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

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Illustrations: Teresa Flavin


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Crisis of Systems, Crisis of Need

During the summer of 1989 a group of health activists wrote with alarm of an unanticipated and unprecedented crisis gripping New York City's health care system (“Beyond Sick: New York City's Hospital Crisis,” Health/PAC Bulletin, Vol. 19, No. 2). In an era of falling hospital utilization and empty beds, they wrote of inpatient units full and overflowing, ambulances diverted from hospital to hospital, emergency room patients by the hundreds waiting cheek-to-jowl in gurneys for admission to the city's hospital beds, and the attendant compromises of access and quality of care for all.

Health/PAC asked itself: Was the crisis solely a New York City phenomenon? Was it a harbinger for the rest of the country? Or were the same developments afoot elsewhere in the nation, but taking a different form? The lead articles in this issue of the Bulletin answer that question.

Stephan Lynn's article, “National Alert: Gridlock in the Emergency Department,” affirms that the crisis of overcrowded emergency rooms and inpatient units is anything but a New York City phenomenon. Speaking from the perspective of the American College of Emergency Physicians, for which he chairs the Task Force on Hospital and Emergency Room Overcrowding, Dr. Lynn paints a picture of medical gridlock first gripping the cities of both the East and West Coasts, intensifying, and then moving to the Midwest and South and finally spilling over into non-urban areas.

In her article, “Not in Cities Only: Georgia’s Health Care Crisis,” Linda Lowe concurs that the crisis is not limited to urban areas alone. Speaking as a member of the Georgia State Access to Health Care Commission, Lowe examines the rising rates of needless illness, death and disability, and lack of access that plague Georgians statewide, regardless of whether their home is rural or urban.

Both make clear that the crisis does not engulf all hospitals, but focuses instead on those hospitals that provide America's safety net for assuring access to care: its public hospitals.

In its earlier Bulletin, Health/PAC asked another question: Was the health crisis witnessed by health care providers and activists a crisis of provider institutions and systems or a crisis of need? Did it have its roots in the failure of the health care system or in the greatly deteriorated conditions that people live under today that have increased their need for care? The articles of that issue of the Bulletin, together with those appearing today, make the answer resoundingly clear. It is both.

What we are witnessing today is the startling result when communities in crisis encounter a health system utterly unprepared and ill-structured to meet their needs.

The most profound crisis lies in America's low-income communities, particularly among poor people and people of color. There the ravages of a decade of Reaganomics have sent the rates of poverty, homelessness, and despair soaring. They have simultaneously torn asunder the fragile fabric of the nation's social programs that kept many poor families delicately poised on the edge of economic viability.

The results are now written in the skyrocketing rates of infectious and respiratory illness, drug-related health crises, violence, mental illness, infant mortality, tuberculosis—all conditions that we know how to treat and that should have been conquered decades ago and more nearly typify a third-world country—as well as of AIDS, which we continue to be largely helpless to treat. Never was the connection between social well-being and health more clear.

The crisis of a people has set the stage for the crisis of a system and the very model of care on which it is predicated. Lack of access to medical care is a hallmark of poverty. But it is also the hallmark of another group that has exploded in numbers over the last decade—the nation's 37 million medically uninsured and its 50 million underinsured, many of whom are not poor, but are working and middle class. And, as the cost of medical care soars and benefits shrivel, even the insured have begun to see access slip beyond their reach.

With access in jeopardy, the most expendable form of care is inevitably primary care. Primary care is the stepchild of a medical system enchanted with high-tech
medicine and the orphan of an insurance system dedicated to risk, not certainty. Unfortunately, it also happens to be the most urgently needed, appropriate, and cost-effective form of care.

Lacking routine access, people wait to seek care until ordinary illness, needing only ordinary intervention, becomes a life-threatening emergency. Then, desperately ill, they crowd into the only source of care available to them—the emergency rooms and inpatient units of America's safety net hospitals where a pound of heroic cure is substituted for what might otherwise have been an ounce of primary care prevention. And they die, quietly, needlessly and prematurely. Lest there be any doubt, a recent article in the *Journal of the American Medical Association* (January 16, 1991) documents this fact. After controlling for differences in age, sex, race, and specific disease, uninsured patients were found to be 1.2 to 3.2 times more likely to die during a hospital stay than their insured counterparts.

The crisis of the health system is not overcrowded hospitals. That is merely a symptom. The crisis is a health system more and more offering what less and less meets the needs of ordinary Americans, poor and otherwise. American medicine increasingly epitomizes a glitzy, death-defying, moon shot approach; the search for technological fixes and higher profits rather than the willingness to examine complex problems of human need and social equity; the willingness to spend untold billions developing and making available ever less effective, high-end cures while refusing to address the need for or effectiveness of basic care. And the down payment on this model of care drives access to basic primary care even further from the reach of ordinary Americans.

Both Lynn and Lowe conclude that there is no solution to the health crises of America's people or to the crises of its health institutions without universal access. But the clear subtext is, access to what?

—Ronda Kotelchuck

The Other War, or, Operation Domestic Storm

As we go to press, the war in the Persian Gulf appears to be over and America has reasserted its position as "superpower" and self-appointed moral authority as a world leader of the democracy police. The victory has cloaked the country in a prideful suit of the Empire's new clothes that reveals the vacuity of the nation's strength abroad in the face of the chronic economic and social distress threatening to overwhelm us at home.

In March President Bush addressed a joint session of Congress, whose raucous members sported American flags and yellow ribbons, and greeted him with football stadium grunts of approval. Basking in the warm afterglow of a deadly, quick, and decisive military victory, President Bush advised his audience, without apparent irony, that "the tactics of terror lead absolutely nowhere; there can be no substitute for diplomacy."

It isn't as if President Bush didn't refer to domestic problems in his remarks to Congress. Several times he suggested that the collective experience of the gulf war could be of help in solving the problems at home. And he implied a sense of national moral purpose when he noted that "if we can selflessly confront evil for the sake of good in a land so far away, then surely we can make this land all that it should be."

Guerrilla art-work by Artfux and Ron English, up less than a week. Broadway and Houston Street, New York City.

But there is no evidence that such a sense of national moral purpose really exists. While the U.S. and coalition casualties in the Persian Gulf are considered "light" (the exact number of Iraqis, both... (Continued on p. 20)
National Alert

Gridlock in the Emergency Department

STEPHAN G. LYNN

As an emergency physician from the American College of Emergency Physicians (ACEP), I'd like to bring a national perspective on what we consider today's most important crisis in health care. We are on the verge—and perhaps over the verge—of a major crisis in health care related to overcrowding in hospital emergency departments. Emergency department overcrowding occurs when admitted patients can no longer leave the department because all staffed inpatient and intensive care beds in the hospital are occupied, and no beds are available in neighboring facilities for transfer. Patients come to the emergency department requiring inpatient care, and there are no beds, no resources, no intensive care units, and no nurses available to provide that care. Those patients wait in the emergency department, sometimes for hours, sometimes for days, until a bed becomes available.

I am personally familiar with patients who have waited as long as eight days in the emergency department for an inpatient bed. There are emergency departments in New York and in other cities throughout the country in which there have been as many as 50 or 60 patients waiting for inpatient beds that were not available. In large metropolitan areas, emergency department overload can develop despite the availability of staffed beds, because additional patients are being diverted from other overcrowded facilities. When a large percentage of a community's emergency departments simultaneously adopt "ambulance diversion," "standby," or some other limited availability status, emergency departments that remain open may quickly become overwhelmed with patients. This set of circumstances can rapidly lead to emergency department "gridlock"—a particularly dangerous situation in which no emergency department in the immediate vicinity can safely accommodate additional ambulance patients. In many communities, overcrowding is severely limiting the public's right to timely emergency medical care and compromising the quality of that care. The problem in simple terms is that we have too many patients requiring access to health care and too few resources available for those patients.

As an emergency physician, this significantly limits my ability to provide quality care. Emergency departments were neither designed, planned, nor staffed to provide inpatient services, and when they are asked to provide those services, they have marginal ability to do so.

In overcrowded emergency departments today, we are able to take vital signs, we are able to give medications, we are able to monitor patients, but we cannot provide any of those things that our patients expect when they are admitted to the hospital. We cannot provide privacy, we cannot turn out the lights, we cannot turn off the noise, and we cannot provide access to telephones or visitors. It is difficult, if not impossible, for us to provide three warm meals at appropriate times. It is extremely uncomfortable for our patients to spend days sitting on an emergency department stretcher with a mattress that is two inches thick. When the emergency department is overcrowded, the quality of care suffers, and, far more important, access to care suffers as well.

When 50 percent of an emergency department's staff, space, and equipment are allocated to provide care for patients who require inpatient admission (and have no need for emergency care), what happens to the next patient who walks through the door? The role and mission of emergency medicine is to provide care to patients in the most severe circumstances, and it is becoming increasingly difficult to do so because of the overcrowding crisis in our hospitals.

Stephan G. Lynn is Director, Department of Emergency Medicine, St. Luke's-Roosevelt Hospital Center in New York City and Chair of the American College of Emergency Physicians Task Force on Hospital and Emergency Room Overcrowding. This is a revised version of a paper presented at the Health/PAC panel on the Urban Health Crisis at the American Public Health Association annual meeting, New York City, October 1, 1990.
Homeless man with pneumonia symptoms in New York City's Penn Station being transported by Emergency Medical Service paramedic.

of an emergency physician is to be constantly available for that next patient, whoever he or she is, whatever his or her problem is, but when most of an emergency department’s resources are allocated to providing inpatient care, we are far less able to do so.

Scope of the Problem

How extensive is this problem? A few years ago, emergency department overcrowding was perceived as a problem of the East and West Coasts, with a few scattered areas in between. Unfortunately, over the last few years we have learned that this problem is substantially more extensive. The American College of Emergency Physicians conducted a survey of its chapters in 1989 to assess the extent of emergency department and hospital overcrowding nationwide. Each chapter was asked whether its members had experienced emergency department overcrowding, and to what it attributed this problem; all 54 chapters responded. ACEP chapters from 41 states (representing 94 percent of the country’s population) reported overcrowding. All four non-state chapters (the District of Columbia, Puerto Rico, Ontario, and Government Services) reported overcrowding as well. Only nine state chapters reported no problem with overcrowding (Idaho, Minnesota, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, Utah, and Wyoming). Similarly, the Emergency Nurses Association polled its state councils during its 1989 Scientific Assembly, and all 50 state councils reported overcrowding.

Last winter, the entire East Coast, from Atlanta through Washington, Philadelphia, New York, Boston, and up to Toronto, was gridlocked; unfortunately, we expect that this will continue. We expect that San Diego, San Francisco, and Los Angeles will be gridlocked, but we know as well that there will be problems in Miami and Memphis. Last year Dallas and Chicago were added to the list of major urban areas that became substantially overcrowded. And when we surveyed ACEP chapters, it was extremely clear that this overcrowding is not simply an urban problem. Our chapters from West Virginia and

Overcrowding is severely limiting the public’s right to timely emergency medical care.
We have too many patients requiring access to health care and too few resources available for them.

Contributing Factors

What contributes to this substantial and increasing problem of emergency department overcrowding? In simple terms, there is inadequate funding and priority for emergency health care services during a period of increasing demand. There is increasing demand because more and more people are utilizing the emergency department every year for a large number of reasons. Our population is aging; we have increased drug abuse and poverty; and AIDS patients that we could never have planned for five or ten years ago are utilizing the emergency departments in our hospitals in ever-increasing numbers. And for those 37 million people we constantly hear about that are uninsured or underinsured, the emergency department has become the provider of last (and, frequently, only) resort.

At the same time that demand for services is increasing, the supply of hospital beds is diminishing. New York City in the last five years has eliminated 5,000 acute care beds. Emergency departments in California, particularly in Southern California, are closing at a rapid rate. In that state, hospitals are allowed to close their emergency departments when they become financially undesirable. There are fewer hospital beds, there are fewer emergency departments available to treat patients. There are not enough nurses; there are particularly not enough skilled nurses in emergency departments and critical care units, and it is these intensive care units that usually become the bottleneck for hospital admissions. There are not enough nursing homes. About 10 percent of the acute care bed capacity in New York City and in the state of Massachusetts in 1989 was occupied by patients who required nursing homes or home health care placement. The resources were simply not available in those states.4

Solutions

What will bring us to the end of this problem? The first solution is universal access to health care and universal access to health care reimbursement. The care for about one-third of all patients who come to the emergency department is uncompensated; in a national study by the American College of Emergency Physicians, 31 percent of all emergency care in this country was uncompensated.3 The emergency department is appropriately mandated to see all patients who seek care there, but society does not provide reimbursement for that care. As a result, our hospitals, our emergency departments, and our patients are suffering.

Another factor that must be addressed is the lack of access to primary care. This is exemplified by a study done in Washington, D.C., for the District of Columbia Hospital Association, which evaluated patients characterized by three very simple factors: the patients (1) had no ability to pay, (2) came into the emergency department, and (3) were admitted.6 Looking at those three characteristics, the study found that about one-quarter of all patients who presented to an emergency department in Washington, D.C., for admission and who had no ability to pay had an “avoidable admission”—avoidable, that is, if that patient had had access to primary care. If one other factor is added to that list—pre-existing chronic disease—the percentage of “avoidable admissions” increases from 25 percent to about 45 percent. Lack of access to primary and preventive care is not only injurious, it causes a substantial number of completely avoidable hospital admissions.

Admissions through the emergency department add cost to the system in other ways, as well. The Health Care Financing Administration compared patients admitted through the emergency department and patients admitted from all other sources in the same DRG. The study showed that the length of stay and the cost to the hospital and to the health care system are substantially higher for patients with the same diagnosis who are admitted through the emergency department.7
Long-Term Vision

The problem of emergency department overcrowding is severe and serious today. On one Monday in September 1990 in New York City, 40 of the 55 emergency departments were on total bypass. That means that each of those 40 emergency departments already had 15 patients admitted and waiting for beds, and no inpatient beds were available. This was in the fall, not a season of traditional overcrowding, with winter still to come.

It is extremely clear that emergency department overcrowding is not simply an urban problem.

We see little hope for a solution in the short term. Major changes are not occurring to deal with either the causes of this problem—increases in infectious diseases, increases in respiratory emergencies, AIDS, drug-related health crises, and poverty—or to bring about the solutions—universal access to health care, more nurses, reweighting of DRGs

Long-term resolution of the problem of hospital and emergency department overcrowding will require a substantial commitment of societal resources and vision—and, perhaps, a revolution in our national health care priorities.

4. Greater New York Hospital Association; Massachusetts Hospital Association.
At the same time that Atlanta is touting itself as a world-class city that is able to attract the 1996 Summer Olympics, it has been downplaying some less attractive facts about the health of the residents in the city and the rest of the state. Atlanta ranks near the very bottom of the country's 50 largest cities on many measures related to health. Nearly two-fifths of Atlanta's children live in poverty, ranking it 49th out of the 50 largest cities. It ranks 44th on infant mortality, with a rate almost double the national average. Atlanta has a high rate of homelessness, with 10,000 to 15,000 homeless people on the streets at any given time. Contributing to this is the fact that the maximum payment under Aid to Families with Dependent Children (AFDC) amounts to only half of the fair market rent in the city.

According to a ranking by the Northwestern National Life Insurance Company, the state of Georgia ranks 46th in the country for life expectancy, 45th in overall health, and 48th on access to health care. It is not surprising that these rankings are so consistent, since access to health care is so closely related to health status and longevity.

Georgia is experiencing a crisis in access. The State Access to Health Care Commission, which has been working and holding hearings across the state for the last year, has done some analysis of who lacks health care insurance in Georgia. About 18 percent of the state's population under age 65 are wholly uninsured. They have no private insurance, no Medicaid, no Medicare. These individuals are not the unemployed; more than three-quarters of them are in working families—a situation that is fairly typical for the rest of the country. Over half of people in Georgia with incomes between $3,000 and $6,000 (between 50 and 100 percent of the federal poverty line) are uninsured. Twenty-three percent of the children in Georgia and almost 28 percent of single-parent families (headed mostly by women) have no health insurance. Of all the people employed in agriculture—and there is quite a bit of agriculture in the state—43 percent are uninsured, reflecting the health crisis in rural areas. Twenty-five percent of those in the service industry and almost 23 percent of those in construction (another major source of employment) lack insurance.

Unnecessary Illness

A major consequence of the lack of access to medical care, particularly to primary and preventive care, is Georgia's significant problem with excess death and early debilitation. A study of hypertension in Georgia showed that about 15 percent of all people who knew they were hypertensive could not afford the necessary medications. These individuals, of course, are at risk of ending up in the hospital emergency rooms with strokes and heart attacks. Similarly, a large number of diabetics in Georgia cannot afford the insulin they need, and may end up in treatment facilities with diabetic coma and kidney failure. Compounding the problems of those who lack early or sustained intervention into their illness is the maldistribution of acute and tertiary care or financial inaccessibility. Anecdotal data from Georgia supports a recent study which, controlling for demographic, clinical, and hospital factors, showed that privately insured patients were 80 percent more likely than uninsured patients to undergo angiography, 40 percent more likely to undergo by-pass grafting, and 28 percent more likely to undergo angioplasty. Medicaid patients were 48 percent less likely than insured patients to undergo angioplasty and about as likely as the uninsured to receive the other services.
Lack of health care is particularly visible in Georgia’s children. As is true nationally, many children are dying in Georgia of treatable conditions such as asthma because they are simply not receiving the necessary medical care.

Georgia has the eighth highest number of AIDS patients in the country, and yet relatively little funding has been allocated for AIDS. As a matter of fact, it was only last year that the state granted funding for a Medicaid medically needy program allowing elderly and disabled people, including those with AIDS, to “spend down”—that is, use their accumulated medical bills to reduce countable income—in order to become eligible for Medicaid. It is still very difficult for people with AIDS to qualify even for that. Compared to other states, Georgia has shown limited response to the medical needs created by the epidemic, focusing instead largely on the issues of testing for HIV antibodies, counseling, confidentiality, and “AIDS transmitting crimes.” The Georgia Department of Human Resources’ Public Health Division has actually been very progressive on these issues, but it has had to fight off the Medical Association of Georgia and others who have demanded HIV antibody testing at the provider’s discretion and without patient consent.

People tend to think that AIDS is an urban phenomenon. In Georgia there are rapidly increasing numbers of AIDS patients in all areas, particularly in south Georgia, where there are high rates of poverty and also where crack is used and drugs are imported. Georgia also has an increasing rate of syphilis that seems to be related to crack use. Public health officials believe that the practice of trading sex for drugs increases the rates of both syphilis and HIV. Savannah, a coastal city on the edge of a large, poor rural area of Georgia, has the second largest number of AIDS cases in the state.

Lack of Physicians

Georgia’s problems of access to medical care are not limited to the crisis for the uninsured or the impact that AIDS, homelessness, and increased drug use are having on health care delivery. An equally important factor is the maldistribution of health care services across the state. The

One study showed that about 15 percent of all Georgians who knew they were hypertensive could not afford the medication.
As bad as health care is in Georgia, the situation for black Georgians is always worse, as witnessed by the following critical indicators.

**HEALTH FACTS FOR GEORGIANS, 1989**

- 110,216 babies were born in Georgia in 1989. 1,355 babies died before their first birthday.

- In 1987, Georgia ranked 48th in infant deaths in the United States. Although the rate of infant death has decreased in Georgia over the past 50 years, it has not kept up with the national decline.

- 9,211 babies, or 8.4 percent, were low birth weight (less than 5 lbs, 8 oz) in 1989. 328 more babies were low birth weight in 1989; however, the low birth weight rate did not change in Georgia from 1988. Low birth weight is due to premature delivery or inadequate intrauterine growth. Low-birth-weight babies are at a greater risk for handicapping, blindness, deafness, and death.

- 18,678 babies were born to teenagers in 1989, or 16.9 percent of all Georgia’s births. 1,398 more babies were born to teenagers in 1989, an increase of 3.7 percent from 1988. Teen pregnancy is associated with increased rates of infant death and disability, interrupted schooling, unemployment, and potential for child abuse and neglect. 27,764 babies were born in 1989 to women who had not completed a high school education. 1,407 more babies were born in this category, or 25.2 percent of all births in 1989. This represented no change in the percentage of births to women without a high school education from 1988. Babies born to mothers with less than 12 years of education are at greater risk for infant death than those babies born to mothers who have completed at least a high school education.

- 8,183 mothers, or 7.4 percent of all women giving birth in Georgia in 1989, did not receive adequate prenatal care, compared to 7,735 mothers in 1988. This represents a 5.8 percent increase. The rate of infant death is about four times greater in babies born to mothers who have not had at least four medical check-ups during their pregnancies. 2,914 mothers (2.6 percent) did not receive any prenatal care in 1989.

Source: Georgia Center for Health Statistics, Georgia Department of Human Resources, Atlanta, September 1990.
Compiled by: Continuum Alliance for Healthy Mothers and Children, Atlanta. Edited for publication.

**HEALTH FACTS FOR BLACK GEORGIANS, 1989**

- 39,370 black babies were born in Georgia in 1989. 722 black infants died before their first birthday. These births represented 35.7 percent of the total births, an increase in number of 2,204, and an increase of 1.7 percent of total births over 1988.

- Black infant deaths represented 53.3 percent of the total infant deaths in 1989; there were 7 more deaths than in 1988. This represents a 6.2 percent decrease in the black infant mortality rate from 1988. Over the ten years from 1979 to 1989, the infant death rate among blacks decreased 10.7 percent, as compared to a 23.1 percent decrease among whites. Black infants are about twice as likely to die (18.3 deaths per 1,000 live births) as white infants (9.0 deaths per 1,000 live births).

- 5,080 black infants were low birth weight at birth. 12.9 percent of black infants were low birth weight, compared to 5.8 percent of white infants in 1989. This represents a 2.4 percent increase in the percentage of black low-birth-weight babies from 1988.

- 23.9 percent of black births occurred to teenagers. The black teenage fertility rate (51.0 per 1,000) is almost twice as high as the white rate (23.7 per 1,000).

- 5,131 black mothers did not receive adequate prenatal care. The rate of infant death is approximately three times greater in babies born to black mothers who have had fewer than five prenatal visits. This represents an increase of 8.3 percent over 1988. 13.0 percent of black mothers received inadequate prenatal care in 1989, compared to 4.3 percent of white mothers.

Financial pressures and personnel shortages aggravate the situation in emergency rooms. Diversion and refusal of patients occur in many places across the state. At least one million of dollars with occupancy rates as low as 30 percent. Many hospitals in Atlanta and elsewhere in the state have higher occupancy rates.
Georgia hospital has been disciplined for turning away people with emergencies. One in particular in Atlanta had advertised that it was the place to be for high-risk pregnancies. Yet the people the hospital was turning away were people staff said were too high risk for their facility. It turned out, of course, that these people were not insured.

Many children are still dying of treatable conditions such as asthma because they are not receiving the necessary care.

Grady Hospital, the main place in Atlanta where poor people can go, has been "on diversion" several times in the last few months. A few other hospitals have tried to restrict their emergency rooms to people who have their own private physicians. Georgia, like so much of the nation, has exacerbated its access problems by allowing for-profit hospitals to take over public hospitals and eliminate services. There have been further threats of hospital closure in already underserved rural areas, but the state is doing what it can to prevent that. This is complicated because, as in all underserved areas or areas where there is a maldistribution of hospital-based health care services, there is a conflict between the need to have high-technology/acute services, usually housed in larger facilities, and the need to provide for basic health care services through small, close-to-home facilities such as clinics and outpatient departments. Short of the long-term solution of providing a better distribution of both basic and acute and tertiary care, the State Access to Health Care Commission has tried to figure out how to promote community and regional planning. The idea is to work from the ground up to meet primary care needs locally and build toward coordination among communities to meet the continuum of health care needs.

Quality of Care

Finally, Georgia has problems with quality of health care. Several hospitals in the Atlanta area have been threatened with withdrawal of federal Medicare funds or with the loss of licenses because of their failure to meet adequate standards of care. The problems extend to nursing homes and other providers. The overall issues of quality of care are tied not only to issues of health industry accountability, but also, again, to the ubiquitous issue of access.

In the face of these mounting problems, many in Georgia are finally taking a look at ways to ensure that people have health insurance. The public hearings that the Access to Health Care Commission has held around the state have been eye-opening for everyone. As a commission member from one of the poorest counties in the state said, "Until these hearings, I knew there were people having problems getting health care, but I had no idea how many people it was, and I had no idea how angry they were about it." Partly as a result of the increasing visibility that the commission has gained for Georgia's problems of health care access, unnecessary illness, lack of health insurance, poverty, and unequal distribution of health resources, many people in Georgia are suddenly interested in looking at national health care as an option.

Although the commission stopped far short of recommending major changes in health care financing or organization, it tried to assure that such issues would receive serious consideration in the future. Included in its set of recommendations intended to reduce costs, improve services, and increase insurance coverage is legislation to reorganize the State Health Policy Council (an existing body attached to the state's health planning agency). The new State Health Strategies Council would be charged with monitoring health care access and cost issues, studying strategies for improvement (including single-payer payment plans), and recommending changes to the governor and legislature. At this writing, the legislation has passed the Senate and has been favorably reported by a House committee.

5. Prepared by Ernest and Young for the Georgia Access to Care Commission, Atlanta, Georgia, 1989.
7. State Health Planning Agency Annual Hospital Questionnaire, Atlanta, Georgia, 1988.
Missing the Point and Passing the Buck
Overlooking Abuse in Mental Health Histories

STEPHEN M. ROSE

Political pressure from the women's movement and other progressive forces has dramatically increased our consciousness of domestic violence, incest and other childhood sexual abuse, rape, and physical abuse. The risk of being sexually abused during childhood is estimated to be nearly one in three for girls and one in ten for boys. Studies of populations with psychiatric histories indicate the existence of even more extensive and enduring abuse among this group; yet the mental health professionals who work with these patients often fail to acknowledge the existence of such abuse, let alone its role in their clients' mental health problems. As a result, many individuals who were abused during their childhoods are diagnosed and treated for years for psychiatrically defined problems without ever having their experiences of abuse mentioned or the existence of these experiences validated.

Mental health professionals, among others, appear reluctant to inquire about their patients' backgrounds of sexual or physical abuse, yet a variety of studies report that people incarcerated in psychiatric hospitals respond readily to structured inquiry about their experience when asked directly in interviews. Most patients have never been asked. Craine and her associates concluded that "some patients may not be identified as sexual abuse victims throughout the entire course of their treatment." In another study that compared data gathered through structured interviews with information from medical records, only 9 out of 100 psychiatric inpatients who reported histories of assault in interviews had those experiences noted in their medical records. Benward and Densen-Gerber, reporting on an inquiry about incest that was "accidentally" uncovered among female drug users living in a residential treatment center, found incest experiences among 44 percent of the residents.

Abuse and continuous traumatic assault have a terrible short- and long-term impact on victims. The failure of mental health professionals to inquire about backgrounds of trauma or abuse, along with the related failure to provide appropriate treatment, is not benign. The refusal or inability to recognize abuse and respond to it constitutes a pervasive invalidation of the victim's experiences. When the invalidation and the abuse continue, people endure greater repression and become more distanced from the causes of their suffering. Clearly, professionals and their invalidating practice models then become a part of the problem rather than automatically components of the solution.

Extent of the Abuse
Recently, I completed a study with two colleagues designed to document backgrounds of abuse as well as the neglect of these crucial experiences among people with extensive psychiatric hospitalizations. We found considerable, undocumented abuse and neglect among our sample, the first 89 clients referred to an intensive case management (ICM) program in Suffolk County, New York. The ICM program was part of a statewide initiative to reach people who had been treated unsuccessfully by the mental health system and were frequent users of its acute inpatient services and psychiatric emergency rooms. People who most often used these services were called "high risk/heavy users" (HR/HUs), and frequently carried such other labels as "dually diagnosed" or "MICA" (mentally ill chemical abuser). Other eligible client groups included homeless people labeled as severely and persistently mentally ill and "extended-stay patients," presumably those remaining in

Stephen M. Rose is Professor of Social Welfare at the State University of New York at Stony Brook.
psychiatric hospitals more than three months. The characteristics of the total client group and the high risk/heavy users are presented in Table 1.

After thorough discussion of informed consent, all 89 clients agreed to participate in the study. The ICM clients were interviewed by their case managers, using a structured interview schedule that asked specific questions about different types of abuse, the abusers, and when the abuse occurred. A number of questions addressed growing up in homes permeated by alcohol or drugs, having to live away from home as a child and the reasons for it, childhood and adult incest, and other sexual or physical abuse.

A history of alcohol or other substance abuse in the family during childhood turned out to be a significant part of the clients’ backgrounds. Half of the total client group reported growing up in families where one or more adults had severe problems with alcohol or drug use. Forty-four percent of the men and 58 percent of the women among the ICM clients were adult children of alcoholics (ACOAs) or of drug users. Among this group, 86 percent became frequent users of acute care inpatient beds and/or psychiatric emergency rooms (p < 0.01).

A background of alcohol abuse often precipitated additional abuse. Among the adult children of alcoholics or drug users, 37 percent were victims of incest, compared to 12 percent of the other clients; and 74 percent of the incest survivors were children of alcoholics (p = 0.01). Similarly, children of alcohol and substance abusers were more likely to have been physically and sexually abused in childhood.

Table 2 presents the relationship between a family background of alcohol or drug use and other abuse variables.

Sexual abuse among the clients also reflected the imbalance in power relations between men and women: women were more than twice as likely to be sexually abused as the men, except for cases of incest, in which women were four times more likely to be victims. In all the cases, men were the abusers. Computed by gender, 50 percent of the women and 22 percent of the men were sexually abused as children; 58 percent of the women and 32 percent of the men had some experience of sexual abuse at some point in their lives. Among the ACOA group, 64 percent of the women and 32 percent of the men were sexually abused (p = 0.03).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Characteristics of Intensive Care Management Clients</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total Client Group (N=89)</td>
</tr>
<tr>
<td></td>
<td>High Risk/Heavy Users (N=66)</td>
</tr>
<tr>
<td>Client Characteristics</td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>50</td>
</tr>
<tr>
<td>Women</td>
<td>39</td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>White</td>
<td>76</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
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</tr>
<tr>
<td>Black Hispanic</td>
<td>2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
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<td>30-39</td>
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<tr>
<td>60+</td>
<td>9</td>
</tr>
<tr>
<td>Marital status</td>
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<tr>
<td>Single, never married</td>
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</tr>
<tr>
<td>Married</td>
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</tr>
<tr>
<td>Living with partner</td>
<td>5</td>
</tr>
<tr>
<td>Divorced</td>
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</tr>
<tr>
<td>Separated</td>
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</tr>
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<td>Widowed</td>
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<td>9th grade or less</td>
<td>12</td>
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<td>10th through 12th grade</td>
<td>47</td>
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<tr>
<td>College or higher</td>
<td>29</td>
</tr>
<tr>
<td>Some vocational training</td>
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</table>

Almost half of the ICM clients were physically abused, most of them while children, by someone in their immediate family. The data on physical abuse, while recorded separately from that on sexual abuse, are parallel: 50 percent of the female clients were physically abused as children, along with 32 percent of the men. Of those who were physically abused as children, 74 percent of the women and 75 percent of the men were later identified as high risk/high users of the mental health system. Being a child of a substance abuser increased the probability of childhood physical abuse. Both sexual and physical abuse occurred among 34 percent of the caseload.
mutilation \( (p = 0.01) \), particularly among the women \( (p = 0.05) \). There is a relationship between childhood sexual abuse and self-mutilation \( (p = 0.00015) \)—they occur together among 79 percent of the women and 50 percent of the men who were sexually abused as children. Among men, there is an interaction between self-mutilation and prior physical abuse \( (p = 0.001) \). The relationship between prior abuse and self-mutilation appears to influence substance abuse, as 93 percent of men on the ICM caseload who were physically abused and who self-mutilate have a substance abuse problem, along with 64 percent of the women who were sexually abused and self-mutilate. Because abuse backgrounds had never been identified or appropriately cared for by service providers, yet seem centrally involved in causing the flashback experiences associated with self-mutilation as well as the perceived need to abuse alcohol and drugs, the routine functioning of the service system has to be seen as part of the problem to be confronted.

Substance abuse was a problem for 55 percent of the clients responding, including 60 percent of the men and 49 percent of the women. Being an adult child of an alcohol or substance abuser also played a role: more than 75 percent of those clients have a substance abuse history themselves \( (p < 0.01) \), including 86 percent of the men in that group and 64 percent of the women. ACOA backgrounds, particularly when accompanied by sexual and physical abuse and followed by continuous abandonment and invalidation by the mental health system, certainly seem to be predictors of later-day high risk/heavy use involve-

Failure of Inquiry

Of these 89 ICM clients, over half of whom had been physically or sexually abused when they were children, who together had undergone hundreds of hospitalizations and had accumulated thousands of inpatient days, who had participated in extraordinary numbers of therapy sessions at hospital-designated clinics and spent endless time in day treatment or vocational training programs—only three of these clients had ever had their abuse mentioned during their extensive treatment, even when they initiated discussion.

None had ever had routine inquiry conducted about the abuse; none ever had staff follow up in appropriate, supportive, validating ways. None had ever received a diagnosis of posttraumatic stress disorder, which would have confirmed the reality of externally imposed assault, domination, and exploitation. None ever had been offered the opportunity to join a self-help support group to confront the oppression or the many possible self-blaming rationalizations she or he might have developed. None was offered the possibility of transforming her- or himself from victim, with its emotional or behavioral residue, into survivor.

In the study we also collected data reflecting the interaction of early abuse with lifelong abandonment by mental health and other service systems. One-third of the ICM clients actively self-mutilate, most of them by cutting themselves. None of the clients were ever asked about what these acts meant or why they committed them. Most were simplistically diagnosed as suicidal, even though their own accounts, when we asked them about suicide, totally contradicted that professional assessment. Many clients described flashback experiences of re-experiencing sexual assaults, which they felt could only be ended by cutting themselves as a means of restoring some control over their experience.

Backgrounds of alcohol and substance abuse in the family during childhood correlate directly with later self-mutilation \( (p = 0.01) \), particularly among the women \( (p = 0.05) \). There is a relationship between childhood sexual abuse and self-mutilation \( (p = 0.00015) \)—they occur together among 79 percent of the women and 50 percent of the men who were sexually abused as children. Among men, there is an interaction between self-mutilation and prior physical abuse \( (p = 0.001) \). The relationship between prior abuse and self-mutilation appears to influence substance abuse, as 93 percent of men on the ICM caseload who were physically abused and who self-mutilate have a substance abuse problem, along with 64 percent of the women who were sexually abused and self-mutilate. Because abuse backgrounds had never been identified or appropriately cared for by service providers, yet seem centrally involved in causing the flashback experiences associated with self-mutilation as well as the perceived need to abuse alcohol and drugs, the routine functioning of the service system has to be seen as part of the problem to be confronted.

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The failure of professionals to recognize and respond to abuse constitutes a pervasive invalidation of the victim's experience.

The family secrecy surrounding childhood abuse colludes with the organizational denial of its impact.

But, left to typical clinical intervention and its methods of payment, self-help strategies and attempts to change the system will fail or will continue to be coopted, leaving provider systems protected in their isolated, unresponsive patterns. Attempts to change the system often evoke the feeling of threat or risk. Now, as we see increases in domestic violence and substance abuse, as we understand their ties to future generational histories of continuing abuse, to institutionalization of various types, and to the chance of HIV infection, we must confront the human and economic risks of sustaining conventional service delivery models and domains.


Resistance to Change

We believe that the brutalized people who responded to our inquiry reflect the interaction of fragmented service delivery systems with obsolete models of practice. The people answering our questions were severely beaten and tyrannized, and then denied validation of their experiences by schools, hospitals, and emergency rooms, perhaps by private physicians, certainly by child protective services and alcohol or drug agencies. The family secrecy surrounding their abuse colluded with the organizational denial of its impact. Even unintentional neglect, however, is not without effect. As Craine and her colleagues put it, "The longer the abuse goes untreated, the greater the repression and the more ingrained the symptomatology."

Medicalized payment systems enhance narrow, restrictive definitions of problems, while simultaneously encouraging expanding costs. Increased recidivism, longer hospital stays, more psychiatric emergency room visits, and more units of outpatient service that remain unrelated to the abuse backgrounds of significant numbers of people in the system only escalate costs. Creating an intensive case management program to reduce these unproductive and often inappropriate types of treatment reproduces the same problems when changes in the system and its dominant treatment paradigm are thwarted. Relying on financing regulations that require primary psychiatric diagnoses and preventing non-medicalized, non-professional self-help group solutions become iatrogenic. The resistance of professionals to such approaches and their implied criticism of the system's performance is as understandable as it is unacceptable.

Abuse victims can be identified; routine inquiries about abuse histories can be made, often in crisis situations; and alternatives to hospitalization can be created. The diagnosis of posttraumatic stress disorder serves as one already existing option when used appropriately and not seen as a medicalized pathology. As one study of this diagnosis concluded, "Recovery from trauma occurs when a victim is transformed into a survivor who is able to integrate the catastrophe into his or her life history and use it as a source of strength."
Safe in Their Hands?

The Health Marketplace Comes to Britain

GEOF RAYNER

Although Prime Minister Thatcher is gone, her plans to introduce the marketplace into Britain's National Health Service (NHS) (see "Disaster for the NHS," Vital Signs, Spring 1989) are so far still on course. Britain's conservative government enacted new legislation for health and social services in summer 1990. Known as the NHS and Community Care Act, it set a tight timetable for implementation. By October 1990, new "streamlined" health authorities had been formed, by November the go-ahead was given to selected hospitals to form "self-governing trusts," and by April 1991 the NHS managers are instructed to begin the first phase in the introduction of a health marketplace.

But the fast pace of change has been achieved at considerable cost to the government and in particular to Mrs. Thatcher. Public opposition to the NHS reform has joined the mass discontent and disorder associated with the installation of a new "poll tax" and Mrs. Thatcher's renegade position on Europe, which has so dismayed British industry. Together, this disapprobation brought about Mrs. Thatcher's rejection as party leader and her replacement in the job of Prime Minister by her chancellor, the anodyne Mr. John Major.

Though not perhaps the most prominent of factors responsible for Thatcher's demise, the imbroglio surrounding the NHS has caused lasting damage for the government. The NHS proposals, with their economic and ideological flavor, sowed confusion and fear, severely denting government's claim that the NHS was "safe in their hands."

Tampering at Their Peril

To understand Mrs. Thatcher's difficulties with the NHS throughout her 11 years in office, it is necessary to comprehend the unique position of the NHS in British society and of the professions that work within it. Since the end of World War II, the NHS has been a hugely popular and venerated institution. Any government tampered with it or appeared to mismanage it at its own peril. In the face of this, Thatcher's reforms promised an economic marketplace for health care along the lines devised by American health economics guru Stanford University Professor

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Waiting area, Kings College Hospital, London.
By April 1991 NHS managers are to begin the first phase in the introduction of a health marketplace to Britain. 

which is notorious for not knowing what individual items of service cost, every transaction will have a price attached. The NHS's new flavor is less public accountability, management by businesspeople, and focus on rapid, acute hospital treatment rather than the care of people with chronic ailments.

In developing the proposed reforms, the government failed to consult with the health professions and rejected any practical testing of the underlying concepts. The British Medical Association's campaign of opposition highlighted the government's intransigence. (One highway billboard, referring to Thatcher's health minister, carried the message, "What do you call a man who doesn't listen to medical advice? Mr. Clarke.") The physicians claimed that the proposals were simply unworkable; however, underlying their concerns were their fears of the government's liberalizing attack on the professions (which also included forays against lawyers and teachers).

Despite large expenditures in getting their own message across, the government significantly failed to explain how the reforms would fulfill their promise to make the health service more effective and responsive to consumers. The failure to link reform with an easing of the tight financial controls on the NHS—the only new expenditures envisaged were for extra accountants and computers—indicated that reforms would not address the enduring difficulties associated with the NHS, especially in London: staff shortages, ward closures due to expenditure cuts, and decaying hospital buildings.

Indeed, the proposals spawned a new obscurantism in NHS administration, replete with a new jargon (for instance, "money will follow patients," "clarifying objectives," "a level playing field with the private sector," etc.) as a means to bolster the morale of managers and project the new management objectives. To the question of how this was to occur without extra resources, the government replied that the health marketplace would generate dividends and entrepreneurialism. No proof could be found to justify these assertions, but with careers on the line, most managers speak their concerns sotto voce.

Though not the most prominent of factors responsible for Thatcher's demise, the NHS imbroglio has caused the government lasting damage.

Implementing the Internal Marketplace

The competitive marketplace envisaged in the legislation won't be properly in place for several years. The key concept—the separation of service providers from purchasers of services and allied competitive tendering for services—will be implemented progressively starting in
April 1991. At present, local health services are operated directly for a given population by an appointed health authority, which manages its own hospitals, clinics, and public health services. In the first phase of the new program, health authorities will negotiate broad “service agreements” with providers. One set of NHS staff will write the specifications of a service for a distinct local population (ranging in size from 150,000 to over 300,000); another group of health services staff will provide it. Much of the work undertaken will be based on block contracts, more or less like an HMO operation; for patients who are not local residents (for example, for super-specialist services), contracts would have to be negotiated in advance. Of course, this agreement opens up a world of game playing and bargaining that didn’t exist before.

The vast bulk of transactions will still take place within the NHS (hence the origin of one expression, “the internal marketplace”). However, although the private sector is quite small, more or less limited to nursing homes and acute care and covering around 12 percent of the population, it has been assessing ways in which it could skim off profitable business.

The government claims that the reforms will end the “monolithic” character of the NHS (presumably to its detriment). However, the appointments to the local health authorities, especially the important positions of chair and general managers, have been controlled by the government’s secretary of state for health through his political advisors and the second-tier Regional Health Authorities.

Put to the Test

During 1991 the workability of the reforms will be tested in practice. Watching the process at work in three large teaching hospitals (St. Thomas’s, Guy’s and King’s College), I found most notable the massive cutbacks in service resulting from the need to start the new financial year of the year, the GP will be allowed to keep the balance. These funds will not be allowed to go directly into the GP’s pocket but must be spent on the practice office to improve patient care. This financial incentive is designed to promote more efficient care both from family physicians directly and in referrals to hospitals. In the current jargon, “money will follow patients” from the GP to hospitals, providing economical and quality care.

No such extensive financial incentives have ever existed in the NHS. Traditionally, health professionals have been shielded from competition and the costs of providing service.

While Margaret Thatcher’s downfall as leader of the Conservative Party last November was not a direct effect of the NHS reforms, the outcome of the next general election may be. But her replacement, John Major, and the new health minister, William Waldegrave, are both committed to continue the pace of NHS reform and recently announced the names of the first wave of self-governing hospital trusts.

The opposition Labour Party has published a new policy document, “A Fresh Start for Health.” Labour would reverse many of the changes initiated by the present government, with abolishing self-governing trusts high on the list. Convinced that after the next election the government would be inheriting a health service in crisis “caused by both underfunding and the dogmatic changes being imposed by the government on an impossible timetable and with inadequate funding,” Labour’s proposals include abolishing the internal market. The funding of district health authorities would be based on performance targets negotiated with regional health authorities.

Although some decry the introduction of competition into the NHS, there is intense interest in seeing how the reforms will work. Unfortunately, there will be little time to evaluate their effects, for better or for worse, before the next general election is held.

---Jennifer Dixon

Jennifer Dixon is a public health physician from the United Kingdom who is spending a year in the United States as a Harkness Fellow studying health care policy.
with a balanced budget, and the managerial confusion caused by NHS administrators acting as "commissioners" in the morning and "providers" in the afternoon. This confusion and fragmentation may only be beginning. In the future, funding of the commissioning bodies will be based on a system called "weighted capitation," with the result that deprived populations will receive similar funds as areas with healthier and wealthier populations who also have private insurance. In places like London, where rental values are high (under the new system, hospitals will be forced to pay interest charges on their assets), populations are poor, and where primary care is weak, the cost of treatment is significantly higher.

What started out as a radical venture has become an indistinct set of measures whose chief trait is a reduction in local political accountability.

The short-term prospects for the NHS are bleak. However, just before Thatcher left office, the aggressive health minister, Kenneth Clarke, was replaced by the emollient William Waldegrave. Some extra cash has already been made available to London health districts.

In a short description of the events surrounding the reforms, the useful changes risk getting damned along with the harmful ones. Certainly, there are positive aspects that a future Labour government would retain if they are seen to be genuinely helpful to the service (the commissioning/provision division may be one). The social services side of the legislation—since delayed on cost grounds—was seen by many as a sensible reform. Responsibility for organizing social (not medical) services for the elderly, the mentally ill, adults with learning difficulties, and the physically disabled, as well as services for drug and alcohol misusers, is now under the auspices of elected local authorities rather than being distributed through a variety of agencies or the social security system.

As to the longer term political consequences, the political damage to the government will surely continue. The Thatcher government may have successfully sold off a significant part of state industry, but in taking on the NHS it has seriously eroded its own popularity. What started out as a radical venture at a high watermark of government popularity has become by degrees, and against a backdrop of steady erosion at the polls and public confusion over the meaning of the reforms, an indistinct set of measures whose chief remaining trait is a reduction in local political accountability. Over time, the legislation lost whatever few friends it had earlier claimed, particularly as managers' public embrace of the measure visibly mellowed in the face of the prospect of a Labour administration taking power in 1992 with a long memory of its friends and an even longer one of its enemies.

It is perhaps ironic, that, in presenting the government a ready-made model for the operation of a market-based National Health Service, Enthoven may have done a greater service to the opposition than to Thatcher. And despite the chaos Enthoven’s health care market may be causing in the short term, if the unpopularity of these measures helps the opposition to bring the shutters down on over a decade of shallow and cynical Toryism, people in Britain may yet have reason to thank him.

The Other War, continued from p. 4

Arthur Levin

Ellen Bilofsky

Bush’s new budget continues this domestic offensive by suggesting $23 billion of cuts in Medicare. He proposes to fight growing infant mortality rates among poor people by withdrawing $24 million from community health center programs and $34 million from Maternal and Child Health Services Block Grants—two very effective programs targeting all 50 states and their underserved communities.

The primary lesson learned from the war, we are told, is that Americans are okay after all; that we are a strong and capable people, who serve and sacrifice nobly for what we believe is right; that we are back on the right track. But, today’s fashionable pride and patriotism only make it easier for the country to ignore the defeat of the vision needed to address the growing immiseration of large numbers of our friends and neighbors. And it makes it easier to look away from the fact that ultimately the war may lead America to snatch defeat from the jaws of victory.

— Arthur Levin

— Ellen Bilofsky
The Fourth International Workshop on Health in Southern Africa was held in Maputo, Mozambique, in April 1990. The conference specifically addressed a vision of health and welfare in a new South Africa. The conference was held in Mozambique to express solidarity between the progressive forces in South Africa and Mozambique, as well as the rest of Southern Africa. A report on the conference, "Health and Welfare in Transition," is published in Critical Health, No. 31/32, August 1990, and may be ordered from Critical Health, P.O. Box 16250, Doornfontein, 2028, Johannesburg, South Africa, for 12R or the equivalent in pounds or dollars for overseas orders.

Standing on the balcony of the eleventh floor of the Ravumo Hotel in the early morning of April 9, 1990, and looking across the Indian Ocean, I could see the harbor. Except for a few small fishing boats trawling around big cargo ships that were now lying idle, this once busy and bustling trade center of the region was quiet and still. Men and women wormed their way between cars in different directions going to work, while others set up tables in the nearby marketplace, ready to sell their produce and bargain with tourists. The grandeur of this exotic subtropical city still stands in spite of the unfinished, tall luxury apartment buildings that were abandoned by the fleeing Portuguese colonialists in 1975. Some of these buildings' facades peer out from behind rows of laundry hanging on wire fences that stretch across the balconies. Scraggly dogs and stray cats wander around, and raggedly

Nonceba Lubanga, a registered nurse specializing in public health, is South African. She is a member of the Executive Board of the Committee on Health in South Africa (CHISA), Director of Health Services for Talbot Perkins Children's Services, a child welfare agency in New York City, and a former Health/PAC Board member.
children play in the streets. This is Maputo, once the Riviera of Southern Africa.

At the end of the colonial rule in Mozambique, capital was removed wholesale to Portugal. Because of the late President Samora Machel's socialist position, the International Monetary Fund (IMF) and the World Bank did not give Mozambique much support, if any. The war waged against the government by the Resistencia Nacional Mocabicanica, or Renamo, has caused great suffering among Mozambican people, especially the children. Despite the deliberate destabilization by Renamo there is a surprising semblance of normal life going on.

We witnessed the tremendous spirit and pride of Mozambicans during our visit for the Fourth International Workshop on Health in Southern Africa. The people of Maputo had gone out of their way to make the stay of the conferes comfortable despite food shortages and rationed water and electricity. We were told by some officials at the medical school where the conference was held, that through donations from various sources, about $10,000 was spent on renovations of the auditorium, conference rooms, installation of audiovisual equipment, acoustics, air conditioning, and the like in preparation for the meeting.

A Collaborative Effort

The conference, a collaborative effort of many groups from the Southern African region, the United States, and Europe, was organized by six groups: the Committee for Health in Southern Africa (CHISA—which had participated in organizing the three previous conferences); the African National Congress (ANC); Anti-Apartheid Movement in London; the National Medical and Dental Association (NAMDA) in South Africa, which set up a coordinating committee representing all the progressive health and welfare organizations within that country; the University of New Mexico Medical School (a WHO-collaborating Centre for Community-Oriented, Problem-Based Medical Education); and the Ministry of Health of Mozambique, the official host. Besides South Africa, delegates represented Namibia, Tanzania, Zambia, and Zimbabwe from the region; Nigeria, Uganda, Senegal, and Benin from elsewhere in Africa; the United States and Canada from the Americas; Britain and France from Europe; and Australia.

For the first time, a remarkable cadre of various health and welfare workers from South Africa met and exchanged their experiences with other South Africans in exile abroad. The conference provided a forum for a joint attempt to forge guidelines for a post-apartheid health system. The focus of the conference was on the achievement of new health objectives in a time of transition and conflict. The central theme was supported by two major subthemes: (1) innovations in health sciences education to address community health needs, and (2) the assessment for socioeconomic and epidemiologic aspects of the HIV pandemic. More than 200 delegates shared information in seminars, lectures, and demonstrations. Delegates included educators, health service administrators, medical and public health officials, and leaders from trade unions, religious groups, and other progressive professional organizations.

The conference provided a forum for the attempt to forge guidelines for a post-apartheid health system.

Political changes in South Africa will produce demands for a health care service in keeping with principles of social justice.

Of further political significance, the Maputo Conference was an expression of the Mozambique government's solidarity with progressive forces in South Africa, a recognition of a shared experience of the tyranny of apartheid and mutual abhorrence of the deliberate and appalling atrocities perpetrated by the apartheid regime. The conference consensus on its Declaration of Health in South Africa was a reiteration of commitment to transforming the existing health and social services in South Africa into a non-racial, accessible, equitable, cost-effective, and democratic national health and welfare system. The Declaration recognized that health and welfare services will serve as a tool in national development and are part of the agenda of a national liberation movement.

Health Care and Social Justice

Participants understood that the political changes and turmoil in South Africa are likely to produce demands for a health care service more in keeping with the principles of social justice. To meet these demands, argued Dr. H. M. Coovadia, Professor of Pediatric Immunology at the University of Natal, South Africa, a new health policy would have to include:

- An affirmative action program.
- A statement of principles, including a bill of rights.
- A single ministry of health, replacing the present 14 different health departments with central planning.
- Decentralized functioning of the ministry of health, including the participation of grassroots organizations.

Cedric de Beer of the Health Policy Studies Center at the University of Witwalesrand in Johannesburg, sounded a note of caution about the problem of the limited resources available to meet these demands. The importance of realistically assessing available resources was discussed at length. The question of what role, if any, would...
and should be played by the private health and welfare system was also considered. Another realization was that any future health service in South Africa will emerge out of the transformation of the present health system. There is a need to focus some attention on different categories of health workers, since they form an integral part of the health sector. Under the present system, a health worker is narrowly defined as one who works in the health field—for example, doctor, nurse, technician, or general worker. In terms of changes needed and the new society envisaged, however, every person must be actively involved in looking after his or her health as well as the health of the community or nation—which makes everyone a health activist. The danger of domination and control by the skilled and articulate workers and by middle-class members of the health care system is a real one, and only by true democracy, accountability, and dissemination of information through the organization to which the health workers belong can this problem be avoided.

Some of the following problems that are found in the present health worker system were discussed:

Bureaucracy. Hierarchical and authoritarian structures within the hospital dominate the worker as well as doctor-patient relationships. One example cited was that of nurses, who are militarized, with uniforms, ranks, codes of conduct, and the like.

Class, race, and sex domination. These relationships reflect those outside the hospital; for example, the middle-class white male professional sits at the top, and the working class, usually a black female worker, is at the bottom of the pyramid.

On August 2, 1989, more than 2,000 people converged on Durban's whites-only Addington Hospital as part of the national defiance campaign called by the Mass Democratic Movement to demand the scrapping of apartheid health services.

Alienation. The patient is alienated by not being in control of his or her own body. Work is divided among categories of health workers, leaving the workers to do bits of tasks, just like on the factory floor.

The myth that science is neutral. In fact, science serves the needs of the ruling class. For example, the heart transplant pioneered in South Africa is available only to the wealthy.

Professional elitism.

The question was brought up of who, among the present group of health workers, would bring about changes. Nurses were identified as one group that can play a crucial role in the transformation of the health sector. They are the largest group of skilled health workers in South Africa and are involved in all levels of health care—primary, secondary, and tertiary. Nurses have the closest contact with patients' families and members of the community. They occupy a key position in relation to other health workers and thus can play an important role in breaking down barriers between different categories of health care workers.

The position of the majority of health workers as state employees and as providers of essential services has severely compromised their ability to show solidarity with the broader political struggles. Recently, however, progressive health worker organizations have had intensive...
discussions focusing on the need to organize nurses so that they can counter the control of the South African Nursing Association (SANA). Already, about 5,000 nurses are members of the National Education Health and Allied Workers Union (NEHAWU), which is affiliated with the Congress of South African Trade Unions (COSATU).

A variety of ideas flowed from other speakers. Doctors and nurses need retraining to be more community-oriented and to realize that they are not necessarily team leaders. They also need retraining so that even sub-specialists are able to do preventive health care. The attitudes of professional health workers have to be addressed. Women must be integrated into all health and welfare initiatives and into all policy deliberations considering future health and welfare programs.

The Role of Traditional Healers

The role of the traditional healers in a post-apartheid health care system is uncertain. Western-trained health workers seem reluctant to face the problem and seek solutions. Clearly, however, the traditional healers play an important role in the African community. For example, some women are happy and comfortable with traditional birth attendants but not with the busy, bossy, often rude and cold doctors and nurses. As the discussion went on about how to integrate the traditional healers into the future health system, some delegates became impatient. One “comrade” shouted, “We have power to make a decision about these people because when we are in power we have to have a policy for them.” I wondered who this delegate was referring to when he said “we.” Finally, it was realized that it is important to understand the traditional healers and how they are organized in a socio-political context. Their role had to be studied and examined thoroughly in order to be understood and respected.

Dr. Leonardo Siamo, the Mozambican Minister of Health and our host, shed some light on how the Western-trained health workers in his country handled ideological confrontation with the traditional healers. The government’s strategy has been to educate the people, to empower them to take the responsibility and rewards for their own efforts, not to attribute them to the effort of supernatural forces as the traditional healers would have them believe. In recognition of the fact that well over half the population consults such healers, and that the overriding need is to reverse patterns of disease, traditional healers are now encouraged to form their own association, which is given recognition by the Ministry. This enables them to protect their own dignity and prestige.

Representatives from the frontline states—namely Zambia, Angola, Namibia, Zimbabwe, and Mozambique—shared experiences and lessons that could be learned from their mistakes since their independence. The low-intensity war waged by South Africa against the frontline states has resulted in economic destabilization and has had a devastating effect on health services, especially in Mozambique. Thus, the importance of regional cooperation with the liberation movement’s effort to replace the apartheid regime with a free and democratic society in South Africa was emphasized by all participants from the frontline states.

The threat of the AIDS epidemic in Southern Africa was a matter of concern to all the conference participants. Though the epidemic is still in its early stages in South Africa, it is estimated that the number of people with HIV infection will double every 8.5 months. One of the things that came up repeatedly during the HIV/AIDS sessions was the lack of confidence that the black population has in government agencies. Delegates from South Africa reported that most people see the government messages about AIDS prevention as genocidal propaganda linked with previous government efforts at population control among blacks. The conference set up a progressive National AIDS Task Force.

Exuberance, Energy, and Exchange

Few words can describe the exuberance and energy displayed by the South African delegates. Before and between meetings, they would spontaneously burst into song with raised clenched fists, stamp their feet, and sway back and forth to the rhythm of the revolutionary songs. At the beginning, it was interesting to watch the astonished and yet mesmerized delegates from other countries, especially the United States. By the end of the conference, some of my American colleagues had mastered the “toyi toyi” dance, and I watched them struggling to pronounce clicks and sing the Xhosa lyrics of the revolutionary songs.

The Maputo conference provided an opportunity to exchange ideas and experiences about issues related to health tasks and problems affecting the entire Southern Africa region. This conference may well prove to be the crucial first step toward an enduring regional network linking educators, health service administrators, medical and public health officials, and progressive professional organizations.
Few books written about public health are theoretical. Thus, The Politics of Public Health, by Meredith Turshen, an avowedly theoretical analysis of selected issues in community health, is a very interesting and useful contribution to the field. Turshen examines the underpinnings of the traditionally accepted analysis of factors associated with health and disease, focusing on the political and economic factors that have shaped public health and medicine. The book cuts a wide swath through the fields of community health, disease causation, women's health, and the organization of medical care. One of its strengths is its international perspective. Turshen draws extensively on her first-hand knowledge of Africa as well as her understanding of policies in Europe and the United States.

Early in the book Turshen articulates her support for a theory of disease summarized as "the social production of health and illness." Many Health/PAC readers will be familiar with this theory in the forms discussed in the United States during the 1970s and 1980s by several groups of health care providers and academics. Turshen argues:

According to this theory, health and disease are products of the way society is organized, of the way subsistence is produced as well as surplus, and of the way subsistence and surplus are distributed among members of society....Disease and health are products of the relationship between the producers of wealth and the owners of the means of production, as well as between the producers and the distributors of goods and services, because the distribution of resources vital for health—such as housing, food, or leisure—is a function of the relative power of different groups. Health and disease are also products of the organization of procreation, child rearing and socialization—the reproduction of social life and economic organization [pp. 24-25].

Prevention and cure are dependent upon the reorganization of the relations of production. Rather than the individual, social classes defined in relation to production become the focus of disease. It follows that, since health and illness are ultimately determined by the social relations of production, the efforts of public health must be to restructure these relations and the social, economic, and political forces that support them.

Notions of Class

The book’s emphasis throughout is the impact of class relations on health, disease, medical care, and the preventive efforts of public health. Turshen, however, is highly critical of how class is conceptualized in most social science work in the United States. She juxtaposes this static conception centered on job status with the more dynamic Marxian notion of class, which includes a theory of power relations. In examining the third world, she points out that the trend is to reduce dynamic notions of class to more one-dimensional concepts of target groups or at-risk populations. She suggests that a far more useful social classification is that proposed by Amartya Sen, who uses the concept of entitlements to describe an individual’s position in society. This opens up additional helpful perspectives that, in tandem with theories that focus on attributes of the culture and individual, serve to explain the...
success or failure of preventive efforts as well the etiology and distribution of disease-specific situations.

The book is held together by its theoretical perspective. It is organized into four sections, each of which covers diverse topics. The first section deals with public health theory, methods, and policy. One of its concerns is with the limitations of the biomedical model of disease. The section also includes a chapter on the redefinition of equity and access and an examination of these concepts in three societies—the United States, the USSR, and China. The section closes with a discussion of how women’s health is affected by gender relations within the social relations of production. Case studies of women’s health in three African countries are used to illustrate this point.

In the second section, “The Limits to Conventional Public Health,” Turshen points out that conventional public health strategies for containing epidemics rely on quarantine and isolation, measures that blame the victim and frequently leave the situation that caused the health problems unresolved. Turning to environmental issues, she examines the sanitary reform movement, linking beliefs about the nature of poverty with environmental problems and population growth. Turshen argues that a structural reorganization of the economic system is a proper focus of work in public health. The final chapter in this section examines international programs designed to eradicate disease, comparing the successful smallpox campaign with unsuccessful efforts to end malaria. Turshen argues that political and economic factors such as the collusion between the chemical and seed-producing companies and opposition of agribusiness to restrictions on the use of DDT determined that antimalarial efforts would fail.

The third section makes use of Turshen’s theoretical analysis to illustrate how public health could offer a broader and more comprehensive approach to specific health issues, namely, preventive medicine, nutrition, mental health, and AIDS. Screening and immunization are taken to represent preventive medicine and are examined in the context of the swine flu vaccination campaign of 1976 and industrial programs of genetic screening. Turshen views the misapplication of preventive health measures in both case studies as illustrating the confusion between prevention and preventive medicine. In the chapter on nutrition and agribusiness, she proposes that access to nutritious food should be part of any preventive health effort, and points out that poor nutritional status is largely a problem of quantity of food in underdeveloped nations. The chapter treats access to food in terms of inclusive systems of food-related activities from production to consumption. Entitlements, the food distribution system for the poor, are also critically examined.

The book’s perspective on mental illness uses concepts of social alienation. Turshen considers none of the three prevailing models of mental health practice—the medical model, the social model, and the public health model—successful. Using illustrative material from Africa, she argues that preventing mental illness will require profound social reorganization. Also in this segment, Turshen examines AIDS in Africa, suggesting that, in fact, the epidemic was transported to Africa via military personnel from the United States. She believes that the currently accepted “scientific” explanations placing the origins of the disease in Africa are racist in nature, and she questions the goals of the current efforts being made by the West to control the epidemic. She also argues that the threat of the epidemic to Africa when compared to other public health problems has been systematically exaggerated by both the scientific and lay press.

The Future of Public Health

In her final section, Turshen lays out an agenda for public health in the future. The framework is the integration of public, private, curative, and preventive services. The integration must also extend into clinical education, necessitating common training of different categories of health professionals. Finally, social science, which has been kept on the margins of medical care, must be incorporated into medical and scientific research. The agenda for action, which is discussed in the last chapter of the book, calls for international coalitions to press for social change. Such change includes a socialized health care system and a concerted effort to address the problems that contribute to the relatively poor health of marginalized groups.

It should be clear from this summary that The Politics of Public Health is both wide ranging and provocative. Turshen is not afraid of taking stands on controversial issues or of stepping across conventional boundaries. This should make the book attractive even for those who do not agree with all of its arguments. It forces attention to the breadth and depth of the world’s current health problems, and in doing so compels the conclusion that broad and systematic approaches must be sought to supplement our current case-by-case and disease-by-disease focus.

Women, Work, and Health


by Wendy Chavkin

W
omen, work, and health are still hot topics. The Supreme Court is currently deciding the fate of the Johnson Control Company’s “fetal protection policy.” In the name of concern about the impact of lead on the fetus, the company excludes all fertile women from jobs with exposure to lead or jobs from which they might be promoted to jobs with exposure to lead. The implications of such a stance, pointed out by one dissenting appellate court judge, could be to foreclose employment for women in 20 million industrial jobs. On another front, local political battles have been waged over whether or not pregnant women should be exempted from working with VDTs.
In this climate, *Turning Things Around: A Women's Occupational Environmental Health Resource Guide* offers a compilation of resource material and organizations for women workers and environmental activists. Although the guide book is addressed to "practitioners, clients, workers and neighbors," the tone and tactics described render it most appropriate for the latter three groups.

The guide is divided into four sections. The first focuses on occupational health issues for women and includes brief mention of stress, VDTs, ergonomic concerns, and chemical exposures on jobs into which women workers are segregated. This chapter concludes with suggestions about taking action and a bibliography.

The second section deals with environmental hazards and activism, specifically, multiple chemical sensitivity, adverse reproductive outcomes, and hazardous exposures in the home. This chapter addresses action on both the community and the global levels, and also offers a bibliography.

The third section offers the lay reader advice about how to use resources and touches on the complicated arenas of conducting and evaluating research, as well as medical and legal resources, governmental agencies, and regulations. All three chapters are sprinkled throughout with case stories and quotes. The guide's final section provides a listing of relevant organizations.

This is a resource guide, not an analytic work. Its usefulness to activists, however, could be strengthened if it prepared them more even-handedly for some of the frustrations and uncertainties they are likely to encounter. Community surveys may not lead to regulatory action, not only because of political opposition, but also because they may be methodologically naive or have access to too small a universe. In another arena, women worker activists should be primed to deal with the labor movement's generally unsatisfactory response to women. Community activists will be able to plan more effective strategies if they anticipate workers' perception that environmental regulation leads to loss of jobs.

While *Turning Things Around* skims over many complicated questions, it provides a starting place for activists in the area of women's work and community health. It acquaints them with issues and approaches, gathers material together, and points them in the right direction.

### Shoring Up the Safety Net


Few of the proprietary and academic medical centers that dominate the picture of the American health care system acknowledge that they increasingly represent only one kind of patient care—the paying kind. Another system of health care is developing as the "safety net" for the uninsured and poor of America. The National Association of Public Hospitals recently published its White Paper on its over 100 member public hospitals in the United States. This document, *America's Safety Net Hospitals: The Foundation of Our Nation's Health System* tells a tale rarely told about the state of health and health care access, quality, and innovation for the nation's poor. With combined gross revenues of over $10 billion, these hospitals serve, as NAPH points out, "as national health insurance by default in most of our nation's metropolitan areas."

The public hospitals' tale is alarming in its depiction of overcrowding, crumbling physical plants, financial losses, woefully inadequate city, state, and federal subsidies, shortages of almost everything and everyone, and increased burdens from new patient populations produced by the HIV epidemic and the collateral effects of impoverishment. But the story is also curiously inspiring, too. It depicts a commitment by these hospitals to health care, a struggle for quality, a far-sightedness, a quest for planning, and a sense of public responsibility rarely seen in any area of American life today. The report also documents a new emphasis on primary and preventive care that has emerged in the last ten years almost entirely from the public hospital setting.

*America's Safety Net Hospitals* should be read by everyone who wishes to take the health care crisis debate in America further than issues of cost containment and insurance reimbursement. Order from: National Association of Public Hospitals, 1212 New York Avenue, N.W., Suite 800, Washington, D.C. 20005, (202) 408-0223.

Of particular concern to New Yorkers is the state of their municipal hospital system. While New Yorkers view both the system and the stresses upon it as idiosyncratic, the White Paper portrays the New York City Health and Hospitals Corporation (HHC) as fairly representative of the role of public hospitals in other American cities. While HHC clearly treats more homeless, drug-using, and AIDS patients, surprisingly, its inpatient, outpatient, and emergency room burdens are roughly equal to

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those of public hospitals serving other major cities.

HHC has prepared a series of documents which, while specific to HHC, have broad policy interest to health advocates and activists. The first is a strategic plan for preserving HHC's mission in the face of swift and pervasive changes in the health care industry, the economic retrenchment of the Reagan/Bush years, and the changes in the populations of New York City. HHC's strategic plan analyzes every facet of health care delivery and presents a plan for a community-based, decentralized health care system which emphasizes primary and preventive care while coordinating acute, in-hospital care as a comprehensive response to the city's health and fiscal crises.

In addition, HHC has prepared a series of issue papers designed to guide policy and planning for New York City's massive public system. These documents present some of the best studies of the changing health status and health care needs of New York City residents, particularly of poor residents. They can be read with an eye to understanding the dilemmas of health care delivery to a diverse population, future trends in utilization of health care services in the city, and special populations as their needs are shaped by the changing economic straits of city and state budgets, not to mention the growing epidemics of homelessness, HIV infection, drug use, and mental illness.

The following studies, as well as the one listed at the beginning of this review, are free and can be ordered from: Office of Strategic Planning, New York City Health and Hospitals Corporation, 346 Broadway, Room 530, New York, NY, 10013, (212) 566-2570.


—Nancy McKenzie

The Center for Immigrants Rights has announced the publication of its long-awaited guide, Immigrants' Legal Access to Health Care. The 100-page guide provides a detailed background on immigration law as well as information about eligibility for programs providing access to health care. The latter includes discussion of special federal Medicaid eligibility rules for aliens, state and local government programs, Medicare and other programs, and approaches to obtaining care for the uninsured.

The guide's second half focuses on potential problems aliens may have with their status as a result of seeking health care. This includes the risks of being reported to the Immigration and Naturalization Service, deportation, and the impact on a person's immigration status as a result of being diagnosed with certain diseases. Issues around the INS's exclusion of gays and lesbians and the need for confidentiality are also included. The guide is fully referenced with both health care sources and immigration case law.

The Center for Immigrants Rights has also just published New York Health Care for Immigrants, which is designed to be an advocate's manual for people working with immigrants in New York City. It is meant to be used in conjunction with the legal guide already described. This guide provides overviews of New York's Medicaid program, special eligibility rules for aliens in New York, and lists of federal, state, and local programs in New York City and Nassau and Suffolk Counties.

The legal guide is clearly a valuable resource that can be used by advocates for immigrants nationally. The New York guide can be useful to those outside the metropolitan region as an example of how to organize such an advocacy guide. For more information contact: Center for Immigrants Rights, 48 St. Marks Place, New York, NY 10003.

—Arthur Levin

—Nancy McKenzie

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LOOKING FOR A FEW GOOD ISSUES?

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.

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I have been thinking about lead a lot lately. The federal Centers for Disease Control has just lowered the "level of concern"—that is, the amount of lead in children's blood that is considered hazardous—to 10 micrograms per deciliter. In the last 20 years, this threshold of concern has fallen 600 percent, from 60 micrograms per deciliter before 1970 to 40 in 1970, 30 in 1978, 25 in 1985, and now to 10.

Research published in the last five years overwhelmingly supports earlier evidence that at blood levels of 10 or 15 micrograms per deciliter (and perhaps less), lead causes decreases in IQ and interferes with attention and auditory processing. It creates learning problems and may interfere with judgment and self-control. It poisons every cell in the body and especially affects the central nervous system.

Lead poisoning makes me think about race—or, more properly, racism. Personally, I wish racism would just go away. Don't get me wrong—I don't think ending racism would be a panacea. Poverty, hyper-tension, heart disease, drug addiction, hatred, and even lead paint poisoning would not disappear even if racism went away. But their victims would be less predictable. And perhaps public health would develop more successful preventive interventions for these problems.

Racism and lead are intimately tied to each other. It’s not that anyone put lead in paint to poison black children—or to poison anyone, for that matter. But action, inaction, and research on lead is all tied up with race. The fact that lead paint, especially deteriorated lead paint, is most often found in slum housing in black and brown communities has slowed attempts to alleviate and abate this problem.

Proving that low-level exposure to lead causes cognitive and neurobiological problems was hampered for years by the fact that lead's primary victims were and still are poor black children living in dilapidated housing. That these children were cognitively impaired or had trouble in school could not easily be attributed to their exposure to lead. Racism and class prejudice—and many studies—suggested that these children could be expected to be less than bright. Researchers hypothesized that children who were cognitively impaired ate lead-containing paint chips because they were stupid, rather than the other way around. Maybe they mouthed lead dust from their hands and toys because their mothers were bad housekeepers or bad mothers or had so many children they didn't know what to do. How could learning and behavior problems of children living in such environments be attributed to their exposure to lead rather than their "social background," critics of the lead research asked.

In order to eliminate "confounding" by race and poverty, Herbert Needleman studied lead exposure and neurobehavioral effects in thousands of white working-class school children in Somerville and Chelsea, Massachusetts. His first results were published in 1979. Then he and David Bellinger studied a cohort of upper- and upper-middle-class infants born at Boston's Brigham and Women's Hospital in the early 1980s. These studies showed the same cognitive and behavioral effects found in other studies in which the backgrounds of children were less well controlled. Once effects had been demonstrated in the white and the well-off, they were accepted as real.

Toxic Use Reduction

In the 1950s and 1960s, lead poisoning was considered a problem of poor black children living in slums who ate paint chips. The Lead Paint Poisoning Prevention Act passed by Congress in 1970 funded screening programs, which found that hundreds of thousands of children had elevated blood lead levels. In 1977, the Consumer Product Safety Commission banned the sale of lead paint. Thus began a national program to eliminate lead in the environment before it was dispersed (known as toxic use reduction).

Through the 1970s and 1980s, researchers demonstrated that lower and lower levels of exposure were harmful. At the same time, screening and national health surveys showed that exposure was much broader than previously believed. Millions of children in the general population (including large numbers of white,
middle-class children) were at risk from lead exposure. The significant sources were not just peeling lead paint, but included gasoline, intact lead paint, food, and drinking water. The toxic use reduction strategy was expanded. Having begun the reduction of lead in gasoline in the mid-1970s, the Environmental Protection Agency cut the lead content of gasoline by 90 percent between 1982 and 1986. The Food and Drug Administration negotiated with food manufacturers to limit lead in food, especially for infants. That’s why baby food comes in jars, not cans—there’s no lead solder.

Lead is a case that demonstrates the effectiveness of toxic use reduction as a strategy. The average blood levels of American children dropped by more than 30 percent from 1976 to 1980 as a direct result of reductions of lead in gasoline. In 1980 the mean blood level of white children under 6 years old was approximately 13 micrograms per deciliter. For black children it was about 20 micrograms per deciliter. Further regulation and other actions taken over the last 10 years have reduced lead in gasoline, food, and water. Preliminary reports from the 1990 National Health and Nutrition Examination Survey show that average levels have now dropped to about 6 micrograms per deciliter. The ratio between black and white has not changed. It is estimated that some 90 percent of poor black children have blood levels exceeding 10 micrograms per deciliter, above which neurological damage occurs. In every income and geographical category, twice as many black as white children have lead levels over 15 micrograms per deciliter. The Environmental Defense Fund estimates that 3 to 4 million children under age 6 have blood lead levels above 15 micrograms per deciliter. This is thousands of times the number of children who get all the infectious childhood diseases combined.

Eliminating toxic chemicals before they are dispersed is relatively cheap and easy, as well as effective. Eliminating a toxin that is everywhere—in the soil and in the walls—is technically difficult, fabulously expensive, and a logistical and administrative nightmare. Thus, the case of lead also demonstrates the limits of toxic use reduction.

After 20 years of research, struggle, and toxic use reduction, the major source of children’s exposure to lead is again leaded paint in old housing stock. The federal Department of Housing and Urban Development has just estimated that 57 million American homes have lead paint. Children under age 7 live in 10 million of them. They are overwhelmingly poor children of color. We have succeeded in removing lead from the environment of most white children.

In December 1990, the federal government announced its intention to eliminate lead paint from the nation’s housing stock over the next 10 years. The cost is about $2 billion a year, $20 billion over 10 years. Over the same period, we will spend $400 billion on the savings and loan fiasco. The feds are not saying where the money for eliminating lead paint will come from. Responsibility for lead abatement will be dumped in the lap of already strapped state and local health departments. Private landlords and home owners will be expected to delead their property. Real estate values are plummeting; foreclosures and evictions are up. Without a budget and funding mechanism, the federal government’s promised “strategic plan to eliminate childhood lead poisoning” will be a pipe dream, not a reality.

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Oregon Redux

Oregon wants to get going with its rationing plan. The idea gained earlier notoriety in winter 1990 when the Oregon legislature backed a plan by the state Health Services Commission to demonstrate that a cost-benefit means test of procedures would generate a more rational allocation of health resources. The plan was to "reorient" care from acute, high-cost procedures to basic care for Oregon's thousands of Medicaid recipients by withholding payments for certain high-cost items and giving the money to fund more prenatal and primary care. (A 1987 plan to put more funds into prenatal care has not put any new prenatal care visits into place in the state.) The "rationing" was being organized by a computer.

The computer set some priorities, and they were so absurd that the commission was embarrassed. The computer-generated set of health procedures had put thumb sucking and acute headaches over treatments for cystic fibrosis and AIDS. Immunizations for children were not on the list at all. According to a Science article in August 1990, Portland, Oregon, pediatrician Harvey Klevit said, "I looked at the first two pages of that list and threw it in the trash can." Others evidently responded similarly, and the Oregon Health Services Commission was forced to go back to the drawing board.

Oregon continued to look for a way to pay only for those procedures that have the highest ratio of costs to benefits. Now, the Health Services Commission is ready to go ahead with a new, less absurd list of health cost rankings. The commission hopes the new list will convince Health and Human Services Secretary Louis Sullivan to give Oregon a federal waiver to limit Medicaid coverage of things like kidney cysts and terminal HIV disease in order to free up money for more coverage of the poor for illnesses like pneumonia and ectopic pregnancy. The "highest benefit" list reads like basic care 101, but judging from the "lowest benefit" list, which also includes blockage of the retinal artery, superficial wounds, and pancreatitis, the state doesn't take pain and suffering much into account. The federal waiver would make Oregon the first state permitted to control monies targeted for Medicaid to AFDC beneficiaries.

Even with a more "reasonable" list (reasonable to whom?), the ranking of health care is obscene (see "Rationing the Irrational," Vital Signs, Spring, 1990). In hearings on Oregon's earlier attempts to get Congress to pass such a waiver, Representative Waxman was adamantly opposed: "If you're going to ration health care, you do it across the population, not just for poor women and children."

Of course, the real issue is why ration at all? Spending $600 million annually, the health care system is not in a state of scarcity. The Oregon plan is what we used to call "double-think"—"On behalf of the poor, we will cut support for services." We should all think twice about it.

—Nancy McKenzie

Blues Getting Greener

During the last several years, subscribers to Blue Cross and Blue Shield plans across the United States have watched their premiums regularly inflate at rates ranging from an alarming 10 percent up to a breathtaking 25 percent (see "NJ Citizens Stop Blue Cross Discrimination," Vital Signs, Winter 1990). Subscribers usually receive a "crying the blues" form letter from their plan prior to the premium increase. The letter explains that recent experience with bad claims have forced a reluctant insurer to hike premiums as an act of fiscal responsibility. Last year's bankruptcy of West Virginia's Blue plan offered a stark reminder that even a mighty Blue could succumb. That insolvency left West Virginia hospitals and doctors with some $50 million in unpaid bills and 270,000 subscribers temporarily without the health insurance they had paid for. (Blue Cross and Blue Shield of Ohio subsequently bought the West Virginia plan and merged it with a smaller plan in the state, and it now covers 300,000 members.)

So it may come as some surprise that, as reported in the December 17, 1990, issue of HealthWeek, an industry trade paper, almost all of the 73 Blues plans nationwide had net gains in 1990 totaling a record-breaking $2.2 billion. This spectacular, yeu miraculous, financial recovery of good eco-
nomic health began in 1989 and continued in 1990, despite a net loss of 500,000 subscribers and their premiums.

According to the insurance-speak of the Blue Cross and Blue Shield Association of Chicago (BCBSA) (which doesn’t insure anybody—it is a policy and planning “industry” organization), the 500,000 who left Blues plans weren’t “forced out”—they just left because they couldn’t afford the ever-increasing premiums. But the plans shed no tears, says BCBSA, because the ex-subscribers were likely to have been heavy users of medical care. Indeed, their leaving probably contributed to the increased surplus income. BCBSA would like their plans to accumulate double that amount—about 4.5 billion dollars in individual plan reserves. 1991 is predicted to also be a good year, but the surplus is expected to be smaller and will be used to reduce rather than eliminate premium increases. BCBSA believes that the Blues run in three-year cycles of feast and famine and that large reserves are necessary to be ready for the next lean period.

The facts appear to suggest that billions of dollars of surplus income are invested and earning interest for Blue plans, while tens of thousands of subscribers who can no longer afford escalating premiums join tens of millions of other uninsured Americans out in the cold. This is the kind of policy that gives strength to the arguments of health care advocates that the only acceptable reform of health care must be founded on the principles of single-payer, universal coverage and the elimination of the health insurance industry.

—Arthur Levin

If Not Now, When?

The AFL-CIO has done it again. Hard on the heels of its non-position on abortion (see “AFL Abstains on Abortion,” Vital Signs, Winter, 1990), the labor federation took a stand squarely in favor of pragmatism on health care reform. At its annual February meeting in Florida, the federation’s executive council of union presidents voted to support a watered-down version of health insurance reform, while reserving a Canadian-style national health insurance plan as a long-term goal. The compromise position supports mandatory insurance coverage financed by employers, known as “pay or play,” in which the employer either “plays” by providing a health plan for employees or pays into a government-financed pool for the otherwise uninsured.

Although health insurance reform has become a priority for the AFL-CIO (see “Labor Confronts the Health Care Crisis,” by Laura McClure, Spring 1990), member unions have taken widely divergent positions that were reflected in the intense debate leading up to the current compromise. The Oil, Chemical and Atomic Workers union has taken a strong stand for a Canadian-style system that covers all citizens and is administered by the government. The American Federation of State, County and Municipal Employees and the United Mine Workers union also called on the federation to maintain a stand in favor of a government-sponsored plan. Service Employees International Union President John Sweeney, head of the AFL-CIO health committee, although frequently a supporter of progressive issues, was a strong proponent of the pay-or-play plan. His allies, Building and Construction Trades President Robert Georgine and Bricklayers President John Joyce, were concerned that a national insurance plan eliminating private insurers would adversely affect union health and welfare funds.

AFL-CIO President Lane Kirkland supported the modified plan as having a more realistic chance of passing in Congress, which is expected to take up the issue later this year. The compromise was seen as allowing labor to be taken seriously by legislators as a negotiating force on Capitol Hill, while remaining on record as ultimately favoring a more sweeping reform. Notwithstanding the federation’s Health Care Campaign, launched in November 1989, and a less-than-successful “Health Day” on October 3, 1990, it has so far given no indication of plans to mobilize its 14.2 million rank-and-file members behind its proposal.

Long-time labor observers may take heart in the fact that the generally conservative labor federation has come out, even in principle, for national health insurance. But, even from a pragmatic point of view, if labor starts with a watered-down position, what will be left to negotiate with? And if labor leaders can’t take a strong stand now for a national system that will truly meet the needs of working people and their families, during the worst health care crisis in 30 years, when do they think they might be able to?

—Ellen Bilofsky
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