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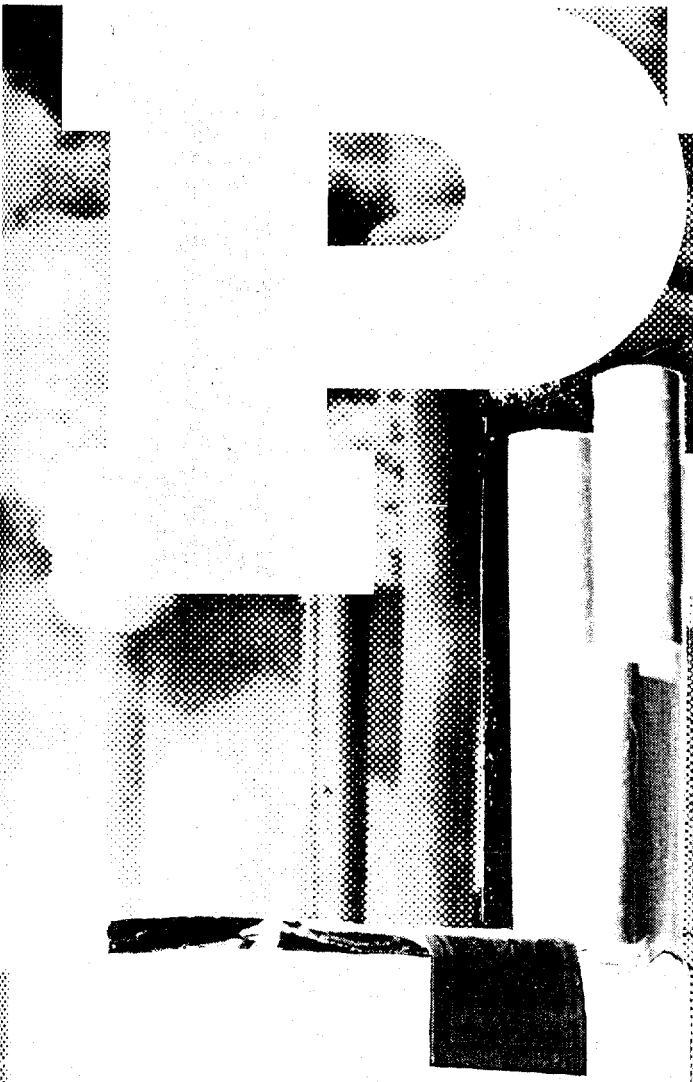
The Fight Against Racist Health Care



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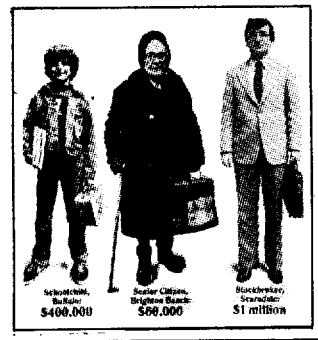

notes and comment

We welcome contributions from our readers on articles in **PL Magazine** and related topics. Both letters, which appear under **notes**, and longer contributions, which are printed as **comment**, should be addressed to:

PL MAGAZINE
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Scientific Racism

To the Editors:

Neither Kamin nor most other writers on the Burt/Jensen issue appear to recognize the following two points, which were also missing from the otherwise excellent articles on Sociobiology in the last issue of **PL Magazine**:

1. Burt's cheating is really a secondary issue. Even if some other researcher were to honestly obtain through experiment the kind of correlations Burt faked, it would not go one iota towards "proving" the genetic basis of intelligence. This is because the I.Q. tests test acquired knowledge, not "inherited aptitude," whatever that might be. Specifically, the I.Q. test is weighted towards information which students of upper-middle and upper-income families are more likely to have learned: abstract math, complex vocabulary, elitist cultural activities. The PLP pamphlet **Racism, Intelligence, and the Working Class** points this out very clearly.

2. Twin studies **cannot** be used to "separate out" genetic and inherited factors in any kind of test, despite the fact that the open fascists (Burt, Jensen, et. al.) and most of the "liberal" social-fascists (like Jencks) assert that they can be so used, and have bullied many honest forces into accepting this false premise. With regard to monozygotic twins,

> "a good experimenter would see that identical environments were actually identical in every significant respect, and that different environments were actually different in all significant respects. The amount and kind of difference in environmental features would be regulated in accordance with the experimenter's hypotheses. Such considerations are almost impossible to achieve with human subjects." (J. P. Guilford, **The Nature of Human Intelligence**, McGraw-Hill, 1967, p. 353).

Sincerely, N. J. Reader

Editors' Note

The editors regret the erroneous statement that Leon Kamin is "intensely anti-communist" in the article on **The Germ of Racism** *in the last issue. After PL and the University Action Group organized a demonstration against Herrnstein at Princeton in 1972, Kamin, a Princeton professor, began the research which showed that Burt had fabricated his twin studies. For his research and anti-racism, Kamin was red-baited by Herrnstein as well as by Sandra Scarr-Salapatek in* **Nature.** *Their puny anti-communism in defense of racism was further exposed by the discovery that Burt had made up his two co-researchers and the general recognition that Burt had forged his data. These racists only proved that Marxism, science and anti-racism are inseparable allies. Professor Kamin's research contributed to the exposure of a bigger scientific hoax than Piltdown man, one which has led to racist atrocities against millions of workers.*

Our disagreements with Professor Kamin focus on the class basis of racism (the role of a capitalist ruling class in fostering the old and new eugenics movements) and on whether good research alone (though it is certainly needed) is enough to stop the racists. These ruling class-kept racist intellectuals like Jensen, Herrnstein and E.O. Wilson receive constant large-scale publicity—witness the fanfare for Jensen's new book defending I.Q. testing in **Newsweek, Fortune,** *and the like, and the insolent parading of Wilson's sociobigotry. A declining U.S. ruling class, bent on war and fascism, will continue to dress Nazi and KKK ideas in the threadbare wrappings of pseudoscience, and "overlook" scientific proofs of their fraudulence and depravity. Kamin's original research and the first blows against these racists were stimulated by a working class anti-racist movement. Their revival proves the inadequacy of reform. Only socialist revolution can crush the class that profits from and continuously engenders racism.*

'The Armed People'

To the Editor:

"Brooklyn Comrade" misses the point, I think, in his letter on "The Armed People" (**PL**, Vol. 13, no. 1). To say that revisionism can be avoided "if the Party controls the armed forces" is to offer an idealist bureaucratic solution to a material political problem, because it ignores the crucial role played by the standing army itself in enabling the Party to go revisionist in the first place. "Winning the working class to a high level of communist consciousness" is just empty phrse-mongering, unless it means winning the working class to a high level of **active participation** in every aspect of the exercise of state power.

As long as the class struggle continues, there will always be opportunist elements in the Party who will be looking for ways to seize power and establish their own domination. A body of armed men (Marx's words) that stands apart, physically and socially, from the rest of the working class will inevitably be used by these elements for their own ends, no matter how dedicated and "trained to serve the working class" it may have been to begin with, because its members have a different relationship to the means of production, and thus a different class interest, from that of the working class itself. It is "pure and simple utopianism in an era of intense class struggle both nationally and internationally" to ignore this fundamental fact.

Saying that we have to choose between the standing army and "the fastest gun in the West" is like saying

notes and comment

that we have to choose between the bourgeoise state and total chaos. As with all "choices" that are posed to us by the bourgeoisie, the real solution lies in an entirely different direction. Clearly the working class needs an "army," just as it needs a "state," but it must not be a **standing** army, with bases, barracks, tours of duty, and all the other trappings that we have been conditioned to associate with the military, just as it must not be a bureaucratic state. **The workers' "army" must consist of ALL members of the working class who are willing to bear arms organized under the leadership of the Party,** and we must struggle constantly to increase their number, just as we struggle to recruit to the Party itself. These workers must continue to live at home and carry on their every-day lives as workers, with military participation fully integrated into their on-going routine. The same applies to all other state functions, such as the prevention and punishment of crime, which must be carried out by Party-led committees of armed workers, not by a separate force of professional police "trained to serve the working class."

The real significance of the "armed people" concept is that only the working class itself can defend the gains of its own revolution. To the extent that the Party remains principled, more and more workers will be willing to fight under its leadership, as well as to take part in other state functions. To the extent that it deviates toward opportunism, the armed workers themselves will be able to straighten it out. The Party leads the working class, but is also directly responsible to it. Without a standing army to enforce opportunist aspirations, the Party will continue to lead the working class only to the extent that it deserves to. Given our line on confidence in, and reliance on, the working class, this is exactly how we should want it.

Ultimately, the Party, the "state," and the "army" will merge to include the entire working class and, thereby, the entire population. A standing army can only inhibit the process that leads to this result, and so has no place in a socialist society.

Boston Comrade

From the Editors

SPECIAL SOVIET ISSUE

The special Soviet Union issue—see *Coming Issues*—is tentatively scheduled for this Winter's issue (14:1). The drafts from which the articles will be drawn have been printed as an Internal Bulletin, and are now being discussed throughout the Party.

REVISTA PL

The current issue of the Spanish edition includes *Social Fascism* (13:1), *Can History Be a Science* (12:4), *Students Must Ally With Workers* (12:3), *The Profits of Racism* (13:2) and an article on recent developments in Central America. To order, use coupon on last page.

HELP WANTED

Comrades and friends who are interested in helping with the editing or production of *PL Magazine* are urgently needed. If you are able to write, edit or review articles before publication, or to do paste-up or other work on the magazine, please let us know.

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Introduction

The Fight Against Racist Health Care

If capitalism exists solely for the production of profits, one may ask if health care is profitable and if not, why does health care for the working class exist at all. Historically, it can be seen that public health care came into being to contain epidemics such as cholera or typhoid, which began in poor districts and necessitated quarantining of the victims. Public hospitals also served to provide training grounds for medical students. Such were the origins of two of the first city hospitals, Bellevue and Philadelphia General.

As the industrial revolution progressed in the 1800's, poor working conditions and long hours markedly eroded the health of workers, causing decreases in productivity. Thus the ruling class recognized that a modicum of health care and improvements in working conditions were necessary to maintain the working class in working condition. This was carefully documented by such health economists as William Farr and C.E.A. Winslow, and is kept up today by the likes of Rashi Fein of Harvard. Such thinking is the origin of programs like the Kaiser Health Plan, established by Kaiser Steel, improved ventilation in the factories in 1908; or the establishment of the National Safety Council.

All gains above this minimal level of prevention and health care were won by workers' struggles. In the late 1800's the Knights of Labor fought for factory inspection laws; the ILGWU led the fight for workmens' compensation in 1910. Striking teachers in Texas in 1929 demanded health insurance, out of which Blue Cross was born. In the 40s, health benefits became a major demand of the mine, auto, and steel unions. During the 60s, ghetto rebellions in Watts, Harlem, and Detroit resulted in some new hospitals and clinics being erected there.

In this series of articles, we try to investigate how capitalism causes disease and how it's able to get away with limiting and cutting back medical services. Racism is the key. Minorities in the U.S. suffer more, and more severe forms, of nearly every disease than do whites. Patient care facilities and jobs are rigorously segregated. These facts not only combine to cause suffering and loss of life to minority people, but lower the standards and expectations of everyone. Moreover, patients and workers, being divided from one another by race and class are less able to mount a movement capable of fighting back. Thus it is essential for whites and minorities to fight for an integrated system of health care and training, or we shall not be able to limit cutbacks or make any gains.

Ultimately, capitalism **cannot** provide good health or health care. It would take too big a cut out of profits. As the economy crumbles, the drive to cut services will intensify. This is already clearly evident in the closings of many city hospitals across the country, layoffs and shortages at voluntary hospitals, and the loss of many public health clinics and programs. Only socialism, under which social energy is allocated to maximize the quality of life of workers, can ever provide healthy living and working conditions and excellent medical care for all.

Only socialism can ever provide healthy living and working conditions and medical care for all.

The following group of articles, herein modified by PLP, was originally prepared by doctors, nurses, and health students in Health Committee Against Racism (HCAR) and the Progressive Labor Party (PLP) for sale at the American Public Health Association (APHA) convention in New York City, November, 1979. It is not meant to be the final word in the analysis of health care, but is a beginning of our effort to develop a body of literature to explain the past, present, and future of health care and to aid in our recruitment of health workers and professionals. Already some sections have been revised and others will be expanded or changed. We invite you to criticize our work and contribute to its revision.

WHAT HCAR DOES

HCAR has not limited itself to ideological analysis. Like the rest of InCAR, HCAR believes that rank and file militant action is the way to build a movement. At the very APHA convention where this pamphlet was introduced, HCAR gained notoriety by egging racist New York City Mayor Koch. This bold action was taken because Koch's massive cuts in health have led to the death and suffering of thousands of people, mostly minorities. Nonetheless, he was invited to be the introductory speaker by the leadership of the APHA, who purport to fight for improved health services. Our aim was to demonstrate that fascists like Koch cause death to workers and cannot be stopped by polite leafletting alone. Although our attempt to prevent him from speaking failed, our action made the question of fascism and the need for violence the prime one at the convention and over 200 contacts were made.

On March 27, one of the doctors who participated in the egging was convicted of assault and faces up to a year in jail, although the prosecution presented no evidence that Koch was struck or injured (technically necessary to prove assault). This verdict shows that fascism (open intimidation and the squelching of protest) is growing, and it also shows our current weakness. Although we did mount two demonstrations during the trial, one right in the courtroom, we are not yet in the leadership of a movement of hundreds or thousands that will be needed to intimidate the bosses from instituting full scale fascism.

FUTURE PLANS

HCAR has recently developed a petition which we are distributing in a mass way and will present a resolution at the next APHA meeting and other conventions. Our members have recently attended the American Medical Student Association and the Student National Medical Association (minority students) conventions, where we presented resolutions against the participation of health personnel in racist war or capital punishment. At each meeting we led a demonstration against racist cuts in the host city and held an independent forum. Our main task now is to build active HCAR chapters at as many medical centers as possible.

In the long run, it is a patient-worker-student-professional alliance that will win struggles against racism in health care. HCAR sees its emphasis on organizing professionals and students as a necessary step in building one arm of that alliance. However, we are also active with the hospital workers in CAR and PLP in joint struggles, such as assisting in the 1199 campaign described elsewhere in this issue.

By L.S.

Capitalist Medicine

Racism and Mass Disease

Racial oppression has been a constant feature of Western society since the beginning of capitalism in Europe in the 16th century. When we recall the sordid history of genocide against the American Indians with smallpox-infested blankets, the extermination of Jews by the German monopoly capitalists as part of their "final solution" to depression and ruin, or the social murder of **apartheid** in South Africa today, we see that ruling class inspired racism has etched deep scars on the face of modern history. Although racism permeates virtually every aspect of social life, it is nowhere more evident than in the health of oppressed minorities. In the United States the super-exploitation of the black and Latin working class carries with it brutal consequences for their health.

The record of the impact of racial oppression on health has much to teach us. Unfortunately, previous study of this question has been very limited in terms of political analysis. This article represents at best a modest beginning. Many thousands of people will have to join in the anti-racist fighting on both a theoretical and practical level, before real advances can be made.

To understand the racism in health care, we must do several things. First, we must have a general measure on the magnitude of the problem. We must understand how it works—its social and biological mechanisms. We must place it in the context of society as a whole. Based on that analysis, we can provide an indictment for these crimes, and offer the fight against racism as the necessary preventive measure.

Racism attacks all workers and their health. The living conditions imposed on these black working-class families, living in the shadow of the mill, help maintain similar conditions for white workers.

RACE, CLASS AND HEALTH

The interaction between race and class gives rise to a complex set of relationships in capitalist society. But, in terms of health care, there is very little on the link between race and class. This is because the capitalists try to hide the fact that **racism is an attack on the working class as a whole.**

Mortality data in the U.S. do not record a person's class, and the only comprehensive study of class and mortality is limited primarily to whites.[1] With minor exceptions, however, and even given the crude nature of the data, a strong relationship can be seen between economic standing and health of different racial groups. In Table 1,* the ratio of death rates between the population as a whole and selected racial groups are ranked by "mortality index" for the period 1959-61. Americans of Japanese descent experienced the lowest death rates, associated with the highest income levels; Native Americans and blacks were 30 per cent lower than the population as a whole. Since blacks form the largest racial minority, these statistics also show that the main burden of racism falls on the black population.

More detailed data, including analysis of class divisions within the white population, would be necessary to separate the independent effects of race and class. A comparison would be necessary between blacks and whites of comparable class position. The absence of any significant amount of wealth in the black population distorts the meaning of average income; in essence, a group of workers (U.S. blacks) is being compared to a group combining workers, professionals and the rich (U.S. whites).

A second, even broader and more important question, which cannot be fully appreciated from the non-class data made available by the ruling class, is the effect of racism on society as a whole. It is clear that racism depresses the social status of blacks, and raises that of the class of financiers, employers and landlords. But what is its impact on the position of white workers? An analysis of race, class and health requires close attention to both of those issues, and they will form the basis of the discussion of the specific disease categories.

*Unless otherwise specified in the text, all data for the tables in this article is drawn from references 1-7 and 12. It should be apparent that many of the statistical sources are inadequate; the official agencies either have no interest in the topic, or an interest in obscuring, rather than illuminating, the problem. In Table 7c, for example, Victor Perlo attempts to derive Marxist categories from official statistics—the result must be at best taken as an approximation.

Table 1

Mortality Index+ and Income of Racial Groups,

Race	Index Ratio	Median Family Income
Japanese	0.68	$6,848
White	0.97	5,893
Chinese	1.16	6,207
Native American	1.28	2.728
Black	1.32	3,047

+Ratio of death rates to U.S. population as a whole

Table 2

Mortality Ratios by Years of School, White, Males, Age 25-64, 1960

	Educational Attainment		
Cause of Death	Less than 8 Years	High School	College
Total	1.14	.97	.77
Cancer	1.09	.94	.83
Ca Stomach	1.25	.97	.83
Ca Lung			
Major CV	1.06	1.03	.80
CHD	1.01	1.07	.80
Hypertension	1.27	.92	.71

Table 3

Indicators of Health Status by Race, 1976

Indicator	Male		Female	
	White	Nonwhite	White	Nonwhite
Life Expectency from Birth	69.7	64.1	77.3	72.6
Age-adjusted Death Rate, per 100,000	798.8	1072.1	439.6	635.1
Infant Mortality Rate per 1,000	15.1	30.1	11.9	25.4

Table 4

Limitation of Activity Due to Chronic Conditions, by Race, 1976

Income Level	Per cent Limited	
	Black	White
All Incomes	17.4	14.0
Less than $5,000	24.9	23.0
5,000- 9,999	16.0	16.6
10,000-14,999	13.3	13.3
15,000 or greater	10.4	10.8

While attempting to make broader inferences about race and class, this article concentrates almost entirely upon data describing the black population of the United States (blacks represent roughly 95 per cent of 'nonwhites'—the code employed on death certificates; in this article these terms will be used interchangeably). Other minority groups in this country are clearly subject to racial oppression, and U.S. imperialism has devastating effects on the neo-colonies[2,3] Appendix 1). Data on the Spanish-Speaking population are only just now becoming available, and few surprises are forthcoming. It is estimated, for example that migrant farmworkers can expect to live no longer than 49 years[4,5]. While not wishing to downplay the role of racism toward other U.S. minorities or poor countries, however, in this article we will examine only the U.S. black population in detail. Blacks remain the largest U.S. minority; the data sources on them, limited as they are, are more extensive than for other groups. The results of this analysis can, with certain modifications, be applied to all oppressed national and minority populations. Also, nationalism and racism should be viewed as two manifestations of the same political concept; international borders have little meaning for capital.

That economic deprivation is related directly to higher mortality is true not only for minority racial groups. Much of the unfavorable health of blacks is caused by the poverty and economic oppression which they share equally with poorer white workers[1,6,7,8,9]. In Table 2 selected mortality ratios restricted to whites depict a consistent relationship with measures of class status (education, in this instance).[1] Similar and more extensive data are available from England, with much smaller minority groups. The differential in both countries between the mortality of workers and of the rich appears to be increasing over time, as the "modern" diseases—heart disease and cancer—are better understood and the affluent classes find ways to protect and cure themselves.[8,9]

Given these findings, some people argue that the oppression of minorities is solely the result of their economically inferior class position, and is appropriately studied from that perspective alone. As some revisionists (phony socialists) put it: "Don't talk about 'racism'; only class oppression is important." For a number of disease categories where adequate data are available, however, it can be shown that **race plays an independent, additive role** and examples demonstrating that point will be discussed later (cf. Appendix 2 in relation to income differentials). Racism is a product of class society, but it is not confined entirely within the limits of economically-based class relations. It should nonetheless be self-evident that the forcible confinement of blacks to lower socio-economic status is racist in itself. The disproportionately greater oppression of blacks is the primary manifestation of racism; sickness and disease are the result. Finally, as we will attempt to show, racism has a separate, independent negative effect on the health and oppression of the majority population—white workers. Racism is not, therefore, **just** 'more of the same' (i.e. oppression of the working class), but involves distinct political and social mechanisms.

DIFFERENTIAL HEALTH STATUS: THE UNDERLYING CAUSE

The three broadest indicators of health and disease for the white and nonwhite populations in the U.S. are presented in Table 3. Mortality rates for black males are 34 per cent greater than for white males, and death rates for black females exceed those for their white counterparts by 45 per cent. By the same token, life-expectancy for black men at birth is only 92 per cent of that for whites, and 94 per cent for black women. Infant mortality rates for non-whites are over 100 per cent greater. Disability rates in the general population, as an indicator of rates of illness, are compared between blacks and whites in Table 4. Although rates at each level of income are similar, over-all rates for blacks are 25 per cent higher, reflecting the fact that more blacks are in the lower income categories, and are more likely to be sick. By this measure the income spread accounts entirely for the black-white health differential. Although the size of the differential varies somewhat by disease category, blacks of both sexes have higher death rates for each of the four major causes—the one exception being heart disease among men, where rates are equal (Table 5). Little change has occurred in the health differential in the last 25 years, as may be seen in Table 6, which compares infant mortality rates and life expectancy in 1950 and 1977. A slight improvement in relative life expectancy was recorded, but the relative status of blacks for infant mortality deteriorated. It is worth noting that the infant mortality rates suffered by blacks in the U.S. are similar to rates in the Dominican Republic. And in 1971 the infant mortality rate in Shanghai, China's largest city, were 12.7[5,10]—**better** even than that for U.S. whites, and **close to ½** that of blacks.

> "The economic structure of society . . . conditions the general process of social, political, and intellectual life."—Karl Marx, *A Contribution to the Critique of Political Economy.*

Class relations also determine health, and must serve as the basis for the discussion of underlying cause. (Appendix 3.)

Every person is assigned a value in society, a compromise between what those in power would impose upon him and what the working class has fought for. The absolute value of labor as human capital may vary widely from one society to another but it is always subordinate to the social relations of production. Under slavery human capital was accumulated as private property by the ruling class. Historical studies have demonstrated that the life expectancy of a newly-bought slave was determined by the relative cost of maintenance compared to replacement.[24]

Under capitalist social relations labor power is bought on an hourly basis, not for the life-time of

Economic deprivation is related directly to higher mortality.

Table 5

Rates for the Four Leading Causes of Death by Race, 1976

(Rate per 100,000, age-adjusted)

	Male		Female	
Cause of Death	White	Nonwhite	White	Nonwhite
1. Heart Disease	303.0	302.8	141.7	190.3
2. Cancer	159.1	202.3	108.2	119.3
3. Violence*	90.1	160.2	31.9	42.5
4. Stroke	53.7	84.6	44.5	72.0

*Accidents, homicide, suicide

Table 6

Health Differential Between Black and White 1950-1977

	Life Expectancy			Infant Mortality		
Year	White	Nonwhite	Ratio, NW:W	White	Nonwhite	Ratio, NW:W
1950	69.1	60.8	0.88	26.8	44.5	1.66
1977	72.7	67.0	0.92	12.3	21.7	1.76

the producer; it can be withheld and is capable of greater productivity. Where workers have organized to exploit these advantages, the value of their labor-power-and their living standards-have risen. Increases in the value of labor power in a capitalist society are unstable and temporary however, and significant differentials can exist between groups of workers. Furthermore, no matter what value labor power acquires in a class system it is consumed in the process of production, and the worker with it. Of course productive work itself is not the source of ill-health. Rather, it is rather due to the specific role of labor under the historical conditions of capitalist society.

The motivating force in capitalist society is the drive for profits, and thereby the accumulation of capital. Profits are generated by exploitation. The employer pays the worker less than the value of what he produces, and keeps the rest. The rate and intensity of exploitation reflects on the one hand, how rapidly labor power is being used up in the process of production, and on the other the expenditure on its maintenance. This, in general is what determines the health status of the worker. The source of the poorer health suffered by minority workers can be traced to the increased rate and intensity of exploitation, or 'super-exploitation,' which they are subjected to in a racist society.

SUPER EXPLOITATION: BASIS OF RACISM

Racist employment practices force minority workers to take the worst jobs—the most dangerous and the lowest paid. Life away from the job, in terms of housing, food, medical care, education (i.e., the maintenance and reproduction of labor power) reflects the smallest possible investment of social capital the ruling class can get away with. Finally, the disproportionate burden of unemployment which is shifted to the black population results in the highest possible rate of exploitation since access to the means of production is denied the unemployed worker and his labor power is totally unrewarded.

The economic consequences of the super-exploitation of the minority working class are well known.[12,13] Table 7a shows that the median family income of nonwhites in 1976 was only 63 per cent of that of whites. A much higher percentage of the black population is composed of workers (Table 7b,c). Almost all of the income of minority families is derived from earnings or social security/unemployment/public assistance, compared to whites who receive over 8 times as much income in the form of interest, dividends, rent, i.e., profit (Table 7d).

As can be seen in Tables 7c and d, however, the distribution of income and class position is very different within the black and white populations, since the upper end of the income spread is missing among blacks. The black : white gap between median income is therefore wider than for "average income." The greater wealth accumulated among whites as profit simply reflects the presence of the capitalist class. We must always remember that black : white contrasts are being made between two noncomparable populations.

Table 7a

Median Family Income by Race in 1976

White	$15,537
Nonwhite	$ 9,821

Table 7b

Occupation of Male Workers, White and Nonwhite, 1966

Occupation	Percentage White	Distribution Nonwhite	Median Income of Occupation
Professional, Technical, Managerial	27	9	$7,603
Clerical and Sales	14	9	5,532
Craftsmen and Foremen	20	12	6,270
Operatives	20	27	5,046
Service Workers	6	16	3,436
Non-farm Laborers	6	20	2,410
Farmers and Farm Workers	7	8	1,699

Table 7c

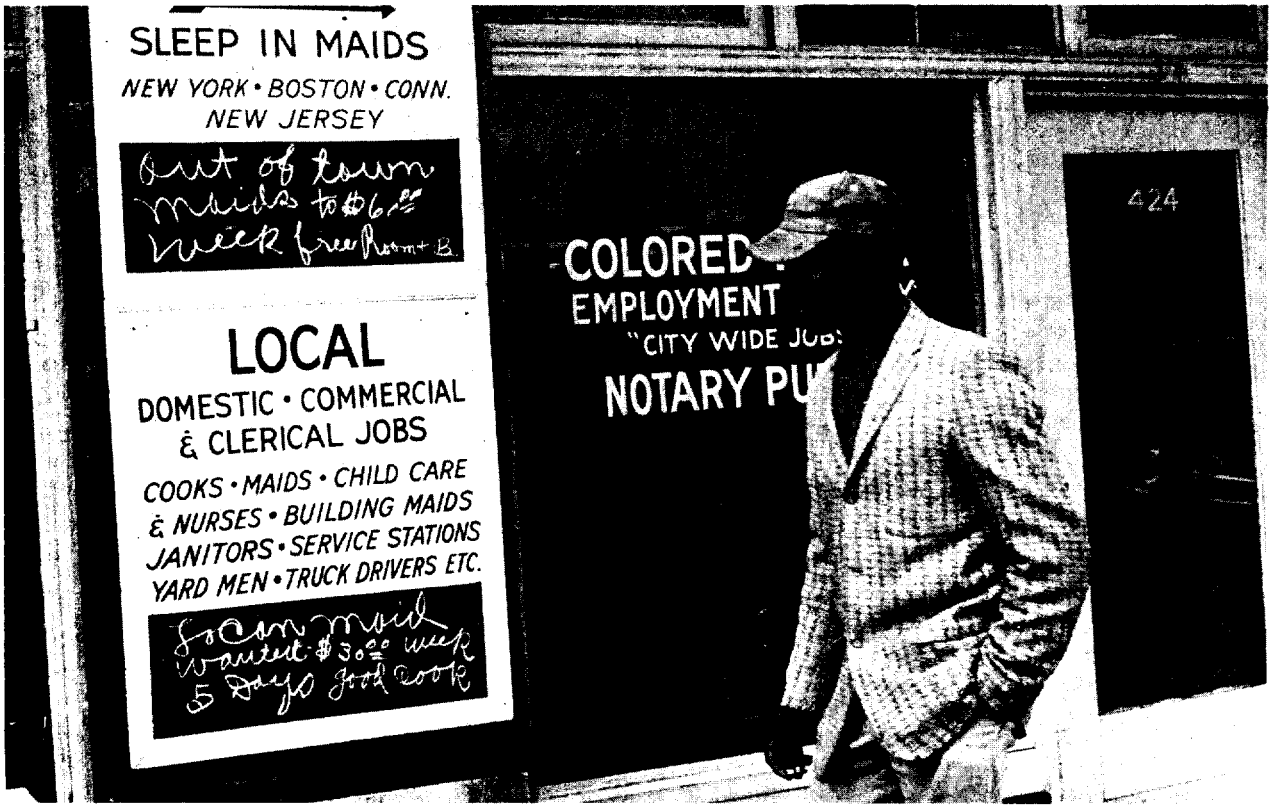
Class Structure of Employed Population, Black and White, 1970

Category	Per cent of Total White	Black
Capitalist, large & small, plus petty bourgeoisie	13.5	3.2
Intellectual workers	13.0	8.0
Working class	73.5	88.8

Table 7d

Percentage Distribution of Personal Income by Race, 1972

Type of Income	Per cent of Total Income White	Black
1. Wages or salary	70.3	77.9
2. Self-employment	8.6	3.0
3. Dividends, interest, rent, etc.	9.3	1.2
4. Social security, unemployment, public assistance	8.8	15.9
5. Pensions, annunities, etc.	3.0	3.2



The segregation of black workers into low-wage, low-skill jobs means super-profits for the bosses, and greater exploitation and mortality for workers of all races. Our party fights to end this system through socialist revolution.

An analysis which takes into account class divisions is necessary to really explain the effects of racism, and the relationship between racist oppression and oppression of the working class. Simple comparisons are offered only because better data are, to our knowledge, not available.

On the average blacks pay a higher price for the necessities of life. This is a result both of a smaller investment of social capital on their welfare and of price gouging in segregated neighborhoods. Less capital in the form of supermarkets is invested in the center of cities compared to the suburbs; food prices are higher.[13] Blacks pay more for worse housing, boosting the landlord's profit.[14,15] Society's ruling-class planners invest less in their education and training, and compensate them less (i.e., exploit them more) for equal educational achievement (Table 7e). In recent years the burden of unemployment has been increasingly shifted to minority groups, particularly young black workers (Table 8). These black : white contrasts serve only to point out the relative inferiority of the position held by minorities—in other words, their super-exploitation. Within the white population income and ownership, as well as better health, are concentrated at the top of the income scale, while white workers suffer the consequences of 'standard' exploitation. In addition —as we will show—white workers are also harmed by the racism directed against minorities.

How do these economic relationships determine the health differential? A general diagram of the development of mass disease is presented in Figure 1. Broad measures of health are only helpful in estimating the **magnitude** of the problem; they tell us nothing about the **mechanism—how** it happens. A technical analysis is necessary to identify the specific social forces and the inter-

Table 7e

Mean Income by Year of School Completed, Males, 25 years or older, 1971

Years of School	White	Black	Per Cent Black of White
Less than 8	$ 4984	$ 3912	78
8	6378	4877	76
9-11	8277	5909	71
12	9772	6748	69
13-15	11248	7483	67
16 or more	15355	10684	70

Table 8

Unemployment Rates by Race, 1976*

	White		Nonwhite	
Age Group	Male	Female	Male	Female
18-19	15.5	15.1	39.0	35.0
20-24	10.9	10.4	20.7	21.7
25-34	5.6	7.6	11.0	13.0
35-44	3.7	5.8	7.3	8.1

*Percent of population

mediary physical and biologic agents of disease. It is a fundamental principle even in capitalist public health that **epidemic diseases have a social basis.** That is to say, diseases which are common enough to affect large segments of the population arise from a shared **environmental** exposure (genetic mass disease would be suicide for the species). In the last several decades an understanding of the modern epidemics—cardiovascular diseases, cancer and violence—has advanced to the point where we can begin to make the connections between social forces, disease agents and the epidemic.

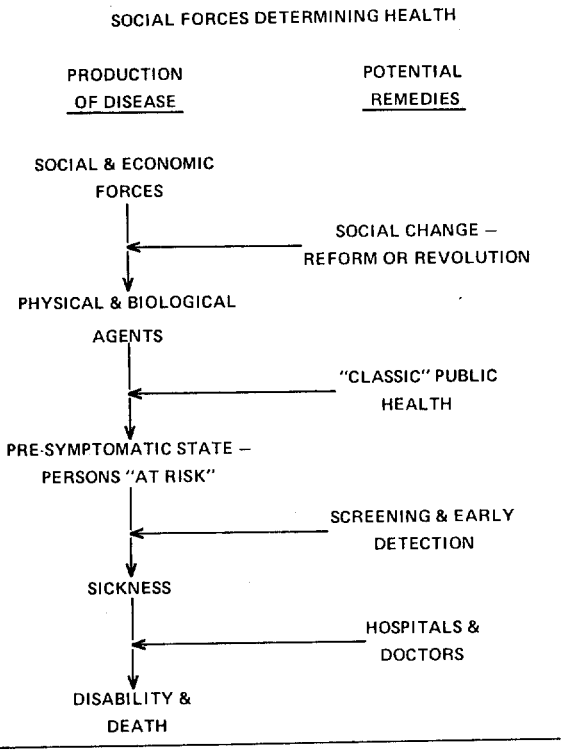
The pattern of disease changes dramatically as society changes. Numerous reports document societies where the chronic diseases of adulthood so common in the industrialized world are virtually absent.[16,17] A few examples include the Kung tribe of the Kalahari desert, the Yanomamo Indians of Amazon basin, the Mabban of the Sudan, and the Solomon Islanders in the South Pacific.[18,23] Many of these communities represent remnants of primitive communism, where an oppressive class structure has not yet developed; others are sheltered in some other way from the production relations of the capitalist world. Perhaps most famous are the Abkhasians living in Soviet Georgia, the stars of the Dannon yogurt commercials.[24,25] By an historical accident their diet fulfills the requirements for ideal human nutrition. Hard work, strong social and family ties and collective organization of production allow many Abkhasians to live a healthy, socially productive existence well beyond the age of one hundred years.

By contrast, waves of the modern epidemics have successively engulfed industrialized societies. Super-exploitation and racism compound and exaggerate the social contradictions within the U.S., and demonstrate even more clearly the nature of the mechanisms which cause mass disease. Just as a given society produces certain food, clothing, language, and religion, so disease too is a **social** phenomenon, produced in a characteristic pattern by each historical form of class relations.

The capitalist era has seen the elimination of previous epidemics of infections, and also the introduction of new mass diseases. There has been an overall improvement in health over the last century. But this improvement has been much less than it **could** have been. The obstacles to eliminating our current mass diseases arise primarily from the nature of the political restraints, not lack of knowledge. These obstacles are due to capitalism. This failure to improve public health, being therefore deliberate and preventable, is qualitatively different from the failures of previous societies.

The social and historical mechanism sketched above forces upon us several crucial questions. Can we document the oppression of minorities in detail through an examination of health and disease? If, with rare exceptions, the mass diseases of the oppressed minorities are in fact the mass diseases of that society, only enlarged and intensified, would not the minority public health picture dramatize and throw into sharp relief the central health issues for the majority population? Would it not be easier to grasp both the causes of public health threats to the entire population, and the potential for their eradication through the study of differential (i.e. racist) mortality and its causes? Would we not then have access to an understanding of the major disease-producing forces of our society, including the social and economic determinants? And, finally, by struggling against the social murder of the oppressed minority, would we not lay the basis for the eventual elimination of the threats to the health of all of us—majority and minority?

Figure 1



This article will show that the answer to each and every one of those questions is, "yes." Each major cause of death will be examined in the following sections to provide concrete examples of the process outlined above.

CARDIOVASCULAR DISEASES: THE MODERN PLAGUE

Cardiovascular diseases are the modern plague, accounting for half of the two million deaths in the U.S. each year. Not only has there been a relative increase in cardiovascular disease (CV) deaths with industrialization and the control of infectious diseases, but an absolute increase has been recorded in virtually every advanced capitalist society.[4,26,27] Because of the link between in-

dustrialization and the appearance of atherosclerosis ("hardening of the arteries") as a mass disease, the common misconception has arisen that CV diseases are "diseases of affluence." It is true that the pre-capitalist ruling classes were the only segment of society whose diet contained the necessary excess in animal fat, cholesterol and calories to lay the basis for atherosclerosis. But the distribution of CV today clearly reflects the oppression of class society.[1,9] The racial differentials for CV diseases are shown in Table 9.

Coronary heart disease (CHD) is the syndrome which results from inadequate blood supply to the heart muscle. Narrowing of the blood vessels to the heart is caused by atherosclerosis, a process of scarring and accumulation of fat (primarily cholesterol) in the lining of the blood vessel. A diet high in cholesterol and other forms of animal fat will elevate the blood levels of cholesterol, initiating atherosclerosis.[41-44] Cigarette smoking and high blood pressure will greatly accelerate the process, and in some individuals the response to stress may play a role.

Only with the level of productivity in agriculture developed under capitalism has the working class had access to a diet containing relatively large amounts of animal products.[28] Monopolization of food production has also led to a growing reliance on processed and synthetic foods which can be made in factories and widely distributed.[29] Fats are crucial in that process. Restaurants, particularly the fast food chains, depend heavily on meat and fat products.[30] The demanding pace and alienation of contemporary life complement the trends toward these convenience foods and toward the extinction of the traditional cuisines based on grains, vegetables and fruits. The economic forces encouraging the marketing of cigarettes in a commodity economy are even more obvious (Appendix 4).

The evolution of racial differences in CHD provides a very instructive lesson in the study of mass disease. Although whites emerged from the period of the Second World War with much higher CHD death rates, this gap has been reversed for women and almost closed for men (Table 10). CHD deaths are now much more common at a younger age for blacks than whites (Table 11). Age-specific death rates, 45 years of age through 64, for men show a black predominance. Only at age 75 do white males clearly exceed black males, and it is the large number of deaths among the elderly that account for the white excess in overall rates. For women CV mortality from each category and at all ages is greater among blacks. In the area of 'premature' mortality for men, the CHD death rates are not only higher for blacks, they are only part of a much higher total mortality. That is, **despite** the competitive effect of other causes of death, CHD still exacts a greater toll among black men. This central fact—the importance of CHD as the largest mortality cause among blacks—is often not

Disease is a social phenomenon produced by each historical form of class relations.

Table 9

Major Cardiovascular Diseases by Race
Age-adjusted, 1976, per 100,000

	Male		Female	
Cause of Death	White	Black	White	Black
Major CV Diseases	378.1	409.3	198.1	278.1
Hypertensive Heart Disease	3.5	10.9	2.7	9.2
Coronary Heart Disease	274.2	249.4	123.6	153.8
Stroke	53.7	84.6	44.5	72.0

Table 10

Trends in the Ratio of CHD, White:Nonwhite, 1940, 1976

	Year	
Sex	1940	1976
Male	1.67	1.09
Female	1.19	0.80

Table 11

Death Rates from CHD by Age, 1976

Sex and Race	45-54	55-64	65-74	75-84
White Male	275.9	752.2	1697.8	3869.3
Nonwhite Male	326.0	794.5	1487.9	2823.9
White Female	11.7	58.5	730.7	2485.3
Nonwhite Female	148.2	421.8	983.0	2277.8

Stress is one of the major factors involved in high blood pressure and other forms of cardiovascular disease. Rates are especially high among black workers. Capitalism intensifies these problems, as on sped-up assembly line above.

placed in focus because of the greater percentage excess of blacks over whites for other causes, particularly stroke and violence. A recent autopsy study from New Orleans on young people who died accidentally showed that the underlying atherosclerosis was twice as severe in the blacks as in the whites.[31].

Trends in rish factors for CHJD—particularly cholesterol and smoking—help demonstrate how social forces influence the spread of disease. As blacks have been gradually integrated into the 'consumer economy,' their dietary patterns have come to reflect the general marketing pressures of the food industry.[32] The Evans County study, in rural Georgia, showed that between 1960 and 1967 serum cholesterol levels of black rose to be equal to those of whites.[33] That phenomenon has occurred across the country.[34,35] The lowest levels of cholesterol are now among the well-off, who have received the best information about prevention and good health and who have the greatest options in terms of individual choice.[35,36]

A Chicago study found that although a sample of blacks from the general population initially knew less about nutrition and health than a comparable group of whites, and had higher serum cholesterols, after a brief educational program they made more significant changes in their diet, with a concomitantly greater fall in serum lipids.[37] In other words, high levels of serum cholesterols among blacks are a result of diet, not of "genes." Second, this study proves that high cholesterol levels—and therefore, high levels of CHD, are technologically easily preventable today. The fact that these high levels are **not** prevented, but allowed to continue and to cut short the lives of millions of workers, white and black, shows the callous attitude of capitalists toward the working class.

In the 1950's blacks smoked less than whites; that situation has now been reversed, particularly for younger age groups (Table 12).[34,38]

The heavy promotion of cigarettes in the black community is a parallel of the process of dumping

Table 12

Smoking Rates Among Workers in Chicago, Ages 18-64, 1967-1973

Sex and Race	Per Cent Current Smokers	Per Cent Former Smokers
White Men	43.0	30.6
Black Men	61.8	20.7
White Women	43.8	16.6
Black Women	46.1	14.1
All	42.2	24.0

Table 13

Death Rates from Cardiovascular Diseases, Charleston County, 1955-1958
(age 35-64, per 100,000)

	Men		Women	
Cause	W	B	W	B
CHD	505	366	112	266
Stroke	136	708	69	761
Htn	37	322	30	266
All Causes	1258	2982	513	2457

obsolete and unsafe products in foreign countries.

The key risk factor accounting for the racial differences in CV diseases in the past has been the two-fold or greater prevalence of high blood pressure (HBP) among blacks. As the cholesterol levels and smoking rates among blacks have risen to levels comparable to whites, the CHD mortality differential will most likely widen. Nonetheless, **as the preeminent disease process of advanced capitalist society**, atherosclerosis continues to be the number one cause of death and disability for all segments of the population. As long as this system—capitalism—is in place, it will prevent any significant extension of life expectancy.

Strokes. There are two common types of stroke—bleeding into the brain from rupture of a blood vessel, and blockage of a vessel from atherosclerosis. HBP is the main risk factor for both types. Stroke is an 'old' disease, common in precapitalist societies, occurring today more frequently in poor countries and among the working class. Apparently it has declined with time.[26,38,37] How the growth of capitalism gradually reduces stroke rates is not known. Death rates from stroke, and other cardiovascular diseases, in Charleston, S.C., in the late 1950s are shown in Table 13.[40] Notice the enormous excess death rate from stroke among both black men and women. Death rates from HBP are also much higher for blacks. In that period lower smoking rates and lower serum cholesterols among black men undoubtedly accounted for their favorable CHD rate, while HBP over-rides that effect for black women, where rates in both racial groups are relatively low. The contrast in all causes of mortality—2½ times greater for black men and almost 5 times greater for black women—provides some insight into the conditions that led to the black rebellions of the 1960's.

For whites in Charleston, and the rest of the South, their "advantage" over blacks is only one aspect of a complex relationship. The anti-labor policies built on Southern racism have kept the standard of living for whites in that region well below other parts of the country. Death rates for southern whites, particularly for stroke, are correspondingly higher.[26] So we see that racism has undermined the social status of workers of both races.

Among the reforms won through the social struggles of the 1960's was an increased awareness of the need to detect and treat HBP and greater access to care for blacks. One of the most important developments in public health has been the dramatic decline in CV diseases over the last ten years, with the greatest change being recorded for stroke.[41,42] To fully appreciate this development it is necessary to understand the concepts of relative and absolute risk, or the 'multiplier effect' of anti-racist struggle. Blacks have experienced a greater relative decline in stroke deaths, while for the white population a much larger **absolute** improvement occurred. Percentage decline from 1960 to 1975 for blacks was 32 for men and 41 for women, while for whites it was only 28 percent for men and 32 percent for women. In the white population, however, 72,700 fewer persons died in 1975 as a result of the decline, while the figure was 14,000 for blacks.[42]

What this shows is that, despite the racial barriers, social conditions are primarily shared by black and white in the U.S.; differences are secondary. (That relationship does not hold, for example, in a country like South Africa.)

This means that, when living conditions for blacks decline, they also decline for white workers. And the reverse is also true; any serious attack on conditions that harm blacks, such as CV disease, will also benefit white workers. This relationship holds generally, and we will see other examples of this. This proves that anti-racism is a vital need for white workers as well as for minority workers.

The effect of intervention against a mass disease concentrated in the minority population is multiplied in the population as a whole. Measured in terms of the lives saved, the improved control of HBP, including its effect on CHD, represents the most significant medical achievement since World War II.[41,42] When previously only 10-15% of persons with HBP were treated and controlled, now roughly 22% of black men and 40% of black women will be receiving adequate therapy.[43]

Two more vital lessons emerge from this experience: Political struggles account for significant changes in health status, and even the modest efforts at community-based treatment which have been undertaken can yield dramatic results.

High Blood Pressure. Of the factors which account for the health differential between black and white, HBP and related diseases make by far the greatest contribution. Perhaps not coincidently, firm knowledge of cause and prevention remains less well-developed for HBP than for any other of the modern mass diseases. A thorough review of this subject is not possible in this paper, and only a few major points will be touched upon.

A number of small isolated societies have been described which lie outside the boundaries of modern class relations and do not produce HBP as a common disease.[18-23] In all other societies, including both peasant agriculture and industrial forms, hypertension occurs at a uniform rate of 10%, with the important exception of blacks in the U.S. and the Carribean.[44-48] HBP is infrequent in African villages, but common in cities, particularly South Africa and the west coast.[44,49-51] There is no good evidence as yet, however, that the disease is as common anywhere in Africa among blacks as it is in the U.S.[39,47,50,51] For both blacks and whites the highest rates in the U.S. are found across the Black Belt, from Arkansas to the Carolinas.[46,47] An independent contribution for race has been well documented.[52,53] Although a distinct class gradient exists for both blacks and

whites, with lower income and lower educational background being associated with higher blood pressure, blacks have more HBP when compared to whites at each socio-economic level (Table 15). Although still somewhat tentative, it is of considerable interest that black adolescents in integrated neighborhoods and schools tend to have lower pressures than inner city youth, and that poor white and black children in rural Kentucky had similar blood pressures, both higher than what was found in middle-class suburbs.[54]

What causes high blood pressure? The controversy rages as hot as ever, and no authoritative, comprehensive body of data can be marshalled to support any single theory. It is almost certainly true that a number of factors converge, in combinations which may vary with time and place, to provoke the disease in susceptible individuals. We do know that many societies are totally free of the disease, so the social origin in modern capitalist society is undebatable. We also know that HBP is 3-4 times more common among blacks in the poverty-ridden counties of central Mississippi than among the white suburban middle class.

Two main theories serve as the framework for the study of this disease : nutrition and psychosocial stress [27,55,56]. Chronic excess sodium intake has long been suspected of playing a causative role.[55-59] It is true that all the societies which have low blood pressures consume very little salt, but they are of course different in many other ways.[56] Likewise, greatly altering an individual's salt intake can change high and low blood pressure.[60] Little difference in salt intake has been documented, however, between blacks and whites to account for the difference in disease rates.[61] Psychosocial stress, as a manifestation of the alienation and social disruption of modern life under capitalism ranks as the second most important potential explanation. [62,63] The fact that workers—especially minority workers—suffer much more HBP in the U.S. is consistent with this hypothesis.[63] Although it has occasionally been shown that heart rate and blood levels of epinephrine are higher in persons with HBP, which may reflect chronic stress, no other objective data exist to measure the impact of stress.[64]

The special prominence of hypertension among black people is undoubtedly the net result of a convergence of several causative factors all rein-

Table 14

Hypertension Rates by Race and Socio-economic Status 1971-72

Level of Education	Rate of Hypertension White	Black
Less than 10 yrs school	23.1	43.9
10-11 yrs	20.8	34.2
12 yrs	17.8	29.9
Some college	16.5	27.1
College Graduate	13.5	27.7

Table 15

Cancer Death Rates by Race, U.S., 1976, Age-adjusted, Per 100,000

	Male		Female	
Cause of Death	White	Nonwhite	White	Nonwhite
All Cancer	159.1	202.3	108.2	119.3
Digestive Organ	40.3	57.3	26.3	32.2
Respiratory	55.6	68.2	14.8	14.2
Breast	0.2	0.4	23.3	20.8
Genital Organs	14.1	25.0	14.9	20.7
Urinary Organs	8.8	7.2	3.1	3.5
Other	40.1	44.2	25.8	27.8

Table 16

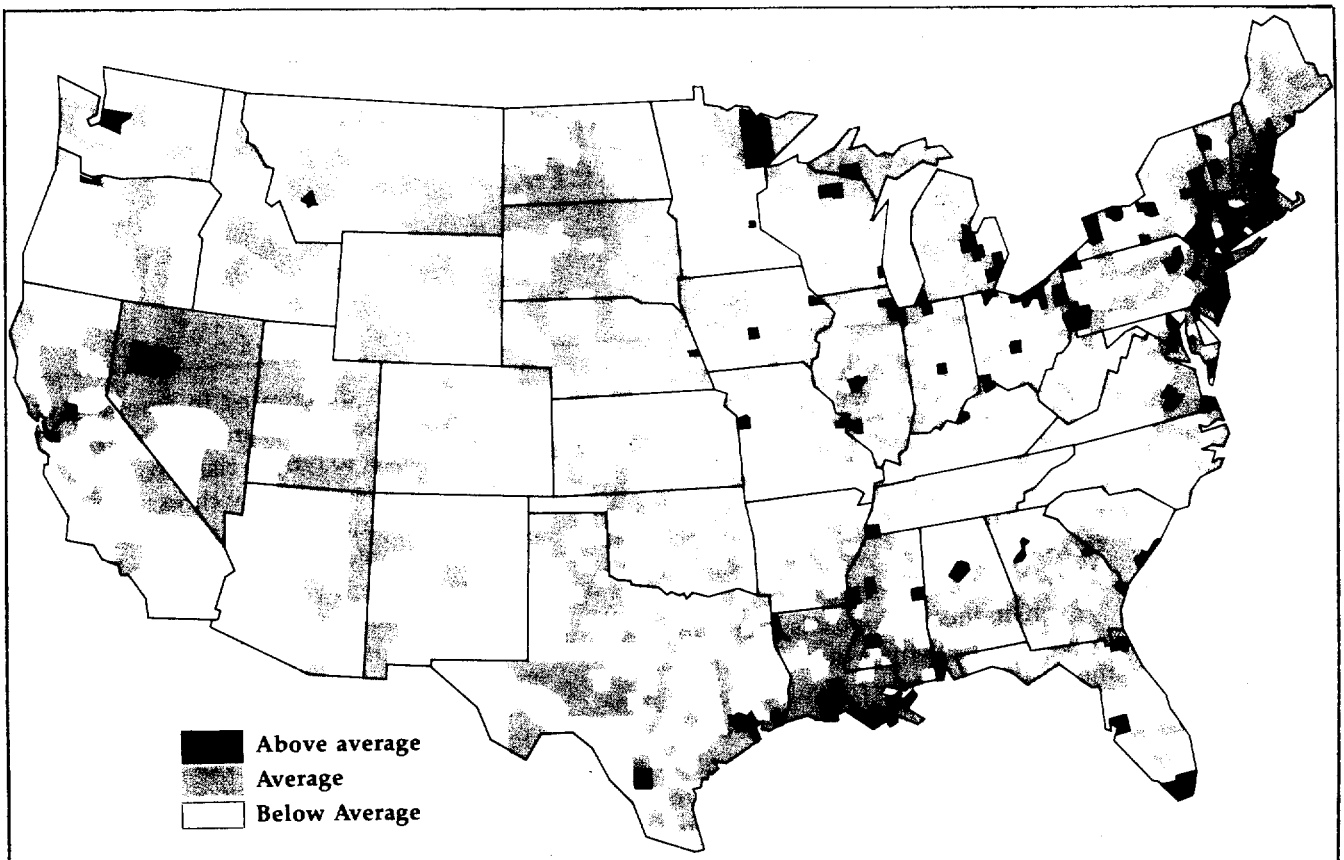
U.S. Cancer Death Rates, by Race and Sex, 1950-1976, Age-adjusted, per 100,000

Year	White Males	Nonwhite Males	White Females	Nonwhite Females
1950	130.9	125.8	119.4	131.0
1976	159.1	202.3	108.2	119.3
Change, 1950-76	+28.2	+76.5	−11.2	−12.7
Percent Change	+22.	+61.	− 9.	− 9.

Table 17

Cancer of the Lung, Men, White and Nonwhite, U.S., 1930-70, Rate per 100,000

Age-Race Group	1930	1940	1950	1960	1970	% Increase 1950-70
White						
45-54	8	20	35	54	68	+93
55-64	13	41	85	152	199	+134
Non-White						
45-54	3	15	34	72	133	+232
55-64	6	20	69	159	232	+236



Map above, prepared by the Occupational Safety and Health Administration, shows concentrations of cancer cases in industrial and mining areas. Although the evidence is clear that many industries pose high cancer risks to their workers and to residents in neighboring areas, it is not profitable for capitalism to correct these conditions. In fact, the bosses try to blame the problem on anything they can—including a claim that the high cancer rate shown in northern Minnesota may be due to ethnic factors. To believe this you have to believe there are no open-pit iron mines in the Mesabi Range.

forcing each other. It is interesting to contrast the social basis of HBP with CHD. Of the three major risk factors for CHD-HBP, high cholesterol, and smoking—blacks had a disproportionate burden of only HBP (until recently, at least). It would appear that a majority of the risk factors for HBP are present in excess among blacks. Hypertension can, of course be treated, and roughly 80% of the expected morbidity and mortality prevented.[65] Given the racism of the U.S. medical system, blacks and particularly black males, are significantly less likely to be treated and controlled.[43] We noted before, however, that the modest gains made in this area over the last decade have resulted in a dramatic improvement in life expectancy for blacks. The current attack on public hospitals and government supported health services will certainly reverse some of these gains. In 1970, for example, 30% of minority patients depended on clinics for their source of regular care.[66,67] While a preventive strategy is being developed for HBP, one of the most important aspects of the current crisis in health services is the need to maintain adequate treatment for this eminently treatable disease. Unlike many contemporary medical services, the saving of lives from the treatment of HBP is so enormous as to be easily measured.

CANCER

It is acknowledged even by bourgeois experts that over 80% of cancer is caused by environmental factors.[68] Over the last few years the rapid expansion of information in this field, along with the growing awareness that many of these findings had been suppressed by government and industry, has created the atmosphere of a public scandal. A host of popular books relate this sordid history. As Table 15 shows, non-whites suffer higher death rates from all causes of cancer combined, and for every major cause except for breast cancer and leukemia. Excess black mortality is most pronounced in cancer of the respiratory and digestive systems, the two leading causes, which together account for 50% of the cancer mortality.

The differential in cancer rates has been changing rapidly. Unlike the decline in cardiovascular mortality, cancer death rates are still climbing among males, and despite the overall decline for females in recent years, the emergence of respiratory cancer as the second most important cause may well indicate a rise in death rates among women in the future. In Table 16 death rates for black and white, 1950 and 1976, are compared. A 22% increase was recorded for white men and an

astounding 61% increase for black men; rates among women of both races dropped slightly. Although some of the increase among black men may represent better reporting (but maybe not—why would better reporting have selectively affected men?) it is generally agreed that most of the trend is real.[69]

The reason for the sharp increase in cancer mortality for blacks over whites in the last two decades has not been adequately investigated. This task is somewhat simplified since the overwhelming bulk of the increase is restricted to cancer of the respiratory tract. The pattern of the increase in cancer of the lung among men from 1930 through 1970 can be seen in Table 17. Beginning at lower rates, it was not until 1960 that blacks exceeded whites, with rates being substantially higher at the present. Of great importance is the finding that **the differential is greater in the younger age groups.** This demonstrated how rapidly and with what force blacks have been exposed to the cancer-causing environment.

Although a direct explanation of this increase would only be possible through a population-based prospective study—which no bourgeois source has yet seen fit to fund—there are some extremely interesting secondary pieces of data. Three generally recognized risks have been identified for cancer of the lung: cigarette smoking, occupational exposure, and city air (presumably polycyclic aromatic hydrocarbons and other chemicals). How do these relate to the black-white differential? In the late 1950's, respiratory cancer mortality was roughly equal between black and white. A nationwide smoking survey in 1956 showed that blacks smoked less than whites.[38] Subsequent surveys, beginning in 1965, have noted a modest increase of black over white[70] (cf, Table 12). Moving from lower to slightly higher rates, however, could not in itself explain the almost two-fold greater death rates recorded for black men ages 45-54 (Table 17).

Certain industrial job categories are clearly associated with an increase in lung cancer. Lloyd's classic study of steel workers describes with utmost clarity the super-exploitation of black workers that is occurring in virtually every branch of that industry.[71] From exposure to the smoke and fumes of the coke oven, steel workers who work around the oven for five or more years have a 300% increase in lung cancer. The racist nature of job assignments, however, shifts most of this burden to black workers. Out of 496 coke oven workers in the study 325 were black, (66%) despite the fact that only 30% of the workers in this segment of the steel industry overall were black. Furthermore, within the coke plant itself, black workers were much more likely to be assigned the most dangerous topside jobs.

What is the consequence in health? In Table 18 the 'predicted' number of deaths from all causes, and lung cancer, are calculated based on the experience of steel workers from the entire industry. Those rates are then contrasted to the "actual" rates among coke over workers, and ratio expressed as the 'Standardized Mortality Ratio' (SMR). As can be seen, whites suffered no increase, or were present in too small a number to provide a rate. Blacks, however, had an SMR of 200 for death from all causes, and 100 SMR for cancer of the lung. **Almost 50% of deaths of blacks working the coke plant were from lung cancer, contrasted to less than 4% in the population at large.** The monopoly structure of the U.S. steel industry has stifled innovation and prevented the building of new plants. As a result, U.S. steel plants have become among the highest-cost and least efficient producers in the world. They can no longer sell their products, so their rate of profit has fallen. Capitalist racism has forced black workers to pay with their lives the price of continuing to generate profitability from these out-moded, unsafe mills. The list of industries that expose workers in the same way is very long—pesticides for farm-workers, asbestos for insulators, vinyl chloride in rubber plants.

It is estimated that between 20-40% of all cancer deaths are related to job exposure, or roughly 65-130,000 deaths each year.[72,73] The potential magnitude of this attack can be seen when it is recognized that the excess mortality from cancer of the lung in Pittsburgh compared to other big cities is accounted for **solely** by the increased rate among black males.[71]

Although minority workers are often subjected to the most intense exposure to occupational carcenogens, they are by no means the only ones so exposed. In many skilled trades, hiring practices limit the work force primarily to whites and the health effect is easily recognized. Bladder cancer in N.J. is the highest in the country and concentrated among **white men**; half of the U.S. chemical industry is located in that state.[68] Furthermore, where the work place is integrated, it is not generally the case that white workers are unexposed, but rather less exposed. In the Lloyd study, for example, although no increase in lung cancer was observed among white coke plant workers, the basis of the comparison was all other **steel** workers; rates were equal but high for both groups. A disastrous situation for blacks should not be allowed to mask a very serious, and, in terms of the **numbers** of people affected, **more** widespread problem for whites. Since cancer of the lung was a very rare disease in the U.S. just 50 years ago, and is still virtually unknown in many parts of the world, the basis of comparison should really be zero.[75] **Relative** differences in a universal exposure only allow us to estimate the nature and magnitude of that exposure **within** the range we observe. But the real problem is that the entire range—black and white cancer rates in this case—is elevated. One effect of racism among the

Coke oven workers have extraordinarily high cancer rates, and black workers get the most dangerous jobs.

majority population can be to promote the illusion that better is good, or, at least, good enough. So racism hurts whites by leading them to accept much higher death rates, so long as they are not as high as those of blacks. Racial differentials, as in occupational hazards, are a warning which the majority ignores at its own peril. **Acceptance of the unequal status of those workers who are condemned to super-exploitation by the ruling class legitimizes those practices which threaten the health and well-being of us all.** Even the passive acceptance of racism can have a negative 'multiplier effect' on the majority.

A final factor increasing the risk of lung cancer death is the air we breathe. Controlling for smoking rates, living in the city doubles lung cancer rates.[74] Over the last half century mass migration of blacks has taken place from the predominantly rural South to the industrialized North, East, and far West. From 1960 to 1973 alone the percentage of blacks living in central cities increased from 52 to 60, while for whites it fell from 31 to 26.[14] As is readily apparent from Table 19 urban residence confers a broad increase in risk of cancer death on black males, contrasted with both white males and black females.[76] Cancer of the lung increases with exposure to urban air pollution, as do tumors of the intestinal tract.[77]

In conclusion, all of the three best recognized factors leading to increased risk of lung cancer have been concentrated on black men. As a consumer in a commodity economy they are heavy smokers (see Appendix 4 for further discussion of the role of commodity consumption). On the job they generate super-profits by operating machinery that the owners refuse to make safe. They are forced to live in neighborhoods with high concentrations of cancer-causing substances in the air. In each social interaction corporate profits are raised, and ever-greater sums of capital accumulated.

Other prominent cancers—intestinal tract, cer-

Table 18

Death Rates Among Coke Oven Workers

Work Area and Race	Number Employed	All Causes: Observed Deaths	All Causes: Expected Deaths	All Causes: SMR (% Increase)	Cancer of Lung: Observed Deaths	Cancer of Lung: Expected Deaths	Cancer of Lung: SMR (% Increase)
Side oven only	496	53	55	96	6	9	146
White	171	16	19	86	2	3	---
Nonwhite	325	37	36	102	4	6	286
Topside	132	35	17	201	15	1.5	1000
White	27	4	3	---	1	0.2	---
Nonwhite	105	31	14	215	14	1.3	1077

Table 19

Ratio of Cancer Death Rates, Nonwhite and White; Male and Female, U.S., 1959-61

Primary Site	Males - Ratio NW:W Urban	Males - Ratio NW:W Rural	Nonwhite - Ratio M:F Urban	Nonwhite - Ratio M:F Rural
Respiratory	1.11	0.75	8.75	6.06
Digestive Organs	1.70	1.52	1.31	1.16
Esophagus	2.60	1.86	4.54	2.93
Liver	2.50	1.67	2.39	2.21
Colon	0.77	0.69	0.92	0.87

Table 20

Five Year Cancer Survival Black and White, 1967-73

Cancer	Per cent Surviving White	Per cent Surviving Black
All types	39	30
Stomach	12	14
Colon	46	35
Lung	9	6
Breast	65	51
Cervix	58	53
Prostate	59	54

vix and prostate—are also more common among blacks, again, with a widening differential. Although currently higher among white women, breast cancer is still increasing among black women, and not among white. A nutritional hypothesis has the most support in regard to intestinal and breast tumors at the present time, and little is known about the cause of cancer of the cerbix or prostate.[78]

Not only are the forces which cause cancer especially brought to bear on blacks, but they receive less treatment when they do get sick.[79] The percentage of patients who survive 5 years after the diagnosis of the major cancer types are contrasted between black and white in Table 20. Even when taking into account the fact that blacks were diagnosed at a later stage, they consistently benefited less from modern medicine and died after a shorter period of time. It has also been shown that poor whites, attending clinics in university hospitals, suffer the same fate.[80]

VIOLENCE

With the development of capitalist society there has been a gradual increase in deaths from violence.[4,81,82] The cause of violent death has gradually changed, as auto accidents and homicide have become more prominent. Homicide in the state of Michigan can serve as an example. About 75 per cent of the blacks in Michigan live in Detroit, as opposed to only about 10 per cent of whites. Considerable migration to Detroit has taken place over the last two decades as blacks sought industrial jobs. State-wide homicide trends are influenced primarily by the Detroit area. In Table 21 death rates for young men are compared between 1960 and 1970; the accidental death rate for blacks went from 85 per 100,000 to 95, while homicide rates went from 9 to 181.[83]

Clearly this epidemic grows out of a society in the final stages of decay. Few countries have higher violent death rates than the U.S.—a notable exception being South Africa, where homicide is 5 times more frequent, and violence is the leading cause of death among blacks.

In 1976 21,000 men, women and children died in the U.S. 'from injuries inflicted by another person with the intent to kill.' Of those deaths, 8,300 were black men. Over the years various economic measures—primarily unemployment—have been shown to correlate very closely with homicide rates. Rates were at the current level during the Great Depression of the 1930's.[82] Although changes in the economy may explain fluctuations in the rate, it should also be recognized that the underlying violence of this society—the use of **force** to maintain the system of capitalist production—'creates a world in its own image.' Violence is constantly portrayed as the means to solve social problems. Most homicides involve family members or friends and reflect an internalization of the class struggle within the family. This phenomenon will increase as capitalism decays and the class struggle heats up further. **Crime is an integral part of the capitalist mode of production.**

Violence has contributed significantly to the declining life expectancy of middle aged blacks, particularly males. Auto- and job-related accidents have increased, but homicide is by far the most important factor.[84,85] It is of some interest that suicide has never been particularly common among blacks, or workers in general for that matter, although there is a recent upward trend.[86-88]

PERINATAL HEALTH

A brief look at the health of mothers and newborn children offers additional insight into what this society means to minority peoples. Despite a downturn in infant mortality in recent years, blacks still lag far behind other racial groups.[89,90] Data by race for 1974 are presented in Table 22. It must be remembered that in this classification, 'white' also includes hispanics, so the figure is artifically raised. In Table 23 the most recent data available relating income and race (1964-66) clearly demonstrate that for each level of income blacks suffer a much higher death rate among newborns. Over the years one of the most striking black-white differentials has been the death rate of mothers during childbirth. In Table 24 maternal mortality by race is summarized from 1930 through 1975. Although the absolute numbers are quite small (maternal mortality is calculated per 100,000 births, while the death rate for infants is per 1,000), the differential has been over 300% since 1950.

Weight at birth is the primary risk factor for early infant death. In Table 25 the birth weights by race are presented for selected years over the last 3 decades. The surprising finding of a rising percentage of low birth weight infants among blacks most likely represents more accurate reporting, with an end to home births. Maternal nutrition, of course, is the main determinant of

Crime is an integral part of the capitalist mode of production.

birth weight, as well as toxemia and other important complications of pregnancy. In an effort to isolate the specific role of prenatal care, a study in Washington, D.C., compared the percentage of underweight infants by race and period during pregnancy when care was initiated (Table 26). The two-fold black-white difference is apparent again. Attending the clinic had little impact for nonwhites. The terrible condition of women who, for whatever the complex reasons, receive no prenatal care is also evident, for black as well as white. Detailed analysis is needed to separate the effect of teenage pregnancy, available income, accessibility and quality of care, etc., in creating this assault on unborn children. Whatever the balance of forces, no one can deny that one of the monumental failures of the 'world's best health care system' is an inability to assist in the birth of healthy children.

After the ghetto rebellions of the 1960's, thousands of neighborhood health centers and well-baby stations were opened to provide preventive health care to the children of the ghettos—primarily nonwhite children. During this period there was a substantial increase in the percentage of children who received routine immunizations. As the militance of the working class died down, so did the number of clinics and health stations, and so followed the number of children immunized, and the difference in immunization levels between white and nonwhite children increased again (Table 27). It is only recently—as outbreaks of measles and other preventable diseases have occurred and affected white children too, that school boards are now requiring adequate immunization for admission. Children are being referred to health stations that are already overworked, however, and these regulations do not affect children under five.

SUMMARY AND CONCLUSION

The health of a social class is determined by the role it plays in society. Since the production of the material necessities of life is the primary function of the social structure, the relationship to the

Table 21

Death Rates from Violence for Men in Michigan, Ages 15-44, 1960-1970
(Rate per 100,000)

Cause	Race	1960	1970
Accidents	White	67.2	84.2
	Nonwhite	59.7	95.4
Homicide	White	3.5	8.6
	Nonwhite	54.0	181.7
All causes	White	195.7	209.2
	Nonwhite	336.3	566.1

Table 22

Infant Mortality by Race, 1974

Race	Deaths per 1,000 Live Births
White	14.8
Black	26.8
Native American	18.5
Chinese	6.0
Japanese	9.3
All Races	16.7

Table 23

Infant Mortality by Race and Income 1964-1966

Family Income	Deaths per 1,000 Live Births: All Races	White	Black
Under 3,000	32.1	27.3	42.5
3,000-4,999	25.1	22.1	46.8
5,000-6,999	18.1	17.8	22.0
7,000-9,999	19.9	19.2	37.6
10,000 or more	19.9	19.4	*

*Numbers too small for estimation

Table 24

Maternal Mortality by Race 1930-1975

Year	Deaths per 100,000 Live Births: White	Nonwhite
1930	575.4	1,080.7
1940	319.8	773.5
1950	61.1	221.6
1960	26.0	97.9
1970	14.4	55.9
1975	9.1	29.0

Table 25

Per Cent of Low Birth Weight+ Infants by Race, 1950-1975

Year	White	Nonwhite
1950	7.1	10.2
1968	7.1	13.7
1975	6.2	13.1

+Live births less than 2,500 gm.

Table 26

Per Cent of Low Birth Weight Infants by Race and Prenatal Care Washington, D.C., 1974

Trimester when Care Initiated	Race: White	Nonwhite
First	5.6	11.4
Second	6.8	12.8
Third	7.0	11.6
No Care	16.4	26.5

Table 27

Per Cent of Children with History of Immunization by Race, Ages 5-9

Year	Immunization and Race: DPT White	DPT Nonwhite	Polio White	Polio Nonwhite
1973	62.5	51.4	72.8	63.4
1974	67.2	52.4	75.2	60.7
1975	61.5	46.4	78.9	61.4
1976	58.6	38.2	73.3	52.1
1977	57.0	35.0	73.2	52.0

Health Consequences of Imperialist War
(a partial listing)

1. Death and injury for combatants in "conventional" warfare.

2. Death and injury to civilian population from conventional warfare (bombings, fires, mass executions, etc.). Over 100 million people were killed in World War II—and this was due largely to non-nuclear warfare.

3. Deaths, disease, and disability due to nuclear weapons. This is a real possibility in the minds of politicians and generals who estimate that nuclear war is "winnable," given that the destruction of the population and industrial plant would be extensive but **not total** (**NY Times**, 2/14/80, p. A27). A 1962 study in the **New England Journal of Medicine** (5/31/62, p. 1126) hypothesized the effects of a 20 megaton nuclear blast over Boston. 2.2 million of three million people would be killed at once by the blast or fire storm. Of the 6500 doctors in the area, almost 500 would be dead and only 900 in physical condition to work. If doctors spent an average of 15 minutes with each injured person and worked 16 hours a day, it would take about three weeks for each casualty to be seen once. Radiation sickness is merely an extra added disaster.

4. Deaths and disease due to starvation. See, for example, the consequences in adult and infant mortality during the Dutch famine resulting from the Nazi blockade in World War 2. Or, look at the mass starvation today in Africa and Southeast Asis resulting from war between imperialists (e.g., U.S., Soviet Union, China) or their "proxy" states.

5. Death and disease from epidemics. Pestilence and war go hand in hand. Even previously controlled infectious diseases can re-emerge as a result of disruption of water supplies and waste-removal systems, lowered resistance (from inadequate food supplies), increased crowding, shortages in medicine, and the altered ecology of disease-carrying rodents and insects. Biological warfare is being seriously discussed. It is hardly coincidental that the great Influenza Pandemic of 1918 came on the heels of World War I.

6. Residual disease and disability. Even aside from the long-term consequences of the destruction of housing, industry, transportation, etc., there will be direct war-related health effects. The carcinogenic (cancer-causing) effects of defoliants used in Vietnam are still being discovered. The potential long-term carcinogenic and teratogenic (leading to infant malformations) effects of radiation exposure are substantial. Chemical warfare, another option being seriously considered (**NY Times**, 2/24/80), can leave residual lung and nerve damage, not to speak of the carcinogenic potential. The effects of war-time injuries (paralysis, amputations, burns, mental breakdown, etc.) can persist for many years.

We repeat: this is only a **partial** listing.

A mass, anti-racist, anti-imperialist war movement, leading to socialist revolution, is in the highest tradition of "preventive medicine."

process of production is the determinant social role. For the direct producers in class society—the working class—that relationship is broadly characterized by exploitation, the expropriation of the fruits of their labor to concentrate privilege and wealth in the hands of the ruling class. The historically determined economic relationships of class society create the political structure within which the class of exploiters and the class of direct producers struggle to advance their own interests. The laws of production, in fulfilling their historical function, necessarily enrich the exploiters and impoverish the producers, including the state of their health.

The mechanisms of social control in a class system are structured to bring the worker to the point of production under conditions favorable to the employer, i.e., for the greatest possible amount of time, with the greatest intensity and with minimum expenditure on wages and safety. Since society operates as a whole, life away from the job will be commensurate with work conditions. Differential pay will be complemented by, and in part "legitimized" by, inferior education, housing, social services, etc., for oppressed minorities. An ideological superstructure, such as the myth of lower IQ, will be further used to legitimate and explain the conditions of increased exploitation.[91]

How does the accumulation of profit sacrifice health? More hours of work, at greater intensity, generate greater returns on a given investment in wages and directly jeopardize health through occupational diseases and accidents. The process of exploitation is broader than what takes place at the point of production, however (Figure 2). Production presupposes and requires consumption to complete the circuit of capital. In the effort to satisfy their material needs and reproduce their ability to work, the masses are compelled to participate in the final stage of the cycle of commodity production as consumers. Many of the commodities so consumed promote disease. Within the broad boundaries of its social value, **the nature of a commodity is determined primarily by the need to maximize profit during the process of production, not by its effect on the user.** Finally, the continued existence of class society generates violence on many levels, physical and emotional, at home, in the street, and between nations, all of which take a toll on the working class.

The decisions made by those in power while setting in motion the forces of production determine the degree and intensity of exploitation, and the differentials within the working class. Those decisions are implemented both in isolation at the point of production, and through the public policy of the government acting as a collective spokesman for the interests of capital. Through an historical process of experimentation those policy decisions have been shaped into a

Imperialist war creates many new health hazards (see box opposite). Above, Chinese health workers caring for wounded Red Army soldiers in an underground hospital carved into a mountain during the Japanese invasion in the 1930s.

social strategy to maximize the general rate of profit. **The use of racism is the primary aspect of that strategy under modern capitalism. Racism lowers the standard of living of all non-exploiters, and although more intensely felt by the minority group, the quantitatively largest effect is on the white majority.**

Figure 2

THE SOCIAL AND ECONOMIC ORIGINS OF DISEASE IN CLASS SOCIETY

I. PRODUCTION
Examples: Occupational Disease
Pollution

II. CONSUMPTION
Examples: Diseases related to diet, cigarettes and alcohol

III. SOCIAL DISRUPTION—Chronic
Examples: Homicide, suicide
Emotional Illness
Auto accidents

IV. SPECIAL OPPRESSION WITHIN CLASSES
Examples: Racism
Sexism

V. SOCIAL CRISIS—Acute (Depression, Fascism, War)
Examples: Famine, deprivation
Genocide
Battle Casualties

The differential between black and white makes it possible to recognize the social forces creating disease, and to understand that **those diseases, for both black and white, are unnecessary, preventable, and man-made.** One of the many contradictions created by the capitalist mode of production is the promotion of mass disease. Racism is an essential element of the social relations of production in this country; it heightens the contradiction between labor and capital and throws into sharp relief the disease producing character of capitalist production.

In this article we have attempted to outline the basic measures of health and disease for black Americans, and the economic forces which create the epidemics they suffer. Several brief examples of the impact of health care, and the lack thereof, have been included where the outcome can be clearly measured.

The continuous state of war between the corporate elite of this country and the minority working class can be witnessed in all its stark brutality in this description of public health. Wholesale attack on a racial group, as can be seen, is not restricted to concentration camps or the use of nuclear weapons; it is a daily occurrence in the drive by U.S. capitalism to amass super-profits from the labor of black workers. Furthermore, black workers are only different from their working class brothers and sisters in the unrelenting intensity with which they are assaulted by

the forces of capital.

The discussion presented here is obviously incomplete. Many further examples of disease categories could be included, e.g., diabetes, tuberculosis, mental health, alcohol and drug addiction; health services and medical training and ideology deserve a thorough treatment. We have not dealt extensively with psychological or stress related factors, nor have we attempted to assess the potential role of population genetics. The process of disease production requires much more detailed analysis. Work on some of those topics is currently underway, and participation of health workers in a growing anti-racist movement will provide the resources needed to accomplish these urgent tasks.

An analysis of the past alone, however, is never enough. Over the last few years it has become apparent that the U.S., and in fact the world-wide capitalist system, is entering a period of intense structural crisis. The immediate economic future of the United Statres is one of increased international competition, falling profit rates and a foreign policy dominated by the need to resort to war. From even the limited analysis of this paper, it should be clear that exploitation will be increased, racism will grow and the standard of living and level of health of the working class will be attacked (Appendix 5). A necessary concomitant will be the tightening of political restrictions and increased reliance on direct force as the primary means of social control. Racism, growing out of the practices we have described, will be the cutting edge of those developments. Far from a trend toward improved health we can anticipate a move toward the 'other face' of modern capitalism —fascism.

The current analysis was undertaken in an effort to broaden the awareness of racism and class society. We conclude by pointing out that what has been described as a chronic, long-term crisis is currently under threat of being converted into an explosive, acute crisis—fascism and war. The underlying structural features of capitalism outlined here serve as the precondition for those social developments. **The everyday treatment of minorities serves as a model for the institution of fascism by making the use of violence by the state and the conditions of super-exploitation acceptable.** Those social conditions are 'proto-fascist,' becoming generalized during periods of economic crisis.

A serious judgment on the truth of those statements is urged upon every reader, because, if true, the whole of society will be dragged into the center of the coming struggle, and fundamental social change—to the right or to the left—will be on the agenda of the day. PL

APPENDIX 1

I. The international relationships between the central industrial countries and their neo-colonies (often referred to as the "Third World") reflect intense racism. Beginning with health issues as basic as the food supply, present-day economic policies are unspeakably cruel to poor workers in those countries. According to the Presidential Commission on World Hunger, "One out of every 8 people on earth—between 500 million and 1 billion—suffers a debilitating form of malnutrition . . . children under 5 make up more than half the total".[92] Health remains imprisoned by social conditions of a century ago. The enormous cost in life from infantile diarrhea in countries like Costa Rica, for example, reflects primarily under-nutrition.[93]

APPENDIX 2

II. In the case of income, for example, if one controls for occupational prestige, age, education, weeks worked, hours worked last week, and the average income of the State of residence, black income increases relative to white but does not reach it (Appendix Table 1). In 1971 the median raw income among employed black men was $7470, compared to 11427 for white men. When adjusted for the specific class-related variables listed above the gap was closed by about half, rising from 65% of that for whites to 85%. **An additional 15% is therefore 'unexplained' by the factors considered and must be ascribed to some other, independent feature of the race difference. If blacks and whites were suddenly equal in class standing blacks would receive 15% lower wages simply by virtue of being dark-skinned.** It is interesting to note that for Puerto Ricans almost all of the wage gap can be accounted for by the lower class standing. A similar analysis needs to be done for health.

Appendix Table 1
Mean Income by Race and Adjustment for Selected Socio-Economic Variables, Males, 1975

	Raw Values		Adjusted Values	
Race	**Mean**	**Ratio to White**	**Mean**	**Ratio to White**
Black	$ 7470	.65	$ 9741	.85
Mexican American	7456	.65	9414	.82
Puerto Rican	8269	.72	11233	.98
AmericanIndian	8302	.73	10575	.92
White	11427	1.00	-	--

APPENDIX 3

III. A detailed analysis of the class nature of disease from a Marxist point of view would go far beyond the scope of this paper. An application of dialectical materialism to public health can effectively demonstrate the origin of the mass diseases of this society in the contradictions of the capitalist mode of production, but for our purposes it is sufficient to frame the general question. An extended version of Mark's well-known formulation of the relationship between the economic base and the social superstructure is included below:

> In the social production of their existence, men inevitably enter into definite relations, which are independent of their will, namely relations of production appropriate to a given stage in the development of their material forces of production. The totality of these relations of production constitutes the economic structure of society, the real foundation on which arises a legal and political super-structure and to which correspond definite forms of social consciousness. The mode of production of material life conditions the general process of social, political and intellectual life.

A Contribution to the Critique of Political Economy, Karl Marx.

In the classical Marxist literature there is little application of those ideas to the problem of mass disease, beyond the infections which accompanied poverty (cf. Engels, **Conditions of the English Working Class; On the Housing Question.**) For a communist view of this question, see "The Dialectics of Disease," **PL**, Vol. 12, No. 2 (Spring, 1979), pp. 62 ff. Also recommended is the excellent review of this topic found in the paper by an MD active in Health-CAR, A. Schatzkin, "Health and labor power: a theoretical investigation," **International Journal of Health Services**, 8:213, 1978.

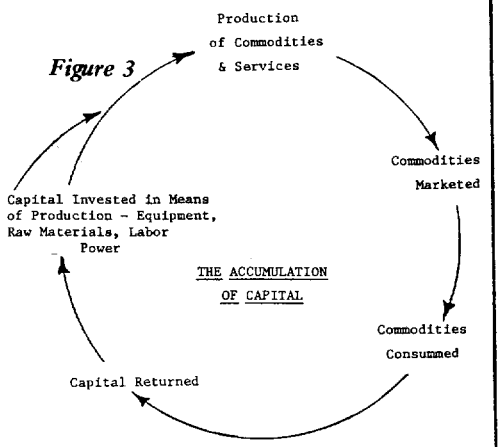
APPENDIX 4

IV. A wide range of the epidemic diseases of capitalism can be related to 'life-style,' or patterns of consumption. It should of course be understood that **life-style is not a matter of individual choice, but in the mean is determined by social conditions.** For example, the diet of the masses in any given society reflects the level and nature of production in agriculture, and is only minimally, and secondarily, influenced by individual choice. Cigarette and alcohol consumption likewise reflect the pressure of the commodity economy. As Marx elaborated in detail in **Capital**, the cycle of production presupposes and requires consumption in order that the use value of the commodities be realized. (Fig. 3) Although brief quotations can distort the significance of Marx's concepts, all of which are highly inter-related, the following statements offer some assessment of the role of commodity consumption.

> Consumption falls within the circuit of capital itself only in so far as it is productive consumption; its premise is that surplus-value is produced by means of the commodities so consumed.
>
> The continuous existence of the working class is necessary for the capitalist class, and so is therefore the consumption of the laborer made possible by . . . (the purchase of commodities).
>
> For our purposes we may call this entire sub-division consumer necessities, regardless of whether such a product as tobacco is really a consumer necessity from the physiological point of view.
>
> Marx, **Capital, Vol. II**

Atherosclerosis is primarily a dietary disease, as is diabetes, and there is good evidence to ascribe a major role to nutrition in regard to cancer of the breast and the gastro-intestinal tract. Consumption of course only fulfills the need of completing the process of production, and it is at the point of production that exploitation takes place and surplus value is generated. Diseases of life style are therefore integral, though secondary to production. By and large commodity production has a contradictory role.

Figure 3



Some aspects of nutrition have improved with increased productivity, while many new problems have been introduced. Capitalism is unable to guide production toward social good and blunders into new epidemics. In order to preserve the opportunity to make a profit, while appearing to heed the warnings of public health, the burden of health-destroying consumption is shifted to minority groups and the neo-colonies. For example half of the cigarettes produced in the U.S. are sold abroad.

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INTERNATIONAL COMMITTEE AGAINST RACISM
FOR SOCIALISM

MAY DAY 1980

Fedayeen May Day rally in Teheran

Marcha del 1ro de Mayo en Santo Domingo, República Dominicana


ALL
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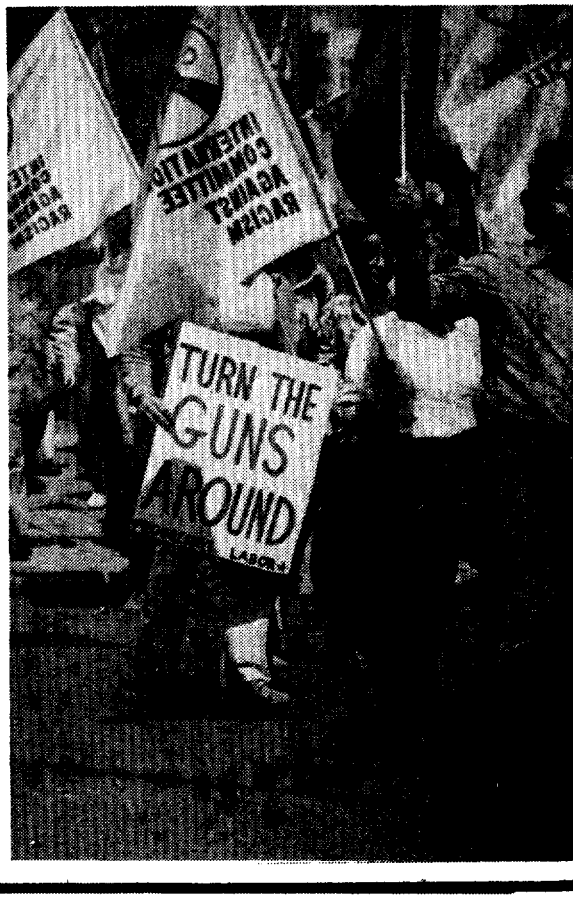
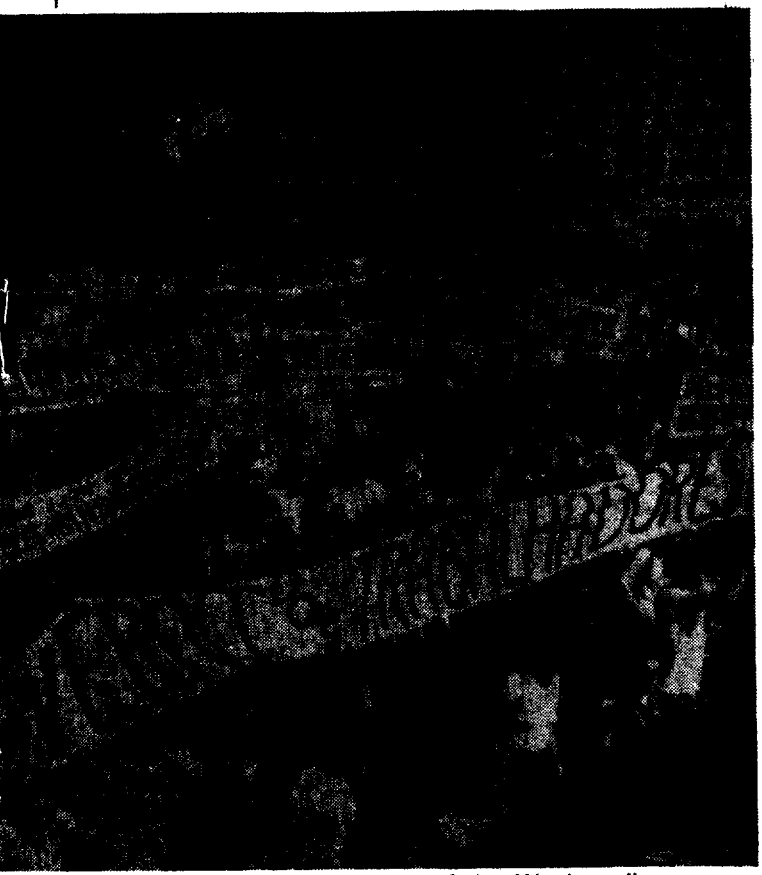
Part of May Day march in São Bernardo. Banner i





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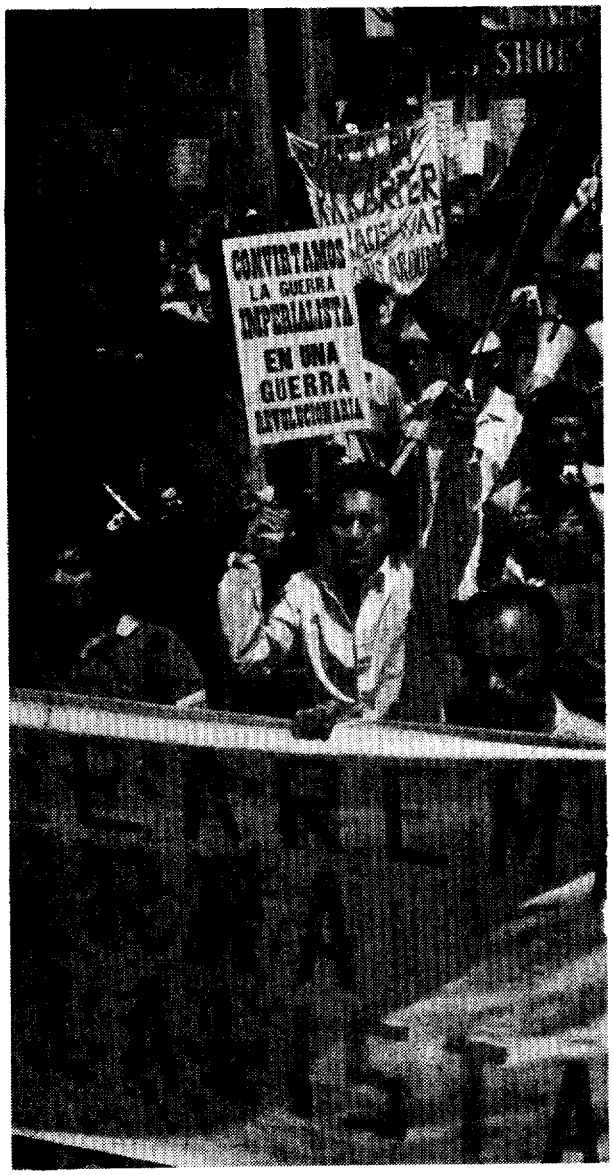

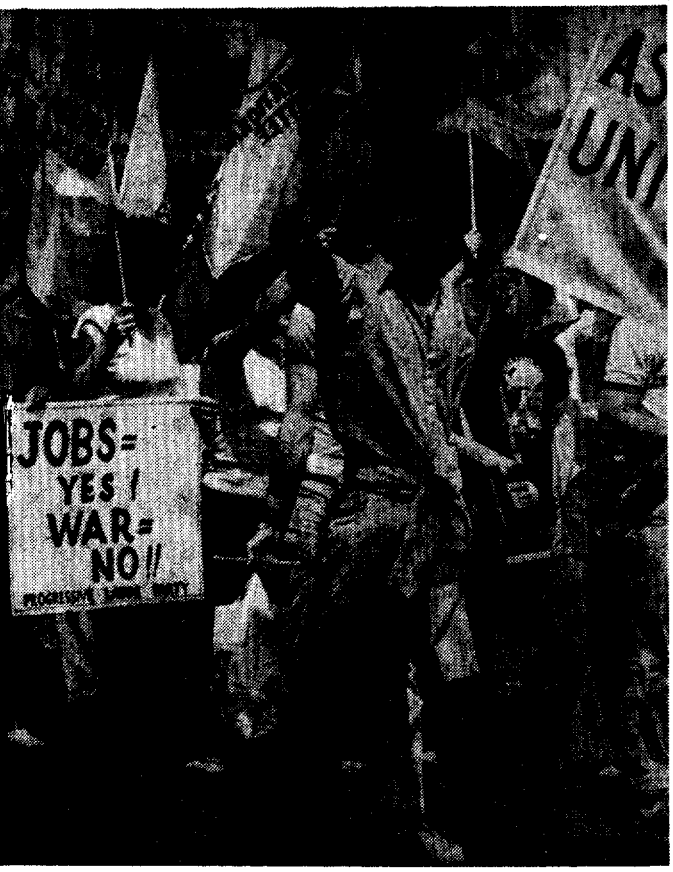

...and on to MAY DAY 1981

By R.T.

Medical Apartheid
Segregation in Health Care

As part of their drive toward fascism at home, the U.S. ruling class is attempting to cut back medical services so more money will be available to beef up the military, develop new supplies of oil, or re-capitalize obsolete and financially shaky industries.

Given all the talk about the "crisis" in medical care, there is one fact that the experts and politicians rarely talk about, a fact that lies at the heart of the government-business plans to bring fascism to bear on medical care: **the U.S. medical care system is racially segregated.**

THE HISTORY OF U.S. MEDICAL APARTHEID

Medical care segregation has had a long and literally bloody history in this country. In the post-Civil War era, a series of U.S. Supreme Court decisions from 1873 to 1898 led to the entrenchment of the "separate but equal" doctrine. A number of states passed the so-called "Jim Crow" statutes, with considerable help from the Ku Klux Klan. Minorities (mainly blacks) came to receive their care in separate wards of general hospitals, if they were admitted at all. In some areas, specific laws mandated that only black nurses could care for black male patients. There were separate hospitals for the mentally ill. Separate or segregated facilities were required in nursery houses, orphanages, institutions for the deaf, blind, and mute, and even in cemeteries![1]

In the early part of this century, in the South, there were either no hospitals for blacks or poorly equipped "colored wards" from which black physicians were virtually excluded. A survey taken in 1912 in

Workers Action Movement coffee wagon at New York City hospital picket line. Our party and its friends have long been active in fighting for an end to racism in health care and hospital hiring.

New York City revealed that 19 of 29 hospitals did not exclude black patients; of these 19, 16 denied black doctors the right to attend patients or perform surgery.

A 1930 survey showed that out of a total of 7259 hospitals in the country, only 225 served blacks. In 1947, 24 of the 127 Veterans hospitals had separate wards for black patients. The 1946 Hill-Burton Act, the major hospital construction legislation in the post-war period, contained an explicit "separate but equal" clause. As late as 1960, surveys of hospitals, especially in the South, showed a continued pattern of conscious racial segregation of patients and denial of admitting privileges to black physicians.

There are numerous reports throughout this century of black patients bleeding to death or dying from other preventable illnesses because they were denied admission to a "white" hospital.[2]

Today, many hospitals seem to have both whites and minorities in the same building or even on the same ward. We shouldn't be fooled, though, by this surface appearance of multi-racial populations. If you really stop to count the racial representation in our hospitals, you find the old "de facto" segregation, with consistent, disproportionate distributions of patients by race.

In most U.S. cities, the division between "private ("voluntary" or "proprietary") and "public" hospitals is the main source of medical care segregation. Look at these two examples: In Philadelphia, the 1969 census showed that Philadelphia General Hospital (now closed!) had 73% black patients; all other hospitals together averaged 1/3 nonwhite inpatients, with some private hospitals over 90% white.[3]

In New York City in 1976, 3/4 of the patients in major teaching hospitals were white; in voluntaries, 5/6 white; and in proprietary hospitals, 7/8 white. In the city hospitals, though, 2/3 of the patients were minority, with some city hospitals having over 90% minority patients.

Many voluntary hospitals are not directly affiliated with or near municipals. In such cases, the apartheid goes on **within** the same facility. At Roosevelt, Mount Sinai, Columbia-Presbyterian, or New York Hospitals in New York City, for example, there are what are officially known as "private" and "service" wards. "Private" patients tend mainly to be white, while "service" patients tend to be primarily minority. At times, the division is as blatant as in South African hospitals.

Medical apartheid reaches into outpatient care as well. A recent study of outpatient care at Duke in North Carolina showed that the public Out-Patient Clinic had a patient population that was 76.2% black and 23.8% white. The Private Diagnostic Clinic, however, had nearly reversed pro-

portions, with 68.6% white and 32.4% black patients.[4]

Segregation is also to be found within the office practices of private physicians. A recent report on CBS television showed a doctor's office in the south with one waiting room for whites and one for blacks. Some black physicians (those practicing in minority working class areas, often deprived of admitting privileges to nearby voluntary hospitals) have primarily minority practices; many white physicians have mainly white practices.

"SEPARATE BUT EQUAL" IS A LIE

One of the major points made by anti-racists, from the anti-slavery movement to the Civil Rights movement of the 1950's and 1960's, has been that "separate but equal" is a lie. Racially segregated facilities are never "equal" under capitalism. Let us look at some examples of this racist inequality in the medical care sector.

Public hospitals have been consistently under-

The public hospital is where you are 'supposed to go.'

capitalized compared to the private sector. In 1969, public hospitals had assets of $115 per patient per day; private hospitals had $132 per patient-day. In 1975 these figures were $137 per patient-day for the public hospitals, $167 for the private institutions. Looking at this another way, in 1969 public hospitals had 87% of the assets of private hospitals; in 1975, it was only 82%.[5]

Staffing levels at municipal institutions are systematically inferior to those in private facilities. Studies have shown that in almost all public hospitals, the staff per 100 average adjusted patient days was lower compared to private hospitals.[6] Nationwide, public hospitals have an average of 6 fewer registered nurses (RNs) per 100 patients than private hospitals.[7] The nursing ratio is one of the key elements of medical care quality. A 1974 law suit in Washington, D.C. showed that the city hospitals (with over 90% minority patients) had lower staffing levels for nurses and technicians, than the voluntary hospitals; the city hospital technicians, for example, had to process many more x-rays and bacterial cultures than their counterparts in the voluntary institutions. The situation in the public hospitals in the country has grown steadily worse. In New York City the Health and Hospitals Corporation lost some 8000 employees over a two-year span from 1975-77, and more have been lost since then.

How about "equality" between the separate "private" and "service" wards **within** the same hospital? Here data is much harder to come by. We can make a pretty fair estimate, though, that expenditures, whether for supplies or staff, will be systematically less on "service" wards. Clearly there is some reason why private physicians generally prefer their patients to be admitted to the "private" wards.

As for ambulatory care, the study of outpatient clinics at Duke reveals specific inequalities: "In general, the facilities for [predominantly white] PDC patients are separate from and distinctly more comfortable and attractive than those offered patients attending the [predominantly black] OPC. The PDC is characterized by cushioned chairs and carpeted floors, while the OPC is furnished with plastic chairs on barren floors." Black patients in the public clinic are cared for by residents and interns who rotate after several months. These patients, as opposed to the predominantly white patients in the private clinic, are thus obligated to see a different doctor every year.[4]

HOW DOES CAPITALISM CREATE MEDICAL APARTHEID?

The capitalist system spawns medical apartheid in several, inter-related ways:

Residential segregation. As a general rule, people tend to go to hospitals and clinics near to where they live. Given the widespread segregation in housing in this country, it is not surprising that medical care facilities would also be segregated. Look at Harlem Hospital in New York City, or nearly all-minority Martland hospital in the largely minority central ward of Newark, N.J. However, the factors of nearness to facilities and residential segregation do not account for all of the medical apartheid in the U.S. A study carried out in Philadelphia showed that 22% of the patients at Philadelphia General Hospital came from Health District #5, far to the east, across a river and several bus changes away.[8] This area was predominantly black. Clearly, causes other than housing segregation must be at work.

Outright racial discrimination. To quote one study of public hospitals: "As with Philadelphia General Hospital, it is common knowledge among the medically indigent in New Jersey that the public hospital is where you are 'supposed to go'."[9] Such a perception of where you are 'supposed to go' generally results from previous inability to get into the private hospitals, or just

The Hidden Content of Medical Education

Maintaining and spreading segregation in medical care requires the participation, or passive acceptance, of this murderous racism by hospital and medical personnel. Since racism doesn't come naturally to workers, the ruling class has arranged to have it taught to us—right in the classroom, along with the professional and scientific training.

The hidden aim of many of the courses is to prepare health professionals to look on minority and working-class patients as objects or "material" and deserving of less-than-adequate medical care—or none at all. This process is not yet so blatant as in the medical schools of Nazi Germany, but that stage is not too far removed from the following examples.

- Numerous texts and medical school lecturers argue that one cause of the higher rates of tuberculosis among black, Latin, Asian, and Native American peoples is an altered immune system, i.e., lowered "resistance." This is a subtle form of victim-blaming. There is no evidence for such a biological deficiency, while there is overwhelming evidence that higher rates of TB and other infectious diseases result from racist living conditions.
- Higher cervical cancer rates among minority women are attributed, subtly and not-so-subtly, to promiscuity among these women. While there may be (and this is hardly proven yet) a causal relationship between sexual activity and cervical cancer, there is certainly no evidence that the higher disease rates among minority women is due to their "promiscuous sexual behavior." Here is the interconnected influence of both racism and sexism on scientific thinking.
- Psychiatry is replete with racist concepts and stereotypes. A southern physician in the mid-19th century "discovered" a specific form of mental illness among slaves which he dubbed "drapetomania" or "running away from the master sickness." It was apparently a very widespread affliction, often associated with "pyromania" and homicidal tendencies (resulting in the burning of plantations and killing of slave owners). It may have been spread by such disease "carriers" as Nat Turner, Harriet Tubman, or John Brown. Other examples of racist psychiatric mythology can be found in **Racism and Psychiatry**, by Thomas and Sillen (Brunner/Mazel, 1972).
- Despite the increasing evidence demonstrating the racial and class biases in standardized "IQ tests," IQ is frequently considered to indicate "intelligence" in psychiatry and other health professional courses. Racist logic concludes from this consideration that blacks and Latins are intellectually inferior because their average test scores are lower. (Arthur Jensen, the leading racist proponent of the intellectual inferiority of blacks and the "hereditary" nature of "intelligence" was recently published, with a big publicity splash, a new book on the subject.) An excellent critique of IQ and all its racist interpretations is to be found in **Racism, Intelligence, and the Working Class**, published by Progressive Labor Party.
- Attempts to explain the higher rate of "psychosis (relative to "neurosis") among nonwhites rarely consider the racial and class biases inherent in the psychiatric diagnostic process. (see Thomas and Sillen.)
- Examples of racist conduct toward minority patients are all too common in **clinical training.** Just one of many examples: a "popular concept" in many medical schools and hospitals is PRH or PRS: "Puerto Rican Hysteria" or "Syndrome." Needless to say, this is a racist perception, has no scientific basis as a disease entity, and frequently leads to minimization and neglect of serious illness. (Medical sociology often teaches that there are different ethnic or national "patterns" of response to illness. We maintain that these claims obscure intro-group differences and contribute to racist stereotyping.)
- Finally, there is a deep-seated reductionist trend in all medical education. Biochemistry, physiology, pathology are stressed, while little emphasis is placed on the social determinants of disease, especially on the effect racism has on health. See "Racism and the Mass Diseases of Capitalism" in this pamphlet for an example of the kind of analysis that is sorely lacking from medical, nursing, and even public health schools.

Health CAR campaigns to expose and eliminate these racist and fascist ideas from medical education. It is only through the unity of all workers—minority, white, native-born, immigrant, professional and non-professional—that our strength as the producers of all goods and wealth can be realized, and used to make a socialist revolution. And only through seizing power from the racist ruling class can we develop and apply "good medicine" for the working class.

outright racist experiences at such hospitals. One administrator at New York Hospital (Cornell) was overheard to say that they "didn't take patients off ambulances." When asked why, he replied: "because they're black." Many minority patients are cared for by minority physicians. However, because many minority physicians have been denied admitting privileges in the nearby voluntary/private hospitals, their patients cannot get into these hospitals.

Financing regulations. De facto racial segregation exists in medical insurance coverage. A larger proportion of minorities, relative to whites, have public insurance (Medicaid, as opposed to private insurance, Blue Cross, Blue Shield, or commercial carriers). The fact is, the private hospitals prefer patients with private coverage. The reason for this has to do with the private physicians using the voluntaries. Private physicians generally dislike seeing patients with public insurance because the reimbursement rates are so low that honest physicians cannot meet overhead (e.g., $4 for an office visit); furthermore, the new Medicaid regulations are punitive to doctors by requiring complex accounting and mystifying rules for services rendered (e.g., no reimbursement for more than two blood sugars a year for diabetics). Reimbursement rates may also differ for the same service rendered to the same patient at different institutions. Medicaid pays a much higher rate to a city hospital than if the Medicaid

Closing of municipal hospitals like Sydenham which serve mostly minority workers, means death for patients and even more overcrowding at understaffed nearby hospitals—many of which are also threatened with closing.

patient went to a voluntary facility with a Medicaid contract.

Voluntary/private hospitals depend on good relations with their physician staff, because it is these physicians who fill up the beds and keep the hospitals full so they don't lose money. Therefore, the hospitals give priority to the private patients of the private physicians, and most of the beds are filled up with these patients. The result is that (disproportionately minority) publicly-insured or non-insured patients without private physicians who come to the emergency rooms get transferred to the city hospitals, or just go straight to the city hospitals in the first place. End result: medical apartheid.

HOW THE BOSSES BENEFIT FROM MEDICAL APARTHEID

Why do business and political leaders let this situation exist? Generally, when those in power permit some social practice to go unchecked, it is because they perceive it to be in their interests. There are two major ways in which medical apartheid benefits the corporate-political elite:

First, medical care segregation represents a tremendous savings in social service investment, very important in a period of declining economic fortunes for U.S. capitalists. It is estimated, for example, that the total difference between public and private hospitals in assets per patient day came to almost $2 billion in 1975.[10] This represents a considerable savings in resources which can be channeled into "needy" industries like Lockheed, Con Edison, or Chrysler, into energy exploration, or into the Pentagon's coffers. And this is just between public and private institutions. Think of the additional savings resulting from reduced expenditures on all those "service" wards.

Medical care segregation also divides the working class and blunts rebellion against service cutbacks. Cutbacks in services are hitting all sectors of the medical care system. This is a common and systematic plan on the part of the dominant interest in the U.S. Minority-used facilities may be getting "cost-contained" the worst, but staffing levels have been reduced in private facilities, and many of the smaller private institutions, servicing mainly the white working class, are being targeted for closing.

Clearly the bosses are afraid of struggle against cutbacks, like the armed strike of integrated coal miners against cuts in medical benefits. However, so long as it is possible for each racial group to regard one segment of the medical care system as its "own," then the progressive dismantling of medical services can proceed in piece-meal fashion. Whites can rationalize the inadequacy or deterioration of services in "their section" by considering themselves "better off" than minorities. In NYC this takes the form of "Montefiore or St. Luke's isn't so great, but thank God I don't have to go to Lincoln or Harlem." Likewise, minorities can

overlook cutbacks and closures in the private sector as having little to do with their "own" medical care needs.

In other words, **a segregated medical care system lowers the level of services for the entire working class** by making it possible for the ruling class to destroy workers' services in piecemeal fashion. **Medical apartheid politically weakens the working class by stopping united, multi-racial opposition to inadequate services and cutbacks.** It's no accident that fascist regimes, from the Nazis to South Africa, depend on racial segregation for their very existence.

What is the correct political strategy to take toward cutbacks? One approach very popular among sell-out union leaders and fake "radicals," is to oppose the continued cuts into the minority-used municipal systems ("fight the cutbacks") and thereby "maintain the integrity of the city hospitals." This is felt to be a strategy which would strengthen medical care overall and specifically oppose racism.

Cutbacks in municipal services certainly are racist attacks and must be opposed. However, a strategy to fight municipals cutbacks in order to maintain or even improve the established municipal medical system comes down to a defense of the old segregationist principle of "separate but equal." As we have shown, "separate but equal" not only means separate and **unequal**, but also inadequate for everyone. Leaving medical services for the poor and minorities segregated in one part of the hospital system makes all services vulnerable to being eliminated in New York, for example, but several thousand voluntary/private beds, many serving primarily white workers, have been scheduled for closing.

In New York, the mass protests against the closing of municipal hospitals like Sydenham and Metropolitan have been largely confined to minority workers (and politicians). Think how much more effective this struggle would be if black, white, and Latin workers in the city all demonstrated together against the closings of Sydenham and Metropolitan. And imagine if this fight were carried over to oppose the proposed cuts at the voluntaries!

Look at it another way. Suppose the South African government threatened to close "Johannesburg General," an all-black "public" hospital. Wouldn't it be a little beside the point to demand the mere "preservation of the integrity of the public sector"? The point is to smash the entire system of apartheid, once and for all. The only answer to cutbacks of medical services is to have a multi-racial, unified movement that demands NO CUTBACKS **plus** INTEGRATION OF THE HOSPITALS (i.e., SMASH MEDICAL APARTHEID). We need to build such a movement, and InCAR is taking the lead in doing so.

A PROGRAM TO SMASH MEDICAL APARTHEID

To stop cutbacks, we must end medical apartheid by demanding:

1. No cutbacks of any services.
2. Admission to all hospitals in given areas to be determined by lottery with the explicit purpose of integrating these facilities.
3. Admissions to any hospital be independent of ability to pay or relation to a private physician.
4. Private physicians to have full admitting privileges to all hospitals.
5. Adequate emergency beds be available in all hospitals.
6. Private physicians must make their services available to Medicaid-insured (or non-insured) patients in a proportion that reflects the proportion of these patients in that physician's area.
7. Medicaid reimbursement rates be made comparable to Medicare reimbursement rates.
8. Elimination of third party payments for health care facilities and physicians not complying with these standards of integration.

We urge that all readers involved in fighting medical cutbacks study the particular form that medical apartheid takes in their area and include a program to Smash Medical Apartheid as part of their struggle. PL★

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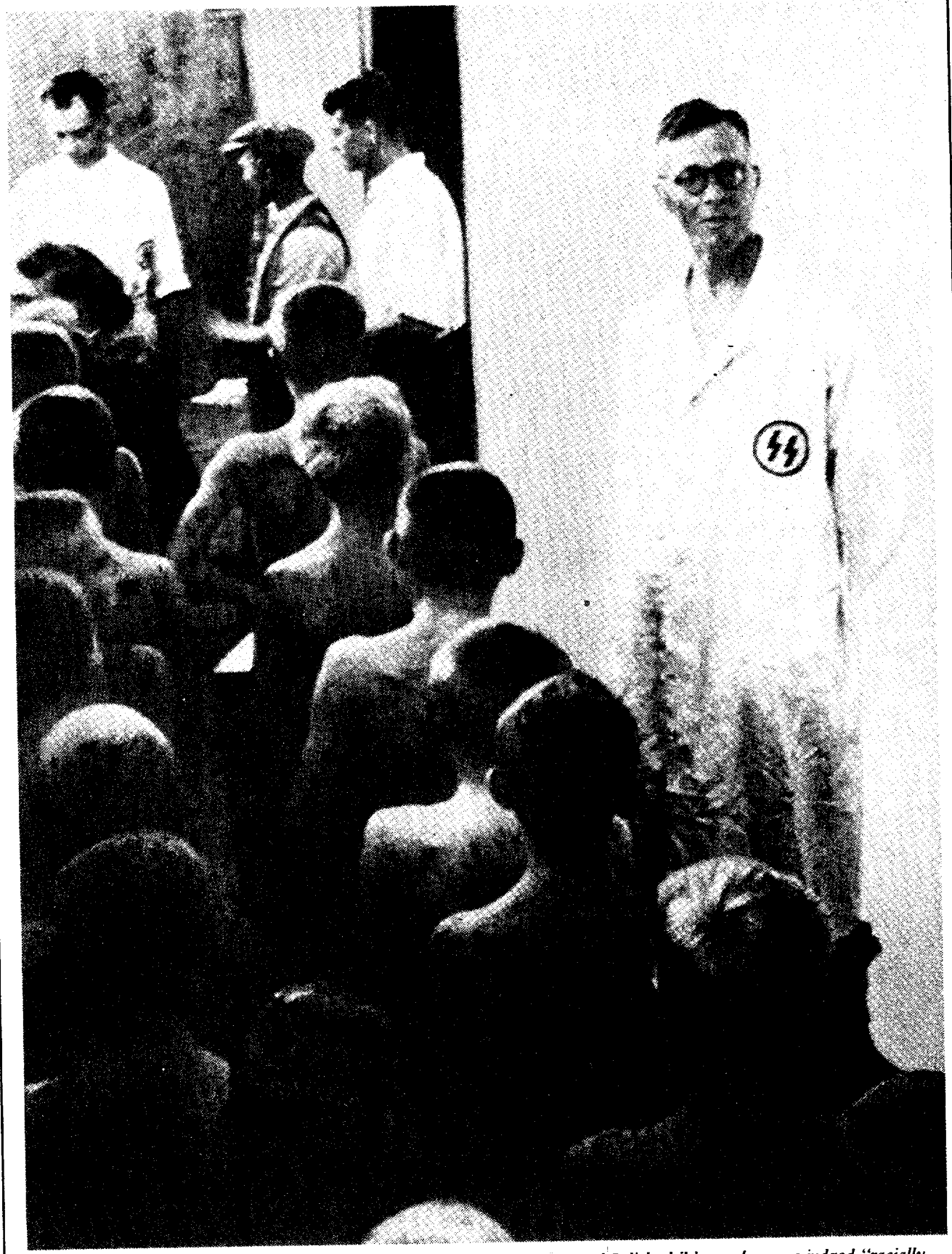


Nazi doctors, wearing SS insignia, are shown inspecting kidnapped Polish children who were judged "racially valuable" in building Hitler's "Master Race" of "pure Aryans." These racist theories of superiority are in no way different from the mouthings of Jensen, Shockley, Herrnstein and others who are receiving wide support from the ruling class.

By G.W.

It IS Happening Here

The Lessons of Medical Fascism

Most of us in the United States, who are used to living under "liberal democracy," assume that this will continue despite flaws in the system or economic ups and downs. We think of fascism as a completely separate entity, foreign to American traditions. However, we would like to convince you that "liberal capitalism" and fascism are but **two sides of the same coin**, and that the signs and symptoms of budding fascism are all around us, in health care as well as in other aspects of life.

WHAT IS FASCISM?

Fascism is government by open terror, under which civil rights (always limited for workers) disappear, and the organization of opposition or strikes is punishable by imprisonment or death. Under fascism, the biggest capitalists rule directly. They use intense nationalism and racism to justify their vicious attacks on workers. Fascism is necessary to those in power when the needs and aspirations of workers and intellectuals cannot be met because of economic decline and loss of flexibility and must be quashed instead. Such was the case in Germany as Hitler came to power (nurtured by the liberal Weimar Republic), in Iran, in Argentina, and many other lands. It is noteworthy that the U.S. openly support many fascists, such as the Shah, Marcos, and Pinochet, to name only a few. Invariably, fascism is justified to the masses of people by racism (problems are the fault of a particular group of citizens) and nationalism (problems are the fault of foreigners).

The U.S. ruling class (big business and the politicians they support) enjoyed rising economic prosperity and the political hegemony in the world

for the majority of this century, but lately things have begun to slip. For the last ten years the rate of profit of American business has been falling steadily, and the control of the U.S. over foreign markets and raw materials has been declining since Vietnam. Competition from Japanese, German, and Russian capitalists has grown stupendously until the U.S. is now in danger of serious shortages, especially fuel. Whereas the U.S. government could once rely on military superiority to take what it wanted, it is now a paper tiger that cannot protect its allies in Iran, scare the Russians out of Afghanistan, or force oil prices down. Thus, U.S. capitalism has had to keep afloat by trying to increase the rate of profit at home, i.e., by increasing productivity, lowering real wages, and **cutting services**.

Like other governments in trouble, the U.S. ruling class promotes racism and nationalism to take the heat off itself. Thus the campaign to blame unemployment on "illegal aliens," blame inflation and worsening services on the poor (Proposition 13, campaigns against "welfare fraud"), and blame decreased professional training opportunities on minority aspirants (the Bakke case). Theories of racial superiority which were anathema after WW II are now promoted openly by top universities and journals, which have disseminated the ideas of Jensen, Herrnstein, and Banfield (the genetic basis of intelligence and success), Moynihan, and E.O. Wilson (sociobiology). Activities of racial violence, such as KKK and Nazi rallies and crossburnings are guarded by the police, publicized by the media, and protected by the courts and the ACLU. Meanwhile, anti-racist activities, such as driving the Nazis out of Marquette Park, or the KKK out of Boston, New Jersey, and Tupelo by CAR and the Progressive Labor Party, are suppressed by the media and punished with arrests, fines and jailings.

Most fearsome of all, the economic and political decline of the U.S. rulers will inevitably lead to war. At some point, perhaps very soon, the government will find it necessary to defend its interests to avoid complete economic and political collapse, probably over oil. That those in power understand this is witnessed by the reinstitution of the machinery of the draft and the great increases in defense spending and maneuvers in the last couple of years.

HEALTH CARE UNDER FASCISM: THE GERMAN EXAMPLE

In health care the fascist trend has become apparent by the dismantling of the public health care system, from city hospitals to community clinics; the falling rates of immunization; the increase in epidemics such as VD and TB; the falling rate in medical insurance coverage; the increase in occupational diseases and accidents, the cuts in research; the increasingly white upper-class make-up of professional student bodies; the growth of medical mysticism; and the ready-made military enlistment of health professionals in the National Health Service (NHS). Let us look at what happened in Nazi Germany to understand the fate of public health under full blown fascism and then compare the results to what is happening here.

As a result of the Nuremberg trials, medicine in Nazi Germany is most well known for being used as a tool in the genocide of the gas chambers and in torture and genocidal experiments. But medicine under fascism was not limited to the 300-400 doctors and 1500 nurses estimated to have contributed directly to the atrocities. The entire field was brought under the tight control of the Nazi Party and directed towards the priorities of the ideology. Health workers and professionals capitulated to anti-scientific medicine, book burnings, firing of colleagues from the universities, and the destruction of medical ethics.

Theories of racial superiority are openly promoted by top universities and journals.

As early as 1933, a major reorganization of German medicine took place under Hitler's direction with the dissolution of the traditional Public Health Department and a new Council of Health formed with departments of "hereditary biology, race hygiene, nature care, and therapeutic cults." The public health priorities were: preservation of racial purity, encouragement of procreation of Aryans, and strengthening of the genetic pool by sterilization. (It should be noted that the eugenics laws enacted at this time in Germany were based on ideology developed previously in the U.S. and applied here in immigration and sterilization policies.)

Research on race was encouraged and required, but scientific research suffered as Nazism continued. The loss of thousands of Jewish doctors and scientists was part of the problem. The restrictions on reading reports and journals from Jews or non-Aryan publication were a problem. But the diversion of many doctors into industry and military responsibilities further weakened the research effort. It is no wonder that scientific dis-

War and the Health Professions

Doctors, nurses, allied and public health professionals will not escape the coming inter-imperialist war. You can be sure that the Pentagon recognizes the vital role of medical manpower and support services in wartime. The Department of Defense has approached the American Association of Medical Colleges (AAMC) for assistance in the recruitment and retention of physicians for the armed forces. (AAMC **Weekly Report**, 1/15/80). The AAMC has agreed to comply. This means a draft, and doctors, both men and women, will be prime draft bait. (They'll also need nurses, medical technicians, etc.).

It is not well known, but in World War II the Army and Navy inducted all of the (mostly male) medical students. These students received formal military training at nearby camps, and attended classes in uniform. Medical students were discharged only at the conclusion of the war (V-J day). This could easily happen again in time of war.

Modern Health Care for March 1980 reported that:

> The Dept. of Defense is seeking industry support of an emergency civilian and military hospital plan. DOD wants 50,000 civilian hospital beds to be on stand-by in case of military action. This contingency proposal, only in the planning stages, must be prepared during peacetime, DOD told those attending the AHA meeting in Washington, DC, last month. An office to work out the details is being set up by DOD Assistant Secretary of Defense for Health Affairs.

No doubt such a development will be accompanied by intensified publicity about the desirability of home-care for the civilian population—with emphasis on "dying at home with dignity."

If you doubt the potentiala for involvement of the health professions in a war in the near future, ask yourself the following question: If the government is not serious about it, why are they making all these plans now?

WHICH SIDE ARE YOU ON

The role health workers and professionals will play in the coming period of war and fascism is hardly academic, as history shows.

One approach was that taken by certain physicians in Nazi Germany who collaborated in mass and individual executions, in torture, and in the worst kind of medical atrocities ("experimentation"). Today we see efforts to enlist the medical profession in proto-fascist activities like executing prisoners with lethal injections (**NEJM**, 302:226-230), performing compulsory sterilization, or genetically " screening" workers for employment "fitness" (NY Times, 2/3/80, p. 1). (See also the article in this issue on "cost-benefit analysis.")

There is another route to take, however, that of mass, militant political struggle. Even under a repressive system, the possibility of anti-racist and pro-socialist activism exists. In the last years of Czarist Russia, many doctors saw the plight of poor peasants in the countryside at first hand. The doctors took the side of progressive social change and turned the meetings of the Pirogov Society (one of the few organizations allowed to meet openly) into open political forums. They declared, for example, that the best treatment for mass infection would be a literacy campaign and economic reform in the countryside. In 1941, Dutch physicians refused Nazi orders, under threat of license revocation and even death. They returned their licenses, saw their own patients secretly, no longer wrote death or birth certificates. Not a single "euthanasia" or non-therapeutic sterilization was performed by any Dutch physician (NEJM, 241:39).

These dramatic and heroic examples of health professional struggle against repressive regimes can—**and must**—be repeated in the coming period of war and fascism. To go the way of passivity and collaboration is to give up all aspirations to providing good medical care, and is ultimately suicidal.

The only "ethical"—and ultimately life-saving—alternative for health workers and professionals is to **refuse to provide support health services in the coming racist-imperialist war and to join with InCAR and PLP in turning the imperialist war into a "civil war"—for socialism.** Any part we can play in stopping the wholesale destruction and slaughter of the coming imperialist war will be a true contribution to medical care and public health.

Capitalism, with its "syndromes" of war, fascism, and depression, is very bad for your health. A good dose of revolution should be just what the doctors and the workers order.

coveries did not emerge from Nazi Germany. And even modern medical care was denied many of the soldiers and civilians because of a decline in training and education. For example, a review of medical care after the war revealed many unnecessary amputations.

Public Health in Nazi Germany. Consideration of the health of the population must first include the direct measures of the consequences of racism and war **in Germany alone**:

8,000,000 German soldiers killed in war
2,000,000 Jews executed by the Nazi regime
7,250,000 German soldiers wounded in war
2,500,000 German civilians killed in war
500,000 German soldiers and civilians executed for fighting the Nazis, disobeying Nazi orders, desertion, etc.

These figures speak for themselves. Of course, the health of the survivors deteriorated.

Although there was increased production of physicians and nurses after 1933, this did not result in increased health care delivery to the population. Thousands of doctors and nurses were drafted in the Wehrmacht, sterilization programs, and concentration camp supervision and experimentation. Hundreds were assigned for epidemiological control among millions of conquered foreign workers and immigrants. The waiting time for sick civilians was longer than previously.

Many diseases increased, including diphtheria, polio, scarlet fever, TB, and typhoid, which were significantly more common than in the U.S. and England, Rickets, malnutrition, and other vitamin deficiencies increased, as did alcoholism, suicide, prostitution, syphilis, and gonorrhea. Deaths among the elderly due to heart disease, stroke, and cancer increased. This was clearly tied to the marked reduction in medical care for the elderly, who were seen as neither a reproductive nor military asset. The Nazis themselves stated in 1944 that "the over sixties are in poor health because they are ill-cared-for medically." Rural citizens suffered because of fewer services, but also from an increased workload on the teenagers when older family members were in the factories or army (dental and orthopedic problems were most marked). Whereas nationally about 2% of young men called for military service were rejected, in the countryside it was as high as 40%. Increasing employment (for which Nazism is often touted as a good thing) had serious consequences for the working class. Hours of work were increased. Youth and even child labor was required as the Nazis prepared for world war. Industrial accidents and worker deaths increased. Although more doctors were directed to industrial clinics, the doctor/worker ratio decreased.

Medical Education in Germany. Medical schools followed the ideology of the Nazi Party. Courses in eugenics and race were required. Faculty positions were restricted to those who professed loyalty to the regime. A severe shortage resulted from this as half of the university teachers were dismissed by 1936 and 1600 scholars had been displaced. Younger university teachers in particular became scarce as Jews and leftists were driven out. At the pre-med level, chairs of race hygiene were created. In medical schools, "Nature Cure" chairs were established.

Winning over the youth had been a major part of the Nazi drive to power, and this was reflected in the militarism of the medical schools, where students wore military uniforms, were under surveillance by student fuhrers, and could have their lectures interrupted if the student fuhrer felt the lecturer was not following the precepts of National Socialism. Student organizations were systemically attacked by Hitler and most fraternities and even the liberal student Deutsche Bundeschaft capitulated to Nazism after goon squad attacks.

In an effort to increase the number of doctors, medical education was cut to two years, and specialization and research training declined.

In 1933 the newly created Eugenics Court specified sterilization for those with diagnoses of congenital weakmindedness, schizophrenia, manic depressive psychosis, epilepsy, chorea-minor, hereditary blindness or deafness, alcoholism, and bodily deformities. The professional organizations passed resolutions supporting these plans. Euthanasia became an extension of the earlier eugenics rulings, and during the war effort this was put use as the Nazis freed up 100,000 hospital beds by extermination of inmates of prisons and mental hospitals. (As an aside, the AMA opinion on euthanasia was that doctors should not allow themselves to be participants: "Medicine should let the persons responsible for introducing it do the killing." But no suggestion of organized opposition to such policies as a responsibility of physicians to preserve life was raised.)

Medical Science Replaced by Mythology. Redirection of health care under Hitler also carried a strong emphasis on "nature cure medicine." This represented a strong antiscience theme which was a part of the folk mysticism and racial myths on Aryan superiority interwoven with Nazism. Nature cure methods were raised to a level in government and academia equal to scientific medicine. A new cadre of "lay practitioners" pushed leeches, nasal reflex therapy, and homeopathy. Hydrotherapy and herbal therapy gained in influence; the study of astrology to predict epidemics was urged. A separate medical service was created with its own hierachy, professors, etc. The courts protected these practitioners even when patients died who might have been saved by standard medicine. The overall effect on health care is difficult to evaluate, but diphtheria statistics are worth noting since prophylaxis and treatment had had dramatic impact on this disease in the U.S. and England since 1920. In Germany the percentage of people with diptheria more than doubled between 1932 and 1938 and the death rate from diphtheria was four times as great in Germany as in the U.S.

The ideology behind nature cure medicine was important to the Nazis. It was linked to the "naturalness of the Aryan race" and the idea that right thinking and proper attitudes were the essence of health. A leading lay practitioner pronounced that the "hand of a true physician and a pair of soulful eyes . . . are of greater worth than physical and chemical apparatus." The "triumph of the will" theme was increasingly important in health care, and a leading surgeon described pain as an enobling experience. Death was emphasized as a family event in the natural order of things. Patients were urged to die at home rather than use up hospital beds.

CAN IT HAPPEN HERE?

Horrifying as it may seem, the parallels to U.S. medicine today are many. Medical care and education in the U.S. are almost as segregated as in South Africa. Only 6% of first year medical students in American schools are black, a mere 2% more than in South Africa and only 7% of nursing

PLP and SDS members drive racist Dr. Saul Krugman from the stage at a medical meeting. Krugman was being honored for Nazi-like experiments in which he deliberately infected retarded children at Willowbrook Hospital with hepatitis.

students are minority. Nearly all blue collar hospital workers, at least in large cities, are non-white.

Approximately 25% of U.S. citizens are without any form of health insurance. In New York City, the uninsured (poor workers and the undocumented) are not admitted to city hospitals, except in cases of imminent death, without payment of $720 cash in advance. For those patients who are insured and eligible for hospital admission, racial segregation is striking, even though Blue Cross, Medicaid, and Medicare pay hospitals comparable fees. At New York City voluntary hospitals, about 70% of the patients are white, while in city hospitals, two thirds are minority, and most of the white patients are the elderly on fixed incomes. Cutbacks in hospital beds and workers have affected all stratas of the population, but they struck much more heavily at minority communities.

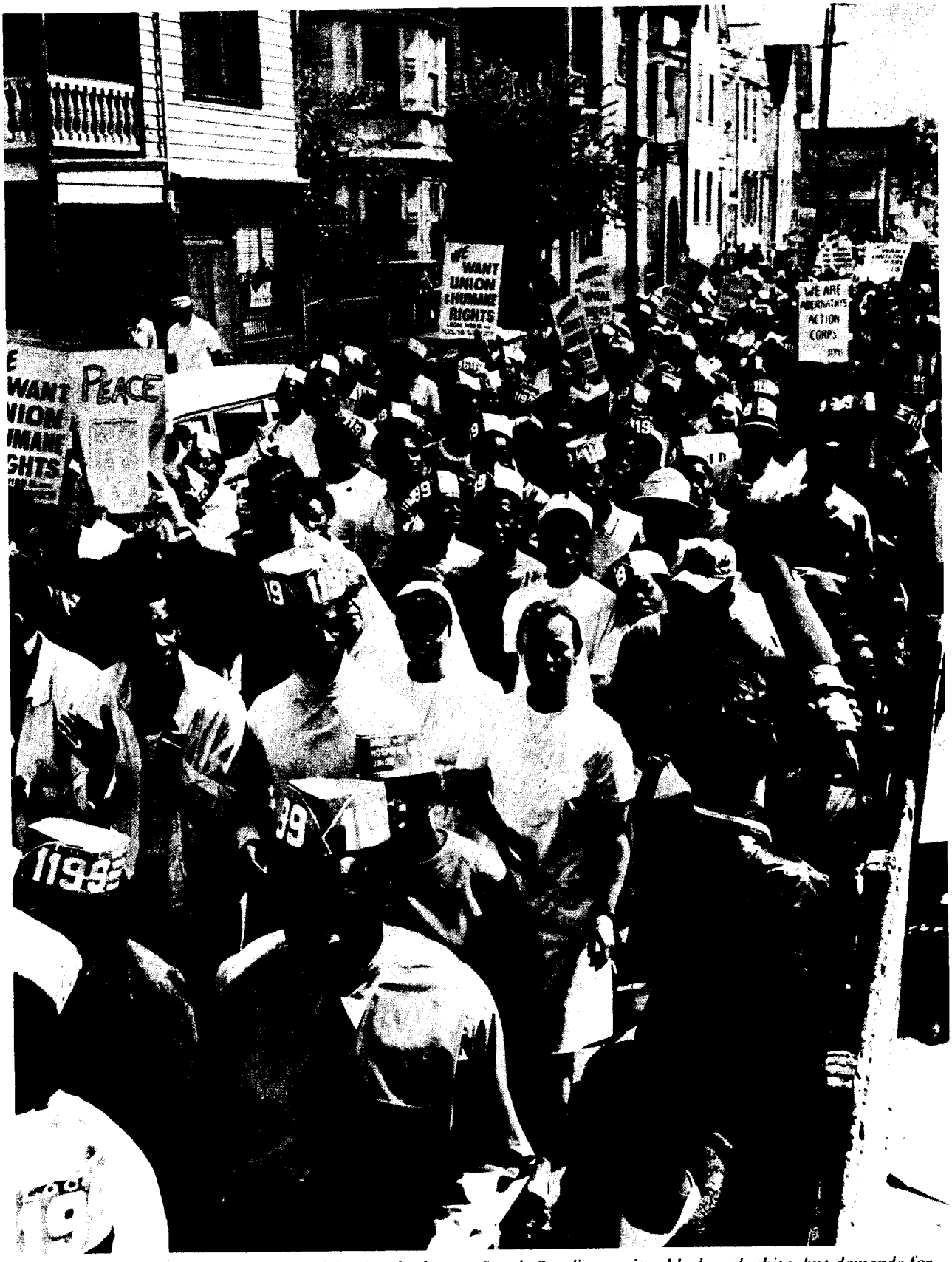
Medical Mysticism. Another major trend in the U.S. is towards herbal medicine, alternative health care, self-care, and mysticism. Although many of the problems addressed by these trends are real, such as the lack of prevention or compassion in conventional medical practice, they offer no solutions and serve only to decrease the demand for increased and improved medical care. For example, the 1978 APHA (American Public Health Association) convention devoted an entire closing session to "future trends in health." Instead of pointing out the need to fight harder in the coming period, there were calls to relax and meditate as opposed to fighting stressful conditions of life or work. A speaker for holostic medicine proposed treating gallstones by applying finger pressure to the head.

The decision of HEW to study Laetrile, a drug with harmful effects and no evidence of benefit, which is promoted by the John Birch Society, while legitimate cancer research is being cut, is another example. This anti-science trend has always blossomed under fascism, for it fosters the acceptance of irrational racist theories and counteracts the trend to fight for better, more, and more humane medical services.

PARTICIPATION IN MURDER BY THE STATE

Recently the New England Journal of Medicine (302:226, 80) reported that four states, have enacted laws allowing physicians to aid in carrying out the death penalty by prescribing and administering lethal intravenous drugs to condemned prisoners. The justification for this procedure is that death by pharmalogic means is "more humane" and may encourage more frequent imposition of the death penalty. Even the authors of the article note the similarity to practices in Nazi Germany, but they fail to grasp that involving professionals in state ordained murder is part of the analagous growth of fascism here. Doctors and medical students in HCAR and PLP are fighting this move by presenting resolutions against it at all meetings we attend.

In other sections of this magazine we discuss in detail potential fascist developments in such areas as minority admissions, medical care segregation, medical and nursing education, and national health insurance. We in CAR who are particularly interested in health care call on our colleagues to take a firm stand against segregation, cutbacks, and mysticism in health care. These trends not only hurt the poorest and most oppressed workers and patients, but they lower the standards for all, divide us from one another, and create a climate for more cutbacks. We are building a multi-racial, rank-and-file led organization that calls for integrating all hospitals, increasing minority admissions, increasing care and research funds, and barring racist teachings in health education. We believe in fighting back militantly, as well as with words, because of the imminence of war and fascism in the U.S. and the life and death questions posed for us now. PL★



Hospital workers' organizing drive in Charleston, South Carolina, unites black and white, but demands for "Peace" and "Union and Humane Rights" will not make a dent in the bosses' attack on affirmative action in hiring and training. The leaders of many unions, including 1199, take active or passive roles in helping the ruling class gut affirmative action and permitting continued racist hiring practices. The fight for affirmative action calls for multi-racial unity and the unity of professionals and non-professionals.

By N.R.C.

Kicking the Minorities Out

The Attack on Affirmative Action

We have discussed throughout this magazine how the major trends in public health and medical care today can best be understood in the context of a drive toward war and fascism in this country. The entire affirmative action controversy, which has had particular relevance to the health professions, is no exception.

History is instructive here. The Nazis didn't kick Jews out of the health professions all at once. Instead, they implemented a whole series of laws and academic "standards" which resulted in the elimination of Jews and political activists from the professions.[1] Loyalty to the Nazi regime and "racial purity" were the "criteria" for admission. In South Africa, to look at another example of "affirmative action" under fascism, blacks are trained at only one medical school and account for 4% of medical students.

Affirmative action, which is supposed to increase the number of minority students in the health professions and elsewhere was forced on the U.S. ruling class by militant struggle. Despite this, they have, from the very beginning, tried to get affirmative action programs. One method has been to popularize the idea that it results in fewer opportunities for whites—so called reverse discrimination.

A little publicized fact about this is that "reverse discrimination" is a lie, a flat-out statistical untruth. First of all, minorities are hardly getting any "special deal" through affirmative action. After nearly a decade of programs supposedly designed to integrate graduate schools, the minority percentage of law and medical school students does not even approximate their percentage in the national population.[2,3] In fact, the percentage of first year black medical students peaked in 1974-75 (at 7.5%) and has declined or remained the same

The Bakke case, built around the lie of reverse discrimination, was one of the bosses' key tactics in driving minorities out of medicine. PLP and InCAR were active in the campaign against the decision.

every year since then (6.4% in 1978-79).[2] New York City medical schools had **fewer** minority students enrolled in 1976 than in 1971. [4]

The other side of the fraud of "reverse discrimination" is that whites actually benefitted from affirmative action programs. Between 1968 and 1974, fully 4900 new medical school slots were created. White students received 77% of them. The number of first year medical places held by whites increased by 49% from 1968 to 1976. This pattern holds elsewhere. 65% of students admitted to colleges under the New York City Open Admissions Program, supposedly a big plum for minorities, were white. An interesting corollary of the benefit to whites during the period of affirmative action initiatives was the increase in the percentage of women and "low-income" white working class students.[2,5]

Anti-racism in general, and affirmative action programs in particular, do not benefit one group at the expense of another, but in fact expand services and opportunities across the board. This "anti-racist multiplier effect" represents the spread of protest against the most glaring example of social inadequacy, racism, to the system-wide inadequacies affecting everyone. The anti-racist movement and rebellions of the 1960's led not only to affirmative action, but also to the concept of a nation-wide "doctor shortage."

THE ATTACK ON AFFIRMATIVE ACTION

It is no accident that the "reverse discrimination" "controversy" hit the headlines at a time when the economy is in trouble and employment and educational opportunities—even for middle class, college-trained young people—are shrinking. The Bakke and Weber cases are part of a campaign that has been waged for several years. The goal of this campaign is to convince a large number of whites, particularly students and workers, that whites as a group are suffering "reverse discrimination," and, therefore, minorities are the source of the reduced opportunities and general deterioration in the standard of living. By focusing attention on mythical privileges minorities are supposed to be enjoying, the press and university officials hope to pit whites against minorities and men against women and thus prevent them from uniting to fight the cutbacks. At the same time, the ruling class wants to convince minorities to rely on "their own kind" (i.e., minority politicians and businessmen), instead of their brothers and sisters among workers and students, to fight racism and worsening conditions.

The anti-affirmative action campaign has had its effect, as demonstrated above by the declining black enrollment in medical schools. It is noteworthy also that, following on the heels of the decline in minority enrollment, there has begun to be a decline in the number of low income whites admitted to medical school and, for the first time in nearly a decade, a **decline in the proportion of women enrolled.**[2] All of this has occurred in conjunction with a series of reports[6] claiming that there is no longer a doctor shortage, that in fact

there may even be a "doctor glut," necessitating the restriction of medical school slots available to aspiring physicians!

The lesson here is clear. Anti-racism (e.g., affirmative action struggles) expands services and opportunities for blacks and whites, men and women. The reversal of anti-racism leads to a decline in opportunities, again for everyone.

One of the major points made by the affirmative action struggles was that the admissions criteria leading to such a low proportion of minority students were objectively racist, an example of institutional or "de facto" segregation. In other words, it was not that minority applicants with lower grades or standardized test scores were "less qualified," but that these grades and scores themselves were "unqualified" to determine who would make a good doctor (or nurse, or lawyer, or whatever). There is, in fact, no evidence to show that the traditional admissions criteria predict those qualities that are most relevant to becoming a good physician.[7,8] Furthermore, broadening of the admissions criteria that came about through the affirmative action struggles allowed additional women, working class whites, and older individuals, as well as minorities, to gain admission to medical school.[9]

Anti-racism expands services and opportunities for blacks and whites, men and women.

The anti-affirmative action campaign has attacked this broadening of admissions criteria and has attempted to legitimize the traditional—and exclusionary—criteria. This legitimation takes the form of saying, or implying, that individuals with higher grades or test scores are really "more qualified." This move to reaffirm the validity of the old criteria is tantamount to legitimizing (and legalizing, with the Bakke decision) institutional segregation. If traditional minorities have lower scores by these traditional criteria, then it follows that these traditional criteria are racist. It is analagous to the old Jim Crow practice of denying voting rights to blacks if they couldn't recite the entire U.S. Constitution by memory. "It's not because they're black, you understand, it's just that they don't measure up to the 'admissions criteria' (reciting the constitution by memory, scoring high on standardized tests). "It can be seen that there is not much difference between this kind of institutional segregation and the direct "for whites only" variety practiced in South Africa. **Medical Apartheid** is indeed an apt term for this situation.

SMASH MEDICAL APARTHEID—INTEGRATE THE HEALTH PROFESSIONS

Much of the affirmative action controversy has centered about quotas. InCAR believes that the struggle for fixed percentage minimum quotas for minority admissions is the only way to guarantee the integration of the health professions. "Goals" and "good intentions" just won't do the trick, as recent declines in minority enrollment have demonstrated. The quota should be set at 20-25%, **more** than the mere minority percentage of the population at large. True integration of the professions, given the abysmally low minority representation today, requires a proportional influx of minorities **greater** than the population proportion. Furthermore, the resulting potential multi-racial unity within the profession, coupled with the anti-racist political leadership given by many additional minority students and professionals, can provide the overall political thrust within the professions to help stem the tide of cutbacks in services and manpower, and help thwart the general drive toward fascism in medical care.

PL★

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By S.N.

Keeping It White

Racism in Nursing

Racism is woven into the fabric of the American health care scene, so its existence in the field of nursing is no surprise. As nurses, we are taught to treat the whole person and we come to believe that race does not affect how we treat that individual. Nurses are the victims of the system that oppresses us all. We blame the problems in health care on the politicians, administrators, unions, and physicians. Everyone is at fault except the mainstream of nursing. We forget that we are socialized into the culture of women becoming bosses, and getting their share of the pie through "professionalism" aided with the appropriate regalia of academia. We consider ourselves to be very different from those people who create the health care system. We need to stop and take a look at some of the trends and realities of nursing today to discover the racism in nursing.

MINORITY REPRESENTATION IN NURSING

The representation of minorities in nursing remains poor. According to a September 1977 survey, an estimated 87,386 registered nurses in the U.S. (6.2 percent of the total registered nurse population) had racial and/or ethnic minority backgrounds. About 2.5 percent of the total population were black; 1.4 percent, Hispanic; 0.2 percent American Indian, and 2.1 percent, Asian. About 1.5 percent did not report their racial/ethnic background.[1]

Despite the rhetoric of affirmative action, the number of black graduates from schools of nursing dropped from 1972 to 1978. In 1972 5.5% of the nurses graduating were black; by 1978 this number had dropped to 4.7%. Hispanic graduations have increased slightly from 1.5% in 1972 to 3.2% in 1978, but the category of "Hispanic" was

Despite chronic nursing shortages, leaders of many nurses' organizations are more concerned with limiting the number of minority nurses and building professionalism than with improving conditions for nurses and patients.

also expanded. Native American and Asian graduations have increased from 0.7% in 1972 to 1.3% in 1978. Overall the percentage of minority graduations from nursing schools has increased slightly from 7.8% in 1972 to 8.1% in 1978. Most of these increases have been at the associate degree level. All minorities are better represented in schools of practical nursing.[2] The increase of minority graduations to 8.1% is only slightly above the percent representation of 6.2% of the nursing population. This increase does not reflect a strong response to affirmative action.

Admissions have increased, but the attrition rate is very high, especially in baccalaureate programs. The lower number of graduations compared to reported admissions and enrollments suggest especially high attrition rates among men and minority students.[3] Some work has been done to help the minority student with nursing education. Grete Malhiot and Mary Ninan, in an article in **Nursing Outlook**, describe a seminar for minority students aimed at academic assistance, emotional and social support, and problem-solving.[4] Their group dealt with the discrimination and feelings of non-acceptance that many minority nurses feel.[5] Other trends in nursing education reflect increasing racism. David Stronch, also writing in **Nursing Outlook**, makes the recommendation that schools of nursing move toward use of grade point average in prerequisite courses (Anatomy, Biology, etc.) and standardized tests.[6] Stronch cites the Bakke reverse discrimination case as the reason why colleges are reevaluating college admission criteria. He states in the beginning of the article that another researcher noted "the use of the SAT decision rule was found to be drastically discriminating in its consequences; almost all non-white candidates in the applicant pool would be excluded from the group accepted."[7] He then goes on to state that most multiple admissions criteria are inappropriate and unsupported by research data. He recommends that colleges weigh grade point averages depending on the "quality" of the institution awarding the degree and the rigor of the course. He closes his article with "Probably the use of achievement tests will continue to grow and to replace many of the other admissions criteris."[8] The logic of the position is continued exclusion of minorities.

Nurses have historically been recruited from the working class of society.[4] Nursing has been a ticket for many working class women to a stable, **relatively** well-paid profession. The above statistics indicate that the recruitment has been primarily from the white working class. Minorities have been involved in hospital work but have been filling the low paying, physically exhausting jobs. This trend has yet to be reversed.

THE 1985 PROPOSAL

The 1985 proposal would require the professional nurse to graduate from a four-year college program. Graduates of associate degree programs would qualify as nurse technicians. The 1985 proposal would further exclude minorities from the ranks of "professional" nursing. Black nurses are more likely than non-minority nurses to have taken their basic nursing preparation in associate degree programs. About 30 percent of the black nurses initially had been graduated from AD programs compared to 11 percent of the non-minority nurses.[10]

Nurses have nothing to gain by 'catching up' in a glut of self interest.

The 1985 proposal promises to create a caste system in nursing where people from poorer, working-class backgrounds would attend two-year schools, while those who can finance a four-year education would attend the colleges. The college graduate will have exclusive access to graduate education and leadership positions in both nursing education and delivery of nursing service. The gains in minority admissions and graduations has mostly been seen at the associate or diploma level.

Nursing leadership wants to set "high standards" for the profession. Standards that build in racism, as the 1985 proposal would do, are not what is necessary. One way to set standards without excluding minorities would be through the "career ladder concept" in nursing education. With a career ladder a nurse could complete a two-year degree, work for several years and then return to school to complete the upper division of a Baccalaureate program in a two-year period. This program would be specifically designed for the returning nurse and be flexible so that a person could go part time or at night. There is, however, debate about the ladder concept in nursing. Some nursing leaders state that the path between the two-year degree and the four-year degree is not continuous, that there is **no** relationship between the content of associate and BSN programs.

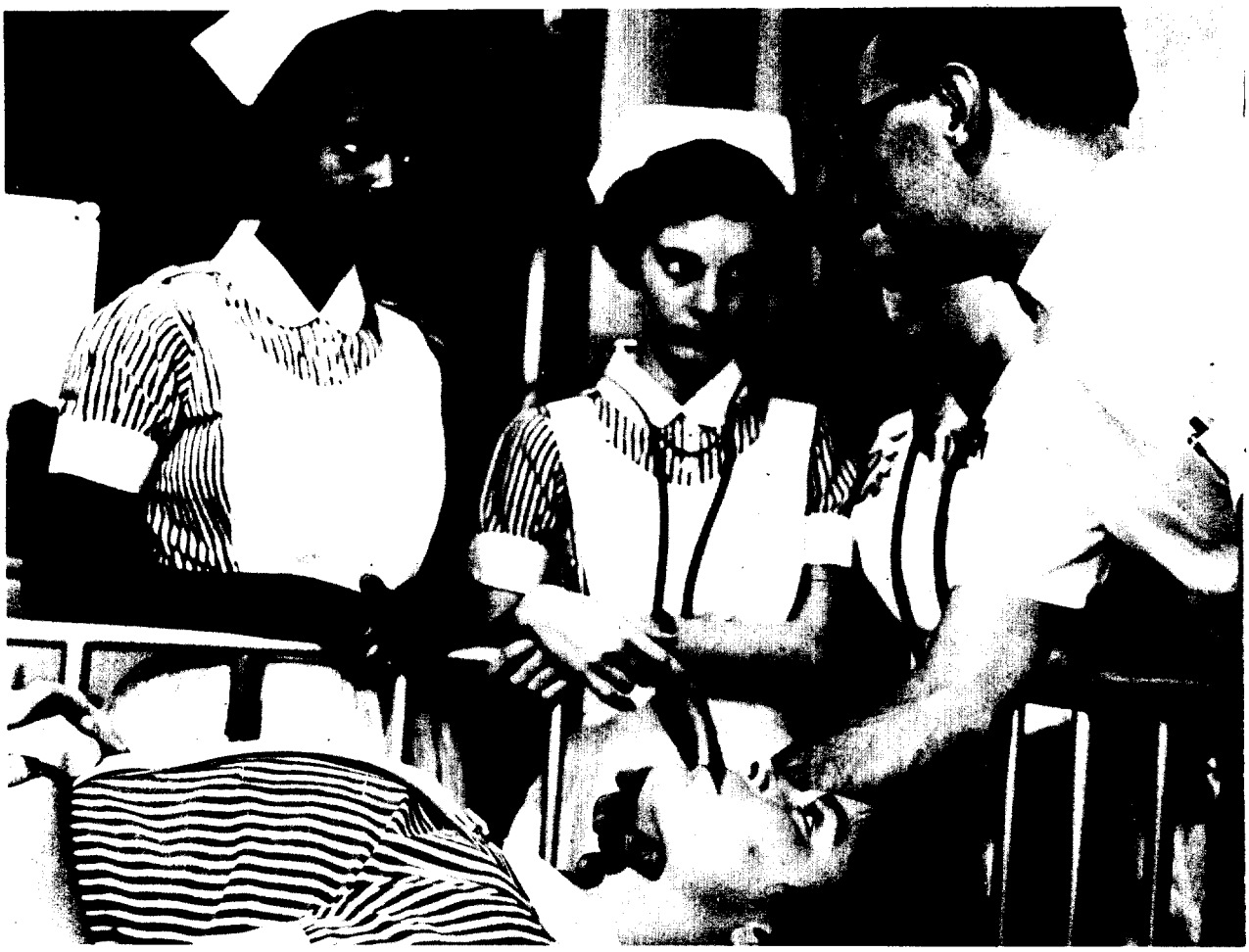
Presently the diploma and associate degree student receives little credit for her professional experience. Not only do they often have to complete all the academic coursework and clinical time but they are treated in an inhumane way as second-class citizens with no recognition for their often excellent clinical competence. In a recent survey of 10,000 RN's done by RN magazine, 91% favored the concept of a career ladder. Despite the opinion of the rank and file nurse, the nursing aristocracy continues to plan in the most provincial, conservative, and **racist** way. Nursing is unable to consider the feelings of its membership. It is not surprising, given this climate, that nursing leadership is unable to effect a real advocacy role for its future minority members.

TRENDS WITHIN NURSING

Nursing leadership talks about making changes in the health care system but there has been little real progress. Present struggles within nursing are concerned with "self-definition," or generating criteria to establish a nursing elite (the Certification Movement).

The idea that health and capitalism are not synonomous is absent from nursing curricula. Nurses have poor status in the present system and the efforts of the present nursing elite is geared toward increasing their status within the system. Nurses and women have been oppressed for many years and are appropriately angry. Nurses deserve decent working conditions, better monetary reimbursement, and recognition for their important work. Building an exclusionary, elitist system that helps a few gain more status does nothing to change the day-to-day working conditions of the average nurse. This system, designed to increase status in a capitalist system, is built on racism. Nurses have nothing to gain by "catching up" with doctors, administrators and the like in their glut of self-interest and self-promotion at the expense of other working people.

Nursing is presently involved in a struggle to prove through research that caring, competent nursing care not only makes a difference but is critical for recovery. The truth is that **everyone already knows that**! That's why nurses are tripping over themselves at places like Harkness Pavillion at Columbia, when down the hall on the "ward service" there is not a nurse in sight. Administrators know that good nursing care is important. They just do not want to pay what it costs. The bosses at the "Big Banks" who decide



If nursing leaders have their way, the black student above will be gone from the training program, as the 1985 Proposal and other anti-affirmative action programs further divide health professionals on racial lines.

to cut services are very aware of the ramifications of their actions and mountains of nursing research will do nothing to change their minds.

The rhetoric of justification for this period of retrenchment in health care has become the major activity of some "authorities." "Cost containment" is the new buzz word in schools of nursing without a critical assessment of the ramifications of this concept. The trend toward fascism encourages administrators to say things like "you can't prove all this health care makes a difference," as a rationalization for health care cuts. It is true it won't make *any* difference to *them.* They won't die in the emergency room at Metropolitan, be denied medical care because they can't pay, or sustain horrible conditions on a day-to-day basis.

The nursing hierarchy is not an activist political force in health care. Nursing today is in collusion with a system that supports profits not people—and racism lies at the heart of that collusison.

It is the job of Communist nurses in PLP and anti-racists to build support for a militant, multiracial, rank-and-file alliance against the bosses who oppress all working people. And it is the job of Communists to show tirelessly, in every way, that racism, poor health care, and degradation for nurse and patient can never end unless the capitalist system which profits by it is smashed.

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By D.H.

Medical Triage

Cost-Benefit Analysis, Profits and Health

Many articles have been appearing in leading medical and social science journals about the need to "ration" health and other social services in this era of "shrinking resources." A number of these articles employ "cost-benefit analysis" to determine, using various statistical and economic calculations, whether certain forms of medical therapy are really "worth it."

Recent issues of the prestigious **New England Journal of Medicine**, for example, have examined the characteristics of users of expensive intensive care units (302:938-942) and of high-cost care in general (302:996-1002), and the cost-effectiveness of "high-technology" therapy in the treatment of acute leukemia (white blood cell transfusions, bone marrow transplants, etc.) (302:1058-1062). The editorial entitled "Can We Afford to Treat Acute Leukemia" (302: 1084-1085) was particularly revealing. The author argues that continued expenditure for research in and treatment of leukemia **is** warranted because such treatment and research have great potential for leading to other important medical discoveries in cancer molecular biology, immunology, etc. Suppose, however, that certain "expensive" treatments have little potential for advancing medical knowledge, but merely keep patients healthy, alive, or comfortable. Should these treatments be abandoned?

The line of argument advanced in these analyses represents a very dangerous trend. In essence, what these articles are doing is presenting a rationale for withholding and ultimately doing away with health services. Seen in the context of the bosses' increasing diversion of resources from social services to the military and industry—a diversion which is necessary for the development of fascism—these articles provide the intellectual justification for the development of

Capitalism reduces everything to commodities, even the lives of workers. Figures are from a New York State Health (!) Department study on where it was financially worthwhile to clean up water supplies—and where it was not.

fascism in medical care. Two specific fallacies underlie this kind of thinking.

The first is that the calculation of "benefits" is not straightforward statistics or economics: it involves some very heavy value judgments. Sometimes "benefits" are equated with years of life saved; a year of life is determined to "cost" so many thousands of dollars. Other calculations look at benefits in terms of lifetime earnings; an investment of so many dollars in medical care will yield a return in so many dollars in lifetime earnings.

Problems emerge immediately. How many dollars is a year of life worth? $10,000, $100,000, or even $1,000,000? If you decide that a year of life is worth $100,000 this year, does the value go down next year if the economy gets worse (and less money is available for medical care)? If earnings is your criterion, how do you evaluate the "benefits" of treatment aimed at individuals who are disabled or too old to work?

The essential fascist principle in this type of thinking is that some people are "worth more" than others, or conversely, that some people are more "expendable" than others. The calculations merely aid in figuring out who the expendable ones are. You can see the ominous redefinition of "expendable" that can be made. First, it's just very old people with severe mental deterioration. After all, these people have no earnings capacity, won't live too long anyway, and have low "quality of life" value.* Then it's the terminally ill or the insane who are defined as "expendable," followed by the very old in general (regardless of their mental functioning). Then it could be prisoners, racial minorities, anti-racisits, union leaders, communists, etc.—all defined as having "inferior social value," as "expendable." Sound familiar? This is just the kind of "expendability" analysis that the Nazis engaged in—with a little help from their fascist medical professional friends. The Nazis found, incidentally, that the most "cost-effective" "treatment" for "expendable" people was the gas chamber and the oven.

Second, the fundamental assumption behind all this analysis is that there are fixed or diminishing resources available for health and other social services. The notion of "available" resources, however, must be looked at in the context of where capitalists are presently investing or planning to

*Yes, they even have a "correction" factor in cost-benefit analysis for "quality of life" (*NEJM*, 296:716-721). This is meant to refer only to the comfort and functioning of individuals receiving chemotherapy, kidney dialysis, etc. You can imagine, though, that under conditions of fascism, medical treatment might be withheld from workers and communists because their "quality of life" is low—at least as far as the bosses are concerned.

invest resources. Does it really follow that there is not enough money available to give intensive care to older workers while we spend literally billions on foreign "aid" and military hardware for various dictators around the world (El Salvador, Chile, Philippines, etc.)? Can we really not afford to have expensive, but often **life-saving**, CAT scanners in city hospitals while the Pentagon considers spending $33-50 billion to put missiles on railroad tracks (the MX system)?

Furthermore, capitalism, by its very contradictions, limits the amount of resources available to society. Socialism, based on a progressively egalitarian and collective mode of production, would lead to a qualitatively greater production of resources available to meet all social needs, including public health and medical care.

So long as billions of dollars are being spent on war and repression at home and abroad, "cost-benefit analysis" of health services investment is completely invalid. We believe this kind of analysis should be **abandoned.** Medical professionals need to organize, along with other workers and students, to protect and expand the level of health services, not to collaborate in their elimination.

DOES CAPITALIST MEDICAL CARE CREATE PROFITS?

Underlying much of the discussion on cutbacks in medical care is the question of whether medical care produces surplus value. This question is a tricky one. There has been a tendency in some of our earlier writings (see **Racism Ruins Medicine**) to deny that medical services create surplus value because this was seen to imply that the ruling class would always want to **expand** services to increase profits. The fact is, medical care can be a profit-making venture and, **at the same time,** the bosses will try to cut back medical care. This works as follows:

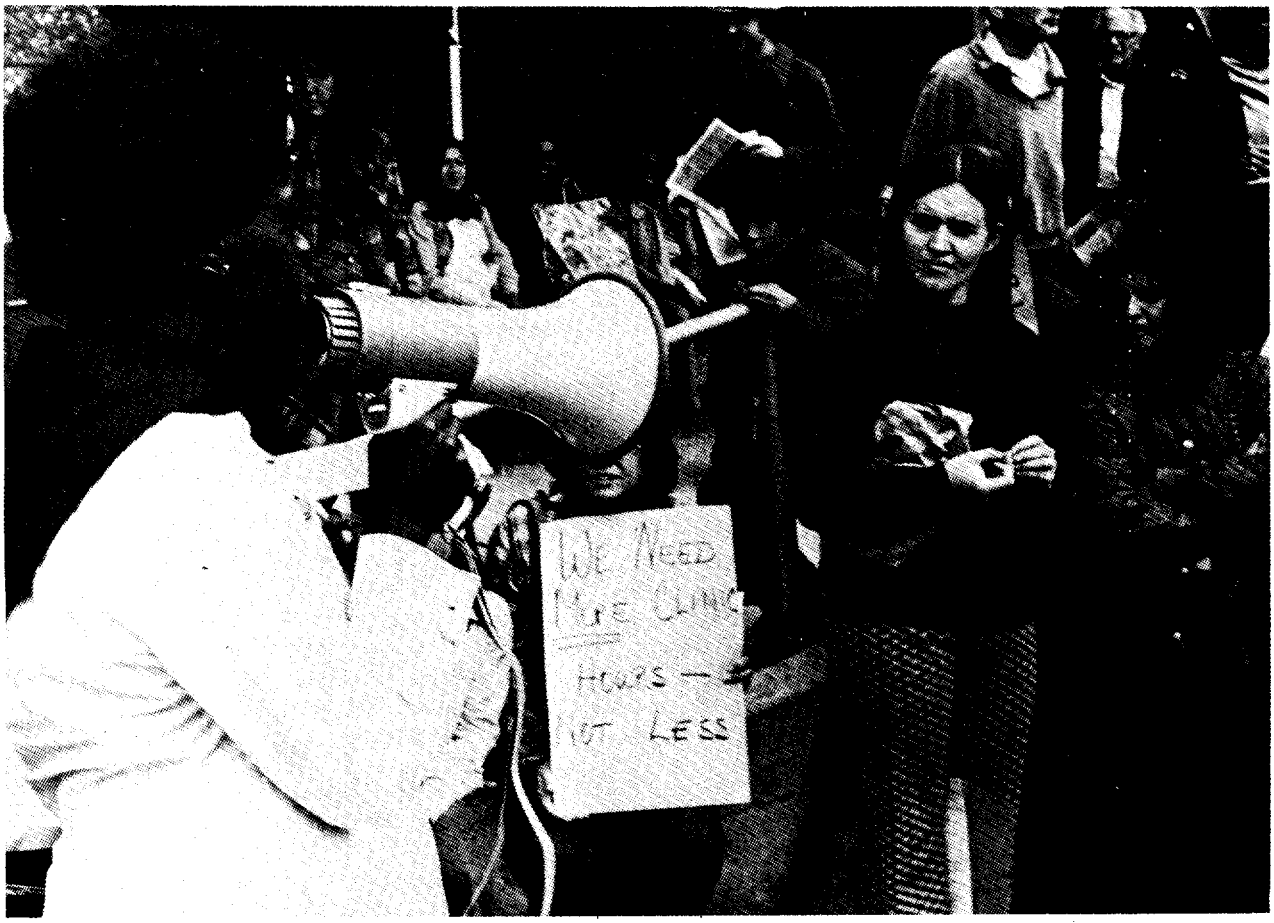
All commodities purchased by the working class have two aspects. On the one hand, they are purchased out of wages. On the other, they create profits for the capitalists who produce the commodity. This goes for shoes, breakfast cereal, movie tickets—and medical services. Medical care, like sanitation and education, is a **social** wage and, like all forms of wages, reduces the surplus value available to the bosses. At the same time, medical care produces big profits for vari-

There's Gold in Them Thar Pills

There are indeed big profits in medical care for various capitalists. The profits of drug companies, equipment manufacturers, and clinical laboratories have been most publicized. With the exception of two of the years from 1963-1976, profits in the pharmaceutical industry were at least 45 per cent higher than the median for the 500 largest corporations (McCraine and Murray, **International Journal of Health Services**, 8:573-587). The hospital supply industry is predicted in one study to show a 10% to 15% profit gain in 1980, with earnings rising to almost $1.1 billion from about $945 million in 1979 (**Modern Health Care**, Feb. 1980, p. 98).

Profits are also being made more and more from the direct rendering of services. There is a definite trend toward private capital "reorganizing" the delivery of certain services, like nursing homes, kidney dialysis center, and home care. In fact, a number of big conglomerates (e.g., Humana, Inc. and National Medical Enterprises) are buying up hospitals and creating chains which are turning a tidy profit. National Medical Enterprises, for example, made some $34 million in profits just from its hospital holdings in 1979. Some companies, like American Medical International (Beverly Hills, Calif.) and Nashville-based Hospital Corporation of America are even engaging in **medical imperialism.** They are constructing and managing hospital chains in Europe, South America, Egypt, Saudi Arabia, and Pakistan. These companies expect "international operations" to become "a larger and larger part of our operations" (**Modern Health Care**, Feb. 1979, p. 46).

Too bad for these bosses that the really big boys in the capitalist class need to cut back medical care in the coming period. Tanks and missiles are more important now than pills and EKG machines.



As the U.S. ruling class declines, more and more workers face health care cutbacks. Here, workers and patients at California's Kaiser Clinic demonstrate against cutbacks in clinic services, demanding more, not less.

ous capitalists (see box).

The decisive factor in this contradiction is the economic and political crisis of U.S. capitalism: the bosses are **forced** to cut the general level of wages, so that more profits are available to rescue "needy" industries and to expand the military and the energy sector. This means that less goods will be purchased by the working class, inventories will swell, layoffs will occur, and the excess industrial capacity will contribute to a falling rate of profit. (See **PL Magazine**, July-August, 1978, Vol. II, No. 2, "The Falling Rate of Profit.")

Remember, though: the reason that the capitalists cut wages in the first place was to **increase** their profits. Capitalists must reduce wages, even if it means that certain profit-making commodities (**including medical care**) can no longer be purchased or provided.

There is much room for research and debate on just how much of medical care is "productive" (creates surplus value) or "unproductive" (drains surplus value). The big profits in certain industries may be balanced by relatively low productivity, even losses, in other areas. But **regardless of how productive or unproductive health services are, the bosses will cut these services (social wages).**

One source of confusion on this question may be the difference between income wage cuts and social wage cuts. Each individual capitalist tries to keep his workers' wages down as best he can. The reduced buying power of these workers will be felt "through the market." Bosses will then complain about the **general** problems of inflation, recession, deficits, etc. Cutbacks in social wages like medical care, however, require visible policy decisions, whether it's closing hospitals or cutting back insurance funds (Medicaid and Medicare, union health benefits, etc.). Therefore, certain medical care industry bosses can **directly** oppose service cuts because such cuts will reduce **their** profits. Our **political** prediction is that the big-money groups in the ruling class will prevail and go ahead with the cuts; they **must** reduce wages in order to restructure industry and "reorient priorities." The drive toward greater state control and fascism (perhaps facilitated in the health sector by the growth of medical conglomerates) will enable the big bosses to bring the small-fry medical care capitalists into line.

One thing is clear: it is certainly to the "benefit" of the working class and its professional allies to do whatever it costs to cure the world of capitalism and its bosses.

By A.T.

National Health Insurance: A Bitter Pill

In the U.S., it is easy to tell when it is near Presidential election time—the politicians rediscover National Health Insurance. Promises are made, analytic pieces appear in the mass media, and then all is forgotten for a few years.

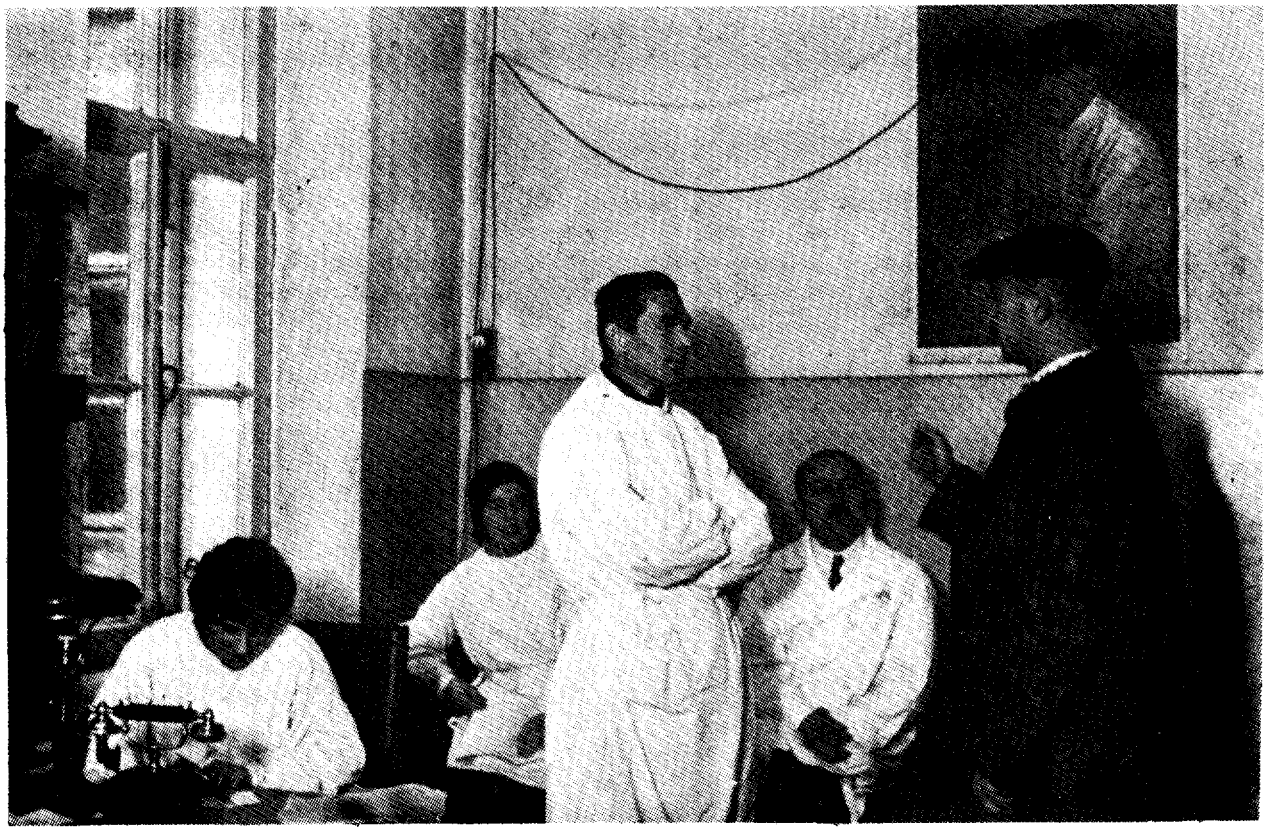
This year might be different, however, because of new and profound economic forces. Simply put, the U.S. government feels that too much is being spent for health care, and it needs desperately to transfer these resources to rebuild basic industries.

How can a program like NHI, presumably presented to make health care freely available, **decrease** the amount of money spent on health care? The paradox is easily resolved by examining the NHI proposals, because they are aimed fundamentally at cutting health services, not at improving health or access to medical care. The proposals are similar to certain current national systems of insurance, and these plans shed light on how NHI might actually look.

Workers have demanded good health care for years, and NHI reflects this aspiration. A major reason for the last coal strike was the coal owners' attempt to reduce health coverage, and the miners resorted to armed violence around this issue. A central demand of the auto bosses this year is to decrease workers' health coverage.

In the U.S. now, the government pays for 55% of hospital bills and 24% of doctors' bills; private insurers pay 37% of each. Thus 92% of hospital and 61% of doctor bills are covered.

Even so, the U.S. has nothing like the comprehensive plans of all major industrial countries, and most people pay substantial amounts out of pocket for health care, and avoid necessary medical care because they cannot pay; this applies particularly to dental and preventive services.



Real national health insurance can only be available under socialism, when the working class will organize health care in its own interests. Above, Soviet ambulance doctors awaiting calls in 1932.

INCREASING GOVERNMENT FINANCING TO CUT SERVICES

It is interesting to note that the U.S. is not the top spender in health care. West Germany spent 12.8% of its GNP on health in 1978, and Sweden 11.3%, whereas the U.S. spent 9.1% in 1979. Britain, with a National Health Service spent 5.6%.

Much of the increasing cost of health in the U.S. comes from increased access to services as a result of Medicare. Medicaid and federal construction funds. The increase directly reflects mass struggle for better economic conditions, and principally the ghetto rebellions of the late sixties and the accompanying strike wave in basic industries, including in the health sector itself. Medical technology also plays a role in raising costs, but the battles for better health care are what made this new technology available.

Inflation also plays a major role in increasing costs, in that services can be restricted by making them too expensive for patients. However, the bulk of increased expenditures in the last few years comes from increased services and technology. This increase was about 10% in 1978.

But just as government expenditures can expand services, they can be used to control, curtail, and eliminate services. For example, the conscious non-payment of $200 million in Medicaid (State and Federal) funds to the New York City Health and Hospital Corporation, which operates the municipal hospitals, by the central government has resulted in large operating deficits, and is used as a justification for cutbacks and hospital closures.

SEGREGATED HEALTH CARE: THE STRUCTURE OF HEALTH SERVICE

The structure of U.S. medicine makes such manipulations possible. In broad terms, the U.S. has three levels of health care: one for the rich, which is adequate; one for the white working class and petit bourgeoisie (small businessman, professionals, etc.), which is inadequate; and one largely for minorities, which is genocidal in terms of modern medicine. The class distinction between the rich and the workers is clear; the racial distinction, which is essentially **de facto** segregation, is intended to keep the working class divided, and enable piecemeal reduction of services. We call this system **medical apartheid** because of its similarity to the system in South Africa, and its murderous effects can be seen in every health statistic as applied to minority groups.

Will NHI change this structure in any way? How would it affect inflation, out-of-pocket costs, access to services, layoffs and the segregated struc-

tures of health care?

Three major national health plans exist already, and they serve as practical models of what we could expect for the future. These three are Medicaid, a program essentially for the very poor (under $5000 a year for a family of four in N.Y. State); Medicare, essentially for all those over 65 years of age; and the Veterans' Administration system, for military veterans.

The Medicaid system varies from state to state, but is characterized by extremely low payment rates to doctors and pharmacists, frequent refusal of payment, high payments to hospital clinics and facilities, and therefore, an incentive to fraud and segregation. In the urban areas, a major percentage of recipients are minorities and the structure of payments leads to few private doctors being willing to care for workers covered by Medicaid. Many services are not allowed or are sharply limited, also reducing payments to private providers. The system results in an average payment, on a practical level of about $4 a visit. Conservative operating costs for a doctor's office alone are $20 an hour. Physicians are not allowed to charge patients additional sums; they must either accept Medicaid as payment in full, or not accept it at all. Hospital facilities are paid on a 'cost-plus' basis—from $25 to $55 a visit. Since almost no private doctors accept Medicaid, those using this insurance are forced to the hospitals, clinics, and high volume "Medicaid mills" because the payment structure makes such services economicaally viable.

Thus, a separate (segregated) class of health care is insured, dictated by the iron law of economics and set by the government through a central reinbursement apparatus.

DEDUCTING THE OLD TO DEATH

Medicare is quite different, and it covers mostly white people. It is run by private insurance carriers (Blue Cross-Blue Shield in many states), and payment rates to doctors are set at the 'usual community rate,' which is kept secret. This rate is on the order of $15-$25 per visit, with higher fees for specialists. This enables private MD's to accept it for most care. The rates also vary substantially from 'community' to 'community,' providing better financing to wealthier areas. Doctors can also charge more for these services and have their patients be reimbursed a portion by Medicare—a practice forbidden by Medicaid.

However, Medicare also requires high 'deductibles'—the amount the patient must pay (e.g. the first $80 each year plus 20% of the assigned fee after that)—and this mechanism separates those with and without money. Poor patients are forced into the clinic systems which don't demand payment of the deductibles for medications and tests— or, more commonly, they must choose between food, heat, or medical care. These deductibles, as well as payment rates, are set ultimately by the government.

"GOVERNMENT SOCIALISM"—THE VA

The Veterans Administration system is a horse of another color. All care is 'free' and most health providers are on government salary. However, every aspect of care is centrally controlled, and cutbacks and hospital closures over the last decade have caused several V.A. and military doctors to rebel against "inhumane care." The standards are determined by the government, and their priority is "cost containment." A recent study of the benefits of cardiac surgery by the V.A. had the arresting sidelight that their mortality rate was several times higher than that in private centers. The patients, of course, pay for such savings—sometimes with their lives.

The government also has a relatively small National Health Service program, with health providers on government salary, providing care to poor workers in rural areas, ghetto, and Native American concentration camps (Indian reservations). This plan is on the whole, a smokescreen to lure young doctors into military service under the guise of serving the needy—and with the overpowering bribe of paying medical tuition.

With the current difficulty the government has in maintaining a voluntary military medical corps, this plan allows them to have the professional and administrative manpower to mobilize quickly to support a war effort. Thousands of medical students are currently indentured to this program for two- to three-year periods, and if 'drafted' would have to pay back several tens of thousands of dollars each to escape service, even if called for a small war in, say, Nicarauga. No government leader is presently calling for the generalized use of such a plan to place all doctors on government payrolls.

THE CATASTROPHE OF CATASTROPHIC HEALTH INSURANCE

Cost containment and political and ideological goals: these characterize current NHI proposals. The most subtle of these is the 'catastrophic illness' insurance proposed by Sen. Long. He proposes that the government pay all expenses over a minimum, which varies from $5000 to $12,000 per year (depending on the news source quoted). This plan guarantees two things: that the hospitals will get paid, and that services will become much more expensive, limiting the number who can afford them. If everything is paid over $5000, what hospital will charge less? All items of care will be inflated, and unless you can pay cash ahead for your $5000 or $12,000, you won't be given care! Many, if not most, hospitals already have a policy of requiring patients to 'deposit' their deductible

before allowing admission. Imagine the spectacle on January 1 of patients thrown out of hospitals because they don't have the new year's deductible! This plan allegedly would help those who are down and out; in the capitalist market, it would make us **all** down and out.

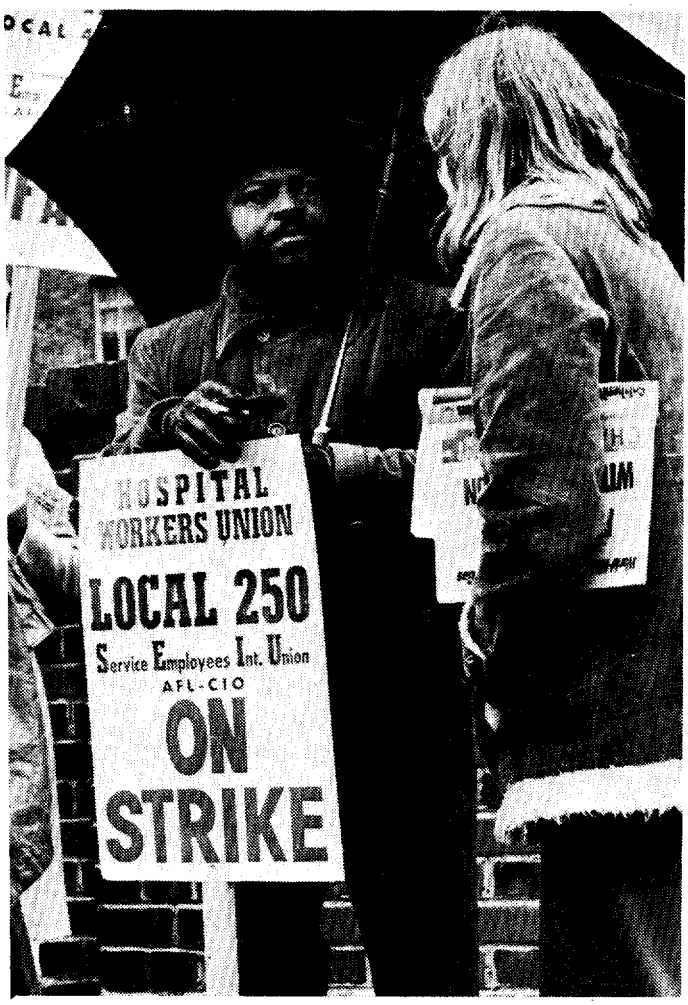
Carter's 'plan' (though barely formulated as such) would provide some federal subsidy to private insurance companies, the giants of U.S. finance capital. This plan resembles Medicare, and would be paid for by payroll deductions (read 'wage cuts'). Besides insuring huge sums of capital for financial manipulation by the insurance companies, this plan would allow the government to control the structure and availability of health services by controlling reimbursement rates and deductibles. The plan essentially would cover only hospital costs, which are 92% covered now, but would legislate sharply restricted payments for services, new growth, salaries for health workers and 'unnecessary' care.

The Kennedy plan is similar, but is broader, and provides even more central mechanisms for payment. Kennedy originally wanted a plan like Medicaid with the government, through the social security system acting as central financial agency, but he has now switched to using private insurance carriers. Payroll deductions, employer "contributions," and taxes would pay for this plan.

THE ROAD TO MEDICAL FASCISM

As should be clear by now, none of the plans call for an expansion of services or jobs, decreased profits to private companies, or an end to segregation in health care. All are designed to do the opposite. The three plans would restrict services through two mechanisms—deductibles and controlled reimbursement. By expanding the deductibles, the government can effectively put many services out of the economic reach of workers. By controlling reimbursements, they can restrict or not allow certain services. For example, they can decide not to pay for kidney dialysis, or can provide funds for only one doctor for three thousand patients, or not reimburse workers for wage increases won in strikes. The capitalist system is seeking to guarantee its existence, and not to improve the general welfare, by legislating tighter and more centralized control. Restricting services, and thereby saving money sorely needed to sustain its disintegrating economy, is their goal. Centralizing government control through controlled monopolization is a hallmark of capitalism in trouble—a landmark on the road to fascism.

We should remember that the Third Reich had NHI—no one had to pay a penny to be sterilized, brutalized, or experimented on. Faith healing by 'lay doctors' was free, immunizations were unavailable, and public health could be described by one word: war. "Free" NHI can easily be turned into systemized brutality by the capitalist system.



In other words, reformist schemes in periods of economic crisis and growing fascism don't change that trend, but themselves become part of the general fascist movement.

Does this mean that free health care is bad, and that we should stick with the current primitive system of private medical care? Of course not! But our political program must reflect and teach the reality of capitalist health care, and we shouldn't be fooled by the current proposals.

The Health Committee Against Racism (Health CAR) calls for multi-racial unity to fight for:

1. No segregated health care; integrate the system now.
2. Free access to health care for all, citizen and non-citizen, employed and unemployed.
3. No layoffs, hospital closures, or cutbacks in care. Expand the resources spent on health care to at least 15% of the GNP.
4. End segregation in the health professions.

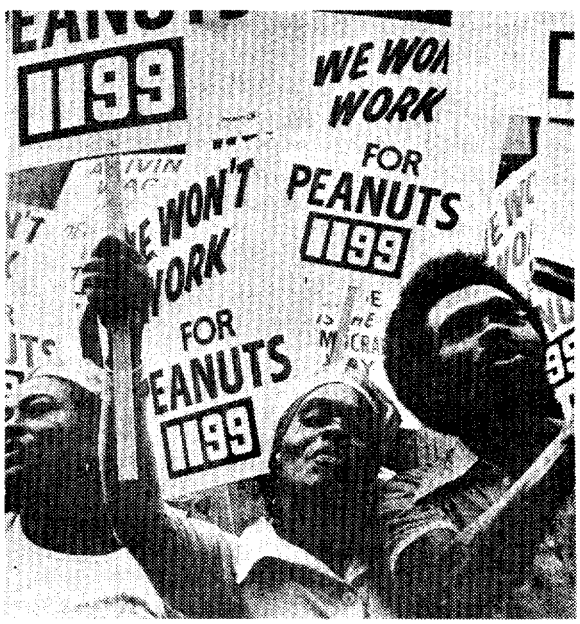
This anti-racist program, which Health CAR is putting forward in professional schools and meetings, as well as on the job, goes a long way toward better health care, and toward building the multi-racial unity that PLP knows is needed to provide the only real health insurance for workers—revolution.

InCAR-PLP Campaign Spreads Anti-Racist Ideas in District 1199

This spring, the Progressive Labor Party and the Committee Against Racism united to take on the entrenched, "social-fascist" leadership of District 1199 in the union's bi-annual election for officers and organizers. Despite many weaknesses, the campaign was a step forward for the communist and anti-racist forces in 1199.

District 1199, National Union of Hospital and Health Care Employees was founded among drug store workers in the early 1930s. The leadership, trained in a revisionist style of work by the old Communist Party, was militant, but failed to put forward communist politics. Once established in the hospital industry, militant reformism quickly gave way to wholesale class collaboration. By the mid-1970s, Davis & Co. were turning their backs on racist hospital cuts and begging for arbitrated contracts. With their eye on millions of unorganized hospital workers nationally, 1199 leaders agreed to play by the bosses' rules in return for NLRB protection for their organizing.

1199's social-democratic leadership stands exposed more than ever as social fascists, helping the bosses to save capitalism by pacifying hospital workers for a fascist future. PLP communists in the union have been the main obstacle to this development.



Davis leadership sold 1199ers out again this July, with a contract that amounts to: PEANUTS! The need for communist leadership is greater than ever.

Today District 1199 has 57,000 members in the NYC area, and has spawned a national Union with another 30,000 members. The membership is predominantly black and Latin, and overwhelmingly women. The bulk of the membership are lower-paid service workers, but about one-third is comprised of technical, professional and clerical workers, and RNs. The union has adopted a system of "Divisions" based on type of work: the Hospital Division for service workers; the Guild for technical, professional and clerical; and new RN Division; and the Drug Division for drug store workers.

The keynote of our campaign in the recent election was an attack on this Jim Crow system of "separate and unequal" Divisions.

PLPers have been active in 1199 for about ten years on many fronts: leading organizing drives; fighting grievances as elected delegates; leading the successful fight against the endorsement of Beame for mayor of NYC; organizing a wildcat strike against the closing of Brooklyn Eye & Ear Hospital; placing on the Delegate Assembly agenda motions for mass action against hospital cuts; opposing contract sellouts; and running against the leadership in six elections, three times for delegate seats at the National Union convention and three times for leadership of the union. We have put forward communist and anti-racist ideas, been quite active in the struggle, and have constituted the main threat to the social-democratic leaders of 1199. This shows that a handful of principled communists can have an impact far beyond their numbers. But errors in style of work, principally lack of basebuilding, have prevented us from growing as much as we could have.

During the summer of 1979, we (PLP and the International Committee Against Racism) formed a slate for the 1199 convention of 12 candidates and succeeded in getting on the ballot in September's election. We keynoted our fight against racist Divisions in 1199 by saying that whereas Klan leader David Duke had proposed segregation, 1199 Pres. Davis had achieved it. At NYU Hospital, where InCAR and PLP had the biggest base, the slate won 60% of the Guild vote on Sept. 24. Encouraged by this show of support, the NYU InCAR chapter issued a leaflet for the following week's Hospital Division vote, leading over the next two weeks to a struggle which saw PLPer Leigh Benin fired and InCAR leader Sam Vargas suspended for five days. This attack on us led to a three month-long struggle against both NYU and 1199.

At NYU there were many leaflets, several picket lines in which 15 to 20 NYU workers participated, $200 raised for Leigh, and 300 workers signed a petition demanding re-instatement and protesting other racist conditions. However, our base wasn't strong enough to win. At the December Guild Division Delegate Assembly, Leigh's firing was on the agenda because 80 delegates demanded it in a petition. In the unprecedented hour-long debate, 15 delegates in a row supported a motion for a union work action at NYU to re-instate Leigh. The leadership used McCarthyite smear tactics to stop us. Our motion lost by a narrow 77 to 58. Several days later, Leigh became the first 1199er to be dropped as delegate pending the arbitration of an unjust firing, and in January, eight organizers (goons) blocked his entrance to the delegate meeting. Such is the fear that the bosses and their labor lieutenants have of communists. They are right to be afraid.

PLP and InCAR did form an integrated slate of seven candidates for leadership of the union and resolved to petition for our amendment to end the racist "Division" system during February, at the same time we would be getting nominating signatures to get on the ballot. The slate was headed by a black worker, David Samuel, who became the first black to run against 1199's president and founder Leon Davis. Brother Samuel pointed out that while the union is predominantly black and Latin, six of the seven executive positions of the union are occupied by whites, and eight of the thirteen V.P.s are white. This is another aspect of Davis & Co.'s racism. Leigh Benin ran for Exec. V.P. We also ran two candidates for V.P. and three for organizers. During February, we received 1,500 nominating signatures, and became official candidates for office.

Our candidates spoke at dozens of local hospital meetings across the city to about 1,500 workers. The response was from good to terrific. At Staten Island Hospital, for example, our anti-racist remarks were vigorously applauded by 100 predominantly white workers at three meetings. Between petitioning, speaking at meetings, handing out 15,000 leaflets and other campaigning, we spoke to thousands of 1199ers and made about fifty contacts. All of us who participated in this effort were impressed by the breadth and depth of dissatisfaction among the membership, and the interest shown in our ideas.

The leadership was desperately afraid of having their weaknesses exposed by the election results. Unwilling to rely solely on undemocratic rules, they resorted to a managed election. They controlled the election machinery.

In spite of all the above, with 30% of the membership voting, the InCAR-PLP slate officially received 8% for president (1,300), 10% for Exec. V.P. (1,500), 12% for V.P. (1,750), 16% for Guild Organizer, and 10% for Hospital Division Organizer. In those hospitals where we were known, the results were even more impressive. At Staten Island, we carried the Guild Division and came very close in the Hospital Division; at Beth Israel, David Samuel got 25% of the total vote; at NYU we received 22%, etc.

This is not to say that these elections represent the road to power in the unions. Far from it. The firing of Leigh, and similar attacks on other candidates, indicate that more votes for us will simply raise the level of struggle. An election victory, even if allowed, would result in the AF of L putting the union into receivership and/or action by the bosses' state power to bar us from office. So long as we don't succumb to illusions about elections, they can help us get our ideas across to workers, and develop our organization.

The most important achievements of the campaign have been a significant number of new contacts. New forces have come forward to lead the anti-racist struggle. The last 1199 InCAR steering committee meeting involved 2 veterans and 5 people who have started working with us as a result of the campaign. This has led to a lot of healthy fraternal struggle over the direction of the anti-racist movement. The main weaknesses have been not signing people up to InCAR and the failure to develop solid chapters in the hospitals where we already have active members.

The upcoming struggle will be the next test of our leadership. The union's demands, some of which we are responsible for, are relatively good. But the strike that the leadership will probably call will exhaust the workers more than it will pressure the hospitals: it is not being prepared for, and will not be directed toward shutting the hospitals down. It will be up to us to seize the leadership of this struggle. The future is ours if we are willing to fight for it.

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