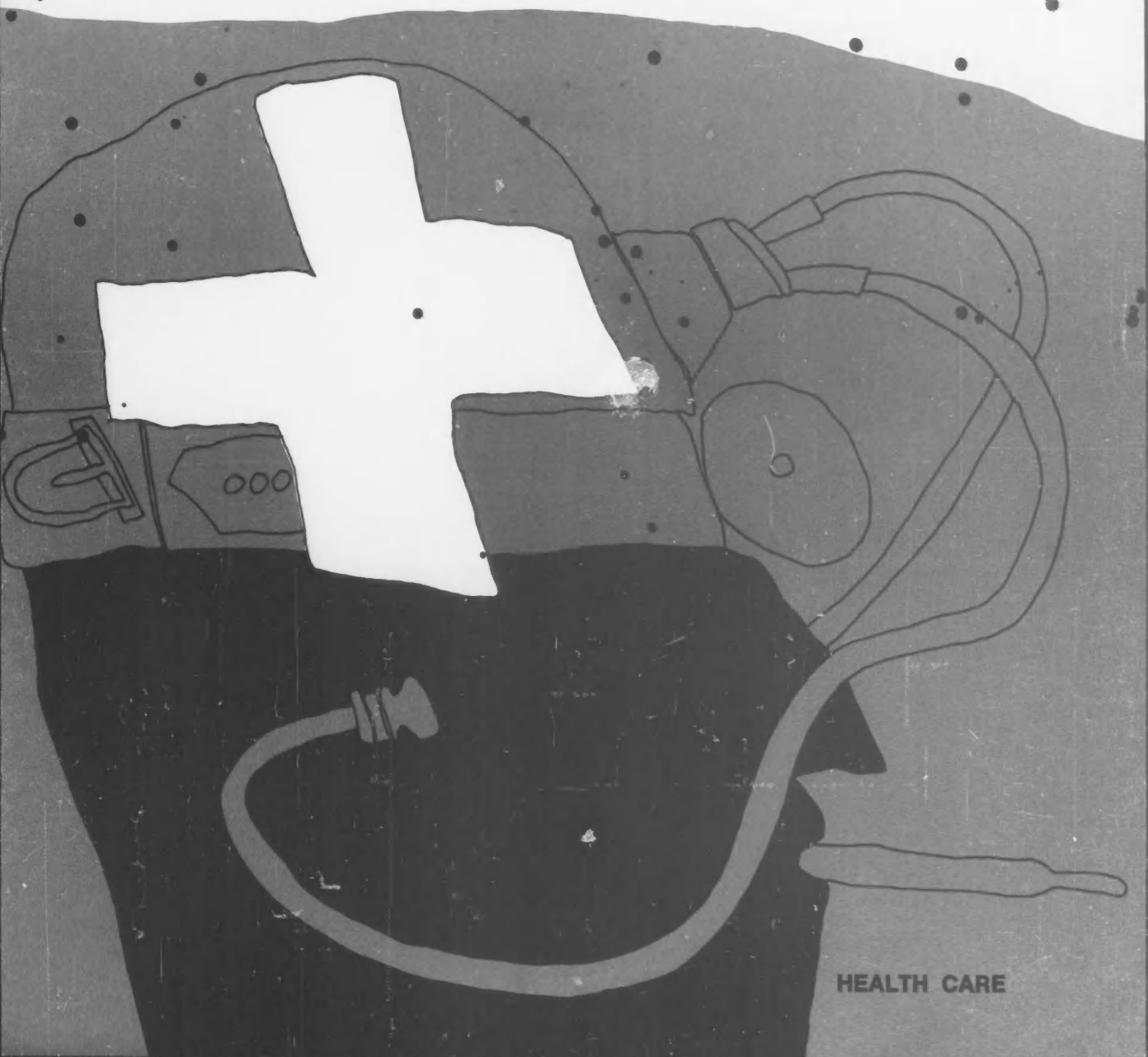


FALL 1977

civil rights digest



HEALTH CARE

IN THIS ISSUE . . . we present five articles on the health care problems of women and minorities. Next year Congress is expected to take up several bills designed to provide national health insurance with varying degrees of coverage. Our authors deal not only with the present situation, but also with the impact such bills might have, emphasizing that none will completely solve health care problems without increased minority and female participation in running our health system, both as professionals and as consumers.

Dr. June Jackson Christmas leads off with an overview of the health status of minorities, the problems they face obtaining services, the lack of minority health care personnel, and the pervasive effects of racism.

Beverlee Myers analyzes the operation of Medicare and Medicaid, pointing out the differences in benefits received by white and non-whites. Her article also recounts the gaps in services left unmet by these programs and lists what a national health program should include.

Francis Chang and Stephen Tang describe the experience of Boston's Chinese community in setting up a health care center. The center is designed to overcome the cultural, financial, and language barriers that prevented Chinese residents from receiving quality health care.

Occupational health and safety issues of concern to women are outlined by Jeanne Stellman, who argues that attempts to restrict women workers because of their reproductive function should be turned around so that the fight for improved conditions for women becomes the cutting edge in the fight to improve the conditions of all workers.

The unique right of Indians to health care derived from the trust relationship is explained by Dr. Everett Rhoades, as is the need to strengthen the Indian Health Service. Lack of facilities, cultural insensitivity, and the shortages of Indian health personnel are also addressed by Dr. Rhoades.

This issue marks our first attempt to illuminate the health care issues facing women and minorities. In the future, we hope to keep our readers up-to-date on developments in this important field.

For more copies of the *Digest* or inclusion on our free mailing list, please write to the Editor, *Civil Rights Digest*, U. S. Commission on Civil Rights, Washington, D.C. 20425.

The *Civil Rights Digest* is published quarterly by the U.S. Commission on Civil Rights as part of its clearinghouse responsibilities. Funds for printing the *Digest* were approved by the Director of Bureau of the Budget on January 29, 1963. Correspondence related to the *Digest* should be addressed to Editor, *Civil Rights Digest*, U.S. Commission on Civil Rights, Washington, D.C. 20425.

The articles in the *Digest* do not necessarily represent Commission policy but are offered to stimulate ideas and interest on various issues concerning civil rights.

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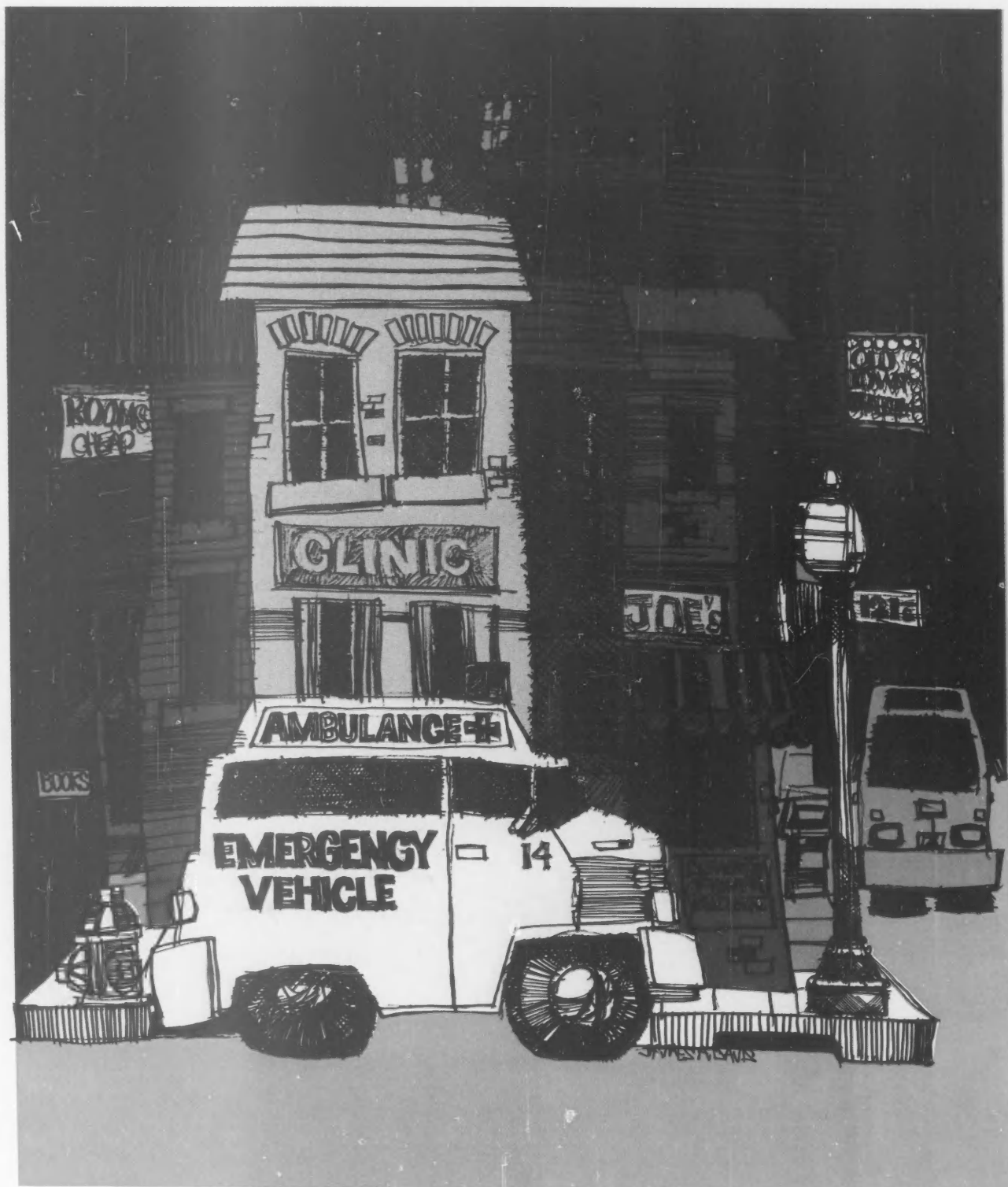
Investigate complaints alleging denial of the right to vote by reason of race, color, religion, sex, or national origin, or by reason of fraudulent practices;

Study and collect information concerning legal developments constituting a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, or national origin, or in the administration of justice;

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Submit reports, findings, and recommendations to the President and Congress.



HOW OUR HEALTH SYSTEM FAILS MINORITIES

By June Jackson Christmas, M.D.

SYSTEMIC DEFECTS AND SYSTEMIC DISCRIMINATION

With national attention focused on the need to control the high cost of health care as a prerequisite to national health insurance, concern with cost-effectiveness is no longer considered inappropriate to the field of medicine. Health care is acknowledged to be an industry, one of the largest in the Nation. Efforts have been undertaken by the administration to stem hospital costs, which contributed a major part of the escalation in annual national health expenditures. Such expenditures more than tripled between 1965-1975.

Cost-containment activities are reluctantly agreed to by hospital administrators; they are hesitantly awaited by middle class families who, though insured with varying degrees of coverage, see their premiums becoming more costly and their benefits relatively diminished. They are awaited as well by the elderly whose social insurance under Medicare is threatened with rising out-of-pocket expenses, by the poor who experience restrictions in Medicaid as States attempt to solve their fiscal crises, and by the working poor who cannot afford private insurance and earn too much for Medicaid. Cost-containment is a matter of high national priority.

At the same time, however, attention is turning to issues of quality and effectiveness. Has the \$140 billion expended for health service in 1975-1976 been spent for care that was medically necessary, of acceptable quality, and most suitable to the patient's medical care needs? Federally-mandated quality assessment efforts have begun to monitor and evaluate effectiveness through local groups of physicians

(Professional Standards and Review Organizations). The problems of an unplanned nonsystem characterized by duplications in services and expensive, untried technology and by overreliance on hospitalization will be addressed by the National Health Planning and Resource Development Act and its regional Health Systems Agencies of providers and consumers.

The basic problems of limited access, maldistribution of resources, and uneven quality of care in the private practitioner's office and in the public clinic—important to the Nation as a whole—are critical to minorities who suffer acutely from the effects of these systemic defects.

Of equal concern is the state of health of the American people. In regard to several key indicators of health status, the United States compares poorly with several other Western, industrialized, though less affluent, nations, ranking 21st in overall life expectancy for males and 25th in life expectancy for males in middle years. In regard to the critical indicator, infant mortality, the United States has slipped in 25 years from 5th place (in 1950) to the point in 1976 where 14 countries have now passed this country in protecting their newborn.

But for minorities the statistics are significantly worse. Moreover, data alone fail to indicate the extent of health problems of racial minorities who are deprived with regard to health care as they are in other social and economic situations. This is particularly true for four groups: Afro-Americans, Mexican Americans, mainland Puerto Ricans, and Native Americans. (The terms "nonwhites" and "ethnic/racial minorities" will refer to these four groups, unless otherwise specified.)

Indeed, the health care system not only fails

Dr. Christmas is Commissioner of the New York City Department of Mental Health and Mental Retardation Services.

these minorities through the omission of essential health services; it also actively discriminates against them in manifold ways that place them at continuing disadvantage. Increasing expenditures of Federal funds for Medicaid and Medicare have failed to address underlying problems of access, of quality and, particularly relevant, of equity. To date, insufficient attention has been paid to the inequities experienced by minorities both in past Federal programs and by the current administration.

A Triple Burden

Minorities are overrepresented among the poor. Ten percent of all American families are classified as poor. Whereas only 8.7 percent of white families are poor, in comparison over 30 percent of black families, 34 percent of Native American families, and 21 percent of families of Spanish origin fall into this category. To be poor means not only to have less money to purchase health care; it also means a greater likelihood of an environment characterized by the overcrowded, unsafe housing, poor sanitation, and inadequate nutrition that predispose to illness. It means segregation on the service wards of an underfunded public hospital—part of a system for the poor that is, *ipso facto*, a poor system.

It means more disability. Poor children lost four times as many school days due to chronic medical conditions as did the nonpoor between 1963–1970; only 40 percent were receiving treatment, according to the National Center for Health Statistics. In 1975 both whites and nonwhites with family incomes under \$5,000 had more illnesses than those with higher incomes; nonwhites, however, had more disabling illnesses for which they sought treatment at later stages.

Although poverty and disease transcend racial lines, to be poor and a member of a racial minority imposes a double burden. But to be a poor member of a racial minority unable to obtain medical care is to be triply disadvantaged. This is indeed the burden imposed by policy barring Medicaid reimbursement for abortions. Its discriminatory effects will be greatest on those minorities who looked to the new administration to redress the past failures of the health care system.

Health Status of Minorities

According to several indicators of health status, minorities are less healthy than whites. In 1975 nonwhites averaged 8.8 bed disability days per person, compared to 6.2 days for whites. The discrepancy

is even more marked among the aging. White persons over 65 averaged 11.7 bed disability days per person; for nonwhites the rate was more than double, 24.6 days.

Infant mortality is considered a significant health status indicator. It is one that is particularly susceptible to increased availability of care. Evidence of this is revealed in the statistics of the pre- and post-Medicaid eras. Whereas between 1950 and 1965 nonwhite infant mortality decreased less than 10 percent, in the period from 1965–1975 it was cut almost in half. Still, today the infant mortality rate of whites is 14.4 per 1000 live births; for nonwhites it is 22.9. The gap between whites and nonwhites is only slightly narrower than in 1950.

The minority child born today is, statistically, deprived of nearly 6 years of life at birth. In 1974–75 the average life expectancy at birth was 72.7 years for whites and 67.0 for nonwhites. During this lifetime, a nonwhite is three times as likely to die of hypertension as is a white of the same age group; twice as likely to die of diabetes; four times as likely to die of kidney disease; and five times as likely to die of tuberculosis. Tuberculosis is a disease closely associated with poverty and presumably susceptible to remission through modern drug therapy. Hypertension occurs among black males at a significantly high rate.

The probability that a nonwhite woman will die of child-bearing complications is five times the rate for a white woman. This statistic bears witness to the fact that nonwhite pregnant women are in poorer health; that prenatal care for nonwhites is inadequate and not sufficiently utilized; and that a higher proportion of nonwhite teenagers and lower income women have unplanned pregnancies for which they have less extensive care.

A nonwhite is twice as likely to die of cirrhosis of the liver and over seven times as likely to be a victim of homicide. The uncontrolled illicit drug industry traffics in most urban minority slum communities; narcotic drug abuse is prevalent.

Discrimination limits access to housing, employment, and recreational activities that are supportive of good health. It contributes to internal conflicts, repressed anger, and inner stress that erupt in outbursts among individuals within minority communities, often against each other or in self-destructive behavior. Suicide has increased, becoming one of the leading causes of death among minority young adult males.

Among Native Americans and Afro-Americans,



alcoholism takes a toll on both men and women; it is becoming, increasingly, a disease that strikes all ages. For numerous other disorders, a similar situation persists, from the greater degree of visual, speech, and hearing impairments to the greater likelihood of psychiatric hospitalization.

Admittedly, it is not certain that increasing health facilities in minority communities would definitely decrease these rates, since certain of them represent, in part, social pathology or social choice. In fact, it has been suggested recently that medical care *per se* may make only a marginal contribution to health. Thus, according to this view, increasing the number of hospitals or physicians will contribute little to improving the health status of the average American; attention might better be given to changing life styles or to the individual's promotion of her or his own health.

But this argument overlooks the fact that the millions of Americans of racial minority background are not average Americans in their health status or in the opportunities afforded them for health education, the technical advances of public health, or in the quantity and quality of medical and other health services available to them. It is indicative of the failure of society at large that such arguments are raised in efforts to restrict costs before such minorities have had their known health needs at all adequately addressed.

Health Services and Minorities

In general, services provided to minority communities are deficient in the characteristics essential to a well-organized system: availability, accessibility, continuity, comprehensiveness, coordination, and appropriateness. Furthermore, by most standards, services that are provided are frequently inferior in quality compared to those provided white communities. It is not only the differences resulting from the two-class system of care (in spite of the fact that almost all care is publicly financed to some degree), with minorities relegated to second-class status and second-class service. Even in comparison to the white poor, minorities experience, on many levels, overt or subtle discrimination that serves to hamper effective care.

Resources are inadequate in number, particularly for rural areas and inner cities, and for certain types of care, such as alcoholism services, long-term care, and home health services. Community mental health and mental retardation programs are insufficient to meet needs, particularly for residential

half-way houses and alternatives to hospitalization. This is especially tragic since the mental hygiene delivery system has tended to ignore the minority retarded, to shunt the minority mentally ill more readily into State hospitals, and to discharge the chronic minority patient more often than the white without followup treatment or rehabilitation.

The rigidity of some migrant health programs, which could serve so many Mexican Americans and blacks, diminishes their usefulness to those populations who, by definition, are mobile. Similarly, the needs of the urban Indian are not taken into account by Indian Health Service programs which focus on reservation Indians, or by other urban health programs that make Native Americans in cities the invisible people, ineligible for services available to the general population.

In the past, continuity in care was provided by the family physician—now disappearing and almost vanished from minority neighborhoods, where clinics may serve as family doctors (for urban residents) or where all health professionals are scarce (in rural areas). Today, physicians prefer to practice in metropolitan and suburban areas, but only in certain neighborhoods are private practitioners found. In New York City, with a large concentration of physicians, there was a ratio of 237 physicians to 100,000 inhabitants in 1970. In nonwhite areas, however, the ratio was as low as 33 per 100,000.

For many inner cities the only alternative to the overcrowded impersonal public hospital emergency room may be the "Medicaid mill" with its frequent practice of unnecessary X-rays, laboratory tests, and examinations, as well as its financial abuses.

In the not-for-profit hospital, minorities are still more readily accepted if they have diagnoses that make them interesting for teaching or research. The difference in quality of care between "service" patients and private patients is exacerbated when the patient is "on Medicaid" and/or a racial or ethnic minority.

Even when quality services are provided in a public hospital they may be second-rate because they are episodic, failing to provide continuity of care, and are not comprehensive. Emphasis is placed on emergency "sickness" care and less on preventive care and health maintenance.

Although these are defects intrinsic to health care in general in this country, their effects are more critical for minorities. When whites seek health services it is usually before an illness has reached an

advanced stage. For nonwhites, health care is customarily sought when one is incapacitated. This is due in part to the lack of health education; it is due also to the economic reality that, for those who are employed, clinic appointments scheduled in the day and requiring time off from work jeopardize already tenuous working situations.

This differential continues during the course of illness. Whites are more likely to be discharged from hospitals at a stage when their condition requires a level of care that can be provided by a family member or home health aide whose services are rarer in minority communities. For minority families, employment of several family members is a standard to be attained; the services of a family member are essential to economic well-being. For poorer families or those unemployed or on public assistance, home health services are less likely to be recommended for patients returning to what is assumed to be an unsatisfactory living situation. Thus, patients frequently remain hospitalized until a more advanced stage of recovery is reached.

Supportive services in minority communities are inadequate, with understaffed, overburdened social service departments. Coordination with community support systems is minimal. Psychological services are often considered luxuries.

Little coordination takes place among categorical health programs aimed directly at the poor, such as maternal and child health, lead poisoning, and venereal disease programs, and other programs mandated to include the underserved, such as alcoholism, drug abuse, and community mental health centers.

Federal failure to collect data relevant to minority needs limits planning. Many unmet needs exist for which funds are insufficient. Lacking a forceful national policy that emphasizes the specific health needs of minorities, program planners at State and local levels fail to institutionalize pilot projects that have proved effective.

A major problem, along with these systemic defects, is the financial barrier to quality service. With the establishment of Medicaid and Medicare, many anticipated that this barrier would diminish. Larger appropriations of public funds have flowed directly to private practitioners and reached the private sector through governmental purchase of medical services or construction, research, and training grants to hospitals and medical schools. At the same time funds have increased to those public facilities where minorities receive a significant

amount of care. In these 10 years, larger numbers of Americans were covered by some form of health insurance, generally through employee benefits.

Still, financial barriers persist. Restrictions in Medicaid criteria, which are established by States, mean that the majority of poor or near-poor people are not eligible. An estimated one-third of the Nation's poor, many of them in Southern States with large nonwhite populations, remain uncovered.

Physician nonparticipation is another barrier to care. While hospitals receiving Federal funds may not legally refuse Medicaid patients, requirements that patients be admitted by physicians with staff privileges allow the more prestigious hospitals to selectively exclude patients, or to admit them provided they become the patients of a hospital-affiliated physician.

Racial discrimination operates subtly and overtly, inhibiting access to adequate health care services. Medicaid and Medicare benefits have been provided differentially to whites and nonwhites.

Differences in Medicaid payments to whites and nonwhites indicate that removal of financial barriers still leaves a large part of the problem untouched; in 1969 an average of \$213 nationally was spent for nonwhites, compared with \$375 for whites. In 1974 expenditures per nonwhite beneficiary averaged \$321; those per white beneficiary totalled \$550. Benefits of nonwhites averaged only 58 percent of those for whites.

Medicare provides only partial coverage, an extreme problem for the minority elderly who have fewer resources than do whites in the same life period. Although Medicare theoretically treats everyone the same, its benefits as well have been unequally distributed between whites and nonwhites. In 1968 Medicare payments per nonwhite enrollee averaged \$195, while payments per white enrollee averaged \$273—a ratio of 71 percent nonwhite/white. Later figures are not available but the trend is believed to have continued.

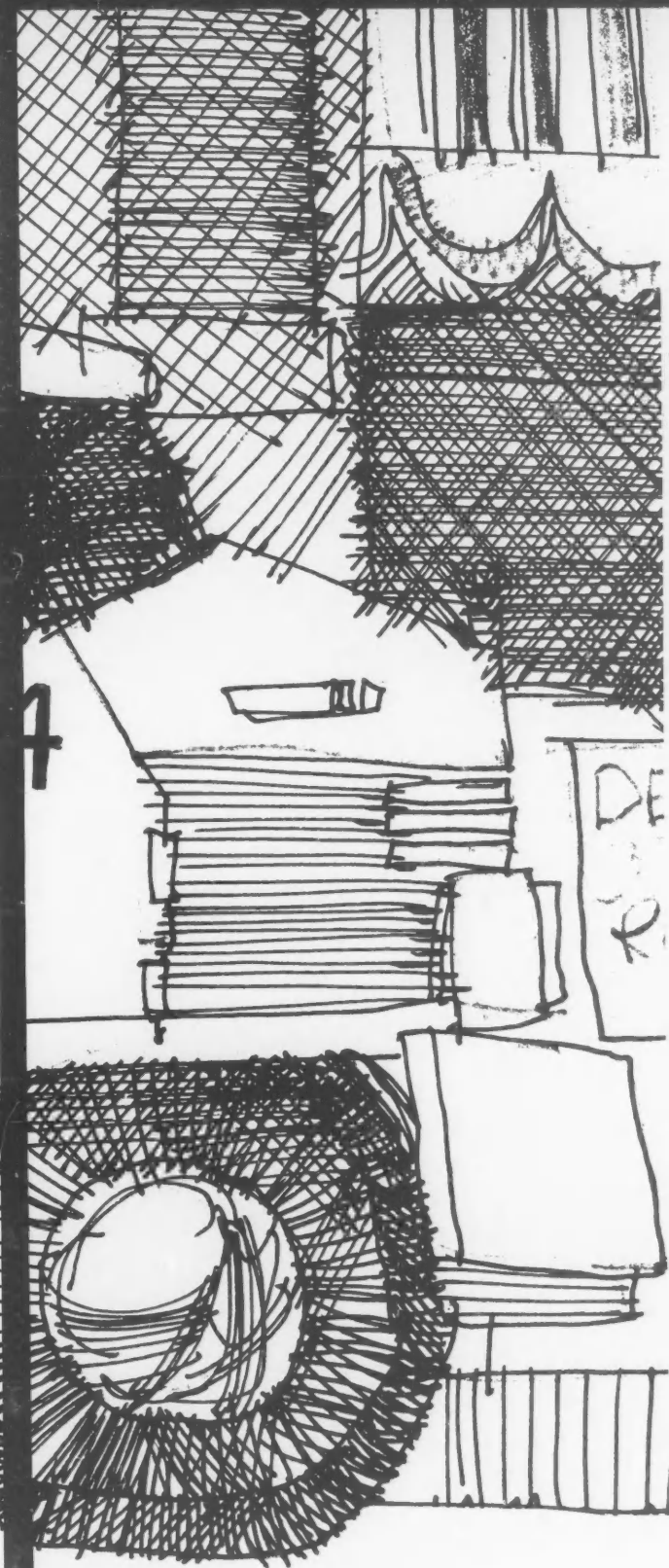
Thus, it will not be sufficient to provide financial access through a national health insurance program; the inequities in access to benefits must also be corrected.

The lack of appropriateness of services to needs is a final critical problem. This includes failure to recognize through adequate programs the special health problems of minorities, such as hypertension among black males and tuberculosis among Native Americans, the lack of health and demographic



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data, and a disinterest in program development for minorities.

Equally troublesome is the lack of sensitivity to racial, cultural, and ethnic factors and a disinclination to explore, for example, the preferences of cultural groups that may contribute to understanding why certain services are used and others not. The lack of health education materials for minorities; the inflexibility of clinic schedules and programs; the lack of responsiveness to locally identified needs; the reliance in mental health on the traditional medical model rather than on more appropriate sociopsychological services—all these reflect, to be generous, lack of concern that services should be appropriate to needs. Surely these conditions are indicative of a situation in which racial minorities are woefully underrepresented among those who make policy, control budgets, or operate programs.

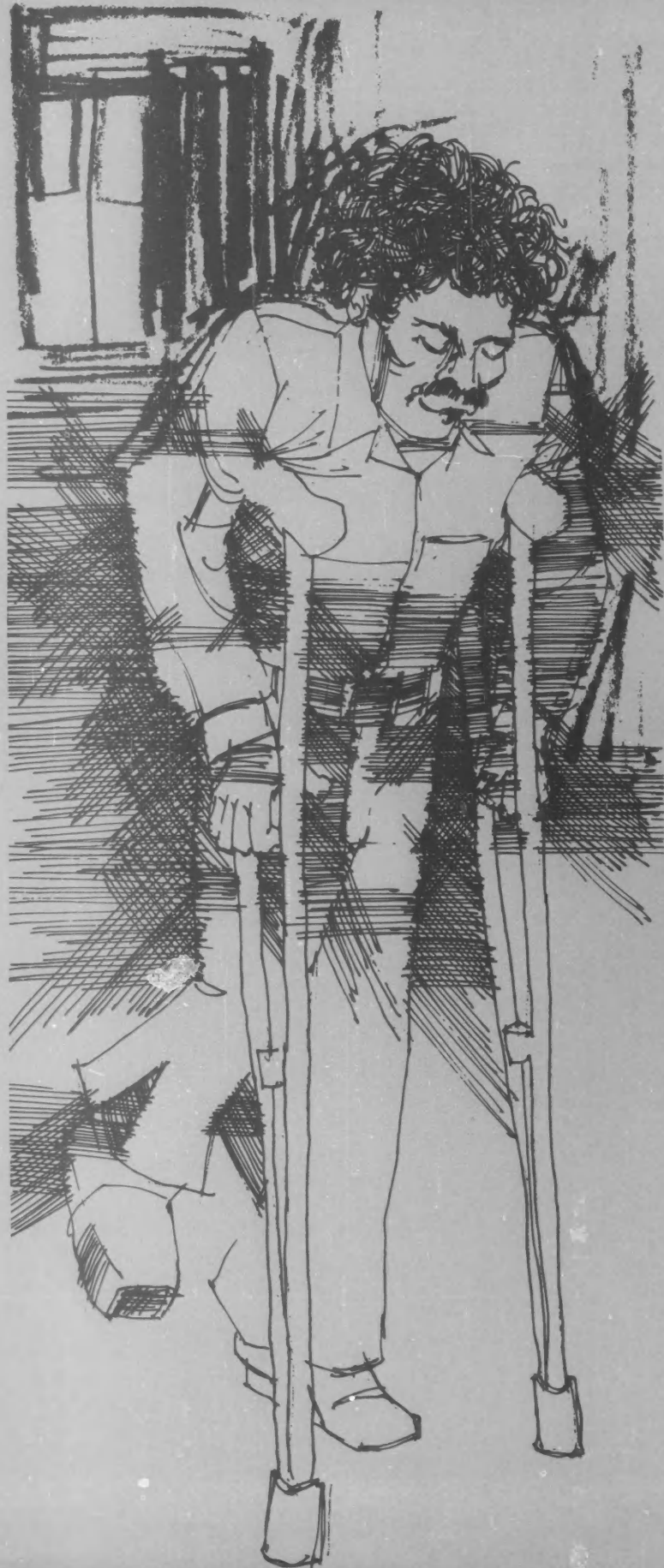
Health Care Personnel

A severe lack of minority health professionals exists, particularly among blacks and Native Americans. Among Afro-Americans, long-standing patterns of racial discrimination and economic disadvantage have resulted in the fact that only 2 percent of American physicians are black, although Afro-Americans represent at least 12 percent of the Nation's population. For reasons of preference and because of the restrictions imposed by discrimination, black physicians primarily serve black patients. Thus, while there are 136 physicians for every 100,000 Americans, with fewer than 6,000 Afro-American physicians there are only 26 black physicians per 100,000 black Americans.

Among Mexican Americans, the second largest minority group representing 2.5 percent of the population, there are only 250 practicing physicians.

Of over one million Native Americans and Alaskans, only 72 are professionally trained physicians. Efforts are being made to establish a much-needed American Indian School of Medicine that will be responsive to the health problems as well as the culture of the Native American. Success should not be used as a reason to absolve medical schools for their past failures to recruit and educate Indian students or to relieve the schools of their responsibility, now and in the future, to develop Native American physicians.

This responsibility toward all minorities persists, and in fact grows. Current legal challenges to affirmative action programs that recruit minority medical students may, if successful, cause an already



deteriorating situation to worsen. Efforts in the late sixties, under pressure of the civil rights movement, to redress these inequities through increased minority enrollment in medical schools reached their peak by 1972-73 and have fallen off. In 1975-76, for the first time in a decade, both the absolute number and percentage of minority medical students enrolled as freshmen decreased. Even at the height of such enrollment, first-year minority students occupied under 10 percent of medical school places.

Nationally, medical school enrollments have expanded, to the benefit of white students. Medical school enrollments have doubled in New York City, for example, since 1969. Yet the percentage of minorities enrolled is less in the past 5 years, while the number of majority students has doubled. Although American minority groups comprise nearly one-fifth of the Nation's population, only one out of fifteen medical students is black, Mexican American, Native American, or mainland Puerto Rican.

Although the geographic and specialty distribution of physicians generally is a problem, for minorities the problem is more acutely that of a shortage of physicians in primary care and in all specialties distributed nationally.

A system of institutionalized racism first bars minority Americans from equal access to medical education. Then, ironically, the shortage of American doctors is cited as justification for employing, to serve these same minorities, foreign-born and -educated physicians who are frequently unable to converse fluently in the language of their patients.

In large cities where public hospitals serve Afro American patients (generally English speaking) or patients whose primary language is Spanish, health care is hampered by such language and cultural barriers.

Commonly, barriers of class and race separate the white health care professional from working-class or poor minority patients. Barriers exist, too, as discrimination persists in the awarding of internships and residencies, in the extensive failure of medical schools (except for Meharry and Howard University) to appoint minorities to faculty positions, and in persistent discrimination in the appointment of minority physicians to hospital staffs. Other health fields fare equally poorly. Minorities serve at the lowest level, as underpaid, undertrained support staff or as menial workers.

Administration, planning, and financing in health care—at all levels in the private and public sectors—are essentially lily-white. Minorities do not share

or participate in making policy or critical decisions. Accountability to these ethnic minorities is virtually lacking, not only on the level of community involvement, but in the newly mandated Health Systems Agencies and in the PSROs as well, and at the national level.

The minority consumer is deprived of a voice in a system in which his or her status is an inferior one, maintained by personal and institutionalized racism. The lack of vigorous enforcement of the Civil Rights Act of 1964 with regard to discrimination in health is additional evidence of the failure to be responsive to minority citizens.

Racism: A Pervasive Factor

The practice of subjecting unwitting or uninformed racial minority patients to experimentation with untried procedures and drugs, unnecessary sterilization of minority women, and other operations performed as part of the training needs of surgical residents may be among the more flagrant medical abuses. Yet, dramatic by their very nature, they are only part of the failure of the private and public health care sectors and of government at all levels to serve racial minorities as well, if at all.

Inequity is the hallmark of health care for minorities. Racial minorities in the United States are disproportionately poor. They face not only financial barriers to the purchase of health services, but also suffer from those conditions stemming from poverty.

Minorities are less healthy than whites. They receive less health care than whites of comparable economic status, and the care they do receive is of lower quality and less appropriate to their health needs. They are discriminated against in the allocation of public funds for health care, including Medicaid and Medicare. They are underrepresented in the health professions, as providers, administrators, and planners and in other positions of authority, decisionmaking, and control.

Finally, Afro Americans, Native Americans, Mexican Americans, and mainland Puerto Ricans are subjected to individual and institutional racism in health care, ranging from ignorance of their cultural backgrounds and health needs to abuses in medical practice.

Unless the Carter administration adopts an active role in addressing the health needs of minorities, as minorities, then a significant segment of American people will find that they are still deprived of a basic human right—the right to quality health care.

By Beverlee A. Myers

THE UNEQUAL BURDENS PAYING FOR HEALTH CARE

The United States is the only developed nation in the world that does not have a national health program providing basic health services to most of its population. While there have been discussions about the need for national health insurance in this country since the early part of the century, opponents of the concept have successfully fought its adoption. As a result, the United States tolerates a system of health care delivery and financing that is inequitable, inefficient, and very expensive.

In 1976, almost 9 percent of the Gross National Product—\$139 billion dollars—was spent on health and medical care. This

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amounted to almost \$640 per person per year, and the expenditures are climbing at a rate of 15 percent per year. Who pays this exorbitant bill? Only one-fourth of the total is paid from private health insurance, such as Blue Cross, Blue Shield, or commercial health insurance companies. About one-third of the bill is paid directly out of pocket by the consumer, for the services or products that are not covered by health insurance or for the deductibles and coinsurance that are imposed by the health insurance companies. (This one-third does not include the consumer-paid premiums for health insurance.)

The remaining expenditures—about 40 percent of the total—come from public sources, including the Veterans Administration, Defense Department, local and State public hospital systems.

The majority of the public financing, however, comes from the Medicare and Medicaid programs. These two programs, enacted by the Congress in 1965, were directed at the two segments of the population believed to suffer from the most severe inequities in access to health care: the elderly (Medicare) and the poor (Medicaid). However, in the decade since the programs went into effect, it has become increasingly clear that the burdens of high costs, inadequate quality of care, and inequitable access to services continue to fall unequally on individuals depending upon their geographic location, economic status, age, sex, and race.

Medicare

Medicare is the nationwide health insurance program for the aged and certain disabled persons.



The eligibility requirements and benefit structure are the same throughout the country, and are available without regard to income or assets.

Part A of Medicare is automatically available to persons when they reach age 65, and to the disabled after they have been covered by social security disability insurance for a period of 2 years. Financed principally through a special hospital insurance payroll tax, Part A covers hospital services (up to 90 days, after a deductible of \$124), 100 days of skilled nursing home care, and 100 home health care visits.

Part B of Medicare is a voluntary program financed jointly through a monthly premium charge on enrollees (\$7.70 per month) and by Federal taxes. All persons age 65 and over and all persons enrolled in Part A may elect to enroll in Part B, which pays for physician visits, laboratory and x-ray services, outpatient hospital care, and an additional 100 home health care visits. These benefits are available after the enrollee pays a \$60 deductible. The program pays 80 percent of the reasonable charges for the covered services.

Medicare will cost an estimated \$26 billion in fiscal year 1978, an increase of 18 percent over fiscal year 1977. Despite this expense, Medicare covers only 42 percent of the medical care costs of the elderly. The elderly were still spending \$390 out of pocket in 1976 for medical care, while in 1965 they spent \$240 per year out of pocket. The poor elderly are spending an average of 15 percent of their incomes out of pocket for health care, while the nonpoor elderly are spending about 6.4 percent of their total incomes.

According to studies conducted by Dr. Karen Davis, formerly with the Brookings Institution and currently with the Department of Health, Education, and Welfare, the elderly with income over \$15,000 per year receive twice as many benefits from Medicare as those with income under that amount. This is accounted for by greater use of services, as well as the fact that the more affluent elderly use more expensive services, such as specialists, while the less affluent may go to general practitioners or clinics. It has also been demonstrated that the deductible and coinsurance features of Medicare act as a deterrent to use of services by the elderly who are poor.

Medicare since its inception has insisted that hospitals provide services on a nondiscriminatory basis as a condition of participation in the program. However, equal treatment for other types of services has not always been assured. Medicare payments per enrolled person were 30 percent higher for elderly white persons than for elderly blacks, 60 percent more for physician services, and more than twice as much for skilled nursing home care. Dr. Davis has demonstrated that the lower use of medical services by blacks is attributable not only to their lower average incomes and poorer educations, but to discrimination and other factors associated with race.

In spite of the fact that Medicare has uniform benefits nationally, major discrepancies exist in benefits by geographic location: elderly persons in the Western part of the Nation receive 45 percent more benefits than the elderly in the South. This is a reflection of both lower prices in the southern region and also

lower use of services in areas with few medical resources.

Finally, it is also the black, the Southern, and the poor elderly who find it difficult to pay the premiums under Part B of Medicare and therefore are most likely not to elect that coverage.

Medicaid

The Medicaid program is a Federal-State matching grant program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. All States except Arizona currently participate in the program. The Federal government's share of the expenses is tied to a formula based on the per capita income of the State, with the Federal government paying a minimum of 50 percent and a maximum of 83 percent. Each State administers and operates its own program, and, subject to Federal guidelines, determines eligibility and the scope of benefits in the program. The programs vary widely from State to State.

Eligibility is linked to actual or potential receipt of cash assistance under federally-assisted welfare programs. In addition, States may elect to cover the medically needy, or those with incomes adequate to purchase food, clothing, and housing, but not adequate to meet costs of medical care. Thirty-two States cover the medically needy to some degree.

States are required to offer inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing home care, home health care, physician services, family planning services, and early and periodic screening, diagnosis, and treatment for children under age 21.

States may also provide a wide variety of optional services—for example, drugs and dental care—and many States do provide services beyond the federally-mandated minimum.

Just as Medicare for the most part has helped many of the elderly obtain care they might otherwise have forgone, Medicaid has achieved much in helping some of the poor to obtain needed care. It will reach more than 20 million of the poor this year, and it has stimulated a marked improvement in the access of the poor to care. As measured by the amount of physician visits per person per year prior to Medicaid, the poor had significantly fewer visits than the nonpoor. Since Medicaid the differences have disappeared, so that the poor and nonpoor are now about equivalent, on the average, in use of physician care.

However, this finding must be qualified. Medicaid does not provide services for all of the poor. In fact, about 9.4 million persons below the poverty income level—or about 36 percent of the poor—are not eligible for Medicaid. This is due not only to State-determined levels of eligibility, but also because Medicaid covers only certain categories of the poor. The following persons are generally not eligible for Medicaid:

- (1) widows under age 65 and other nonelderly single persons;
- (2) families with a father working at a low-paying job;
- (3) families with an unemployed father in the 26 States that do not extend welfare payments to this group;
- (4) medically-needy families in the 21 States that do not cover this group;
- (5) women pregnant with their first child in the 27 States that

do not provide welfare aid or eligibility for the “unborn child;”

(6) children in poor, non-AFDC families in the 35 States that do not take advantage of this optional Medicaid category.

It must also be noted that the poor have more severe health problems, and that use of physician services on a par with the more affluent may not necessarily mean that the needs are being totally met or that the poor are participating in the “mainstream” of medical care because of Medicaid. In fact, studies show that a greater percentage of the poor than of the nonpoor either have no regular sources of care or are very dependent on clinics rather than individual physicians. Also, using “disability days” as an index of need for care, the number of physician contacts per 100 disability days for the nonpoor was substantially greater (16) than for the poor (11).

There also remains a sizable difference in use of hospitals and dentists. The lowest income groups have hospital admission rates about twice those of the nonpoor, giving an indication that the greater needs for ambulatory care are not being met. A substantially smaller proportion of those in the lowest income groups (23) percent see a dentist during the year than those in the highest income group (67 percent); 34 State Medicaid programs provide dental care benefits, but usually on a very limited basis.

Medicaid, like Medicare, is strongly oriented toward institutional care, with almost 70 percent of expenditures going to hospitals, nursing homes, and intermediate care facilities. Less than 15 percent of expenditures in the program go to physician services.

This discrepancy is reflected in part by the fact that while 18 percent of the recipients under Medicaid are elderly, 38 percent of the expenditures under the program are for services to the elderly. On the other hand, children represent nearly half of the recipient population but receive only about one-fifth of the program expenditures.

The geographic differences in the Medicaid program also reflect the State nature of the program. The national average expenditure for a family eligible for the Medicaid program was almost \$1,000 per family per year in 1975. However, the range was from \$334 per family in Mississippi to \$1,824 per family in New York. Montana spent \$70 per eligible child in 1975, while New York spent \$389 per eligible child in that year.

Few children in rural areas receive Medicaid benefits. Many of the rural poor are families with unemployed or underemployed fathers, who are not eligible for Medicaid. Medicaid expenditures per city child are about 15 times greater than Medicaid expenditures per rural child.

While 70 percent of the black poor are eligible for Medicaid, in contrast to only 50 percent of the white poor, Medicaid payments for the white poor person average 71 percent higher than for the black person. Whites receive five times as much nursing home care under Medicaid as do blacks. This is evidence of substantial discrimination, according to testimony in 1974 before the Senate Judiciary Committee. White Medicaid patients also receive payments for physicians' services that are 40 percent higher than those for blacks. Evidence from studies and congressional testi-

mony reveals that blatant discrimination in physician offices still exists in some areas, with segregated physician waiting rooms and longer waiting times for blacks.

Gaps Remain

From the evidence, one can conclude that much progress has been made in the past decade in respect to reducing, and in some instances eliminating, the gaps in health care between the poor and nonpoor, and between the white and nonwhite populations. In particular, the gaps that once existed in the use of hospital and physician services, areas where Medicare and Medicaid have concentrated, have largely been closed. However, in an area like dental care, which has been largely ignored by these programs, there is no evidence of any change in use of services as between the poor and nonpoor, black and white.

Even though the use of medical services has increased among the poor, evidence from the National Health Interview Survey, conducted by the National Center for Health Statistics, indicates that the poor still feel the impact of illness more than do the nonpoor. The proportion of the population with a limitation in activity is the primary measure used by the survey to report the long term impact of chronic illness. And the survey results show that the poor continue to have considerably higher levels of limitation of activity, with only minor changes over the past 10 years. It is difficult to determine which is the cause and which is the effect in examining illness and low income, since high levels of illness and limitation of activity may well have a negative effect on family income. Also, it cannot be expected

that increased access to and use of health care by the poor would result immediately in reduced proportions of the poor with activity limitation. Over the long run, the gap might be narrowed.

One measure of health status that is frequently cited to compare population groups is infant mortality, or the death rates for infants under one year of age per 1,000 live births. After more than a decade in the 1950s and early 1960s when the United States infant mortality rates remained relatively stable, they began a dramatic decline in the mid-1960s, and by 1974 had declined to the lowest points in recorded history. Since 1960, the decline in the United States for both whites and blacks has been marked, and the gap between the two racial groups has narrowed, but the mortality rate for minority infants is still two-thirds again as high as the rate for white infants. Some of the reduction in overall infant mortality, perhaps a major part, must be attributed to the programs in-

augurated in the 1960s that emphasized increased access to prenatal, postnatal, and pediatric care, such as Medicaid and improved maternal and child health programs.

However, it must be noted that the United States still ranks 15th among the industrial nations of the world in infant mortality rates. Even though the U.S. infant mortality rates have declined by 33 percent in the past decade, the rates in other countries, while declining at slower rates, still are much better than ours. Sweden, which ranks first among the nations, has an infant mortality of 9.2 per 1,000 live births while the United States rate is 16.5.

National Health Programs

It is tempting to point out that every nation which ranks above the United States in its infant mortality rate has a national health program. Many leaders in this country feel the time is right for a national health insurance program in the United States.

INFANT MORTALITY RATES

Ranking	Country	Rate*
1	Sweden	9.0
2	Finland	10.0
3	Netherlands	11.0
4	Japan	11.3
5	Norway	11.8
6	Denmark	12.2
7	Switzerland	13.2
8	Canada	15.5
9	France	15.5
10	German Democratic Republic	16.0
11	New Zealand	16.2
12	United Kingdom	16.4
13	Australia	16.5
14	Singapore	16.5
15	United States	16.7
	U.S. White infant deaths	14.8
	U.S. Non-white infant deaths	24.9

*Per one thousand births

Source: U.N. Demographic Yearbook 1974

Monthly Vital Statistics Report - Feb. 1976 HEW

And indeed, if the national public opinion polls are accurate, a large majority of the American people believe a national health insurance program is needed.

The evidence from Medicare and Medicaid, and indeed from the effects of private health insurance, suggests, however, that simply paying the bills under a national health program will not remove the unequal burdens which we have discussed here. Many of the national health insurance proposals currently before the Congress would, in effect, simply inaugurate programs along the lines of Medicare to pay the bills

for some services, for some people. Proposals to expand Medicare, reform Medicaid, cover only catastrophic costs, or cover only mothers and children appear to accomplish little more than adding dollars onto the Federal budget.

Proposals that would mandate that employers provide and pay for most of the costs of private health insurance are also deficient to the extent that they would cover only the employed population and for the most part would discriminate against women who tend to obtain their health insurance through their husband's employment. The Standing Committee on Women's Rights of

the American Public Health Association has pointed out that family-related, contributory eligibility for a national health program (or for a private health insurance plan, for that matter) poses a critical problem for women: it cannot guarantee continuity of coverage. Women would have no individual entitlement to benefits and any change in marital status would lead to disruption and possible loss of benefits.

If the unequal burdens of health care costs, access to services, and quality of care are to be eliminated, the evidence from Medicare and Medicaid seems to suggest that a national health program must:

- provide universal coverage of all Americans under the same health care program, regardless of income, place of work, age, past medical history, sex, or any other factor;

- offer comprehensive benefits, including care in the doctor's office, as well as hospital, and emphasizing preventive care, early diagnosis, and treatment;

- reform the delivery system to eliminate waste, encourage efficiency and economy, control of total health expenditures under budgeting procedures, and give the consumers of health care a greater voice in how the system will operate;

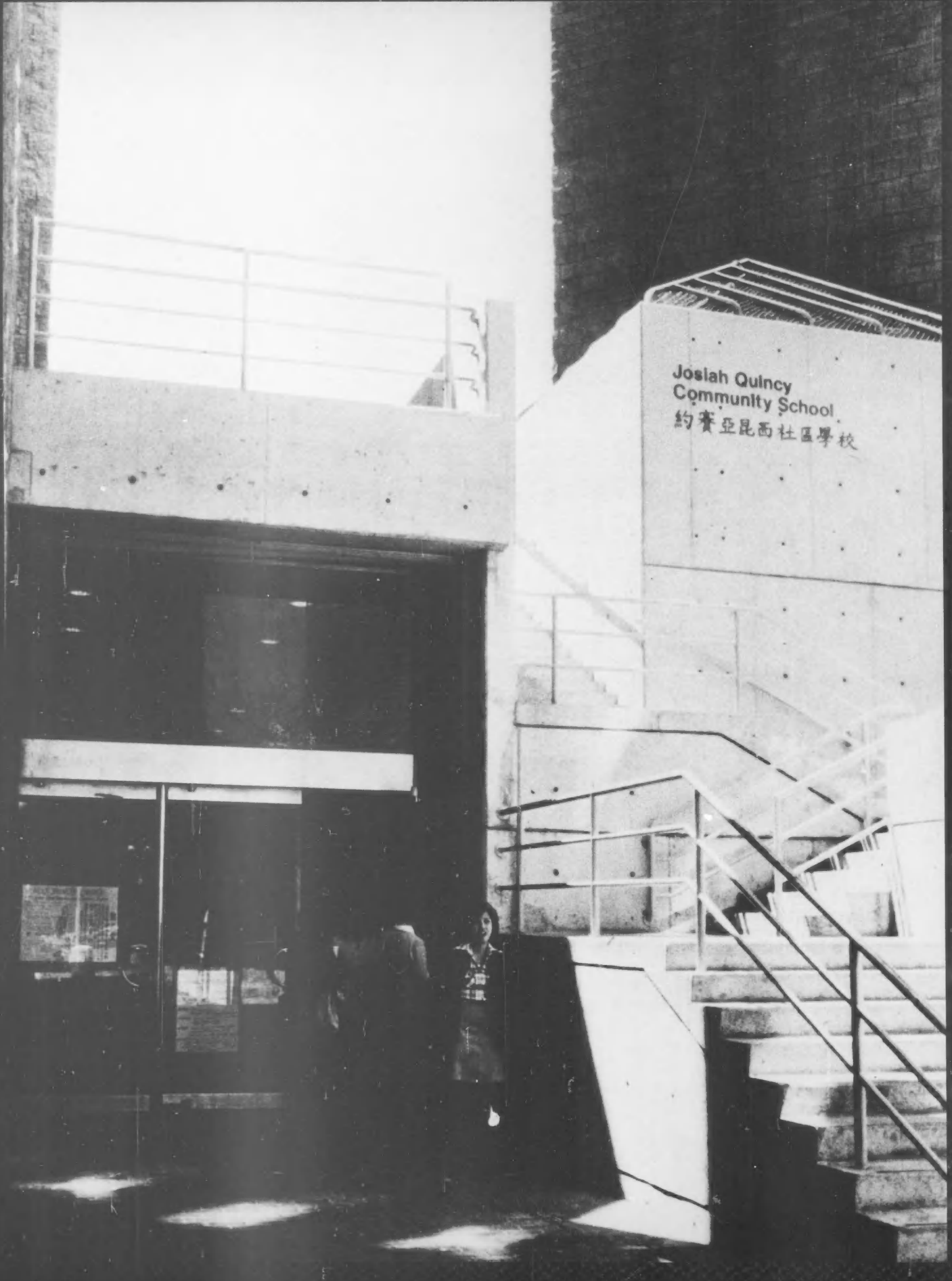
- assure a strengthening of the public-private partnership in medicine, by removing the physician's concern about whether the patient can afford the care needed; and

- assure that high quality health resources are more equitably distributed, so that where you live, how old you are, or what race you are does not determine whether you have access to decent care.

LIFE EXPECTANCY AT BIRTH

MALE		
Ranking	Country	Rate*
1	Sweden	72.12
2	Norway	71.24
3	Netherlands	71.20
4	Denmark	70.70
5	Japan	70.49
6	Israel	70.23
7	Switzerland	70.15
8	Spain	69.69
9	Canada	69.34
10	Italy	68.97
11	England & Wales	68.90
12	German Democratic Republic	68.85
13	Bulgaria	68.81
14	France	68.60
15	Ireland	68.58
16	New Zealand	68.19
17	Belgium	67.79
18	Australia	67.63
19	Greece	67.46
20	Federal Republic Germany	67.41
21	United States	67.40
FEMALE		
1	Sweden	77.66
2	Norway	77.43
3	Netherlands	77.20
4	France	76.40
5	Canada	76.36
6	Switzerland	76.17
7	Denmark	76.10
8	Japan	75.92
9	England & Wales	75.10
9	United States	75.10

Source: *Demographic Yearbook, 1974, United Nations*



Josiah Quincy
Community School
約賽亞昆西社區學校

Small text or notices posted on the glass entrance doors.

A NEIGHBORHOOD HEALTH CENTER

ONE COMMUNITY'S SOLUTION

By Francis H. Chang and Stephen Tang

This story is about the experience of one small Asian community whose working poor population has developed its own solution to its health care problem—unequal access to health care services due to culture and language. We suspect that for many other poor and working poor communities, especially those handicapped by race or culture, the same situation exists.

More than a decade ago, the Boston Chinese community began to question the poor level of health care then available to its members. At that time, no bilingual clinics, no professionals, and no provider network were available for a population of whom over 80 percent did not understand English. This human-service and resource-poor community labored under the outside world's misconception that "the Chinese take care of their own."

Today, this community owns and operates a neighborhood health center fully staffed with bilingual professionals in both physical and mental health. The success achieved to date is no guarantee of future security under national health insurance. In this article we will explain the community we serve, how we developed our services, what we provide as current services,

the impact of proposed national health insurance, and suggestions for national health insurance.

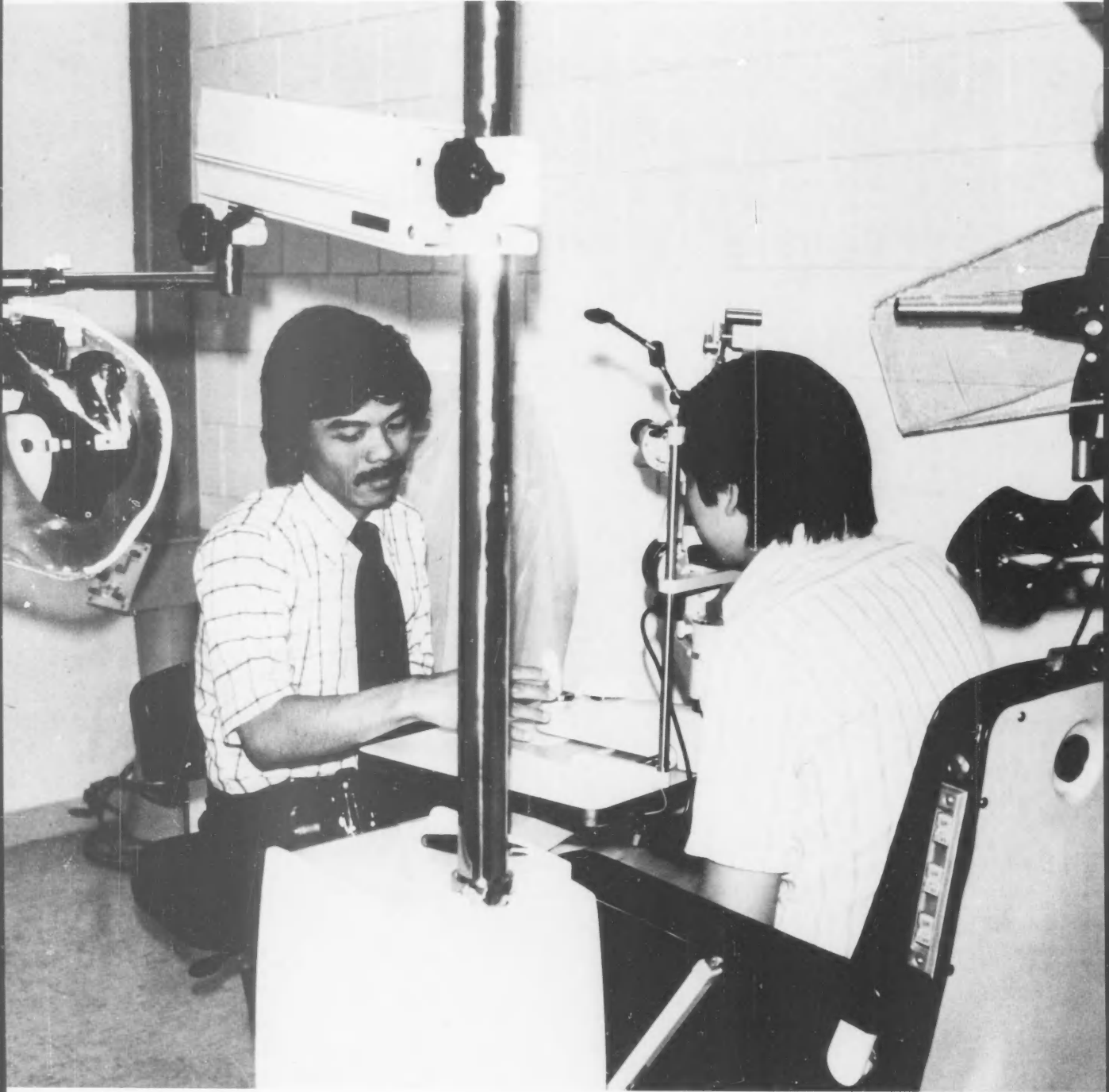
Who We Serve

What does our community look like? Boston Chinatown is an old and small Chinatown as Chinatowns go. It has neither the physical size nor the constant influx of a New York or a San Francisco. Rather there are proportionately more people who have come to Boston because their families came before them and more families who are the descendents of the Toisanese who originally came to the United States at the end of the 19th century.

The Boston Chinese community has long been physically constricted in Boston's garment district, bounded by a decaying red-light zone, the Boston financial district, and two major expressways.

In the middle of Chinatown, Tufts-New England Medical Center, Tufts Dental School, and now Tufts' new Nutrition and Veterinary Schools are growing and expanding. The growth of additions to Tufts and the construction of the express-

Francis H. Chang is associate director of the South Cove Community Health Center in Boston. Stephen Tang is a member of the health center's executive committee.



ways dispossessed and displaced over 50 percent of Chinatown's residents, forcing them to move beyond the expressways.

Two low-income housing projects have been built in the last 10 years and new housing for the elderly has just opened. However, there is virtually no middle or upper class housing; indeed the housing stock itself remains in large part the brick walk-ups built when the South Cove was filled in over a century ago. And, because of commercial development and the proximity of the downtown business district, most of the buildings in Chinatown are multi-use—social clubs in the basement, stores and restaurants at ground level, and light industry, sweatshops, and housing on the upper stories. For new immigrants who live in Chinatown, these conditions may mimic a similarly crowded Hong Kong. But for American-born Chinese and for mobile immigrants, Chinatown does not continue to be the place to live. In Boston, many have moved to Brookline and Allston-Brighton, just as San Francisco Chinese move out of Chinatown to the Richmond and Sunset districts. However, Chinatown remains the cultural bridge.

Thus, despite the inadequate facilities, crowded conditions, and poor environmental factors, this community has continued as a culturally viable focal point for the daily activities of its residents. These nearly 15,000 residents are working-poor, with women employed as stitchers in the local garment district and men in Chinese restaurants within a 60-mile radius of Chinatown. Since English is not necessary for these jobs and shuttle service is provided where required, residents bear the low wages and, for men, long working hours (over 60 hours per week). Shopping and entertainment take place largely in Chinatown at Chinese-speaking establishments. The end result of these factors is the isolation of

the community behind a bamboo curtain from the mainstream of opportunities and services available to other Americans residing in Boston.

Developing Services

The environment confronting this community created a situation where health care was provided on a crisis basis, by non-bilingual personnel, and in institutions whose major goal was the training of students.

Over 10 years ago, residents sought ways to rectify this situation. At first, they approached Tufts-New England Medical Center, the major teaching hospital physically located in the community. After much negotiation, the Medical Center provided space for an evening clinic staffed by a small number of volunteer doctors and translators.

This experience in the first "trimester" of our development decade convinced the community that our community's health status was not a high priority for the Medical Center. The community then decided to develop its own primary care health center. It took the second "trimester" of our development decade first, to secure a Federal planning grant and second, to secure Federal, city, and other grants to open a pilot clinic for our community.

Based on the community's positive response to the pilot clinic, the third "trimester" was spent in creating a viable, fully staffed, and community-operated primary care health clinic. Increased resources from Federal and city governments were obtained, including not only fiscal help but also 10,000 square feet of clinic space in a new community center and school.

During this period, we realized that our health center and the Tufts Medical Center could not continue to operate separately without a future of competition for patients and a damaging lack of coordination for patients moving between our pri-

mary care facility and their specialized secondary and tertiary care center. Thus, with much vigor the community sought and obtained a unique agreement with the Medical Center that made us partners in the coordinated health care of our community, and that designated areas of responsibility, provided ongoing resources to our health center, and a joint commitment toward better educating community medicine professionals. In effect, after 10 years the health status of our community became an institutional priority for the Medical Center.

Since opening our doors in July of 1976, the South Cove Community Health Center has enrolled over a third of our community and this proportion is steadily growing. We act as the health advocates for our community both within our clinic and with outside agencies. We are viable due to the continued efforts of our community to change a health resource system characterized by benign neglect and inequality of access due to language and cultural barriers.

Ours is a medium-sized, independent, nonprofit clinic funded by the U.S. Department of Health, Education, and Welfare and the city of Boston, with assistance from Tufts-New England Medical Center. As a freestanding clinic, the health center is perhaps closer to an expanded group practice owned by the patients than anything else; it is run by a community board of directors and all employees, doctors through receptionists, receive a salary. It provides primary care—what you would expect to receive in a doctor's office, not the secondary or tertiary care you might receive in a hospital or in a subspecialty clinic. The range of care, however, is considerably broader than that of any group practice, though not as wide-ranged as the care that a large Health Maintenance Organization with its own hospital, like the Kaiser plan or the Harvard Community Health Plan, might offer.



Where We Are Now

The health center's services include adult medicine, OB/gyn, pediatrics, dental and eye care, health education, nutrition, adult and child mental health, family planning, and social services. Providing these services are over 40 bilingual fully-qualified staff. Fully-qualified means, for instance, that all physicians are board-certified in a primary care specialty; all social workers are M.S.W. level or higher; and all support staff have the professional qualifications necessary for

their particular jobs. Bilingual means bilingual in Cantonese and English.

For our working poor, ethnic community, the health center provides more than simple primary care services, because without either an Asian human service network or a back-up system that can respond to monolingual or bicultural users, the health center has become a service provider of first and often last resort. This is especially true for mental health services; a traditionally underserved popula-

tion is not yet even being maintained by health center staff, but is still (and continually) being located—an old man in a room by himself for years, a mildly retarded Vietnamese refugee with no home, or a wife newly arrived from Hong Kong bereft of family and, terrifyingly, language.

But it is equally true for services simply unused by a working poor community. Faced with choosing between clothes or fluoride for their teeth, the immediate choice is obvious. But the long-term results—

the pyorrhea and gingivitis of poor dental health—describe the real costs of that choice. Thus identifying and locating widespread problems like these, which may be neatly encapsulated in axioms like "kids need better dental treatment," result in programs for preventive care, both physical and mental, to keep as many problems as possible from becoming acute. And, as described above, a working poor community must make these choices quickly and correctly simply to survive.

Bilingual and bicultural services are the services of choice. Most of our patients are recent immigrants; 80 percent of them are working poor. With both parents working, families aren't eligible for medical assistance, but neither their pay nor their benefits allow for comprehensive insurance such as a Blue Cross/Blue Shield master medical plan. What is more likely instead is a catastrophic health insurance plan or, worse, no health insurance at all. Although the health center has reflected this lack of coverage in its rates, it has had to rely increasingly upon third party receipts—the money it gets from Medicaid, Medicare, and private insurance—and thus on the ever-inflating system of spiraling health costs.

The health center currently receives 40 percent of its financial support directly from HEW. This money is used to subsidize part of the cost of care for its predominantly working poor population.

Health Insurance

Given all this, any national health insurance program that calls for universal entitlement would appear to be the solution to a major problem for community health centers—that is, financing care for the near poor and medically underserved. However, one must look with cautious optimism at the beginning of national health insurance. As stated earlier, the South Cove Community Health Center delivers "comprehensive" health care to its

community. The key word is health. Of the 40,000 visits to the center this year, only a little more than half will be able to receive primary medical care services (i.e., pediatrician, nurse, etc). The remainder will be for a wide variety of related health care services such as counseling, mental health, social services, health education, dentistry, eye care, etc.

Community health centers represent one of the last bastions of Lyndon Johnson's Great Society whose dominant bureaucracy, OEO, funded neighborhood health centers to bring badly-needed primary medical care to "medically-underserved" areas. The health centers of the late '60s ranged from free clinics to hospital satellites; today, they are diverse, both in their organization and in their outlook. Boston alone counts some 27 neighborhood health centers, ranging from off-site hospital outpatient clinics to independent free-standing clinics. The sweeping changes possible under proposed national health insurance can either enhance our decade long work or destroy it.

What will likely be offered as the first phase of national health insurance will really be national medical insurance, meant to entitle the mainstream of the population. It is unlikely that any "nonmedical" services will be covered and it is even less likely that the reimbursement rate will be sufficient to support the high cost of delivering services in a poor urban area to cultural and linguistic minorities. In other words, it is likely that national health insurance will discriminate in some manner against working poor and minority communities.

The Chinese community of Boston has secured for itself a primary health care system. That system may well be endangered by the first phase of national health insurance if safeguards are not included in the legislation to ensure that community health centers and other programs serving the poor and minorities will continue.



BARRIERS TO HEALTH CARE

THE UNIQUE PROBLEMS FACING AMERICAN INDIANS

By Everett R. Rhoades, M.D.

There seems to be general agreement that at the time of first contact with non-Indians, Indians were an exceptionally vigorous and healthy group of people. This can be explained in large part by a high mortality rate for the disabled and afflicted, but may, in fact, also be due partly to a superior health care system. Historical evidence exists of a very sophisticated system of medical treatment, with results often superior to that of the non-Indian.

Almost immediately after contact with Europeans, Indians began to suffer a decline in health. This decline reached devastating proportions in the middle 1800s with epidemics of cholera, measles, and smallpox. Only recently have significant improvements in many areas of health occurred. Many of the acute communicable diseases that afflicted Indian people during the 19th and early 20th century are now finally approaching the low levels seen in the rest of the population.

Unfortunately, at a time when these diseases are coming under control, other types of afflictions seem to be assuming epidemic proportions. Alcoholism and its physical consequences are increasing among Indian people at a rapid rate. The death rate for alcoholism has nearly doubled for Indian people in the past decade. Death rates from cirrhosis continue to rise. The suicide rate for Indians has greatly exceeded that for the general population in the past few years. Indians die from accidents and trauma at a rate three to four times greater than the general population. These disorders are more profound and subtle than the germ-caused diseases. They result from the profound loss of identity, alienation, and hopelessness that is so widespread among Indians.

Cultural differences between Indians and non-Indians create various

Dr. Rhoades is past president of the Association of American Indian Physicians.

barriers preventing adequate utilization of the health care facilities controlled by the "dominant" society. This is particularly true when the clash of cultures is as great as it is between Indians and the non-Indian society. Indians traditionally have no experience with gross, vulgar, scrambling society and do not compete well in an atmosphere of sharp business practices, of "beat the other guy," or of back-slapping, rib-poking gaucheries that so often characterize the non-Indian community. The aggressive, probing, often callous techniques of modern "scientific" medicine also often put Indians off.

To an Indian, the circumstances surrounding an individual encounter with another person are as important as the content or purpose of the encounter itself. This is a reflection of the predominant Indian drive for harmony. In the absence of harmony an Indian may even avoid bringing up the very reasons for the encounter. Such a factor is often at work in the environment of the busy clinic, with its impersonal waiting room where the Indian patient is told to take a number, "and the doctor will see you when he is free." This initial nonharmonious encounter may eventually be followed by an examination, perhaps by a rude physician who pokes and probes with strange and rather frightening instruments. The physician may make a strange and frightening diagnosis and prescribe an even more frightening remedy.

Many of the above barriers of course are not unique to Indian experience even though circumstances certainly magnify them for Indian people. However, other uniquely Indian barriers are more institutionalized and in many instances of greater concern. Problems caused by these barriers will be considerably more difficult to solve.

The Federal Responsibility

Proper understanding of these unique "Indian" barriers require an understanding of the historical and political position occupied by Indian people. This unique position derives from the special trust relationship existing between the United States Government and Indian tribes. This trust relationship grew out of treaties with certain tribal leaders who relinquished great tracts of land to permit white settlement. It has grown through a series of congressional,

executive, and judicial acts over the past 200 years. The Federal government only provides services to tribes with which it has signed treaties or has "recognized." These tribes have a special relationship with the Federal government. This relationship sets Indians off as distinct from any other group in the country.

The trust relationship has placed certain responsibilities for Indian welfare on the Federal government. Some of these include education, supervision of land held in trust, and health services. But it has become commonplace, especially within government bureaucracies, to regard Indians as just another minority group. This tendency to lump Indians together with other minorities and disadvantaged groups has been responsible for denial of these services to Indians. They have often simply been lost in the shuffle. For example, many Indian people are denied services to which they are entitled because they do not fit arbitrary "poverty" guidelines.

The Federal responsibility for health care to Indians has evolved over the last 200 years, often in a piecemeal and uncoordinated fashion. A number of treaties with Indian tribes provided for a physician and certain other services. Gradually the provision of health services grew more elaborate, with the building of hospitals for Indian people and the development of preventive and other services. Finally in 1921, with the passage of the Snyder Act, Congress formally acknowledged responsibility for Indian health by authorizing the Secretary of Interior to expend such sums of money as Congress may from time to time appropriate for the relief of distress of Indians. Thus, a congressional mandate exists to provide health care to Indians. It is important to note that passage of the Snyder Act resulted from an obligation freely assumed by the Federal government to provide services that Indians were entitled to by treaty. Thus, the "rights" to health care by Indian people are of a different historical, moral, and legal order from that of any group.

The mechanism developed by the Federal government to meet its responsibility in the field of health care is the Indian Health Service (IHS), which operates in 12 areas having recognized tribes. Its headquarters are in Rockville, Maryland. IHS is charged with delivering a spectrum of medical serv-

ices to Indians and also has important responsibilities for preventive medicine, sanitation programs, and building and maintenance of facilities.

Little tabulated data exists relating to specific instances of denied care to Indians. However, IHS has sponsored a few surveys in an attempt to estimate the needs of urban Indians. Such a survey in Oklahoma City showed that of a total of 108 Indians

interviewed, only 17 (11 percent) reported having no difficulty obtaining health care from some facilities (including non-IHS). Of the remainder, the largest group (43 percent) reported insufficient funds as the reason for the difficulty in obtaining health care. In descending order, other reasons given were: lack of transportation (15 percent), distance too great to travel (11 percent), and lack of available clinics





(4 percent). Three individuals cited lack of health insurance and four individuals cited difficulty in obtaining time off from work as problems.

Even when questioned about difficulty in obtaining care from IHS facilities, the largest percentage (33 percent) reported lack of funds as the cause of the problem. Lack of transportation accounted for the next largest percentage (21 percent). Because lack of funds was almost certainly related to transportation (since the latter should be the major cost of receiving care in an IHS facility), one can see the enormous problems caused by lack of transportation. The IHS facility nearest to Oklahoma City is a clinic 40 miles away in Shawnee. Even though eligible for care in an IHS facility, 5 per cent of the interviewees reported that they were turned away because of their residence in Oklahoma City.

Surprisingly, 2 per cent were refused care in an IHS facility because they were not deemed indigent. This policy is directly contrary to guarantees made by treaties and is a denial of the special status of Indian people. The Snyder Act does not specify that the government will provide services only to indigent Indians. As Indians slowly climb to higher economic levels this matter will become more pressing.

There is no reason to expect that the above problems are different from those found in most of the urban areas in the United States where significant numbers of Indian people live. Actually, the problems are not that different from those voiced by many people on reservations also. From these data one may conclude that the vast majority of Indian people perceive several significant problems with obtaining medical care. Variations in different areas such as California and Alaska usually serve to make problems more, not less, severe.

Lack of Resources

Although financial support for IHS has steadily increased from 1955 to the present time, this support has been insufficient to meet the needs of Indians. The appropriation for IHS in fiscal year 1956 was \$35 million. This has risen to about \$350 million in the past year. Even with this increase, it has been estimated that IHS only meets the needs of 50 to 75 percent of the people it should serve. In addition to chronic underfunding, Congress ordi-

narily appropriates money by categories of disease. When such funds run out, as they often do, then services are abruptly discontinued. This has resulted in a great backlog of needed services that are not available in many areas. Thus, it is more correct to say that IHS provides for some health care of Indians sometimes.

It is clear that the responsibility for this situation rests with Congress. Indeed Congress actually has set policy for Indian health care, through its annual appropriations acts, which not only denotes what programs will be funded, but also specifies which Indian tribes may benefit from the appropriations. There has never been a clear-cut comprehensive program designed to improve Indian health. It is the stated policy of IHS to "raise the health of Indians to the highest possible level." This is indeed a commendable position, but it suffers from a lack of specificity. Congress would provide a great service by developing a comprehensive plan and funding it adequately.

The lack of facilities within IHS has resulted in a need to supply considerable health care to Indians by means of contract with private physicians and institutions. There are never enough contract funds to meet these needs either, so that, once again, priorities are established that have the effect of denying services to Indian people. These priorities are often manifested in capricious ways. For example, an Indian who lives in a city but who is a member of a tribe in another State is given a lower priority for care than an Indian from a nearby tribe.

Dual Entitlement

In the past few years the concept of dual entitlement has been reaffirmed for recognized Indian tribes. According to this doctrine, Indian people are eligible for all the programs that all citizens are entitled to. In addition, Indians, because of their special relationship to the Federal government, are entitled to certain other benefits. Paradoxically, the concept of dual entitlement has often resulted in denial of care rather than in ensuring it. What happens all too often is that State or other agencies, believing IHS to have the primary responsibility for health care, refer Indians to IHS. IHS, on the other hand, with its limited resources is often unable to

provide for all needed services. The patient is thus caught between two systems, with the result that often health care is not received at all. It is ironic that dual entitlement, which should be a guarantee of care, actually results in a denial of care.

In an attempt to correct the problems created by dual entitlement, in 1974 a tri-agency memorandum of agreement was signed by the Office for Civil Rights (OCR), Indian Health Service (IHS), and Social Rehabilitation Services (SRS)—all in HEW. OCR agreed to require State and local agencies to publicize the availability of services to Indian people who often do not know of their existence. In addition, OCR agreed to seek information from providers relating to acceptance or refusal of Indian patients, as well as to receive complaints and begin formal enforcement of dual entitlement. SRS agreed to inform all State agencies that no plan or program permitted denial of services to Indians on the grounds that IHS services are available.

The Task Force on Health of the American Indian Policy Review Commission devoted a chapter to this difficult topic. Actually, at the time the Task Force was collecting data, only a few cases had been reported to OCR, which naturally concluded that little or no problem existed. This is in contrast to considerable testimony received by the Task Force. The Task Force recommended the creation of a special office of civil rights within a new cabinet level Department of Indian Affairs. In the meantime the Intra-Departmental Council on Indian Affairs of the Department of HEW could be given authority to monitor the memorandum of agreement. To date little has been accomplished.

The Need for Guarantees

Officials of IHS often point out that it operates as a health maintenance organization (HMO). Indeed, when considering the breadth of services offered, including preventive and sanitary programs, one is justified in regarding IHS as an HMO. The usual HMO, however, provides all members the same entitlement to a specified set of services that each member is entitled to. Under Medicare, the U.S. Government has defined certain citizens as being eligible for a full range of services, the cost of which is borne by the government.

Both with the usual HMO and with Medicare then, there is a package of benefits to which every person is equally entitled. We have seen above that the inadequate funding for IHS and the lack of an overall policy result in denial of care. In addition, the absence of a guaranteed package has the same effect as denial of services to Indians. It would be simple for Congress to define a set of services to which all Indians are entitled and then appropriate funds automatically to provide these services. This would virtually eliminate most of the institutional causes of denied health care.

The Absence of Facilities

Indians residing on reservations frequently live great distances from the nearest health care facility. This distance is sometimes measured in hundreds of miles. An Indian who cannot reach a health care facility obviously is denied the benefits provided by that facility, whether an IHS facility or a private one. It is meaningless to declare entitlement that is not backed up with facilities and services.

This denial of services also extends to the nearly 55 percent of the Indian population living in urban areas. These persons are willingly treated if they can get to an IHS facility, but IHS has insufficient funds to provide for contract care for those Indians who have moved to urban areas. The legislative mandate for IHS until 1976 did not exclude urban Indians; there just have been no IHS facilities available for them. Tribal leaders from home communities have naturally feared a draining off of services to urban areas and have generally opposed IHS support for urban programs.

The denial of health care to indigent Indian people by the private sector is so gross and so insidious that it is useless to discuss it further. It is obvious that the overwhelming preponderance of the "private sector" has little or no interest in dealing with Indian problems. Where exceptions exist, such as in volunteers at urban clinics, or where Indians have achieved some financial security, results have been more gratifying.

Some Suggested Remedies

The Indian Health Care Improvement Act of 1976 contains features that will, if properly funded, go a

long way toward correcting some of the deficiencies. This law provides authorization for funds to wipe out the extensive backlog of needed services. In addition, it explicitly sets forth a national policy for the United States to raise the health level of Indian people. The act states:

The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

This statement provides a much more profound basis for Federal responsibility than the brief comment in the Snyder Act. In addition, the act proposes to wipe out inequities by permitting IHS facilities to receive third party payment for services without penalizing the basic funding of the facility. Finally, this law clearly sets out a beginning program for delivery of services to urban Indians. Whether Congress will properly implement the new bill with adequate funding remains to be seen.

One of the more hopeful developments in the past few years has been the rising level of sophistication of Indian people, especially organizationally. In 1971 the Association of American Indian Physicians was formed. This organization, although having only approximately 50 members, is already beginning to have an impact upon health care. Other Indian professional organizations such as the American Indian Nurses Association and organizations of urban health workers are rapidly building cadres of bright young Indians ready to engage the dominant society on its own terms.

An important remedy—perhaps the ultimate one—would be the elevation of Indian people to a status where they could pay for health care on the “open market” or, in the case of remote reservations, have an economic base that itself would support a health care system. There seems little hope that this will occur. Paradoxically, some evidence exists in individual cases that the special trust relationship so vital to continued Indian identity and viability places

Indians inevitably in a dependent position that itself seems to be associated with atrophy of self-motivation. This is just another of the many paradoxes and contradictions that Indian people live with every day.

It is also foolish to expect that a system of national health insurance will provide the answer. Such a system in itself would do nothing to alleviate the cultural barriers mentioned above. In addition, it makes no sense to provide an Indian with financial support for health care when that person resides in a remote reservation hundreds of miles from a facility where care can be purchased. Ironically, even with all the problems IHS has, there seems to be fairly universal Indian agreement that any national health program must not further erode the programs of IHS. It would not be surprising, in view of all the failed good intentions of the past 200 years, if a national health program in fact resulted in even further barriers to health care of Indian people.

Much more insidious is the very real “backlash” of non-Indians in the past one or two years. This backlash seems to have arisen from the recent gains made by Indians. The effect of this backlash must not be underestimated. It has had significant effects already. For example, the near defeat of Rep. Lloyd Meeds of Washington has been attributed in part to his championing of Indian causes. The energy crisis has also stimulated a new surge of non-Indian greed for mineral land owned by Indian tribes. The future therefore must be regarded with some concern. Indians remain in an extraordinarily precarious position with regard to access to systems such as health care.

Because of the profound alienation and loss of hope of Indian people, it is obvious that the very nature of the health facility itself may prove to be a barrier to health care. A very special atmosphere and attitude will have to be developed in health facilities in order not to drive the Indian patient away. A hostile, unfriendly, and barren atmosphere, so common in so many facilities, thus becomes a very real part of the problem. Great ingenuity and patience will be called for if a successful system is to be achieved. This challenge must be met before significant improvements in Indian health care can occur.

THE HIDDEN HEALTH TOLL

A COST OF WORK TO THE AMERICAN WOMAN

By Jeanne M. Stellman

The hazards that workers face on the job are gaining greater recognition each day. Coal mine disasters, exposure to exotic cancer-causing materials, disabling lung diseases all seem to be the subject of growing attention in the news media and in the scientific, governmental, and legal communities.

In part this recognition led to the passage of the Occupational Safety and Health Act (OSHA) in 1970, which established at last the right to a safe and healthful workplace for all American workers. Steady progress toward achieving the basic guarantee of workplace safety has been slow and difficult to achieve, however.

Unfortunately, most people associate workplace hazards with "man's" work: hot, noisy, dangerous, and rough, but large numbers of women also work at jobs that present serious, though often less dramatic, health hazards. It doesn't require the noise and vibration of a pneumatic drill or the dust, heat, and rigor of a steel mill for work to be potentially harmful to one's health—those dangers are just more obvious and intense.

The thousands of women employed as technicians in clinical medical laboratories or in dialysis units, for example, face a severe risk of contracting hepatitis, a serious long-lasting liver disorder. They can also unknowingly bring this disease home to

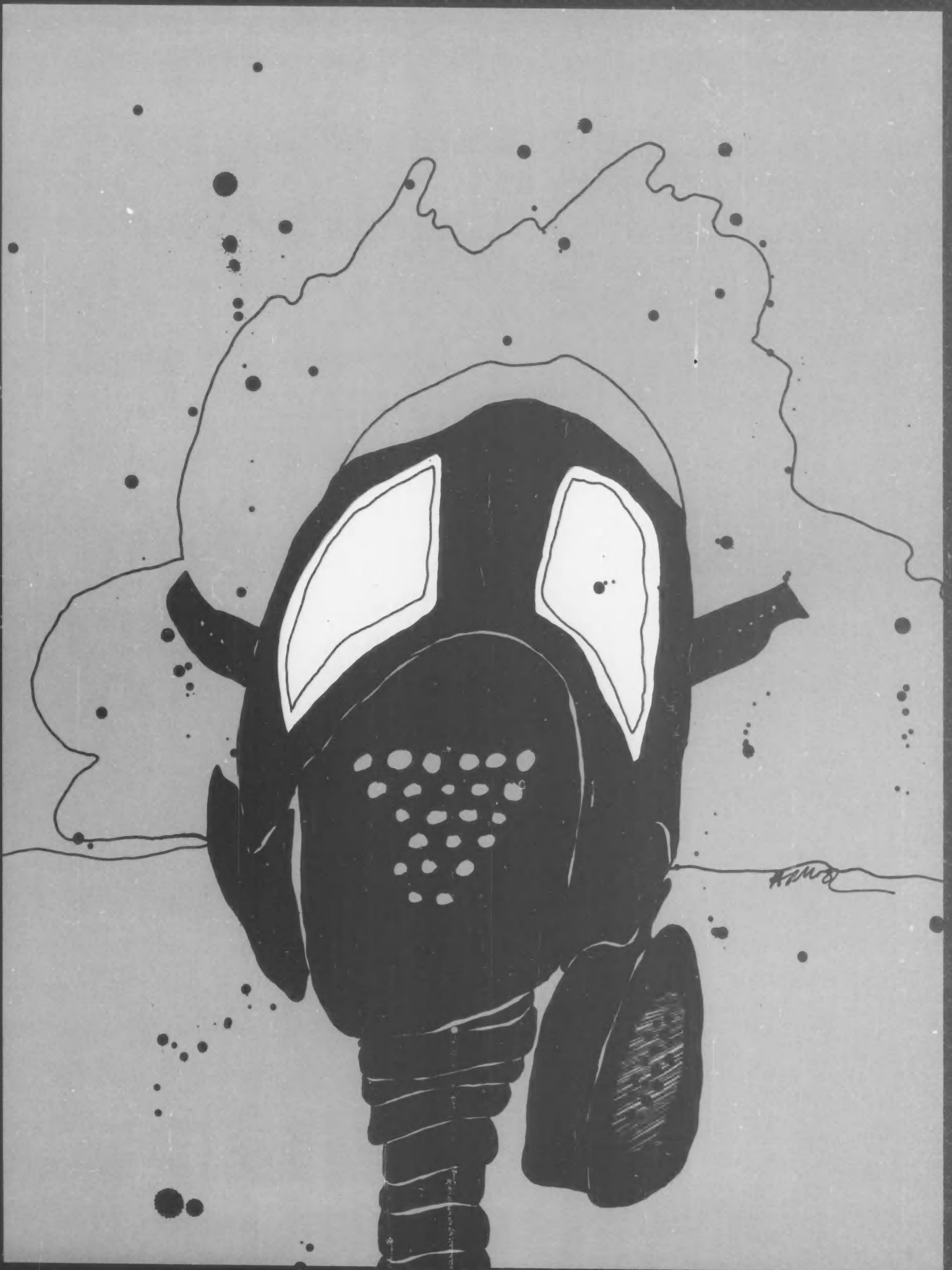
their families. Or consider the hundreds of thousands of women employed in the service sector, as cooks, maids, nurses' aides, and so on, who can develop skin disease and back disorders from their jobs. Thousands of women are exposed to relatively high levels of x-irradiation, levels many times higher than those considered safe for the "general public." The potential health cost, both to women and to their offspring, if women are pregnant on the job, is unknown. Yet such exposure exists throughout the huge medical industry.

How Great the Toll?

It is difficult to estimate the numbers of women who are injured on the job or who may suffer impaired health because of their work or because of the rigors of combining paid employment outside the home with household and family duties. It is difficult enough to estimate the annual toll of occupational injuries and illnesses on the total work force. One estimate comes from the National Institute for Occupational Safety and Health (NIOSH). Its figure is that each year 390,000 Americans contract occupational diseases and that about 100,000 people die annually from work-related illnesses and injuries. No realistic estimates, or even guesses, have been made about the number of these injuries and illnesses that are sustained by women in the workplace.

There are several reasons why the impact of work on women's health is not understood. One is that women in the workplace are usually treated as an

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anonymous sector when studies and surveys are carried out. For example, a major monograph on stress and work released recently by NIOSH specifically limited itself to male workers. Most of the other studies it reviewed were likewise limited to males. As we will discuss shortly, because of various socioeconomic factors and the nature of "women's work," women are subjected to a great deal of stress on the job, as well as to the stress of combining the role of work at home with work in the marketplace. No one really knows the health costs of stress on women—and no one is actively looking.

The anonymity of women in the workplace is not new. In 1946 Dr. Anna Baettjer published an excellent monograph, *Women in Industry: Their Health and Efficiency*, commissioned by the Air Force because of the large numbers of women filling wartime jobs. In that work Baettjer treated the subject of occupational health hazards of all sorts, not so much to elucidate them, she stated, but rather to demonstrate the potential gravity of the situation and the need for more research and information. Ironically another NIOSH monograph, *Occupational Safety and Health*, published in 1974 still relied heavily on Baettjer as one of the major references in the field, even though *Women in Industry* is now more than 30 years old—a good indication of the lack of progress in the area.

In a comprehensive review of the medical literature pertaining to women in the workplace that has been published in the United States and abroad, Dr. Vilma Hunt has noted that the "literature . . . describing the health experience of women workers is sparse, despite their concentration in a relatively few industries. . . ." She also notes how "surprising" it is that women are so often explicitly excluded from the study design, just as in the NIOSH stress study example.

Identifying Work-Related Disease

Another major reason there is very limited knowledge about the potential occupational health hazards faced by women on the job is inherent in the very nature of occupational disease. Unlike sudden death or accidental injury that occurs quickly and noticeably, such as during an explosion, most occupational diseases develop slowly and imper-

ceptibly. Many years of low-level exposure to substances like pesticides or solvents may lead to a chronic disease like high blood pressure or cancer. Such chronic diseases, of course, also develop in people not employed in hazardous situations.

Many different factors contribute to the development of chronic diseases. Because of the long period of time it takes for chronic diseases to appear and the number of factors involved in their causation, it is difficult to pinpoint the exact cause of a particular cancer, heart attack, etc. In fact, there may not even be a single causative factor but rather an array of contributing factors, often called risk factors, involved.

(These are exceptions, of course. Cancer of the stomach or lung lining, mesothelioma, is a very rare disease among the general population and is virtually associated only with asbestos exposure, yet even in the case of mesothelioma, smoking may be a complicating risk factor.)

Since some of the factors that can cause chronic disease occur elsewhere in addition to on the job, and since chronic diseases take so long to develop, the association between the cause and the effect requires extensive statistical study and scientific experimentation. In the case of cancer, it may take 20 to 30 years for a particular cancer to grow—so that it may be years before a cause and effect can even *begin* to be established. Often the necessary studies may not even be possible. For one reason, the health care system in the United States is not notable for its extensive recordkeeping. For another reason, we live in such a highly mobile society that the likelihood that a statistically large enough population has remained in one place to be identified and studied is poor.

The nature of modern industry is such that it may not be possible to determine just what the conditions and exposures were that workers were subject to 20 to 30 years earlier. Processes change routinely. Companies are bought and sold. Many chemicals are unidentified or known only by trade name or code number. For these reasons it is only the very rare disease—like mesothelioma—or the extremely potent toxic substances—that we have already recognized and earmarked as occupational diseases and hazards. Hopefully OSHA record-

keeping requirements may somewhat rectify this situation in the future.

An additional complicating factor is that physicians are not trained to recognize occupational diseases. Unless a particular disease is extremely rare, it is more than likely that a patient will not even be asked to give any detailed information about his or her work—the environment in which that person, of course, has spent the majority of each day. The unlikelihood of being asked about your work is especially true for women. An excellent example is found in a 1963 survey carried out by the U.S. National Center for Health Statistics on the effects of employment on pregnancy. Incredibly in that study, which surveyed a selected population of childbearing women, only data on the occupation of the *father* was gathered; the mother's job and job history was not taken. It is certainly true that if little is known about the dangers of work for men, still less is known about the effects of working conditions on women in the workplace.

A Panorama of Hazards

It is interesting though dismaying to note that despite the rhetoric of affirmative action, most women are still segregated into "women's work." It is also interesting that many of the hazards that women face on the job are a reflection of the hazards that they face in the home—the hazards complement and exacerbate each other. Back injuries and backaches are common to workers on the job as well as to the mother of young children and to the housekeeper. Skin irritation and disease occur widely among hospital workers, service workers, and industrial workers (in fact, they are the leading recognized occupational disease), just as they occur among women who fulfill the home role of cook and cleaner.

Many women on the job are exposed to infection from close contact with young children, a plight shared by the mother of children who always seem to develop one infection after another. It is also important not to overlook the obvious stress and fatigue associated with long hours "at work" on the job and long hours "at work" in the home.

More than three million women are employed in the health industry. The majority are in the service

and clerical sectors. Hospital service workers have the dirtiest and least rewarding work. They must lift heavy patients, clean up in often infected areas, carry heavy burdens, and tolerate the smells and heat of the hospital. Service workers are frequently endangered by wet floors. They must handle sharp objects and are wounded by needles and other equipment improperly disposed.

Many hospital service workers are employed in laundries, an occupation held by more than a quarter of a million American women. Laundry work is dangerous and dissatisfying. The temperature and humidity are often unbearable, undoubtedly taking a toll on the cardiovascular system. Equipment is frequently poorly maintained and designed. Some laundry machine doors can be opened before the scorching steam has dissipated, exposing workers to hot steam, or wires are often frayed, despite the ubiquity of wet floors. This presents a serious electrical hazard. Mangles are left mechanically unguarded and are not built with an automatic shut-off mechanisms in case clothing or a limb are caught in the rollers—a dangerous situation.

In addition to these more obvious hazards laundry workers can also be exposed to the toxic contaminants left on the laundry. Cases of silicosis and asbestos-related diseases have been recorded among laundry workers washing dusty work clothes. Hepatitis has also occurred. With the passage of the Occupational Safety and Health Act (OSHA) and its requirements for the provision, in some standards, of clean workclothes by the employer, it can only be expected that the dangers of laundry work will increase.

Another 15 percent of the female work force is employed in blue collar factory work. The electronics industry and the clothing and textile industries are the largest employers. In the assembling of printed circuit boards, women are exposed to solvents like trichloroethylene, which has been found to cause cancer in test animals and is suspected of causing liver damage. They are also exposed to soldering fumes that can contain cadmium, a metal associated with kidney damage and cancer as well. These are but two examples.

Exposure to cotton dust can produce a disabling lung disease sometimes called "brown lung." Most

cotton mill workers work in unorganized plants with no union rights and benefits. If they develop this allergic lung disease to the cotton dust, they must leave their work, often with little chance for other employment in their impoverished mill towns and certainly with no union benefits or appropriate compensation. They are economically and physically disabled. The Public Health Service has estimated that there are at least 500,000 cases of "brown lung" in our society today, male and female.

Fifteen percent of the female work force is also employed in retail sales. Many of these women must stand for long hours each day, a working condition that undoubtedly contributes to the fact that 40 percent of American women have varicose veins. Sometimes saleswomen must wear girdles to "keep up their appearances," a practice strongly contraindicated if a woman has varicose veins. One cannot underestimate the stress of this job which requires dealing with both the public and with extensive direct supervision simultaneously.

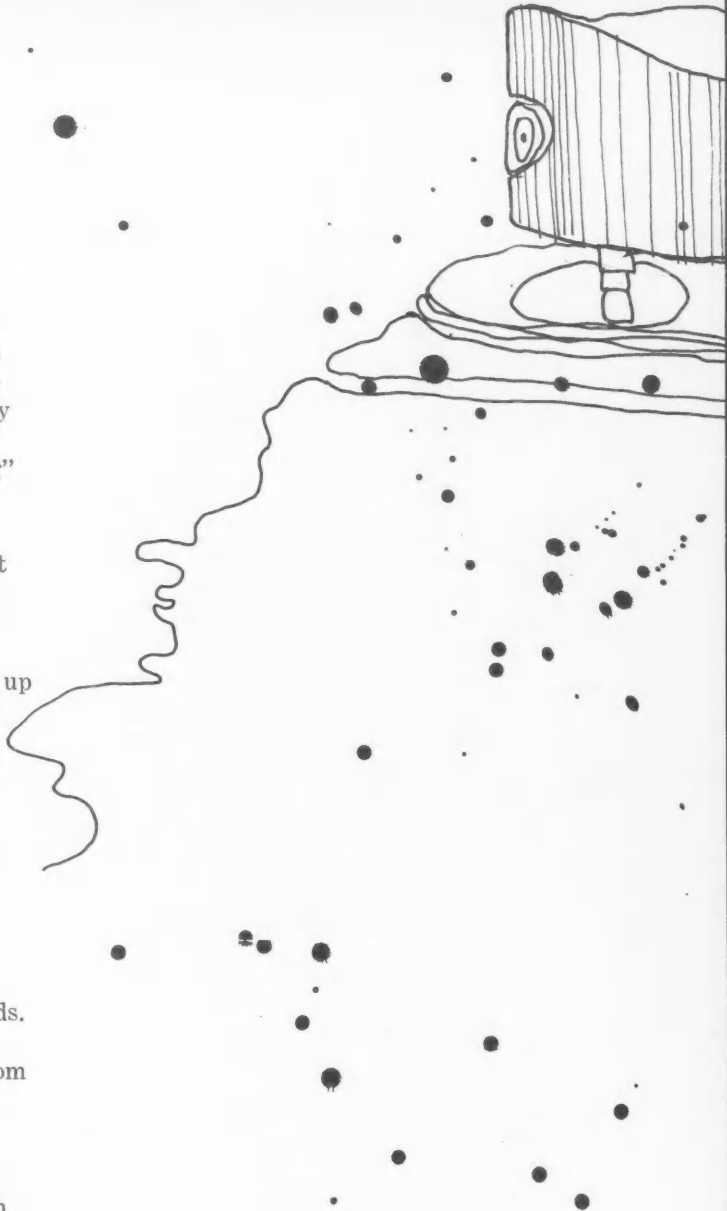
Even office and clerical work, the major employment area for women, has its hazards. From the exotic solvents used in office supplies to the fluorescent lighting and sometimes contaminated airway ducts, as well as to the poorly designed work areas and chairs, the office can present hazards. In one large survey of potential office hazards, injuries ranged from infected puncture wounds from staples to broken limbs from tipping file cabinets.

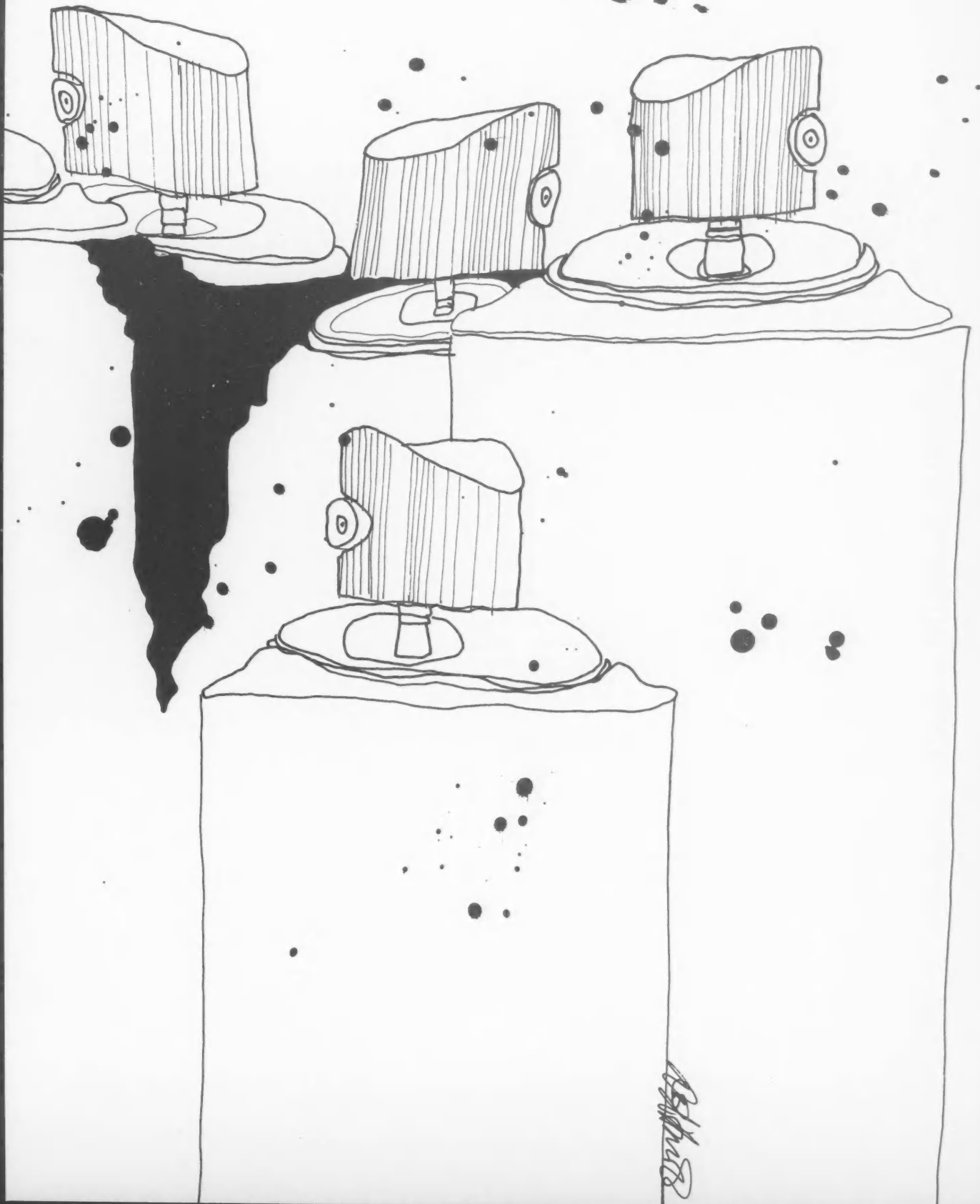
Stress and Women's Work

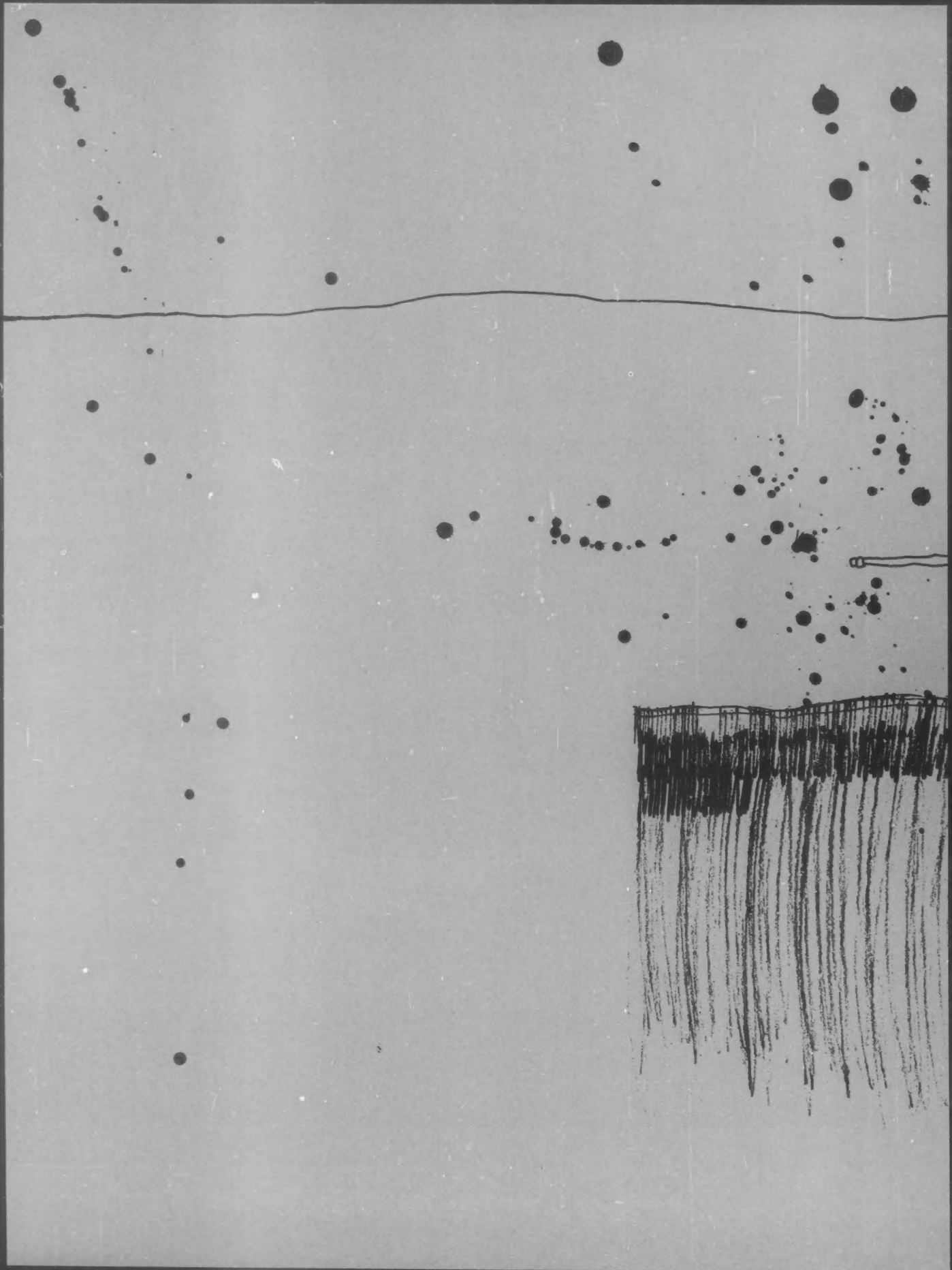
Not all work is dangerous because of the direct physical dangers involved. Stressful conditions can also affect one's health. In the office example just cited, a workplace filled with the clatter of clacking typewriters, ringing telephones, vibrating ventilating systems, and conversations presents a seriously stressful environment. Some scientists have even quantified the annoyance levels of sound, an example of a physical stressor.

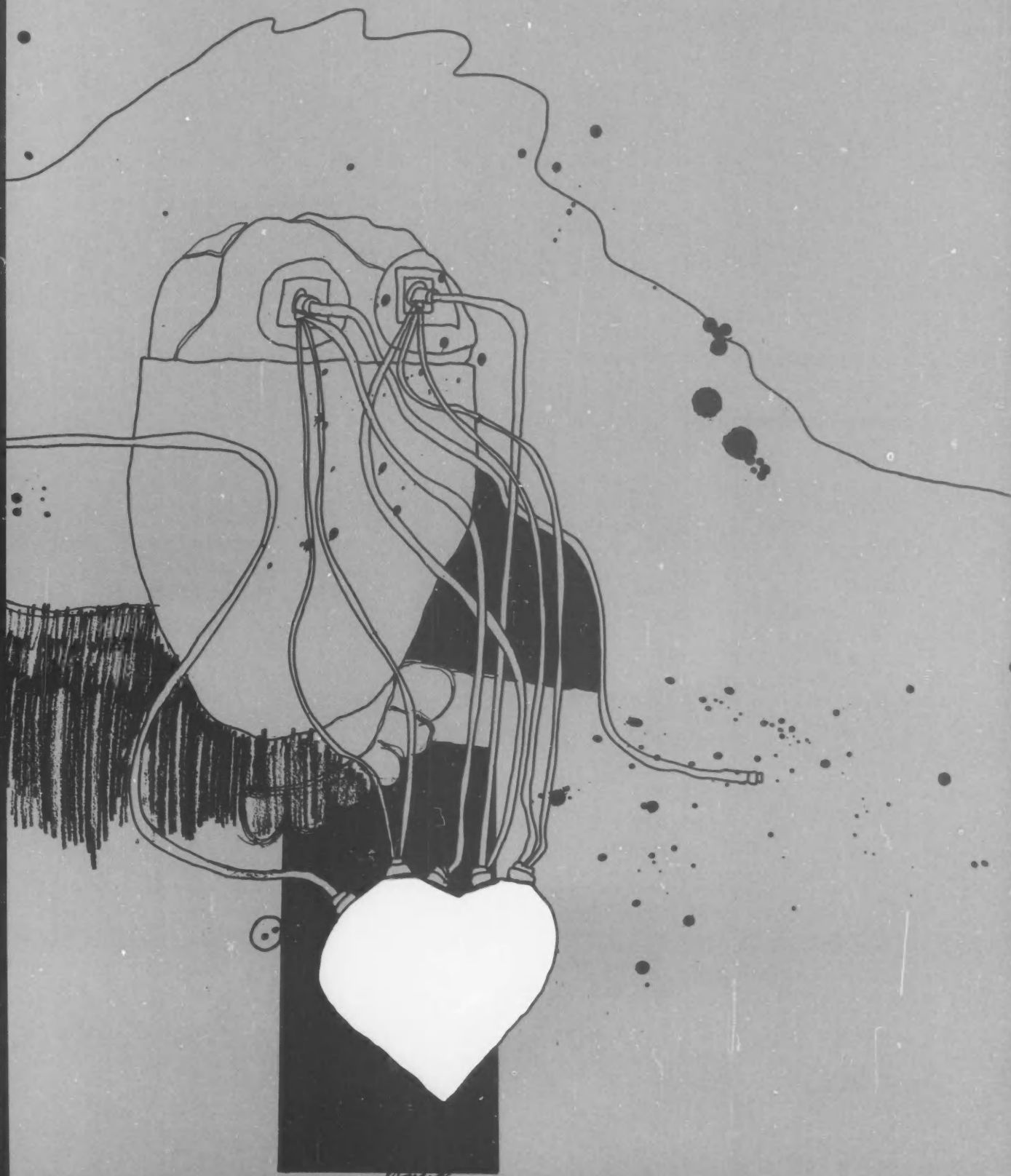
If a person is exposed to a source of stress, whatever its nature, her body will respond. The blood pressure will be elevated, the heart rate will increase. The adrenalin level in the blood will rise and other chemical balances will be altered to meet and cope with the stressor.

Such biological changes are part of the "stress response," a natural defensive mechanism that enables the body to maximize its energy and efficiency. The stress response is a useful and necessary part of life, and indeed, life would be rather dull without some stressful input: love, the excitement of sports, exercise, are all positive stresses. Unfortunately, biological stress mechanisms cannot differentiate between positive inputs and unenjoyable or dangerous stresses. The body reacts the same way to a kiss as to a noisy office.









R. JONES

The end result of too much stress is an increase of disease, especially chronic disease like heart disease. No one really understands how stress and the stress response affects the course of a disease, but it is clear that many of the risk factors of chronic disease are also factors of stress.

Women are faced with a variety and abundance of sources of stress. Social scientists and behavioralists have identified many workplace factors as sources of workplace stress. Job dissatisfaction, such as work that is boring and routine or that is far below one's qualifications, is stressful. Insufficient rewards, such as not enough pay or recognition, are other sources of stress. These sources of stress are endemic to many women's jobs.

Fatigue and excessive demand are stressful. The working woman with family obligation will work as many as 80 hours per week, fulfilling her dual role of home and job. And the working woman without a family is under the stress of not conforming with society's norms. Also, women earn about 60 percent of the wages of men with equal education and training. The earnings gap is widening and represents an obvious source of dissatisfaction and stress, especially since most women's earnings are vital for family support.

It is difficult to quantify the long-term effects of stress on women's health. First, women seem to be protected against the development of heart disease until they reach menopause—and heart disease is the major chronic disease associated with stress. Thus even though women do develop heart disease, their rate never reaches that of males. Around age 50 women begin to have a higher rate of hypertension than men, which is also stress-related. Unfortunately, few studies are seeking to learn what the true effects of stress on women's health are. Of the millions of dollars being spent annually on cardiovascular disease research, the vast majority is spent on research devoted solely to males.

Perpetually Pregnant—Perennially Protected

It is ironic that although women spend most of their lives *not* being pregnant, the majority of the time and attention of researchers and lawmakers in the area of occupational health has been devoted to protecting women from the perils of the job during

pregnancy. Such concern has in the past usually "protected" women out of the highest paying jobs that represent the greatest potential for advancement. The protective laws, however, usually left them still exposed to the rigors of jobs like laundry work, health care, and housework, where their labor is probably performed in more hazardous conditions than are found in the "protected" jobs.

Even today the majority of the meager funds available for research on the health of women in the workplace has been devoted to research on the effects of work on human reproduction. It is also ironic that while clear and abundant evidence exists that the reproductive health of men in the workplace is *also* jeopardized by their working environment, it is the women workers whose jobs are once again apparently being threatened by restrictive workplace health regulations, despite the purported protections of Title VII of the 1964 Civil Rights Act and the guarantees of OSHA.

For example, it has become a general policy of the Lead Industries Association, Inc., already adopted by major companies like General Motors and St. Joe's Minerals, that "no fertile, gravid [pregnant], or lactating female be employed in the lead industries until such time as adequate information has been developed regarding the effects of lead . . .," a policy that simply restates an old exclusionary hiring practice, apparently only temporarily set aside in the aftermath of the passage of equal employment opportunity legislation. The discriminatory practice is spreading. Now the Occupational Safety and Health Administration has asked for comments on whether *all* women of childbearing capacity should be barred from working with lead under the proposed OSHA lead exposure standard.

The irony of the situation is that much of the data on adverse reproductive effects of lead is out of date and faulty, based on personal opinions and prejudices of turn-of-the-century researchers. While it is undoubtedly true that lead exposure during pregnancy is not without hazard, and high levels of lead are harmful to the developing fetus, it is also true that such levels of lead are harmful to adults. Adults are also susceptible to low levels of lead—though the effects may not be readily apparent. Furthermore, low levels of lead have been found to affect the male's

ability to produce normal and abundant sperm—male reproductive ability. Thus the policy of excluding females from employment with lead exposure has an obvious disparate effect on women, while not protecting the reproductive abilities of male workers.

Although large numbers of women are not currently employed in the heavy lead industries—largely because of past discriminatory hiring practices—the potential effect on other job opportunities is enormous. With the pervasiveness of chemicals and adverse working conditions throughout industry, regulations such as those adopted by the Lead Industries Association could have an enormous economic impact on women and still not protect the health of all workers.

Another irony of the lead case is that while some women are being excluded from jobs with lead exposure, as a “precaution” until low level effects of lead on the female reproductive abilities are better known, other women still continue to work with x-rays, which are known to be able to cause birth-defects at low levels, a paradoxical repeat of history. Women are protected out of higher paying jobs and allowed to continue to work in those jobs where their labor is essential, even if there are potential health effects.

Some Solutions

The Occupational Safety and Health Act guarantees every American man and woman a workplace free from recognized hazards. It also guarantees that no worker be exposed to conditions that adversely affect his or her functional capabilities (presumably not excluding the reproductive functions). Yet OSHA has already begun to consider barring certain “susceptible” groups of workers, like women of childbearing capacity, from certain working conditions. This is clearly in contradiction to the OSHA mandate.

Functional capacity can only be retained when exposure to toxic substances is limited and general workplace conditions are improved. In the past women have been the driving wedge toward achieving improvement in other working conditions. It was first for women that the restrictions on the legal hours of work were achieved. It was first for

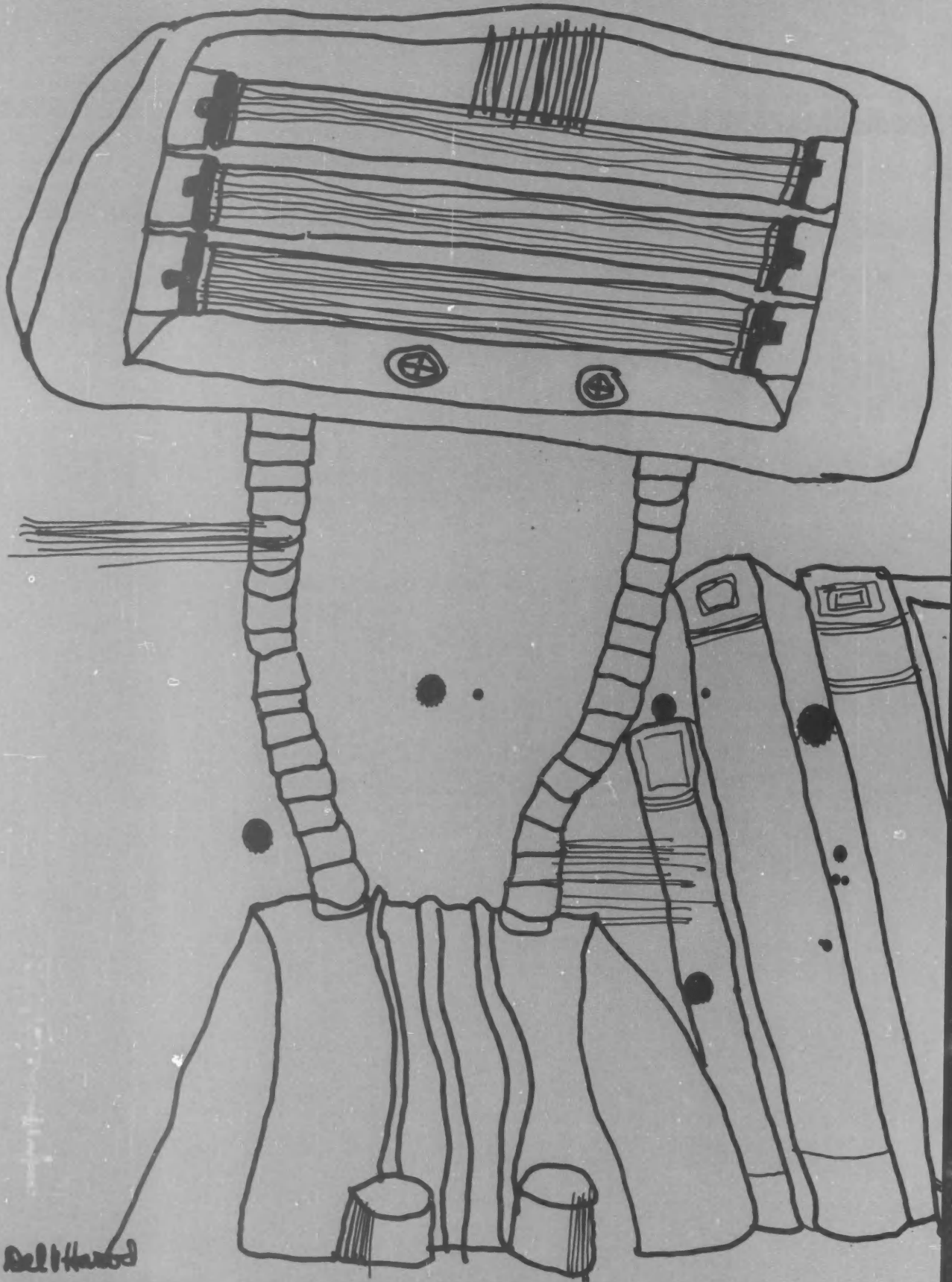
women that a minimum wage was passed. These gains were subsequently extended to men. Hopefully, the special needs that women may have when pregnant can likewise be the driving wedge for improved working conditions for all workers—including potential fathers and nonchildbearing adults.

Perhaps also the remedy to the excessive obligations and stresses of the dual role of home and work will lead to the recognition that no one—male or female—should have to work under the stresses and rigors of continual long hours of employment and achievement during the years of relative youth, when one's family is young and demanding, only to face the loneliness, uselessness, and often poverty of retirement even though many older workers are still vigorous and eager to remain economically functional. Flexible shifts, job-sharing, equitable part-time work with advancement opportunities would be a significant gain for all workers—male and female.

Perhaps fathers will once again be allowed to resume more of the parenting role, as they did not so very long ago, so that women can once again resume some of their economic roles, roles that have been wrested from them by the industrial revolution and the displacement of economically productive work from the home. The history of modern industrial times spans only a few hundred years—much modification may be necessary to achieve equality.

Many health experts now believe that the modern killers of humans, chronic diseases like heart disease and cancer, will demand extensive changes in lifestyle if they are to be conquered. So too will the equalization of opportunity for women in the workplace and the alleviation of work-related stress. Men and women thus share an obvious interest in rectifying working conditions.

If OSHA is to meet its mandate of a safe and healthful workplace for all workers, then standards that are applicable to all workers—not just the healthy young males who can “take it”—must be promulgated. And if the occupational health problems of women are to be appreciated and solved, then more time and effort will have to be directed toward all aspects of women's work, at home and on the job, and not simply limited to the perception of women as reproductive vessels.



Del Howard

READING & VIEWING

BOOKS RECEIVED

Talkin and Testifyin by Geneva Smitherman (Boston, Houghton Mifflin Co., 1977). An examination of Black English as a form of the English language, with a discussion of attitudes and suggestions for public policy regarding the place of language in education and employment. *291 pp.*

Minorities in U.S. Institutions of Higher Education by Frank Brown and Madelon D. Stent (New York, Praeger Publishers, 1977). An analysis of minority enrollment combining statistics from a variety of sources, with specific recommendations for increasing the number of minority persons enrolled in all segments of higher education. *179 pp.*

A Passion For Equality: George Wiley and the Movement (New York, W.W. Norton and Co., Inc.,

1977). A biography of the man who was chiefly responsible for the growth of the National Welfare Rights Organization; contains a great deal of material on the civil rights movement in the 1960s as well. *372 pp.*

PAMPHLETS

Understanding You and Them by Carlos E. Cortés, with Fay Metcalf and Sherryl Hawke (Boulder, Colo., Social Science Education Consortium, Inc., 1976). A guide for teachers on presenting ethnic studies, including suggested activities and advice on resource materials. *61 pp.*

Registry of Private Fair Housing Organizations/Groups (HUD-EO-217) U.S. Department of Housing and Urban Development. Provides data about organizations involved in fair housing activities. Copies may be obtained free from the Office of Fair Housing and Equal Opportunity, Rm 5202½, HUD, Washington, D.C. 20410.

COMMISSION REPORTS

Window Dressing on this Set: Women and Minorities in Television. Focuses on the portrayal of women and minorities on network television and their employment at television stations, with reference to the role of the Federal Communications Commission. Contains findings and recommendations. *181 pp.*

COMMISSION STAFF REPORTS

School Desegregation in Waterloo, Iowa.
School Desegregation in Berkeley, California.
School Desegregation in Tulsa, Oklahoma.
School Desegregation in Wichita, Kansas.
School Desegregation in Kirkwood, Missouri.
School Desegregation in Stamford, Connecticut.
School Desegregation in Greenville, Mississippi.
School Desegregation in Santa Barbara, California.
School Desegregation in Dorchester County, Maryland.

School Desegregation in Raleigh County, West Virginia.

School Desegregation in Tempe, Arizona.

School Desegregation in Bogalusa, Louisiana.

SAC REPORTS

The Silent Victims: Denver's Battered Women (Colorado Advisory Committee). Includes data on the number of battered women and on the options open to them when seeking aid, as well as recommendations to legal and social service agencies. *22 pp.*

The Working and Living Conditions of Mushroom Workers (Delaware and Pennsylvania Advisory Committees). Examines the situation of mushroom workers, who are almost all Spanish speaking and who are, the report says, among the lowest-paid, worst-housed, and most medically impoverished groups in the two States. *65 pp.*

Equal Opportunity in the Fort Wayne Community Schools: A Continuing Struggle (Indiana Advisory Committee). Traces the activities of Federal, State, and local agencies involved in school desegregation in Fort Wayne since 1968 and identifies current problems. *47 pp.*

Abortion Services in Wyoming (Wyoming Advisory Committee). Details the unavailability of abortions in Wyoming, including apparently unconstitutional policies of public hospitals denying abortions; approximately half of all Wyoming women who obtained abortions obtained them out of State. *49 pp. plus appendices.*

TRANSCRIPTS

Hearing before the U.S. Commission on Civil Rights: Chicago, Illinois Volume 1, June 17-19, 1974, and Volume II, November 22-23, 1974. Covers the economic condition and concerns of women, including employment opportunities, public assistance programs, and child care.



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