

CELEBRATING 10 YEARS

Greg Palast Finds Our Missing Votes

Fall 2006

# yes!

*Building a Just and Sustainable World*

## Health Care For All

ISSUE 39

**American Health Care. A System to Die for?**

**Canada's Cure** :: WHO SPENDS THE MOST? WHO'S HEALTHIER? :: JUST THE FACTS

**Winning Strategies** :: A GROWING MOVEMENT :: AMERICANS SPEAK OUT

**How Communities Care** :: ART OF HEALING :: HEALTH CARE WORKER-OWNERS







"COMPASS-ION": ACRYLIC, CHARCOAL, GOLD LEAF ON CLAYBOARD AND WOOD, 36 X 36.  
COPYRIGHT 2005 MIMI CHEN TING

**“The embrace of compassion knows no bounds  
and seeks no rest.”**

Translation of “Wu Xian Ci Huai Xiao Bu Mei” (an incantation set to the cadence of Taoist Sung Ci poetry, 960-1279 A.D.) It appears in calligraphy in this recent work by New Mexico artist Mimi Chen Ting. Says the artist: “Kuan-Yin is the traditional embodiment of compassion, but her iconic poses are generally passive. I made my lady of compassion an animated, embracing body with an opening in her womb for all.” [www.mimichenting.com](http://www.mimichenting.com)



## A New Design for YES!

You've probably noticed, the issue of *YES!* you're holding looks different.

For more than a year, we've been asking how *YES!* might better serve you and the work of creating a more just, sustainable, and compassionate world. Our 10th year seemed like the right time to ask if the design of *YES!* is conveying the powerful insights and possibilities of our time.

After consulting with our board and contributing editors, and soliciting your opinions through surveys, interviews, and focus groups, we set these goals.

**:: Make *YES!* more accessible.** We want you to feel you can jump into the magazine anywhere, or read it cover-to-cover. It should be a magazine you can give your brother-in-law, your city council member, or your favorite teenager.

Our new fonts should make the magazine easier to read. On page 17, you'll find a guide to the theme section. And there are more markers on the tops of pages to tell you where you are in the magazine. You'll also find "*YES!* Picks" throughout the magazine where we let you know our favorites in various categories.

You'll also find web "bugs" that indicate where on our website you can find more on a topic. Our website has fresh content available only on-line, so stay in touch with *YES!* between issues at [www.yesmagazine.org](http://www.yesmagazine.org).

**:: Make *YES!* more beautiful.** Reading the magazine should nourish your head, heart, and soul. We don't believe our emotional and spiritual lives need to be left at the door when we get involved in making change. Our new art director, Tracy Loeffelholz Dunn, has a talent for finding and creating images that complement the articles and themes of *YES!* and also tell a story of their own. And we've got a full 32 pages of color—the whole theme section.

**:: Make *YES!* an even more powerful reflection** of the danger and opportunity of this time in human history, and be more explicit about our stance in the world.

In the Table of Contents, we've mapped out the issue to make clear how each theme article relates to at least one aspect of our theory of change.

We've added "People We Love" as a place to celebrate the courageous, creative people who are changing the world. (Send us your nominations!)

"Signs of Life" replaces "Indicators," but it will continue to bring you short news bites on the big stories that are shaping our future.

Finally, after 10 years with the tag line: "A Journal of Positive Futures," we have selected a new line to go with *YES!*: "Building a Just and Sustainable World."

There's a lot about *YES!* that hasn't changed. We still have the mission we had when we started (we spell it out on pages 2 and 61). We are still ad-free (the display announcement on the inside back cover is for an event that we and our partners are involved in—the Green Festival. We continue our policy of not accepting paid advertising). And we continue to be among the few publications to print on 100 percent post-consumer waste, recycled paper. We pay a premium for this paper, but we feel it is one of the most important ways we walk our talk.

This redesign is a milestone for us as we begin our second decade of publishing. Please tell us what you think. We value your feedback as *YES!* continues to evolve.

In the meantime, enjoy this first issue with the new design and the articles on ways our health care system can become healthier.

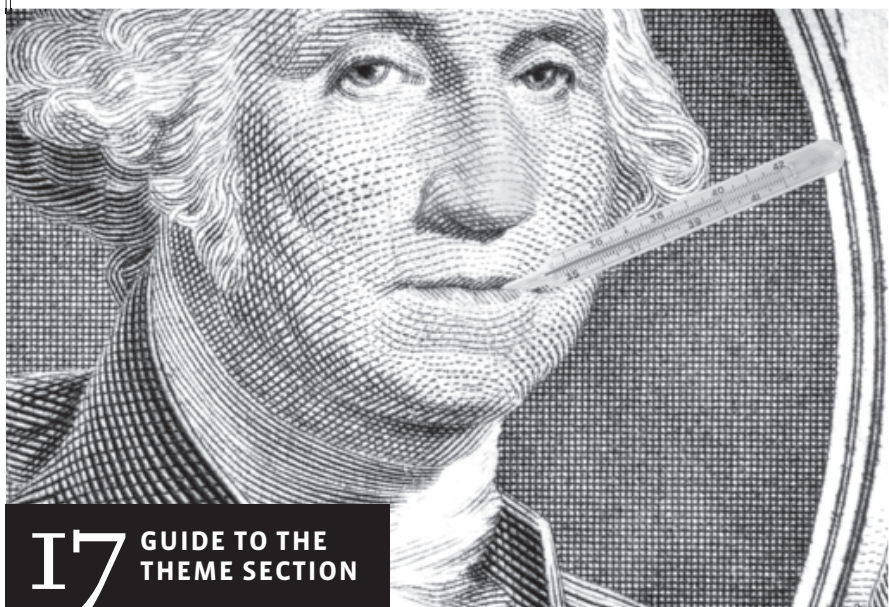
**Sarah Ruth van Gelder**  
Executive Editor

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is to support you and other people worldwide in building a just, sustainable, and compassionate world. In these pages you'll find ...



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Solving today's big problems will take more than a quick fix. These authors offer clarity about the roots of our problems and visions of a better way.

#### WORLD & COMMUNITY

Here you'll find new models that foster justice, real prosperity, and sustain the Earth's living systems. How can we bring these models to life and put them to work?

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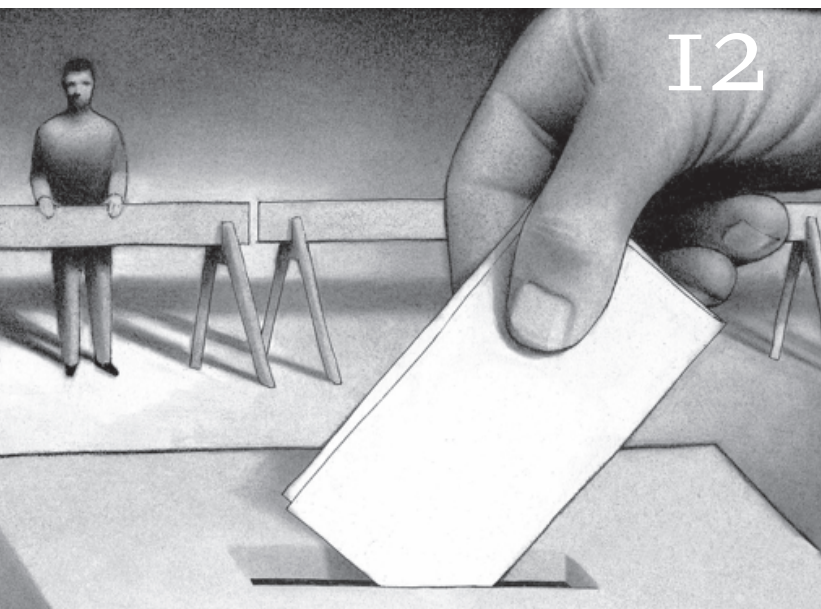
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## READERS FORUM

**Tell us.** Send your response to a YES! article, your stories about making the world a better place, and your ideas for connecting with YES! readers to [editors@yesmagazine.org](mailto:editors@yesmagazine.org) or to PO Box 10818, Bainbridge Island, WA 98110.

### Surrender, Pollyanna

I was pleased and overwhelmed in reading the summer issue. For the first time I felt a sense of honestly confronting the crisis of our times. While I understand and respect your intention to avoid the doomsaying that is all too prevalent among peace, social justice, and environmental advocates, your “positive futures” inevitably have carried a touch of Pollyanna—always looking on the bright side ...

I hope you will continue to sustain the delicate balance between acknowledging the desperate situation we live in and refusing to view with alarm and outrage everything that is happening in today's world. We need to face the tragic dimensions of the human condition, but that need not lead us to self-hatred and despair.

RHODA GILMAN  
St. Paul, Minnesota



### WANT THIS ISSUE?

[www.yesmagazine.org](http://www.yesmagazine.org)  
or call 800/937-4451

Empire thinking.

If we are to turn from this, we must embrace John Mohawk's advice in “Indigenous Prophecies” to learn from the past. Then we must take this further and start thinking about where we *should* live instead of where we *can* live.

KRISTAN COCKERILL  
Boone, North Carolina

### No Writing on the Rock

Rock art, either petroglyphs or pictographs, is one of our most cherished and fragile cultural resources. Vandalism, which ranges from simply touching the petroglyphs, thereby destroying their fragile ecosystems, to blatantly writing on the rocks themselves, is one of the most prevalent conservation problems.

I know your messages were only superimposed on the photo of the petroglyphs for the purpose of your magazine's cover (back cover, Summer 2006), but it gives your readers a message that writing on existing petroglyphs may be okay.

Writing on existing petroglyphs is an act of vandalism punishable by law.

JACK SPRAGUE  
Chair, Conservation and  
Protection Committee, American  
Rock Art Research Association

### The Great Turning Away from Humanitarianism?

The bit on “Alternative Spring Break” in New Orleans, combined with “The Great Turning” and “How Likely Is Collapse?” (Summer 2006), point out that turning from our notions of Empire will require turning away from seemingly humanitarian endeavors.

Several of the books featured in “How Likely Is Collapse?” highlight the problem of ignoring environmental conditions and/or assuming we can control the physical environment.

Endorsing rebuilding New Orleans is symptomatic of the Empire and not of turning from it. Encouraging development in a location that is already below sea level and sinking rapidly epitomizes





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## Self-sufficient Communities

I was thrilled by your current issue of YES! Not only did you present very graphically David's overview and focus of moving toward a world community, you painted where we are now. I am sure it took guts to just put it right out there for people to look at, no matter the variety of their possible reactions.

We are not living in normal times and business as usual is hardly what is called for now. We must prepare as well as we can and begin building avenues for local communities to become self-sufficient.

THOMAS TOOMEY, *via email*

## No Imagining Required

Michael Marien's article "How Likely Is Collapse?" (Summer 2006) was informative and interesting. But I was amazed by this statement: "Imagine if medicine were practiced in the same way [as other fragmented academic disciplines and professions]: a world of specialists in brains, eyes, ears, lungs, skin, feet, etc., with no general practitioners to assess the whole body."

"If"? Has he missed the whole loss of integrative thinking and practice in our medical schools?

The "ownership" of the AMA, FDA, CDC, etc., by the pharmaceutical industry?

The medical model is a poor model for the point he was attempting. "Imagine a world of medical specialists"? We don't have to imagine. They are here in bold, living color. LIVE! USA! In an office/university near you.

MIDGE O'BRIEN  
*Lexington, Kentucky*

## YES! for Prisoners

Thank you once again for your generous donation of six cases of old YES! magazines.

As you may know, we send reading material to hundreds of prisoners across the country each month. We—and they—depend on donations such as yours to have worthwhile, educational, and progressive books and magazines to read.

BOOK 'EM  
*Pittsburgh, Pennsylvania*

**CORRECTION:** In YES! Issue 37, Spring 2006, we ran the following headline: "Omar Freilla / Sustainable South Bronx." Omar Freilla has no connection with the organization Sustainable South Bronx ([www.ssbx.org](http://www.ssbx.org)). YES! apologizes for the error.



**Hey, look!** This is no ordinary dull white paper with occasional imperfections. The paper you are holding is New Leaf 100% recycled, 100% post-consumer waste, processed chlorine-free paper. Wow.

## PLANNING YOUR WILL?

## Keep the YES! Voice Going for Decades

Name the Positive Futures Network (publisher of YES!) in your will or as a beneficiary of your investment account.

Questions? Call Ezra Basom, 206/842-5009 Ext. 213



# Signs of Life

SMALL STORIES ABOUT BIG CHANGE



## HUMAN RIGHTS

*Nearly a year after Hurricane Katrina, thousands still wait to return home. Can protesters convince HUD to fix, rather than demolish, badly needed housing?*

### You *can* go home again—if you organize

Public housing residents displaced by Hurricane Katrina have erected a tent city outside the 1,300 empty apartments on St. Bernard Avenue in New Orleans. The Survivors Village group demands the “right to return” to safe, decent, and sanitary housing for all people displaced by the hurricane; the preservation—not privatization—of all current public housing stock; and the reopening of all public housing.

Rather than fixing up housing units in New Orleans for the 5,146 displaced, predominantly African Americans, the Department of Housing and Urban Development (HUD) spent \$1.5 million to board up the units. HUD plans to tear down 5,000 of the city’s 7,100 public housing units. Many are undamaged by the hurricane or sustained only minor damages. Only 880 families have been allowed to return, says Judith Browne, co-director of the Advancement Project, a national civil rights and racial justice organization.

“HUD plans to keep low-income families out of New Orleans,” says Browne. “HUD and HANO’s [the Housing Authority of New Orleans] plan discriminates against black residents by



BILL HABER / AP

Former tenants and supporters erect a “Survivors Village” in front of the St. Bernard Public Housing Complex in New Orleans. Former residents are protesting plans to demolish 5,000 public housing units—many of which sustained little or no damage.

excluding them with no clear plans of when, how, and if they will be able to return.”

According to Browne, many of those displaced from the city cannot return due to the loss of nearly half the rental housing and a 25 to 30 percent increase in rental rates.

A class-action lawsuit was filed on behalf of public housing residents by the Advancement Project, Bill Quigley, Tracie Washington, and the law firm of Jenner & Block, LLP against

HUD Secretary Alphonso Jackson and HANO demanding that they reopen public housing.

“The ‘reconstruction of New Orleans’ has become a euphemism for the destruction of the city’s cultural, historic, and ethnic heritage,” said Tracie Washington, counsel in the lawsuit. “We’ve got to bring back all of the people—not just those who are rich and white.”

— Daina Saib

**Interested?** See [survivorsvillage.com](http://survivorsvillage.com) or [www.advancementproject.org](http://www.advancementproject.org).

## UN: Indigenous people have rights

👍 In its first meeting, the new UN Human Rights Council adopted a “Declaration on the Rights of Indigenous Peoples.”

It affirms that indigenous peoples—about 370 million people worldwide, according to UN estimates—have the right “to determine their political status and freely pursue their economic, social and cultural development,” and it holds member states responsible for implementing these rights.

The Council replaces the UN Commission on Human Rights, which was criticized for the composition of its membership.

—Rik Langendoen

**Interested?** See [www.unhchr.ch](http://www.unhchr.ch).

### ALSO ...

👍 Refugee girls will soon have better access to a formal education. Ninemillion.org, a new global online campaign launched in June by the UN refugee agency (UNHCR) seeks to raise awareness of issues faced by the 9 million refugee and displaced children worldwide. It plans to encourage attendance with improvements to camp schools.

Also planned is Right to Play, a program that allows girls to engage in sports to overcome physical and psychological trauma.



## “The looting by the foreign companies has ended.”

**BOLIVIAN PRESIDENT EVO MORALES**, WHOSE APPROVAL RATING AFTER SIX MONTHS IN OFFICE IS 81 PERCENT. A SOCIALIST AND THE COUNTRY'S FIRST INDIGENOUS HEAD OF STATE IN MORE THAN 450 YEARS, MORALES HAS NATIONALIZED THE GAS AND OIL INDUSTRIES, RAISED WAGES, HALVED THE SALARIES OF PARLIAMENTARIANS AND OTHER HIGHLY PAID PUBLIC SERVANTS, AND BEGUN TO REDISTRIBUTE PUBLIC LAND.



### DEMOCRACY

*The 14th Amendment, designed to protect freed slaves, has mainly been used to protect corporations.*

### Two strikes, corporations are out

👍 In the June 6 primary election, voters in Humboldt County, California, ejected non-local corporations from local politics.

The new ordinance, known as Measure T, passed with 55 percent of the vote. It forbids a corporation from donating to local campaigns if it is not based in the county—or if even one employee or shareholder lives outside the county.

Nonprofit organizations may donate if all board members live in the county, and labor unions need to have only one local member to contribute.

This measure challenges the long-established legal principle that corporations are “persons” under the law, and that corporate “free speech,” in the form of campaign donations, is protected.

Kaitlin Sopoci-Belknap, co-manager of the Measure T campaign, said two cases in which out-of-town corporations each donated more than \$200,000 to shift local politics show why the new law is needed.

The first was Wal-Mart's effort in 1999 to change zoning laws to allow the siting of a Wal-Mart store on the Eureka waterfront. The second was Texas-based Maxxam, Inc.'s attempt in 2004 to recall the local district attorney for trying to enforce environ-



KYANA TAILLON

Humboldt County's new ordinance, known as Measure T, passed with 55 percent of the votes. It forbids a corporation from donating to local campaigns if it is not based in the county and challenges the notion that corporations have the legal rights of persons.

mental regulations against the company. Both corporate efforts failed, but Sopoci-Belknap said such cases erode citizen confidence in the political process.

“By challenging corporate personhood, Measure T has reshaped the whole debate about corporate hegemony,” said Ward Morehouse, co-founder of the Program on Corporations Law and Democracy, which works to address corporate abuse of power.

— Michelle Wallar

**Interested?**  
See [www.votelocalcontrol.org](http://www.votelocalcontrol.org)

#### ALSO ...

👍 In November more than 1.6 million voters in Minnesota, California, and Washington state will decide whether to use Instant Runoff Voting (IRV) in future elections.

In this system, the voter ranks the candidates—first choice, second choice, and third choice in a three-candidate race. When the votes are tallied and it becomes clear which candidate is in last place, that candidate's votes are redistributed to one of the two top contenders, based on the voters' priority rankings.

IRV has the support of the League of Women Voters and is already in use in San Francisco, Oakland, and Berkeley, California, as well as Burlington, Vermont, and Ferndale, Michigan.

**Interested?** See [www.fairvote.org](http://www.fairvote.org).

#### ALSO ...

👍 At its annual national convention in June, the League of Women Voters endorsed voter-verified paper balloting, noting that electronic voting systems, which the League had previously supported, “are not inherently secure, can malfunction, and do not provide a recountable audit trail.”



### DE-NUKING

*Fifty years after Hiroshima and 20 years after Chernobyl, Europe is taking steps to distance itself from nuclear weapons and nuclear energy.*

### Blix Commission wants U.S. WMDs out of Europe

👍 “So long as any state has nuclear weapons, others will want them,” says a report released June 1 by the Weapons of Mass Destruction Commission. The only way to prevent proliferation, the report says, is to outlaw nuclear weapons.

Chaired by Hans Blix, former chief UN weapons inspector for Iraq, the independent, 14-member panel of international experts represents five of the eight nuclear countries.

Its report, *Weapons of Terror*, calls for the destruction of all nuclear, chemical, and biological weapons worldwide, and for better controls on nuclear fuels.

Demanding that the nuclear countries, particularly the United States, honor their commitments to reduce weapons, it calls for the removal of U.S. WMDs from Europe. It also criticizes U.S. disregard of signed treaties, such as the Nuclear Nonproliferation Treaty, and condemns the U.S. “drive for freedom of action to maintain an absolutely global superiority in weapons and means of their delivery.”



STEVE RINGMAN / KRT

Shirley Morrison of Seattle adjusts the hood of a fellow demonstrator before the start of the Ground Zero anti-nuclear march earlier this year outside the nuclear sub base at Bangor, Washington. A majority of Americans—66 percent according to a 2005 AP/IPSOS poll—believe no country should have nuclear weapons.

But the Blix Commission disappointed nuclear power critics by failing to call for a phase-out of nuclear power. All new nuclear weapons states such as India, Pakistan, Israel, and North Korea, they note, developed their nuclear weapons as a result of their “peaceful” nuclear programs.

The Commission was established by the Swedish Government at the request of the UN Under-Secretary-General.

—Alice Slater

**Interested?** You can find the report at [www.wmdcommission.org](http://www.wmdcommission.org).

unnecessary in Spain, its opponents argue. New wind-power generators, installed in 2005, now generate four times as much electricity as the Zorita nuclear power plant did before it was closed in April.

—Lilja Otto

#### ALSO...

👍 On June 16, the European Parliament voted to spend 1.6 billion euros on research and development of renewable energies. With this decision, it has dedicated two-thirds of its total research budget for non-nuclear energy to renewables and conservation.

**Interested?** [www.million-against-nuclear.net](http://www.million-against-nuclear.net), Nuclear Information and Resource Service: [www.nirs.org](http://www.nirs.org).

#### ALSO ...

👍 According to a recent survey of 20,000 people in 19 countries, popular support for nuclear energy is lukewarm (49 percent), while 80 to 90 percent of respondents favor tax incentives to encourage the use of alternative energy. Eighty to 90 percent worry about environmental impacts of energy policies.

Nevertheless, the G8, the world's eight richest nations, voted at their summit on July 16 to support nuclear energy as part of a drive for “energy security.”

### “Adios” to nuclear power

👍 In his state of the nation address, Spanish prime minister José Luis Rodríguez Zapatero confirmed plans to phase out the country's eight nuclear reactors in favor of clean, renewable energy.

Spain follows the example of Sweden, Italy, Belgium, and Germany, who have introduced phase-out legislation. Five other European countries have no nuclear reactors at all.

Nuclear energy has proven



# “Whether we win in court or pay for the Farm with money on the table, we intend to get this land back.”

REPRESENTATIVE MAXINE WATERS, AMONG THOSE FIGHTING TO KEEP A 14-ACRE PLOT OF LAND IN SOUTH CENTRAL LOS ANGELES FROM BEING DEVELOPED.

## GLOBAL ORGANIZATIONS

*NGOs have won their place at the policy-making table. But have they compromised too much?*

### Charter signing points to growing role of NGOs

👍 Amnesty, Greenpeace, Oxfam, and other prominent charities have pledged to walk their talk. This June, the heads of 11 leading human rights, sustainable development, and environmental organizations joined forces to endorse the first global accountability charter for international nongovernmental organizations (NGOs).

The charter recognizes NGOs' growing global responsibility. NGOs routinely rank higher in public trust surveys than the UN, governments, or for-profit companies. Public funds are increasingly channeled through nonprofits, and NGOs often influence public policy.

A number of recent NGO scandals have spurred calls for accountability. “If we are to point the finger at others we need to be completely clean in our own back yard,” Burkhard Gnaerig, director of Save the Children, told *Ethical Corporation*.

The Charter outlines basic operating principles for international NGOs, such as ethical fundraising, political and financial independence, responsible advocacy, annual reporting, effective programs, and good governance.

—Elle McPherson



VELCROW RIPPER

South Central Farms, recently destroyed by developers' bulldozers, was not only a source of food for nearly 3,000 people, but a center for cultural festivals.

## URBAN FARMING

*Urban land is a high-dollar commodity. But what is its “highest and best use”?*

### South Central L.A. Farm under Siege

👍 South Central Farms was a 14-acre plot of vacant land in gang-ridden South Central Los Angeles when the city offered it to 360 low-income Latino families in 1992.

The families brought in their own dirt, seeds, and recycled fencing, and planted over 500 trees. They created a safe place for children to play, a venue for cultural festivals and a Sunday farmers market, and a vital

source of food for upwards of 3,000 people. But in 2003, without public input, the city sold the land, which it had bought in the 1980s under eminent domain laws, to developer Ralph Horowitz, one of the original owners.

The farmers challenged the sale in court. But on May 23, before they could complete the legal process, the sheriff posted an eviction notice.

The farmers sent out an urgent appeal, and an encampment of supporters was formed to hold the land. Julia Butterfly Hill, Joan Baez, Daryl Hannah, and John Quigley began a tree-sit, and celebrities and political and spiritual leaders visited the farm to show their support dur-

ing the three-week standoff.

The farmers and their supporters raised \$16 million—full market value for the land and triple what the developer paid for it—but Horowitz refused to sell. The police moved in with a massive show of force, paving the way for the developer to destroy the farm with a phalanx of bulldozers one week before the farmers' final July 12 court date.

Despite the devastation, the farmers and their supporters have vowed to take back the land and replant the gardens. At press time, supporters were awaiting the court decision.

—Velcrow Ripper

**Interested?**

[www.southcentralfarmers.com](http://www.southcentralfarmers.com).



**Lt. Ehren Watada** refused to fight in an “illegal” war

“THE WAR IN IRAQ is not only morally wrong but a horrible breach of American law,” says Ehren Watada, a first lieutenant in the U.S. Army. Watada refused to board an Iraq-bound plane with the 3rd Stryker Brigade of Fort Lewis, Washington, in June arguing that it is illegal to obey an illegal order.

On July 5, the military formally charged Watada with missing movement, two counts of contempt, and three counts of conduct unbecoming an officer and a gentleman. If convicted of all the charges, Watada faces more than seven years in military prison.

Watada’s actions have inspired many to speak out against the Iraq War, including other military officers. More than a thousand people in over 30 cities rallied in support of the June 27 National Day of Action to Stand Up with Lt. Watada. His supporters plan more demonstrations in the future.



In memoriam.  
**Jane Jacobs**,  
champion of cities

IN THE 1960s, when city planners were promoting skyscrapers and suburbs, Jane Jacobs pioneered a human-scale vision of cities.

Busy sidewalks, street-level small businesses, mixed-use neighborhoods—these, she said, make a city come alive. Freeways and sterile suburbs don’t. Her 1961 book, *The Death and Life of Great American Cities*, was called “one of 20th-century architecture’s most traumatic events.”

Today, Jacobs’ ideas about what make cities thrive, or die, are widely accepted.

Though known for her books and ideas, Jacobs was no arm-chair activist. She was once arrested for second-degree rioting when she disrupted a meeting about an expressway. She led the fight to stop a freeway that would have carved up her beloved lower Manhattan. And when her boys reached draft age, the entire family relocated to Toronto, where she led a battle against another freeway.

We will miss her.



**Conchita Picciotto** has been a neighbor to presidents since 1981

FOR 25 YEARS Concepcion “Conchita” Picciotto has lived on the street in front of the White House, protesting nuclear arms. Hers may be the longest continuous vigil in history.

In 1981, when Picciotto took up residence in Lafayette Square, Jimmy Carter was president. She counts off the others on her fingers: “Ronald Reagan, two terms, then President Bush’s father, then President Clinton, two terms too, and now the son of the father.”

But in all that time, she’s never talked to any of her presidential neighbors.

Asked what one message she would give President Bush if she could, Picciotto says, “My goodness! The first thing, to come to his senses and stop killing.”

Conchita is regarded as a permanent fixture in D.C. She’s been listed twice in the Berlitz guide to the city, and she appeared in Michael Moore’s *Fahrenheit 911*.



High school teacher  
**Rob Cornell** asked the  
hard questions

“IF AMERICA ever ceases to be good, America will cease to be great.” That observation by Alexis de Tocqueville was the basis of Rob Cornell’s graduation speech at Corvallis High School in Corvallis, Oregon.

Chosen by the students to deliver the address, the veteran math teacher dared to ask the obvious follow-up question: “Has America ceased to be great?”

“Would a good America have a policy of pre-emptive war?” he asked. “Would a good America ... ignore ... international laws such as the Geneva Conventions?”

Scattered “Boos” erupted from the audience. A Marine recruiter walked out, along with a few others.

But Cornell continued, calling for a search for complex truths and civil disobedience if necessary.

When he finished, students jumped to their feet in a standing ovation.



[www.YesMagazine.org](http://www.YesMagazine.org)

Read the full text of Cornell’s speech



COMMENTARY :: *Ajamu Baraka  
and Tonya M. Williams*

## POST-KATRINA: WHAT IT MEANS TO BE DISPLACED

In March 2006, the U.S. Human Rights Network launched the “Hold the U.S. Accountable” campaign.” It argues that those Americans displaced by Hurricane Katrina are neither “evacuees” nor “survivors”—terms that carry little international recognition or obligation. Instead, under the Guiding Principles on Internal Displacement, they are “internally displaced persons” or IDPs—the second largest internally displaced population in the Western Hemisphere.

IDPs? Evacuees? Survivors? It may seem like a trivial matter of semantics, but there’s much more at stake. Defining Katrina’s victims as IDPs establishes the government’s obligations to protect the rights of the Gulf Coast residents who were dispersed across the country.

Those obligations are explicitly laid out in the Guiding Principles on Internal Displacement, adopted by the UN Commission on Human Rights in 1998. Compliance with this framework is not unprecedented. The United States Agency for International Development has developed a comprehensive strategy, based on the Guiding Principles, to address the special concerns of IDPs.

If the United States had employed this human rights framework domestically, as it has done within the international context, displaced Gulf Coast residents would be entitled to significant benefits. For example, they would be entitled to housing throughout all phases of their displacement, rather than the six, nine, or 12 months arbitrarily permitted by FEMA. Furthermore, the Guiding Principles explicitly prohibit discrimination, particularly “when the affected areas have pre-existing patterns of discrimination.”

In the wake of Katrina, the pre-existing poverty and exploitation of poor communities of color—compounded by the devastation and displacement wrought by the hurricanes and the institutionalized racism woven throughout American society—created a discriminatory relief effort. This discrimination was illuminated on television screens around the world and continues to manifest itself in the post-disaster assistance and reconstruction efforts.

An example is the governmental assistance in the rehabilitation and reconstruction of housing in the Gulf Coast region, which discriminates against lower-income renters. Only homeowners are eligible for compensation under the state homeowner assistance plans funded by the federal gov-



YES! MAGAZINE 2006

*“Not to worry—here at the FDA, we eat genetically modified food all the time, and it’s had no effect on me.”*

Larry Langley



[www.YesMagazine.org](http://www.YesMagazine.org)

More reader captions and more essays

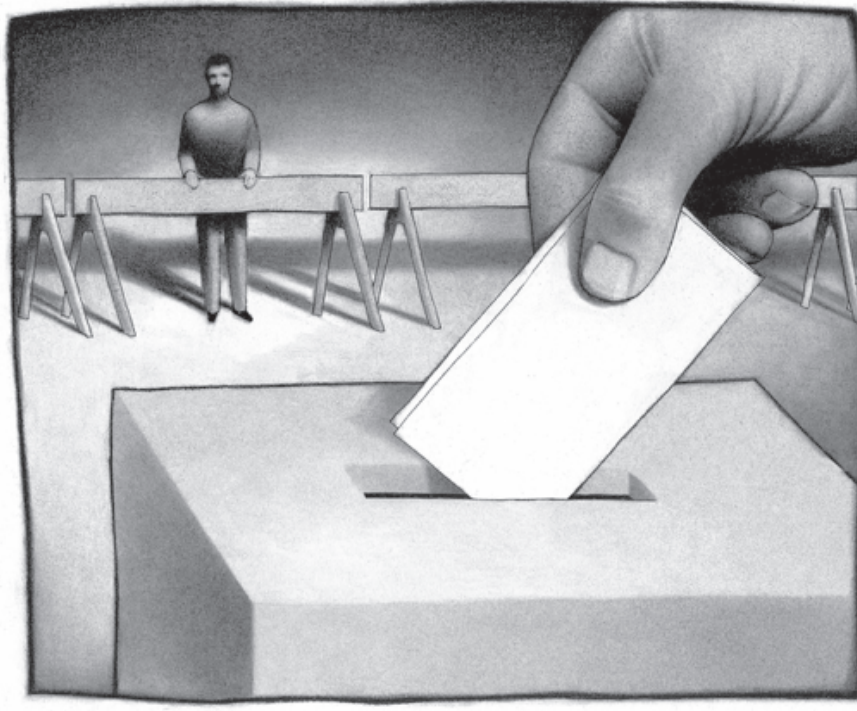
ernment’s community development block grants. And current funding leaves out those homeowners, predominately low-income households, who did not possess adequate insurance before the storm and who today have few resources to draw on for rebuilding.

The idea of Katrina victims as IDPs is hard for most Americans to swallow. Although we recognize those displaced by the tsunami in Indonesia, the earthquakes in Pakistan, or the conflict in the Sudan as IDPs, few Americans acknowledge that the hundreds of thousands of Gulf Coast residents displaced by the hurricanes are also IDPs, in need of protection and assistance throughout their displacement. And few of the proliferating reports on the disaster—by governmental and non-governmental agencies, private institutions, grassroots organizations, scholars, and activists—use a human rights yardstick to measure either the post-disaster reconstruction efforts or the extent to which the U.S. government has complied with international norms regarding people displaced by conflict or natural disasters.

But why shouldn’t the rights of IDPs apply to people in the United States? If the fundamental rights of displaced people apply in countries far less able to cope with such disasters, they certainly apply here.



**Ajamu Baraka** (abaraka@ushrnnetwork.org) is executive director of the U.S. Human Rights Network, where **Tonya M. Williams** is a senior fellow and co-coordinator for the “Hold the U.S. Accountable Campaign.” Learn more at [www.ushrnnetwork.org](http://www.ushrnnetwork.org). You can read the Principles at [www.unhchr.ch/html/menue2/7/b/principles.htm](http://www.unhchr.ch/html/menue2/7/b/principles.htm)



DOUG GRISWOLD / KRT

# Recipe for a Cooked Election

Greg Palast

A nasty little secret of American democracy is that, in every national election, ballots cast are simply thrown in the garbage. Most are called “spoiled,” supposedly unreadable, damaged, invalid. They just don’t get counted. This “spoilage” has occurred for decades, but it reached unprecedented heights in the last two presidential elections. In the 2004 election, for example, more than 3 million ballots were never counted.

Almost as deep a secret is that people are doing something about it. In New Mexico, citizen activists, disgusted by systematic vote disappearance, demanded change—and got it.

In Ohio, during the 2004 Presidential election, 153,237 ballots were simply thrown away—more than the Bush “victory” margin. In New Mexico the uncounted vote was five times the Bush alleged victory margin of 5,988. In Iowa, Bush’s triumph of 13,498 was overwhelmed by 36,811 votes rejected.

The official number is bad enough—1,855,827 ballots cast not counted, according to the federal government’s Elections Assistance Commission. But the feds are missing data from several

cities and entire states too embarrassed to report the votes they failed to count. Correcting for that under-reporting, the number of ballots cast but never counted goes to 3,600,380. Why doesn’t your government tell you this? Hey, they do. It’s right there in black and white in a U.S. Census Bureau announcement released seven months after the election—in a footnote. The Census tabulation of voters voting in the 2004 presidential race “differs,” it reads, from ballots tallied by the Clerk

of the House of Representatives by 3.4 million votes.

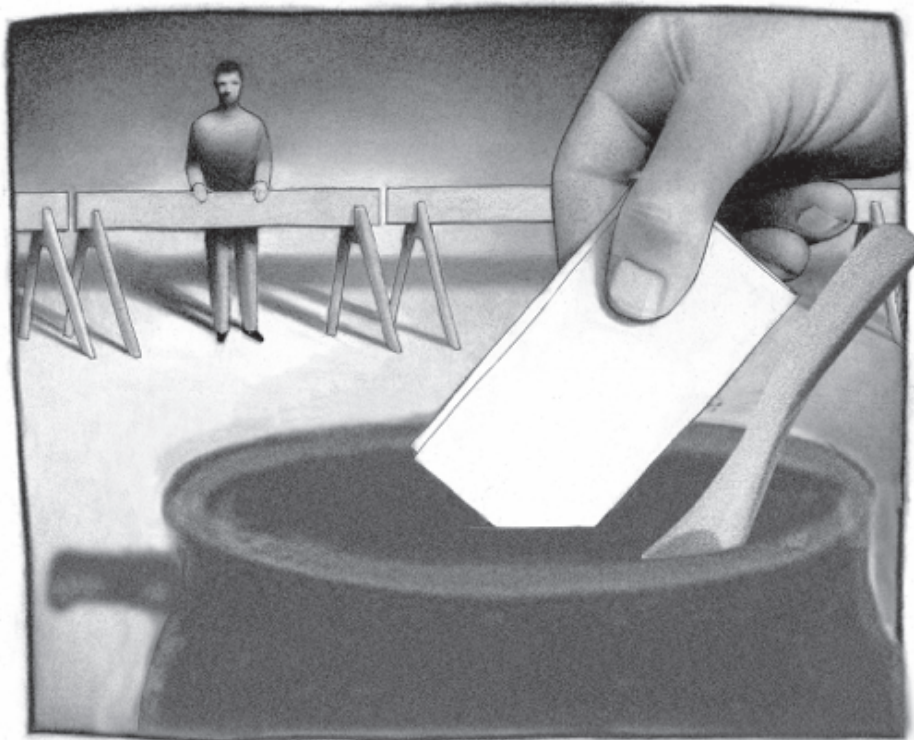
This is the hidden presidential count, which, with the exception of the Census’s whispered footnote, has not been reported. In the voting biz, most of these lost votes are called “spoilage.” Spoilage, not the voters, picked our President for us.

Unfortunately, that’s not all. In addition to the 3 million ballots uncounted due to technical “glitches,” millions more were lost because the voters were prevented from casting their ballots in the first place. This group of un-votes includes voters illegally denied registration or wrongly purged from the registries.

Joe Stalin, the story goes, said, “It’s not the people who vote that count; it’s the people who count the votes.” That may have been true in the old Soviet Union, but in the USA, the game is much, much subtler: He who makes sure votes don’t get counted decides our winners.

In the lead-up to the 2004 race, millions of Americans were, not un-





YES! MAGAZINE /  
APOLOGIES TO DOUG GRISWOLD

reasonably, panicked about computer voting machines. Images abounded of an evil hacker-genius in Dick Cheney's bunker rewriting code and zapping the totals. But that's not how it went down. The computer scare was the McGuffin, the fake detail used by magicians to keep your eye off their hands. The principal means of the election heist—voiding ballots—went unexposed, unreported and most importantly, uncorrected and ready to roll out on a grander scale next time

Like a forensic crime scene investigation unit, we can perform a post mortem starting with the exhumation of more than 3 million uncounted votes:

**:: Provisional Ballots Rejected.** An entirely new species of ballot debuted nationwide in 2004: the "provisional ballot." These were crucial to the Bush victory. Not because Republicans won this "provisional" vote. They won by rejecting provisional ballots that were cast overwhelmingly in Democratic precincts. The sum of "the uncounted" is astonishing: 675,676 ballots lost in

the counties reporting to the federal government. Add in the missing jurisdictions and the un-vote climbs to over a million: 1,090,729 provisional ballots tossed out.

**:: Spoiled Ballots.** You vote, you assume it's counted. Think again. Your "x" was too light for a machine to read. You didn't punch the card hard enough and so you "hung your chad." Therefore, your vote didn't count and, crucially, you'll never know it. The federal Election Assistance Commission totaled up nearly a million ballots cast but not counted. Add in states too shy to report to Washington, the total "spoilage" jumps to a rotten 1,389,231.

**:: Absentee Ballots Uncounted.** The number of absentee ballots has quintupled in many states, with the number rejected on picayune technical grounds rising to over half a million (526,420) in 2004. In swing states, absentee ballot shredding was pandemic.

**:: Voters Barred from Voting.** In this category we find a combination of incompetence and trickery that stops voters from pulling the lever in

the first place. There's the purge of "felon" voters that continues to eliminate thousands whose only crime is VWB—Voting While Black. It includes subtle games like eliminating polling stations in selected districts, creating impossible lines. No one can pretend to calculate a hard number for all votes lost this way any more than you can find every bullet fragment in a mutilated body. But it's a safe bet that the numbers reach into the hundreds of thousands of voters locked out of the voting booth.

### The test kitchen

But do these un-votes really turn the election? Voters from both parties used provisional or absentee ballots, and the machines can't tell if a hanging chad is Democratic or Republican, right? Not so. To see how it works, we went to New Mexico.

Dig this: In November 2004 during early voting in Precinct 13, Taos, New Mexico, John Kerry took 73 votes. George Bush got three. On election day, 216 in that precinct voted Kerry. Bush got 25 >>

# Recipe for a Cooked Election

» votes, and came in third. Third? Taking second place in the precinct, with 40 votes, was no one at all. Or, at least, that's what the machines said.

Precinct 13 is better known as the Taos Pueblo. Every single voter there is an American Native or married to one.

Precinct 13 wasn't unique. On Navajo lands, indecision struck on an epidemic scale. They walked in, they didn't vote. In nine precincts in McKinley County, New Mexico, which is 74.7 percent Navajo, fewer than one in ten voters picked a president. Those who voted on paper ballots early or absentee knew who they wanted (Kerry, overwhelmingly), but the machine-counted vote said Indians simply couldn't make up their minds or just plain didn't care. On average, across the state, the machine printouts say that 7.3 percent—one in twelve voters—in majority Native pre-

cincts didn't vote for president. That's three times the percentage of white voters who appeared to abstain.

In pueblo after pueblo, on reservation after reservation throughout the United States, the story was the same. Nationally, one out of every 12 ballots cast by Native Americans did not contain a vote for President. Indians by the thousands drove to the voting station, walked into the booth, said, "Who cares?" and walked out without voting for president.

So we dropped in on Taos, Precinct 13. The "old" pueblo is old indeed—built 500 to 1,000 years ago. In these adobe dwellings stacked like mud condos, no electricity is allowed nor running water—nor Republicans as far as records show. Richard Archuleta, a massive man with long, gray pigtailed hands as big as flank steaks, is the head of tourism for the pueblo.

Richard wasn't buying the indecision theory of the Native non-count. Indians were worried about their Bureau of Indian Affairs grants, their gaming licenses, and working conditions at their other big employer: the U.S. military. On the pueblo's mud-brick walls there were several hand painted signs announcing Democratic Party powwows, none for Republicans.

Indecisive? Indians are Democrats. Case closed.

## The color that counts

It wasn't just Native Americans who couldn't seem to pick a President.

Throughout New Mexico, indecisiveness was pandemic ... at least, that is, among people of color. Or so the machines said. Across the state, high-majority Hispanic precincts recorded a 7.1 percent vote for nobody for president.

We asked Dr. Philip Klinkner, the expert who ran stats for the U.S. Civil Rights Commission, to look at the New Mexico data. His solid statistical analysis discovered that if you're Hispanic, the chance your vote will not record on the machine was 500% higher than if you are white. For Natives, it's off the charts. The Hispanic and Native vote is no small potatoes. Every tenth

New Mexican is American Native (9.5 percent) and half the remaining population (43 percent) is Mexican-American.

Our team drove an hour across the high desert from the Taos Reservation to Española in Rio Arriba County. According to the official tallies, entire precincts of Mexican-Americans registered few or zero votes for president in the last two elections. Española is where the Los Alamos workers live, not the Ph.D.s in the white lab coats, but the women who clean the hallways and the men who bury the toxins.

This was not Bush country, and the people we met with, including the leaders of the get-out-the-vote operations, knew of no Hispanics who insisted on waiting at the polling station to cast their vote for "nobody for President."

The huge majority of Mexican-Americans, especially in New Mexico, and a crushing majority of Natives (over 90 percent), vote Democratic. What if those voters weren't indecisive; what if they punched in a choice and it didn't record?

Let's do the arithmetic. As minority voters cast 89 percent of the state's 21,084 blank ballots, that's 18,765 missing minority votes. Given the preferences of other voters in those pueblos and barrios, those 18,765 voters of color should have swamped Bush's 5,988 vote "majority" with Kerry votes. But that would have required those votes be counted.

## The voting-industrial complex

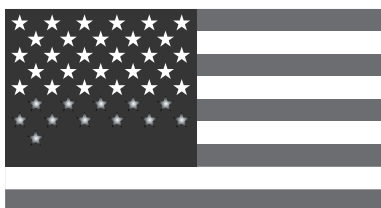
New Mexico's Secretary of State, Rebecca Vigil-Giron, seemed curiously uncurious about Hispanic and Native precincts where nearly one in ten voters couldn't be bothered to choose a president. Vigil-Giron, along with Governor Bill Richardson, not only stopped any attempt at a recount directly following the election, but demanded that all the machines be wiped clean. This not only concealed evidence of potential fraud but destroyed it. In 2006, New Mexico's Supreme Court ruled the Secretary of State's machine-cleaning job illegal—too late to change the out-

## Growing Popularity of Paper

In 2002, two states required that all votes be cast with a verifiable paper record.



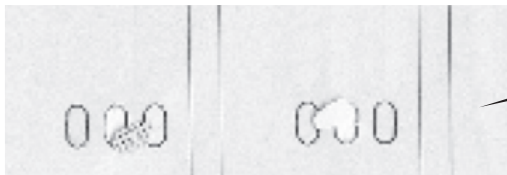
In 2006, 28 states require a paper record. An additional 12 states have legislation proposed but not yet enacted.



Source: [verifiedvoting.org](http://verifiedvoting.org)

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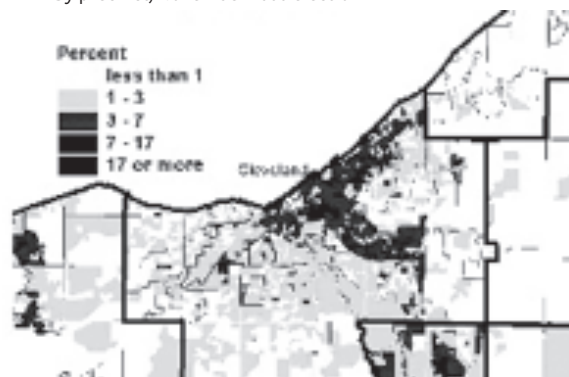
Actual-size photo of hanging chads. Could you tell this voter's intent?

## The Cleveland Example

Is ballot spoilage random? What would happen if you mapped the concentration of uncounted ballots in the Cleveland area in 2000, and mapped the percentage of African-American voters in Cleveland precincts? You be the judge.

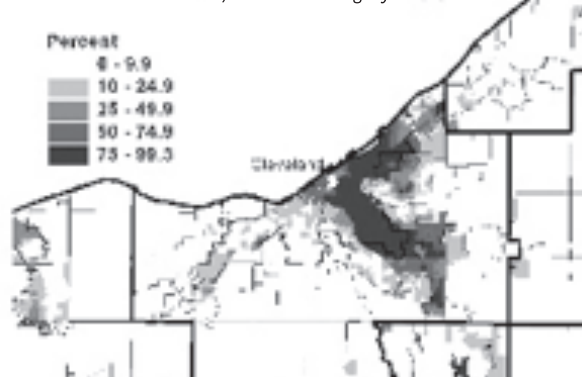
### Percentage of ballots that were not counted

By precinct, November 2000 election



### Percentage of African American voters

Persons 18 and Older, One Race Category



Source: Maps by Mark J. Salling, Ph.D., Maxine Goodman Levin College of Urban Affairs, Cleveland State University. Used by permission.

YES! MAGAZINE GRAPHIC 2006

come of the election, of course.

But who are we to second-guess Secretary Vigil-Giron? After all, she is a big shot, at the time president, no less, of the National Association of Secretaries of State, the top banana of all our nation's elections officials.

Vigil-Giron, after putting a stop to the recount, rather than schlep out to investigate the missing vote among the iguanas and Navajos, left the state to officiate at a dinner meeting in Minneapolis for her national association. It was held on a dinner boat. The tab for the moonlight ride was picked up by touch-screen voting machine maker ES&S Corporation. Breakfast, in case you're curious, was served by touch-screen maker Diebold Corp.

At the time of this writing, Vigil-Giron is busy planning the next big con-fab of vendors and state officials—this time in Santa Fe, "the city different." But aside from Wal-Mart signing on as a sponsor, nothing much is different when it comes to the inner workings of the voting industrial complex.

Except for one thing.

### Where's the action?

While Vigil-Giron is greeting her fellow Secretaries and casually introducing them to this year's vendors, it is likely she'll keep quiet about a few things.

Voter Action, a group of motivated citizens, some jumping into activism for the first time, sued the state of New Mexico in 2005 over the bad machines and the failure to count the vote. The activists ran a public campaign with their revelations about New Mexico's broken democracy. Last year, Voter Action invited our investigations team to lay out our findings to huge citizens' meetings in Albuquerque and Santa Fe. Soon, the whole horrid vote-losing game was on local community radio and TV stations.

It worked. Governor Richardson, who ducked the issue for three years, and his Secretary of State, once openly hostile to reform, had to relent in the face of the public uprising. In February of 2006, Richardson signed a model law requiring that all voting in the state take place on new paper bal-

lot machines, with verifiable tabulating systems. Richardson now claims the mantle of leader of the voting reform campaign.

Voter Action, successful in New Mexico, is now pursuing lawsuits in seven states to stop the Secretaries of State from purchasing electronic voting systems which have records of inaccuracy, security risks, and have been proven unreliable.

In New Mexico we learned, once again, that the price of liberty is eternal vigilance. To protect your right to vote, you must know what is happening in your state—before, during, and after Election Day—and be willing to hold your leaders accountable. **Y**



**Greg Palast** is the author of the New York Times bestseller, *Armed Madhouse: Who's Afraid of Osama Wolf?*, *China Floats Bush Sinks*, *the Scheme to Steal '08*, *No Child's Behind Left* and other Dispatches from the Front Lines of the Class War from which this report is

adapted. Matt Pascarella, writer and researcher working with Palast, contributed the update to this report. See their work at [www.GregPalast.com](http://www.GregPalast.com)

U.S. administration's budget request for border security at the U.S.-Mexican border: **\$1.9 billion**

Cost of the 300-mile border wall: **\$900 million**<sup>1</sup>

Total U.S. Agency for International Development budget for aid to Mexico for education, democracy, micro-finance, the environment, and capacity building for FY 2006: **\$31 million**<sup>2</sup>

Square miles of Borneo's rainforest inhabited by the endangered orangutan saved from clear-cutting by an international grassroots e-mail campaign by the nonprofit group Ecological Internet: **6,300**<sup>3</sup>

Percentage of university faculty classified as adjuncts, or part-time teachers, in 1970: **22**<sup>4</sup>

Percentage in 2005: **44**

Percentage who receive health benefits or contributions to retirement: **less than 20**<sup>5</sup>

Percentage of consumers polled who say they would pay more for books or magazines printed on recycled paper: **80**<sup>6</sup>

Percentage increase nationwide of dependence on the food stamp program in the last decade: **8**

Percentage increase in counties with Wal-Mart stores: **15.3**<sup>7</sup>

Number of bras strung together by activists in Cyprus, Greece, to raise awareness of breast cancer: **114,000**<sup>8</sup>

Percentage of adults who support condom use to prevent HIV and other sexually transmitted infections: **92**

Percentage of Catholics who support: **93**<sup>9</sup>

Fine an elderly woman in California received for crossing the street too slowly: **\$114**<sup>10</sup>

Number of daily postings in the entire "blogosphere": **1.2 million**

Number of daily postings on MySpace, a networking site popular with 16 to 34-year-olds: **1.4 million**<sup>11</sup>

Estimated number of people who die in the U.S. each year due to a lack of health insurance: **18,000**

Number of people who died on 9/11: **2,819**<sup>12</sup>

Barrels of oil the U.S. consumes per day: **20 million**

Barrels of oil the U.S. would have saved in 2006 alone if, starting in 2001, the government had implemented plans to raise fuel economy standards to 40 mpg by 2012: **500,000**

Amount consumers would save at the gas pump this year: **\$8.7 billion**

Tons by which carbon dioxide emissions would be reduced: **34 million**<sup>13</sup>

**Complete citations at [www.yesmagazine.org](http://www.yesmagazine.org)**

**1.** The Associated Press, May 18, 2006. **2.** U.S. Agency for International Development (USAID), Budget Summary Mexico Program, 2006. **3.** Ecological Internet, Inc., May 15, 2006. **4.** *The Washington Post*, July 21, 2002. **5.** The American Federation of Teachers, October 31, 2005. **6.** Co-Op America, December 1, 2005. **7.** *Social Science Quarterly*, June 2006. **8.** Reuters, April 30, 2006. **9.** The Harris Poll #78, October 20, 2005. **10.** NBC 6 News, South Florida, April 10, 2006. **11.** *Christian Science Monitor*, May 17, 2006. **12.** *Seattle Post-Intelligencer*, May 2, 2006. **13.** U.S. PIRG, December 2005.



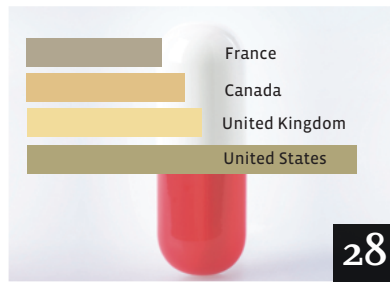
# Health Care For All

The United States stands alone, the only industrialized nation without universal health care. Americans know it's time to do more than patch up a flawed and over-priced system. Can we afford to cover everyone? Can we afford not to?



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**American Health Care. A System to Die For?** Spend more, get less. It's the American way. It doesn't have to be.



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**Just the Facts.** The U.S. health care system, by the numbers.

**Better Health Through Fairer Wealth.** Beyond inequality & poverty.



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Innovations that are working, from Common Ground in New Orleans ...



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**Speaking of Health Care.** Personal stories from patients, doctors, and activists.



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**If You Ask Maine.** One state moves toward universal coverage.

**Americans Speak.** Americans know what they want in a health care system.



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... to Ithaca, Oakland, The Bronx, and Bhopal, India.



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**Has Canada Got the Cure?** A 35-year experiment pays big dividends.



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**A Growing Movement.** Like the social movements that changed U.S. history, grassroots activism is changing what's possible with health care.



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**Healing Arts.** Snapshots of creative healing, from medieval relaxation to clowns in hospital gowns.

# Health Care. It's What Ails Us



We outspend the world to buy an under-performing system. What are the effects of America's patchwork system? **What will it take to fix it?**

## **Doug Pibel and Sarah Van Gelder**

For Joel Segal, it was the day he was kicked out of George Washington Hospital, still on an IV after knee surgery, without insurance, and with \$100,000 in medical debt. For Kiki Peppard, it was having to postpone needed surgery until she could find a job with insurance—it took her two years. People all over the United States are waking up to the fact that our system of providing health care is a disaster.

An estimated 50 million Americans lack medical insurance, and a similar

and rapidly growing number are underinsured. The uninsured are excluded from services, charged more for services, and die when medical care could save them—an estimated 18,000 die each year because they lack medical coverage.

But it's not only the uninsured who suffer. Of the more than 1.5 million bankruptcies filed in the U.S. each year, about half are a result of medical bills; of those, three-quarters of filers had health insurance.

Businesses are suffering too. Insurance premiums increased 73 percent between 2000 and 2005, and per capita costs are expected to keep rising. The National Coalition on Health Care (NCHC) estimates that, without reform, national health care spending will double over the next 10 years. The NCHC is not some fringe advocacy group—its co-chairs are Congressmen Robert D. Ray (R-IA) and Paul G. Rogers (D-FL), and it counts General Electric and Verizon among its members.

Employers who want to offer employee health care benefits can't compete with low-road employers who





TRACY LOEFFELHOLZ DUNN / YES! MAGAZINE

offer none. Nor can they compete with companies located in countries that offer national health insurance.

The shocking facts about health care in the United States are well-known. There's little argument that the system is broken. What's not well-known is that the dialogue about fixing the health care system is just as broken.

Among politicians and pundits, a universal, publicly funded system is off the table. But Americans in increasing numbers know what their leaders seem not to—that the United States is the only industrialized nation where such stories as Joel's and Kiki's can happen. And most Americans know why: the United States leaves the health of its citizens at the mercy of an expensive, patchwork system where some get great care while others get none at all.

The overwhelming majority—75 percent, according to an October 2005 Harris Poll—want what people in other wealthy countries have: the peace of mind of universal health insurance.

#### **A wild experiment?**

Which makes the discussion all the stranger. The public debate around universal health care proceeds as if it were a wild, untested experiment—as if the United States would be doing something never done before.

Yet universal health care is in place throughout the industrialized world. In most cases, doctors and hospitals operate as private businesses. But government pays the bills, which reduces paperwork costs to a fraction of the American level. It also cuts out expensive insurance corporations and HMOs, with their multimillion-dollar CEO compensation packages, and billions in profit. Small wonder “single payer” systems can cover their entire populations at half the per capita cost.

In the United States, people without insurance may live with debilitating disease or pain, with conditions that prevent them from getting jobs or decent pay, putting many on a permanent poverty track. They have more difficulty managing chronic conditions—only two in five have a regular doctor—lead- >>

## Speaking of Health Care

From interviews by Daina Saib

» ing to poorer health and greater cost. The uninsured are far more likely to wait to seek treatment for acute problems until they become severe.

Even those who have insurance may not find out until it's too late that exclusions, deductibles, co-payments, and annual limits leave them bankrupt when a family member gets seriously ill. In 2005, more than a quarter of insured Americans didn't fill prescriptions, skipped recommended treatment, or didn't see a doctor when sick, according to the Commonwealth Fund's 2005 *Biennial Health Insurance Survey*.

People stay in jobs they hate—for the insurance. Small business owners are unable to offer insurance coverage for employees or themselves. Large businesses avoid setting up shops in the United States—Toyota just chose to build a plant in Canada to escape the skyrocketing costs of U.S. health care.

All of this adds up to a less healthy society, more families suffering the double whammy of financial and health crises, and more people forced to go on disability.

But the public dialogue proceeds as if little can be done beyond a bit of tinkering around the edges. More involvement by government would create an unwieldy bureaucracy, they say, and surely bankrupt us all.

The evidence points to the opposite conclusion.

The United States spends by far the most on health care per person—more than twice as much as Europe, Canada, and Japan which all have some version of national health insurance. Yet we are near the bottom in nearly every measure of our health.

The World Health Organization (WHO) ranks the U.S. health care system 37th of 190 countries, well below most of Europe, and trailing Chile and Costa Rica. The United States does even worse in the WHO rankings of performance on level of health—a stun-

ning 72nd (see page 22). Life expectancy in the U.S. is shorter than in 27 other countries; the U.S. ties with Hungary, Malta, Poland, and Slovakia for infant mortality—ahead of only Latvia among industrialized nations.

### The cost of corporate bureaucracy

Where is the money going? An estimated 15 cents of each private U.S. health care dollar goes simply



**Brian Salmon**

*Perfusion Assistant, Chicago, IL*

A little over five years ago, I was diagnosed with testicular cancer. Even with my insurance, it still took me years to pay off the thousands of dollars of out-of-pocket costs.

After three years of follow-up visits, my insurance company told me that they no longer considered my hospital a provider for their plans. I had developed a relationship with the doctors, nurses, and staff at the hospital. They had been there during some of the toughest times of my life.

When it comes to a person's well-being there isn't much of a choice. Who chooses not to seek treatment for cancer? When the doctor tells you to do something or you will die, who says, "Gee, that's a little more than I was hoping to spend today"? It isn't like choosing between Coke or Pepsi.



**Kiki Peppard**

*Clerical worker, Effort, PA*

I found out I had fibroid tumors in 1996. I had to postpone my surgery for two years, until I found a job with insurance. My insurance company would only pay for a one-day stay, after surgery that left me with a feeding tube in my nose and two catheters. My surgeon intervened and I was covered for my entire stay.

Right now I have to decide which pill I can take that day depending on what the household bills are. I will alternate days just to make the pills last. It's like Russian Roulette. I have to ask, "What am I going to have to give up today to get the healthcare I need?"

In America, we just can't afford to get sick. That's the bottom line.



**www.YesMagazine.org**

*Additional interviews online*

to shuffling the paperwork. The administrative costs for our patched-together system of HMOs, insurance companies, pharmaceutical manufacturers, hospitals, and government programs are nearly double those for single-payer Canada.

It's not because Americans are inherently less efficient than Canadians—our publicly funded Medicare system spends under five cents per budget





## Jay Bhatt

*Medical student and president, American Medical Students' Association (AMSA), Reston, VA*

We've inherited a medical system that's broken and leaving people behind. Health care is more than just a political or ethical issue—it's a social justice issue. The uninsured crisis is a national problem in need of a national solution. That solution, we believe, is a national health insurance system—publicly financed, privately delivered.

AMSA is the birthplace of medical student activism. We're working to engage medical students in change and to help them become socially responsible physicians. Our campaigns are mobilizing the future doctors of the U.S. to partner with organizations, community groups, education, and people like those of *Gesundheit* (see page 45) to bring health care to all. AMSA sponsors National Pharm-free day. Thousands of doctors and medical students have signed a pledge to say "no" to pharmaceutical company promotions—to say "our critical judgment is not for sale."

dollar on administrative overhead. And the Veterans Administration, which functions like Britain's socialized medical system, spends less per patient but consistently outranks private providers in patient satisfaction and quality of care.

But in the private sector, profits and excessive CEO pay are added to the paperwork and bureaucracy. The U.S. pharmaceutical industry averages a 17



## Roy Farrell, M.D.

*Medical Director of Hospitals, Group Health Cooperative, Seattle, WA*

We provide world-class health-care to a certain segment of our population who has insurance and at the same time we make other people go through bankruptcy to get the care they need. What's happening now is the uninsured are growing slowly; the *underinsured* are growing dramatically.

We need a rational way to allocate our limited health care resources. I was an emergency physician for 30 years. All the dysfunction of society and our irrational system shows up there. All we have as emergency physicians is the very expensive alternative to preventative care. It's a tragedy that we can't give access to a meaningful relationship with a good primary care physician.

percent profit margin, against 3 percent for all other businesses. In the health care industry, million-dollar CEO pay packages are the rule, with some executives pulling down more than \$30 million a year in salary and amassing billion-dollar stock option packages.

Do those costs really make the difference? Studies conducted by the General Accounting Office, the Con-



## U.S. Checkup

In 2001, 54.5% of bankruptcies were caused, at least in part, by illness or medical debt.

gressional Budget Office, and various states have concluded that a universal, single-payer health care system would cover everyone—including the millions currently without insurance—and still save billions.

Enormous amounts of money are changing hands in the health-industrial complex, but little is going to the front line providers—nurses, nurse practitioners, and home health care workers who put in long shifts for low pay. Many even find they must fight to get access to the very health facilities they serve.

Doctors complain of burnout as patient loads increase. They spend less time with each patient as they spend more time doing insurance company-mandated paperwork and arguing with insurance company bureaucrats over treatments and coverage.

## Americans know what they want

In polls, surveys, town meetings, and letters, large majorities of Americans say they have had it with a system that is clearly broken and they are demanding universal health care. Many businesses—despite a distaste for government involvement—are coming to the same view. Doctors, nurses, not-for-profit hospitals, and clinics are joining the call, many specifically saying we need a single-payer system like the system in Canada.

And while we hear complaints about Canada's system, a study of 10 years of Canadian opinion polling showed that Canadians are more satisfied with their health care than Americans. Holly Dressel's article on page 24 shows why. Although you'd never know it from the American media, the number of Canadians who would trade their system for a U.S.-style health care system is just 8 percent.

Again, the public dialogue proceeds from a perplexing place. Dissatisfied Canadians or Britons are much talked about. But there's little mention of the >>

» satisfaction level of Americans. The Commonwealth Fund's survey, for instance, shows that, in 2005, 42 percent of Americans doubted whether they could get quality health care.

At a series of town hall meetings in Maine, facilitators asked participants to discuss dozens of complex health care policies but excluded single-payer as an option. (See Tish Tanski's article on page 30). Only after repeated demands by participants was the approach that cuts out the corporate middle-men allowed on the list.

The same story played out across the country at town meetings convened by the congressionally mandated Citizens' Health Care Working Group. In Los Angeles, New York, and Hartford, participants simply refused to consider the questions they were given about trade-offs between cost, quality, and accessibility. They insisted that there's already enough money being spent to pay for publicly funded universal health care.

But it's not only about the money.

Comments from participants in the town meetings, from Fargo to Memphis, from Los Angeles to Providence, revealed an understanding that this is about a deeper question. It is an issue of the sort of society we want to be—one in which we all are left to sink or swim on our own or one in which we recognize that the whole society benefits when we each can get access to the help we need.

Likewise, when we asked readers of the *YES!* email newsletter what would make *you* healthier, nearly all answered in terms of "*we*." Any one of us could get sick or be injured. Any one could lose a job and with it insurance. Our best security, they said, is coverage for all.

#### What form might this take?

As elections near and the issue of health care tops opinion polls as the most pressing domestic issue, various proposals for universal health care are circulating. The bipartisan NCHC looked at four options: employer

mandates, extending existing federal programs like Medicaid to all those uninsured, creating a new federal program for the uninsured, and single-payer national health insurance. All the options saved billions of dollars compared to the current system, but single payer was by far the winner, saving more than \$100 billion a year.

Meanwhile, the Citizens' Health Care Working Group, which held those

#### Corporate Health Care

**Example:** United States

**How it works:** Individuals or employers purchase coverage from mostly for-profit insurance companies. The elderly, disabled, veterans, some children, some low-income people are covered through public programs.

**Who pays:** Employers and individuals pay premiums. Most plans require co-pays and deductibles, and some costs are excluded. Government subsidizes employer plans through tax breaks and covers some families through publicly funded programs.

**Who chooses doctor:** Choice restricted by insurer; penalties may apply for seeing "out-of-network" provider. Some providers don't take Medicaid or Medicare.

**Who is covered:** Those with insurance, those covered by the Veterans Administration (which works like socialized medicine), Medicaid, and Medicare (which function like single-payer systems). Those with chronic illness or pre-existing conditions may not be able to find coverage at any price. About 50 million have no insurance, including 9 million children.

**Cost per capita:** \$5,711

**WHO rank for U.S.:** 72

## HEALTH CARE OPTIONS AT A GLANCE

### Socialized

**Example:** Britain (also, the Veterans Administration)

**How it works:** Government hires doctors and runs hospitals.

**Who pays:** Government

**Who chooses doctor:** Patient

**Who is covered:** Everyone

**Cost per capita:** \$2,389

**WHO rank\* for Britain:** 24

### Single-Payer

**Example:** Canada

**How it works:** Doctors have private practices, hospitals may be owned by nonprofits or by government. Government pays the bills based on fee structures negotiated with health care providers.

**Who pays:** Government

**Who chooses doctor:** Patient

**Who is covered:** Everyone

(NOTE: This is the system proposed in Rep. John Conyers National Health Insurance Act, HR 676.)

**Cost per capita:** \$2,989.

**WHO rank for Canada:** 35

### Nonprofit Multi-Payer

**Example:** France

**How it works:** Medical practices and hospitals are private (nonprofit or for-profit). Nonprofit, regulated "sickness" funds collect payments and pay health care bills under the terms of a negotiated fee structure.

**Who pays:** Payroll contributions (compulsory) from employers and employees. Funds cover 75% of medical bills. Remainder comes from government, patients, and supplemental insurance.

**Who chooses doctor:** Patients

**Who is covered:** 99% of population

**Cost per capita:** \$2,902.

**WHO rank for France:** 4

\*The World Health Organization (WHO) performance on level of health ranking measures how efficiently a system translates spending into overall health—a "bang for the buck" rating.



## U.S. Checkout

Every minute, nearly five people in the U.S. lose their health insurance.

town meetings around the country, has issued interim recommendations. They state the values participants expressed: All Americans should have affordable health care, and assuring that they do is a shared social responsibility. Sadly, that bold statement is followed by inconclusive recommendations: more study, no preference for public funding, and a strong commitment to get everybody covered by 2012—but with no means to do it. The commission will make final recommendations to the president and Congress, and is accepting public comment through the end of August. (See page 33.)

### What is the obstacle?

With all the support and all the good reasons to adopt universal health care, why don't we have it yet? Why do politicians refuse to talk about the solution people want?

It could be the fact that the health care industry, the top spender on Capitol Hill, spent \$183.3 million on

lobbying just in the second half of 2005, according to PoliticalMoneyLine.com. And in the 2003–2004 election cycle, they spent \$123.7 million on election campaigns, according to the Center for Responsive Politics.

Politicians dread the propaganda barrage and political fallout that surrounded the failed Clinton health care plan. But in the years since, health care costs have outpaced growth in wages and inflation by huge margins, Americans have joined the ranks of the uninsured at the rate of 2 million each year, and businesses are taking a major competitiveness hit as they struggle to pay rising premiums.

Health Care for All is holding town hall meetings throughout the United States (they've held 93 so far), and people are pressing their representatives to take action. Over 150 unions have called for action on universal health care, and polls show overwhelming majorities of Americans feel the same way.

Some political leaders are pressing

for universal health care. Remember Joel, who was kicked out of the hospital with \$100,000 in medical debt? He started giving speeches about the catastrophe of our health care system, and eventually got hired by Rep. John Conyers (D-MI) to head his universal single payer health care effort. Conyers' "Medicare for All" bill now has 72 co-sponsors. Rep. Jim McDermott's (D-WA) Health Security Act has 62.

Around the United States, state and local campaigns for universal health care are making progress. (See Rev. Linda Walling's update on page 34).

One of these days, the lobbyists and their clients in government may have to get out of the way and let Americans join the rest of the developed world in the security, efficiency, and quality that comes with health care for all. **y**

### Health Savings Accounts

**Example:** U.S. as of 2004

**How it works:** Individuals buy high-deductible insurance and they (or employers) contribute to tax-free savings accounts used to pay bills.

**Who pays:** Individuals, employers, and government (through tax breaks).

**Who chooses doctor:** Plans may restrict doctor choice.

**Who is covered:** Appeals to those with low medical expenses. Low-income people and those with accounts too low to cover deductibles are on their own.

**Costs:** Requires complex expense tracking. Incentive to postpone preventive care. Cost controls not addressed.

### Individual Mandate

**Example:** Massachusetts as of 2006

**How it works:** All are required to carry insurance, through employers or by buying their own policy.

**Who pays:** Individuals, employers, government (subsidizes premiums and offers Medicare for the low-income).

**Who chooses doctor:** Insurance plan. Medicare recipients choose any doctor who accepts Medicare.

**Who is covered:** In theory, all. But barriers remain for low-income families.

**Costs:** Government subsidy makes coverage affordable to some low-income families, but there is no change to the main drivers of high costs.

### Tax Credit

**How it works:** Tax credits offset the cost of private insurance premiums.

**Who pays:** Individuals and government (via tax breaks).

**Who chooses doctor:** Restricted by insurance plan.

**Who is covered:** Those who qualify for a tax credit and can afford to make premium payments. Some proposals call for restricting the credit to low-income people.

**Costs:** Tax breaks offset premium costs, but there is no provision for impoverished families. Individuals still pay co-pays, deductibles, etc. There is no change to the main drivers of high costs.

### Buy-In Option

**How it would work:** Under a plan studied by the National Coalition on Healthcare, the uninsured could buy into Medicaid, Medicare, or SCHIP.

**Who pays:** Individuals pay on a sliding scale, with government subsidy sufficient to make it affordable.

**Who chooses doctor:** Private plans determine choices. Publicly covered patients choose participating doctors.

**Who is covered:** Everyone

**Costs:** NCHC says in the first decade health care savings would total \$320.5 billion; businesses now providing health insurance would save \$848 billion, and families who currently carry insurance would save \$309 billion.



# Has Canada Got the Cure?



Publicly funded health care has its problems, as any Canadian or Briton knows. But like democracy, **it's the best answer we've come up with so far.**

## Holly Dressel

**S**hould the United States implement a more inclusive, publicly funded health care system? That's a big debate throughout the country. But even as it rages, most Americans are unaware that the United States is the only country in the developed world that doesn't already have a fundamentally public—that is, tax-supported—health care system.

That means that the United States has been the unwitting control subject in a 30-year, worldwide experiment comparing the merits of private versus public health care funding.

For the people living in the United States, the results of this experiment with privately funded health care have been grim. The United States now has

the most expensive health care system on earth and, despite remarkable technology, the general health of the U.S. population is lower than in most industrialized countries. Worse, Americans' mortality rates—both general and infant—are shockingly high.

### Different paths

Beginning in the 1930s, both the Americans and the Canadians tried to alleviate health care gaps by increasing use of employment-based insurance plans. Both countries encouraged nonprofit private insurance plans like Blue Cross, as well as for-profit insurance plans. The difference between the United States and Canada is that Americans are still doing this, ignoring decades of international statistics that show that this type of funding inevita-

bly leads to poorer public health.

Meanwhile, according to author Terry Boychuk, the rest of the industrialized world, including many developing countries like Mexico, Korea, and India, viscerally understood that “private insurance would [never be able to] cover all necessary hospital procedures and services; and that even minimal protection [is] beyond the reach of the poor, the working poor, and those with the most serious health problems.” Today, over half the family bankruptcies filed every year in the United States are directly related to medical expenses, and a recent study shows that 75 percent of those are filed by people with health insurance.

The United States spends far more per capita on health care than any comparable country. In fact, the gap



TRACY LOEFFELHOLZ DUNN /  
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is so enormous that a recent University of California, San Francisco, study estimates that the United States would save over \$161 billion every year in paperwork alone if it switched to a single-payer system like Canada's. These billions of dollars are not abstract amounts deducted from government budgets; they come directly out of the pockets of people who are sick.

The year 2000 marked the beginning of a crucial period, when international trade rules, economic theory, and political action had begun to fully reflect the belief in the superiority of private, as opposed to public, management, especially in the United States. By that year the U.S. health care system had undergone what has been called "the health management organization revolution."

U.S. government figures show that medical care costs have spiked since 2000, with total spending on prescriptions nearly doubling.

#### **Cutting costs, cutting care**

There are two criteria used to judge a country's health care system: the overall success of creating and sustaining health in the population, and the ability to control costs while doing so.

One recent study published in the *Canadian Medical Association Journal* compares mortality rates in private for-profit and nonprofit hospitals in the United States. Research on 38 million adult patients in 26,000 U.S. hospitals revealed that death rates in for-profit hospitals are significantly higher than in nonprofit hospitals: for-profit patients have a 2 percent higher chance of dying

in the hospital or within 30 days of discharge. The increased death rates were clearly linked to "the corners that for-profit hospitals must cut in order to achieve a profit margin for investors, as well as to pay high salaries for administrators."

"To ease cost pressures, administrators tend to hire less highly skilled personnel, including doctors, nurses, and pharmacists..." wrote P. J. Devereaux, a cardiologist at McMaster University and the lead researcher. "The U.S. statistics clearly show that when the need for profits drives hospital decision-making, more patients die."

#### **The value of care for all**

Historically, one of the cruelest aspects of unequal income distribution is that poor people not only experience material want all their lives, they also suffer more illness and die younger. But in Canada there is no association between income inequality and mortality rates—none whatsoever.

In a massive study undertaken by Statistics Canada in the early 1990s, income and mortality census data were analyzed from all Canadian provinces and all U.S. states, as well as 53 Canadian and 282 American metropolitan areas. The study concluded that "the relation between income inequality and mortality is not universal, but instead depends on social and political characteristics specific to place." In other words, government health policies have an effect.

"Income inequality is strongly associated with mortality in the United States and in North America as a whole," the study found, "but there is no relation within Canada at either the province or metropolitan area level ... between income inequality and mortality." The same study revealed that among the poorest people in the United States, even a 1 percent increase in

»

» income resulted in a mortality decline of nearly 22 out of 100,000.

What makes this study so interesting is that Canada used to have statistics that mirrored those in the United States. In 1970, U.S. and Canadian

mortality rates calculated along income lines were virtually identical. But 1970 also marked the introduction of Medicare in Canada—universal, single-payer coverage. The simple explanation for how Canadians have all become

equally healthy, regardless of income, most likely lies in the fact that they have a publicly funded, single-payer health system and the control group, the United States, doesn't.

## Speaking of Health Care

From interviews by Daina Saib



**Sandy Schmidt**

Milwaukee, WI

I've had a string of health crises since 2005, and my husband Rick and I are unemployed now. Since he lost his job with benefits in 2002, we have paid over \$50,000 for medical insurance and uncovered charges. We have exhausted most of our savings and cashed in our retirement annuities.

We now live on Rick's social security, a small pension and some disability benefits. I received "charity care" for a year with one of the health care systems in Milwaukee. The deductible on my insurance is \$2,500 and my quarterly rate has just increased to \$1,863.

Access to health care should not depend on one's job or ability to pay. Health care is a right, not a privilege. There is no understanding that people are really suffering. People are just one paycheck away from disaster.



**Don Mayer**

*Chair, Vermont Businesses for Social Responsibility (VBSR). Owner, Small Dog Electronics, Waitsfield, VT.*

As employers, we are faced with a crisis of rising premiums. The family rate for my employees last year was about \$10,500 and will increase to about \$12,000 this year. Employers are paring down their coverage or switching to catastrophic-only coverage. Employees are stuck in dead-end jobs because they are afraid of losing medical coverage or of new insurance classifying them with pre-existing conditions, or want to keep the same coverage they have.

VBSR are for a publicly financed, universal system that will reduce the administrative burden. We would like to see a business plan for health care that is efficient and will reduce costs while still providing the best quality health care for everyone.

### Infant mortality

Infant mortality rates, which reflect the health of the mother and her access to prenatal and postnatal care, are considered one of the most reliable measures of the general health of a population. Today, U.S. government statistics rank Canada's infant mortality rate of 4.7 per thousand 23rd out of 225 countries, in the company of the Netherlands, Luxembourg, Australia, and Denmark. The U.S. is 43rd—in the company of Croatia and Lithuania, below Taiwan and Cuba. All the countries surrounding Canada or above it in the rankings have tax-supported health care systems. The countries surrounding the United States and below have mixed systems or are, in general, extremely poor in comparison to the United States and the other G8 industrial powerhouses. There are no major industrialized countries near the United States in the rankings. The closest is Italy, at 5.83 infants dying per thousand, but it is still ranked five places higher.

In the United States, infant mortality rates are 7.1 per 1,000, the highest in the industrialized world—much higher than some of the poorer states in India, for example, which have public health systems in place, at least for mothers and infants. Among the inner-city poor in the United States, more than 8 percent of mothers receive no prenatal care at all before giving birth.

### Overall U.S. mortality

We would have expected to see steady decreases in deaths per thousand in the mid-twentieth century, because so many new drugs and procedures were becoming available. But neither the Canadian nor the American mortality rate declined much; in fact, Canada's leveled off for an entire decade, throughout the 1960s. This



was a period in which private care was increasing in Canadian hospitals, and the steady mortality rates reflect the fact that most people simply couldn't afford the new therapies that were being offered. However, beginning in 1971, the same year that Canada's Medicare was fully applied, official statistics show that death rates suddenly plummeted, maintaining a steep decline to their present rate.

In the United States, during the same period, overall mortality rates also dropped, reflecting medical advances. But they did not drop nearly so precipitously as those in Canada after 1971. But given that the United States is the richest country on earth, today's overall mortality rates are shockingly high, at 8.4 per thousand, compared to Canada's 6.5.

### Rich and poor

It has become increasingly apparent, as data accumulate, that the overall improvement in health in a society with tax-supported health care translates to better health even for the rich, the group assumed to be the main beneficiaries of the American-style private system. If we look just at the 5.7 deaths per thousand among presumably richer, white babies in the United States, Canada still does better at 4.7, even though the Canadian figure includes all ethnic groups and all income levels. Perhaps a one-per-thousand difference doesn't sound like much. But when measuring mortality, it's huge. If the U.S. infant mortality rate were the same as Canada's, almost 15,000 more babies would survive in the United States every year.

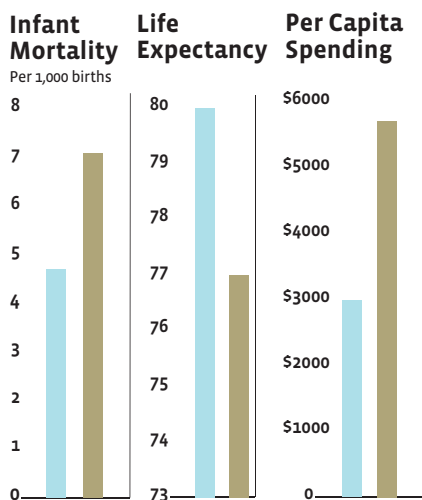
If we consider the statistics for the poor, which in the United States have been classified by race, we find that in 2001, infants born of black mothers were dying at a rate of 14.2 per thousand. That's a Third World figure, comparable to Russia's.

Comparing that number to only 5.7 deaths for white babies has engendered some "blame the victim" scenarios. Studies have blamed black

## Side-by-Side: No Comparison

Canada U.S.

Canada and the U.S. used to be twins on public-health measurements. Here's how it looks after 35 years of Canadian universal health care.



Source: World Health Organization; CIA World Fact Book, Centers for Disease Control

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mothers who, for "cultural" reasons, don't breastfeed or eat properly during pregnancy, for the high death rates. But now that the United States has begun to do studies based on income levels instead of race, these "cultural" and "genetic" explanations are turning out to be baseless. Infant mortality is highest among the poor, regardless of race.

### Vive la différence!

Genetically, Canadians and Americans are quite similar. Our health habits, too, are very much alike—people in both countries eat too much and exercise too little. And, like the United States, there's plenty of inequality in Canada, too. In terms of health care, that inequality falls


### U.S. Checkup

Canada ranks about 18th worldwide on fairness in contribution to the health care system. The U.S. ranks about 54th.

primarily on Canadians in isolated communities, particularly Native groups, who have poorer access to medical care and are exposed to greater environmental contamination.

The only major difference between the two countries that could account for the remarkable disparity in their infant and adult mortality rates, as well as the amount they spend on health care, is how they manage their health care systems.

The facts are clear: Before 1971, when both countries had similar, largely privately funded health care systems, overall survival and mortality rates were almost identical. The divergence appeared with the introduction of the single-payer health system in Canada.

The solid statistics amassed since the 1970s point to only one conclusion: like it or not, believe it makes sense or not, publicly funded, universally available health care is simply the most powerful contributing factor to the overall health of the people who live in any country. And in the United States, we've got the bodies to prove it. 



**Holly Dressel** was born south of Chicago and lives in Montreal, Quebec. She is a writer/researcher and the best-selling co-author, with David Suzuki, of *Good News for a Change* and other works.

This article was adapted from Holly Dressel's book *God Save the Queen—God Save Us All: An Examination of Canadian Hospital Care via the Life and Death of Montreal's Queen Elizabeth Hospital*, to be published in 2007 by McGill/Queen's Press.



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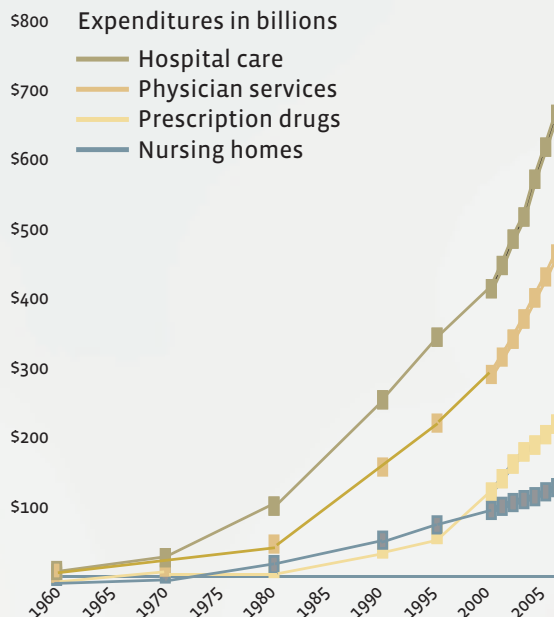
A footnoted version is available online.

# Just the Facts

Research and graphics by Lilja Otto

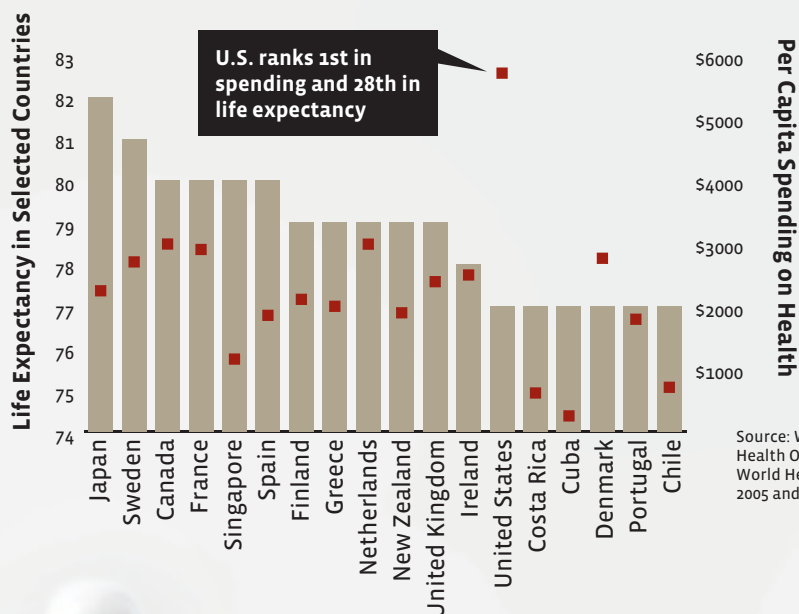
## Cost Keeps Going Up

Total annual spending has increased 77 times since 1960.



Source: Centers for Disease Control and Prevention, 2005; Centers for Medicare and Medicaid Services, 2005

## We're Not Getting Our Money's Worth



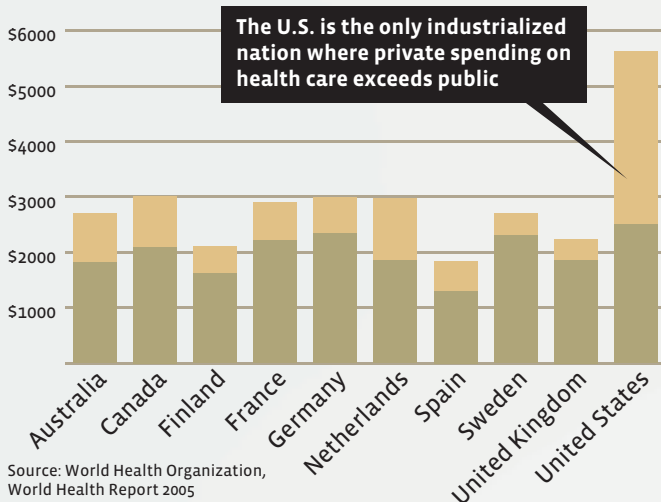
Source: World Health Organization, World Health Report 2005 and 2006



## It's the Highest in the World

U.S. public per capita spending covering 26% of the population is higher than public spending for universal health care in Europe, Canada, and Australia.

Per Capita Public and Private Expenditure on Health

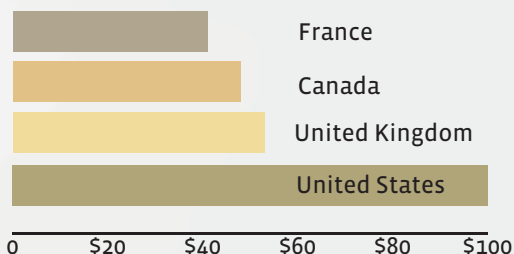


Source: World Health Organization, World Health Report 2005

## U.S. Drugs Cost More. Why?

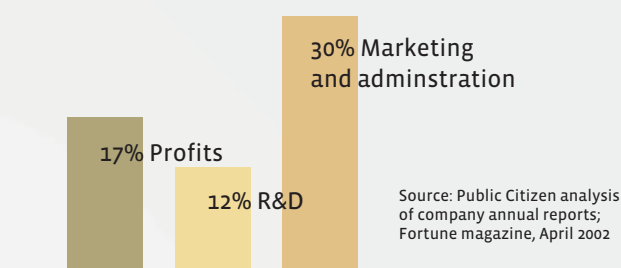
- 1 In Europe and Canada, governments negotiate drug prices.

Relative cost of 30 drugs in 2003



Source: G.F. Anderson et al., "Doughnut Holes and Price Controls," Health Affairs, July 21, 2004

- 2 The drug industry says research and development cause high prices, but here is where its revenues go:



Source: Public Citizen analysis of company annual reports; Fortune magazine, April 2002

# Better health through fairer wealth

Brydie Ragan

I recently saw a billboard for an employment service that said, “If you think cigarette smoking is bad for your health, try a dead-end job.” This warning may not just be an advertising quip: public health research now tells us that lower socio-economic status may be more harmful to health than risky personal habits, such as smoking or eating junk food.

In 1967, British epidemiologist Michael Marmot began to study the relationship between poverty and health. He showed that each step up or down the socio-economic ladder correlates with increasing or decreasing health.

Over time, research linking health and wealth became more nuanced. It turns out that “what matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed, the better the health of that society,” according to the editors of the April 20, 1996 issue of the *British Medical Journal*. In that issue, American epidemiologist George Kaplan and his colleagues showed that the disparity of income in each of the individual U.S. states, rather than the average income per state, predicted the death rate.

“The People’s Epidemiologists,” an article in the March/April 2006 issue of *Harvard Magazine*, takes the analysis a step further. Fundamental social forces such as “poverty, discrimination, stressful jobs, marketing-driven global food companies, substandard housing, dangerous neighborhoods and so on” actually cause individuals to become ill, according to the studies cited in the article. Nancy Krieger, the epidemiologist featured in the article, has shown

that poverty and other social determinants are as formidable as hostile microbes or personal habits when it comes to making us sick. This may seem obvious, but it is a revolutionary idea: the public generally believes that poor lifestyle choices, faulty genes, infectious agents, and poisons are the major factors that give rise to illness.

Krieger is one of many prominent researchers making connections between health and inequality. Michael Marmot recently explained in his book, *The Status Syndrome*, that the experience of inequality impacts health, making the perception of our place in the social hierarchy an important factor.

According to Harvard’s Ichiro Kawachi, the distribution of wealth in the United States has become an “important public health problem.” The claims of Kawachi and his colleagues move public health firmly into the political arena, where some people don’t think it belongs. But the links between socio-economic status and health are so compelling that public health researchers are beginning to suggest economic and political remedies.

Richard Wilkinson, an epidemiologist at the University of Nottingham, points out that we are not fated to live in stressful dominance hierarchies that make us sick—we can choose to create

more egalitarian societies. In his book, *The Impact of Inequality*, Wilkinson suggests that employee ownership may provide a path toward greater equality and consequently better health. The University of Washington’s Stephen Bezruchka, another leading researcher on status and health, also reminds us that we can choose. He encourages us to participate in our democracy to effect change. In a 2003 lecture he said that “working together and organizing is our hope.”

It is always true that we have choices, but some conditions embolden us to create the future while others invite powerlessness. When it comes to health care these days, Americans are reluctant to act because we are full of fear. We are afraid: afraid because we have no health care insurance, afraid of losing our health care insurance if we have it, or afraid that the insurance we have will not cover our health care expenses. But in the shadow of those fears is an even greater fear—the fear of poverty—which can either cause or be caused by illness.

In the United States we have all the resources we need to create a new picture: an abundance of talent, ideas, intelligence, and material wealth. We can decide to create a society that not only includes guaranteed health care but also replaces our crushing climate of fear with a creative culture of care. As Wilkinson and Bezruchka suggest, we can choose to work for better health by working for greater equality.

**Brydie Ragan** is an indefatigable advocate for guaranteed health care. She travels nationwide to present “Share the Health,” a program that inspires Americans to envision health care for everyone.

## U.S. Checkup

An overwhelming majority of Americans—75 percent—want what people in other wealthy countries have: universal health insurance.





# If You Ask Maine

State officials in Maine wanted the people's opinion. They got answers they didn't expect.

## Tish Tanski

Over 130,000 Maine residents—12 percent of the state's nonelderly population—don't have health insurance. Even those with insurance face high deductibles, reduced coverage, and escalating medical costs. Thirty-eight percent of Mainers with insurance pay more than 5 percent of their income on insurance premiums, and the median deductible is over \$4,000. People across the nation are struggling with the same concerns, but there is a difference: In 2003 the Maine Legislature passed the Dirigo Health Reform Act—sweeping new health care legislation to expand access, improve quality, and contain costs. And Maine officials are reaching out in new ways to involve ordinary citizens in developing strategies to meet those goals.

## What's the law?

The legislation included an integrated set of strategies:

**DirigoChoice**—a new insurance program targeted to small businesses, sole proprietors, and un- or underinsured individuals. It offers robust benefits—including prescriptions and preventative care. It provides sliding-scale discounts, for those with household incomes under 300 percent of the poverty level, that can reduce or entirely eliminate the monthly premium, the annual deductible, and out of pocket costs. DirigoChoice is a groundbreaking step toward more universal coverage in Maine.

A two-pronged effort to improve the quality of care in Maine by encouraging

## Americans Speak

*In 2005, Congress created the Citizens' Health Care Working Group to ask people what health care in America should look like. AmericaSpeaks dialogues in 31 cities across the country revealed that Mainers are mainstream—there's wide recognition that the system's broken and overwhelming demand for universal health care. Here are voices from those meetings.*



KENNETH C. ZIRKEL / ISP

**"Every citizen has a basic right to have basic health care, and it can't be based on the type of job they have." — Salt Lake City**

**"We have rural areas here in Indiana where you can't even get a paramedic." — Indianapolis**

**"Cost is keeping people from getting the care." — Phoenix**

**"We want health care delivered equitably at the community level by people we trust." — Memphis**



TAN KIAN KHOON / ISP

**“It’s often more stressful to deal with the insurance company than it is to deal with the disease.” — Des Moines**

**“We have lost time-intensive care. Providers right now don’t have time to spend with us! You only get two minutes with your doctor.” — Indianapolis**

**“You can’t get through this system without luck, a relationship, money, and perseverance.” — Salt Lake City**

**“There should be no waiting period before becoming eligible for coverage.” — Lexington**

**“I feel like we are only as good as our weakest link, and so many people can’t afford care.” — Fargo**

the medical community to integrate best medical practices, and providing consumers with health information and comparative data on health care providers.

**Other system reforms**, such as cost containment, overseen by the Governor’s Office of Health Policy and Finance and an 11-member Health Care Systems Advisory Council, which includes consumer representation.

**Creation of a biennial health plan** to make Maine the healthiest state in the nation. The plan sets health goals for individuals, communities, and government, and identifies initiatives to improve cost, quality, and access.

The legislation earmarks savings produced by Dirigo Health Reform to fund these initiatives, including low-income subsidies for the DirigoChoice insurance product. For example, if cost containment efforts reduce the cost of health care for insurers, the savings can pay the subsidies in the DirigoChoice program.

#### **Hearing from the people**

A core goal of Dirigo Health Reform is to engage ordinary people in an informed conversation about health care reform. Traditional surveys are limited in that they do not provide substantive background information and

#### **U.S. Checkup**

The VA health system has outranked private providers in patient satisfaction for six consecutive years. VA prescriptions are filled accurately 99.997% of the time; the error rate nationwide is 3 to 8%. VA patients pay \$8 per prescription.

participant discussion. Public forums are often dominated by paid lobbyists representing specific interests. Maine officials wanted a new approach, one in which a representative group of people could learn about the issues, discuss options, and express their opinions. After an exhaustive review of alternative citizen engagement models, the Governor’s Office of Policy and Finance selected the AmericaSpeaks “21st Century Town Meeting™” model, because of its use of “deliberative democracy,” to begin the process with a forum called “Tough Choices.”

The deliberative democracy model requires that a large number of people work collaboratively to understand the issues, engage in lively and informed dialogue, learn from each other, and come to understand differences in perspective. An additional advantage of the “21st Century Town Meeting” was the ability to include participants from across the state through simultaneous linked videoconference.

To ensure that Tough Choices would draw on the informed voices of Maine’s people, organizers recruited nearly 400 participants for the May 21, 2005, event who were broadly representative of the state in gender and race. The youngest and oldest age groups were somewhat underrepresented; income levels were close to state benchmarks except for the lowest income level of \$14,800 or less.

Participants wrestled with complex health-care policies and priorities. Initial discussion generated broad agreement on values that should guide policy development:

:: Health care should be a right, not a consumer good.

:: Everyone should have access to >>

## » affordable health care.

:: High-quality health care should be available to everyone.

:: Health care should be affordable for employer and employee.

:: Costs to individuals should be based on ability to pay.

:: Funding prevention saves money and improves health.

:: People need to take personal responsibility for their health.

:: Health care should include mental health and substance abuse coverage.

The meeting structure called for participants to focus on options presented by the forum organizers. But participants insisted on adding their own, including reducing cancer-causing agents in the environment, providing universal health care, eliminating insurers, and capping insurance company CEO pay.

During the course of the day, participants generated additional options and participated in more than 40 rounds of substantive voting. The degree of agreement waxed and waned, and participants frequently flexed their muscles.

Participants were strongly against mandating that individuals carry their

own insurance (as Massachusetts has subsequently done); mandating employer coverage; limiting insurance benefits for prescription drugs, tests or procedures, reducing insurance regulation; and segregating high-risk individuals into a “high-risk pool” as other states have done.

Participants spontaneously and vigorously demanded adding the option of promoting a single payer health care system. By the end of the day, no single system change garnered a majority, though 48 percent expressed support for a single payer system, followed by expanding DirigoChoice and MaineCare (30 percent).

Participants endorsed incremental strategies including increasing focus on preventative health; encouraging, but not requiring, individuals to increase healthy behaviors; establishing best practice standards and treatment guidelines for medical care; creating a statewide system to allow providers access to electronic medical information; and creating report cards on the quality of care for consumers.

The toughest part of Tough Choices

was focusing participants on tradeoffs needed to increase health care access or quality, or decrease cost. There was significant support for cost reductions that might be achieved by eliminating private insurance and reducing CEO pay. When asked to consider a scenario where additional reductions might be needed, participants were unable to come to agreement on other strategies.

**What effect?**

The voices heard at Tough Choices did have a powerful influence on the new State Health Plan, which includes many of the strategies that came out of Tough Choices and subsequent traditional public forums. Prevention is a major focus; there are initiatives to encourage healthy behavior; there is a strong emphasis on medical best practices; and the plan endorses electronic medical records. The plan stops short of establishing a single payer plan for Maine. It recommends continuation of DirigoChoice and MaineCare. A national conversation is now underway through the congressionally appointed Citizens Health Care Working Group, which has used the AmericaSpeaks

## Getting “clean” in Maine—the power of public campaign funding

In 2003, when Gov. John Baldacci (D) proposed that the Maine legislature pass the Dirigo health care law, which would provide near-universal health care coverage for Mainers, a majority of legislators had won their offices under a system known as Clean Elections.

Clean Elections candidates collected a set number of \$5 contributions from individuals, then received public funding to run their campaigns. At the same time, they had to promise to take no more private money.

No private money meant no campaign contributions from hospitals, or insurers, or from any other big-money interest that might want to scuttle the Dirigo plan. “Publicly funded legislators were free to support this legislation without any concern for the big-money special interests that might oppose such a law,” wrote Rep. Jim Annis, a Republican, and Rep. John Brautigam, a Democrat, in a piece for the *Hartford Courant* in October 2005.

The citizens of Maine approved Clean Elections via refer-

endum in 1996, and the law went into effect in 2000. It has been increasingly popular among candidates—80 percent of them are running Clean in the 2006 elections. The system helps level the playing field so qualified people without access to special interest money can run for—and win—office. Similar laws are in place for some offices in Arizona, Connecticut, New Jersey, New Mexico, North Carolina, and Vermont, and in Albuquerque, and Portland, Oregon.

“Clean Elections makes a huge difference,” says Tammy Greaton, executive director of the Maine People’s Alliance, one of the groups that pushed to pass the Dirigo health care law. “[The legislators] listen to people when they show up. They ignore lobbyists more than I’ve ever seen.”

**Nancy Watzman** is research and investigative director for Public Campaign, a nonprofit, nonpartisan organization dedicated to reducing the role of special-interest money in American politics, and co-author of *Is That a Politician in Your Pocket? Washington on \$2 Million a Day* (Wiley Books 2004).



model to gather input from thousands of Americans, and now has draft recommendations posted for public comment on their website ([www.citizenshealthcare.gov](http://www.citizenshealthcare.gov)).

There is contentious debate between state officials, insurers, and hospitals over how much money the broad Dirigo Health initiative has saved, and whether those savings will fund the subsidies needed for DirigoChoice. The state's superintendent of insurance has extensively examined the issue and concluded that there are \$43.7 million in system-wide savings to fund Dirigo Health initiatives. Insurers and some businesses disagree. As the legislative session closed and the smoke began to clear, it was clear that DirigoChoice would continue, despite defeat of a legislative proposal to allow the state to be self-insured and administer DirigoChoice rather than fully insured through a private insurance company.

As the November elections approach, the issue of health care is front and center, with different candidates taking different positions. The Tough Choices exercise was not intended to be vox populi, but it does tell us one thing. Health care is on the citizens' agenda in Maine. And it's likely to be there for some time to come. **V**



**Tish Tanski** is President of T\_S Strategy in Bar Harbor, Maine. This article is based on a prior publication with Ron Beard of the Cooperative Extension Service of the University of Maine.

## U.S. Checkup

The drug and health industries spent \$800 million in lobbying and campaign contributions in the last seven years—more than any other industry.



MARMION / ISP

**“[We need] culturally competent care and funding to encourage more minority physicians and providers.” — Indianapolis**

**“Enrolling everyone in a single pool would spread costs and yield savings.” — Providence**

**“There should be progressive rates for health care, based on ability to pay, through income taxes as part of a single-payer system.” — Hartford**

**“Employer-sponsored insurance worked when it was a perk, an extra offered by employers. But now coverage is a necessity, not a privilege.” — Billings**

**“Eliminate medical middlemen — insurance companies and direct-to-consumer advertising by pharmaceutical companies in exchange for universal health care.” — Hartford**

**Add Your Voice**—The Citizen's Health Care Working Group issued interim recommendations on June 1. Although their preamble includes goals that people raised in nationwide meetings—like universal, affordable health care—the interim recommendations propose no plan to finance or work toward those goals. Read the report at [www.citizenshealthcare.gov/recommendations/interim\\_recommendations.pdf](http://www.citizenshealthcare.gov/recommendations/interim_recommendations.pdf). You can comment until Aug. 31, when they'll issue final recommendations to Congress and the president. Let them hear from you:

**Online and Email** instructions on website.

**Mail** to Citizens' Health Care Working Group, Attn: Interim Recommendations, 7201 Wisconsin Ave., Rm. 575, Bethesda, MD 20814

# A Growing Movement

Below the radar, a movement for universal health care is sweeping the nation, and **the wins are beginning to roll in.**

## Reverend Linda H. Walling

In the U.S. people struggle to pay for needed prescription drugs while pharmaceutical companies post record profits. People die prematurely because they cannot get the care they need while hospital beds remain empty and medical equipment sits idle. We watch lawmakers rebuff health care reform efforts while they themselves enjoy the best of health care benefits. Such dismal truths can make the problems of the U.S. health care system seem too overwhelming and complicated to solve.

Yet, for the first time in over a decade, people all over the country are finding reasons to be hopeful. Why? After struggling for nearly 100 years to make "health care for all" a reality in the U.S., what is different about this moment that suggests a new day is dawning?

The short answer is that the escalating crisis is forcing us to take action.

The longer answer points to our understanding of how successful social change happens. Consider the major social reforms of the last century—civil rights, women's rights, and environmental protections. In each of these, our country went through a process in which our cultural understanding of the issue evolved, our institutions were transformed, and laws were written that redefined our rights and responsibilities. The parallels



MICHAEL HOGUE / KRT



we see as we confront our health care crisis suggest that significant change is beginning once again.

Our cultural understanding on the issue of health care is changing as frustration with the status quo builds. Even opponents of government intervention in health care are beginning to express concern about the cost of doing nothing. While there is not consensus on how to make it happen, opinion polls overwhelmingly show that we as a society do believe everyone should receive the health care they need. What was once lip service from a few is now a chorus of voices calling for reform.

and affordable. Even though legislators differ in their solutions and sincerity, few dare say that health care doesn't need to be reformed. While there has never been a vote on universal health care in Congress, state and local governments are moving forward to cover more of their residents. We're seeing additional progress, as well, in state legislation that makes prescription drugs more affordable for more people.

#### **States take the lead**

Historically, in the absence of federal action, state actions have become the catalysts for social change. In response

repealed a year later, citizen support for reform increased thanks largely to grassroots supporters who fought against the big businesses that outspent them eight to one. Energized activists continue to raise the issue throughout the state and, in response, the mayor of San Francisco unveiled a proposal this summer to achieve universal health care access for the people of the city.

: : Also in 2003, Maine passed its Dirigo Health Reform Act—a bill that sets a 2009 goal to achieve health care for all. The plan began in January 2005 and now covers over 10,000 previously uninsured state residents. Particularly

**After struggling for nearly 100 years to make “health care for all” a reality in the U.S., what is different about this moment that suggests a new day is dawning? The short answer is that the escalating crisis is forcing us to take action.**

Many of our institutions, often opponents of reform, are changing as they recognize how the health care crisis affects their ability to fulfill their mission. Business leaders acknowledge that the way we structure our health care system puts them at an economic disadvantage in the global market because they must compete with companies that are not burdened with the costs of employment-based benefits. Health care institutions are searching for greater efficiencies and ways to provide more health care for our money. Governments struggle to provide insurance for those not covered through their work. Schools acknowledge that health insurance costs for faculty and staff erode classroom resources, and union leaders recognize that protecting expensive health care benefits ultimately undermines job security and cuts into salary increases and pension benefits.

Our laws are changing to reflect this new understanding and redefine our rights and responsibilities in making health care more accessible

to the passage of health care reform legislation in Massachusetts and Vermont, a *Boston Globe* editorial noted, “The states are the laboratories of democracy, as Supreme Court Justice Louis Brandeis once said, and the test tubes are bubbling” (May 21, 2006).

Within those laboratories are scores of grassroots activists testing the waters. Health care justice groups are becoming re-energized; faith communities are reclaiming this issue; labor groups are committing financial resources to work on health care for all; social service organizations are reporting on how the health care crisis hinders their efforts to help low-income people; and numerous other organizations are adding health care reform to their priorities. Their work is seen in a number of state efforts emerging around the country; six have actually passed meaningful legislation.

: : In 2003, California passed a bill requiring businesses with 50-plus workers to either provide coverage for their own workers or pay into a fund that would cover the uninsured. Although the law was narrowly

notable is that this plan was passed by a legislature in which over half had been elected under the state's new clean election laws, thus freeing them from dependence on special interest funds. (See page 32.) Citizen activists continue working to maintain support for the plan in the face of opposition funded by groups outside the state.

: : The Health Care Justice Act of 2004 in Illinois did not propose a particular plan for reform, but rather a state-wide process to gather citizen input to generate several proposals for reform. That process will conclude this fall when the legislature selects from the proposals one plan that will be implemented in mid-2007. In the midst of this process, the statewide public hearings generated a consensus about the importance of covering children and, as a result, the legislature adopted the Illinois Health Care for All Children law in 2005.

: : Maryland enacted a more limited health reform bill when the Democratic legislature passed the Fair Share Health Care Act of 2006, overriding

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» the Republican governor's veto, in large measure because of the efforts of health care justice, labor, and faith coalitions in the state. Requiring employers with 10,000-plus workers, such as Wal-Marts, to designate a specified portion of their payroll expenses for health care benefits, the bill saw widespread citizen support. Part of a multi-state campaign to force large employers to accept responsibility for health care, the Maryland success has energized activists in numerous other states where similar bills have been introduced.

: : The Massachusetts health reform package passed last April was a landmark event because it was a compromise between a Democratic legislature and a Republican governor who agreed on the goal of health care for all. While not perfect, the reform package does represent what can happen in a politically divided environment when all the stakeholders can at least agree on the goal. It offers hope in the midst of the political partisanship that immobilizes reform efforts. That hope was brought closer to reality by an active faith network that helped build the bridges necessary to make compromise possible.

: : Vermont, inspired by Massachusetts, revived a previous effort and passed its Health Care Affordability Act of 2006. Frustrated by rising health care costs and an increasing number of uninsured, in 2005 a group of labor, business, health, and government leaders developed key principles for reform, wrote a bill and got it passed in the Democratic legislature. When the bill was vetoed by the Republican governor, the largest coalition in the state's history was formed. The bill was reintroduced, and it passed last May.

### The challenges

All of this activity in the states, coupled with decades of debates, provides valuable insights into the challenges ahead and what will be needed to move the health care agenda forward.

The first challenge is the perceived contradiction between the dual goals of reform—to improve access or to contain costs while maintaining quality.

Legislative efforts usually have focused on one or the other. The truth is, however, that we must take on all the goals. Successful efforts will concurrently address how to increase access, reduce costs, *and* improve quality.

At the heart of the debate is the second challenge: Am I my brother's or sister's keeper? Some say "no" and promote individual responsibility. Others see health care as a shared responsibility that includes everyone. Successful reform will embrace both. Individuals will be called to make healthier lifestyle choices and society will be called to care for those unable to care for themselves. In addition, all players in U.S. health care—individuals, governments, health care providers, insurers, and employers—will be called to accept the shared responsibility of making health care affordable and accessible to everyone. As seen in several successful state efforts, the faith community, through their moral message, can play a critical role in bridging the political divide.

The moral dilemma informs the third challenge—determining whether human needs are better served by markets, individual ownership, competition and profits, or by governments and laws that ensure access and the fair distribution of costs? Again, instead of reducing the discussion to polarized stances, we should find solutions that promote a creative mix of effective government regulation and financing with fair market incentives.

The fourth and perhaps most daunting challenge is the economic self-interest of key health care stakeholders. While almost everyone in the United States would benefit from health care reform, a number of well-financed, tightly organized special interests, such as pharmaceutical and insurance companies and some big businesses, fear they would lose out.

For example, in 2003, the year the Medicare prescription drug benefit was passed, there were 637 registered pharmaceutical industry lobbyists—1.5 for every member of Congress. These lobbyists succeeded in adding the pro-

vision in the Medicare package that prohibits the federal government from negotiating Medicare drug discounts, despite the fact that it successfully negotiates Medicaid and veterans' drug discounts.

Strong public demands for change and lawmaker accountability are necessary to prevent special interests from blocking progress toward reform. Active, well-organized grassroots advocacy over an extended period of time is needed to promote reform, to prevent special interests from blocking progress, and to help sustain and protect reform once it is enacted. In addition, at least some of the key wealthy and influential stakeholders must be convinced to put the larger public interest above their own short-term, narrow economic self-interest.

### Will Washington, D.C. get on board?

Sustainable statewide reform that can resist well-financed and powerful opposition will require federal action. Several federal efforts reflect a range of perspectives on how to make reform happen.

One approach is the comprehensive reform packages such as The U.S. National Health Insurance Act, HR 676, introduced by Michigan Representative John Conyers. Modeled around U.S. Medicare and the Canadian single-payer system, it seeks to enact change with a single piece of legislation.

Another set of proposals cover particular populations such as children, or those with chronic diseases such as diabetes.

A third approach sets up processes to engage the various health care players in dialogue about what kind of reform would work for all of us.

The Citizens' Health Care Working Group is seeking public input for recommendations it will submit to the president and Congress this fall. In addition, the bipartisan Senate Bill S.2007, would establish a commission to examine the circumstances that contribute to problems in health care in order to develop public and private policies to address rising costs and the

# Principles of Real Solutions

## Cover everyone.

:: Health care is a public good. Like fire or police protection, universal coverage benefits each one of us and society as a whole. Unlike consumer choices, we don't know when we—or a loved one—may need expensive treatment.

:: Universal coverage reduces the risks of contagious diseases, disability, bankruptcy, and the use of expensive emergency services for problems that are better addressed through normal patient care.

:: Health insurance companies profit from “cherry picking” the healthy, and excluding people and treatments that may be expensive. We need a system that is designed not to exclude, but to optimize treatment for all; not to maximize profits, but to minimize suffering.

## De-link coverage from jobs.

:: Rising health care premiums are making U.S. companies and workers uncompetitive, and polarizing labor negotiations.

:: Employer-based insurance hurts entrepreneurs and independent workers, the self-employed, the unemployed, part-time workers, freelancers, artists, and the working poor.

:: Employers are ready to off-load the expense and administrative burden of choosing and paying for employees' health insurance.

:: Unlike previous generations, we switch jobs frequently. Switching jobs shouldn't mean changing or losing health coverage.

## Control costs by cutting bureaucracy.

:: Enormous savings are available simply by freeing doctors from the burdensome paperwork required by insurance companies. Negotiated fee structures and a single payer—or a few regulated payers—would save enough to cover the uninsured, studies show. (See *Options on page 22*.)

:: In most of the industrialized world, private health insurance exists only to provide premium services. Keeping profit-driven health care insurance at the center of our system costs Americans billions extra each year.

## Invest in prevention.

:: Coverage should include common sense screening and immunizations, and the complementary health care practices that have proven benefits.

:: We should support healthy habits through treatment of substance abuse, smoking, and domestic violence. Open spaces, bike trails, and community gardens improve health, too, and we should reduce the toxins that contaminate our food, water, air, and soils.

## Reduce poverty and inequality.

:: Poverty, powerlessness, and inequality damage the health of the entire society, and each one of us, rich and poor (see page 29). A huge health dividend would result simply by reducing excessive CEO salaries and profits, and raising up those at the bottom of the income scale. We could start with the health care sector.

— Sarah van Gelder



### U.S. Checkup


Estimated annual pharmaceutical sales in the U.S. are \$200 billion.

Estimated total worldwide is \$400 billion.

number of uninsured.

Perhaps most promising of these process proposals is the Health Partnership Act (S.2772). This bipartisan Senate bill involves the federal and state governments, private payers, and health care providers in developing approaches for reform on a state-by-state basis. It provides federal grants and support to states that commit to specific reductions in the numbers of uninsured, and to specific measures to reduce costs and improve the quality of health care. The benefit of this proposal is that creative thinking is encouraged and funded, federal financial incentives help block opposition from well-funded special interest groups, and the will of the people can be implemented with federal support that is not hampered by federal political deadlock.

In the immediate days ahead, we must work to protect the people in Medicare and Medicaid and those in veterans' health care programs. Losing ground in any of these programs will compromise the goal of affordable health care for everyone.

Meanwhile, concerned citizens are making a difference, generating pressure to move the issue forward. There are important legislative opportunities both in the states and at the federal level. These simultaneous efforts are moving us from despair to the hope that we can in the next decade achieve the dream of 100 years—affordable health care for all! 

**Rev. Linda Hanna Walling**, the National Education and Faith project director of the Universal Health Care Action Network, works with faith communities on health care justice. She is an ordained minister in the Christian Church (Disciples of Christ).

NEW ORLEANS, LOUISIANA

## Where FEMA Feared to Tread

*Post-Katrina volunteer medics on bicycles created  
a new model of community health care.*

### Tim Shorrock

In the days after Hurricane Katrina slammed into New Orleans, the city's Algiers neighborhood was one of the few that stayed dry. Although Katrina's winds caused extensive damage to roofs and toppled trees and power lines, there was no water in the streets or in houses as there was in the rest of the city.

Still, Algiers was left without electric power or running water for many days, and the invasion of the city by thousands of soldiers, federal police officers, and private paramilitary personnel created an atmosphere of tension and trepidation. In Algiers, as in other neighborhoods, the National Guard imposed a mandatory dawn-to-dusk curfew. In one area, white residents, frightened by rumors of car-jackings and looting, camped out on their roofs and organized patrols, guns at the ready. Late one night, National Guardsmen and a SWAT team from the New Orleans Police Department raided the Algiers Fischer Housing Development in search of someone who had fired at a cell phone truck; black youths then took guns from local pawn shops and vowed to fight the troops and what they called white vigilantes.

Algiers resident Ronald Ragens, 55, remembers those days as lonely and frightening. "All you was seein' was police, military, and all kinds of huge trucks running supplies here and there, and helicopters flyin' over like it was a war zone," he recalls.

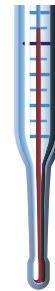
Then one morning four days into the storm, something happened that melted the fear and eased the tension. Four young people on bicycles showed up in Algiers, knocking on doors



KIKE ARNAL

After Katrina, when FEMA was AWOL and the Red Cross was nowhere in sight, medics on bicycles rode through the streets of the Algiers neighborhood offering first aid and solace.





## U.S. Checkup

In the industrialized world, one nation has a higher infant mortality rate than the U.S.: Latvia. (Full disclosure: The U.S. is in a tie for next-to-last with health care powerhouses Hungary, Malta, Poland, and Slovakia.)

and asking if anyone needed medical attention. Asked if they were from the Red Cross or the Federal Emergency Management Agency, neither of which had yet made an appearance in Algiers, the medics said no, they were just volunteers who had come without authorization. They offered first aid, took blood pressure, tested for diabetes, and inquired about symptoms of anxiety, depression, and disease.

"It was just about the noblest thing I've ever witnessed in my life," recalls Malik Rahim, a lifelong Algiers resident, local housing activist, and former Black Panther Party member who helped arrange space for the medical workers in a local mosque.

"It was the street medics who really stopped this city from exploding into a race war, because they were white and were serving the black community at a time when blacks were fed up. Those are the real heroes of this thing."

As New Orleans moved from tension and fear to FEMA tents, the Common Ground Clinic took over the task of providing local health care from devastated hospitals.

Rahim, a friendly, outgoing man with graying dreadlocks and a soft voice, is now the symbolic leader of the Common Ground Collective, an unlikely tribe of activists and health care practitioners who have descended on New Orleans to provide "solidarity, not charity" to the people of this devastated community. The "street medics" on their bikes—part of a loose national network of nurses and medical assistants who provide first aid to protesters at antiwar demonstrations—were among the first to respond.

"The whole place smelled like death," recalls Noah Morris, a wiry anti-corporate activist from St. Louis who recalls seeing four gunshot victims, their bodies crudely covered by sheets of corrugated tin.

Most of his initial patients, Noah says, suffered from high blood pressure, which he treated with herbal remedies and nutritional supplements "to help get the pressure down just a little bit." The medics were followed a few days

later by a caravan of doctors, nurses, and grief counselors from San Francisco. Then, as word spread, scores of health practitioners and political activists from all over the country began making their way to New Orleans.

## Eclectic medics

Common Ground has drawn an eclectic crew. Michael Kozart, the first doctor to spend substantial time at the clinic, belongs to a group called the Bay Area Radical Health Collective. He decided to come after hearing Rahim speak about Algiers on KPFA, the Pacifica radio affiliate in Berkeley.

"I thought, how can a society as rich as ours have folks being neglected because our water and medical systems and the government itself is completely inefficient?"

Liz Rantz, another doctor, has spent two stints here on leave from her job in Missoula, Montana, where she's the medical director for the state's Department of Corrections.

The California Nurses Association has sent a steady stream of RNs. Acupuncturists Without Borders has organized several teams of volunteers. Volunteers have come from Minnesota, Massachusetts, Iowa, Texas, New Mexico, and Canada; during the first week, there were two French volunteers from Doctors Without Borders. From the triage station to the makeshift pharmacy, there are plenty of nose rings, dreadlocks and body jewelry on display—as well as the cleanly pressed uniforms of nurses fresh from their hospital jobs.

"I was completely unaware they were a bunch of activists," says Lynne Crawford, a bubbly nurse from Harrisburg, Pennsylvania, who spends most of her time working at the mobile clinics. Crawford, who wore her blue scrubs while doing her rounds, found her way here after being laid off from her last job. Unlike many of her colleagues, who sleep on the clinic's floor or in camping tents set up in the backyard, Crawford managed to find a room on a Coast Guard cutter docked in New Orleans.

When I ran into her one afternoon,

she confesses to having suffered "a very big cultural shock" in her first days at Common Ground. She pointed to some of her new friends, clustered outside on a smoke break: "Why don't they shave their legs? I just don't get it," she said, laughing. "But now I love the people here. We all have a common purpose."

For activists accustomed to being marginal, Common Ground has been a revelation too. "How many political actions do you have when all of a sudden the community kind of descends on you?" asks Scott Weinstein, a tall, bearded RN from Washington, D.C., who was one of the first arrivals and serves as a liaison with what's left of the New Orleans medical community. He says the clinic has reshaped the way he thinks about politics. "Most people think of direct action as taking a street during a demonstration," he says, "but big deal, so you got a street. This is not about taking the streets, it's about taking health care."

## Oasis of care

The Majid Bilal Mosque sits on a busy street corner three blocks down from the levee. There, just past a warehouse storing colorful floats from past Mardi Gras, you can see the city's skyline, the Superdome, and the two Carnival Cruise ships that were leased by the federal government for nearly \$200 million to house emergency workers. Big tugs, ocean-going tankers, and container ships pass by in a steady stream. The clinic itself is surrounded by tiny, one-story houses, most of their roofs patched with blue plastic tarps. A sign on



» the building's back door reads: "No Weapons Allowed. Please Respect the Mosque"—a reference to the ubiquitous guns toted by the National Guard and private security guards at every government facility in the city.

Andrew Summer, a laid-off shipyard worker living in nearby Gretna with his brother, came to the clinic to get his medications refilled. Summer is tall, lanky, and visibly tired. He survived Katrina in the Lower Ninth Ward, was brought by boat to the Convention Center, and eventually flown to Houston. He can't fill his prescriptions because Charity Hospital, the famed hospital that once served most of New

Orleans's poor, has been shut down.

For many of Common Ground's patients, the clinic is a relief not just from Katrina and the healthcare vacuum that followed—suddenly there were no doctors or hospitals in New Orleans, and neither the Red Cross nor FEMA seemed able to provide any—but from a quieter, long-term emergency. According to Rahim, 85 percent of the men in Algiers are uninsured, "and for many of them, the last time they saw a doctor was in prison or in emergency at Charity."

Common Ground has found itself serving some unexpected needs too. During its first month, its medical

teams gave immunizations to hundreds of laborers employed by subcontractors for the likes of Shaw Inc. and Halliburton—companies that left their workers, many of them Latino immigrants, to figure out for themselves which shots they needed and where to get them.

When Rita flooded hundreds of square miles in the bayou towns around Houma, Louisiana, Common Ground fielded the only relief team to visit the area; neither the Red Cross or FEMA ever made it, according to Dr. Rantz and three other volunteers who went.

Most of Common Ground's medical work happens at three crude work stations in what used to be the mosque's

#### SAN FRANCISCO, CALIFORNIA

### HEALING ART OF WALKING SLOWLY



DAVE RAZAVI

#### Labyrinth Garden, California Pacific Medical Center

Medieval labyrinths have become valued features of healing environments. California Pacific Medical Center led the way in 1997 with a replica of a stone labyrinth laid on the floor of the Chartres Cathedral in France over 800 years ago. Since then, more than 60 health care facilities across the country have installed them for use by nurses, doctors, and patients.

worship hall. Station One is a card table with makeshift shelves holding cotton swabs, rubber gloves and other equipment; a stethoscope hangs over the one corner. Station Two consists of a pair of stools standing next to a set of shelves that looks like it came from a motel room. Stacked neatly are donated supplies the clinic is handing out: Tampax, witch hazel, Enfamil formula, calcium supplement. Station Three is the only “private” room in the clinic, partitioned from other stations with bedsheets. After a brief intake from a triage volunteer, patients wait their turn in the line of chairs that serves as a waiting room; when their name is called, they head for one of the stations, where a nurse practitioner takes their vitals and consults with one of the doctors about what to do.

In the adjoining room, past the busy phone and fax machine, is a crude pharmacy stocked with supplies that have been donated from organizations like Veterans for Peace and Food Not Bombs. At the back is a bank of computers linked to the Internet through a sporadic wireless connection provided by FEMA from the cruise ships across the river. On one wall are lists of important projects and tasks that need volunteers, including “critical incident debriefing” and “medical legal support,” under which someone has scrawled “or covering our heinies.” One task is more general: “Infusing all we do with anti-oppression intentions.”

Although hierarchy is frowned upon here, some people at Common Ground clearly play leadership roles. One of them is Moe, an RN and herbalist from Montana who has been here since early September. She is often one of the first to greet newcomers and the person to find when there’s a problem with no ready solution. Moe is short, with a moon-shaped face that seems to be framed in a perpetual smile. Like Noah, she’s part of the street medic network that descends on cities like Seattle or Washington, D.C., whenever there’s a big demonstration. She is gentle, low-key, and pragmatic. In late November, it was Moe who pushed

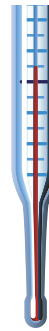
hard to get the clinic to close every Friday so volunteers could take a break. “We couldn’t get anything done” for the stress, she tells me.

For the people working here, Common Ground is the polar opposite to the time-crunched, profit-driven, top-down environment that’s become standard in the health care industry. When the clinic crew learns that a patient is bed-ridden and can’t get out of the house, someone drives there to pick her up and then arranges for transportation back home. The same doctor might make a diagnosis, write a prescription and go to the back room to fill it. One day, Max Fischer, who’s in his fourth year of medical school at Columbia University, sees 10 patients in 15 hours—a fraction of the load he’d handle at a hospital or regular clinic. One is a 19-year-old mother with an advanced bone infection in her leg; with Charity closed, she had no idea where to find a doctor. Max calls for an ambulance to take the woman to West Jefferson Hospital in Gretna—and rides along with her when it comes. “I see myself as a patient-advocate,” says Fischer.

### Human contact

Alternative styles of medicine are big at Common Ground. “In those moments, in that half an hour I’m talking to someone, it’s just love that I feel,” says Marenka Cerny, a trauma counselor and massage therapist from Oakland who has set up a table just outside the clinic. Her steady stream of customers approaches her shyly but get up from her table looking relieved. “We’re providing human contact, the most basic thing you can do for people facing so much devastation and loss,” she says.

Next to her table, Korben Perry, an acupuncturist from Philadelphia, has put out a couple of chairs and a sign. One afternoon I find him working on Willy Kerr, who says he’s been coming to the clinic ever since he got back to Algiers from Houston, where he was evacuated after the storm. He’s never seen Chinese medicine before, but Perry persuades him the needle



### U.S. Checkup

15 cents of every dollar Americans spend on private health insurance goes to administrative expenses

treatment will help relieve the pain in his back and gums. “I’m trying to stop smoking,” Kerr confides. As Perry places needles in his earlobes and neck, Kerr chuckles, and then settles down for a 20-minute wait. “These people here are treating me real nice,” he says. “I’d hate to see them go.”

Later that afternoon, two camouflaged U.S. Army trucks pull up outside the mosque. As their engines idle noisily, a young lieutenant jumps out, identifies himself as Louisiana National Guard, and announces that he has several boxes of supplies for the clinic. Moe, who spends much of her time organizing donated supplies of dubious utility, smiles widely when she sees the packets of cortisone and the children’s antibiotic Zithromax. For the next 15 minutes, soldiers just back from Iraq and a couple of anarchists who’ve been protesting the war unload the truck together, swapping anecdotes about New Orleans and the French Quarter.

### Neighborhood volunteers

By the time I visit again in December a steady stream of people from the neighborhood (including Willy Kerr, the acupuncture patient) are signing up to volunteer. A lifelong Algiers resident, Sandra, is now working as the clinic’s cook, doling out helpings of gumbo and bread pudding. A community advisory board is being set up, and the clinic is eyeing a larger site down the street. “That clinic is gonna be a permanent clinic,” Malik Rahim tells me, “served by the people it’s serving right now.”

**Tim Shorrock** is a journalist based in Memphis, Tennessee. This article was adapted from *Mother Jones* magazine, March/April 2006, with permission.



OAKLAND, CALIFORNIA

## Fighting the Cancer, Healing the Soul

*The Charlotte Maxwell Complementary Clinic treats cancer's side effects with "an outpouring of love."*

### Pamela O'Malley Chang

The Charlotte Maxwell Complementary Clinic is "a place of loving kindness that opens your heart, feeds your body, heals your soul. It's a place where everyone sustains and uplifts each other, [creating] a pocket of good energy that each woman takes as she leaves and spreads around." That's the philosophy of volunteer Casey Fisher who's worked at CMCC off and on since its inception.

Social worker Charlotte Maxwell, for whom the clinic is named, died of ovarian cancer in 1988—but not before passing on her fierce belief that low-income women should have access to the acupuncture and herbal therapies that eased her final months. In 1989, six women pooled \$4,000 to found what would eventually become the Charlotte Maxwell Complementary Clinic. The clinic opened in Oakland, California, in 1991, offering free acupuncture, herbs, massage, and other treatments one afternoon per week to about a dozen women with cancer. Now, 15 years later, the clinic is open two and a half days per week in Oakland and one day per week in San Francisco and, with a handful of staff and some 150 volunteers, helps 300 clients cope with the physical, spiritual, and social side effects of cancer.

### Bread and roses

On clinic days, CMCC's waiting room has the ambience of a common room before a dorm social. An overstuffed sofa and armchairs line three walls. A long table along the

fourth wall and a coffee table are laden with baskets of fruits, vegetables, dip, and crusty loaves of bread. Buckets of flowers stand in the corner.

Sarah Hom, who comes from Nevada once a month to volunteer, offers me a cup of tea as she explains that she has just picked up donations of organic produce from Full Belly Farms and bread from Semifreddi's Bakery. Nothing here speaks of 'clinic' except perhaps the corner bookshelves that house a lending library of cancer-related titles.

Shortly, the room fills, mostly with mid-life and older women. Every client accepted at CMCC is a low-income woman with a cancer diagnosis, and each is offered free treatment.

Except for their name tags, the volunteer practitioners are indistinguishable from clients. Elena Calderon is waiting for an acupuncture treatment to help build her immunity and overcome the side effects of chemotherapy. She's been coming to the clinic for about two years for ovarian cancer diagnosed in 2002. Ms. Calderon said she used to get nauseous just anticipating chemotherapy sessions. She'd go to patient support groups but would just absorb everyone else's complaints and feel worse. At CMCC by contrast, "people come out of treatment smiling."

"Here, they welcomed me, made me feel like family, helped me communicate better with my family," she said. "They taught me how to visualize my fear of chemotherapy ... as a black ball in the middle of my chest that I could lift out and throw into the ocean. ... People touch you like they love you; they

give you food and love. Anything I can say about this place won't be enough."

Raelyn Gallina echoes Ms. Calderon. CMCC is "love, an outpouring of love." Before she was diagnosed with 'galloping' inflammatory breast cancer, a rare and highly malignant cancer, Ms. Gallina was a jewelry artist. After super-aggressive treatment, she now has arthritis, nerve damage, and edema and can no longer grip her jeweler's tools. She characterizes cancer treatment as barbaric.

"You're held hostage by cancer, by the diagnosis, by the treatment. Chemotherapy may save your life, but it may devastate the life you knew."

Ms. Gallina has tried acupuncture, lymph drainage massage, reiki, and therapeutic visualization, none of which she would be able to afford without CMCC. She can't pinpoint how effective her CMCC treatments have been, but, two years post-diagnosis, she's grateful to be alive, and she's starting to find ways to create art again.

According to executive director Cari Napoles, the risk of death from breast cancer is four times greater for below-poverty women.

### Enough to spread around

In an orientation meeting, staff members review a client's medical records with her to make sure that she understands her options for both conventional and complementary alternative medicine (CAM) treatments. The clinic offers CAM therapies only—acupuncture, Chinese and Western herbs, homeopathy, massage, and therapeutic imagery—to help relieve pain

and the fatigue, nausea, nerve damage, and other side effects of chemotherapy and radiation. CMCC's care includes helping clients meet basic survival needs: social service benefits, housing, legal aid, emergency funds, and, in one case, a bed of their own for the children of a sleep-deprived patient.

Social workers also may provide written summaries of CMCC treatments to help a client communicate with her conventional-care doctors.

In addition, the clinic provides home-visits to house-bound patients, transportation to and from the clinic, food, and education programs, all pro-

vided by volunteers or supported by donations from individuals, local businesses, and private foundations.

Winding up their day at CMCC, clients each pack a bag of produce and bread and make a flower arrangement to take home. Sarah Hom returns from driving a client home smiling cheerfully. Ms. Hom learned about CMCC at a kayaking fundraiser event, then stayed to volunteer. She enjoys sharing in a community where "everyone speaks openly" and where she can be among strongly motivated people who face cancer. "They add so much to our lives," she says.



#### **U.S. Checkup**

Only 2 out of 5 Americans are very satisfied with the health care they receive.

As I leave, I find myself smiling and cheerful, too. Casey Fisher is right—I've partaken of CMCC's good energy and am eager to spread it around.

**Pamela O'Malley Chang**, a *YES!* contributing editor is studying traditional Chinese medicine in Oakland, CA. The Charlotte Maxwell Complementary Clinic can be found at [www.charlottemaxwell.org](http://www.charlottemaxwell.org)

#### **EVERETT, WASHINGTON**

### **HEALING ART OF FEELING BETTER**



JOHN LOK / KRT

#### **"Look Good ... Feel Better"**

Free classes for cancer patients coping with the side effects of treatment is part of an American Cancer Society program managed by local hospitals. Cancer survivors offer tips on care for dry skin and brittle nails, how to wear wigs, and how to tie head wraps or go proudly bald.

## THE BRONX, NEW YORK

# Quality Job, Quality Care

*Home health care workers often struggle with low pay and low-status, back-breaking jobs. But these home care aids are owners of their company, and that changes everything—for them and for their vulnerable patients.*

## Eric Laursen

New York's Cooperative Home Care Associates (CHCA) is one of the most successful worker-owned companies in the U.S. What's more, it thrives in a business that traditionally is scarred by near-sweatshop conditions, minimal job training and security, low wages, and few benefits.

CHCA is a fast-growing cooperative of 950 workers who tend to elderly and disabled patients in the Bronx and upper Manhattan. In recent years, the cooperative has been extending its formula to other cities and even to rural areas.

CHCA worker-owners have always believed that a quality job means quality care. They pay themselves above-average wages and guarantee each worker a minimum number of hours a week. The co-op offers comprehensive training, health and life insurance, career support—such as subsidies for college-level nursing courses—and 401(k) retirement contributions. All of this creates a core of workers who provide more professional care.

So does worker democracy. Workers and patients agree that the agency's model increases its responsiveness to the needs of both workers and patients. Workers say their quality of life is better than with other agencies, not just because their wages are higher, but because CHCA's training program aims at creating something more like a corps of professionals than an assembly-line of low-wage, low-skill medicine dispensers.



Workers practicing blood pressure monitoring during their 5-week comprehensive training. The industry standard is two weeks.

Here's how it works: Eighty percent of CHCA's workers are also owners, meaning they each own a share in the company. A share costs \$1,000, but each worker need only pay \$50 up front, plus \$3.65 out of her weekly paycheck, to cover the purchase. Each worker can buy only one share, however, and it can't be transferred. As soon as she signs up, she's entitled to all the rights of a full shareholder, which include electing eight of 13 members of the cooperative's board. The board sets wages, benefits, bonuses, dividends, and retained earnings. In addition to being part of the decision-making and ownership structure, worker-owners get a share in CHCA's profits. In most

years, they each receive a dividend of between \$200 and \$800.

The worker-owner structure has helped CHCA evolve employment practices that minimize the disadvantages felt by new recruits, 70 percent of whom have been on public assistance. CHCA charges no fee for training and provides a stipend for new employees to purchase uniforms. Employees have the opportunity to move up into administrative and training positions within the cooperative, and CHCA encourages workers who want to become nurses to pursue training to do so.

The cooperative's focus is on improving the status of home health care as an occupation, making it a viable, long-term decent living for the workers and their families. So the emphasis is on helping workers to stick with it rather than seek other occupations. For instance, CHCA has a tiered wage system so that workers move up as they acquire more skills and experience. It also clusters workers in five regions, which enables them to develop better and stronger relationships with their supervisors.

As a result of these policies, turnover is low—some workers have been with CHCA for as long as 18 years.

Another result is that the worker-owners have built a culture sufficiently rewarding to them that they have been willing to make sacrifices at times when it's in their—and the cooperative's—best interest. In one recent year, for example, when earnings were especially good, the board voted to reduce the dividend. Concerned that too few workers were contributing to their 401(k) retirement accounts, it decided to use part of the earnings to make a substantial contribution to each account and keep some of the rest as retained earnings. The result was a financial cushion for CHCA—and enough encouragement to boost workers' 401(k) contribution rate to 95 percent.

CHCA has also developed a training program that's more extensive and less hierarchical than other agencies' and emphasizes people skills more heavily. All workers get the same comprehen-



sive training, regardless of whether an individual spends most of her time doing catheter irrigations or preparing meals for clients, and are paid accordingly. New recruits get four to five weeks of training rather than the more typical two. Much of the additional time is devoted to “soft” skills needed to work with clients living on their own, rather than just “hard” skills needed to provide technical services.

All of this reflects the worker-owners’ desire to create a model of care that better reflects the demands of the situation in which they operate. When workers sense a need or a deficiency in the care they’re providing, they have the power to make changes. CHCA’s training emphasizes soft skills, for example, because workers understood from experience that their patients, who often lead isolated lives, need conversation and companionship as much as they do medical attention.

#### Worker Democracy

CHCA is taking its worker ownership model on the road. Eight years ago, it

set up the Paraprofessional Health-care Institute (PHI), a non-profit that is bringing the cooperative’s model to 13 other states and helped launch successful cooperatives in Philadelphia and rural New Hampshire.

CHCA and PHI believe they can raise the status of home health care work. As the population ages and America’s 77 million baby boomers begin retiring, the low wages and low status of home health workers will improve, says CHCA president Michael Elsas. “The baby boomers are not going to want to go into nursing homes.”

CHCA has been actively exploring ways to expand its market. Five years ago, Rick Surpin, who founded the cooperative in 1985, left to start Independence Care Systems, a Medicaid-funded long-term care program for disabled people who want to live independently—a market other providers had mostly ignored. Independence contracts with CHCA to provide home health care workers to its clients, creating a new pool of business—a major reason its staff has nearly doubled



#### U.S. Checkup

Profits for the top 17 U.S. health insurance companies rose 114% from 2000–2004. Profits for the S&P 500 rose 5%, the number of the uninsured rose by 6 million, and insurance premiums rose 60% in the same period.

over the past five years.

CHCA hopes to maintain its cooperative business model in spite of its rapid growth, but that may take some adjustments. The best response may be a stronger dose of what remains one of CHCA’s greatest strengths: worker democracy.

“Rather than having our meetings [in the cooperative’s headquarters on East 149th Street], we’ll have them in six locations around the Bronx,” Elsas muses. A small move, perhaps, but yet another way to keep “ownership” close to the workers.

**Eric Laursen** is a New York-based independent journalist. He is currently writing a history of the Social Security debate.

#### ARLINGTON, VIRGINIA

### HEALING ART OF GESUNDHEIT



**Patch Adams, M.D.**  
Founder of The Gesundheit! Institute

“The Gesundheit! facility will be a microcosm of life, integrating medical care with farming, arts and crafts, performing arts, education, nature, recreation, friendship and fun. ... We want to subvert greed and selfishness and replace them with compassion and care. ... We don’t want to be a Band-Aid for ailing health care; we want to change the system, to bring about a peaceful revolution.”

ITALO BERTOLASI

BHOPAL, INDIA

## Making Life Possible

*Twenty years ago, the world's worst industrial accident killed and maimed thousands in Bhopal, India. Today, a clinic treats those living with the effects of the original accident and the continued contamination from the abandoned site.*



PHOTOS COURTESY OF SAMBHAVNA CLINIC

Patients in Bhopal await treatment in the waiting area of the Sambhavna clinic. The free clinic treats those harmed by the 1984 chemical spill disaster, using Western and traditional Indian Ayurvedic medicine, yoga, and counseling. The clinic uses rainwater, solar energy, and gardens to enhance the healing effects on people, while caring for the environment.



## Somnath Baidya Roy

*Sambhavna* is a Sanskrit word which means “possibility.” Read as *sama* (same) and *bhavna* (thought), it denotes a sense of compassion.

Etymology however fails to convey what *Sambhavna* means to the people of Bhopal. To them, it stands for the difference between hope and despair, between dignity and humiliation, between life and death. *Sambhavna* is also the award-winning clinic that provides free medical care to those affected by the Bhopal gas disaster.

The Bhopal disaster is the worst industrial accident in history. On December 3, 1984, a Union Carbide pesticide factory spewed 27 tons of toxic methyl isocyanate gas out across the sleeping city of Bhopal, India, immediately killing thousands of people. Even today, 15 to 30 people die each month due to complications from the exposure. The death toll is now over 20,000. More than 120,000 are still sick, many permanently disabled.

Carbide, now owned by Dow Chemical, fled India after the disaster, leaving behind a site so contaminated that its chemicals have seeped into the groundwater. Lead and mercury have been found in women’s breast milk, and birth defects, menstrual disorders, tuberculosis, and cancers are on the rise.

The failure of the public health care system is contributing to the continuing tragedy. With no research, long-term monitoring, or established treatment protocols, doctors treat only superficial symptoms. Indiscriminate use of steroids, antibiotics, and psychotropic drugs is compounding the damage caused by the gas exposure. On top of that, patients have to deal with a corrupt and insensitive staff at the overcrowded, under-equipped, and unsanitary hospitals. Not surprisingly, despite the expenditure of millions of rupees, the health of the survivors and their children continues to deteriorate.

In this situation of despair, the *Sambhavna* clinic creates possibilities by generating compassion. Established

in 1996, the clinic offers free medical care and rehabilitation to the gas-affected. Doctors trained in western as well as traditional Indian Ayurvedic medicine, yoga therapists, and psychiatrists work together to design customized treatment regimens for each individual. Community health workers follow up with patients, spread awareness, and help women break taboos of talking about gynecological problems.

The Documentation Center is a repository of medical data meticulously collected as a part of the clinic’s pioneering “Verbal Autopsy” program. Studies done by the researchers at the clinic are published in international journals, including the prestigious *Journal of the American Medical Association*.

The integrative philosophy of *Sambhavna* is reflected in the architecture of the building. Its double-skinned walls conserve energy, large windows and skylights provide natural light, rainwater is harvested for washing, a garden of medicinal plants is irrigated with naturally treated waste water, and solar panels generate 10 kilowatts of electricity.

People matter at *Sambhavna*, and barriers of orthodoxy do not stand in the way. The clinic administration eschews formal hierarchy, and all decisions are made by consensus. A network of grassroots groups and ordinary people work through the



### U.S. Checkup

The U.S. spends a higher percentage of its gross domestic product on health care than any other country but ranks 37th out of 190 countries for system performance.

Bhopal Medical Appeal to raise money for *Sambhavna*. The BMA is the main “sponsor” of FC United of Manchester UK, the breakaway fan-owned soccer club started by Manchester United fans fed up with the commercialization of the club by its new American owner. Turning conventional wisdom on its head, instead of asking a sponsorship fee, the club raises money for the clinic. Powered by the support from Bhopalis, the team won its division in the very first year!

With unique partnerships like this, the clinic has overcome seemingly insurmountable odds and healed more than 10,000 people. Most importantly, *Sambhavna* has shown that, even in the bleakest of situations, through creative and collective intervention, it is possible to generate hope.

**Somnath Baidya Roy**, sbaidyaroy@gmail.com, teaches at the University of Illinois Urbana-Champaign and serves on the advisory board of Students for Bhopal. More on Bhopal is at: [www.bhopal.net](http://www.bhopal.net), [www.bhopal.org](http://www.bhopal.org), and [www.studentsforbhopal.org](http://www.studentsforbhopal.org).







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resourceguide39](http://www.yesmagazine.org/resourceguide39)

### A system to die for?

**Citizens Health Care.** People sharing their own powerful stories of their experience with health care. [www.citizenshealthcare.gov](http://www.citizenshealthcare.gov)

**Uninsured in America: Life and Death in the Land of Opportunity**, by Susan Starr Sered and Rushika Fernandopulle, tells stories of the uninsured and the downward spiral a single health problem can set off. University of California Press, 2005.

**One Nation, Uninsured: Why the U.S. Has No National Health Insurance**, by Jill Quadagno, traces the efforts of powerful interest groups to block universal health care and lays out why health care needs to be a social right. Oxford University Press, 2005.

**As Sick As It Gets: The Shocking Reality of America's Healthcare, A Diagnosis and Treatment Plan**, by Dr. Rudolph J. Mueller, offers a down-to-earth analysis of our health care system, with examples drawn from the lives of the author's patients. Olin Frederick, 2001.

**The Health Care Mess: How We Got Into It and What it Will Take to Get Out**, by Julius Richmond and Rashi Fein, is an authoritative account of the current system and a plan for universal health care. Harvard University Press, 2005.

**Denied: The Crisis of America's Uninsured**, book and photography exhibit from Talking Eyes Media, a multi-media organization advocating for social change. 973/746-9096, [www.talkingeyes-media.org/uninsured.html](http://www.talkingeyes-media.org/uninsured.html)

### Health & inequality

**Unequal Health: How Inequality Contributes to Health or Illness**, by Grace Budrys, sorts out the reasons for health disparities across the U.S., looking beyond age, gender, and race lines, and points to access to medical care, stress, and social inequality as defining factors. Rowman & Littlefield Publishers, 2003.

**The Impact of Inequality: How to Make Sick Societies Healthier**, by Richard G. Wilkinson, links poor health performance in the U.S. to record levels of inequality and maps out the link between health and equality, cooperation, and personal control. New Press, 2005.

### Environmental health

**Health Care Without Harm** is a global coalition working to protect health by reducing pollution in the health care industry. Find a resource kit for pollution prevention, information for nurses as environmental activists, environmental health news, and events. [www.noharm.org/us](http://www.noharm.org/us)

**Luminary: nurses lighting the way to environmental health** captures stories of nurses' activities to improve human health by improving the health of the environment. [www.theluminaryproject.org](http://www.theluminaryproject.org)

### Take action

**Health Care Now** does grassroots organizing for universal health care, and supports groups in organizing citizen/congressional hearings around the country. 800/453-1305, [www.healthcare-now.org](http://www.healthcare-now.org)

**Universal Health Care Action Network (UHCAN)** promotes comprehensive health care for all. Find advocacy and campaign resources for national and state-specific action. 800/634-4442, [www.uhcan.org](http://www.uhcan.org)

**American Medical Student Association** rallies future doctors for universal health care. Educational resources with statistics, primers on different health care systems, action kits, and updates on developments in different states and Congress. 800/767-2266, [www.amsa.org/uhc](http://www.amsa.org/uhc)

**Physicians for a National Health Program** unites physicians, medical students, and other health care professionals that support a national single payer health care system. 312/782-6006, [www.pnhp.org](http://www.pnhp.org)

**Americans for Health Care**, a project of SEIU, unites working families, small business owners, seniors, health care workers, community leaders, and policy makers to fight for affordable, quality health care for all. 866/4280837, [www.americansforhealthcare.org](http://www.americansforhealthcare.org)

**Everybody In, Nobody Out (EINO)** supports state organizations working at the grassroots for universal health care, focusing on the right to health care to empower communities. 919/402-0133, [www.everybodyinnobodyout.org](http://www.everybodyinnobodyout.org)

**Forum on the "Right to Health Care"** provides online legal documentation for establishing and recognizing the right to health care. [www.righttohealthcare.org](http://www.righttohealthcare.org)

### State organizations

**California Health Care for All** supports a single payer bill, SB 840 (CHIRA), that passed the California Senate and the State Assembly Health Committee. 888/442-4255, [www.healthcareforall.org](http://www.healthcareforall.org)

**Illinois Campaign for Better Health Care**, grassroots coalition of over 300 organizations working for accessible, quality health care that provides for all. 312/913-9449, [www.cbhconline.org](http://www.cbhconline.org)

**Maryland Health Care for All Coalition** developed a plan for universal health care in Maryland with a detailed financial analysis of its costs and benefits. Worked on "fair share" legislation forcing large employers to devote a percentage of payroll toward health benefits. 410/235-9000, [www.healthcareforall.com](http://www.healthcareforall.com)

**Pennsylvania Health Care Solutions Coalition** supports the state's Balanced and Comprehensive Health Care Reform Act of 2005, a universal coverage plan. 412/749-1882, [www.pahcsc.org](http://www.pahcsc.org)

**Ohio Single Payer Action Network** supports the Health Care for All Ohioans Act. SPAN meets monthly and organized a walk for health care justice across the state to help collect the necessary signatures for placing the initiative on the ballot. 216/736-4766, [www.spanohio.org](http://www.spanohio.org)

**Can't find your state?** Find more state resources at [www.familiesusa.org/resources/state-information](http://www.familiesusa.org/resources/state-information) and check out national organizations for local chapters.

### Community approaches

**Health Democracy: Liberating Americans from Medical Insurance, the Ithaca Health Alliance experience**, by Paul Glover, presents a can-do approach to organizing health care in your community. Health Democracy, 2006, 215/805-8330, [www.healthdemocracy.org](http://www.healthdemocracy.org)

**Community-Based Participatory Research for Health**, by Meredith Minkler, Nina Wallerstein (Eds.), offers tools and information on conducting health research with communities to promote social change. Jossey-Bass, 2002.

**The Robert Wood Johnson Foundation's Communities in Charge** program shows how towns and counties can finance local health care now. 216/736-7940, [www.communitiesincharge.org](http://www.communitiesincharge.org)

### Art and healing

**Arts and Healing Network** is an international resource on the healing potential of art. Features projects combining art, community, and healing, the annual AHN Award, and grant information for artists. [www.artheals.org](http://www.artheals.org)

**Patch Adams' Gesundheit! Institute** started as an experimental clinic offering holistic care, free of charge. Efforts now focus on building an ideal hospital incorporating art, recreation, and play in a home-style, green setting. 208/323-0848 (fax), [www.patchadams.org](http://www.patchadams.org)

ITHACA, NEW YORK

## Health Democracy

*Community insurance co-ops offer access, and so much more*

### Paul Glover

Millions of Americans without health insurance can't wait two years, five, 10 or 20 years for Congress to enact universal health coverage. And they needn't. Several communities have started their own nonprofit health systems. Members of the Ithaca Health Alliance, for example, join for just \$100 per year, and can get reimbursement grants or loans for the costs (without deductible) of such everyday emergencies as broken bones, ambulance rides, emergency stitches, burns, certain minor surgeries, and some dental.

All grants and all denials of grant requests are listed on the Alliance website, in order to keep the system transparent.

Today, about 1,000 people are members. As more join, the menu of medi-

cal grants increases. Members own a free clinic and receive discounts at over 100 Ithaca-area healers and healthful businesses like organic farmers and bike shops. The Alliance also offers access for low-income families to fresh foods and nutritional education. Members elect their board of directors, and anyone in New York State may join.

Co-op health systems like Ithaca's make sense in any city since they help reduce costs to taxpayers, and everyone's health is protected when public health is improved. They also strengthen the campaign for universal coverage:

:: They provide immediate benefits while organizing for universal coverage among the millions of uninsured.

:: The nonprofit health infrastructure demonstrates that good quality medical care can be provided at far lower cost when liberated from profits,

bureaucracy, and excessive CEO compensation. These systems will be ready to receive federal money when universal coverage begins.

:: They organize citizens to defend universal coverage, once enacted, from inevitable attacks.

One hundred years ago, "fraternal benefit societies" like Moose, Elks, and Odd Fellows built nonprofit medical centers, orphanages, sanatoria, and old folks' homes, and paid most of their members' medical and burial costs. They paid widows. Their medical plans were gradually legislated to death by corporate lobbyists.

Today's co-ops can be much more. They can promote the public foundations of health: clean food; clean water; clean air; and creative, relaxing lives. A national network of community initiatives could confront the contaminants that cause disease, promote holistic therapies, set high standards of integrity, and liberate Americans from HMOs. They can become a powerful force that heals the nation.

**Paul Glover** is author of "Health Democracy," founder of the Ithaca Health Alliance [www.ithaca-health.org](http://www.ithaca-health.org), and Ithaca HOURS local currency. For more information see [healthdemocracy.org](http://healthdemocracy.org). He can be reached at 215/805-8330, [www.paulglover.org](http://www.paulglover.org).

BROOKLYN, NEW YORK

## HEALING ART OF PAYING



WOODHULL MEDICAL CENTER

### Woodhull Hospital Artist Access Program

A pilot project at Woodhull Medical Center, one of New York City's public hospitals, recognizes that artists possess talents that can lift spirits and bring hope. Artists who offer their time receive credits they can trade for health care services. At left, artist Keith Haring, who died 5 years ago, offered Woodhull his signature murals throughout the center.

# Southern Revival

Social Forums borrow their old-fashioned, bottom-up approach to leadership and organizing from the great progressive social movements that changed history. Yet they offer something new: a way to experience the “other world”—the just, inviting, gentle, joyous place—that we know is possible.



At the conclusion of the Southeast Social Forum, June 2006, everyone was up front celebrating.

COURTESY OF PROJECT SOUTH

## Sarah van Gelder

That this would be no ordinary conference was clear right from the opening ceremony of the Southeast Social Forum. There were no big-name speakers on the agenda. Instead the aspirations and heartache of the poor and disenfranchised came into the space through performance and the arts.

There was no hotel ballroom. The opening took place instead at the historic Hayti Community Center, built in 1891 as a church and later converted into a hall that accommodated the likes

of Langston Hughes, W.E.B. DuBois, and Martin Luther King, Jr.

The organizers of the Southeast Social Forum, held in Durham, North Carolina, in June, made clear who was at the center of the gathering. Mothers and fathers, factory workers, labor organizers, farm workers, community organizers—each group was asked to rise to applause.

People who had worked hard to raise the funds and bring a delegation spoke of what they hoped to take back when they returned to Miami, Atlanta, the

Gulf Coast, and Virginia.

“We are the ones we’ve been waiting for,” someone said. And moments later, the historic church filled with the famous Sweet Honey in the Rock song—in three-part harmony.

Organizers prepared participants for the coming days’ work by reminding them that they would have many workshops and activities to choose from. But, “if you are not getting what you need out of this, you’re organizers! You know what to do.” Space would be available for spontaneous sessions called by



participants, along with opportunities to announce these sessions.

Every voice had been raised, and the stage was set for two days of work aimed at strengthening and connecting the progressive movements of the South and laying the foundation for the U.S. Social Forum, which will take place in Atlanta in the summer of 2007.

#### **You are how you meet**

The design of social forums is radically different from that of ordinary conferences. The organizers set up a space and time, establish the process, and define the major themes. But it is the participating organizations that provide the substance for the sessions and organize their members to attend.

political clout to change the direction of society, the movements need to come together.

"There is so much division in the United States," says Guerrero. "We're too quick to burn bridges, too competitive and unwilling to recognize the contributions that everyone makes."

"We have to figure out how to have differences and still work together," he adds. "And we need to look at the broad scope of the progressive movement and how it all fits together."

"We've reached a critical moment," said Stephanie Guilloud, one of the lead organizers, and program director for Project South. "We are running out of options. Reforms are being rolled back; small gains are rolled back. We

ers wanted to build the Durham event from the grassroots up, with strong participation by youth and working-class people, and a majority of people of color. And they were hoping to have at least 500 people attend from throughout the south.

They invited organizations with grassroots memberships to rent buses, hold fundraisers, do whatever was necessary to bring the people who seldom go to conferences.

To prepare the young people, Project South held four weekends of "Building a Movement" (BAM) workshops, culminating in the social forum.

To get a strong representation of Latinos, the mainly African-American organizers hired an outreach organizer

**"We've reached a critical moment. We are running out of options. Reforms are being rolled back; small gains are rolled back. We need to change tactics. This is the time for transformation on a larger scale."**

Social forums are designed to build grassroots leadership. The content of the workshops "has to be things participants can put to use in their lives, and it has to come from their lives," says Alice Lovelace, the lead staff organizer for the U.S. Social Forum. "We start by acknowledging that everyone in the room has knowledge."

People want to know what tangible outcomes they can expect from the forums, said Michael Guerrero, coordinator of Grassroots Global Justice (GGJ). GGJ has been bringing delegations of American grassroots leaders to the World Social Forums for the last several years. "How can the social forum be a strategic point in your work?" he asks these groups. "How can we use forums to integrate the movements and to start developing a long-term vision?"

While single-issue organizations can galvanize their members to make change, in order to muster sufficient

need to change tactics. This is the time for transformation on a larger scale."

#### **Coming, at last, to the U.S.**

North America is the last region of the world to host a national or regional social forum, and few Americans have attended the World Social Forums.

When the International Council of the World Social Forum first began pressing for a U.S. or North American Social Forum, GGJ argued against it.

"There was not enough awareness early on," says Guerrero. "We felt that there was a lot of work to do to raise awareness in communities of color and grassroots groups, so it would be representative."

The Southeast Social Forum was a test to see if a U.S. forum was possible. Organizing for the regional forum began early this year out of the Atlanta offices of Project South, on a tight timeline, with little money. Organiz-

with money raised at a special fundraiser. Simultaneous translation was available throughout the forum.

Organizers wanted the forum to be a place to address the tensions between African Americans and Latinos that had grown in the wake of the massive immigrant rights demonstrations. And they wanted to fully involve those who are organizing in the devastated areas along the Gulf Coast.

"We knew the risk," says Guilloud. "And we knew we were succeeding when the registrations began coming in," she said. "We'd get phone calls from people saying, 'I'm bringing 18 people on a bus. We're bringing moms and kids.'"

People came from across the South—rural Georgia, Atlanta, Miami, and the Gulf Coast. "We had people from immigrant groups, people working on fair wages, the environment, housing, civic justice, labor rights for >>



SARAH VAN GELDER

Rosalinda Guillen, bottom right, a farmworker organizer and part of the U.S. Grassroots Global Justice delegation, is embraced by members of the Brazilian Workers' Party during the opening march at the 2005 World Social Forum in Porto Alegre.

## What is the World Social Forum?

Social Forums have been taking place around the world since 2001, when organizers, principally from Latin America and Europe, brought together 20,000 people in Porto Alegre, Brazil. The idea was to go beyond protesting outside the World Economic Forum, where the rich and powerful set a global agenda. Instead, through a World Social Forum, ordinary people could set the agenda under the banner "Another World is Possible." (See the YES! coverage at [www.yesmagazine.org](http://www.yesmagazine.org)).

The forum was inspired in part by the 1999 WTO protests in Seattle, which were accompanied by participant-organized seminars and teach-ins on topics ranging from food and agriculture to women and development. Rather than have a central group plan activities, organizers set up the space in which social change groups from around the world could organize their own sessions.

The next **World Social Forum** will take place in Nairobi, Kenya, January 20–25, 2007. See the World Social Forum web site at [www.foro-socialmundial.org.ve/Ingles/](http://www.foro-socialmundial.org.ve/Ingles/) and the **U.S. Social Forum** web site at [www.ussf2007.org](http://www.ussf2007.org).

» service employees, and people from progressive churches," says Lovelace. "We had farmworkers, domestic workers, low-income people of all kinds."

### Showing up, fully human

The spirit of the forum was felt not only in the content of the sessions, but in the ways that participants' emotional and spiritual needs were addressed.

For those tired from the travel, burned out, or in recovery from

Katrina—for anyone who wanted a respite—there was a Healing Sanctuary. Inside was an altar to any who participants wanted remembered, a quiet space for meditation, prayer, or rest, and a room where massage and various forms of body work were offered and gratefully accepted.

Elsewhere, a dorm lounge was transformed into kids' space with tents, hip-hop dance, a vision quilt, and a map where children could show where they

had come from.

"People often see these sorts of things as fluff," Guilloud said. "But this is quite necessary. We need to stop compartmentalizing ourselves and integrate our whole selves into our work."

### U.S. Social Forum—2007

The day after the forum, organizers met to take a breath, and to celebrate, before plunging into preparations for the U.S. Social Forum. They had exceeded their goals on all counts. Nearly 600 people had come, nearly a third of whom were youth, and 80 percent people of color.

"We are making history together," said one of the organizers. "If we can do this in a few months with few resources, imagine what we can do in a year!"

"What we saw is that people are ready to engage and confront the edges that have kept us apart," said Guilloud.

"We're building a movement that is democratic," said Guerrero. "Building from the bottom up is slower and harder, but it will pay off."

The U.S. Social Forum is starting with grassroots groups, communities of color, and indigenous groups. "These are the groups with the least resources, usually the last to be brought into a process," Guerrero said. "If we didn't start here, these would be the hardest groups to integrate later."

Other groups from the peace movement, the global justice movement, the progressive political movements, and so on will be invited, too, to a process that is open to all.

"It will change this country. I know it will," said Lovelace. "This is part of a long-term process to work together and to envision what transforming this country and this world means." ⑦



HARAZ N. GHANBARI / AP

Establishing  
“Camp Casey D.C.”  
September 2005

# “The voice of a mother is powerful”

After Cindy Sheehan lost her son Casey to the war in Iraq, she went to Crawford, Texas, to ask President Bush to explain the noble cause her son had died for. Thousands joined her at Camp Casey, outside the Bush vacation home, and a movement was born.

## **An interview with Cindy Sheehan by Sarah van Gelder**

**SARAH:** After you lost Casey, in Iraq, what made you decide to speak out about the war? Why did you think you could make a difference?

**CINDY:** It was my daughter's poem, *A Nation Rocked to Sleep*, that made me ashamed of myself for not speaking out sooner. I did not think that one person could make a difference, but I thought I would try or I would die trying.

I wanted to show people the pain of having a child killed in a needless war and to have people wake up. Most Americans are against this war, but we have to translate our opposition to the war into activism that can affect policy.

**SARAH:** In your travels around the world, what are you hearing from the people you encounter?

**CINDY:** People tell me that before they heard of me, they didn't realize that there were people in the U.S. against the war. >>



## “The Voice of a Mother is Powerful”

» And they say that it gives them hope when they see that Americans aren't just rolling over any more, we are trying to take our country back and get our troops out of Iraq, and we truly care, not just about our country, but about the world.

**SARAH:** In the foreword to your book, Greg Ruggiero calls you Mom Laureate, Subcomandante Momus, Nobel Peace Mom, Dr. Mom, Jr., Mahatma Mom ...

**CINDY:** He's such a weirdo!

**SARAH:** So, what is it about a mother's voice that has such power?

**CINDY:** The voice of a mother is powerful not because not everybody is a mother, but everybody *has* a mother. You can remember when your mom went to advocate for you at the principal's office or with a neighbor. Your mom is always there for you; she always loves you unconditionally.

There are some people who sneer at me and attack me, and I think that that is really off base, because even if I wasn't a mom, I am an American and I have a right to do this.

**SARAH:** You've used the term *matriotism*. Can you talk about what that means to you?

**CINDY:** The industrial-military complex and the war profiteers use a false sense of patriotism to get our children involved in the military or to get our country to support needless wars of aggression, for profit. From the time we're in school learning the Pledge of Allegiance, we are told our country is the greatest country on Earth and it's worth dying for. We are taught that we are supposed to love this territory and these false borders more than we love ourselves as human beings.

Matriotism is the love of all human beings, no matter where they live. And a matriot would never send her own children or anybody else's children to kill other people's children and die in needless wars. It is not a matriarchy in the sense of a society that's ruled by women. It's a society that's ruled by the

heart and love and integrity, no matter what gender you happen to be born or no matter what side of the border you are born on.

**SARAH:** We are talking on June 2nd as more news is coming in about massacres of civilians in Iraq by American soldiers. What is it like for you, when you hear these stories?

**CINDY:** Our kids are being driven to do things that they would have never thought of doing before; they're turning into people we don't even know. This is what war does to people. This entire invasion, war, and occupation of Iraq is a crime against humanity.

The only people being punished for these crimes are privates and specialists. The people who started this, the war criminals in D.C., are the ones who should be prosecuted for war crimes and crimes against humanity.

**SARAH:** You've come to a different understanding of the role that the United States is playing in the world through your experience. How did you come to that view?

**CINDY:** I had barely used my passport before my son was killed. Now, traveling around the world, I realize what war is all about and what we have an army for. It is basically to make the world safe for our corporations and to spread corporate colonialism and to enrich the war machine and to line people's pockets. General Smedley Butler said: "War is a racket, it always has been, it always will be." Our kids are used as cannon fodder and pawns in these games for power, control, and money.

**SARAH:** You've challenged President Bush to identify the noble cause that your son died for. What noble cause do you think might bring our country together? What's a noble cause we might live for?

**CINDY:** Peace. One of the prophets in the Old Testament said: Beat the swords into plow shares. That is a noble cause. A noble cause is taking the money out

of the Pentagon and putting it into our communities, making everybody feel loved and supported and educated and building a society where everybody from small children to leaders of countries solve problems nonviolently. That's the noble cause. My son died to make this a reality, and I will work until I die to make it a reality. And I believe that is the noble cause.

**SARAH:** I hear Camp Casey is going to happen again this summer in Crawford, Texas. Are you looking forward to it?

**CINDY:** I am so looking forward to it! It is like going home. I have a place in Berkeley, where my stuff stays, and I don't go there very often. It's a small apartment, where I am by myself. When I go to Camp Casey, I am home with my family and people who are like-minded, and it's a peaceful society where we all strive together and work for the common good.

**SARAH:** What has this experience been like for your three children Carly, Andy, and Jany?

**CINDY:** Well, I can't speak for them, but I can speak to my relationship with them. It's been difficult, and it's been mostly trying to deal with their brother's death, and then to do as much as I can for them. And everybody is realizing that we are doing this for all the world's children now.

**SARAH:** What sustains you?

**CINDY:** I am not exactly sure, but I do have a lot of strength and a lot of energy. I am on an airplane at least four times a week. I can't stand thinking that there are innocent Iraqis and American soldiers dying because of lies and deceptions. It is so urgent that we do everything we can to bring this travesty to an end.

And I get lots of hugs, lots of love, and lots of support. ♡

You can learn about Cindy's fast, with dozens of others, to stop the Iraq War and other anti-war activities through the Gold Star Families for Peace [www.gsfp.org](http://www.gsfp.org) and Code Pink [www.codepinkalert.org](http://www.codepinkalert.org).



KAREN TAM / AP

**Cindy Sheehan wears a memorial  
to her son's birth and death.**

### ***Carly's Poem—A Nation Rocked to Sleep***

Have you ever heard the sound of a mother screaming for her son?  
The torrential rains of a mother's weeping will never be done  
They call him a hero, you should be glad that he's one, but  
Have you ever heard the sound of a mother screaming for her son?

Have you ever heard the sound of a father holding back his cries?  
He must be brave because his boy died for another man's lies  
The only grief he allows himself are long, deep sighs  
Have you ever heard the sound of a father holding back his cries?

Have you ever heard the sound of taps played at your brother's grave?  
They say that he died so that the flag will continue to wave  
But I believe he died because they had oil to save  
Have you ever heard the sound of taps played at your brother's grave?

Have you ever heard the sound of a nation being rocked to sleep?  
The leaders want to keep you numb so the pain won't be so deep  
But if we the people let them continue another mother will weep  
Have you ever heard the sound of a nation being rocked to sleep?

— Carly Sheehan

Poem reprinted with  
permission from  
*How to Stop the Next  
War Now: Effective  
Responses to Violence  
and Terrorism*, edited  
by Jodie Evans and  
Medea Benjamin.

# Big Rewards for Small-Mart Shoppers

## THE SMALL-MART REVOLUTION



HOW LOCAL BUSINESSES ARE  
BEATING THE GLOBAL COMPETITION  
MICHAEL H. SHUMAN

### The Small-Mart Revolution: How Local Businesses are Beating the Global Competition

MICHAEL H. SHUMAN

Berrett-Koehler, 2006, 270 pages, \$24.00

REVIEWED BY JILL BAMBURG

Michael Shuman has written a worthy successor to his first book on local economics, *Going Local: Creating Self-Reliant Communities in a Global Age*. That book offered an alternative to globalization before the Battle of Seattle made that issue a *cause célèbre*. This one enters the marketplace six years later, declaring—in its subtitle, at least—victory for the local alternative.

The Small-Mart Revolution begins by personalizing the issue of globalization as a battle between two “female” protagonists: TINA (There Is No Alternative) and LOIS (Local Ownership and Import Substitution). TINA is an acronym for the prevailing economic worldview on globalization, as articulated by Margaret Thatcher, Thomas Friedman, George Bush and others. LOIS is the new girl in town—or at least a new name for an alternative set of ideas that grow out of the work of E. F. Schumacher, Jane Jacobs and—yes—Michael Shuman.

By expanding his support for local ownership to include ideas about import substitution, as well as the role of trade in a world of place-based economies, Shuman has begun to refine the argument in significant ways. The short version:

“As more and more communities join in the Small-Mart Revolution, trade will of course continue, but it will be in goods and services less and less vital to day-to-day survival. If we’re trading primarily art, music



#### AN EXCERPT ::

And the biggest loss was this: I never expected to buy most of this stuff in the first place. I came to buy \$15 sneakers, and wound up spending \$275 on a half-dozen bags of junk. Caught up in the superficial frenzy of discounts and deals, I wound up spending nearly twenty times more money than I intended, much of it on goods of shoddy quality in a shopping excursion that wasted two hours of my time and gave me an enormous headache. Even more embarrassing, the sneakers I came to buy, which wound up not having a price tag, actually cost twenty-six dollars, about the same price I would have paid at a dozen other stores in Washington.





and wine instead of oil, wheat, and water, our local economies will be healthier through self-reliance in the basics, less vulnerable to unpredictable global calamities, and we will all be less inclined to go to war over real or perceived needs.”

The bulk of the book is a “how-to” manual for advocates of local economies, each addressed as a separate audience in separate chapters: consumers, investors, entrepreneurs, policymakers, community builders, and globalizers (those concerned with providing economic opportunities for residents of the world’s poorest countries). The chapters are an interesting mix of statistics, case studies, personal observations, legal arguments, economic theory, and common sense—all dished up in an engaging and encouraging style. Each of these chapters ends with a numbered checklist of very practical suggestions for supporting LOIS in today’s TINA world. And for those whose interests in localization are professional as well as personal, the book is wonderfully well footnoted for further research.

In the past, I have been somewhat skeptical about the claims of the localization movement on three counts. First, I was not convinced that

local firms could effectively counter the price advantages of large-scale producers. Second, I believe in the idea of comparative advantage—that some regions are intrinsically better suited to provide some types of goods and services, by virtue of raw materials and history, if nothing else. Third, while I’ve never been a fan of TINA, I have been a reluctant believer: I just don’t see the multinationals yielding their hegemony any time soon.

Shuman addresses each of these objections directly and practically. First, he argues persuasively that for a very wide range of goods and services, local is, in fact, no more expensive than global. Second, as he points out several times, he is advocating “Local First,” not “Local Only.” If advantages of scale and locale fall elsewhere, he is realistic enough to recognize that rational consumers may opt for non-local choices. Third, he doesn’t second-guess the ultimate outcome of a clash between LOIS and TINA—he simply offers a powerful and compelling vision of what a LOIS world might look like. And his arguments against state and local “economic development” subsidies for the plant siting of multinational firms should be required reading for every government official—and taxpayer!

Shuman opens his book with an amusing tale about a trip to Wal-Mart and the “true cost” of a \$15 pair of sneakers—\$275. I can close with an example of my own: a recent trip to PetSmart, a 45-minute drive from my home. I went there in search of a pet rat for my daughter. But when I got there, they had only two rats available, both of them males, and we had been advised to buy a female. From the aisle of PetSmart, I belatedly called our local pet store to see if they had what we were looking for. Sure enough, they had female rats – about 10 of them. Price: \$5.99. The price at PetSmart? \$8.99.

Shame on me. Next time, I’ll listen to Michael.

**Jill Bamburg** is author of *Getting to Scale: Growing Your Business without Selling Out*. Berrett-Koehler, 2006.

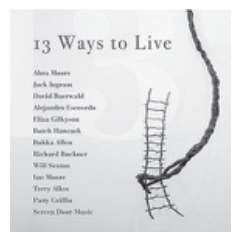
## YES! PICKS ::

**Musical inspiration while putting out this issue**



### “Son”

Great new music from Latin American vocalist **Juana Molina**. Layers of texture—acoustic guitar, Latin electronica, and traditional percussion—underlie Spanish lyrics that are languid, critical, and political. The music is self-reflective and experimental, offering a taste of Molina’s world.



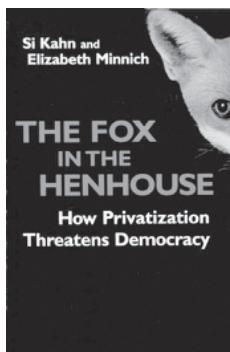
### “13 Ways to Live”

A collection of original songs offered by the alt-rock and indie-folk set inspired by the Iraq War. Profits go to a human rights group. It’s impassioned, and its judgment on this war is relentless. **Richard Buckner** is mesmerizing, and **Butch Hancock** defines “troubadour.”



### “Stella Maris”

**Trio Mediaeval** keeps the form of Gregorian chant contemporary. For this, their third recording, the trio from Norway adds the tenor of John Potter as the ethereal leader in “O Maria, stella maris, conductus.” The result is incandescent and healing.



**The Fox in the Henhouse:  
How Privatization  
Threatens Democracy**

SI KAHN AND

ELIZABETH MINNICH

Berrett-Koehler, 2006, 288 pages, \$14.95

REVIEWED BY DAVID BOLLIER

The privatization of our common assets is one of the great unacknowledged trends of our time. Si Kahn and Elizabeth Minnich give a fresh accounting of this epic struggle in their new book, *The Fox in the Henhouse: How Privatization Threatens Democracy*.

Kahn, community organizer and executive director of Grassroots Leadership of Charlotte, North Carolina, teams up with Minnich, a feminist philosopher and professor, to describe the many public assets and government services that are being privatized. It's a long list. Kahn and Minnich focus on Social Security, health care, schools, public lands, the military, and prisons. They also explain—and debunk—the overarching justifications for privatization.

This book arrives at a propitious moment. For six years, George W. Bush and the Republican-controlled Congress have systematically sought to “starve the beast,” that is, to reduce government budgets (except those of the military), in an attempt to discredit and paralyze government programs. They have installed political cronies throughout government, dismantled important research programs, curbed government regulation that protected the public, and championed the

privatization of diverse government services—all the while sweetening the deal for favored industries (and campaign contributors) with gratuitous subsidies.

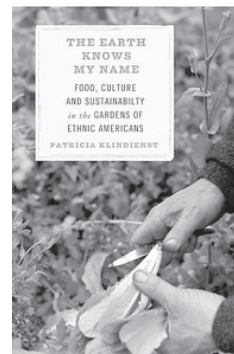
Kahn and Minnich’s real achievement is connecting the dots among the wide array of privatization campaigns. They describe the various guises that privatization takes. Government outsources services, for example, or enters into “partnerships” with private parties. It leases out public assets, such as forests and wilderness areas, and provides subsidies to Big Pharma, Big Oil, and Big Media. It cuts funding for public services until they perform so poorly that private takeovers seem attractive. And it simply sells off public assets outright (public hospitals, for example), or, in effect, gives them away (mineral rights on public land).

The virtue of *The Fox in the Henhouse* is that it is written for a popular readership. The public needs a clear, factual accounting of how public assets and government services are being (mis)managed and privatized if they are to understand the problem and make the needed changes.

“What will we do when our government has been so weakened that it cannot work for us, and cannot stand up against the privatizing corporations that now take the whole world as their domain?” Kahn and Minnich ask. “What do we do when government itself is privatized?”

The Bush administration has made this question inescapable. *The Fox in the Henhouse* sets forth what is at stake. The challenge we face is developing effective new strategies that will reassert and protect the common good.

David Bollier is editor of OntheCommons.org and author of *Silent Theft: The Private Plunder of Our Common Wealth*. Routledge, 2003.



**The Earth Knows My Name:  
Food, Culture, and Sustainability  
in the Gardens of  
Ethnic Americans**

PATRICIA KLINDIENST

Beacon Press, 280 pages, 2006, \$26.95

REVIEWED BY ANN LOVEJOY

Most garden books today focus on pretty flowers or tasty vegetables. This one looks instead at the deep connections between people and the land. Traveling across America, Klindienst interviewed gardeners whose relationships with the earth mean more than having picture-perfect beds and borders.

She traces the travels of sacred white flint corn, one of America’s original sustainable crops, still grown both in Tesuque Pueblo, New Mexico, by Tewa tribal gardeners and in Stonington, Connecticut, by an eleventh-generation farmer whose family has shared it with local Mohegan people since 1637.

Gullah elders on St. Helena Island off the South Carolina coast also grow corn in gardens without fences. For these once-isolated offspring of former slaves, the land itself is considered freedom, sanctified by the labor of many generations.

Khmer gardens in Massachusetts, Punjabi and Italian gardens in California, Japanese and Polish gardens in Washington—all hold sacred crops rooted as deeply in ancient cultures as in today’s garden soils. Anyone who feels most at home in the garden will revel in this book.

Ann Lovejoy, gardener and garden writer extraordinaire, is author of 18 books on gardening.



VELCROW RIPPER

## FILM ::

**ScaredSacred** Documentary, 2006, Zeitgeist Video, 105 min.

Directed by Velcrow Ripper.

REVIEWED BY JONATHAN LAWSON

"Breathe in suffering, breathe out compassion." This instruction from the Buddhist tonglen meditation practice serves as a kind of guiding principle for Velcrow Ripper's extraordinary new documentary, *ScaredSacred*.

The film's principal locations are all places of intense suffering, destruction, and fear—the most challenging places in the world to look for hope and beauty. The film's search for the "ground zeros of the world" takes us to Bhopal, Israel, and Palestine, Sarajevo, Kabul, Hiroshima, and the killing fields of Cambodia.

Director and narrator Ripper unearths ways in which witnesses and survivors of unspeakable tragedy have been transformed by their experiences, grounding the film in extended interviews with remarkable individuals: Zoelya, a young leader with the Revolutionary Afghan Women's Association, whose mother was killed by the Taliban; Sensei Enkyo O'Hara, an American Zen teacher in Manhattan opening herself to the fear and confusion of the September 11 attacks.

Thankfully, the film is also a real pleasure to watch; its gorgeous images and evocative sound design helped *ScaredSacred* win a series of prestigious film awards in Canada, including the Genie award for best documentary.

Ripper, who describes himself as a "Sufi Buddhist Baha'i," presents his subjects in various cultural and religious settings with a sense of engaged solidarity, avoiding both dogmatism and the critical distance that plagues many world-religion documentaries. By seeking out stories of possibility and compassion in these landscapes disrupted by war and disaster, Ripper affirms in a powerful way that even in times of intense, sustained trauma (perhaps especially in such moments) there remains the possibility for great moral action.

Ripper's forthcoming film *Fierce-Light*, the second in a projected trilogy, will explore sacred activism around the world. Follow the film's progress through Ripper's blog and podcast at [www.scaredsacred.org](http://www.scaredsacred.org).

**Jonathan Lawson** is executive director of of Reclaim the Media ([www.reclaimthemedial.org](http://www.reclaimthemedial.org)) in Seattle.

## YES! PICKS ::

**Maddening and motivating independent films**

### **The New Medicine (120 min)**

Ironically, this film is mostly about bringing back the best elements of *old* medicine—caring, touching, and attention to emotions. Hosted by Dana Reeve, the film documents the gradual shift toward integrated medicine in medical schools and research institutions, and the changes in private practice that have resulted since the topic was explored 15 years ago by Bill Moyers in his PBS series *Healing and the Mind*.

### **The Motherhood Manifesto (60 min)**

Based upon the book of the same name written by Joan Blades, co-founder of MoveOn.org and Kristin Rowe-Finkbeiner, this documentary film captivates with its heartfelt stories of real working moms across the country and the frustration they feel at being discriminated against just because they are mothers. But, like Blades, filmmakers John de Graaf and Laura Pacheco highlight positive stories—companies, programs, and countries with successful family policies and family-friendly legislation.

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## FROM THE PUBLISHER



**You told us you want a health care system that works, not just for yourself, but for everyone. That desire, which many of you articulated so passionately, became the frame for this issue of YES!**

# Your Help Creating *YES!*

Are you one of the growing number of readers who are helping create *YES!* magazine? If you are already responding to the questions in our email newsletters—let me say thanks! If not, let me invite you to join the fun. You can start by signing up for our email newsletter at [www.yesmagazine.org/newsletter](http://www.yesmagazine.org/newsletter).

You, our readers, are leading the way to a healthy world with your community actions, lifestyle changes, and political and social involvement. So we're eager to hear from you. Many of you write us hard-copy letters and individual email notes, which we greatly appreciate. Now, through our e-newsletters, we've found a great way to elicit thoughts from many more of you. Let me tell you how we've begun doing this.

We took our first step in our March e-newsletter in which we asked you to tell us your ideas for "How to Survive and Thrive in the Next 10 years." We posted 25 of your many answers on our website. My favorite: "Dress up and play 'world leaders' with your children. Listen to their solutions to the poverty and war questions." (You can find the rest of the responses at [www.yesmagazine.org/readersurvive](http://www.yesmagazine.org/readersurvive)).

Your great response to our first invitation emboldened us to ask a harder question. In April, we were fleshing

out ideas for this Fall issue of *YES!* on health care. So in our April newsletter, we posed the question: "What health care changes would contribute to your health and well-being?"

As your answers came pouring in, what we saw was this: We had posed our question in terms of "you" as an individual, but you answered in terms of "we" as a society. Sarah van Gelder wrote in her blog, "You nailed it on health care." It was clear that despite contrary arguments about political realities and fiscal practicality, you want a health care system that works, not just for yourself, but for everyone. That desire, which many of you articulated so passionately, became the framing concept for the research and writing for this issue of *YES!*. You can find what people told us at: [www.yesmagazine.org/readerhealth](http://www.yesmagazine.org/readerhealth).

Next we asked for your help on humor. Our office is full of people who laugh easily and have a great time, but we've had a hard time bringing humor into the magazine. So much that passes for humor involves insults and putdowns—not the *YES!* style.

So what to do? Turn to you, of course. Tracy Loeffelholz Dunn, our new Art Director, drew a cartoon of a guy with bunny ears at a computer, and we asked you to provide a caption.

I will tell you, when I saw her cartoon, I couldn't think of a single caption. Fortunately we've got readers with more imagination than I. I was laughing out loud as I went through the suggested captions. You'll see our favorite on page 11.

As we prepare for future issues, we'll want your ideas on framing the topics, finding the stories, suggesting actions—and yes, providing great cartoon captions.

Currently we're preparing for the Winter issue of *YES!* on the vexing problem of the economy. We'll feature innovative folks who are creating business models that solve some of the most difficult social and economic dilemmas of our time. We'll want to get your thoughts on that, too, in a future newsletter.

If you haven't yet signed up for our monthly e-newsletter and want to join in creating *YES!*, sign up now at [www.yesmagazine.org](http://www.yesmagazine.org). The newsletter also gives you timely news items, suggestions for action, and commentary from some of your favorite writers.

I look forward to hearing from you online.



**Fran Korten**, Publisher

## WHO WE ARE ::

YES! Magazine is published by the Positive Futures Network, an independent, nonprofit organization supporting people's active engagement in creating a just, sustainable, and compassionate world. The work of the Positive Futures Network is to give visibility and momentum to signs of an emerging society in which life, not money, is what counts; in which everyone matters; and in which vibrant, inclusive communities offer prosperity, security, and meaningful ways of life.

## NEWS AND NOTES ::

**10th Anniversary Celebrations ...** You're invited! Please join us in celebrating our 10th Anniversary at the Green Festivals in Washington, D.C. and San Francisco. In D.C. the party's on October 14 and in San Francisco it's on November 11. Both are from 5:30 to 8:00 p.m. Find us at our Green Festival booth for the party's location. Or go to our website, sign up for our e-newsletter, and we'll send you the details. Hope to see you.

**Get YES! by e-mail ...** It's free. Sign up for a free YES! monthly e-newsletter. Go to [www.yesmagazine.org](http://www.yesmagazine.org), and find the sign-in box on the lower left side of the home page. Be assured, we never share or sell email addresses.

**YES! in Spanish ... ¡Sí! se puede! YES!** magazine is now available in Spanish, online. For free. Our friend Guillermo Wendorff, from Argentina, has been translating issues of YES!, and we now have the Winter, Spring, and Summer 2006 issues online in Spanish. Check it

out at [www.yesmagazine.org/espanol](http://www.yesmagazine.org/espanol) and spread the word to your Spanish-speaking friends.

**Dal LaMagna joins the board ...** Our newest board member is Dal LaMagna, who brings us business and political savvy and a passion for changing the direction of the country. Through his company, Tweezerman, Dal pioneered social responsibility in the production of tweezers. He also founded [ProgressiveGovernment.org](http://ProgressiveGovernment.org), which recently merged with the Backbone Campaign. He co-produced two Iraq war films, "The Ground Truth" and "The War Tapes." Dal is on the board of our neighbor, the Bainbridge Graduate Institute, as well as a leader in the Social Venture Network, the Kennedy School of Government, and Business Leaders for Sensible Priorities.

**On the web: The Great Turning ...** Check out the latest from Dave Korten's travels and dialogues at [www.yesmagazine.org/greatturning](http://www.yesmagazine.org/greatturning).

## YES! PICKS ::

### Things To Do, Places To Go



[www.YesMagazine.org](http://www.YesMagazine.org)

For an expanded listing of upcoming events

#### Days of Peace

Sept. 21 is the International Day of Peace. Fly a giant peace dove, issue a proclamation, hold a vigil, join in song, or find other ways to join the worldwide movement to create a global cease-fire and day of peace. [www.internationaldayofpeace.org](http://www.internationaldayofpeace.org)

Sept. 16, the Peace Alliance campaign for a U.S. Department of Peace is organizing walks for peace around the U.S. [www.thepeacealliance.org](http://www.thepeacealliance.org)

#### Bioneers

Oct. 20-22, San Rafael, CA. The Bioneers Conference is a hub of practical solutions for restoring the Earth and the people. [www.bioneers.org](http://www.bioneers.org)

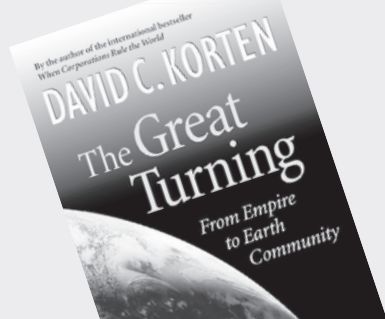
#### Southwest Border Social Forum

October 13-15, Ciudad Juarez, Chihuahua, Mexico (across from El Paso, TX). The movement building work of the social forums continues. See article on page 50.

#### Green Festivals

October 14, 15 in Washington, DC, November 10, 11, 12 in San Francisco, CA. Thousands gathering to learn about creating sustainable economies, ecological balance, and social justice. Visit with YES! staff and volunteers at our Green Festival booth. See display announcement on page 65.

## Become a Dedicated Friend of YES! with a monthly donation of just \$10.



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## YES! BUT HOW?

IF YOU'RE SEARCHING FOR PRACTICAL WAYS  
TO LIVE SUSTAINABLY, JUST ASK US.

Send questions to [editors@yesmagazine.org](mailto:editors@yesmagazine.org)  
or to YES! But How? PO Box 10818, Bainbridge Island, WA 98110

### NAIL POLISH

*I love the look of a French manicure, but I can't stand the smell of nail polish. Can you recommend a more natural alternative?*

We agree. Not only does nail polish stink, it's bad for the environment. Almost all nail polishes contain toluene, which is toxic; formaldehyde, a known carcinogen; and dibutyl phthalate, a hormone disrupter. While there are alternatives, those still contain petroleum solvents, which are stored in body fat and can even be passed on to babies through breast milk.

Fortunately, you don't have to choose between beautiful nails and protecting yourself and the environment. You can achieve the look of a French manicure sans nail polish by using a method women have used since the 1930s. It is inexpensive and simple, but you will need a few supplies: a cardboard emery board, a manicure stick (also called an orangewood manicure stick), a fine pumice sand stick, a fine-grit pumice stone block, a buffing chamois, and a nail-whitening pencil.

Begin by using the emery board to file your nails into the desired shape. Do this while nails are dry to prevent breakage. Uneven grain can cause uneven filing, so replace emery

boards after eight uses.

Next, wash hands and soak them in soap and water. Sesame or avocado oil work well to soften cuticles, but you can also use a fruit acid solution, which contains alpha-hydroxy.

Shape cuticles using the blunt end of the manicure stick by gently pushing them back. Clean under the nails using the pointed end of the stick.

Dry hands and sand and buff the nails. Use the fine pumice sand stick to sand and polish nails and remove ridges. Repeat the process with the fine grit block. The buffing chamois will smooth the tops of nails for an extra shiny look.

Finish by taking the nail whitening pencil and running it underneath the edge of each nail. *Voila!* This completes the look by brightening the tips of your nails.

For more on natural hand and nail care, see *Better Basics for the Home*, by Annie Berthold-Bond.

DAINA SAIB

### GARBAGE DISPOSAL

*I was wondering about the value of using a garbage disposal to avoid putting food scraps in the trash. Is using a garbage disposal bad for the environment?*

A garbage disposal grinds food you put in the sink and

sends it into the septic tank or sewer system. It adds extra volume to your septic tank; if you are connected to your city's sewer, it puts more pressure on that system, making sewage treatment more costly. Sewer systems are designed to process pre-digested material, not fresh kitchen scraps.

A garbage disposal uses about two gallons of water per minute—about 700 gallons a year with average use. That amount of water will make seven pots of tea a day or do six loads of laundry a month.

Composting kitchen waste is the best alternative. You keep material out of sewer systems

and out of landfills, where even biodegradable components may not decompose for decades due to a lack of ventilation. At the same time, you create your own fertile soil, for free.

There are various composting options: an outdoor worm bin, compost tumbler, or traditional compost heap. For city dwellers, look for composters that can be used indoors. Indoor kitchen composters are fitted with charcoal filters that prevent odors. If you want to make your own, Seattle Tilth has a design for an outdoor worm bin—the same model we use here at the YES! offices.

### Our Issue 39 researchers

Lilja Otto is from Germany, via Spain. She is passionate about the environment and incorporates many practical Yes! But How? -like tips into her everyday life. Daina Saib, a native Chicagoan, is new to the concept of living sustainably, and is finding it's easier than she thought.



Daina Saib



Lilja Otto



You can also make a small, indoor worm bin out of two plastic boxes fitted with vents and drainage valves. A Tilth volunteer has been happily using one in her kitchen for two years now, and her worm soil is nutrient-rich, has great water holding capacity and smells good.

LILJA OTTO

**More info** on composting at [www.seattletilth.org](http://www.seattletilth.org). Request the plan for their Off the Shelf Worm Bin at: 206.633.0224, [info@lawnandgardenhotline.org](mailto:info@lawnandgardenhotline.org)

## JAM SESSION

*The forest behind my house is full of berries and I'd hate to let them go to waste. Do you have quick and worthwhile ways of conserving this sweetness for the winter to come?*

Canning is a great way to keep your consumption of local foods high even outside your area's growing season. Unless you choose locally produced jams and preserves, what you buy probably traveled hundreds of miles before the jar got to the store. Making your own is even better since you can re-use the mason jars indefinitely, have no excess packaging, and know exactly what went into the sweet spread. It's cheaper and doesn't take much time.

Got two hours? Go! The traditional jam recipe is 1:1, a pound of sugar for a pound of fruit. But I prefer less sugar, which preserves the flavor of the fresh fruit rather than just tasting sticky sweet.

To make berry jam: Wash six pounds of berries, cut them into pieces or lightly crush with a potato masher to release the natural pectin. Boil in a large pot with half a cup of water, and add two ounces of pectin mixed with about seven tablespoons of brown sugar or

honey—adjust the amount to your taste. Stir the pectin-sugar mix in slowly to keep it from clumping. Keep the mixture at a rolling boil for three minutes, stirring constantly. For a special touch, add a vanilla bean (cut it open and scrape out the pulp) or the peel of a pesticide-free lime while cooking and try combinations of different fruit. Put the hot jam into sterilized glass jars, screw on fresh lids, turn jars over, and let them sit upside down for five minutes. This sterilizes the air left in the jar.

For those concerned about food poisoning, making berry jams is the safest place to start, since botulism spores cannot grow in the acidic environment. For canning foods with a pH under 4.6, like most vegetables, use a pressure canner. Refrigerate jam after opening, and to keep out mold always use a clean spoon for serving.

Make sure you label your jars with the type of fruit, the cooking date and any other details—the meadow where you collected the fruit or who helped with the canning—to bring back happy memories when you eat your jam this winter.

LILJA OTTO

## INDOOR AIR

*I have been experiencing asthmatic symptoms and have heard that they may be triggered by indoor air pollution. What can I do today that will decrease the level of indoor air pollution in my home?*

Indoor air can be up to 10 times more polluted than outside air. It's the top source of personal exposure to pollutants, according to the Environmental Protection Agency, and a major potential hazard for those suffering from asthma. People with asthma and allergies are more susceptible to airborne particles than average people.

Mold is a big asthma trigger. It can grow on any surface and emits volatile organic compounds (VOCs), which can cause headaches, decreased attention span, difficulty concentrating, and dizziness. Household mold can also cause allergic responses such as itchy or watery eyes, a runny nose, coughing, sneezing, and throat irritation.

So what can you do? Optimize ventilation. Open up all of the doors to the rooms inside your home every day to improve air circulation; open windows when possible.

Reduce relative humidity to between 30 and 50 percent to slow mold growth. You can maintain this level by using a dehumidifier and using a ventilator fan when showering or cooking.

Wash bedding weekly in water that is at least 130 degrees F to reduce dust mites, which spread mold spores. Covering pillows and mattresses with allergen-impermeable covers is also a good idea. Use washable window coverings and remove decorative objects like knick-knacks, which often become dust collectors.

If you hate to vacuum, here's some good news: people with asthma should avoid vacuuming, since it stirs up dust and other allergens, such as VOCs, or use a High Energy Particulate (HEPA) filter to reduce the release of particles. Get rid of carpets or replace them with carpets made from natural fibers. Besides absorbing dust, synthetic carpets can emit VOCs into the air for up to five years. Get rid of chemical household cleaning products, perfumes, and room deodorizers or replace them with ones that contain little or no VOCs.

DAINA SAIB

**More info:** EPA, [www.epa.gov](http://www.epa.gov), and American Lung Association, [www.lungusa.org](http://www.lungusa.org)

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# Just a Bunch of Suits Having a Good Time

The SurvivaBall is designed to protect the corporate manager no matter what Mother Nature throws his or her way," said Fred Wolf, who spoke today at the Catastrophic Loss conference held at the Ritz-Carlton hotel in Amelia Island, Florida.

At today's conference, Wolf and a colleague demonstrated three SurvivaBall mockups, and described how the units will sustainably protect managers from natural or cultural disturbances of any intensity or duration. The devices will include sophisticated communications systems, nutrient gathering capacities, onboard medical facilities, and a daunting defense infrastructure to ensure that the corporate mission will not go unfulfilled even when most human life is rendered impossible by catastrophes or the consequent epidemics and armed conflicts.

"It's essentially a gated community for one," said Wolf.

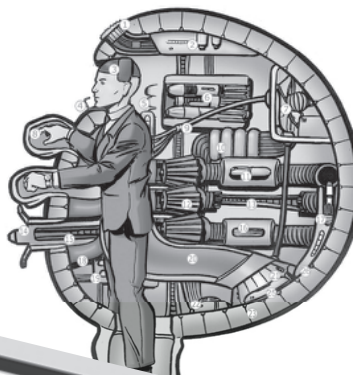
—From the Yes Men press release off the spoof Halliburton website: [www.halliburtoncontracts.com/about/index.html](http://www.halliburtoncontracts.com/about/index.html)

The Yes Men infiltrated a trade conference pretending to be Halliburton executives. They gave a presentation touting inflatable global warming survival suits. They shook hands and passed out press releases. The Yes Men have been featured in a book and a documentary. Their website is [www.theyesmen.org](http://www.theyesmen.org). Alas, they are not related to YES! Magazine.



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8. Maniple Pods (for interaction with people, technology, and the environment)
9. Nutrition Utility Transfer (conveys nutrients from Food Repressor; 6)
10. Electrical Guffing (secures against power loss)
11. Dynamo
12. Motors (powered by dynamo and Maniple Pod plug interface)
13. Electromagnetic strips (generate electricity for dynamo and allow external linkage)
14. Maniple Pod deployed as rotor (applicable to all MPUs)
15. Defense Enhancement Unit (2 of 3; non-lethal)
16. Power converter
17. Defense Enhancement Unit (3 of 3; rear)
18. Power conduits with inline power converters and dynamo
19. Medical Analysis Unit (runs constant scans on health and energy)
20. Personal Treatment Unit (conveys cast-off to Nutrition Refunction Center; 43)
21. Nutrition Refunction Center (extracts nutrients from cast-off)
22. Persistent Nutrition Unit (delivers small amounts on an ongoing basis)
23. Suspension Grid (elasticated cable system)
24. Hyperline Elasticity Units (impart added momentum)
25. Medical Stability & Emergency Unit
26. Communications and Infrastructure Monitoring Assemblage

