CELEBRATING 20 YEARS OF ADVOCACY
Still here – still fighting
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.
Protecting the Words from Bush

This issue marks the Health/PAC Bulletin's second decade of publishing. That a progressive health care journal of the late 1960's still survives in the late 1980's is notable, perhaps even remarkable, and so we are devoting most of these pages to a celebration of Health/PAC's long life.

In these nasty times of growing hunger, homelessness, and the continuing federal neglect of the AIDS epidemic, the obstacles to organizing a health care movement—as part of a larger movement for peace and justice in this country—could not be more formidable or the need greater. The Bulletin persists in the hope of bringing such a movement to life. With your support, it will continue to offer reporting and analysis of critical health care issues and be a forum for all who seek a rationally organized and truly democratic system of health care in this country. To quote from our 1969 prospectus: "Health is a human right and a biological necessity."

This simple principle—and the companion political goal of organizing our communities into healthy places to live—will have to be even more vigorously defended in the Bush-Quayle years.

The election of such unqualified and dishonest men poses enormous, even historic challenges to those of us who are worried about the fate of our most basic health rights. We can be sure that President Bush will closely resemble candidate Bush, which is to say that the White House will become a launching pad for continued attacks on all our rights. More than Reagan, former CIA director Bush is a seasoned agent of right-wing corporate and political forces. The next four years are certain to see an increase in the millions these interests spend in manipulating words and images to limit national debate and control the way we think.

We have watched with growing alarm as vital words and concepts have been contorted, maligned, and redefined in recent presidential campaigns. "You know, if I listened to Dukakis long enough," Reagan told reporters this fall, "I would be convinced we're in an economic downturn and people are hungry and going without food and medical attention and that we've got to do something about the unemployed."

Drawing on the Reagan legacy, it is all too easy to imagine Bush and his youthful Spiro Agnew dismissing as "liberal" the advocacy of such elemental rights as access to health care, housing, education, and justice. We've come to the point where the meaning of these words and concepts is up for grabs.

As we face a four-year extension of the Reagan regime, health advocates must work to safeguard not only the world of people, but the world of meaning as well. If, in its third decade, this magazine can contribute even modestly to this effort, it will have an important role to play.

—Joe Gordon, Executive Editor
Giving Power to the People:
The Early Days of Health/PAC

BARBARA EHRENREICH


Since leaving Health/PAC, Ehrenreich has continued to combine writing and activism into what she calls a "checkered career." She is the author or co-author of numerous books and articles on health issues, feminism, and social concerns. Ehrenreich has served on the editorial board of Ms. magazine and writes a regular column for Mother Jones. She is a Fellow of the Institute for Policy Studies and co-chair of the Democratic Socialists of America.

At Health/PAC's 20th anniversary retreat, held last July at Vassar College, Ehrenreich's closing presentation was titled "20th Anniversary Reflections and Projections." In this article, adapted from that talk, she reflects on the mood of Health/PAC and the country during the organization's early years in the 1960's and 1970's, and discusses possible directions for its future role in the 1990's.

I want to talk about the early days of Health/PAC—I have to talk about the early days because that's when I was there—and the kind of political outlook that emerged from Health/PAC at that time. Increasingly I've come to appreciate how much of my own political outlook was shaped at 17 Murray Street almost 20 years ago. Then I want to look ahead just a bit and ask about the relevance of what we learned then to what's coming next. So let me start with a somewhat personal report of how I got to Health/PAC.

That was in early 1969. In 1968 I received my PhD in biology at Rockefeller University and promptly tossed it over my shoulder and went out looking for some way to be relevant. I could have been a research scientist, but we all had a problem in those days—to be relevant somehow. I could have been a research scientist, but we all had a problem in those days: our minds kept wandering to the war in Vietnam and how to organize to stop it. I spent so much of my graduate years marching and organizing and leafletting that I probably should have gotten a PhD in something like political subversion rather than cell biology.

Barbara Ehrenreich

But I did get the PhD and decided that, since I had studied biology, the natural path for me to "relevance" was going to be through health. So I started by getting a job in New York City Mayor John Lindsay's budget bureau. He had a "brain trust" in the budget bureau, so called, which was doing what was euphemistically known as "health planning." The idea was to have smart young technocrats, including myself, who would sit way up high in the Municipal Building and figure out what the people on 125th Street or on Avenue D needed, which of course they wouldn't get anyway because of the war in Vietnam.

One of the things going on around me in the Municipal Building was the beginning of the plans for the Health and Hospitals Corporation (the big quasi-public authority that now runs the city hospitals). I would read all the documents and memos describing the plans of the Health and Hospitals Corporation and even sit in on some of the planning meetings. And as I read and listened, I found out some of the things that ruined my career in health planning once and for all.

First I found out who made the decisions, which was not the mayor, not even anybody in the public sector, but bankers and medical school deans and heads of brokerage firms and various sorts of high society types. I also found what seemed to me at the time a
smoking gun: a statement in one of the memos by Lewis Thomas, the former dean of the New York University Medical School. (I think he’s been rehabilitated since then as some sort of science-philosopher.) He wrote that even though Medicaid now appeared to offer some way to go beyond a two-class hospital system, even though it seemed as if we could come up with a one-class system for all people, we should not do that because it was necessary to keep poor patients in a second-class system as “teaching material” for the young doctors-in-training.

I was not a very politically sophisticated person at the time, and this statement really opened my eyes. I saw that this was what was meant by “institutionalized racism.” This was organized class oppression, not to mention just plain meanness, nastiness, and general disregard for human dignity.

So I made a big decision, which took me about 15 seconds, and xeroxed all those documents and carried them out of the Budget Bureau (I’m skipping some steps for the sake of narrative tightness), and I more or less walked across the street to Murray Street, where there was a guy named Robb Burlage who, I had heard, might have some interest in these things.

He was interested; in fact he offered me a job, clipping the New York Times and answering the phone for Health/PAC for just about exactly half the pay I was getting from the city. I was absolutely thrilled.

I want you to know that there was no heroism whatsoever involved in that little bit of whistle-blowing. True, I had lost a good job, one of the only jobs I’ve ever held in my life. But I hate wage slavery, and that was one of my two encounters with it. So when I found Health/PAC I was ready to do anything – sweep the floor, if necessary. Because what Robb and Maxine Kenny and Ruth Galanter and other members of the group Robb was assembling represented was an entirely different vision of health planning, a radically different idea of how young professionals ought to be using their skills and knowledge.

But before I say more about that idea, I just want to say a little bit about what Health/PAC was like in those years, 1969-1971, when the revolution (remember that old word?) did not seem far away, and it sometimes seemed like it might begin at 17 Murray Street, or at least that we were some kind of important outpost.

Where to Find the Power

New York was at that time in the midst of a powerful grassroots insurgency coming from, mostly, the black and Hispanic communities, as well as from hospital workers and young professionals. It was an insurgency not only demanding better services, like health and education, but demanding power, demanding “community control.” And our job, as Robb defined health planning or advocacy or whatever it was we did, was not to tell the people what to do, or what to ask for, but to tell them where to go, to tell them where to find the power. That was the point of all our research on the medical empires and medical-industrial complex and all the huge structures of government agencies that had been set up: to locate power, so people could see how to go after it.

I wish I could convey to you some of the excitement of those days, the swirl of people and activity coming through Health/PAC. There were Black Panthers; there were black church leaders; there were the Young Lords, speaking their particularly endearing mixture of Marxism and barrio slang. There was Howard Levy, fresh out of federal prison—he was the personal hero and martyr of Health/PAC. There was Leslie Cagan, now an important peace activist, just back from the first Venceremos Brigade in Cuba and talking about revolution. There was Rick Diehl, coming up from organizing coal miners in Appalachia. There were Ollie Fein and Charlotte Fein, pioneers in community organizing in SDS’s Cleveland ERAP project. And, of course, someone who is not with us now, our old friend and beloved intellectual guru Harry Becker, who actually worked at Albert Einstein Medical Center. He was a pragmatist and a political populist, and he gave us a way of thinking about what we were do-
We learned to respect our skills and our knowledge, and in the process we learned to respect ourselves.

Political Perspectives

You probably think these were the absolute highlights of life at Health/PAC in those days. But they are just the things I happen to remember. There was much more, and out of all this came a certain kind of political perspective. And I would emphasize the words "out of this," because political perspectives, as we used to say (I am plagiarizing Mao), do not come out of the sky. They come from practical experience, they come from work, they come from concrete attempts to actually change the world. And this is what we were engaged in—confrontation and action as well as research and discussion.

How would we characterize that particular Health/PAC kind of politics, which I admit is still very much

We had worked with people who needed the facts but couldn’t find them, who needed to speak but had no way of making themselves heard.

We believed, first, like all conventional socialists, and most decent liberals, in a redistributive politics, or, in plain words, that you’ve got to spread the good stuff around—the money, the opportunity, the good jobs and good places to live, the good things to eat, and the high-quality health care. You’ve got to spread it around.

But we also believed—and this made us different from the liberals and even from many of the old-style socialists, who often saw us as far more dangerous and subversive and wild than ordinary Reds—that in addition to everything else that had to get spread around to people, you’ve got to spread around the power. You’ve got to take the decision-making, the so-called “planning”—and spread it around to the kinds of people Jesse Jackson talks about, the people who take the early bus, the people who change the bedpans, the people who don’t ordinarily get heard from at all. So we became radical, small-"d" democrats.

Professional Politics

But there was also a more personal, or maybe professional, politics emerging out of 17 Murray Street in those days. Many of us—not all of us, certainly—were professionals. We had higher degrees, even if they were sort of discarded degrees, as in my case. We even had some MD’s, and most of us were college educated. We were trying to come to some kind of understanding of our role as professionals in a process of social change that was not really being mobilized by people like us, but by people who were different. So we were trying to figure out how people like ourselves, who had the privilege of education, fit into this kind of movement of poor and working class people and people of color.

I think we learned two things. One was humility. We had seen too much of the professional arrogance of people in all kinds of elite positions—MD’s and administrators being probably the most outrageously arrogant.
An example—a story I've never forgotten because it illuminated so much to me about professional thinking at its worst—was the challenge at Harlem Hospital, when community groups demanded that the clinic hours be changed so that working people could get care without losing a day's pay. Now, that would have been inconvenient for some of the doctors and administrators, and one of their responses to the community was, "You want to tell us when to have clinic hours. Next you'll tell us how to operate!"

Now, that I thought was very interesting. That was a very revealing statement. It showed a lot about the professional mentality that extends from a specific skill in a specific area of expertise to some kind of generalized authority about how everything ought to be. In this case it was surgical skill suddenly becoming some kind of expertise about clinic administration. Of course, the next thing we thought was, "Yeah, maybe we will tell you how to operate!" (Which, when you consider the extremely high hysterectomy rates at Harlem hospital compared with other hospitals, would not have been such a bad idea.)

Our vision is not just of a system that gives people the services, but a system that gives them the power.

So, professional expertise could be used as an excuse for unjust authority over the lives of others. We at Health/PAC didn't want to do that. We wanted to be humble, we wanted to remain within the limit of whatever expertise we had.

But we also learned—and this was rarer for the times, or at least rarer in the radical circles of the New Left that many of us moved in—to respect our skills and our knowledge, and in the process, I think, we learned to respect ourselves. It was hard to do that in 1969, when the student left was falling apart in an apocalyptic mood of self-hate. But we at Health/PAC had worked for a long time with people who needed the facts but couldn't find them, with people who needed to speak but had no way of making themselves heard. So we were proud to find ways to use our skills to find the facts and to amplify the voices of people who needed to be heard.

The Intervening Years

In the intervening years (I wish we could have skipped a few of those intervening years), we saw a lot of the promise of those movements in the sixties die. We saw liberalism, for example, go underground, so that even that old liberal goal that we used to criticize so much at Health/PAC—national health insurance—became too radical for mainstream political discourse. We saw health policy as an organized public effort, however halting, come to an end—unless you want to count as "policy" systematic neglect and surrender to the private forces, the elite in the private sector, which by this time of course doesn't just mean the voluntary hospital empires but the huge, overtly profitable chains.

We saw an epidemic, AIDS, that tested America's six hundred billion dollar medical system and found it almost universally lacking at every level, from basic research to the low-tech end of delivering care to the dying. And we saw the return of absolute deprivation, of conditions among the American poor that increasingly match the conditions among the third world's poor—hunger, homelessness, vagrancy, and despair—so that for the poor of today, some of the issues that were at the forefront 15 years ago, like health care and education, have become almost luxury issues in the eighties, relative to the issues of food and shelter. And that's a painful thing to grasp.

Another thing that happened to many of us, certainly to me, in those intervening years, was that we learned that the problems of the health care system were not just problems for someone else. For one thing, we had children, and children put you into an entirely new relationship to the health care system. We had to figure out how to cover their needs with limited health insurance. We learned about other kinds of prejudice in the medical system in addition to racism, in addition to class prejudice; we learned about sexism and homophobia.

I turned into a feminist—a feminist of the heart, I mean, and not just the head—during the time I received prenatal care during my first pregnancy. I have always had a debt to the OB clinic at Lenox Hill Hospital for the truly fine job of consciousness-raising Barbara Ehrenreich at the lectern.
they did, which showed me that you could be white, that you could have a PhD, all these advantages, and still be treated, as we used to say, like a piece of meat. And that sent me from Health/PAC into the women's health movement, where I was an activist for many years, until other concerns pulled me away.

The Next Left

Moving on to the present and the next few years, I believe we are entering into a time that in some ways will be like those dramatic years of '68, '69, and '70. I see it on the campuses, where the selfish, negative, trancelike mood of the eighties is breaking, and a new generation of activists is springing up (including, I am deeply proud to say, my own daughter Rosa, the first baby born at Health/PAC).

I see it in the communities I visit, all over the country, where the spirit is no longer “How to stop big government.” The mood that I see is “How to take the government back and make it work for us and meet our needs.”

What especially inspires me is the presidential campaign of Jesse Jackson, which articulated so much of the vision that was born in the movements of the sixties and that will sustain and inspire the movements of the nineties. Seven million people voted for him, and that success represents not only his personal charisma, but a lot of old-time, grass-roots organizing.

So this is a time of new opportunity that we’re going into. I think that things are going to change dramatically, and I see two things that we who are health activists, health professionals, and health advocates can do and must do. One is pretty obvious: carry on the push for a just and an equitable and humane national health care system. I would just add, as one tiny lesson from Health/PAC, that our vision is not just of a system that gives people the services, but a system that gives them the power. Because if there is one thing we learned, it is that just as healing is a form of empowerment, so is empowerment a form of healing.

The second and the last thing I want to say has to do with the kind of movement we will find ourselves in during the next five years, or in the coming months, I hope. Because the next left (not the New Left) will be different. The next left will be the Rainbow left. Not only students, but workers and farmers. Not only the poor, but the near-poor: blue-collar, pink-collar, gray-collar, and people of all colors. It will be larger than anything in our past experience and perhaps more challenging, chaotic, unruly, and brash. People like ourselves who have special skills and education have a place in that movement, a role and a responsibility. And by “people like ourselves” I mean professionals, doctors, nurses, planners, teachers, intellectuals, veterans’ leaders, students, and the people we work with too.

Perhaps the biggest challenge to us is going to be conveying to new generations—both with our words and our lives—that in an unjust society, a commitment to human services is also and inevitably a commitment to social change. There is no way around that. It is a commitment that has to see us through the grim periods of reaction and retrenchment as well as through the glory days of activism and advance. And we need to convey that it is a commitment that we do not undertake in a spirit of self-righteousness or self-importance or even altruism, but in a spirit of humility and hope, with respect for our own contributions and respect also for the contributions of people very unlike ourselves, contributions very different from those that we can make.

Finally, maybe most importantly, we want to convey to future activists that this kind of commitment has its own rewards: plenty of laughs, all kinds of satisfactions, and, most of all, the opportunity to be with the very best company you could possibly find.
Molly Joel Coye is the Commissioner of Health for the state of New Jersey. In a keynote speech at Health/PAC's 20th anniversary retreat last July, she traced her experiences from her days as a student of Chinese history at Berkeley to her current role. As a policymaker for Republican Governor Thomas Kean, Coye has successfully combined activism and a progressive perspective with an influential administrative position.

I have taken rather an unusual course over the last 20 years, from student of Chinese history to Commissioner of Health in New Jersey. In giving an account of my personal odyssey, let me begin with the ending. As one of a growing cadre of activists who have gone on to be policymakers, let me say that policymaking is exhilarating and wonderful. The opportunity to try one's own hand at the wheel is enormously satisfying.

I've now had only a little more than two years on the job, so it may seem early to be offering you much in the way of impressions. But, for the six months before that, I was deputy commissioner of regulatory affairs in the New Jersey Health Department, responsible for hospital rate setting, certificate of need and facility licensure, and inspections, and, for the previous year, I was Governor Kean's policy advisor for health and the environment. At his request, I spent that year designing policy initiatives in indigent care, maternal and child health, environmental health, and health care for the aging. Now, of course, I'm responsible for implementing all of the initiatives I recklessly proposed.

From my early involvement in Chinese history, through work in community medicine, occupational medicine, and now broader aspects of public health, I have tried to pursue two themes. First is that intellectuals have a role and a responsibility to foster social change. Second is that one should insist upon working with and for a constituency. Life is not fulfilling without the first, and it's no fun without the second.

To China and Back

Like hundreds of other Americans in college during the sixties, I was enthralled by the Cultural Revolution taking place in China. There, for the second time in a half-century, an entire society was determined to remake itself. Individual afflictions—hunger, venereal disease, tuberculosis, schistosomiasis—were understood to have social origins and social cures.

I came home convinced that I did not want to live my life as an observer.

You remember the "little red book" of Chairman Mao Tse-tung's sayings. This book actually achieved some fame, or notoriety, in the United States. Here it was regarded as a curiosity, but in China it was a basic text, a "how-to" manual for social change. The phrases collected there embodied the experiences of 30 years of the most massive social transformation in modern history, boiled down into a booklet smaller than the Washington Manual. These phrases captured our imagination in the late sixties, and some of them are curi-
ously resonant today.

In China of that epoch, it was the role of the intellectual in medicine to investigate and elucidate the social causes of illness, and to do so not only for, but together with, those who suffered. The red book said, "You can teach the people only when you are their pupil." Intellectuals were responsible to their constituencies, that is, to those whom they studied. During the Cultural Revolution, these constituencies often judged intellectuals harshly for arrogant and self-interested behavior, sending them to the countryside to learn from the peasants and to observe the consequences of their own work. At the University of California in Berkeley, where I was studying Chinese history, we imagined with great relish sending our professors to Fresno and Bakersfield.

The red book said, "You can teach the people only when you are their pupil."

But travel truly is broadening, and the three years I spent living in Asia introduced me to a new America. As I grew homesick, I spent a lot of time at the USO in Taichung, China, talking with American soldiers who were on R and R from Vietnam or had been posted at a nearby airbase. I learned a lot about Fresno and Bakersfield, and I came home convinced that I did not want to live my life as an observer. I wanted to be involved directly in the changing of society, and I wanted to work in my own country. Eventually, I decided to study medicine, inspired by physicians who had "served the people" both in China and at home.

One of my heroes was Norman Bethune, a Canadian physician who was a pioneer in the surgical treatment of tuberculosis before leaving his country to join the Republican forces in Spain. There, he introduced the practice of blood transfusions on the battlefield, and helped to develop ambulance services. From Spain, he returned home briefly, and then in 1936 left again—this time to join the Chinese Revolution. He died in China of an infection from a scalpel wound to his finger, because the supply lines had been cut and the reserves of sulfa drugs exhausted. I read the biography of Bethune and heard of him all over China—and I was determined in my own life to combine, as he had, the power of knowledge with the passion of the fighter for social justice: the scalpel and the sword.

The Disenchanted '70s

Ironically, my own studies of China culminated in the early 1970's just as the Cultural Revolution did—and just as the backlash was beginning in the United States against the "War on Poverty" and the "Great Society." Growing disenchantment with the limitations of many of these social programs in the United States was paralleled by growing mockery of the idea that social problems were a legitimate focus of government...
concern and effort. In frustration and self-vindicating, some of our colleagues resorted to polished academic versions of victim blaming. The “me generation” was born in academe as well as in the yuppie cafe society.

I entered medical school at the Johns Hopkins University, determined to practice what was then newly titled “community medicine.” At the end of my first year, I spent the summer studying health services in East Baltimore—the poor and black part of town. There, I learned to my discomfiture that Johns Hopkins was often referred to as “the plantation,” and by the end of the summer I was very discouraged. Where was the community—the organized constituency that could define their own needs and deal with physicians as equals in power? Despite their most egalitarian impulses, the physicians working in East Baltimore seemed to me to have become medical missionaries, defining the community’s needs for them as well as providing for those needs.

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The next year I attended an introductory seminar on occupational health at Howard University. Eureka! This was it: a field in which the patients—the workers—were already organized and were used to deciding what they wanted for themselves. They wanted our technical knowledge, but they knew that the power to change their conditions derived not from our knowledge, but from their own organizational strength. That relationship, a balance of skills and a respect between equals, has been an abiding source of satisfaction to me in occupational health ever since.

By the time I had finished medical school, there was no longer any serious discussion of organizing communities to change or eradicate the sources of illness. Funds had ceased to flow for the amelioration of conditions identified as the social causes of illness. The tasks of medicine, and even public health, were now understood to be providing individual medical services or altering individual behaviors. In our occupational health clinic in San Francisco, we saw more and more workers whose employers had introduced screening programs for obesity and hypertension, while they ignored lead poisoning, chemical bronchitis, and hearing loss. In the Clinical Scholars Program at the University of California at San Francisco and Stanford, my professors helped me to understand these changes and taught me new skills with which to analyze them.

Academics in medicine and public health continued to research and describe many of the socioeconomic forces that support particular patterns of disease. But as the social movements of the preceding decade ebbed, many academics—like much of the rest of society—seemed to renounce responsibility for changing the world. In this wholesale retreat from political involvement, however, academics missed the boat. They failed to create both a clear role in policymaking for research and a clear articulation between individual research agendas and broader social agendas.

This lack of articulation between research and policy makes it difficult to justify many clinical and social interventions. Without clear evidence and a strong conviction that certain interventions make sense, how can we expect resources to be allocated to these interventions?

John Wennberg illustrated this in his excellent editorial on the variations in rates for hospital admissions and surgical procedures by geographic area, published in the New England Journal of Medicine early in 1988. He warned, “Government and business have become bold in their willingness to interfere in the clinical decision-making process to save money.” He added, “Unless the medical profession accepts the responsibility for the question of ‘which rate is right,’ others will see to it that the ‘least is always best’ theory dominates by default. After all, if physicians can’t agree on what is best, why do more?”

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neutral” axmen do the choosing. Resources are limited, and difficult choices are the only kind we get to make today. But we also know that no choices are neutral. Instead, the choices represented in the federal budgets and congressional actions this year reflect a
prejudice against societal responsibility for the welfare of the citizenry.

I observed this change in microcosm at the National Institute for Occupational Safety and Health (NIOSH), where I began work in 1980. By the end of my five years there, the agency was rarely testifying on behalf of the creation of new standards for worker protection. It was publishing few technical or policy reports. It was tempering its conclusions, implementing self-censorship within and bowing to pressures from outside the department. In my last year, the Occupational Safety and Health Administration (OSHA) was under a federal court order to produce a field sanitation standard providing portable toilets and drinking water for farm workers or to show cause for not doing so. While at NIOSH, I had done a great deal of field research on occupational health in agriculture. In 1984, OSHA routinely requested that I testify for NIOSH on the need for a field sanitation standard. OMB, however, was adamantly opposed to such a standard — and for the first time, NIOSH refused to let its own staff expert testify. As a gesture of support, my colleagues raised the air fare to send me to Washington, and I did testify on behalf of the American Public Health Association.

If we don't want the green-eyed shade boys at OMB and elsewhere to determine our social agenda, we, as health scientists and activists, will have to wield both the sword and the scalpel. We will have to interweave our science with our social ideals.

Truth vs. Facts

Most of us share a common characteristic: curiosity. We want to know how decisions in our field are made, how new truths are discovered and then confirmed, and how eventually they, in turn, must be revised. We also want to know how we can discover new pieces of information — facts — that will challenge existing truths. We share a desire to get our heads above the water, knowing that what we observe is constantly changing in a tumultuous flow of events. We see ourselves as the civil engineers of society, building dams, dredging safe harbors, and otherwise meddling on a grand scale.

Resources are limited, and difficult choices are the only kind we get to make today.

These truths that we are curious about dictate everything, from choosing a pharmaceutical for treatment of a disease to choosing a method for financing indigent care. We investigate these issues by conducting research. As we know, this research not only can enrich our understanding, adding to past knowledge, it also can unearth new sets of facts, capable of altering what we understand about the world. At its best and most effective, it will alter the interventions we design to solve our problems.

When we arrive at policymaking positions, we find that often there isn't much of a relationship between truth and facts.

We are scientists, after all, and Chairman Mao — himself a social scientist par excellence — told his people to "seek truth from facts." Yet the sad fact is that when we arrive at policymaking positions, we find that often there isn't much of a relationship between truth and facts. Facts are presented as a hodge-podge of isolated verities, and larger truths are asserted without much respect for these facts. When some facts contradict these truths, we find ways to dismiss them. If they won't support an intervention we want to propose, we can be quite ferocious in attacking those who advance them. So the relationship between facts and truth is not always straightforward. This is particularly true in the political arena, where the half-life of facts often depends upon their relationship to prevailing ideologies.

The result of this, of course, is a predictable and perhaps healthy level of cynicism. Since many Health/PAC readers did not live through the generation of the "little red book," I thought I might draw upon another major influence in my life — one more recent and better known — to illustrate this point. So I quote not from Chairman Mao but from the rock group the Talking Heads, who cynically affirm that "Facts all come with points of view / facts won't do what I want them to."

Politics and Policy

But the gap between individual facts and summary truths is not nearly so serious as the gap between truth and policy (the "don't confuse me with the facts" school of policy formulation) or the making of policy in the absence of any information at all. Let me paraphrase Voltaire's succinct comment on the law: health policy is like sausage; if you love it, don't watch it being made.

And there is no question that even with a far more effective articulation between research and policy development, we will continue to be derailed by the political process on a regular basis. Karen Davis, a professor at the Johns Hopkins School of Public
Health, has described aptly and with humor the extent to which the best laid plans of policy advisors are influenced by political ideology, the personal experience of policy officials, special interest groups, media attention, and even happenstance. The drug-related death of athlete Len Bias, for instance, helped to catalyze a flood of proposed legislation on drug abuse—we had 94 separate pieces of such legislation pending in the New Jersey Legislature last year.

Research does get used in the public policy process; the question is, under what circumstances? The opening for policy analysts comes when there is a conjuncture of public attention and concern, political interest, available funding (often modest), and a sense that "something must be done." In the past year, this conjuncture has occurred in the areas of maternal and child health, drug abuse, home health care for the elderly, nursing home reform, and organ harvesting and distribution systems. The onus is on the activist as researcher to make his or her work understandable, available in a timely manner, and useful.

When these openings occur, legislators or the governor turn to their public health experts and ask what a reasonable, and preferably not too costly, solution might be. If it's too costly, the health department may be able to get a demonstration project out of it. If one can show evidence of cost savings, of course, the enthusiasm is heart warming. I have to say I am more sympathetic than I thought I would be to this response. I am increasingly aware of the scarcity of resources, and how desperately we need vigorous evaluations of our efforts. The evidence for cost savings is, in fact, what has helped us to be so effective in obtaining support for maternal and child health programs—we have made good use of the Institute of Medicine's finding that $1 spent on prevention will save $3.25 in subsequent costs.

At those moments when there is a conjuncture of political will, funding, and program interest, the most troubling prospect is the possibility of wasting the opportunity, of spending scarce resources on an intervention that is not even capable of affecting the problem. In some cases, there are strong social assumptions about the necessity of particular solutions, and one may be pressured into adopting such programs despite suspicions or even certain knowledge that these interventions are likely to be ineffective or even fruitless. In the flood of drug abuse legislation I mentioned earlier, for example, most of these bills rely on methods for which there is no evidence that they will work. Yet some of these bills will be passed, and we will be expected to implement them. I faced this same problem when I was conducting field investigations for NIOSH, and before that when I worked for the Oil, Chemical and Atomic Workers' International Union. Union members would complain, for example, that their company wouldn't even provide yearly chest X-rays and wanted to enlist my
support in their struggle to obtain this service. Since the average age of the work force was 25, I knew what a waste of scarce preventive health service dollars this type of intervention would be. I was not always successful, however, in dissuading them.

In fact, I used to be at some pains to make it clear to the union at the beginning of an investigation that the best service that I could provide them with was a frank and honest yes or no: Was the exposure they were worried about potentially harmful, and was it harming their health now? As in every area of health research, false or misleading confirmation of their suspicions could force them into using their limited influence, often in a protracted struggle, in order to protect themselves from an exposure that was not a hazard. Research has the potential, therefore, not only to guide us to new and more productive programs; it can also save us from costly mistakes.

The Bold Advance

As a policymaker in public health, remembering what I learned in the study of China as well as in working for a union, this is the constant challenge: to push the limits of what is possible, with care not to waste our efforts, our scarce resources, and our often scarce political capital on fruitless endeavors. We must painstakingly consider the options before us, in search of worthwhile enterprises—changes that will merit the struggle entailed and the other possibilities forgone. Lest this sound too tentative in tone, let me finish by saying that despite all of these caveats, only the bold advance will be worth the effort: we must not be timid. In its 20 years of work in health and medicine, Health/PAC has clearly demonstrated how much we and the citizens of this country stand to gain when we manage these bold steps forward. □
Surviving the Reagan Years
A Look at the Bulletin Through the 1980’s
TONY BALE

From Alan Sager, “Survival of the Fattest,” Part II

Hospitals in minority neighborhoods and smaller community hospitals generally may be old, run-down, and inadequate when they go under, but using these characteristics as a justification for closures is like saying people should starve to death because they don’t have enough to eat.

Vol. 12, No. 8, November-December 1981, p. 27

From Ronda Kotelchuck, “In the Grip of PPS”

Rapid and radical changes are transforming the hospital’s role in American health care. The single most powerful force in this transformation has been implementation of the Medicare Prospective Payment System (PPS). Why? Because PPS totally reverses the financial incentives by which hospitals have traditionally been managed.

Vol. 17, No. 1, November 1986, p. 7

Health/PAC Bulletin, now 20 years old, is one of the few journalistic voices originating in the 1960’s that continues to refine the political project and analysis begun by the New Left movement.

The magazine survived not only because, for many who were touched by that movement, it remained a link with their youthful past; not just because the Bulletin was the vehicle for generating a seminal radical analysis of the structure of the health care system, widely disseminated and absorbed through Health/PAC’s 1970 book The American Health Empire; not even because for 20 years it has in large measure expressed the vision of its founder, Robb Burlage, one of the most important political thinkers in the early SDS milieu (see interview in this issue). The Bulletin has survived mostly because it has continued to be a vital tool for investigating the structure of the health care system by progressives interested in fundamentally changing it. In the face of the cruel spectacle of a financially bloated health care system neglecting the fundamental survival needs of large numbers of Americans—of widespread pain, suffering, death, and indignity imposed by ill-conceived public policy—the Bulletin has been a small, persistent voice for decency and social justice.

In its early days, the Health/PAC staff generated numerous seminal articles, drawing on the experience of an active health movement to analyze areas of interest to that movement, many of which had not previously been subjected to a serious radical analysis, and to produce work that informed the movement’s practice.

The 1980’s have been a different time. Rather than being put out by a staff collective, the Bulletin in the 1980’s has been the product of a volunteer editorial board, two talented movement journalist-editors, Jon Steinberg and Joe Gordon, and writers from around the country. With the movement dispersed and aging, conservatism ascendant, and the health care system undergoing rapid, wrenching reorganization, the heady days of the late 1960’s and early 1970’s have been replaced by the health movement’s search for personal, organizational, and political survival; for small victories and a new understanding of the rapidly shifting terrain; and, at present, for a new, unifying, progressive national thrust. The Bulletin’s great achievement of the 1980’s has been not only that it has survived as a beacon of hope to the often unfocused and demoralized health movement, but also that, better than any other publication, it has reflected the reality of that movement—its strengths and weaknesses—while continuing to develop analysis and reporting to advance the movement’s understanding and political struggle.

In this article I will look at some of the dominant thematic voices in the Bulletin to help gauge where the movement has been in the Reagan era and where it might go. By thematic voices I mean writers who have had a strong presence in the Bulletin and who, in their own individual

Tony Bale has been a member of the Health/PAC board since 1978.
From Geraldine Dallek, “Six Myths of American Medical Care”

Patchwork quilts can be beautiful, but our health care system is a flawed one, so small it leaves millions of people uncovered, threadbare in places, and threatening to come apart at the seams. Perhaps it is time to trade it in for a more serviceable blanket system providing prenatal care to all women, dental care and needed hospitalization for all our children, and basic services to all Americans. In exchange we may lose some of our beautiful and exciting patches—the artificial heart program for one—but for our society as a whole it would still be a wonderful deal.

Vol. 16, No. 3, May-June 1985, p. 15
From Joanne E. Lukomnik, "Gender Slap"

The daily stress of trying to cope with too little money, the occupational hazards of working at low-paying jobs, the inability to see health providers early for primary and preventive services, the fear amid threats to cut Social Security and Medicare of surviving to an impoverished old age without resources, all take their toll. It may be years before we fully understand all the ways in which the Reagan program has harmed women's health.

Vol. 15, No. 4,
July-August 1984, p. 13
From Louanne Kennedy, 
“Hospitals in Chains”

More than a decade ago Health/PAC was pointing out the contradiction between the goals of the “non-profit” medical empires—teaching, research, control of community health centers, profits built on public funds—and the need for appropriate care and community control. Since then the empires have honed an extraordinary talent for providing the most intensified services possible for any patient whose insurance will cover them....Public and community hospitals, unable to imitate this high technology care and management, are going the way of the roadside diner. Yet amidst this carnage of closures, mergers, and conversions...the empires also drift uneasily, aware that the new terrain of cost control is threatening them with new dangers and far more formidable competition: the corporate health care chains.

Vol. 12, No. 7, September-October 1981, p. 9

imminent advance for the health care movement at the federal level, Dallek wrote, “while fighting Federal cuts we can seize opportunities at the state and county level.” In fact, much of the health movement shifted its attention to state and local arenas, where its influence could be felt, and where progressive political coalitions, sometimes including providers, could win small but meaningful victories to protect or enhance some lives.

Mid-Decade: Restructuring the Health Care System

In early 1984 Ronda Kotelchuck sounded another major theme of the Reagan years, one she chronicled for the Bulletin in five valuable, widely read articles. Her theme was the Reagan era’s major measure for the restructuring of health care: a prospective payment system for Medicare based on DRG’s (diagnosis-related groups). Enacted in 1983, the new system threatened to shift the incentives for hospitals from “do more” to “do less,” with uncertain impact on access to and quality of care. Later in 1984, in a special issue on “American Health in the Reagan Era,” a series of articles documented the changes Reagan’s first term brought for the hungry, homeless, disabled, poor, women, children, and others. (Real people, of course, might occupy several of these categories.) Michael Clark’s introductory piece spoke of two major themes: increasing class polarization in a system of clear “winners” and “losers,” coupled with an ideological and economic offensive to turn health care into a “nakedly capitalist” system dominated by “new entrepreneurs.”

In several articles in 1984 and 1985, I addressed the process of class polarization in the health sector at the high point of the Reagan era’s dizzy capitalist joyride. The recession of the early 1980’s had been an important historical watershed. A conjunction of factors produced a squeeze on providers as well as sharply declining health insurance coverage, particularly among recently unemployed workers who had previously enjoyed good benefit plans. Together, these constituted a crisis in access to health care, a continuing political phenomenon acted out in Congress and in the states. The principal successes, in its own terms, of this sleaze-ridden administration (before its secret dealings out in Congress and in the states. The principal successes, in its own terms, of this sleaze-ridden administration (before its secret dealings and pervasive corruption helped trim its sails), were inflated financial markets and tax cuts that increased the absolute and relative worth of the wealthy.

This new configuration of greed and power was mirrored in the service sector, particularly in health care. New health fortunes were being created and augmented, while the relative condition of the predominantly low-wage workers in health care worsened. Everywhere, new financial risks were translated into new hardships for many and new wealth, buoyed by the financial bubble, for a few. The access crisis and more restrictive private health care plans were part of a reconfiguration of class relations. Under this reconfiguration there was a greater insecurity for large numbers of displaced or easily displaceable workers and others; this went along with the creation of numerous new technology and service businesses, some of which led to instant paper fortunes through winning Wall Street’s fickle favor. The restructuring of the health care system was not simply the result of a change to for-profit ownership and new austerity policies; rather, it was part of a social and economic transformation throughout society.

In late 1984, Louanne Kennedy further refined her analysis of the radical changes sweeping the hospital industry. While public hospitals were continuing to disappear, those voluntary hospitals not taken over by for-profit chains were either being “proprietarized”—fundamentally changing their mission and function to resemble for-profits—or closing. Strategies such as mergers, vertical diversification, aggressive marketing, and conversion to a less accessible institution were necessary to entice the financial community to provide financing. This proprietarization had a negative impact on access, costs, and accountability in
health care; it probably had deleterious effects on quality of care as well.

In the following issue, Ronda Kotelchuck analyzed the competitive disadvantage at which the new prospective payment system placed hospitals, particularly public ones, that served a disproportionately poor clientele. The Bulletin reported on issues such as the dumping of outpatients, documented by health activists around the country as further tragic manifestations of the access crisis. Peter Downs's article in Spring 1987 told the story of the battle over proprietorization of public health services and the public hospital in St. Louis in the 1980's. There, as well as around the country, community-based public interest coalitions were struggling against both for-profit control and plans for hospital expansion that ignored community needs.

The Movement's Response

Geraldine Dallek's widely read "Six Myths of American Medical Care" helped sound the movement's response to four years of Reagan-
From Nick Freudenberg and Miriam Kahn, "Educatng for Illness"

In the United States today, disease educators, those who seek to convince the public to engage in habits or practices that damage health, are far more powerful and wealthy than health educators. Only the federal government has the resources to challenge them. But rather than strengthening our ability to make better informed choices about health, the Reagan Administration has consistently weakened regulations, reduced access to impartial information, and cut back programs that educate and empower people. Increasingly, the responsibility for health education is being turned over to the private sector, whose primary aim is to convince people to buy its products whatever their health consequences. Four more years of the Reagan Administration will guarantee a growing epidemic of health illiteracy, and a growing burden of preventable diseases.  

Vol. 15, No. 4, July-August 1984, p. 19
health, economic and civil rights,” as a December 1987 editorial put it. Drawing on the imagery and politics of the civil rights movement, a response is emerging to the fundamental economic and social polarization of the Reagan years. We face such monumental challenges as combating the spread of AIDS, ending rampant homelessness, ensuring civil rights and independent living for persons with disabilities, and caring for the elderly. These issues are generating local initiatives that merge a growing understanding of the economic system with the desire to construct systems of caring that go beyond medical care to include elements of mutual aid and community solidarity. People working for change in all parts of the health care system are eager to find one another and develop a common sense of purpose and new progressive initiatives as part of a broader push for social justice.

By 1988, Alan Sager, who eight years earlier had written about the imperiled hospitals serving low-income communities, was now able to build on positive aspects of the recent Massachusetts experience. He proposed a way of developing a cost-controlled “linked incrementalist” program to squeeze fat out of the hospitals and force them to provide care for all low-income uninsured citizens. Geraldine Dallek’s final review of the Reagan years found that the feared-for major changes for the worse have been mostly blunted by strong public opposition. Much good has been accomplished at the state level, and, perhaps most important, a new movement with considerable political sophistication has shown that it can operate effectively at the state and local levels, working around initiatives for groups like poor children and the uninsured. With major health issues clearly on the national political agenda, the remnants of the health movement of the 1960’s and many who identify with its political project have reawakened to the possibility of being an effective political force. Once again, the Bulletin has come to reflect that new energy and spirit.

A New Generation

The Health/PAC Bulletin has done more than just survive the Reagan years. It has been a vehicle for shaping the progressive response to a rapidly restructured health care system. It has also provided a bridge between the experience and analysis of health activists of the 1960’s and a newer generation, all tested in the crucible of the difficult early eighties. It has helped deepen our understanding of a perversely changing system, providing a place where ideas and experiences relevant to its alteration could be developed and exchanged. Although certainly not alone in this role, the Bulletin has been an important resource to health activists, particularly as it has become much less New York-centered. In recent years, the Bulletin has drawn on a geographically wider network of writers, including contributions from Chicago’s Health and Medicine Research Group.

Collectively, the magazine has reflected the experience of health activists who felt overwhelmed by inexorable economic forces and triumphant political reaction, only to find that the health movement still exists, that it can still win victories and change people’s chances for a healthier and longer life, and that it has developed a more complex and satisfying understanding of the health care system. The movement also reaffirmed that its goals and ideas are still right, never as unpopular as we may have been misled to believe. And, because our ideas are right and sensible, they are likely to find fruition, possibly in a new round of progressive response to the Reagan era. Whatever the future may hold for the Health/PAC Bulletin, I believe the Reagan years have been its finest. □
Poppa of the PAC
An Interview with Health/PAC Founder Robb Burlage

Robb Burlage, teacher, organizer, and community activist, ranks among the most creative health policy analysts on the left. In 1968, just a year after the release of his groundbreaking expose-analysis of the New York City municipal hospital system, known as "The Burlage Report," he helped to found Health/PAC and became its first director. Over the last 20 years he has been one of the organization's major supporters, infusing Health/PAC with his rich ideas, linking it with hundreds of creative people, and worrying like a father about its future.

Robb is the author of a number of influential concepts that are now part of the health policy lexicon, including the terms "medical empire" and "medical-industrial complex." In addition to his academic credentials from Texas, Harvard, and Cornell Universities, his experiences as a young leader in SDS, as an organizer, planner, and advocate for poor people's rights in Appalachia in the 1970's, and in later rural and urban struggles have served to keep him linked to a world of social action.

Robb, at 51, remains a steadfast ally for people in need. He is a highly specialized academic of considerable analytical skill. He is also a highly accessible man of great personal generosity and warmth. He has influenced many Columbia University public health and urban planning graduate students, many of whom bring an activist approach to their mainstream jobs in the health care system. At Health/PAC and Columbia, Robb has helped create an ongoing agenda for thousands of radical health advocates by linking health care with the larger movement for social change in this country.

Today, the affable Texan with the deep Southern drawl and intricate speaking style has set up permanent home in New York City with his wife, Judy Smith, a psychotherapist, and their newly adopted infant son Matthew. The following interview is excerpted from a two-hour exchange with former Health/PAC staff member Barbara Ehrenreich that took place over a pot of dark tea last November. —Joe Gordon

BE: What do you think about Bush and Quayle and "four more years"? What are health radicals, or radicals in general, supposed to do?

RB: I certainly think that building the Rainbow left is important. But I'm very worried not just about what Bush and Quayle mean, but also about the kind of repressive proprietarization—every person for himself—of this society that we're seeing. In the Bulletin we've increasingly tried to deal with societal polarization and how it reflects what we've seen in the health system. Clearly, poverty is the biggest health issue. And racism can now be said to be what institutions are all about—led by the Republican candidates with their emphasis on racial division. So, in some ways, it's back to the drawing board. On the other hand, I have a sense of determination about the ongoing opportunity that I think the Rainbow movement represented and opened up.

We face new kinds of corporate medical empires, new kinds of government and market frameworks of health care, old and new social epidemics, and we also face very dramatic new movements. The homeless folks who are holding a vigil on the City Hall lawn and whose leaders are here at 17 Murray Street sharing the Health/PAC and Food and Hunger Hotline offices are in some ways at the front line of the resistance to homelessness. It isn't very organized. It's very sporadic. I think health care for the homeless, as a service, in some ways has gotten in the way of homelessness, of permanent housing, as issues in themselves.

BE: This is a question that comes from my own life experience. Does it make any sense to be specialized in health care? Because of the vast number of people who are concerned with just finding a place to sleep, does it make any sense today to say, "Well, I'm a health radical or health leftist"? There's nobody in Washington waiting for you or me to come in with brilliant health ideas.
RB: Health care progressives have to critique the system and emphasize the basic problems of people wherever they are in that system, whether it’s doing analysis of technology, as we’ve always done historically—as experts, as specialists—or analyzing the myth of regionalization that’s being used to rationalize why the big medical centers get all the resources.

BE: But who’s the audience? What good do those critiques do? In 1969 things were fairly flush with Medicare and Medicaid, and it was one thing then to be the radical saying, “Look, all these liberal programs aren’t good enough.” But what is the point of becoming very critical in a technical way of a system that is as screwed up as this? Who wants to consume these critiques, when they already know that people are being dumped from the local private hospitals and that their families don’t have any insurance, and so on?

RB: I think the basic issue you’re raising has to do with the environment 20 years later compared to the late sixties. The reason I talk about the opportunity and responsibility of the Rainbow movement today is I think that it’s potentially one of the few integral kinds of people movements. There certainly isn’t a sense of progressive social movement in general in society today, compared to the sixties and early seventies. That’s why I think of the current health movements such as people with AIDS in direct action or people in environmental action as potentially part of the larger movement. It’s not just inner-city poverty and housing and hunger issues. There’s a much broader, direct action going on. The struggle to maintain reproductive choice and women’s health rights, for instance. So that in terms of direct action, all of these issues may increase and converge toward a potentially more progressive movement.

In the short run, what a progressive health activist looks at today is how to be effective for one’s immediate constituency, perhaps with more fragmentation and specialization, but always trying to reach to a larger movement. Health/PAC has been called “a ministry of hope,” or a gatherer of people in the name of hope for a larger movement, and I think that’s a very positive and critical role to play. In an odd way, I think people have to specialize more just for survival.

BE: To go back to the Bush victory, what I see is that people were all geared up for the “first 100 days” of Dukakis and there was this mood that things were going to change. We were going to be in there with our child care proposals, our health proposals, etc. Everyone was all ready with their plans. Now there’s no one to listen at the top anymore for four to eight years. That kind of elite access is not a possibility. People have to reorient downwards. How do we deal with crushed expectations?

RB: It doesn’t mean simply that we tear up the visionary “first 100 days” perspective. We have to deal with the continuity of the cutbacks, the repression, the disappointed environment, and questions of how we mobilize people and institutionalize the Rainbow or its equivalent in particular cities. We have to look even more at our particular cities and regions, as well as at the national level—for example, toward the New York City elections a year from now. This is going to be a major battle, maybe with Rainbow proportions to it, or maybe not. There may be a fragmentation of politicians up against Koch. I think the issues of seeking a “healthy city” against the “sick city”—that go beyond health care and health care access—are at the core of the need for change in this city.

BE: Sometimes I look back at some of the things we did in the sixties and seventies and I’m amazed that white people did these things in New York City. Of course, it was often in coalition with other groups. Now I don’t live in the city, and I wonder, in speaking of New York City, what kind of role do white activists have in the city’s future?

RB: I think there are an amazing number of interracial support efforts and activity, amid a deepening of street and institutional racism in the city and nationally. I experience it with some of the students I work with at Columbia, who are mostly graduate students in public health and urban planning. They are working in many low-income, predominantly minority communities, fighting for services, and, to that extent, are in interracial settings. There are also many places in New York, from the Upper West Side to Chelsea to Park Slope, where progressive whites try to raise issues of integration, improvement of schools, homelessness, gentrification. But there is a different setting today in a lot of ways. The need for a critique from within of what’s happening with the institutions and the way resources are allocated amidst this basic health crisis is greater than ever.

We have to simultaneously raise the issues of universal access, primary and preventive care, and decent social relations.

Without universal access, people are treated as cattle.
What's interesting in New York City—and is at least half true across most of the rest of the country—is that medical empires still exist. They're more corporatized and proprietarized, but even where proprietary hospital chains have come to dominate care in Nashville or Houston or Beverly Hills or Los Angeles, the academic medical centers are more integrated and linked to them, and there's a pattern of skewed and generally inappropriate institutional power. That's where the resources are now, in a new kind of mix. Health/PAC's role of challenging that is still crucial. In New York, there's an awareness of the lack of hospital beds, of people being rejected for service, etc., but there's not yet the willingness to make a new kind of public health commitment in this city, except finally a response to AIDS in a very slow and fragmented way—but certainly not by challenging the basic priorities. And this calls for concerned people not just within community settings, but within the institutions themselves, to raise these issues.

BE: But it is a new setting in many ways. Race relations are very different. What about that setting changes the role not just of Health/PAC, but of radicals in the professions who may be white and are very likely college educated and different from the constituencies?

RB: As an example, AIDS has become a much broader issue that impacts very heavily on the minority community. It calls for very special education, advocacy, and services that go to the heart of the addiction crisis in this city. I think that's a role that crosses racial lines—as advocates, as service providers. In this sense, we are working in an integrated setting. It's also true in terms of the issue of home care, for instance. There again, other health workers have played a role—journalists, organizers, have also played a part in emphasizing that issue across the unions and, to some extent, across racial backgrounds and settings.

We've gone from the 1960's romance of working with the Young Lords and the Black Panthers and learning a lot about the strengths we had and the things we had to bring, as well as the way we carried racism in our own backgrounds and our own lives—to a time when there really aren't identified minority-group radical organizations in the same way. The relationship now is
very ad hoc. I think institutionalized racism is as big an issue nationally and locally now as it was in the sixties. You’re raising a very difficult issue—how coalitions are made across communities. There aren’t always obvious national movements to join and support; so that each person is forced to work that out.

**BE:** I think it’s harder today. Speaking of other things that have changed since you first got me involved in all this, one was the emergence of the women’s health movement and the emphasis on issues of sexism and so on. It was actually here in this Health/PAC setting that I first had a women’s group discussing women’s health issues. The women’s movement came to me here. How did this movement affect you and your understanding of what needed to be changed and who was going to do it?

**RB:** I think Health/PAC has always had very strong women’s leadership, and the qualitative aspects of Health/PAC’s analysis have been brought to it by the women’s health movement’s analysis. In the current setting of cutbacks and basic health priorities, the qualitative critiques of health care systems now are mixed with the need for basic survival access. The women’s health movement has now broadened to emphasize poverty and social epidemics as being at the heart of those issues, so it’s come full circle, and continued deepening as well.

In the late sixties, I personally felt that the health movement part of the larger civil rights and democratic movement in the country needed to be led primarily by minority communities and health workers and women. I think a lot of issues that were identified went much deeper than just power structures and appropriateness of care, to focus on the social relations and consciousness of that care and of society.

Personally, then, everyone began thinking about not just how they were most relevant in the larger movement but where they were most relevant. I went back to West Virginia and Appalachia to support the miners’ and mining communities’ movement. My response was my parents were from a white working-class background and that’s where I ought to go. By the late seventies, I got involved in advocating a national health service. I began to realize that there wasn’t necessarily a base that people went to as their natural community just because of their background. People find their way in all kinds of ways. I’ve learned a lot from students; I’ve learned a lot from communities that I’ve worked with.

Today, I live in Chelsea. I’m concerned about gentrification, I’m concerned about the lack of services across the city. I live within a block of the primary center of Gay Men’s Health Crisis and both the support there and the sense that there’s the AIDS epidemic surrounding us. And so—Ich bin ein New Yorker—I am a New Yorker—which I think is the most surprising outcome of my personal evolution. In the turn of the later 1960’s, I felt that I was learning so much from predominantly minority community movements, including radicals and revolutionaries, and from the women’s movement, but I had to go “find my place.”

I went through a process, a half-decade of learning what that was, but also came back and realized that I have to now carry these insights in some way to whatever turf I live and work in.

**BE:** Part of the problem in dealing with the next four to eight years is how to keep alive that qualitative critique when it’s a fight just to get people into the emergency rooms. We used to go through this in Health/PAC a long time ago: every time there was a budget crisis we’d be lining up there with the medical empire guys begging for money and forgetting all the past differences between us. It’s a real defeat to have to give up the critique of professional domination, micro-racism and micro-sexism within the medical care interaction, critiques of the technology...

**RB:** I don’t think those critiques have been given up at all. If anything, for example, the embattled pro-choice movement and women’s movement for reproductive rights continues those critiques and is struggling for basic services and against a backsliding of sexism in society.

**BE:** Concretely, within health care, it’s already at a point where the only thing anybody can focus on nationally is the 37 million people with no insurance. It seems almost inad- decent to raise the high rates of unnecessary surgery and all the more “qualitative” issues.

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**We must not buy into our own fears or sense of fragmentation, but must find a way of unifying.**

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**RB:** On the contrary, that’s “waste” in the system as well as danger or exposure of people. I think simultaneously we have to raise the issues of more and universal access and the issues of primary and preventive care and appropriate and decent social relations, in part because of the increasingly imposed scarcity of resources. We were geared up before the 1988 election because there were going to be a lot of conferences and gatherings to put together progressive national legislation again, but those alliances and those arguments must continue to take place in local government, in local institutional struggles as well, not just the national arena. In many ways the imposed scarcity means we have to raise those issues more than ever—and always so that effective preventive and community-oriented primary care is the basic goal of access. And so that this in turn links to housing and basic education and basic community development. Health services must be part of a progressive quality-of-life and environ-
mental movement that challenges the systemic causes of illness and neglect.

BE: There’s a real disillusionment with the poor, specifically the black poor—the idea that there’s an underclass. We always had a more fluid notion of people going in and out of poverty; we didn’t tend to see the poor as characterologically distinct from other people. We said, “These are the people who know the problems, so they have to be in charge of meeting them.” The attitude today, even among white, left-wing, middle-class sorts would be the stereotype of the poor—who are at least a quarter of the population. It’s addicts, it’s muggers—it’s Willie Horton. This absolutely blocks people’s vision of the possibility of reform. If that’s who you think is “down there,” all you can do is technologically administer something to channel them in better ways or control them. But that vision of democracy which was Health/PAC’s not many people have held to.

RB: One of the exciting things about Jesse Jackson was that he went to places where people have not been supported, including people trying to survive gang settings and addiction-terrorized housing projects, and gave hope. There is a “crime problem,” there is an addiction crisis, an international economic conspiracy. In everyday life, people feel frightened and disjointed. On the other hand, I think that many, if not most, progressive professionals have a relationship with people who are unfortunately labeled as members of the “underclass.” I don’t like the concept of an underclass because as far as I’m concerned, the reason why we have to advocate so strongly for universal access to health services is that everyone must be regarded and treated as “entitled,” not as a recipient of charity. Without entitlement, people are treated as cattle. They are treated in racist ways. I think that’s why people also must have homes, because without a stable “unit” how can you be “registered”? How can you be politically involved? How can you have a basis for community and workplace participation?

We have to advocate for the location of people so that they have an identity, an entitlement, a participation. Then we can talk about what the unity is. We’re struggling against the “underclassification,” the fragmentation, the social epidemics of the population as well. We are trying to carry on some of the New Deal demands and old “liberalism” to that extent—as basics of entitlement and participation in this society. We have more radical ideas about what the quality of that participation should be and how our institutions ought to be reorganized democratically. But we also realize that people need a human and humane material basis. When all is under attack politically, economically, and culturally, I don’t think we can just assume that the material basis of work or social support is there. For years now we’ve realized that such basic economic entitlement has to be somehow in place for us to struggle for real democratization.

BE: So you’re saying—I don’t know the fashionable academic words, but they would probably be something like that we almost have to construct the individual once again to talk about that kind of democracy—that people without addresses can’t be participants.

RB: I think that family units and communities and a desire for a real workplace are there in most individuals in this society, even in those who suffer addiction and uprootedness. We must not buy into our own fears or sense of fragmentation, but find a way of unifying and caring for each other. I do it through my expertise and through my contacts with students, as well as through the Bulletin and Health/PAC. To that extent, my life as a New York City resident is slightly different from my life in education and my life in the movement. How each of us integrates our various energies and concerns is more of a challenge than ever before.
HEALTH IS THE CITY'S BUSINESS

The affiliation plan for New York City hospitals has been exposed as a disaster—costly in dollars and lives. The private health establishment that created it has failed. Those persons who desperately need health services are turning to city government for disaster relief.

This health crisis must be solved by positive government and community action. Hospitals are public business. These most precious resources of public facilities and funding for health must not be given away through affiliations or organizational fronts that leave all real operating and planning power in private health establishment hands.

The City must establish new public accountability, not sell out the little that remains. The City must not "get out of the hospital business."

Hospitals here will be threatened by the fires next time, as they have been in Newark, Detroit, Philadelphia, and elsewhere, unless the picture changes dramatically. It is time for Mayor Lindsay to go beyond symbolic visits to the burning streets and the calling of hand-holding task forces.

A year ago our report on New York City's municipal hospitals, an unofficial, unestablished, and independent analysis of the so-called affiliation plan for 19 City hospitals and numerous City health centers, was publicly released. Our conclusion: that loosely spent public dollars through affiliation contracts were a backward step from positive public and community leadership for a health services system that serves all persons equally well and excellently.

We found Private Health Establishment leaders were essentially concerned with expanding the financing, institutional economies of scale, patient population control, and faculty-staffing teaching and research opportunities of the private medical centers and private voluntary teaching hospitals. They were facing capital shortages and fading control of charity patient populations with the advent of Medicare and Medicaid. Thus, they acted to bring under private institutional control the potentially competitive resources of municipal hospital financing, facilities, professional staffs and

A Political Coalition That's Bad Medicine

A HANDMAIDEN TO the State Medicaid cutback in Governor Rockefeller's proposed compulsory health insurance plan, it is advertised as a device to cover the working poor and the medically needy lost in the Medicaid cutback and as a guarantee of medical coverage for all (with more incentives than Medicaid for efficiency of utilization and of services administration.) However, critics have called it an administratively unworkable payoff to the private and non-profit insurance plans that would cost more, as well as tax the poor for a service that should be theirs by right.

The plan is given little chance of passage this year and is seen by many as a Rockefeller flag for national attention in the election year, rather than as the most humane and efficient policy for New York State Governor Rockefeller proposed such a plan on a national basis in testimony before Senator Ribicoff's Committee in Washington in late April as the key point of what was called his major Presidential campaign policy position on health.

That this kind of medicine might be better for the Republican political coalition than for the patient is perhaps evidenced by the following statement from the special assistant to Governor Ronald Reagan (R-Calif.) in response to an inquiry from HEALTH-PAC:

"Governor Reagan... is in agreement with Governor Rockefeller's Plan to assess charges against the medically indigent with small incomes in order that costs may be minimized under the government-sponsored program..."
tors, and medical staffs and their own private plans and powerless in the face of the Establishment assault endorsed by the Mayor, as well as City Hospitals and Health officials—and operational deterioration of public hospitals, and the medical establishment, increased alienation between in-"uninteresting" or "socially difficult" patients, increased individualism "uninteresting" or "socially difficult" patients, increased alienation between indi-

The General Agenda:

EXPANSION

Columbia Medical Empire Faces Harlem Community Rebellion

The evidence of crisis has mounted even as the declaration of plans for at least a coherent and comprehensive beginning. Failures of loose city hospital affiliations and about the tragic conception today to be progressive in 25 years, it must verge on the revolutionary." Unfortunately, this awareness does not reflect a membership of those persons actually served. There are new Federal financial and administrative resources generously provided a grant for support of the Center. The Institute for Policy Studies of the Burlage Report on Community hospitals and health institutions must be revitalized, strengthened, and made accountable to their commun-

Community hospitals and health institutions must be revitalized, strengthened, and made accountable to their communities. The community must work directly with the professionals, and its own rooftops. Community hospitals and health institutions must, in a sense, take the place of the community clinics of the past. Community hospitals and health institutions are the places where the patients come in for the first time, and this is why they must be revitalized, strengthened, and made accountable to their communities.

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with awareness of developments elsewhere seen particularly in the diverse New York City context, to encourage promising re-

(continued page 3)
Socializing Medicine


by Hal Strelnick

Six months before Black Monday hit the stock market, Black Wednesday hit the “match.” The “match” is short for the National Internship and Residency Matching Program, a computerized system that assigns almost every medical school graduate to his or her hospital residency program. In March 1987 the world of academic medicine was shocked when internal medicine, its largest and most prestigious specialty, saw a 10 percent drop in the number of graduates choosing its residencies after two decades of continuous growth. In the wake of “not matching,” chairpersons and chiefs of service at many major teaching hospitals have been perplexed and confused. Why have medical students lost interest in their specialty? Had they read Terry Mizrahi’s book, they would have a large part of the answer.

Professor Mizrahi, currently at the Hunter College School of Social Work, spent a year observing more than 100 residents in internal medicine at a large southern university medical center that included clinical rotations at a Veterans Administration hospital, a large public general hospital, and a smaller private hospital. She was also able to follow up her original observations five years later with one-quarter of the physicians then in practice. Her dispassionate observations, drawing heavily on her field notes and quotations from the physicians-in-training and their faculty, prove a powerful indictment of the system in which they are educated.

In the past, most serious attention to the education and socialization of physicians has been visited on medical students, who are more convenient to study than interns and residents. (Many have quipped that, after the E. coli bacteria, the medical student is the most exhaustively studied organism on earth.) The training experiences of house staff have been best depicted in such exposes by insiders as Intern, by the pseudonymous Doctor X (1965), and Samuel Shem’s fictionalized comic novel, The House of God (1978).

‘Bunker Mentality’

As an outsider approaching a subject as a participant-observer, Professor Mizrahi has exposed the distorted values of a system that exploits young physicians and in the process erodes what idealism, compassion, and commitment to service remains after medical school. Because of the long, tedious hours and difficult and often incurable health problems that they confront, the residents begin to view themselves as powerless victims of their patients and their patients’ needs.

Their response to this sense of victimization, a variation of blaming the victim, is a bunker mentality. They develop their own culture, rich with its own slang and aphorisms, which fundamentally orients their behavior and learning.

The essence of this culture is captured in the book’s title—the ultimate goal for the typical internal medicine resident is not cure or education but getting rid of patients. The author lets the residents speak for themselves:

“Boy, you can really see the changes that have occurred over this year, can’t you? In the beginning we were bright-eyed and bushy-tailed, now we can’t wait to get them [patients] out.” (Intern Charen)

“There’s no great competition [here] but I think there is some....I think it’s manifested in the little things, such as how big is your service. You know, I have fewer patients than you do; therefore, I’ve done a better job of getting rid of people.” (Junior Resident White)

In the Emergency Room one day, Senior Resident Fable was observed commenting to Intern Kots, loudly enough for everyone to hear, “Let’s get that fucker out of here!” referring to the same patient who had been called a “turkey” by someone else earlier. “Let’s get moving. Why can’t we get those winos out?” When someone told him they couldn’t because [the patient] was still wheezing, Fable told the interns, to their faces, “You’re all slow as shit. Let’s get moving!”

Another powerful indictment of the training system that Mizrahi identifies is the abdication of the faculty of the responsibility for socializing the young physicians. She writes, quite accurately:

The empirical reality of the residency years is that house staff provide primary patient care and are, by default, the primary physicians even for patients formally under the supervision of the attending faculty. The house staff develop a subculture that is insular; it constitutes itself as an ingroup, making attendings an outgroup, thus systematically excluding them from important socializing activities....House staff view the attending faculty as “above” their concerns and regard them as exemplars only insofar as they can diagnose complex symptoms or teach the finer points of medical knowledge....Any attempts beyond those [formal] boundaries are resented by the house staff, who perceive such action as an infringement on their autonomy.

The quotes from house staff throughout the book were painful reminders for me of my own training experience. Mizrahi’s insights into the attending faculty’s com-
plicity stimulated me to reassess my own current role, teaching in an academic medical center. Our small faculty has recognized how values, as well as medical knowledge, are conveyed throughout residency. We must struggle daily with the same exploitive structures to prevent our physicians-in-training from learning primarily how to despise and get rid of patients, especially the poor and socially stigmatized, as Mizrahi describes.

Reforming the System

Recently, New York State has begun to re-examine the working conditions for residents, a consequence of the death of Libby Zion at New York Hospital in 1984. The patient, the 18-year-old daughter of writer Sidney E. Zion, died less than a day after she was hospitalized with an earache and fever. The grand jury investigating the case attributed her death to mistakes made by exhausted and unsupervised interns and residents. Dr. Bertrand Bell, the director of ambulatory care at Bronx Municipal Hospital, chaired the state health department’s Ad Hoc Committee on Emergency Services, which, in order to address the grand jury’s findings, recommended imposing restrictions on the hours of house staff. He frequently brought Getting Rid of Patients with him to public appearances to document the other detrimental effects of the century-old tradition of 100-hour work weeks. California, Hawaii, Pennsylvania, and Massachusetts are considering following New York in implementing restrictions on the hours that interns and residents work.

While shorter hours are helpful, the pressures on hospitals from diagnosis-related groups have created new financial incentives for getting rid of patients that extend far beyond the house staff subculture.

Humiliation

As an outsider, Mizrahi was probably unable to observe the persistent use of humiliation as a method for faculty to socialize and control house staff. The response that I received from an attending physician when I was an intern, for example, is still vivid in my mind some 13 years later. Working in a New York City public hospital and taking care of a middle-aged Puerto Rican woman who was in a coma from her diabetes, my first such gravely ill patient, I found myself without supervision, my resident and my chief resident having disappeared by late afternoon. Since the deputy chief of internal medicine was renowned for his knowledge of diabetes, I called him, confessed my ignorance in handling this complex case, and described the patient’s condition and what had been done so far. Before telling me what I should do, he asked, apparently quite seriously, “Did you get your medical training at Auschwitz or at Buchenwald?”

The following morning, the chief of medicine examined my patient, who, fortunately for us both, was awake and alert, with her diabetes coming under control. Though I do not remember what he told me about diabetes, I learned the cost of asking a question that shows your ignorance.

To what extent humiliation continues to be a major pedagogical device and its consequences for patient care remain dark secrets in the rites of passage for physicians. Perhaps the scrutiny that Getting Rid of Patients brings to medical education will accelerate the reform process it so badly needs.

Although Mizrahi recognizes the importance of reforming the system she has described, she has left defining the necessary changes to others. Only by understanding her message, however, will medical educators avoid future Black Wednesdays and front-page stories in the New York Times about the declining interest in pursuing medicine as a career.

Hal Strelnick is a Health/PAC board member and a physician who teaches in Montefiore Medical Center’s Department of Family Medicine.
RU-486, Where Are You?

The recent uproar over RU-486—the wonder drug that could make surgical abortions virtually obsolete—ended in a worldwide sigh of relief when the French government ordered the drug’s manufacturer, Roussel-Uclaf, to resume production of the drug. It also served as another grim reminder, however, of the enormous political and economic power of the United States’ right-to-life movement.

A few months ago, the French government permitted Roussel-Uclaf to market the drug in France; days later, the company bowed to pressure from French right-to-life groups and stopped its distribution. The government ultimately decided that preventing access to such a useful drug was irrational and unlawful and ordered the company to continue distribution.

Drug companies in the United States, however, have been deterred from introducing the drug here by Section 1008 of Title X of the Public Health Service Act, which prohibits federal funding of abortion-related research. “There are presently no attempts to win FDA approval,” says Craig Lasher of the Population Crisis Committee in Washington.

RU-486 functions as a progesterone antagonist, which causes the uterine lining to be shed even when a fertilized egg is present; therefore, it undermines the visual exploitation of the remains of surgical abortions as a weapon of the anti-abortionists. Since the drug could thus spell the end of one of the American right-to-lifers’ most effective tactics, it faces considerable political opposition.

Large companies, which can more readily afford to market the drug, risk the threat of boycotts against their other products, as briefly happened in France. Here, though, there is no chance that the new administration will react with moral outrage to the right-to-life movement’s attempts to restrict freedom of choice. —Anna Reisman

Workers Testify to Health Care Crisis

Overwhelming caseloads, poor patient care, and hazardous working conditions were cited by health care workers at a public hearing held this fall on New York City’s health crisis. Nearly 40 workers—ranging from social workers to technicians to maintenance workers—testified before the New York State Assembly’s Standing Committee on Health Care.

Thelma Correll, an x-ray technician at St. Luke’s-Roosevelt, testified that mandatory overtime is the norm in her hospital. “It seems like the only thing I do at home is sleep and get ready for work.” Susan Belasco, a chemistry technologist at Bronx-Lebanon Hospital, said that lab workers are often required to cover additional day, night, and weekend shifts. “We can no longer make plans with our families,” she continued. “We’re in a constant state of jet lag....We get even more discouraged when we see administrators constantly being hired, sitting in spacious, immaculately clean, plush, air-conditioned offices.”

Workers emphasized that the loss or shortage of orderlies, lab assistants, and maintenance and service workers at their hospitals has added more stress to their jobs. Staff registered nurse Jean Winston testified that at Beth Israel Hospital, for example, the “inadequate numbers of aides and orderlies” forces nurses to perform the work of others and potentially place patients in danger. “If we’re out transporting, or mechanically breathing for a patient, or any one of a hundred things that we have to do because of short staffing—any time we’re away from our unit—a life-threatening situation could arise. We try to cover everything. Sometimes all we can do is pray.”

Hematology technician David Abels added that when he and other co-workers expressed their concerns over stressful working conditions—specifically that such high-pressure increases their chances of accidentally contracting AIDS—“Management... said, ‘Lab work—
ers come a dime a dozen.'” Abels told the committee, “I chose my career because my mother always told her children about the excitement of laboratory work and the importance of living a life dedicated to serving people. As conditions stand today in the labs, I would never, under any circumstance, recommend that a child of mine work in a lab or a hospital.”

—Caren Teitelbaum

The Disgrace of Homelessness

In a sharp and controversial break from tradition, an Institute of Medicine (IOM) panel convened to study the health care needs of the homeless bucked the opposition of its sponsoring agency, the National Academy of Science, and issued a statement calling homelessness in the United States “an inexcusable disgrace.”

The six-page statement was issued separately from the panel’s IOM report on health care for the homeless because panel members felt strongly, according to the statement, that the scientific format required by the IOM could not “capture our sense of shame and anger about homelessness.”

The nine members of the panel who prepared the supplementary statement stated their full support for the IOM report but felt that its focus was too narrow and too dry. “We analyzed mortality data for the homeless but lacked any platform from which to shout that our neighbors are dying needlessly because we are incapable of providing the most basic services,” they wrote. “The frustration we all experienced working on this report arises from the nature of the problem we were charged to address. Contemporary American homelessness is an outrage, a national scandal,” the statement charges.

The supplementary statement, unlike the original report, offers recommendations to deal with the root causes of homelessness, including universal access to health care. “The most basic problem of homeless people,” the statement says, “is lack of a home.”

Bruce Vladeck, president of the United Hospital Fund of New York and a panel member, told Health/PAC that the National Academy of Sciences (NAS) refused to publish the report if the supplementary statement was attached. So panel members were forced to distribute the statement without NAS sponsorship.

“It is very interesting how timid people in D.C. are these days about saying simple blunt things about social problems,” Vladeck said. “It has to do with the way the administration mocks such statements and sets up false counter-assertions, such as that ‘people are homeless because they want to be.’ This mood is part of the reason why the president of NAS was so nervous about printing our supplementary statement.”

The Supplementary Statement on Health Care for Homeless People can be obtained from the United Hospital Fund, 55 Fifth Avenue, New York, NY 10003, (212) 645-2500.

—Tammy Pittman

New OSHA Standards Leave Workers Exposed

The federal Occupational Safety and Health Administration (OSHA) has allowed another cloud to form around the issue of workers’ health. Last summer, OSHA announced a sweeping proposal to change existing health standards or add new ones for 428 substances. If adopted, this would supposedly represent the greatest, most significant change in health standards since OSHA was created.

Fully 205 of the 428 substances would be regulated by OSHA for the first time. In comparison, up to now, OSHA has adopted only 24 new health standards during its entire 17 years of existence. OSHA also proposed lowering the existing permissible exposure level (PEL) for about 100 substances, including such important industrial chemicals as acetone, carbon tetrachloride, and toluene as well as...
lowering the short-term exposure limit (STEL) for another 70 chemicals.

These proposals were announced under the Reagan administration, however, a fact that should make us hesitate before we celebrate. Although the standards lower allowable worker exposure levels, they are weak in almost all cases. Every one of the 428 standards is limited to changes in the permissible exposure levels (PEL's) or short-term exposure levels (STEL's) of these chemicals. No warning signs are required for any of these chemicals. No medical examinations are required for anyone who works with these chemicals. And no training is required for workers about the hazards they face or how to protect themselves. And worse, the proposed standards do not lower exposure levels enough anyway.

These deficiencies are perhaps not surprising, considering that most of the new and changed standards are based on the recommendations of a private, supposedly neutral organization called the American Conference of Industrial Hygienists (ACGIH) whose recommendations have been found to depend to a large extent on information from the industries being regulated. In fact, a study recently published in the American Journal of Industrial Medicine found that, in 15 cases, the only information used to make the ACGIH recommendation was unpublished company data. In the case of some chemicals made by large multinational industries such as Dow, Dupont, Kodak, and Shell, representatives of the companies were given the primary responsibility for developing the ACGIH recommendations.

Despite this evidence, OSHA used the ACGIH data as the main source of its own recommendations. No wonder the proposals are so weak. —David Kotelchuck

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Winter 1988
For many public health and elected officials, testing for antibodies to the AIDS virus (HIV) has become the cornerstone of their strategy for controlling the epidemic's spread. A bill approved by Congress last year, introduced by Senator Edward Kennedy, provides $400 million for additional testing and counseling services. The New York State Department of Health recently mandated that family planning providers must offer the AIDS test to all women who use their services. Already the federal government requires prisoners, military recruits, immigrants applying for legalization, and Job Corps members, among others, to be tested.

While proponents of testing argue about exactly who should be tested, and whether testing should be confidential or anonymous, mandatory or voluntary, they seldom discuss why testing and counseling is a more effective control strategy than, for example, counseling alone, community education, or, for that matter, quarantine.

The strongest public health rationale for HIV testing is that knowing one's personal infection status will help a person to reduce the risk of infecting others or becoming infected. The validity of this hypothesis seems to depend on who is tested. Among educated gay men, for example, testing and counseling do seem to lead to reductions in risky behavior. For intravenous drug users, at least some studies and anecdotal reports suggest that learning one's infection status may lead to increases in unsafe drug and sexual behaviors. Those who test positive feel they have nothing to lose; those who are negative sometimes believe they are immune. Proponents of testing argue most strongly for testing of women in their reproductive years so as to prevent the birth of more infected babies. However, preliminary studies of the effects of testing in New York City indicate that pregnant infected women in drug treatment programs are no more likely to choose abortions than are uninfected women.

In sum, building AIDS prevention policies on the foundation of widespread testing and counseling may leave us with a house of cards that collapses when accumulated evidence demonstrates that it has not had the desired results.

Given this possibility, how can public health professionals and advocates develop prudent policies? First, we must reject simplistic solutions. Effective prevention requires adequately funded interventions at many levels: mass-media campaigns, workplace and community education, school-based programs, condom distribution, and counseling and testing. Second, we must address the underlying conditions that have contributed to the rapid spread of the human immunodeficiency virus — through more and improved drug treatment programs, comprehensive health and sex education, and better access to primary and preventive care.

Counseling and testing programs will continue to play an important role. To be both effective and ethical, however, they require the support and resources needed to do the job right. These include rigorous protection of confidentiality for all who are tested; the option of anonymous testing for those who want it; a commitment to providing all who are tested with needed health, mental health, legal, and social services, including making experimental treatments such as AZT available to all infected people who request them; counseling and education to provide both infected and uninfected people with ongoing support for reducing risky behavior; adequate training for staff in counseling, risk-reduction education, and AIDS epidemiology; and sufficient staff to ensure that other needed health services are not compromised.

Testing for HIV is a means to an end, not an end in itself. Proponents of expanded testing and counseling programs must be challenged to put their money where their mandate is. Otherwise, testing becomes an excuse for inaction rather than an effective measure to control AIDS.

Nick Freudenberg is director of the Program in Community Health Education at Hunter College School of Health Sciences/CUNY.
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