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December 15, 1980

Mrs. Ruth Van Cleve
Deputy Assistant Secretary-Policy
Territorial and International Affairs
United States Department of Interior
Room 4310
Washington, D.C. 20240

Dear Mrs. Van Cleve:

I am writing on behalf of the people of Bikini to comment on the papers presented by the three contractors at the December 10 meeting regarding implementation of the three programs called for under Section 102(a) of Public Law 96-205 ("the Act"), and to recommend a decision the Secretary of Interior should make in his upcoming report to the Congress, which is mandated by Section 102(b)(1) of the Act. That section requires the Secretary to submit his plan to the Congress by January 1, 1981 "together with his recommendations, if any, for further legislation."

My comments are limited to the comprehensive health care plan covered by Section 102(a)(1) of the Act, which was prepared by the Loma Linda University School of Health. I have no specific comments on the other two reports, mandated by Sections 102(a)(2) and (a)(3) of the Act, which concern an education and information program regarding nuclear radiation and periodic comprehensive surveys and dose assessments for Bikini, Enewetak, Rongelap and Utirik Atolls.

At the outset, I believe that, given the time constraints and the scopes of work pursuant to which the three studies were conducted, all three organizations prepared excellent plans. Nevertheless, in light of the results of the Loma Linda study, the Secretary's plan to Congress should recog

nize the shortcomings of the study's two plans and propose a third plan.

The Loma Linda study proposed two five-year budgets for the operation of comprehensive primary, secondary and tertiary health care programs in the Marshall Islands -- one for the entire Marshall Islands (population approximately 33,000) and one for the people of the four atolls of Bikini, Enewetak, Rongelap and Utirik (population approximately 3,000). The budget figures are as follows:

	Entire Marshall Islands	Four Atolls
Year 1	$10,908,200	$10,603,700
Year 2	$12,103,300	$11,917,100
Year 3	$14,824,100	$14,598,200
Year 4	$18,120,500	$17,766,700
Year 5	$21,124,500	$20,700,000

See pages 104 and 110 of the Loma Linda study.

The differences between these two programs are miniscule. According to the Loma Linda study, the five-year cost of the four-atoll program would be $75,585,700. For an incremental cost increase of less than 2 percent -- $1,494,900 -- comprehensive health care could be provided for all the Marshall Islands.

The reason for the slight difference is simple: The Loma Linda study interpreted the "people" of the four atolls to include all the people of such atolls, wherever they may be residing. The "peoples" of Bikini, Enewetak, Rongelap and Utirik are now living on approximately one-half of the 26 atolls in the Marshall Islands, including the heavily populated atolls of Majuro and Kwajalein, so that over 75% of the present Marshallese people have members of the four-atoll populations among them. As a result, the Loma Linda projections for a four-atoll program closely parallel its projections for a comprehensive program.

While Loma Linda's cost projection for a comprehensive program may be realistic, they seem to make no sense when

applied to the people of the four atolls. For example, the Loma Linda contractor stated at the December 10 meeting that, statistically, only "a handful" of the peoples of the four affected atolls would be expected to require secondary or tertiary health care in any given year. Yet the Loma Linda figures for the four-atoll program provide that $7.2 million of the first year's budget of $10.6 million will be spent on secondary or tertiary health care. These expenditures, as explained in the report, relate primarily to improvements in the Majuro and Ebeye hospitals. Yet the Loma Linda report fails to compare the secondary/tertiary costs associated with improved hospital facilities in the Marshalls to the costs of referring this "handful" of people to other hospitals, such as Tripler in Hawaii. As the Loma Linda spokesman admitted at the December 10 meeting, this $7.2 million cost, which is projected to rise annually, could be reduced by approximately 90% by referring the "handful" of patients from the four atolls in need of secondary or tertiary care to hospitals outside the Marshalls.

The key to this entire problem, as noted above, lies in the assumption made by the Loma Linda report, and apparently by the Department of the Interior, that "people" of Bikini Atoll means all the people of Bikini, wherever they may be located. There are today approximately 925 Bikinians. Nearly 550 reside on Kili Island, about 140 are on Ejit Island in Majuro Atoll, approximately 100 live on other parts of Majuro, approximately another 100 live in Ebeye. The remainder are scattered throughout the Marshall Islands, and some are attending school in the United States.

It is important to recognize that not all of the people of Bikini have received the same treatment from the U.S. Government in the past. For example, in 1946, when the U.S. Government first became involved with the people of Bikini, it moved the 170 people living on Bikini Atoll to Rongerik, but it made no provisions for the 48 Bikinians who were then related to the Bikini community but living elsewhere at that time. See R.C. Kiste, The Bikinians: A Study in Forced Migration 39 (Cummings Publishing Co. 1974). Over the years, between approximately 60% and 75% of the Bikini population has remained together as a "hard-core," exclusive Bikini community. In 1946, 78% of the community lived on Bikini. In 1964, 282 of the 459 Bikinians, or 61%, lived in the hard-core group on Kili. In 1969, 344 of the group's population of 540, or 64%, lived on Kili. Kiste, supra, p. 39. Today,

approximately 550 of the 925 Bikinians, or 60%, live on Kili, while an additional 140, or 15%, live on Ejit. The combined Kili and Ejit populations comprise 75% of the total Bikini population.

Different U.S. programs have benefited the Bikinians differently. For example, all 925 Bikinians share equally, on a per capita basis, in the trust fund established by Public Law 94-34 and augmented by Public Law 95-348. However, only the Bikinians living on Kili and Ejit receive U.S.D.A. supplemental food; the Bikinians living elsewhere in the Marshalls do not receive these direct benefits. Other U.S. programs, such as the proposed airstrip for Kili, will be of direct benefit only to the Kili residents. In sum, different U.S. programs serve different needs. Some programs have been directed to all the Bikinians, some to those Bikinians on Kili and Ejit and others only to those on Kili.

I have found nothing in the legislative history of Public Law 96-205 suggesting that Congress intended to provide health care for all the people of Bikini. That is not to say that the Bikinians would oppose such a measure; indeed, they would welcome such a program. However, if the first year's cost of providing health care to all the people of the four affected atolls is $10.6 million, and the cost of providing nearly the same health care to most of the people of such atolls is 90% less, the second option should be seriously considered, especially in light of the new mood on Capitol Hill regarding federal expenditures.

The program I propose -- which was not one of the two budgeted in the Loma Linda report -- would consist of the following:

1. For primary health care, establish on Kili and Ejit Islands, and Eneu, if the people decide to move back to Bikini Atoll, a dispensary/clinic together with a resident health officer or assistant and adequate supplies. This will serve the primary health needs of 75% of the Bikinians, a group consisting of those most in need of -- and deserving of -- primary health care. Other Bikinians, now living in Majuro, Ebeye and other parts of the Marshall Islands or the United States, would continue to rely on existing primary health care facilities in their communities.

2. Provide all Bikinians with photographic identifica-

tion cards that will permit them to receive free secondary and tertiary health care at certain specific hospitals, such as Majuro and Ebeye or, as required, Kwajalein or Tripler. This system is presently employed for all the peoples of Rongelap and Utirik Atolls, including the directly irradiated population and the control groups.

This type of program, which could be copied for Enewetak, Rongelap and Utirik Atolls, would accomplish several goals. First, it would achieve the basic purpose of the legislation -- providing comprehensive health care to the direct victims of the U.S. nuclear testing program in the Marshall Islands. Second, it would effectuate such a program at a reasonable cost. The two Loma Linda proposals amount to nothing less than comprehensive health care programs for the entire Marshall Islands, complete with major improvements in the Majuro and Ebeye hospitals -- a laudable goal but not the Congress' intent in enacting Public Law 96-205. Third, this program would minimize the Loma Linda report's concern that it is "ethically impossible" to provide special health care, let us say, for the Bikinians living on Ebeye and deny it to their neighbors. In fact, it does no more than bring primary health care to Ejit and Kili and provide all Bikinians with the same level of care as is presently enjoyed by the people of Rongelap and Utirik.

I urge you to ask the Loma Linda University team to estimate the annual costs for the above-described proposal and that the Secretary give strong consideration to such a program in his report to the Congress.

Sincerely,

Jonathan M. Weisgall

Jonathan M. Weisgall

JMW/dmk
cc: The Honorable Phillip Burton
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