HEALTH IN THE INDUSTRIAL HEARTLAND

America's greatest industrial concentration lies in a relatively small nine state area, extending from Pittsburgh to St. Louis and from the great lakes to Northern Appalachia. Over 40 percent of the nation's manufactures are produced in this area, valued at more than $103 billion. It is the home of the nation's largest industrial corporation, General Motors; it is the leading source of coal, which now supplies more than 50 percent of the nation's electric power; it is the major production site for steel, automobiles, tires, and machine tools. It is America's "Industrial Heartland."

In this issue, the BULLETIN turns to this industrially-important region of middle America. We focus on two industrial cities, Cleveland and Cincinnati, and a major source of raw material for their industries, Northern Appalachia.

Behind both urban and rural settings, there lurks a similar industrial power structure. Whether absentee, as in Appalachia or ever-present, as in Cleveland, this industrial elite plays a central role in the health of the region. It dominates the boards of the largest, most prestigious medical institutions, as demonstrated in Cleveland and recently confirmed in a study of Detroit (published in Hospitals August 1, 1971). Less obvious, is the relationship of this industrial establishment to inadequate, public health institutions, like Cincinnati's Department of Health. These tax-supported institutions suffer from chronic under-financing caused in large measure by low corporate taxes (Ohio ranks lowest in the nation for corporate taxes) and maintained by the consistent lobbying efforts of powerful industrial interests.

The industrial elite not only dominates the major medical resources, it is also a major cause of health hazards which plague the region. It pours pollution over the cities and devastates the countryside with strip mining. Its plants are the source of rising industrial accidents and newly-recognized industrial diseases. For instance, the mechanization which brings the coal industry more profits, brings its miners black lung more quickly and more devastatingly.

Meanwhile, the major medical institutions of the region make only gestures to meet the mounting industrial casualties. Programs for treating industrially-related diseases are token; industrial health research and teaching is virtually nonexistent; and advocacy on behalf of the industrially-injured is unthinkable. This institutional behavior reflects the priorities of the industrial establishment that dominates the major medical centers.

Yet it is often difficult to identify the role of the industrial establishment and to hold it accountable for the failures of the health system. Boards of Trustees function in elusive, non-public ways. The health movement is often forced instead to deal with the front-men—the administrators, deans and Commissioners of Health. Public institutions become the major focus of insurgent activity, as in Cincinnati, because they bear the public responsibility for health services, yet are given only a pitance of the resources. The health movement must find new strategies to move beyond these front-men and public institutions, to the people that hold the real power over health conditions and health care.

The Appalachian coal miners pose one such strategy. By focussing on industrial health and safety, the miners find themselves locked in battle with the industrial elite which is responsible for the major cause of the miners' poor health, as well as the lack of facilities to treat it. In so doing they not only confront the true source of power in their own health area, but they are also launching an exemplary preventive health struggle.
CINCINNATI:

A PEOPLE'S HEALTH MOVEMENT

Cincinnati, Ohio, situated across the river from Kentucky, is a midwestern city with a southern exposure. It is a strongly Republican town, the home of the "Taft Dynasty." Political conservatism is a way of life in Cincinnati. Despite the political climate, an insurgent health movement has sprung up there. To understand its origins, requires a deeper look at the context from which it has flowered.

Cincinnati is the home of Procter and Gamble, General Electric, General Motors, Ford and the Cincinnati Milling Machine Company. It also hosts the Cincinnati Reds for which a new $50 million river-front stadium was completed last year, at, of course, the taxpayer's expense. The city fathers and businessmen are euphoric about the city's "major league facility." The people who live in the city's dilapidated housing, ride its privately-owned, expensive buslines, send their children to its overcrowded schools and use its inaccessible and inadequate health services, however, think the city's human service facilities are strictly "bush league."

Each year thousands of people migrate to and settle in Cincinnati's black and Appalachian white ghettos. It is the first industrial oasis on the way north. The new immigrants' litany is familiar: high unemployment, crime, drugs, poor housing and health, discrimination and abuse from the local police. "White" poverty is very visible in Cincinnati where Appalachian whites become a "colonized" minority, separated from affluent Cincinnatians by their culture, chronic poverty and dialect. Both black and Appalachian people are virtually excluded from the industrial job market because of inadequate education and their so-called "unadaptable" culture.

Bush League Empire

Cincinnati's health resources are dominated by a "medical empire": in this case the University of Cincinnati Medical College. All of the city's major health institutions are located within three-quarters of a mile from one another. Adjacent to the medical college is the only acute care public hospital, the 610-bed General Hospital which is controlled by the medical college. Cincinnati Medical College's department chairmen are also the department heads at General. In fact, General Hospital is the medical college's major teaching and research center.

Across the street is the research-oriented Children's Hospital, partially built with Proctor and Gamble's sudsy money. Children's Hospital has a $1.23 million research endowment, but constantly runs in the red for hospital operating expenses. It is also utilized by the medical college as a teaching and research center but remains semi-autonomous.
Nearby, are the other hospitals with which the medical school maintains teaching affiliations: Veteran's Administration Hospital, Jewish Hospital, and, for the medical care of the city's well-to-do citizens, the 94-bed elite Holmes Hospital. Not far off are Christ, Bethesda and Good Samaritan Hospitals.

Cincinnati hospitals have been involved in major building programs. A new building for in-patient care at General Hospital was opened just two years ago. However, its out-patient department remains in the dreary, over-crowded quarters. Helter-skelter expansions at Christ Hospital, resulted in a recently completed $2 million pediatric pavilion despite the lack of a pediatric staff. Meanwhile, from its windows one can see the recently expanded and underutilized Children's Hospital with its full-resident coverage and renowned staff of pediatric experts.

The General Hospital-Medical College (GH-MC) complex is the colossus of medical care in Cincinnati. It has an intern-resident staff of over two hundred doctors, and in addition, trains another six hundred medical students as well as hundreds of nursing students.

Because GH-MC has major responsibility for the care of the poor, it is a much-used facility; it is also very much hated and criticized. Since 1965, the Medical College has graduated only one black student. During the 1967 ghetto-rebellions, the hospital was guarded by the Ohio National Guard (of Kent State fame). Despite this vigilance, bullets were fired at the hospital.

Chronic Crisis

Insurgency within Cincinnati's medical empire has been slow in developing. The hospitals and health institutions have, by and large, been successful in preventing or stifling union activity among hospital workers. The student and intern-resident staff are, for the most part, conservative or "apolitical." A housestaff association exists, but it is primarily concerned with salary issues. It has successfully raised salaries from $3,500 in 1967 to the present $9,000 a year. The relatively few activist students at the medical and nursing colleges have worked primarily outside their schools helping to organize a free clinic, researching and organizing a screening program for lead poisoning with the community council of Mt. Auburn, and participating in antiwar and women's liberation groups. The Cambodian invasion saw the temporary involvement of many more students who went out on strike, thereby closing the university and medical college.

Cincinnati has been in the throes of a chronic health care crisis. Several areas of the city have been without direct medical services for decades. Over the years, sporadic outcries have forced the City's Health Department to provide pediatric care through half-day, well-baby clinics held in several poor communities. And, over the years, small concessions to a few needy areas have been made with expansion of the Health Department's adult services beyond VD and TB control to some general care.

Still the entire Health Department budget is only $9.5 million a year, and less than $2 million of this amount is spent on community facilities. This does not include the nearly $2 million spent recently for the new Health Department Headquarters, which provides limited clinic services, appropriately enough, in its basement. That the care rendered is poor is no secret. A few months ago a member of the medical school faculty and Assistant Health Commissioner of the Health Department, Dr. Mary Agna, said: "The city has a totally inadequate, second-class system of public health. Its services and equipment are extremely poor. The equipment and methods are so bad I'm surprised anyone practices medicine down there."

Health conditions are so poor in Cincinnati that the development of a health movement could not be postponed forever. In 1969, despite the quiescence of health students and health workers, the East End Community began to act. Led by welfare rights members, this community, lacking any doctor or health facility and isolated from mass transportation, organized itself. With some additional help from a United States Public Health Service (PHS) officer, this primarily white, poor and low-income community, developed a plan for a neighborhood health center.

Health Councils

A mass meeting was held and plans for a community-controlled health center were approved. Four thousand dollars "seed money" was obtained from a Cincinnati foundation; a building was rented and refurbished by the community using donated and secondhand equipment. The clinic now has a budget of $26,000 which is raised from charitable, private sources. It has maintained community control by avoiding city funds, which are invariably associated with economic guidelines and central supervision by the City's Health Department.

Although it was unrealistic to expect
private philanthropic agencies to finance health centers in every neighborhood, communities followed the lead of the East End community and neighborhood health facilities soon became a priority issue. In one neighborhood, community people, together with several young people working as conscientious objectors, began organizing around health care demands. Other communities "got it together" with no outside help. By August, 1970, groups sprang up in English Woods, Price Hill, Winton Woods, Clermont County and several other communities. In each of these neighborhoods, community residents created "Community Health Councils" which determined priorities and operational procedures.

The Health Department soon became the target of insurgent community groups. The inadequate Department of Health clinics became vulnerable as the most visible manifestation of the city's lack of concern for people's health needs.

English Woods, an integrated community concentrated in the Metropolitan Housing Project, and Price Hill, a white area composed of a large concentration of Appalachians, were the pacemakers. Representatives of the Community Health Councils from these communities spoke before the City Council demanding the resignation of the unresponsive Health Commissioner, as well as immediate funds for health services in their communities. The people attended council meetings en masse, with full media coverage. Mrs. Beverly Dixon of English Woods, and Mrs. Icey Judd of Price Hill demanded $20,000 for each community to establish health centers. Petitions followed, demanding increased health services and the resignation of the Commissioner of Health.

In August, 1970, residents of English Woods descended upon the City Council Finance Committee, to demand city funds for the operation of a health center in their community. They were angry and frustrated at the run-around they had been given by the City and Department of Health since their initial request in February, 1970. The English Woods Health Board demanded the right to control the facility, set the budget, hire and fire all personnel and to determine policy. After further pressure at a full City Council hearing, the community was given $12,000 for operation of a health facility for the last quarter of 1970. The English Woods Health Board (a seven-member board elected by the community) began interviewing and hiring personnel from custodians to doctors. They obtained space in the Metropolitan Housing Project and began to furnish it. In October, when the English Woods Health Board had obtained commitments to contracts for doctors and nurses, the Board and community supporters went to the Health Commissioner for endorsement of the contracts and release of the committed monies. The Commissioner was under great pressure from the City to curb the community revolt against his department. After a series of long meetings with the community and night-long vigils at his office, he affirmed the local boards' right to direct the clinic, and signed a contract with the English Woods Health Board to this effect. The clinic started operating in October, 1970, with an approved budget of $48,000.

By March, 1971, the English Woods Health Center had expanded to five days a week, with evening sessions arranged for working people. Its staff, largely from the community, has worked collectively under the direction of the Community Board's policy guidelines. In the wake of this success, the Price Hill community has begun a campaign to expand the Health Department Clinic in Price Hill and turn it over to the Community Health Council for operation. So far, the City has not met these demands.

**Lundberg Report**

While communities challenged the Health Department for expanded and community-controlled health services, a crisis developed within the Health Department itself. Doctors, nurses, assistant administrators and maintenance workers resigned in increasing numbers, complaining of low salaries, poor working conditions, and inadequate patient services provided by the Health Department. The crisis reached the point where a clinic in the black community of Avondale had to be closed for lack of a doctor. A petition demanding the resignation of the Health Department's Commissioner, Dr. James Whorton, drew the signatures of 176 employees and was made public.

At the same time, the community broadened its attack against the Health Department to include the Board of Health. The Board of Health is a five-member board appointed by the Mayor for 10-year terms. Some board members had served since 1952. The Board approves health expenditures and sets policy for the Department of Health. Community groups accused the Board of "being an exclusive club which holds secret meetings and attempts to maintain all power." They called for a reorganization of the Board to represent the interests of the consumers of health services.

With both the Board of Health and the Health Commissioner under fire from the
community and Health Department workers, the City Council agreed to an outside study of the Health Department. Three University of Cincinnati faculty members were selected as the investigating team. Their report, the Lundberg Report, was a severe indictment of the Health Department. It called for the resignation of the Commissioner as well as the entire Board of Health. It noted “strong resistance to innovation and change. Sluggish bureaucratic methods have proved ineffective in dealing with the problems raised by community pressures.” Attention was called to the “norm of secrecy” and a “climate of distrust.” The report criticized the absence of any long-term planning and dissipation of energy in “crisis solutions.” The Board of Health was called “ineffective, and trapped in traditional solutions and methods.”

PHM

Meanwhile, some community people, feeling the need for a unified voice, organized an open membership group called the People’s Health Movement (PHM). PHM’s early membership consisted of 80 to 100 people representing welfare families, industrial workers, professionals, health workers and students.

At first, the Health Commissioner refused to release the results of the Lundberg Report. But under growing pressure from the alliance between lower-echelon Health Department workers, the community and the People’s Health Movement, the

It Stank—They Struck

While trade journals advertised Cincinnati’s “healthy labor climate,” 650 members of the International Chemical Workers Union, Local 342, fought a nine-month long strike against the Hilton Davis Company in Cincinnati.

The strike began on June 8, 1970 in conjunction with a strike of chemical workers at the Rensselaer, New York plant of the Sterling Drug Company, parent company of Hilton-Davis. Sterling had a total net sales in 1969 of $594,159,000 and makes Phillips Milk of Magnesia, Hall’s M.O., Fletcher’s Castoria, Lysol Products, Midol, as well as owning Winthrop and Breon Laboratories.

Hilton-Davis workers demanded a safety committee with worker representation to inspect the plant because of hazardous working conditions and dangerous pollution both inside and outside the plant. They also demanded an 80-cent-an-hour wage increase including a cost-of-living clause.

The strike received support from many elements of the community. Organized labor called for a boycott of Bayer aspirin and other Sterling products. Electrical and auto workers on strike at the time against G.E., G.M. and Ford over issues including health and safety, gave monetary aid to the Chemical workers and walked on the picket line. Members of Operating Engineers Union, Local 20, were fired for honoring the Chemical Workers’ picket line. Activists from the People’s Health Movement (see above) gave strong support to the Sterling boycott and walked the picket line. Workers were joined by students from Antioch College and the University of Cincinnati whose arrests gave the strike almost its only publicity. The press played down the strike and the issues behind it, especially the air pollution issue.

During the strike, Hilton-Davis workers got $25 a week in strike benefits and food stamps. In December the company canceled the workers’ health and hospital benefits and workers experienced first hand the inadequate health facilities available to the poor in good as well as in hard times.

Hilton-Davis refused to consider the demand for a health and safety committee. After 20 weeks of the strike, the company issued its “final offer,” and then placed classified ads for “replacements” for over 500 positions and began hiring in an attempt to break the strike. Finally, in March 1971 the union called an end to the strike. The workers were forced to settle for 33-cents-an-hour wage increase for this year, with a five percent hike over the next two years, and a partial cost-of-living clause. None of the health and safety demands was met and no health and safety committee was established in the plant.

Since the strike, a number of Hilton-Davis workers, together with workers laid off from other industries (10,000 workers have been laid off in Cincinnati during the last six months) have joined the struggle for improved health care as a result of their experience with poor health conditions in the work-place and their encounter with inadequate health facilities in the community.
Health Commissioner resigned in November, 1970, to be followed shortly thereafter by the resignation of the entire Board of Health.

PHM began to draw up demands for the reorganization of the Board of Health with a resident-consumer majority, and for a voice in choosing the new health commissioner. Following the resignations of the Board and Commissioner, PHM appeared before the City Council with 60 people. Mrs. Dorothy Green of English Woods said, "The Commissioner is one man and can't be all the problem. The poor and working people have to control the Board of Health."

In January, 1971, the Mayor appointed a new Board of Health. In a token concession to the community, Lorena Jewell, a 40-year-old working mother was appointed to the Board. She had been recommended by community groups, including PHM. However, the other four members of the new Board included two reappointments from the old board, and two establishment health leaders. Protests mounted against the composition of the new board, but were unsuccessful.

In April a rally was held in a downtown park with the slogan "Unite To Fight, Health Is A Right." About 300 persons heard speakers from the People's Health Movement, Welfare Rights Organization, Black Workers Liberation League, health workers and consumers from all parts of the City. After the rally, 200 people marched into the City Council under the PHM banner and demanded a charter amendment for a People's Board of Health and comprehensive health services.

The continuing pressure over these demands from the community and PHM has forced the Council to draw up a charter amendment revising the Board of Health to a 9-member Board with 3-year terms. The health movement is now rallying to secure a provision in the amendment requiring a resident-consumer majority before the proposal is placed on the ballot in November.

The community received another slap in the face in the selection of an acting Commissioner of Health. The Community Health Councils and PHM asked for veto power in both the choice of the new Commissioner and in the interim appointment. These demands were ignored when Dr. Mitchell Zavon, Assistant Commissioner for Environmental Health was appointed as acting Commissioner of Health.

Zavon, Shell and Lead

The community distrusted Dr. Zavon because of his position on lead poisoning, among other things. Dr. Zavon denies that lead poisoning is a "serious" problem in Cincinnati, and opposes lead screening clinics and education campaigns as "scare" tactics. He rejects the Surgeon General's guidelines on toxic lead levels and thinks treatment is warranted only in symptomatic children.

Yet, in August, 1971, the results of screening 194 preschool children in the predominantly black Mt. Auburn community showed that sixty children had abnormally elevated blood levels of lead. Follow-up testing is still being performed, but already 29 children have had the diagnosis of lead poisoning (by the Surgeon General's standards) confirmed.

In addition, Dr. Zavon, while he was Cincinnati's Assistant Commissioner for Environmental Health, also maintained a private industrial consulting firm and was a paid consultant to the Shell Oil Company, even testifying on behalf of Shell before Congress. He was the only health officer in the United States to endorse Shell's "No-Pest Strip." (see box p. 7.)

Because of Dr. Zavon's activities on behalf of Shell and against the community with regard to lead poisoning, PHM, citizens groups and Department of Health employees have called for his resignation. This is consistent with PHM's program calling for environmental protection and factory inspection programs, as well as comprehensive neighborhood health centers and free transportation to health clinics and hospitals.

Workers Arise

Health workers are becoming a vital part of Cincinnati's health movement. The Cincinnati Health Employees Council, made up of public health staff nurses, sanitarians, clerical and maintenance workers, has evolved out of the widespread discontent felt within the Department of Health. At a recent meeting held to discuss pay, benefits and career advancement, its Chairman said, "The community people are the ones who are speaking up and they are going to win. And notice, they're not saying request, they are saying demand! I suggest that we put that word in our vocabulary and stop acting like third-class citizens."

These and other health workers are becoming active in PHM, as are women active in women's liberation groups. A group of students at the medical college are researching Cincinnati's health power structure. This growing health movement is being given feature prominence in the City's new worker-oriented newspaper Movin' on Up.
Zavon's Shell Game

Shell Chemical Company's "No-Pest Strip" is a slow-release pesticide whose active ingredient is Vapona, DDVP. DDVP was discovered in 1955 by the Public Health Service (PHS) and is chemically related to nerve gases used in World War II. The organic-phosphate compound was tested by the PHS in Haiti, Upper Volta and Nigeria.

"No-Pest Strip" was approved for human use by the Department of Agriculture in 1963, over the objections of the PHS. It has since been learned that three Department of Agriculture consultants who were involved with the regulatory status of "No-Pest Strip" were employed by Shell Chemical. One of these consultants was Dr. Mitchell Zavon, until recently Cincinnati's acting Health Commissioner.

By 1970, the Food and Drug Administration had taken a second look at "No-Pest" and discovered that when it is used in kitchens, the strip leaves unacceptable levels of insecticide in foods. After initial resistance, Shell Chemical included a package warning against the kitchen use of "No-Pest."

But the controversy is still unsettled. Prof. Goran Lofroth of the University of Stockholm claims that DDVP makes dogs more susceptible to barbiturate poisoning, may cause chromosome abnormalities in peas, and may increase mutation rates in bacteria. Many scientists recommend a maximum intake of DDVP far below the level produced in the three month life-span of "No-Pest Strip."

At the present time, neither the FDA nor the Department of Agriculture contemplates any further action against the product.

APC—All Purpose Cure

The health movement in Cincinnati has scored some impressive gains. Until now, however, it has chosen not to attack the most powerful health institutions in the city—the General Hospital Medical College (GH-MC) and the large voluntary hospitals. Previous community pressures against GH-MC have been deflected by the creation of Ambulatory Patient Care, Inc. (APC).

APC was formed under the impetus of a $131,375 OEO grant to the University of Cincinnati in 1969. Its board consisted of "representatives of the poor" selected from the thirteen target areas served by the local OEO agency, the Community Action Commission. The medical school and hospital contributed some deans, professors and administrators. The Chief Administrator of General Hospital was chosen as Chairman of the Board of APC, Inc. The Board was supposed to develop plans for a $7 million neighborhood health care program. Two years later and most of the money spent, a plan was submitted to OEO calling for General Hospital to send $7 million to develop neighborhood health centers in three poor communities, two black and one white. OEO rejected the proposal as too poorly planned and chided the administrator to improve existing services at General Hospital. With its veneer stripped away, GH-MC is now more vulnerable than ever before.

The Lundberg Report fueled opposition against the Department of Health. Community groups, health workers and a sprinkling of industrial workers and students, are beginning to see that the Lundberg Reports' criticisms of the Health Department can be applied with equal justification to GH-MC and to all of the private medical institutions in the City. As the empire expands, people demanding better health care are beginning to realize that they are merely afforded the right to listen to the next promise and the next of the empire's grandiose schemes.

The perspective of the health insurgents, especially the community people, has developed through struggle with autocratic and unresponsive agencies of the City government and the health bureaucracy. While major institutions such as General Hospital-Medical College Complex have so far escaped the brunt of an organized attack, the insurgents' commitment to and their understanding of community control and its ramifications is growing rapidly and threatens this empire's security.—Gene Inch, M.D., former resident at Cincinnati Children's Hospital. He is presently serving with the U.S. Army, Fort Bragg, N.C.
In the last five years an occupational health and safety movement has flourished among Appalachian soft coal miners despite the concerted opposition, or at best indifference, of the coal companies, the United Mine Workers’ Union, local, state and federal government officials, and the universities and medical centers of Appalachia.

The struggle for minimal guarantees of health and safety have led to wildcat strikes, marches on Washington, and successful multi-million dollar law suits. Following the disaster at Farmington, West Virginia which took 78 lives in 1968, miners and an aroused public pushed through the federal Coal Mine Health and Safety Act. This granted the legal basis for the first real protection against the twin scourges of mining accidents and coal workers’ pneumoconiosis or black lung disease. In the course of this struggle, insurgents have knocked the United Mine Workers, once revered for its concern about health, reeling under charges of graft, collusion with management, and denial of members’ rights.

The mobilization of Appalachian miners is a significant development in an arena of increasing attention and concern within the health movement—that of occupational health and safety. What has caused miners to mobilize? Why has the opposition seemed so monolithic? And having at last cracked the monolith, what course will the struggle take now?

For generations miners in the eastern coal fields have battled a rapacious coal industry, which had guilefully bought up mineral rights of most of the Appalachian coal fields with broad form deeds; extracted vast sums of wealth from the mines at fantastic profit to absentee owners; fought pitched battles with mine union organizers; and built a society in which homes, stores, doctors, county and state governments were literally owned by the coal companies. During the 1930’s and 1940’s the heroes were the United Mine Workers with its legendary president, John L. Lewis, who for the first time brought the companies to their knees and brought some measure of dignity to a miner’s life.

But when John F. Kennedy toured West Virginia in the spring before the 1960 election, and Harry Caudill in 1962 wrote Night Comes to the Cumberlands, Americans learned of desolation, hunger and unemployment in the mountains, a dying coal industry and a union which although it had built eight Miners’ Memorial Hospitals where virtually no modern health services had existed before, no longer seemed able or even willing to fight for its members.

The New Economics of Coal

Ten years later too few Americans understand the new economics of coal. Coal production is now well over 500,000,000 tons a year, within shouting distance of its peak year in 1947. Though the railroad and home heating markets have disappeared, coal now supplies 53% of the electric power of the nation, and according to Fortune has an excellent long term outlook: “The federal government now views coal as ‘the cornerstone of our energy philosophy for the coming generations.’” Conversion of coal to gas, gasoline and oil, now on a pilot plant basis, is becoming feasible and economical. Coal, in terms of heating value, comprises 75% of the known fuel reserves in the U.S., whereas oil is but 5% and shale oil 13%.

With this new picture, several of the largest coal companies have been bought up by oil firms. Consolidated Coal, largest in the industry and long dominated by the Hanna-Mellon interests of Cleveland and Pittsburgh, has been taken over by Continental Oil, heavily infused with Rockefeller money. Indeed, Consolidated was the special creation of George M. Humphrey, Cleveland lawyer and financier. (See pp. 15 and 19.)

The mergers have given the coal industry giants exceptional capital resources and financial flexibility with which to carry through large scale mechanization of the mines. This has meant increased
Productivity on the one hand, and wholesale cuts in the workforce on the other. Productivity of American miners, with the new machinery, is 4 or 5 times that of miners in England and continental European countries. The price of this productivity, however, has been increased health and safety hazards for those who mine the coal.

Recent years have brought drastic change not only to underground mining. Strip mining has been transformed and has boomed due to the development of huge trucks and earth moving machinery and new road construction. Strip mining requires a relatively small but extremely productive workforce and little investment compared to the expense of extending and operating deep underground mines. But it also ruins the land in an especially devastating way: mountain tops and sides, trees and top soil are torn away irrevocably. Rivers are filled with acid drainage and silt. People’s homes are crushed. Left behind is devastation, resembling post-war Vietnam or the mountains on the moon.

It is this devastation which has called forth such vigorous protest, by mountain people, editors, writers, ecologists. And caught in the bind, as is often the case, are the poor and working people of the mountains. They are asked to choose between jobs free from the dangers of roof falls and black lung, on the one hand, and the integrity of their land on the other.

The United Mine Workers

Much of the history of Appalachian soft coal miners in the last forty years is the history of their union, its heyday and its decline.

Decades of mine wars launched by open-shop coal operators and fought by their gunmen were finally won in the 1930’s by the United Mine Workers of America (UMWA). Drawing heavily on the benevolent support of President Roosevelt, the union signed up hundreds of thousands of members. The union forced operators to sign contracts and wages rose rapidly under the impact of massive strikes. By the end of World War II the national union membership stood at 600,000 active members; the rest are retired.

By 1950, however, the industry had entered a decline, hastened by its loss of two mainstay markets, the railroads and home heating, to a competitive fuel oil. After the final bitter national strike of 1950 (there has been none in 21 years since), union president John L. Lewis negotiated the first industry-wide contract in coal history. The industry agreed to pay 30 cents a ton royalty to the UMWA Welfare and Retirement Fund and in return, the operators were given a free hand to mechanize the mines without union opposition.

This, in effect, lent union leadership support to the process of eliminating jobs for union members. It also tied the interests of the leadership to production and productivity, not only by its acquiescence to mechanization, but by its interest in higher royalties for the Welfare Fund.

For the union the result has been in many ways disastrous. The union’s membership dropped from 600,000 nationally to 193,000 in 1969. Only half of these are active members; the rest are retired. The unionized sector of the industry began to shrink drastically in the late fifties and early sixties, especially in Eastern Kentucky. Small non-union mines began to spread rapidly, and miners, forced to work in them to feed their families, lost their union welfare benefits. Moreover, the union began to cooperate with big management in support of coal’s fortunes in Congress and elsewhere. For example, Lewis lent union funds to Cleveland millionaire Cyrus Eaton to buy into a non-union Kentucky coal firm seeking to enter the Tennessee Valley Authority’s coal market. When Eaton was successful and became chairman of the board, he reciprocated and, signed a union contract with his creditors.

Yet this cozy relationship of union leaders with big operators did not extend to the membership. Union members were unable to elect their leaders. Large salaries, pensions and job security became the rule for the union leaders; low wages, unsafe working conditions, threatened unemployment and scabbing once pension became the lot of the miners.

The UMWA Welfare Fund had financed a benefit program for health and other needs of the men and their families. Eight Miners’ Hospitals were built in the early sixties (for union members only), bringing high quality medical care to the mountains for the first time. But the Fund could not long afford the expenses of underwriting private medical care in a depressed single industry society. Rather than close them, the UMWA unloaded ownership of the hospitals to a non-profit regional chain, Appalachian Regional Hospitals, set up and financed by church and government leaders.

More recent revelations, however, have shown extensive manipulation and mismanagement of the Welfare Fund. Millions had been lost by investing Welfare Fund money in non-interest-bearing accounts in the union’s own National Bank of Washington.

In this situation a struggle for democ-
racy in the union arose. Rank-and-file movements in the late sixties focused on mismanagement of the welfare fund, neglect of health and safety issues and change of the leadership of the union.

W.A. (Tony) Boyle, John L. Lewis' successor since 1950, faced opposition candidate Jock Yablonski. Boyle won primarily on the strength of the vote of retired miners (still members of the union), whose pension was raised $35 a month just before the election.

Yablonski's assassination by hired thugs 21 months ago only increased the furor in the coal fields. Retired miners and widows sued in federal court to expose mismanagement of the welfare fund and recently succeeded in knocking Boyle out as trustee of the fund. New organizations, such as Miners for Democracy, have emerged within the union, focusing on the soft coal contract which ends October 1. A recent report in The Miners Voice, newspaper of the rank-and-file movement within the UMWA, points out that rank and file contract demands center on a unique combination of economic and health and safety issues. Particularly important is the demand for a required safety shift for maintenance and repairs, and time to let coal dust settle, in addition to a six-hour work-day with three production shifts. Other safety demands are:

- that a doctor or nurse be present at the mines at all times;
- that all dust samples be taken by union men;
- that the right to strike during the contract over safety issues or repeated contract violations be guaranteed.

Safety

Coal mining has long been the most dangerous and disabling occupation in the United States. 100,000 have died violent deaths in the mines since the turn of the century and well over a million suffered injury. Massive explosions, taking scores to hundreds of lives, have been repeatedly attributed to the same causes through the years: critical accumulations of methane gas, inadequate ventilation, sparks from unshielded electrical equipment. And repeatedly accounts of these disasters tell of defective safety measures by the companies: ungrounded machinery, poor maintenance, improper handling of explosives, lack of safety programs and the like. Like a litany, too, are repeated accounts of state and federal inspections that fail to lead to the correction of safety violations before disaster strikes.

The 1969 Coal Mine Health and Safety Act was passed after miners, public and Congressional uproar following the tragedy at Farmington, W. Va. in Consolidated Coal's huge No. 9 mine in which 78 died. Far stricter controls than ever before were imposed on methane gas, on dust levels permissible in the mines, and on the shielding and grounding of electrical equipment, etc. Federal mine inspectors were, for the first time given authority to close a mine if it poses an imminent danger. Yet not only did the coal operators fight the law every step of the way before passage, but by law suits and political influence they succeeded in nullifying any real enforcement of its new safety provisions for many months.

The Bureau of Mines delayed several weeks in publishing the details of mine safety requirements set forth in the new law, prompting three Congressmen and a West Virginia miner to finally sue for their immediate publication. Later a group of small Eastern Kentucky operators sued the Bureau. When a judge granted a restraining order to prevent enforcement of the safety rules in that area, the Bureau stopped all safety enforcement in all mines throughout the country by its entire staff of inspectors.

The Bureau was supposed to have 1000 inspectors in the field by June 30 of this year. On May 28, the Wall Street Journal said the Bureau had hoped to have 705 by June 30, but in fact would have only 500. On May 29, in actuality, the Bureau had 251 inspectors in the field and 52 supervisors.

The uproar over mine safety enforcement became so great last year that Senator Harrison Williams of New Jersey, in August, succeeded in launching an investigation of the Bureau of Mines by the General Accounting Office (GAO), which is responsible to Congress. The GAO released its report early last June and charged thoroughgoing negligence on the part of the Bureau. The report disclosed that:

- Only 31% of the required safety inspections, and only 1% of the required health inspections had been made by December 31, 1970.

- The Bureau had failed to use its power to close mines when inspectors found repeated safety violations. Inspections had been "at times extremely lenient, confusing, uncertain and inequitable" concerning safety enforcement.

- The Bureau had failed to force operators to begin required dust sampling and had allowed them to submit "erroneous data."

- It had done little to induce operators to submit required plans for roof control,
ventilation and emergency action when a fan fails.

In the face of this barrage of criticism, one of the first moves of Rogers C.B. Morton, Nixon's new appointee as Secretary of the Interior (whose department oversees the Bureau of Mines), was to hire public relations man Harry Treleaven, with high GOP connections, to seek ways to improve the public image of the Bureau. Following the study, Treleaven, on his own initiative, launched a public relations campaign claiming that the key to the dangers in the mines was the miners' carelessness, not company negligence and pressure for production. A year-and-a-half after new "strict" federal law, safety enforcement in the mines continues to be lax. In 1970 deaths in the mines actually increased from a previous yearly average of 140 to 200 and over 10,000 injuries were recorded.

Unable to secure action from industry, government or their own union, miner's have resorted to wildcat walkouts to rectify conditions. Two large mines in southwestern Pennsylvania were struck in early January. At the Gateway Coal Company miners demanded a special federal inspection for excessive coal dust. At the Buckeye Coal Company mine in Nemacolin, they acted to speed workmen's compensation benefits to a miner injured on the job.

Black Lung

Less dramatic but far more prevalent than mine disasters is black lung or coal workers' pneumoconiosis (CWP). This newly designated disease was unknown to medical scientists in this country only a few short years ago. In fact, standard medical textbooks of the 1950's state coal dust is harmless. Yet evidence is fast accumulating that coal dust already known to propagate fire and explosion in a mine, is responsible for a specific respiratory disease of miners that can, within as little as five years in extreme cases, leave a man choking for breath, blue from lack of oxygen, and, in all, totally disabled and doomed to an early death. Known treatment is ineffectual. In fact, by far the best treatment is prevention of the disease by reducing the dust in the mines.

The 1969 Coal Mine Health and Safety Act for the first time gave legal recognition to this disabling disease. The Act established compensation for men already disabled by the disease and in addition it set maximum permissible concentrations of dust in the mines, to reduce or prevent future cases of illness.

One of the first rounds in the struggle for the new health and safety law focused on the permissible level of dust in the mines. Most experts felt no more than 3 milligrams of dust per cubic meter of air was acceptable. Yet when the coal operators in 1969 screamed they could not meet that standard in mines producing coal for federal contracts, Nixon's Secretary of Labor, George Schultz, obligingly relaxed the standard to 4.5 milligrams, half again the acceptable level. When the law was finally passed, it did require the 3 milligram dust level by June 30, 1971.

In a report delivered to a mining conference on November 7, 1970, Robert K. Jones of the Kentucky State Department of Health revealed that some miners in that state were breathing not half again, but 75 times the maximum concentration of coal dust deemed safe by federal law. This study also revealed that 37.4% of the state's underground mines exceeded the federal limits effective June 30, 1970.

For a three-year period ending in 1972, the new law set up a federal compensation program for black lung cases, to be administered by the Social Security Administration. After 1972, the program will revert to the states, whose workmen's compensation funds are paid mostly by the employers.

Administration of the black lung program by Social Security has been incredibly bureaucratic and restrictive. The Social Security Administration has relied on inexpensive and possibly misleading X-ray and breathing tests to establish diagnosis and state of total disability. The burden of proof has been placed totally on the miner (or his widow). Social Security has done virtually nothing to make available adequate testing facilities, staffed with competent, sympathetic doctors in the coal country.

Closer to the coal fields and fortified by an unmatched experience of examining some 4,000 miners in the last eight years, Dr. Donald Rasmussen of the Appalachian Regional Hospital in Beckley, West Virginia, has reported that X-rays and breathing tests are not at all a reliable guide to degree of disability. He states that gas studies of blood oxygen and carbon dioxide correlate best with functional disability. Rasmussen warns that not only are traditional researchers underestimating the extent of black lung, but the new mining methods of recent years, particularly new drilling machines, are making pulmonary cripples earlier and faster than older methods. Hence he forecasts a rising tide of black lung cases in the next several years.

As of April 30, 1971, 286,000 claims had been filed across the country and 246,000 processed (45,500 in West Virginia and...
28,000 in Kentucky). Of those processed, no less than 58% were disallowed. Denial letters did not even tell of rights of appeal. Even more incredible, the denial for miners (not widows) varied from 33% in Pennsylvania, which has a public-run black lung diagnostic and compensation program, to an enormous 78% in Kentucky (highest in the country). Some have sought to explain this discrepancy by the greater poverty and resulting "compensation-itis" in Kentucky. However, they appear to have overlooked the great influence of the coal companies on both state and federal office holders in Kentucky, as state takeover of the black lung program looms 16 months ahead.

State university medical centers have made gestures toward the black lung problem faced by miners. The Public Health Service has set up the Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD), sometimes known as the "Byrd Sanctuary" after its mentor, Senator Robert Byrd, at the University of West Virginia. In its two years of existence the laboratory has spent most of its time and energy preparing for expansion into a luxurious new building equipped with extensive machines and a salubrious surrounding golf course. At the present, ALFORD is engaged in a clinical (largely X-ray) study of 31 mines with 20,000 to 30,000 miners participating. A report on its findings is said to be due later this year.

The University of Kentucky, recently under attack for its stingy attention to the problems of poor people and miners of the eastern region of the state, has responded in a publicity release that quantified its efforts on the miners' behalf. During 1970, 280 miners were referred by Social Security for lung function tests. About 100 new patients a year from the mountains are seen in the outpatient clinic for chest disease. 50 to 60 a year are inpatients with similar disorders. And 60 to 80 are carried as long term outpatients with chronic lung disease, paid for up to recently by a federal research grant that has now run out.

The Black Lung Movement

This is the setting in which the Black Lung Association (BLA) has sprung to life and grown rapidly in the Appalachian coal counties. It was born in December, 1968, when miners in West Virginia's Fayette and Kanawha Counties joined to demand of the state legislature that workmen's compensation be allowed for black lung victims. Three doctors, Rasmussen, Buff and Wells, traveled the state speaking to miners' groups in their behalf. In Febru-

Goals of the B.L.A.

"1. To make coal mining a safe and healthy occupation. To ensure enforcement of the federal coal mine health and safety act of 1969. To improve state laws and their enforcement.

2. To improve the administration of all benefit programs for coal miners and to work for their improvement: state workmen's compensation programs, federal social security disability programs, the federal black lung program, the UMWA Welfare and Retirement Fund.

3. To return democracy to our union. To return constitutional rights of the rank and file to elect their district officials. To end corruption and featherbedding by relatives of our union's leaders."

In the summer of 1970, another dissident group stepped forward. The Disabled Miners of West Virginia, stung by progressive reductions in medical benefits and pensions from the UMWA Welfare and Retirement Fund, sought unsuccessfully time after time to meet with W.A. (Tony) Boyle, union president and trustee of the fund. Circulating by means of roving pickets, they soon pulled 200,000 miners off the job in West Virginia, Eastern Ohio and Western Pennsylvania. Employers sped to the courts to get federal injunctions against the wildcat walkout. Over a 3-month period they were eventually successful, and the walkout was defeated. But the struggle for rights within the union had advanced and was picked up by others in the movement.

September, 1970, brought the first major wave of benefit denials under Social Security and the Black Lung Association began an educational campaign on the rights of appeal. As a result, 14 or more local chapters of the Association sprang up in Virginia, West Virginia and Ken-
ALB worked to train lay advocates to press black lung claims and appeal of denials. And during the 1971 West Virginia legislative session, BLA joined other union dissidents to form the Workers Alliance for Fair Compensation. While the Alliance did not achieve its main goals, it made significant gains, including cost of living escalators for those on workmen's compensation.

Fed up with the evasions and delays on the part of the government black lung program, this past June BLA organized hundreds of miners and miners' widows in a bus delegation from the coal fields to Washington. The delegation presented the following demands:

- All eligible miners and widows have a right to complete and impartial examinations.
- We want properly equipped clinics, such as the one in Beckley, established throughout the coal fields.
- We want the use of X-ray evidence stopped. This is not the law and must be removed.
- We demand proper assistance in filing and processing claims.
- We want widows' claims decided on more liberal evidence.
- We want a dollar for dollar offset between compensation and black lung benefits stopped.

The health and safety movement has succeeded in crossing old lines that usually divide the rank and file from retired and disabled miners. It includes both miners and their families; black as well as white workers. In an industry which in many places has been deserted by the union, the movement unites both union and non-union workers. It cooperates with welfare rights and poor people's organizations and has merged the struggle for a better union contract with that for democracy within the union itself.

The organization of Appalachian miners around occupational health and safety issues holds important lessons for the health movement as a whole. The workplace makes up one-third to one-half of every worker's health environment, and if the health movement is to address the causes of poor health rather than simply its treatment, it cannot ignore occupational health and safety conditions. In attacking the causes of black lung, mine explosions and roof-falls, miners are truly conducting a struggle for environmental and preventive health.

Not surprisingly, to achieve these goals, the miners find themselves pitted against the major economic forces of that region—the coal companies which control its resources and which are responsible for its low wages, widespread unemployment, lack of medical facilities, blight, pollution, and supine governmental system. And, unfortunately they find themselves facing reluctant health institutions, which are not yet ready to make this commitment to treating the causes of illness.—Des Callan

CLEVELAND'S HEALTH ESTABLISHMENT

Cleveland—"the mistake on the lake"—is no accident. Its major problems—poverty, pollution, racial strife—are a predictable consequence of the city's economic and social setting. Cleveland is a city with an economic concentration in a few heavy industries—iron ore, steel, oil and steel-using companies (machinery, trucks, automobiles) and a social concentration in the core city of black and poor whites surrounded by a white middle and upper income suburban ring.

Unlike most midwestern cities, Cleveland is regarded by many as a progressive leader in private social welfare and health. It is the site of the first "red feather" campaign for community-wide support of private welfare agencies. It boasts a nationally renowned medical school with a reputation for innovative, community-oriented teaching.

But, today, Cleveland's health record
people, ringed by wealthy white suburbs of a city's major health institutions are University Hospitals, the major source of demonstrated so clearly that the leaders of corporate and banking elite. Rarely can it be and parcel of the city's industrial, corporate community.

But in Cleveland, perhaps more than in most cities, this health crisis can be linked to a health establishment, which is part and parcel of the city's industrial, corporate and banking elite. Rarely can it be demonstrated so clearly that the leaders of a city's major health institutions are also the leaders of its business and social elite community.

Health Institutions

Cleveland proper is divided into two sub-cities, the east side and west side, separated by the Cuyahoga River and its surrounding industrial "flats." The east side is predominantly black with several small enclaves of white European ethnic people, ringed by wealthy white suburbs like Shaker Heights. The west side is almost entirely white, including many poor Appalachians, people of middle European descent, and some Puerto Ricans.

More and more Clevelanders find it difficult to afford a private practitioner. Increasing numbers of them must resort to outpatient clinics at Cleveland's major hospitals. Meanwhile, the small voluntary hospitals and even the major teaching hospitals, caught within the city limits, increasingly serve a suburban population.

On the west side there are only a few small voluntary hospitals and most of them do not offer outpatient services. This leaves Cleveland Metropolitan General Hospital (Metro) as the major hospital with outpatient facilities on the west side. It is also the only public acute care hospital in the entire city. So, it must serve not only a sizable indigent west side community, but also those poor from the east side who are either rejected from clinics and emergency wards of the major private hospitals or who choose to obtain their care at Metro. Over 60 percent of Metro's patients pay the dollar, to travel 1/2 hours to come from the east side by bus. Metro is the typical public hospital: long lines of patients wait in the registration area; the outpatient clinics are flowerless and drab and almost always overcrowded; inpatient wards are understaffed; and there are virtually no outreach or satellite services in the community. As one west sider (a long time neighbor of the hospital) remarked: "Our hospital's still thought of as a butcher shop 'round here."

Virtually all of Cleveland's major private hospitals are located on the east side. They include such middle-sized voluntary institutions as Mt. Sinai, St. Luke's and St. Vincent's hospitals, all of which have outpatient clinics and emergency wards. These hospitals were built, not to serve the poor people now living on the east side, but to serve the rich people who once lived there.

The Cleveland Clinic is a 600-bed voluntary hospital modelled after the Mayo Clinic. It operates entirely on a fee-for-service basis, with a staff of full-time salaried specialists. For those, who need (and can afford) a kidney transplant, open heart surgery or specialty diagnostic work-up, it's a great place to go. There are well-appointed, wood panelled waiting rooms; multi-course dinners and butcheries; even a plush motel, the Clinic Inn, run by the Clinic for patients undergoing diagnostic check-ups. But there is no outpatient department and only limited emergency room services, so that the black community which surrounds the Clinic can hardly set foot inside it. Only a third of the Clinic's patients come from Cleveland anyway; the others like an Argentine government official recently flown to the Clinic for heart surgery, come from the "whole world."

Even though the Cleveland Clinic has an international reputation, its significance in the Cleveland health system pales in comparison to the University Medical Center (UMC). Located just twenty blocks from the Clinic on Cleveland's east side, the University Medical Center is the city's largest and most prestigious medical complex. It consists of the Case Western Reserve University Medical School (CWRU) and its affiliated University Hospitals, a seven-hospital, 565-bed complex.

UMC is rich. Its yearly operating budget totals more than $50 million. The medical school budget alone has grown from $2.2 million in 1950 (with 34 percent of the funds coming from the federal government) to $16.4 million in 1970 (with 59 percent from federal funds). With this 750 percent increase in funds in the last twenty years medical student enrollment at CWRU only increased 12 percent.

UMC is powerful. Its trustees include some of the most powerful and wealthy
doctors at UMC—hold all the power. But
deep probing unearths another group
—the business and high society representa-
tives—who, through their presence on the
boards of the leading health and social
welfare institutions, command the major
role in Cleveland's health establishment.
For purposes of clarity, this group is sep-
ated into "business oligarchs" and "high
society." Of course, this distinction is
somewhat artificial. Both the "business
oligarchs" and the "high society" repre-
sentatives overlap, control enormous
wealth and ultimately make decisions
based upon their own political and
economic interests.
The Business oligarchs: Cleveland is
run by a group of no more than 50 men,
the men who direct its top corporations.
(See "The Cleveland Papers," prepared
by the Cleveland Radical Research
Group, 2238 Grandview Avenue, Cleve-
land Heights, Ohio.) These men control
the city economically through their power
as employers of hundreds of thousands of
workers, culturally through their control
of the schools, newspapers and museums,
and politically through their ability to
finance mayoral candidates and lobby at
City Hall and in the State Capitol. They
exert their influence in every sector of
community life—housing, education, so-
cial welfare and health. A few examples:
Willis Boyer, the president of Republic
Steel (Cleveland's largest company un-
til recently) sits on the boards of Univer-
sity Hospitals, CWRU, the Cleveland De-
velopment Foundation (a major funder
of urban renewal) and the Commission
on Health and Social Services (spo-
nored by the United Appeal). He has also
served on the boards of the United Ap-
peal and the Regional Hospital Planning
Council. In his business life, he is a director
of Sherwin-Williams paint and chemical
company, National City Bank of Cleve-
lancd and the Marathon Oil Company, as
well as Republic Steel. (Republic and
Hospital Workers'
Hospital workers, particularly non-professional workers, have been among
the lowest paid of all American workers. In Cleveland in 1966, nurses' aides
(women) were earning a mean wage of $38.50 a week, while kitchen help (wom-
en) were earning $1.38 an hour and porters (men) $1.60 an hour. In addition to
low wages, hospital working conditions have been poor, with no avenue for
redress of grievances. To fight these injustices, hospital workers have struggled
to form unions. In Cleveland, the conflict between the hospital workers and the
administrators/trustees surfaced in the mid-60's.
As early as 1963, University Hospitals bitterly attacked unionization efforts
among its workers. Part of the anti-union campaign was a letter to all em-
ployees: "University Hospitals, however, as your employer, is opposed to rec-
ognizing any union or organization which seeks to act for hospital employees.
This has been our position for many years." As reasons, they offered: (1) UH
has a good record of improving wages; (2) the ultimate threat of a union is a
strike "which in a hospital is unthinkable"; and (3) as a non-profit institution,
UH is not required by law to recognize a union.
Not much union organizing occurred until 1967. Then Local 47 of the Build-
ging Service and Maintenance Workers led a year-long strike at St. Luke's
Hospital for higher wages, better working conditions and the right to organize
hospital workers at St. Luke's. Tensions ran high. Several trustees' homes were
firebombed, and many striking employees were arrested.
For the first six months, the trustees refused to negotiate with the workers.
An arbiter was called in, but was unable out work out a settlement. After ten
months, Mayor Stokes and the City Council threatened to pass a labor rela-
tions law, requiring non-profit institutions (such as hospitals) to recognize any
duly elected union. Pressure from throughout the health establishment was
placed on St. Luke's to recognize Local 47, since other hospitals did not want
to be forced to hold union elections.
St. Luke's gave in. Subsequently, Local 47 led successful drives to unionize
maintenance workers at Forrest City and Women's Hospitals, and presently
has cases in court against Lutheran and Fairview General Hospitals. However,
attempts at unionization have been squashed at the big private hospitals on
Cleveland's east side—Mt. Sinai, UMC and the Cleveland Clinic.
The model union-buster has been Mr. Sidney Lewine, administrator at Mt.
Sinai. Lewine has his administration approach each long-term employee indi-
Sherwin Williams are among Cleveland’s top polluters.

George Karch, the chairman of Cleveland Trust Bank, sits on the boards of CWRU, Cleveland Clinic, Health Hill (a private pediatric hospital), the Cleveland Foundation and the Cleveland Development Foundation. He is a director of Ogle­bary Norton (iron ore mining), Reliance Electric Company, Cleveland Twist Drill Co., Medusa Portland Cement, Warner and Swasey (machine tools), White Motor Co., North American Rockwell Corp., and over ten smaller firms.

J.D. Wright, chairman of TRW Corp. (auto and airplane parts), sits on the boards of University Hospitals, the Cleveland Foundation and, formerly, the United Appeal. He is a director of Republic Steel, Goodyear Tire, National City Bank, Sher­win Williams and Eastman Kodak.

H. Stuart Harrison, chairman of Cleveland Cliffs Iron Co., is on the board of University Hospitals, the Cleveland Foundation and the Cleveland Development Foundation. He is a director of over 19 companies, including Jones and Laugh­lin Steel, Medusa Portland Cement, Cleveland Trust Bank, White Motor Com­pany, Weatherhead (ordnance), Mid­land Ross and LTV (a conglomerate).

Traditionally, these men, plus others not listed, hold the ultimate power over long-range planning for Cleveland’s health institutions. As hospital and medical school trustees, as members of important city-wide health funding and planning bodies, they control hospitals’ long-term construction and expansion programs and set the overall tone of health policy in Cleveland.

But the corporate interests of these men often run against the health interests of the people of Cleveland. They direct the companies which have poisoned Lake Erie and made Cleveland’s air a health hazard. They direct the banks which refuse to finance decent homes for poor people. They are members of the Chamber

**Union Story**

...with a personal appeal for the hospital and against the union. Short­term employees are reached through the most sympathetic long-term workers. This, combined with judicious letters and selective pay raises, resulted in union defeat by 12 votes in 1968.

Similar tactics have been used at UMC and the Cleveland Clinic. In 1968, James Harding, the Cleveland Clinic’s administrator sent the following letter to all employees: “We are sure you are aware that for the past few months a ‘dues hungry’ building service union has been pressuring Cleveland Clinic employees to sign cards . . . You should be warned that in an attempt to win an election and take over all Cleveland Clinic employees, this union will say everything and promise anything which it thinks will persuade you into voting it into power. When you read this slick union propaganda, always keep in mind that employees in another hospital who fell for the union found themselves out on the sidewalk without a job, without pay, in a strike that lasted for nearly one year.”

In Cleveland’s public hospitals, the struggle was less protracted. In 1967, Local 1746 of the American Federation of State, County and Municipal Em­ployees (AFSCME) conducted a six-month strike at Sunny Acres Hospital (a public chronic care facility). Rather than face strikes at the two remaining public hospitals (Metro and Highland View), the county government recognized the union for all three hospitals.

In 1969, nurses at St. Vincent’s Hospital fought to get the Ohio Nurses’ As­sociation recognized as their bargaining agent. Concerned primarily with issues of working conditions and “dignity”, the nurses walked out. For two months, St. Vincent’s administrator refused to recognize the Ohio Nurses’ Association, until City Council forced capitulation by passage of the Cleveland Labor Relations Law.

Responses to these organizing efforts have consistently met with bitter oppo­sition. Striking non-professionals got little or no support from their professional co-workers. Professional associations did not want to be linked with “workers struggles”. Not one doctor supported the striking nurses at St. Vincent’s. White workers were separated from black workers. Out of the 450 striking workers at St. Luke’s, 448 were black. These divisions maintained through racism, sexism and professionalism stood the hospitals in good stead.
of Commerce which consistently lobbies for lower corporate taxes, hence inadequate Medicaid and underfinanced public health services. They direct companies whose indifference to workers' safety leads to hundred of industrial accidents each year in Cleveland. To them, hospitals do not represent health care institutions so much as they represent concentration of wealth and real estate. Control over the city's health institutions is just one more way that these men control the life of Cleveland.

High Society: The power of the business oligarchs in the city is economic, and is based on their institutional positions as top officers and directors of leading corporations. "High society" members of the health establishment, on the other hand, derive their civic importance simply from who they are—their family and social connections, their membership in exclusive clubs, etc. Their names appear—not in the business section of the paper—but in the "society" section, in Cleveland's Blue Book and the Social Register. They are Cleveland's cultural and social arbiters, whose influence extends from the symphony and the Garden Center to the hospitals, social service agencies and foundations.

To be sure, many of the high society health leaders were once business oligarchs or descended from families who made their fortunes in coal, iron ore, oil or shipping. Families such as the Boltons, the Oglebays, the Hannas, the Severances and the Mathers, after making their fortunes, set out to make Cleveland a great cultural and medical capital of the midwest.

In many cases, their current descendents have sold-out their shares in the family corporation, but retain their control over the family foundation, e.g., the Bolton Foundation, the Elizabeth Severance Prentiss Foundation, or the various Mather and Hanna Trusts (all of which fund health services). They also sit on hospital and health agency boards, having "inherited" these positions along with the family wealth and social position.

In the area of health, the old-family members of high society cluster, not surprisingly, around the University Hospitals board. The Humphrey/Hanna/Ireland family grouping has been mentioned. Another example is Severance Milliken (of the old Severance family as well as the Millikens) who sits on the Boards of University Hospitals, St. Luke's Hospital, and the Cleveland Development Foundation. Then there are the Boltons, for whom CWRU's nursing and dental schools are named. Mrs. C.C. Bolton was on the board of University Hospitals until her death last year, while Mr. C.B. Bolton (board chairman of the exclusive Hawken School, a prep school) served on CWRU's board.

There are two other categories of health leaders in Cleveland, both subordinate to business oligarch and society-dominated boards of trustees. These are men who lack economic or social leverage of their own, and are important only because of the staff positions they occupy in health institutions or agencies. They are "professionals"—doctors and administrators. They have power in the internal decision-making within their institutions: decisions about personnel, administration and medical services. But their long-range decision-making powers are limited.

The Promoters: These are the most visible day-to-day "operatchniks" of the health establishment. They participate in the decision-making of their own institutions, often spearheading new programs with high public relations output. They are involved in the doings of the Hospital Association and the Regional Medical Program. They consult with the Cleveland Foundation and the Welfare Federation and lobby at the State Capitol for favorable legislation. They are the institutional representatives to the public eye. Among these leaders are Dr. Frederick Robbins, Dean of CWRU Medical School; Mr. Samuel Wittman, Associate Dean of CWRU Medical School; Mr. Stanley Ferguson, chief administrator of University Hospitals; Mr. Sidney Lewine, administrator of Mt. Sinai Hospital. Although these leaders appear to have considerable independence within their spheres, their objectives and activities must conform to those of the trustees that comprise their boards.

The front-men: These men are not truly health leaders at all, but they are easily mistaken for leaders. The best examples are the directors of the City Health Department and of the Metropolitan Health Planning Commission. Both take flack from health consumers for unpopular health policies, although both belong to essentially powerless agencies. For example, Dr. Frank Ellis of the City's Health Department is often blamed for the city's failure to staff the newly built west side health clinic. But it's not his fault that the city hasn't the funds to occupy the expensive new building. Witness his impotence when the mayor, last winter, subjected the Health Department to a disastrous 50 percent cutback. When Dr. Lee Podlin, director of the Metropolitan Health
Planning Commission was urged by local activists to take a strong stand against UMC's threatened cutbacks in clinic services (due to inadequate Medicaid reimbursement and the Trustees unwillingness to continue subsidizing poor people's medical care), he maintained a gentlemanly silence. "That isn't how things are done around here," he said.

Are the health leaders, specifically the businessmen and socialites, just a random collection of names, or do they comprise a coherent establishment? There is no evidence that they sit down together periodically to hammer out health policy for the city of Cleveland. But there is evidence that they share an implicit health policy and that they use hospitals for their own narrow purposes. These points are well illustrated by two case examples: the role of Cleveland's health leaders in resisting prepaid group practice and in promoting urban renewal.

Community Health Foundation

The Community Health Foundation (CHF) was founded in 1962 by the steelworkers', painters', plumbers', retail clerks', meatcutters', machinists', and automobile workers' unions. It was conceived as a traditional prepaid, group practice program providing doctor's office and home visits, hospitalization and limited psychiatric care but excluding dental care and drugs. Membership in a group, usually a union, was prerequisite for joining.

For the average Clevelander, prepaid group practice represented a real improvement in health care delivery. It meant that medical care could be obtained without regard to its cost and that preventive check-ups were encouraged. The entire family could be cared for under one roof, with a continuous medical record from doctor's office to the hospital, and an end to fragmented health services. CHF was designed to make minimal reforms, but not to solve the major shortcomings of the American health system, such as the availability of health care for the poor.

(See November, 1970 Health-PAC BULLETIN for analysis of prepaid group practice.) Nonetheless Cleveland's "health establishment" resisted its development strongly.

The first sign of resistance occurred in June, 1962. After eleven months of negotiation between consultants hired by the unions and UMC, the word came down: UMC would not affiliate with CHF. This came as a shock to those associated with CHF. The negotiations had proceeded well, with considerable support from most of the chiefs of service at University Hospital, including Dr. Robert Ebert, then chief of medicine, now dean of Harvard Medical School. Although there was some dissension among the doctors, none wished to block the program. The proposal was novel. CWRU was to be the site of the first prepaid group practice program affiliated directly to a medical school. (Since that time, many medical schools have established such programs, including Harvard).

For CHF the benefits of a medical school affiliation were clear. First, it would guarantee high quality medical practice, at least as defined by the medical school. Second, perhaps more important, it would assure adequate physician manpower for the program. And third, it would guarantee a back-up hospital for CHF admissions.

For the medical school, a prepaid group practice provided a convenient "captive" population for teaching, as well as the opportunity to shift the focus of medical student and house staff training from purely hospital-based medicine to outpatient medicine. The importance of finding a "new" teaching population was uppermost to those like Dr. Ebert who favored Medicare and other national health insurance programs which, by providing new medical opportunities for indigent patients, threatened to eliminate their traditional use as "teaching material."

Why then did UMC turn CHF down? In part, UMC refused because the decision was not left up to its chiefs of service. Apparently, the issue reached University Hospitals' Board of Trustees. Two reasons are commonly given to explain the Board's negative response. The first revolves around George M. Humphrey, one of the most prominent members of the Board. Humphrey had drawn up the constitution and by-laws of University Hospitals in 1920. Shortly thereafter he became President of the M.A. Hanna Company and in this capacity, developed a strong anti-labor bias, which he often expressed while later serving as Eisenhower's Secretary of the Treasury. CHF had been initiated and funded by labor unions. Humphrey wasn't about to let "his" medical center affiliate with a union-dominated health plan.

The clincher, however, was the drop in donations to UMC's $54 million expansion program. In April, 1962, UMC announced a dramatic building program which included new nursing, dental and medical school buildings. Shortly thereafter, news about the potential UMC-CHF affiliation was leaked to the press. Conservative alumni and other potential funders apparently withdrew their support from UMC's expansion drive. When it was all
over, CHF was told by one UMC spokesman, "You've cost us over $2 million already without even affiliating."

UMC's refusal to affiliate with CHF was a severe blow to the newly-incorporated organization. Planning and operating goals were set back by one year at least. The whole project appeared in jeopardy. Despite the risks, the labor unions backing CHF insisted that plans move forward.

On July 4, 1964, CHF opened the doors of its new outpatient building located on the east side. Capital for construction had been raised through loans amounting to $500,000 from the unions and $650,000 from Central National Bank. The health plan grew rapidly. Within four years, membership passed 30,000. A second outpatient facility was opened in Parma, a southwestern suburb of Cleveland.

But CHF was plagued with economic problems. Many of these stemmed from the lack of a CHF-owned hospital. As hospital costs leaped upward in the post-Medicare era, CHF was unable to negotiate the same reduced hospitalization rates as Blue Cross. CHF ended up paying as much as $176/day for patients hospitalized at University Hospitals. Furthermore, Blue Cross lagged in raising its rates as Blue Cross. CHF ended up paying as much as $176/day for patients hospitalized at University Hospitals. Furthermore, Blue Cross lagged in raising its own subscriber premiums. The final economic straw was the purchase of a proposed new hospital site in Independence, Ohio (south of Cleveland) for $400,000. After buying the land, the town unexpectedly denied CHF the necessary zoning clearances.

Rising economic problems threatened CHF with extinction. Cleveland's business and society "health leaders" now had the opportunity to rescue the program. Its dramatic growth had demonstrated CHF's vitality. But the banks closed their doors. Even Central National, which had advanced the original loan to build the east side center, reneged on its promises to help finance the new hospital. CHF was forced to turn outside the Cleveland community for help.

In 1968, CHF sought the aid of the multi-million dollar west coast Kaiser Foundation Health Plan (with 1970 revenues of $313 million). After several months of negotiation, an agreement was reached. Kaiser offered $3.5 million to construct a CHF hospital in Cleveland, in return for virtually complete control of the program. CHF became the Kaiser Community Health Foundation (KCHF) and Kaiser demanded that of the new nine member board, six seats be reserved for Kaiser. Until the merger with Kaiser, CHF had a decidedly local flavor. Although it had been established with the aid of nation-wide consultants, CHF had been initiated and controlled by local Cleveland labor unions. This had given CHF a measure of subscriber control. With the entry of Kaiser, and its persistent opposition to any form of subscriber control, CHF lost its independence. Industry now controlled KCHF and would operate it like the "business" that most prepaid group practice is about (see Health-PAC BULLETIN, November, 1970).

The case of the Community Health Foundation illustrates how Cleveland's "health leadership" has thwarted the development of improved forms of health care delivery through prepaid group practice. These same forces have collaborated in using hospitals for their own ends, in the second case presentation: Cleveland urban renewal. For it is here, that Cleveland's major hospitals became pawns in a larger enterprise—black removal by white institutional real estate interests.

Urban Renewal

Since the mid-1950's, the central part of Cleveland's east side has been almost entirely black. Blocked from settling in better neighborhoods, blacks coming from the South were forced to crowd into already deteriorated areas, like Hough, Central and Glenville on the east side. Rising black unemployment in the late fifties and early sixties led to more crowding and further deterioration. The slums extended from the heavy industrial flats around the Cuyahoga River and the downtown commercial district on the west, to the university and upper class suburbs on the east.

As early as 1954, Cleveland's top business leaders, the heads of Republic Steel and Cleveland Electric Illuminating Company (the chief utility), decided to take action to save the city from "blight" as they called it. First, they formed a nonprofit corporation, the Cleveland Development Foundation (CDF) to promote urban renewal in Cleveland. With over $1 million in contributions from Cleveland's top firms and a $5 million grant from the Hanna Fund, CDF was supposed to provide "seed money" and planning assistance to the city government's urban renewal agency. Actually, CDF quickly supplanted the city and became a kind of private "government" for urban renewal. In addition, the University Circle Development Foundation (UCDF) was founded in 1957 to concentrate on redevelopment of CWBU and UMC and their environs. Trusted by top board members from University Hospitals, Case and Western Reserve Universities and initiated by a grant from the Mather family, UCDF rep-
resented the same interests as CDF.

The pattern of urban renewal undertaken by the two development foundations strongly suggests that they shared a common strategy to reclaim the east side from the blacks. First, urban renewal on the east side has been primarily used to create land for industrial, commercial and institutional re-use, not for low-income housing. Second, the urban renewal projects comprise a dumbbell-shaped area. At one end is Erieview, the CDF-sponsored downtown renewal project, slated for office buildings, luxury apartments, malls and fountains; at the other end is University Circle, developed over the last ten years into a gleaming island of cultural institutions. Along the bar of the dumbbell lie the University-Euclid renewal project, the Cleveland Clinic and Cleveland State University. Just south of the bar is St. Vincent's Hospital's urban renewal area.

A former top staff member of CDF admitted that this arrangement was not accidental, but the result of a conscious strategy (a "planning concept," as he put it). That strategy was, first, to build up two white-dominated enclaves at either end of the east side—Erieview on the northwest and University Circle on the southeast—and then connect these enclaves by a white corridor running through the ghetto.

The Hospitals were willing instruments in the implementation of this strategy:

St. Vincent's, with planning funds from CDF, displaced over 1200 families, 95% of them black, to make room for luxury high-rise apartment buildings. When no developers could be found for the high-rises, the land was sold, at reduced rates, to Cuyahoga Community College, to the Boy Scouts and the Salvation Army for new headquarters, and to some lesser voluntary agencies. At the outset of the project, St. Vincent's board chairman described the project's relation to CDF's overall plans with touching humility: "We admit that Charity Hospital [St. Vincent's] represents but a small part of this broad development picture. The hospital is but a tiny plot of ground, 10% of the area involved in the entire plan [the entire St. Vincent's plan]. But in our small way we wanted to be part of this movement to reawaken the heart of Cleveland."

Cleveland Clinic in the early sixties, revealed its plans to expand four blocks along Euclid Avenue (the main artery of the "white corridor") and cover a total of seven square blocks. By 1965, it had acquired all but 25 percent of the needed land, and began to look to urban renewal as a way of getting the rest. The clinic proceeded to hire a full-time urban renewal coordinator and arranged with UCDF to get a piece of the University-Euclid project pie. The Clinic set up its own multi-institutional development foundation including the Health Museum, Women's Hospital (a small voluntary hospital) and the Harshaw Chemical Company, which was planning to build a research lab in the area. Since then, the Clinic has decided that urban renewal meant "too much red tape," and returned to its private land-grabbing operations. This meant that, instead of having the right of eminent domain to displace die-hard landowners, the Clinic has, according to residents of the area, resorted to intimidation to secure the last little lots. Even though the Clinic has broken off its plans to work directly with UCDF on the University-Euclid project, it retains ties to UCDF. The present director of Cleveland Clinic's expansion program Neil Carothers, is the former president of UCDF. (Prior to that he was an executive of the construction firm which did most of the re-building of University Circle for UCDF.)

University Hospitals and the CWRU medical school were not simply instruments of the overall strategy. As key institutional members of UCDF they were, in effect, co-conspirators. The boards of University Hospitals and the University are closely interlocked with those of CDF and, of course, UCDF. University Hospitals and the medical school, which together garnered over half the funds spent on University Circle redevelopment, must be considered chief beneficiaries of UCDF's implicitly racist policies.

When UCDF went into business in 1960, then-president Neil Carothers, explained: "On several sides University Circle has fine stable neighborhoods, but on other sides are badly deteriorating sections where crime and disease are skyrocketing. And no apple stays good when there are bad apples around it... Something had to be done. [UCDF's] 20-year development plan is the answer."

UCDF's short-term answer was to hire a private police force to keep the "crime and disease" out of University Circle proper. Its long term answer was the University-Euclid urban renewal project. Ostensibly designed to rehabilitate slum housing, the project actually worked to force out the slum dwellers. By 1966, only 11 percent of the homes slated for rehabilitation had had even perfunctory repairs. Hundreds more homes were destroyed to make room for commercial and institutional building, forced people to crowd even more tightly into the remaining dilapidated structures. Then, because the area was slated for urban renewal, the
city suspended enforcement of housing codes and cut back on garbage and police services; landlords cut back on home maintenance. Rats multiplied, garbage piled up, and disease spread—right on the doorstep of Cleveland's most prestigious medical complex. It was UCDF's "gift" of urban renewal to the people of Hough that set the stage for the week-long riots of 1966.

The net results of Cleveland's east side urban renewal projects, for which the medical institutions deserve so much credit, can be summarized quickly:

■ Twice as many housing units were destroyed by urban renewal as were built, leaving Cleveland with a severe housing shortage: Cleveland now has 55,000 substandard housing units and the number is growing every year, but the city's vacancy rate is a dangerously low 1.5 percent.

■ Over 4500 families, almost all black, were displaced by urban renewal. Only 40 percent of these were relocated by government agencies, the other 60 percent had to fend for themselves. Of those who were "lucky" enough to be relocated by the city, 56 percent were sent to areas which were already over 90 percent black; 89 percent to areas which were over 50 percent black. The St. Vincent's and University-Euclid projects were responsible for most of the displacement.

Cleveland's program is the classic case of urban renewal as black removal. Thomas Westropp, president of a minor Cleveland bank, said in 1970: "For some, the urban renewal program has worked very well indeed. Hospitals and educational institutions have been constructed and enlarged. So have commercial and industrial interests and many service organizations—all with the help of urban renewal dollars. With respect to housing, however, the urban renewal program has been a disaster . . . I wish I could believe that all of this was accidental and brought about by the inefficiency of well-meaning people—but I just can't. The truth, it seems to me, is that it was planned that way."

The history of Cleveland's urban renewal programs illustrates how the city's health establishment, both business oligarch and socialite, uses health institutions to advance their own interests. Cleveland's east side "blight" (read blacks) had to be cleared to preserve the city's downtown office center and university cultural area. Through the process, Cleveland's major east side medical institutions became "real estate empires," as well as medical empires.

Both case examples, point to the existence of a health establishment beyond the hospital administrators, the deans, the heads of planning agencies and health departments. There is no reason to believe that the interests of this health establishment coincide with the interests of the majority of Cleveland health consumers. To a man and to a woman, Cleveland's elite does not live in the city proper, but in the eastern suburbs. None of them uses the hospital clinics, the wards, the smaller hospitals and the prepaid group practice that the average Cleveland health consumer must depend on. In fact, there are reasons to believe, that the interests of the health establishment actually conflict with those of the average Cleveland health consumer. The former looks to a health institution as a source of prestige or as a block of real estate; the latter looks to it as a source of basic survival services. The same "boss" on the job is ultimately "boss" of the health system. For in Cleveland, perhaps more clearly than in any other American city, the health establishment is the city's "ruling class." — Cleveland Women's Health Research Group