HEALTH APARTHEID IN THE UNITED STATES
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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- **Young Adults in the 1980s: Why Mortality Rates are Rising**
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- **Barriers to Care: The Case of Breast Cancer**
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The Emerging Health Apartheid in the United States

Critics of the U.S. health care system have made a cliche of the observation that among industrialized nations, only the United States and South Africa lack a national health care program. That comparison usually introduces a discussion of what reforms are needed here and what sort of health care system should serve as our model. Rarely discussed is another much more disturbing similarity between the United States and South Africa: the devastating impact of class and race on health status and access to care. In this issue of the Health/PAC Bulletin, we draw attention to the evidence that there is emerging in the United States a growing state of “health apartheid.”

Overcrowding in Bellevue Hospital emergency room, New York City.

The articles in this and past Bulletins chronicle some profoundly disturbing developments of the last decade, all of which hinge on class and race. They include the growing polarization between the poor and the rich in income and wealth; an alarming rise in poverty, homelessness, and despair; the rapid growth in the numbers of the uninsured and underinsured; and the widening gap in access to care, as seen in the contrast among the overflowing clinics, emergency rooms, and hospital beds for the urban poor, the absence of any care for the rural poor, and the excess of hospital beds and physicians for the affluent. This Bulletin adds more focused examinations of the economic backdrop to this crisis and of the growing racial disparities in health status, such as quantifiable “excess” rates of illness, disability, and death for black Americans and other people of color.

But disturbing as they are, disparity and polarization alone do not constitute apartheid. Apartheid requires isolation, stigmatization, and the legitimation conferred by ideology and policy. In this respect, over the last decade we have witnessed some ominous developments: increasing numbers of mentally ill and homeless persons without shelter or care; skyrocketing numbers of young people in prisons; and untreated social epidemics of drug abuse, HIV-related disease, and interpersonal violence. All of these disproportionately affect people of color. Moreover, these conditions and events, which isolate and threaten the existence of our most impoverished and vulnerable communities, are met by growing indifference. There is an increasing unwillingness to provide even basic, humane levels of sustenance, particularly for those who can be characterized as less than “worthy” of our concern. It is precisely the stigmatization and dehumanization of certain populations—for example, people in prison, intravenous drug users, and people sleeping in the streets—that permits government to adopt deliberate policies of malignant neglect.

President Bush elevated this neglect to official federal policy in his recent University of Michigan speech as he criticized the Great Society programs for misguidedly having “tried to assume roles once reserved for families, schools and churches.” No longer encumbered by his “kinder, gentler” disguise, the warrior president has revealed the mean spirit of his domestic policy agenda, as in his recent attempt to fund an infant mortality initiative by taking funds from community health centers and other programs serving minority communities.

In 1986, in a departing gesture as Secretary of Health and Human Services, Margaret Heckler released the seven-volume Report to the Secretary on Black and Minority Health. This report found 55,000 excess deaths among African-Americans each year—more deaths in a year than all the U.S. losses in the Vietnam War! Since 1986, conditions have only grown worse. Excess deaths now...
total 60,000. Were the United States judged on African-American infant mortality alone, we would rank 35th in the world, rather than our current rank of 24th. Considering just white infant mortality, on the other hand, would move us up into the top ten.

Byrd and Clayton's article in this issue on "The Slave Health Deficit" explores the specific disparities behind this toll. Disease by disease and condition by condition, they detail the devastating differences in the suffering of communities of color compared to that of their white counterparts. Yes, thanks to Heckler's report, we may now have a federal Office of Minority Health giving out tens of millions of dollars in grants each year. But this is sheer tokenism compared with the billions lavished on the Health Care Financing Administration or the National Institutes of Health—or with the actual magnitude of the need.

While Byrd and Clayton detail the catastrophic consequences of the convergence of racism and class, in "Barriers to Care: The Case of Breast Cancer," Barry Skura focuses on a single example to examine these dynamics in depth. What happens when women are locked out of health care, without access to breast cancer screening and treatment? And finally, Joseph Mangano uses another measure—excess deaths—to examine the recent ravages of illness and lack of access on America's young people.

Not since the Great Depression has it been worse to be poor in the United States. Over the last ten years, there have been dramatic changes in the depth and consequences of poverty. Today, poverty is more endemic, more difficult to surmount, and more structured into every institution of American life. It seals the fate of many, but none more assuredly today than those in our communities of color.

What has trickled down to the poor from the federal level is indifference, as cities and states, under growing financial pressure, cut funds from programs that keep people from death. In this issue of the Bulletin, McKenzie and Bilofsky document the systematic destruction over the last decade of the safety net of benefit programs that, while never lifting people out of poverty, in the past kept many perched just this side of misery, despair, and destruction.

Rodrick and Deborah Wallace carry the argument beyond the notion of mere neglect in their article, "Contagious Urban Decay and the Collapse of Public Health." They identify an intentional policy of social and community destabilization and examine its effects on the health and well-being of the poor.

The notion of a U.S. health apartheid is a sobering one for health activists. Debate about national health care and universal access has become more intense than at any time since Truman's presidency. And, while health system reforms can redress some aspects of health apartheid, it is clear that they cannot address the tragic consequences of de facto social and economic apartheid.

Public health and medical care advocates must join forces with those fighting racism and with advocates for housing, nutrition, education, community development, economic access, and social welfare to forge a coalition that confronts this growing apartheid-like division in American life. The discussion of need, medical access, and poverty must include an assessment of institutionalized racism that, like de jure apartheid, separates communities of color from political power and full economic participation. We must include, too, a critique of the ideology that suggests the poor and the sick deserve the conditions from which they suffer, and society has no larger responsibility.

The United States and South Africa share yet another frightening social attribute. They rank the two highest among the world's nations in the percentage of their populations in prison. We strongly reject the official policies of apartheid for which South Africa stands. Can we ignore the policies that increasingly spell health apartheid in the United States?

—The Editors

David Axelrod: Old Fashioned Leadership

We would be remiss if we did not take time to express our sorrow over the tragic stroke suffered by Dr. David Axelrod and as well our sense of loss at his retirement as New York State's commissioner of health after 12 years of selfless service.

Dr. Axelrod exhibited a unique dedication to public service and the health of the residents of New York State, and as a result was considered by many to be a national model for what aggressive health policy leadership could achieve. Believing in and fighting for a more humane and responsible health care system, he often became the vilified "target" of the enmity of both organized medicine and the hospital industry.

We didn't always agree with the commissioner's decisions, some of which seemed to be exactly contrary to his own stated public and community health objectives. His unwillingness to depart from the academic medical center model, his belief that hospitals could be bludgeoned into becoming agents of community-based ambulatory care, and his stubborn faith in the powers (Continued on page 12)
Shredding the Safety Net
The Dismantling of Public Programs
NANCY McKenzie AND ELLEN BILOFSKY

Despite the promise of Ronald Reagan's budget director, David Stockman, in 1981 that they would preserve a safety net for the nation's needy, monumental and continuing cuts in what might be called the "safety net" programs—programs that guarantee a minimal standard of living in terms of food, shelter, and health care for the poor—have taken place over the last decade. And these already decimated programs are being further dismantled just when they are needed more than ever to offset the effects of the current recession.

This overview of the safety net essentially assumes that the anti-poverty programs of the 1960s and 1970s worked in keeping people poised above abject poverty. And they did. The programs did not bring people permanently out of poverty by giving them economic independence, but they did keep them from starvation and death's door. What is different now is the level of immiseration to which individuals are allowed to sink. In the last ten years, while economic conditions for the poor have deteriorated, discretionary programs intended by Congress to target poverty and disease have been gutted.

The only major program that has held its own financially in the last 11 years has been food assistance, with a modest expansion of the Special Supplemental Food Program for Women, Infants and Children (WIC). But, as in other entitlement programs, changing eligibility criteria have shut many people out of federal food programs, even as some specific groups were targeted for special assistance. The story of entitlements for those in need is not a seamless one, but, overall, the federal government has given with one hand and taken back with the other.

Nancy McKenzie is Executive Director of Health/PAC, and Ellen Bilofsky is Editor of the Bulletin.
Starting in the early 1980s, the progress toward eliminating hunger in this country that began in the late 1960s with WIC, food stamps, school meals, and food programs for the elderly began to be reversed by a combination of economic factors and budget cuts in discretionary programs.

All safety net programs have been cut, failed to keep pace with inflation, or have lost their effectiveness in the face of the population's multiplying needs. The longer these needs remain unmet, the harder it becomes to reverse the trend (see Figure 1). And, economic and social conditions, exacerbated by this dwindling of public benefits and resources, tend to make health and health care delivery a focal concern of the poor.

Unemployment, for example, is a major correlate of ill health because it undermines a person's ability to address physical needs—either directly, through food and shelter, or indirectly through medical care. Inadequate housing is also a major factor in the destruction of health. The poor currently divert a huge proportion of their income to housing—78 percent in 1986. And lack of housing is not only a cause of disease but is a major obstacle to people's attempts to regain their health by obtaining health services. When cuts in health services are added to unemployment, homelessness, and the illness consequent upon them, a line to recovery is broken. Many individuals become irrevocably lost to social and health services. And the sum of their neglect (in the devastation of individuals and their communities) is greater than its parts.

Economic Backdrop

Unemployment and Underemployment. The effects of the recession that began in 1987 have been greatly magnified by the cumulative erosion of the safety net programs—and vice versa. Unemployment (as measured by unemployment insurance claims alone) was fairly low going into the current recession—5.3 percent in June 1990. But in the next nine months it climbed to 6.8 percent, representing 543,000 new claims. The total number of unemployed is now nearly 8.6 million. This is the highest rate since January 1983, the peak of the last recession. The numbers of discouraged workers, long-term unemployed, part-time workers who would prefer full-time jobs, and the length of unemployment—none of which are represented by the official unemployment figures—are also increasing. And, to add to the burden of those looking for work, 1.5 million jobs have been eliminated since the summer of 1990, and that trend is expected to continue even after the economy recovers.

In addition, because of tighter federal and state unemployment insurance regulations, far fewer of the unemployed are eligible for benefits or are receiving them than in the past and fewer qualify for extended benefits beyond 26 weeks. Only about 37 percent of unemployed people received benefits in 1990, compared with as many as 75 percent of the unemployed in the 1974-75 recession (see Figure 2). According to the Center on Budget and Policy Priorities (CBPP), "in the 35 years for which data are available, the nation has never entered a recession with such a weak unemployment program." Moreover, federal funds for employment and training programs to help jobless workers find new employment fell 56 percent from fiscal year 1981 to 1991 (after adjusting for inflation), and many of these programs would be cut further under Bush's proposed 1992 budget.
to the Census Bureau, 13 percent of the population—11.7 percent of whites, 20.2 percent of blacks, and 26.5 percent of Hispanics—are uninsured.

There have also been great changes in what employment represents. A full-time job no longer guarantees benefits or even economic security, particularly if a family has only one wage earner, and currently one-third of those employed in the United States are part-time or temporary employees. This means that they are largely cut out of job security or health and retirement benefits. The minimum wage has not kept pace with inflation, and real wages have declined across the board. According to CBPP, in 1990 average wages were at their “lowest level of purchasing power since 1964.” As the economy has shifted to low-paying, largely service-sector jobs (one-third of which are temporary or part-time), “half of all jobs created since 1980 fail to keep American families out of poverty.”

The poor were already hurting as we entered the current recession in 1989, with the U.S. poverty rate at 12.8 percent. Although this was down from the previous high of 15.2 percent during the 1983 recession (see Figure 3), this “recovery” figure is higher than it was at any time in the 1970s and is only the starting point for the current downturn. Poverty, of course, does not affect all segments of the population equally: In 1984, the average income of blacks was 57 percent that of whites. Moreover, the criteria used to establish the official poverty level, as we know, creates an artificially low standard. Currently, the federal poverty level is set at an annual income of $6,280 for an individual, $8,420 for a family of two, and $12,700 for a family of four. Is it necessary to state that without additional assistance, more than 31 million Americans living on $6,280 or less per individual translates into hunger, homelessness, and sickness?

As already noted, federal and state budget cuts have taken their toll on unemployment insurance, the government’s “first line of defense during a recession.” Moreover, two forms of cash assistance to the poor, AFDC and state or local general assistance programs, have been cut back over the last decade. A single-parent family of three living at 75 percent of the poverty level that was eligible for AFDC benefits in 42 states in 1980, would today qualify for benefits in only nine. Maximum AFDC benefits for a three-person family fell 39 percent from 1970 to 1990 (adjusting for inflation), and 18 percent from 1980 to 1990.

But the cutback in benefits is not the only gauge of the jeopardy for the nation’s poor. In addition, the length of time individuals, families, and communities have suffered from unemployment, housing, and multiple medical needs, as well as the degree of their current immiseration, affects the possibility of their recovery from impoverishment. According to Brown and Gershoff, government programs to aid the poor are less effective than they were 12 years ago. “In 1979, almost one of every five families with children who had incomes below poverty was lifted above poverty by federal cash benefits programs. By 1986, that ratio had dropped to one of every nine families.” Whole communities have been affected by federal policy on employment, housing, and health care (see “Contagious Urban Decay and the Collapse of Public Health” in this issue).

### The effects of the recession have been magnified by the cumulative erosion of the safety net programs—and vice versa.

New Cuts. Bush’s current budget proposals promise more of the same. The budget would slash $46.6 billion in benefit payments to individuals in the next five years. Although these cuts—in Medicare, veterans’ benefits, school lunches, farm subsidies, and student loans—were framed as targeting mainly middle- and upper-class individuals, they will nonetheless further undermine already vulnerable populations.

Where the Cuts Are

**Housing and Communities.** A major factor in the current health care crisis is the loss of federal subsidies for low-income housing and housing assistance programs. Between 1980 and 1992 (if Bush’s latest cuts go through), total housing and community development assistance will have fallen by 63 percent when adjusted for inflation (see Figure 4). These losses include a more than 50 percent decrease in community development block grants, the elimination of urban development grants, and a 61 percent decrease in Section 8 lower income housing subsidies. Rural programs for housing declined by 75 percent. As the table shows, these cuts have targeted those groups most likely to have multiple health needs—low-income inner-city and rural communities and the elderly, handicapped, and homeless.

**Health Care.** Health program funding showed large and definitive declines over the decade, with the exception of Medicare and Medicaid entitlements and specific infusions for crisis responses in 1990 and 1991. Indeed, some of
the most effective and important health programs have already been eliminated.

Neighborhood health clinics, for example, were established in the 1960s and 1970s with direct grants from the federal government under the Office of Economic Opportunity. Some of them were later funded by the Public Health Service and specifically mandated to serve pregnant women as well as children. The clinics were directly responsible for the decreases in excess mortality and infant death rates that began to occur in the 1960s. At the high point of federal support there were one-third more community clinics than there are now. Many clinics still remain, but their funding is largely through Medicaid benefits, which hardly cover costs, although some receive county, city, or state funds.

These community clinic programs received a welcome boost from the National Health Service Corps. This federal program of support for physicians had three parts: medical scholarships for individuals willing to work in community clinics in underserved areas; loan forgiveness or payback of medical school costs to encourage physicians to locate in these communities; and direct payment of salaries

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### Table: Selected Human Services Budget, Fiscal Years 1980-1992

<table>
<thead>
<tr>
<th>Budget Authority</th>
<th>FY 1980 (in millions of dollars)</th>
<th>FY 1982 (in millions of dollars)</th>
<th>Percentage change</th>
<th>Real growth (percent)</th>
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<tr>
<td>Health</td>
<td>FY 80-82</td>
<td>FY 80-82</td>
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<td>Medicare</td>
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<td>$113,811.0</td>
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<td>150.0</td>
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<td>533.6</td>
<td>30.6</td>
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<td>Alcohol/Drug/Mental Health Block Grants</td>
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<td>1,311.8</td>
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<td>Preventive Health Block Grants</td>
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<td>107.5</td>
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<td>AIDS - CDC Funding</td>
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<td>AIDS Health Services</td>
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<td>Food and Drug Administration</td>
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<td>118,204.6</td>
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<td>30,853.9</td>
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*Figures in parentheses are totals of included programs.
The only major increase for health services in Bush's 1992 budget is for immunization. His proposal for a program to fight infant mortality in ten cities created an uproar when he announced plans to fund it in part by cutting $24 million from community health centers and $34 million from Maternal and Child Health Services Block Grants. Congress rejected this plan and instead appropriated $25 million for the campaign in fiscal year 1991. However, Bush still wishes to divert money from these programs in 1992, despite their proven effectiveness in aiding low-income communities and individuals. If Bush's proposals go through, block grants for maternal and child health, as well as for preventive health, will have declined by about a fourth over the decade, although some of these losses are recouped by the expanded eligibility for maternal and child health within Medicaid programs.

Medicaid and Medicare

The only exceptions to the marked decrease in federal support are the entitlement programs, such as AFDC and Medicaid, whose funding is mandated for every eligible individual. The budget increases in these programs actually indicate trouble, however—either that more people are entitled to benefits and are enrolled or that inflation has increased the cost of the coverage. Over the last 11 years, coverage in these programs has become thinner in many states, since the states have discretion over the level of poverty at which benefits begin. There is also wide variation in the kinds of coverage or eligibility an individual receives under Medicaid. New York, for instance, which has a very progressive policy covers almost all health care costs, while Alabama allows individuals access to Medicaid only if family income is below $1,700.

There have been constant attempts by the federal administration to control costs for both Medicaid and Medicare, but the cutbacks have not been instituted with the ferocity that they have been in other benefit programs. This has to do with the fact that the constituency for Medicaid and Medicare is not only the poor and elderly but also medical providers, who have resisted cuts in reimbursement for their programs.

Although funding for Medicaid has increased in real dollars by 152 percent between 1980 and Bush's 1992 proposals, it only covers 38 to 40 percent of the poor. Unlike Medicare, it is not indexed to inflation in most states. And, as recent analyses point out, having Medicaid is not synonymous with access to medical care when, for instance, only 25 percent of doctors in New York State participate in the program, even though New York State itself is one of the most vigorous supporters of public benefits through Medicaid. Moreover, more than 60 percent of Medicaid benefits nationwide go to nursing home residents who have exhausted their resources.

Besides the fact that only 40 percent of Medicaid goes to the poor, the benefits they finally receive may be altered by the way states seek to control their mandated participation in the programs offered to their residents. States can and have made large gains in balancing budgets that were drastically reduced by the withdrawal of federal funds by juggling Medicaid funds. Where benefits are mandated by

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Unemployment is a major correlate of ill health because it undermines a person's ability to address physical needs.

Under Bush's current plan, funding for family planning clinics will have been reduced by 40 percent (in real dollars) between 1980 and 1992. In 1992, Bush proposes to cut grants for health professional education by 76 percent, and health services to those living in congregate housing would be eliminated altogether. Alcohol, drug, and mental health programs grew by 36 percent from 1980 to 1992, but this gain was almost entirely related to drug monitoring, interdiction, and control. Bush is proposing that federal grants for advocacy for the mentally ill and mental health clinical training programs be eliminated altogether in 1992. And the president plans no additional funding for AIDS health services in 1992, which in real dollars represents a 4 percent decrease of an already grossly inadequate response to the epidemic.
federal programs, for example, states are trying to make compensatory cuts in optional benefits. Recent federal rules mandated increased benefits for maternal and children's health services to take place in July. To compensate, some states are proposing cuts in optional services such as dental, optometric, podiatric, and chiropractic care and hospice care for the terminally ill, as well as in optional coverage of people who are not poverty stricken but whose resources have been depleted by high medical bills. Others are seeking federal waivers to reorganize public hospitals and emergency rooms are the repository of those who are no longer kept from disease and death by a safety net of benefits.

“priorities” within Medicaid benefits to their residents (see “Oregon Redux,” Vital Signs, Spring 1991). And it is now a well-established practice for states to try to cut down on Medicaid health costs by subcontracting services through increasingly mandatory prospective payment programs.

Medicare spending has increased enormously in the past 11 years, but there has been a drastic cutback in what a Medicare dollar buys in yearly health care costs. Medicare A (part one of the Medicare Trust Fund) pays for hospitals and completely covers elderly and disabled beneficiaries. Individuals must purchase Medicare B—the “major medical” part that pays for doctor care, preventive care, and some limited long-term care. Besides the monthly premiums, they must also pay out-of-pocket co-payments and deductibles. As a result, Medicare may, in fact, cover only 60 percent of beneficiaries' yearly health care costs. The secretary of health has the option to increase Medicare co-payments and deductibles, and this option has been exercised repeatedly over the last 11 years.

In late 1990, Bush signed legislation to cut Medicare payments to hospitals, doctors, laboratories, and suppliers of medical equipment by $32 billion over five years. Then, in February, he proposed $23 billion of additional cuts, the largest of which would be in payments to private teaching hospitals, which serve greater numbers of poor, inner-city, and sicker patients. As these cuts limit access to urban teaching hospitals, more of the poor will be shunted to the nation’s public hospitals, another weakening segment of the safety net.

Transferring the Burden

Reagan’s “new federalism” shifted much of the burden for maintaining the safety net to the states (and Bush's 1992 budget includes additional new federalism proposals), without a concomitant shift in resources. This “transfer” has amounted to an abandonment of federal responsibility. And the states are not going to be able to pick up the slack from federal budget cuts. On the contrary, state and local budgets are being squeezed as never before by contracting revenues and cuts in federal grants. Between 1980 and 1990, federal funds as a percentage of city budgets declined by 64 percent, from an average of 17.7 percent to 6.4 percent in 1990.

Moreover, most states are required by law to balance their budgets. Thus, the New York Times reports that “legislators in almost every state have considered cuts in health, welfare or housing programs, even as the demand for assistance rises.” The programs being targeted are, as already noted, some of the most basic safety net programs supporting the poorest of the poor—AFDC, Medicaid, and certain housing programs.

The Arena of Last Resort

Concern over access to health care has increased in recent years along with the dramatic increases in the numbers of the uninsured and the almost impossible burden placed on public hospitals. As this brief review tries to make clear, this is the result of an unprecedented confluence of factors, as increasing health care costs converge with the federal government's decreasing political willingness to offer a financial response and with a new level of impoverishment and immiseration that is affecting the health status of low-income communities.

It is not surprising, then, that America's public hospital system is operating at a great deficit. Members of the National Association of Public Hospitals (NAPH)—over 100 hospitals across the country—
averaged 30 percent operating deficits in 1988. Occupancy rates in these hospitals are over 80 percent, and the individuals served are those most affected by the worsening economy and distorted priorities of the United States over the last 11 years. Minority communities in particular rely on a shrinking number of providers, largely in emergency rooms. In inner-city hospitals, 50 percent of all admissions are through the emergency room.  

When individuals already affected by poverty and homelessness develop multiple health problems, and these affect their employability or their ability to hold on to their housing, recovery becomes almost impossible. As the downward spiral of loss of employment, food, and housing is hastened by the wholesale decimation of programs that kept people from going over a physical and emotional precipice, health care delivery becomes the last stop before the final outcome—which is, of course, death. When health care delivery itself becomes impoverished, it is unable to intervene effectively. Excess deaths and early debilitation are the results.

The end stage of this downward spiral, which got its momentum from the “new federalism” of the 1980s, is that the public hospitals and emergency rooms across the nation have become the repository of those individuals who are no longer kept from disease and death by a safety net of benefits. These refuges are themselves suffering a striking depletion as a result.  

The “new federalism” included more than the “dismantling” and “transferring” of federal programs. It also included “cost/benefit” policies—the term for deregulating the workplace and removing the environment from federal oversight and responsibility and for the introduction of market principles into the federal services that remained. Like the institution of DRG (diagnostic-related group) categories for in-hospital treatment under Medicare financing in 1983, these strategies affected the poor and powerless directly in myriad untold ways. The end stage of this downward spiral, which got its momentum from the “new federalism” of the 1980s, is that the public hospitals and emergency rooms across the nation have become the repository of those individuals who are no longer kept from disease and death by a safety net of benefits. These refuges are themselves suffering a striking depletion as a result.  

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On the occasion of Ronald Reagan’s election in 1980, progressives across America were outraged at the new “trickle down” ideology, fearing that the new order would substantially harm the poor. Few, however, no matter how long their view, foresaw how far-reaching the affects would be. Today, as we witness the substitution of shelters and streets, prisons and hospitals, for communities, jobs, and housing, and see death becoming the baseline of the new poverty, we are stunned by the magnitude of the devastation.  

2. Ibid., p. 436.
3. Unemployment was 10.7 percent in January 1983. The worst unemployment since the 1930s was 10.8 percent in the 1981-82 recession. Uchitelle, Louis. “New Jobless Claims at 8-Year High,” New York Times, April 4, 1991; and Hershey, Robert D., Jr., “Jobless Rate Rose to

Congregate shelter for homeless families, Roberto Clemente State Park gymnasium, Bronx, NY.

7. Ibid., p. 19.
11. Shapiro and Greenstein, op. cit., p. 4; and Brown and Gershoff, op. cit. The number of officially poor in 1983 was 31.5 million. In 1989, each additional percentage point in the poverty rate represented 2.5 million people. With today’s larger population, even though the poverty rate is lower, about 31 million people are still living below the poverty line.
25. See ibid., especially p. 4.
based ambulatory care, and his stubborn faith in the powers of regulation and micromanagement could be frustrating. But Dr. Axelrod was also willing to listen to and involve those most affected by his decisions, be they normally unheard community groups or labor unions.

In New York State Dr. Axelrod crafted many elements of a uniquely progressive and compassionate health care system: parity for Medicaid inpatient rates that eliminated financial reasons for hospitals to discriminate against the poor; a bad debt and charity care pool to cover large portions of the cost of treating the uninsured; emergency room requirements that have minimized patient dumping among New York hospitals; and regulations that virtually rule out profit-making hospitals.

Dr. Axelrod had an admirable commitment to public access to information about the performance of hospitals and doctors as a means of improving the quality of medical care and weeding out the incompetent. Under his leadership, the Department of Health improved data collection and analysis, beefed up its hospital incident and complaint investigations, and produced a number of quality health education and information materials. The latter include manuals on childbirth, caesarean section, and environmental and occupational toxics and reports on hospital hysterec-tomy and caesarean section rates. Dr. Axelrod understood the overriding need for confidentiality in regard to HIV status for patients and practitioners alike and enabled New York City to attempt an experiment in needle exchange.

Finally, Dr. Axelrod represented what some today might characterize as an "old fashioned" style of leadership. He exhibited a steadfast vision of the moral responsibility of doctors and hospitals to the public health, accepted a wide breadth of responsibility, and used his mastery of the tools and power of his office to achieve goals he thought would better health outcomes across the state.

We can only hope that whomever Governor Cuomo decides to appoint as New York State commissioner of health will bring to that office a similar commitment to accessible, good-quality health care and the will and strength to take on the feisty and powerful established medical and hospital interests. —Arthur Levin

Goodbye and Hello

Rod Sorge, our office manager, assistant editor, and in-house activist has left Health/PAC for more hands-on work. Rod will now be director of the new Harm Reduction Institute of the PWA Health Group. Health/PAC has gained enormously from Rod's energy and talents. We don't really lose Rod, however, but gain a colleague and an affiliation with the rights and health need of people who use drugs. Rod has agreed to serve on the Health/PAC Board, and we look forward to future collaboration.

We welcome Sharon Lerner, policy assistant at the Gay Men's Health Crisis. Sharon, another multi-talented activist and writer, comes on board in the middle of many changes here at Health/PAC. We are excited to have her with us and expect that she will not only weather the transitions but help us shape our future.

As a biological phenomenon, HIV is indifferent to politics, social status, or sexual preference, but as a national health crisis AIDS raises a number of complicated social, economic, and ethical issues. With pieces by leading researchers, activists, and social commentators, The AIDS Reader is a strong, well-rounded collection about one of the most important issues of our day.

The Crisis in Health Care

A thought-provoking anthology that addresses the major social, political, and medical issues in American health care, The Crisis in Health Care offers an authoritative and compassionate look at the major challenges facing our health care system — and what we can do to meet them successfully.
Contagious Urban Decay and the Collapse of Public Health

RODRICK WALLACE and DEBORAH WALLACE

Rodrick Wallace and Deborah Wallace have done considerable research on the relationship between public health deterioration and the destruction of housing and communities in New York City. A version of the original study from which this excerpt is drawn was published in the Bulletin of the New York Academy of Medicine (September-October 1990), and contains a detailed examination of the epidemic of housing fires and abandonment, population migration, and deterioration of health conditions in New York City during the 1970s and 1980s. The section of the paper presented here, most of which has not been published elsewhere, walks the reader through a hypothetical example of the process of urban decay, showing in capsule form the interrelationship between the loss of housing and the health care crisis.

Wallace and Wallace take the widespread burnout and destruction of the South Bronx between 1974 and 1978 as their model of urban decay, but similar processes of devastation have affected inner-city areas across the country. The authors believe that much of the deterioration in the South Bronx stemmed from a policy of “planned shrinkage” on the part of the city—deliberate abandonment of the area (as well as other sections of New York) by cutting municipal services, fire services in particular, in order to displace the largely minority population and open areas for urban and industrial renewal. While many may not accept this theory of the origins of urban decay, this does not alter the usefulness of the Wallaces’ analysis of its results.

The urban afflictions of homelessness, addiction, mental illness, AIDS, and sick children overwhelming our hospitals, and crime and violence overwhelming our neighborhoods and jails, are not separate and disparate problems. Rather, they are part of an interwoven pattern of urban ecological collapse and desertification whose remedy requires degrees of understanding and political will not often brought to public problems in the United States. This article examines the interplay between destruction of housing and community and the general collapse of public health. We examine how New York City’s housing famine and the processes that caused it have produced several parallel, interacting public health crises that disproportionately affect communities of color and that are deeply implicated in the conditions of “medical gridlock” that now affect New York City’s hospitals. What we see in New York City, through implementation of “planned shrinkage,” is an apparently deliberate reversal of the great advances in public health made during the first part of this century that followed upon vast improvements of the living and working conditions of the poor.

Urban Decay and Public Health

Tuberculosis is a classic historical and, increasingly, current example of disease involving housing, overcrowding, social disintegration, and truncation of social networks. It has been suggested that onset of the epidemic of acquired immune deficiency syndrome (AIDS) accounts for recent increases in tuberculosis in New York City. Historically, however, tuberculosis is intimately related to the social conditions of the poor, conditions which have recently deteriorated badly there. But it would be difficult in any event to invoke the deus ex machina of AIDS to explain the patterns of irregular increase in homicide, suicide, gonorrhea, salmonellosis, drug abuse, elderly and infant mortality, low birthweight, rat infestation, and medical gridlock since the mid-1970’s. On the whole, another simpler and more unifying hypothesis suggests itself: that the massive, continuing destruction and disintegration of housing and community (which results from a continuing failure to provide the municipal services needed to maintain urban population densities—the implementing of New York

The massive destruction and disintegration of housing and community are having serious impacts on public health and welfare.

Rodrick Wallace is a research scientist with the Epidemiology of Mental Disorders Research Department, New York State Psychiatric Institute, Columbia University. Deborah Wallace is President of the Public Interest Science Consulting Service of New York City. This article is based on a presentation given at the Workshop on Housing and Health: Interrelationship and Community Impact, held by the Committee on Public Health of the New York Academy of Medicine, New York City, November 1989. Address comments to the authors at 549 W. 123rd Street, #16F, New York, NY 10027.

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Health/PAC Bulletin
City’s planned shrinkage program among black and Latino communities are having serious impacts on public health and welfare and on utilization of health services.

We are suggesting that the consequences of withdrawing municipal services from poor neighborhoods and the resulting outbreaks of contagious urban decay and forced migration that shred essential social networks and cause social disintegration have become a highly significant contributor to the decline in public health among the poor. This process of urban decay is probably also a strong ultimate cause of serious behavioral pathology, which expresses itself, among other ways, in chronically rising mental illness, substance abuse, violence, and homicide.

A large literature shows that proper socialization, the prevention of psychiatric illness, and the control of socially unacceptable behavior and violent outbreaks all require strong personal, domestic, and community networks within as socially integrated a community as possible. A review of the criminology literature shows how the loss of social integration and networks, from planned shrinkage or other causes, is destined to increase such behavioral patterns. These patterns themselves become convoluted with processes of urban decay that are likely to further disrupt social networks and cause further social disintegration.

These processes may, we suggest, be a fundamental cause of the patterns of rising usage of the health care system that are causing medical gridlock in New York City—that is, a nexus of increasing rates of low birth-weight, rising substance abuse, and associated psychiatric disorder, all compounded with the relentlessly increasing incidence of AIDS, which may itself be convoluted with the process of contagious urban decay. If so, then no conceivable system of acute medical care provision can meet the health needs of a poor population for whom living and social conditions are rapidly deteriorating, thus causing a decline in general health status, and for whom, further and consequently, public health measures have failed. That is to say, a purely medical intervention paradigm will be ineffective, and compulsive fiddling only with the modalities of acute health care provision cannot solve this crisis. As the living and working conditions of New York City’s black and Latino poor regress toward those of the 19th century, so inevitably must their health status, irrespective of purely medical interventions.

A Hypothetical Example

Let us take a walk through a hypothetical example showing the nesting of critical phenomena and variables in a single outbreak of recurrent contagious urban decay and its intertwining outcomes.

Suppose a community is subjected to reductions in municipal services or other conditions that trigger an outbreak of contagious urban decay. That is, levels of municipal services cease to be adequate to maintain urban levels of population density and to preserve badly overcrowded housing units.

First, a number of geographically scattered occupied buildings deteriorate and are abandoned by their landlords, some as the result of uncontrolled fires. After a time, buildings close to those initially abandoned are also abandoned and receive no maintenance services, so that the initial scattering of individual abandoned buildings becomes a scattering of clusters of abandoned buildings. Some of these, in turn, suffer fires or other disasters and become vacant. People begin to move out of abandoned or nearly abandoned and occupied buildings, causing deterioration in their own domestic and personal networks and in the surrounding community network.

Legitimate neighborhood economic activity begins to decline rapidly as outmigration proceeds.

Vacant and abandoned buildings now become centers of illicit activity, mainly drug related, further accelerating neighborhood decline. Fire becomes ubiquitous in the
affected neighborhoods, and fire setting in vacant build-
ing becomes customary, driving many from still-sound
nearby occupied buildings. Many of the stronger people,
with the financial and emotional resources, now move
completely out of the neighborhood, further seriously
depleting community networks. The initial clusters of
abandoned and vacant buildings now grow greatly and
coalesce into a moving front of fire and abandonment.

A population concentration, bringing with it badly
overcrowded housing, flees in a wave before the
oncoming front of abandonment and fire. Those in the
wave suffer increasingly depleted personal and domestic
networks, as do those left behind. Indices of public health,
including contagious disease and infant mortality, begin to
show serious degradation among both the displaced pop-
ulation and that left behind, as social nets disintegrate for
both groups.

Children, forced to move time and again, and to contin-
ually reform their own networks of friendship, fail to learn
to read. Schools increasingly seem to “fail.” Collapse of
social networks before and behind the urban decay front
triggers violent episodes within and between families and
“acting out” by children, who are now largely unsuper-
vised outside of the home. Gangs of unsupervised adoles-
cents congregate on street corners, contributing to a
sudden, marked rise in street crime and initiating many
criminal careers.

Rising levels of criminal activity, coupled with
decaying levels of legitimate neighborhood economic
activity, further accelerate the process of abandonment by
landlords.

Those individuals with marginal mental disorders who
had relied on support from personal, domestic, and com-
munity networks now begin to require increased hospital-
ization, often for more extended periods. Moreover,
collapse of networks and decline of “quality of life” con-
tribute to the community’s disempowerment and helplessness
and feed back into processes of contagious urban
decay and further deterioration of mental and public
health. Substance abuse and homicide become ubiquitous
in the devastated neighborhood, and begin to rise among
displaced refugees with truncated social networks who are
now crowding into nearby neighborhoods.

As we have shown for the Bronx, what had been a
sharp geographic concentration of intravenous drug
abuse, the principal vector for the introduction of HIV

Compulsive fiddling with
the modalities of acute
health care provision only
cannot solve this crisis.

infection to the heterosexual population, now becomes
broadly diffused throughout many neighborhoods. These
neighborhoods suffer truncation of the social networks
needed to successfully diffuse information about the con-
trol of AIDS and to reinforce limitations on high-risk
behaviors. This seriously compromises subsequent
attempts to control the spread of HIV.

Neighborhoods near those that burned, which received
displaced refugees from devastated areas, begin to suffer
severe housing overcrowding and stress on the social net-
works of the original residents, who themselves begin to
move out from underneath the avalanche of refugees. The
conditions of “susceptibility” to contagious urban decay,
which underlay destruction of the first community—
extreme housing overcrowding coupled with extreme
poverty—now begin to exist in those nearby areas that
were forced to receive displaced refugees.
The vast wave of outmigration by more affluent, largely white, middle-class residents from the now-deteriorating neighborhoods that absorbed refugees temporarily makes available their generally larger apartments to the displaced poor, lowering the percentage of badly overcrowded housing occupied by the very poor. Thus, the number of housing units susceptible to the fire/abandonment process falls below the epidemiologic threshold, and the initial outbreak of contagious urban decay begins to slow.

A large remnant elderly white population remains in the previously middle-class neighborhood now overwhelmed by displaced refugees. As the richer white population evacuates, these elderly become more and more isolated, and are often unable to make social connections with the refugees of color who move into the neighborhoods, themselves suffering, and suffering from, depleted social networks. Along with the increase of substance abuse among the displaced refugees comes an inevitable increase in victimization of this remnant elderly population, both from the general rise in community violence that comes with increased social disorganization, and from their particular targeting as “easy marks” for mugging or push-in robbery.

As fires decline in the partly devastated neighborhood, the municipality begins even further reductions of essential municipal services, causing faster outmigration of the population into adjacent, “ripening” areas, hastening renewed outbreaks of contagious urban decay.

Contagious loss of housing continues in the already devastated areas, driving doubled-up residents, many of whose friends may have moved from the neighborhood, into homelessness, as middle-class outmigration from the city slows.

The now-inevitable outbreaks of disease in the newly crowded zones, particularly intensified by homicide, substance abuse, and AIDS, also contribute materially to increasing the susceptibility of these areas to contagious urban decay by encouraging another round of outmigration by those with the resources. Behavioral and mental disorders, substance abuse, violence, contagious disease, and contagious urban decay have become obsessively intertwined.

Now the health care system begins to become overburdened by the sudden increase in the rate of low-birthweight babies; by dual substance abuse and psychiatric disorder; by AIDS; and by the impossibility of finding housing for convalescent indigent patients outside of shelters for the homeless.

As homelessness proceeds and the poor begin doubling up again, housing overcrowding in poor neighborhoods begins to rise. The stage is now well set for another outbreak of contagious housing destruction in the newly overcrowded regions, and for its severe impact on community, domestic, and personal social networks. Thus, in the absence of effective interventions, a full-scale process of urban ecological collapse synergistically amplifies and replicates itself, just as the consequences of the first outbreak become unmanageable.

Housing Famine and the Collapse of Health Care

New York City’s low-income housing famine is evidently the most important cause of its crisis of homelessness, although the exact mechanisms may be subtle. We have suggested here a necessary parallel track to homelessness: deterioration of public health and an inevitable resulting collapse of health care provision. Thus, the concept of a housing famine provides a unifying paradigm that may help us understand, explain, and correct many otherwise disparate aspects of the accelerating New York crisis.

The dynamic nature of the failure of public health in New York City suggests that until emergency measures—including provision of adequate housing for the poor and success of programs to reestablish their social networks—can take effect, demand for acute medical care can and probably will continue to increase relentlessly and without foreseeable limit. What may be limited, however, is provision of medical care for the poor. Just as the effects of the housing famine are structured according to our social hierarchy, falling most heavily on the poor, so too may be the effects of medical care shortfall. The revenge of the poor may be to die on the doorsteps of the rich, raising, beyond certain moral niceties, questions regarding the value of real estate in a plague city.

In short, the “slow disaster” of contagious urban decay triggered by planned shrinkage has, after a relatively short delay, become a housing famine that, classically, is rapidly evolving to an interacting complex of “slow plagues,” increasingly overwhelming the city’s medical care system. The public health outcomes of urban burnout may, in fact, constitute yet another great disaster, as may the parallel track of collapsing public order.

In any event, it is now clear that other, more rapid and more contagious, plagues are no longer inconceivable in New York City. Both medical care and public health mea-
or, in some cases, as early as 1974, rapidly accelerating in the late 1980s. The evident Occam’s razor hypothesis is that deterioration of public health and health care in New York City, possibly including psychiatric illness, substance abuse, low birthweight, and a whole spectrum of behavioral pathology, is intimately related to massive “planned shrinkage” destruction of housing, and hence of community, in poor neighborhoods caused by outbreaks of contagious urban decay. The destruction of low-income housing has, likewise, become one of the principal wellsprings behind the city’s burgeoning parallel crisis of homelessness, which may have its own, separate but related, dynamic impacts on public health and health care.

The evidence strongly suggests that the impacts of the spreading and possibly recurrent epidemic of urban decay on the physical and mental health status of New Yorkers are likely to be extreme, especially given the effects of time and cuts in federal programs. It seems increasingly possible that we have only just begun to see the health and other problems that “planned shrinkage” has engendered.

Possible remedies, like apparent causes, lie in public policy:

1. Improvements in fire and other municipal services can serve as “immunization” against the recurrent cycle of contagious urban decay that continues to erode communities and displace population.

2. Communities and social networks disrupted or disorganized by New York City’s planned shrinkage program must be reknit by concerted community organizing.

3. Low-income housing must be rebuilt, while preserving existing social structures, and new or rehabilitated housing must be preserved with adequate municipal services. Evidently, rehabilitation and renewal must be done in such a way as not to further destabilize existing communities, a subtle point not adequately addressed here.

Without such a closely coordinated three-fold program explicitly designed to reverse social disintegration, significant public health improvement seems literally impossible, and relentlessly increasing social disintegration, public violence, homelessness, and medical gridlock appear inevitable.

New Yorkers now endure a famine of human habitat and community, triggered and sustained in large measure by government’s continuing refusal to deliver the municipal services needed to maintain urban population densities. As with more conventional famines, the principal cause of mortality is likely to be disease concentrated among groups traditionally affected by famine: the poor, the very young, and the very old.11 We have suggested mechanisms by which this might occur. However, there is likely to be ignition of another wave of “South Bronx” epidemic in New York City just as it is overwhelmed by the consequences in terms of health and homelessness of the last. There seems little time for delay of corrective measures, particularly the simplest one involving restoration

Three-year-old Damian lives with his mother in an abandoned building on New York City’s Lower East Side.

Indices of public health status and health care utilization in New York City show sharp deterioration after 1978 pressures are increasingly overwhelmed, while the population densities of the very poor are increasing rapidly. New York City now contains one-quarter of the AIDS cases in the United States, largely the result of factors of “social medicine” that could well apply to more rapidly spread but equally incurable diseases.

One of the principal characteristics of an event officially defined as a “disaster” is the availability of relief efforts on a very large scale. It is difficult to escape the inference that the South Bronx catastrophe has been, and remains, a continuing disaster without benefit of relief. Failure to recognize that catastrophe as a disaster may further compound the victimization of those affected. Health, behavioral, or psychological pathologies consequent on victimization may be blamed on the victims themselves. It is, of course, always ideologically useful to blame the failures of a social system or governmental structures on the victims of those failures. Indeed, blaming the victim is as American as apple pie and violence.

Victim-blaming comments and sentiments—such as Senator Daniel Moynihan’s comment in 1978 to the effect that “people don’t want housing in the Bronx, or they wouldn’t burn it down”—affect public policy. The currently popular media term “underclass” also comes to mind when thinking of those remaining in the devastated zones of New York City. However, what has been stigmatized as a particular group—an “underclass”—seems better characterized as a process producing a spectrum of symptoms and outcomes among those who have been subjected to a slow, but intense, disaster without relief. These are the effects of “planned shrinkage,” a virulent and systematic program of malfeasance, misfeasance, and non-feasance conducted by agencies of government for the political purposes of a ruling oligarchy.

Recommendations

Indices of public health status and health care utilization in New York City show sharp deterioration after 1978.
of fire extinguishment and sanitation services to ghetto neighborhoods.

Relearning History

In matters of public health and welfare—particularly involving contagious phenomena well known to undergo uncontrollable explosive outbreak—a very conservative attitude appears prudent. Requiring excessive standards of scientific proof for programs to improve public health—for example, reopening of ghetto fire companies—while allowing grossly relaxed standards for implementation of ideologically driven service reduction schemes (such as the fire service cuts instituted following the recommendations of the Rand Corporation in 1969 and more recently renewed by the Koch and Dinkins administrations) has already proven fatally counterproductive on a considerable scale. Continuation of such a bizarre reversal of standards will very likely have even greater fatal impact.

Hinkle and Loring describe the decision-making process for projects which, like the provision of clean water to New York at the turn of the century, caused vast and lasting improvement of public health:

One of the traditional foci of public health administration, to prevent or reduce disease and injury in a human population, has been to change conditions in its physical environment. Historically numerous ideas for such interventions were acted upon before definitive research had determined the nature of the relationship between a particular object and a disease.11

We have seemingly unlearned that history: A hundred years after the beginning of the great reform movement in New York City, and more than 60 years after its success, it is yet again necessary to call for adequate fire extinguishment, adequate sanitation, and other municipal services in the ghettos of the poor as important instruments of public health. New York City, and by inference other devastated cities of America, stands in evident need of a renewal of that great reform movement, which first brought adequate public health to the poor and, indeed, to the nation. □


8. Ibid.


Young Adults in the 1980s
Why Mortality Rates are Rising

JOSEPH J. MANGANO

Mortality is one of the most basic measures of a society's health status. As the United States moves into the 1990s, overall mortality figures would seem to indicate that the health of the nation was never better. The most recent age-adjusted mortality rate for 1988 stood at 535.5 per 100,000 population, an all-time low and a decrease of 8.6 percent since 1980. Rates for groups that traditionally experience the highest mortality, namely, the elderly and infants under 1 year, continue to drop. The average life expectancy reached 75 years by the mid-1980s, an all-time U.S. high.

This positive scenario assumes a different cast when we examine the figures more closely, however. Specifically, in the years since 1983, mortality rates for young adults have started to climb, raising troubling questions about the causes of such trends. Some observers attribute this increase solely to the effects of AIDS and HIV illness on this group, and indeed the effects have been devastating. But in fact, a conservative estimate shows that, even excluding AIDS, there were some 14,000 more deaths among people ages 15 to 44 than would be expected, based on prior death rates, just in the five-year period from 1983 to 1988. What is happening to these people? Analysis of the data, particularly which segments of the young adult population are dying in greater numbers, shows that AIDS is far from the only factor operating here.

When Death Rates Rise

Since World War II, mortality rates for all age groups in the United States have consistently declined. The one exception to this prevailing pattern before 1983 was in the 1960s, when death rates rose for each of the age groups from 15 to 24, 25 to 34, and 35 to 44 years. Subsequent reviews of data on the causes of death during this time showed that, in large part, the increased death rate for Americans 15 to 44 years old was due to non-medical, social causes—accidents, homicide, and suicide. During the 1960s, young Americans began to drive cars in greater
numbers, resulting in more fatal accidents; and increasing violence in society showed up in higher homicide and suicide rates. The increases in death rates between 1960 and 1970 thus did not suggest inadequacy or failure in the health care delivery and financing system.

In the 1970s, these increases were reversed, and death rates resumed their steady downward march for all age groups. The trend continued through the early 1980s. By 1983, death rates for every age group stood at an all-time low. The technical proficiency of preventive and curative health measures in this country, along with increased access to care through improvements in public health insurance coverage, were heralded as the catalysts for a new age in American health. The future looked particularly bright for young adults age 15 to 44, who make up nearly half the U.S. population, as their death rates were at especially low levels. In fact, the 1980 death rate for this population was only about one-fifth what it was in 1900.

But, beginning in 1983, a new and unsettling pattern began to emerge. Once again, the three age groups whose mortality increased during the 1960s—ages 15 to 24, 25 to 34, and 35 to 44—deviated from the general downward trend. Starting in 1983, death rates for each group began to rise, continuing through 1988; and preliminary estimates for 1989 and 1990 show these figures continuing to grow (see Tables 1 and 2).

Specifically, from 1983 to 1988, death rates for the 15-to-24 age group increased from 96.0 to 102.1 deaths per 100,000 population, up 6.3 percent; for the 25-to-34 age group, the change was from 121.4 to 135.4, up 11.5 percent; and for ages 35 to 44, the death rate went from 201.9 to 219.6, an increase of 8.8 percent. Mortality rates for 1989 and 1990 suggest that current death rates for the three groups have climbed back to about what they were in 1980, 1979, and 1981, respectively. Figures for 1989 and 1990 are only estimates, but experience in previous years has shown that such estimates of death rates are highly reliable.

What factor or factors account for this “lost decade” of unexpected mortality among the young? Table 3 compares the mortality rates for the seven major causes of death (including AIDS) in young adults for 1983 and 1988. Clearly, the AIDS epidemic has had a considerable effect on death rates, to the point where changes in mortality rates for these age groups might be considered a function of AIDS deaths. Four of the other six categories showed little change or an increase in rates (malignant neoplasms and major cardiovascular diseases are the exceptions). Examining these tables more closely reveals that each of the three age groupings has a distinct set of diseases or other factors contributing to recent mortality trends.

In addition to AIDS, the increase in mortality rates for the 15-to-24-year-olds was due to three major causes: suicide, homicide or legal intervention, and accidents and adverse effects. Together, these factors account for three-quarters of deaths in this age group. All are conditions rooted directly in social influences and not in the health care delivery system. Although all the reasons for these increases are not clear, at least for homicide increased economic pressures on lower socioeconomic groups is the most likely reason for the increase in rates. As for conditions that are highly dependent on the preventive and therapeutic efficacy of the health care delivery system, the combined rates for major cardiovascular diseases and malignant neoplasms dropped during this period. The remaining major category was the grouping termed signs, symptoms, and ill-defined conditions, which include deaths that can’t be attributed to a definitive diagnosis, for

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### Table 1

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<tr>
<td>45-54</td>
<td>-3.4</td>
<td>-20.0</td>
<td>-8.3</td>
<td>9.2</td>
</tr>
<tr>
<td>55-64</td>
<td>-4.4</td>
<td>-18.8</td>
<td>-3.5</td>
<td>-4.9</td>
</tr>
<tr>
<td>65-74</td>
<td>-6.3</td>
<td>-16.4</td>
<td>-4.0</td>
<td>-5.0</td>
</tr>
<tr>
<td>75-84</td>
<td>-8.5</td>
<td>-16.4</td>
<td>-3.8</td>
<td>-1.9</td>
</tr>
<tr>
<td>85 and over</td>
<td>-17.7</td>
<td>-22.2</td>
<td>-5.1</td>
<td>2.8</td>
</tr>
</tbody>
</table>


### Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
<th>Population (thousands)</th>
<th>Death Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>49,027</td>
<td>24,487</td>
<td>115.4</td>
</tr>
<tr>
<td>1981</td>
<td>48,782</td>
<td>40,257</td>
<td>121.4</td>
</tr>
<tr>
<td>1982</td>
<td>49,287</td>
<td>41,231</td>
<td>121.1</td>
</tr>
<tr>
<td>1983</td>
<td>51,852</td>
<td>42,027</td>
<td>123.4</td>
</tr>
<tr>
<td>1984</td>
<td>56,530</td>
<td>42,779</td>
<td>132.1</td>
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<tr>
<td>1985</td>
<td>57,701</td>
<td>43,313</td>
<td>133.2</td>
</tr>
<tr>
<td>1986</td>
<td>59,137</td>
<td>43,669</td>
<td>135.4</td>
</tr>
<tr>
<td>1987</td>
<td>61,240</td>
<td>43,835</td>
<td>139.7</td>
</tr>
<tr>
<td>1988</td>
<td>50,240</td>
<td>37,082</td>
<td>141.5</td>
</tr>
</tbody>
</table>

### Table 3
**Change in Death Rates for the Most common Causes of Death, Ages 15-44, 1983-1988**

<table>
<thead>
<tr>
<th>Cause of Death (ICD-9-CM Code)</th>
<th>Death Rate Per 100,000 Population</th>
<th>Percentage change, 1983-88</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15-24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS (042-044)</td>
<td>0.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Malignant neoplasms (140-208)</td>
<td>5.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Major cardiovascular diseases (390-448)</td>
<td>3.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Symptoms, signs, and ill-defined conditions (780-799)</td>
<td>1.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Accidents and adverse effects (E800-E949)</td>
<td>48.5</td>
<td>49.5</td>
</tr>
<tr>
<td>Suicide (E950-E959)</td>
<td>11.9</td>
<td>13.2</td>
</tr>
<tr>
<td>Homicide and legal intervention (E960-E978)</td>
<td>12.4</td>
<td>15.4</td>
</tr>
<tr>
<td>All other</td>
<td>11.8</td>
<td>10.7</td>
</tr>
<tr>
<td>Total</td>
<td>96.0</td>
<td>102.1</td>
</tr>
<tr>
<td>Age 25-34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS (042-044)</td>
<td>1.5</td>
<td>16.7</td>
</tr>
<tr>
<td>Malignant neoplasms (140-208)</td>
<td>12.8</td>
<td>11.9</td>
</tr>
<tr>
<td>Major cardiovascular diseases (390-448)</td>
<td>11.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Symptoms, signs, and ill-defined conditions (780-799)</td>
<td>3.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Accidents and adverse effects (E800-E949)</td>
<td>39.0</td>
<td>38.3</td>
</tr>
<tr>
<td>Suicide (E950-E959)</td>
<td>15.8</td>
<td>15.4</td>
</tr>
<tr>
<td>Homicide and legal intervention (E960-E978)</td>
<td>15.4</td>
<td>16.0</td>
</tr>
<tr>
<td>All other</td>
<td>22.3</td>
<td>21.3</td>
</tr>
<tr>
<td>Total</td>
<td>121.4</td>
<td>135.4</td>
</tr>
<tr>
<td>Age 35-44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS (042-044)</td>
<td>1.7</td>
<td>19.1</td>
</tr>
<tr>
<td>Malignant neoplasms (140-208)</td>
<td>45.6</td>
<td>44.2</td>
</tr>
<tr>
<td>Major cardiovascular diseases (390-448)</td>
<td>48.1</td>
<td>42.7</td>
</tr>
<tr>
<td>Symptoms, signs and ill-defined conditions (780-799)</td>
<td>4.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Accidents and adverse effects (E800-E949)</td>
<td>31.7</td>
<td>32.8</td>
</tr>
<tr>
<td>Suicide (E950-E959)</td>
<td>14.6</td>
<td>14.8</td>
</tr>
<tr>
<td>Homicide and legal intervention (E960-E978)</td>
<td>11.8</td>
<td>10.9</td>
</tr>
<tr>
<td>All other</td>
<td>44.1</td>
<td>48.9</td>
</tr>
<tr>
<td>Total</td>
<td>201.9</td>
<td>219.6</td>
</tr>
</tbody>
</table>


example, conditions such as chest pain or abdominal pain. The mortality rate for this classification jumped from 1.9 to 2.3 deaths per 100,000, an increase of 21 percent. One likely reason for this jump is a rise in HIV-related deaths that are not categorized as AIDS.

The increase in mortality for ages 25 to 34 is virtually all due to AIDS. Rates for the three non-medical conditions (accidents, homicide, and suicide) changed little from 1983 to 1988. Apparently the social forces affecting these conditions have a more pronounced effect in the younger age group. However, biologically based causes had an uneven record. Cardiovascular disease deaths were unchanged, while fatal malignant neoplasms decreased. Once again, rates for signs, symptoms, and ill-defined conditions rose sharply, from 3.6 to 4.8 per 100,000.

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**For blacks the increases in death rates not due to AIDS are nothing short of shocking.**

As with the preceding age group, virtually all of the increase in death rates among 35-to-44-year-olds can be ascribed to AIDS. Combined rates for the trio of accidents, homicide, and suicide rose slightly from 1983 to 1988. Rates for cardiovascular diseases and malignant neoplasms, which account for about 40 percent of the deaths in this age group, both declined. The signs and symptoms category showed a substantially greater death rate (an increase of 44 percent, from 4.3 to 6.2), a consistent trend in all three age brackets.

**Sex, Race, and Death**

Perhaps the most basic approach to analyzing age-specific mortality data is to examine race and sex cohorts to detect any obvious characteristic patterns of mortality. Table 4 divides 1983 and 1988 death rates for ages 15 to 44 by race and sex, and presents the change in rates for those groups over that period. Even though AIDS is such a strong factor in death rate increases, this breakdown helps explain which sectors of the population are most affected by the trend. The table provides two clear messages: first, the rise in men’s death rates is greater than that in women’s; and second, death rates for blacks have soared far more than those of whites. These findings are consistent across all three age groups.

Table 5 refines the age, race, and sex analysis by displaying 1983 and 1988 mortality rates for all causes other than AIDS. Removing AIDS deaths from the analysis provides a rate for “non-AIDS deaths.” From 1983 through 1988, this rate increased 4.6 percent for ages 15 to 24, decreased 0.4 percent for ages 25 to 34, and decreased 0.4 percent for ages 35 to 44. For Americans age 15 to 44 as a whole, the non-AIDS death rate increased 3.9 percent (from 132.4 per hundred thousand in 1983 to 135.7 in 1988).
Findings regarding mortality rates for specific age, race, and sex groups do not change markedly when AIDS deaths are removed. Overall increases in non-AIDS deaths for males are greater than that for females in two of three age groups, and the gap between blacks and whites remains extremely large. For blacks, death rates not due to AIDS have increased by 23.4 percent, 6.0 percent, and 7.6 percent for the three age groups, respectively—figures that are nothing short of shocking.

Precise measurement of AIDS and non-AIDS mortality rates are limited because of the suspected under-reporting of human immunodeficiency virus (HIV) as a cause on death certificates. Some AIDS deaths are reported late to the federal Centers for Disease Control by state or local health departments. Other death certificates for individuals that in fact died from AIDS-related disease fail to include AIDS as a cause, principally due to a lack of awareness and understanding of the HIV virus on the part of physicians, coroners, and coders. The CDC estimates that by the end of 1989, between 71 percent and 92 percent of 1987 HIV-related deaths for men ages 25 to 44 were actually identified as caused by AIDS on death certificates eventually sent to the CDC. However, two additional factors concerning AIDS undercounts must also be considered in comparing 1983 and 1988 rates. First, the official definition of HIV-related deaths was expanded twice during this period; and second, the awareness of HIV as a contributor to disease and death improved among those who affect the accuracy of reporting. Both factors make it likely that the undercount of AIDS deaths was more extensive in 1983 than in 1988. Thus, it is not clear that trends in actual non-AIDS mortality rates from 1983 to 1988 would be substantially different than trends using reported data. One way in which the undercount may be reflected, however, is in the higher rates of mortality in the signs and symptoms category.

Once we have established that death rates due to causes other than AIDS have risen since 1983, a number of questions arise. Why are death rates not decreasing as usual? Are aspects of health status or health care delivery contributing to this pattern? Clearly, the simplistic “it's just AIDS” rationalization is not sufficient.

Why Excess Deaths?

The most serious implication of these figures is the possibility that some causal factor or factors are affecting the downward trend of mortality rates and that somehow a portion of the current deaths in the 15- to 44 age group is avoidable. It is impossible to identify or calculate “excess” deaths with any measure of precision; however, even a modest expectation that some of these deaths are avoidable, even when AIDS is excluded, produces alarming figures. From 1970 to 1983, death rates for ages 15 to 44 fell about 2 to 3 percent per year. So if we posit even a limited expectation of a 1 percent annual decrease in the death rate after 1983, the actual change, an annual rise of 0.8 percent (3.9 percent over the period 1983 to 1988) yields a yearly “excess” death total of 1.8 percent or nearly 2,800 deaths (1.8 percent times 155,000, the average number of non-AIDS deaths for ages 15 to 44, from 1983 to 1988). The hypothetical total of excess deaths for the five-year period conservatively approaches 14,000, and the total has increased since then.

In explaining death rate changes since 1983, several major schools of thought are possible. The first two listed here offer simple, one-dimensional explanations. They do not suggest any serious flaw in the health status of young Americans (other than AIDS) nor in the system of health care delivery and finance. They are contradicted, however, by the data presented here. The others offer more probing, more disturbing scenarios that call for immediate and thorough redress.

"It's only AIDS." The American public—and even health care policymakers—has a general tendency to believe that any aberrant pattern in death rates for young Americans is due solely to AIDS. But, although AIDS accounts for a substantial part of increases in deaths since 1983, we have already seen that rates for other common causes of death have not decreased, or have even increased, for the 15- to 44-year-old age group in this period. Thus, while AIDS remains perhaps the most pressing public health problem among young adults,
cult, if not impossible. While 1983 death rates for Americans 15 to 44 were at their lowest levels ever, the thesis that a bottom has been reached is a questionable one. Death rates for all other groups (except for those over age 85) are still in decline. In particular, deaths rates for ages 1 to 4 and 5 to 14, which are even lower than those for 15-to-44-year-olds, continued to fall after 1983. These findings suggest that the rising mortality for the 15-to-44 age group after 1983 is due to factors that have disproportionately larger effects on young adults than on other groups.

**Funding cutbacks.** In 1981 the federal government initiated Reagan-era cutbacks in an array of health services and insurance programs. The cuts had a profound impact on the entire health care delivery and finance system. Before long, state and local governments were struggling under the weight of a newly increased burden; and private insurers and health care providers also sought ways to avoid a drop in financial status as a result of federal reductions.

If all Americans felt the impact of less federal spending, specific subpopulations were particularly hard hit. Eligibility rules for Medicaid were tightened. An attempt was made to reduce the number of disabled Medicare beneficiaries. Funding for programs designed to assist medically underserved populations (the National Health Service Corps, Indian Health Service, etc.) were slashed. These cuts, at least in part, have left the most appalling health legacy of the 1980s: the emergence of a large segment of the population with no health insurance, now estimated at between 31 and 37 million. Many of these are young adults and their dependents who, because of their lack of coverage, do not use the health care system properly. Most seek no care at all, except in emergencies, and have no private physicians.

Another legacy of the 1980s was the federal government’s retreat in commitment to disease prevention and hesitation in earmarking new funds for this purpose. The most glaring example of this was the delay in funding activities to prevent the spread of HIV. Not until the epidemic was well underway, with many already dead and dying, many more infected with the HIV virus, and predictions of increasing prevalence abounding, did the Reagan administration commit itself to budgeting large-scale amounts specifically for AIDS. Other cuts, to the Alcohol, Drug Abuse, and Mental Health Administration, for example, have affected programs in the areas of drug and alcohol abuse prevention, education, and rehabilitation that might have affected the increasing rates of suicide, homicide, and accidents.

It is virtually impossible, of course, to connect budget cuts and higher death rates in an epidemiologically sound cause-and-effect link. We cannot determine whether the cuts had a greater effect on young adults than on children, for example, without a more sophisticated analysis. However, one cannot ignore the fact that young adults’

---

**Table 5**

<table>
<thead>
<tr>
<th>Group</th>
<th>Age 15-24</th>
<th>Percentage change</th>
<th>Age 25-34</th>
<th>Percentage change</th>
<th>Age 35-44</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population</strong></td>
<td>95.8</td>
<td>103.3</td>
<td>119.9</td>
<td>119.5</td>
<td>200.2</td>
<td>199.4</td>
</tr>
<tr>
<td>Males</td>
<td>140.1</td>
<td>148.1</td>
<td>171.9</td>
<td>168.9</td>
<td>263.3</td>
<td>263.8</td>
</tr>
<tr>
<td>Females</td>
<td>50.7</td>
<td>51.5</td>
<td>68.6</td>
<td>70.0</td>
<td>140.1</td>
<td>136.6</td>
</tr>
<tr>
<td><strong>Whites</strong></td>
<td>93.2</td>
<td>94.2</td>
<td>106.8</td>
<td>107.0</td>
<td>176.7</td>
<td>175.2</td>
</tr>
<tr>
<td>Males</td>
<td>136.9</td>
<td>138.2</td>
<td>153.4</td>
<td>152.4</td>
<td>230.8</td>
<td>232.5</td>
</tr>
<tr>
<td>Females</td>
<td>48.3</td>
<td>49.1</td>
<td>60.0</td>
<td>60.7</td>
<td>123.3</td>
<td>118.2</td>
</tr>
<tr>
<td><strong>Blacks</strong></td>
<td>113.9</td>
<td>140.5</td>
<td>221.3</td>
<td>234.5</td>
<td>413.1</td>
<td>444.7</td>
</tr>
<tr>
<td>Males</td>
<td>164.3</td>
<td>216.0</td>
<td>326.5</td>
<td>341.6</td>
<td>582.0</td>
<td>628.2</td>
</tr>
<tr>
<td>Females</td>
<td>65.4</td>
<td>66.9</td>
<td>129.1</td>
<td>139.0</td>
<td>275.8</td>
<td>291.1</td>
</tr>
</tbody>
</table>

Death rates had been declining since 1970 (about the time when the large-scale federal commitment in health care took effect) and began to climb after 1983 (when the impact of budget cuts had made itself felt). More troubling is the effect budget cuts may have had on the considerably greater rise in mortality rates for blacks, a population that is generally more indigent than whites and that thus stands to benefit more from public health programs. The effects of budget cuts on health status measures such as mortality merit further, more detailed analysis.

**Biology and physical environment.** Very often, a new disease carries with it a mysterious, unknown component, at least for a period of time after its appearance. Scientists are still striving to understand the true etiology of the HIV virus and the AIDS epidemic. A similar quest is underway for the causes of other conditions that began to affect young adults in the 1980s, such as Lyme disease and chronic fatigue and immune dysfunction syndrome. Much of the research centers on biological or environmental concerns. What caused these diseases to proliferate? Why are certain human beings more susceptible than others? What can be done to infected people to retard the disease? Can people not yet infected be strengthened to reduce the chance of infection?

To address these exceedingly difficult queries, much more detailed work needs to be done. We must continue to comb morbidity as well as mortality statistics to search out patterns of disease and death. The identification of certain subgroups with greater rates of disease and death may hold clues.

**Social environment.** Another likely factor affecting mortality rates since 1983 is the changes in social factors and socioeconomic status for large segments of the population. The reasons why people age 15 to 44 have higher rates of AIDS or other illnesses may involve social conditions and processes. Part of the answer may involve the proliferation of poverty, use of crack and other illegal drugs, and violent behavior among this age group. Obtaining answers to etiologic questions will go a long way in developing needed preventive and therapeutic measures and improving the future health status of young Americans.

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6. Ibid., Vol. 2, Sec. 7.
10. Ibid.
The ‘Slave Health Deficit’
Racism and Health Outcomes

W. MICHAEL BYRD AND LINDA A. CLAYTON

Many attempts to explain the great disparities in health status between blacks and whites in the United States today, as shown in the accompanying table, downplay race and focus instead on class or economic factors. But a mere economic analysis ignores the long history of institutional racism in health care delivery and its effects on the health outcomes of African-Americans.

Poor health status and outcome for blacks has been a continuum for 370 years. Since their arrival in the North American English colonies in 1619, African-Americans have experienced the poorest health status and outcomes of any racial or ethnic group in the United States. For a complex matrix of reasons this “slave health deficit” has never been corrected.

From its 17th and 18th century beginnings, the American health delivery system was rigidly structured on the basis of race and class. Thus, blacks have never had equitable access to quality health care. Initially, as chattel, African-Americans were trapped in a disorganized, often brutal, inferior, and inconsistent slave health subsystem. This infrastructure was dominated by the exigencies of the slave system, race and class bias, and the scientific-biological myth of black inferiority.1 The nation’s earliest hospitals, such as the New York Hospital, were rigidly segregated on a race and class basis from their founding. Due to the social realities of medical racial customs, a racially segregated society, and racial discrimination, combined with class and caste bias, when African-Americans were allowed any access to care, they were restricted to the inferior, underfunded public health care sector of the system.2

Blacks as healers date back to ancient times in Egypt and prehistoric times in sub-Saharan Africa. But, as a result of changes wrought by the Atlantic slave trade, blacks were not allowed to participate as trained health care providers in the United States until after the Civil War, when staggering black death rates and denial of health care to ex-slaves triggered the opening of black medical, nursing, and dental schools.3

More than a dozen black medical schools had opened by 1910. Only Meharry Medical College in Nashville and Howard University in Washington, DC, survived the medical education reform movement of the early 20th century, which set standards for accreditation that eliminated a number of existing black institutions.4 Since their inceptions in 1876 and 1868, respectively, these two remaining institutions served as virtually the only advocates for blacks in health care and, until the civil rights era, were virtually the sole producers of black health professionals, who themselves served as initiators, promulgators, and promoters of the tradition and ideology of first-class health care for all Americans despite considerations of color, class, or caste.

After the Civil War, health care for blacks was either nonexistent, inferior in quality, or brutally discriminatory and was racially segregated.5 In the few places where racial segregation and discrimination practices allowed health care to be available to blacks, the inferior public health care sector, supported by taxes and charity, was the predominant delivery system available to them. This evolved into a loose network of public and charity hospitals and clinics that came increasingly under the control of the medical schools and health departments. A large proportion of African-Americans remain trapped in this inferior, public-supported tier of the health system today.6

Health Reform, Health Neglect

With the breakup of the sketchy, inferior slave health subsystem after the Civil War, blacks were denied access to any health care, and their death rates (Continued on p. 28)
## Racial Comparison of Health Data

<table>
<thead>
<tr>
<th>Health Parameters</th>
<th>Black/White Comparison</th>
<th>Comments/ Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight infants (less than 2,500 grams)</td>
<td>Black rate 110 percent higher than white rate.</td>
<td>Racial discrepancy widening; low birth weight associated with large numbers of deaths, physical and mental handicaps; blacks currently experiencing rates seen in 1950s by whites.</td>
</tr>
<tr>
<td>Very low birth weight infants (less than 1,500 grams)</td>
<td>Black rate 2.5 times the white rate.</td>
<td>Physical and mental handicaps often impair survivors; racial discrepancy may be widening.</td>
</tr>
<tr>
<td>Neonatal mortality (death in first 28 days of life)</td>
<td>Black rate 97 percent higher than white rate.</td>
<td>Reflects pre-pregnancy health and prenatal, intrapartum, and neonatal care; gap may be increasing.</td>
</tr>
<tr>
<td>Post-neonatal mortality (death from day 29 to day 364)</td>
<td>Black rate over twice the white rate.</td>
<td>Reflects quality of health care for children, including prevention of controlled, treatable diseases; rate is worsening for urban blacks.</td>
</tr>
<tr>
<td>Infant mortality (death in first year of life per 1,000 live births)</td>
<td>Black rate twice the white rate (21.4 per 1,000).</td>
<td>A major indicator of health status and a measure of overall standard of living; black rate worse than that in Jamaica or Cuba.</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>Black rate 3.3 times the white rate; amounts to 43 percent of U.S. total.</td>
<td>Reflects lack of access to obstetrical care; current figures are probably an undercount; 75 percent of these deaths are preventable.</td>
</tr>
<tr>
<td>Immunization rates (black children)</td>
<td>48.4 percent immunized against diphtheria, pertussis, tetanus; 39.1 percent immunized against polio.</td>
<td>Black children still die, lose vision and hearing, and suffer brain damage from these easily preventable diseases.</td>
</tr>
<tr>
<td>Childhood tuberculosis</td>
<td>Black rate 4 to 5 times the rate for whites.</td>
<td>Funds for children’s health programs being reduced despite high rates in black community.</td>
</tr>
<tr>
<td>Dental care</td>
<td>40 percent of black children under 17 years of age have never seen a dentist.</td>
<td>Overall, two-thirds of black children have not seen dentist in past year.</td>
</tr>
<tr>
<td>Childhood anemia</td>
<td>20 to 33 percent of black children are anemic.</td>
<td>Easily diagnosed and treated with basic child care; reflects poor nutrition; adversely affects school performance.</td>
</tr>
<tr>
<td>Toxic lead levels</td>
<td>15 to 20 percent of black urban children may have high blood lead levels.</td>
<td>First loss is intellectual function; many children are either undiagnosed and untreated or mislabeled as retarded or “slow learners.”</td>
</tr>
<tr>
<td>Childhood deaths (per 100,000 children)</td>
<td>Much higher among blacks: <strong>Age</strong></td>
<td>Many deaths are preventable with immunizations and early diagnosis and treatment; more of these children are being locked out of the health delivery system.</td>
</tr>
<tr>
<td></td>
<td><strong>Blacks</strong></td>
<td><strong>Whites</strong></td>
</tr>
<tr>
<td>1 – 4</td>
<td>97.6</td>
<td>57.9</td>
</tr>
<tr>
<td>5 – 9</td>
<td>41.7</td>
<td>28.4</td>
</tr>
<tr>
<td>10 – 14</td>
<td>36.6</td>
<td>29.8</td>
</tr>
<tr>
<td>Tuberculosis among persons under 45</td>
<td>Black males: 17.4 times white death rate; black females: 15.6 times white death rate.</td>
<td>Reflects lack of access to minimal health care.</td>
</tr>
<tr>
<td>Hypertension among persons under 45</td>
<td>Black males: 10.2 times white death rate; black females: 13.4.</td>
<td>Reflects lack of access to minimal health care.</td>
</tr>
<tr>
<td>Health Parameters</td>
<td>Black/White Comparison</td>
<td>Comments/Significance</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anemia among persons under 45</td>
<td>Black males: 6 times white death rate; black females: 5.2.</td>
<td>Reflects lack of access to minimal health care.</td>
</tr>
<tr>
<td>Cancer incidence among persons</td>
<td>Blacks: 27 percent increase; whites: 12 percent increase.</td>
<td>Reflects increased exposure to toxic environmental substances, poor diet, and high-risk lifestyle; gap is widening.</td>
</tr>
<tr>
<td>under 45</td>
<td></td>
<td>Rates were even in 1950 when there was little treatment; black access to early diagnosis and treatment being curtailed annually.</td>
</tr>
<tr>
<td>Cancer deaths among persons</td>
<td>Blacks: 40 percent increase; whites: 10 percent increase.</td>
<td></td>
</tr>
<tr>
<td>under 45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death rate for persons under 45</td>
<td>Black rate twice the white rate.</td>
<td>Huge numbers of person-years lost; responsible for a large portion of poverty and matriarchal families.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>33 percent more prevalent in blacks.</td>
<td>Programs providing care for chronic disease are regularly cut.</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Black death rate over twice that of whites.</td>
<td>Largely preventable with good outpatient medical care; funding for such care is being cut.</td>
</tr>
<tr>
<td>Stroke</td>
<td>Twice as common in blacks.</td>
<td>Programs providing care for chronic disease are being cut.</td>
</tr>
<tr>
<td>Deaths from pneumonia and</td>
<td>Black death rate 1.25 times higher than white rate.</td>
<td>Largely preventable with good outpatient medical care; funding for such care is being cut.</td>
</tr>
<tr>
<td>influenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths from nephritis, nephrosis,</td>
<td>Black rate 3 times the white rate.</td>
<td>Largely preventable with good outpatient medical care and timely hospitalization; access for blacks and the poor is being curtailed.</td>
</tr>
<tr>
<td>and nephrotic syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excess deaths (numbers of deaths)</td>
<td>Blacks suffer 59,000 annually; 42 percent of black deaths</td>
<td>If death rates for races were equal, four of ten black deaths would not occur.</td>
</tr>
<tr>
<td>beyond those expected with equal</td>
<td>are &quot;excess.&quot;</td>
<td></td>
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<tr>
<td>mortality rates across racial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lines</td>
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<td></td>
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<tr>
<td>Leading causes of death</td>
<td>Blacks lead in 13 of 15 categories.</td>
<td>Many of these deaths are preventable with known, basic cost-effective medical treatments.</td>
</tr>
<tr>
<td>Longevity</td>
<td>Blacks live 5 to 7 fewer years than whites.</td>
<td>The &quot;gold standard&quot; of health system performance; recent gains for blacks have slowed if not stopped.</td>
</tr>
<tr>
<td></td>
<td>Black life expectancy 69.6 years.</td>
<td>Black life expectancy has decreased since 1984.</td>
</tr>
</tbody>
</table>


soared. This frightened Congress into passing the Freedmen's legislation, which opened hospitals and clinics all over the South. They were underfunded and halted too soon to have a permanent salutary effect on black health status, however. Blacks' health status plummeted in the 1870s with increasing neglect, segregation, and discrimination in the health system, both legal and informal. Led by a tiny, isolated emerging black medical profession from the black medical schools, black civil rights groups, such as the Afro-American Council (1880s), the Niagara Movement (1905), the National Association for the Advancement of Colored People (NAACP) (1910), the National Urban League (1912), and the United Negro Improvement Association (1918), perceptively connected community health programs with racial, social, and political progress. Thus, the black health professional organizations were the sole professional leadership of progressive health reform for African-Americans. Other health disadvantaged groups always benefitted from these activities.

The years 1965 to 1975 marked a "civil rights era" in health care for African-Americans, with the implementation of the 1964 Civil Rights Act, hospital desegregation rulings in the federal courts, passage of Medicare and Medicaid, the Voting Rights Act, and the community health center movement. The resulting changes in the health system itself were superficial, and enforcement measures designed to bring civil rights to the health care delivery system were virtually nonexistent. Nevertheless, blacks' health status improved dramatically for ten years because of increased access for large blocks of the black population to some health care and the initiation of federal funding for health services. But special programs and shifts in health care financing had been substituted for important changes in the structure and policies of the health system. As the commitment, political support, and funding for these stopgap measures waned, blacks' progress in health stopped by 1975.

Left Out of Progress

Mounting evidence indicates that African-Americans are failing to share in this country's highly touted medical progress. Rising racial differentials in infant mortality, maternal mortality, cancer survival, cardiovascular mortality, childhood immunization rates, hospitalizations, and length of stay all indicate that blacks are not receiving adequate, high-quality, basic health services. African-Americans' lack of access to the desirable, expensive, high-technology treatments so dominant in our health system over the past 30 years is becoming more obvious with the frequent reports now being published in the medical literature.

The contemporary black health crisis is due to many factors, but race remains a major contributor to poor African-American health status and outcome. These factors include:

• An unchanged health care delivery infrastructure, which was erected and perpetuated on the basis of race.
• Underrepresentation or non-representation of blacks in the medical profession and in health policy.
• Screening of African-Americans by the white health providers and the health delivery infrastructure out of more costly, high-technology, desirable therapies such as cancer chemotherapy, coronary by-pass surgery, and transplant surgery.
• A health care distribution system based not on need but on demand generated by the ability to pay.
• A conservative national ideological bent.

This adds up to an artificial, need-creating, commodity-like, Wall Street-driven health delivery system that perpetuates virtually pre-determined and institutionalized racial differentials in health outcomes in an overly dual health system.

Since the Civil War, African-Americans have been the only racial or ethnic group in America that has been forced to look to civil rights protections to guarantee their access to health care. Until health care is in fact declared a civil right, it is unlikely that African-Americans will obtain justice and equity in health care in the United States.


4. Ibid.


Barriers to Care
The Case of Breast Cancer
BARRY SKURA

One out of nine women will develop breast cancer sometime during her lifetime. The disease can be treated relatively easily if it is detected at an early stage. Yet this year breast cancer will kill 44,500 women.\(^1\) Many of them will die unnecessarily. This is largely due to lack of access to early detection and treatment—particularly among the poor. With proper screening, 30 percent fewer women would die of breast cancer.\(^2\)

During the 1980s, more and more young, highly educated women were screened for breast cancer, leading to the detection of more early-stage disease. No corresponding increase in screening or detection occurred among low-income women, however. As a result, a curious pattern had developed by the end of the 1980s. Better off women were more likely than poor women to be diagnosed with breast cancer, but poor women were more likely to die of it. This was a direct result of poor women being treated at a later stage of the disease.

During the same period, a similar discrepancy developed between New York City, with its large low-income community, and the rest of the country. Far fewer New Yorkers were diagnosed with breast cancer, but more of them died. The reported incidence of breast cancer in New York City is about 30 percent lower than in the country as a whole, but the mortality rate is 21 percent higher.\(^3\)

This discrepancy is all the more striking because New York City is one of the world’s centers of medical research and teaching. What those centers offer, however, is technological medicine, geared to rescuing a few hospital patients—at great cost—from acute illness. As the case of breast cancer demonstrates, however, many more lives would be saved if the health care system were more suited to providing ordinary women with basic medicine. Basic medicine can easily detect breast cancer at the very earliest stage, when it is most easily (and cheaply) cured.

In its incidence and treatment, breast cancer thus dramatically illustrates one of the underlying causes of our health crisis. As Ronda Kotelchuck noted in her editorial in the last issue of the Bulletin, “what we are witnessing...
Surviving Breast Cancer

As breast cancer develops, it passes through several different stages. During the earliest stage, the cancer cells are confined to the breast. They are so small that they cannot be detected through physical examination. During later stages, the cells begin to grow and spread to other tissues—first, to nearby tissues in the same general area (such as lymph nodes) and, later, to more distant organs. A lump develops only after the cancer has already begun to spread.

It is the spread of the disease that kills the woman, not the initial breast cancer itself. If unchecked, the cancer cells will grow and ultimately spread to vital organs, such as the lungs and brain, where they interfere with the organs' normal operation.

Early detection is the single biggest factor influencing whether someone survives breast cancer.

Early detection is the single biggest factor influencing whether someone survives breast cancer. If the disease is brought under control before it spreads to other organs or at least in time for the "escaped" cells to be killed (through chemotherapy, for example) or removed, the patient survives. (Most breast cancer patients do not need to have their breast removed. Unfortunately, surgeons often perform mastectomies when a far more localized operation—lumpectomy—would be sufficient.)

Early detection also reduces the cost of treatment. It is about five times more expensive to treat a breast cancer after it has spread to distant organs (at a cost of about $100,000) than when it is still confined to the breast.

Medical researchers have extensively documented the fact that early detection greatly increases the chance of survival. For example, in 1990, the National Cancer Institute analyzed all breast cancers detected in nine geographic areas between 1973 and 1987. Women (mostly over 50) who were diagnosed when their cancer was still confined to the breast lived an average of over 13 additional years. Those diagnosed when the cancer had spread to other organs in the same general region lived 6.9 years. But those diagnosed when the cancer had already spread to other, more distant organs died within 1.2 years.

Most medical organizations agree on the methods for achieving widespread early detection—safely, cheaply, and effectively. Consensus guidelines have been issued by the National Cancer Institute, the American Cancer Society, and 19 other major medical organizations. The guidelines involve screening all women over 40 who do not yet have symptoms through clinical examination of the breast and mammography (low-dosage X-ray). Asymptomatic women should get a mammogram and a clinical examination of the breast every year if they are over 50 and every one to two years if they are between 40 and 49. Clinical examination by itself is inadequate because it will not detect breast cancer during the very earliest stage, when the cells are still microscopic. Mammography can detect a breast cancer up to two years before the woman can feel it.

A screening mammogram usually costs between $75 and $150. When performed outside a hospital, it can be even cheaper. For example, in New York City, the Guttman Institute charges $55 for each woman screened through its mobile van, and as little as $40 for patients on its sliding scale.

Early Detection and Access to Primary Care

Since the mid-1980s, more and more women have received mammograms. Yet most women are still not screened regularly. In a 1987 New York State survey, the state health department found that only 25 percent of women over 40 were getting mammograms. Three years later, a national survey found that only 43 percent of women that age had received a mammogram within the last year.

When women neglect to get a mammogram, their most frequent reason is that their doctors never recommended that they do so, even though most doctors agree that mammography screening is medically desirable. In fact, in a 1984 national survey, only 11 percent of primary care doctors reported that they complied with the guidelines on screening all asymptomatic women over 40. The main reason given for noncompliance was the cost of mammography. Since then, there has been an increase in the number of doctors who comply, but they are still in a minority. In a 1989 national survey only 37 percent complied and, in a 1988 Long Island study, only 48 percent did so.

Many physicians order a mammogram only for the purposes of "diagnosis," that is, only when there is already a lump, as the first step in determining whether the lump is cancerous. Often by then the lump is so big that the woman brings it to the physician's attention herself. This practice virtually ensures late treatment.

Some doctors even neglect to examine their patients' breasts. For example, in a 1988 survey of doctors on Long Island, only 63 percent reported performing regular breast examinations of all asymptomatic patients over 50. Twenty-two percent do not even have confidence in their ability to do the exam.

Nevertheless, the more regularly a woman visits a doctor, the more likely it is that she will be screened. Those who are least likely to get a mammogram are those who do not even have a doctor—the poor and those without health insurance. Public hospitals do not fill the breach. For example, not until May 1991 did the New York City Health and Hospitals Corporation (HHC) issue a policy requiring that its hospitals comply with mammography guidelines. For many years, HHC's policy was to perform mammography only after a woman had already developed symptoms, but not to screen them before then. Not surprisingly, most of the cancers detected at HHC hospitals—roughly 65 percent—are late-stage cancers.
Economic Triage

The American Cancer Society is hardly the new ACT UP. Yet, it is apparent even to ACS that poor people have not benefited from the various “advances in cancer prevention, detection and treatment. For these Americans, a diagnosis of cancer is most often a needless death sentence.”

Poor women are 2½ times as likely as middle-class women to die an avoidable death from breast cancer. In New York City, patients diagnosed with breast cancer at a municipal hospital are three times as likely to die within five years as are women nationally. The cities with the highest rates of breast cancer mortality are those with the largest low-income communities. The lowest rates are found in cities with expanding and relatively more affluent economies, like Tampa, Honolulu, Lexington, and San Antonio. Thus, the number of women who die of breast cancer, per 100,000 residents, is 33 in New York City, 27.3 nationally, and 22 in San Antonio.

Similarly, African-American women are more likely than whites to die of breast cancer. It is generally agreed that this is due to the effects of poverty. In 1987, the mortality rate was 30.3 per 100,000 for African-American women but 27.1 for white women. Thirty-six percent of African-American women diagnosed with breast cancer die within five years, but this is true for only 22 percent of the whites.

More Death From Fewer Cases

In spite of their “excess mortality,” poor women are actually less likely to get breast cancer in the first place. In 1986, the number of breast cancers detected among women without insurance may never even receive the treatment they need. In one case reported in the Wall Street Journal, June Kirchik, a 58-year-old Miami woman who had discovered a large lump in her breast was denied treatment at a private hospital because she was indigent, having recently been laid off, and her case was not an emergency. Mrs. Kirchik was referred to a public hospital where she eventually received a positive biopsy and an appointment for treatment three weeks later. But because she had not yet applied for the requisite documentation from Medicaid, Mrs. Kirchik could not get her treatment. She tried yet another public hospital, where she was turned away because she was not a resident of that area.

This woman's story has an unusual twist: it was leaked to the press, and the first public hospital admitted her into a private room, some four months after she had first discovered the lump. This is not a fair tale, though, and the story's ending is more typical: two weeks after she was admitted, Mrs. Kirchik died. The final question may be, what killed her: her cancer, her poverty, or the health care system's neglect?

—Ellen Bilofsky
African-American women was 94.6 per 100,000, but 108.4 among white women. Some of this may be due to differences in screening and detection, but, in fact, poor women are less likely to have many of the key traits that put women at risk of contracting breast cancer: age over 50, not having had any children, and deferring child-bearing to a later age.

The fatal flaw underlying the health care crisis is a medical system not geared to the needs of ordinary people.

To reiterate: poor women die more often because they are less likely to receive timely diagnosis and treatment. For example, the likelihood of a breast cancer being detected while it is still confined to the breast is about 20 percent higher among white women than among African-Americans. A critical reason for this is that these women are less likely to get mammograms. While 65 percent of all American women over 40 report having had at least one mammogram sometime in their lives, this is true of only 30 percent of African-American women.

Similarly, in New York City, the total number of reported breast cancers is greatest in the older, more affluent neighborhoods, but these cancers tend to be in the early stages of development. The distribution of late-stage cancers is very different; they tend to be concentrated in the city’s poorest neighborhoods.

As noted, there is a similar pattern of differences between New York City as a whole and the rest of the country. Fewer cases of breast cancer are detected in New York City, but more of them are at a late stage, and more of the victims die.

Access to Resources

Illness results from lack of access to the resources for staying healthy (for example, food, heat, and tests for early detection of disease). When one group gets greater access to those resources than another, differences in illness are also likely to increase. This principle accounts for the divergence discussed here between middle-class and poor women with respect to trends in the incidence of and mortality from breast cancer during the 1980s.

During the mid-1980s, young, highly educated women made increasing use of mammography. This led to a big increase in the number of cancers detected. Between 1980 and 1986, the reported incidence in the country as a whole jumped 25 percent—but most of the additional cancers were early stage. As a result, there was virtually no change in overall mortality. From 1980 to 1987, the number of white women dying from breast cancer increased a mere 1.9 percent (from 26.6 to 27.1 per 100,000)—mostly among older women. In fact, the overall rate of mortality should actually go down in a few years, once there is time for the recent increase in early detection among younger white women to affect the total number of deaths.

On the other side of the medical tracks, poor women did not participate equally in the increased use of mammography. On the contrary, the Reagan-Bush budget cuts made it harder for them to get any kind of medical care at all. Medicaid reimbursements, for example, fell further and further behind the actual cost of care, and fewer people were eligible in the first place; moreover, Medicaid covered fewer and fewer services. At the same time, private providers came under greater financial pressure, leading to even greater reluctance to provide so-called “charity care.”

As a result of not participating in the increased use of mammography, the trend in breast cancer detection and mortality among poor women was the opposite of the trend among the middle class. There was little change in early detection among the poor. The likelihood of a poor woman being diagnosed for breast cancer was roughly the same at the end of the 1980s as at the beginning, but more of them were dying. For example, African-American women were 15.2 percent more likely to die of breast cancer in 1987 than in 1980 (the mortality rate was 26.3 in 1980 and 30.3 in 1987).

The same pattern occurs when the trend in New York City, with its large low-income community, is compared with the trend in the rest of the country: in New York City, increased mortality without an increase in the number of cases diagnosed; in the country as a whole, more detection, but not more mortality. For example, during the same period, 1980 to 1986, when mammography was leading to a 25 percent increase in the detection of breast cancer in the country as a whole, the rate of detection in New York increased by only 1.7 percent. Prior to the mid-1980s, the difference between the local and national rates was relatively small. But, beginning in 1983, when mammography started to be heavily promoted, the rates began to diverge markedly. In 1980, the number of cases detected was 79.7 per 100,000 in New York City and 84.8 per 100,000 in the country as a whole. Six years later, the rate crept up to 81.4 in New York City, but jumped to 105.8 in the country as a whole. The 1986 rate is 30 percent higher in the country than in the city.

In spite of the lower incidence of breast cancer, there was an explosion in the number of New Yorkers who actually died. From 1982 to 1988 (a period when the city’s population was declining), the absolute number of New York City, but more of them are at a late stage, and more of the victims die.
Yorkers dying of breast cancers increased by 18 percent. In 1988, breast cancer killed 1,581 of the city’s female residents. The likelihood of dying of breast cancer is now roughly 20 percent greater in New York City than in the rest of the country.

The pattern of “fewer cases, but more death” shows the relationship between the deficiencies of the medical system and the crisis of need. Compared to the rest of the country, a higher proportion of New Yorkers are poor. As a result, women are less likely to be screened, leading to less detection of early-stage breast cancer. This reduces the total number of cases detected here, but it also increases mortality, since the cases that are detected tend to be late-stage cancers. This is occurring, moreover, in a city known for its centers of medical research and teaching. Clearly, those centers do not offer what ordinary women need.

An Ill-Designed System

Until quite recently, the breast cancer epidemic has not received much attention from health care or women’s activists. Yet in 1988 (the most recent year for which data is available), 1,581 women died of breast cancer in New York City—2 1/2 times as many women as died of AIDS. Like people with AIDS, women with breast cancer suffer not only from a disease, but from an ill-designed health care system.

Although breast cancer directly affects only its victims, the underlying problem—the short-shift given to basic primary and preventive care—has implications for everyone. The disparity in breast cancer mortality outlined here exemplifies the skewed structure of health care delivery in America—a structure that favors high-tech, hospital-based, esoteric, end-stage cures, rather than bread-and-butter primary care.

Late detection is not the only reason why more poor women die of breast cancer. They also receive less adequate treatment. Both need to be improved. But, it is also clear that low-income women should be targeted for screening, since this is where expanded screening would save the greatest number of additional lives.

It is tragic that so many women die of breast cancer when their lives could so easily be saved. This illustrates the fatal flaw underlying the health care crisis: that we are afflicted with a medical system that is not geared to the ordinary needs of ordinary people.

5. This estimate is taken from figures cited by Michael Rozak, in an article in the March 1990 issue of Business and Health.
18. As elsewhere in this article, intergroup and local-national comparisons are based on the following sources, unless otherwise cited: Time Trends in Cancer Incidence 1977-1986; Cancer in New York State; and Cancer Statistics Review, 1973-87.
21. Much of the evidence is summarized in Smart, op. cit.
22. The rates for the rest of the state, excluding New York City, regularly fall in between the city and national rates.

Resisting the Quick Fix

Screening is Not Enough

Barry Skura’s analysis of excess breast cancer deaths among poor and black women argues that this unfortunate outcome is the result of a lack of access to mammography screening. Skura’s ready acceptance of American Cancer Society dogma on screening and early
diagnosis is shared by a great many of those interested in health care policy. It is unfortunate because it contributes to the myth of technological silver bullets as solutions both to our health outcomes crisis and to racial and socioeconomic disparities in death rates.

Skura accepts as given a direct causal relationship between utilization rates for a technological diagnostic intervention (mammography) and delay in diagnosis, delay of treatment, and, ultimately, higher death rates from breast cancer. I am far less convinced that the existing evidence supports the notion that differences in access to mammography screening between black and white women are the cause of black women’s higher breast cancer mortality rates.

We know that the incidence of breast cancer is higher in white and more affluent women than in black women. There are also a number of studies that show that older women in general, and black women in particular, are at greater risk of being diagnosed at advanced stages of breast cancer. Whatever the reason for this trend, women with advanced disease obviously have a poorer prognosis. Breast cancer mortality rates for black women in the United States have been increasing by around 1 percent annually since 1973. Whether the reason for this poorer prognosis is lack of access to screening, poorer care after diagnosis, or some other factor inherent in poverty or race is not self-evident from these facts. Skura’s “fewer cases, but more death” analysis may therefore be more a reflection of the city’s changing racial and socioeconomic composition than demonstrative of the “relationship between the deficiencies of the medical system and the crisis of need.”

A recent study published in the Journal of the National Cancer Institute concluded that the disproportionate number of blacks at lower socioeconomic levels accounts for much of their excess cancer burden. In the accompanying editorial, Dr. Harold Freeman of Harlem Hospital commented, “While neither race nor poverty is an absolute indicator of cancer incidence and survival rates, each is a surrogate of predictable conditions and circumstances.”

An earlier study in Cancer came to a different conclusion. It looked at ten-year survival rates from breast cancer among blacks, whites, and Hispanics, controlling for the effects of age, socioeconomic status (SES), stage of disease, and delay in seeking treatment for symptoms. Each of these factors affected survival when considered separately, and blacks were less likely to survive than either white or Hispanic women. Despite similar SES distribution among blacks and Hispanics, it was whites and Hispanics whose survival experience was similar, and ethnic differences between whites and Hispanics were not significant when the other variables were taken into account. Moreover, regression analysis found that the ethnic differences in survival between blacks and other groups remained when age, SES, stage of disease, and delay in treatment were controlled for. Also, the analysis did not detect any effect of delay in treatment on survival when ethnicity and the other variables were controlled for. Thus, this study points to race itself, or yet some other factor connected to it, as a determinant in survival, independent of class or of the delayed treatment that lack of access to screening would produce.

Treatment Differences

Skura does not comment on the possibility that treatment differences may affect death rates of black women with breast cancer. He equates early detection with automatic better survival. Yet a 1987 study in the American Journal of Public Health suggests otherwise. Looking at the treatment of 36,905 black and white women with breast cancer, researchers at the National Cancer Institute found that blacks received different treatment than whites, even after adjusting for age, clinical stage of the disease, and tumor histology. The authors concluded “that treatment differences may be found in the future to play a role in the black/white survival differential.”

If policymakers were to accept the argument that excess death from breast cancer among black women in New York City could be substantially reduced by opening up access to mammography screening, they must then take into consideration other problems such a policy will create—ones that Skura does not discuss. For example, although newer, improved low-dose equipment and film have minimized radiation exposure and risk, surveys show that there is considerable variation in quality among
facilities and operators. It is likely that existing high-quality mammography facilities do not presently have the capacity to absorb the numbers of black women at risk. Therefore, there will be a need for a far greater investment of resources, either to create new facilities or improve quality and expand capacity in existing ones. There will also need to be investment in providing the follow-up care without which any screening program is unacceptable. If such resources aren't available (and in today's fiscal climate they are not), then a policy of providing black women with access to screening will be merely a self-congratulatory public health exercise.

Although this is not the place to engage in a more in-depth critique of problems of mammography screening, I would be remiss if I did not point out some serious questions about two statements in the article. First, despite Skura's unquestioning acceptance, there remains controversy about whether to start regular mammography screening at age 40 or 50. Because studies to date have not been able to show a statistically significant advantage in screening women ages 40 to 49, the U.S. Preventive Services Task Force in its 1989 report recommended a mammography exam every one or two years after age 50. Second, Skura describes breast cancer as a simple disease, which progresses (without treatment) from local occurrence to nodal involvement to distant spread (metastasis). This description may be convenient for those arguing that early detection and treatment equals cure. However, breast cancer is in fact a complex disease, and a certain percentage of women whose cancer is detected at a local stage and who receive “optimal” treatment nevertheless go on to die of advanced disease within ten years. Some experts have hypothesized that breast cancer may be more than one disease, some forms of which may start with malignant cells at distant sites as well as those locally present in breast tissue.

The poor and people of color, as always, bear the brunt of a swiftly deteriorating national environment, and their health status continues to suffer as a result. The lack of access of black women to mammography is but one symptom of the deficiencies that exist within our health care service system. We need to better understand the influence of race and socioeconomic status on high breast cancer mortality rates. And we need to resist the temptation to rely on quick fixes for problems rooted in centuries of racism and economic oppression.


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For more than a dozen years of commuting to my practice in the Bronx, I have passed the Morningside Heights campus of Columbia University and the Washington Heights campus of its health sciences center. Only after reading Columbia Professor Eli Ginzberg’s latest book, The Medical Triangle: Physicians, Politicians, and the Public, did I recognize the light-years that separate those Olympian heights from the Kingsbridge Heights and Morris Heights neighborhoods where I have served as a family physician and health advocate.

Professor Ginzberg brings an Olympian breadth and perspective to the health care system, covering topics from psychiatry before the year 2000 to rationing cancer care with a personal sense of much of our health system’s postwar history. His Olympian perspective yields a distant “middle course” where, as he writes in his preface, he has tried “to focus on analysis, not ideology.” What ultimately results, however, is a bound version of the highly ideological Conventional Wisdom.

How does one recognize the Conventional Wisdom (when not found in the Newsweek column of the same name)? In Ginzberg’s book the Conventional Wisdom is regularly quoted: “The conventional wisdom about high-tech medicine is...” (p. 46); “the conventional wisdom views the Academic Health Center...” (p. 74); “the assumption prevailing throughout the first three post-World War II decades...is no longer conventional wisdom” (p. 121). Whether quoting or challenging its authority, Ginzberg seems to be sparring with the zeitgeist itself. Ginzberg speaks unselfconsciously with the voice of authority: “The United States unequivocally rejected a comprehensive system of national health insurance” (p. 36); or, “In years of budgetary surpluses, there is nothing that politicians prefer more than appropriating additional money for good causes, such as biomedical research, which enjoy enthusiastic public support” (p. 43). In the Bronx our leading politicians are in federal prison, having made Wedtech, Reagan’s favorite minority-owned business, a synonym for Abscam or Watergate. As far as the Conventional Wisdom is concerned, the gritty, streetwise, bloodied Bronx does not exist.

The Medical Triangle is a collection of essays written in 1985, yet the AIDS epidemic merits its first mention in the last paragraph of the chapter on New York City’s health system, and drug abuse is mentioned only once in the entire book in the description of the partitioning of the National Institute of Mental Health from the National Institutes of Health and the creation of the Alcohol, Drug Abuse, and Mental Health Administration. Equally neglected are the office-based private practitioners and community hospitals that account for the vast majority of the health services provided in the United States. Instead, Ginzberg concentrates on the interests of academic medical centers—medical education, foundations, privatization, physician supply, and high-tech medicine. To his credit, Ginzberg has chapters on both community health centers and medical care for the poor, both increasingly of interest to academic medical centers. What one chooses to analyze is ultimately ideological.

In his most interesting chapter, “The Politics of Physician Supply,” Ginzberg shares his 30-year involvement with this issue by giving an overview that begins at the turn of the century and ends with the Conventional Wisdom’s chimera of the medical care surplus. Here, and in his chapter on “The Reform of Medical Education,” where his analysis leads to specific recommendations for change, Ginzberg is most critical of the Conventional Wisdom and the status quo. Both chapters are lively and controversial, yet neither convinced me that the author understood the need to correct the maldistribution of physicians in regard to specialty and geography. The view from Olympus bears a remarkable resemblance to the view from the Ivory Tower.

The Medical Triangle” of the book’s title alludes to the “Iron Triangle”—the recognition that the military-industrial complex thrived through its relationship with Congress. Ginzberg’s triad—physicians, politicians, and the public—ignores the health care industry and its institutions (while his essay “American Medicine: The Power Shift” includes ten power centers). A more apt title might be Medical Realpolitik: The Way Things Are Is the Way They Were Meant.
Abortion: Where We Came From, Where We’re Going


by Ellen Bilofsky

Not quite 20 years after the Supreme Court’s Roe v. Wade decision legalized abortion, and nearly 30 years after the beginning of the modern movement for reproductive rights, the abortion rights movement is going back to rediscover and record its history. Challenges from the anti-abortion movement have spawned some frightening judicial decisions as well as a flood of restrictive legislation touched off by the Supreme Court’s Webster decision. In the face of this attack and the prospect of having to refer old battles, a spate of articles and publications have appeared reminding us of how we won this tenuous right to abortion in the first place and how we coped in the dark ages when all abortion was illegal.

Two publications from South End Press make excellent additions to this literature. Abortion without Apology is actually a long pamphlet that aims to teach the history of the abortion struggle to young women and serve as an organizing manual for a new generation of activists. It also has considerable value for those of us who were there when it was happening. Author Ninia Baehr emphasizes some little-known history, starting with the criminalization of abortion in the 1880s, and sets it in the context of the medical profession’s attempt to gain control of women’s health.

Baehr’s focus, however, is the “radical history” of the abortion rights movement (“radical,” as in calling for a change in the balance of power), beginning in 1959 with the “army of three”: Patricia McGinnis, Lana Clarke Phelan, and Rowena Gurner. These women were organizing for women’s rights and the repeal of abortion laws even before the second wave of feminism. The text, sprinkled with vintage illustrations, is largely based on interviews with these long-forgotten pioneers and others like them. Their gripping testimony about illegal abortions and the sense of empowerment they experienced in the women’s self-help movement will get even jaded movement veterans angry and motivated again.

Perhaps Baehr’s most important contribution is rescuing from obscurity the distinction between the liberal movement to legalize abortion and the radical movement to repeal abortion laws altogether and to put control of reproductive decisions in women’s own hands. The efforts to win legal reforms of anti-abortion laws led to compromises of the more radical demands in order to achieve “winnable” gains. This process culminated in the flawed Roe v. Wade ruling, which granted a limited right to abortion but reasserted state and medical control over the decision to have one. Since this ruling made abortions accessible to middle- and working-class women, the fight was essentially declared over, even while abortions were still financially and logistically denied to many poor and third-world women.

Baehr points out that we lost some of our abortion rights in the 1980s because of the way they were defined in the 1970s. The legacy of those earlier compromises is the necessity of undertaking a new struggle to preserve the narrow right to abortion. Renamed the “pro-choice” movement, it has made abortion, Baehr says, “the right that dare not speak its name.” In an attempt to placate potential foes, abortion has been redefined as a necessary evil, and lost in the shuffle are all other demands for reproductive rights and control over one’s sexuality, as well as the political reasons why abortion has been denied to women and the connection of abortion to other issues such as the struggles of poor women, women of color, and lesbians.

Baehr concludes Abortion Without Apology with some “Lessons for the 1990s” about building a more inclusive coalition and broadening the demands into a true reproductive rights movement. Her last chapter is a brief organizing outline, describing her own “Abortion Rap” sessions with groups of young women. She appends a useful bibliography and list of resource groups.

Abortion Rights vs. Reproductive Freedom

From Abortion to Reproductive Freedom essentially starts where Abortion without Apology leaves off, with a comprehensive analysis of the current movement and an attempt to define a broader one. As the title implies, Marlene Gerber Fried (a long-time activist with the Boston-based Reproductive Rights National Network, known as R2N2), writing as Baehr, draws a distinction between a “pro-choice” movement for abortion rights and a movement for reproductive freedom, and her aim is to show how we can create the latter. The large number of articles in this anthology (nearly 50 in all) may be hard to digest, but its many insights are well worth absorbing. The book’s great contribution is to put abortion in the context of other issues that affect women’s lives. It shows the limits of a single-issue focus—even a radical one—and who is left out of such a limited movement.

In her own essay, “Transforming the Reproductive Rights Movement:
The Post-Webster Agenda,” Fried argues that by in effect dissolving after abortion became legal and then reconstituting itself as a “pro-choice” force, the abortion rights movement lost its guiding principle as well as its momentum. It thus gave the Right the power to set the terms of the abortion debate (“defenders” versus “destroyers” of the family) and the tactics (judicial and legislative attacks on the one hand and Operation Rescue’s clinic attacks on the other). In responding to the “pro-lifers” on their own terms, the pro-choice movement has also allowed them to determine the grounds for its defense of abortion—the “necessary evil” argument. Fried sees today’s mainstream pro-choice movement as an actual obstacle to broader reproductive rights goals through its narrow strategies of framing the issue in terms of privacy and civil rights rather than in terms of women’s liberation and sexual freedom; shaping strategy and politics in accordance with the concerns of white middle-class women and ignoring the needs of other groups of women; relying on those in power to create change rather than pursuing grassroots empowerment strategies; and isolating abortion from other issues.

We have become a movement on the defensive, and, as Baehr also argues, we cannot succeed until we actively pursue our vision of what a society based on reproductive freedom would look like. Fried sees the current crisis brought on by the right-wing attacks as a chance to “get back on the offensive, and to transform our movement.”

Defining the Agenda

The remainder of the articles amplify this position and begin to define a larger agenda and coalition. The editor has clearly gone to great effort to include every possible group and interest, particularly women of color. The collection includes, among others, the voices of blacks, Hispanics, Asians, lesbians, gay men, teenagers, disabled women, religious women, poor women, women with AIDS, and women in the workplace.

The book is divided, somewhat arbitrarily, into four sections. The first, which starts off with Fried’s essay, is “The Politics of the Abortion Rights Movement.” It focuses on analyses of the current situation, including pieces by Angela Davis and Alice Walker on racism in the movement, by Jacqui Alexander on reproductive freedom in the third world, and by Rhonda Copelon on key Supreme Court cases.

The second section, “Speaking Out for Women: Choosing Ourselves,” includes a variety of personal stories. Reproductive Rights activists have not forgotten the old women’s liberation slogan, “the personal is political,” and they know that activism grows out of our own needs and our anger. In addition to essays and poems recounting women’s experiences with illegal abortion, there are articles about how women—both black and white—took control of meeting their own needs. Here are the stories of the National Black Women’s Health Project, the Jane collective, and the menstrual extraction movement. Here too is Ellen Willis’s essay, reprinted from the Village Voice, on left anti-abortionists, entitled “Putting Women Back in the Abortion Debate,” in which she reminds us that we need to redefine women, their bodies, and their needs as the center of the abortion debate instead of “merely the stage on which the drama of fertile life and death takes place.” (Readers should note that the identification of previously published work is some-what obscure, so that only a tiny footnote identifies the article on menstrual extraction as 12 years old.)

“Defending Abortion Rights: Confronting Threats to Access” includes a number of articles that detail the attacks from the right wing and some of the ways the pro-choice movement has fought back. There is also a balanced discussion of RU-486 by Judith Norsigian of the Boston Women’s Health Book Collective that outlines both the positive and negative aspects of the widely touted “abortion pill” and the necessity of testing it in a variety of circumstances and populations.

The final section is entitled “Expanding the Agenda: Building an Inclusive Movement.” It includes statements from women representing a variety of the constituencies listed earlier describing their interests in reproductive rights and the need for coalitions among these groups.

While there is plenty of room for debate and for a variety of strategies and tactics within the abortion rights movement, there is clearly need for reinvigoration—even after the brief post-Webster upsurge of activity—and for greater inclusiveness. Abortion without Apology and From Abortion to Reproductive Freedom should be required reading to help remind us where we came from and where we should be going.

Ellen Bilofsky is Editor of the Bulletin.
Asbestos: The Conspiracy Goes On

On behalf of asbestos victims let me thank you for the excellent coverage of our issues and those of society in dealing with this terrible disease-producing substance (Vol. 20, No. 4).

Tony Bale is quite right in the editorial when he states the main issue is “all of us, here and now.” Perhaps the sheer size of destruction caused by asbestos, which was sold to the public as a safe product to use and work with, is the reason that Bill Raveneau’s brilliant work cannot be seen by the public due to lack of funds for exhibitions.

The article by Debbie Socolar was very complete, and we deeply thank you for publishing our location and phone number to assist our organizing efforts. We have included some documents which will explain in part why our attorneys are currently arguing with the asbestos industry, insurance industry, courts, and Manville Trust in a new attack against the victims which has been dreamed up by Judge Weinstein and those parties. The conspiracy goes on and reaches into sections of our society which you would not expect.

David Kotelchuck has been a longtime friend to and advocate for asbestos victims. We would like to reprint his article for distribution to our students in the training classes we conduct.

We again thank you for excellent coverage and wish you well. Feel free to call or write the White Lung Association (WLA) for any information you may need.

PAUL SAFACHUCK
President, White Lung Association. Baltimore, MD

Indispensible

I’m still on educational leave from local 1199, subsisting on a part-time job at the Benefit Fund, while I slog my way through the Elysian Fields of Columbia's MPH program. My constrained income was dictating a cutoff of contributions to many organizations.

But the “Breath Taken” issue of Health/PAC reminded me that you’re all indispensable—so I’m squeezing $27.50 out of my tight budget, my last pennies of disposable income. Keep up the good work.

TOM DAWES
New York, NY

Gulf War Resister

I want to call the attention of the medical community to the important issues raised by Yolanda Huet-Vaughn in her stand of conscience against service in the Gulf War.

Dr. Huet-Vaughn is a 39-year-old board-certified family physician from Kansas City, Kansas, who is a captain in the U.S. Army Reserve Medical Corps and a mother of three. When called to active duty in December, she declared her refusal to be an accomplice in a war that she, and we, deem immoral, inhumane and unconstitutional.

In her statement of January 9, she wrote: “My oath as a citizen soldier to defend the Constitution, my oath as a physician to preserve life and prevent disease, and my responsibility as a human being to the preservation of this planet, would be violated if I cooperate with Operation Desert Shield” (later Desert Storm).

Dr. Huet-Vaughn also questioned the military’s rules for prioritizing treatment. Under these rules, a physician is required to treat a combat soldier with a broken finger before caring for civilian casualties with far more serious injuries.

She was sorely concerned, too, at the likelihood of extensive civilian casualties in Iraq in the face of the massive air war. Children less than 15 years of age constitute 47 percent of the civilian population of Iraq. A delegation of the International Physicians for the Prevention of Nuclear War, an organization which won the Nobel Peace Prize, reported that Iraqi teaching hospitals in Baghdad had no insulin or suture materials and insufficient IV fluids and medicines prior to the onset of the military offensive.

Dr. Huet-Vaughn wrote: “Perhaps the greatest medical catastrophe awaiting civilian and military personnel is the possible use of chemical, biological or nuclear weapons. There is no guarantee that what may start as a conventional war won’t quickly escalate to a war in which weapons designed to incinerate or irradiate massive population centers will be used.”

I support Dr. Huet-Vaughn’s courageous and patriotic stand of conscience over unthinking obedience to the state, her commitment to prevention over futile triage and treatment, and her concern for the well-being of all human beings regardless of nationality or military status. I hope that others will follow her example of fidelity to the moral and ethical dimensions of our medical profession, whatever their political convictions.

If Dr. Huet-Vaughn is convicted at court-martial, she faces up to two years in a maximum security military prison and loss of all pay and benefits. She may face loss of her license to practice medicine. Although much of her legal counsel is contributed, legal expenses are large, and she must continue to provide for her children. A defense fund has therefore been established. Tax-deductible checks may be written to “Alternatives to Militarism” and sent to: Committee to Defend Dr. Yolanda Huet-Vaughn, c/o Citizen Soldier, 175 Fifth Avenue, Suite 808, New York, NY 10010.

ELI MESSINGER
New York, NY

Editor’s Note: As we go to press, the Army has charged Dr. Huet-Vaughn with “desertion with intent to shirk hazardous duty,” which carries a sentence of up to five years’ imprisonment. In addition, two private physicians have filed charges of “gross misconduct” against her with the Metropolitan Medical Society of Greater Kansas City, based on her refusal to be deployed to the Persian Gulf. Another Army physician, Capt. David Wiggins, who had filed for conscientious objector status before being sent to the Gulf, is awaiting trial in Saudi Arabia on charges including dereliction of duty and discrediting the armed forces. For more information, contact Citizen Soldier, (212) 777-3470.

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