The PUBLIC i

The *Public i*, a project of the Urbana-Champaign Independent Media Center, is an independent, collectively-run, community-oriented publication that provides a forum for topics underreported and voices underrepresented in the dominant media. All contributors to the paper are volunteers. Everyone is welcome and encouraged to submit articles or story ideas to the editorial collective. We prefer, but do not necessarily restrict ourselves to, articles on issues of local impact written by authors with local ties.

EDITORS/FACILITATORS:
Sarah Boyer
Lisa Chason
Darrin Drda
Linda Evans
Belden Fields
Meghan Krausch
Paul Mueth
Laura Stengrim
Maggie Quirk
Bijan Warner

THE PUBLIC I
Urbana-Champaign IMC
218 West Main St.,Urbana, IL, 61801
217-344-8820

email:
imc-print@publici.ucimc.org

Websites:
http://publici.ucimc.org
www.ucimc.org

Get Involved with the Public i

You don't need a degree in journalism to be a citizen journalist. We are all experts in something, and we have the ability to share our information and knowledge with others. The *Public i* is always looking for writers and story ideas. We invite you to submit ideas or proposals during our weekly meetings (Thursdays at 5:30pm at the UCIMC), to post a story to the web site (**http://www.ucimc.org**), or to contact one of the editors.

- Become a citizen journalist; write a news story or opinion piece.
- Make a tax-deductible contribution.
- Help distribute the public i around the Champaign-Urbana area.
- Help with fund-raisers.
- Join the editorial board.

UPCOMING EVENTS

IMC Shows

WEDNESDAY, NOVEMBER 5TH, 2003
Mark Erelli and Jeff Foucault
with Jason Bentley
Folk/Acoustic. 8pm.

This show is located at Channing-Murray Foundation (right above the Red Herring), 1209 W. Oregon, Urbana.

IMC All Ages Fest:

NOVEMBER 15TH, 1PM-MIDNIGHT
@ Channing-Murray / Red Herring
The lineup, subject to change:
The Trembling (power pop from detroit)
Vice Dolls (area punk rawk)
Solo Mono (local melodic hardcore)
Missing in Action (chicago punk)
Failed Resistance (See above)
Missing the Point (local pop-punk)
Ryefieldcrane (hardcore from Peoria)
New Grenada (Detroit punk/pop/politico)
Jiggsaw (local rock and or roll)
Folk performers:
Aerin Tedesco & Andrea Bunch (Chicago)
Ripley Caine (Chicago)
MJ Walker and Fictive Kin (local)
Jaik Willis (local)
Sunil Chopra (local)
Darrin Drda's Theory of Everything (local)
Gabe Rosen (local)
Kate Hathaway (local)
Rory Miller (Chicago)

Food provided by the Red Herring

NEOLIBERALISM – WHAT DOES IT MEAN?
with Jan Nederveen Pieterse, professor of sociology, UIUC
SUNDAY, NOVEMBER 9, 3 TO 5 PM
at the IMC, 218 W. Main St., Urbana

Neoliberalism is one of the defining terms of our times, but do we share a common understanding of what it means? Where does the term come from? Who uses it? What are its greater implications?

Nederveen Pieterse has an international reputation in the areas of globalization and transnational culture. His most recent books include *Globalization and Culture: Global Melange* (2003) and *Globalization or Empire?* (2004).

Everybody welcome!

Refreshments will be served.

Sponsored by **AWARE**, the Anti-War Anti-Racism Effort (www.anti-war.net)

Sustaining Contributors

The *Public i* wishes to express its deep appreciation to the following sustaining contributors for their financial and material support:

SocialistForum: An Open Discussion and Action Group, *Meets 3rd Saturdays of the month, 3-5 pm, at IMC, 218 W. Main St. (U)*

World Harvest International and Gourmet Foods
519 E. University, Champaign

The AFL-CIO of Champaign County

The Union of Professional Employees (UPE)

Home of Gourmet Chinese and Thai Eat-in or Carry-out Restaurant
604 E. Daniel, Champaign; 344-7483

The Natural Gourmet
2225 S, Neil, Champaign; 355-6365

United Car Center: Quality Cars, Wholesale Prices
606 E. University, Champaign; 352-7870

The Social Equity Group, Financial West
Socially Responsible Investing

Illini Quality Used Auto Sales
308 W. University, Urbana; 367-5044

That's Rentertainment
516 E. John, Champaign; 384-0977

Caffe Paradiso
801 S. Lincoln, Urbana; 384-6066

Staff of OJC Technologies
www.ojctech.com
278-3933 115 W. Main, Urbana

National Fish Therapeutic Massage
113 N. Race, Urbana, 239-3400

The *Public i* would also like to extend thanks to the following individual sustainers:

David Green and Harriet Bursztyn

If you or your organization would like to become a sustaining contributor to the *Public i*, or would like more information , please call 344-7265, or email imc-print@ucimc.org.

The PUBLIC i
A Paper of the People
Published by the Urbana-Champaign Independent Media Center
November 2003 • V3 #9

THE HEALTH CARE ISSUE

Our Failing Health Care System
Peter Rohloff & Chris Erb
Page 1

Tips for Surviving Medical Treatment
Linda Evans
Page 4

Projects of the CCHCC
CCHCC Staff
Page 6

Why We Must Fight Globalization
Megan Krausch
Page 10

The PuBLiC
A Paper of the People
November 2003 • V3 #9

Diagnosis of a Failing Medical System

by Peter Rohloff and Chris Erb

Peter Rohloff is a medical student and member of the Medical Scholars Program at the University of Illinois. He has a PhD in pathobiology from the University of Illinois.

Chris Erb is a PhD student in the department of Community Health and a member of the Medical Scholars Program at the University of Illinois. He is also a predoctoral fellow of the National Institute of Mental Health.

Few would dispute the assertion that the United States health care system is in deep crisis. Health care spending for 2001 was more than $1.4 trillion, or 14.1% of the GDP. This comes to spending per person of $4,631, compared to an average of $1,983 per person in other industrial nations. Premiums for employer-sponsored health insurance plans are currently rising more than 10% per year. And data just released from the Census Bureau reveal that 43.6 million persons—one out of seven in the population—were uninsured in 2002; indeed the number of uninsured increased by 2.4 million from 2001 to 2002.

In a recent survey aired on NPR one in five Americans thought health care was one of the two most important issues to be addressed by the government—only the economy and war were mentioned more frequently. Furthermore, at least half of respondents expressed concern about their ability to afford health care or the adequacy of their current insurance coverage. With the 2004 presidential campaign now getting underway, candidates will soon be vying for public support for their various plans for health care reform. Typically, however, such plans are characterized by technical or vague language. In order to facilitate public discussion, simple explanations of the various issues at stake are badly needed.

THE UNINSURED

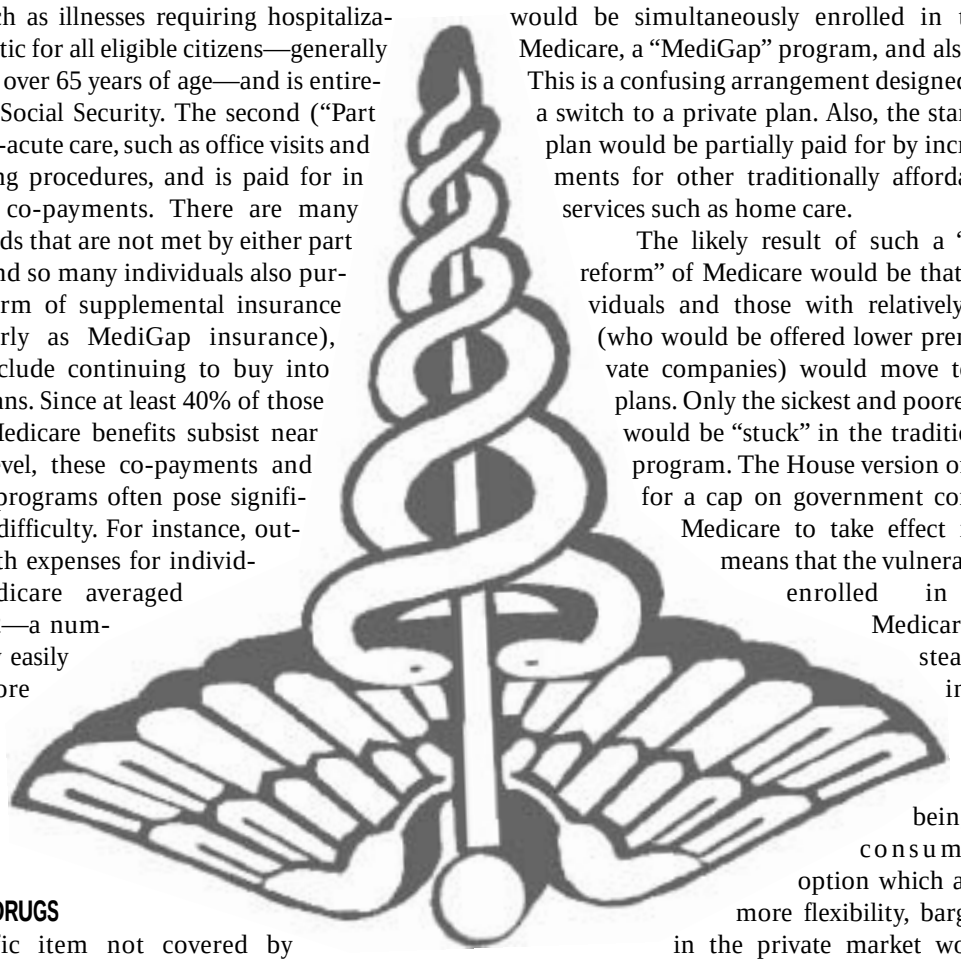
In addition to having the most expensive health care system in the world, the United States remains the only major developed nation not to offer some form of universal health coverage for all its citizens. The reasons for this are complex and include both residual cold war fears about "communism" and business interests. These interests are extensive, since 56% of health care spending in the United States is privatized. This number is approximately twice that of most other developed nations.

The lack of health care insurance is a serious problem, particularly for the poor. Those earning less than $28,256 for a family of three (known technically as "200% of the federal poverty level") make up the majority of the uninsured. The situation is even more desperate in rural areas; in a few states, such as Maine and Montana, over 70% of the uninsured are from rural areas. Since the majority of health insurance in the United States is provided through programs offered by employers, a popular stereotype of the poor is that they do not have insurance because they do not work. In reality, however, only 18% of uninsured persons do not work—in fact, 70% have at least one full-time worker per family.

More typically, especially in rural areas, uninsured persons are likely to be employed by small companies that do not offer health insurance plans. And the crisis is even extending to those who work for companies that do provide insurance. For instance, work-based health care premiums rose 14% last year. This means that the average employee is expected to contribute $2,400 per year to their insurance premium, a number which could easily be 10 or 20% of a poor family's annual income. As evidence of the scope of this problem of affordability, a report released just this month shows that the number of employees of large companies—which have traditionally had the best rates of insurance coverage—who lack insurance increased by 7% in recent years.

MEDICARE

Founded in 1965, Medicare became the second major piece of health insurance legislation in the country after worker's compensation. Currently, Medicare provides limited coverage for 35 million elderly adults over the age of 65 and 6 million permanently disabled younger adults. Medicare has two parts. The first ("Part A") covers acute care, such as illnesses requiring hospitalization, is automatic for all eligible citizens—generally meaning those over 65 years of age—and is entirely paid for by Social Security. The second ("Part B") covers non-acute care, such as office visits and health screening procedures, and is paid for in part by high co-payments. There are many health care needs that are not met by either part of Medicare, and so many individuals also purchase some form of supplemental insurance (known cleverly as MediGap insurance), which may include continuing to buy into work-based plans. Since at least 40% of those who receive Medicare benefits subsist near the poverty level, these co-payments and supplemental programs often pose significant financial difficulty. For instance, out-of-pocket health expenses for individuals on Medicare averaged $3,757 in 2002—a number which may easily represent more than 20% of the annual income of the poorest among them.



PRESCRIPTION DRUGS

One specific item not covered by Medicare that has received a great deal of attention in recent years is the cost of outpatient prescription drugs. In 1999, 40% of the elderly were unable to afford "MediGap" insurance and, therefore, had no prescription drug coverage. Prescription drug spending is currently the fastest-growing component of the health care system—for instance, in 2001, drug costs increased 16%, compared to an 8% increase for hospital expenses. Many factors have contributed to the rapid growth of this problem, including rising manufacturing costs, increasing use of expensive patented drugs, and the complicated health problems of the elderly which often require them to take many drugs at the same time. The bottom line is that Medicare recipients are under ever greater financial pressure, and their average personal spending for drugs has increased 50% in the last three years.

Under pressure from the Bush administration, Congress is currently attempting to draft some form of Medicare reform legislation to improve prescription drug coverage. Although draft measures for $400 billion in assistance over 10 years were passed in both House and Senate in June, significant differences exist between the two plans, and so it remains to be seen whether this legislation will be implemented anytime soon. However, some general observations can be made.

First, and most importantly, both plans would not expand current traditional Medicare coverage. Rather, they would create an expanded role for private insurance firms in the Medicare population. Individuals on Medicare would be encouraged to drop their enrollment in traditional Medicare and, with limited financial assistance from the federal government, purchase instead a comprehensive private plan with prescription drug coverage. Those who chose to remain within the traditional Medicare structure would have the option of purchasing the drug plan as a stand-alone option. In real terms, however, this second option means that many individuals would be simultaneously enrolled in three plans—Medicare, a "MediGap" program, and also a drug plan. This is a confusing arrangement designed to encourage a switch to a private plan. Also, the stand-alone drug plan would be partially paid for by increased co-payments for other traditionally affordable Medicare services such as home care.

The likely result of such a "market-based reform" of Medicare would be that wealthy individuals and those with relatively good health (who would be offered lower premiums by private companies) would move toward private plans. Only the sickest and poorest individuals would be "stuck" in the traditional Medicare program. The House version of the plan calls for a cap on government contributions to Medicare to take effect in 2010. This means that the vulnerable clients still enrolled in traditional Medicare would face steadily increasing co-payments. Although this reform is being billed as a consumer-friendly option which allows patients more flexibility, bargaining power in the private market would really be restricted to the wealthy and the healthy. The long-term outcome may be to limit participation in and undermine the viability of traditional Medicare.

In addition to these market reform provisions, both House and Senate versions of the legislation *do* provide some additional direct drug benefits for the poorest individuals. However, both allow critical gaps in these benefits. For instance, the House plan would provide financial assistance for drug costs up to $2000, but no assistance for costs between $2000 and a "catastrophic" limit of about $5000. Because of this the financial assistance percentage for an individual with $4000 in drug costs would be less than for someone with $2000. Another alarming feature of both plans is that they require individuals to submit to asset-testing to determine poverty level in order to be eligible; until now, the great strength of Medicare has been to "treat everyone the same" in this regard.

(continued on page 11)

Letters

In Defense of No Schooling

To the IMC editors:

This is in reference to the articles on public schooling by Belden Fields and Margaret Kosal in the October issue of Public I, ostensibly rebutting my essay "Children's Liberation"(Se[tember issue).

I do not mind someone writing a defense of public education. In fact, this is what an open society should encourage – healthy debate and disagreement. I would point out to Fields, however, that nowhere in my essay have I mentioned"abolishing public education." I advocate rejecting compulsory schooling. I have researched the documents he cites; they talk about education, not schooling. They also say that the parent is the proper determiner of a child's education. This is not at all in conflict with what I have said.

It is odd that Fields calls compulsory schooling a "right." This sounds dangerously like Newspeak. Aren't we lucky we haven't the "right" to compulsory military service?

Fields claims that public education is a mechanism of upward mobility. Since compulsory schooling has been around for about 150 years, most of us alive today should have experienced this "upward" mobility. On the contrary, the U.S. currently has the greatest disparity in income and largest concentration of wealth in our history.

"What are the non-affluent to do if we were to abolish public education?"

Again, this is not about "public education," it is about compulsory schooling.

If compulsory schooling were rejected, we may go back to a nation of fiercely independent freethinkers that we were at the birth of this country. Citizens could demand several billion dollars be redirected from the military budget to a fund paying stay-at-home parents to raise their own children.

Public education should encompass town meetings, public lectures, debates, forums, presentations, public performance, revolving apprenticeships, volunteerism, and open, ungraded classes. Public education would not be age-segregated (except for obvious safety reasons).

Fields' advocating removing the child from the family is downright frightening. Family has the right to pass on values and traditions. Our infamous "Indian schools" and historical treatment of non-compliant Amish should give enough pause to think of the harm this does. Family gives the child a protective bond to develop confidence in dealing with people and in learning about the world. The parent's job is to protect the young and see them to adulthood, not to force "independence" on them before they are ready. The "independence" of compulsory school is, in reality, a transfer of responsibility for the child to the system. Schools do not permit children independence of mind or body. They actually keep people children a great deal longer than nature. I addressed the betrayal of young people permitted no meaningful existence in my original essay.

Schools do not "teach respect for differences," however much we would like them to; they teach compliance with authority and conformity; the need to maintain order demands this.

Children are already "intellectually curious;" they need space in which to exercise that curiosity. Forced curriculum and the humiliation of grading and constantly vying for teacher's attention don't do it.

Finally, it is ironic and sad that Fields had a miserable compulsory school experience, but advocates the experience for others.

Kosal's "Challenging Unschooling" is dismissive and devoid of facts.

Kosal charges that my essay is "unsubstantiated propaganda," "not worth publishing," "littered with inaccuracies," and "has an unstated undercurrent of economic and social privilege," yet she provides no evidence for any of these charges.

Kosal disputes my list of those with little or no formal schooling. Specifically, that my claim about Einstein is erroneous. Einstein famously hated school and attended sporadically.

George Washington attended school for two years. He became a surveyor's apprentice at the age of 16 and amassed a fortune in his own right using that skill by the age of 21.

Abe Lincoln: one year of schooling. (Privileged? Remember the log cabin story?)

Ben Franklin went to school for 2 years. He learned his printing trade by apprenticeship and everything else on his own. (Privileged? His father was a candlemaker with seventeen children.)

Thomas Jefferson had eleven years of formal elementary/secondary education. That schooling was not compulsory and much of it was with the same teacher. His eclectic accomplishments grew out of intellectual curiosity, not forced curriculum.

T. Roosevelt had no formal schooling before college.

FDR went to school for 4 years to prep for college.

Thomas Edison went to school for 12 weeks. A teacher called him "addle-headed," so his mother took him out and taught him herself. (Privileged? Middle-class.)

Andrew Carnegie: no schooling. (Privileged? Destitute immigrant.)

Henry Ford also famously hated school, which he attended for eight years. He apprenticed at the age of 16. Ford omits mention of his forced schooling in his account of his early life in his autobiography. (Privileged? Son of farmers.)

All of these facts are freely available (I recommend the public library). Not one of these idols would credit forced schooling with their education and success in life.

Kosal says, "revoking public education is not going to produce some utopian (or economically privileged) unschooled society, but rather a source of cheap labor."

I am disappointed in this statement, since it reveals that Kosal did not read my entire essay. I devoted much of it to how unschooling our society would be difficult and revolutionary. With parents approaching their roles seriously, children couldn't be exploited as cheap labor. It should not be considered "economic privilege" to raise your own children. The actual "utopian" idea is that forced schooling benefits anyone but corporations.

Kosal calls my thesis a "conspiracy theory of education."

Unfortunately, I cannot claim credit for discovering the true nature of compulsory schooling. I cite several people who have much greater right to that than I. What is the purpose of education? Is it to fit humans into prefabricated corporate and social slots? Or is it to help people become "fully human" (to use Gatto's expression)? The system isn't broken and in need of repair. It is fully functional: creating docile, ignorant, uninvolved, manipulable, self-centered consumers.

Human beings have been passing on knowledge and learning about the world for a hundred thousand years without forced schooling; some societies still do (even "non-affluent" ones!). It is the height of hubris to think that our current system of forced schooling is the unequivocal pinnacle of social evolution, particularly with all the undisputable social, psychological, ethical, and economic problems we face as a society.

I expected that my essay would make some people uncomfortable and defensive, but a rebuttal should extend the courtesy of carefully reading the essay. A few facts couldn't hurt, either.

-Gina Cassidy

Cartoon by Darrin Drda

"Baring Witness" Calendar

NOW YOU CAN ORDER The 2004 Baring Witness International Calendar!
C-U women braving the cold are the December illustration.

Go to www.baringwitness.org to see the calendar and order through PayPal or to print an order form for payment by check.

9x12 wall calendar. Each page shows one of the iconographic Peace images from the global grassroots movement to protest the invasion of Iraq and all acts of war. Average extraordinary women and men from the USA, Hong Kong, Argentina, Canada, Australia, Japan, and Italy, all ages, all professions, all shapes and sizes, bonded with the earth to demonstrate their frustration and their belief that peaceful, sustainable alte natives to war must be used to solve conflict.

PRICE: $12.00 each; 11 or more, $10.00 each. Plus shipping. Please order copies for yourself and friends today.

The perfect holiday gift!

Net proceeds for the 2004 edition will be directed to the non-profit organization Baring Witness.

LoCaL

Experiences Within and Without the Medical System

After deciding upon the theme of "health care" for our November issue, the *Public i* editorial collective asked fellow community members to share their personal experiences with the health care system, whether positive or negative (we anticipated more of the latter). The responses we received – limited but thoughtful – appear on this page.

A Journey Home

This is an account of our journey back to our home. It is one of the paths that has led away from institutional and corporate control of our family, to a more natural and satisfying life. We have learned that being a so-called expert does not make a person 'correct' and it is a mistake to always give up control to such 'experts'. We've learned it is important to take complete responsibility for your life. This includes nutrition, finances, education, and health. Officially sanctioned experts (i.e. not self taught) and institutions always believe they know what's best for you, whether or not it is really best for you or anyone, and corporations are always first interested in quarterly profits.

My partner and I are expecting a child soon. This will be our fourth. As with all major life experiences, we have learned much from each birth. Our oldest daughter was born at Covenant Hospital. We chose a doctor because she was a woman with children and because of her relatively low Cesarean rate (she had the official credentials). We were new to this situation, received no good advice from our parents or childless friends, but wanted as natural an experience as possible. A natural experience is not what we received. We sat in clinic waiting rooms for hours during the pregnancy. Every visit would require an unnecessary internal exam. We were encouraged to take useless, painful and potentially harmful tests like amniocentesis (It primarily detects Down Syndrome, to allow time for an abortion of, what some people call, a 'defective fetus' - pretty vile).

When the baby failed to make her appearance on time, the doctor told us the baby was not in the right position. We had numerous sonograms and a personal visit to the doctor's office for a talk on how horrible a birth like that could be. Since it was two weeks past the due date, she asked us if we wanted an immediate C-Section. We scheduled one for the following Monday.

We did our own research and discovered a book that said if a woman lies on her back with her pelvis raised, an engaged baby often can change positions. Fortunately, we did this (the doctor never heard of this special positioning). Arriving at the hospital on Monday (before the doctor's office hours), we were told that since we were already there, we should induce labor. We were very happy to hear this, since, to us, induced labor is better than surgery. While it is better than surgery, it is not very pleasant. My partner was strongly urged to lie in bed for the birth, something she detested. She was also constantly hooked up to the fetal monitor, which she also detested. Eight hours later (after the doctor's office hours), our daughter was born.

The new responsibility of a child is something that makes you forget other worries, so it was not until our second child was expected that we thought about the bad experience in detail and looked for ways to minimize the problems. My partner refused to return to the first doctor after it became evident that the doctor did not remember (or review) anything of the first experience. Our records were listed as having a C-Section.

I called around and found out that one doctor in town would do a water birth. After watching a truly wonderful video on water births, we decided this option was for us. Water birth also had the advantage that no one can make you lie down or strap electronic equipment to you while you're in the water.

We took our time getting to the hospital, rather then rushing in at the first contraction. We walked around the Engineering Quad until the contractions were intense and then went into the hospital. We timed it well, our son was born less than 1 hour after we checked in. It was a much better birth experience, they let us hold him for a couple of hours before they took him away to be worked on. We had taken charge of the situation and were better off.

Our second experience was bad after the birth. We didn't want to hang around a hospital, we wanted to go home the next morning. The nurse wouldn't check us out because our son 'looked slightly jaundiced' and they needed to wait for the results of some test. I was scolded for carrying my son around. We spent most of a day trying to get out, and finally got home for a late dinner. We were not in control in the hospital and were frustrated by not being able to do what we knew was right for us. We still listened to authority figures, so called

The author's newborn son, Emerson

experts, at that time.

Nurses now had different advice for us than the first time. This time my partner was to nurse the baby until he was done, not 15 minutes on each side (as they insisted with the first baby). This time we didn't have to have 'security photos', which we were told would identify our daughter if she was kidnapped. (Too many people complained about this racket.)

Upon learning we were expecting for the third time, we were determined to have a truly good birth experience. We had spoken with a number of women in our homeschooling group who had birthed at home. They recommended midwives and we met with one. We had never met a person we felt was so relaxed and confident in what she did. We now know this is a sign of a competent individual who's secure in their role.

Let me mention that the midwife I'm talking about is not a medical doctor. She does not practice medicine, which is illegal in Illinois if you are not licensed. She does not dispense drugs or do internal exams. She has no medical degree. She is not affiliated with a hospital or clinic. My insurance won't pay for her. What are her credentials? She has helped deliver hundreds of babies. She worked as an apprentice for years before setting out on her own and she has her own apprentices. Beyond that, she treated us like people. A typical pre-natal visit would involve taking blood pressure, taking my partner's and the baby's heart rate, feeling for the position of the baby and a couple of tape measurements. Then our family would sit and talk with her about babies and whatever else. Often we would have a meal together. We shared hugs when she arrived and left. She doesn't hurry in, glance at a chart and hurry on to the next patient.

When talking about this with family and coworkers, we received comments about homebirth similar to those that we got about homeschooling and veganism. People are afraid that unless you use society's 'approved' methods, things will go wrong. "You can bleed to death in 1 minute from a hemorrhage." "What if the cord is wrapped around the baby's neck?" are reminiscent of "How will your child be socialized?" and "What about calcium?" We discussed all these possibilities with the midwife and were satisfied. The midwife recognizes there are birth complications that do require medical intervention. She is very frank about what is not within her capacity or function as a midwife. These complications are not commonplace as many people are led to believe. Giving birth is a natural experience that has been happening for millions of years, and does not generally require massive amounts of computer technology, Doppler radar and biochemical engineering. Medical science, like schooling, spends too much time matching people to 'standardized' results and not enough time dealing with people as unique individuals.

Our second daughter's birth involved my partner and I walking around our neighborhood park until it was too difficult to walk, then going into our house. About 2 hours later, we had a new daughter. She was not subjected to the medical procedures hospitals perform on newborns. She just stayed with her mother for the first weeks of life. No painful blood tests, no eye drops, just comfort from mom. When our homeopath and a friend showed up the next day, they were surprised and delighted to see a newborn.

Now that we're expecting again, we have our visits with our midwife. Our oldest daughter is very interested in what is happening and spends time talking with the midwife. This is a terrific homeschooling experience and allows for countless educational opportunities to present themselves. It is a family event that we can all share: no clinic waiting rooms, no painful exams, only relaxed and friendly conversation. It is not institutionalized; it is real and natural. If you want more details of the birth experience, you'll really need to talk to my partner. She'll be happy to talk about it. I can tell you it was painful. Allopathic medicine does have a place, but read those forms they have you sign at the hospital. One said, "I understand that the practice of medicine is an art," protecting so-called experts from malpractice lawsuits. Also remember that hospitals are for sick people and, despite insurance form claims, pregnancy is not a disease.

We understand that things out of our control may happen and all we can be sure of is that we will continue to learn from our experiences. We are learning on our own, in our home, with our family.

Addendum: Our fourth child, a son, Emerson Quinn Urban, was born at home on Sunday, October 26th. The midwife came over to our house at about 4:30am and stayed until everything was finished, around 3:00 in the afternoon. She encouraged us, gave us positive suggestions, but mostly left us to our own devices during the earlier stages of labor. In discussing our birth the next day when she stopped by for baby and mom checkup, she mentioned that Emerson's shoulder had been stuck, but she quickly and gently dislodged him. We didn't know this had happened at the time. I can imagine what would happen at the hospital.

– Ken Urban

Fractures in the System

I had a bike accident (ok, that's overly-dramatic; I fell off my bike when it was hardly moving at all) and had a compound fracture of my radius. I had to have surgery to put a metal plate in my arm. The insurance company refused to cover the plate, calling it "a prosthetic." In fact, of the $15,000 bill, they ended up covering about half. In addition, I was laid off that month, and only the initial hospital visit was covered, so all the castings and x-rays afterwards were not. I ended up with a very large hospital and clinic bill, on unemployment. Two months later they sent the bill to a collection agency. I then found out that because of my income level, I was eligible to have some of my bill waived...if I had asked. They aren't required to tell you about it. And since they had already sent it to the collection agency, when I finally did ask, it was too late. This collection went on my credit report, and although it was paid in a timely fashion, my credit rating went down and it was difficult a few years later to buy a house. Lesson learned: insurance doesn't mean anything if it's not from a company that your clinic is in bed with, because there is no such thing as a "customary charge."

-Clint Popetz

Discriminatory Pricing

I had decided to get a vasectomy, and called around to check prices. The price quoted to me on the phone by someone at Christie Clinic was the lowest, so I went through the procedure there. When I received the bill it was three times as high as the quote, with no complications and no explanation. I called and asked about this discrepancy, and was told "Who gave you a quote? We never do that." Later, I found out (from CCHCC) that the clinic practices discriminatory pricing. Prices are lower if you have insurance, because insurance companies cut deals, and the clinics recoup their uncollected-debt by gouging uninsured clients. So the price I was quoted was probably for those with insurance, which I did not have.

- Anonymous

LoCaL

Adding Health and Care to Our Health Care System

by Linda Evans

Linda Evans is a Champaign native. She lived in the Washington DC area for several years before serendipitously moving back to the C-U area two years prior to her mom's hospitalization. She is a 'retired' computer consultant. Currently, she is a full-time homeschooling mom/volunteer/activist.

WHEN I FIRST THOUGHT OF contributing a personal anecdote on health care I was immediately inspired to write about my mother. My mother's "missed" diagnosis, her unnecessary surgery, her fight for life after the surgery, the month in the hospital that ended in her death, the cancer that would have killed her regardless, points in her life that possibly contributed to her disease and definitely contributed to her lack of health, and so much more. As I started to write, I realized I was peeling back the layers of an onion that needs to be written for my own health, but is not ready for public viewing. Also, as with an onion, I was too sensitive to the affects of the vapor to write an article without a lot of tears. Thus, I decided to distill my many different experiences with health care and hospitalization, in particular, and write some tips.

These tips are primarily based on three major health care events in my life within a six month period: the surgery and month of hospitalization of my mother (in her late 50s) resulting in her death, the weeks of hospitalization of my paternal grandfather (in his 90s) resulting in his death, and the major surgery performed on my son (then 2 years old) who is still alive. These events happened in three different hospitals in the central Illinois area. I am not a paid health care provider, a trained medical practitioner, nor do I play one on TV. I'm sure most of you out there could add some suggestions of your own and I hope that you do. The "tips" are in no particular order.

TIPS FOR THOSE UNDERGOING TREATMENT OR FOR THEIR CLOSE LOVED ONES:

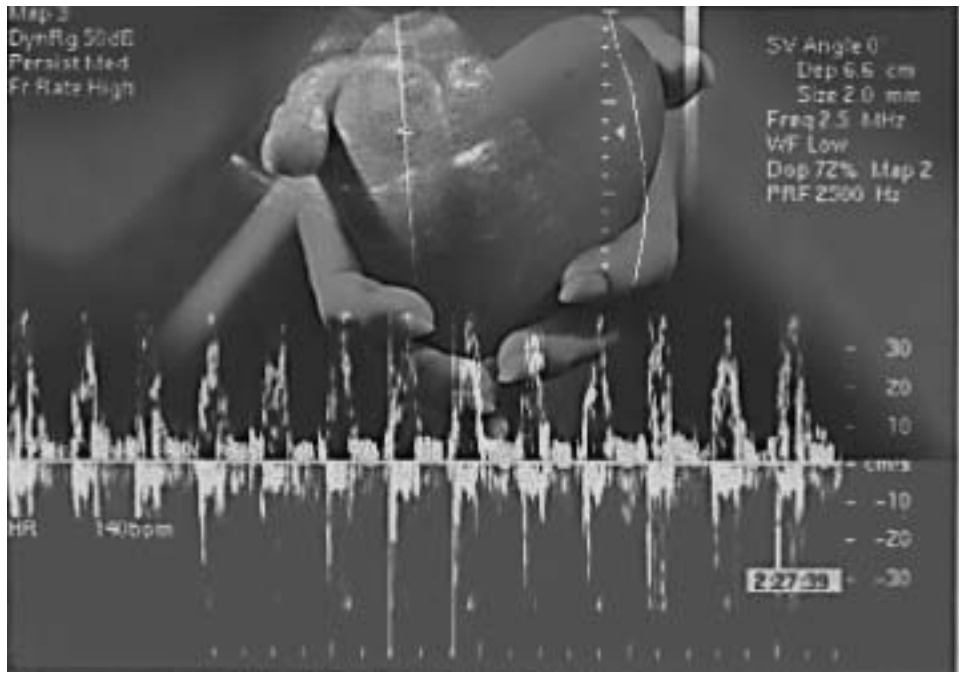
1. Take Charge of Your Own Health. I cannot emphasize this enough and this really encompasses a lot of the other suggestions.

2. Ask Questions. You cannot ask too many questions. Ask questions of your physician, ask question of yourself, research, talk to others, call the nurses/doctors and double check your understanding of medical advice, know your medication/know your doses (okay I got this one from the movie 12 Monkeys, but seriously it is very important), read books, surf the internet, try to understand what is going on with your body. If you do not feel up to this task, please, please, ask someone close to you to research for you. Which leads me to my next suggestion.

3. Whenever Possible Have Someone With You. Take along an advocate. I am talking about the simple doctor's checkup to the stay in the hospital. It is always good to have a second set of ears. Your partner may think of a question that never occurred to you. It also gives another perspective on the event. I accompanied my father to a cardiologist appointment recently. My father and I came away with completely different perspectives on his health. After discussing the appointment, we both came to some middle ground. If I had not been at that appointment, it is likely that my father's view of his own health would still be based on the obviously very sick person he saw exit the examining room prior to his visit with the doctor. Comparatively, my dad was feeling great.

4. Never Leave Someone Overnight in the Hospital Alone. Really. If there is any way to avoid leaving a loved one in the hospital alone, please be with them. If you are the one being hospitalized, ask someone to come and stay with you. I know we are all busy, but this is really important. We all know the amount of things that are done out-patient these days, so when you have to spend the night in the hospital then it is pretty serious. I heard a nurse from a national nurses organization say they had arranged a buddy system for nurses who have to spend time as patients in the hospital. Even the nurses, maybe especially the nurses, realize how important it is to have an advocate with you while in the hospital. This is especially important if the hospitalized person is being medicated. Let's face it, being in the hospital is stressful; when you are medicated and/or stressed you cannot be expected to make the best decisions for yourself and your health. My family ended up being with my mom around the clock and oh how I wish we had planned this from the beginning. We took shifts and it was tough, but it was worth it. Unfortunately, we did not do this for my grandfather and I regret it. I discussed with the original surgeon staying in the OR with my son during his surgery. The surgeon was open to this and I watched tapes of open heart surgery to prepare me for the event. The last thing I wanted to do was cause problems in the OR and I trusted the staff (obviously, with my son's life), but I also knew the risks and I wanted to be there. Against my better judgment, my husband convinced me to go with the older, more experienced surgeon who was not open to my being in the OR. I did, however, stay with my son until he was anesthetized and I was in the room as he woke up. Other than that, a loved one was always at my son's side.

5. If It is Important to You, Ask for It. My sister was spending nights with my mother and sleeping on a very uncomfortable chair, we asked for a couch and received it. Since family was with my mom as much as possible, we quickly took over bedpan duties.. This made my mom more comfortable, helped out the overworked nursing staff, and made us feel like we were doing something. Eventually, the staff was comfortable with our collecting linens from the hospital supply closet so the messy jobs didn't have to wait for available hospital staff. For my son, it was important to me to sleep next to him since I knew he wouldn't be able to get up right away. I demanded a regular



sized hospital bed and I was in bed with him as he was waking up post-op until we left the hospital. Some of the hospital staff was supportive, some were not, but I stood my ground. It made a difference to me and my son and I believe it aided in the healing process. Even during my son's birth, I wanted to keep my own special nightgown on.. The nurses said "no" for whatever wonderful hospital protocol. Luckily, I had my doula (again, an advocate) who could talk to the staff while I was concentrating on my contractions and explain that in the case of an emergency they could tear the thing to shreds. I birthed my son in my own warm nightgown. Maybe not as important as the other situations I noted, but it meant something to me.

6. You Deserve to Be Treated with Respect. After a particularly tough day at the hospital with my mom, I came home with my little 2-year-old son and made signs for my mom's room. Most of the signs were these tips or variations of them. The next day I took them into my mom's room, read them to her, and posted them on the walls. They were for her, but also for the hospital staff. I wrote them in first person as though she was telling herself and the staff, "I deserve to be treated with respect at all times," and everyone read them. I received a lot of comments. During her month in the hospital, mom was not always treated with respect, not even close. Some people on the staff were kind, some were clueless, some seemed to hate their jobs and take it out on the patients, and some seemed to border on sadistic. When people (and there were so many people) who cared for my mom would ask what they could do, she would answer, "Bake something for the hospital staff" and they did. I watched some of the nurses, who had complained in front of my coherent mother how heavy she was and how much they didn't want to move her to change the sheets, eat the baked goods and I would almost wretch. I would listen to my mom tell her primary care physician (who happens to have also been her surgeon) how he was "the best doctor in the world" (okay she was on morphine that day, but still) and I would feel so ill. Sure, treat the staff well, they do deserve it, even the most clueless among them. Caring for people is tough, especially in our current health care system. But, please don't forget that you deserve to be treated with respect at all times. If this respect is not automatically shown, demand it!

7. Listen to Your Body. You know your body better than anyone else in the world. Listen to it. Your body tells you when something goes wrong. There are all sorts of clues to your health communicated to you through your amazing body. Listen. Then, if something feels wrong, let your loved ones and your health care providers know. If those around you are not listening or minimize your feeling, talk to someone else. Get another physician. Now you are listening to your body, and you deserve to have someone listen to you.

8. Get a Second (Third, Fourth, etc.) Opinion. Do not be afraid to get a second opinion. I kept asking my mom to get a second opinion prior to her surgery, but she eventually confided to me that she was "too tired". Bells and whistles should have been going off for both of us, but I didn't push enough or listen enough or take her to another doctor myself. In the end, she still would have died. The difference might have been that she died more comfortably at home without enduring some of the unnecessary pain. Maybe it wouldn't have changed a thing. I will never know. When my son's pediatric cardiologist suggested open heart surgery for a child who was showing no symptoms of his congenital heart defect, you better believe we got a second, third, and fourth opinion. It wasn't a matter of trust, I really have liked most of the medical staff who have worked with my son, but a matter of taking charge of one's health. Obviously, we went ahead with the surgery, but after traveling to different hospitals around the state we were better equipped to make educated decisions on where, who, how, when, and why the surgery would be performed.

9. Always Get a Copy of Medical Records and Test Results. I cannot tell you how often I have seen patients carry their medical records around the hospital to another doctor and say something about wanting to take a peak at them.

Most of the time they are all sealed up and the adults look down at the package with a guilty look on their face when they say they would like to read the "forbidden" information within. Reality check. This is your life, your information, your records and you are entitled to read them. In fact, I would say it is your duty to read them. Ask for a copy of your medical records and always get a copy of test results. This is information that helps you take charge of your health. Yes, they may charge you a copying fee or threaten to charge you. Yes, the information quite often sounds like someone writes them just for the court to read in a malpractice suit. Yes, some of the information will make little sense to you. You will, however, learn quite a bit, you will have a reference to refer back to, you might notice that you understood something differently than the doctor worded it in her/his notes. Quite often I will read the records and ask a question of my physician based on these records and this leads to better communication and understanding on both sides. With the small amount of time allotted to physicians to spend with their patients these days, it is not surprising there may be misunderstandings or lack of communication.

10. Have Someone Keep Track of the Bills. Heath care can be very costly. Some of the suggestions I make here could sound even more costly. Many people don't seek a second opinion due to finances. Many people stay with a doctor who doesn't listen to them due to the HMO coverage. You are busy trying to heal yourself or looking out for your loved one so assign one of those well-meaning "what can I do for you" people to researching financial aid, or talking with your insurance company, or looking into alternative options for long-term care, or whatever it is that you think might help. Sure, the insurance company may only speak to a family member, but friends can do some leg work for you. Looking at an itemized bill of a month stay in the hospital makes you think about taking your own tissues with you during your next hospital stay. Nothing is worse than "sticker shock" after a loved one dies. We actually had staff sit the family down and say how hard they were working with the insurance company to "let" my mother stay at the hospital when I was fighting as hard as I could to take her home. It was, to say the least, surreal.

A FEW TIPS FOR THOSE FRIENDS OR ACQUAINTANCES OF PEOPLE WHO ARE HOSPITALIZED:

1. Do Something. I know, we all have been through that feeling of "What could I do?" but just do something. Ask what you can do, but if told nothing, do something anyway. Anything. Just do it! I cannot tell you the loneliness I felt during my mother's hospitalization. I would drive to the hospital every day and think about all these people driving to their destinations and they had no idea that the most incredible person was lying in an inadequate bed dying while I felt alone and helpless to do anything to ease her transition. I would drive home and once in a while I would find on my doorstep a wonderful home-cooked meal. I have to say this person is not a long-time friend or someone I even see very often, she is not someone who cooks often, and my family could be considered hard to cook for due to our dietary/life choices which do not match those of my friend. The friend who left these occasional meals brought indescribable light into a very dark time in my life. I am so grateful to her and I love her so much for "just doing". So many people in our lives stayed away and didn't know what to do. I don't fault them, I did fault them, but now I understand. It is tough. My friend with those quiet meals left on the doorstep with no question or fanfare, she is compassion.

2. Send the Card. Go ahead, pick up a card and send it to the hospital, to the home, to the family, to the person undergoing health care. It will make a difference to someone. We wallpapered my mother's hospital room with cards from literally hundreds of people. We kept the cards. Sorry, I didn't get thank you cards out to all of you like I had envisioned. I love you all, especially those of you I never knew who chose the perfect card. My son still looks at the cards he received. My grandfather never received one.

3. Talk About It. If people are fine, there is a hospitalization, or if they die. Talk about it. Don't pretend the entire thing didn't happen. I love the kids who came up to my son and asked about his scar (he is fond of going topless). I explained that a hole in his heart was patched by the same material their raincoats are made out of and they nodded their heads as if this is the most logical thing in the world, they showed off their scars from skinned knees and went about their happy play. The adults were hanging on every word, but they didn't have what it took to ask about it themselves. We have so much to learn from children.

For all those skeptics out there: Yes, I am available to accompany you to your doctor's visit, call me if you want me to spend the night in the hospital with you, let me at your health care bills, and I'm sure I can whip up a hot meal. Even if you just want to talk about it. Drop me a line.

linda.evans@erols.com

Now That MRI Has Got Its Nobel Prize

by Amit Prasad

Amit Prasad earned his B.Sc. and masters at Delhi University and is currently a Ph.D. candidate in the department of sociolgy at UIUC. His dissertation is a cross-cultural study of MRI research and development in the United States and India.

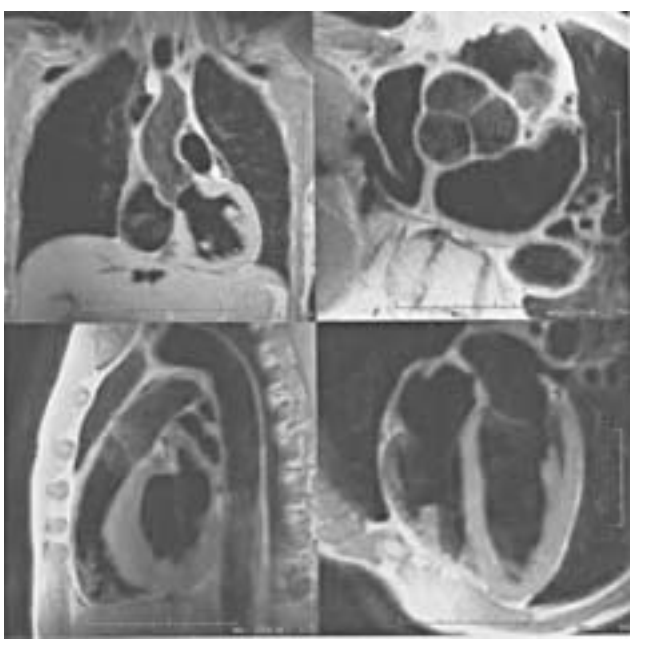
LAST MONTH PAUL LAUTERBUR AND PETER MANSFIELD were awarded the Nobel Prize in medicine for their contribution to the development of Magnetic Resonance Imaging (MRI). I would like to take this opportunity to congratulate Paul Lauterbur, who has been associated with the University of Illinois at Urbana-Champaign for more than fifteen years.

From the vantage point of the present the emergence of MRI as a cutting-edge diagnostic imaging technology may seem to have been inevitable. However, if we examine the history of MRI we find that its development in the last thirty years has been uneven and contested. In the early 1970s even the scientists were not convinced about the possibility of magnetic resonance imaging. And in most of the later half of the 1970s very few had faith that a diagnostic technology using magnetic resonance could be developed. The path of MRI development has also been contested, with the continuing dispute over its "discovery" between Raymond Damadian and Paul Lauterbur played out in different arenas even after the award of the Nobel Prize. And there have been other areas of contestation, too. For example, in the mid-1980s MRI used to be called Nuclear Magnetic Resonance (NMR) because it had developed out of this technology. But radiologists did not wish to use the word "nuclear" because of its negative connotation and hence, in spite of the protests of scientists, decided on the name MRI.

The development of MRI occurred at the intersection of the interests of scientists, radiologists, multinational and insurance companies, as well as government regulating agencies located in several nations. If technology development and deployment is located at the crossroads of so many interests, it makes me wonder why there is so much resistance to regulation of healthcare benefits such as MRI scans in the United States. The pros and cons of healthcare in the US in contrast to Canada, where the government is the healthcare provider, have been debated for a long time. Yet somehow there is a sort of (often resigned) acceptance that the US healthcare system as it is presently set up is inevitable.

It is not that the US government has not tried to regulate the development and deployment of medical technologies. Yet at present nearly half the MRIs in the world are in the US and MRI scans continue to be very expensive here. In the 1970s the Federal Drug Agency's (FDA) approval of medical technologies before they could be marketed was made mandatory. MRI received the FDA's approval in 1984. At the same time, however, the Certificate of Need (CON) was legislated to control the proliferation of expensive technologies such as MRI. But private clinics remained outside the purview of CON. The result was the emergence of a new professional class of radiologist-entrepreneur in the US. Many MRIs were installed in private clinic settings and this led to another problem. It was found that in many cases radiologists who had ownership rights of particular MRI imaging clinics tended to markedly over-refer patients for MRI scans. The ineffectiveness of CON in controlling the proliferation of expensive technologies led to its being disbanded in most states. Does the failure of CON, however, strengthen the case against regulation of healthcare? In the American public discourse we cannot discount the power of the twin inevitabilities of technology development and free market forces.

Two years ago a friend of mine was having severe back pain and he decided to go to one of the local clinics in Urbana for a check up. The doctor said that he would need an MRI scan of my friend's back so that he could make a better diagnosis. Before going to the radiological laboratory my friend checked his insurance coverage. The insurance agent told him that actually he was not covered at all during the summer so he would have to pay around $2000, and this did not include doctor's fees. The cost of MRI scans in the US varies from region to region, ranging between $700 and $2000. With 43.6 million people without medical insurance in the US, it is difficult to imagine how they manage to get even basic health care. However, is it possible to regulate the development, deployment and cost of MRI?



With the development of better imaging techniques high-resolution MRI images can be produced by much lower magnetic fields. Use of magnets with a lower magnetic field can reduce the cost of MRI by half. Radiologists in India are shifting to lower magnetic field MRIs precisely for this reason. According to them these MRIs are very effective for most pathologies and if there are more complicated cases, as for example with multiple sclerosis, higher magnetic field MRIs could be used. Such changes would need a regulation of the healthcare system in the US, but there appears to be little interest for such changes. I think the public discourses around the American need for ever more sophisticated technologies and free-market propelled equity is the biggest hindrance in having a more balanced and perhaps even more effective healthcare system in the US.

LoCaL

Projects of the Champaign County Health Care Consumers

By Claudia Lennhoff, Executive Director, Champaign County Health Care Consumers

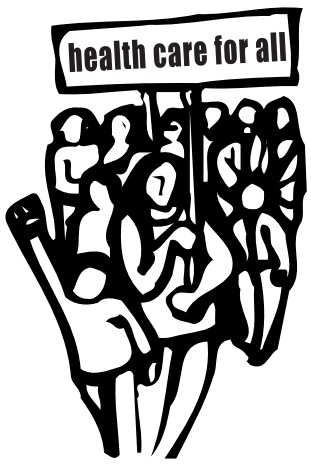
Claudia Lennhoff is the Executive Director of the Champaign County Health Care Consumers (CCHCC). She has worked as a community organizer for CCHCC for 7 years, and has been Executive Director since 1999. In 2002, Claudia and CCHCC received the Robert Wood Johnson Community Health Leadership award for community organizing efforts to increase access to health care in Champaign County.

IN 1977 A HANDFUL of Champaign County residents (led by Mike Doyle), concerned about the lack of citizen/consumer representation on the local health planning board, formed Champaign County Health Care Consumers (CCHCC).

In the 1970s, the federal government required the formation of local health planning boards in order for communities to make decisions about how to allocate resources and federal funding for health care at the local levels.

The federal government required that a certain percentage of the members of each local health planning board be made up of "consumers" in order to ensure that the interests of the people who use the health care system be represented in the local decision-making process. "Consumers" are distinguished from health care "providers" (such as physicians, hospital administrators, etc.).

This is where the Champaign County Health Care Consumers got its name, and the word "Consumers" refers to this federal government distinction. CCHCC does not use the name "Consumers" in a capitalistic sense – this is not a reference to "purchasers" of health care. In fact, it is CCHCC's view that health care is an essential service and should not be a service left up to the "free market." "Consumers" is a statement of the interests represented by CCHCC, and those are the interests of the people who are supposed to be served by the health care system.



At the time that CCHCC got started, the "consumers" on the local health planning board were not truly representing the interests of the community, and especially not the interests of low-income Champaign County residents who had limited access to health care as a result of Medicaid discrimination or inability to pay.

CCHCC struggled to make the community aware of the local health planning board and its role in the allocation of resources in Champaign County, and to get real consumer representatives elected to the Board. Shortly after this struggle, CCHCC moved on to its fight against Medicaid discrimination.

From its inception, CCHCC has organized to increase the influence of consumers who have traditionally been excluded from the health care decision-making process. Twenty-six years and many victories later, CCHCC is still empowering consumers to fight for quality, affordable health care for all.

CCHCC is a non-profit, grassroots, citizen-action organization founded on the belief that access to quality, affordable health care is a basic human right. Through CCHCC's community campaigns, people realize that they can make changes in the systems that shape their lives. CCHCC has over 6000 members who have dedicated themselves to fighting for justice in the health care system. By engaging and empowering consumers in the struggle for improving health care – at the local, state, and national levels – CCHCC works to better the day-to-day lives of people in Champaign County and beyond.

CCHCC's efforts have created the Consumer Health Hotline, established a county-wide public health department, expanded dental access for people with low incomes, changed illegal and harmful medical billing and debt collection practices, implemented contraceptive coverage for women in employee health coverage plans, and made the local health care system more responsive to consumer needs.

Throughout the years, CCHCC's grassroots work has received national attention, and CCHCC is increasingly becoming a national resource for other consumer advocacy organizations. In addition, hospital executives from around the country, government officials, and policy makers frequently consult with CCHCC on issues of medical debt and collections, and other access-related issues.

In September 2002, CCHCC was awarded the Robert Wood Johnson Foundation's Community Health Leadership Award, a prestigious national honor. In 2003, CCHCC was featured in the July/August issue of Lifetime Magazine, and quoted in an August issue of The Nation. Most recently, CCHCC's work resulted in a front page article of the October 30, 2003 Wall Street Journal, which focused on the use of "body attachments" (warrants for arrest) and incarceration of low-income people by local hospitals in their collection efforts. This national story revealed to the nation that a debtors' prison does indeed exist for people who owe money for hospital bills.

Claudia will be giving a presentation at 6:30pm on November 15th in the Wisegarver Lounge of the IDF building, corner of Sprignfield and Wright in Champaign.

Why Gun Regulation is a Health Care Priority

By Allison Jones, Organizer, Champaign County Health Care Consumers

Allison Jones is a part time staff member at CCHCC and a student at the University of Illinois. Some of her projects at CCHCC include work on the Women's Health Task Force, the Gun Regulation Project, and the Medical Debt Coalition.

THE HEALTH AND WELLBEING OF ALL PEOPLE is dependent not just on health care, but also on a decent standard of living –including adequate food, clothing, housing, and social services – and on a safe community. It is not enough for people to have access to health care once they are already ill or injured; our community must also use a public health perspective to prevent illness, injuries, and deaths from occurring in the first place.

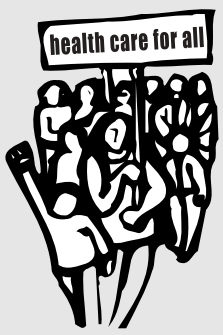
Right now, the health and wellbeing of our communities are undermined by the epidemic of gun-related injuries and deaths. Approximately 29,000 people in the United States were killed by guns in 1999. Twice as many people were treated in emergency rooms for non-fatal gun-related injuries that year.

Many of these injuries and deaths are preventable. Champaign County Health Care Consumers (CCHCC) is working to mobilize a local coalition to fight for more sensible national policy on guns that emphasizes consumer rights and public health. We are working for federal legislation that would regulate guns as a consumer product and on legislation to re-authorize and strengthen the federal Assault Weapons Ban.

REGULATING GUNS AS A CONSUMER PRODUCT

Guns – like prescription drugs, insecticides, household chemicals, and many other products found in American homes – are inherently dangerous. Yet guns, unlike other inherently dangerous products, and unlike nearly all other consumer products in America, are not regulated for health and safety. The history of consumer product regulation clearly demonstrates that a significant number of illnesses, injuries, and deaths can be prevented by health and safety regulation.

CCHCC has endorsed the Firearms Safety and Consumer Protection Act, which would subject the gun industry to the same health and safety regulations as virtually all other products sold in America. The bill would give the Department of Justice strong consumer protection authority to regulate the design, manufacture, and distribution of firearms and ammunition. This legislation would finally end the gun industry's deadly immunity from regulation and make our communities safer, but without limiting the public's access to guns for sporting and other legitimate purposes, and without outright banning all guns. For more information about the Firearms Safety and Consumer Protection Act, visit www.regulateguns.org.



RENEWING AND STRENGTHENING THE FEDERAL ASSAULT WEAPONS BAN

CCHCC has also begun a campaign to reauthorize and strengthen the federal Assault Weapons Ban. Civilian assault weapons are semi-automatic versions of military weapons designed to rapidly lay down a wide field of fire, often called "hosing down" an area. This increased lethalness makes them particularly dangerous in civilian use.

In 1994, Congress passed and President Clinton signed a ban on the production of certain semi-automatic assault weapons and high-capacity ammunition magazines. This law banned a list of 19 specific assault weapons and other assault weapons incorporating certain design characteristics. The law is scheduled to sunset on Sept. 13, 2004. If not reauthorized, it will then be perfectly legal for the gun industry to begin mass-producing and marketing semi-automatic military-style assault weapons like AK-47s to civilians.

But it is important not just to re-authorize the current law, but also to strengthen it. Over the past decade, the gun industry has circumvented the law, designing and marketing "post-ban" assault weapons like the Bushmaster XM15 — the rifle used by the Washington, DC-area snipers — that incorporate slight cosmetic modifications to evade the ban. Therefore, the reauthorization of the ban must include substantial improvements to prevent the gun industry from continuing to flood America's streets with these deadly weapons. CCHCC has joined a broad coalition of more than 260 national, state, and local organizations (including 20 other organizations in Illinois) that is supporting the legislation to implement a stronger, more effective assault weapons ban.

Representatives Carolyn McCarthy (D-NY) and John Conyers (D-MI) have introduced the Assault Weapons Ban and Law Enforcement Protection Act of 2003 (H.R. 2038), which would significantly strengthen current law to address limitations in the ban that have allowed the gun industry to circumvent it. H.R. 2038 currently has 100 cosponsors. A companion bill, S. 1431, has been introduced in the Senate by Senators Frank Lautenberg (D-NJ) and Jon Corzine (D-NJ).

Over the next year, until the current Assault Weapons Ban expires, Champaign County Health Care Consumers will be working to educate the community about the need to renew and strengthen the Assault Weapons Ban through video showings, leafleting, letter writing, educational reports, and other activities. CCHCC will also be working to communicate the public support for ban renewal to our area representatives and Illinois Senators. For more information on the Assault Weapons Ban, visit www.banassaultweapons.org.

We are urging community members to tell congress that our community's safety and wellbeing outweigh the gun industry's interest in increasing profits. If you are interested in receiving more information, helping with either of these two projects, or being added to the gun regulation project mailing list, please contact CCHCC at 352-6533.

LoCaL

CCHCC and local immigrants kick off campaign for improved hospital interpreter services

By Brooke Anderson, Community Organizer, Champaign County Health Care Consumers

Brooke Anderson is a Community Organizer for Champaign County Health Care Consumers. Brooke was the lead organizer on CCHCC's recent statewide legislative victory mandating contraceptive coverage in all health insurance plans with prescription coverage in the state of Illinois, and now works on a variety of health care justice issues for CCHCC.

9.1% OF THE STATE population and 11.1% of the Champaign County population have Limited English Proficiency. This means that a growing number of people in our community face the danger of being unable to adequately communicate with health care providers. Failure on the part of health care facilities to provide interpreters and other language services may result in an inability to access needed health care, misdiagnosis, unnecessary or inappropriate testing and treatment, less frequent use of primary and preventive care services and more frequent visits to the emergency room, and sometimes even death from medical error and miscommunication.

Champaign County Health Care Consumers (CCHCC) became concerned with the growing number of calls to our Consumer Health Hotline from local immigrants about inadequate interpreter services at local health care facilities. We are aware that too many people in our community have faced significant barriers to accessing health care and have suffered injury, illness, and inappropriate treatment as a result of inadequate language services at our local hospitals and other major clinics.

In response, we have launched a new campaign for improved hospital interpreter services. The campaign hopes to identify major areas of concern for patients with Limited English Proficiency, educate consumers about their right to language services in health care facilities, and initiate collaboration with local health care providers to improve these services.

As Alejandra Coronel, CCHCC volunteer and immigrant from Venezuela, says: "Health care is a basic human right. It is what maintains our life in times of injury and illness. When we, as immigrants, cannot access health care because of language barriers, we are made to feel less human, less deserving of our lives and our wellness than non-immigrants, when we contribute to and love this community as much as any other people here."

LEGAL MANDATE

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin by any person or institution receiving federal funding for programs or activities. The federal government and the courts have determined that the prohibition of discrimination based on national origin includes protections for people of different nationalities who do not speak English well.

In health care settings, this means that providers who receive federal funding (such as Medicare and Medicaid) must work to ensure that patients with limited English skills have meaningful access to any program services and benefits that are offered to other patients. This includes virtually all hospitals, clinics, doctor's offices, nursing homes, managed care organizations, state Medicaid agencies, and home health care agencies. Further, the Title VI protections extend to all the operations of the organization or business, not just those departments or patients for which they receive federal funding.

More specifically, the Office of Civil Rights requires all recipients of federal funding to:

1. Provide translation services at no cost to the Limited English Proficient (LEP) individual.
2. Have written policies regarding language access services and staff who are aware of the policies.
3. Determine the language needs of prospective patients at the earliest possible opportunity.
4. Systematically track LEP clients and clients' needs.
5. Identify a single individual or department charged with ensuring the provision of language-accessible services.
6. Provide written notices to clients in their primary language informing them of their right to receive interpretive services.
7. Not use minors to translate.
8. Use family and friends as translators only as a last resort and only with informed consent.
9. Ensure the availability of a sufficient number or qualified interpreters on a 24-hour basis – including telephone services.
10. Use only qualified and trained interpreters with demonstrated proficiency in both English and the other language, knowledge of specialized terms and concepts in both languages, and the ethics of interpreting.

These services must be provided to all patients with Limited English Proficiency, not just those patients who are recipients of Medicare, Medicaid, and Kid Care.

Are YOU Getting the Interpreter and Language Services You Need?

Have you, or someone you know, ever needed health care and:

- Not been provided an interpreter by the health care provider?
- Been provided an inadequate or untrained interpreter?
- Had to rely on a family member or minor to interpret?

Alejandra Coronel speaking at the recent Rally for Immigrant Rights (the C-U stop of the national Immigrant Workers Freedom Rides; see page 9) about CCHCC's hospital interpreter campaign. Alejandra is an immigrant from Venezuela and a consumer leader for CCHCC.

- Been denied care because you do not speak English well?
- Been treated rudely because you do not speak English well?
- Suffered greater illness or injury because of language barriers or miscommunication?

If so, or if you want to support the effort to bring more and higher quality interpreter services to our local health care system, then we need you to get involved!

For more information, to report a personal account of inadequate interpreter or other language services in the health care system, or to get involved in community efforts to address these problems, contact Champaign County Health Care Consumers at (217) 352-6533 or at cchcc@prairienet.org.

Servicios de Interpretación en los Hospitales

¿SABÍA USTED?

Las personas de habla inglesa limitada deben recibir servicios de interpretación de intérpretes calificados y familiarizados con la terminología médica para así dar la verdadera asistencia sanitaria al paciente.

Las leyes y las pautas federales requieren que todos los proveedores de la asistencia sanitaria, que reciben el financiamiento federal, proporcionen el acceso significativo a los servicios de interpretación para las personas de habla inglesa limitada.

¿Está Usted Recibiendo los Servicios de Interpretación y los Servicios de Lenguaje que Necesita?

¿Ha Usted, o alguien que Usted conoce, necesitado atención médica y:

¿No se le proporcionó un intérprete por parte del proveedor de los servicios de asistencia sanitaria?

¿Se le proporcionó un intérprete inadecuado o sin el entrenamiento adecuado?

¿Tuvo que depender de un miembro de su familia o un menor como traductor?

¿Se le negó la asistencia médica porque no hablaba bien el inglés?

¿Le trataron de forma descortés porque no hablaba bien el inglés?

¿Sufrió una grave enfermedad o herida debido a las barreras del idioma o a los errores de comunicación?

¡Si es así , o si Usted quiere apoyar el esfuerzo de ofrecer más y mejores servicios de interpretación a nuestro sistema local de asistencia sanitaria, necesitamos que Usted ¡particípe en nuestros esfuerzos!

Para más información, para informarnos de un incidente personal en que le ofrecieron a Usted un traductor inadecuado u otros servicios de lenguaje en el sistema local de asistencia sanitaria, o para participar en los esfuerzos comunitarios para dirigir estos problemas, llame al Champaign County Health Care Consumers al (217) 352-6533 o por correo electrónico al.

(Medical) Debtors Prison Alive and Well in Champaign County

By Brooke Anderson and Claudia Lennhoff, CCHCC Staff

MEDICAL EXPENSES ARE OFTEN UNEXPECTED and unplanned, and with the rising cost of health care, many people are quickly plunged into debt, bankruptcy, financial ruin, and poor health as a result of mounting bills and hospitals' aggressive collection practices. Champaign County Health Care Consumers' work to put an end to these practices has gained national attention – including a recent front-page Wall Street Journal article on local hospitals' use of arrests and incarceration to seek payment from consumers with medical debt.

Since 1997, the CCHCC Medical Billing Task Force has been organizing with local consumers to address erroneous, unethical and illegal medical billing and collection practices. As a result of our organizing for fair, humane, and legal medical billing and collection practices, Ralph Nader called CCHCC's Medical Billing Task Force a "national leader in the field – the first local group to take on this scandal in health care."

Anyone can incur medical debt. Medical debt affects the insured, the underinsured, and the un-insured. However, uninsured consumers, who tend to have lower incomes than insured consumers, and are least able to pay, are also charged the highest prices for their health care, and are therefore often plunged into the deepest debt. Health care providers, such as hospitals and clinics, typically charge their highest prices to uninsured consumers because there is no third party payor negotiating a discounted price on behalf of these consumers.

As a result of high prices and aggressive collections, the life-sustaining service of medical care can be transformed into a painful burden, driving people into debt and sometimes even bankruptcy – even for consumers who are working hard to make payments toward their debt and who have

(continued on next page)

MEDICAL DEBT *(continued from previous page)*

very limited income and ought to be receiving free or discounted care from the hospital.

When patients cannot afford to pay their bills at the rate demanded by the health care provider, that provider often will send them to a collections agency. The last stage of the collections process involves a lawsuit on the outstanding debt, heard before small claims court. In small claims court, medical providers make up a large proportion of the docket. According to the research of the Land of Lincoln Legal Assistance Foundation, in a six month period in 2001, an average of about seven people per week were directly sued by medical providers in Champaign County small claims court.

Broke and desperate for relief from collections and court hearings, many debtors file for bankruptcy. According to a national study (Melissa B. Jacoby, Teresa A. Sullivan, and Elizabeth Warren, "Medical Problems and Bankruptcy Filings," Nortons Bankruptcy Adviser, May 2000) at least 40% of bankruptcies in 1999 were due at least in part to medical debt. The percentage of bankruptcies in East Central Illinois is even higher. According to research by the Land of Lincoln Legal, 58% of the studied bankruptcy filings in East Central Illinois involved medical debt. Even not-for-profit health providers are suing for collection of medical debt. About 20% of the studied lawsuits were by not-for-profit providers.

Other consumers have had their wages garnished and their assets seized, their credit ruined, liens put on their homes, their meager retirement savings taken, and have even been arrested and incarcerated on "body attachment" orders requested by hospital attorneys. That's right – local consumers have actually spent time in jail for unpaid medical bills even though there is not supposed to be a "debtor's prison" in this country.

These aggressive and inhumane medical debt collection practices by the hospitals are unthinkable, but not unstoppable. CCHCC has conducted courthouse research, interviewed community members who have been victims of these brutal collections efforts, written reports, held community meetings, sought meetings with our local hospitals and with elected officials, and worked to provide information directly to consumers about their rights, even taking to the steps of the courthouse to distribute pamphlets for people who are being sued over medical debt.

Three of the consumers with medical debt featured in the Wall Street Journal at an October 30th CCHCC press conference. Shown are Diane and Marlin Bushman (on the left, sitting), and Harold Quinn (standing, on the right).

This past month alone, CCHCC's medical debt work has won many important victories and has succeeded in shining a national spotlight on our local struggle for fair medical debt policies.

On October 22nd, two vans full of community members and CCHCC staff members went to a legislative hearing in Chicago and provided written and verbal testimony to the Illinois Senate Health and Human Services Committee Hearing on Hospital Pricing and Medical Debt Collections Practices. As a result of the hearing, Illinois Attorney General Lisa Madigan announced that her office is opening an investigation into hospital pricing and debt collection.

On October 29th, representatives of CCHCC's Community Coalition on Medical Debt met with Provena Covenant to talk to them about these practices and to try to get changes made at the local level. At the meeting, Provena agreed to on-going community dialogue about needed reforms to their debt collection and free care policies. A meeting between the Community Coalition and Carle Hospital is scheduled for late November.

On October 30th, the Wall Street Journal printed a front-page article on our local hospitals' medical debt collection practices. The article focused on the local non-profit, tax-exempt, charitable hospitals' practice of seeking body attachments (warrants) to arrest and jail consumers who owe medical debt. When these consumers are arrested and jailed, the bond money that their frightened families scrape together is then applied to the hospital's judgment against them – making one wonder whether our local courts are helping local hospitals kidnap and hold for ransom consumers who owe them money for needed health care services.

It is our collective outrage and revulsion at these practices that is the driving force behind the reforms to come. We are truly in the midst of a national crisis of increasingly unaffordable, inaccessible, and inhumane health care. While the problem is national, and while there is evidence that the practices of our local providers are particularly egregious, the movement must (and has!) started here at the local level with the involvement and leadership of those consumers most affected by the policies at hand. We need a consumer-led revolt against the current structure and profit-driven priorities of our health care system.

If you are experiencing problems with medical debt and need help, or if you are interested in getting involved in community efforts to end harsh medical debt collection practices, contact CCHCC at (217) 352-6533 or at cchcc@prairienet.org.

Health Justice Act Before Fall Veto Session

by Jim Duffett of the Campaign for Better Health Care

Universal Health Care process is before the Illinois Senate this fall. A coalition based in CU is a major activist group agitating for its passage.

The Health Care Justice Act of 2003 initiates a process to achieve universal health care. It is not one specific plan to achieve universal health care. It requires the creation of a Bi-partisan Health Care Reform Commission by September 1, 2003 to oversee the gathering of public input and recommendations for a universal access heath care plan. The Commission and its operations will operate under the Illinois Department of Public Health. This Commission will hold two sets of 10 public hearings around the state seeking public input on the development of the Health Care Justice Act of 2003. Health care providers, health care consumers and others will assist in developing and proposing several different plans ranging from single-payer plan to other ideas for Illinois to implement.

The Public Health Department will task the commission and a final report will be presented to the Governor and General Assembly in early 2005. This report will be based upon the public meetings and research and will include a comparative analysis of the different proposals submitted by interested parties to achieve universal health care coverage. The bill provides for further public discussion during the spring through fall of 2005 with the Commission presenting the options to the General Assembly which is obliged to then pass affordable and accessible health care for Illinois.

HEALTH CARE JUSTICE'S LEGISLATIVE HISTORY AND ITS FUTURE

The Health Care Justice Act of 2003 HB 2268 passed the House Health Committee on March 11th with bipartisan support and passed the full House (60 Yes, 45 No, 11 Present, 2 Present) . THe Health Care Justice Act passed out of the Senate Health Care Committee, but was stopped by the insurance industry from having a full Senate vote. When the House bill passed, it was assigned to the Senate Insurance Committee instead of the Health Care Committee where it passed on April 29th. It stalled in the regular session but the deadline for Senate approval has been extended until the end of this year, which allows for it to be passed during one of the two short Fall Veto sessions. These are November 4th to 6th and 18th to 20th. It is extremely important that State Senators be contacted regarding the importance of this bill in this time period. Should it have passed in the first days of the month, calls should be made to the governor for his quick signature and attention be focused on how the process will be continued and implemented.

Call State Senator Winkel and tell him it is time that he stands up for consumers and businesses

HOW WRETCHED THE CURRENT CRISIS IS!

Our health care system is decomposing at an accelerated rate. The central office of the Campaign for Better health Care is in Champaign, and there are also offices in Chicago. CBHC is Illinois' largest grassroots health care coalition, representing 321 diverse organizations. Every component of the health care system is in cardiac arrest. A total meltdown will occur if President Bush succeeds in forcing our parents and people with disabilities into private managed care plans in order to be able to access prescription drugs. Bush's backdoor approach to block grants to the Medicaid program will cause havoc for millions of Illinoisans and bankrupt the state.

Health care costs are soaring at double digit rates and it is projected that similar levels of increases will continue for the rest of this decade. In 2001 the United States spent $1,424,000,000,000 on health care, an increase of $114,000,000,000 from 2000. Conservative estimates for 2003 predict that our country will spend $1,750,000,000,000. This figure will represent per capita spending of nearly $5,500 per person. Of countries with a universal health care system, even those with the highest expenditures are still only spending $3,000 per person. And yet 45 million Americans are uninsured and another 75 million are underinsured.

Here in Illinois the health care crisis has reached epidemic levels. As the economic recession continues, more Illinoisans are unemployed, thus becoming uninsured. For many low income workers Medicaid is the only answer. For others it is the emergency room. This spring, CBHC released the most extensive study ever in Illinois detailing the number of uninsured. This report revealed that 3.1 million Illinoisans were uninsured at any given moment in 2001. The Health Care Justice Act of 2003 commits the state of Illinois to enact universal health care by June of 2006. This proposal will force this debate back on the political agenda.

Of those politicians, organizations and policy makers who do support universal health care, there is no agreement on what approach should be taken. Those in support must be more committed than was the case in the early 1990s to move this fight forward. This proposal is strategically designed, first, to win the public and political battle to make a commitment to implement universal health care. Once we achieve this major political hurdle (which will not be easy), we can move to stage two: determining what solution will work best. The first hurdle will be a political battle that will be just as tough as winning the type of health care system, which would be fair and equitable. We must win this debate first. If we do not take this two-step approach, the forces opposing us will succeed in implementing piecemeal reforms and expand the stranglehold of the medical industrial complex.

For more information about the Health Care Justice Act please access CBHC's web-site at www.cbhconline.org, the Illinois General Assembly's web-site or call CBHC. Call State Senator Winkel and tell him it is time that he stands up for consumers and businesses. The health care crisis is causing havoc for employers and employees. Passage of the Health Care Justice Act would be the biggest economic stimulus plan for our state. In addition to calling Winkel, call Senator Obama and tell him that you are behind his effort to call this bill during the Fall Veto session and getting it passed out of the Democratically controlled Senate. The time is now, not next year.

LaBoR/eCoNoMiCs

New Freedom Riders Rally Supporters in Urbana and 100 Other Cities

By Ricky Baldwin, regular contributor

JUST AFTER DARK ON SEPTEMBER 29, a crowd of nearly 200 gathered in front of the Champaign County Courthouse in Urbana to welcome 45 bus riders from Chicago. The bus was part of "La Caravana de la Libertad para los Trabajadores Inmigrantes," or "Immigrant Workers Freedom Ride," which drew busses from ten major US cities through 30 states and more than 100 cities on the way to Washington, DC, and finally New York City on October 4.

One of the Freedom Riders, Juan Pablo Chavez of Chicago's Southwest Organizing Project, told supporters at the Urbana rally that despite post-9/11 setbacks, immigrants and their advocates are far from giving up. "We are strong," he said. "We are like a wounded, gigantic elephant that heals and comes back for more."

A local student named Claudia Blanca choked back tears to tell her story of one health problem after another, resulting in near-total deafness. As the crowd chanted, "Claudia! Claudia!" Blanca said she has found medical help in the US and now has regained part of her hearing. Representatives of sponsoring groups also addressed the crowd, including Champaign City Councilman Giraldo Rosales, director of the Latino Cultural Center, and Alejandra Coronel of Champaign County Health Care Consumers, which is campaigning for improved interpretation services at hospitals in the area.

Nationwide, Freedom Riders described a sense of being "part of a movement" rather than simply a campaign for driver licenses, in-state tuition and a new general amnesty for undocumented workers already in the US. And welcoming rallies along the route seemed to demonstrate the same feeling. One march outside Atlanta grew unexpectedly from 2000 at its start to well over 5000 by the end, as local workers and students dropped what they were doing to swell the ranks.

ILLINOIS'S FOURTH BUS

Four Freedom Rider busses left Chicago. Three trekked up to Dearborn, Michigan, home to a large Arab-American population, before continuing across to Western New York and down to DC. The fourth bus, the one that passed through Urbana-Champaign, was organized and funded separately by the Chicago-based Illinois Coalition for Immigrant and Refugee Rights (ICIRR), a 16-year-old umbrella organization with around 130 member groups. This bus was the only one in the Freedom Ride that took a separate route through its home state rallying support for local issues.

Illinois was also the only state that began the Freedom Ride over a month early. On August 9, a crowd of almost 2000 rallied in downtown Chicago in support of striking Congress Plaza hotel workers, then marched down Michigan Avenue to surround the hotel.

By the time the Freedom Riders got to Urbana, their bus had already seen rallies in Aurora, Elgin, Rockford, the Quad Cities, Beardstown – where 800 Mexican immigrants eke out a living slaughtering pigs for Excel – Springfield and Bloomington. They spent one night in town and attended a couple of events the next day before hitting the road again. One was a luncheon thanking University Chancellor Nancy Cantor for her help on a state law granting in-state tuition to the children of undocumented workers, a change the Freedom Riders hope to see go national.

After leaving Urbana-Champaign, the bus headed south toward a migrant labor camp in Cobden, Illinois, surrounded by orchards where the workers pick fruit. But before Cobden, the bus turned to stop at a tiny, desperate town outside Carbondale called Ullin.

The local economic prognosis was so bad a few years ago that the town's political leaders made a deal with the Immigration and Naturalization Service (INS). Under intense economic pressure, Ullin agreed to be the site for a new private for-profit INS detention center, which

doubles as the county jail. The detention center meant 50 new jobs for the needy town, and the INS pays for the local jail, but the price may have been too high. The local economy is still bad, only now relatives of many INS detainees from Chicago have to travel six hours south to Ullin to see their loved ones.

Another effect of siting the detention center in Ullin, ironically, is that a number of people in a small town in southern Illinois have now learned, through direct contact they would not have otherwise had, that "illegal aliens" are not the inhuman vermin depicted by anti-immigrant lobbies. One local official was even willing to express a certain ambivalence about his role. According to ICIRR's executive director Joshua Hoyt, the State Attorney in Ullin applauded the Freedom Ride. "He told us, I think what you're doing is great. These are nice people, not criminals," Hoyt said. "We wish everyone here was as nice as these detainees, because we'd be out of a job."

But the purpose of the Freedom Ride was also to challenge this system, not just feel bad about it, and for the undocumented among the Riders, that meant taking some risks. "We [Freedom Riders] went inside the detention center," says Demian Kogan. "We couldn't see the cells – they call them 'pods' – or meet with the detainees, but there were 45 of us and some were undocumented. It was very symbolic, very powerful." Kogan is a senior in political science at UIUC and an organizer of the Urbana-Champaign events.

In Washington, however, Freedom Riders who attempted to meet with Congressman Tim Johnson (D-IL) encountered a distinctly different attitude than they found in Ullin. "You have no respect for the political process," Johnson told Kogan, when the young activist stopped Johnson in the hallway. Kogan had already been meeting with Johnson's labor aide, who knew little or nothing about immigration issues. Johnson's immigration aide, Kogan was told, would not be available. But when Kogan told Johnson that he was there from Johnson's district, the Congressman listened briefly, remaining noncommittal.

The Freedom Riders' five-point agenda includes establishing legal protections for all workers, loosening restrictions that prevent legal immigrants from being joined by their families for up to 15 years, and opposing the so-called CLEAR Act, which would extend the authority to detain people on immigration violations to local law enforcement.

PROGRESSIVE FEINTS

On the day of the Urbana rally, the News-Gazette ran a vicious attack on the Freedom Riders as a "guest commentary". The piece called the Immigrant Workers Freedom Ride (IWFR) a "mockery" of the "real Freedom Riders who put their lives on the line in pursuit of justice." The author was a California resident who runs an anti-immigrant website.

Congressman John D. Lewis (D-Georgia), who was one of the original Freedom Riders, couldn't disagree more, but his comments were nowhere to be found in the News-Gazette. Lewis welcomed the busses to DC, telling Freedom Riders, "You have rekindled the spirit of justice in this country." He also rode one of the busses part of the way.

Around the same time a union local, AFSCME 444, also in California, wrote a letter to AFL-CIO President John Sweeney explaining why Local 444 refused to support the new Freedom Ride. The letter cited objections similar to the above "guest commentary". Then, accusing the AFL-CIO of neglecting its responsibilities to fight for "American workers", the letter argued that, in the current context, the Freedom Ride simply meant more workers competing for scarcer and meaner jobs. This argument is nothing new. For many years the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) fought for tougher restrictions on immigration and against immigrant workers' rights. Yet even then, some unions – the United Farm Workers, HERE, Service Employees, Needletrades, United Food and Commercial Workers and the Laborers Union – took a different tactic. They organized the immigrants into their unions and fought hard to raise the living standards of all their members. Eventually, in February of 2000 the AFL-CIO reversed its longstanding policy on immigration, embracing immigrant workers' rights.

And according to spokesman David Koff, the jobs-competition argument is not only nothing new, it's flat wrong. On loan to the Immigrant Workers Freedom Ride from the Hotel Employees and Restaurant Employees (HERE), Koff says the issue is not "open borders or closed borders" but "smart borders."

"The fact is," says Koff, "they are here and they will continue to come. The US, like every other industrialized nation, is dependent on foreign-born labor to expand its economy." According to the 1990-2000 Census, Koff says, foreign-born workers filled nearly half the new jobs created. "There are 8-10 million undocumented people living in the country right now. There can be no more visible sign of the failure of US immigration policy than such a large population of unprotected workers."

So when organized labor dropped its restrictionist or anti-immigrant policies, says Koff, it was partly in recognition of the fact that "you can't have a subclass of vulnerable workers who can be deported without holding down the capacity of all workers to improve their lives." In other words, as workers in this country struggle to improve wages and working conditions, the growing population of undocumented workers "becomes an anchor that holds down the efforts of others."

"Legalization," says Koff, "is essential so everyone in the workplace is on an equal footing."

Unplug the Christmas Machine!

Consumer Credit Counseling Service of Central Illinois is sponsoring a 2½ hour workshop called Unplug the Christmas Machine, to help people plan a more rewarding Christmas holiday.

Based on the popular book, *Unplug the Christmas Machine*, written by Jo Robinson and Jean Staeheli, this workshop helps people reduce their stress and increase their enjoyment by planning simple changes in their celebration. Participants will be given a chance to examine their current practices, define their values, plan a Holiday budget, create a fantasy Christmas, then combine all their insights into a workable plan for the coming Holiday season.

The workshop will be held Tuesday, November 18th, from 6:30pm – 9:00pm at the Urbana Civic Center, 108 Water St., Urbana (1 block North of the Courthouse). Cost is $10. Registration is encouraged.

To register, or for more information, contact Nancy Dietrich-Rybicki, workshop facilitator, at 337-0334.

LaBoR/eCoNoMiCs

Why We Must Stop the FTAA

By Meghan Krausch

Meghan Krausch is a somewhat recent graduate of the University of Chicago, but she is not a "Chicago boy." She lives in Champaign with her dog, cat, and partner. She did not consider herself to be a radical until recently.

THE NEXT ROUND OF NEGOTIATIONS for the Free Trade Area of the Americas (FTAA) is coming to Miami this November 17-21, and I, for one, plan to be there. What is the FTAA? It's an agreement that stands to have a devastating affect on our wages, our job opportunities, our environment, our laws, our quality of life. The FTAA is an ambitious plan to link the Americas in a neoliberal trade agreement by 2005. It is an expansion – both geographically and ideologically – of an agreement out of which I can find no evidence of positive results, NAFTA.

This agreement is being negotiated by trade ministers from all countries in the Caribbean and North, South, and Central America except Cuba. The effort is being led by those with the most to gain, the coporate interests in our own US government. Armed with his newly granted Fast Track authority, President Bush can consent to anything submitted to him by our negotiating trade official without the approval of Congress. You can thank those you do have a chance to vote for in the next Congressional election cycle. I can tell you that Timothy Johnson, for one, deserves a big fat "thank you" from the farmers in his district who only stand to lose their subsidies from lower and lower trade barriers. He, along with 215 other "representatives," voted in favor of granting President Bush Fast Track authority

To summarize: this agreement will be negotiated behind a multi-million dollar fence, under armed guard, without congressional input, by a man appointed by a President who was not elected. Do you feel as though your best interests are going to be well represented?

SO WHY DOES *ANYONE* SUPPORT THIS?

Of course, there is a theory behind agreements like the Free Trade Area of the Americas: "all boats rise with the tide." The basic idea is that any growth is good for everyone inside an economy. The neoliberal model states that macroeconomic indicators are the most important measurements of an economy's health because they affect the relationship between that economy (in this case, a nation) and other institutions globally. Good macroeconomic indicators increase foreign investment, which increases the number of available jobs. If there are more jobs, the unemployment rate decreases and wages will rise with the increased competition for workers. Meanwhile, employment increases and wealth spreads in the countries that supply the investments. Everybody wins. Right?

Wrong. No country in modern history has ever succeeded in industrializing under this model. The model is an abstraction based on economic assumptions that are flatly contradicted by history. All of our contemporary powerful industrial economies expanded under the shelter of tariffs and other protectionist efforts. These measures allowed industries to gain strength domestically before they were forced to compete with cheap imports from stronger economies. When a market is opened prematurely, it is swarmed with foreign interests. Agricultural prices drop, and those who make their living picking crops lose their jobs. Thus, wages do not rise because there are always so many more workers than jobs. Union busting is easy for international corporations that have no local ties and that can move production anywhere wages are low – consumers in richer countries make no distinction between Nicaragua and Honduras.

SO HOW DID WE GET AN 8-HOUR WORKDAY?

Unionization, not free trade zones. Remember how those robber barons fought against child labor laws, the 8-hour workday, and the minimum wage? They had to be forced. Workers had to walk off the job under threat of violence and boycott union busters. But we made gains. And now we're giving those gains up by claiming that the men of the elite who run today's corporations will make decisions in our own best interest, if only we let them function more "efficiently" without the restriction of government regulation.

Liberalization of trade usually also means privatization of basic services like water and energy. Private companies, however, have no incentive to provide these necessities to those who cannot afford them, and they have no incentive to keep the prices affordable. Furthermore, the national government gains income from the one-time sale of energy or water facilities, but it loses the steady income it can earn from these assets. Privatization may be a better business model, but there is no evidence that it is a better model for consumers. In most countries where this experiment has taken place, prices have almost immediately skyrocketed, causing a crisis for most of the population. Electricity and water, I think we can all agree, are not just the trappings of consumer society but rather necessities for urban living. Privatization, as we can see from the price gouging that caused an energy crisis in California, has not been demonstrated to be effective.

THE SCARIEST POSSIBILITIES ARE ALREADY REALITY

The best reason to protest the FTAA, though, is something that has already happened. Under Chapter 11 of NAFTA, corporations' right to profit now legally trumps governments' right to protect their citizens. Foreign corporations have the right to sue the government of their host country for damages if its actions inhibit the ability of the corporation to make a profit. This provision, unbelievable as it sounds, has already been acted upon by at least 20 corporations, including US-based Metalclad. When a Mexican state government killed its plans to build a hazardous waste plan in San Potosí on the grounds that the plant would contaminate local groundwater, Metalclad sued for damages. Metalclad won a $15.6 million settlement with the Mexican government.

Hearings under this agreement take place in secret, with one judge appointed by each party to the dispute, and one mutually agreed upon judge. The judges are not under any obligation to consider testimony from groups other than the two parties to the dispute. There is no mechanism for input from civil society. Furthermore, the threat of lawsuit under NAFTA can be so chilling to a government that it may repeal the law before the suit is even filed.

There is no reason to believe that similar provisions will not be made under the FTAA if it is signed. And if there are, it is likely that we in the public won't know about such provisions until after they have already been agreed to.

WHAT NEXT?

We didn't rise up when our President was appointed instead of elected. We didn't rise up when our President then started a war of conquest with patently monetary motives (see www.thenation.com/outrage/index.mhtml?pid=978 for evidence of Dick Cheney's personal fiscal gain from the "War on Terror"). When are we going to wake up? If we don't get out in the streets and put a stop to business as usual now, will we lose our democracy forever? Will we sit back and allow our only avenue to a better world to be stolen right from under our proverbial, collective noses?

Now is the time for causing a disruption and getting the point across. So let's educate ourselves, and then let's get out there in the streets and take back what's ours. Starting in Miami.

For more information on joining the FTAA protests in Miami this November 17-21, contact N20@chambana.net. If you can't make it to Miami, consider organizing or participating in a solidarity event here in town on November 20. The protesters are seeking home support people to help out with coordination during our time in Miami. We also welcome any offers of legal support or medical training. And, of course, donations are appreciated.

Media Reform Conference

November 8 & 9, Madison Wisconsin

Moving beyond critique to action, the National Conference on Media Reform is a groundbreaking forum to democratize the debate over media policymaking. A broad range of media reform activists will join members of Congress, the FCC, and leaders of major groups working for civil rights, women's rights, rural renewal, the environment, labor, community development and other issues to:

– Mobilize new constituencies;
– Strengthen coalitions working in Washington and at the grassroots;
– Develop unified action plans for immediate and long-term reforms; and
– Generate policies and strategies that will structurally improve the media system.

Take part in workshops, panels, and concerts addressing:

- Public broadcasting
- FCC media ownership rules
- Media and antitrust claims
- Low-power radio & TV
- Internet governance
- Copyright issues
- Children's media regulation
- Regulation of advertising
- Cable/satellite and public access
- Billboard advertising
- Advertising in schools
- Political advertising/campaign finance
- IndyMedia Centers as a policy issue
- Community media watches

PANELISTS AND SPEAKERS

ADELSTEIN, Jonathan
BALDWIN, Rep. Tammy
BLETHEN, Frank
BRAGG, Billy
BOWEN, Wally
BROWN, Rep. Sherrod
CHESTER, Jeff
COATES, Inja
COHEN, Jeff
CONYERS, Rep. John
COOPER, Mark
COPPS, Michael
DICHTER, Aliza
DOUGLAS, Susan
FEINGOLD, Sen. Russ
FOLEY, Linda
GOODMAN, Amy
GONZALEZ, Juan
HACKETT, Bob
HAZEN, Don
HERNDON, Sheri
HINCHEY, Rep. Maurice
JACKSON, Janine
JENSEN, Robert
JHALLY, Sut
JOHNSON, Nicholas
KIMMELMAN, Gene
KLEIN, Naomi
LEWIS, Charles
LLOYD, Mark
MAHAJAN, Rahul
McCANNON, Bob
McCHESNEY, Robert
McGEE, Art
McGEHEE, Meredith
MILLER, Mark Crispin
MILLER, Patti
MINER, Barbara
MITCHELL, Pat
MOYERS, Bill
NEWBY, David
NICHOLS, John
PINGREE, Chellie
ROGERS, Joel
RUSKIN, Gary
SANDERS, Rep. Bernie
SCHECHTER, Danny
SCHWARTZ, John
STAUBER, John
SWEENEY, John
SNOW, Nancy
THEMBA-NIXON, Makani
TOOMEY, Jenny
TRIDISH, Pete
WALLACH, Lori

Please note: This is a partial list and subject to change.

MeDia

Teenagers in Journalism

By Maggie Quirk

Maggie Quirk is a junior at University Highschool. For the past two years she has been a reporter at her school paper, *The Gargoyle*. More recently she has worked for local and national 'zines.

I ATTENDED the Illinois State High School Press Association's (ISHSPA) journalism conference at the Illini Union along with 800 others students on Friday, October 3. Surrounded by other kids like myself, I attended sessions taught by members of the local community, and keynote speaker Toni Majeri, an editor of the *Chicago Tribune*. The theme of this year's conference was "Do It Yourself," which taught me and other students the importance of teenagers expressing themselves through journalism, especially without the help of a supervisor.

The ISHSPA journalism conference was organized by David Porreca, also the advisor of the Uni High school paper, and was funded by the U of I journalism department. Although the first year of the annual conference is unknown, it may have started as early as in the 1920s. "[The conference is] to promote scholastic journalism throughout the state," Porreca says. "It does that primarily by bringing together schools each year at the conference."

At last year's conference, also organized by Porreca, 30 schools and 400 students attended. This year Porreca was planning for a turnout near that size, but representatives from 59 schools attended, bringing together 800 high school students. Students crammed into the meeting rooms of the Illini Union; some sessions were moved to other campus buildings. Recently teenagers have recognized the importance of journalism because of the recent war and unstable economy. Students from schools as far away as Belleville West High School, near St. Louis, and Hononegah High School, near the northern Illinois border, attended.

As the advisor at the Uni High Gargoyle, of which I am a staff member, Porreca is so dedicated he regularly skips nights of sleep. This inspires students to come in on weekends and stay after school. Several years ago students used to stay at school until 2 a.m. until the administration found out and put an end to it. The dedication of students to work long hours, beyond the work required to get an A, shows that, once inspired, teenagers will take up journalism with an almost maniacal fervor.

Since the beginning of the conference series the point has been to show that teenagers should be involved in journalism. Participating in journalism can help students of any age or level of education teach others of their experiences and try to influence others with their opinions. Because of new developments in technology journalism is accessible to a much wider group of people. Independent from school, teenagers have the means of researching the war on Iraq, writing their own opinions, and giving them to someone in a different country. Even ten years ago, this would have been impossible.

The "Do It Yourself" aspect of the conference is almost as important as getting teenagers to participate in journalism. Several of the sessions in the conference were about publishing a zine, a "Do It Yourself'" magazine, and I saw determined teens decide to start their own publications. My friends and I are in the process of editing our own zine. Although funded by Porreca, we are not under the close watch of an advisor. When teenagers achieve something without the help of an adult supervisor, it is often more beneficial than if they were supervised. It is up to the student to decide the audience of their production and to make sure the articles are timely and written appropriately. Teenagers will be more critical of one another, and by taking the advice of their peers, they learn just as effectively as from a teacher's editing.

Sessions on the war and today's culture were well attended. The sessions taught students that it is important for teenagers not only to participate in their own publications, but also to watch the news and pay attention to media around them. Because of today's diverse media, teenagers are bombarded with all points of view on current issues. With easy access to television and the Internet they can have the knowledge to decide their political stands for themselves. With speakers from media outlets as different as the IMC and the Sun Times, students at the conference listened to a well-rounded variety of speakers.

Of all the teenagers at the conference only a small percentage will seriously pursue a career in journalism. But that doesn't matter. Every student who attended, including myself, learned several important things. I learned the importance of the media, especially in recent troubled times, and that anyone can participate in journalism, regardless of their age or level of education. More students will start "Do It Yourself" zines or be involved in publishing of some kind. Others will pay closer attention to, and learn to be more critical of, the media for the rest of their lives.

DIAGNOSIS OF A FAILING MEDICAL SYSTEM

(continued from page 1)

MEDICAID

Enacted as companion legislation to Medicare, Medicaid is the largest public health program in the nation with more than $200 billion in annual spending. Currently, it finances health care for nearly 50 million individuals. In order to qualify for Medicaid, individuals must meet financial criteria, meaning that all individuals on Medicaid are among the very poor. It is the only form of health insurance available for one in four children and also many low-income parents. Additionally, it covers the health care needs of more than 60% of nursing home patients. Medicaid functions as a state-administered program that is partially funded from federal sources, and it generally ranks after education as the second-largest state budget item.

Medicaid and the supplementary State Children's Health Insurance Program (SCHIP) serve as a critical safety-net for low income families. For instance, although work-based insurance coverage has been decreasing in recent years, they have been able partially to offset this crisis. In 2002, the uninsured population grew by 2.4 million, but this number would have been much worse had not Medicaid maintained the coverage of children from affected families and also added 1.6 million poor parents to the program.

Because Medicaid is a state-administered program, the current nation-wide state budget crises are alarming. In 2002, average state income fell by 5.6%—the first decrease in recent years. Consequently, although demand for Medicaid services increased 13% over the same period, all states have had to impose "cost-containment strategies" such as controlling drug costs and freezing payments to participating physicians. Additionally, over thirty states have had to restrict eligibility, reduce benefits, or increase co-payments.

PERSPECTIVES

Although the crisis and inefficiency of the United State's health care system is readily apparent to any critical observer, it is difficult to pinpoint any single factor as the primary culprit. Consequently, any solution will need to address many issues and carefully thought out. Only one Democratic presidential candidate, Dennis Kucinich, has elaborated a cogent universal health care platform. Such a universal single-payer plan—that is, an entirely publicly-funded system which covers everyone—is often advanced as a progressive way to solve the nation's health care woes. However, this type of broad reform is opposed by the majority of Americans, and, in light of the heavy investment of private capital in health care, it is difficult to envision its implementation in the near future.

Historically, universal plans have emerged in other countries only slowly or in response to financial instability in the private sector. In Canada, for instance, the national program began as a proof-of-concept program in the single province of Saskatchewan in 1947; this was followed by nationalization of hospital care in 1957 and physician services in 1971. In Great Britain, a national program emerged as a response to a post-war financial crisis among private hospitals.

In our view, therefore, a national health plan in the United States is not yet a viable option because the necessary grass roots organizing has not occurred, nor is the financial situation of the private health care market dire enough. However, individuals and community groups can still promote health care change in significant ways. First, through letter-writing and other more cohesive lobbying efforts, they can advocate at the state level for pilot health care projects and incremental near-universal coverage programs. For instance, state governments could be prompted to expand the eligibility and reduce the restrictiveness of financial criteria for Medicaid and SCHIP. Additionally, nearly all states sponsor other small health care initiatives—such as vaccination clinics, drug assistance programs, and child and pregnancy welfare programs—which might be expanded.

Secondly, since a critical limiting factor for reform is the lack of public interest or awareness, groups can begin to initiate dialogue in their communities about efficiency, innovation, and the universal right to health care. Such efforts should also strive to increase the dialogue between physicians and patients and to view physicians, nurses, hospitals, and other professionals as potential allies in the fight to improve health care. As evidence that such measures can have perceptible effects, initiation of public discourse and moderate health care reform in Vermont, under the tenure of Governor Howard Dean, succeeded in extending health care eligibility to 99% and enrollment to 96% of the population.

Blind optimism in the ability of the market to reform health care spending should be treated with a healthy dose of skepticism. Although rhetoric about the efficiency of private insurance is regularly touted by the current administration, the facts are to the contrary. In 2002, the United States spent $112 billion on health administration costs. The administrative costs of private insurers averaged 12% of total spending—on the other hand, publicly administered programs like Medicare averaged only 4.6%. What's more, the administrative costs of the United States' largely privatized health care system is 6 times that of Canada's nationalized system.

Another major strategic approach to health care reform is to reduce the profitability of medical industrial enterprises. For instance, in 2001 the average profit margin for pharmaceutical companies was 18.5%, compared to 3.3% for all Fortune 500 firms. At the same time, direct-to-consumer marketing expenditures by pharmaceutical companies has nearly doubled since 1996, indicating that this is an expanding market. Community groups, therefore, can lend their support to innovative measures to reduce this profit. As just one example, Governor Blagojevich's recent call for the FDA to allow the state of Illinois to purchase all their drugs from the Canadian market—where the same drugs often sell for half the price—is an interesting development.

Finally, it must be emphasized that the push for better health care is not just about policy, legislation, and community dialogue. It is also, proverbially, a matter of "putting one's money where one's mouth is". Champaign-Urbana has many excellent community- and charity-based organizations working hard to address the special needs of the homeless, migrant workers, the elderly, ethnic minorities, and other at-risk populations. These programs include the Crisis Nursery Center, the Francis Nelson Health Clinic, the Greater Champaign AIDS, Project, A Woman's Place, El Centro por los Trabajadores, The Center for Women in Transition, and the St. Jude Catholic Worker House, to name just a few. Nearly all of these organizations are chronically under-staffed and under-funded. Champaign-Urbana citizens can make an immediate difference for the health of our community by volunterring weekly at or donating money to these and other like organizations.