Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the Health/PAC Bulletin and the books Prognosis Negative and The American Health Empire, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a “medical-industrial complex" which has yet to provide decent, affordable care.

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Never Say Never

The 1988 election campaign offers the prospect of getting the vital issue of universal access to health services before the electorate, and Health/PAC has been doing its part to generate discussion— and energy—around the campaign for a national health program.

As we all know, we’ve never had a greater need for a unified, publicly accountable health system which provides comprehensive services to everyone within our borders. There is less agreement, however, over the form a national program should take and the strategies needed to propel it past the dense barriers confronting a rational system of health care in this country.

Last June, Health/PAC and the New York University School of Law organized a conference in New York City that brought together some 200 students, scholars, health workers, trade unionists, and senior health activists. The conference, called “Rethinking a National Health Program in the Post-Reagan Era,” featured papers, discussions and debate (and even some booing and hissing). In this, and future issues, we offer a sampling of some of the ideas and strategies that emerged.

First, a few flashbacks. Debates over creating a system of national health insurance, as opposed to a national health service, abounded in the 1960’s and early 1970’s. By the mid-70’s a variety of health-insurance proposals had been put forth in Congress, including the Delum’s national health-service bill. Many health-policy analysts believed that some national scheme would soon become law. By the late 1970’s, however, the debate had become muted, and by the 1980’s it was hardly a whisper.

The effects of the Reagan-led march up the mountain of free enterprise in the last eight years has made protecting even the shameful status quo compelling. Many public health advocates struck a defensive pose as prior gains in expanding access to medical care faded from view, as did federal commitments to programs of public, family, environmental and occupational health. Progress towards a national health service or insurance system was halted by the onslaught of Reaganomics. Defunding in the name of “containing costs” and corporatization in the name of competition—to cite just two of the destructive pressures felt by patients, workers, and communities—forced advocates into sudden-death struggles for the survival of vital health-care programs.

As you’re about to read, serious interest in a national health program has reemerged in recent years, owing in large part to the human failure of the Reagan presidency and the increased urgency felt by millions of citizens for long-denied, as well as newly-lost, health protections. Some of the questions underlying the dis-

- Robb Burlage, for the editors
TOWARDS A NATIONAL HEALTH PROGRAM

National Health is Back on the Agenda

HERBERT SEMMEL

The author details the difficulties that recent structural changes in the nation's health-care system have imposed on physicians, hospitals, and patients, and suggests that the resulting dissatisfaction has prepared the way for a national health-care campaign. Unless progressives insist on the democratic control of health care, he argues, the nation will continue to find the terms of that care dictated by corporate, as opposed to public, interests.

Once again, people in the United States are asking important questions about their right to decent health care. The questions have a special resonance coming at the end of the Reagan years and point to the public's vast dissatisfaction with the way health and other social services have been ravaged during this time. Many people are questioning why ours is the only industrialized country, other than South Africa, that does not have a national health program which provides everyone with the basic necessities of health care; why, only in America, the sick are turned away from hospital emergency rooms and doctors' offices because they either lack insurance or have the wrong kind.

In the early years of the Reagan '80s, such questions seemed rhetorical, designed to provoke argument but lacking any power to instigate change. Political work towards a national health program came to a virtual halt and little intellectual consideration was given to the organization and financing of such a program. But in the past two years a noticeable change has taken place, and the concept of a national health program has returned to the country's political and intellectual agenda.

The Coalition for a National Health Service has been revived as the Coalition for a National Health System, and held a successful organizing meeting in Washington in May with over 100 people from across the country in attendance. The National Health Care Campaign has been established in 32 states to develop grassroots support for a series of incremental steps leading to universal coverage. The Committee for National Health Insurance is once again giving priority to a comprehensive national program. And the American Public Health Association has declared the establishment of a national health program its priority for 1987.

This new interest in a national program is found not only among progressive organizations and the public, but also among providers and businesses that had previously opposed it. This improved climate, what's more, is not a byproduct of any cyclical political swing, but the result of structural changes in health delivery wrought by several forces, the most significant being the current obsession with cost containment. These structural shifts are changing patients' and providers' attitudes and assumptions about our health-care system.

Physicians and hospitals who once opposed a national program for fear of government regulation and interference are finding themselves already regulated beyond their worst fears. Similarly, patients sense that they are getting less in the way of care even as their substantial out-of-pocket expenses remain the same (30 percent of total expenditures). The canard that a national health program (or socialized medicine) will lead to a bureaucratic, depersonalized system of limited choices becomes less frightening as many see themselves faced with such a system already, without the benefits that a national program would bring.

Hospital associations are virtually demanding some form of coverage for the entire population, at least for hospital care, and even the medical societies no longer oppose the concept of universal coverage mandated by law. In Massachusetts, the Chamber of Commerce is supporting a statewide health insurance plan; legislation for such a plan has been introduced there and in several other states, including California. Federal legislation mandating coverage for all workers has been introduced in Congress and is receiving serious consideration.

The basic structure of the American health-care system has changed dramatically in the past 20 years and is still evolving. A number of forces have catalyzed this process, including technological changes, the emergence of the corporate health-care industry, and the proprietarization of the voluntary sector. The major catalyst, however, has been the repeated attempts over the past fifteen years to curb the nation's expenditures on health care, costs which have been rising at more than twice the general inflation rate.

Until 1965, health care in the United States was largely financed through employers' contributions to the cost

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of health insurance and through out-of-pocket payments by individuals. Care was delivered by physicians in private practice who were compensated on a fee-for-service basis. Hospitals, typically, were independent institutions with strong roots in their communities. Regulation of the financial aspects of the industry was nonexistent and regulation of the quality of care was perfunctory. Physicians enjoyed almost total autonomy in determining how medicine should be practiced and what to charge. They also dominated the governing of hospitals.

Twenty years later, we see a substantially different picture, one which is still rapidly changing. From the physicians' standpoint, the most important shift is the decline of autonomy—recognized as the single most important factor in job satisfaction. As sociologist Wolf Heydebrand explained at Health/PAC's conference on national health, physicians are becoming de-professionalized, losing their traditional power and authority. According to the American Medical Association, 25 percent of all physicians are now full-time employees and 50 percent are employed at least part time. Hospital administrators, not doctors, now sit at the helm of the health-care ship. And the administrators themselves are increasingly becoming the agents of third-party payers (business insurers and government), and are making changes, in the name of financial restraint, that affect both physicians' income and their right to practice as they see fit.

Many of these changes pressure doctors to hold down the number of people using costly services. Those doctors who do not comply with such directives are subject to a variety of sanctions, including the loss of admitting privileges. PRO's (Professional Review Organizations) and PSRO's (Professional Standards Review Organizations) have been established to review physicians' decisions with an eye to both utilization and the quality of care; physicians may be suspended from participation in Medicare if a PRO finds substantial deviation from good practice, even before the physician has had the opportunity to contest the finding.

In one California lawsuit, a physician testified that he was required to discharge a patient after a utilization-review agency determined that inpatient care was no longer necessary. The physician was actually mistaken about the law—the ultimate decision to discharge remained with him—but his testimony reflected medicine as it is practiced in many hospitals.
Nor are doctors seeing more money to make up for their loss in autonomy. Physicians' income, calculated in real dollars, showed no increase between 1975 and 1985, and real income has actually decreased for physicians in general and family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. There are several reasons for this. An oversupply of doctors in many areas and specialties continues to erode physicians' power in the marketplace. New methods of restraining prices are becoming common as practitioners are increasingly being drawn into the alphabet soup of HMO's, PPO's, IPA's and other new forms of practice; some of these simply pay physicians a salary, some are based on capitation payments, which pay a flat rate to providers for each patient, and some are based on the traditional method of fee-for-service, albeit at lowered rates of compensation.

Hospitals are facing their own problems from the pressure to contain costs. Although most institutions are adapting—and appear to have done well initially under the system of DRG's (diagnostic-related groups)—the fat in the system which allowed hospitals to shift the cost of the uninsured onto paying patients is being stripped away. Hospitals are now looking for government assistance, in the form of social insurance, or "charity pools," to cover the costs of the uninsured patients they serve. With at least 35 million people lacking any coverage, public or private, and millions more underinsured, the problem of paying for the costs of uncompensated hospital care is a pressing one.

The introduction of DRG-based capitation payments and tight utilization review, moreover, has resulted in empty beds and hospital closings. The once-hot performance of the hospital stocks is a thing of the past. Hospital Corporation of America saw its stock decline by 25 percent in less than a year and its earnings drop by 44 percent from 1985 to 1986. HCA responded by announcing plans to sell 104 of its 230 hospitals, mostly to employee groups that had little choice: employees could either mortgage their pension plans to buy their hospital or find themselves out of work.

From the patients' standpoint, marked changes have occurred as well, most of them likely to create dissatisfaction. Central to these changes is a rapid shift in the relationship between physicians and patients, from the cordiality of the traditional family doctor's office, as depicted in the quaint paintings of Norman Rockwell, towards an increasingly depersonalized arrangement. This change is a result not only of the new forms of practice but also of a growing reliance on specialization, which assures that patients will encounter a number of physicians over the period of their treatment.

New forms of reimbursement, which emphasize capitation payments, create a conflict of interest between physicians and patients, a conflict patients will soon be feeling. The simple fact is that per-capita payment systems reward underutilization. With them, physicians, once the care-givers, are becoming rationers or deniers of care. In some plans, the physician case manager is rewarded or penalized based on the utilization record of his or her own patients, or that of the patients of a small group of practitioners. In other plans, such as the giant Kaiser system, physicians share in the cost savings which result from the collective lowering of use among all Kaiser patients. Furthermore, patients are increasingly restricted to one group of providers and their ability to express dissatisfaction with their care by changing physicians is rapidly disappearing.

These great shifts in the way health care is delivered, and the anxieties they engender, do not automatically translate into a program acceptable both to hospitals and physicians and to the public. Rather, a political struggle is likely to take place, in which will be felt the staggering weight of a new force: major corporate employers and organized business groups. Health insurance is the costliest of fringe benefits which corporations pay; the total value of such benefits runs to many billions and is a natural target for cost-cutting.

The concept of a national health program has returned to the country's political and intellectual agenda.

The future of American health care, as envisioned by corporate leaders, is one in which businesses decide what form of health care their workers receive, leaving government programs to take up the slack for the unemployed. In his book, The American Health Care Revolution (1986), Joseph Califano, secretary of health and human services under President Carter, reveals what such an employer-dominated system means to most Americans: corporations use their power in the health-insurance market to obtain "efficient delivery" at
lower costs. While everyone has access to some system, that access is controlled by managers of benefit programs who are accountable to third party payers — either the employers or their insurance companies. The family doctor — who once answered to his or her patients — becomes a case manager or gatekeeper who now answers first to employers. The cost of a patient’s care will be covered only when the gatekeeper gives approval. The dissatisfied patient will have nowhere else to turn but to his own pocket.

For all its drawbacks, the fee-for-service system, where costs were largely covered by insurance, left patients free to seek an alternate provider if they were unhappy with the treatment they were receiving. Under a system dominated by corporations, however, consumers have few alternatives and no voice in determining policy (except in the rare situations of those unions that have the strength and willingness to struggle over health coverage).

The model Califano analyzes also features measures, designed to make employees “cost-conscious” about health care, that collectively deserve the epithet “draconian.” Higher deductibles, co-insurance and taxes on the currently tax-free health insurance premiums paid by employers are proposed methods of “educating” workers about costs. In addition, financial penalties would be imposed on those who do not follow good health practices, including smokers, drinkers, and people with high cholesterol levels or who are substantially overweight. Even missing a periodic check-up could result in a penalty. Absent from this corporate “good-health” model are environmental and engineering controls, whose costs fall primarily on industry. For example, Califano, a director of Chrysler Corporation, makes no call to install air-bags in automobiles, even though they may save hundreds of lives and avoid thousands of injuries each year.

To prevent these corporate dreams from becoming a national nightmare, activists must make democratic control of the health-care system the primary criterion when evaluating any proposal for a national program. Whatever methods of financing and providing service such a program incorporates, it will certainly also include some form of utilization control, given the inflationary pressures produced by technological developments and the aging of the population.

A system which leaves ultimate control of our national health care in the hands of those whose dominant consideration is cost — and who only afterwards think of the patient’s well-being — will bring Big Brother into health-care decisions and deny us the freedom to participate in decision-making, either individually or collectively, about our own health.

The issues of democratic control and public accountability pose difficult intellectual and political challenges, for it is rare that a health-care system has any such safeguards. But these challenges must be met if we are to achieve a truly humane and responsive national health-care system that serves all of us, and serves us well. The public’s growing dissatisfaction with the ill state of health care in this country gives us a unique opportunity to forge ahead.

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**Even the medical societies no longer oppose the concept.**

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**Taking Stock & Turning Corners**

H. Jack Geiger

Tracing the complex changes that have taken place in the nation’s health-care system over the last eight years, Geiger points out why opportunities are now ripe for change. If progress is to be made towards establishing a national health-care program, he argues, we must shift the terms of the debate away from fiscal and technical details and return it to the arena of public concern and social responsibility.

The central premise of the Health/PAC conference on national health was that we are on the threshold of change. Some of us glimpse not just a change in the health-care system but a massive shift away from the regressive thrust of the past eight years. We know, in broad terms, the outcomes we want. We must discuss, now, how we get from here to there.

Let’s begin, in that context, by looking at how we got to where we are, by examining what was on the nation’s mind with regard to health care in the ‘60s and early 70s, what happened, and why. It was a time, first of all, of industrial growth, rising expectations, and an expanding economic pie. The middle class was doing well. It was the beginning, furthermore, of one of those periodic cyclic swings that Arthur Schlesinger and others have described: every thirty years or so Americans turn liberal, egalitarian, and, rediscovering poverty and inequity and their consequences in our society, palliate these problems up to the point where such reform threatens a real redistribution of resources.

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Despite its relative comfort, the middle class did have one big problem back then: its growing difficulty in paying for the medical care of its aging parents. What was on our national mind in the early '60s, therefore, was the cost of care for the elderly. Then, with the rediscovery of “the other America”—the underprivileged—a broader dilemma came forward. The nation began to focus on inequity in health care, specifically on lack of access, on the financial, geographic, racial, and cultural barriers to decent health care particular to certain communities. We talked about fragmentation of care, the particular lack of primary care, and the lack of participation and influence—let alone control—by consumers. The times seemed ripe for major change.

Because of the larger political climate, the dramatic swing to the Left, we were able to introduce certain health-care innovations that stood outside the established system, notably the attempt to create a network of neighborhood health centers, primary-care institutions that were community-based and consumer-controlled. Underlying this development was a concern for the health status of populations, not just of individuals, and an attempt to integrate self-care, preventive and curative, with the classic approaches of public health. We even dreamt that such new health-care institutions would be instruments of empowerment and vehicles to broader economic, political, and social change.

Our own progressive efforts (I’ll call them that, rather than merely liberal) reached their apotheosis in the '70s with the Dellums Bill, which called for a unified health care system, integrated and budgeted nationally but controlled by communities, prepaid, oriented toward prevention, and focused on primary care. This was a direct challenge to the mainstream, to a ‘private’ sector that was driven by profit, centered on continually expanding hospitals and, although supported essentially by public funds, rather poorly regulated.

But the conception of pluralism upon which the system built its ideological framework is deeply grounded in American values and traditions—and its beneficiaries have deep pockets from which to fund public relations and lobbying. The Dellums Bill, as we know, went nowhere.

What Congress gave us, instead, was Medicare and Medicaid, with their underlying premise of “mainstreaming,” which does not seek to change the system, but gets the old, the poor, and minorities into the system by removing financial barriers which stand in the way of individual members of these groups.

Some of us did understand, then—and it is inescapably clear in retrospect—that a bargain had been struck with the medical establishment: access to the health-care system would be expanded, but only on that establishment’s terms, without structural change. The inevitable consequences followed—a huge increase in costs as a result not merely of the number of new people in the mainstream but also of the built-in incentives to provide more care than necessary. The system, with an underfunded, second-tier ‘public’ system for the poor and unwanted now existing beneath the ‘private’ sector, remained fragmented, chaotic, and elitist—wholly unsuited as an instrument for improving the nation’s health.

At the same time the nation embarked on a massive expansion of the physician pool and a substantial increase in the number of hospital beds. Few paid attention to the fact that medical-care costs were already rising at a rate higher than inflation—from $185 per capita in 1960 to $229 per capita in 1965; that is from 5.3 to 5.9 percent of the Gross National Product. If anything, people thought the share of the GNP devoted to health care should be higher. Nor did anyone worry very much about another force whose effects were already evident: our national attraction to ever more sophisticated and more expensive technology.

Americans still believe in the right of health care for everyone.

Meanwhile, the larger political climate was itself changing. As medical-care costs rose, so did the costs of the Vietnam War; the political costs even more than the financial. Meanwhile, the economy was slowing (even before the oil crunch of 1973), and the reforms of the Great Society had not turned out to be so great. In 1970 Nixon warned the nation that it faced a crisis because health-care expenditures totalled $75 billion—7.5 percent of the GNP or $292 per capita.

What followed, inevitably, was not deep reform, but an endless series of attempts to regulate costs. All these measures failed. Health Maintenance Organizations (HMO’s) were developed with federal support and heralded as obviating any need for more fundamental restructuring. Their own architects now concede their inadequacy. Attempts were made to cap or limit capital expenditures, with only partial success.

What was failing—and being desperately propped up—was a free-market system of health care. But the public perceived the failure as the government’s—as that of ‘social welfare policy’—because the government was paying so much of the bill of this supposedly free enterprise. And that, ironically, contributed to the larger shift in the nation’s political mood, which assured Reagan’s election in 1980. This, in turn, buttressed the Right’s ongoing attempt to redefine health care as a commodity, rather than as a social responsibility, as something best handled by, that’s right, a free-market model.

Other, more general trends are exacerbating the crisis in our health care. The United States is growing grayer, and the demands of the elderly cannot be ignored, for senior citizens are organizing themselves ever better; the American Association of Retired Persons now
boasts more than 23 million members.

Our economy is undergoing a major and permanent shift from manufacturing industries to services. One result of this is a decrease in the number, membership, and power of unions, and in their ability to negotiate effectively for health benefits. We are experiencing an almost unprecedented widening of the gap between rich and poor, a steady increase in the number of people who are downwardly mobile, and a revolution of shrinking expectations. Their corollaries are a further disintegration of the inner city, an increase in rural poverty, chronically high unemployment and underemployment, and a devastating impact on the nation's children, more than 25 percent of whom now live in poverty. Finally, of particular relevance to the health care system, we are plagued with the AIDS epidemic.

With all this, the past seven years has seen a change in the very identification of the fundamental problem of our health-care system. Where once people worried about access, equity, and health status, now the public and its representatives are most concerned with cost. (There are some good reasons for this: in 1987, Americans will spend approximately $500 billion on health care—a record 11.4 percent of the GNP. That works out, after the figures are adjusted to account for inflation, to a per-capita increase of 143 percent since 1960.)

And so now we face, above all, soaring costs, a function not merely of the irrationality of the present system but also a consequence of the increased use and technological intensity of its services. Furthermore, this problem has overwhelmed all others; we have moved from considering health a policy issue to considering it a budget issue. We have, for almost eight years, moved from a definition of health care as a public and social responsibility toward its definition as a function of the market, a problem to be solved by "competition," "entrepreneurial efficiency," and the great engines of private-sector investment and innovation (and never mind that government is still paying most of the bill!).

The consequences are known to all of us. We are immersed in attempts to control cost and utilization, essentially by restricting eligibility and coverage—that is, by removing people and services from the system. Yet these attempts are failing spectacularly to control costs, to limit the Medicare bill, the Medicaid bill, the total national health-care bill, and the extent to which medical-care costs rise faster than our very modest general inflation. We confront a huge increase in the number of uninsured, which now stands at 35 million, not counting the possibly 20 million who are deeply under-insured. Seventy percent of these people work full-time or are members of families which include two people who hold part-time jobs.

This last calamity has, in turn, created an impending crisis for hospitals, which no longer can lay the costs of the uninsured on others. The crisis is so severe that even for-profit hospitals are clamoring for publicly-funded coverage for such patients. Hospitals and
governments are now attempting to shift these burdens to the individual patient, increasing his or her costs, while eliminating peripheral services and reducing access to the services that remain. The messages from the health-care establishment have become: don't come into the system; if you're in, get out as fast as possible; and if you're in a hospital bed, get out even faster! DRG's—so many hundred dollars for this disease, so many hundred for that, the ultimate commodification— are part of this attempt to limit the availability of health care. Yet these mechanisms are neither controlling costs nor preserving the financial viability of providers, as witnessed, for example, by the growing tendency of HMO's to abandon certain populations, such as the elderly, and simply renege on their contracts.

These financial failures have also come to characterize the large chains, both for-profit and non-profit, despite increasingly frenzied marketing on their part. The proprietary corporations are getting out of acute care hospitals and into medical supplies, home health care, rehabilitation and psychiatric hospitals. This comes on top of their expansion into sports medicine, substance-abuse treatment, wellness clinics, weight-reduction centers and other forms of middle-class health care. Meanwhile, the aging population presents us with an impending crisis in our ability to provide long-term care.

Changes in health care will keep happening with us or without us.

Physicians are facing simultaneous threats to their autonomy and income. There is growing public unease and suspicion, moreover, about their incentives, motivation, and loyalties. Perception influences interpretation. When medicine is primarily patient-oriented, a gatekeeper is a guide and helper. When medicine is seen as a business, especially in prepaid or capped plans, a gatekeeper may be seen as a barrier to care.

On all providers, finally, there is enormous pressure to minimize risk, avoid the sick, the poor, the elderly. The one exception is the public hospital system, and—as part of the abandonment of public responsibility—that is being slowly destroyed. (A sad and ludicrous attempt is now under way by the federal government to "recover" 10 hospitals of the Public Health Service that were sold, abandoned, or given away in the last decade, in order to turn them into a national network of pesthouses for AIDS patients.) We already have, in consequence, a system of at least three tiers. The indigent and uninsured, together with the poor on Medicare and Medicaid, make up 99 percent of the patients in public hospitals. The middle-class sick go to the non-profits. The for-profits look for plastic-surgery cases.

That is what's happening now. As we consider this and plan for the future, there are some informed predictions that we should keep high in our minds. Eli Ginzberg, in a recent issue of the New England Journal of Medicine [April 2, 1987], identified the following four pillars of the efforts at cost containment and predicted that all of them would crumble.

(1) Prospective financing for Medicare hospitalizations. This is ultimately doomed to fail because of population growth, continuing advances in technology, the need to increase salaries of hospital workers, and continued resistance to closing hospitals or scaling back some of their operations despite chronically lower rates of occupancy.

(2) HMO's, Prospective Payment Organizations (PPO's), and other forms of prepaid health-care delivery. These are failing because of their inability to capture more than a limited share of the market, due in part to their inability to provide employers with the savings they promised; the steeply growing costs of marketing; the difficulties of structuring and managing large prepaid plans; and the growing insistence of employers and consumers on mechanisms of quality control.

(3) The abundant supply of physicians. This will continue to increase, given the large number of students already being trained. But even though an increase in the number of physicians tends to depress the income of each individual doctor, such an increase would actually make total health-care costs rise. For one thing, expenditures for physicians' incomes would remain constant. For another, utilization of services increases with the number of physicians—that is, more treatment takes place when there are more doctors around. Finally, as a doctor's income falls, he or she will tend to order more procedures in order to prop up his or her income.

(4) For-profit enterprises. These are not quite failing yet, but there is also no evidence that for-profit hospitals provide equivalent care for less money than non-profit hospitals. As I have already noted, several chains have moved from the acquisition of hospitals to their divestiture, and those they still retain show rates of occupancy many percentage points below those of non-profit hospitals.

These failures, if they continue, will steadily increase the cost of health care. They may also help convince the middle class that the policies of the last eight years—indeed, the whole structure of the health-care system—doesn't work. And they will, simultaneously, both hurt the middle class and cost it a great deal. In that same issue of the New England Journal of Medicine, Victor Fuchs lists these and other factors—among them concern about the physician-patient relationship, concern about quality, and the fears of health-care workers—as contributing to a counterrevolution in
health-care financing, a return to the belief that the federal government must act, and widespread support for a system that mandates coverage for everyone and emphasizes equity.

Merely addressing the issues of access and equity will not be enough.

When this happens, a strategy of coalition-building, of forging common interests between the poor and the middle class, will seem anything but absurd, despite what people think of such a possibility now. But Fuchs warns that we will not be able to avoid the problem of cost. Merely addressing the issues of access and equity will not be enough. And much will depend on the timing of the next change in the political climate and the overall state of the economy.

These are things we need to keep in mind as we rethink a national health program. It is vital that we consider not merely the mechanics of a plan, and not only its political and philosophical underpinnings, but also the ways in which we can use the contradictions and failures of the present system, as they become increasingly evident, to build political support, incrementally, across class and race and regional lines for whatever system we propose. In other words, even after we have defined our plan, we will still face the problem of getting from here to there.

This realization gives special urgency to the formulation of such a national health program. The 1988 election campaign has already begun. Congress still seems committed both to piecemeal initiatives and to evermore regressive types of coverage, to a continuing shift from entitlement to means-testing. The changes in health care I have briefly described will keep happening with us or without us.

There are many specific and technical topics to be addressed in our planning for a national health program: the organization of care, the development of new models of primary care, the problems of equitable financing, the huge problem of costs. They must be addressed, but, as we prepare to do so, I want to add an urgent warning.

To the extent that we present the provision of health care as a primarily technical problem, a matter of organizational mechanics and financial mechanisms, the progressive cause will suffer. For almost two
decades now, we have permitted the problems of the health-care system to be presented as technical. Yet, for most Americans, the choice of a health-care system for the nation is a values-based choice, and we must say so over and over again. For here there is room for optimism. Americans do still believe deeply in the right of everyone to health care, in fairness, and in equity. They continue to believe in the social responsibility of government. They want more, not less, done about housing and hunger and homelessness.

Indeed, polls show quite clearly that, despite the (until recently) high personal popularity of President Reagan, the American people have never adopted his fundamentalist, right-wing ideology; there has been no great ideological shift in the last decade. What has occurred, instead, is a disillusionment with what are perceived as formulaic “liberal” or “social-welfare” proposals as routes to the democratic and equitable solutions that are still deeply desired.

That imposes on us the responsibility to question the values that underlie any proposal for a national health program, not only its organizational and technical details. In so doing we take the issue out of the hands of marketplace technicians—the “saviors” of the past decade, now failing—and return it to the arena of public concern and social responsibility.

By making that effort, finally, we will help make the national debate on the health-care system part of a broader movement for social and political change. I mention this because we are unlikely to achieve fundamental or structural change in one single sector of the political economy, health care, without simultaneous change in other parts of the system. We want a rational and decent national health program. We want a more just and equitable society. The two are inseparable.

The Components of Care

MILTON TERRIS

The writer contends that incorporating all the components of health, not only medical care, should be our goal as we strive for a comprehensive national system. In discussing the prospects for a national health program, Terris draws on the ideas and observations of Henry Sigerist, the noted medical historian who brilliantly analyzed the political preconditions for the establishment of national health insurance. Finally, he argues that the lessons of Canada offer progressives here a valuable point of departure.

Before discussing any proposal for a national health program, we must be certain to distinguish health care from medical care. One of the weaknesses of the medical-care movement, to call it by its proper name, is the assumption that the two terms are identical, that creating a national medical-care system is equivalent to establishing a national health program. The title of the June conference ("Rethinking a National Health Program") bears unwitting witness to this misconception.

As Kristine Gebbie, Oregon’s chief health officer has so aptly remarked, “It is regrettable that in a general discussion with the public, ‘health care’ is the euphemism for ‘illness care’ or ‘treatment’.” The confusion results from a desire, conscious or unconscious, to sell the product to the public, to make the idea of such a system palatable. This is understandable, but hardly commendable, since the technique is strictly Madison Avenue, that is, the misusing of words to make things seem what they are not.

In the years preceding the establishment of the British National Health Service, progressives in Great Britain were much clearer on this point. The British Medical Association, for example, stated that "greater attention should be paid to the economic, social and environmental determinants of health.” And in 1934 the London Labour Party’s Health Research Group, which included such notable members as Herbert Morrison and Somerville Hastings, declared that “the three major causes of ill-health, in order of importance, were poverty, defective environment, and inadequate medical care.”

The experience of the British and Canadian medical-care systems has underlined the critical differences between true health care and medical care. Attempts in both countries to mitigate poverty have foundered on the rocks of increasingly unstable economic systems; unemployment rates of over 10 percent appear to have become permanent features of these societies. Nor have the British and Canadian health authorities paid serious attention to the prevention of disease; their entire focus has been on medical care. Scotland has the dubious honor of having replaced Finland as the nation with the highest rate of death from coronary heart disease, and England and Wales are not far behind. In Canada during the 1970’s, the rate of death from lung cancer rose by 60 percent and from cirrhosis of the liver by 25 percent. These are all preventable diseases—beyond the reach of medical care but ameliorable through a comprehensive national health program.

Furthermore, equity in access to medical care has failed dismally to assure equity in health. In England and Wales inequality in mortality between social classes has actually widened since the establishment of the National Health Service. The two highest social classes (I. professional and II. managerial) had a standardized mortality ratio (SMR) of 91 in 1951, 80 in 1961, and 80 in 1971. The two lowest classes (IV. semi-skilled and V. unskilled) had SMR’s of 110 in 1951, 115 in 1961, and 121 in 1971. The difference in SMR’s, therefore, rose from 19 to 35 to 41 during those years.

Nor has the Canadian medical-care system done
much better. Georges Desrosiers, citing studies done in Quebec, concludes that the Canadian system “has not substantially reduced inequality in the face of sickness and death. The underprivileged social classes still pay a heavy tribute.”

Clearly, the achievement of equity in health status requires equity in socioeconomic status. Health workers have a primary obligation, therefore, to help achieve for all Americans: full employment and adequate income, decent housing, good nutrition, greater financial support for public education and the elimination of financial barriers to higher education, increased cultural and recreational opportunities, and affirmative action to end discrimination against minorities in all areas of our national life.

The most rapid and dramatic improvement in the health of the public will result from preventive measures. This was also true in the past; the conquest of infectious diseases resulted primarily from environmental control and immunization.

During the 1920’s, ’30’s, and ’40’s, noninfectious diseases emerged as the main causes of death and disability. But medicine was powerless to combat them; their epidemiologies were unknown, and physicians clothed ignorance of them in such polysyllabic terms as “degenerative,” “idiopathic,” “essential,” and “psychosomatic.”

Unable to prevent the occurrence of these diseases, medicine retreated to a second line of defense, namely, early detection and treatment—so-called secondary prevention. But secondary prevention has—with few exceptions—proved disappointing; it cannot compare in effectiveness with measures for primary prevention.

The periodic physical examination, the cancer detection center, multiphasic screening, and a host of variations have incurred enormous expenditures for relatively modest benefits. Once a patient contracts a disease for which no effective treatment is available, it is simply too late. Unfortunately, for most noninfectious diseases treatment is ineffective whether given early or late. Important exceptions include cancer of the cervix, for which early detection has proved dramatically effective, and, to a lesser extent, cancer of the breast, for which secondary prevention is still not feasible on a large scale because of the high cost of mammography and medical examination.

Beginning in 1950, dramatic breakthroughs occurred in the epidemiology of noninfectious diseases. During the next three decades, epidemiologists forged powerful weapons to combat most of the major causes of death. In doing so, they initiated a second epidemiological revolution which, if we act appropriately, will result in an enormous reduction in premature death and disability.

Heart disease, the leading cause of death, results, investigators discovered, from high levels of serum cholesterol caused by a diet rich in saturated fat, and from hypertension, cigarette smoking, and a lack of physical exercise. All of these are amenable to public-health programs.

Cancer is the second major cause of death in the United States. Etiologic agents have been discovered for some of the most important cancer sites; these include radiation as well as tobacco, alcohol, and many other chemical carcinogens. All of these are amenable to
public-health programs designed to establish epidemiological barriers between agent and host.

Cerebrovascular disease, the third leading cause of death, can be effectively prevented by treating hypertension, its major risk factor.

Accidents are the fourth leading cause of death, but rank first in the number of potentially productive years they take. Furthermore, accidents are not really so accidental—they are often avoidable; every accident results from the action of a specific agent or from environmental factors. Many of these can be eliminated through appropriate public-health programs.

Chronic obstructive pulmonary disease, the sixth most frequent cause of death, results almost entirely from cigarette smoking, and is therefore preventable.

Chronic liver disease and cirrhosis, the eighth leading cause of death, is almost entirely a product of the consumption of alcohol, and is therefore preventable.

Given that most of the leading causes of death are in large part the result of human action, not of the agency of microorganisms, the highest priority in our national health program must be the prevention of heart disease, cancer, stroke, accidents, chronic obstructive pulmonary disease, and cirrhosis of the liver. Nor must we neglect the infectious diseases; our victories on this field are far from complete. Major respiratory, enteric, and venereal infections still elude effective control, and most will doubtless rely as heavily on public-health measures as on benchtop research for their elimination. Furthermore, new epidemics arise as a result of technological and social changes which facilitate the growth and spread of microorganisms. Recent examples include legionellosis, the cause of which has been traced to the cooling towers used in large-scale air conditioning; genital herpes, whose spread can be ascribed to changes in sexual mores; and the most frightening of all modern plagues, acquired immunodeficiency syndrome, related to changes in sexual mores, widespread abuse of intravenous drugs, and the use of blood transfusions.

Humanity is threatened not only by microorganisms and other living agents, but by the products of its own making—both nuclear and chemical. Chernobyl and Bhopal were grim reminders of these new dangers, but both were acute incidents—sudden epidemics, as it were. The chronic effects of exposure to radiation and toxic chemicals are always with us in the form of cancer, birth defects, and other diseases. It is urgent that a national health program mobilize investigatory, epidemiologic, and other scientific resources to control and eliminate the occupational and environmental hazards resulting from industrial development.

We need also to strengthen greatly our programs for maternal and child health—diseases of infancy and childhood remain high among the causes of illness, disability, and death. The barriers to early prenatal care for all women must be removed; family-planning programs need to be greatly strengthened; nutrition supplementation for women, infants, and children should be expanded to help prevent not only deficits in physical and mental development, but common illnesses, as well; immunization must include every last child; and childhood screening programs should be extended to the entire population to prevent the burdens of chronic illness and disability from being carried into adult life.

Faced with these challenges, we can no longer afford the luxury of spending many billions of dollars for medical care and only a pittance for prevention. The irony is that much of the vast sum spent for care goes for the treatment of diseases and injuries that could have been prevented in the first place.

Achieving equity in health status requires equity in socioeconomic status.

Much of the current discussion of alternative medical-care systems in the United States fails to recognize the political preconditions for their development. These were outlined more than 40 years ago by Henry E. Sigerist, the great medical historian, who considered three factors to be crucial to the emergence of national health insurance: (1) industrialization, with its attendant economic and social insecurity, (2) the emergence of new political parties representing the interests of the workers, and (3) the occurrence of a revolutionary threat to the established order. In 1943, Sigerist brilliantly and thoroughly analyzed the genesis of the first national health-insurance legislation, enacted by Bismarck in 1884; he concluded that the three factors underlying this advance were the growth of German industry after the Franco-Prussian War, the development of a strong socialist party in Germany, and the alarming example of the French Commune which, in Sigerist's words, "had demonstrated that socialism was not an arm-chair philosophy but could become a very tangible reality."6

A similar constellation of events brought about national health insurance in Britain in 1911 when, as Sigerist noted, "the second industrial revolution was very strongly felt. The Labour Party entered parliament and from a two-party country England developed into a three-party country. The Russian Revolution of 1905 was suppressed to be sure, but seemed a dress rehearsal for other revolutions to follow. Social legislation was enacted not by the Socialists, but by Lloyd George and Churchill."7

Sigerist describes a third wave of health insurance legislation "following World War I when again the industries of every warfaring country were greatly expanded, when, as a result of the war, the Socialist parties grew stronger everywhere, and the Russian revolution of 1917 created a red scare from which many countries are still suffering. Again social-security legislation was enacted in a number of countries."8

Canada, too, followed the pattern outlined by

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Sigerist; the emergence of a socialist party, the Cooperative Commonwealth Federation (later called the New Democratic Party) was the key factor in the development of the Canadian system of medical care. Unlike in Europe, the new socialist party itself pioneered the development of the Canadian system. The CCF enacted legislation in Saskatchewan mandating hospital insurance, later extending the system to cover physicians' services. The more conservative Canadian parties followed suit and instituted health insurance nationally in response to the growth of the CCF, just as Bismarck had acted to counter the German Social-Democratic Party and Lloyd George had responded to the emergence of the British Labour Party. As Sigerist stated, "every historical pattern we set up is to a certain extent artificial and history never repeats itself unaltered."9

What does this mean for the United States? For one thing, a nation which has not even achieved the political prerequisites for national health insurance can hardly be expected to muster the forces required to nationalize its health resources by creating a national health service. It took decades of Labour-Party development, the devastation of World War II, and the election of a Labour government to bring about the nationalization of health in Great Britain. It took many decades of growth of the powerful socialist and communist parties of Italy before that country's conservative leadership undertook to develop a national health service. Most of the Social-Democratic governments of Western Europe have not yet moved away from their mixed medical-care systems, which combine salaried services and national health insurance, to establish a completely salaried national health service.

If a national health service must be considered politically unfeasible at this time, is this not also true for a national medical system based on payment to individual practitioners and facilities? This may well be the case: if one followed Sigerist's thesis to the letter, one would be forced to conclude that such a system will not come into being until after a new party arises to challenge the Republicans and Democrats—whether a labor party in the British tradition, a farmer-labor party in the CCF mold, a socialist party, as in Europe, or a new American variant which combines blacks and other minorities, labor unions, the aged, women, the peace movement, and environmentalists.

On the other hand, it is possible that the development of a broad coalition for a national medical-care system may be one of the catalysts that bring about a fundamental restructuring of political forces in the United States. The need for such a realignment becomes increasingly evident as the Republican Party moves to the extreme right and the Democrats swing over to now-vacant conservative positions. A countervailing force is essential, and a citizens' coalition for a national health program—directed at prevention, care, and a raising of the standard of living—can help create it.

Any proposal for a national medical-care system must take into account the unique features of the American situation. The United States is the only country in the world where capitalist development of the medical-care industry has been permitted to proceed to its logical conclusion: the increasing dominance of large-scale, profit-making corporations operating nationally. In other countries this development was halted at the level of the small producer, the practitioner for whom national health insurance meant economic stability and survival.

_A citizens' coalition for a national health program can help restructure political forces in the U.S._

Given this situation we cannot blindly copy the Canadian system, since Canada is one of the countries to have solidified the role of the fee-for-service solo practitioner through national health insurance. Indeed, as John Hastings10 and Theodore Goldberg11 have pointed out, the Canadian system has, in one regard, played a retrogressive role; it has actually set back the movement for health-service organizations and community health centers in that country.

Nevertheless, we have a great deal to learn from the many positive features of the Canadian system; an American medical-care system would do well to adopt them. Our system should cover the entire population; provide all needed services, including medical, dental, and long-term care, not excepting care in nursing homes; emphasize preventive services, home care, and rehabilitation; and fund all services without including deductibles, co-insurance, or extra charges. Finally, the program should be financed entirely through general tax revenue, rather than regressive social-security taxes, and should calculate payments on the basis of a global budget, one that covers the full cost of efficient care by accounting for all services together.

We need to adapt the program, however, to take

**The most dramatic improvement in public health will result from preventive measures.**

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account of American experience and the specific features of the American situation. Payments to practitioners should be made only through organizations: community health centers (CHC's), group-practice plans (HMO's), and individual-practice associations (IPA's). These payments should be made on a capitated basis—a fixed amount per patient, with that sum reflecting the range of services provided by the organization in question. The capitation fees received by these organizations should be unaffected by their status as public or private, profit or non-profit. They should be allowed to pay their practitioners by any method they see fit: fee-for-service, salary, capitation, or any combination of these. The strengths and weaknesses of the several organizations and their methods of payment will be tested in the competition for subscribers; this will furnish the incentive, one hopes, for providing better and more attentive care.

There should also be higher capitation allotments for underserved rural and urban areas as incentives for physicians to move to those communities. Special assistance will be needed for construction of community health centers and other facilities in such areas, and for the affiliation of these local facilities with district and regional hospitals.

Administration of the national medical-care system should be the responsibility of federal, state, and local health departments which would administer other health services as well, including programs for the prevention of disease, for environmental health, and for health research. All departments of health should be responsible to boards of health consisting of representatives drawn from all sections of the population. In addition, all providers, whether for-profit or non-profit, private or public, should be required to establish elected consumer councils to meet regularly with the directors of these institutions and which councils would have the right to appeal to the boards of health for investigation of and action on deficiencies in care.

Federal standards are essential to improving the quantity and quality of medical care and to assuring that an equal level of service is provided across the nation, but these standards must be developed in consultation with the state and local departments of health. Furthermore, there should not be one overarching federal program. Instead, the states should submit plans which meet the requirements of the national system, but should also have considerable latitude in devising ways to improve the basic program and tailor it to their needs. Such flexibility is necessary to prevent the solidification of existing patterns of service and administration.

A national health program should be able to garner the support of the growing number of citizens concerned with the need for effective disease prevention, an adequate standard of living, and government funding of medical care for the entire population. These concerns are shared by many groups—environmentalists, who see the EPA not only crippled, but setting standards that favor polluters; labor unions, whose members' health and safety are increasingly unprotected by OSHA; the unemployed, who have lost their health benefits; women, whose reproductive freedom is under attack and many of whose children suffer from sharp cutbacks in nutrition programs; families who have been dropped from Medicaid or who have had their benefits severely reduced; the aged, who see their inadequate Medicare benefits being further whittled away; and, indeed, everyone whose health protection
has been undermined by the appalling escalation of medical-care costs, as well as by the decimation of public-health programs by the Reagan Administration and its Republican and Democratic supporters in Congress.

Political leadership for a national health program will have the support of all these groups—in other words, of a majority of our nation. We must build a new movement, one that will provide this leadership and take the action necessary to make certain that health becomes a right, not a privilege, in the United States.

8. Ibid.
9. Ibid.

Turning 20 and Looking Ahead

As we enter our 20th year, the Health/PAC Bulletin faces enormous challenges—journalistic, political, and financial.

1988 will be a critically important year for the nation, a year in which we'll need to expand our ability to publish timely reports on pressing health-care issues. While we will continue covering the health struggles in Central America and South Africa, the battle against AIDS and AIDS-related discrimination, and the growing resistance to the corporate health agenda—to name just a few areas where the Bulletin has done ground-breaking work in recent months—we will have to do more: dozens of unreported stories demand to be told; vital issues beg for careful analysis; and important plans and strategies require more space in which to be read, considered, and critiqued.

This is why we need your help. The Bulletin has survived the Reagan years with little grant money, no large donors, and virtually no advertising. In many ways, the crises that have plagued health care have hurt us as well. Rising costs have compelled us to publish less frequently. And—this is what hurts most—we've had to decline the queries of committed, talented writers because we simply lack funds to pay contributors.

Despite these difficulties, few other publications have reported on overlooked health care subjects as fearlessly and consistently as this magazine has. As in the past, our longevity depends on the support of readers who share our conviction and generously contribute money and labor. In recognition of the generous support that so many people have offered Health/PAC over the last 20 years, we are planning a series of celebrations this spring. These events will not only celebrate a proud past but help us forge plans for the future. We hope you will be with us in spirit, if not in body.

In 1988, we're going to do all we can—not merely to survive, but to grow. We believe deeply in our journal's importance in creating a forceful movement for health and health care in this country. Help us by sending a contribution, by recommending the Bulletin to a friend, colleague, or library, or by taking out a gift subscription or membership for your union or community organization. Your support is vital to securing the future of this lively 20-year experiment in independent health-care journalism.

Joe Gordon
Executive Editor
A Brush with Justice
The New Jersey Radium Dial Painters in the Courts

TONY BALE

The New Jersey radium dial painters who became fatally ill from ingesting radioactive radium and mesothorium while licking their brushes to a point were the most famous occupational disease victims of the 1920s. Approximately 800 young women painted luminous watch dials at the United States Radium Corporation plant in Orange, New Jersey, between 1917 and 1924. Between 1922 and 1933, 22 of these women had been medically confirmed to have died from such work-related causes as bone cancer and aplastic anemia.

The current wave of asbestos litigation is the most spectacular of a long series of struggles workers have waged in the courts for compensation of their work-related illnesses. This is the story of the struggle of the New Jersey radium dial painters, perhaps the most enduringly famous group of American occupational disease victims. The story involves charges of criminal negligence rising to the level of homicide, problems with statutes of limitations, corporate bankruptcy, insurance litigation, the interplay of the tort and workers' compensation systems, and relatively few large financial recoveries. These features of this pioneering struggle for compensation and justice are now echoed in asbestos litigation, and, to some extent, in other toxic tort struggles.

The clear connection between the dial painters' misfortune and the nature of their work, their concentration in one company, and the public uproar over their condition all contributed to their faring better in the mixed workers' compensation and tort (personal injury lawsuit) system than other groups of workers at the time with work-related illnesses. However, the New Jersey statute of limitations for torts helped drive down recoveries. These features of this pioneering struggle for compensation and justice are now echoed in asbestos litigation, and, to some extent, in other toxic tort struggles.

The radium poisoning cases were initially confused with phosphorus poisoning, which was well known to cause rotting away of the jawbone, known as necrosis of the jaw. The medical picture was clarified in 1925 when Harrison S. Martland, the Chief Medical Examiner of Essex County, published a complete account of radium poisoning in two deceased and five living workers from the United States Radium Corporation plant. Over the years, medical investigators photographed the radioactivity from their breath, measured the radioactivity in their bones, developed dose-response estimates for internal radiation exposure, and exhumed their corpses, when necessary.

Dangerous Practices Were Mandatory
United States Radium not only taught the dial painters to point the camel-hair brushes with their mouths, but, in fact, required them to do so. They not only ingested the paint but also got it on their skin. In the darkroom used for inspecting the painted dials and watch hands, where they were often reprimanded for their poor work, some of them "fairly shone in the dark." United States Radium had sufficient scientific resources to evaluate the literature on the health effects of radium; its founder was the inventor of the paint, Sabin A. von Sochocky, a physicist who had studied with Lord Rutherford at the Cavendish Laboratory and who died in 1928 after an excruciating eight-year illness from aplastic anemia brought on by radium poisoning.

Although not directly aware of the harm it was doing, United States Radium insisted the dial painters use work practices it knew or should have known might be dangerous. Certainly it was aware of less hazardous methods. Whether the company was negligent in exposing its workers to radium before 1924, when it became aware of the first cases, or whether the dial painters were killed by a form of homicide, was never decided by a jury.

United States Radium responded to the early assertions that its workers were dying from radium poisoning by alleging that the mystery surrounding radium had stimulated the women's imaginations.

Scientific Opinion is Mixed
In 1917, when exposures began at United States Radium, scientific opinion was mixed as to whether ingested radium was harmful, and if it would end up deposited in the bones. At the time, radium salts were applied internally through drinking, injections, or intravenously as a therapeutic treatment for numerous medical conditions. Some of the dial painters reported the radium "pepped [them] up." No studies had been done on the type of long-term, low-level exposure experienced by patients and the dial painters. However, there were some indications in the late 1910s and early '20s that internal radium exposure might be harmful. Dangers to the skin, including production of skin can-
cer, were well known, and some scientists argued that internal radium would be deposited in the bones. Less dangerous methods of dial painting were being used in Europe, while the only safety rule at United States Radium prohibited eating in the workroom. Ventilation was restricted to reduce the rate at which the paint dried on the dials. It was only in the fall of 1923 that United States Radium finally ended the practice of pointing brushes by mouth.

No Criminal Charges Sought

Dr. Harrison Martland, in his role as medical examiner, chose neither to close the factory nor report it to the district attorney for possible criminal prosecution. By the time he had established the causes of the deaths, production had dwindled and the practice of pointing the brushes in the mouth had stopped. Writing in 1929, Martland explained why he had not recommended criminal prosecution: "In spite of the way in which this plant had treated its employees in continually refusing to admit that an occupational poisoning existed or to assume any responsibility, allowing any number of girls to spend their entire savings and in many instances the savings of their families and relatives in extensive dental and medical bills, I have always been of the opinion that the company did not intentionally intend to harm its employees." For Martland, United States Radium's imposition upon its workers of a lethal risk that it might well have suspected and thus avoided was not sufficiently criminal to warrant prosecution. For that, the company apparently would have to have wanted the injuries to happen.

Workers knew there was a risk, but did not realize the full extent of their peril. A young woman who left her dial painting job after two weeks in 1921 because of fear for her health told the New York Times, "Many of the girls knew the work was dangerous, but they were earning from $15 to $20 a week and were willing to risk the danger for the money."

In May 1926, United States Radium made the first settlements of lawsuits against it. A husband received $1,000 for his deceased wife; and, following the peculiar way the tort system places values on lives, a father received $9,000 and $3,000 respectively, for his two deceased daughters. Because of this litigation, United States Radium delayed publication of a Harvard University industrial hygiene report it had contracted for.

The report showed widespread radium contamination throughout the plant, raising the likelihood that inhaled as well as ingested radium contributed to the deaths.

In the summer of 1925, Katherine Wiley, secretary of the Consumers' League of New Jersey, called on a former dial painter, Katherine Schaub, who began dial painting at the age of 15 during the World War I boom in the industry. Wiley had been investigating conditions in the radium plant and became concerned when she heard of Schaub's problems with her teeth and jaw. According to Schaub's account, Wiley asked her whether the dial painters had ever been "warned not to point the brush with their lips and whatever made us do such a thing. . . . I told her that of course we were given no warning or intimation of any kind that the work as we did it was dangerous."

At Wiley's suggestion, Schaub went to see Martland for a diagnosis. Martland's test showing radioactivity in her expired air confirmed the diagnosis of radium poisoning that she had already strongly suspected. Martland's diagnosis came as a death sentence. She had the same condition that had recently killed her cousin. "I was not as frightened as I thought I would be," she wrote. "At least there was no groping in the dark."

Schaub hoped there was a way to alleviate the financial problems brought on by her attempts to "stop at nothing" to seek treatment for the problems with her jaw:

The county medical examiner's diagnosis furnished perfect legal evidence for a lawsuit. This gave me hope in another direction. Although I might be condemned to permanent disability, perhaps I could claim enough compensation to relieve the family of their already heavy financial burden."

Over a year passed before she found a lawyer to take the case. The New Jersey statute of limitations for torts barred claims more than two years after the last exposure at work; Schaub, like many others, last worked with radium in 1921, before a large workforce reduction at the plant. Most attorneys felt her case was hopeless; however, lawyers were eventually engaged and, in May 1927, Schaub and four other women who had been examined by Martland filed suits against the United States Radium Corporation.

The cases were moved from the New Jersey Supreme Court to the Court of Chancery, a state court concerned with questions of equity. Schaub testified in the chan-
When Schaub and the other four doomed women lived past their allotted year, most newspapers reported it as good news; but some others viewed their continued living as evidence of a fraudulent scheme to extract money from the company. On December 7, 1929, Quinta McDonald became the first of the five women to die.

Following Schaub and her co-plaintiffs' settlements in 1928, many additional suits were filed against the company. Soon after the settlements United States Radium settled a disability case for $4,000, using the workers' compensation amount as a guidepost. None of the suits were tried to a verdict. Helen Tuck's suit produced a mistrial in 1930 after the first day of testimony to allow for further legal maneuvering on the statute of limitations. Her claim was settled for $10,000. Out of the glare of worldwide publicity, the value of these cases fell close to where they had been in 1926. After 27-year-old Anna Stasi became the eighteenth radium poisoning fatality in 1930, her husband and three-year-old daughter were only able to negotiate a $3,000 settlement the following year.

United States Radium's insurance policies for employers' liability and workers' compensation never paid the corporation anything. This was because the policies only covered liability imposed by law for "personal injuries accidentally suffered," while the courts interpreted the radium poisonings to be "occupational diseases"—the opposite of accidents—and hence not covered. Facing a large legal liability without insurance coverage and with a product few wanted to buy, United States Radium quickly fell into bankruptcy, making it even harder for the dial painters to collect compensation.

In 1927, radium-mesothorium necrosis was added to New Jersey's workers' compensation schedule of covered occupational diseases. Martland noted that many people would die from radium-related causes without any jaw necrosis, and would thus be ineligible for compensation under this narrow provision. The law covered only those workers whose diseases were literally written on their faces, but those dying just from anemia or bone cancers would not be compensated. Through 1929, the tort system had provided compensation for only four of the fifteen women who were known to have died from radium poisoning. Many more were disabled and had severe financial problems, but were unable to obtain workers' compensation or tort recoveries.

The Rules Change

In 1935 a federal district court disallowed the attempt of the radium dial painters to get around the statute of limitations for torts on the theory that United States Radium had fraudulently concealed their danger, and was thus using the statute of limitations shield to conceal its fraud. The court considered the methods used in the plant around 1920 merely negligent according to the standards of the time, even though the court said it would consider them criminal if used in 1935. The federal court held that the fragmentary and conflicting state of knowledge in 1920 was such that the dangerous aspect of the occupation of dial painter was unknown, and there was no industry negligence in having failed to look for or discover them then. The opinion stated that only when the first case came to its
attention could the company be held for legal purposes to have been on notice of the danger. This decision closed off the litigation, as the lawsuits were filed more than two years after the last exposure. Unfortunately, the issue of the extent of the United States Radium Corporation's negligence was never tried before a jury.

This most publicized occupational disease of the twenties led to some considerable financial recoveries in the tort system, although most victims were uncompensated or badly undercompensated. The resolution of this struggle created a limited workers' compensation remedy which excluded many deaths from radium poisoning and shielded the industry from tort liability and, finally, a further closing off of the tort remedy by the statute of limitations. Large-scale tort recoveries speeded up the eventual successful process of bankrupting a United States Radium left bare of insurance coverage.

Two years after her settlement, Katherine Schaub suffered a well-publicized fracture near the knee of her radium-weakened leg. She rapidly declined as did the lump sum she received through the settlement. As she fell deeper into illness and disability, the company objected to her medical bills, labeling her "neurotic." Schaub developed cancer on her left thigh bone from which she died in 1933 at the age of 30.

Radium Still Haunts Us

By 1979, for women employed in Orange before 1930, excesses had appeared not only for the early recognized bone and nasal cancers associated with radium exposure but for cancers of the stomach, colon, lung, breast and uterus as well. But the story will not end when the last New Jersey dial painter dies. In a 1980's twist, residents of over 700 homes in three northern New Jersey communities learned several years ago that their homes rest on landfill containing radioactive waste from the United States Radium Plant. Public health officials have warned them that even an innocuous chore like gardening can stir up radioactivity and lead to contamination of their houses brought in on clothes and shoes. Unable to dispose of this soil promptly, the Environmental Protection Agency proposes measures such as lead shielding for the basements. Residents have filed lawsuits concerning their radon-contaminated homes and yards and their increased cancer risk. Meanwhile, the 5,000 barrels of contaminated soil that have been sitting silently on several Montclair, N.J. lots for the last three years, pending a decision on their removal to a permanent disposal facility, form a grotesque monument to the misery wrought by the negligent handling of these radioactive substances beginning seventy years ago and continuing today, as cleanup efforts lag.

In another modern twist, the dial painters' unwitting exposure became the occasion for the wanton, deliberate exposure of 20 elderly people to up to 34 times the permissible body burden of radium and thorium. In 1961-1965 the Atomic Energy Commission funded the Massachusetts Institute of Technology to study the metabolism of the thorium and radium injected by the dial painters and to calibrate counting equipment used in the study. Volunteers from the Age Center of New England, a non-profit research facility established to investigate aging and the needs of the elderly, were ingested and fed these substances in experiments which promised no possible medical benefit to them or anyone else. They were monitored for 120 days; however, no long-term follow-up was conducted of the health effects. These human nuclear calibration devices were latter day guinea pigs in the radium dial tragedy, as well as part of the extensive program of unethical human subject radiation experiments conducted by the government in the 1940's-1970's.

The radium dial painters' agony alerted the world to the hazards of internal radiation, a lesson that has yet to be fully learned and acted upon. They were the first victims of the wanton use of radioactive substances to alert the public to this new danger on the frontiers of science, the first group to seek compensation and a measure of justice in the courts for a new class of socially-produced cancers and other illnesses. Even with some receiving relatively large financial recoveries for the time, the dial painters as a whole, like most occupational disease victims today, were left to bear most of the financial loss and all of the suffering. Nevertheless, the compelling poignancy of their story and the subsequent flood of other innocent radiation victims ensures them a continuing measure of fame—and respect.

7. Ibid.
8. Ibid., p. 140.
9. Ibid.
10. Ibid.
War is Nicaragua’s Worst Health Problem

An Interview with Health Minister Dora Maria Téllez

I’ve just arrived from the Pan American Health Organization meeting, where different ministers of health evaluated the state of health in their respective countries. Our own report centered on how our difficult economic situation has affected health care in Nicaragua. We also talked about how this mercenary war—the contra war—has affected health in our country. It has had both a direct and an indirect impact on health care. There is a direct impact from the war and from the contras directly destroying health-care facilities, and there is an indirect effect of the economic crisis’ impact on health care. These two situations lead to new problems in public health. We presented some alternative solutions to our situation. Of course, our main solution has been our people’s participation in creating their own health care and in having a relationship with their government in health care.

Trying to make our health-care system much more efficient has one objective: to stop the deterioration of the health care of the Nicaraguan people. We are talking about stopping it from getting worse, not developing or improving. The war is destroying the state of health care—destroying the infrastructure of the health-care system and limiting the human, material, and financial resources that can be given to health care.

We won’t allow what we have accomplished in the last seven years to be destroyed by the war. How is really very hard to answer. To try to see a way to stop a war—a generalized war—not just from the contras but from the U.S. would be a real solution, a fundamental solution to the basic problems that we are having now.

Please explain what you mean by the direct and indirect effects of the war.

One of the main direct effects has been death caused by war. And death caused by war has rapidly become one of the principal causes of adult deaths in Nicaragua. It’s inching up to becoming number one. In the last five years there have been 16,000 people killed in this war, and by 16,000 people I don’t just mean the soldiers who are defending their country but also the mercenaries who are Nicaraguans.

We are talking about a country that has 3,400,000 inhabitants. You can easily figure out the high ratio of people who are being wounded and disabled as a result of this war, and the impact this has on our underdeveloped health-care system. People who have lost limbs, people who are paralyzed, people who have lost their vision, people who have mental problems—all types of disabled people. Most of those who are disabled are between 18 and 24 years of age. We have 6,000 to 7,000 orphans due to the war and about 250,000 peasants who have been displaced from their homes and have had to go to other parts of the country. The migration of these farmers is a very important point.

The contras have destroyed about 60 health-care facilities, including one hospital. Nicaragua has 32 hospitals, five of which were built by the revolution. About 20 health-care personnel—doctors and nurses—have died and 31 health-care workers have been kidnapped, including quite a few doctors. Many have been wounded, too. These were people who were working.
These are the direct effects.

Then there are the indirect effects. Although these are not seen, they are much more serious and just as acute. Before the war started, most of Nicaragua's resources went into production, education, and health care. Just a little bit was for defense. But now, we have fewer resources than we did in 1982, we have to spend 40 percent of our national budget on defense. The prices have come down for a lot of our exports like cotton and sugar. Production to feed our own population has also fallen because a lot of the peasants that we talked about before have been displaced from their land. This leads to a lot of restrictions in the delivery of health care. For example, most of our medicine comes from imports. We produce a little bit of medicine but not that much. Our industry mixes medications. There has been a restriction on the things that we can import, such as replacement parts and whole pieces of technology. Even the maintenance of the physical plant is very costly and we don't have the capacity to do it.

Let me give two examples. A lot of the hospitals have had to close down three or four out of their six operating rooms because we can't buy replacement parts for the air conditioners that have broken down. The air conditioners come from North American companies. We are finding it very difficult to locate the parts. You can see how serious and violent the war's impact is on the economy and, therefore, on the health care of the country. Also, we were reducing the incidence of malaria in the country for the last 6 years. Last year we had two problems. We couldn't buy the insecticides—the ones you put up on the walls to repel mosquitoes—and there were also zones which, because of the war, we could not fumigate. So now, in the last year, the incidence of malaria is going up. The incidence of leishmaniasis and TB is also increasing. The social hygiene of the entire country has been deteriorating at a fast rate. Of course, the effect of this on epidemics and any disease is tremendous. There are more viral diseases, there is more diarrhea. This is only a brief synthesis of the impact that all of this has had.

**What is happening to medical education?**

After the revolution we began a new medical school. We opened it up with 500 new medical students. In 1985, those 500 medical students graduated. We plan to maintain it at the same level. Nicaragua is one of the few countries in the world where, before the revolution, asking for more medical students was considered subversive by the Somoza regime. They only used to allow 50 medical students. We won the right to have 120.

The same with nursing schools. Before the revolution there was only one nursing school in all of Nicaragua. Now there is a nursing school in every province of the country. We plan to maintain that.

**Is it true that you are using nontraditional treatments like acupuncture and herbal medicines to cope with equipment and medicine shortages?**

We are studying two things now to deal with the scarcity of medications. At this point our policy is one of survival. The first thing we are doing is studying popular folk medicine and natural medicine. We have a very long history of using folk medicines. We have studied 82 different varieties of herbs and plants that have been used in one region of the country. These have all been photographed and classified. We have catalogued their uses, the recipes to prepare them, and the indications of their uses. This has really been an incredible work. We've had the participation of students, local doctors and even *curanderos* [folk healers] who are very smart and very knowledgeable. We are already using these medications in some areas. The ones who are using them are basically the doctors and nurses in primary care. We are also providing training for them.

We don't want to overdo it by overextending ourselves. We don't want to use these medications to treat every kind of pathology or illness. We have tried to deal with some specific illnesses instead. The best example is in the treatment of parasites. In our country there are many, many plants which are used against parasites.

When I was a little kid, I used to take some of them myself. We are expanding this approach to many rural areas and are now starting to bring herbal treatments to certain cities. One of the other ways that we use herbal medicine is to reduce the use of psychotropic medications like Valium. We've had very good results. Once the study is finished and the war is over, we plan not just to keep it at this level but to begin to cultivate these plants and to sell them, say 20 years from now.

The acupuncture project is now beginning to take shape, too. We are starting by getting Chinese doctors to instruct us because they really understand it. There are a number of conditions that no one can cure, such as headaches, which aspirin doesn't touch, and ulcers. People walk around with a shopping bag full of medicine that doesn't help them. We are trying to see if we can use acupuncture instead. I had the idea to place an acupuncture doctor and acupuncture nurse in each health care facility in Managua, so they can begin to resolve medical problems without resorting to medications which are toxic or have numerous side effects.

There is a lot of discussion about acupuncture among doctors and the giants of medicine. No one has proved that it causes harm. There are many people who say it works. If we are willing to take medications that harm us, then why not use this method which is less harmful and can provide some benefits? The equipment is easy to use and is very inexpensive. For example, for those wounded in the war, acupuncture is very useful for pain and to prevent shock, as opposed to morphine, which is very expensive.

**What has the impact of war been on mental health, specifically on depression?**

That's an interesting question. In a beginning analysis of mental health that we made in some communities, we found that the better organized a community is, in terms of dealing with such things as defending the children, protecting the village, producing and providing food for the people, the fewer mental...
health problems there are. In general, the people who are in the war zones do not have mental health problems because they are dealing with a much more acute situation. They have to defend their lives and protect their homes.

Now in the city, where the war is seen from a different perspective, it's different. It's not so much a problem of depression but of anxiety. But our people in general are very optimistic. They have an ability to free themselves from these kinds of anxieties and pressures. For example, the mothers of those who have fallen in the war have their own organization in which they give each other mutual support and visit the soldiers in the war zone. They help those mothers who are newly grieving. This kind of activity helps free them from depression. But at the same time, when we looked at the causes of mortality, we found that deaths related to car accidents in the cities are going up. We don't know what is causing this, but it's something that we need to investigate further to see if it is linked to problems generated by the war.

What kind of alcohol and drug-abuse problems do you have in Nicaragua?

As you know, in Latin America alcoholism is a cultural phenomenon. For the Latin American, drinking is linked to his self-esteem, to put it one way, or to machismo, to put it another way. People drink all the alcohol that is produced. The same is true of all the cigarettes. As a matter of fact, it seems that the incidence of the consumption of these two things is increasing, but there is a very good reason for this. You have an 18-year-old soldier who feels that he is now responsible for himself. He is no longer a student. He feels more adult, and he feels that he can now handle more adult things, even though adults are mistaken about many of these things. We don't have all the facts right now because it's not the number one problem in our country, but we are beginning to study it. It is possible that the incidence of alcoholism is increasing.

What we don't have is drug addiction. There's none. There is a peculiar phenomenon with drug addiction. After the 1972 earthquake in Managua the incidence of drug use and drug abuse went up. It started to go down in 1977. This was at the same time that the fight against the dictatorship was increasing. Since then it has never gone up.

People become drug addicts because they reject life. They have no motivation to go on. The revolution gives young people space. We need their rebelliousness. Our young people are more involved in sports. They go on literacy campaigns. They do volunteer work cutting cotton, picking coffee, or cutting sugar. They fight. They have much more motivation. There are more things to do, so the level of drug use has never gone up again. From the police aspect, there's no drug-trafficking problem. It doesn't mean that there are no drug addicts in Nicaragua. There probably are some, but it's not a problem there.

Physician comforts a mother whose child was killed by the contras.
Sidney Kark in America

H. Jack Geiger

Mervyn Susser's poignant reminiscence of the work of Sidney and Emily Kark in South Africa [August 1987, Vol. 17, No. 4] has a second, American, chapter. In ways that are still unfolding, and insufficiently recognized, the Karks have had a direct and profound effect on community medicine in the United States. Sidney Kark is, in a sense, the "grandfather" of the U.S. community health center network, and mentor, friend, and consultant to a generation of American community-health workers.

In 1940, fresh out of residency, Sidney Kark created the first modern comprehensive community health center at Polela, a 500-square-mile rural area in what was then termed a Zulu "tribal reserve." Over the next decade Kark, his wife Emily, also a physician, and their colleagues added five more health centers to serve African, Asian, and poor white urban communities, and created the Institute of Family and Community Health in Durban to serve as the training center and intellectual headquarters for all of these.

In 1954, the whole operation was incorporated as the Department of Social Medicine of the University of Natal Medical School, an institution that trained African and Asian students. To study social medicine at the Institute was to be immersed in practice as well as theory, to work at real health centers serving real communities, defined populations, and to do so through a strategy of community diagnosis and intervention.

Kark's American connection began by merest chance: in 1956, as a sophomore medical student in Cleveland, I stumbled across a report on Polela. I had been reading the American literature on social medicine with increasing despair; it was full of references to what was then called "comprehensive care" of the "whole man"—in other words, attention to social and emotional problems of the individual patient. Social medicine, apparently, wasn't something you did; it was just an attitude you held. If the word "community" appeared, it was in the public-health literature, and public health—in the prevailing culture of medical education—was a lowly territory of sewers and statistics, the province of failed clinicians, unconnected with "real" medicine.

And then, suddenly, there was Polela: health teams, community organizers, epidemiological surveys, applied social science—physicians who treated patients but were out to change whole communities. I scrambled, juggled elective time, begged; in June of 1957, on a scholarship from the Rockefeller Foundation, I arrived in Durban for a six-month clerkship.

I was put to work first in the health center at Lamontville, an African housing project of 22,000 people on the edge of Durban. It was a clerkship, I think, unlike any other. Zulu community organizers walked me through the endless jumble of cinder-block homes and squatters' shacks, teaching me the social structure of a community that mixed people from half a dozen tribal origins and languages with second-generation urban residents and just-arrived rural migrants. Public-health nurses took me on their rounds and taught me which subgroups were at special risk: in Merebank, an East Indian satellite community living in patriarchal, multi-generational families, it was always the wife and children of the youngest son who were malnourished.

I also received a crash course in environmental sanitation, housing, and nutrition; my first patient, a mother of seven, had typhoid fever, her oldest child had tuberculosis, and her youngest had kwashiorkor, a severe form of malnutrition. As in real life, there was no way to separate an individual's medical chart from those of other family members; they were literally stuck together. On the wall of the examining room in which I saw my patients hung a long row of epidemiological charts for Lamontville: rates of infant mortality and hypertension, incidences and prevalences of infectious disease, growth and weight curves by family composition and income, social networks, and charts of ethnic origins.

Later, in the health center serving the thatched huts and clustered hilltop villages of Polela, the same message came through. One never merely saw an individual patient; one saw patient, family, and community, and the community—a social entity, not just a defined population—was the ultimate focus of concern. The disciplines of epidemiology, the social sciences, and biology were the basis for diagnosis of and intervention in whole communities, and they were as central as all the clinical diagnoses and treat-

I realized that Kark's model might fit the third world that exists within the U.S.

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ments of individuals. In a community health center, “clinical medicine” and “public health” were one and the same.

There was a profound limitation, however. As some senior staff at Polela and Lamontville bitterly complained, the whole program was cautiously and carefully apolitical. Community organization never meant community control and never aimed at fundamental social change. The community health centers at Polela and Lamontville never addressed the roots of disease and poverty in South Africa’s oppression and apartheid, and probably could not have and still survived. Health, not liberation, was Kark’s concern, and though he surely understood the connection between the two, the health centers never acknowledged it directly.

Seven years later, while in Mississippi with the Medical Committee for Human Rights to provide medical support for voter registration and community organization during the “freedom summer” of 1964, I realized that Kark’s model might be modified to fit the third world that exists within the United States: blacks and Hispanics in the urban ghettos, blacks in the rural south and Mexican-Americans the in the southwest, poor whites in Appalachia, and Native Americans on reservations. At the end of that long hot summer and fall, at a meeting of civil rights activists in Greenville, I described Polela and Lamontville and suggested (as I had, to no effect, in my senior medical-school thesis six years earlier) that an American medical school and its department of preventive medicine should develop a center for the teaching of community health based on those models. Count Gibson, then chairman of preventive medicine at Tufts, volunteered his department.

The United States had had “health centers” before—the term covered many different models—but they were, almost without exception, public-health clinics, limited to preventive services, divorced from clinical medicine, and, most important, lacking a social and political mandate.

Gibson and I took the idea of a Polela-like center to the brand-new Office of Economic Opportunity, which boasted of its commitment to “maximum feasible participation.” Everyone knows, I argued, that the primary determinants of health are social—housing, food, income, the physical and social environment—not strictly medical. But why couldn’t health services themselves—based in community health centers—be used as a route to community organization and social, economic and, political change, be used to attack the deepest causes of disease? And shouldn’t we have a new model for primary care, drawing on the resources of the people themselves and of their communities, making them active colleagues in health-care teams?

Six months later, after a long and nerve-racking review, the OEO approved our first grant, for a research project that would also serve as a model: the Tufts Health Center at Columbia Point, a predominantly black housing project on the edge of Boston. In 1965 Columbia Point opened its doors. A year later, the Tufts-Delta Health Center began serving a 500-square-mile area around Mound Bayou in the Mississippi Delta. We had, almost unconsciously, replicated the Lamontville housing project and Polela sites. By then, six other demonstration projects, patterned after these models, were in the works at OEO. That same year, Senator Ted Kennedy came to visit us, and Congress soon passed legislation authorizing the national network of OEO-sponsored community health centers and creating a health-care arm of the War on Poverty.

All of Sidney Kark’s ideas informed those first models in Mississippi and Boston: the community as focus; the development of family health teams; the primacy of community organization and health education; the training of indigenous workers as family health aids, environmental sanitarians, and health educators; and the emphasis on demography and epidemiology.

But there were important additions. Community boards and the principle of community control, however poorly implemented, were new, as were political organization and voter registration, early childhood intervention, legal services, and a thrust for economic independence. This last was especially emphasized in Mississippi, where the community vegetable garden of Polela was reborn as the 600-acre North Bolivar County Farm Cooperative, property of a thousand of the poorest families in the county. An in-service training program grew into a full-fledged educational enterprise that allowed hundreds of local residents to obtain high school equivalency diplomas, technical certification, and college and professional degrees, including 13 MDs, four PhDs, and more than 20 degrees in nursing, social work, and public health. The profound difference in scale and implication between a struggle for the civil rights of a minority and an incipient movement of national liberation by an oppressed majority provided a political latitude that did not exist in South Africa.

All of Sidney Kark’s ideas informed our models in Mississippi and Boston.

At the same time, Kark’s influence was spreading around the world. In 1958, after fleeing South Africa with his colleagues, he assumed the chair of the Department of Epidemiology at the University of North Carolina School of Public Health. The following year, Kark moved to Israel, but John Cassel, the former director of Polela, stayed behind in North Carolina to become one of the great social epidemiologists in the United States. Other colleagues also settled at Chapel Hill, or at Duke, including Cecil Slome, Eva Salber, and Harry Phillips. John Bennett, another former medical
director at Polela, went on to chair the Department of Community Medicine at the University of East Africa, working in Kenya, Tanzania.

Norman Scotch, an American anthropologist and epidemiologist who wrote his PhD thesis on “hypertension among the Zulu” at Polela, returned to the United States to head programs at Harvard and Johns Hopkins and ultimately to chair the Department of Community Medicine at Boston University and create its school of public health. Guy Steuart, director of community organization at Lamontville, became chair of the Department of Health Education at Chapel Hill, where he supervised the Ph.D. thesis of John Hatch, the director of community organization at the Mississippi Health Center and now a professor at the University of North Carolina.

In Israel, Kark founded the department of social medicine at Hadassah-Hebrew University Medical School in Jerusalem, instituted a five-year residency in social medicine—establisthing a new community health center, at Kiryat Hayovel, as its teaching base—and inaugurated an international health workshop that trained hundreds of third-world physicians and health planners, as well as a number of Americans, including Joanne Lukomnik and Pyser Edelsack.

In 1967 Kark returned to the U.S. as a visiting professor, first at Tufts and then, with Kurt Deuschle, at the University of Kentucky. In 1979 and 1980 he joined me again as visiting professor at the Sophie Davis/CUNY Medical School, helping to develop a curriculum in community-oriented primary care. While in New York, he taught a year-long seminar for the residency program in social medicine at Montefiore.

In 1980, Kark published the last of his three books, *The Practice of Community-Oriented Primary Health Care*. (The first two are *A Practice of Social Medicine*, 1962; and *Epidemiology in Community Medicine*, 1974.) Fitzhugh Mullan, Max Pepper, Deuschle, and myself, along with other of his American students and colleagues, brought this body of work to the attention of the Institute of Medicine of the National Academy of Sciences. This initiative resulted in a number of major conferences and a series of IOM publications, under the editorship of Paul Nutting, that have given new impetus—even in the Reagan years—to the work of community health centers and departments of community medicine in the United States.

There is a final, wonderfully ironic fulfillment just beginning. Most traces of Kark’s work have been erased in South Africa, but a new and militant generation of African, Asian, and liberal white South African physicians, organized as the National Medical and Dental Association (NAMDA) has read Kark’s books and remembers Lamontville and Polela. As they plan medical care for a post-apartheid South Africa, these physicians are consulting American leaders in community medicine and social epidemiology, particularly Kark’s former South African colleagues and American students. What most excites Mervyn Suss, George Silver, Joyce Lashof, myself, and all the others is the prospect that the coals, at last, may be coming back to Newcastle, that Kark’s pioneering vision may find expression in the long South African struggle ahead—right where it all began.

In this 1967 photo, a public health nurse tends to a sharecropper in Bolivar County, Mississippi.
California Dumping

A California hospital has become the first to feel the sting of a 1985 federal law prohibiting patient dumping. Even so, the expulsion of the medically indigent from private facilities continues.

Earlier this year, the Health Care Financing Administration, acting on information uncovered by state investigators, cited five cases in which Brookside Hospital in San Pablo refused to treat patients in need of emergency care and transferred them instead to a nearby county facility. In view of these revelations, HCFA threatened to discontinue Brookside's contracts with Medicare and MediCal, the state's Medicaid program, demanding that the hospital formulate a plan to improve its emergency care. Eighty percent of Brookside's patients are covered by Medicare and MediCal; loss of these contracts would bring financial ruin.

The hospital's plan, submitted in April, calls for major changes in the way Brookside delivers emergency care. Government monitors credit the hospital with improvement since then, but it's not out of the woods yet: the original five cases are being examined by HCFA's Office of the Inspector General. If found guilty of dumping, the hospital will face fines of up to $25,000 per patient.

The most notorious case involved the refusal of service to an uninsured woman, brought to Brookside in labor, who delivered a stillborn infant after being transferred by ambulance from Brookside to a county hospital. The case underscores a chilling feature of patient dumping that has become almost routine nationwide: it is disproportionately directed at women in labor. A recent survey by the Children's Defense Fund indicates that hospitals in at least 28 states frequently deny admission to women who are in the process of giving birth. (Because most poor adults in this country are women, a large portion of uninsured hospital patients are maternity patients—as much as 40 percent, according to a study at Vanderbilt University Hospital.)

But in Tennessee, at least, people are fighting back. A coalition of grassroots organizations there convinced an initially recalcitrant state administrative agency to issue rules that would prohibit hospitals from transferring a patient without the consent of both the patient and the receiving facility. The regulations are now awaiting final approval by the Tennessee legislature.

-W.D.

The Medicap Flap

State policymakers are asking the question: are prepaid plans a good way of providing quality and cost-effective care? In Rochester, New York, the idea looked a lot better on paper.

A pilot program begun there two years ago replaced traditional Medicaid reimbursement with the payment of a flat fee per patient. The program, appropriately termed Medicap, was designed to cut Medicaid costs by reducing the use of expensive emergency services for nonemergency care. The county's 40,000 Medicaid recipients were required to choose and enroll with one provider from a network of 10 HMO's and health centers. Providers were responsible for coordinating all care for their patients, including emergency care and referrals to specialists.

Access to routine care improved under the program. An estimated 10,000 people who had no regular medical care received care under Medicap. Many private doctors who previously did not accept Medicaid patients participated in the program. But while enrollees, in a survey, indicated considerable satisfaction with the care they received, the study also uncovered numerous problems in obtaining prescriptions and referrals to specialists.

While the use of emergency services by enrollees declined, the state does not yet know if the program was less costly than Medicaid. And while the county believes it saved about $100,000 by using Medicap, it had anticipated savings of $1-2 million. Providers affiliated with the program, however, lost $2.8 million
in 1986 when the state reduced reimbursement by over 11 percent. As a result of losses incurred under Medicap, one large community health center announced cutbacks in services and laid off about 10 percent of its staff, including interpreters and community-outreach workers; another health center is reducing its staff by one-fifth.

While providers argued that the state wasn't reimbursing them adequately, the state countered that Medicap's financial problems were due to inefficient management and excessive administrative costs on the part of the providers. The plan collapsed last June after the two sides failed to work out an agreement.

—Cheryl Merzel

Painfully Poor Access

Detailing what most of us already suspect, a new report finds dramatic deterioration in access to medical care in the last four years for the poor, minorities, and the uninsured. A recent publication of the Robert Wood Johnson Foundation, entitled "Access to Health Care in the United States: Results of a 1986 Survey," shows marked declines in access to medical care as compared to a similar survey in 1982.

The study measured access to care by gauging several factors: use of health services, including physicians, hospitals and emergency rooms; satisfaction with care received; and general health.

Surveys among the Hispanic community uncovered the most disturbing findings, with 30 percent of those surveyed reporting no regular source of care, as compared to 10 percent in 1982. Twenty percent have no health insurance, with an equal percentage describing themselves as in fair or poor health.

More than 16 percent of all those surveyed—38.8 million Americans, if the study's findings are extrapolated over the entire population—had difficulty obtaining health care during the twelve months preceding the survey. Eighteen percent said they have no physician, clinic, or hospital as a regular source of medical care.

The study also noted that the insured were hospitalized at a rate one-and-a-half times greater than the uninsured. Rates of hospitalization for all groups have declined by 29 percent since the earlier survey.

—T.P.

For-profit Medicine Man Whistles New Tune

A leading advocate of competitive, for-profit, health care has confessed to an error in judgment. On second thought, says Dr. Paul Ellwood, crack consultant and free-market promoter, national health insurance, not the megacorporation, is the wave of the future.

Dr. Ellwood, formerly of the research organization Interstudy, believes that "supermecs" have hit the wall and that, as a result of superfast growth, many of them are now "falling apart at the seams." In an address to the National Employed Physicians Forum last July, Dr. Ellwood pointed to the Kaiser Foundation and the Hospital Corporation of America, with its recent spate of divestitures, as examples of giants with giant-sized ambitions that have fallen asunder.

Dr. Ellwood's vision of a dozen supermecs dominating American health care has been overshadowed by several looming realities. Vertically integrated, for-profit systems, Ellwood told his audience, cannot thrive in a nation where $37 billion remain uninsured, where health-care costs continue to spiral, and where the full impact of the potentially astronomical costs of AIDS has yet to be felt.

What's the solution? Most likely, said the former free-market guru, a national health insurance plan "within the next five to ten years."

—T.P.

60 Hours Without A Break

The age-old rite of passage requiring young doctors to work up to 60 hours without a break may soon be relegated to the history books in New York State. The state's Department of Hospitals is likely to enact new regulations soon limiting the hours worked by physicians-in-training.

A committee appointed by Dr. David Axelrod, state commissioner of health, recommended the changes after a grand-jury report blamed the death of a young woman at a New York City hospital on the long hours worked by the facility's interns and residents. In 1984, Libby Zion, 18, died at prestigious New York Hospital eight hours after being admitted with a fever and an ear infection. The grand jury concluded she had received "woefully inadequate" care from unsupervised interns and residents.

The committee's recommendations propose a maximum shift of 15 hours and would prohibit residents from moonlighting at other health facilities. Hospitals would also be required to have attending physicians on the premises at all times. Axelrod is expected to endorse the recommendations and submit them to the State Hospital Review and Planning Council for final approval.

The ultimate fate of the proposals will reverberate through the country; New York, a leader in medical education, trains more than 10 percent of the nation's doctors.

The Committee of Interns and Residents, a union representing more than 5,000 housestaff physicians in New York, New Jersey, and Washington, D.C., applauded the proposals. "Our members are very excited," said CIR president Janet Freedman, adding "We have been calling for a reduction in work hours since the formation of our union 30 years ago."

CIR has proposed additional recommendations aimed at supporting the committee's goal of improved patient care. Their proposals include limiting the total number of hours worked by doctors-in-training; increasing the number of ancillary staff, including nurses, aides, and technicians; maintaining the number of residents in public hospitals; and prohibiting hospitals from cutting residents' salaries.

—T.P.
Just as social scientists have pronounced the traditional community dead, a victim of urbanization and industrialization, health educators are proclaiming it the hottest thing since computerized instruction.

Disappointed with the limited effectiveness of programs aimed at changing individual behavior, these educators have given the community a new life as the fashionable arena for their interventions. Established community programs have attracted renewed interest and funding, and newer models have sprung up as well.

Is the community alive and well, or has it followed the mom-and-pop grocery into extinction?

Much confusion over the community’s place and unique function as an agent of change stems from differing definitions of the word itself. The traditional community, in which residents share values, customs, and local institutions, has found no place in our cities, where socioeconomic and cultural differences among people living in a given geographic area are often as great as are their similarities. The separation of residential areas from places of employment, together with the rise of the mass media and the isolation they engender, have further loosened the ties that once bound people together.

Another, broader meaning of community has come into use. Under this definition, the word refers to a group of people with a common ethnicity, religion, or sexual orientation. We speak freely of the black, Hispanic, and gay communities, yet by doing so refer to groups spread throughout the socioeconomic spectrum. Meanwhile, the neighborhood has taken over many of the functions of the traditional community. Here, face-to-face contact exists and people use common stores, schools, churches, and health centers; it is this type of community on which I will focus.

Despite these problems of definition, the idea of community is all the rage. Cognizant of new research showing the importance of peer and social support in maintaining health, and desirous of the financial advantages of using existing channels of communication and networks of influence, health educators have become intrigued with the community as a level of intervention.

Until now, however, they have failed to realize the full potential of organizing in such a way. While community newspapers, local leaders, merchants associations, and health providers have been effectively enlisted in these campaigns, most of the projects aimed at reducing chronic disease, although ostensibly dealing with the community, actually emphasize the reduction of individual risk factors—cigarette smoking, high-fat diets, high blood pressure. Only a few have addressed institutional issues such as access to health care, stressful work conditions and the availability of recreational facilities.

In addition, health educators have generally been unwilling to engage in the adversarial tactics practiced by community organizers schooled in the radical movements of the past decades. This has had two negative effects. First, the efforts of educators have usually failed to attract the passion or commitment that more confrontational tactics arouse. More important, the failure to challenge the people who permit illness makes it difficult for educators to mobilize the political power needed to win significant improvements in public health.

That mobilization, getting communities to change communities, is surely difficult, but the AIDS epidemic provides an ideal opportunity to develop such an approach. Only by organizing people to demand the reallocation of public money, both within each community and at the state and federal levels, can health activists relieve the underlying conditions that have caused the rapid spread of HIV infection.

The community offers progressive health educators an important arena for linking their commitments to public health and social justice. The challenge in the years to come will be to translate these concerns, and this new interest in community, into sensible models that can be implemented around the country.

Nick Freudenberg is director of the Program in Community Health Education at Hunter College School of Health Sciences/CUNY.
Last year the feisty Gray Panthers forced the chairperson of the Health Committee of Chicago's City Council to hold hearings on a rather controversial issue: the need for a national system of health care. After the committee heard testimony from all quarters that was strongly in favor of such a system, the City Council, usually a bitterly polarized body, unanimously voted its support of a national health service. Nevertheless, local mavens debated: Did this resolution represent meaningless political posturing or was it a possible harbinger of a national victory?

Until now, progressive critics of the health system have been cursed with this Sisyphean toil: We clearly document our country's massive health problems. We propose sensible programs to cure them. And yet we are continually frustrated in our efforts to effect wholesome reform. Beneficent legislation has been invariably subverted. Witness Medicare, flawed at its inception, now in high jeopardy from DRG's and the relentless shifting of costs to its aged "beneficiaries." Chronically underfunded, Medicaid is in an even more grotesque predicament, each year serving a smaller portion of the nation's poor—and serving them very poorly indeed. Neither program considers preventive medicine or the social context of care relevant. Instead, these liberal reforms have served to magnify every contradiction in our fee-for-service health industry, even as right-wing analysts revile their failings as inevitable products of government medicine.

Permit me a heady pronouncement: the opportunity to break out of this cul-de-sac may be at hand. My optimism reflects three recent phenomena: Canada, corporatization, and something I'll describe for the moment as critical mass.

First, Canada. When it developed a national health plan 15 years ago, Canada left the U.S. alone in the bleak company of the Union of South Africa as one of only two other industrial nations without a national health system. For the Dominion, the plan has brought several diamond-hard problems to solution. Access to care is now universal. Health care costs are now but 8.6 percent of the nation's per capita GNP (ours are 11.4 percent of our higher income) and patients pay no extra fees. The system is very popular with the Canadian public—and doctors, while they may be grumbling, are still receiving about 80 percent of the income of their American colleagues without having to scale our mountains of paperwork; the Canadian example clearly has much to say to us.

The second phenomenon is the rapid corporatization of health care, a historic shift from a doctor-dominated cottage industry to an unabashedly profit-seeking business run by venture capitalists. This has worked a profound transformation, unleashing the forces of the market on an unprepared system, with dreadful results for the poor, for overall access, and for the control of costs. The corporate colossus has become the new adversary in the struggle for decent health care. No longer is the political opponent your friendly local doctor, but profit-seeking national corporations instead.

Now to the significance of our "critical mass": the tens of millions of people outside the shield of public and private insurance, who desperately need health care. (And even the protected are increasingly anxious about the erosion of their benefits.) Trade unions, the elderly, and minorities have urgent new reasons to modernize and humanize our dysfunctional health structures. We're at a new, critical juncture, where fresh strategies offer great promise. Canada's proximity permits for neighborly visits and scholarly exchanges in abundance. The growing corporate hegemony requires public education about the dangers of having health-care providers who are dedicated solely to profits. A critical mass of vulnerable people evokes the prospect of a majority coalition expressing its will through referenda, party platforms, elections of legislators, and passage of laws. The Chicago City Council resolution is one of many sparks across the country that need to be fanned.

Quentin Young is a physician and the president of Chicago's Health and Medicine Policy Research Group.
Washington Watch

Manufacturing a Grassroots Campaign
Barbara Berney

While hospitals and doctors have come out strongly in favor of the bill to add catastrophic coverage to Medicare, legislation which sailed through the House this past July and now must pass the Senate, drug companies have been decidedly less enthusiastic. The Pharmaceutical Manufacturers Association has spent more than $3 million on a direct-mail campaign designed to stir up grassroots opposition to a provision of the bill that—in return for an annual deductible of $500—will cover 80 percent of the cost of medication above an annual deductible of $500.

The association launched its all-out campaign in response to the bill's mandatory substitution of generic (read: less profitable) for brand-name drugs. The pharmaceutical companies support drug benefits for the elderly poor, since these consumers often can't fill their prescriptions for lack of money. Insurance for this group, especially coverage that has no deductible, means new income for the pharmaceutical companies, even if purchases are restricted to generics. But catastrophic coverage which includes the middle- and upper-income elderly, precisely what this bill proposes, threatens drug companies with the substitution of generics in a population now buying brand-name products.

Taking the PMA to task for its tactics, Jacob Qayman, president of the National Council of Senior Citizens, said the association is "deliberately attempting to mislead, and frighten senior citizens," by giving them "incorrect and incomplete information" to persuade them to contact senators and urge their opposition to the drug coverage.

The direct-mail blitz has at least been successful in generating letters; Senate staffers report receiving mail from seniors who are against additional premiums, but in favor of reimbursement for the purchase of prescription drugs. The PMA's effort also includes a follow-up phone campaign which asks permission of seniors to use their names on mailings the association sends to senators.

Since hospitals and doctors support the bill, it would appear the drug companies are using a logic of their own to evaluate the expansion of federal health programs, but this is not the case. All providers support programs that will expand their market. For doctors and hospitals, catastrophic coverage represents payments that might otherwise be lost, since the catastrophic III are the least likely of all patients to pay their bills. For the drug companies, any advantage would be erased by losses suffered from the colossal switch from brand-name to generic medication. They've also learned a lesson from the hospitals: with federal money comes federal regulation and examination.

Under the bill, beneficiaries of Medicare would pay the entire cost of reimbursement for medication through increases in their premiums. The bill calls for an increase in the Part B premium of $4/month, in the Senate version, and $6.60, in the House, and for an additional premium to be paid by those enrollees whose earnings exceed $30,000.

The debate over the drug benefit revolves around whether these increases in premiums are acceptable and whether the estimates of the program's cost are correct. The Congressional Budget Office estimates the cost at $16 billion; HCFA, the Health Care Finance Administration, at $6 billion.

The current debate shows how strategies for incremental improvements may be subverted to meet the needs of providers, rather than consumers; and powerful lobbies; and the pharmaceutical industry will continue to spend millions to distort the health-care financing system in their favor. Thus, in this era of huge budget deficits, ever higher military spending, and a general abhorrence of tax increases, Congress and the public must choose between improved, if still very limited, universal coverage and expanded coverage for the poor alone.

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Harassment of Health Workers in El Salvador

Although El Salvador has faded from the front pages lately, its seven-year-old civil war shows few signs of coming to an end. The conflict has produced over half a million refugees and led to the collapse of the national health infrastructure in that country. In the areas where conflict is occurring, even the delivery of the simplest primary health care remains a daunting task.

Aesculapius International Medicine, a private, non-profit organization based in New York City, has maintained a team of health-care professionals in Chalatenango province since 1984. The team works with the Catholic Archdiocese of San Salvador to provide basic health services to areas which are poorly served or not served at all by the Salvadoran government’s health system.

The Aesculapius team manages a small rural clinic in a village of 2,000 people and supervises a network of 50 health workers in 25 communities in Chalatenango. Many of these communities are small and isolated. In addition, transportation and communication are often disrupted by the war. Army operations throughout the zone and occasional boycotts of transportation called by the rebels make travel impossible at times.

Although the number of politically-related deaths and disappearances has decreased from the extremely high levels of the early 1980’s, violations of human rights continue. These include the continuing use of coercion to relocate civilians living in areas of conflict, destruction of their homes and crops, mistreatment and sometimes torture of detainees, and violations of medical neutrality. The Salvadoran armed forces continue the practice of capturing and dismantling medical units, announcing these actions openly in the national press. In addition, the military continues to harass and arrest health workers who give medical assistance to civilians in places where fighting is taking place. Health workers are frequently questioned about the origins and uses of their medicines, the content of their training courses and who teaches them, and other strictly medical matters. On several occasions medicines have been confiscated.

Humanitarian organizations which provide medical care in areas of conflict are always under suspicion of giving medicine to the guerrilla forces. It is common for health workers to be denied permission to enter or to carry medicine into certain areas. Several organizations have had workers detained or interrogated about their work.

Over the past three or four years the Catholic Church and several private organizations have been able to maintain some very small and low-key programs of primary health care and community education in conflicted areas. However, these activities continue to be viewed with suspicion by the military. The fear and uncertainty about what is permitted make health care and community education extremely difficult, if not impossible, in many areas of the country.

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South African Detentions

The August 1987 issue of the Health/PAC Bulletin (Vol. 17, No. 4) provided timely coverage of a range of vitally important South African health matters. I was impressed, as were other members of the National Medical and Dental Association, with Health/PAC’s journalistic support of the struggle for health care in my country. I would like to return readers’ attention to one of the urgent issues addressed in the magazine, namely the pervasive detention of citizens without trial during the 1986-87 state of emergency.

There can be little question that South Africa is in the midst of a civil war. This became clear when the army was sent into the black townships to put down popular uprisings. Despite the existence of several draconian laws, the government, which was unable to crush the present wave of resistance to apartheid, declared the state of emergency on 12 June 1986. This provided the authorities with sweeping new powers, particularly with regard to detention.

As the Bulletin made clear, detention in South Africa means imprisonment without charge. The detainee is usually without access to law-yers or family; in fact, the authorities seldom inform the families of those who are taken into detention. Depending on the law under which a detainee is held, the period of detention can be as short as 48 hours, or can last indefinitely. As you reported, detentions have lasted up to 490 days, and solitary confinement during detention is commonplace.

During the first year of the state of emergency, the Detainees Parents Support Committee (DPSC) has estimated that more than 25,000 people were detained under emergency regulations. Official statistics have been difficult to obtain: there is no legal obligation for the government to reveal either the names or the number of people in detention. In April of this year, however, General Johan Coetzee revealed that 19,209 persons had been detained between 12 June 1986 and 15 April 1987. These figures exclude detentions under the Internal Security Act and detentions in the homelands, which, for 1986, were 4,132 and 520 respectively. It is not known whether the official statistics include detainees held for less than 14 days, so that the actual number may be closer to the DPSC estimate.

It is particularly worrisome that, according to NAMDA and DPSC estimates, 40 percent of the detainees are children aged 18 years or younger. The abusive treatment of these children was made clear in your abridgement of NAMDA’s “Report on the Detention of Children and Adolescents.” Readers should also know that in 1986 a national campaign spearheaded by the DPSC called “Free the Children” was banned by the government. In South Africa, campaigning to free children carries a possible ten-year prison sentence.

In response to the urgent need to treat the unique mental and physical health problems facing detainees, NAMDA, with the detainee support committees and the Organization For Appropriate Social Services in South Africa, has been providing special clinics for ex-detainees in six centers throughout the country. In 1986, more than 1,000 ex-detainees were seen at these clinics. In addition to providing vital therapeutic and rehabilitative services, information collected at these clinics has been widely publicized. Such publicity, however, increases the risks that organizations like DPSC and NAMDA will face government suppression. For this reason, international support for these organizations is important for their survival and effectiveness in continuing the fight against apartheid.

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