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Health Policy Advisory Center

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Two Days in October

It took less than eight hours, yet the great stock market crash jolted the nation's thinking. Our most fundamental assumptions about the future and what we can expect from it were radically disrupted. Just eight days before, though, an event of a different sort occurred—the National Gay and Lesbian March on Washington, an event involving people, not profits, an event which offers hope for the future of grassroots activism and health care.

Whether the market recovers from "Black Monday," October 19, or plunges farther, one thing is clear: as long as Wall Street continues to control the capital that determines how, where, and to whom health services are delivered, patients and workers, not investors, will be the big losers.

We will lose because the bulls and bears of Wall Street exist on a terrain of speculation and profits far removed from the needs of the tens of millions of Americans who have little or no access to our nation's health-care services. As we've long been saying in these pages, it is simply crazy, if not criminal, that a service as vital as health care is largely controlled by a financial community whose sole interest is its own profit.

The future will be grim under such an arrangement: health care will follow the haves and avoid the have-nots as the public's access to affordable services continues to evaporate. While we're certain of this prognosis, we can only guess how the crash is likely to affect the fiscal condition of the health-care industry.

From Heyday to Doomsday

Health care, like other sectors of the economy, shared in the profligate bull market of the Reagan Era. The growth of for-profit corporations and the proliferation of paper fortunes quickened to an astounding pace as the new corporate health stars won the confidence and dollars of Wall Street investors.

Over the past 20 years— but particularly in the last 10—new types of health-care organizations sprang up and were absorbed into the Medical-Industrial Complex. Their concern was finance, not health care: attracting capital, repelling mergers and takeovers, and spending fortunes on marketing, advertising, and real estate. In their hunger to satisfy the frantic greed of the affluent—as opposed to improving the quality and accessibility of health services—they siphoned money away from the bedside and turned patients away at the door.

It's been getting worse for a long time, and those who can tell you best are not the economists, but the hospital workers—the nurses and aides and doctors whose ability to provide care has been crippled in the name of cost-cutting and profits.

But with all their scheming—and this is the important point—the corporate health giants failed even on their own terms. October 19 wasn't the first time the ground crumbled at their feet. Responding to low occupancy rates, low profits, and the industry's overextension into the insurance business, investors began backing away from health care two years earlier. On Oct. 2, 1985, the stocks of the four largest hospital chains lost \$1.5 billion; within a year over one-third of their worth disappeared.

Investors' belief in full-service, vertically-integrated

Demonstrators at the Gay and Lesbian March on Washington explore the monumental quilt memorializing nearly 2,000 people who have died of AIDS. More than half a million people marched Oct. 11 demanding a humane, national response to the epidemic.



Rolf Sjogner/Impact Visuals



Anthony Yarrus/Impact Visuals

organizations that would pay big dividends was now in full retreat. The once-profitable chains' rapid expansion was curtailed severely, as were their dreams of dominating America's health-care.

On "Black Monday," decline turned into free fall for many of the larger corporations. The stock of the for-profit HMO chain Maxicare dropped a whopping 37.2 percent, the Hospital Corporation of America's fell 31.9 percent, Humana's declined 16.2 percent, and those of Beverly Enterprises and Manor Care, the huge nursing home chains, lost 26.8 and 14.1 percent.

More Cuts Ahead

Sweet though the sound of the fall of the mighty might be, the loss of investor confidence—coupled with the diminished ability of markets to raise money—will probably make it harder to obtain financing for any kind of health-care organization, for-profit and voluntary alike. The crash also created the prospect of further deep cuts in government health programs, leading to new hardships for patients and more belt-tightening for providers. The president and Congress have already proposed severe reductions in funding for Medicare and research as part of deficit-reduction measures designed to placate financial markets and foreign lenders.

Yet these very measures may well set off a deep recession, stripping even more Americans of insurance coverage and intensifying the crisis of access triggered by the first Reagan recession. Some analysts contend, moreover, that a recession could actually benefit the large HMO chains, since employers and consumers will be seeking health care at the lowest possible cost, accelerating the consolidation of the HMO industry around these corporations.

The drought of a coming recession, though, may prove to be a wellspring of reform. As greater and greater segments of our population are locked out of

What the papers didn't say: The crash's impact will be most dearly felt by workers, the poor, and the medically indigent.

health care, the public and its elected representatives may finally understand the need to reorganize health services around more publicly accountable financing and delivery. In reaction to the proliferation, and ultimate failure, of for-profit organizations that grew wealthy on public funds, the pendulum may well swing back towards the public's interest, towards efficiency and equity. Already, pressures are intensifying to develop a broad federal, state, and local response to the AIDS epidemic and the huge unmet need for long-term care and broader health coverage. It is therefore crucial that progressives continue to insist on fundamental reform amid the fiscal austerity and recession that looms ahead.

On Sunday, October 11, more than half a million people, outraged over the nation's response to the AIDS epidemic, took to the streets of the capital. The March for Lesbian and Gay Rights was a response to the homophobia that has permitted the malign neglect of Congress and a reckless administration, and to the hysteria which has fired a "second epidemic" — the attack on liberties in the name of "public health." October 11 was a day on which an increasingly visible group of Americans demanded full health and civil rights from the nation.

The march thus held out the promise of a broad-based health and civil rights movement, one through which women, minorities, and workers can win universal entitlement to health coverage and constitutional protections against discrimination. If the energies harnessed in the march can be joined to those of the civil rights and labor movements, we can finally make sure

that no one, neither people with AIDS nor the unemployed nor the homeless, is denied access to our nation's health services any longer.

The need for a movement that seeks to guarantee basic health, economic and civil rights became all the more apparent only three days after the demonstration, when the Senate overwhelmingly banned the use of federal funds for educational materials on AIDS that "promote or encourage, directly or indirectly, homosexual activities." Even as the epidemic's death toll mounts, the prohibition further frustrates efforts to inform people about safer sex. Such a discriminatory attack not only endangers "at risk" populations, but, in legitimizing legislation by bigotry, jeopardizes everyone's health rights.

The nation is at a critical turning point. We cannot allow conservatives to use the collapse of Wall Street to gut health programs even further. We must stop the reactionary victim-blaming that continues as the corporations and the financiers struggle to recover their losses. Now, while Reaganism is in decline and the victims of Reagan's policies are about to experience even fiercer attacks on their fragile supports, we must not waste any opportunities to act on our agenda as health progressives.

We must stop the diversion of health-care funds from the poor, the elderly, and the unemployed to the proprietary health-care corporations. We must make it clear that health is not a commodity to be bought or sold in the marketplace but a state of being that is *created* in the way people live, build their communities, and use services to make themselves whole and well. We must insist on basic economic rights for all—a health imperative—so that people can exercise greater control over their own lives. It is our responsibility to show how issues of access, equity and rational financing can be advanced in this shifting and unsteady economic climate.

Faced with the depth of our economic and social problems, we cannot view 1988 as just another year of presidential politics, or any other kind of politics-as-usual. Health-care advocates and analysts must be ready to recognize and act on the new opportunities to forge a health and civil rights coalition to create, at long last, a national health program that meets the needs of *all* the people.

-The Editors

Baby girl in stroller and man in wheelchair were among the many people with AIDS who demonstrated.



The Massacre of MASSCARE

Dukakis' Health-Insurance Plan and Why It Was Defeated

DAVID A. DANIELSON AND SUSAN ABRAMS

The authors critique the health-insurance plan proposed by Governor Michael Dukakis, and recount the uproar that followed its introduction into the Massachusetts legislature this past fall. With Dukakis having emerged as a leading contender for the Democratic presidential nomination, and with much hope for fundamental reform of our nation's health-care system hinging on the outcome of this year's elections, the plan, and its fate, may well provide a taste of things to come.

In September, Governor Michael Dukakis submitted a plan to the Massachusetts legislature designed, in his words, "to assure that high-quality, affordable health care is made available to all citizens of the Commonwealth." It's been called Duke Care by the press, the Mass Health Partnership in the Senate, and "dead in the water" by the House of Representatives. We've dubbed the proposal MASSCARE. While its future is still in doubt, political pundits consider the passage of at least a scaled-down version likely soon.

Crisis in the Commonwealth

Of Massachusetts' six million people, one-tenth have neither public nor private health insurance. The problem of the uninsured here, as across the nation, has worsened as employment has shifted from the unionized manufacturing sector to the service and trade industries. Of Massachusetts' workers in finance, transportation, and manufacturing, only four percent are uninsured. By contrast, 52 percent of workers in trade, 25 percent of those in services, and 12 percent in construction lack coverage.¹

One-third of the uninsured—some 220,000—are children. Fifty-eight percent of uninsured adults are employed, 13 percent are unemployed, 12 percent are classified as homemakers, 10 percent are students, and 6 percent are disabled or retired. These are the stated targets of the Dukakis proposal. Massachusetts is in an admittedly fortunate position. In the nation as a whole, 16–17 percent of the population, about 40 million people, lack health insurance, and another 18 million have such poor coverage that they are "effectively outside of the medical care system."² The state's unemployment rate is about one-half of the national average, and its

budget shows a substantial surplus.³ Governor Dukakis has acknowledged that a less wealthy state with a greater percentage of uninsured citizens could not enact his program; it was Candidate Dukakis who said "We've asked the uninsured in Massachusetts and 40 million others in this country to wait long enough. The time is now."⁴

Footing the Bill

The original proposal is quite simple: employers would be required to pay 80 percent of their employees' medical insurance. The proposal also outlines minimum standards for that coverage. In order to cover the unemployed, businesses would continue to pay the surcharge on health-insurance premiums that funds the Massachusetts free-care pool, which currently subsidizes hospital care for all the uninsured. These contributions, which reached 13.6 percent in 1987, would be capped at around 12 percent initially, and would continue at rates set annually by the administration.

Although the major costs of the Dukakis proposal would be absorbed by employers, workers would have a large burden to shoulder, too. Employees working more than 17.5 hours a week, and earning \$4.19 per hour or more, would pay 20 percent of their insurance premiums.

Of Massachusetts' six million people, one-tenth lack public or private health insurance.

But that's not all. MASSCARE also includes a deductible: \$250 for individuals, \$500 for employees with dependents. After that is met, employees would pay a 20 percent copayment on all medical costs up to a maximum of \$1,500 per year for individuals, and \$3,000 for families. While that requirement would not apply to prenatal or well-baby care, the plan would provide no coverage for medication, medical devices, or routine and preventive care, nor could expenses for these be used to offset the deductibles and copayments.

No major taxes are proposed, but some new trickles

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Gov. Michael Dukakis testifies before the Massachusetts legislature in September on behalf of his bill for state-wide universal health insurance coverage.

of revenues are opened up by the bill. For the first time, the premiums paid to HMO's, Preferred Provider Organizations, and health insurance companies (with abundant loopholes) would be taxed (at 2.3 percent). The state would maximize its revenues from the federal government by continuously enrolling eligible individuals in federal health programs and monitoring federal policies and Medicaid rates to obtain every federal dollar available to the state. The plan also incorporates user fees and special assessments against hospitals and insurance companies.

Other forms of creative financing abound in the bill. All full-time college students, for example, would be required to carry health-insurance coverage, with colleges billed for any use of the free-care pool by uninsured students. Colleges and universities would thus, in essence, be required to levy a health-insurance tax on students and their parents in the form of increased fees.

One Small Problem

Dukakis' initial proposal hinges on Congress granting Massachusetts exemption from ERISA, the Employee Retirement Security Act of 1974. ERISA prohibits state regulation of employment contracts. Although members of the Massachusetts delegation are well-placed by committee assignment to pull off the legislative legerdemain needed to get the exemption, many concerned parties in the state doubted that they would, in the end, pull it off, and insisted that Dukakis formulate a fallback plan, which has been dubbed Plan B.

The alternative seeks to have business pay for insurance indirectly, through taxes. A surcharge, set initially at 12 percent of the first \$14,000 of each employee's wages, would be imposed on the contributions to unemployment insurance already paid by all employers.

The rate would rise as needed to cover the state's cost for providing insurance. Employers would pay an additional surcharge, one-sixth of one percent, to fund insurance for persons receiving unemployment compensation. Employers already offering medical benefits meeting or exceeding those required by MASSCARE would be exempt from these surcharges.

Bureaucratic Leviathan

Dukakis proposes to operate MASSCARE through a mega-agency endowed with administrative, regulatory, and rate-setting functions. In addition to running the new program, the agency would take over Medicaid, now in the Welfare Department; the state employees'

MASSCARE would not cover medication, medical devices, or routine and preventive care.

benefit program; and the health segment of the independent Rate Setting Commission. It would be charged with administering Medicaid (including a new "buy-in" for disabled people who return to work, allowing them to be employed without losing services), setting up

health-insurance plans for residents not covered for specific benefits by their own policies, and operating an insurance plan, directly or through intermediaries, for small businesses unable to obtain health insurance at competitive rates.

The agency would also control its own budget and have sweeping powers to determine hospital charges and rates of reimbursement for health services provided to state employees.⁵ Contracts signed by Blue Cross/Blue Shield with hospitals or HMO's would require the approval of the agency, both for content and for rates of reimbursement.

Busy with his presidential campaign, Dukakis failed to line up adequate support for his bill.

Finally, the agency would be responsible for providing technical assistance to hospitals reorganizing the use of their beds (as explained below) and for setting up retraining programs for laid-off hospital employees, giving special attention, in designing such programs, to patient-care services and the nursing shortage crisis.

Cost and Quality

Medical costs are sky high in Massachusetts—hospital costs, for example, are 25–30 percent above the national average.⁶ Cost containment, therefore, is an important feature of Dukakis' proposal. Its linchpins are a cap on the rate at which hospital charges may rise (two percent above the national rate of medical inflation), and strong incentives to convert hospital beds not needed for acute care to other health, rehabilitative, and social purposes. (The administration has accepted estimates by health planners that there are 5–10,000 excess hospital beds in the state, and a "secret list" of 27 hospitals whose survival is in doubt is circulating at the State House.) Other methods of cost containment, such as reducing profits for insurance carriers, streamlining health-care bureaucracies, and reducing paperwork, are either ignored or not fully developed in the proposal.

Dukakis' proposal also addresses the need to assure that high standards of care are maintained. The existing powers of the Professional Review Organizations and the Board of Registration in Medicine would not be changed, but the role of the state Department of Public Health (DPH) in assuring quality would be significantly expanded. The governor promised to request major funding for a new unit within the department to evaluate quality of care, while DPH will also be empowered to enforce the state's sweeping Patients' Rights Act, and to take action on complaints arising from the DRG (Diagnosis Related Groups) program in hospitals. As a partial corrective for the bill's evisceration of existing

regional health planning, DPH would be allowed to license hospitals on a service-by-service basis and to attach conditions of quality and access to such licensure. (These proposed powers provoked strong opposition from the Massachusetts Medical Society, which has gone along with most of the governor's other proposals to improve access to medical care.)

Special Interests on the Attack

Governor Dukakis introduced his proposal on September 16, just two weeks before the expiration, under a "sunset clause," of the legislation that created the hospital pool four years ago. Urging "speedy" passage, Dukakis had the assured support of many key legislators, but, busy with a campaign for the presidency and enmeshed in the Biden affair, he failed to line up adequate support for his bill.

The hospitals, having always fiercely and effectively resisted any cap on their charges or change in their practices, were the first to come out against the bill. At stake, for many of them, is their survival. For the hundreds of thousands of hospital workers—hospitals are Massachusetts' second largest employer—jobs, status, independence, and future salary increases are all seen as riding on the cost-containment provisions in the governor's bill.

Attempts by the administration to split the Massachusetts Hospital Association (MHA) have not worked. These ruses included a proposal to set aside \$60–100 million for some strategically located community hospitals, and an agreement to continue a special adjustment for the teaching hospitals that compensates them for their high levels of occupancy. The industry has stuck together, exerting political pressures upon the state legislature unsurpassed in at least 20 years, loosing thousands of its white-coated troops on the State House. The administration, supported by some consumer groups and hospital workers in the Service Employees International Union (SEIU), has publicized the hospital industry's good financial health—profits increased

Urged on by shills for the hospital industry, legislators proceeded to dismember the proposal.

from \$63 million in 1981 to \$127 million in 1986—but nevertheless failed to outweigh the political mass of the MHA.⁶ The hospitals succeeded in eliminating from the bill all the measures designed to contain their costs.

Businesses, which will bear the lion's share of MASS-CARE's cost, have been just as fierce in their resistance, pushing an agenda that is the direct opposite of that of the hospitals. The large multinational corporations and their trade associations originally supported the plan



Massachusetts Hospital Association

because of its cap on contributions to the hospital pool and other strategies for "getting tough" on spiralling hospital costs. But support from corporations dissipated as the legislators caved in to the hospitals' pressure. Businesses failed to stay on board the bandwagon even when legislators acceded to their main demand: lowering employers' contributions to the price of insurance from 80 to 50 percent of premiums.

Small businesses, predictably, came out strongly against the plan. Working with larger employers renowned for their greed, such as the fast-food and supermarket chains, their strategy was to pry open loopholes exempting companies from covering part-time workers (under 25 hours a week), seasonal workers (less than four months on the job) and workers in small companies (fewer than 50 employees). Through their trade organizations, they put pressure on every legislator, conjuring visions of hometown businesses boarded up and of jobs being exported up Route 93 to the "banana republic to the North"—New Hampshire.

The private insurance companies, working behind the scenes, have demanded—under the slogan of "creating a level playing field"—an end to the preferred status enjoyed by the Blues. Meanwhile, they supported those provisions which would gut the Certificate-of-Need process and place decisions about capital investment in private hands. In their one public flexing of

Over 7,000 hospital employees rally outside Boston's State House Sept. 16 to oppose a provision of the Dukakis bill setting a cap on hospital charge increases. The rally was organized by the Massachusetts Hospital Association.

muscle, they forced the governor's staff to announce publicly that the MASSCARE mega-agency would not compete with private health insurers, thereby forcing Dukakis to go on record with a preemptive surrender to the insurance industry and its unhindered escalation of the costs of premiums.

The Blues, under competitive pressures from HMO's and under attack by the commercial insurers, waffled temporarily but finally opposed the legislation. In a full page ad in the *Boston Globe*, they declared that the bill would be unable to control hospital costs and claimed that it would result in a 17-percent rise in insurance premiums next year. The ad went on to say that MASSCARE would destroy protections against balance billing (the direct billing of patients for amounts above Blue Cross/Blue Shield rates, now prohibited in Massachusetts), place an unfair burden on businesses, and put the populations that the Blues now enroll in MEDEX—Medicare Supplemental Insurance—at risk.

The media divided sharply over MASSCARE. The *Globe* hailed Dukakis' reforms as "bold" and "visionary," while the *Herald*, the city's other daily, and the in-

MASSCARE's Flaws

Dukakis' original proposal for statewide access to health services had major problems. It became subject, in the state legislature, to intense pressure from private interests and turned into a full-fledged disaster. The following table summarizes MASSCARE's most serious shortcomings.

The benefits are meager. The proposal specifically excludes payment for preventive care services, except, as required by federal guidelines, for children up to the age of six. Other essential services are not covered, including long-term care, rehabilitation, home care, occupational health services, prescription drugs, and medical devices.

The costs to low-income workers are exorbitant. Between deductibles and copayments, a worker with dependents could end up paying over \$3,500 a year. Add to this 50 percent of the cost of an insurance premium and it's clear that the poor will have to shoulder what will be for many an intolerable burden.

The financing is both inadequate and regressive. Income from taxes on businesses and the near-poor will not be adequate to cover the costs of the plan, especially now that the major proposals for containing hospital costs have been gutted.

Small businesses are burdened unfairly. Imposing a 12 percent surtax on wages places a major burden on employers. Small businesses may be forced to close, while others may transfer health-

insurance costs to their employees in the form of wage reductions, reduced overtime, and delayed raises, or increase their reliance on part-time and temporary workers.

Accountability to citizens and communities is absent. Leaving control of the funds involved to the private, and largely unregulated, insurance industry, absent effective cost controls, will be a fiasco.
-D.A.D. & S.A.

This October cartoon from the *Boston Globe* followed the Dukakis team's bungling of the now infamous "video-attack" on Joe Biden, an incident which "hospitalized" the Governor's presidential campaign.



fluent suburban newspapers excoriated them, playing to the public's fears of big government, socialized medicine, and the closing of local hospitals.

Meanwhile, Back at the State House

Under such attack, the proposal was sent to the House Ways and Means Committee, whose Chair, Richard Voke, was previously Chair of the Joint Health Care Committee. The bill was prettied up and sent to the floor in early October with more than one hundred amendments, most of them designed to placate the hospitals and small businesses. Also corrected were some clauses in the governor's proposal that consumers had most opposed; it even contained a thoughtful program extending comprehensive care to near-poor women and children. Its arrival on the floor of the House of Representatives was inauspicious. A Republican motion to delay any action for six months was barely repelled. Many key supporters of the governor were conspicuously absent from the chamber, and even Chairman Voke himself strolled off the floor, reportedly to go to lunch. Urged on by shills for the hospital industry, legislators proceeded to dismember the proposal in a series of lightning moves until the Democratic

leadership rescued it and remanded it back to committee [see table].

Round One is over. Responsibility for further action now rests with the Senate, specifically with Patricia McGovern, the Chair of the Senate Ways and Means Committee. In late October the House of Representatives was forced to extend the legislation for the free-care pool to allow funds to continue to flow for the care of the indigent. Ironically, that bill, now in the Senate, will serve as the vehicle for a renewed attempt to enact the Dukakis proposal. By attaching a scaled-down version of the governor's plan (and, perhaps, elements of Senator McGovern's previously introduced Health Partnership Program⁷) to the House bill, supporters would send MASSCARE to a conference committee dominated by legislative leaders loyal to the governor, not back to the contentious lower house.

It is too early to say if the efforts of Senator McGovern, and of David McKenzie, a member of her staff, will eventually result in a MASSCARE program or yet another massacre in the Senate. The MASSCARE mega-agency and measures for containing hospital costs, especially, have an uncertain future. Regardless of what happened, the Committee for a

National Health Program will reintroduce its own progressive plan for truly universal, comprehensive coverage in the coming year.⁸

The Progressives' Dilemma

By referring to health care as a basic human right and proclaiming the need for universal coverage even as he puts forth flawed, regressive proposals for implementing those ideas, Dukakis has simultaneously drawn attention to progressive health-policy goals and co-opted them. Even the meager benefits proposed, while inadequate to produce enthusiastic consumer support, were costly enough to provoke daunting opposition from the powers that be.

We progressives find ourselves in an all-too-familiar dilemma regarding the Dukakis proposal: Do such reformist measures advance the goal of a comprehensive national health program or do they merely distract the public and the media from the real issues involved in this debate? Those who point out the dichotomy between the rhetoric and reality of the proposal can easily appear to be rejecting the aims progressives worked so hard to have accepted by voters and public officials.

Dukakis has both drawn attention to progressive health-policy goals and co-opted them.

We've found ourselves being viewed as churlish and impractical for pointing to the weaknesses in MASSCARE and fighting for improvements in a glossy program that exploits the very people it proclaims to help. Having been viewed until this point as pie-in-the-sky idealists who want the best of all possible health plans, we need now to present ourselves as the true realists. We need to persuade others that a well-thought-out program would cut costs by opening up access and taking care of needs when they arise—not after they've developed into more expensive illnesses.

Will MASSCARE represent an irreparable setback for the cause of a national health program, or a first step towards its attainment? If the woefully-flawed bill passes, can we in Massachusetts enlist the help of legislators in correcting its more egregious errors, or will its inevitable failure discourage legislators from considering more comprehensive proposals in the future?

Lessons and Hopes

The fight over MASSCARE has given us a foretaste of the attacks that powerful interest groups will launch if elected officials ever take seriously progressive proposals to restructure the medical-care system. We've become more aware how important it is to deepen public support for such proposals and to build a much broader

coalition if the general desire for improved access to medical care is ever to be translated into reality.

A 1986 Massachusetts referendum, calling on Congress to establish a national health program, passed by 2 to 1 through the efforts of a network of grassroots organizations. It was one of several developments that provided the impetus and public backing for efforts by Dukakis and members of the legislature to develop a state plan [see *Bulletin*, Spring 1987, p. 16]. Could strong grassroots support possibly have counter-balanced the enormous lobbying efforts of the Massachusetts Hospital Association?

It seems vital, in this regard, to inform the public about the vast profits and exploitative practices of the insurance industry. It is equally apparent that progressives need to seek allies in the business community, which could well become a proponent of broad public funding of health benefits.

Among the many other questions we need to consider are these: How can we educate the public and the media more effectively so that the progressive point of view won't be largely ignored, as it was this time? How can we make people aware that universal coverage means coverage for everyone, with no if's, and's or but's? Not even having made clear yet what universal access means, how best do we begin to explain what a comprehensive program means?

Other industrialized nations have learned that truly universal and comprehensive care is more economical in the long term and a better way to maintain health than insurance-based systems, with their high overhead and large profits. The governor and legislature in Massachusetts—and, indeed, elected officials across the country—need to face that reality squarely.

Advocates for progressive change, meanwhile, need to think more carefully about models that could serve as transitions toward a true national health program. We need to have such alternatives in hand, carefully analyzed as to cost, to counter such rhetoric-laden, meager, competition-oriented models as that suggested for Massachusetts. Discouraged as progressives may feel now about how little impact we've had on this specific proposal in this oh-so-progressive state, we might just come out of this better able to make health care a major issue in the 1988 presidential campaign. We should be forewarned and forearmed to head off a similar massacre in the next state that tries to make health care a right, not a privilege. □

1. *The Massachusetts Health Partnership, a Senate Ways and Means Report*, David McKenzie and Senator Patricia McGovern, July 2, 1987.
2. Melvin Glasser, Executive Director, Committee for National Health Insurance, public address, Boston, Mass. October 28, 1987.
3. *New York Times*, Matthew L. Wald, p.1, August 21, 1987.
4. Testimony of Governor Michael S. Dukakis, Gardner Auditorium, State House, Boston, Mass., September 22, 1987.
5. Senator Edward Burke, Senate Chair of the Joint Health Care Committee, has vowed to retain budgetary control and oversight functions in the legislature; these provisions will not appear in the final bill.
6. *Boston Globe*, Richard Knox, p. 29, August 23, 1987.
7. *The Massachusetts Health Partnership Program*, Senate Bill 1639, State House, Boston, Mass., July, 1987.
8. "The Massachusetts Health Security Act," *Journal of Public Health Policy*, Summer, 1986.

Anatomy of a National Health Program

Reconsidering the Dellums Bill after 10 Years

LEONARD S. RODBERG

Ten years ago Representative Ronald Dellums (D-Ca.) introduced his Health Service Act in Congress. Despite the continuing failure of his colleagues to take up serious discussion of the bill, Dellums has reintroduced the legislation every two years, with the convening of each Congress.

With the exception of his stubborn persistence in making the case for national health, progressive health politics has virtually shut down in Washington. Now, however, with the approaching end of the Dark Age of Reagan, many of us anticipate a resurgence of progressive health activism. To help us prepare for this coming period of struggle around national health policy, I would like to review the objectives of the Dellums bill, and the reasoning behind its design. Since the issues we addressed in the mid-'70's remain the most critical problems facing health care today, the design put forward then is a valuable guide to a renewed progressive approach to health policy.

The Dellums bill was the first legislation ever introduced into Congress to create a national health service. Although those who participated in its development

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Dan Bernstein

were charged with being utopian, we were under no illusion that the bill would be enacted quickly, or even that it would soon be widely debated in the media. Our objective at that stage was not to pass legislation, but to create a vehicle for educating the public on the need for a new way of organizing and delivering health services.

There were other reasons, too, why the charge of utopianism was mistaken. The Dellums bill did not spring from the heads of a few off-beat ideologues, but was an outgrowth of the progressive movements of the 1960's and early '70's. When Dellums decided to prepare such legislation in 1972, he asked the Medical Committee on Human Rights, an organization of health workers allied with the civil rights movement, to prepare a draft of the principles that should underlie a national health program. That draft became the basis for the Health Service Act.

As the legislation evolved, many other groups, representing the elderly, minorities, women, social workers, trade unionists, public-health professionals, and health-policy analysts, became involved in its preparation and gave it their support. The bill was backed by the American Public Health Association, the National Association of Social Workers, the Gray Panthers, and the United Electrical Workers, among others.

Above, a public health nurse and sharecropper in Bolivar County, Mississippi, 1967.

The experiences of these groups, and the specific improvements they sought in health services, were reflected in many provisions of the Dellums bill.

This support made it clear that the concepts which underlie the Dellums bill had a significant constituency. It was not a constituency that counted for much in American politics, but it was substantial and it was broad. Polling data indicated that, if the bill's provisions could be made widely known, they would gain the support of a much wider part of the population; when the public is asked its views on the nation's health system, between 30 and 40 percent consistently say they favor making the government responsible for providing health care.

Pragmatism in Service of Ideals

Finally, the Dellums bill was realistic because it proposed a system which could actually solve the problems it addressed. Those of us who supported a national health service found that our principal debate was with the advocates of national health insurance. (Those who opposed a significant government role in health care refused to engage either of us in debate!) In our view, the supporters of NHI were the utopians, but because of well-publicized proposals like the Kennedy bill, the general public now identifies national health with NHI. It is therefore important to differentiate between such a scheme and a true national health program.

National health insurance would not offer significant benefits to more than the 15-20 percent of the population which now lacks insurance or is underinsured. While these people surely need help, they lack health insurance precisely because they have no political power. Are they likely to generate the political power needed to achieve passage of national health insurance? Our opposition to NHI was thus a matter not only of ideals but of realpolitik, as well; only if the system had something in it for everyone—not just for the poor and uninsured—would it garner the kind of political backing needed for adequate funding and longevity.

The issues the bill addressed in the mid-'70s remain the most critical problems facing medical care today.

We felt the system had to be designed to serve everyone and be available to all, regardless of income or citizenship. Under our plan, health care would be the right of every resident. This country had been the first to establish the idea that education is a basic human right; it would now catch up with the rest of the indus-

trialized world by assuring access to health care for everyone.

The Dragon of Cost

The three primary issues we sought to address in designing the Health Service Act were cost, access, and democratic control.

First came the issue of cost, not because it was central to our concerns, but because it was the primary issue in health care 10 years ago, as it is today. Upon assuming power, the Carter administration set up a 40-member task force to develop a national health plan; one member was a physician, 39 were economists. Recognizing that most policymakers, and the mass media, believed the problem with American medical care to be simply one of expense, we made sure to propose a plan that would not add fuel to the inflation of medical costs.

Under our plan, health care would be the right of every citizen.

It is instructive to recall how others were addressing this problem 10 years ago. The liberal solution was to impose some regulatory mechanism that would constrain cost increases without tampering with the organization of health care. Conservative economists, ironically, agreed with us that such a strategy was futile, and that the problem of cost was deeply embedded in the structure of American medical care. That structure married fee-for-service payment, in which payment is made on the basis of the type and quantity of service delivered, to third-party insurance coverage. This mix of an entrepreneurial market with third-party reimbursement inevitably touched off an explosion of costs.

The conservative solution was to retain fee-for-service and make "consumers" (as patients have come to be called) responsible for holding down costs. Whether by accepting higher deductibles and co-payments, paying taxes on health-related fringe benefits, choosing the least expensive providers, or discontinuing high-cost in-patient services when their DRG's are used up, patients would shoulder the burden of costs.

Our alternative was to replace fee-for-service with a budgeted plan. It made no sense to continue to act as if medicine were still a cottage industry. The massive institutions which today dominate medical care require a constant stream of capital to remain stable; payment has to be assured in advance. The growing popularity of pre-paid health plans attests to the recognition of this on the part of both consumers and many members of the health-care industry.

Fee-for-service payment, moreover, arose when medicine was oriented toward acute, curative care. This



Joseph Svcc

Clinic care at Cooke County Hospital in Chicago.

may have been appropriate practice a century ago, or even 25 years ago, when infectious and viral diseases were the principal threats to health. As Milton Terris has forcefully shown, however, the principal illnesses we face today—cancer, heart disease, stroke—require long-term preventive action aimed at both the individual and society [*Health/PAC Bulletin*, Vol. 17, No. 5]. We need a reorganization of the health-care system that emphasizes prevention as well as cure while providing the financial stability that health-care institutions require.

Although circumstances forced us to focus first on the problem of cost, no less central to our concern was the severe maldistribution of medical resources. Large numbers of people in this country lack access to adequate health care. According to the federal government, 50 million people—nearly a quarter of our population—live in medically underserved areas. This problem was, in fact, the principal one for the constituencies most responsive to the proposal we developed.

We felt, too, that the medical-care system needed a dose of democracy. It was not being run with the participation of the people who used it or worked in it. Hospital boards did not represent the people who use

hospitals, and physicians behaved as private entrepreneurs. We needed a process that would assure democratic control over the health-care system, that would make the system more responsive and accountable to the people who worked in it and the communities which it served.

Applying Federalism to Health Care

The bill calls for the creation of a community-based national health service. Our intention was to design a national system without creating a giant bureaucracy. (Neither we nor anyone else wanted a large and unaccountable agency running our medical-care system.) Instead, the Dellums bill seeks to apply federalism, the principle of involving each level of government in an appropriate way, to the health-care system. While the proposed health service would be funded nationally and mandated by the federal government, it would rest on a network of community-based pre-paid health plans coordinated at the regional level.

The system would be funded nationally so that economic inequality would not be a barrier to the equitable provision of health services. It would be mandated federally to guarantee access to residents of every com-

munity. Regional coordination would ensure that both general and specialized services would be available to every region on a rational and equitable basis. A firm basis in the community would provide the core of democratic control we believed to be essential. Finally, the network would be built on a pre-paid health program, to replace the obsolete and inflationary fee-for-service system with one that would be prospectively budgeted and oriented to prevention.

Our intention was to design a national system without creating a giant bureaucracy.

Under the Dellums bill, health care would be funded through federal tax revenues. Funds would be disbursed on a per-capita basis, so that low- and middle-income communities would have the same access to quality medical services as would wealthier communities. Money would not be distributed, as it is in an insurance system, based on the fees institutions charge, but on the number of people served. A supplementary fund would be provided for the elderly and the poor, whose more extensive needs would require more funds per capita than the national average. Service would be provided by salaried workers, although the bill would not attempt to eliminate private practice. Funds would be made available through annual budgets for capital and operating expenses, placing the establishment and provision of medical services on a secure financial footing.

From the Bottom Up

The geographic organization of the system would follow the rationale espoused by nearly every health planner. Primary care would be offered through community-based facilities, making it accessible to people in the localities where they live and work. General inpatient services would be provided on a somewhat broader level, and specialized services on a still-broader, regional level. Strategic planning and basic research would be conducted at the national level.

The plan envisions, then, a four-tiered structure beginning with what we called the Community, an area of between 25,000 and 50,000 people where primary care would be provided. Our inspiration for this arrangement was the community health center, of which there are now hundreds throughout the country, mostly in low-income areas. The plan does not require each community to build a physical structure called the "community health center." Instead, it views the community health system as a network of primary-care providers integrated so that people can find their way through it without the kind of turmoil and confusion

that patients experience today.

The second level of organization would be the District, serving approximately a quarter of a million people with general inpatient hospital services. Above the District would be the Region, serving a metropolitan-sized area with specialized inpatient services (e.g., trauma services, organ transplants). Regions would also be responsible for the education of health workers. The national level would establish standards for the provision of care and priorities for research.

Medical schools, nursing schools, and other training programs would be integrated into this national health system. A community-based, prevention-oriented approach would inform the education of health-care workers. Much of their training would take place in primary-care settings, rather than in tertiary-care facilities providing specialty services. The legislation also provides for ladders of training, through which health workers could progressively expand their skills and acquire broader responsibilities. In an attempt to deal with the current dominance of medical care by physicians, the bill envisions teams of health-care workers, in which the supervision of patient care would be a collective responsibility.

Physical therapist and patient at Connecticut's Mansfield Training School.



Assuring Accountability

Democratic control of this system would be provided by a governing structure operating in parallel with the medical-care structure. Each community would elect a health board, in the same way school boards and the boards of community health centers are presently chosen. Voting would coincide with Congressional elections in order to maximize participation. Boards would be composed of representatives of users of the system and representatives of those who work in it, with the former outnumbering the latter by two to one.

The Dellums bill remains relevant in spite of the changes that have occurred.

The Community Health Board would not only administer local health facilities, it would act as a "health advocate" for the community. Because the entire system rests on the belief that the health problems facing us are best dealt with through prevention, a primary responsibility of the community health boards would be to press local governments to take action to eliminate health risks.

District health boards would be composed of representatives from the community health boards, regional boards of representatives of districts, and the National Health Board of regional representatives. These boards would be responsible for allocating funds to the institutions under their respective supervision. Control would therefore run from the bottom up, and those who use the system, and those who work in it, would be represented at every level.

The Dellums Health Service Act was devised as a vehicle for education, using concepts that had been developed in the civil rights movement and in other progressive movements. The Act has been used across



George O. Withers

**California Congressman Ronald Dellums.
Progressive stalwart on capitol hill.**

the country to show a different, progressive vision of how medical care can be organized. The Act remains relevant in spite of the changes that have occurred in health care since its preparation. The problems it addresses—escalating cost, maldistribution of resources, lack of emphasis on prevention, absence of democratic control—are with us still, exacerbated by the growth of the corporate, for-profit medical industry. The Dellums bill still describes the kind of health care system progressives ought to want. If it is, in fact, what we want, we should organize to get it. □

Holding the Line

Labor's Safety & Health Movement

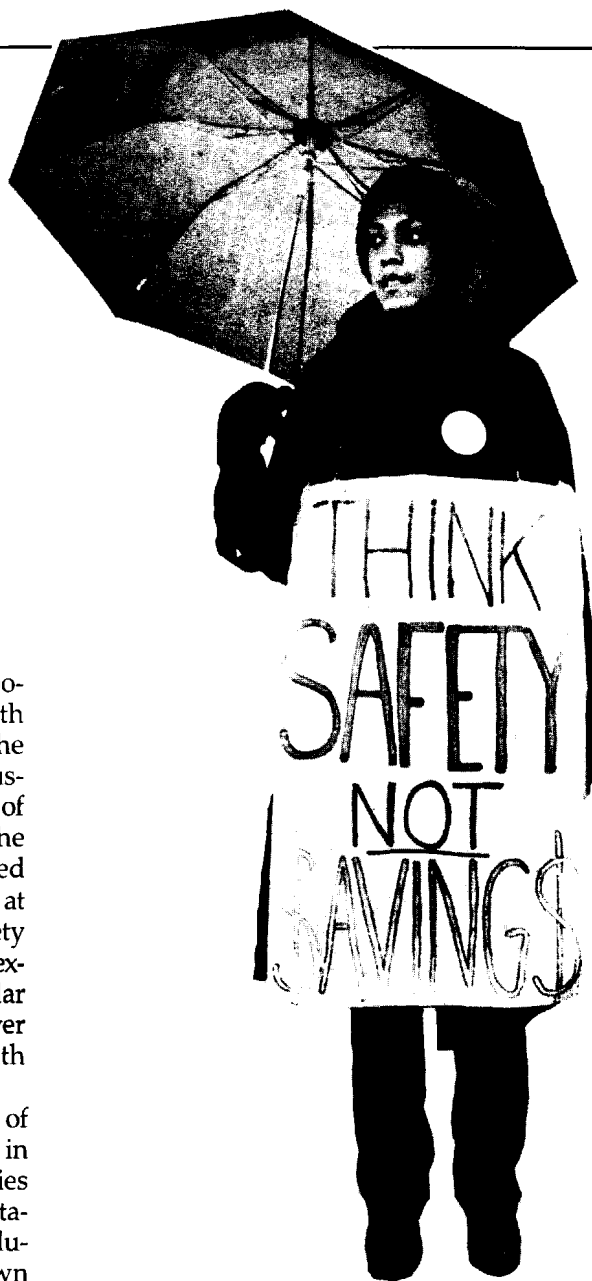
LANCE COMPA

The rash of fines recently inflicted on major corporations by the Occupational Safety and Health Administration (OSHA) has put the state of the American workplace higher in the national consciousness than it has been since the early, crusading days of the Occupational Safety and Health Act of 1970. IBP, the nation's largest meatpacking company, was slapped with a record \$2.6 million fine for falsifying records at its Dakota City, Neb. plant. Chrysler's penalty for safety and health violations at its Newark, Del. facility exceeded \$1.7 million. General Dynamics, Caterpillar Tractor, and John Morrell & Co. were each fined over half a million dollars for various violations of the health and safety statute.

Is OSHA finally enforcing the law after years of laxity? Or, as most activists and analysts involved in safety and health believe, do the high-profile penalties constitute an attempt by OSHA to shore up its reputation? A recent independent federal study, the conclusions of which were confirmed by the agency's own consultants, found OSHA in a state of "total paralysis." Another, private, study by the National Safe Workplace Institute showed that OSHA's inspections are inadequate and untimely, that the agency consistently fails to insure that what hazards it does uncover are corrected, and that it often and unjustifiably reduces its fines against firms that willfully and repeatedly violate the law.

OSHA's surrender of its responsibility, moreover, began at the same time as the "Get OSHA Off Our Backs" campaign conducted by business during the early 1980's—a campaign which combined political rhetoric with pseudo-academic complaints about over-regulation. The Right has had license under Reagan to suffocate the issue of occupational safety and health from both within government and without.

But the issue has refused to go away—the persistence of death, disease, and injury in the workplace has made sure of that. Equally important to maintaining



Michael Kaufman/Impact Visuals

public concern over workers' safety and health—concern that ultimately led OSHA to levy its face-saving fines—has been the work of occupational safety and health activists. For while the labor movement as a whole has suffered a sharp decline in membership and strength over the past two decades, labor's safety and health activists have refused to retreat. Indeed, the enduring vitality of the occupational safety and health movement has provided much of the energy driving labor's efforts to reverse its fortunes and grow again.

Hard Times for Labor

The unions' decline has been acknowledged not only in the press, but by the labor movement itself. Thirty years ago, unions represented more than one-third of

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Above, member of the Independent Federation of Flight Attendants pickets outside the TWA terminal at New York City's Kennedy International Airport.

the American workforce; that figure has fallen below one-fifth. With strikes rarer than ever, concessionary bargaining marks the strategies of many of today's labor negotiators. Perceptions of Big Labor as a powerful political and legislative force turned to skepticism in the wake of the Mondale debacle and a long series of setbacks in Congress.

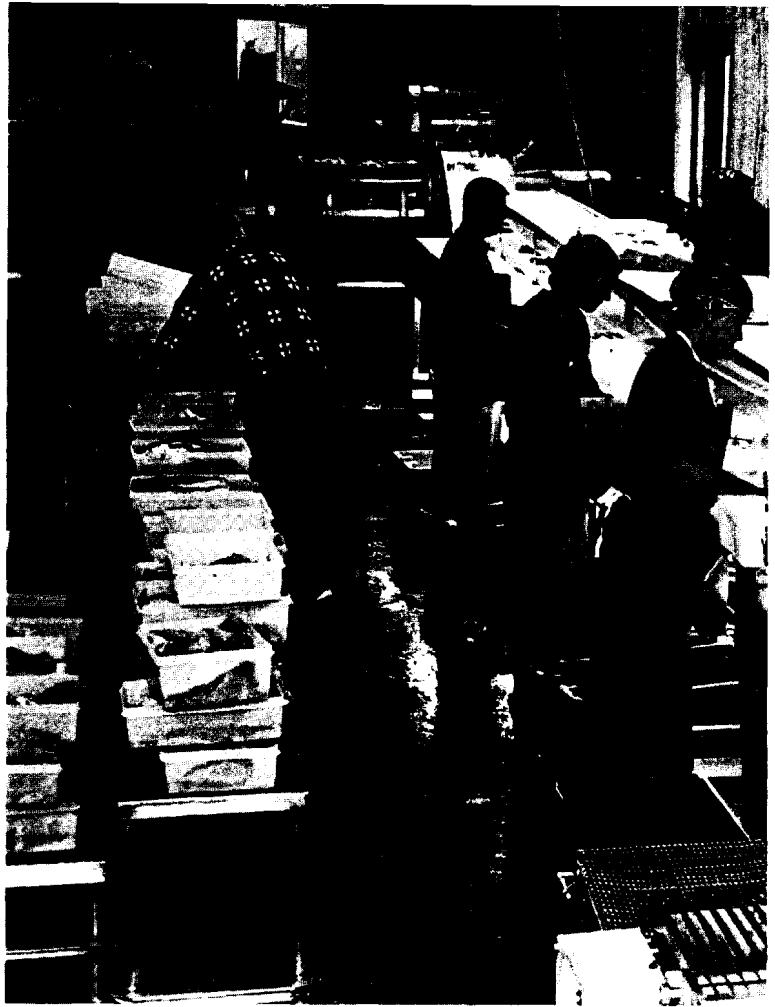
Most analysts blame the downturn in labor's fortunes on structural changes in the economy. The service sector is growing, traditional union bastions in basic industry are shrinking, and what growth in manufacturing is taking place occurs largely in non-unionized sectors, such as high technology. As massive, old urban factories employing thousands of workers reach the end of their useful lives, companies are replacing them with smaller plants in semi-rural areas devoid of union history and sentiment.

The demise of the union, however, stems from more than just economic restructuring; business has hurried the process. During the postwar economic expansion, industry could afford to accede to some of labor's demands. Unions returned the favor by expelling their left-wing members and wedding themselves to the Cold-War, free-enterprise philosophy embraced by both government and business. But when American domination of the world economy began to falter in the 1970's, companies returned to a time-tested method of juicing up profits: union-bashing. Many employers are now not just resisting union organization in new facilities by hiring union-busting consultants who specialize in stopping organizing drives, they're even trying to rid themselves of incumbent unions through decertification campaigns and strikebreaking.

Internal weaknesses, too, have contributed to labor's difficulties. Many union leaders are now questioning labor's ideological commitment to capitalism, fearing it has disarmed them of clear alternatives to the corporate agenda. Others argue that, as lawyers and economists have taken over the functions of organizers and mobilizers, labor has become bureaucratized, its grassroots character poisoned. Finally, political action has been largely confined to rote support for Democratic candidates, with few attempts at independent political action.

Energy and Commitment

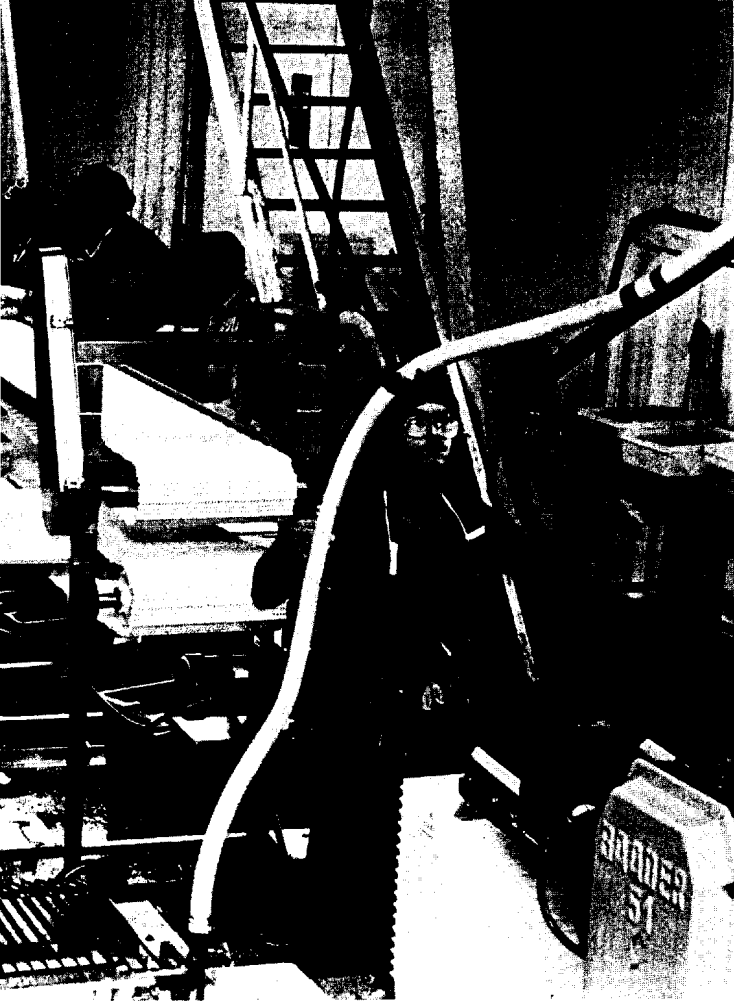
While labor has stalled, though, its safety and health movement has pressed forward, serving as a core of activism while organizing, bargaining, and political work are in turmoil. With all their problems, many unions were able to stay on the offensive over safety and health issues. Thousands of young workers who might otherwise have been made cynical by their unions' stumbling have instead become labor stalwarts thanks to their involvement in health and safety advocacy on the shop-floor. Safety and health staffers hired to run new union programs brought with them an energy and commitment that local union leaders and members had not seen for decades, while a flood of conferences and publications educated local unionists about workplace hazards and about their rights—under both OSHA and their contracts—to fight for a safer workplace.



Several successful efforts at unionization started as disputes over occupational health. The education of workers and the public about the hazards of cotton dust by members of the Amalgamated Clothing and Textile Workers Union contributed mightily to the union's success in organizing J.P. Stevens & Co. in the late 1970's. Safety and health problems became key organizing issues in the United Electrical Workers' successful effort at the Litton microwave-oven plant in Sioux Falls, S.D., the United Steelworkers' breakthrough at the Newport News Shipbuilding Company in Virginia, and last year's victorious campaign by the United Food & Commercial Workers Union to organize thousands of catfish-processing workers in the Mississippi delta. The hazards of the workplace were critical issues in strikes by meatpackers, miners, and others.

Under the guidance of the AFL-CIO, unions have stopped OSHA's attempts to relax standards governing the presence of lead and cotton dust in the workplace and to weaken regulations mandating access to medical records. The unions have pushed OSHA to propose standards for the safe manufacture of ethylene oxide, asbestos, formaldehyde, benzene, ethylene dibromide and other chemicals. Galvanized by the conviction, for murder, of executives of a film-processing plant in Illinois who deliberately allowed their employees to be poisoned, state and local prosecutors are bringing new criminal actions against other managers of unsafe workplaces.

The issue of occupational safety and health, moreover, has linked the labor movement to community groups, environmentalists and feminists. In many cit-



Katherine McGlynn/Impact Visuals

Fish-processing workers, like these in Rockland, Me., have a high incidence of skin disease from performing repetitive tasks with their hands immersed in water, chemicals, and fish.

A Workplace Victory

In 1986, workers in the central supply department of Washington Hospital in Washington, Pa. decided they'd had enough. For several years they had been experiencing burning, itching, and numbness from working with the hospital's sterilizing equipment, and suspected that some of their former co-workers had developed cancer for the same reason. But the hospital agreed to take action only after the workers confirmed that they were being poisoned by ethylene oxide gas (EtO), a sterilant and carcinogen, and campaigned to stop it through their union's safety and health committee.

The workers' first move was to contact Laura Job, director of the Occupational Safety and Health Program of 1199, the National Hospital Union. Job analyzed the federal standard designed to protect employees from EtO and created a checklist which the workers used to gauge the extent of the violations. Together, they documented 14 violations in all. They also compiled a list of workers with complaints traceable to EtO exposure and another of those suspected to have developed cancers from the gas.

Armed with these specifics, the committee organized union members at the mid-sized rural hospital around the goal of winning maximum protection. "Quickly it became a union-wide issue," reports Job. Workers campaigned until management agreed to meet and remedy the problem. "I told [management] if they wouldn't give us what we needed, I'd just grab onto their jackets, or their pantlegs, or take them by the hand until they gave in," Twila Martin, a worker at Washington, told the union's newsletter *Occupational Health Matters*.

The hospital agreed to install a new sterilizer, provide protective equipment, conduct regular examinations and tests to detect any effects of exposure, and draft an emergency plan against the occurrence of a gas leak or spill. Even before the plan was completed, however, a leak occurred that exposed one worker directly and indirectly exposed several others. The workers, already trained by their committee, evacuated the central supply office and went directly to the emergency room for examination. None had been harmed.

"Workers realize that it is foolish to rely on management or the government to protect them. They know they have to protect themselves," Job told the *Bulletin*. "The safety and health arm of our union is anything but a library; it is an organizing force which strengthens and educates workers about their rights and powers. If safety and health is about anything, it's about empowering people."

-Joe Gordon

ies, local coalitions on safety and health, known as COSH groups, have united union and community activists in creating programs to promote health in the workplace and the environment. In many states and cities these groups have successfully campaigned for "right-to-know" laws and ordinances, which require companies to disclose the nature and effects of chemicals and other materials used in the workplace and which have forced OSHA to issue its own right-to-know standards for the manufacturing industries.

The AFL-CIO's Industrial Union Department has formed the OSHA-Environmental Network to defend, through joint action by labor and environmental activists, regulations relating both to occupational health and to environmental protection. The Network's support for the federal High Risk Notification Bill, which requires industry to disclose information about dangerous workplaces, helped get the legislation through the House of Representatives last October. Unions and communities worked together to stop the Schweiker bill, a 1980 OSHA "reform" measure that would have gutted the Act; the effort remains a model of grassroots political action that taught valuable organizational and lobbying skills to thousands of workers.

And just as the issue of safety and health has helped the unions, the presence of unions helps workers win gains in safety and health. A recent study by Harvard's



Jim West/Impact Visuals

UAW members strike Chrysler's Highland Park, Mich. plant, demanding adequate blower systems to ventilate carcinogenic dust created in the modeling of plywood plastics. There was a high incidence of cancer deaths in the plant, where workers won safety gains in the 1983 action.

Center for Business and Government found that union representation gives workers dramatic advantages in OSHA proceedings. While union employees exercised their "walkaround" right—their prerogative of accompanying OSHA inspectors on tours of their workplaces and assisting them in identifying hazards—in 70 percent of inspections of union sites, only four percent of non-union workers exercised this critical right. The presence of a union in large workplaces, moreover, vastly increases the probability of inspection: non-union companies with more than 500 workers face a 16 percent chance of receiving an OSHA inspection each year, while for a comparable site that is organized, the likelihood is 95 percent. And when inspections do occur, the typical OSHA official devotes 24 hours more to his or her inspection of a unionized workplace than to that of a non-union plant.

In part because safety and health activists kept fighting during the lean years, the crisis of trade unionism has eased. In June the nation's 11,000 air traffic controllers voted to form a new union; their earlier one, PATCO, was smashed by Ronald Reagan during their 1981 strike. Though many had been strikebreakers, the controllers, forced to collective action by traditional union issues such as workload, work pace, mandatory overtime, and mistreatment by management, voted for renewed union representation by a margin of two to one. In the same month, over 2,000 workers at a printing plant in Kingsport, Tenn. voted to reorganize 25 years after their original union had been ousted following a broken strike.

A Brightening Outlook

These notable returns to unionism reflect a discernible shift in labor's fortunes. The decline in membership, which neared half a million a year in the early 1980's, dropped to just 21,000 in 1986. The typical union member got a raise in pay of \$21 a week last year, compared to one of \$10 a week for his or her non-union

counterpart. "Her" indeed: the number of women in unions actually rose by 70,000 last year, a sign that the most significant social migration of this half-century—the movement of women into the workforce—is attracting new converts to unionism.

All over the country union staffers report a lift in prospects for organizing and bargaining. The paralysis of the Reagan presidency has played a part in this. While Reagan was riding high, his reputation as an anti-labor president made workers wary of agitating for their rights. With the president slipping out of his saddle, workers have gained new confidence, believing that what happened to the air traffic controllers can no longer happen to them.

The shift in the national mood has political consequences for labor. Unions played a key part in winning the Senate from Republican control in 1986, and with the Democratic Party having a good chance of recapturing the White House in 1988, labor's political apparatus—the one that took such a licking in 1984—is now geared for work with a tough campaign's worth of skills and experience at the ready. Labor's role could be decisive in the election, paying dividends in the policy fights to follow.

There is good reason to think all this new optimism is not misplaced. The American labor movement has taken the worst blows an anti-labor administration in Washington and an anti-union offensive by employers could throw at it—and still it stands, ready to swing back.

Occupational safety and health activists, furthermore, have not only fueled the resurgence of the labor

movement, they have formed an ideological vanguard, as well, by confronting the philosophical choices that will determine the future of the labor movement.

Industrial Unionism vs. Enterprise Unionism

Union professionals who deal with health and safety, for instance, sharply debate the extent to which their issues are politically neutral—that is, capable of being solved regardless of which economic system predominates. They argue over the merits of joint labor-management committees where safety and health concerns are seen as a shared interest, as opposed to independent, union-only committees that approach safety and health problems as an issue resolvable through adversarial bargaining. Finally, they discuss the danger of “technocratization,” of their becoming specialists in a highly technical field, whose job consists of relieving rank and file workers of, rather than involving them in, safety and health matters. All these are dilemmas which the larger community of labor activists will have to face soon, if they are not facing them already.

In many respects these discussions are tributaries of the most important debate going on in the labor movement, the debate between industrial unionists and enterprise unionists, a struggle whose outcome will shape the labor movement into the next century. The new industrial unionists want to revive CIO-style militance, industry-wide structures for organizing and bargaining, and independent, class-based political action in the labor movement. Enterprise unionists see the CIO model as outmoded in today’s economy and today’s society. For them, unions must cooperate with management, tailoring their strategies for organizing

and bargaining to the needs of the firm in question and taking responsibility for that firm’s financial success. The tying of increases in wages to productivity and profits, the presence of workers on boards of directors, their participation in management, and their ownership of stock—these, according to enterprise unionists, are the new initiatives that unions must turn to if they are to survive and prosper in the 21st century.

Clearly, the movement for occupational safety and health lies squarely in the camp of industrial unionism. The movement has created a community which cuts across the jurisdictional lines that bedevil the labor movement, bringing unions together in struggles for stronger legislation, tougher enforcement by OSHA, and environmental protection. There is no surprise in this: a machine operator swallowing cutting oil fumes at a lathe in a Rockwell plant in California has the same problem as a worker at the same lathe in Baltimore’s Bethlehem Steel plant. They need a single solution to their problem, not one solution at Rockwell and another at Bethlehem Steel, each dependent on the relative profitability of their employers.

Occupational safety and health activists, from the epidemiologist and the industrial hygienist on union staffs, who study the problem at its broadest level, to the shop floor steward taking up a specific health-related grievance, are critical players on a team of organizers trying to rebuild democratic industrial unionism in the American labor movement. □

Unhealthy and dangerous working conditions are rampant among migrant farmworkers. Here a nine-year-old laborer with family members on a Maryland cucumber farm.



The Clash over Quackery

Protecting Alternative Care

RONALD L. CAPLAN



While energy pills, panaceas, and snake oils belong to a vanished past, the greed and naiveté that permitted them are with us still; quackery is bigger business today than ever before. The incidence of medical fraud in the United States has increased more than fivefold over the past 25 years; in 1986 alone Americans paid over \$10 billion to unscrupulous promoters of fraudulent medical therapies, remedies, and gadgets. Those who suffer from chronic or terminal diseases—particularly arthritis and cancer, and now, AIDS—are the easiest marks, often willing to buy anything that promises cure or symptomatic relief.

The Pepper Report

The lid has been pulled off quackery only recently, through an investigation by the House Select Committee on Aging, a study which undoubtedly stands as the most comprehensive ever undertaken. Between 1980 and 1984, the committee held hearings in half a dozen states; reviewed mountains of books, periodicals, newspapers, and correspondence; examined and investigated scores of suspect devices, therapies, machines, and compounds; conducted hundreds of interviews and surveys; and worked closely with a large number of public and private organizations, including the American Medical Association and the Food and Drug Administration.

Following the committee's findings, Chairman Claude Pepper (D-Fla.) introduced three pieces of anti-quackery legislation in Congress in July 1984. The bills called for the creation of "a clearinghouse for consumer health education and information," and for greatly increased criminal penalties for those who willfully sell or try to sell drugs, devices or medical treatments knowing them to be unsafe or ineffective or "unproven for safety or efficacy." They also sought to establish a strike force to investigate the sale and promotion of these unsafe or unproven drugs, treatments, or devices.

But in his zeal to bring the hucksters to justice, Pepper cast too wide a net. The bills' language effectively discredited all types of 'non-scientific' medicine, not only out-and-out quackery. The release of the commit-

tee's report and the introduction of Pepper's bills instigated an uproar in the holistic health-care community. Advocates of a whole host of alternative forms of health care—from acupuncture to Zen—opposed the bills as a serious threat to any unconventional health-care practice and immediately launched a nationwide campaign to defeat them, largely in response to which the bills were withdrawn.

The threat the bills embodied, however, remains. In September 1985, the FDA, the Federal Trade Commission, and the U.S. Postal Service cosponsored a national conference on health fraud, the first since 1966, to publicize the Pepper committee's findings. Three months later, the FDA and the Pharmaceutical Advertising Council launched a campaign in the national media against quackery which relied heavily upon the work of the committee.¹ During 1986, the FDA held regional conferences on health fraud to build support for legislation modelled after the Pepper bills. Since

Quackery is bigger business today than ever before.

such legislation will likely soon be introduced in Congress, we ought to reexamine the holistic community's objections to the original bills, and clarify the purpose of any anti-quackery legislation.

The Vice-like Grip

Pepper's efforts to identify and eliminate fraudulent practices within the health-care industry appear, at first glance, beyond criticism. In defining medical quackery as the "promotion of remedies known to be false, or which are unproven," his committee seems to have taken a sensible approach. The bills also employ a seemingly straightforward and effective strategy in calling for both the education of consumers and the jailing of offenders.

Most practitioners of alternative healing, however, regarded Pepper's proposals as an attempt by the practitioners of conventional medicine to continue their domination of American health care. Their suspicions were well-founded; for over 50 years, the medical community, led by the AMA, has opposed nearly every

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form of health care that has significantly differed from—or seriously competed with—conventional medicine. At one time or another, the AMA has denounced homeopathy, osteopathy, optometry, acupuncture, self-care, chiropractic, midwifery and lay analysis as being either dangerous, or fraudulent, or both.²

While the AMA eventually shifted its position on some of these therapies, the principal aim of the organization has not changed. In setting the boundaries of legitimate health care, the AMA has consistently demonstrated a far greater concern for the financial well-being of its members than for the health of the American people. Its primary objective remains the control of both the theory and practice of American health care. The result is the existence of a medical-care monopoly that, multiplying inefficiency by inequity, distorts the proper allocation of resources and consistently provides less health care at a higher price than would exist in a more competitive environment.³ Moreover, this medical elite has erected formidable barriers to practice, such as overly strict licensing laws, that, together with its close alliance with the insurance industry, help maintain its position and perpetuate these distortions^{4,5} [see box]. These tactics assured that alternative health-care providers were, for many years, largely denied access to consumers.⁶

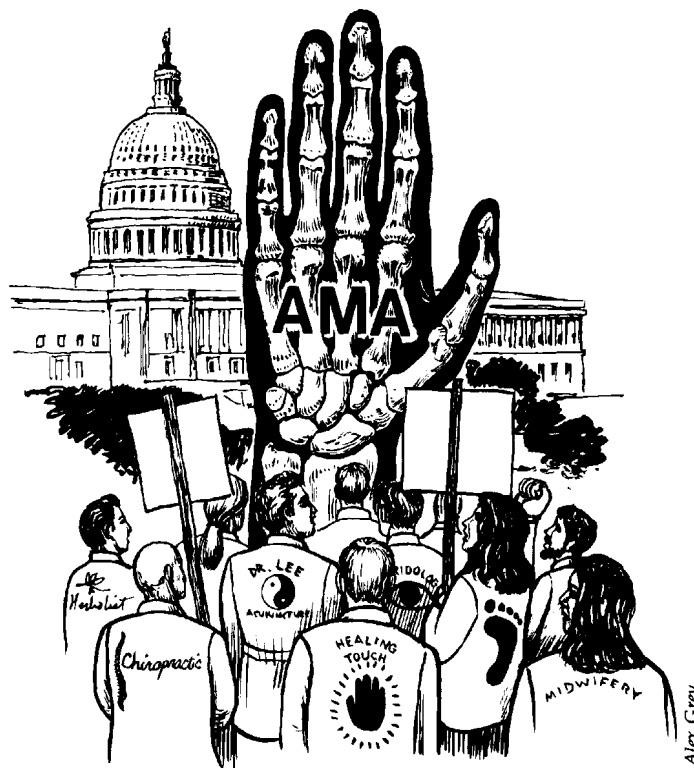
A Growing Constituency

Yet despite the systematic suppression of alternative medicines, a steadily growing segment of the American people has, since the mid-1970's, openly challenged—and even rejected—many of the doctrines and practices of conventional medicine. A significant number of Americans are, in fact, seeking alternatives in “unscientific” and “unproven” therapies, from chiropractic to psychic healing.⁷ Many of these alternatives are now the preferred choice of millions of consumers and enjoy a well-satisfied and loyal constituency.⁸

The Pepper approach implicitly denies the validity of health-care paradigms different from, but not necessarily less scientific than, the model that dominates American medicine. The committee's report acknowledged that “some of what is unproven may yet prove of benefit” and cautions against a blanket condemnation of all “unproven therapies.” But by branding as quackery any health-care practice which is known to be false or which is unproven, the committee failed to heed its own advice.

Clearly, not all unconventional forms of health care are “sciences in the making.” By the same token, not every health-care practice opposed by the medical establishment is, in fact, medical quackery. The definition of medical quackery is always socially determined—the product of interactions among economic, political, and cultural factors that extend far beyond the laboratory and the examination room. The real problem, of course, is how to separate the true charlatans from those healers who practice an as yet unproven, but nevertheless efficacious, form of health care.

The exclusion of alternative approaches from the medical marketplace is intimately related to judgments about their legitimacy as therapy. The hegemony



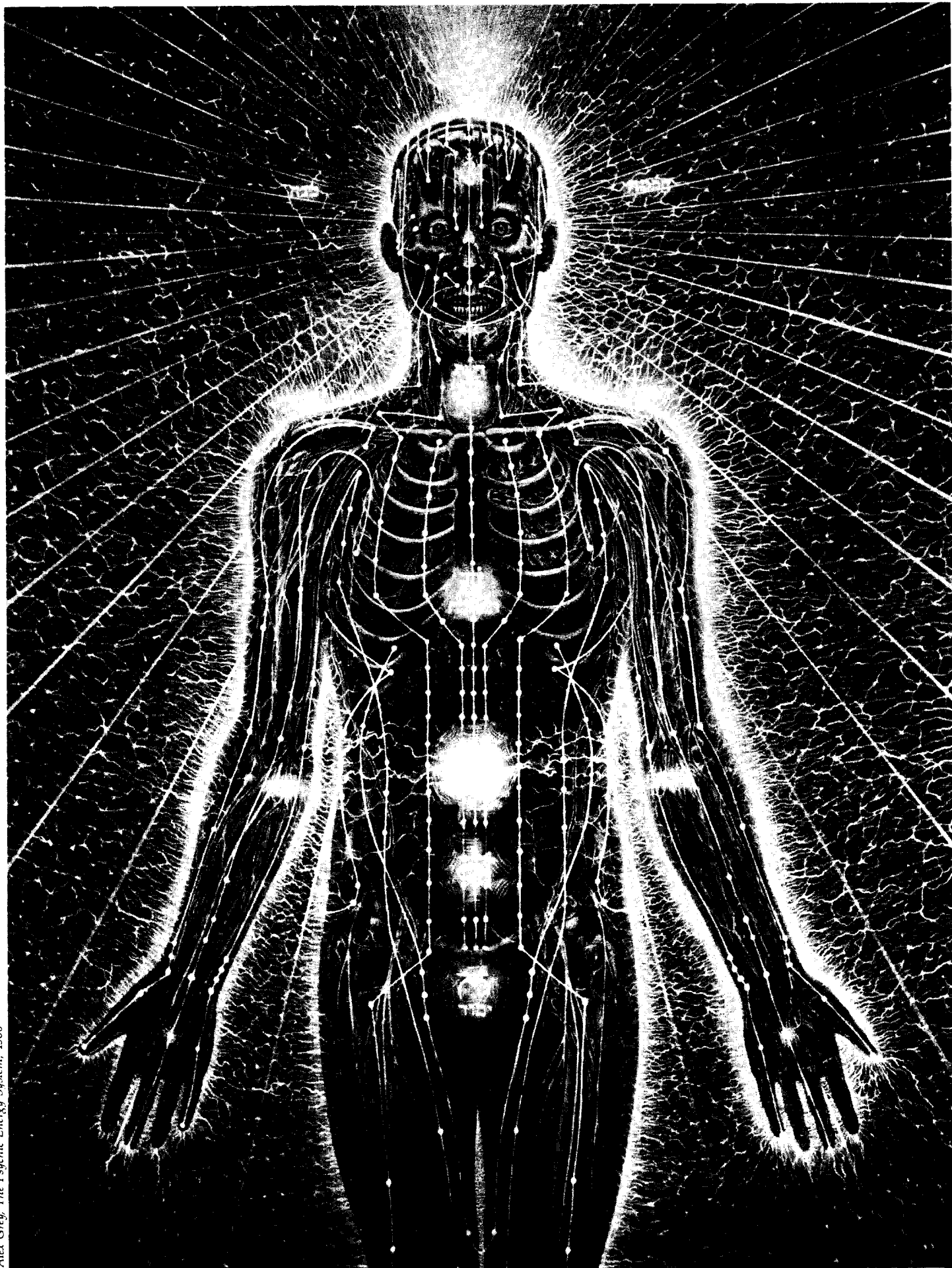
of conventional health care remains largely unchallenged precisely because orthodox medicine wraps itself in the mantle of science and brands as unsound all opposing outlooks. At a time when competition within health care is intensifying and the relative status and income of physicians are on the decline, it is simply unwise to give undue influence to the medical establishment's views on quackery. We must not repeat the mistake of the Pepper Committee by allowing physicians and their allies to determine the design of anti-quackery legislation.

Wheat from Chaff

While the vultures who prey on disease and fear must be caught and punished, safe and effective forms of alternative health care should be supported as legitimate substitutes for—or complements to—conventional medicine. The question is, how do we separate one from the other?

The definition of medical quackery is always socially determined.

A prudent place to begin is with those healers who have already amassed a large amount of evidence demonstrating the safety and effectiveness of their practice and who claim to have logical theoretical bases



for their treatment. Chiropractors, homeopaths, and acupuncturists are clearly among the leading candidates. To be fairly judged they must be evaluated on their own terms—that is to say, according to their own scientific principles, which are not necessarily those governing “scientific” medicine.⁹

A great deal of costly research will be needed to test these methods adequately, and practitioners of alternative medicine and the organizations which represent them lack the resources to undertake it. Nearly all the major sponsors of health-related research are closely identified with the theory and practice of conventional medicine and rarely fund projects that depart from the mainstream; the money will clearly not come from them. Therefore, the federal government should sponsor a series of studies (patterned after its recent assessment of bone-marrow and artificial-heart transplants, elective hysterectomies, and psychotherapy) to determine the efficacy and cost-effectiveness of the more promising forms of alternative health care.¹⁰

*At one time or another, the
AMA has denounced
optometry, acupuncture,
self-care, chiropractic,
midwifery, and lay analysis.*

Our nation’s “irregular” practitioners have been legitimately challenged to “demonstrate that their theories are sound, their diagnostic techniques accurate and their treatments effective.”¹¹ They should not be forced to lose by default. Those who succeed should be accepted as legitimate therapists and integrated into the mainstream of delivery and reimbursement. Those who fail, along with those who simply refuse to try, should be blocked from the marketplace, for they will have been exposed as the real quacks and charlatans of American health care.

The value of a particular health-care practice may be judged by the rigor and persuasiveness of its scientific underpinnings, the quantity and quality of its empirical evidence, and, if it is to reach those it can help, the size and scope of its popular appeal. If all forms of health care are to receive fair judgment in accordance with these criteria, the power and influence of the AMA and its allies will have to be greatly curtailed. At a time when the dominant paradigm in American medicine is being challenged by a growing constituency, the government should not, either intentionally or unwittingly, remain its unquestioning ally.

The protection and development of the most promising alternatives to conventional medicine is an indispensable part of progressive health-care reform. A new and improved division of labor within the health-

Barriers to Alternative Practice

While some physicians truly believe that all alternative healers are cultists or quacks, much of the recently rising opposition of conventional medicine to alternative care—and the consequent governmental suppression of such care—originates in the increasing economic squeeze practitioners are feeling. At the federal level, the most recent clash between the two philosophies has centered around the Pepper bills. At the state and local level, the conflicts have revolved around licensing and malpractice.

Some states, encouraged by the medical establishment, have enacted a very broad definition of medical practice, thereby necessitating certification for a much wider spectrum of practitioners. In 1978, authorities in California, at the urging of the State Medical Society, arrested the operator of a health-food store for practicing medicine without a license. Her offense appears to have involved giving nutritional advice to her patrons. Since then, two owners of health-food stores in Indiana were charged with a similar offense. The Alaskan State Medical Board recently outlawed midwifery and naturopathy, ruling that they constitute unlicensed medical practice. As health-care reform increasingly comes to mean cost containment, alternative healers will inevitably be subject to greater scrutiny, and greater censure.

With the deregulation of the medical marketplace has come an explosion in the number of malpractice cases and in the cost of premiums for liability insurance. Some practitioners, unable to afford adequate protection, are going out of business. Physicians and hospitals, fearful of escalating rates, are practicing defensive medicine; even those who have used and supported unconventional therapies or techniques in the past are now much less willing to do so—the risks have become too great.

This new timidity is most evident among obstetricians, who pay the highest rates for malpractice insurance and are most likely to be sued. Heretofore open-minded obstetricians feel tremendous pressure to follow strict protocol by performing routine fetal monitoring and “medically indicated” cesarean sections. Natural childbirth, which minimizes intervention, is now often regarded as too risky for the patient and the physician. The crisis in malpractice insurance, while not yet directly affecting most practitioners of alternative therapies, may yet become another formidable barrier to their integration into the mainstream of care.

-R.C.



Congressman Claude Pepper examines an Oxydonor, a gadget purporting to cure arthritis and rheumatism, at a 1980 hearing of the House Select Committee on Aging that investigated unproven drugs, devices, and medical treatments.

care industry would be achieved if various types of practitioners—physicians, chiropractors, homeopaths, nutritionists, and others—could work together for the betterment of their patients' health. Unfortunately, any legislation which follows the thinking and recommendations of Congressman Pepper's report would move us in exactly the opposite direction. □

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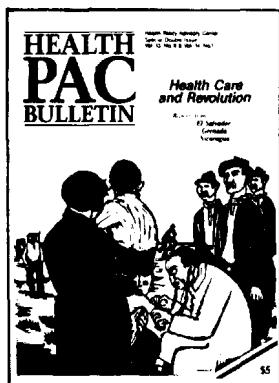
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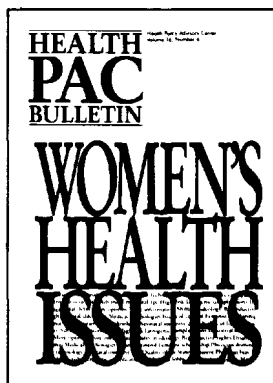
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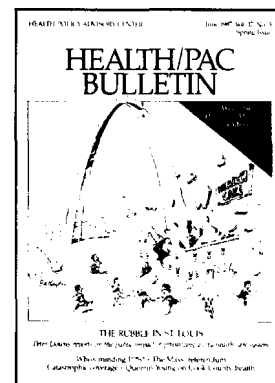
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Uncle Sam Promotes the Marlboro Man

American Cigarettes Come to Taiwan

ELISE AND DAVID RAY PAPKE

In Taiwan, young women in miniskirts pass out complimentary packs of Winston on city streets. Brands like Kent and Marlboro vie for attention in magazines and on posterboards. Phillip Morris and R.J. Reynolds attach their names to sporting events in return for sponsorship.

Common occurrences in the United States, these phenomena have come only recently to the Republic of China as part of the Reagan administration's efforts to inflict the benefits of the American tobacco industry on our Far-Eastern allies. Ultimately, the influx of American cigarettes reflects the administration's efforts to reduce the trade deficit, but the resulting political gains and corporate profits come at the expense of public health—of people's lungs and lives—abroad.

In recent years Taiwan has run up annual surpluses of \$10–15 billion in trade with the United States, its most important commercial partner. In 1985 the Reagan administration began looking for ways to correct the imbalance. In addition to opening direct negotiations with Taiwan, the government listened to plans put forth by several American industries, each hoping to be promoted as an exporter. The tobacco industry, with its powerful lobby, spoke loudest of all. Having recently lost ground to public-health advocates in the United States, the industry has reason to look hungrily at the Taiwanese market.

Not So Fast

On the other side of the Pacific, the Taiwan Tobacco and Wine Monopoly Bureau put up a stiff resistance. The bureau, which generates an astounding 11 percent of the government's revenue, relies on heavy import tariffs to restrict the entry of foreign cigarettes, beer and liquor into Taiwanese markets. American champions of the "free trade" which fills the coffers of the tobacco industry negotiated with the bureau for over a year. While Taiwan agreed early in the talks to remove its tariff on cigarettes, negotiations foundered on two related issues: pricing and advertising. With tobacco, as with other nonessential goods, a subtle combination of the two incubates desire and urges purchase.

In October of 1986, American negotiators got nasty. They threatened to invoke the 1974 Trade and Tariff Act,

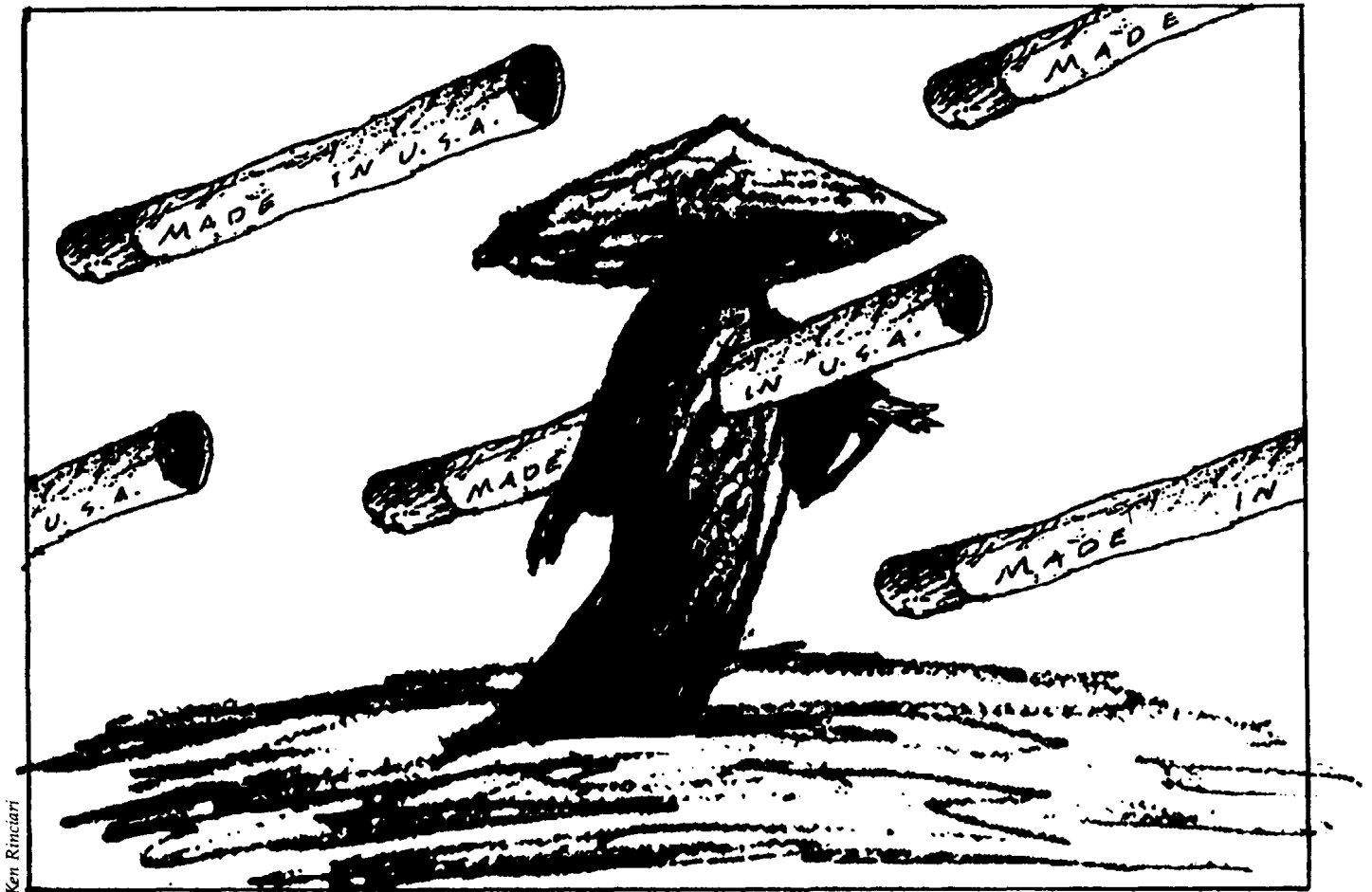
which permits retaliatory measures against nations using "unjustifiable and unreasonable" means to harm American commerce. The president went as far as signing a preliminary determination judging Taiwan to be so acting, and the administration prepared to retaliate against Taiwanese industry. The strong-arm tactics worked immediately: the exporters of garments, shoes, and electronics put pressure on their government and an agreement was hammered out by December.

The tobacco industry has reason to look hungrily at the Taiwanese market.

Since the agreement went into effect on January 1, 1987, 120 brands of foreign cigarettes have entered the market, with American makers leading the charge. Prices for those are comparable to those in the United States, about 50 percent more than the cost of local brands (one of which is named "Long Life"). Prohibited from advertising on local television and limited to 120 magazine ads annually for each brand, American companies have been forced to become more resourceful. In addition to sponsoring sporting events, they have pasted their logos and advertisements on every street-corner and, in the case of Phillip Morris, have developed plans to build a raceway. R.J. Reynolds (makers of Winston and More) and Brown and Williamson (Kent) have budgeted \$4.9 million for advertising between them. The budget for Phillip Morris' Marlboro, the most visible brand on the island, would add millions more to that figure.

When Reynolds unveiled a tactic that has become old hat to Americans—the distribution of free cigarettes by attractive young women—the company stirred up more attention than it had expected. The women, who station themselves in Taipei's discos as well as on the streets, have been denounced by one local legislator as "pretty little devils." The Taiwan Housewives Federation has started patrolling the discos in response, provoking several ugly scenes. Meanwhile, the National Health Administration has allocated new funds to what had been a lagging anti-smoking campaign, and citi-

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Ken Rincicari

zens groups have sponsored an anti-smoking day and an anti-smoking month, formed an "I Quit Smoking Club," and distributed information explaining how to

Images of happy smokers riding Marlboro steeds have created new smokers.

use acupuncture to kick the habit. But in the face of the deluge of advertising, such energetic and noble countermeasures seem doomed to fail.

Profits Before People

Just over a year after Taiwan opened its markets to American cigarettes, it's already clear who the winners and losers are. The American tobacco industry has

access to a large new pool of users (and the administration has attempted to open markets in Japan and South Korea as well). Republicans have an example of the benefits of free trade to wield against protectionist Democrats, and well-justified expectations of future contributions from the tobacco industry. And even the Taiwan Tobacco and Wine Monopoly Bureau is smiling. Despite fears that American cigarettes would capture 50 percent of local sales, the market for domestic cigarettes has actually expanded slightly. Images of happy smokers riding Marlboro steeds or strolling through Salem's green fields, it seems, have created new smokers. Some, after an initial fling with American brands, settle for cheaper domestic cigarettes.

The losers are the people of Taiwan and any Americans who think our nation's trade policies should respect public health as much as they do corporate profits. The American Institute in Taiwan, our de facto embassy, has insisted in official publications that "health is not the issue." But it should be. The seduction of "free trade" has obscured the most important fact about the tobacco industry: its products kill. □

Vital Signs

Edited by Tammy Pittman

That Ole Radium Show

The radium industry's travelling cleanup circus came to New York last fall after stops in northern New Jersey [see "A Brush with Justice," *Bulletin*, Vol. 17, No. 5]; Athens, Geo. (where the show cost over \$600,000 before it closed); and Ottawa, Ill. (a \$6.5 million production). The only thing left of the famous industry, which once gave us radioactive mouthwash and hair tonic, are the radium dumping grounds continually being discovered and the halting efforts to clean them up. Now, the show's moved to a highly contaminated storage plant in Queens.

The question is, who will pay? In Georgia and Illinois, the state and federal governments, having borne the cost of the cleanups, are now in court trying to recover their money from the responsible parties, the Radium Chemical Company and its owner, Joseph Kelly, Jr. New York State Attorney General Robert Abrams has learned his lesson: last October he forced Kelly to promise to reduce radiation in and around the plant to legal levels as quickly as possible, to remove thousands of vials of radium from the premises, and to develop a plan to decontaminate the plant completely. Although the agreement saves Kelly and Radium Chemical from a civil suit, the government isn't sure they have the money to fulfill it. In any case, the 75-year-old company, which has left a deadly trail of its radioactive spoor across the country, may also face criminal charges.

Although New York State ordered the company to vacate and decontaminate its facility in 1983, appeals delayed the process for four years. The plant, which bristled with environmental and safety violations of almost every imaginable type, would have precipitated a major disaster in the event of fire. As the appeals process droned on and the plant sat there radiating, public officials kept New Yorkers in the dark. Only after Maurice Hinchey, an upstate assemblyman who conducted an investigation of the matter, held a dramatic press conference at the plant in September to announce his shocking findings did public outrage force appropriate

action. When it will be cleaned up, and who pays, remain to be seen. Next stop? -Tony Bale

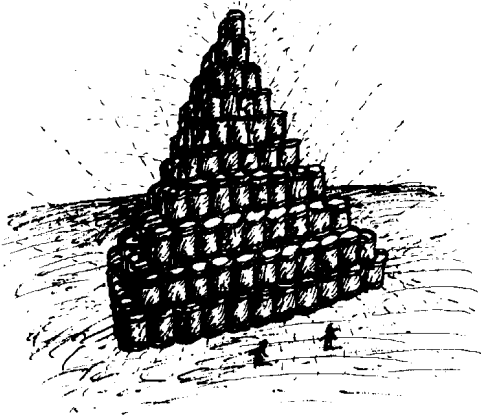
APHA: Health Care for People

Jesse Jackson picked up the progressive health banner in an address to the American Public Health Association last October in New Orleans, labelling the state of American health care "immoral," and calling for a national health program.

Speaking to a crowd of several thousand at the organization's 115th annual meeting—a session which no television network or major newspaper bothered to attend—Jackson argued for "a living wage" for home health workers and greater government funding for AIDS education and prevention. He blamed hospitals for rising medical costs and lambasted the galloping trend toward for-profit health care. "I am not opposed to legitimate profits," he declared, "but I am opposed to greed."

Jackson's words echoed the meeting's theme: "Health Care for People or for Profits?", an idea which found expression in a resolution opposing the growth of investor-owned or -operated health-care institutions. In other resolutions, the APHA urged government not to shrink from including explicit information about sexual practices in its educational material on AIDS, and recommended that the president's AIDS commission, as currently constituted, should be barred from meeting. The APHA also came out strongly against the Reagan administration's decision to withhold funding from family-planning programs which provide abortion counseling. The resolution urged Congress to "reaffirm its historical commitment to the principles of informed consent," and asked medical, public-health, and women's groups to add their voices in opposition to the decision.

The APHA went on record as opposing aid to the Nicaraguan contras, testing of nuclear weapons, and development of the Strategic Defense Initiative (Star Wars). Reaffirming its opposition to South



Ken Rinciarri

Africa's racial policies, the association criticized the South African Nurses Association for its passive role in opposing apartheid in health facilities, including its refusal to campaign publicly against the poor working conditions in black hospitals. Compromise with the racist regime was ruled out: the APHA "strongly urged the international nursing and medical community to sever ties with the South African Nursing Association until apartheid is abolished." -Sally Guttmacher

The Sounds of Silence

One of Washington's best-kept secrets this year has been the federal government's AIDS-education campaign, launched in late 1987, the seventh year of the epidemic, and marked so far by thundering indecision.

Sadly, the loudest AIDS-related noises coming from the government have been those of the presidential commission on AIDS breaking apart. Add to those the sound of Congress squelching educational efforts by approving the Helms amendment to withhold funding from materials "appearing to condone homosexuality," and the dying gasps of the Centers for Disease Control's AIDS-information brochure, and the sum, from the point of view of public health, is cacophony.

The brochure, carrying the inspirational title "America Responds to AIDS," was produced by a Madison Avenue advertising firm at a cost of \$4.5 million. Originally intended for mailing to every household in the country, the pamphlet required the approval of the president's commission before distribution could begin. But at their very first meeting on Sept. 9, the members of the commission decided they weren't ready for such a controversial decision. Since then the brochure, cornerstone of the government's AIDS-education campaign, has been gathering dust.

The pamphlet, one imagines, would contain frank discussion of high-risk sexual practices for it to have so thoroughly intimidated the commission.

Far from it. According to *Science*

magazine, which obtained a draft, the pamphlet does not use the word "homosexual" even once, nor does it mention anal intercourse. The word "condom" appears three times, less frequently than the phrase "mutually faithful, single-partner relationship," and the word "family" or "families" appears 12 times. "Having sex with an infected person" is the full explanation offered of how the disease is transmitted sexually. Displaying a deep understanding of human sexuality and feeling, the authors of the brochure invoke the famous Reagan dictum in their advice to the young: "Just say 'no,'" they intone. For adults they recommend monogamy, or, failing that, urge that you "at least be sure to reduce your risk by using a condom."

The fate of the glossy brochure and its air-brushed analysis of AIDS transmission is uncertain. Instead of mailing it to everyone directly, the CDC may distribute it through supermarkets, drugstores and community organizations, according to a spokesman for the Centers. If so, the CDC would be following the lead of the presidential commission in minimizing its responsibility for the dissemination of life-saving, but apparently politically unacceptable, information. -T.P.

Improving Prenatal Care

A report released last September by the U.S. General Accounting Office found that poor women are continuing to get insufficient prenatal care in most states.

As Congress permitted in 1986, 19 states have expanded Medicaid eligibility to include pregnant women earning up to 100 percent of the poverty level. These states, according to the report, have seen notable improvements in access to prenatal care. In the states that have not expanded eligibility, many women continue to receive little or no prenatal care and run a high risk of bearing low-birthweight babies.

The 1,157 women interviewed in eight states, all uninsured or Medicaid-insured, were found to be 63 percent less likely to obtain sufficient prenatal care than women who

have private insurance. In 20 of the 32 communities studied, more than half the women interviewed received inadequate care. Women who were uninsured, poorly educated, black or Hispanic, under 20 years old, or from large cities were the most likely to receive inadequate care, according to the report.

The barriers to care most frequently cited were lack of money, lack of transportation, and lack of awareness of pregnancy. Women who are covered by Medicaid were more likely to have sufficient care than uninsured women and less likely to cite inadequate funds as the most important barrier to care. Of the babies born to the interviewed women, 12.4 percent were of low birthweight. The national average is 6.8 percent.

The report recommended that all states raise the level of eligibility for Medicaid-funded prenatal care to the federal poverty line, and cited a study by the Congressional Budget Office that estimated the cost of such action at \$190 million. This figure does not, however, take into account the savings that would be gained from the reduced need for intensive and long-term care. A study by the Institute of Medicine conservatively estimated such savings at three dollars for every one dollar spent.

The GAO's report is entitled *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care*, Sept. 1987, GAO HRD-87-137. It is available by writing to the United States General Accounting Office, Washington, D.C. 20548. □ -T.P.

Body English

Out, Out, Damned Fat!

Arthur A. Levin

1987 may be remembered as the year in which we were told to say no not only to drugs and sex, but to fat as well. The nation's public-health policy makers are gearing up for a major campaign to clean up our diets and clear up our bloodstreams in an attempt to reduce the incidence of public-health enemy number one: coronary heart disease. While the effort is being heartily endorsed by the American Heart Association (AHA) and the National Heart, Lung, and Blood Institute (NHLBI), controversy abounds over its clinical merits. Such an effort, moreover, would consume a tremendous amount of resources at the expense of other primary-care programs.

This past June, a panel of experts convened by the AHA, kneeling at the altar of primary prevention, revealed the new anti-fat gospel in a study entitled "Cardiovascular Risk Factor Evaluation of Healthy American Adults." Reaffirming the dogma of cholesterol as evil, the study provided practitioners with a liturgy of treatment. In October, the NHLBI issued similar guidelines through its National Cholesterol Education Program (NCEP).

The new guidelines recommend routine, periodic cholesterol screening for all adults and treatment of those found to have "elevated" cholesterol levels. Treatment—involving 25–50 percent of adults—would begin with dietary modification, followed by drug therapy where necessary.

Efforts to screen for cholesterol began picking up steam only four years ago. In 1984 the Lipid Research Clinics concluded a 10-year study involving 3,806 men, aged 35 to 59, with blood-cholesterol levels in the highest 5 percent of the general population. The men were divided, at random, into two groups: one received the cholesterol-lowering drug cholestyramine, the other a placebo. At the end of the study, the cholestyramine-treated group had significantly lower levels of blood cholesterol, fewer symptoms of heart disease and fewer deaths from heart attack.

That same year, the NHLBI joined the AHA and others in efforts to

promote the so-called "prudent diet." The diet's goal: lowering the daily consumption of fat of every American to no more than 30 percent of total calories, of saturated fat to no more than one third of total fat, and of cholesterol to no more than 300 milligrams.

Until last June, however, there was no study that showed just how lowering cholesterol levels reduced the risk of heart disease. That month, the Cholesterol-Lowering Arteriosclerosis Study (CLAS) was published amid great media hoopla and provided what was purportedly the first visual—angiographic—evidence that treatment could slow the growth of, and in some cases even reduce, arterial lesions. But despite the power of direct evidence, any extrapolation from this study to a policy appropriate for the general population requires a leap of great faith. The study's participants were men who had undergone coronary bypass surgery—hardly a representative sampling of healthy adults. In addition to special diets, half were given two cholesterol-lowering drugs (niacin and colestipol), half placebos. Only the former group showed any significant reduction in cholesterol levels or stabilization or improvement in the condition of coronary arteries.

Aggressive screening for and treatment of elevated cholesterol levels represents a major public-health commitment—a sort of war on fat. It has been said that this policy will cause major changes in the way that medicine is practiced, yet many doctors are less than enthusiastic about it. □

Arthur Aaron Levin is president of the Health/PAC board and director of the Center for Medical Consumers, publisher of the newsletter **HealthFacts**.

In October, 1986, Congress reauthorized the EPA's superfund legislation, including in it a new section called Title III, the Emergency Planning and Community Right-to-Know Act. The new law, which requires factories to disclose the chemicals they store and manufacture, is a major victory — the first such federal right-to-know statute. The initial filing deadline arrived last fall, though, and with it disturbing signs that Title III might not deliver all that it had promised.

Still, the passage of Title III gave us much to be proud of — it was the direct result of years of activism. Workers, supported by environmentalists, began agitating for RTK ten years ago with acts of guerrilla theater — opening vacuum-sealed cans at city council hearings and pasting day-glow stickers demanding, "What's in this stuff?" on pipes and drums in factories. Ultimately, these coalitions won RTK laws in 24 states.

Then came Bhopal and Chernobyl and the poisoning of the Rhine. Confidence in government's and industry's commitment to controlling toxic substances was shaken by the reign of Watts and Gorsuch-Burford, and by the discovery of Love Canal, Times Beach, and many other hazardous-waste sites. With progressive activism, widely-publicized tragedies, and a growing awareness of the inadequacy of American plants and transportation facilities to handle toxic materials, Congress' hand was forced. One result is Title III.

Title III mandates the creation of state and local emergency response commissions (SERC and LERC), requiring their membership to include hospital officials, environmentalists and public-health professionals. Factories must provide these commissions with information on the hazardous materials they store, use, and release. The initial reports, submitted either as material safety data sheets (MSDS) or as a list of MSDS chemicals, were to be filed by Oct. 17, 1987. Factories are also required to disclose emergency, as well as routine, release of toxics.

The law provides for a national data base to store this information. Ideally, the data base will be de-

signed so that anyone will be able to go to the local library and discover what chemicals are being stored at or discharged by a neighboring plant and what the health hazards of those chemicals are. The data base might even allow us to pinpoint the source of various air pollutants, compare the emissions of companies producing similar products, and even estimate the carcinogenic risk of using one's lungs in South Central Los Angeles.

Industry, however, is not rushing to comply. Only 10 percent of facilities covered by Title III met the deadline for filing the MSDS reports, according to a source in the EPA. And industry has plenty of allies in government. The Senate has appropriated \$10 million for the legislation, but, according to Senate staffers, the money may not survive a joint House-Senate conference because many in Congress see Title III as unwieldy and burdensome. Moreover, the Office of Management and Budget, which must approve the forms used in the regulatory activities of government agencies, has rejected some of Title III's paperwork, making the statute temporarily unenforceable.

Hank Cole, Director of the National Coalition Against Toxic Hazards, says that "we cannot rely on EPA and OSHA, but can ourselves use the available data to expose and control hazards." The information gathered under Title III will provide ammunition with which to confront companies, mount media or legislative campaigns, pursue lawsuits, and build coalitions between workers, community groups and environmentalists. Indeed, RTK may bring workers and citizens closer to winning the right to inspect worksites, demand improvements, and shut down dangerous operations.

"Having won the right to know, we must now use it to shift actual decision-making power," says Gerald Poje of the National Wildlife Federation. Title III's greatest value will be to show people how their lives are directly affected by corporate decisions about what and how to produce, and to encourage them to demand their right to participate in those decisions. □

Watching Washington

Know Your Rights

Barbara Berney

Barbara Berney is a consultant on health care and occupational health in Washington, D.C.

Speaking of Health & Medicine

Dealing With
Doctors
Quentin Young

Some two decades ago, I delivered an address at a meeting of the Medical Committee for Human Rights in which I heaped attack upon vitriolic attack on the reactionary medical establishment, so redolent of racial discrimination, professional arrogance, and downright venality. As I rose loquaciously to my jeremiad, excoriating American physicians to the point, virtually, of banning them from the company of decent folk, I was interrupted by a tug at my sleeve. Turning to my side, I saw Desmond Callan—now a primary care practitioner in upstate New York—crooking his finger to draw my ear close to this whispered plea: “Quentin, remember, they are the only doctors we’ve got.”

In the years since, dramatic and destabilizing events have reshaped the power, prestige, and position doctors formerly enjoyed. Their once-exclusive ranks have been swelled by ever-greater numbers of medical school graduates and immigrant physicians: the so-called doctor glut. Educational supports from the federal government, including the wonderful National Health Service Corps, have been Reaganized into extinction; the newly-trained physician now leaves the hallowed halls of medical school wearing a saddle of mega-debts and micro-options. Cost controls and market strategies have voided their cushy deals, devastated their comfy cottage industry, and broken up their guild monopoly, shattering, in the process, naive professional preferences for laissez-faire approaches.

This is not, of course, a pity-the-poor-doctor story, for the whirlwind of distrust and disdain that my colleagues are reaping is a result of nothing but the selfishness they have sown since the beginnings of the century. Nevertheless, if we want progressive change, we must recognize new opportunities as they arise and use the new power relationships to formulate whatever strategies might be effective. In search of such change, I have come to believe that important segments of the American medical profession are ready for, maybe seeking, a new alliance to help them address the monstrous dilemmas of medical

practice.

Many physicians, for instance, are genuinely alarmed at the mechanisms which limit care in managed health systems like HMO's. Others resent the discipline corporate interests impose on the medical workforce—which now includes myriad salaried physicians—as free-market health-care systems expand. Physicians bridle at the mountain of paperwork and miles of bureaucratic maze these systems compel them to deal with; practice is stifled and satisfaction replaced with drudgery.

With all this, salaried physicians (including those in training), primary physicians and those in small group practices, and public health doctors are all viewing the world and their work very differently. Hitherto unthinkable possibilities are suddenly credible, perhaps even practical.

The time has come for health-care consumers—the elderly, the disabled, the handicapped, members of unions and minority groups—to form coalitions, locally and nationally, with those physicians' organizations that are ready to deal. Both partners, will, by definition, have to benefit from these agreements. Consumers want quality as well as stable and fair costs. This could include mandatory Medicare assignment, capitation, elimination of deductibles and copayments, and increased preventive services. The doctors will want more patients, less red tape, and protection from ruthless market practices and the control of corporations; these aspirations are not inimical to patients' interests.

A collaboration between physicians and their patients can define the path the United States must travel in order to achieve a humane, affordable health system. The doctors know they must either lie with the hounds (the corporations) or run with the hares (the people). Des Callan's warning against writing off our doctors makes even more sense now than it did 20 years ago. □

Quentin Young is a physician and the president of Chicago's Health and Medicine Policy Research Group.

Know News

2001:

A Health Odyssey

Nicholas Freudenberg

2/15/01: Begin my interviews with health educators on the frontlines for piece in Health/PAC's electronic *Bulletin*. Two hours late to first meeting—couldn't find a jet cabbie who'd take me to Newark. First subject named Thad, 25, works at ITT/Seagram distillery in new subterranean work/leisure/sleep zone beneath city's ruins. Thad's working on campaign to market vitamin-fortified wine coolers (Fruit Looped) to high schoolers. We preview video featuring Michael Jackson, who's looking younger every year. Video sure to be big hit: MJ shimmys across screen, juggles cans, does the Mars Walk. Thad gives me cup of Fruit Looped. Tastes like melon-flavored freon. Nutri-booze campaign perfect for Thad, who shows me copy of his master's thesis from Kaiser University's School of Health Promotion: *Changing Nutritional Behavior Through Tele-manipulation of High-visibility, Pseudo-erotic Role Models*. Impressive.

2/17/01: Saw Mini today, on Thad's recommendation. Mini head of health ed. unit of New Orleans health dept. Four hours late—Superconductor Express hit heavy rail traffic outside of Graceland. Mini's responsibilities: awards contracts to private-sector health-ed companies, health-dept. liaison to NO Chamber of Commerce, develops promotional videos for area HMO's. Mini tells me (overjoyed) that Jane Fonda Health Spas recently given major health-ed. franchise: "The Janey-Spas have just launched a campaign to media-expose the benefits of three 20-minute aerobic cardiovascular jazzercise workouts in the city's Janey-Gyms," adds (ecstatic), "they have five convenient locations." So far, 98% of registrants are white, middle-class women from the condo district, no low-income minorities. Mini's working out arrangement—city will pay Fonda \$2,000 bounty for every low-income person they recruit. Mini: a real problem-solver.

2/18/01: Back in New York. Heavily overcast day; Blue Cross/Blue Sieve health-radio put available sunlight level at 35%. Visited Andra in Great Neck, once a patient educator in the old vol-hosp days. Six hours late for

appointment when shuttle copter got lost in smog bank. Ended up taking bus from Brooklyn. Andra is Director of Health Education, Public Relations and Utilization at Mega-Humana 743. Business has been white-hot since deregulation of hospital industry. Ask her about proudest achievement. She describes 743's cardiovascular outreach program: "For a modest fee, anyone can sign up for our Happy Heart health program. Members meet weekly at the hospital's penthouse gym. If, at any time, they need cardiac surgery after successfully completing the course, they're entitled to a 10 percent discount." Happy Hearts' success has spawned spin-off they're offering to members of 743's local HMO's. Users participating in Mega-Humana's video home care program and who stay out of mainframe hospital for 12 months get free weekend in Humanarest, new hospi-hotel facility. "A lovely place to stay that makes efficient use of the hospital's swing beds," Andra explained. Good thinking.

2/19/01: Last interview: Mull, head of health education department at Columbia Business Sch. (B-school acquired health-ed after Sch. of Public Health dismantled). Eight hours late — forgot to set alarm clock. Mull's students take marketing, public relations, accounting, management, video production. Also an elective in public health, two semesters in ethics ("instills professional standards"). Mull worried that tuition, now fifth highest in country (\$35,000), will keep away low- and middle-income students, but mentions new Marlboro Man Health Promotion scholarship—Reynolds pays 50% of student's tuition for five-year commitment after graduation. A real go-getter.

2/21/01: Didn't feel like writing piece today—sharp toothache. Called Gatekeepers' Health Plan, switchboard physician told me wrap string around tooth, other end to door-knob, slam door. Said co-payment bill for consultation would arrive tomorrow. Felt lousy—drank three cans of Fruit Looped. Felt better. □

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

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Labor's Safety & Health Movement

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