

A NEW OUTLOOK ON HEALTH



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Contents

NOTE FROM THE PUBLISHER	5
INTRODUCTION	
The US Auto Industry's Cyclical Crises	10
Healthcare Adopts the Car Industry's "Lean Management Principles"	15
Crisis of Consolidation and Overcapacity in Healthcare	22
Why is the US in Particular Failing so Hard?	28
Healthcare in a Different Economic System	30
COVID-19 Unmasks the US Healthcare System	34
A NEW OUTLOOK ON HEALTH	
Preface	39
Chapter 1 The Fatal Illness of Medicine in America	43
Chapter 2 The Medical-Industrial Complex	59
Chapter 3 Only We Can Change the Way It Is	75

NOTE FROM THE PUBLISHER

When Foreign Languages Press decided to republish *A New Outlook on Health*, it was well before the beginning of the global COVID-19 pandemic at the end of 2019. Uncertain at first about how to proceed given the urgency to confront the concrete fallout from many of the same contradictions described in the original 1975 pamphlet, we decided to go ahead with it and do our best to give some current context to this relevant text about health and healthcare in the United States. With a new introduction written by the Redspark Collective, we are republishing the entire pamphlet in its original form with the addition of some detailed footnotes. The footnotes include more current statistics and some updates about how healthcare and the US economy has changed in the past forty plus years.

We hope you find the text to be informative and galvanizing in “understanding the world in order to change it.”

INTRODUCTION

When this pamphlet was originally published in 1975, its authors wrote:

We have the most advanced material base of any society in history and the highest standard of living in the world. Our technology enables us to produce goods to satisfy any conceivable material wants. Yet seven other societies have more doctors per capita than we do. In thirteen other countries pregnant women receive better care. Life expectancy for males in this country is shorter than in twenty-one other countries.

This quote about the contrast between the US' advanced capitalist economy and wealth and the state of the health of its population is especially stark at the time of the writing of this introduction. The COVID-19 global pandemic, which started at the end of 2019 and began peaking in the US at the end of April 2020, has stripped the world of any illusions that the US could handle the outbreak better than any other country—as it was projected and as the Trump administration boasted. As we send this book to press, the current number of confirmed cases in the world is more than 4.7 million and confirmed deaths is more than 315,000 (although epidemiologists agree that the real numbers for both statistics are orders of magnitude higher). The US alone accounts for

almost a third of all of the cases and over a quarter of the fatalities in the world, even though its population is only 4.25% of the global population. Reports of chaos in the medical system include:

- The Centers for Disease Control and Prevention refuse WHO test supplies and then send out faulty tests across the country;
- States fight to outbid each other and the federal government for scarce medical supplies;
- COVID-19 hospitals allot nurses one surgical mask per week;
- Hospital workers wear rain ponchos and trash bags as surgical gowns and bandanas as masks;
- The federal government gives Carte Blanche to private corporations to develop their own tests that are rushed to market without regulation or regulatory agency approval leading to wildly inaccurate results;
- Contradictory information about which health insurance companies would cover the cost of tests and treatment and how much individual patients would be responsible for;

- Elected officials call on the elderly to sacrifice their lives to save the economy;
- Federal health agencies actively advise the population that wearing masks is useless, then reverses course several weeks later to advise everyone to wear face coverings in public;
- Sick but uninsured people are turned away at health clinics and hospitals only to succumb to the illness at home;
- Bodies buried in mass graves because hospital morgues can't keep up with the dead;
- The US president suggests that COVID-19 could be eliminated by beaming sunshine directly inside the patient or injecting disinfectant into the lungs.

These reports, and many more, are true.

When *A New Outlook on Health* was published, hospitals were flush with money from federal grants for expansion and modernization. Most Americans were covered by the then-nonprofit Blue Cross health insurance, and the method for hospitals to maximize profits was extended inpatient care with excessive testing. Today, on the other hand, the US is facing a deadly pandemic with hospitals lacking the most basic supplies like gloves, masks and disinfectant. How did we get here?

The answer to this question, as with most societal contradictions, lies in the path that capitalism and imperialist expansion has charted and the cyclical crises inherent in the capitalist mode of production. As this introduction will outline, capital investment into healthcare made human health a commodity. The medical industry followed the example of the car industry's methods to eliminate "waste" to cut costs. And privatization eventually led to a crisis of overcapacity in the medical industry: private health insurance companies crowded the market with a myriad of health plans; pharmaceuticals churned out more and more expensive medications; and private hospitals grew to fight for a bigger share of the market. This expansion of capital into healthcare occurred while people increasingly could not afford the insurance, the medications or the hospital services. To try to resolve this growing crisis, the government used public money to subsidize the private sector in order to increase the number of "consumers."

The US Auto Industry's Cyclical Crises

In the US in the pre-deindustrialization 1970s the union movement, although already under attack and in a gradual decline, was still relatively strong. In particular, the United Autoworkers (UAW) held a lot of power in the years leading up to the massive relocation of auto manufacturing overseas. At that time, high school graduates

who went to work in car factories could still expect to earn enough money to buy a house, a vacation cabin and cars and send kids to college, work with full healthcare benefits and retire with those same benefits and a pension.

However, in the early to late 70s the US economy faced skyrocketing inflation brought on by “cheap money” (low interest rates) to promote short-term growth, and a nearly four-fold increase in fuel prices when OPEC dared to flex its muscle against US imperialist expansion in the Middle East. US automobile corporations were faced with a situation where Japanese carmakers produced smaller, more fuel-efficient, more reliable and cheaper cars, which began to challenge the market domination of US carmakers. In contrast, US cars were big, heavy, unreliable “gas-guzzlers,” made with some of the most expensive factory labor in the world. In the early 1900s Henry Ford faced a similar situation when his workers were increasingly unable to afford the cars that they produced. He solved this contradiction by extracting more surplus labor¹ from the workers through assem-

¹ Surplus value is a Marxist analysis of how worker labor is exploited by bosses for profit. That is, the amount of money that they are paid for their work is less than the amount of money that what they produce is sold for (minus the capital investment that an owner has to make for machinery and its depreciation). The difference in value, the surplus value is how owners make profit. The more surplus value an employer can extract from each worker, the higher the percentage of profit they can extract from their labor.

bly line production. The result of the adoption of assembly-line production was more cars, produced cheaper and more quickly²—and at a much higher rate of alienation to the worker.³

In the 1970s, at the time this pamphlet was written, the automobile lobby had already succeeded in securing federal backing for building highways and quashing efforts to build public transportation, making car ownership a necessity in most parts of the US. Car sales were fairly steady (until the recession in the 1980s), but with Japanese car-makers increasing their production and building cheaper and more reliable cars, the US car industry faced a growing problem: how to continue to expand when the US market was already saturated, and while the US industry was losing its market dominance to the Japanese. Many began to move their factories from the Midwest to the southern states where workers were largely unorganized and states had “Right to Work” laws.⁴

² Ford’s Model-T dropped from \$900 in 1910 (\$24,453 in 2020 dollars) to \$395 in 1920 (\$5,098 in 2020 dollars). While there were only about 500,000 cars on the street in 1910, in 1920 there were almost 26 million new car sales alone.

³ The boredom and stress of working on the assembly line doing the same repetitive labor every day for eight hours led to “Blue Collar Blues” in the 70s. Absenteeism doubled in a decade and workers and GM workers in Lordstown, Ohio went on a 22-day strike against the relentlessness of the assembly line.

⁴ “Right to Work” laws stipulate that unions are not allowed to negotiate contracts that require all members who benefit

With Ronald Reagan's election in 1980 and the subsequent "liberalization" of trade, the "protectionist" trade barriers that had advantaged US carmakers came down. So too did the barriers to the US auto industry's ability to open *maquiladoras*⁵ across the Mexican border where environmental measures were lax, and most importantly, labor was unorganized, not well regulated, and cost a fraction of what it cost to pay a UAW member. As they moved most manufacturing to Mexico, US car makers also learned from its competition, studying the Japanese manufacturing model called "Lean Manufacturing," developed by Taiichi Ohno of the Toyota Corporation.

The Japanese manufacturing model came to the forefront in the 1980s⁶ as part of the race to make cars more quickly at lower costs, solving one crisis, but eventually driving the industry to its

from the contract to pay union dues. These laws are presented as giving individuals the right to decide if they want to join the union, and in reality are a way for employers to promote disunity among the workers in an organized shop.

⁵ Maquiladoras are foreign-owned factories in Mexico where cheap labor assembles duty/tariff free products for export and consumption outside of the country

⁶ Japanese carmaker Toyota even tried to demonstrate the superiority of its model on US soil, opening a joint venture plant in Fremont, California with General Motors in 1984, a unionized shop. Winning over shop leaders to the Toyota way, the plant still faltered until it was shuttered in 2010. Toyota went on to build several manufacturing plants in the US, but none of them were ever unionized: organized workers made production less "lean."

next crisis of overcapacity.⁷ The bits of manufacturing that remained in the US out of convenience because of its dependency on geographical location or more specialized skills or machinery began to employ “Lean Manufacturing Principles” to eliminate waste. The main “waste,” or cost that most impacted their profit margin, was permanent, unionized labor with health and retirement benefits. With the ever-present threat of plant shut-downs and relocation to Mexico, the UAW lost its base and what remained of its already faltering militancy.

Beginning in the early 2000s, the opening up of the car market in China saved the car industry’s overcapacity crisis; private car sales in China went from 5.6 million to 27.6 million at its peak in 2017. Domestically, easily approved auto loans⁸ helped drive the constant need for customers to buy new cars. Americans owed more than \$800 billion in car loans in 2007, which, in addition to its crisis in overcapacity and the exponentially larger bubble created by the same predatory and

⁷ Overcapacity is a crisis of capitalism. As imperialism expands to try to conquer ever more markets, it must produce more and more goods at cheaper and cheaper costs to out-compete others. This results in contradictions in the industries like the car industry where manufacturers are still trying to expand production when there are already too many cars compared to the number of consumers.

⁸ Sub-prime loans both in cars and housing are loans given to people with poor credit (or poorly demonstrated ability to repay the loan) at high interest rates.

aggressive lending practices in the housing market, led to the financial crisis and “Great Recession” of 2008. Rather than letting the market “correct itself,” as neoliberals always advocate, the federal government handed \$80.7 billion of public money over to the auto industry. This money from the State saved the carmakers from going out of business but could not resolve the basic contradiction of overcapacity. With the saturation of the Chinese market, in 2020 overcapacity reached over 14 million cars per year; more than 14 million new cars are produced every year that cannot be sold. US auto loan debt reached \$1.3 trillion in 2019.

Healthcare Adopts the Car Industry’s “Lean Management Principles”

What happened in the auto industry happened across all manufacturing industries in the US and in most imperialist nations.⁹ This changed both the access that workers had to healthcare, as well as their attitudes towards it. The number of unionized workers in the US plummeted (overall from 25.7% in 1975 to 10.3% in 2019 and in the private section specifically from 25% to 6.2%), as did the number of workers with employer-provided healthcare benefits. In addition, to replace the traditional health plans formerly enjoyed by a more unionized labor force, the Health Maintenance

⁹ In the 1980s Ronald Reagan in the US and Margaret Thatcher in the UK coordinated efforts to push the neoliberal agenda, decimating barriers to imperialist expansion.

Organization (HMO) Act was passed in 1973 during the Nixon administration. This legislation funneled millions of dollars to help the private healthcare industry start up HMOs. Significantly, the Act also overwrote state laws that gave doctors the final say in determining medical treating, turning that power over to the insurance companies.

Healthcare, once a full benefit to which workers felt entitled, rapidly became a commodity that workers needed more resources in order to consume. With the decline of the manufacturing industry rose the corporatization of the service sector, with its irregular, low-skill, low-wage and oftentimes immigrant-based workforce. Employers in the service sector that provided access to health insurance were rare, and those that continued to provide access in any sector demanded more “employee contributions” in the form of monthly payments deducted directly from paychecks.¹⁰ HMOs normalized “copays”—low point-of-service fees initially marketed as giving individuals a financial stake in determining whether they actually needed to seek medical care. The cost of copays rose quickly, with higher fees required to see specialists and take specialized tests such as CT or MRI scans.¹¹ Blue Cross Blue Shield, once the

¹⁰ It wasn't until 2014, after the implementation of the Affordable Care Act (ACA), that employers who employed 50 or more full-time employees were required to offer some sort of health insurance plan to their workers.

¹¹ In 2003 “deductibles” and “coinsurance” were legalized,

bastion of the traditional “Cadillac” healthcare plans for organized labor that is referenced in the *New Outlook on Health* pamphlet below, had its non-profit status removed in 1986 because the government deemed its purpose to be “commercial” rather than “charitable.” Although it retained some special provisions, it became a fully for-profit corporation in 1994.¹²

Those without access to employer-based health insurance were unable to buy health insurance on their own unless they were extremely wealthy; this left uninsured people with few options for medical care apart from emergency room visits (although it wasn’t until 1984 that it became illegal for emergency departments to turn away people because of lack of healthcare).¹³

giving insurance companies the opportunity to offer health insurance plans that set a “deductible” amount that people would pay out of pocket before the insurance plan started paying anything, and “coinsurance,” which was a percentage the patient was responsible for after their deductible was met. For instance, if a plan’s deductible was \$5000 a year with a 20% coinsurance, the patient would pay for all medical costs up to \$5000. Any costs after that first \$5000 would be paid by the insurer at 80% and the patient at 20%.

¹² Blue Cross developed during the Great Depression in the 1930s, at first as a collection of community or employer-based benefit plans. When the American Health Association stepped in with guidelines for those plans organized the Blue Cross emblem, two of its tenets was that they should stress “public welfare” and run as a non-profit.

¹³ Even those with employer-based healthcare plans were not covered for “pre-existing conditions,” or medical conditions that existed before they began their insurance coverage. For instance, if a worker signed on to their health plan in 2000

Hospitals faced a growing population of people who could not seek treatment—who could not buy their services—when they were sick. Most people who ended up in the emergency departments incurring enormous bills they were unable to pay in full in the end. They often had to declare bankruptcy instead, which meant that hospitals didn't get paid.

These contradictions mirror the crises that occur cyclically in other sectors as part of the capitalist economy. What has happened in health-care in the US is a consequence of the relentless advance of imperialism, the penetration of capital into every sector of society. In this late stage of imperialism, where capital is scouring the planet, overturning every rock in every corner to find new markets to expand into, the public sector in imperialist countries has been its most recent solution. Sectors that were formerly public domain such as energy, water and transport were the first to be privatized. Then the onslaught began on education and healthcare, turning students and patients into consumers and commodifying the minds of young people and human well-being. Vital to this process was changing the discourse from the logic of “the public good” to the logic of “profit and loss.” In the last few decades, the notion that school dis-

and was subsequently diagnosed with stomach cancer, their insurance company could deny payment by collecting “evidence” that the cancer had already occurred before the first date of coverage.

tricts and hospitals should perform financially just as any other corporate business became “common sense.” Profit and loss became the measure of the success and failure of something as fundamental as the development of young minds and caring for the sick and aged.

To support its continued expansion and search for more profit, the medical industry needed more customers to buy more of its products. With different market forces jockeying to make money off of the healthcare sector in a new neoliberal era, profit-making became more complicated. Hospitals, health insurers, pharmaceuticals all competed for more healthcare dollars. At the same time, fewer people had the ability to pay for all of the costs associated with getting sick. With the increased competition and as sick people could less afford to buy their products (just as autoworkers in Ford’s time couldn’t afford to buy the cars they made), hospitals followed the example of the car industry: eliminate waste to extract greater profits.

In 2007 the “Global Lean Healthcare Summit” was convened in the UK. According to its promotional material, “The event sold out with 320 people (over half from hospitals) attending from 147 organizations from the UK, Ireland, Denmark, Norway, Sweden, Netherlands, Belgium, Germany, Italy, Spain, Turkey, Poland, Switzerland, France, USA, Canada, Brazil, India, South Africa, Singapore, Australia and New Zealand.”

This summit introduced the concept of transplanting the principles of “Lean Management,” developed by Toyota’s Taiichi Ohno, who was inspired by observing customer behavior and inventory methods in supermarkets, to the health-care sector. The application of “Lean Principles” in the auto industry helped carmakers resolve some of the contradictions it faced to expand and increase their profits. Now the healthcare industry looked to the same solution to extract increasing profits when medical treatments had become too expensive for sick people to afford.

With presentations from think-tanks, business schools, supermarket chains, hospitals and medical conglomerates all extolling the virtues of “Lean Healthcare Principles,” the forum foretold the health industry’s wholesale buy-in of the concept. The call was for a new management style, but also to minimize waste: waste in hospital beds and other infrastructure, waste in supplies, and most importantly, waste in labor. By eliminating waste, hospitals began to create scarcity. During the previous stage of capitalism, hospitals grew profits by bringing patients in and keeping them in; the new practice was to maximize profit by cutting costs. Hospitals that were unable to compete by stripping down their costs—such as the many run by religious orders—were forced to close. In 1975, there were 7156 hospitals in the US. By 2010, there were only 4985.

In implementing “Lean Principles,” the hospitals realized that it saved them money if there were patients waiting in the hallway for beds at all times, rather than having a few empty beds and no wait for transfer from the emergency department. It saved money to order supplies frequently rather than build large stockrooms to store and staff to manage them. It saved money when they hired fewer nurses to care for more patients and filled some of the gaps with low-wage, low-skill, non-unionized nurses’ aides.

A key part of “Lean Manufacturing” is “just-in-time inventory management.” It involves reordering the entire manufacturing supply chain. Rather than produce car parts locally and store them in giant warehouses awaiting orders, production of parts shifted to anywhere in the world where it was the cheapest and then shipped to the plant on demand, where they were assembled “just in time.” This method cut costs from infrastructure for storage, but most of the “savings” came from cuts to labor costs. The repackaging of imperialism into the concept of “globalization” meant that neoliberal policies removed barriers so that corporations could access the cheapest labor and natural resources for their production needs.

This brings us full circle to the 2019 COVID-19 pandemic and why the medical staff in one of the most technologically advanced medical systems in the world are wearing rain ponchos instead of sur-

gical gowns and bandanas instead of masks. “Just-in-time inventory management” during ordinary times might cut some costs at hospitals. During a pandemic, it has proven to be fatal.

Crisis of Consolidation and Overcapacity in Healthcare

Simply eliminating waste to increase profits is not enough to survive in a capitalist economy. Companies that do not grow and out-compete others in the market to generate more returns for its investors go out of business. In the auto industry, in addition to eliminating “waste” by moving manufacturing overseas, practicing just-in-time inventory management, and gutting unionized labor, US carmakers increased production to try to fight off growing dominance of the Japanese carmakers—which increased their production exponentially and led to the crisis of overcapacity in the industry. The healthcare industry, too, followed a similar pattern.

In 1973, at the time of the passage of the HMO Act, there were only about 30 private companies offering HMO plans. In 1975 there were 183 and by 1986 there were 400. Mergers and acquisitions are essential business strategies to any major corporation in capitalist society in order to try to dominate the market. By squeezing out competitors, corporations can be better positioned to dictate terms to consumers, including pricing and stan-

dards. After Blue Cross became for-profit in 1994, private companies moved to consolidate their assets to dominate the market through acquiring and merging with struggling Blue Cross affiliates and other companies.

But many Americans were uninsured. In 2009, in the midst of the last Great Recession, health insurance companies increased their profit by 56% by raising the cost of premiums, (especially for people who were the sickest and therefore cost them the most money) co-pays and deductibles. As a result, 2.7 million people lost their private health insurance coverage. By 2010, 46.5 million people lacked health insurance—a number that continued to increase every year. While the American people identified their growing inability to afford to be sick as a crisis in healthcare, the medical industry identified it as a crisis of capital. The consolidation of the health insurance industry coupled with the consolidation of hospital systems meant that both payers and providers reached what (bourgeois) economists term “bilateral monopolies,” or a stalemate where neither side could go to other competitors to leverage lower or higher payments.¹⁴ Without more overall consumption of its commodities, that is, without increasing the number of sick people who could buy insurance

¹⁴ In many smaller “markets,” the one large insurer would be forced to negotiate prices with the one large hospital system; each monopoly unable to pressure the other to raise payments or lower fees because of the lack of competition.

and medical intervention, the capital investment in the industry was at risk.

Enter the Affordable Care Act (ACA, also known as “Obamacare”) of 2010. Subtler than Obama’s \$80 billion bailout of the car industry, it was marketed as the solution to the healthcare crisis faced by Americans. In reality, the ACA was actually a public subsidy to the private health insurance industry. It required every person to buy health insurance through a “Healthcare Marketplace” of private vendors if they weren’t insured through their employers. Those who refused were made to pay a penalty (until it was eliminated in 2019).¹⁵

At its peak in 2016 the ACA enrolled about 12.7 million people through the Marketplace. Those 12.7 million people became monthly premium paying consumers of private health insurance plans. Through its various other provisions, including the expansion of Medicaid (for the poor), the total numbers of uninsured people in the US decreased from 46.5 million in 2010 to 27 million in 2016.¹⁶ The expansion of Medicaid was

¹⁵ The penalty, known as the “Individual Mandate” was \$695 per adult and \$347.50 per child in 2016 (with a maximum of \$2,085 for a family), or 2.5% of total income, whichever was greater.

¹⁶ In 2018, the number of uninsured climbed to 28.6 million. Numbers are rising because health insurance premiums and copays/deductibles are going up as compared to the “Individual Mandate” penalty. Figures are projected to be higher still in 2019-220 because of the elimination of the

also a boon for private healthcare insurers; more than two-thirds of Medicaid recipients received care through federally funded but privately owned managed care plans. Altogether, in 2016 the ACA facilitated the introduction of more than 21.5 million people as new and regular consumers of private health insurance. This helped fuel another cycle of capital expansion in healthcare. Now in 2020, there are over 900 different private health insurance companies. Similarly, in 2020, the number of US hospitals increased by 1,161. In addition to an overall increase, between 2013 and 2017 almost 20% of all of the country's hospitals were acquired or merged with another hospital. For-profit hospitals as a percentage of total hospitals grew almost 10% between 2000 and 2018.

In a broader sense, the passage of the ACA was the federal government's use of public money to help solve both the consolidation and overcapacity crises brought by private capital investment in the medical industry.¹⁷

mandate.

¹⁷ Johnathon Gruber, an MIT professor of economics and the director of the Healthcare Program at the National Bureau of Economic Research, was a major advisor to the Obama administration on the ACA. He has been a staunch advocate for the funneling of public money to private corporations for medical research, which he claims would “jump-start” the economy by creating jobs. His “new” theory is actually a re-hashing of the same theory that in the Reagan Era was called “Trickle-Down Economics”: giving public money to rich people and corporations will trickle down to poor people through job creation and bolstering the economy. This

Unsurprisingly, neither the HMO Act of 1973, nor the ACA of 2010 actually did what they were marketed to the “public” to do: lower healthcare costs for the individual or the State. By 2019 individuals with employer-sponsored health insurance actually paid an average of \$3673 more per year than before the ACA was signed. The average monthly cost for individuals unsubsidized ACA plans grew to \$448 a month from \$393 in 2013 (the first year the ACA took effect).

In 2019 federally subsidized ACA plans averaged \$593 a month with a \$514 a month subsidy and a total of \$62 billion in federal subsidies went to private health insurance companies in the Healthcare Marketplace. In fact, the Congressional Budget Office reported that in 2018, the federal government spent more per person in subsidies to ACA (\$6,300 per subsidized adult) than on Medicaid (\$4,230); such figures make unconvincing the claims that a “single payer,” federally managed healthcare system would be too expensive.

Overall, total healthcare spending in the US is expected to exceed \$4 trillion in 2020—up from \$3.6 trillion in 2019. (34% of that \$4 trillion goes to administrative costs. That is, \$1.36 trillion goes to non-medical management of healthcare.) This represents a more than six-fold increase from 1975 after factoring for inflation. Health insurance com-

theory, or rather, propaganda, has been irrefutably disproven, yet continues to be recycled.

panies alone took in \$23.4 billion in 2018 with a profit margin of 3.3%. This level of penetration of capital into healthcare would not have been possible without the State subsidizing the private sector to increase the number of consumers. The contradictions inherent in the healthcare sector over the last several decades clearly and logically follow the path of other sectors—like the automobile sector—under neoliberalism. But when we factor in the idea that human health is qualitatively different from spark plugs or headlights, the contradictions become absurd.

Innovations such as “Lean Manufacturing” and the Healthcare Marketplace were and are created to solve problems of capital. And capitalism has proven to be nothing if not creative in the way it solves its crises, by shifting the burden of those crises to the poor in order to continue to extract more surplus value from workers and more resources from the planet to make more profit. At times, capitalism’s drive for profit may overlap with meeting the needs of society and the environment—as in the case of the creation of the public education system to prepare an educated and disciplined workforce. Most of the time, the overlap is incidental—as in the case of some new medications that actually cure diseases while they make its manufacturer a bunch of money. But we must not be confused about its purpose.

The overarching purpose of healthcare in capitalist society is not to care for health. If we confuse this capitalist project as caring for the well-being of humans, we will be confused about how to effectively confront these contradictions. “Lean Principles in Healthcare” and the ACA were innovative solutions to capital’s problem of shrinking profits in the medical industry at a time when capital necessitated expansion. Before the onset of the COVID-19 pandemic, a less than a decade after the ACA went into effect, the healthcare industry faced the same contradictions in a different phase of its cycle; after a brief cycle of new hospital and health insurance growth, we were seeing growing consolidation and a decrease in its consumer base, or people without insurance.

Now, in the midst of the COVID-19 pandemic, hospitals and insurers are concerned more with projections of “catastrophic” losses in terms of profits rather than human lives. In its aftermath, these capitalist business ventures will again require a massive bailout from the government with public funds to solve their crisis.

Why is the US in Particular Failing so Hard?

When “public” is no more—when all of the sectors that used to be considered public (education, transport, energy, public safety, ambulances, prisons, hospitals, government) have been or are in the process of being privatized—public health no lon-

ger exists, either in concept/culture or infrastructure. Fighting and containing pandemics require both a conceptual understanding of the “public” by the masses and a public infrastructure driven by public welfare rather than profit motive. The US has very little remaining of either.

The myth of “individual” freedom in the US has achieved a level of unquestioned primacy. Few people will act for the public good until they are directly affected—which is why social distancing and mask wearing were largely disregarded until transmission rates were so high that it was difficult to find someone who didn’t personally know someone who had contracted COVID-19. Some of the most advanced medical centers in the world reside in the US, yet none of them were adequately prepared to handle the onslaught of COVID-19 cases, even with several months to prepare. Very few hospital administrators were able or willing to spend the time and resources to prepare for the coming pandemic, because they have been so habituated to the logic of short-term capital demands.

Each state, each region, each county, each city, each hospital, each hospital unit is operating as a separate entity from the whole. When several state governors on the West and East coasts banded together to form pacts to avoid competing with one another and coordinate the reopening of their economies, it seemed a novel and refreshing idea. (A columnist from *The New Yorker* satirically sug-

gested the governors might get together to form a country and quipped that it would be “amazing to have a President right now.”¹⁸) Big inner cities with large poor populations are pitted against smaller, wealthier suburbs. Hospitals in the same city, confronting the same disease in the same population, fight over scarce supplies. Nurses, doctors, nurses’ aides, cleaners and kitchen staff in the same hospital are given different levels of protective equipment, not based on exposure, but based on status decided on by hospital bureaucrats. It’s difficult to imagine any other advanced capitalist country of this size floundering so thoroughly in the face of such a grave threat.

Healthcare in a Different Economic System

A close look at the US provides a stark picture of healthcare under advanced capitalism, its system a model that is being pursued by the majority of countries in the world today. However, we have historical examples of how healthcare differs when it is not driven by capital. For instance, healthcare in China during its socialist period.

When the communists in China won the revolution and established a new socialist state in 1949, the country had seen over a century of war, famine and catastrophic natural disasters. The overwhelming majority of the vast population lived in the poor countryside farming with basic hand

¹⁸ *The Borowitz Report*, April 13, 2020.

tools. There was very little national industry, and most people were illiterate. The complex tasks of providing healthcare and education piled on top of the more immediate tasks of feeding, clothing and sheltering 542 million people. And yet, by the mid-1950s, the majority of children were learning to read and write in elementary schools, and a whole system of more than 200,000 rural doctors who were trained to provide basic healthcare was established.¹⁹ Later, these rural doctors came to be known as Barefoot Doctors because they were of the villages and lived and worked in the fields with everyone else. Because of their continued integration in production and in village life, they were well situated to understand their potential patients and the context in which they might have fallen ill.

Hospitals were gradually built throughout the country on a county-wide level, so that medical resources were not concentrated in the cities.²⁰ Rural doctors were trained to recognize when conditions were beyond their skill levels and transferred patients to the nearest hospital.

¹⁹ At the time of Liberation in 1949, China estimated that it had about 40,000 doctors who were concentrated in the cities, or one doctor for about 13,500 people. During the 1960s, over 1.5 million Barefoot Doctors were trained and working to provide basic medical care in rural villages. As a consequence, between 1949 and 1979, infant mortality fell from 200 to 34 per 1000 live births, and life expectancy increased from about 35 to 68 years.

²⁰ In 1949 there were 2,000 hospitals and there was one hospital bed for 6,500 people. In 1979 there were 65,009 hospitals and one bed for 502 people.

These hospitals did not have many resources, but they did have trained staff whose purpose was to care for the health of their patients, a priority dictated not by the bottom line of the hospital, but by the needs of the people, both individuals and the larger public. They had basic medicines and relied on family members to provide the lower-level day-to-day nursing care. Care was provided to patients at low cost, because wages and medical supplies were managed by the State as part of an overall plan to build the healthcare infrastructure in the entire country.²¹ Rather than being motivated out of concern for their own livelihoods, hospital workers approached their work on the principle that humans were the most important resource and that because China was a poor country, saving money and material resources was important for the greater good.

Much has been written about how China was able during this time to eradicate diseases such as malaria, typhoid and schistosomiasis—diseases that killed (and continue to kill) millions in poor countries around the world. They accomplished this predominantly through education and mobilization of the masses to improve nutrition and hygiene. One of the best examples of how a poor, socialist country such as China dealt with a disease threatening public health is the case of tuberculosis

²¹ State Communes contributed small amounts to the hospitals from their common welfare funds.

(TB) in the dairy industry. TB is a bacterial disease that attacks the lungs, is spread by coughing and can be fatal if left untreated. It can be transmitted to humans through cows by breathing in the bacteria or drinking contaminated milk. In the West, the method to stop the spread of TB in cattle was to immediately slaughter any cows that tested positive. However, in China, livestock was in short supply and the milk they produced was critical to raising the nutritional level of the people. Instead of slaughtering TB-positive cows, they isolated them in their own herds and treated the disease. Many recovered and were integrated back into the main herds. State farms and cooperatives were able to use this method because they did not face the same contradictions that capitalist dairy farmers faced, where labor costs and the bottom line meant that wholesale slaughter was more economical than isolation and treatment. (This example sits in stark contrast to the current situation in the US where the COVID-19 pandemic has disrupted the food supply chain to the cities, so that farmers are slaughtering millions of chickens and dumping tons of milk while grocery store shelves are bare. The capitalist economic system simply does not allow for getting excess food to hungry people, because its supply methods are dictated by the market and profit/loss, rather than human need.)

In post-Liberation China, all of the healthcare infrastructure, as well as the culture about the *care of health* that surrounded it, was built deliberately with planning by the State. The enormity of this task—how to provide the broadest access to the most advanced healthcare as possible given resources and conditions to the greatest number of people—was overcome through detailed planning based on thorough and ongoing investigation and following the ideological line that the welfare of the majority of the people, the public, was the determining factor. All of the training, construction of buildings, designing and manufacturing equipment, researching and developing medicines and medical techniques, were not organized by the logic of profit and loss. The costs and resources were weighed against other infrastructure and immediate needs, rather than expansion or contraction based on market forecasts.²²

COVID-19 Unmasks the US Healthcare System

The US, unlike most countries in Western Europe, never saw social democracy. In spite of

²² Almost all of the medical infrastructure in China after the capitalist coup was privatized and the remaining public hospitals were made into their own accounting units responsible for their own profit and loss. That change gave administrators and doctors license to follow the Western capitalist model, buying state-of-the-art equipment, importing brand name medications from Europe and the US and training highly specialized doctors—and then increasing the numbers of tests and fees to pay for it all.

all of the social democrats' betrayals, dirty deals and, ultimately, complete opportunistic embrace of their own national capitalism and imperialism, one positive consequence of their legacy remains the notion, albeit tattered, of the "public." With the advance of imperialism, that legacy is, and will continue, to be necessarily under attack and destroyed. However, some vestiges still remain in countries like France, with its mostly intact "single payer" healthcare system, and the beloved National Health Service in the United Kingdom. In this sense, the US, stripped early on of its "public" culture and infrastructure, provides us with the clearest example of how healthcare develops under capitalism.

COVID-19 has provided a terrible lens through which we can understand the consequences of capitalism on public welfare. The "failure" of the healthcare system to effectively fight the pandemic is actually a logical result of the penetration of capital into every corner of society—itsself a function of imperialist expansion. What is happening now—healthcare workers without protective gear who succumb to the coronavirus while trying desperately to save lives, farmers who destroy crops while people go hungry—is not a mistake or malfunction of the system; it is the consequence of the steady march of imperialism, largely impervious to the public good (unless it intersects with its expansion), in search of new investments and markets

to solve its own contradictions. There is nothing to “fix” here from the perspective of the people, because it is not broken from the perspective of the bourgeoisie; what is there to repair in a system that is working as it should?

We, who believe that human beings are not cars; we, who believe that an economic system that holds the public—the collective good—as paramount: for the survival and thriving of the human race on our one and only planet, we must learn the lessons that COVID-19 has unmasked and proceed with our work accordingly.

REDSPARK COLLECTIVE

MAY 2020

A NEW OUTLOOK ON HEALTH

PREFACE

This pamphlet is addressed to those American men and women who have begun to wonder why it is that in this country which is so technologically advanced, so few people have any knowledge of their bodies and have therefore become so dependent on pills and drugs to keep them going from day to day. For both rich and poor, women, men, and youth, pills appear to be the answer for everything—from waking to sleeping, from birth to death. They pacify us and at the same time encourage us to evade facing the causes for our discomforts. Tranquilizers, vitamins, uppers (diet pills), downers (sleeping pills), and other drugs are thrust into our lives by television, radio, newspaper advertisements, over-the-counter advice from sales clerks, office advice from our doctors, and bedside advice from nurses in hospitals. For the slightest pain, we rush for a pill—the cure-all. Many people realize that the vast output of drugs in this country is the result of the drive by drug manufacturers for more profit. We know that individuals often die from drug overdoses, that many drugs produce allergic reactions, that some produce deformities, and that practically all prevent our bodies from developing resistance to common illnesses. Yet we persist in taking them because these drugs have become our crutch and our mainstay for stability in an unstable society.

We have the most advanced material base of any society in history and the highest standard of living in the world. Our technology enables us to produce goods to satisfy any conceivable material wants. Yet seven other societies have more doctors per capita than we do. In thirteen other countries pregnant women receive better care. Life expectancy for males in this country is shorter than in twenty-one other countries.

The American government has been able to make remote-control airplanes to bomb human beings in distant lands and to build spaceships that have taken men into outer space beyond our imagination. But it has been unable to create a health system which would make us more self-reliant in caring for ourselves here on earth. Every year the government spends billions of dollars through Medicare, Medicaid, and dozens of health agencies, allegedly to serve the health needs of the population. The more money which goes into the American healthcare system, the more dependent Americans have become on doctors and drugs, and thus the less able we have become to take care of ourselves and each other.

In order to create a new health system in this country, we must first realize that no demons created our present poor system. People did it. And only we, the people, can change it.

To change it, we must first understand how the present health system developed and why it is so

full of contradictions. Then, collectively, we can struggle to change it.

To do this, we must examine not only the health system but our own outlook towards health. Only by struggling with ourselves, with each other, as well as with doctors and the growing number of health workers and health bureaucrats in organized medicine, the insurance industry, and various health agencies, can we begin to create a new health system.

In writing this pamphlet, we have observed first-hand the failures in healthcare which take place around us every day. We have witnessed how not only the drug industry but doctors, hospital administrators, nurses, aides, and other health workers support the present medical system because it benefits them economically despite the helplessness and healthlessness which it creates in us, the American people. But we have also witnessed how most Americans go along with this system, refusing to take care of or learn about our own bodies, because we are depending upon the magic of pills to relieve us of the responsibility to struggle for a better way for everyone to live.

We are convinced that the time has come for all of us to struggle together to change the social practice of medicine for the well-being of all.

This pamphlet has been written as a weapon in this struggle. We urge everyone—regardless of race, sex, class or age—to read and discuss it with

your co-workers, families, friends, neighbors, classmates and club-mates. It can be the beginning of a whole new outlook on yourself and on everything and everybody else in this society.

USA
FEBRUARY 1975

CHAPTER 1

THE FATAL ILLNESS OF MEDICINE IN AMERICA

To be in need of medical care in America today can be an experience filled with many anxieties and fears. In our daily encounters with the healthcare system, an assembly-line atmosphere exists. The patient is treated as a product, rushed from one specialist to another, with each specialist asking questions in his specialty, and no one taking the time to answer questions or to explain the treatment procedures. Our diseases are treated only as symptoms, occurring in one part of our body with no relationship to ourselves as whole individuals living in society. Often we feel that we are being treated like guinea pigs for some research project. Usually we are made to feel not only helpless but too stupid to understand what is going on in our own bodies.²³

Routine visits to a doctor's office may end up as mental and financial nightmares. We wait hours for office medical care, often to be told that the doctor will not be in the office at all that day. In emergency rooms we spend hours waiting for medical

²³ The assembly line method of healthcare has also impacted the doctors, training them to be mindful of only the potential diagnosis within their specialties, not the patient as a whole, complicated, interconnected human being. Like the assembly line worker, the specialist no longer understands how their "part" works in the larger "machine." If they don't understand it, the alienation makes it difficult to maintain interest.

care. Then we are sent away with no understanding of the cause of our illness or what treatment we will receive—only a prescription and a reminder to return in a week.

Because of the way we are treated by the physician and other health workers, we often feel that to be sick must be a sin. Many of us are hesitant to seek medical care due to our previous experiences with doctors. Thus, only in an emergency and often when it is too late, do we seek medical services.

In the last twenty years the cost of medical care has increased by 330 percent. Americans are now spending some 10 percent of their income for healthcare amounting to a total expenditure of nearly 75 billion dollars yearly. In major hospitals the bill for patient care has tripled in eight years. But we who have been patients in a hospital or even visited someone in a hospital during these years know that medical services have become worse.²⁴

In city hospital corridors many patients are forced to wait on cots. In these hospitals there is a high death rate, almost twice that of voluntary hospitals. In voluntary hospitals, where we are paying hundreds of dollars a day for care, we are usually told that our doctors are unavailable when we ask for them.

²⁴ In 2019 the poorest 10% in the US spent on average 35% of their income on healthcare, whereas the richest 10% spent 3.5%.

Many doctors have unlisted home telephone numbers. So we lie in a hospital bed watching television, wondering what is going on in our bodies, and unable to get any answers from the nurses whose main function appears to be the administration of an assortment of drugs to each patient several times a day.

Throughout this great country there are only 340,000 allopathic (M.D.) and osteopathic (D.O.) physicians who are responsible for directing the healthcare for 200,000,000 Americans. In a wealthy suburb like Beverly Hills, California, there is one doctor for every 225 persons, while a few miles away in the black community of Watts, there is only one doctor for every 2,700 persons.²⁵

These figures alone reveal what a dilemma we, Americans, face. Even though the cost of educating our doctors is borne by all of us, we have nothing to say about where doctors should practice or how they should practice medicine. Many communities in this country are without any type of medical care. Many people in large cities and in rural areas must travel long distances to find some kind of medical care.

²⁵ These figures have changed dramatically: in 2019 there were three doctors per thousand people in the US. In the past forty-plus years the US has churned out more doctors, but mostly highly specialized, high salaried ones. It is ranked 53rd, still behind almost every advanced capitalist country in the world, with Cuba topping the list with eight doctors per thousand people in 2017.

We are not adequately informed about illnesses even if a terminal illness exists. The doctor usually has a superior attitude, preventing rapport between him and the patient. Most doctors have no interest in helping us understand medical knowledge. As patients, we know little about our body and our bodily functions, even though we live in a country that stresses education. To ask questions is forbidden in most doctor's offices and hospitals. Doctors neither explain nor inform us of test results on the premise that only medically trained personnel are privileged to medical knowledge about our bodies. Even our temperatures and blood pressures are often kept secret. Medical terms are used to create a type of mystique which overwhelms us and which we feel unable to penetrate. This mystique is increased by prescriptions scribbled illegibly and in a code which only the doctor and the pharmacist can decipher.

Most of us do not know what medicine we are taking. Many danger signals of various diseases are unknown to us because no one has taken the time to make this knowledge available to us. Most doctors are more interested in treating symptoms than in explaining to us how we can get better and stay well. Often we are told that we are taking valuable time from sick people if we insist on preventive medical care.

More and more specialists are being turned out by medical schools to treat a small number

of people daily at exorbitant fees, while there is a growing shortage of family doctors or general practitioners. These family doctors can rarely provide adequate healthcare for all of us. This is not only because of overwork but also because, having been accredited for life, most doctors do not feel the need to keep up with developments in medicine. So they become increasingly dependent upon the drug-pushing salesmen from the huge pharmaceutical houses to educate them about drug products.²⁶ Despite the obvious shortage of general practitioners, even family care doctors are now being trained as specialists. This means that they must spend more time in medical training, further increasing the shortage of doctors available to the public. As a result of over-specialization and too many specialists, it is extremely difficult to obtain routine healthcare, while the growing number of specialists are tempted to perform unnecessary medical procedures in order to keep busy and keep the money coming in.

Meanwhile, we, the patients, sit idly by, complaining about the situation, but making no effort to determine how it came about and what we can do about it.

²⁶ Many doctors don't understand the potential side effects or interactions of the drugs they prescribe. With doctors becoming so compartmentalized, oftentimes it is left up to an attentive pharmacist to warn a patient if, for instance, their medication for insomnia interferes with their medication for high blood pressure.

How is it possible that such a backward health system could exist in a country as advanced as the United States, where the great majority of the population has received a high school education and where so much money is spent on healthcare every year? To find the answer to this question, we must go back into the history of medicine in this country.

The practice of medicine in the United States today is not the same as it was in the 18th and 19th centuries. At one time doctors were willing to make house calls and were much more available to large numbers of people, at least in the country and in small towns. The doctor of the horse and buggy era, with his little black bag, was not the highly trained physician whom we know today. (In describing the way things are, we refer to the doctor as “he” because males do, in fact, dominate the medical profession today.) In the early days, the doctor was often self-taught or might have served an apprenticeship with an older doctor. Sometimes he was just the local barber who had some knowledge of the body already and then expanded on this knowledge by his own studies and practice. Many frontier and country doctors had learned about herbs from the Indians and blacks from Africa.

These early doctors responded to the needs of the people in the communities where they lived. Most people considered the doctor a member of the family who was usually present both for births and

deaths. This doctor was able to care for non-complicated illnesses, such as sore throats, chickenpox, and for fractures, cuts, sprains and uncomplicated childbirth. The community affectionately referred to him as “Doc,” as we have seen so vividly portrayed on television in *Gunsmoke*. He was a family friend and a family advisor.²⁷

People often died from serious illnesses or in epidemics, but for the most part Americans in the country and small towns enjoyed better health in those days than today’s city-dwellers because the way of life was healthier.

Meanwhile, poor people in the big cities had very little medical care since only the rich received early diagnosis and any type of reasonable treatment. The poor went to hospitals when they were nearly dead. Most health institutions were known as “pest-houses.” Childbirth fever was the fear of all pregnant women who delivered their children in hospitals. Blacks had practically no healthcare. There were few black doctors and no access to hospitals for blacks until after the Civil War.

Towards the end of the 19th century it became clear that this absence of healthcare for the poor city dwellers was becoming a serious social problem. The population was shifting from the countryside to the city, from agriculture to industry.

²⁷ Living conditions in the countryside during that time period were still very difficult, especially for child-bearing women and infants, with infant mortality rates at 165 per 1,000 in 1900.

Immigrants were pouring in from Europe to meet the needs of industry. Many people lived in squalor, which bred social diseases among the poor, such as tuberculosis, hepatitis and syphilis. Congestion and inadequately heated dwellings added to the health problems.

So massive were these new health problems created by urbanization and industrialization that it was unrealistic to think only in terms of treating each individual problem. The supply of labor was being threatened by the spread of these diseases. Because these diseases could be so easily spread, the rich were also threatened. Therefore, under pressure chiefly from social reformers and humanitarians, the new diseases were treated first and foremost as social diseases, which had to be reduced by preventive measures. Public health departments were created, supported by public funds. Water purification and rat control projects were organized to reduce the danger of plague. Massive programs for vaccination were introduced. Programs for early detection of tuberculosis and sanitariums to provide rest, good food, and healthy conditions were organized for those with this dreaded disease known as the "Great White Plague."

It is important to note that not doctors but social reformers and humanitarians, dedicated to eliminating the social evils of the industrial revolution, played the leading role in pressuring city officials to implement this social or preventive atti-

tude towards diseases. Nevertheless, because the practice of medicine had not yet developed into an elite and lucrative profession, doctors in that period were not hostile to this social approach to disease which was beginning to take root in our society at the turn of the century, and which was beginning to make clear in practice the inseparable connection between good health and fresh air, pure water and a balanced diet.

Meanwhile, along with the rapid developments taking place in industry, science and technology, changes were also beginning to take place in the field of medicine. Medical schools began to spring up all over the country to train doctors for the growing demand. Most of these institutions were set up for the purpose of giving more rigorous training to medical students and imparting to them a more systematic knowledge of anatomy and physiology. Others were set up by quacks seeking to make a quick dollar.

In order to keep these quacks from operating as well as to take advantage of rapidly expanding scientific knowledge, the Carnegie Foundation, (established by Andrew Carnegie, the steel magnate) and the American Medical Association sponsored a study of basic curriculum and teaching methods for medical training. The immediate effect of implementing this study, published in 1910 and known as the Flexner Report, was to restrict the practice of medicine to highly trained

individuals whose skills and knowledge had been acquired through rigorous training and indoctrination within those few medical schools approved by the American Medical Association.

Only one road for the training of doctors was left open—the road leading through elite institutions like Harvard, Johns Hopkins and the University of Chicago. Only such institutions could afford the expensive equipment and laboratories for the kind of scientific research recommended in the report, and only the sons of the rich could afford to attend them.

Equally disastrous, medical instruction in these schools was based on the recently discovered theory of the germ origin of disease, supported chiefly by laboratory research on animals which had been made possible by advances in technology. Medical practice based on this theory did not view the patient as a human being developing and living in a particular environment. Instead it focused on the disease at an isolated location in the body which could be treated in and of itself. Based on this philosophy, the social approach to illness, which had sparked the massive public health programs of the late 19th century, was excluded from the medical curriculum. Excluded also were all other systems of therapy based on fundamentally different concepts of the human body and the human being, especially those based upon helping the body to keep healthy and to heal itself.

Whatever had been of value in the traditional medicine absorbed from the Indians and from blacks and practiced by the country doctor was abandoned. Also excluded was osteopathy, which had been founded by A.T. Still in 1874, and which is based on the theory that most ailments result from structural derangement of the body; and homeopathy which is based on the principle that disorders can be corrected by small doses of drugs producing effects similar to the disorder. (After World War II under the pressure of the need for more family doctors, osteopathic physicians were accredited. General practitioners nowadays in the inner city are likely to be osteopaths, but they are just as likely as the M.D. to over-prescribe drugs to their patients because they have the same elitist attitude to patients as the M.D.)

All theories of the causes of illness which place responsibility upon society to tackle the social conditions, or on the patient for greater self-reliance, or on the natural forces within the body to restore equilibrium, were discarded. Only the germ theory of illness was accredited, because it is the theory best suited to a medical system based on the bourgeois outlook that all knowledge and power should be concentrated in an elite, while the masses of people are regarded as less than human. They are only bodies, no different from animal bodies, which can be examined under a microscope in a laboratory,

incapable of developing knowledge about or caring for themselves.

The standardization of medical education along the lines recommended in the Flexner Report was a turning point in American medicine. Not only was a limit placed on those who could become doctors, but those doctors produced by the new, narrow approach to the human body and to human beings began to think of their patients only in the narrowest terms, isolated from their environment and from each other. Their illnesses were now viewed chiefly as invasions of the body by demon-like germs which must be driven out by the magic bullet of drugs, injected or prescribed by the highly trained medicine man.²⁸

As the years passed, elitism became more deeply rooted in the medical profession. Not only was admission to medical schools limited to those who came from affluent families, but even those few of humble social origin, who by some stroke of good luck gain admission to medical school, become indoctrinated with an elitist outlook to their

²⁸ The practice of medicine did become narrowly focused with the discovery of "germ origin of disease," with many negative consequences in the context of capitalist development as described. However, the discovery itself is still a medical advance. Civilization without the developments based on discovering microbiology would mean a society without vaccines or antibiotics; just because capitalism has used this knowledge to extract profit as the primary prerogative, doesn't mean that the knowledge has to be used in such a way. China during socialism and Cuba provide far different examples of its applications.

patients as “cases,” i.e., as dehumanized objects of scientific analysis. In medical school, students learn the practice of medicine as a “science.” Then, during their internships, usually in city hospitals where poor people come for emergency treatment, the student doctors see their patients in isolation from other people and from their social environment. So the tendency of the student doctor to see human beings as diseases and not as total persons is constantly reinforced.

As medical practice became a passport to privilege, doctors became more and more distant from people as human beings and more and more divorced from social responsibility to any community. More and more they began to think of medicine as a career for themselves as individuals. The more the patient was viewed only in terms of separate parts—a diseased heart or lung or liver—the more doctors began to think in terms of specializing in the knowledge and treatment of specialized parts of the body. People as individual human beings living in communities, capable of caring for themselves and each other, were ignored. As more and more training was required to become a specialist, doctors began to feel that the only adequate reward for their prolonged study was more money and higher status. Hence more and more doctors began to flock to affluent neighborhoods, abandoning any idea of service to the poor. As the monetary and social rewards of being a specialist

became obvious, medical students began to choose careers as specialists, leaving fewer and fewer general practitioners for the general population. Faced with the choice of serving the many or serving the few, more and more doctors decided to serve the few. In other words, they chose the elitist or the bourgeois road.²⁹

Poor people, black people, and women—in other words, the majority of the population—have been the ones who have suffered most from the elitism inherent in the present medical system. Those who were better off or better educated were able to command some respect from their doctors. Often their doctors were friends of the family.

In 1973 infant mortality among blacks was almost twice that of whites.³⁰ Poor children of all ethnic groups develop at a slower rate than those

²⁹ The attitude of doctors, many of whom might have entered into medicine because they actually wanted to help people, are put in an environment where they feel they have to prioritize their finances (average medical school debt in 2019 was over \$200,000), and are pressured to rush through patient care by insurance companies that allow most doctors only 7-8 minutes per person. Some insurance companies even hire full-time staff to trail doctors and question every decision they make under the pretext of saving money. While American doctors (general practitioners) have the highest salaries in the world, recent studies show that about half would be willing to take a drastic pay cut for less stressful work conditions.

³⁰ While this rate has decreased slightly since 1975, the ratio of about 2 to 1, black to white has remained constant, and the US still leads imperialist countries in its overall rate of 5.9 deaths per 1000 live births.

who are not poor. Chronic and infectious diseases occur much more often among those who earn the least money.

Rich or poor, women have not been treated as equals, either in the doctor's office or in the medical profession generally.

In the first place, women have been kept out of medicine because the more elite the profession became, the more natural it has seemed, within a male-dominated society, that only men were capable of such elevated work. So midwives were more and more excluded from participation in the process of childbirth, and only male doctors were regarded as capable of delivering a child. Then pregnancy itself, as well as all the natural stages by which a woman's body develops, menstruation and menopause, began to be seen as diseases which only the highly trained obstetrician and gynecologist could treat. In the doctor's office, women are talked down to like children. Already regarded by a sexist society as brainless bodies, in the doctor's office they are treated like mental incompetents, incapable of knowing about or caring for their own bodies.

The resulting underdevelopment of women has meant that they are at the mercy of the many doctors who recommend surgery as the first solution despite the consequences to the individual. For example, hysterectomies are still the second most common surgery performed today, even though

surveys have shown that one out of three hysterectomies performed today is unnecessary. In 95 percent of these operations, the woman involved simply took the word of the doctor, without asking questions as to the practicality of less drastic procedures.

The whole society has suffered because of the underdevelopment of women inherent in the present system. Women are the ones most responsible for the healthcare of their families, including not only their daily feeding but their whole approach to their bodily functions. Therefore, as long as the women in a family believe that pills are the first resort in the case of discomfort, as long as they do not have a preventive approach to illness, their children will grow up with the same approach.

Thus, what began as a progressive measure—to eliminate quack medicine and to establish the practice of medicine on a sound scientific basis—has created a situation where a chosen few are enjoying the monetary and social benefits of the practice of medicine, while the rest of us are at their mercy.

CHAPTER 2

THE MEDICAL-INDUSTRIAL COMPLEX

During the 1920s and 1930s, the fundamental weaknesses inherent in a medical system based upon the growing knowledge and power of an elite and the growing passivity, dehumanization and ignorance of the majority, were not apparent because most people lacked the money for health-care and did not yet feel that they had a human right to such care. However, in the last thirty years, the progressive struggles of the various oppressed sections of the American population for healthcare have brought to the surface the internal and intolerable contradictions of a healthcare system based upon this bourgeois outlook.

After World War II, with the growth of the bargaining power of the unions and the rising expectations of the American people generally, the average worker began to feel that he was just as entitled to healthcare as anybody else in this society. What he conceived healthcare to be was what he had perceived during World War II.

During the emergency conditions of World War II it had been necessary for the armed forces to produce medics rapidly in order to perform on the battlefields. Also, during World War II Americans became conscious of the miracles which could be achieved by penicillin and other antibiotics, cortisone, and blood pressure medications. Since

all kinds of wonder drugs and equipment had been used in army hospitals and on the battlefield with such excellent results during the war, people became convinced that these scientific discoveries could lead us into a perfect health system.

Convinced that better health could be achieved through greater access to doctors, drugs and hospitals, workers began to demand that Blue Cross insurance be provided by the company. This became a key bargaining point in union negotiations and was won by most of the big unions.³¹ Then the aged, now living longer than ever, began to insist on improved healthcare for themselves. At the same time, as a result of the pressure by blacks and the rebellions of the 1960s, medical coverage for the poor was further expanded. The result of all these struggles is that today approximately 70 percent of the American population is covered by Blue Cross, Medicare (for the aged) or Medicaid (for the poor).³²

³¹ This situation has changed dramatically since 1975 when about a third of the country's workers were unionized, compared to the 10.3% in 2019. The Reagan administration successfully broke the backs of the already increasingly bureaucratic unions and created the hegemonic idea that unions, with their "Cadillac health plans" for members, were bad for the economy and out of touch with other workers. As a result, the sense of "entitlement" that workers, especially non and newly organized workers, began to have about healthcare has greatly diminished.

³² This figure has diminished to about 32% in 2020 as more restrictions have been placed on Medicare and Medicaid, fewer private employers offer insurance through the workplace, and the opening up of the healthcare "market"

However, instead of this extended medical coverage resulting in improved health for the great majority of the people, it has only resulted in our greater healthlessness and helplessness. This is because the various sections of the working people have each struggled only for more medical care for themselves without questioning the bourgeois concepts upon which the American medical system is based. The masses of the people have been only interested in getting more of what the system produces.³³ So what we have gotten is more power concentrated in the hands of doctors and their allies, and more powerlessness in the people. This relationship of growing inequality is precisely what every institution in a capitalistic society is constantly producing and reproducing in ever more extreme forms.

The great majority of Americans accept the system's premise that health comes from treatment by highly trained physicians of the symptoms of individual illness. The result is that while more of us

has meant the influx of smaller insurance companies. Also, those who are covered by Blue Cross have seen their benefits greatly reduced, while their "individual" contributions" have skyrocketed. See footnote 2.

³³ Again, during the economic crisis in the 1980s, the Reagan administration's anti-labor, anti-poor policies led to a shift in the overall consciousness of the masses from one of entitlement to one of being grateful for the scraps. Those who retained any access to healthcare, even at great cost with fewer benefits, thought themselves lucky. Public sentiment increasingly turned against those in the public sector who still hung on to their benefits, like teacher and civil servants.

now have access to doctors and hospitals than ever before, we are not any healthier or more knowledgeable about our bodies than we were thirty years ago.³⁴ But we are all more dependent upon doctors and drugs than we have ever been.

Moreover, in the process of struggling to obtain medical care for ourselves as individuals on the basis of the system's assumptions, we have created a monster—the Medical-Industrial complex—whose survival and expansion depends not on our increased health and wellbeing but on our increasing illness and need for hospitalization. This Medical-Industrial complex consists not only of doctors but also of the drug industry, hospital staffs and all those working in the many agencies which have been set up to administer the many programs created to appease the popular demand for institutionalized healthcare.

The drug industry is one of the fastest growing and most profitable industries in the United States.³⁵

³⁴ Because of the decrease in the numbers of people insured, as well as the quality of the insurance, people, particularly poor people, also have a decrease in access. Even those who have the ability to see highly specialized doctors have long waits, e.g. wait times for first appointments for neurologists are on average over 32 days.

³⁵ “Big pharma” (the largest, most dominant pharmaceutical companies) has only grown exponentially in the last four decades, placing more and more of a burden on individuals. The US has the highest cost for prescription medication in the world; in 2018 people spent \$535 billion for prescription medicines. This situation prompts many to cross the border

In the past medications had been manufactured but on a limited basis, usually with caution. Many of our drugs used to be herbs, such as sassafras, cloves and others found in local pharmacies. Drugs like insulin, aspirin and vaccines used to account for most of the drug industry's sales. However, in the last twenty-five years, the drug companies have realized that with the emerging social forces in our society all demanding healthcare for themselves and with the population convinced that pills can perform miracles, they can reap substantial profits by the discovery, mass production and marketing of wonder drugs—whether they work or not.

So the production and marketing of more and more miracle drugs have become the main business of the pharmaceutical houses. Greedy for profits, they have often put these drugs on the market without adequate testing or simple precautions. For example, a few years ago, when the poliomyelitis vaccine was produced, some people contracted the disease from the vaccine because the drug industry was so anxious to reap the monetary rewards from its sale that it rushed the vaccine on to the market.

With advanced technology, medications are easily produced and more cheaply produced. But the price of drugs continues to rise. The drug companies insist that the rising price of drugs is nec-

to Mexico or Canada to obtain healthcare and buy more affordable medication.

essary because of the high costs of research. But they spend four times more on promotion of their products than on research.

The drug industry carries on a multimillion-dollar campaign in the media to convince the doctors and us that pills will change our lives from sorrow to happiness. Today commercials are everywhere encouraging the population to pop a pill and thus escape from the troubles of daily life. These advertisements are geared to children as well as adults.³⁶

Drugs are produced in such abundance that they are sold openly on our streets. This has made the pharmaceutical companies one of the largest manufacturers for street pushers. Phenobarbital, sleeping pills, pep pills, narcotics, morphine and methadone circulate freely through our society.³⁷

³⁶ In 2012 pharmaceutical companies spent \$3 billion on marketing drugs to individuals and \$24 billion marketing to doctors. These figures have only increased.

³⁷ Since 1975, the prescription of mental health meds has skyrocketed. As society becomes less secure and more alienating, the logically consequential feelings of loneliness, depression, anxiety, anger and isolation are treated with meds that make us more even-tempered, with less ability to have varied emotions. These prescriptions are so prevalent that they are detectable at increasing levels in the municipal drinking water. In a 2017 report, 118 pharmaceuticals were found in drinking water samples from 25 US treatment plants. Of the top five drugs found in the drinking water, three were anti-depressants (the other two were a chemical in tobacco which metabolizes nicotine, and a medication for high blood pressure). The majority of the contaminants are not from factory/production waste or improper disposal, but excretion from humans in our waste.

Many physicians, already drug and profit oriented, have come to depend upon the drug industry for their education as to which pills are good for which illness. Drug salesmen become the ones who familiarize doctors with what is available in the way of drugs. Often these salesmen are the products of a two-week quickie training course and see no difference between their job selling drugs and a job selling liquor or cosmetics. Beginning with an elitist outlook and under pressure from a growing patient load, more and more doctors now find it easier to give a pill or an injection instead of listening to the patient. The drug industry gives away plenty of free samples to health workers, especially doctors, in order to encourage doctors to prescribe these medications.³⁸ Made more affluent by more patients from whom they have become more distant with these new developments, more and more doctors have become businessmen, spending much of their time taking care of their investments and using their medical practice only as a means to acquire more capital for more investment.

³⁸ For decades pharmaceutical representatives have incentivized whatever new and expensive drugs they were peddling by taking doctors out to expensive meals, bringing gifts to their offices and hiring them for token speaking engagements on all-expense paid trips to resorts on tropical islands. In 2010, the Physicians Payment Sunshine Act began to require pharmaceutical and other medical supply companies to disclose their gifts to physicians—but did not do anything to limit the practice.

As a result of this collusion between the drug industry and doctors, we now have a drug-dependent society with our young people accepting pill-taking as the key to wellbeing. Raised in households where the medicine chest is full of pills, our youth take drugs orally and intravenously, sometimes resulting in death.

Why do we continue to allow the drug industry to get away not only with skyrocketing prices but with its increasingly degenerative role in creating a drug-dependent and even drug-addicted society? First of all, we do so because we have not questioned or challenged the elitist, drug-oriented approach of the American medical system which has been steadily entrenching itself since the eve of World War I.

Secondly, because a large section of the population—the aged, who are on Medicare and the poor, who are on Medicaid, as well as many who are on Blue Cross—feel that these drugs are “free.” In other words, we feel that they are being paid for by somebody else: the government, or the company, or “society.” We do not stop to ask who is paying the cost for what we get “free” or to wonder whether what we are getting “free” may also be addicting. We do not stop to think about other people who have to pay the inflated prices for prescriptions out of their own pockets.

Thirdly, because in the process of struggling for expanded medical care for the great majority of

the population, without questioning the premises on which the medical system is founded, we have created a huge bureaucracy which now has a tremendous stake in the continued expansion of the system as it is. We now have an increasing number of healthcare workers who work in hospitals and medical laboratories, as well as growing numbers of people in the various health agencies such as Blue Cross, the Health, Education and Welfare department of the Federal government, and local social service agencies. The job of all these "third party" agencies is to see to it not only that the great majority of Americans can go to the hospital without fear of bankruptcy, but also that doctors get their fees, pharmacists their money for drugs, and hospitals their patients.

As these "third party" agencies have expanded along with the growing health programs to meet the demands of various interest groups, their administrators and employees have also become careerists whose main aim is to expand their agencies and to win larger budgets so that they can advance themselves. Like the Welfare worker whose job depends on an increasing number of Welfare clients, these "third parties" depend for their jobs on a constantly expanding patient population.

The scandalous situation in American hospitals today is a glaring example of the way in which these "third parties" and health careerists operate

together to keep a bankrupt system going and growing.

During the Depression of the 30s and the World War II years, there was an acute bed shortage because few hospitals had been built or modernized for many years. After World War II hospital groups across the country took advantage of the Federal Hill-Burton Act (passed in 1946), which provided grants for hospital construction and modernization. Initially the administrators of the Hill-Burton Act focused on the kind of planning which would bring about coordination between hospitals and interrelationships between community health facilities and services. They also developed a licensing program to elevate the institutional quality of community-based facilities.

The Hill-Burton Act was so successful in achieving its purpose that many regions in the country constructed a surplus of beds. For example, Detroit has a surplus of 1,300 beds, and other regions of the country are also over-bedded. This is partly because too many beds were constructed in the first place to take advantage of the easily available funds, and also because medical advances in the past three decades have acted to decrease our need for hospital beds. Antibiotics, improved surgical techniques, and safer anesthetics make the hospital stay much shorter. Also many patients can now be treated on an out-patient basis.³⁹

³⁹ Since the adoption of "Lean Healthcare Principles" in the

Despite the growing scandal of over-bedding, health career people and “third party” agencies support continued hospital building, because they now have a vested interest in hospital expansion. The more hospitals are built with more elaborate equipment, the more jobs there are for nurses, aides and laboratory technicians, and therefore the more chances for advancement for hospital administrators. The fancier and larger hospitals become, the more power and prestige and funds accrue to “third party” agencies like Blue Cross. If hospital costs soar as a result, all they have to do is raise their rates.⁴⁰

As a result of all these factors, patients today in hospitals receive less medical care and poorer quality treatment at higher prices than ever. Many hospitals have evolved into country clubs and motels which have beautiful grounds and decorations but cannot deliver healthcare to the patient. To keep surplus hospital beds occupied, we are kept in the

early 2000s, most hospitals have turned to creating shortages—in staffing, beds, inventory, etc.—to reduce “waste” and maximize profit. Patients are still charged high profit fees for everything from tests to two-minute checks by specialists, but are rushed through and out. Procedures that used to require lengthy recuperation times are now done on an outpatient basis. Even childbirth will afford you only 24-48 hours with no complications, down from an average four-day postpartum stay in the 1970s.

⁴⁰ Since the capitalist forces reached a dead-end in extracting increasing rates of profit from patient/consumers, hospitals were unable to keep raising their rates. This forced the adoption of “Lean Healthcare Principles” to “eliminate waste.” See Introduction.

hospital longer, and unnecessary treatments are performed. Often there is an overuse of drugs to keep us, the patients, sleepy or tranquilized in order to justify a long hospital stay. Many of these hospitals have become so research-conscious for the sake of prestige (which can lead to more funding) that they allow the drugs and medical technology industries to test their products on us, the patients, often without our approval.

Surplus beds drain the community financially. Each new bed costs almost \$100,000 to construct. When the new bed is empty, the cost of maintaining it must be added to the bills of all patients. Hospital administrators and doctors are pressured to fill these beds. With hospital expansion comes staff and other medical personnel expansion, increasing the patients' bills still more and contributing to overall inflation.

Hospitals are supposed to be non-profit institutions.⁴¹ But large sums of money are made and paid out by hospitals. Many hospitals invest in other projects to make even more money. The public receives no benefits from these profits. Hospital administrators and their business-oriented boards are constantly lobbying for more funds to build unnecessary beds to enhance their own reputations

⁴¹ Hospitals are no longer supposed to be non-profit institutions, and the nature of the non-profit in terms of what it pays its staff has changed. In 2018, 13 non-profit hospitals paid their CEOs between \$5 million and \$21.6 million in annual salaries.

or to provide business for local contracting firms. Waste is rampant because most health institutions operate on cost-plus, which means that the more you spend the more you can charge the patient or society through the “third party” agencies.

Is it any wonder that with this orientation to medical care in terms of economic benefits to those administering the care, the concern for patients has declined inside the hospital? Most hospital personnel have no sense of responsibility to the needs of the community. They are only interested in “getting theirs.” Many physicians act as if they are responsible to no one. We, the patients, may stay in a hospital for days without seeing a doctor. Some hospitals are unclean. Many doctors are summoned to the patient only in a crisis. Hospitals have taken on the role of a manufacturing plant with the industrialization of human care the means to acquire more ultra-expensive technology, as well as more prestige for the ultra-specialist who is wooed by the hospital administrator because he adds prestige to the hospital. Medical care for the average patient has taken a back seat.

Hospitals function around the convenience of the doctors. Patients are forgotten, unless they have a rare disease or have undergone a spectacular operation which can be exploited to attract more money for the hospital. Any one of us who has been in the hospital in the last few years has seen nurses sitting around and refusing to respond to

the calls of the sick. The workers in hospitals no longer seem to care about us. From the administrators to the kitchen helper, their main interest is in more pay for themselves, even if it means an increase in bed costs for us, the patients.

So what began as a move to provide more medical care for more people has ended in a nightmare. We are beginning to fear for our lives in hospitals as people did in the 19th century when hospitals were called "pest houses".

Yet there has been no serious popular effort to challenge the hospitalization system in the United States. We complain individually, but in general we accept the situation. One reason for this is that only 10 percent of hospital income today comes directly out of the pockets of individuals. Fifty percent comes from the government and forty percent comes from the various health insurance plans.⁴²

So many of us go to the hospital in order to get a rest or because we feel that we are being ignored by our families or friends, and hospitalization is one way to get attention. Many workers ask their family doctors to put them into the hospital. Their doctors often comply because the more patients the doctor has in the hospital, the greater his income.

⁴² While actual statistics are hard to come by, the cost to individuals for hospital care has risen dramatically with the advent of copays for anything from doctors to x-rays and bloodwork, as well as high deductibles. In addition, an estimated 8.4% of the population is uninsured, not including undocumented immigrants who are not counted in the Census.

Often workers who have been put on disciplinary layoff go into the hospital immediately in order not to lose any income. This is what they consider a cheap way to ride out the period when they are off from work.

Because most people on Blue Cross, Medicare or Medicaid have the illusion that hospitalization is “free” or being paid for by somebody else, we boast or joke about our huge hospital bills. We do not stop to count the financial drain of the hospital system on our society. Nor do we ask ourselves whether we may be using “hospitalization,” like drugs, as a crutch to avoid confronting the very real social problems of frustration and boredom which have achieved the dimensions of a plague in modern American society.

CHAPTER 3

ONLY WE CAN CHANGE THE WAY IT IS

Most Americans want better medical care but they want someone else to provide it for them. Most of us share the outlook of the system: that healthcare should be the monopoly of physicians, and patients should have nothing to say about it. We have the same attitude towards other professionals: teaching should be for teachers, law for lawyers, engineering for engineers. We place all these people on a pedestal without realizing how we are demeaning our own selves by so doing. Then we wonder why these people treat us with contempt. By accepting their monopoly of professional skills, we also give ourselves an excuse for not getting involved in our own healthcare or that of other people.

The medical system, like every other institution in capitalist America, has made most of us see ourselves only as passive recipients and consumers, and not as prime movers and self-determiners to resolve the contradictions in our relations with doctors, nurses and other providers of healthcare. Nevertheless, the growing crisis in our relations with all these people is forcing us to ask ourselves some fundamental questions. The long waits in the doctor's office, the soaring costs of hospitalization, side by side with the decline in services, the drug

dependency now rampant in all sections of our society—why do these get worse with every year?

Up to now we have thought that the more money put into healthcare, and the more people with access to the healthcare system, the more healthy we would become. Now we can see that the more demands we put on the system as it is, and the more concessions the system grants us, the less healthcare we receive and the more we help the system to operate and to expand against our own best interests.

It should therefore not be too difficult for us now to understand that the medical system in this country was never set up to take care of the health needs of the great majority of the population or to deal with the human needs of the human being. It was set up by an elite to train a chosen few to treat the symptoms of sick people.

Therefore the American medical system cannot possibly cope with the health needs of hundreds of millions of Americans.

A medical system which is based upon increasing the powerlessness and meaninglessness of the patient cannot possibly cure disorders which in most cases are themselves the result of our frustration from growing powerlessness and meaninglessness in our lives.

Like the social reformers and humanitarians of the late 19th and early 20th centuries recognized that tuberculosis and plague were social diseases,

3. Only We Can Change the Way It Is

we must now recognize that most of the diseases that are reaching epidemic proportions in the United States today are social in origin.⁴³ Our ill health in most cases is not due to the presence of germs at a particular site within their bodies but to the way that we are living.

The years since World War II have brought a great decline mentally and physically to the American people. As migration to the cities has increased, the countryside has become depopulated.

Water and food pollution were among the most important causes of disease seventy-five years ago. Today air pollution has become the “pestilence that stalketh in the darkness.” As a result, chronic bronchitis now afflicts millions of people. [Asthma rate: almost 7%] The exhausts of motor cars, all the toxic products of industries released into our environment, the numerous aerosol sprays, tobacco, and the pulverized rubber of tires—all create an

⁴³ Now, some of the old socially borne diseases are coming back because of the largely petit-bourgeois movement of anti-vaccine parents. This movement has many different complicated origins, but a big impetus is from people who are of enough means to feel empowered to go against the current and against the advice of medical personnel, and also feel disempowered to do anything about larger social issues. As a result, they have the resources to turn a microscope inward and try to solve social problems in the context of the individual, or the nuclear family. In addition, there is a backlash against the generalization of medical care. The art of medicine has been lost, and doctoring and prescribing is done by test results and “standard of care,” without any recognition that “consumers” are actually humans who can have very different norms.

environment resulting in physical decline. The use of radioactivity for industrial purposes and of chemicals in the plastic industry add to the dangers and to the complexity of the disease patterns in this and subsequent generations.

The World Health Organization (WHO) estimates that 75-80 percent of all cancers are triggered by environmental agents such as industrial chemicals. The use of these chemicals has increased tremendously since the end of World War II. For example, polyvinyl chlorides, which are used in the plastic industries to produce thousands of household items from floor tiles to containers, have been found to produce a rare type of invariably fatal liver cancer when minute particles of them are inhaled. Coke oven workers are excessively exposed to coal tars which have been known to produce cancer since 1775. In three foundries in Muskegon, Michigan, employing 3500-4000 men, about ten percent of the work force is disabled every year because of silicosis.⁴⁴

⁴⁴ The public has begun to be more aware of consequences of using chemicals in all of what we consume, from food and water, to clothing, shampoo, etc., as well as toxins from the capitalist mode of production. (There are 200+ chemicals that are commonly used in the US in cosmetics and personal care products that are banned in the EU because they're known to be cancer causing. But companies in the US continue to use them because they are cheaper and there is little regulation.) However, rather than a mass movement to call to stop the poisoning of the earth and its inhabitants, those who can afford to buy capitalism's solution: the organic food and product industry. The creation of those new mar-

3. Only We Can Change the Way It Is

Growth of young people in the past was often stunted by nutritional deficiencies resulting from lack of food. By contrast, modern children are fed and sheltered like prized plants. But while the young grow fast and tall, society provides them with little incentive to exert their physical and mental energies except in competitive, money-making sports. Isolation from nature is the theme of the day. Today mechanization and automation liberate the muscles from exertion but produce more and more boredom. Automation has not only led to the dehumanization of work but also to the devaluation of work. To grow up to do nothing today has become a goal in life for many. Manual labor is now considered demeaning. Our social order and our communities are rapidly disintegrating, leading to loneliness and despair. Through drugs and at the mercy of drugs, many people are consciously escaping from reality.

Millions of others find an escape from the pressures on them by fantasizing.⁴⁵ Thus mental illness has grown enormously in the last thirty years, and—at the present rate, one out of every four

kets often contributes to the environmental problems they claim to solve and employ equally exploitative labor practices. Those who cannot afford to buy their way out of environmental hazards continue to bear the brunt of the consequences.

⁴⁵ This pressure and increased alienation have given rise to compulsive internet use, by some estimates affecting over a third of the population, and the use of social media to replace real relationships.

Americans can expect to spend some part of their lives in mental institutions.⁴⁶

Sexual promiscuity has become another escape from boredom and loneliness, leading to the spread of venereal diseases on an epidemic scale, especially among our young people.

Poor eating habits and the addition of chemicals and other additives to our foods are ruining our health. The mass media controls our lives by its emphasis on the purchase of junk foods. So food becomes a crutch to hang on to when problems arise and we lack the strength to struggle for their resolutions.

When frustrations arise, some of us turn to food, others to pills, and still others to alcohol—consciously seeking to escape from reality.⁴⁷ Thus, the fast food industry, the liquor industry and the drug industry all profit from our weaknesses. Alcoholism now afflicts at least five percent of the American population.⁴⁸ Obesity is everywhere. In fact, more Americans today suffer from the malnutrition of overeating than used to suffer from the malnutrition of insufficient food. From obesity have come new contradictions, such as the doc-

⁴⁶ In the last three decades, suicide rates continue to climb steadily, with an increase of over 30% in the last 17 years. Over 100 people kill themselves every day and over 400 attempt suicide.

⁴⁷ The US is also first in the world in the number of plastic surgeries performed.

⁴⁸ In 2017 the alcoholism rate rose to 12.7%.

3. Only We Can Change the Way It Is

tors who distribute large numbers of diet pills, the growing number of profit-making weight-reducing clubs and exercise salons, and the huge diet fad industry which is only another enterprise of big business.⁴⁹

While modern medicine has accomplished much to overcome physical pain, it has also been weakening our understanding of the agony as well as the ecstasy which is necessary to the good life. Years ago, when two and three generations lived under one roof, the death of the aged was experienced and recognized as a natural and necessary part of life. Now we are being led to believe that death can be indefinitely postponed. So the dying are treated like human guinea pigs as the medical profession uses experimental drugs to prolong life, often against the desires of the dying. Many are forced to spend their last days among strangers in an isolated hospital room. Often they are not allowed the choice of remaining at home with family and friends because this would put an added strain on the doctor to make house calls. The dying must face the indignities of guilt and despair because with all the technology and miracle drugs

⁴⁹ In 2020, the obesity rate reached almost 40%, with over 60% of all Americans either obese or overweight. At the same time, the malnutrition rate in the US is 12.3%. Both obesity and malnutrition afflict poor people disproportionately; the poor don't have enough to food, and the food they have readily accessible because of proximity and cost, causes obesity.

now available, we no longer realize that death is an extension of living.

More money for more healthcare for more people, more health insurance plans, more research for the specific germs which cause specific diseases, more elaborately equipped hospitals, more doctors trained in the present practice of medicine—none of these can possibly cure Americans of these social ills that are obviously the result of our way of life.

To reduce the incidence of bronchitis, we need to reduce air pollution, which means that we must be ready to struggle for a mass rapid transportation system and curb our own desire to own more powerful cars.

To check the spread of venereal disease, alcoholism, over-eating, drug addiction, and mental illness, we must be ready to struggle to create the kind of society in which people are not bored and lonely and frustrated but are living meaningful and purposeful lives at work and at home in their communities.

Only through such profound changes in our outlook and in our way of life can we reverse the trend towards bronchitis, drug addiction, alcoholism, and over-eating, which are as much social diseases as are syphilis and gonorrhea.

The struggle to create such a new way of life in America will not be an easy one. For example, it will require that some of us who work in the auto industry be willing to confront other auto work-

3. Only We Can Change the Way It Is

ers with the fundamental contradiction between everyone's desire for good health and the continued expansion of the auto industry. Only when a substantial number of auto workers have united around the realization that their stake in a new, more healthy way of life is greater than their stake in their jobs of producing more and more cars will it make any sense to confront those who own and control the auto industry.⁵⁰

The same kind of struggle must be carried on in the drug industry, with those of us who work in the research laboratories as well as those who work on the line filling bottles or on the road pushing pills. It must be carried on with the nurses, aides and medical technicians in hospitals or the keypunch operator or computer programmer at Blue Cross or in the Health, Education and Welfare department of the federal government. We must be able to confront all these workers and to help them realize that what they are doing has become only a job or a means to advance their own careers, and that instead of serving the people, they are only helping to reduce them to numbers on a Blue Cross or a Medicare card. Only then will we be able to confront and eventually overpower the bureaucrats

⁵⁰ Since this pamphlet was written, the opportunity for auto workers to exert this kind of power with a raised consciousness has passed. With the decimation of US based manufacturing (auto and otherwise), the UAW stopped organizing for anything but the basest bread and butter struggles, privileging older members over new hires.

who run these agencies or who administer the modern hospital.

The first step is the struggle to free ourselves of the bourgeois concept that the doctor knows everything and that we are completely dependent upon him/her to cure us of all our ailments. To free ourselves and others of this concept, we urge everyone to study this pamphlet carefully and to discuss it with others so that we can struggle together to deepen our understanding of the bankruptcy of the present system.

After we have done this, we will be ready to engage in the kinds of struggles which will give us and others a greater sense of power and of self-reliance in taking care of our health needs and therefore lessen the power and control of doctors, the drug industry, and the entire medical-industrial complex over our minds and lives.

The following are examples of the kinds of struggles we can engage in:

1. The present system is based upon increasing the knowledge of the few and keeping the majority of the population in ignorance of their bodily functions.

Therefore, we must struggle in our schools for health classes from the earliest grades to the highest grades, which systematically educate our young people in the functioning of their bodies and the importance of good food, rest, physical exercise,

3. Only We Can Change the Way It Is

and a healthy social environment. The goal of these studies should be that by the time young people reach high school age, they can carry on programs in the health education of their communities and also function as “medics” in community clinics.

2. The present system is based upon maintaining the monopoly of the medical profession in healthcare.

Therefore, we must struggle to de-professionalize health work. We can do this by struggling for a crash program which will within two years create millions of community health workers who will have responsibility in their community for first aid, primary medical care, post-illness follow-up, health education, midwife assistance, birth control and abortion education. This kind of crash program was carried out by the US armed services during World War II in the creation of millions of medics.

In less than five years, backward China, with a largely illiterate peasant population, was able to create more than a million “barefoot doctors” who continue to live and work in their communities but who provide elementary health services for their fellow-workers and neighbors. In an advanced country like the United States, we should be able to create twice as many “barefoot doctors” in less than half the time.⁵¹

⁵¹ After the capitalist coup in China in 1979, healthcare in

At the same time we should demand that universities, as well as federal and state agencies, give grants-in-aid only to those medical students who agree in advance that upon the completion of their medical training, they will practice in those areas in the United States that are in need of doctors.

3. The present system is based upon putting the doctor on a pedestal and keeping us, the patients, passive and ignorant.

Therefore, we must begin to organize groups of friends and neighbors in our communities and at our places of work, with whom we can discuss our illnesses, share information about our doctors, and prepare ourselves to ask the kinds of questions of our doctors that will make it impossible for them to keep treating us like children and ignoramuses.

Today most of us do not know what questions to ask or we are afraid to ask questions of our physicians, even though our lives are involved. Most of us would not think of dealing that way with a plumber or a carpenter who is working on our houses. We must now develop together the knowl-

China underwent a dramatic shift. Through a steady assault on the socialist infrastructure and economic base, the Barefoot Doctor program was abandoned, hospitals became their own separate accounting units (responsible for their own profit and loss), and the masses lost their easy access to health-care. While the notion of recreating the Barefoot Doctor program in capitalist countries persists, not many efforts have succeeded past the stage of wishful thinking, because of the contradictions such a program poses when not funded and implemented as part of a broader revolutionary plan.

edge and hence the confidence to ask questions and criticize our doctors.

4. The present system is based upon using drugs to cure symptoms and not upon the maintenance of good health through rest, the eating of nutritious foods, and the exercise of participating in sports or doing outside work, such as gardening, planting and caring for trees, and improving our streets and neighborhoods.

Therefore, we should begin to organize health clubs in our neighborhoods and at our places of work through which we can study and put into practice together the kind of food habits, exercises and communal physical activities which will not only improve our health but also enhance our surroundings.

5. The present system is based upon the increasing hospitalization and institutionalization of the sick and the feeble, and the increasing exclusion of nonprofessionals from participation in their care. The result is not only the growing cost of institutions but also the drying up, from disuse, of the human capacity of people to care for one another. For example, medicaid is now spending about \$10 billion a year to care for the elderly poor in nursing homes. These nursing homes are not only a source of huge profits to their operators but in many of them the elderly person is treated like a criminal.

Therefore, we should begin to organize from among the people within the community, and especially from school children and the unemployed, volunteer groups who will help to provide the kind of services which old and sick people need to remain within the community, such as shoveling snow, raking leaves, cutting grass, and running errands. In this way, our young people particularly will learn from us and at an early age how people can care for one another, not for money but because caring for one another is the only way for people to live together in a community.

At the same time we should insist that all hospitals and nursing homes within our communities be subject to a review board which will include representatives from citizens' health groups, and will have the power to check upon the kind of care which the hospital or nursing home is providing.

All these struggles will not only lead to better healthcare for sick people in our society at less cost. They will also begin to create the kind of new social ties among us which will make our lives more meaningful and thereby reverse the present accelerating rate of drug addiction, alcoholism, over-eating and venereal diseases, all of which are social diseases afflicting someone in almost every family in the United States.

The above are all forms of activity and struggle in which everyone in our society—regardless of race, sex, class or age—can engage together with

3. Only We Can Change the Way It Is

others. Because we in our society are being made more helpless by the present medical system, it is necessary for all of us to engage in one or more of these activities which will not only make us more healthy and less helpless in our relations with our doctors, but also help us to become more capable of creating new, more meaningful relations among ourselves in every sphere.

Women can play an especially important part in these struggles. They have the greatest reasons to do so because they are the ones who have suffered most as a result of the elitism inherent in the present medical system. They are the ones who have the most frequent and direct contact with doctors, both as patients themselves, and as the person in the family who most often takes the children or even an elderly parent to the doctor. Once women as well as men understand why it is absolutely necessary for us to bring about a fundamental change in our whole approach to healthcare, we will make opportunities to begin discussing with others the need to get together to struggle for a new approach to healthcare. We can talk to the many others waiting in the doctor's reception room and help them understand that we do not have to remain long-suffering victims. We can begin by sharing our experiences and our questions, writing them down so that when we go into the doctor's office we do not feel so helpless.

As small groups within each community and in shops and offices begin to develop more understanding and trust in one another through practical experience in these struggles, they can combine to carry on actions on a wider scale. It is important that these massive actions be deeply rooted in groups that have been formed within the community or at our places of work. Only through struggles beginning and continuing on the level where we are in constant contact with one another, can we, the people, internalize new concepts of caring for our bodies and ourselves. Only through grassroots struggles can we make our own evaluations of our actions and develop our own leadership, instead of being dependent on the mass media to do this for us.

In the struggle to take care of our bodies in a new, more human way, we can discover a new humanity in ourselves—a humanity which will manifest itself not only in the good health of the individual but in healthier relations among all of us in the communities where we live and the places where we work.

If you would like to pioneer in developing this new outlook on health in yourself and in others, let us hear from you.

Collection “Works of Maoism”

1. *Collected Works (1968-1987)*
Communist Party of Peru
2. *Selected Works, Volume VI*
Mao Zedong
3. *Selected Works, Volume VII*
Mao Zedong
4. *Selected Works, Volume VIII*
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