B R E A T H  T A K E N

The Landscape and Biography of Asbestos
Page 4
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.

Breath Taken: Exposing the Ongoing Tragedy of Asbestos
Debbie Socolar presents Bill Ravanesi’s “Breath Taken” photo-documentary of the asbestos public health disaster

The Third-Wave Asbestos Conference: High Drama in Science
David Kotelchuck examines the recent challenge to the scientific consensus on the dangers of in-place asbestos

Terminal Illness? The Mounting Evidence of Hazards from Computer Emissions
Ellen Bilofsky summarizes the growing evidence that extremely low frequency magnetic radiation is a threat to computer users—and others

Oil and Water? A United German Health Care System
The Association of Democratic Physicians of West Germany considers the consequences of merging two health care systems in a united Germany

When No Policy is a Policy: APHA and the Marriott Hotel Union Busters
Leslie McNeill outlines the uproar over the APHA meeting at the non-union hotel

Biting the Hand That Feeds Them: Organizing in the Welfare Rights Movement
Terry Mizrahi reviews a case study of the welfare rights movement and interviews author Jacqueline Pope

Media Scan
Reading up on occupational health

AIDS Watch
Nick Freudenberg weighs the pros and cons of case management for people with HIV/AIDS

Vital Signs
NJ residents win insurance discrimination battle; the AFL-CIO waffles on abortion rights; and more
Asbestos in Focus

When Joe Darabant, a longtime Manville, New Jersey, asbestos worker, told photographer Bill Ravanesi in 1989 that “once you get asbestos in you forget about it,” he was referring to his severely disabling, and soon to be fatal, case of asbestosis. But after we look at Darabant’s haunting image and the other photographs from Ravanesi’s powerful exhibition, “Breath Taken: The Landscape and Biography of Asbestos,” featured in this issue of the Bulletin, we are not likely to forget about it, or about him. Reflecting on his suffering, Darabant continued:

I wish I could die this very moment. At least I got to see my granddaughter anyway. I didn’t think I’d live long enough. Five months old. I’ve been pushing. Trying to keep alive.

His efforts to keep alive, to fight his impending death, thus centered on an act of seeing. Gazing at death, Joe Darabant and Bill Ravanesi invite us to do the same: to use an act of intense seeing, not just looking, to help keep us alive, and, in the process, keep Joe Darabant and others like him from being forgotten.

This documentary photographic exhibit invites us to look at a collection of representations of reality that point to a deeper, collective meaning, to a bigger story embedded in the space connecting them all. But the reality of these faces, bodies, and places frozen in time owes as much to the photographer’s vision, to his apprehension of a story, as they do to any underlying documentary truth. Through putting together his vision of the texture of people and places formed into a larger story, he is inviting us to see some of what he has seen, to find images that compel us, to make up our own story. The exhibit allows us to move back and forth among images that almost reach out to us to make sense of what is happening, if only to calm the unsettling influence of this collection.

But, of course, these images present only a small slice of the asbestos story. For, unlike the mercury poisoning disaster photographed in Minamata, Japan, by W. Eugene Smith, the asbestos story is not confined to a single town, or even several, but is virtually everywhere. The exhibit takes us to an extensive exterior landscape of people and places and an interior landscape seen in the faces of individuals with asbestos-related disease. Because of the scope of the disaster, the types of places shown are necessarily only a small slice of the important locations. Nor do we see the silent course of low-risk, yet potentially fatal, asbestos exposures occurring throughout our built environments. The landscape of asbestos is formed by myriad invisible and unknown exposures to asbestos in our environment that continue in our bodies, not only in a far away place, like the streets and mines of Asbestos, Quebec.

Bill Ravanesi’s “Breath Taken” is an invitation to revisit, in the most engaging form we know, the biography of asbestos, a story the Bulletin has been covering for almost 20 years. It is an opportunity to see some of what those who have been doing this work have seen, or only imagined; it invites us to look past the surfaces and glib answers.

Some people experiencing “Breath Taken” will focus on particular images they find most compelling; others will form a story combining various elements of the exhibit organized around an emotional and intellectual core. Some will be most drawn to the magnitude of preventable human suffering; others to corporate crime and the search for justice; still others to possible lessons for preventing such disasters in the future.

For me, all these important elements together still do not make up the core of the story. It is more than a public health morality tale about unheeded medical warnings and prevention; more than a search for retribution for corporate homicide; more even than an opportunity to use the suffering and social upheaval generated around asbestos to protect future generations.

Viewed together with the imagery generated from the numerous other stories making up the American toxic experience, these photographs say that much of our world involves living a lie—in the sense that Eastern European intellectuals such as Vaclav Havel use that phrase. In order to live in truth, we have to see deeper and deeper; unravel the past in the present; achieve a measure of justice; and literally reconstruct, physically, intellectually, and morally, many of our places and environments. It is not the victims who are the main issue, not even their grandchildren, but all of us, here and now.

See for yourself. —Tony Bale


Winter 1990

Health/PAC Bulletin
Breath Taken
Exposing the Ongoing Tragedy of Asbestos
DEBBIE SOCOLAR
Photographs by Bill Ravanesi

Health/Pac has been covering the asbestos tragedy for nearly 20 years, but never has the personal devastation and meaning of the industry cover-up been brought home more compellingly than in Bill Ravanesi's photographic exhibit, "Breath Taken: The Landscape and Biography of Asbestos." The exhibit opened at the Boston University Art Gallery in spring 1989 and continues to tour the country under the auspices of the Center for Visual Arts in the Public Interest. Debbie Socolar walks Health/Pac readers through this brief glimpse of the exhibit and summarizes some of the many issues it touches on in portraying the ongoing occupational, environmental, and public health disaster of asbestos.

The images in "Breath Taken: The Landscape and Biography of Asbestos," a mixed-media photographic exhibition by Bill Ravanesi, powerfully illuminate the continuing human destruction wrought by the avarice of the asbestos industry and the complicity of government and medical experts. Ravanesi's more than 90 large color photographs reveal the anguish and despair of families crippled and destroyed by asbestos. They also show the anger and determination of activists still fighting for adequate compensation and for regulation of this deadly hazard here and abroad.

About 20 million Americans have sustained significant occupational exposure to asbestos, according to the exhibit's narrative, written by investigative journalist Paul Brodeur. Brodeur's articles in the New Yorker in the 1960s and his later books on the asbestos industry were instrumental in bringing the public health danger and the industry cover-up to public attention. The exhibit's narrative, displayed with the photographs, along with a half-hour videotape by Ravanesi also entitled Breath Taken, documents the history of conspiracy, the victims' stories, and key current issues in the struggle to contain the ongoing environmental contamination in the United States, Canada, and the developing world.

Already recognized for his social documentary photography on working class America, Ravanesi conceived this project after his father, a shipyard worker during World
War II, died of asbestos-related disease. Raising public awareness of the continuing asbestos calamity is now Ravanesi's primary purpose. He spent six years photographing and recording asbestos workers, activists, and scientists, from whose interviews Brodeur effectively drew for portions of the exhibit's text. Ravanesi is currently preparing an exhibit catalogue that will include essays by, among others, Brodeur and Dr. Irving Selikoff, the Mt.

Above, Bowlby and his wife, Georgine, at Somerset Medical Center, Somerset, NJ, September 1986. Bowlby developed lung cancer, which metastasized to his brain. Below, Tom Bowlby, dead at age 55, Somerset Medical Center morgue, September 1986.

Sinai Medical Center clinician and epidemiologist and preeminent asbestos researcher whose studies in the early 1960s provided the undeniable scientific evidence that industrial exposure to asbestos was an extreme hazard. Selikoff's research, Brodeur notes, "marked a turning point in the views held by doctors and health officials in many parts of the world."2

The Visual Evidence

The "Breath Taken" exhibit begins with a group of Margaret Bourke-White's glowing portrayals of the Johns-Manville asbestos plant in Manville, New Jersey, commissioned during the Depression by Fortune magazine. Her photographs feature dignified executives, well-muscled workers hefting sacks of asbestos, and streamlined machinery—the epitome of corporate vitality. The show also presents Johns-Manville's own promotional photographs, which became public documents in the 1970s when the firm was sued for compensatory damages by thousands of ill asbestos workers and their survivors. The company's pictures include men and women in the 1940s spinning asbestos thread and handling raw asbestos to be used in shingles and cement pipes. Advertisements from the 1920s to the 1950s touting the "mineral of a thousand uses" illustrate the many uses to which asbestos was put throughout the country. A display of asbestos products safely sealed in plexiglass, including a block of the fibrous mineral and an asbestos glove, rounds out the exhibit.

In stark contrast to what we know today about Johns-Manville's safety record are photographs of company signs displaying platitudes about safety and a gleaming factory medical center that opened in 1957. At that time, Brodeur tells us in the exhibit's narrative, the company had a well-established policy of not telling workers when they developed indications of lung disease. The publicity photos show physicians examining the X-rays of presumably healthy workers and nurses taking care of minor injuries such as a cut finger. Such photographs are dramatic evidence of corporate duplicity and medical complicity (see sidebar).

The core of "Breath Taken" is Ravanesi's haunting portraits, many life-sized, of asbestos workers and their families. As Ravanesi observed in a recent interview, the images of sorrowful faces, ruined bodies, and ravaged families "empower the issue in a way the written word alone can't do." Accompanied by the workers' own words, the photographs provide compelling evidence of deception and devastation, as well as the pervasiveness of the deadly substance in everyday life.

In the days when asbestos was glorified to the public as the "magic mineral," unwitting families made children's blankets out of felt that had been used on asbestos factory conveyor belts. Individuals recall children exclaiming, "Here comes daddy the snowman!" as their fathers returned home from work covered in white asbestos dust. Clementine Szukis, now 70, told Ravanesi that as a child she made flowers for her hair out of bunches of asbestos.
fibers she found near her home in Manville, New Jersey. Later, as a hairdresser, she had many customers who came to her straight from work at the Johns-Manville factory, their hair coated with asbestos. Her fingertips began thickening in the 1960s—a sign of poor circulation resulting from oxygen deficiency caused by asbestosis, a disease in which the lungs become scarred and constricted. Today she suffers serious coughing fits and shortness of breath.

Paris Jenkins, formerly a boilermaker at the Charleston, South Carolina, Naval Shipyard, is portrayed holding the inhaler that helps him breathe; in the window of his car are the medicines he cannot go far without. Large numbers of black shipyard workers where hired during World War II and then laid off; most have never been compensated for resulting diseases.

Ted Kowalski, a 20-year Manville worker, is president of the Association to Improve Benefits for Retired Disabled Workers and Their Dependents. He appears with his wife in successive portraits, increasingly frail, crippled with asbestosis although he is only 60 years old. “Years back, everybody that got sick with a lung problem was diagnosed as having TB, when actually it was asbestosis,” he says. “They misdiagnosed you on purpose.” As late as 1980, his doctor was still treating him for chronic bronchitis. Asbestosis has also stricken his wife, who never worked for Manville, and his son, who only worked there for a few days.

Joe Darabant, one of the strong young men in Johns-Manville’s publicity photos, reappears in Ravanesi’s exhibit at age 65, dependent on oxygen day and night. Interviewed for the video-tape, Darabant gasps, “It is like living in hell. I can’t even brush my teeth.... My wife has to wash me, dress me....I pray to God every night to take my life....You don’t know the pain, when you can’t breathe.”

Several of the people Ravanesi photographed died only days or weeks afterward. And several had only brief exposure to asbestos.

Unwitting families made children’s blankets out of felt that had been used on asbestos factory conveyor belts.

Environmental Asbestos

Asbestos filled literally thousands of needs because of such properties as its tremendous resistance to heat and corrosion, great tensile strength, and flexibility. Asbestos is present today in virtually every engine, automobile, and building in some form. Because the government was so slow to regulate the use of asbestos, it is no longer pri-
The Disease and the Cover-up: A Case of Medical and Government Complicity

Tens of thousands of people have already died of asbestosis and asbestos-related cancers, cancers of the lung and colon and the once rare and virtually always fatal mesothelioma. In Bill Ravanesi’s *Breath Taken* videotape, journalist Paul Brodeur lays out the scope of the tragedy:

Dr. Irving Selikoff...has estimated that between two and three hundred thousand American men and women will die of asbestos-related lung cancer alone in the next 20 to 25 years....Out of the 20 million people who have undergone occupational exposure, about one in 10 of them will either develop or die of asbestos-related disease. So we’re talking two million people who will develop some form of it.

The first phase of this national public health disaster brought disease to asbestos miners and workers manufacturing asbestos products. The second wave swept workers using asbestos products—the shipyard and construction workers who applied asbestos insulation and others who worked near them. Now problems are emerging among workers and other people exposed to installed asbestos (including merchant seamen, auto mechanics who work with asbestos brake linings, building custodians, and firefighters) as well as among families exposed to asbestos carried home from the workplace.

Brodeur’s books *Expendable Americans* and *Outrageous Misconduct* exposed how the danger was deliberately hidden for more than 40 years, and he outlines this history in the text that accompanies the “Breath Taken” photo exhibit and the forthcoming catalogue. Insurers, physicians, and government officials all participated in the cover-up. As a result, the corporations did not have to change the way asbestos was used or institute adequate safety measures. Millions of unsuspecting workers did not receive compensation, and, worse, did not get the information that might have led them to change jobs or obtain medical advice.

As early as 1918, Brodeur reports, the federal government knew that some life insurers refused to cover asbestos workers because of “assumed health-injurious conditions” in the industry. By the 1920s, numerous researchers had reported a lung disease arising from asbestos exposure. By 1931, Brodeur writes, executives of Johns-Manville, the largest asbestos firm, knew that signs of asbestosis had appeared in over half their textile workers, who spun and wove asbestos fibers. Facing 11 damage suits from workers suffering asbestosis, Manville agreed in 1933 to settle the claims on the condition that the plaintiffs’ attorney stop filing cases against the company.

In 1935, the first reports linking asbestos and lung cancer appeared. That same year, high officials of the two biggest asbestos firms exchanged letters agreeing that “our interests are best served by having asbestosis receive the minimum of publicity,” but this key evidence of conspiracy remained hidden until the 1960s.

**Medical Complicity**

The asbestos companies’ role in covering up the extent of the health hazard has become public knowledge. But Brodeur also documents the complicity of the medical profession in hiding the evidence of disease from both the public and their patients. In 1934, Vandiver Brown, Manville’s top lawyer, “persuaded a physician at Metropolitan Life Insurance to delete unfavorable information” about disease among asbestos workers from a forthcoming industry-funded report. Several companies funded animal experiments on the effects of breathing asbestos and then suppressed the results. In 1943, Brown informed another asbestos company that Manville regularly withheld from workers X-ray results showing asbestos disease because, if told, workers would quit or sue. In 1948, company X-rays of 708 workers at the Jeffrey Mine and Mill in Quebec found only four with normal lungs, but the workers were not informed. In 1952, a major medical conference of physicians, public health officials, scientists, insurers, and industry representatives heard medical evidence that exposure to asbestos caused lung cancer. This information was not made public, however,
so that, as Brodeur notes, it was another decade before the press published the story.

By the early 1950s, asbestosis was so widespread among workers at Manville's plant in Waukegan, Illinois, that, according to Brodeur's exhibit text, the company physician "lightheartedly invited a fellow doctor to visit the facility so that he could 'see the manufacture of asbestosis and silicosis as produced at Waukegan.'"

Ravanesi recounted in an interview how one worker told of being shown a chest X-ray by his factory's doctor. The physician reportedly proclaimed, "See, you have the lungs of a 20-year old!" When the worker asked which were the ribs he had once broken, the doctor "almost fell over backwards." The physician had been showing his patient "a stock photo—they were the lungs of a 20-year old!"

In the Breath Taken videotape, Brodeur deplores "the old boy network" that still exists among physicians: They have been able literally to get away with murder....At least half a dozen of the nation's leading pathologists...made tens if not hundreds of thousands of dollars each year, going around the country testifying for the asbestos industry against sick, disabled, and dying asbestos workers. Now these doctors...testifying that so-and-so's mesothelioma probably wasn't due to his exposure to asbestos,...a premise that was utterly absurd and that they wouldn't have dared say in a group of their peers....And even when the hospital authorities...did find out what some of these men were doing...they did nothing about it, because the medical profession refuses to criticize its own.

Government Complicity

Despite the companies' pursuit of profits at any human cost, much of this carnage could have been averted had government—and unions—acted more aggressively to protect workers and the public. While the British government began regulating asbestos in the early 1930s, Brodeur reveals how U.S. officials delayed acting even after Dr. Irving Selikoff's conclusive findings about the hazards of asbestos were published. In the 1960s, a top federal industrial hygienist responsible for asbestos factory inspections entered into confidentiality agreements with asbestos manufacturers that prevented him from giving out any details concerning the asbestos exposure of any of the workers. As a result, the Public Health Service did not make any recommendations to asbestos workers or to their unions about how workers might protect themselves.

The U.S. Department of Labor, Brodeur observes, set standards that allowed asbestos workers "to inhale hundreds of millions of fibers and fibrils each day," and for years the Environmental Protection Agency (EPA) continued to permit use of sprayed asbestos insulation in construction.

And government's failure to protect people from asbestos continues. Under court order, the Occupational Safety and Health Administration (OSHA) is on the verge of tightening some occupational asbestos standards. But the Nation recently reported on the controversy over regulation of three asbestos-like minerals that occur naturally with talc, limestone, and other stones used in gravel and cement and even children's play sand.

In 1989, the EPA finally announced regulations to phase out the manufacture, importation, processing, and distribution of asbestos, beginning in August 1990, with the ban to take full effect in 1996. But, as environmentalist Barry Castleman observed at a symposium held in conjunction with the exhibition, "At the rate the industry is declining, EPA's regulation may amount to nothing more than closing the coffin after the banned industry is already dead."

—D.S.

Father Richard Pankowski (January 1986), dying of mesothelioma. The main tumor on his right side can be seen breaking through the rib cage.

in Manville, New Jersey, right next to the plant.

George Armenti, a former mayor of Millington, New Jersey, for 50 years the site of an asbestos shingle factory, remembers driveways and ponds being filled with asbestos-shingle scrap. The town is now an Environmental Protection Agency Superfund clean-up site. Even today, illegal asbestos waste dumping is widespread, according to a Massachusetts official, another of Ravanesi’s subjects, who notes that the wind can magnify the hazard.

Selikoff reports in the Breath Taken video that some 30 million tons of asbestos from construction and other uses is still in place, and much of it is becoming sufficiently damaged to become airborne and then be inhaled. Conflicts are now developing around the enormous problem of “in place” asbestos, most notably in the schools, with community and health activists confronting real estate interests who attempt to minimize the problem. (See “The Third-Wave Asbestos Conference,” this issue.)

The United States has 200,000 miles of water pipes made of cement with asbestos added for strength, according to Ravanesi. Dating to the 1950s, these transite pipes have probably deteriorated under the impact of increasingly acid water and higher volume, allowing asbestos to enter our drinking water. The government has not prohibited further use of transite pipe. Illegally dumped asbestos may also contaminate drinking water. Manville worker Tom Bowlby, whose portrait begins this article, told Ravanesi that he was frequently ordered on rainy days to open barriers to allow asbestos-loaded water to flow out of settling pools and into a New Jersey river from which towns downstream drew their water. According to Ravanesi, this situation has never been investigated or covered in the press.

Still Going On

Despite what is known about the effects of asbestos on the health of workers and the public, asbestos is still being mined, used in manufacturing, and, increasingly, exported to third-world nations (see sidebar, p. 12). Along with Ravanesi’s photograph of a bleak Vermont pit—one of two still-working asbestos mines in the United States—the exhibit spotlights Canada’s still-active asbestos industry, which mines more asbestos than any other country except the Soviet Union. In the 1970s the government of Quebec bailed out and took over much of the industry in that province, where Ravanesi photographed the town of Clementine Szukis (1988), age 70, displays finger clubbing from asbestosis. A hairdresser in the Manville, NJ, area, she was exposed to asbestos in the environment and in her customers’ hair.
Asbestos and the mile-wide Jeffrey mine (now owned by the Canadian JM Asbestos Company).

In Asbestos, “nobody seems concerned about the two-hundred-foot piles of asbestos-laced waste that surround the town,” commented the Wall Street Journal in 1989. The Canadian government “is spending heavily to prop up sagging asbestos companies,” has “threatened to sue the U.S. for [its impending] ban on most asbestos,” (see sidebar on medical and government complicity) and “is exporting close to half its asbestos to the Third World, where many workers are still oblivious to its dangers.” To protect fewer than 3,000 jobs, Canadian mining unions, including the United Steel Workers, have joined industry and government in seeking new markets for asbestos in countries eager for cheap building materials.

In decisions on regulations and other policies, choices are often posed between protecting the health of the public or protecting the health of business and the economy. Clearly, policy in the United States has been guided by the needs of businesses, who often argue that the risks are uncertain. But, as one writer notes, “Waiting for proof beyond any doubt is akin to experimenting on humans.”

Asbestos road pavement and cinema, Asbestos, Quebec. In the 1940’s, “You could see little rolls of asbestos fiber rolling along the street like tumbleweed.”

A Measure of Justice

As part of the “Breath Taken” exhibit, a stack of computer printouts several inches thick lists thousands of plaintiffs whose compensation cases for asbestos-related illness have been pending for years, each with a story just as devastating as those told in the exhibit. Ravanesi says that his own mother has been waiting eight years since filing the claim over her husband’s wrongful death, and will likely have to wait five more.

Over 155,000 victims have sued Johns-Manville, along with many thousands who have sued other asbestos manufacturers, but they represent a tiny fraction of those who have suffered in this unparalleled occupational disaster. As environmentalist Barry Castleman notes in the Breath Taken videotape, the long latency period of asbestos-related diseases and their occurrence in people who had only limited exposure to asbestos means that many victims never realized the cause of their problem. Although money can never adequately compensate asbestos victims for their losses, it is a small measure of the justice due to them, and it is essential for the survival of many victims and their families.

During the 1930s and 1940s, many states took away the right of workers to sue their employers over certain occupational diseases, including asbestosis, by bringing them under state workers’ compensation laws. As a result, the industry and the insurance companies could cover claims at far lower cost, as Paul Brodeur’s exhibit narrative points out. Beginning in the 1970s, victims and their survivors sued successfully under product liability law. Particularly after documents proving the cover-up were exposed, victims won substantial compensatory and punitive damage awards from asbestos manufacturers.

“Breath Taken” includes portraits of some leading advocates for the victims of asbestos. Among them is Tony Mazzocchi, secretary-treasurer of the Oil, Chemical, and Atomic Workers International Union, one of the few unions that fought hard to protect the health and safety of all asbestos workers. At a national scientific convention in 1971, Mazzocchi reported the horrendous levels of asbestos that union members at the Pittsburgh Corning Corporation plant in Tyler, Texas, were breathing daily. He exposed the lack of enforcement of safety regulations and the trivial fines levied by the Occupational Safety and Health Administration (OSHA). Alongside his photograph are his words:

I wanted the whole country...to understand that what had gone on there—...the whole long, lousy history of neglect, deceit, and stupidity—was happening in dozens of other ways, in hundreds of other factories....I wanted them to know that murder was being committed in the workplace, and that no one was bothering about it.

The Tyler workers later won nearly $6 million from the U.S. government, Brodeur notes, in settlement of a lawsuit that charged federal collusion with the asbestos industry.

In 1982, facing thousands of lawsuits, the Manville corporation filed for bankruptcy—although it had more than
In the case of asbestos, as with lead, radiation, and so many other hazards, by the time reasonable regulations are instituted, grave harm has already been done to the public's health. "Breath Taken" is a moving testament to the urgency of reversing our priorities to put people's health first.

In the Breath Taken video, Brodeur warns that we will face disasters similar to the asbestos story in the future unless we stop permitting occupational and environmental health policy to be driven by profits.

The lesson we should learn from the asbestos tragedy is how to prevent another one from happening....New hazards are coming to light today, and they're every bit as pervasive as the asbestos hazard. But we're dealing with them in the old ways. We're allowing industry to deny them. We're allowing Congress to shilly-shally and not do anything about them. And eventually people will sicken and die and then they'll go into the courts and they'll be compensated. And then if enough of them sicken and die...and it becomes too expensive, then the

$2 billion in assets. While the legal contest between the company, its creditors, and the victims dragged on in bankruptcy court for over six years, the victims received nothing. In the exhibit catalogue, Brodeur quotes from Dr. Irving Selikoff's letter to the trial judge protesting this unconscionable delay:

Men are dying of mesothelioma or lung cancer unable to seek medical care to ease their last days, and others are not able to afford the medical surveillance that could save their lives. Still others......no longer able to make a living, can't keep their families together....Some have written me that they came close to begging in the streets.

During that period, the U.S. Bankruptcy Court allowed Manville to settle with its insurers for a low figure, while the insurers gained court protection against any future claims by Manville victims. Out of 48 other defendants, 30 are now out of business, and 7 more have sought bankruptcy protection.

A trust fund created for Manville victims began paying claims in 1988. But the fund was another form of victimization, charged White Lung Association Executive Director Jim Fite in the Breath Taken video:

It was just a shell game....The insurance companies and the asbestos companies hoarded their monies for years and years, and they set up this sham trust, which, after 15,000 people went through, is bankrupt. And 100,000 people are waiting, and 2,000 a month tile.

With more claimants than the settlement assumed, and higher than expected payments and legal costs, the Manville trust ran through most of its funds in less than two years, paying only the earliest claimants. A November 1990 restructuring plan for the trust proposes to set priority on payments to the sicker victims and put some limit on lawyers' fees. It will also slash the average amount paid on claims from $43,000 to less than half that amount, possibly as low as $2,000 for those who “only” have asbestosis, Fite said in a recent interview. Attorneys and the trust staff are all being paid before the victims. Fite’s gravest concern about the restructuring, however, is that it would dismiss thousands of pending suits and set a terrible precedent for victims in other occupational hazard cases.

Environmentalist Barry Castleman points out in the Breath Taken video,

People who knowingly, willfully, and recklessly expose the public or their workforce or their consumer or customers to mortal hazards...—powerful individuals who manage vast industrial enterprises...consider that the cost of human disease they create...(1) is probably not going to be borne by their company, and (2) if it is to some extent, it'll be borne as a cost of doing business, something they can buy insurance for, or a few percent of their profits that they may ultimately have to give up.

...as long as it's treated as something different from some hoodlum going around shooting people and stabbing people—...because the guys who are doing it are wearing thousand dollar suits and do it for profit...—it's going to go on. And so we really need to think in terms of imposing serious criminal sanction to prevent the kinds of things that have happened with asbestos from happening again and again.

To date, however, there have been no criminal prosecutions against top asbestos company officials for exposing their workers.

—D.S.

Exposing Death

Along with its asbestos, Canada has been exporting the related health problems to the third world. At a symposium entitled "Asbestos, the Persistent Plague," held in conjunction with the "Breath Taken" photo exhibit by Boston University's School of Public Health, environmentalist Barry Castleman presented evidence of high exposure levels in such countries as Mexico, India, and Brazil, where workers cut and spray asbestos materials without protective measures. Canada's government-funded Asbestos Institute has been promoting asbestos materials over wood pulp and safer substitutes. Castleman tells Bill Ravanesi in the Breath Taken video, "They've been marketing what they call safe use of asbestos, but mainly they've been marketing the use of asbestos. They hold two-day seminars in places like Egypt and pronounce the country a free zone for the continued sale of asbestos.

The Canadian government has intervened when other countries tried to control asbestos use—for example, per companies that are responsible can file for bankruptcy, and the whole cycle begins all over again.

[This is] how the private enterprise system as presently constituted in the United States deals with major occupational and environmental health problems. And only the public can change this—the public through political pressure, anger, outrage, and information, and can make it known to the politicians that there is no longer tolerance this kind of situation, where it and their children are in danger.

The "Breath Taken" photo exhibit will be at the Marion Locks Gallery, Philadelphia, in May 1991; the Walzlers Gallery, Rutgers University, in November 1991, sponsored by the Rutgers Labor Education Department, the Oil, Chemical and Atomic Workers Union, and others; and the Museo Latino Americana, San Francisco, in February 1992. For information about additional showings and the exhibit catalogue, contact the Center for Visual Arts in the Public Interest, 548 Congress Street, 3rd floor, Boston, MA 02110, (617) 425-9777.

The Breath Taken video is available from Rainlight Productions, 47 Halstead Street, Boston, MA 02129, (617) 524-0980.

The White Lung Association, a key nationwide asbestos victims group, along with the Black and Brown Lung Associations, has developed a model Toxic Substances Compensation Act to create a national fund for workers disabled by toxic substances paid for by all corporations that use them. It is also organizing protests against the restructuring of the Marquette Trust. The White Lung Association is at P.O. Box 1483, Baltimore, MD 21203-1483, (301) 243-5864.


The Third-Wave Asbestos Conference: High Drama in Science

David Kotechuck

Until recently, the scientific consensus that exposure to asbestos poses a serious risk to human health seemed well established and unlikely to change. But now a prestigious group of scientists has challenged one aspect of that consensus, creating controversy and turmoil among scientists and occupational health advocates.

In this context, the international conference on "The Third Wave of Asbestos Disease: Exposure to Asbestos in Place," held June 7-9, 1990, in New York City, provided a moment of high drama in the scientific community, with elements at once scientific, social, political, and personal. The conference was sponsored by the Collegium Ramazzini, an international body of environmental and occupational health scientists.

The Controversy Crystallizes

Since the early 1980s, following key articles by scientists such as Dr. Irving Selikoff, now Professor Emeritus at Mt. Sinai Medical Center and President of the Collegium Ramazzini, and reinforced by hundreds of later studies, a scientific consensus has emerged and gathered powerful momentum that asbestos dusts are hazardous to human health, causing asbestosis, lung cancer, mesothelioma, and gastrointestinal cancers. This in turn has helped shape a public consensus in the United States that asbestos dust and asbestos materials in place at work and in the community, especially in schools and other public buildings, must be carefully monitored and regulated.

Among the remaining areas of scientific debate are whether certain crystalline forms of asbestos dust are more harmful than others, and thus should have lower permitted levels in the air. The federal Occupational Safety and Health Administration (OSHA) has a single exposure standard for all types of asbestos fibers, a position supported by Dr. Selikoff and many other U.S. scientists. However, the American Conference of Governmental Industrial Hygienists, an important private consensus group, recommends a standard for chrysotile asbestos fibers two-and-one-half times greater than that for crocidolite asbestos fibers. Such a standard is in effect in England, reflecting the views of many British scientists that chrysotile is less dangerous than crocidolite. Notwithstanding this difference, both the U.S. and British standards regulate asbestos stringently.

Then, in January 1990, in an article in the prestigious Science magazine, several prominent scientists in the United States and Europe broke with the existing scientific consensus on asbestos. They argued that chrysotile asbestos fibers, the type most commonly mined and used in North America, present a far less serious cancer risk than all other types of asbestos fibers (called amphibole fibers). Their contention was that many cancers among asbestos workers can be attributed to a percent amphibole contamination in North American chrysotile deposits, and that in any case "data do not support the concept that low-level exposure to asbestos is a health hazard in buildings and schools." The authors are prominent scientists at major academic institutions, including Dr. Morton Corn, former Director of the Occupational Safety and Health Administration under President Gerald Ford and now Director of Environmental Health Engineering at Johns Hopkins University; Dr. J. B. L. Gee, a pulmonary physi...
A prestigious group of scientists has challenged the consensus that all exposure to asbestos poses a serious risk to human health.

(AHERA) of 1986, which concerned asbestos in schools, far from being a reasonable response to the problem, instilled "fear" and "panic" among parents.

The impact of the article on the scientific community was substantial. Occupational health scientists debated, at first informally, the article's sharp break with current thinking and the evidence for its so-called amphibole hypothesis. Also, the timetable for the New York City conference, some organizers have acknowledged, was moved up to allow prompt discussion of and response to these views.

The Social Impact

The social impact of the article was substantial as well, catching many supporters of asbestos workers and their families by surprise. We had heard about the so-called Harvard Asbestos Conference held in early 1989, a by-invitation-only private gathering of the asbestos industry and its legal and scientific allies—no Mt. Sinai scientists, for example, were invited. Although the extent of Harvard’s official participation was to rent the facilities on campus to the gathering, the conference was widely reported on as "the Harvard Conference," with the implied imprimatur of the university.

In part, the media response was the result of an aggressive, organized publicity campaign by the Safe Buildings Alliance, a publicity and lobbying arm of the asbestos building supply industry, including firms such as W. R. Grace, Celotex, and U.S. Gypsum. The New York State Asbestos Advisory Committee, in its February 1990 report to Governor Mario Cuomo, accused the Safe Buildings Alliance of having conducted "an extensive and highly misleading disinformation campaign," including articles placed in Readers Digest and Forbes magazines.

But behind the success of such a lobbying group was also a great demand from a variety of groups to hear this "good news." First and foremost, the North American asbestos industry benefits directly, since over 90 percent of the asbestos used in the United States is chrysotile fiber, the one type of asbestos fiber that is supposedly much less dangerous according to the amphibole hypothesis. Given the clouded history of asbestos research, opponents of the asbestos industry have looked for—and found—associations with asbestos companies among scientists propounding the amphibole hypothesis (see sidebar).

Also, the powerful real estate industry, suddenly stuck with vast amounts of empty office space and the gathering momentum of an economic recession, is desperately seeking to cut back on expensive asbestos removal and to fight proposed new state and local laws assessing and regulating asbestos in buildings (see Update, p. 15). By April 1988, 38 states had passed laws regulating asbestos. One such law is now moving toward passage in New York City, for example, where 84 percent of all large office buildings and 72 percent of all large apartment buildings contain asbestos, most of it in damaged condition. These figures are probably not too much different from those in many other U.S. cities. Individual homeowners, who also face the health threats, emotional uncertainties, and financial risks of asbestos contamination in their homes are likewise a receptive audience for such "good news."

Of course, financially beleaguered state, county, and local officials, facing increasingly heavy asbestos-related expenditures during times of fiscal crisis, were quick to take note of the Science article and the relief implicit in its arguments. For example, during a March 1990 meeting with officials of the New York City Fire Department about possible asbestos awareness training, several of the officials asked this author whether I would speak about the "Harvard article." Obviously, these people had heard...
Update: Asbestos Control Legislation

While evidence mounts about the health hazards of low-level asbestos exposure, legislative and regulatory activity addressing this threat has just recently started cropping up across the country.

A proposal that would be by far the most comprehensive asbestos control law in the country is expected to be introduced into the New York City Council before the end of the year. The bill addresses dangers posed by “in-place” asbestos—deteriorating or disturbed asbestos in factories, offices, schools, and other buildings. The New York City law would provide for inspection, evaluation, and appropriate remedial action to abate asbestos hazards in the city’s 750,000 public and private buildings. Building owners would be required to prepare and implement a plan to cope with in-place asbestos on their property, setting in motion a 10- to 15-year control program.

Opposition to the bill is expected from the so-called Safe Buildings Alliance (SBA), an organization of former asbestos manufacturers. Based in Washington, D.C., SBA lobbyists conduct nationwide publicity campaigns and testify against control legislation at local, state, and federal hearings. Their goal is to reduce liability of member corporations against lawsuits from building owners and individuals exposed to asbestos. Prominent SBA members include Celotex Corporation, W. R. Grace & Company, and U.S. Gypsum. This trio has spent tens of millions of dollars to settle personal injury lawsuits filed by victims of asbestos exposure, and they are expected to fight tooth and nail against the New York City measure.

Meanwhile, the State of California is considering a measure calling for inspections of commercial buildings for asbestos. This bill follows on the heels of a 1988 notification law that essentially gave workers the right to know about any asbestos in these buildings. And back on the East Coast, a state law has been proposed in Virginia that would require asbestos inspections in all hospitals and day care centers.

On the federal level, the Service Employees International Union (SEIU) is suing the Environmental Protection Agency in an effort to speed the drafting of asbestos control regulations. The union is calling for a law that would provide for inspections in public and private buildings; notification of workers of any potential asbestos hazards; and establishment of asbestos control procedures. SEIU, which represents thousands of maintenance workers and others thought to be at risk from low-level asbestos exposure, filed the suit last year. —Jim Young

Jim Young is Director of Public Affairs, New York Committee for Occupational Safety and Health (NYCOSH), New York City.

The conference focused on the diseases caused by exposure to the 30 million tons of asbestos put into place in the United States since 1900. Many of those affected—building maintenance and repair, transportation, and other workers in public and private sector employment—are not normally considered asbestos workers, yet as the conference showed, they suffer in surprisingly large numbers from asbestos-related diseases. Earlier waves of asbestos deaths were associated with the mining and manufacture of asbestos products (the first wave) and the use of asbestos products among construction and shipyard workers (the second wave).

In his keynote address, Dr. Selikoff updated his continuing critical studies on mortality among asbestos construct—

Opponents of the asbestos industry have found associations with asbestos companies among scientists propounding the amphibole hypothesis.
found similar increases in lung cancer risk per unit of asbestos fiber exposure for all but one of the studies. The amphibole hypothesis would have predicted much lower cancer risks for several of the studies, those which involved primarily chrysotile exposure.

Nicholson also attacked as misleading some of the key evidence that Mossman and others had presented to support their arguments. They noted that upon autopsy, many victims of asbestos disease who had worked primarily with chrysotile showed elevated levels of the amphibole fiber tremolite, which is normally a 1 percent contaminant of North American chrysotile, and presented this as evidence that tremolite was causing the lung cancer. Nicholson asserted that this simply reflected the body's greater ability to break down chrysotile than tremolite fibers during the several decades it took the cancer to develop. It is a fallacious argument, he went on, to make inferences about the cause of a disease from events that took place decades later, at the end of the disease process.

In another key session on "Diseases Resulting from Asbestos Exposure in Buildings," three independent studies of asbestosis among building custodians were reported. Dr. Christine Oliver of Harvard Medical School reported that 33 percent of 121 Boston school building custodians showed X-ray evidence of asbestosis lung disease. In New York City, Dr. Stephen Levin and colleagues at Mt. Sinai Medical Center studied 660 school custodians, members of the Operating Engineers Union, and found 28 percent with evidence of asbestosis. Among those in this group with 35 or more years on the job, 39 percent—almost two of every five workers—had asbestosis. In Los Angeles, Dr. John Balmes of the University of California in San Francisco found 13 percent of the custodians studied showed X-ray evidence of asbestosis lung disease. In New York City, Dr. Stephen Levin and colleagues at Mt. Sinai Medical Center studied 660 school custodians, members of the Operating Engineers Union, and found 28 percent with evidence of asbestosis. Among those in this group with 35 or more years on the job, 39 percent—almost two of every five workers—had asbestosis. In Los Angeles, Dr. John Balmes of the University of California in San Francisco found 13 percent of the custodians studied showed evidence of asbestosis. Since these custodians all worked in U.S. buildings, which therefore contained primarily chrysotile fibers, and since all the cases involved incidental exposures in school settings, the high incidence of asbestosis in this group flatly contradicts the Science article's assertion that "available data do not support the concept that low-level exposure to asbestos is a health hazard in buildings and schools."

These reports were followed by an epidemiological study of the occupations of 254 mesothelioma cancer mortality cases in Wisconsin, drawn from the state's cancer registry, by Dr. Henry Anderson and associates. As expected, they found the greatest likelihood of developing mesothelioma among insulation workers and ship-
Winter 1990

Health/PAC Bulletin

PhilaPOSH picketing City Hall Annex, Philadelphia, 1986, to protest high levels of ambient asbestos fibers floating throughout the building.

builders. But of particular interest were statistically significant elevations in the odds of developing the disease among "non-asbestos workers," including fire fighters, law enforcement officers, school employees, postal workers, and janitors. These workers have in common offices and employment in public buildings, many of which are contaminated with asbestos dust.

More than 50 other studies were reported at the conference, the full proceedings of which will be available soon from the New York Academy of Sciences. What was most persuasive was not any individual report, but the cumulative impact of report after report describing worker groups and some communities around the world struck by asbestos disease. Many of those reporting from countries outside the United States were not only prominent scientists in their native lands, but important public health officials there as well. And if many had been slow to overcome their initial skepticism about the extent of asbestos-related diseases during the 1960s and 1970s, they are now clearly convinced of the health hazards of asbestos and are gathering strong evidence to buttress their views.

They heard reports of major new findings on the effects of asbestos in schools, as well as new results that extended the boundaries of occupations affected by asbestos exposures and communities affected by dust from asbestos mineral outcroppings. These results vault over the artificial distinctions constructed in a recent *New York Times Magazine* article on the conference that "No new evidence was presented to demonstrate that deteriorating asbestos in schools and public buildings was causing increased cancer rates in the general population. However, a moun-


8. Mossman et al., op. cit., p. 299.


15. Mossman et al., op. cit., p. 299.


17. "Buildings with Asbestos Shunned."


Terminal Illness?
The Mounting Evidence of Hazards from Computer Emissions

ELLEN BILovsky

In the brave new world of the 1990s, virtually no business or office—not even Health/PAC—can function without computers. With some 40 million computers in workplaces across the country, the discovery that their use presents some danger would have widespread ramifications indeed. Paul Brodeur, the muckraking journalist who was instrumental in revealing industry's cover-up of the risks of asbestos, is now crusading to expose what may prove to be a new occupational health disaster: the hazards of electromagnetic radiation from computer display monitors.

In the cover story of the July 1990 issue of Macworld, a magazine devoted to Macintosh computers, Brodeur reviewed the accumulation of evidence that extra-low frequency (ELF) emissions from the video display terminals (VDTs) of computers affect human health, including the immune system's ability to fight cancer. The focus of concern is low-frequency, non-ionizing, 60-hertz (cycle per second) magnetic radiation—the same frequency generated by power lines and ordinary household appliances. While there is also concern about radiation from these other sources, many people spend hours—often their entire workday—in front of VDT screens in the type of white-collar work environment that is usually assumed to be free from risk.

In some ways, Brodeur's story (recounted in greater detail in his 1989 book Currents of Death: Power Lines, Computer Terminals, and the Attempt to Cover Up Their Threat to Your Health) is not news. A variety of ergonomic and other health problems, ranging from headache and eyestrain to carpal tunnel syndrome, have been traced to prolonged work on VDTs. Concern about radiation first surfaced in the United States in 1976 when the Newspaper Guild called for investigation of the unusual development of cataracts among two young men at the New York Times Company who worked on VDTs. Shortly after that, clusters of miscarriages and birth defects began to be reported among women who worked on computer terminals in the United States and Canada—seven such reports between 1979 and 1982.

These reports were investigated—and dismissed, in what was probably a combination of incompetence, stubborn ignorance, and deliberate denial—by nearly every U.S. government health agency. The National Institute for Occupational Safety and Health (NIOSH) found negligible levels of radiation at the Times' computers—but, according to Brodeur, their measurement technique was inaccurate. Most subsequent reviews of the question by such agencies as the Centers for Disease Control, the National Academy of Sciences, the New York State Department of Health, the Army's Environmental Hygiene Agency, and the Food and Drug Administration's Bureau of Radiological Health, as well as by Canadian health officials, have relied on these inaccurate measurements. Moreover, previous industry standards had focused on high-energy radiation that might cause heating of tissue, and investigators concerned to ignore the ELF and VLF (very low frequency) radiation. Needless to say, investigations by major users of computers, such as Bell Telephone Laboratories, IBM, and the New York Times Company, have also denied the existence of any problems. And the print media, which converted to computer technology in the 1970s, have not been eager to publicize the story.

The Evidence Accumulates

Yet scientific studies have repeatedly shown the health risks of prolonged exposure to alternating 60-hertz electromagnetic fields. In 1979, Nancy Wertheimer published her research findings that children who lived near certain high current power lines died of leukemia at twice the normal rate. (This potentially even more far-reaching aspect of the hazards of electromagnetic radiation has so far not gotten the serious attention that VDT emissions have received.) Perhaps this is because citizens concerned about the effects of power lines near their homes don't wield the clout that the editors of Macworld can muster, perhaps because the power companies are an even more formidable enemy than the VDT makers. Other studies showed that electricians, telephone workers, power line workers, and others who worked in close proximity to electromagnetic fields had much higher than usual rates of certain cancers.

Investigations relating specifically to the type of radiation emitted by VDTs found spontaneous abortions and birth defects among laboratory animals exposed to it. The only completed large-scale epidemiological study of the effects of working on VDTs on humans was conducted by researchers at the Northern California Kaiser Permanente Medical Care Program in Oakland, California. It found an 80 percent higher risk of miscarriage among women who worked with VDTs—but only those who performed such work for 20 hours or more a week, suggesting to some that the stress of the work might be a factor.

Despite the evidence, government health officials have, until recently, insisted on comparing the hazard from computer terminals to exposure to a light bulb—which, in fact, gives off no magnetic emissions. The risks of exposure to household appliances that emit similar ELF radiation has recently gotten media play, no such appliances, with a few exceptions such as electric blankets, are used in close quarters for long periods of time.

In an attempt to determine the actual extent of the hazard to computer users, Macworld measured the emissions of ten different models of Macintosh computers, obviously, a limited sample. In front of the computer screen, the emissions measured from 1.1 to 4.9 milligauss at 12 inches, dropping off to less than 1 milligauss at 28 inches (arms length). (A gauss is a measure of the strength of a magnetic field.) The radiation at the sides and back of the computer were much stronger—as high as 15.8 milligauss at 1 inch, though much measured much less. By comparison, the magnetic fields in the houses of the leukemia victims in Wertheimer's study measured approximately 2 milligauss. New York Tele-

phone cable splicers, who contracted leukemia at a rate seven times greater than other telephone workers, were exposed to power lines generating a 60-hertz magnetic field of 4.3 milligauss.

Swedish Health Protection Institute has developed voluntary guidelines for ELF exposure, according to VDT News, setting a limit of 2.5 milligauss at 50 centimeters (20 inches). Monitors that don't use cathode ray tubes, such as the liquid crystal displays used in many laptop computers, generally do not emit significant magnetic fields. Screens designed to block electric fields are not effective in reducing magnetic radiation, which passes easily through furniture, walls, and the human body.

However, according to the New York Times, a number of computer manufacturers, including IBM and Apple, are now voluntarily acting to develop products with reduced magnetic emissions, generally in line with the Swedish guidelines.

In the meantime, Macworld recommends that operators sit at arms length from their video displays and that people sit no closer than four feet from the sides or back of other monitors—particularly important in workplaces where people are working on computer terminals nearby. Pregnant women or those contemplating pregnancy may wish to transfer to another position—if that is possible. And computer users may wish to give special thought to children's exposure to VDTs. For some time, organizations such as the local "COH" (groups committees on occupational safety and health) and the people have been offering recommendations on how to mitigate the various hazards of working on VDTs by limiting work periods and improving the comfort of work stations. San Francisco's new landmark law regulating VDTs addresses these issues but does not deal with emissions. Until government agencies take seriously the hazards of VDTs and fund studies to set reasonable safety standards for ELF and VLF radiation, we will never know whether our brave new workplaces are safe places.

What makes Brodeur's Macworld article different from other books and articles with the same information is the courageous stand he takes, as an offshoot of the implicit industry, in recognizing that the industry owes something to the people who work in it. Editor-in-Chief Jerry Bennett's commentary in the same issue clearly situates the potential occupational hazard of magnetic radiation from computers in the tradition of the industrial poisoning of workers by asbestos, lead, mercury, and...
cotton dust and the exposure of soldiers to atomic bomb detonations and Agent Orange. Borrell recognizes that it is up to the workers in the computer industry and other users of the technology to force an admission of the danger, because clearly neither the industry nor the government will do so on their own.

Opinion Shifts

In early 1990, analysts in the Environmental Protection Agency (EPA) recommended that ELF be classified as a probable human carcinogen, based on review of the existing literature. But Director of the EPA’s Office of Health and Environmental Assessment Dr. William Farland ordered this recommendation deleted from an early draft of the EPA’s report on electromagnetic fields because the mechanism of ELF’s action is not yet understood. Some suggest that political pressure from the Bush administration nixed the recommendation. Yet the report clearly identifies ELF as a potential hazard, even though it refrains from conferring that status officially. The final report is due in early 1991.

Coming soon after EPA’s draft report, Brodeur’s Macworld article reached tens of thousands of computer users around the world, along with his concurrent article in the July 9 New Yorker on power lines and cancer. This publicity apparently succeeded in creating something of a stir in both the computer industry and the government, where pure research had hitherto failed. As noted, several computer companies are now working on a technical solution to the problem of magnetic emissions. They complain, however, that they have no standards for safe levels of radiation to work toward. The government agencies that once so cavalierly assured computer users of their terminals’ safety are now hedging, and they are actively pursuing new research and existing evidence instead of writing it off. According to Macworld, for example, the Occupational Safety and Health Administration (OSHA) and the Office of Management and Budget requested that the White House Office of Technology report on existing studies; and NIOSH was to convene a workshop in January to develop a national research strategy on the effects of electromagnetic radiation on the health of workers.

Congress held hearings in July chaired by Rep. James Scheuer (Dem.-NY) on funding of research on the health effects of electromagnetic fields and approved some funding for studies under EPA. Despite real concern about the hazards, a major consideration was the cost involved. Studies that damn VDTs as hazards will be condemning electrical power lines as well, and while the expense involved in shielding computers can be passed on to the consumer, the cost of burying or removing power lines all over the country could be astronomical. Electric power utilities may turn out to be a much greater opponent than the computer manufacturers in the attempt to make the true extent of the hazard known.

Is there sufficient proof that ELF electromagnetic radiation from computers can cause cancer or reproductive hazards? No. Although several significant studies are nearing completion (including a NIOSH study of computer users and pregnancy at a telephone company and a study of pregnant women by Mt. Sinai Hospital in New York City), federal officials told Macworld that they believe solid data is still three to five years away. Is there enough evidence to warrant taking precautions when workers are exposed to frequent and extended doses of ELF and to pursue the question in substantial studies? Clearly, the answer is yes. We don’t know what damage may already have been done to computer users and others who have been exposed to ELF in the workplace and their homes for years, but there is no reason to compound the neglect. For once, perhaps, the government could err on the side of preserving workers’ health and safety instead of industry profits. •

For detailed information on the ELF issue, some excellent sources are VDT News (212-517-2802) and Microwave News (212-517-2800), both published by Louis Slesin, P.O. Box 1799, Grand Central Station, New York, NY 10163; and the Labor Occupational Health Program at the University of California at Berkeley, 2521 Channing Way, Berkeley, CA 94720, (415) 642-5507. Macworld is at 501 Second Street, San Francisco, CA 94107, (415) 243-0505.
Oil and Water?
A United German Health Care System

In light of the rapid political changes occurring in Europe, Health/PAC thinks it important to examine how those changes are affecting health policy. The unification of Germany in particular brings health care policy changes into focus because it entails the joining of two very different health care systems. This article concentrates on the debate among physicians in both West Germany and East Germany, but also highlights the extent to which the debate on the left is ongoing and heated.

The Verein Demokratischer Ärzte (VDÄÄ) or Association of Democratic Physicians, is a small organization of progressive physicians in West Germany that, in coalition with other physicians' associations, works in opposition to the conservative physician board that has determined health policy in West Germany. This declaration was originally issued in 1989 and was published in the June/July 1990 issue of Dr. med. Mabuse, a progressive West German health policy journal.

Nancy McKenzie met with the editor of Dr. med. Mabuse, Hermann Löffler, in New York in October. Dr. Löffler, himself a member of the VDÄÄ, was reluctant for Health/PAC to publish the VDAA declaration without also printing his editorial commentary, which accompanied it in Dr. med. Mabuse, a progressive West German health policy journal.

On the Union of the Public Health Systems of the Federal Republic of Germany and the German Democratic Republic

A DECLARATION OF THE ASSOCIATION OF DEMOCRATIC PHYSICIANS (VDÄÄ of West Germany)

Against the backdrop of political upheaval in East Germany (the German Democratic Republic), the proposed unification of the GDR and the Federal Republic of Germany (FRG) has given rise to major problems in many areas of society because of the differences in the two systems. One of these areas is public health, which in East Germany, with a few minor exceptions, is state run, whereas in the Federal Republic it consists of a combination of state, autonomous, and private organizations. Currently, the anxiety and criticism expressed by East bloc physicians are being used by physicians' associations in the West to push one issue—the need to establish private practices. This is being done rashly and without consideration of the consequences for the entire health care system, consequences that will be difficult to correct under unification.

The unification of Germany has given rise to major problems in many areas because of the differences in the two systems.

Two West German physicians' associations, the Hartmannbund [Hartmann Association] and the Marburgerbund [Marburg Association] have already established chapters in the German Democratic Republic. The Bonn government is already making low-interest Marshall Plan-type credits available to those wishing to establish private practices there. And, since March 1990, the German Physicians Journal [West Germany] has been sent free of charge to 10,000 physicians in the GDR. What these endeavors share is the conviction that the public health system in the FRG is exemplary and should be adopted by the GDR.

During a fact-finding trip to the GDR, Dr. Winifred Beck and Prof. Dr. Hans-Ulrich Deppe, members of the Board of the Verein Demokratischer Ärzte, discovered that these activities have caused considerable problems for and have often been rejected by a large part of the public health community in the East. During the trip, many members of the public health community expressed the position that the system of preventive medicine in the GDR has proven successful and should not be dismantled. Physicians also repeatedly stressed that the dissolution of the polyclinics [clinics run by the state] and their replacement by private practices could lead to existential, as well as to preventive medicine problems. On the other hand, they ranked highly the decentralization of health care [in the West], the autonomous administration of the public health care system, and the earning levels of those employed in public health.
Shortcomings of the FRG

In view of the activities of the physicians’ organizations in the FRG, we find it necessary to point to the shortcomings of our own public health system:

• The monopoly by the Kassenärztliche Vereinigung [Alliance of National Health Service Physicians] on outpatient treatment has led, it is true, to the highest income level of physicians in the European Economic Community. However, it has also brought about a separation of outpatient and inpatient care that has led to obvious disadvantages for the patient: extra examinations, a lack of continuity of treatment following inpatient release, and hospitals’ refusal to administer outpatient therapies or follow-up treatments.

• Reimbursement for individual treatment in outpatient care has led to an overemphasis on technical or technological measures along with a neglect of “medical dialogue.” This has resulted in an increase in the volume of treatment and has fostered an economic interest in illness rather than health. It promotes the “entrepreneur physician” and impedes the doctor who solely follows medical criteria.

• The powerful influence of the pharmaceutical industry and the lack of control over more than 70,000 specific items on the pharmaceutical market, as well as the dominant role played by the medical equipment industry, had led to a significant break with the psychosocial principles of medicine.

• There is a lack of qualified and specially trained personnel for emergency care.

• Service in industrial medicine is negatively affected by its financial dependence on factory management.

• The Bundesärztekammer [Federal Chamber of Physicians] misuses its compulsory membership of over 200,000 physicians to the benefit of the highest earners within the medical profession. The domination of “democratic centralism” hinders democratic control of the numerous commissions and committees. In this way, opposition within the medical profession is denied proportionate representation on all the major committees.

• The Law on Health Reform, with its negative consequences for the weakest in our society, has led to additional burdens on the handicapped, the chronically ill, and the elderly. The six million people listed on the rolls of welfare organizations as living below the poverty level suffer additional discrimination under medical and social/psychological criteria.

• The division of federal health insurance into more than 1,000 plans has led to highly discriminatory rates structured according to risk factors and to the insured’s income. The existence of a private insurance system for the 10 percent of the population with high income and low medical risk frees this group from contributing to the less powerful majority of the population.

Comparing the Systems

Apart from the severe shortage of caretakers in the GDR’s public health system, there are organizational structures in that system that could have a positive effect on public care in a future joint German health system. It should not be forgotten that in the process of West European integration, the medical care of more than half of all citizens of the European Economic Community will be carried out by national health services for a long time to come.

In comparing the two systems, it must also be kept in mind that the current share of the GDR’s gross national product expended for public health is nearly half that of the FRG’s. Nonetheless, in the GDR, as in England, there is:

• An emphasis on preventive medicine as opposed to purely curative medicine.

• A close, coordinated intertwining of outpatient and inpatient care.

• Overlapping of technical and professional outpatient agencies, with an emphasis on the treatment of certain syndromes.

• Independence of industrial physicians from factory management in carrying out their therapeutic duties.

• Equal distribution of medical care agencies throughout the country.

• Close cooperation among diverse professional groups, which are independent of commercial considerations.

In view of the situation presented here, we find it appropriate to call physicians from both systems to meet on common ground to compile the advantages and disadvantages of both systems and to develop concepts that would allow the union of these diverse health systems with the least possible friction and social hardship for all involved. We see this as an opportunity to eliminate the apparent inadequacies in our own health system as well, and to achieve progress in health services for all concerned.
As a first concrete step we suggest the reestablishment of health centers, under public or cooperative regulation, with the participation of physicians from the various areas of specialization, together with other professional groups from the public health sphere such as psychologists, physical therapists, social workers, druggists, dentists, etc. A prerequisite for this, however, would be the immediate annulment of the exclusive state contract with the Alliance of National Health Service Physicians. This monopoly is in conflict with any prototype for outpatient care.

In addition, we demand to retain the federal, decentralized character of medical autonomy in the Landesärztekammer [states’ Chambers of Physicians in the East]. Once the states’ Chambers of Physicians of the GDR have joined the Federal Chamber of Physicians in the FDR, this concentration of power must be replaced by a new State Chamber of Physicians. Such an association will play a purely coordinating role in terms of introducing democratic regulations, as is the case in all other parliamentary chambers.

—Dr. Winifred Beck
—Prof. Dr. Hans-Ulrich Deppe (translated by Edna McCown)

According to Dr. Löffler, the debate within the VDÄA centers around the abuses and deficiencies now being discovered in the East German health care system, such as the existence of special clinics for higher-ups in the East German government, dilapidated conditions in psychiatric clinics and nursing homes, antiquated concepts of psychiatric treatment, lack of respect for individual confidentiality, and connections between the mental health system and the Stasi (the East German secret police). The question is whether these conditions are historical and occasional malfunctions due to lack of funds and to individual abuses or are directly tied to the structures in the East German health system —structures that the VDÄA declaration finds praiseworthy.

Many physicians in the East find they are unable to ignore these deficiencies or the GDR’s well-known history of suppressing internal discussion of the health care system and concealing health statistics within the GDR. According to Dr. Löffler, the VDÄA must avoid embracing the formula, “the right criticizes the East; the left criticizes the West.” Criticism of the East German health care system is justified, but there cannot be a double standard out of fear of abandoning the left.

Even as late as last year, the left in the West thought that reports of abuses in the East were yellow journalism. But the left cannot ignore the discoveries of the terrible environmental problems in the East and the medical tragedies that go with them; the plans to build internment camps for the enemies of the GDR; or specific instructions from the Stasi to psychiatric institutions on the treatment of individuals. The VDÄA’s criticism of the West German health care system loses credibility if it operates with a double standard. What is required, according to Dr. Löffler, is radical openness, deep criticism, and open discussion of an improved health care system for the new German Republic.

—Nancy McKenzie

Criticism of the West German health care system is justified, but there cannot be a double standard out of fear of abandoning the left.

Health/PAC Panel Defines Urban Health Crisis

In a panel discussion on the Urban Health Crisis, held on October 1, 1990, during the American Public Health Association annual meeting in New York City, Health/PAC brought together physicians and health care advocates from all over the country to outline the national scope of the current crisis. Panelists included:

Zoe Clayson, Institute for Policy Studies, and member of the San Francisco Community Health Coalition, San Francisco, CA

Linda Lowe, Health Policy Specialist, Georgia Legal Services, Atlanta, GA

Stephan Lynn, Director, Emergency Medicine, St. Luke’s-Roosevelt Hospital Center, New York, NY

Geoff Modest, Medical Director, Uphams Corner Health Center, Boston, MA

Gordon Schiff, Director, General Medicine Clinic, Cook County Hospital, Chicago, IL

Panelists quickly concluded that the crisis in health care isn’t confined to urban areas or even to the poor. They described almost total gridlock in the emergency rooms in both public and private hospitals; the financial plight of urban hospitals; and the lack of access to care among communities of color, immigrant groups, and rural communities. The simplest definition of the crisis, offered by Stephan Lynn, was “too many patients today requiring access to health care and too few resources available for those patients.”

Speaking in both medical and political metaphors, panelists described the near “collapse” of health care delivery in their institutions; “bypass” remedies for an overloaded system; and medical “apartheid” and “homelands” for poor and minority patients seeking health care. While discussion focused on the immediate need to gain political attention for patients unable to get care, many health care advocates noted that the frustration and anger of people from every social stratum over the lack of adequate health care may provide a broader coalition for change.

The Spring 1991 issue of the Bulletin will feature a selection of the presentations from this lively and important discussion. Health/PAC welcomes reports from our readers on the face of the health care crisis in their areas.
Pro-labor members of the American Public Health Association (APHA) called off their threatened picket of this year’s annual meeting at a union-boycotted hotel after a last-minute agreement between the Marriott Corporation and the New York Hotel and Motel Trades Council. But APHA’s Governing Council, faced with heavy criticism and internal dissension over its insensitivity to labor issues, finally voted to develop a policy on patronizing non-union hotels in the future.

The 1990 APHA national meeting was held in three hotels in New York City this past fall. Governing Council meetings and hundreds of smaller events were held in the New York Marriott Marquis Hotel, the site of a three-year-long labor boycott. Future meetings are scheduled at Marriott hotels in six cities through the year 2000. The Marriott Corporation specializes in providing facilities capable of handling large-scale conventions like the APHA meetings. It is notorious for its vigorous anti-union campaigns around the country, and there is an ongoing union boycott of the Marriott Hotel in San Francisco.

During the often bitter and ultimately fruitless negotiations with the union and concerned APHA members over the use of the Marriott Marquis, APHA executives said the association did not have an official policy on using non-union hotels. Members of the APHA Labor Caucus were deeply disturbed at the claim that the organization has no special ties to labor. In the 1990 newsletter of the APHA’s Occupational Health and Safety Section, Chairperson Linda Rae Murray expressed the section’s understanding of the relationship between unions and public health as well as the rationale for the section’s strong support for the boycott:

Occupational Health and Safety is concerned directly with conditions in the workplace... Without a union, health and safety are often a joke....This understanding that a union is a prerequisite for health and safety in the workplace, is the reason why our section has a long-standing policy of holding our APHA sessions in a unionized hotel if one is available.

The statement also pointed to the role of labor in securing a decent standard of living and other important social reforms that affect the health of the nation’s citizens, including Social Security, Medicare, and civil liberties. It concluded, “The American Public Health Association must be in the forefront of groups protecting basic rights of workers if we are to live up to our responsibility to protect the health of the public.”

The Marriott Boycott

The New York Hotel and Motel Trades Council has been carrying on an informational campaign and picketing against the Marriott Marquis since 1987 because of a series of anti-union activities, and it asks organizations not to patronize the hotel. The National Labor Relations Board has issued three formal complaints against the Marriott Marquis since 1988 alleging numerous violations of labor law, including firing employees for union activity. According to a Trades Council leaflet, the Marriott remains non-union only because it broke an agreement it signed with this Union prior to the construction of this hotel. In 1982, Marriott agreed to recognize our Union when 50% of this hotel’s employees signed union cards. After the Hotel opened, however, Marriott broke that agreement and denied its employees their right to be union members.

APHAs staff leadership was alerted to the situation at the Marriott in fall 1989 when the Occupational Health and Safety Section requested that their 1990 section meetings not be held in the Marriott. The following spring, both the Public Health Association of New York City (PHANYC) and the Host Area Committee (HAC), the local conference organizing committee, wrote asking APHA to move the Governing Council meetings and related activities out of the Marriott as a gesture of support for the union’s campaign. Although the union had originally asked APHA not to patronize the Marriott at all, it reduced its request before its first meeting with the association. This position was later misrepresented in an August 1990 editorial in the Nation’s Health, the APHA’s official newspaper, as a demand by PHANYC, HAC, and the union to transfer all 1990 convention meetings and functions to other facilities.
The APHA Executive Board met with PHANYC, HAC, Local 6 of the Hotel, Restaurant, and Club Employees Union, and the hotel management during its April meeting and continued to negotiate separately with the parties through the summer. At the April meeting, the APHA Executive Board decided not to shift any of its meetings from the Marriott. It cited both its fear of liability for financial damages to Marriott and its view that there were no health or safety concerns in the dispute as reasons for its decision. From the union’s point of view a health issue is directly at stake in the dispute, since about 20 percent of Marriott employees are “on call,” with no set work schedule, no benefits, and no health care coverage at all.

APHA met with the New York Hotel and Motel Trades Council on May 29 to explain their decision not to move any meetings out of the Marriott Marquis and “to request the Labor Council and local unions to refrain from picketing or other adverse actions during our Annual Meeting to avoid embarrassment for our members and guests.” In a leaflet distributed at the annual meeting, the APHA’s Labor Caucus commented:

Thus on behalf of thousands of generally comfortable, well-paid professionals, the Executive Board asked hundreds of low-income, often immigrant working people, most of them people of color, to suspend their struggle for higher pay, health benefits, and some measure of job security to spare us embarrassment!

Future Policy

As it happened, APHA was spared the embarrassment of the picket line and rally the union had planned for the week of the meeting. The union and the Marriott Corporation reached an agreement just three weeks before the conference: The Marriott would cease interfering in union organizing efforts; in exchange, the union would call off its informational campaign and picketing for two years. This “neutrality agreement” applies specifically to a new Marriott hotel under construction in New York City. Union officials were reluctant to disclose how the agreement, which was still in negotiation at the time of this writing, would affect the Marriott Marquis Hotel. However, union sources said they will continue organizing at the Marquis.

Although the last-minute accord canceled plans for picketing and mass rallies, Labor Caucus members passed out leaflets at this year’s APHA meeting asking “Is APHA a Friend of Labor?” and many members sported buttons that answered, “This APHA member is a friend of labor.”

The leaflets explained the history of the controversy and urged APHA members to sign petitions and voice their opposition to APHA’s further use of Marriott facilities.

The continued pressure apparently had some effect, though whether it will actually alter APHA’s stance is uncertain. As a result of the dispute, the Governing Council of the APHA voted during its New York meeting to develop a policy on using union and non-union hotels for future meetings. The council also passed a separate motion to identify conference hotels that are unionized and not engaged in labor disputes in materials sent to APHA members about future annual meetings. The APHA Executive Board is responsible for developing a policy by next year’s annual meeting.

Judging from the board’s actions this year, taken after months of discussion and meetings with labor advocates, the union, and Marriott management, it appears unlikely that they will come out with a strong pro-labor stance. The August editorial in the Nation’s Health cites Executive Board leaders’ assertions that the APHA has “never had an official pro-union position” despite its “long standing advocacy for workers rights in promotion of worker health and safety.”

So, as the APHA Executive Assistant for Governance, Rusty Boyce, suggested when asked about the charge to the board, “They might just reaffirm the current policy, which is to have no official policy on it. You know,” she added, “that is a policy.”
'Biting the Hand That Feeds Them'

Organizing in the Welfare Rights Movement

TERRY MIZRAHI

The welfare rights movement flourished from the late 1960's through the early 1970's, with the aim of making public assistance a recognized national entitlement while improving the conditions and enhancing the opportunities of welfare recipients. *Biting the Hand That Feeds Them: Organizing Women on Welfare at the Grassroots Level*, by Jacqueline Pope (Praeger, 1989), is a case study of the contribution of one organization, the Brooklyn Welfare Action Council (BWAC) in New York City, to this movement.

The book documents the role that urban, female, predominantly African-American welfare recipients played (with active support from white Catholic clergy and VISTA volunteers) in increasing benefits and opportunities for low-income women. Pope also touches on the larger social, political, and economic context of the times—the turbulence and mobilization of oppressed minorities, and the changes from liberal to increasingly conservative local and federal administrations. However, Pope mainly treats the local scene, so to provide more of the national context of the welfare rights movement, I will also look at a little-known work by Guida West, *The National Welfare Rights Movement: The Social Protest of Poor Women* (Praeger, 1981).

For those of us who were activists in the late 1960's (I was a health organizer on New York's Lower East Side), Pope's work reawakens memories of the struggles and successes of those days. Given the many parallels between welfare rights organizing and organizing in other arenas such as health, Pope contributes to our understanding of this important historical period, especially emphasizing the role that poor women themselves played in shaping the times. We can use her account of the failures and accomplishments of BWAC to learn from mistakes and to distinguish those factors that were within the control of the leaders from those historical conditions and trends that were uncontrollable and unpredictable. Her book is also useful to those of us who are still involved or concerned with social and economic justice issues in helping us consider what organizing can accomplish when a social movement exists in which to ground our work and when it does not.

Local Organizing, National Movement

The documentation for Pope's analysis of the strengths and weaknesses of BWAC comes from extensive interviews with 39 former BWAC members, organizers, supporters, and public officials, as well as from her own involvement, first as a welfare recipient volunteer and later as a paid staff person for the National Welfare Rights Organization (NWRO), of which BWAC was an affiliate.

Pope, an African-American woman who went on to do an internship at Health/PAC on the occupational status of blacks and whites, approaches the material as a policy analyst and planner, and in so doing, omits any personal discussion of how she influenced and was influenced by the welfare rights movement. I only wish she had located herself in those events so that the richness, even including the biases, of her own experiences could be shared.

Overall, Pope presents a balanced account of the successes and failures of BWAC, but relates those achievements more to local circumstances than to the efforts of the national movement. She demonstrates what an organized group of welfare recipients could accomplish for its members and the larger constituency of welfare recipients, with support from some outside individuals and organizations. Regardless of the definition of success used, many tangible and intangible benefits accrued to all welfare recipients from the work of BWAC. In addition to improvements in financial benefits, social services, and public assistance...
policies, the whole ethos of welfare as an entitlement and the self-esteem of the welfare client changed for the better. Mutual aid as a model was practiced. Those directly involved with BWAC (including Pope herself), gained in individual development and mobility. Members became empowered and developed for themselves, individually and collectively, a whole range of transferable skills.

To complement Pope's account of local organizing, I highly recommend Guida West's comprehensive as well as complex analysis of the contributions and contradictions of the national movement. In *The National Welfare Rights Movement*, West provides extensive documentation for viewing the welfare rights movement as a social protest movement. The traditional divisions of race, class, and gender within the dominant social order manifested themselves in internal struggles within the movement and its organizations. Especially acute were tensions between the poor and non-poor, blacks and whites, and women and men (and, I would add, between outside professional and indigenous grassroots leaders). West applauds the movement's attempts to find new strategies of equal partnership in a world of unequals. She also demonstrates that handling these internal tensions, along with mobilizing the poor and their supporters to confront the welfare power structure, ultimately exhausted NWRO's resources and people. Internal differences about how best to bring about changes in the welfare system as

The divisions of race, class, and gender in the society manifested themselves in internal struggles within the movement.

well as differences about the goals of the movement itself grew over the years, at the same time that the external political and social climate became more conservative and recalcitrant.

Both Pope and West pose major underlying questions about the movement. First, was mass mobilization or organization building the appropriate method to achieve significant social change by poor people? Both authors point to Richard Cloward and Frances Fox Piven, the major theorists of the welfare rights movement, for promoting disruptive social protest strategies over membership recruitment. (Indeed, no understanding of the welfare rights movement is complete without reading Cloward and Piven's *Poor People's Movements: Why They Succeed, How They Fail*, Vintage Books, 1979.)

The second question is whether the goal of the movement was a guaranteed annual income or training and jobs. More specifically, was the goal to get people all the benefits to which they were entitled (by enrolling new recipients and increasing the benefits to current recipients), or to develop a fundamentally different system that guaranteed a minimum income as an entitlement? The third and fundamental question to which both authors allude in different ways is who made those basic decisions and by what criteria? The fact that there were no clear-cut answers to these questions may have been one reason the movements ultimately floundered.

The Role of Outsiders

BWAC, a Brooklyn-based coalition of 46 neighborhood groups, was formed in 1967 at the same time as other local welfare rights organizations and NWRO. Pope gives much credit to the work of specific activist nuns and priests and direct financial support from the Catholic diocese for the success of the coalition. At the national level, West discusses at length the role that outside individuals and institutions played in supporting (or not supporting) NWRO and its affiliates. Some outside people functioned as active fundraisers, advisors, witnesses, and staff. Some groups formed parallel coalitions outside NWRO to support it. Although recognizing these individual and collective contributions, West nevertheless highlights the tensions that surfaced as a result of the receipt of resources from some major organizations. (Both authors also discuss the lack of support from significant other religious, civil rights, and women's organizations, which ultimately limited the movement's strength.)

Conflicts often emerged in welfare rights organizing (as I also witnessed in much of the health organizing occurring then) between the goals of the recipients/clients, who were predominantly poor or working class and minority, and the professionals/outsiders who were predominantly white and middle class. The former aspired to a piece of the "American pie," and the latter to more fundamental, structural change. It is surprising that more debates on these issues, if not tensions, did not surface among BWAC’s leadership and supporters.

 Pope seems ambiguous, as well as ambivalent, about the role of the outside planners and organizers. On the one hand, she exhorts planners in general to take a creative role, but on the other hand speculates about the restrictive role they may have played in BWAC's organizational development. Unfortunately, she gives no specific examples of negative behavior or conflicts that occurred during
BWAC’s existence. The impact of possible class biases from the involvement of (predominantly) white outsiders was apparently raised as an issue by those she interviewed in 1984 for the book. While she alludes to the possibility that this may have been a conservatizing element, many white individuals who became involved in protest move-

ments were ideologically radical, if not members of the sectarian left. In fact, Pope makes an effective case for the fact that the white clergy and other staff (paid and volunteer) were welcome, trusted, and effective in the roles they played—training, advocacy, facilitating, and brokering—and were committed in word and deed to a model of empowerment and system reform. Nevertheless, one cannot help but speculate as to whether their contributions, both financial and in-kind, had an impact on the control and scope of BWAC’s agenda.

West also notes (in one of her few explicit references to BWAC) that gender may have been a factor in explaining why there were fewer power struggles in that organization than in other welfare groups where there were more male (predominantly white) organizers. It is not clear whether this simply meant that women got along better or that they consciously worked to minimize hierarchical differences. A further examination of the gender issue in women organizing women would have helped fill a gap in the organizing literature that usually omits sex-related dynamics.

Pope defends the less radical approach of incremental change that BWAC adopted as being more in tune with the aspirations and needs of the female membership. A more radical approach might have held out for greater reforms. At the same time, though, she questions whether the class (not race or gender) of staff and supporters may have stifled an exploration of other long-term pursuits. In hindsight, she criticizes the outside participants for not challenging the local women leaders more, and for not helping to shape a long-term agenda when times got tough.

The question remains: can low-income or otherwise disenfranchised groups organize from the bottom up, without outside involvement? To answer no may seem eli-


The movement grossly underestimated the strength and resiliency of the public bureaucracy.

Inside Conflicts

Pope, unlike West, minimizes the role color played, except to indicate that it was rarely raised as a negative factor. On the other hand, she attributes the lack of support from black national membership and local community-based organizations and churches to their class orientation and the need to control the few resources that were coming in at that time from the federal government to black urban neighborhoods. She also blames BWAC itself for its lack of willingness to involve or join with others—not just the more establishment black organizations, but with other citywide and national welfare rights groups as well. In hindsight, Pope thinks this isolationist posture was a mistake.

As an organizer, I understand that some measure of aloofness and perceived arrogance was the price to be paid for establishing the group’s own organizational autonomy, identity, and power base. BWAC’s mistake perhaps was in not reaching out more formally as an organization once it was established. (Pope notes that many BWAC members were involved as individuals in other community struggles.) A contradiction remains; however: when groups are strong enough to build alliances or coalitions, they often don’t think it is necessary. When BWAC and the movement needed outside support a few years later in negotiating with an establishment that had demonstrated its power to coopt and resist, this support was not readily forthcoming.

Pope questions whether the positive outcomes for the active women and their families were the results of self-selection (the type of person who got involved) or the socialization (the experiences in which participants were engaged). Clearly the answer has to be both. Some women would have made it anyway, but many more could have taken advantage of the opportunities presented by BWAC. In this regard, I wish that Pope would have reflected more on leadership and membership issues. Did the upward mobility of individuals ever conflict with the social goals of building BWAC? What tensions, if any, existed among the grassroots women inside and outside BWAC? For example, Pope criticizes as politically uninformed those welfare recipients who were picked by the welfare department to serve on community advisory councils (no doubt created in the first place as a result of pressure from BWAC). In the health organizing occurring at the same time, local people were often selected to serve on many institutional health boards.
created as the result of demands by consumer groups. These appointments were often mandated by city, state, or federal policy, but many were attempts at cooptation of local service recipients. We encouraged these consumers, successfully at times, to represent the views of community health groups, and at other times they were challenged to be more accountable for their actions.

Demise of the Movement
West, and to a lesser degree, Pope, discuss the demise of the welfare rights movement, and they (as well as Cloward and Piven) have different explanations for its limitations. Although NWRO officially closed its doors in 1975, its most effective years were from 1967 to 1972, corresponding to the life of BWAC. Much of the national movement's energy went into raising consciousness about the inadequacies of public assistance and then in opposing, reluctantly, President Nixon's proposed Family Assistance Plan (FAP), which had both progressive and regressive features. It seems clear that the movement lost steam after FAP was defeated with NWRO's assistance. Groups returned to local issues, but no long-term agenda on a national or local level emerged that could attract substantial outside support.

Internal conflicts loomed large, and one cannot discount the fact that momentum slowed at the same time that the leadership of the declining NWRO was shifting from the hands of its charismatic leader and director, George Wiley, a prominent black male professional, to a group of black women leaders who were former welfare recipients. Wiley resigned to form a new (and probably competing) organization, the Movement for Economic Justice. In doing so he was attempting to develop a broader poor people's agenda to include working as well as welfare poor. (Tragically, Wiley died in an accident shortly thereafter, and neither movement progressed

---

‘Every Woman is One Divorce Away from Welfare’

Interview with Jacqueline Pope

Jackie Pope doesn't like to think of herself as exceptional, although very few former welfare recipients (or non-welfare recipients, for that matter) have achieved the success she has. Yet, she firmly believes that every woman is one divorce away from welfare.

Born into a middle-class family in Philadelphia (her parents were both educated) and raised in the Bedford-Stuyvesant section of Brooklyn, Pope returned to Philadelphia where she completed high school and married. She was trained as an X-ray technician, but she worked only sporadically while she had her four daughters. After six years of a stormy marriage, she fled back to New York with her children in the early 1960's. Although she struggled to make it, she was a woman without work experience. Unskilled odd jobs at low wages were all she could find, and with inadequate child care available, she found herself unemployed and isolated. After two years of struggling she finally, painfully applied for public assistance.

Perhaps more than those who had never known another way of life, Pope was devastated, but not defeated. She had been raised believing the negative myths about those on welfare, and she was so ashamed of her status that she didn’t tell her family for almost a year. During the five years she was on welfare, her family always spoke of her circumstances as exceptional. “You’re different,” she can still hear them saying.

She enrolled her children in a local Catholic school in Brooklyn and began volunteering her services. One day in 1965, one of the nuns invited her to a meeting on welfare recipients. Six women showed up to trade horror stories. It was the first time any of them had spoken about the shame and loneliness they felt. Self-blame was rampant. The rest, as they say, is “herstory.”

Biting the Hand That Feeds Them begins here. Pope recalls the first time a group went down to the local welfare center. Together they completed and turned in minimum standard forms, and much to their surprise, they received their checks the same day. Apparently most welfare recipients rarely took advantage of this procedure to receive an additional allowance. With the assistance of the nuns and Catholic Charities, they formed the Neighborhood Action Center (NAC).

She has nothing but admiration for the work of the nuns—whom she says, she wants to write about someday. They trained the welfare mothers using an empowerment model, gradually allowing and expecting the women to run the office themselves. However, sexism was alive and well in the church as in society. The nuns brought the priests into the organization in order to get the added recognition and resources needed to expand.

Pope's involvement and commitment grew over time. In 1967 she moved from NAC to the Brooklyn Welfare Action Council (BWAC). Because she was educated and articulate, she took on the public relations functions, including editing the newsletter. She continued to do most of the talking to the press and much of the outreach to other organizations and to the National Welfare Rights Organization in Washington, D.C. At the time, there was much concern that there were no former welfare recipients on the staff of the national office, and in 1969 she was hired by NWRO to edit the Welfare Fighter and to develop training and advocacy programs to implement a federal program known then as WIP (Work Incentive Plan). She welcomed the opportunity to have an impact on the national movement, but she wasn't prepared for all the turmoil and struggle at the national headquarters.

After a year she returned with her children to New York. The movement had taken its toll, and after four years she left it for other jobs in the field of human services. Once she decided to return to college in the mid-1970’s, she knew she would write from her perspective as a woman of color about this important movement—one that was so crucial to her life and to the lives of thousands of women across the country.

—T.M.
Mobilization vs. Organization Building

In re-examining theories of social change, Pope concludes that both mass mobilization and organization building, which were occurring simultaneously, were needed to significantly improve the lives of poor people. It is not clear how one could sustain long-term mass disruption without, as Pope notes, either offering incentives to do so, or risking the emergence of an antidemocratic, demagogic figure. On the other hand, if the organizational base is built without simultaneously raising the members’ consciousness and connecting their struggle to larger issues, the leaders and staff become bogged down in administration, service delivery, and organizational maintenance. Numbers of members become the end rather than the means to an end. (This became a significant problem for health advocacy groups that received funds to become community health providers.)

While Cloward and Piven believe that groups with few resources cannot continue to provide tangible benefits to sustain members’ involvement, neither does it seem that mass mobilization efforts can be sustained and expanded, short of a revolutionary climate and consciousness. To build a grassroots, democratically controlled movement, mechanisms are needed to hold leadership accountable to their membership. With a mass base and accountability, leadership can be effective in negotiating on the inside—

for its constituency rather than for itself. Pope seems right to criticize BWAC (and presumably all welfare rights organizations) for not anticipating and thus participating creatively in electoral strategies and voter education. (Ironically, this is the precise strategy posed and developed by Cloward and Piven, among others, in the 1980’s.)

During the same time period during which welfare recipients were organizing, I helped organize the Lower East Side Neighborhood Health Council, an organization of consumers and health workers striving to improve the access to and quality of health care in their community. (One aspect of its development is highlighted in chapter 19 of Health/PAC’s 1970 book, American Health Empires.) Similar processes, tensions, and outcomes emerged in health organizing as in the welfare arena, and many organizing issues were the same, including (1) organizing from inside versus outside of the system; (2) playing the game on establishment terms by obtaining counter-expertise versus changing the rules of the game; (3) tensions between long-term and short-term goals; (4) how to obtain legitimacy and recognition without cooptation; (5) case versus class advocacy; and (6) the organizer’s power over consumers and consumers’ trust of the organizer.

In some ways it was easier to organize around welfare issues because the target in each locality was a single public administrative bureaucracy, while the power structure in health care was largely in private institutional hands. Welfare recipients were a fairly homogeneous group, dealt with in a standardized manner, whereas health consumers are more varied and have different needs. Because highly prestigious professionals dominated the medical scene, it was harder to achieve meaningful participation from health consumers without educating them about technical as well as political and ideological issues. (It still isn’t easy to counter the “doctor knows best” syndrome.)

Nevertheless, organizing around health care has certain advantages. No one likes to think of themselves as getting sick, but everyone does, which makes health organizing a unifying agenda for a community. Health rights are also supported by the people less ambivalently than are welfare rights, although as of the 1990’s, this country has failed to achieve either goal.

The 1980’s were a time for defensive organizing—holding on to the symbolic and tangible victories won in the previous decades. If the 1990’s are to see a resurgence of both the mobilization and strategic organization building necessary to forge ahead with an agenda for progressive social change, we will need the increased knowledge and skill garnered from examining and analyzing our previous efforts in books such as Biting the Hand That Feeds That Feeds Them. □
Update on Asbestos


As the current issue of the Bulletin shows, the somber and seamy story of asbestos continues to unfold. Barry Castleman, a consultant to and expert witness on behalf of asbestos victims, has played a major role in providing the technical, legal, and historical case against U.S. asbestos companies. As he writes in the introduction to the third edition of his major text, Asbestos: Medical and Legal Aspects, "This is an attempt to tell the history of asbestos and public health in a comprehensive manner. However, it can only be an attempt to piece together and analyze what is revealed; it is not all that is known, still less is it all that happened. The historical background will no doubt continue to emerge, as time goes on."

In reviewing the second edition (see Health/PAC Bulletin, Spring 1987), David Kotelchuck found it an "indispensable reference book" that is "required reading" for anyone interested in the history of and arguments against the asbestos industry or in the social origins of measures to prevent occupational disease in the United States.

At long last, academic and community activists in the occupational health and community health movements have a publication that lets them talk to each other and to others who want to learn what they are saying. It's called New Solutions: A Journal of Environmental and Occupational Health Policy. This large quarterly magazine is published by Anthony Mazzocchi, secretary-treasurer of the Oil, Chemical, and Atomic Workers Union and edited by Professor Charles Levenstein of the University of Lowell in Lowell, Massachusetts. The second issue features articles on notification of workers at high risk of toxic illness, the Johnson Controls fetal protection case before the Supreme Court, a comparison of health and safety in the United States and Great Britain under Reagan and Thatcher, and the issue of job blackmail in a struggle against a polluting paper plant. New Solutions costs $40 for a year's individual subscription.

Also worth noting is the current issue of Labor Research Review on "Organizing for Health and Safety," published by the Midwest Center for Labor Research. The focus is on union organizing, but throughout, the important link with community environmental concerns is made. The journal's first section features articles on successful campaigns to organize the unorganized in industries with appalling health and safety conditions, such as chicken processing. A second section deals with community-labor coalitions around such issues as reproductive hazards in the workplace. The final set of articles covers organizing within existing unions, including the role of the "COSH" groups (local committees on occupational safety and health) and a union project to educate health care workers about the realities of AIDS transmission in the workplace. Labor Research Review offers both practical information and inspiration for organizers whose participation can make a difference in the lives and health of working people and their communities...
AIDS Watch

Case Management: A New Solution for Caring for People with AIDS?

Nick Freudenberg

As the United States enters the second decade of the AIDS epidemic and as the second 100,000 diagnosed cases of AIDS rapidly accumulate, it has become clear that caring for people already affected by HIV illness poses as daunting a challenge as finding a cure. Throughout the United States, and particularly in the cities most severely hit by the epidemic, AIDS care is imposing a heavy load on health care and social service systems that were already stretched thin.

One solution that is frequently proposed to address this challenge is a case management system. The concept was first developed in the mental health system to organize care for patients discharged from mental hospitals. Case management refers to the coordination of the full range of medical, nursing, social, housing, long-term, and home care and other support services needed from the time HIV illness is diagnosed through death. Case managers, located in hospitals or community agencies, provide counseling, support, and referrals. Most frequently, case managers are social workers (or, in inpatient settings, nurses), but many programs have experimented with using people without professional degrees to manage care.

Increasingly, federal and state governments and foundations are mandating that case management be part of the AIDS services they fund. What are the strengths and weaknesses of this approach to AIDS care and how should progressive health care workers respond to the case management bandwagon?

At first glance, the case management system seems like an attractive idea, especially in a fragmented system of care that lacks central planning. Who could be against coordinating the range of services that a person with HIV illness needs? And certainly, having one person provide these services makes it easier for clients to negotiate the bureaucracies. Moreover, given the diversity of services that people with HIV/AIDS need—housing, home care, and access to entitlements—nurses and physicians are better suited to provide health services than manage care, a task that requires different skills.

Proponents of case management also argue that it is cost-effective. Even if people with managed care receive more services initially, early intervention and coordinated care should prevent duplication of services that may reduce the need for more intensive care. After all, saving only a day or two of hospital care for a person with AIDS can pay for case management services for an entire illness.

Lack of Services

Unfortunately, no single innovation can solve the underlying structural defects in our health care system. The single most significant factor impeding care for people with HIV/AIDS is the lack of needed services. Without adequate treatment slots for chemical dependency, home care services, housing for people with AIDS, health care providers, long-term care beds, and access to affordable prescription drugs for AIDS and HIV-related conditions, even an army of case managers cannot get people the services they need. Given the grossly inadequate services not only for people with HIV/AIDS but also for older people, drug users, those with mental illness and poor people, case managers become de facto triage workers, helping the lucky few jump the line for their care.

Even if more services were miraculously to appear, case management systems would not in themselves solve the problems of fragmented, uncoordinated care. The root of these problems lies in an unplanned, competitive delivery system in which each institution looks out for its own interests and no one is accountable for delivering care to a defined group of people. Case managers may minimize some of these problems for individ-
uals but they have neither the political clout nor the skills to force health care providers to work together. In some cities and states, consortia of providers have worked together to coordinate case management services, but these positive efforts rarely command the resources to challenge institutional prerogatives.

In practice, many case management systems offer an overly institutional model of care. They attempt to link clients with needed services, rather than help an individual manage an illness. Some of the AIDS organizations that originated in the gay community have a more community-centered approach and help people find the support they need from friends, family, and community groups. Similarly, some neighborhood organizations in the African-American and Latino communities have always helped people in crisis to find shelter, food, and health care and are now doing the same for people with AIDS. But few programs have successfully linked coordination of medical services with help in mobilizing available family, friends, and neighborhood networks. Community-based organizations can play a much stronger role in caring for people with AIDS, and they need government resources to do so.

Developing standards of case management for people with AIDS can help to ensure that services achieve a defined quality of care. By specifying what must be included in reimbursable care, funders can promote a more comprehensive definition of case management. Standards can also spell out roles for professional health workers and other personnel, specify the skills needed to carry out these roles, and define the institution’s responsibility for caring for the clients it staff manages.

Second, activists can insist that policymakers clarify their rationale for case management. Both economic and quality-of-care arguments have been advanced in its favor, and both are desirable outcomes. Sometimes both ends can be achieved simultaneously—for example, providing care at home is both cheaper and more humane than hospital care—but often these two goals conflict. Case management systems need to be evaluated on their cost and quality of care. If these two ends are confused, we might inadvertently accept a system that provides second-rate care.

Finally, the development of new case management programs must always be linked with finding additional resources to increase the full range of services that people with HIV/AIDS need. Case management is not a substitute for developing new services; indeed these services are essential if case management is to work. The recent defeat of funding for the federal AIDS Disaster Relief bill, which would have provided additional dollars for cities hardest hit by the epidemic, shows that Congress does not yet support giving local governments the resources they need to cope with AIDS.

As part of an integrated, comprehensive, and accessible system of care, case management programs can help to make sure that individuals’ needs are matched with health care, social services, and community resources. Without such a system, case management is one more Band-Aid on a health care structure badly in need of major surgery.

---

### 1990 Health/PAC Advocate Awards

Health/PAC hosted its Tenth Annual Party in New York City’s Roseland Ballroom during the 1990 American Public Health Association meeting held in early October.

Each year, Health/PAC presents its Health Advocate Awards to honor local health activists. Recipients of this year’s awards included a number of individuals and organizations in New York City known for taking action where a vacuum had previously existed.

ACT UP/New York (AIDS Coalition to Unleash Power) was recognized for providing a model of praxis by combining well-researched analysis and direct action to change the priorities of the health care system and empower those most affected by its failures. ACT UP’s work extends well beyond the AIDS crisis, reconfirming that challenging the system and helping to develop alternatives can result in change.

Karen Benker of Brooklyn was honored for the personal integrity and embodiment of principles she has demonstrated as a public health physician. She is an active member of the Brooklyn Health Action Committee, which focuses on community organizing in that borough. Dr. Benker has also done extensive work on the health of the homeless and hunger and is the author of a 1989 report for the Public Interest Health Consortium of New York City critiquing congregate care facilities for young foster children in New York City.

Marshall England is a well-known community organizer in Harlem and the Bronx. He has been an active leader in efforts to stem health care cutbacks and the closing of facilities in some of the city’s most medically underserved areas. He is the executive director of LABOR and was founder of the New York Coalition for Community Health and the Harlem Health Alliance. He also served as chair of the Harlem Hospital Community Board. One of his current projects is the Bronx Homeless Task Force.

Mini Liu is a family physician who has worked at community health centers on New York City’s Lower East Side. She has been a leader in numerous community struggles for control of health services and tenants’ rights, and against service cutbacks. She is also active in the Committee Against Anti-Asian Violence.

Yolanda Serrano is the founder of ADAPT (Association for Drug Abuse Prevention (Continued on p. 35)
As health care costs skyrocket and insurance companies scramble for ways to cut their losses, Blue Cross-Blue Shield plans around the country have followed commercial insurers in targeting their rate increases to those most at risk and least able to pay. The plans have been repudiating the principle of community rating on which Blue Cross was founded in 1938, in which everyone in a community is placed in the same rating pool and charged the same rate for their insurance. Their steady move toward risk rating—basing insurance rates on an individual's health status, so that those at greater risk of illness pay more—hurts the poor, minorities, the elderly, and of course, the sick.

But in at least one victory for health care consumers, a grassroots coalition of groups, particularly those representing women, blacks, and the elderly, has succeeded in defeating a major Blue Cross-Blue Shield plan's attempt to risk rate its community pool.

In 1988, Blue Cross and Blue Shield of New Jersey (BCBSNJ), moved to shrink its pool of community-rated subscribers. The company claimed that commercial carriers were siphoning off healthier subscribers, leaving it with the "actuarial dregs" and increasing its losses. BCBSNJ then submitted rate increases for the community pool to the New Jersey commissioner of insurance that sharply discriminated by sex, age, and place of residence. The rates were approved, and, despite repeated appeals, both Governor Tom Kean and Commissioner of Health Molly Joel Coye supported the rate increases as necessary.

The New Jersey Public Health Association led a protest demanding that the problems resulting from the competition of commercial carriers not be taken out on the most vulnerable citizens—namely, individual subscribers whom commercial carriers do not want. The association affirmed the principle of community rating, and drew on this writer's research showing that BCBSNJ had no actual evidence that its community-rated pool was becoming higher risk and thus had no empirical basis for its discriminatory rates.

Press conferences and letters had little effect, so the New Jersey Public Health Association organized an Ad Hoc Coalition for Fair and Reasonable Health Insurance. Members included the New Jersey Council of Churches; the New Jersey chapters of the National Organization of Women, the National Association for the Advancement of Colored People, and the American Association of Retired Persons; New Jersey Citizens Action; and Common Cause. Together these groups represented 1.5 million health care consumers or 20 percent of all voters.

After a year of mounting public pressure through the press, the group switched tactics to focus on legal action. When the huge rate increases were repeated in 1989, legal representatives from several of the member organizations, led by the NAACP Legal Defense Fund, formulated a case to challenge their legality. Together, these strategies persuaded the New Jersey public advocate to assume the legal challenge.

In March 1990, the appellate court ruled that demographic rating of the community pool based on age, sex, and residence did not constitute community rating and therefore violated the laws governing BCBSNJ. Its decision prohibiting risk rating reversed discriminatory rate increases for 600,000 New Jersey citizens. These increases were slated to be three times higher than the average for single mothers in New Jersey, and 2.5 times higher for older workers. The decision may well apply in other states,
depending on the specific actions of Blue Cross-Blue Shield and the state's statutes. A broader case can be made, however, that for a public, non-profit insurer to offer risk-rated insurance is unconstitutional, as are the laws that allow it to do so.

As interest in national health insurance coalesces, it is important to specifically document and challenge rate changes that label a growing list of health problems as "high risk" or " uninsurable." Rate-setting policies that exclude increasing numbers of the most vulnerable from health care insurance are simply not viable alternatives.

—Donald Light

The writer is chair of the Public Affairs and Legislative Committee of the New Jersey Public Health Association.

AFL Abstains on Abortion

After a six-month-long delay, the AFL-CIO decided not to take a position supporting abortion rights. Only three of the federation's 34 executive council members (each representing a major union in the AFL-CIO) voted to adopt a pro-choice position—even though 12 unions have already adopted pro-choice resolutions at their union conventions.

The federation adopted the position recommended by the committee it had assigned to study the abortion issue. The position, while defending women's "privacy" on the question of reproductive rights, failed to affirm their right to legal abortion.

Union women may soon mount another campaign to get the AFL-CIO to support abortion rights, says Kathy Parrent, reproductive rights organizer for the Coalition of Labor Union Women. CLUW, a membership organization sanctioned by the AFL-CIO, led the prochoice fight. Noting that it took the house of labor a long time to come around on supporting the Equal Rights Amendment, Parrent says, "There's discussion afoot about whether we'll try to regroup, get stronger and come back, say, at an AFL-CIO convention."

The federation was heavily Lobbed by "right-to-life" groups during the six months preceding its decision. Abortion opponents threatened to organize union members to stop paying dues if the organization came out in support of abortion rights.

—Laura McClure

Reprinted from the Guardian newsweekly.

Health in Transition

A first-of-its-kind international symposium on "Occupational and Environmental Health During the Societal Transition in Eastern Europe" was held June 22-27, 1990, at the Institute of Social Sciences and Public Health, Medical University of Pecs, Pecs, Hungary. The 78 participants included leading scientific and governmental representatives from all Eastern European countries, as well as 30 delegates from the United States. They addressed such questions as: Is it possible to have both economic development and environmental protection in Eastern Europe during this time of transition? How can citizens in these new Eastern European democracies best guard against the excesses of a market economy?

The proceedings of the symposium have been published in English, and are available for $20.00 plus $4.00 postage and handling ($8.00 outside the United States) from Proceedings, Attention: Barry Levy, MD, Program on Environment and Health, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130. Make checks payable to Management Sciences for Health.

—David Kotelchuck

Awards (continued from p. 33)

and Treatment). Under her leadership, ADAPT has become a successful model of community-based health promotion and education, providing a realistic antidote to the "just say no" mentality of federal and local drug prevention policy. Working directly in the streets with drug users, ADAPT distributes needle-cleaning kits and counsels users on how to reduce their risk of contracting HIV and other diseases.

Marie St. Cyr is the founder and director of the Women and AIDS Resource Network (WARN), which provides education and outreach to women with HIV disease and those at risk. St. Cyr is a forceful advocate who is largely responsible for bringing the issue of women and HIV to the attention of the professional community and the public.

Joann Thompson is the founder and director of the Health Action Resource Center (HARC). Sponsored by the Religious Committee on the New York Health Crisis, HARC provides advocacy on the city and state levels for the improvement of health care for poor and minority communities throughout the city. In addition to HARC, Thompson has helped organize the Public Interest Health Consortium of New York City and community-based health action coalitions in Manhattan and Brooklyn. Through these organizations, she has built a citywide network that provides a unique advocacy forum covering a range of public health issues.

Finally, a surprise award was given to Health/PAC President Arthur Levin. Every organization has someone who works selflessly behind the scenes and without whom the organization could not survive. Art has been that person for Health/PAC, serving as both an organizational and intellectual leader. He also directs the Center for Medical Consumers, which operates a resource library on medical and health subjects.

—Cheryl Merzel
Casualties of War: Rethinking Drug Policy

U.S. drug policy ignores the health needs of drug users. Health/PAC discusses the drug policy philosophy known as harm reduction and presents the stories of seven U.S. needle exchange programs that are breaking ground in providing care for drug users. Also, a decade of AIDS: a report from the San Francisco conference.

Can We Get There from Here?

Health care activists look at so-called universal health care proposals in four states, examining the circumstances and forces that shaped them. Do these state efforts divert pressure that could be used in the fight for a national plan, or do they move us closer to that goal? Plus, a look at Canada’s system — can it happen here?

Women and AIDS

Why are women neglected in defining, diagnosing, and treating AIDS? Physicians on the front lines report on the missing women in the AIDS epidemic. Plus, living with AIDS: women talk about their lives with HIV disease; a grandmother’s story of hope. Includes photo essay by Catherine Smith. Part one of a two-part series.

Send $5 for each issue ($12 for institutional subscribers) with your name, address, the issue(s) desired and your check or money order to:

Health/PAC Back Issues
17 Murray Street
New York, N.Y. 10007

Visa and MasterCard will be accepted for orders of $15 or more. Please be sure to include the full account number and expiration date.

Health Policy Advisory Center
17 Murray Street
New York, New York 10007

2nd Class Postage
Paid at New York, N.Y.