RACE AND HEALTH CARE

Perspective from Chicago

bindu t desai

In the past 30 years the US expenditure in health care has multiplied several times now amounting to more than one billion dollars per day. This fantastic growth has not led to a closing of black-and-white health differentials. The health care system mirrors the racism and inequalities in American society. This article begins with a 'tour' of a medical centre complex in Chicago's financial and business district where the racial divide from a white, private luxurious hospital to a non-white, public, run-down hospital is unashamedly acknowledged. It goes on to show how black health statistics which had improved are now undergoing a reversal, and the Reagan administration's health budget cuts drastically affect the poor and the blacks. The oppression and exploitation of racial minorities is not unique to the US, The status of blacks in the US and the treatment meted out to them has obvious parallels to the situation of dalits in India. This article, we hope will motivate similar studies of casteism, communalism and sexism in the Indian health sector.

The United States and South Africa are the only two industrialised countries in the world lacking a system that guarantees medical care for all who need it. The past 35 years have seen an exponential growth in the United States both in the general economy and in the expenditure on health care which by itself now amounts to more than one billion dollars per day (Blendon and Altman, 1984). This growth has not led to equal access to health care or to a closing of black-white health differentials.

This perspective will examine health care in the US at different levels. First we will tour the conglomeration of hospitals and universities known as the Medical Center on the west side of Chicago. The outward differences noted on this tour will be shown to accurately mirror the larger racism and inequality in American society. We will then examine population-based health statistics as they pertain to race. After discussing medical education and affirmative action (the rough US equivalent of a reservation system in medical schools) we will analyse future trends in US health care.

A Tour of the Medical Center

About a mile west of the Loop, Chicago's financial and business district, lies the sprawling Medical Center complex comprising two medical schools, four major medical institutes and said to contain, with typical American hyperbole, "the largest collection of medical expertise in the world." The apex of this medical pyramid is the Rush Medical school with its Presbyterian-St. Luke's Hospital (PSL).

This complex occupies six buildings, four of which were built in the last 10 years, elegant hulks of steel and aluminium, spacious, airy, the newest resembling a Hyatt hotel, complete with an atrium and indoor plants. Across the street from PSL is the bottom of the pyramid, Cook County Hospital (CCH). Consisting of eight buildings, a complex built at the turn of the century, CCH is the only institution for the poor of the Chicago area. Unlike PSL there are no carpets in the foyer of CCH, no cushioned chairs either. *When one crosses Harrison street, one crosses the racial divide in the US from a white, private, luxurious hospital, to a non-white, public, run-down, hospital.* A casual visitor cannot fail to notice that something very fundamental has changed in that short walk across a street.

A block away from CCH is the Abraham Lincoln School of Medicine affiliated with the University of Illinois (U of I) Hospitals. The medical school and hospital are run by the state of Illinois. They too have spanking new buildings, neat columns of cement and glass that are centrally air-conditioned, along with old red brick structures that house the prestigious Neuropsychiatric Institute and the old hospital. At the south-west edge of the Medical Center is the West Side Veterans Administration (VA) Hospital, an institution run by the federal government. The U of I hospitals and the West Side VA form the body of our pyramid.

These four institutions cover the different types of hospitals in the US except for the newest and fastest growing type of hospital — the for profit hospital — a separate entity in itself which we will discuss later. PSL dominates the area in terms of the facilities offered to the patient, both those providing physicial comfort and the latest in medical investigative technology. At PSL there are no long waits in the Emergency Department (ED). The patient is admitted to a private or semiprivate room with an attached bathroom, each bed has a television set, a

telephone, and the hospital is centrally air-conditioned. A patient who requires an x-ray procedure or a visit to a subspeciality clinic is seen without long delay. The waiting rooms of these clinics are cheerful, provided with magazines, and so on.

In contrast, CCH patients often have to wait eight to ten hours before being seen in the ED. As the hospital has very few semiprivate rooms, most of the patients are in a large general ward. The wheel chairs could very easily be exhibited in the Smithsonian's museums, patients share a common bathroom, bring their own television set or radio and may use the few pay telephones that are available in each ward. Except for the Intensive Care and Trauma units there is no airconditioning. The many buildings of CCH are unsatisfactory both in summer and winter. The wards are stuffy and hot in summer and draughty and cold in winter. Leaky ceilings and falling plaster are not uncommon. In fact the author's office, which is on the third floor of an eightstory building, was flooded after a thunderstorm and many books and journals were damaged! The patients at CCH wait for nearly everything—wait to be seen by a physician, wait for the diagnostic tests to be performed, wait for their medicines, wait in the corridors and hallways of the hospital. No magazines are provided for these patients.

CCH patients also have to wait before a Health Systems Agency grants a certificate of need for expensive x-ray equipment. The hospital was amongst the last in the Chicago area to obtain a CT scanner and paid PSL nearly 500,000 dollars per year to use PSL's scanner. Presently PSL already has the equipment for Magnetic Resonance Imaging so that the trend of an "underfunded public hospital spending some of its scarce resources to enrich an already wealthy private institution continues" (Schlosser and Cohen, 1981). PSL and CCH are the two ends of the pyramid - the apex rich and powerful serving largely white patients, the base poor, relatively powerless serving largely black and Spanish-speaking patients, mostly from Mexico and Puerto Rico (Latinos). The U of I and Westside VA fall somewhere in between these two extremes in their facilities and equipment though in neither hospital are the patients forced to wait long hours in crowded halls nor do they have to be in a large general ward.

Since 981 when President Reagan began cutting back on health expenditures, CCH has seen a phenomenal rise in outpatient visits and transfer of patients from other hospitals. Outpatient visits have gone up from 114,262 in the first quarter of 1981 to 150,146 in the same period in 1984, an increase of 24 percent whilst transfers of patients, largely because of lack of third-party payment whether by private or governmental agencies, have gone up from 110 a month to 900 a month (Pharmacy Newsletter, 1984). There is the typical capitalist picture of smaller private hospitals closing units and laying off or dismissing staff whilst CCH becomes more and more overcrowded (Kotulak, 1984).

Let us now leave the Medical Center and survey the larger issues that determine the architecture, the distribution and the racial composition of the complex.

A Portrait of the USA

a. Demographic : The black population, which has risen from 9.9 percent of the total in 1950 to 11.7 percent in 1980, forms 26.5 million of the US total of 226.5 million people. The Southern states of the US account for more than half of the total black population, 14 out of 26.5 million. Blacks have moved from the rural areas to the centre of cities and the suburbs, whereas whites have moved out of the centre of cities to the suburbs. In the past two decades the population of farm workers who are black has dropped from 16 percent to 4 percent. In 1970 seven major cities had a black majority compared to seventeen in 1980. In an additional 13 cities blacks comprised 45 percent to 50 percent of the total population.

The seventies saw a decline in the number of male-headed family households from 73 percent to 63 percent and an increase in the number of households headed by women. for blacks it rose from 31 percent to 47 percent, for whites from 8 percent to 13 5 percent. Fifty-five percent of all black children were born to unmarried mothers compared to 9.5 percent of white children. Forty-two percent of all black children lived in two-parent families compared to 83 percent of white children. Forty-four percent of black children were living only with their mother compared to 13.5 percent of white children. Moreover, the marital status of these mothers differed considerably by race: 29 percent of the black mothers were single, 37 percent separated, 9 percent widowed and 25 percent divorced, whilst the figures for whites are 7 percent, 29 percent, 12 percent and 52 percent respectively

b. Income : In 1975, the peak of a 25-year upward trend, median black family income was 62 percent of white family income. By 1982 it had dropped to 55 percent. Black families with incomes

under 10,000 dollars rose from 36.5 percent of the black total in 1970 to 40.5 percent in 1980, whilst the figure for white families remained stable around 16 percent. In the past decade, the poverty rates have gone up for all races, for blacks from 31.4 percent to 35.7 percent, for Latinos from 22 percent to 28.4 percent and for whites from 8.4 percent to 12.1 percent (Pear 1984). The income gap between black and white families varies with the composition of the household and work experience. When a family has two earners black median income is dollars 20,000 compared to dollars 25,000 for whites (81 percent of white income) whereas for a family headed by a woman, black median income is dollars 7,425 compared to dollars 12,000 for whites (62 percent of white income) (Hacker, 1983).

Seven-and-a-half percent of black families earned more than 35,000 dollars compared to 17.5 percent of white families. At the highest income levels in excess of 75,000 dollars there were 548,000 white men (0.6 percent), 11,000 white women (0.01 percent), 4,000 black men (0.03 percent) and less than 500 (0.004 percent) black women. The programs of the past 20 years that were meant to aid minority businesses have had little impact. *The total assets of all minority business amount to less than 1 percent of the assets of the Bank of America alone.* The top 100 black business listed in Black Enterprise together have assets less than that of the 500th corporation listed in Fortune Magazine's top 500 corporations (Stokes, 1981).

c. Employment : The overall unemployment rate which was 7.1 percent in June 1984 is 18 percent for blacks and 4.3 percent for black teenagers. The proportion of black males participating in the labour force has declined from 83 percent in 1960 to 71 percent in 1980; whereas that for black women increased from 48 precent to 53 percent, and for white women from 37 percent to 51 percent. *Black Americans are over-represented in poor paying jobs such as garbage collectors (55 percent) and household servants (54), whereas they form fewer than 1 percent of all elected officials, engineers, lawyers and 2.6 percent of all university professors and physicians.* The public sector is a relatively better source of employment for black college graduates. Fifty-seven percent of black male college graduates were employed by the government, compared to 27 percent of whites. The figures for women are 72 percent of blacks and 56 percent of whites respectively. Whilst blacks comprise 14 percent of the federal civil service they form 30 percent of the army and 20 percent of all US defense forces. These percentages have doubled in the last decade. However only 5.6 percent of the officers are black. Black employment in the public sector is a matter of necessity. The US labour market is generally manipulated by big business to keep blacks out of private sector jobs. They are discriminated against in hiring and are forced to take lower paying jobs regardless of their qualifications. For instance, black women with education similar to white men earn only half as much as white men, and earnings of black men are 70 percent of an equivalently qualified white worker. Blacks have low seniority because of past discrimination where certain trades did not admit blacks to their rolls, and they have less work experience because of unemployment and denial of equal training and educational opportunities. If there were equal opportunity in the labour market the black-white ratio of per capita earning would be 89 percent instead of 58 percent. The estimated losses due to employment discrimination exceed by a factor of 11 the estimated excess welfare payments to blacks (Swinton, 1983).

d. Crime and punishment : Blacks formed 22 percent of the total number of arrests made in 1980 and 48.5 percent of a total state prison population of 272,348 in 1981. The US black imprisonment rate of 498/100,000 population for 1981, which can be compared with South Africa's 471/100,000 for 1976. (King and Whitman, 1981), is the highest in the world. The US white imprisonment rate is 75/100,000. *Forty percent of the prisoners on death row are black.* Since 1930, when records were first kept, 405 blacks have been executed for rape compared to 48 whites. This figure does not include the men lynched by white mobs.

e. Education : In the past 15 years black enrollment in colleges has doubled from 5 to 10 percent. Although 70 percent of their parents had never attended college and 45 percent had not finished high school, these parents by working at two jobs and so on have guaranteed their children higher education which they themselves were deprived of. Government programs have also played a role but the Reagan administration has cut back aid and reduced spending for disadvantaged students by 17 percent and on loans by 27 percent (Pear 1984). Twenty five percent of black college graduates, 20 percent of high school graduates and 30 percent of high school dropouts were unemployed compared to 6.6 percent, 6.4 precent and 16.4 percent (respectively of whites). For black students 45 percent do not complete high school, another 30 percent graduate from high school and 25 percent go on to

college, whilst among whites the figures are 14 percent, 30 percent, and 56 percent, respectively.

The State of Black Health: The life expectancy for blacks (68.3) is shorter than whites (74.4) by 6.1 years. The infant mortality rate for blacks is twice the white rate, 21.8 vs 11.4 deaths per 1000 live births, a phenomenon attributable to low birth-weight, pneumonia, and influenza, and effect of maternal disease upon the newborn. However, as Sullivan points out, "These averages obscure some apalling figures in some rural areas and inner cities of our country. For example, in Georgia (in the Southern US) today the average life expectancy of blacks is 8.4 years shorter than that for whites. In six rural counties in Georgia, the life expectancy for black males is only 49.6 to 51.5 years whereas the average life expectancy for white males in the same counties is from 59.5 to 69.6 years. In Kenya, one of the less developed and poorer countries of the world, the average life expectancy of the male population is 51.3 years, exceeding that in some rural counties in Georgia. In 1980 in 50 rural counties among Georgia's 159 counties, the infant mortality rate for blacks was higher than 30 per 1000 live births and in 16 counties the rate was higher than 43 per 1000. Similar rates are found in many rural areas and inner cities all over the United States" (Sullivan, 1983). A black mother is three times more likely to die of complications of pregnancy, labour and puerperium than a white mother. A black mother is more likely to have had very little or no prenatal care. In spite of the severe social and economic stresses on black families the incidence of recognised child abuse is similar for blacks and whites, around 11/1,000

The incidence and causes of head injury differ for blacks and whites, the black incidence for both inner-city and suburban blacks being twice that of whites (400 vs. 196/100,000). Interpersonal attacks were either the leading cause as in inner-city blacks (176/100,000) or the second most common (100/100,000) as in suburban blacks compared to the fourth most common cause for suburban whites 18/100,000) (Whitman et al, 1984). These head injury figures convey only the tip of the iceberg. For example, in 1979 murder was the leading cause of death to men 15 to 44 years of age in New York City and black men in this age group had " . . . a 1 in 20 chance of being murdered, a rate that is twice the odds of an American soldier being killed in combat during World War I " (Chicago Sun-Times, 1980) Homicide is the leading cause of years of life lost

Death Rates (per 100,000 Population) Homicide According to Race and Sex

	1960	1970	1979
Total	5.2	9.1	10.4
Black Males	44.9	82.1	71.3
White Males	3.9	7.3	10.1
Black Females	11.8	15.0	14.3
White Females	1.5	2.2	3.0

(Source : U S. Department of Health and Human Services Health, United States, 1982. DHSS publication No. (PHS) 83-1232 Washington D.C. : US Government Printing Office Dec. 1982)

for non-white men in the US. Age-adjusted death for homicide have climbed steadily in the past 20 years (see Table). As the table indicates, the homicide rates for black men are seven times that for white men, whose rates are lower than those for *black* women. Blacks have a higher death rate than whites for 13 of the 15 leading causes of death. Other significant differences are in diabetes, nephritis, septicemia and chronic liver disease and cirrhosis, where the death rate is twice that of whites. Deaths from cirrhosis increased by 50 percent for whites in the past 25 years whilst for blacks they increased 20 percent.

Let us look at some other health statistics. Regular dental health care is usually unaffordable (APH, 1982). In 1978, 82 percent of rural Southern blacks did not visit a dentist. For a white family a perfect set of teeth with the ability to flash a brilliant smile is a status symbol, and middle-class families, of either race, can spend nearly 1500 dollars, per child for orthodontia. Semi-annual dental visits for regular cleaning of teeth are routine for them, while dental care is out of reach for poor families, black or white.

When asked in 1978 to rate their overall health and "well being" as part of a Federal National Health Interview Survey, black females reported the lowest level of positive well-being of all groups 37 percent compared to 70 percent among white males. Access to health care is dependent on income level. This strongly affects families headed by black women as 71 percent of them live below the poverty level compared to 40 percent for white and 51 percents for Latinos. Government — sponsored programs — Medicare and Medicaid and tax subsidies for private health care have spent a trillion dollars

since 1965. Yet 34 million people remain without health insurance of any kind. Only 33 percent of people with income *below* the poverty level are covered by Medicaid, 27 percent have no health insurance of any kind. Uninsured blacks have a 42 percent lower Physician visit rate compared to whites, lower rates of elective surgery, are less likely to have a regular source of care, and have to travel further to obtain care. It is estimated that one out of every four black adults suffers from hypertension, which develops earlier in blacks, is frequently more severe and results in higher mortality at a younger age. For black women of all ages the prevalence of hypertension is equal to or higher than that of black men.

Let us now turn our attention to the delivery of health care. Though forming 12 percent of the population, less than 2 percent of the faculties of medical schools are black. The percentage of black physicians in the country has increased only marginally from 2.1 percent in 1950 to 2.6 percent in 1980. Further, the proportion of black medical graduates has decreased in the past four years from 793 out of 14,393 graduates (5.5 percent) in 1978 to 763 out of 15,985 (4.8 percent) in 1982. Six medical schools in the US have no black enrollment and in 75 (61 percent of all medical schools) the black enrollment is less than 5 percent. Black physicians, who have always faced difficulties in getting hospital privileges, are likely to face more difficulties in obtaining these privileges as hospital administrators try to keep hospitals financially solvent amidst cost-cutting measures initiated by government and private health insurance agencies. Black physicians tend to have a patient load which is predominantly poorer, sicker and less likely to bring in revenues to the hospital. Administrators are expected to try to eliminate the physicians who admit those kinds of patients — another example of economic racism (AM News, 1984).

Note that the percentage of black physicians has increased only marginally even with the positive impact of affirmative action programs. The changing and increasingly right-wing political turn which began in the late 70's can be further expected to decrease black enrollment. Additional factors that will contribute to the decrease are of equal importance. Black students in high school and college are victims of a pervasive inequality in education. A survey of high school students in the Chicago area (which contains 92 percent of all minority students in the metropolitan greater Chicago area) showed that 56 percent had seldom or never worked in a laboratory, the dropout rate at high school averaged 47.4 percent and about half of the graduating seniors from high school were deficient in the rigorous academic subjects that are required for medical school (Orfield, 1984). The cost of medical education rises each year; in 1984 the average medical student will owe a debt of 50,000 dollars Financial assistance is becoming increasingly short with a very grave impact on black students, 80 percent of whom come from families earning less than 25,000 dollars a year. At other levels of the health industry blacks become more commonly represented as one descends in the hierarchy. In the nursing sector blacks form 11.4 percent of the registered nurses, but 30 percent of the aides and orderlies.

The American Health Care Industry

Between 1950 and 1982 US health expenditures increased more than 25 fold. The proportion of the GNP accounted for by the health sector has increased from 4.4 to 10.5 percent (Ninzburg, 1984). In the past 10 years the number of people employed in the health sector has increased from 4.2 to 7.5 million. In sharp contrast to other sectors of the economy the health industry has expanded unaffected by any of the recessions of the past 30 years. Hospital room costs have gone up by 515 percent in the last 15 years and physician services by 311 percent. In 1981 hospital costs accounted for 41 cents of each dollar spent on health, physicians, services for 19, dentists services for 6, drugs 8, appliances 2. Other costs included nursing-home care 8, public health 3, research 2, new construction 3, and administration and others, 8. Health care costs average 1500 dollars per American of which dollars 906 come from private funds and 594 dollars from public programs.

For-profit hospital chains, a relatively new phenomenon, have grown and are expected to own 20 percent of all hospitals by 1990. In 1982 the largest chain, Hospital Corporation of America, owned 351 hospitals with 50,000 beds with revenues of 3.5 billion dollars, up 47 percent from the previous year. Humana, Inc, another chain, had 14 billion dollars in revenues with stocks worth 18 dollars per share in 1968 now worth 336 dollars (Starr, 1982). The for-profit hospitals, which are touted as being more cost-effective, have actually charged more per patient than their not-for-profit counterparts, whilst generating a very high net income for their owners (Relman, 1983). These chains are also moving into outpatient centres

called Emergicenters or Urgent Care Centers, which are open 12-16 hours a day, resemble the fast-food chains in their appearance, and have a potential market of between 2—5 billion dollars a year.

Health expenses in the US are met in two major ways, either by private health insurance or by government programs like Medicare and Medicaid. In 1974 the national average expenditure per non-white beneficiary was 57 percent lower than that for white (321 dollars vs 560 dollars). As we mentioned earlier, 34 million Americans are without any kind of health coverage, because they are too poor to afford private health insurance and earn more than the minimum requirements to qualify for government assistance.

The Indian Connection

The relationship between race and health care has obvious parallels for India, such as the hospitals based on class and the use of affirmative action in medical education, which if similar to the reservation system for Scheduled Castes and Tribes in India. Both in India and in the US there is yet another link, the Indian medical graduate (better known as F.M.G. or Foreign Medical Graduate), either in training or practising in the US. There are presently about 14,000 FMGs of Indian origin in the US, forming 10 percent of all FMGs and 3 percent of all physicians in the US. Note that there are *more* FMGs of Indian origin alone than the total number of black physicians in the US. A relatively large number of Indian doctors work in inner-city or county hospitals which serve the urban poor who are largely black. There is a decreasing number of Indians as one moves into the 10 most prestigious medical schools, the so-called Ivy League.

Black and Indian relations within the medical system have not been marred by overt conflicts, which is heartening considering the generally racist attitude of most Indian physicians. The federal government has backed affirmative action in admissions to medical schools though this backing has never been whole-hearted and can presently be said to be nonexistent. *White attitudes to affirmative action parallel those of caste Hindus in India. The very same arguments are used - selection should be on 'merit,' concern is expressed for lowered standards of medical care, and so on.*

The presence of large numbers of Indian doctors also strengthens relations between the Indian elite and the health care industry in the US. They have already begun to play a role in creating American-modeled hospitals in India like the Apollo hospitals in Madras and Hyderabad and the proposed Modi-Hospital Corporation of America hospital in New Delhi.

Conclusion

Black health statistics which improved in the 60s and 70s as a result of political changes stemming from the civil rights movement which stimulated government programme appear to have peaked and a reversal may have begun. The statistics of black health must be viewed in light of the moneys poured into health care in the past 30 years. In that unprecedented period of economic growth when real income doubled for most Americans, medicine was an "important ideological prop for the ruling class in the maintenance of the domestic tranquility and social stability needed for production and profit . . . health care has been used by the ruling class to cushion some of the most savage aspects of capitalist industrialization and forestall more radical working-class demands" (Himmelstein and Woolhandler, 1984).

But the stagflation of the seventies has heralded some fundamental changes in government policies. The Reagan adminstration has cut the health budget and reduced funding for education for poor and handicapped people by 20 percent (Stokes, 1981). Maternal and child health received 25 percent less federal money in 1982. A rise in the overall foetal death rate from 10.2 to 12.2 per 1000 from 1979 to 1981 may be the first indication of the effects of present cost-cutting measures (Pouissant, 1983).

The increase in the number of black people below the poverty line, the general low income of black people, the poor opportunities for advancement in employment are not features that are unique to the US. A recent publication from England (PSU, 1984) describes the black population as occupying the same "precarious and unattractive" position in society as in the 50s. The British National Health Service encourages a "ghettostyle" employment pattern with hospitals having British porters, Spanish cooks and West Indian domestic staff (Lancet, 1984). Doubtless the pattern can be documented in other white nations with regard to their racial minorities — Turkish in West Germany, Algerian in France, Maoris in New Zealand and Australia, leading to the conclusion that "Racism is not a 'mistake' or a 'failure' of this society — it is one of its great successes" (Cooper, 1983).

As the US changes to an hour-glass economy, a large section of the population will be left in low-paying dead-end jobs. In August 1984 the US

Census Bureau showed that the number of Americans living in poverty had risen to its highest level in 18 years. As a result of Reagan Administration tax policies, families. earning less than 10,000 dollars annually suffered a net loss of dollars 400 or 4 percent of income, whereas those earning over 80,000 dollars gained 8,270 dollars or about 10 percent. This will further limit the number of blacks who can climb out of the poverty and degradation they are born into. Increasingly large US cities have a black majority population. The white exodus from the cities is matched by a loss in jobs in the manufacturing, wholesale, retail and service industries. In the past 10 years alone New York, Chicago, Philadelphia and Detroit have lost a million jobs with white unemployment levels staying relatively static whilst black unemployment levels have zoomed to nearly 55 percent for teenagers. These trends are likely to continue.

"Profit has made America what it is" is the proud slogan of American capitalism, which wishes to be known by its new, gleaming, dazzling, forprofit hospitals where the birth of a baby is celebrated by the parents with champagne. In their shadow lies the decay of overstrained public hospitals serving non-white citizens and bearing an uncanny resemblance to large municipal hospitals in India. Their burden will be greater than before as for-profit hospitals both "cream" off capital and resources and leave to them unprofitable diseases and the care of minorities and poor people.

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Dr. Bindu T. Desai
221. South Oak Park Ave
Oak Park
Illinois–60302 (USA)

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42. Two particular issues of the *Journal of Occupational Medicine* detail tasks for corporate medical directors: a special section on "Cost Effectiveness of Occupational Health Programs" In *JOM* 16:3, March 1974: and a special issue on "HMOs and Occupational Medicine" in *JOM* 17:10, October, 1975. See also Jesse Steinfeld. "The Workplace as a Health Care Resource," *JOM* 12 8. August 1970, pp 315-317: Robert O'Connor, "The Role of Industry in the Health of the Nation." *JOM* 10:3, March 1968, p. 379: and J. Williamson and M. van Nieuwenhuzea, "Health Benefit Analysis: An Application in Industrial Absenteeism. "*JOM* 16:4, April 1974. pp. 229-223.

43. For an excellent discussion, see: Sander Kelman "The Social Nature of the Definition problem in Health" *IJHS* 5:4, 1975, pp. 625-642.