

Rebuilding the US Health Left

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With this issue *Social Medicine* begins a series of invited papers on the topic: “Rebuilding the US Health Left.” In this editorial, we will outline our vision for this series.

We undertake this project aware that our good friend and mentor, Dr. Walter Lear, one of the leading health activists of the 20th century, lies critically ill. Walter was the creator and custodian of the US Health Left Archives, a collection that is now with the University of Pennsylvania library. The collection reminds us of the important role Left health care workers played in US history throughout the 20th century. They advocated for a national health program (Committee on the Costs of Medical Care, Physicians Forum, Medical Care Section/APHA, HealthPAC, Physicians for a National Health Program, National Physicians Alliance), provided international solidarity (American Soviet Medical Society, international brigades during the Spanish Civil War, Central American Solidarity Movement, Committee to Help Chilean Health Workers, Doctors for Global Health), traced the connections between disease and social class (Sigerist Circle, Spirit of 1848 Caucus/APHA), fought for workers’ health (Councils for Occupational Safety and Health; Occupational Health and Safety Section/APHA) participated in anti-war movements (Medical Committee for Human Rights, Physicians for Social Responsibility, International Physicians for the Prevention of Nuclear War, Peace Caucus/APHA), created new models of health care delivery (Health Cooperatives, Prepaid Health Maintenance Organizations, Community Health Centers, National Health Service Corps, Free Clinics), were central to the struggle for women’s rights (Planned Parenthood, Physicians for Reproductive Choice and Health), supported the civil rights movement both in medicine and in the broader

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society (National Medical Association, Medical Committee for Human Rights), played key roles in the movement for gay rights (ACT-UP, Gay & Lesbian Medical Association, Lesbian, Gay, Bisexual, and Transgender Caucus/APHA), challenged traditional models of medical education (Student Health Organizations, AMSA, Residency Program in Social Medicine), and worked in many, many other fields.

It is not by chance that “leftie” physicians were specifically targeted during the McCarthy era. Tragically, the repression of progressive ideas within the medical community had a chilling impact during the 1950’s when many progressive physicians were blacklisted and some saw their careers ruined.¹ Organized medicine – through the AMA – made its peace with the nascent medical-industrial complex, becoming ever more conservative and eschewing the social values that had informed much of the medical community in the earlier parts of the century. By 1961, the AMA’s Women’s Auxiliary (composed of doctor’s wives) participated in “Operation Coffeecup” during which they met to listen to Ronald Reagan discuss “the evils of socialized medicine”; their goal was to defeat an early version of Medicare.²

However, the 1960’s also saw the flowering of new progressive initiatives within health. As one example, federally-supported community health centers were created and then expanded throughout the country. These health centers, modeled on community-oriented primary care, incorporated democratic controls (e.g., community representatives on their boards of directors), responsibility to a community, and engagement with the social determinants of health beyond strict medical care.

¹ Editors. An Interview with Dr. Walter Lear. *Social Medicine* 2009;4(1):70-79.

² This recording is available at: <http://www.youtube.com/watch?v=fRdLpem-AAs>

We have an extraordinarily rich legacy on which to build. This should give us heart as we face the difficult challenges ahead.

The Predicament of the Health Left in 2010

The climate in 2009 seemed propitious for real change with respect to health care reform. Many on the Left hoped for a “single payer plan” that would have established a national health care program similar to that of US Medicare or the Canadian system. Under this latter proposal, health care would be publicly financed through taxes and delivered largely through private providers. Polls indicated that single payer enjoyed popular support, while the current system of employer-based, private insurance was hugely unpopular. President Obama had openly declared that health care was a human right and there is evidence he at one time supported a single payer plan as a State Senator in Illinois.³ Activists, who had been preparing themselves for years were ready and devoted enormous energy to pushing for a variety of options that would guarantee universal health care coverage. Yet in early 2010, we are left with a largely unsatisfactory bill that Physicians for a National Health Program, the leading single payer advocacy group in the US, has decided is worse than no bill at all.

Even if a single payer bill had passed – and not even this much was accomplished – this would be only part of a much larger agenda for the Left in the US. Some parts of that agenda are open for public discussion. Other concerns are off the table within the mainstream, discussed only in academic journals and small alternative media, far from the popular consciousness. Elements of our agenda include topics such as the distribution and composition of a health workforce that is largely concentrated in urban areas and is racially stratified. The discussion of racism, sexism, and classism, important issues in both health and health care, is largely confined to unrealistic pieties (*e.g.*, eliminating racial/ethnic disparities in a decade without changing the educational and health systems) or endless streams of research documenting the problem. The current

³ More detail on the Single Payer option is available at: www.pnhp.org.

focus on “Global Health” hides an imperialistic system which drains health care professionals from other countries, exports our dysfunctional health care system, creates new markets for our drugs and technology, and relegates key health problems to “orphan” status. What are we to think of a world in which one US citizen – Bill Gates – wields financial power over global health on a scale comparable to the World Health Organization? Medical ethics needs to broaden its vision to consider questions of organizational ethics (such as institutional racism); new technologies are important not just for the ethical problems posed for individual patients, but also for questions of social justice. How can we repair the divorce between clinical practice – typically devoted to curative practices – and public health – concerned with prevention and the broader social determinants of health⁴? Why should genes, the common heritage of mankind, be privately owned? Discussion of the development of democratic and community-based ways of running health care institutions has been shelved as health care comes ever more under the control of the large corporations and not-for-profits that are run like for-profits. The legislative debates of 2009 have demonstrated yet again that Congress – drunk with corporate money – seems more concerned with protecting corporate interests than acting as the representative of the American people. As Will Rogers noted: “We have the best Congress money can buy.”

The “American exceptionalism” demonstrated in the way these concerns are – or rather are not – addressed in the US is quite remarkable. All these issues are discussed, debated, and acted upon in other countries by mainstream policymakers, health professionals and academics, not just by activists. To take one example, the 2008 report of the Commission on the Social Determinants of Health received widespread international attention and immediate editorial comment in both *The Lancet* and *British Medical Journal*.^{5,6} Yet it was virtually

⁴ Levy BS, Sidel VW. *Social Injustice and Public Health*. New York: Oxford University Press, 2009.

⁵ Addressing the inequities in health: a new and vital mandate. *Lancet*. 2008;372(9640):689. *The Lancet*

absent from the US media and was mentioned only in JAMA the following year.⁷ This is particularly striking because no less than 4 of the 20 commissioners are located in the US: David Satcher, former Surgeon General under Clinton and Bush; William Foege, a Professor at Emory, advisor to Bill Gates, and past APHA President; Amaryta Sen, currently a Professor at Harvard; Gail Wilensky, currently at Project HOPE. Perhaps the virtual censorship of the Commission's report in the US occurred because its implications largely favored public models, not corporate ones.

For those of us on the Left, it would seem vital not to accept the logic of American exceptionalism. There is much to learn about efficiently and effectively promoting health and providing treatment for all by examining the experiences of other countries. The recommendations of the WHO are considered irrelevant for US medicine and public health. The result is that companies like Nestle can openly promote baby formula in the US (even with the collusion of the American Academy of Pediatrics⁸) when such activities are illegal in other countries. Big Pharma and key players in the medical-industrial complex (like General Electric) operate internationally. Resistance to them must be international.

Not only are we isolated internationally, the US health Left is also fragmented into a rainbow of issue-specific groups. We have any number of outstanding advocacy groups each working within its own area of interest. While this is an ideal model for issue-oriented political advocacy, it is not necessarily a good way to advocate for larger social changes. Professionalization of advocacy can lead to putting organizational development ahead of movement building and to excluding the "ordinary"

people affected by the issues. However, without a strong Left party in the United States (and the Democrats are clearly not such a party), it is probably unrealistic to expect much unity within the Health Left. This editorial is not the place to consider why we don't have a Left Party, but such a lack is not an accident of history. The US ruling class has clearly decided to limit political debate within the narrow (and evermore rightward) limits of a Republican/Democrat dyad.

Despite these limitations, we feel that there is something about work in health that will continue to foster and sustain progressive movements. Why did Virchow consider the physician to be the natural advocate of the poor? The daily work of health care brings us into close contact with the vast majority of Americans who are not wealthy and who are victimized by the system. For those who can see the connections between our patients' problems and their social context, clinical work is a rich school and leads naturally to a desire to want to change the context within which ill health and suffering arise. We will not, indeed we simply cannot, stop our advocacy to make sure health is a right, that war is consigned to humanity's pre-history, and that people are guaranteed a healthy diet, a clean environment and a good education.

We would like to suggest reasons that our advocacy work would best be done with a common sense of identity and analysis.

Developing a common analysis & identity

The focus on issue politics can lead to what Maria Gottschalk has called a "Stockholm Syndrome" among the Left:

Time and time again, major attempts to reform the US health care system fall victim to the "Stockholm syndrome" – like the famous Swedish bank hostages who became emotionally attached to their captors and even defended them after they were released. Held captive for so long by neoliberal ideas about how to best organise the US economy and society, many advocates of universal health care put

devoted an entire issue to evidence in support of "closing the gap" in November 2008.

⁶ Davey Smith G, Krieger N. Tackling Health Inequities. *BMJ* 2008;337:a1526

⁷ Marmot MG, Bell R. Action on Health Disparities in the United States. *JAMA*. 2009;301(11):1169-1171.

⁸ See

<http://www.socialmedicine.org/2008/08/04/breastfeeding-is-the-american-academy-of-pediatrics-helping-babys-r-us-promote-formula/>

competition and consumer choice at the centre of the latest push for health reform. Dozens of major organizations close to the Democratic Party, including the AFL-CIO (the country's pre-eminent labor organization), Moveon.org, and the Children's Defense Fund, mobilized on behalf of a breathtakingly modest solution: creation of a public health plan – essentially a nonprofit insurance company – to compete with the commercial health insurers. [...] This push for a competitive public insurance plan indicates that faith in market-led solutions for health reform remains largely unshaken despite the recent financial collapse, which has prompted even former Fed chairman Alan Greenspan to publicly question the market uber alles.

As the problems of the US health system have mounted over the last four decades, the vision of what is possible in healthcare reform continues to shrink.⁹

Gottschalk's analysis poses a challenge for us: how can we go about enlarging the vision of the possible while still engaging in the political compromises and alliances that are necessary to real political change? Clearly, there are no simple, unchanging, universally applicable answers to this question. Rather, answers must emerge from debate, disagreement, and action; this implies a structure where a common, broad understanding of health can be discussed and developed. We believe that this discussion needs to be self-consciously progressive and political. It needs to be built around a culture of mutual respect and cooperation among different types of health care workers and with patients. While it should include academics and health care workers, it should not be limited to these groups. We need the input of economists, sociologists, anthropologists, political scientists, activists and,

⁹ Gottschalk M. "US health reform and the Stockholm syndrome" in Panitch L, Leys C, eds. *Socialist Register 2010: Morbid Symptoms: Health Under Capitalism*. Monthly Review Press, New York, 2009.

importantly, the people who are directly affected by the problems we are trying to solve.

This discussion should also include voices from outside the US. US public policy – in matters of globalization, environment, health care reform, trade, foreign and humanitarian "aid", political intervention, and immigration – has dramatic global health impacts. The United States' illegal invasion of Iraq in 2003, for example, had immediate, negative consequences for the health of the peoples of both countries.¹⁰ A US movement for social justice must be aware of these linkages and work together with all those affected by the policies of the government which acts in our name. We could also benefit from the experiences and support of the many movements (such as the People's Health Movement) – and even governments – who are attempting to realize the vision of "Health for All" enunciated at Alma Ata in 1978. This vision is as relevant for the US as it is for the rest of the world.

It is not even a foreign vision. A proposal introduced by Congressman Ron Dellums in the 1970s that has been introduced in each succeeding congressional session as H.R. 3000 by his successor, Congresswoman Barbara Lee, would establish a United States Health Service (USHS). The USHS would finance the education and training of all health workers and professionals, who would have an obligation to provide salaried service to the NHS. Everyone residing in the United States would be eligible for care without charge in USHS hospitals and other health care facilities that would be financed to provide primary and specialty care integrated with public health services on a regionalized basis with additional funding to address health inequalities. Governance would lie in the hands of community, patients, and health workers. In short, the proposal calls for "socialized medicine" for the United States. Not surprisingly this proposal has received little attention, even while the limited reforms enacted as "health reform" were being denounced as "socialized medicine."

Why have proposals like this failed? A more robust discussion within the Health Left may allow

¹⁰ Levy BS, Sidel VW. *War and Public Health*. New York: Oxford University Press, 2008.

us to better learn from our mistakes and our history. Hopefully we may be more effective in our advocacy of social change by pooling our resources and knowledge.

Rebuilding the US Health Left

We plan to use the forum of Social Medicine and Medicina Social to publish a series of papers examining key issues for the Health Left. We begin in the current issue with an article by Linnea Capps and Martha Livingstone examining the role of health care reform in the socialist agenda. We will also publish invited commentaries on these papers as well as comments sent to us by readers. Please email any comments to MattAnderson@socialmedicine.org.

The initial set of topics we plan to consider include: health care reform, racism in medicine, corporate control of medicine, imperialism in global health, democracy in health care, reconceptualizing medical education, food safety, health promotion, workers health, environmental toxins, and the problems of immigrants and foreign workers. We will also consider additional topics as suggested by readers.

As is the custom in the journal, all articles will be translated into Spanish and we invite commentaries from readers in any country, not just the US. Similarly, we welcome comments from people outside of the specific field of health care and from non-physicians. We will be especially open to views from people actively engaged in the struggle for the right to health.

An immodest proposal: Paying tribute to Dr. Walter Lear

We will not present only positions with which we agree. Rather, we are looking for thoughtful pieces expanding the field of debate. Our goal is to foster discussion with the hope of contributing to more unity among the health Left. Ideally, that unity might take an organizational form in the future.

However, we feel that fitting tribute to Dr. Walter Lear might be the convocation of a meeting to discuss not just the history of the US Health Left, but also its future. We would be interested in hearing from our readers about the organization of such a meeting.

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