not require the questionable practices used to amass it, even blue chip corporations seem unable to shake the habits developed on their way to the top. Venerable, established blue chips also get caught with their hands in the cookie jar.

Number One in the production of health care products has not been disputed in many years—Johnson & Johnson rang up almost $5 billion in sales in 1980, more than twice the gross of American Hospital Supply.

In July 1981 a Federal jury in Minneapolis found Johnson & Johnson guilty of fraud in acquiring an electronic painkilling device in order to suppress it and keep it from reaching the market to compete with its best-selling painkiller Tylenol. According to Judge Miles Lord of the U.S. District Court, the evidence indicated that Johnson & Johnson had engaged in fraud of "the most extreme and culpable nature." 13

In 1970 two employees of Medtronic, a leading pacemaker manufacturer, developed a method for electrically stimulating the skin that relieved and sometimes cured debilitating chronic pain. They called their invention a "transcutaneous electrical nerve stimulator" and in 1971 set up their own company, Stimulation Technology, Inc., known as Stimtech. Sales of their product reached $1 million in 1974, and Stimtech remained the market leader despite competition from the Japanese and other American firms.

Seeking more capital for research to decrease the cost and size of their device, the inventors accepted Johnson & Johnson's offer to buy Stimtech out for $1.3 million. They were promised a share of up to $7 million in future profits, a Johnson & Johnson label, and active international marketing. Instead, the acquisition produced only headaches—the device lost money, the inventors were dismissed from their new positions and Johnson & Johnson refused to sell Stimtech back to them even though it was losing money.

In May 1979, the inventors sued Johnson & Johnson for breach of contract and for fraudulently buying their device to suppress it. Two years later a Federal jury found in favor of the inventors and ordered Johnson & Johnson to pay $170.4 million in damages and anti-trust fines. Meanwhile, Stimtech’s sales reached $5.3 million in 1979, but since the suit was initiated both by the Dow-Corning Corporation and the 3M Corporation have marketed competing devices—with a price and size about a third of Stimtech’s.

While the nerve stimulator was giving Johnson & Johnson stress upsets, executives at Hoffman-LaRoche, the Number One producer of vitamins and tranquilizers, were probably reaching for their best-selling Valium or Librium over their own legal problems.

In 1974 the European Economic Community brought charges against Roche for abusing its dominant position in the vitamin mar-
### Medical Industry Dishoner Role

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<thead>
<tr>
<th>Firm Name</th>
<th>Year</th>
<th>Illegal Practice</th>
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<tbody>
<tr>
<td>Abbott</td>
<td>1971</td>
<td>60 count indictment reduced to single count of conspiracy for 3.4 million bottles of contaminated intravenous solution. Plead nolo contendre and paid $1,000 fine.</td>
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<td></td>
<td>1982</td>
<td>among several American firms charged by Dutch government with &quot;price fixing.&quot;</td>
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<tr>
<td>Airco, Inc.</td>
<td>1982</td>
<td>$3 million in punitive damages assessed for respirator marketed 8 years when known to be defective with &quot;reckless regard for the consequences.&quot;</td>
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<td>American Cyanamid</td>
<td>1974</td>
<td>price fixing (dyes); nolo plea.</td>
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<tr>
<td></td>
<td>1981</td>
<td>settled suits for international price fixing of antibiotics with governments of West Germany, India, Columbia and the Philippines.</td>
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<td>Bristol-Myers</td>
<td>1979</td>
<td>FTC administrative law judge found advertising for Bufferin and Excedrin misrepresentative.</td>
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<td></td>
<td>1981</td>
<td>settled ten year suit with Justice Department for fraudulently procuring the patent for the antibiotic ampicillin.</td>
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<td></td>
<td>1982</td>
<td>among American firms settling in an international antibiotic price fixing suit (see American Cyanamid).</td>
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<td></td>
<td>1982</td>
<td>among American firms charged by Dutch government with price fixing.</td>
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<td>Dupont</td>
<td>1974</td>
<td>price fixing (dyes); nolo plea.</td>
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<td>Lilly</td>
<td>1979</td>
<td>defendant in more than 95 product liability suits for DES-related problems.</td>
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<tr>
<td>Litton</td>
<td>1974</td>
<td>price fixing (paper labels)—trial conviction.</td>
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<td>3M</td>
<td>1973</td>
<td>illegal campaign contributions—company and chairman pleaded guilty.</td>
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<td></td>
<td>1975</td>
<td>SEC consent decree for $643,000 illegal political slush fund.</td>
</tr>
<tr>
<td></td>
<td>1979</td>
<td>defendant in sex discrimination suit brought by NOW</td>
</tr>
<tr>
<td>McDonnell-Douglas</td>
<td>1979</td>
<td>indicted by Justice Department for fraud and conspiracy in Pakistani bribery scheme.</td>
</tr>
<tr>
<td>Merck</td>
<td>1974-82</td>
<td>defendant in more than 350 product liability suits for DES-related problems.</td>
</tr>
</tbody>
</table>

The case was based largely on documents leaked by one of its own executives, whom Roche had arrested for industrial espionage in Switzerland in 1975. In 1976 Roche was found guilty of breaking the Common Market’s laws of commerce and fined $390,000. In 1979 the European Court of Justice upheld the conviction on appeal but reduced the fine to $260,000.
<table>
<thead>
<tr>
<th>Firm Name</th>
<th>Year</th>
<th>Illegal Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pfizer</td>
<td>1968</td>
<td>patent fraud (with American Cyanamid) in obtaining tetracycline patent; price fixing (with American Cyanamid &amp; Bristol Myers) of antibiotics.</td>
</tr>
<tr>
<td></td>
<td>1981</td>
<td>settled international price fixing suit (see American Cyanamid).</td>
</tr>
<tr>
<td></td>
<td>1982</td>
<td>among American firms charged with price fixing by the Dutch government.</td>
</tr>
<tr>
<td>Richardson-Merrell (now Dow-Merrell)</td>
<td></td>
<td>Admitted falsifying data required by the FDA and $80,000; nolo plea.</td>
</tr>
<tr>
<td>Schering Plough</td>
<td>1979</td>
<td>defendant in more than 20 DES-related product liability suits.</td>
</tr>
<tr>
<td>Smith Kline</td>
<td>1981</td>
<td>Justice Department investigation for illegal delays in reporting adverse reactions to the anti-hypertensive medication, Selacryn, later withdrawn from the market.</td>
</tr>
<tr>
<td></td>
<td>1982</td>
<td>defendant in more than 50 Selacryn-related product liability suits.</td>
</tr>
<tr>
<td>Squibb</td>
<td>1981</td>
<td>settled international price fixing suit (with American Cyanamid, Bristol-Myers, Pfizer, and Upjohn).</td>
</tr>
<tr>
<td>Sterling Drug</td>
<td>1978</td>
<td>SEC violations for inadequate financial disclosures to stock holders.</td>
</tr>
<tr>
<td></td>
<td>1980</td>
<td>defendant in patent infringement suit.</td>
</tr>
<tr>
<td>Upjohn</td>
<td>1981</td>
<td>settled international price fixing suit.</td>
</tr>
<tr>
<td>Warner-Lambert</td>
<td>1978</td>
<td>Supreme Court upheld FTC's order to include $10 million of disclaimers for their cold treatment products.</td>
</tr>
<tr>
<td></td>
<td>1979</td>
<td>convicted of reckless manslaughter and criminally negligent homicide in magnesium stearate-related factory explosion.</td>
</tr>
</tbody>
</table>


Hospital Corporation of American, the Number One proprietary hospital chain, has also run into legal problems. In August 1982 HCA was charged by the FTC with anti-trust violations in Chattanooga, Tennessee, where it had acquired hospitals through takeovers of two other chains in 1981. The case is awaiting trial.

It might be argued that being Number One leads to undue scrutiny by regulatory agen-
cies and the courts, unsympathetic treatment by juries, and nuisance suits by disgruntled employees. However, as the accompanying table indicates, a sizeable proportion of the 'ethical' pharmaceutical and medical supply industry has already been caught on the wrong side of the law. Despite lax enforcement of anti-trust laws and token prosecution of white collar criminals, corporate convictions still run from patent fraud to political fraud in maintaining illegal slush funds.

The health care industry, unfortunately, is not unique. A 1980 Fortune study of 1,043 major corporations found 11 percent convicted of bribery, fraud, tax evasion, illegal political contributions, and/or criminal anti-trust violations. This remarkable figure actually excluded civil anti-trust suits (like American’s), FTC complaints, and undetected criminal or corrupt practices. According to Stanley Sporkin, the SEC’s enforcement director, corrupt corporate practices derive from the "bottom-line philosophy. . . . Where people are not lining their own pockets, you can only explain corporate crime in terms of 'produce or perish.'" This "philosophy" obviously infects the products and business practices of the manufacturers and distributors of drugs and medical equipment upon which patients all over the world rely. Irwin Ross, author of the Fortune study and no radical, concluded, "Simple economic incentives explain most illegal behavior: corruption seems to pay. . . ."

Consumers and patients ultimately pay for such practices—in higher prices and defective products—while the corporations defend their profits and themselves as American Hospital Supply did, justifying their actions by arguing that this is just "what salesmen do for a living."

Ha J Strelnick

(Acknowledgements: Special assistance in preparing this article was provided by Health/PAC interns Dana Hughes, Ellen Kolter, and Steve Meister, made available through the Health Science Research Training Program of the New York City Department of Health.)

Footnotes

6. Ibid.
11. Ibid.
12. Ibid.
No Golden Door
The Health Care and Non-Care of the Undocumented
by Sally Guttmacher

An estimated 3.5 million to six million workers and their families are living in the United States with little, if any, recognized right to health care. These people are, in fact, denied the full range of social and economic rights, with the justification that they have violated our immigration laws by working here without the necessary legal papers. Not only is this situation contrary to the U.N. Charter of Basic Human Rights, but it would seem contrary to our self-interest since many of us come into intimate contact with these workers as restaurant staff, house cleaners, and babysitters.

The common image of undocumented workers is men and women slipping across the Rio Grande to enjoy higher pay in jobs which rightly belong to American citizens. Reality, however, is more complicated. Most of these people come to the U.S. as victims of the world economy; in many cases it would be fair to say that they are already participants in the U.S. economy before they leave home.

Although the impact of U.S. interests abroad is complex and much debated there is little doubt that the policies of U.S. multinationals can ultimately compel people to migrate. To cite one stark example, when American agribusiness corporations purchase local land, peasants may be forced to leave for urban centers already flooded by unemployed refugees from the countryside. Corporations, certainly, say the real culprit for massive unemployment is government policies. The local government often ping pongs the blame back. Meanwhile the problem grows year by year.

To the hungry, the U.S. may not appear to be the land of milk and honey, but at least it offers the hope of steady pay at wages far above what they could expect to find at home. Word of the opportunities comes not only from friends and kin who have already found their way, but from recruiters who actively seek out and transport workers eager to enter the United States despite the risk of being discovered without proper documents. This recruitment is at least tacitly supported by many agricultural and industrial employers because the workers brought in accept low pay and poor conditions and the chances that the Immigration and Naturalization Service will seize and deport them are relatively low.

This system also serves broader economic interests. It generates antagonisms and fears which impede unionization and other forms of organizing, and makes it possible to deny a significant segment of the workforce social welfare and health services without a politically awkward formal decision to exclude people indisputably in need. It is difficult for the undocumented to protest.

The United States is not alone in employing foreign workers; all the Western European nations do (if we include Italy, where the migrants are actually Italians from the impoverished south). As in the U.S., many labor economists argue that these workers are doing jobs which the native workforce considers too ill-paid or unpleasant. Closer examination, however, suggests that in each country policies respond to political pressures from particular industries and to more gen-

Sally Guttmacher is an assistant professor in the Department of Urban Studies at Rutgers-Newark; an adjunct assistant professor at the School of Public Health, Columbia; and a member of the Health/PAC Board.
eral wage and employment considerations.

Whatever the variations within Europe, the "guest workers," as they are commonly called there, can expect treatment sharply different from what their counterparts in the U.S. receive. In Europe, the rate of immigration is strictly controlled. The status of the immigrants is explicitly defined; often they are guaranteed significant legal protection and social services. All residents, including non-citizens, have access to health care through the national health services.

In the U.S., the flow of labor is not regulated. Despite lip service to the idea that immigration should be carefully controlled and occasional publicity campaigns and round-ups, the borders remain unsealed. The status of these migrants is at best marginally defined by law—aside from regulations governing immigration and providing for deportation. Federal, state, and local governments all deny responsibility for the health care of undocumented patients. Those who cannot pay for private care find themselves at the mercy of local practices and the whim of individual administrators and functionaries.

If anything, the situation is deteriorating. Although the Federal government, as the source of immigration law, would seem to be the most appropriate agency for dealing with immigrant problems, the current Administration is unlikely to do anything other than pass the problem to the states. Given their rapidly rising Medicaid expenditures and depleted resources, it is hardly surprising that they have not been enthusiastic about taking on an additional health care burden. Local governments are reducing the little they have offered, citing Federal cuts and their shrinking tax base.

The rise in the number of undocumented workers from Central and South America and the Caribbean is a direct result of the intensification of economic and political pressures in those areas. If INS apprehensions of the undocumented are any guide, immigration from our neighbors to the South began to jump sharply after the new immigration legislation was passed in 1965. This legislation drastically changed the composition of the immigrant labor force to the U.S.. Prior to that time, quotas for each nationally established in the 1920's greatly favored the British and Northern Europeans. The new system set limits in various immigrant categories, but no longer favored specific nationalities to the same extent. New immigrants did have to prove that they had a specific offer of employment at the prevailing wage rate before they could obtain a visa, but with the easing of national restrictions, poor and working class Latin Americans began to outnumber the better off European migrants. As the flow of legal immigrants increased from Latin American countries, so did the flow of the undocumented, who were now able to hide and be sheltered in sizable compatriot communities.

Exactly how many people have chosen to circumvent the U.S. immigration system is difficult to determine, partly because of the variety of migration patterns that have developed. These patterns are related to type of employment, the expense of travel, and the ease of crossing the border without being picked up by the INS. Some cross the U.S.-Mexican border daily, others several times a year. Thousands of Mexicans immigrate seasonally, following the harvest from crop to crop in the Southwest and then returning home when the season is over. Some West Indians and people from the Spanish-speaking Caribbean do the same on the East Coast. Other immigrants who are unable to travel back and forth frequently due to the expense or to the political situation may stay here for years at a time. Manufacturing, for example, often provides more permanent employment in a single location than does agricultural work. Thus, Caribbeans or Chinese who migrate to New York seeking work in the garment industry may essentially settle in a community of compatriots.

These different patterns as well as social class origins and whether or not the workers are accompanied by their families can be expected to affect health status and health needs. In general, by virtue of their conditions of living and working, migrants—and illegal immigrants especially—risk ill health more than non-migrants of comparable age and other personal characteristics. Among the negative factors are low income, poor occupational safety and health conditions, poor diet, unfamiliarity with health services, and stresses generated by living in a strange and sometimes hostile environment. Not the least of their problems is the constant fear of being reported, detained, and ultimately expelled. This in turn exacerbates stress, compels them to tolerate over-priced, crowded, substandard housing, and makes them reluctant to complain about working conditions. It also may
"They don't suffer; they can't even speak English.

Immigrant coal workers eventually won shorter hours, higher wages and union recognition, setting precedents for organized labor. Today, a new underclass struggles for economic justice: working women who on the average earn only 59 cents for every dollar a man makes.

Pay Equity. Another step toward justice.

Service Employees International Union, AFL-CIO, CIC = 9to5, National Association of Working Women
deter them from seeking out those public health services to which they may be entitled, such as pre- and post-natal care. These problems may partially explain the resurgence of tuberculosis, an infectious disease which had been thought no longer a threat, in major metropolitan areas such as New York City. Serious dental problems, hearing loss, and other disorders easily preventable through adequate screening programs and prophylactic care are also endemic among the children of migrant workers. Diabetes, hypertension, and other chronic diseases afflict migrant farmworkers disproportionately. Many also suffer the affects of pesticide poisoning.

The peculiar context of the lives of undocumented workers generates stress with its negative consequences not only among undocumented workers themselves, but also in their families and others intimately connected with them. According to the Archdiocese of Brooklyn, N.Y., there is a disturbingly high amount of domestic violence in households of undocumented workers, commonly resulting in a high incidence of child abuse and battering. Relatively high frequencies of emotional disorders have also been noted. These are probably caused in part by the pressures of daily living in the "host" country, but may also stem from a sense of failure or rejection by the mother country where the workers have been unable to sustain themselves and their family. Children of undocumented workers who grow up in the U.S. may not face the same variety of infectious and parasitic disease as their migrant parents were exposed to, but as they reach adolescence they must learn to deal with drugs, violence, and other dangers that fall heavily on those living in impoverished conditions in the United States. And they must often cope on their own. Migrants generally have limited access, at best, to effective informal familial or community support structures.

There are numerous reasons why it is very difficult to develop reliable health statistics about people residing here illegally. With the exception of government income maintenance or public assistance programs, citizenship papers are not necessary to receive services. Health or social service agencies rarely require them. Estimates of family utilization are difficult to obtain because of the variation in the status of different family members; frequently parents who are undocumented have children born here, who are automatically U.S. citizens. Another big gap in the available information is the extent to which undocumented workers rely upon private physicians whom they pay in cash. It is reasonable to suppose that people here illegally would prefer to use private practitioners, who are less likely than institutions to turn their patients in to the INS.

Although it is impossible to have full confidence in the accuracy of any facts about the use of health services by undocumented workers and their families, some rough conclusions can be formulated.

Although there may be substantial socio-economic and sex differences in the demographic profile of workers who migrate to the Southwest U.S., chiefly from Mexico, as compared to those who come to the Northeast from the Caribbean and Central America, most migrant workers tend to be young adults between 15 and 44. In general, people in this age range tend to be light consumers of health services, except for maternity care.

Attempts have been made at some more specific estimates. According to one researcher who examined the use of health services by six groups of undocumented workers apprehended by immigration authorities between 1976 and 1978, roughly one quarter to one half used hospital or clinic services while in the United States. This level of usage is high given the relatively short time that many of the people had been in the country.

Statistics complied by the Los Angeles County Department of Health in 1980-81 suggesting that the unreimbursed costs for inpatient care for the undocumented amounted to $103.3 million were used by the American Hospital Association to argue that the undocumented contribute to the financial shortfalls of hospitals in certain regions. This approach of blaming migrants for overloads in social programs is common, but not necessarily justified. Los Angeles County also reports that only 40 percent of hospital charges to undocumented indigents are never paid. Furthermore, the study mentioned above found that about two fifths of the undocumented workers apprehended between 1976 and 1978 had had hospitalization insurance premiums deducted from their wages. Unless they are paid "off the books," all undocumented workers pay Federal, state, and Social Security taxes; and like everyone else all pay sales, excise, and gasoline taxes.
New York City has an undocumented population estimated at between 400,000 and one million. It is thought that the largest single group is from the Dominican Republic, on the assumption of proportionality between registered and unregistered aliens—New York City Department of City Planning data for 1980 indicate that there are 88,350 registered aliens of Dominican origin; Chinese, numbering 44,443, are the second largest group.\(^9\)

Even though many of these people are not subjected to the extreme conditions found in some agricultural situations, theirs are bad enough. One of the industries in New York which has attracted a large proportion of Hispanic and Chinese women workers is garment manufacturing. As companies have escaped union labor by fleeing to the South or the Third World, they have been replaced by sweat shops reminiscent of those found in New York City at the turn of the century. These shops typically have a life-span measured in months. They close before they can be detected or inspected by OSHA or other authorities who might fine them for being poorly lit, crowded, and badly ventilated. Franz Leichter, a state legislator from New York City, has reported that the women who work in these shops are commonly paid around $15 for an eight hour day.\(^10\) At a conference on the situation of undocumented workers in New York City held in May 1982, a machine operator who worked in such shops reported that with the recent cuts in public funding for daycare, many women had no choice but to bring their small children with them to work.

Garment piece work done at home, a system common in Third World countries, is re-emerging in the U.S. and other industrialized Western countries. This is even more poorly paid than work in the sweat shops, and sometimes involves small children directly in the work process. There is little doubt that this system increases the probability of injury at home, especially for children; accidents were already the leading cause of morbidity and mortality for U.S. children, and are particularly high for those who live in poverty.

According to an official report issued in 1982, since 1978 newly reported cases of tuberculosis in the city have risen by 21 percent. The increase in TB among very young children is particularly worrisome, a jump of 112.5 percent for children under five.\(^11\) According to the report this can be attributed in part to the influx of immigrants from countries in the Caribbean, Central and South America, and Asia, where TB is common. City officials fear the public health problems will grow even worse, since the undocumented try to avoid contact with public authorities. In addition to the problems associated with delay in seeking care, they are concerned about the dangers of having a substantial number of
cases which go undetected. They fear many of them will go unmonitored by public health authorities because private physicians treating undocumented workers do not want to expose their patients to possible deportation by reporting positive TB results to the Department of Health.

Eligibility for Health Services

New York has a relatively progressive policy toward the undocumented and has historically had a fairly broad network of social services available to the poor and needy regardless of citizenship status. Undocumented workers are, however, at significant disadvantage and their vulnerability is heightened by the cutbacks in public services. Hospitals and other institutions are under heavy financial pressure to diminish non-paying case-loads. Many facilities important to the well-being of the uninsured working poor—hospitals and clinics, day-care centers, legal aid offices, and more—are required to provide emergency care to anyone who needs it, including the undocumented, but this does not actually guarantee that individuals who appear at an emergency room for treatment will actually be cared for. Emergency care partly depends on the willingness of hospital staff to designate a case as an emergency, and staffs of different facilities differ in the degree to which they limit access. For example, although the law requiring emergency treatment applies to all hospitals, there is an understanding that the publically funded hospitals have a stronger obligation than either the voluntary or proprietary hospitals. It also appears that this obligation may be felt more or less strongly at various municipal institutions. It has been reported, for example, that Bellevue was routinely turning the names of suspected undocumented patients over to the INS.

A further deterrent to use of hospital emergency services is the forms promising guarantee of payment, which patients or their families are usually required to sign at the time of admission. It is not uncommon for people to interpret these forms as signifying that treatment will be withheld until paid for. In fact, any hospital that has been supported by Federal Hill-Burton money—and most large institutions have been—is required to treat emergency cases before it establishes the patient’s ability to pay. However, not many immigrant workers know enough about the peculiarities of our health care system to enquire about Hill-Burton funding when they are brought to the hospital admitting room.

In addition to these obstacles, foreign migrants confront state administrators who have frequently been known to say that only United States citizens and legal permanent residents are eligible for Medicaid. This is not quite accurate. Courts have ruled that many foreign migrants without permanent resident status—the technical phrase is "otherwise permanently residing in the U.S. under color of law"—have certain entitlements. People in this group as well as those in a number of entitlement categories such as Public Assistance Recipients Under Home Relief or Aid to Families with Dependent Children (AFDC) would be Medicaid eligible under New York law.

The problem is, the meaning of these designations is subject to varying interpretations. The U.S. Department of Health and Human Services has interpreted the category of aliens eligible for Medicaid very narrowly to include only those who have been granted indefinite voluntary departure status or indefinite stays of deportation; those who arrived in the United States before June 30, 1948; and refugees who have been granted conditional entrance to the

Health/PAC Bulletin
United States. New York City, on the other hand, defines "Immigrants Living in the United States Under Color of Law" as all aliens who reside in this country with the knowledge and acquiescence of the Immigration and Naturalization Service. This would presumably include all individuals who are awaiting legal determination of their right to remain in the United States.

The City of New York’s Health and Hospital Corporation estimates that it lost about $57.5 million in fiscal 1982 because the Federal Government and New York State refused to cover the cost of services provided to undocumented workers and their families. Concern about this loss of Medicaid reimbursement is the primary reason that New York City is currently suing the Secretary of Health and Human Services as well as the Acting Commissioner of the New York State Department of Social Services for Medicaid coverage of undocumented aliens.

The city maintains that the Medicaid eligibility requirement promulgated by the Secretary of Health and Human Services, which states that only citizens, legal aliens or Aliens in the United States Under Color of Law are entitled to Medicaid coverage, is in conflict with the Social Security Act, which explicitly does not exclude aliens from the Medicaid program. The city is also arguing that the eligibility requirement which excludes medically needy persons from the Medicaid program solely because of their status as aliens is in conflict with the express purpose of the Medicaid program, which is to aid those individuals whose incomes are insufficient to meet the cost of necessary health care.

The irony is that if New York City wins, this victory could have negative long-term implications for some of the undocumented, as shall be explained below.

These attempts and pressures to limit the availability of publicly funded health care mean that foreign migrants who wish to assert their eligibility are likely to require a legal advocate who will argue their case in court. Needless to say, this option is unavailable to all but a handful, especially after the cuts in legal services to the poor.

Spurred by concern about the high proportion of non-whites among the current wave of migrants, about unemployment among United States citizens, and by fear that the deterioration of the international economy will lead to a totally uncontrollable flood of aliens, as well as by humane considerations, the Government appears on the verge of passing new immigration legislation. The expressed goal of this legislation is to stem the tide of illegal immigration. An implicit intent is to increase the employment opportunities of U.S. citizens who, some argue, must compete with undocumented workers in the labor market.

During the first two weeks in April both the House and Senate immigration subcommittees completed markup of the Immigration Reform and Control Act of 1983. On May 18th it was passed in the Senate. Passage in the House is expected in the next few months. The Act is basically a reintroduction of the immigration bill sponsored by Senator Alan Simpson (R-WY) and Congressman Romano Mazzoli (D-KY) which failed to pass in the House of Representatives during the lame-duck session of the 1982 Congress.

Although the Senate and House versions of the bill differ to some extent, both retain the three major provisions of last year's—sanctions against employers who knowingly hire undocumented workers; a legalization or am-
nesty system to cover all undocumented workers and their families who arrived in the U.S. before a specified date; and a continuation of the H-2 program for the employment of temporary agricultural workers.

Employer Sanctions

Employers who knowingly hire an undocumented worker will be liable for penalties of $1000 to $3000 per offense. In the House version, employers of four or more workers will be required to verify the resident status of their employees. Documents such as a U.S. passport, social security card, birth certificate, driver's license, or alien identification card must be presented to the employer to satisfy this requirement.

Critics of this aspect of the bill such as the American Civil Liberties Union, argue that employer sanctions pose a threat to civil liberties. Members of the Hispanic community, which would be a permanent target in any crackdown because of the large number of recent immigrants from Latin America and the Caribbean, have been quick to point out that since there would be limited resources for enforcement, the bill may actually encourage discrimination or even blackmail along racial and ethnic lines. Employers may simply refuse to accept as valid the documents of those they wish to avoid hiring.

The new legislation may also allow employers to take advantage of workers who are uncertain of their immigrant status.

The 1982 Senate bill totally barred Federal assistance for the undocumented. The House version of the 1982 bill, however, contained provision for limited medical disability assistance to legalized aliens who are determined by the Attorney General and the Secretary of Health and Human Services to require medical assistance in the interest of public health, or because of serious illness or injury; or to require assistance of some kind because of age, blindness or disability. The 1982 version also had a provision that each state can determine the eligibility status of aliens for state funded financial or medical programs as long as it remains consistent with Federal program restrictions. It is likely that the current version will have similar wording.

Although the proposed immigration reform
would ease the situation of those undocumented workers who are legalized, it would increase the difficulties of those who out of fear of rejection or for some other reason do not apply for amnesty, or who have arrived in the U.S. after the period designated by the legislation. Under the new bill these latter categories are likely to be large. This is problematic, because analysis of the less restrictive amnesty programs in Canada, Great Britain and France during the 1970’s has indicated that for an amnesty to succeed its terms must be attractive and non-threatening enough to encourage most of the undocumented community to register.

Finally, even if the employer sanctions and legalization were effective in stemming the tide of illegal immigration, another part of the bill would permit the continued hiring of temporary (H-2) agricultural workers. In the Senate version of the bill growers would not be penalized for hiring undocumented laborers for at least the next three years to give them a chance to adjust their hiring to the new immigration law. This policy is aimed at insuring agricultural employers that their source of cheap labor will not abruptly be cut off. History has proved, however, that many migrants who enter as temporary workers choose to join the ranks of the more permanent undocumented by remaining in the host country after their temporary work permit has expired.

Even though the diverse interests of groups concerned with the problem of illegal immigration have not been reconciled, and even though in reality there is no conceivable way to seal the U.S. border against the flow of migrants, it looks as if we are about to get a new immigration law.

If cynical, we might argue that the new bill is mostly window dressing, intended to allay the fears of a general public concerned about rising unemployment and increasing competition for jobs. But this legislation may also serve a more important function. Although it won't stop the flow of migrants to the U.S., it will help to control them while they are here. Those who choose to apply for amnesty will be subject to governmental control as well as employer intimidation, a new underclass of residents without full rights. Fearful of jeopardizing their immigrant status, they will be difficult to organize into unions. Those who choose to exist outside the legal mainstream will constitute a new marginalized subculture of laborers and employers. Any attempt to organize or unionize these "outlaw" workers may in itself constitute a criminal act. Their needs could legitimately go unrecognized, their rights unattended.

Many critics question whether at a time of economic crisis the government is willing to provide the substantial additional resources needed to enforce the new law. They note that blaming rising unemployment and increasing competition for entry-level jobs on an influx of migrant workers is a well-worn strategy for dividing workers. Since one of the major concerns dominating U.S. immigration policy is a desire to remain competitive on world markets, one might suspect that it is not by chance that the pending legislation would codify and create strata likely to be docile and willing to accept low wages.

However miserable and degrading their conditions in the United States, foreign workers will continue to come by the millions as long as hope for a better life back home dries up, as Langston Hughes put it. Like a raisin in the sun. To deny health and welfare services to these people—men, women, and children who are at exceptionally high risk by virtue of
their living and working conditions—is a denial of human rights conferred by birth, not citizenship.21

Notes

7. Dallek, Geraldine, op. cit.
8. Arnold, Fred, op. cit.
12. Dallek, Geraldine, op. cit.
13. For a more complete discussion of legal access of undocumented workers to health services in New York City, see "Undocumented Workers in New York—Legal Access to Health Care", memo, Nov. 4, 1982 by Janet Calvo, Director, New York University Law Clinic.
18. Calvo, Janet, op. cit.

continued from p. 4

The PAC’s are perfectly legal and their contributions generally go for the slightly more reputable purpose of spattering campaign spots on the air. Future generations, nevertheless, are likely to find it pathetic that while tens of millions of Americans are deprived of health care by financial constraints, political contributions by a relatively few health care corporations and professional groups play the predominant role in determining how tens of billions of public health dollars are spent.

Jon Steinberg

Readers who would like to know exactly where specific health PAC’s fas opposed to Health/PAC) contributed money can drop us a line; we’ll be happy to share our detailed information obtained from the Federal Elections Commission. •
Legal First Aid

Readers of the *Health/PAC Bulletin* will certainly be interested in the facts contained in each issue of the *Health Advocate*, newsletter of the National Healt Law Program. Subscriptions are $15 a year, payable to NHeLP, 2639 S. La Cienega Blvd., Los Angeles, CA 90034.

WIOES Whys

The Western Institute for Occupational and Environmental Sciences produces books, pamphlets, fact sheets, tapes, and audio-visual materials on subjects ranging from "A Worker's Guide to the Federal Employees Compensation System" to "PCB V to "Allergic Disorders." For a literature list write WIOES, 2520 Mil via Street, Berkeley, CA 94704.

Whole Health Catalogue

The 1983 Guide to Health-Oriented Periodicals is now available, listing everything from the *Health/PAC Bulletin* to publications on raw foods and spiritual health. Each entry includes a brief description of the publication. Copies of the Guide are $3.95 plus $1 postage from Sproutletter Publications, P.O, Box 60, Ashland, OR 97520.

Canadian Propaganda

Free information on acid rain, long range transport of air pollutants (LRTAP), and health is available from the Information Directorate, Health and Welfare Canada, Ottawa, KIA OK9, Canada. Ask for copies of the brochure "Acid Rain, LRTAP, and Your Health" and/or the booklet "Acid Rain and Your Health." What's In The Wind, a 17-minute videotape, is available on loan.

Toujour Gai

The producers of "Before Stonewall," a public television-funded documentary on the U.S. lesbian and gay male community prior to 1970, are looking for photographs, home movies, tapes* art, letters, etc, for possible inclusion. They ask that you write and tell them what you have but do not send original material. AH responses will be kept strictly confidential. Contact them at Before Stonewall, 630 Ninth Ave., Suite 908, New York, NY 10036, or Mass Productions, 110 First St, San Francisco, CA 94105/

Ayuda

Despite tremendous advances—popular health campaigns, virtual elimination of polio and measles, massive vaccination programs, construction of clinics—Nicaraguan officials readily admit that there is much to be done. Their work and popular health is suffering acutely from U.S. economic, military, and political pressures. Resources, from small items like thermometers and gloves to technical equipment, are urgently needed.

Two American medical students, Jim Krieger and Jan Diamond, recently completed a study tour for the World Health Organization and collected an extensive list of materials needed in the hospitals and clinics. In addition, they report that the Nicaraguan government is very eager to arrange lecture tours for M,D/s and professors in technical fields such as respiratory therapy.

For further information, contact Jim Krieger, 131 Belvedere St, San Francisco, CA 94117, (415) 753-0475; or Richard Garfield, 910 Riverside Drive, New York, NY 10032, (212) 927-1921.

Let Them Eat Poison

*For Export Only: Pills and Pesticides*, a two-part film series dealing with the export of products banned in the VS. to the Third World, is available from Icarus Films. Part I deals with Pesticides, Part II with pills. Each is 56 minutes and rents for $100. Write Icarus at 200 Park Avenue South, Suite 1319, New York, NY 10003.
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of Defense has launched a new offensive to sign doctors up for the fastest-growing practice in the country—the U.S. Armed Forces.

The Air Force approach is subtle. First the doctor receives a set of golf balls anonymously in the mail. Next the postal carrier brings an anonymous set of tennis balls. Then comes a full color brochure with the pitch—you’ll have more leisure time with the Boys in Blue.

The Army and Navy have a more preemptory approach. Undeterred by the failure of the Equal Rights Amendment, they have begun a drive to revive the old "doctor draft" but this time with the inclusion of registration (and therefore potentially draft) of women physicians, nurses, physical therapists, pharmacists, podiatrists, veterinarians, and "any other ancillary or technical" health care workers between the ages of 18 and 46. Lt. Col. Tom Schumann, director of health manpower at the Pentagon, explained to columnist Ellen Goodman of the Boston Globe that "It's just a need. When you consider that many of the health-care occupations are composed primarily of females, you're not going to get the numbers you need if you can't go after the females." The DoD has already brought proposals to the American Medical Association and the American Nurses Association to obtain their support.

We anticipate that not to be outdone by its earthbound competitors the Air Force may soon add another mailing to its series: a draft notification letter accompanied by dog tags, I.D. bracelet, and radiation detector.

**Caseload Victory**

As readers of the Bulletin (Volume 13, No. 6) will recall, the Visiting Nurses Association of Cleveland strike was particularly significant because the primary issue was the nurses' attempt to gain control over caseload, which has traditionally been a management prerogative.

After maintaining their strike for six months while management refused to negotiate, the nurses won a contract which they unanimously accepted. Although it does not stipulate a specified caseload ceiling as they demanded, the nurses regard the settlement as a victory. Caseload is now covered in the grievance procedure and objective standards have been established for determining how heavy it should be. Nurse complaints about excessive loads still must go up through management, but provision is made for an outside arbitrator if there is no satisfactory resolution.

Structural changes have already been made at VNA to ease workloads, including installation of dictaphones for the nurses and efforts to make clinical supervisors more responsive to field nurses. Management has promised to hire more staff, including central intake personnel to facilitate referrals.

Why VNA offered a reasonable settlement after months of refusing to negotiate at all is unclear. One possibility is that it feared its reputation would be irreparably harmed by the nursing shortages and inadequacies of many nurses brought in during the strike.

After the six month strike only 13 of the 44 nurses who had originally walked out reclaimed their jobs; tensions and bitterness are reported between them and the RN's who did not join them. The strikers' Ohio Nurses Association still represents the agency, and they are trying hard to win their colleagues over soon since a recertification election could be called as early as this summer.

**Health Tacks**

Members of Congress seem to get as much pleasure from marking up the U.S. Tax Code as adolescents do from putting their imprint on a public toilet, but the results are considerably less benign. In 1982 1,846 new deductions, credits, and exclusions were proposed to expand loopholes already allowing an estimated $253.5 billion to escape the Treasury every year.

As taxpayers know, the main beneficiaries of recent changes in the tax structure are the rich; when the regressive Social Security tax increase is taken into account, many lower-income people are actually paying more taxes than ever.

This broader redistributionist policy applies in taxes related to health care. The new limits on personal medical deductions and the Reagan Administration's proposed tax exemption ceiling on employment-related health insurance contributions are well publicized. Some proposed new treats for the wealthy, however, have received less attention.

Representative Phillip Crane (R-IL) has gone beyond the dictum of "You can't take it with you," to propose that "At least we'll make sure the government doesn't get it." His legislation would give a special $25,000 deduction on final income tax and on estate tax for deceased persons who donate an organ for transplant.

Crane argues that if his write-off is adopted, livers, bladders, and other organs will soon be piling up in the donor banks at 26
The humorist S.J. Perelman once wrote that every few years he decided it was time to allow wild Mongolian horses to drag him to the dentist. Many others who make it on their own eagerly snap up the two year old copies of Time and Reader’s Digest in the waiting room, hoping their remarkable resemblance to quivering jello will pass unnoticed.

Although almost one tenth of the population has never graced a dental chair, such reactions do not arise from fear of the unknown. By age 65, one half of the population chews its potatoes with teeth first placed in the mouth by the firm fingers of a dentist. In 1977 it was estimated that by age 15 the average adolescent has 11 decayed, missing, or filled teeth.

The anxiety, the sense of vulnerability, and the power relationships inherent in the examination and manipulation of our bodily orifices by some-one outside a peer relationship are a fascinating topic. We won’t discuss it here. The next two columns will be limited to teeth, the mouth, dentistry, and dentists.

The dental profession tells us that many problems associated with teeth are preventable through regular dental care. Even dentists, however, agree that as far as caries are concerned, the elimination of sugar from the diet and fluoridation of water are probably the most effective preventive efforts.

To their credit, dentists have long practiced preventive care through educating their patients about the dangers of sugar and the need to brush and floss effectively as well as by providing dental hygiene services. In this respect they are different from physicians, who have traditionally been less concerned with prevention and education than with invasive, curative approaches.

Dentistry as a profession differs from medicine in other ways as well, although many people believe that the educational requirements are equally rigorous. Unlike medicine, for example, it remains a generalists’ profession, although there has been an increasing trend towards specialization over the past decade. As in medicine, specialists are required to complete at least two years of training beyond the basic four year course. The specialty areas include:

- Periodontics, which concentrates on treating gum disease and related tissue diseases with deep curettage and surgery.
- Endodontics is treatment of
- Disease affecting the inside of the tooth, pulp, and nerves.
- Root canal work is one example.
- Orthodontics takes care of teeth that are out of position and other oral defects. Children with braces know such specialists all too well.
- Pedodontics is a general dentistry for children.
- Oral Surgery is concerned with extraction. While many generalists do simple extraction, complicated or extensive surgery will most likely be referred to a specialist. Oral surgeons have more experience with inhaled and intravenous anesthesia, and therefore are deemed better able to avoid or treat any anesthetic complications.
- Oral Pathology involves diagnosis and treatment of diseases of the oral cavity, including malignancies.

With the exceptions of oral pathology work and orthodontics, most generalists can probably do much of what the specialist can. Whether they do it as well is a matter of debate within the profession. There is evidence in medical literature that greater experience and exposure to cases and procedures often produces better results.

The whole subject of quality control in dentistry is murky. As many patients will attest, it is difficult to know whether you are receiving good care or bad until you suffer from the latter. Because most dentists are in solo practice even if they share an office, there is little opportunity for concurrent peer review. Judgements on performance usually occur only when the patient becomes dissatisfied and visits another practitioner. Any bad-mouthing of a predecessor’s work at that point doesn’t improve the physical condition of the patient; in any case the new den-

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**Body English**
tist's bias is difficult to measure.

There is strong evidence that dentistry could benefit from quality assessment and assurance. A 1974 survey showed that one half of all dental x-rays submitted to Pennsylvania Blue Shield were unsatisfactory for diagnostic purposes. Other studies have outlined additional areas of poor quality dentistry that could benefit from quality control. Since dental care, like medical care, is largely elective and very seldom life-saving, the potential for abuse looms large. Under our current fee-for-service system a dentist’s income, like a physician’s, is based on the number of procedures done, so there is an incentive to do more than is required rather than less.

Only a handful of states attempt to compensate for the lack of quality assurance and peer review opportunities by requiring continuing education for relicensure. In another handful of states, dental societies require continuing education as a condition of membership. However this may be lip service: there is scant evidence that continuing education alone improves quality.

Many authors have written guidelines to help consumers pick a dentist who offers the appropriate high quality care. A list of negative practices may provide the easiest method for spotting the poor, inappropriate dental care which should be a signal to seek another practitioner. The following are some of the most easily recognized dental flaws:

- Does not provide emergency care.
- Does not take a complete dental and medical history, including medications being used, if any.
- Does not do a complete examination of the oral cavity, both visually and with fingers.
- Does not use a probe to explore and examine your gums.
- Does not provide instruction in good preventive care, particularly brushing and flossing techniques.
- Does not discuss treatment plans and fees in advance.
- Does not use a lead apron when taking x-rays to shield reproductive organs and does full mouth x-rays frequently (see the Body English column in the May/June 1982 Bulletin for a more detailed discussion of this.)
- Does not have the necessary equipment to treat you for an allergic reaction to anesthesia.
- Does not appear to realize your mind is in the same head as your teeth and mouth. The practitioner should answer all your questions, fully describe the treatment plan, and discuss the pros and cons of options based on your individual needs, resources, and preferences.

No list can be complete, nor can it assure quality care. Choosing a good dentist is not an easy task and will most likely involve some trial and error. Many of the above practices can be checked during a first visit. If your judgement is that the care you are getting is not what it should be, or unnecessary, it's time to change dentists.

Because the number of practitioners is growing much faster than the number of patients, the laws of supply and demand work in the consumer's favor giving you some control over both quality and costs.

Although more people probably have dental coverage today than a decade ago, fluoridation and other measures have reduced the amount of dental diseases requiring treatment. Traditionally, general dentistry practitioners have gotten most of their gold from filling cavities; today it is not uncommon for young people to remain virtually decay-free if they have been drinking fluoridated water all their lives, followed some basic dietary rules, and brushed and flossed regularly.

Gum disease is currently the biggest threat to tooth loss, and many of the known preventive efforts for problems related to it or dental caries are matters of individual behavior—diet, dental hygiene—rather than professional care.

Like motherhood and apple pie, the wholesomeness of the semiannual dental checkup is now in question. The only scientific study of the dental checkup, described in Lancet in 1977, concluded that there was no demonstrable benefit for patients who came in twice a year as compared to those who had less frequent checkups. The authors say that dental caries in adults take two years to progress to the point of penetrating tooth enamel, and this should be the major factor in setting standards for examination frequency.

They did agree that those who had twice yearly dental examinations had slightly less tooth loss than those who went less frequently, but pointed out that in the latter group 50 percent of the dental caries left untreated remineralized by themselves, and people who visit more often run a higher risk of overtreatment, greater x-ray exposure, and thinner wallets. Since adolescence is the most active caries period, the Lancet study concluded that a 12-year-old who comes in twice a year will have had less caries than one who goes every other year.

Medical sociologist Irving Zola had spent a lifetime thinking about illness and health. Yet as a husband, father, counselor, teacher, and writer, he went about his business as if the braces and cane he had carried since adolescence as a result of polio and an auto accident were no more a part of him than the car he drove.

Then, during a 1972 sabbatical from Brandeis University at the Netherlands Institute of Preventive Medicine, he spent a week at Het Dorp. Specially designed and self-contained, but not a medical institution, Het Dorp was a community in which 400 disabled adults resided, worked, and played.

Rather than just observe, Zola placed himself in a wheelchair. What could have been an anthropological exercise became a rite of passage. Zola rediscovered his disability and began another rehabilitation with the help of the Dorp's residents.

Missing Pieces is the account of this turning point in his life, blending personal confession with social observation to create a success story with a new message: If we overcome our weaknesses by denying, we diminish ourselves and others; by recognizing weaknesses, we lay the cornerstone of a new integrity.

That it took ten years for this story to be published is evidence that Zola and Het Dorp were ahead of their time. It was only after many friends had read the manuscript that he decided to submit it for publication. The list of publishers which rejected it is long. Zola persevered. His concern seems to have been not so much "Can society be reformed?" as "Can the reader be rehabilitated?"

When he first arrives at Het Dorp, Zola feels it's too good to be true. Among its innovations are giving residents the ability and the room to move—90 percent use wheelchairs—and providing attendants who are always on call to carry out the residents' instructions.

He fears that residents will see through his act, but once in a wheelchair he finds that he has become handicapped in new ways. He has chosen sides; the staff is suddenly no longer available for interviews. Shopping at the supermarket, opening and closing doors, getting dressed, and visiting become tests of the assumed identity. "Washing up was a mess," he relates, "Though the sink was low enough I nevertheless managed to soak myself thoroughly. . . My body angle in a wheelchair was different. . . splashing with water was out, and the use of a damp washcloth, what I had once called a 'sponge-bath,' was in. Again a patient-childlike feeling swept over me, but I was too busy coping to let it stay."

Mastering the chair gradually, he learns the symbolism of (im-) mobility, how much we rely on images of the body to describe the spirit's condition. There is nothing good about being disabled, Zola believes, even if "being of sound mind and body" isn't all it's cracked up to be.

He is all the more able to interpret the deeper stigmata of disability because Het Dorp has eliminated so many physical signs and obstacles—attendants' white coats, architectural barriers, prohibitions on various kinds of work and play. At the Recreation Room, the Equipment Adaptation Room, the sheltered Workplace, the Administration, the Gala celebration, and the Council meeting, Zola discovers, as one of his chapter titles says, "It all depends on whether you stand or sit."

As he also becomes aware, the Administrative still regards the community's rights as privileges and treats residents as dependents. A pecking order within the community is no less problematical. More than by class differences, the community is divided by the distinction between disability and disease. Although one requirement for membership is medical stability, about 40 percent of the residents have progressive conditions such as multiple sclerosis. Because the Administration asks people to leave when their condition deteriorates, the fear of exclusion is acted out in prejudice directed against the less healthy by the healthier.

Are these sour grapes simply the natural taste of an academic? Perhaps that could be argued if the rest of the author's body were not engaged in the affair. Zola becomes a critical booster of the Dorp because the members he meets hold this perspective.

With their physical needs met for the first time, Het Dorp^
residents must begin to undo a lifetime’s socialization. Even there, as Missing Pieces shows, they have to be exemplary students to survive—in fact, a disabled person can be defined as someone who does not take learning for granted.

We have labelled this capacity to learn through overcoming a "handicap." For most of us rehabilitation is too painful to think about, let alone to experience. Even Zola in this "socio-autobiography," as he calls it, borrows the form of Utopian narratives in which the brave new world sheds light on the old. Although the residents claim him as one of their own, Zola clings to the view of a "normal" outsider. In choosing his subjects, he not unwittingly finds people who are self-sufficient as he is. Whether they have paraplegia or multiple sclerosis, most are active enough in and outside the community to excite mutual envy and admiration.

In his conclusion, Zola speculated about such missing pieces as sexuality, anger, vulnerability, and potentiality. He shows why social barriers are more destructive than architectural ones; why the personal and the physical are political. This is such a "political" book that the word is hardly used or needed.

It is all the more striking, therefore, that Zola ignores the work of the grassroots movement of disabled people of which he is a member. Since the early 1970's this movement has grown on a mixture of civil rights and self reliance. How can an American sociologist write about Het Dorp without mentioning the centers of independent living in the U.S.? How can a founder of the Boston Self-Help Center not include illustrations from his own organization's files? The appeal to self-interest—sooner or later we will all be disabled—may raise the reader's consciousness, but minimizing the efforts of disabled folks to change matters risks trivializing any political action on their behalf.

This missing piece in an otherwise fine chronicle may remind readers of the Health/PAC Bulletin that in 15 years of publication we have supported the right to health care of almost every other minority but have virtually ignored the conditions of the group that is almost synonymous with the consumption of illness in our society, the physically disabled.

This is not merely a lapse, it is a problem. As Missing Pieces suggests, if we cannot rehabilitate ourselves we will never be able to prevent disease in others; it will always seem easier to bury mistakes than to confront and eliminate them.

Carl BJumenthal

(Carl Blumenthal has worked for the Massachusetts Multiple Sclerosis Society and is a member of the Health/PAC Board).

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a rate of 10,000 a year. He predicts the savings would be substantial, including at least some of the $3 billion Medicare spends each year on kidney dialysis.

What Crane doesn't mention is that under his plan the value of a pound of flesh would vary considerably. Since how much deductions are worth depends on the tax bracket, the wealthy would gain far more from donating a posthumous cornea than would those who pay little tax or the two thirds who do not itemize deductions at all.

Only estates valued at more than $275,000 are now taxed, so no one but heirs of the rich would derive any benefit from the second $25,000 write-off. Perhaps a kidney fed on pate de fois gras and caviar is more valuable, but we'd like to see the scientific data.

Representative Frank Guarini (D-NJ) has contributed something for the wealthy while they are still alive—at least for those who work. He attached an amendment to the gasoline bill that sailed through Congress last year which restores the deductions for conventions aboard American-owned cruise ships. For the first time since 1980 doctors will be able to enjoy their Continuing Medical Education credits and their sun all the more, knowing they are publicly subsidized.

So far only four vessels qualify—two Mississippi steamboats and two Hawaiian cruise ships—but President Reagan's Caribbean Basin Initiative would extend the deductible conventions to include any in the Caribbean (except in Cuba and Nicaragua), including those on ships stopping there.

If this proposal goes through, course material for health professional cruises would be easy to find. For starters, we suggest "Sunburn, Sunstroke, and Sun Oil Depletion Allowances"; "Portal Hypertension and Port-of-Call Portfolios"; and "Tropical Medicine and Tropical Tax Havens."
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The month interval between examinations might be best for ages 12-16, and 18 months for those above 16. Many dentists, it should be said, believe this is too seldom, basing their conclusions on their own practical experience. Hopefully further scientific studies will resolve the issue.

The etiology of dental deterioration (both caries and gum disease) is believed to be closely linked with the way we live—principally the way we eat.

What we know as a cavity is the result of progressively destructive infectious dental caries. The bacterial organisms responsible for the damage are locally concentrated on a specific site in the form of what is known as bacterial plaque, a kind of gooey layer that adheres to the surface of the teeth. In the presence of sucrose, glucose, and fructose (all forms of sugar), a fermentation process occurs. This leads to a drop in pH, the concentration of hydrogen ions, which is more commonly known as acidization.

Repeated cycles of this process cause demineralization and development of the so-called "carious lesion." Beginning in 1960, researchers, notably P.H. (no relation to pH) Keys, established that a bacterium known as streptococcus mutans may be the prime culprit. Other bacteria have also been implicated, lactobacillus acidophilus and various actinomycetes. Irving D. Mandell, DDS, notes that the human mouth is a virtual paradise for s. mutans: warm, moist, and "replete with a profusion of gourmet foods to dine upon." His portrait of the epidemiology of dental caries is remarkably similar to descriptions of the other major diseases thought to have a dietary connection.

Caries was in evidence even before the Iron Age, although it has been found in less than five percent of the teeth from that era examined. Through the Roman era and later the incidence stayed around ten percent. Towards the end of the 17th century, however, a dramatic increase began in the industrialized world. The only break in this steady rise occurred during World War II, when European countries experienced a marked drop. Epidemiological studies of caries in the 1950's and 1960's which compared industrialized nations with less developed areas of the world found caries was much more common in the more prosperous countries, what might be called the Candybelt. More recently researchers have found that as nations have industrialized and adopted Western diets (that is, eating habits, not Beverly Hills), caries incidence has risen.

Many epidemiologists have concluded that this pattern points the way to a noncariogenic diet, consisting of the following:

1. A relatively low exposure to sucrose, fructose, and glucose.
2. A lot of fibrous foods. These promote vigorous chewing, stimulate salivation, and have a natural "toothbrush-like effect."
3. Eating foods with "protective factors" such as trace minerals and other ingredients not clearly identified as yet.

In contrast, the cariogenic diet which became widespread toward the end of the 17th century contains large quantities of refined flour and sucrose. The latter was consumed in the form of sugarcane products, then flooding the market at moderate prices. Thus it could be said that there was a strong connection between slavery and the rise of tooth decay.

By the twentieth century sugar consumption had soared to an average of 125 pounds per year per person in the U.S., roughly the equivalent of eating five jellybeans every waking hour. Much of this is in the form of sucrose or corn syrup, both used to sweeten everything from ketchup to frozen egg rolls. It would be fair to assume that sugar is the first ingredient listed on more than half the prepackaged food containers in any kitchen cabinet.

Although few people would say only diabetics should avoid 125 pound sugar cubes, most experts believe that the pattern, form, and frequency of sugar ingestion are the most important factors in producing caries.

Although it is reasonably clear that the so-called "mechanical" variations—fluoridation, good brushing and flossing techniques frequently performed—as well as dietary modifications can reduce susceptibility or increase resistance to caries, we still don't know why some people will develop them and others with similar habits will not. Nevertheless, anyone with teeth is lengthening the odds of keeping them by following a diet low in sugar and high in natural, coarse grains and practicing good plaque control in oral hygiene.

The next Body English column will complete our writings on dentistry. (Obviously oral problems should be heard, and we invite our listeners in New York City to listen to the Body English program on WBAI every fourth Thursday of the month at 3 p.m.) The final column will discuss current controversies in treatment of gum disease; concerns about the adverse effects of excess expo...
sure to fluorides and mercury; and what's new in dental techniques.

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