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SPECIAL ISSUE:
Socialist Perspectives on
Health Care in the United States

EDITORIAL

Within the next several months, the Supreme Court will decide whether employers can bar women from industrial jobs unless they are willing to be sterilized. The case, *International Union v. Johnson Controls*, involves a company policy excluding all fertile women from many jobs in its battery-making operations based on the employer's determination that lead exposures are uniquely hazardous to fetuses. The rule applies whether or not the women are pregnant, intend to become pregnant, or are likely to become pregnant. In essence, sterility is a condition of employment.

Workers and their union challenged Johnson's "fetal protection" policy as sex-based discrimination, violative of Title VII of the Civil Rights Act of 1964. They claimed that lead exposures are hazardous to workers of both sexes, that most women workers will not become pregnant and that health risks can and should be reduced or eliminated to make the workplace safe. These arguments, however, were rejected by both a federal district court in Wisconsin and the Seventh Circuit Court of Appeals. The Seventh Circuit upheld Johnson Control's policy under Title VII, dismissing evidence of male reproductive risk and failing altogether to consider other health risks posed by lead, the consequences of barring women from lucrative employment, or alternatives to exclusion.

The Supreme Court's decision will have broad implications. According to dissenters on the Seventh Circuit, if policies like Johnson Controls' are held valid, women could be excluded from as many as 20 million industrial jobs. For unskilled women, these jobs may provide the only escape from poverty. Many worked for minimum wage or received public assistance before obtaining factory jobs that doubled or tripled their income and offered important benefits such as health insurance. With heavy responsibilities for children or elderly parents, many women simply cannot afford to give up these jobs; sterilization is the only option. Indeed, some have already "chosen" this route.

Johnson Controls and business groups supporting its position have advanced two main justifications for "fetal protection" policies. First, claiming a "moral" imperative to protect fetal health, they argue that adult workers are safe, but no exposure is safe for a fetus. This argument, however, rests on selective and biased interpretation of the evidence; it ignores both the findings of federal health and safety agencies and an emerging body of scientific research. In 1978, the Occupational Safety and Health Administration carefully considered the question of occupational risks from lead exposures, including reproductive risks. It concluded that there was *no* basis for excluding fertile women from lead exposed jobs and recommended that *both* men and women planning pregnancies reduce exposure to achieve blood leads lower than those considered safe for other workers. More recently, scientists have confirmed this conclusion, finding that lead -- as well as many other workplace toxins -- affects sperm, as well as the egg and embryo, and that such effects may be irreversible and may affect subsequent offspring.

Beyond the issue of reproductive harm, it is clear that lead has adverse health effects on adult workers. For example, the Environmental Protection Agency has found that lead poses a significant cardiovascular risk to men *at the same level of exposure that Johnson Controls claims is uniquely hazardous to a fetus*. The point is that lead is a highly toxic substance, harmful to all workers. A policy that excludes women based on questionable gains for potential fetuses leaves men and their future children at risk and adversely affects the health and well-being of the existing families of the women who are unwilling to submit to sterilization. So much for morality.

A second justification for fetal protection policies may be more to the point -- but on close examination, is equally unpersuasive. Employers have claimed that unless they exclude all fertile women from the workplace, some women might become pregnant in the face of a risk; of these, some might bear a child adversely affected by exposure; and of these some might sue for damages and win. Both as a statistical and a practical matter, this possibility is extremely remote. Indeed, employers have been unable to point to any examples. Moreover, companies that handle toxic substances face an array of potential lawsuits. As one federal appellate court has stated, "the potential for litigation rests in almost every human activity.... The employer is, of course, free to protect itself from financially ruinous lawsuits by purchasing insurance and maintaining the degree of care required by law."

This last point is significant. An employer who complies with applicable standards and regulations, who implements all available technological means of reducing exposures and who adequately warns workers of any remaining risk is not likely to be found negligent and held liable. And where the employer has fulfilled its legal obligation, the job of balancing the risks and benefits of employment can and should be left to individual workers, based on their own uniquely personal considerations.

The notion that an employer can substitute its own risk/benefit calculation for that of a worker, that it can exclude those it considers "hypersusceptible" rather than making the workplace safe has implications beyond "fetal protection" policies. Some employers claim that certain genetic conditions, which disproportionately affect racial or ethnic groups, can be exacerbated by toxic exposures. Is the next step mandatory genetic testing? Will employers attempt to exclude workers on the basis of race or ethnic origin to "protect" them or their offspring? The decision of the Seventh Circuit, unless reversed by the Supreme Court, might open up such possibilities.

Let us hope the Supreme Court adheres to the plain language of Title VII which prohibits discrimination against women who are willing and able to work. If so, the decision may foster renewed corporate efforts to develop and implement strategies for safer workplaces. Clearly, the best way to protect the health of workers and their children -- as well as those who live near industrial plants -- is to reduce exposures at the source, and the technology to do this is at hand. For example, the possibility of a lead-free battery is on the horizon, but it will take the combined efforts of engineers, employers and worker and community groups to make it a reality. It's time to move away from discriminatory and ineffective solutions and get to work. ●

Attorneys Joan Bertin and Liz Werby are co-counsel for the ACLU Women's Rights Project on the Johnson Controls case.

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DSA Demands a Socialist Solution to the Health Care Crisis

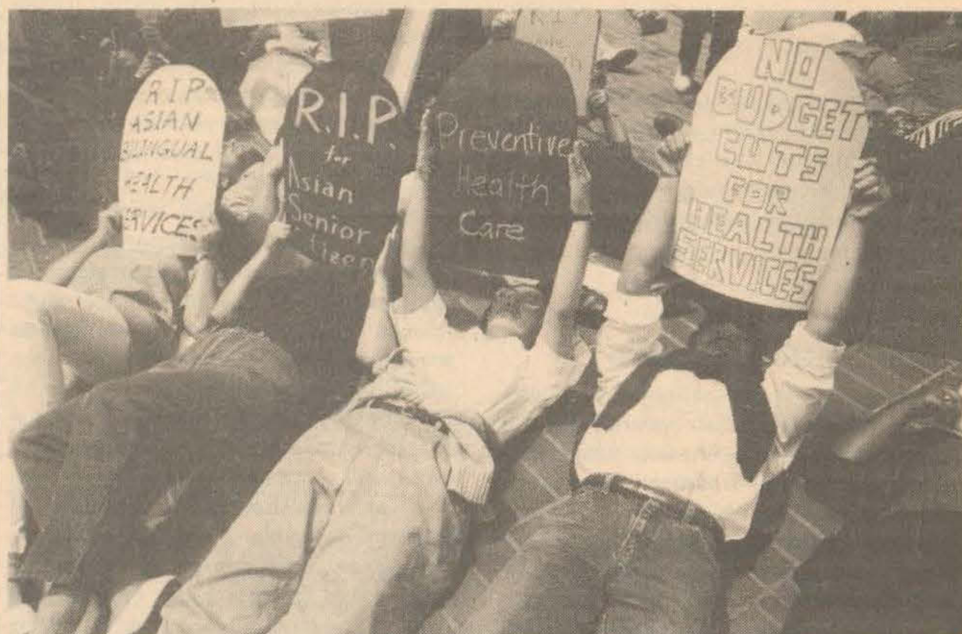
At the Democratic Socialists of America's recent National Board meeting, delegates adopted a resolution which helps define our organization's efforts toward establishing a national health care system. DSA brings a special understanding to this struggle, and while there are many proposals being offered for national health care programs, DSA's are distinguished by several points:

1. DSA strongly advocates the adoption of a universal and comprehensive plan offering services free at the point of delivery by the health care provider of your choice. All people would have equal access to quality care, but traditionally underserved populations, such as the poor and people of color, and traditionally underserved areas, such as rural states and the inner cities, would be brought to parity with the rest of the country.

2. DSA is the only organization advocating an explicitly democratic socialist program, one which advocates not only for better preventative and health maintenance care and better public health programs, but also recognizes that programs that advance "social health" -- increasing environmental protection, increasing job safety, increasing reproductive freedom, etc. -- is an essential element for any new system.

3. DSA strongly advocates for the adoption of democratic planning mechanisms at the local, state, and regional levels so that ownership and control of the health care system is primarily exercised by consumers, not health care professionals and politicians.

Yes, the political gridlock at the national level is unlikely to produce any type of meaningful reform in the next few years -- unless national Democrats adopt this extremely popular public policy as their platform. In fact, without strong pressure from below, the gridlock and lack of Democratic leadership is likely to produce band-aid "solutions" that fall far short of what is truly needed. Therefore, DSA is committed to advocating for the "left-wing of the possible" to ensure that the debate over the public provision of health care produces a national system that rivals those of other advanced industrialized countries. ●



John Jernegan/Impact Visuals

A Socialist Perspective on the U.S. Health Care System

by Victor W. Sidel

As socialists it is vital that we articulate the principles behind our work for a national health care program. I believe those principles should be:

* Health care, like all other essential services, should be provided for use rather than for profit. This precludes making people think they need a service they do not need and precludes providing services more dangerous or more costly to patient, family or society than are needed.

* Health care, like all other essential services, should be provided without exploitation of those who provide it. This precludes taking the limited amount of resources available to pay for such services (whether the source is patient, family or society) and distributing them in ways that reward some providers with obscenely high returns and others with relatively low ones.

* Health care, like all other essential services, should be provided in ways that enlighten and empower people rather than mystify or alienate them or increase their dependency.

* Health care, like all other essential services, should be provided in way that permit the recipients to evaluate it, to select among alternative services and, where appropriate services do not exist, to insist that they be provided.

Different Needs Mean Different Care

Any analysis of a nation's health care system must distinguish between "health services," which are generally designed to promote health and *prevent* illness, and "medical services," designed to treat people who *are* ill. One of the most important failures of what is mistakenly called the "U.S. health care system" is its almost exclusive focus on medical services at the expense of health services. The most important determinants of the health of the vast majority of people in any society lie not in the quality of their medical services or even in the quality of their health services, but rather in the nature of their economic, social and cultural environment. This is particularly important for illnesses known to be preventable by measures such as immunization, safe water, adequate food supplies, adequate housing, good education and protection from environmental hazard. But it is also in large measure applicable to problems such as infant mortality that can in addition be reduced by good prenatal and postnatal medical services and to infectious diseases treatable by antibiotics.

Care for the individual who has become ill -- the usual definition of medical services -- is, of course, important. But its importance almost always lies in the improvement of quality of life for individuals or their families or the lessening of mortality rates. Medical services can make people's lives better through reduction in anxiety and amelioration of symptoms or of other aspects of illness. But medical services rarely have a major influence on the reduction of mortality rates. The tasks of medical services are generally limited to binding up the wounds. The wounds have usually been made long before the patient arrives for medical services and often continue to be made, despite those services, in the homes (or lack of them), in the work (or lack of it) and in the communities.

Many physicians and other medical workers throughout the history of medicine have accepted as a part of their work attempts to maintain the health of their patients, often referred to these days as "preventive medicine" in contrast to "public health" or "social medicine." There is no doubt that preventive medicine -- the precedents for which extend back to Hippocrates and beyond -- can help to maintain or even improve the health of many individuals and families. The problem with this approach, however, is that it focuses on "patients" (people cared for by a doctor or other elements of the medical care system) rather than on everyone in the community. Perhaps even more importantly, it focuses on the patient's individual lifestyle choices. Nonetheless such interventions can be useful, and if physicians and other medical workers were better trained in providing them and better motivated to spend their time on them their patients would be better served.

But for most patients -- and certainly for most people in the community -- such techniques rarely scratch the surface in dealing with the determinants of poor health. Most of these determinants lie largely outside the control of individuals or of families: nutrition and other elements of nurturing during the prenatal period; adequate diet and living conditions during infancy and childhood; effective education; resistance to community pressures to use tobacco; alcohol and other drugs; safety in home; workplace and streets; and protection from environmental hazards are all of critical importance in determining levels of health. Counselling individual patients and families on these issues, important as that counsel may be, too often ends up "blaming the victim" rather than accomplishing significant change in these determinants.

The specific ways in which people in the United States are victimized are well known: inadequate housing; high prevalence of hunger and of malnutrition; pressures to use harmful substances (e.g., cigarettes ads) often focused on minority populations; jobs that cause illness and injury; and racism, which continues to deny equal opportunity, and to increase risks to those seen as different from the dominant group. Perhaps most important, poverty has over the past decade been increasing. We now have the greatest gap between rich and poor in the history of the collection of such statistics. One-fourth of all children under the age of five in the United States live below the officially-designated "poverty line" and one-half of all African-American children under the age of five live below that level. Furthermore, the "poverty line" is purposely set low and millions of children and adults who live just above it are also in terrible need.

Robert Fox/Impact Visuals

The Access Crisis

Medical services, which are estimated to consume over ninety-five percent of the resources devoted to the U.S. "health care system," fail to meet our needs on many grounds. The most publicized barriers to medical services are gaps in insurance coverage. For some people in the United States -- those who are wealthy or have excellent medical care insurance policies (usually through their employment) or are guaranteed high-quality public medical facilities such as those for the military forces -- there is indeed relatively good access. Others are not so fortunate.

* Among people age sixty-four or younger, approximately 35 million (estimates range from 31 to 37 million), including some 12 million children, are not covered at all.

* The number of completely uninsured people has jumped thirty percent since 1980.

* In 1981 alone federal budget cuts resulted in the elimination of two million people from the program.

* In the mid-1970s sixty-three percent of the "poor" were enrolled in Medicaid; now fewer than forty percent are enrolled.

* In general, Medicaid gives lower and slower reimbursements than either Medicare or private insurers; this limits access by patients to the large number of providers who do not accept Medicaid patients at all or accept them grudgingly.

Private insurance in the United States is generally tied to employment. There is a wide range of co-insurance rates and of benefits. The services covered are often far less than comprehensive. Preventive, rehabilitative and long-term services insurance have coverage so inadequate that a major illness would mean financial ruin. Yet, in general, people don't understand the gaps in their coverage until they become ill. Lack of insurance coverage is well known to limit access, particularly to non-emergency services. For example, a recent examination of survey data found that sixty-four percent of insured women were adequately screened by breast examination compared to only fifty percent of uninsured women.

Overall, even for those who are insured, barriers associated with poverty, race, language and social conditions limit access to services. For example, although they were all covered by Medicaid's End Stage Renal Disease Program, only twenty percent of African-American patients on dialysis received renal transplants in 1983 compared to thirty percent of white patients, only twenty-one percent of women compared to thirty-one percent of men, and only three percent of those over age fifty-five compared to eighty-five percent of those aged from eleven to thirty-five.

The Quality Crisis

a. Payment patterns. The costs to providers for billing and collection from patients and insurers are immense. These costs are a major component of U.S. physician and hospital expenditures. It is estimated that thirty percent of hospital

Health Care Principles

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The specific problems of access and quality have attracted most of the attention of those seeking solutions to the problems of the U.S. health care system. The principles proposed by the Coalition for a National Health System (CNHS), for example, are largely devoted to medical care concerns:

1) **Universal Coverage.** Access to care must be universal and cover all residents in the system in order to avoid a "two-class" system of care.

2) **Comprehensive High Quality Care.** Coverage should include prevention, treatment, and rehabilitation services in all disciplines of medical and healing arts. Freedom of choice in choosing providers in all disciplines of the medical and healing arts should be guaranteed to all.

3) **Local Control.** Communities should control their own health and medical services, which should be accountable to democratically-elected boards representative of the people served by and those that work in the program and those who work in it.

4) **Rationally Organized.** A network of services should be developed that are easily accessible and available to all. The quality and availability of services must be of a uniform high standard in all parts of the country, with integrated quality assurance.

5) **Equitably Financed.** The funding of the system should be through progressive federal taxation methods. All jurisdictions would receive proportionate funding based on population and special needs, through a centralized funding process. Inequitable differences in incomes among health workers should be eliminated.

6) **Elimination of Financial Barriers.** Out-of-pocket payment and other charges made at the point of service delivery should be totally eliminated because they are barriers to access that are administratively unwieldy and unnecessary. Financial incentives that interfere with the exercise of professional judgement, potentially leading to overcare or undercare, should be closely regulated or eliminated.

7) **Sensitivity to the Particular Health Needs of all.** Services should be designed to address the specific health needs of the community, particularly to the hitherto underserved and oppressed populations, to bring all communities up to national health standards along with affirmative action provisions to ensure equal participation for all groups.

8) **Efficient in Containing its Cost.** The system should be publicly owned and administered locally with all personnel salaried. Rational and efficient expenditure of funds based on priority of needs will be the guiding principle in policy development.

9) **Integration of Research and Training.** Health services training and research much be an integral part of the system. The cost of education should not bar any entrant into health care work, nor leave debt that would discourage public service.

Victor Sidel

and physician overhead is devoted to billing, attributing costs for supplies to individual patients, bad debt service and dealing with 1500 different insurance carriers. The costs to insurers for payment and audit are also immense. Private insurance firms in the United States have an average overhead of twelve percent compared to two percent overhead for the tax-based governmental payment system in Canada and 3.5 percent for the U.S. Medicare and Medicaid programs. Such administrative expenses divert resources from patient care. Furthermore, current insurance mechanisms may lead to discharge of patients from hospitals "quicker and sicker" because the limitation of payments to providers push them to do so.

b. Unneeded services. Along with the failure to provide needed services, our fee-for-individual-service reimbursement system provides hard-to-resist incentives to provide unneeded services for those who are insured or who can pay for them. Furthermore, the threat of malpractice litigation has caused many physicians to practice "defensive medicine," performing tests or procedures to protect themselves from suits rather than because they are truly needed. Such unneeded services are not only costly to patient and/or insurer, but can be dangerous.

c. Inadequate training and supervision. Medical licensure in the United States is regulated on a state-by-state basis. Most states are extraordinarily lax or inefficient in regulation and monitoring of medical practice. In addition, because of duplication of services, many doctors and institutions perform specific complex procedures too infrequently for maintenance of needed skills.

d. Provider incomes. The large gap in incomes between doctors of different specialties, the much larger gap between the income of doctors and those of other health workers and the enormous profits of drug companies and other medical suppliers have been widely discussed. One reason for the demand for high physician incomes is of course their extremely high outlays for education and training.

A cause of relatively-low nurse incomes is nursing's tradition as one of the predominantly-female occupations, which are rewarded at consistently lower levels than traditionally male occupations.

e. Limits on alternative services. In large part because of control by medical professionals of licensure requirements and of designation of services for reimbursement, there is limited access to alternative services such as acupuncture, community support groups or culturally-based medical care for specific groups such as Hispanic-Americans and Native Americans.

f. Problems of cost. The cost of the U.S. health care system is the highest in the world (currently almost twelve percent of GNP, $2500 annually per person) and growing rapidly, far faster than inflation. It has been estimated that the cost will reach fifteen percent of the GNP by the year 2000. In theory, this cost should not be worrisome; one would rather see resources used for good medical and health then, say, for military purposes. But when one examines how the money is currently distributed within the "health industry," when one contemplates who currently pays the cost (e.g., worker-paid premiums for family health insurance rose seventy percent since 1987), and when one considers how public funds pouring into the industry are being diverted from public education, public housing, reconstruction of our infrastructure, the cost of the health care system is indeed an important issue. Indeed, according to the National Association of State Budget Officers, medical costs account for almost twelve percent of state budgets -- the second largest expenditure after elementary and secondary education.

DSAers Report from the Field

Dave Rathke, President Missouri Citizen Action: We introduced a Canadian-style single-payer bill in the Missouri state legislature for the first time last year. We have reintroduced it this year and are currently gathering as many cosponsors as possible. Our goal is to have the bill debated on the floor of the legislature for the first time this year. If we don't succeed in the legislature, we're contemplating an initiative petition drive in order to make it the central issue of the 1992 state elections. We're also taking a look at Congressman Dick Gephardt's response to Illinois Congressman Mary Russo's single-payer federal bill.
-Tom Gallagher

Rick Brown, UCLA School of Public Health: The activity of progressive California health care groups centers on Health Access, a statewide coalition of 140 groups including advocacy groups, senior citizens, people of color, and labor unions. Health Access has been planning to place a tax-funded universal access health care plan on the California ballot in 1992, but plans are now up in the air following the recent election, since everything with a big price tag, a complicated plan, or particularly vicious opposition was defeated. Since the Health Access plan will run up against all three of those obstacles, its supporters are in the process of assessing what exactly should go on the ballot.
--Tom Gallagher

Terri Burgess, Recording Secretary of Northeast Ohio Coalition for National Health Care: Our primary activity is to build grass-roots support for universal health insurance bill in the state legislature. This bill would establish a Canadian-style state health care plan and is the first such bill introduced in the United States. Since youth and students are the group least covered by existing insurance, I am focussing on outreach to them. Seniors, particularly union retirees have taken the lead in organizing for support of this plan. We've worked with Citizen Action in designing the bill. DSA'er Ken Frisof is president of the Coalition and part of the state-wide Ohio Coalition formed to lobby for the bill. We don't expect the legislature to act against the interests of the insurers and the AMA unless people are angry and organized enough to give the state representatives no choice but to act. Many states are looking at Ohio as a model for other similar state-based efforts.
--Michael Lighty

Demands for Change

Every poll shows large majorities of the public calling for substantial change in the medical care system. Even among physicians, although many fear loss of autonomy and of income, fifty-six percent in a 1986 poll favored some form of national health insurance. (Yet seventy-four percent of the physician respondents though most other doctors were opposed to such a change.)

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Organizing Health Care Workers

by Liz Jacobs

This Spring the United States Supreme Court will rule on bargaining units in health care in a suit brought before it by the American Hospital Association (A.H.A.). At stake is a slight easing of strangling restrictions that make it virtually impossible to organize private sector health care institutions. Lower courts have ruled against the A.H.A. and for the AFL-CIO/National Labor Relations Board(NLRB). The issue is the specificity of bargaining units the NLRB will allow a labor union to file for in an election petition. The A.H.A. calls for broad units, Professional or Non-Professional. The NLRB/AFL-CIO argues for seven specialty units.

Non-profit health care institutions were not included under the National Labor Relations Act until after the passage of a Congressional amendment in 1974. This was a difficult fight, and in deference to hospital management, Congress applied tighter regulations on organizing in health care than in any other industry. Consequently, the traditional common sense rules that define a bargaining unit -- working conditions, duties and skills -- do not necessarily apply. An individual department almost never forms the basis for a bargaining unit. In passing the 1974 health care amendment, Congress directed the NLRB that due consideration should be given to prevent the proliferation of bargaining units in the health care industry (1974 U.S. Code Congressional and Administrative News 3946,3950).

The definition of the "appropriate bargaining unit" can determine the success or failure of an organizing campaign. This Congressional statement was interpreted as mandating either one large wall-to-wall unit (everyone in one unit) or one all non-professional and another all-professional. Unions have experienced the difficulty of organizing so many diverse classifications at one time. SEIU Local 250 and the California Nurses Association petitioned for a non-professional and professional unit respectively at Queen of the Valley, a large Catholic hospital in Napa, California. The non-professional unit had over forty departments. The professional unit of 336 employees had fifty-five classifications. The CNA filled authorization cards from over eighty percent of the RN's. After five days of hearings and a two month delay, the union was forced to go with an all-professional unit (their preference being an RN unit), that included several anti-union groupings, in this case pharmacists, dieticians, and social workers. After a bitter campaign where the hospital spent over one million dollars on a union-busting consultant, the CNA lost by nineteen votes.

In 1982, the NLRB issued a revised position in the case of St. Francis Hospital. Under this ruling the NLRB allowed seven specific employee groups: Service and Maintenance, Skilled Maintenance, Business Office Clerical, Technical, Registered Nurses, Physicians, and all other professional. This ruling has been frozen since last year when the American Hospital Association filed their suit. In the meantime the NLRB will recognize only five units.

What significance will there be for the future of organizing if the Supreme Court upholds the lower courts decision in favor of the AFL-CIO/NRLB and more bargaining units? Registered nurses will most obviously benefit. RNs are usually the largest single employee group with the most bargaining power in hospitals today. The ability to petition for RN only units will no doubt result in more petitions filed and more elections won. As at Queen of the Valley, without this chance the CNA will have a difficult time winning all professional units in California.

For other hospital employees, their remains two factors to consider. The first is what combination of employees will it take too win. The second and equally important is the ability to win a decent contract. That takes bargaining power; at this point in time RNs and some technical classifications (respiratory therapists, x-ray technicians, and LVNs) have the greatest strength. If the court upholds the seven units, there remains the dilemma: Does a union go for the sure win even if it's a service and maintenance unit with limited bargaining power and subsequently less chance of winning a good first contract, just to get a foot in the door? One improvement will be the ability to initially separate the traditionally anti-union business office clerical from the service/maintenance unit. Going for as much of the pie at once has obvious advantages: Even in one unit, unity demonstrated by an overwhelming vote in favor of the union also increases leverage. The more workers you represent the stronger the union's position at the bargaining table. The rules would also promote other tactics such as filing in several units at the same time to win two out of three instead of one big win or loss.

Regardless of the new court rules it doesn't change the number of hurdles a worker must jump through to get a union. No matter the breakdown of units, an employer who wants to buy time can almost always get a unit determination hearing and win a two to three month delay. As long as anti union consultants are allowed to practice their evil trade, union access to employees is severely limited, and going on strike can mean losing your job permenantly, workers in this country will continue to face an extremely uphill battle in the road to unionization. ●

DSA member Liz Jacobs, R.N., organizes health care workers in Northern California for the Service Employees International Union, Hospital & Health Care Workers Local 250.

NLRB Bargaining Unit Definitions

1. SERVICE AND MAINTENANCE

Combines all non professional service employees such as nurses aides and kitchen workers with all maintenance including janitors, clerks, housekeeping, dietary, nursing assistants etc.

2. SKILLED MAINTENANCE

Operating engineers, boiler operators, grouds-keepers, painters, carpenters.

3. TECHNICAL

The test for a technical employee (not hard and fast): requirement of a license, certification, registration, specialized training or work experience. LVN, X-ray technicians, respiratory therapists.

4. BUSINESS OFFICE CLERICAL

Key factors that set them apart are joblocation, duties that are related to business rather than patient care and separate supervision.

5. REGISTERED NURSES

6. ALL OTHER PROFESSIONAL

Exercises independent judgement, usually possess a college degree (four-year)

Social workers, medical technologists, pharmacists physical therapists etc.

7. PHYSICIAN

Michael Kamber/Impact Visuals

Sidel

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the United States "rationing" is now accomplished by limiting the coverage of public or private insurance programs, as in the recent Oregon proposal to deny Medicaid coverage for specific procedures or by failure to provide accessible or acceptable services. Patients with sufficient private resources or insurance with comprehensive coverage can, and usually do, obtain the services they want. These can range from purely cosmetic plastic surgery to organ transplants. Mandating limitations only on those patients covered by public programs would perpetuate a "two-class" medical care system.

The most important difference between the proposals at the beginning of the list (*see box, page 5*) and at the end of the list is that the ones near the end would control costs by limiting the supply of medical services and providing rational methods for making certain they are equitably distributed. Proposals near the beginning of the list would place no limit on supply but would control costs by placing limitations on what individual patients could obtain. The principles on which the proposals near the end of the list are based are similar to those of countries with health care services based on socialist principles; the proposals near the beginning of the list are much more likely to be based on ability to pay and therefore preserve capitalist principles.

How then can the rich be prevented from distorting the system by buying whatever services they want? The answer is an almost-exclusively public system, as in Sweden and in the United Kingdom before Thatcher. To approach a "one-class" system, those who want private services must pay the true costs of the facilities, the education of the professionals and the opportunity costs for others. The true cost is likely to be so high that only a tiny percentage can afford the non-covered care and, if they do, they will contribute substantially to funding the improvement of care for everyone else.

Paying for It All

Where is the money for such ambitious programs to come from? For the medical services portion of the program, reorganization that markedly reduces the extraordinarily high administrative expenses of the current medical care system, eliminates duplication of services, curbs physician income and private sector profits and reduces the provision of unneeded services would permit large sums to be shifted to the provision of care. These might be sufficient, given adequate controls on cost inflation and technological expansion of the system to meet the needs. For the health service portion, additional sums might be needed, but these would not be overwhelming. The large additional costs would come in attempts to reduce the societal causes of illness through community services.

Some of these funds could of course be recaptured from the military, the so-called "peace dividend," but we are unlikely to see a great deal of these resources in the immediate future. The other source, of course, is progressive taxation. At this point more than thirty-five percent of our national wealth is owned by the top one percent of our population, very similar to the situation in 1929, which was followed by the economic correction called the "Great Depression." There was then a fall, to twenty-three percent of wealth owned by the top one percent. Now, as a result of the tax breaks for the rich and other economic advantages for the, we are back to an obscene and dangerous maldistribution of wealth. Higher taxes on the wealthy and on corporations is the only just response to this maldistribution, and it also happens to be an answer to our need for publically-financed services.

Sweden, which may collect too much in taxes, collects them at a level of fifty-seven percent of its Gross Domestic Product (GDP) at the national, provincial and local level. Sweden is followed, in descending order of percent of GDP collected, by Denmark (fifty-one), the Netherlands (forty-six), Norway (forty-six), Begium (forty-five), France (forty-four), Luxembourg (forty-three), Austria (forty-one), Ireland (thirty-nine), Italy (thirty-eight), Finland (thirty-eight), West Germany (thirty-eight), Great Britain (thirty-seven), Greece (thirty-six), Portugal (thirty-five), Spain (thirty-four), Canada (thirty-three), Switzerland (thirty-two), Iceland (thirty-two), Japan (thirty-one), Australia (thirty-one), and the United States, which collects only thirty percent of its GDP in taxes. To meet the needs of our people and to conform to principles of justice, the United States will have to move from its current tax levels to the levels of Western Europe, from thirty percent to thirty-five or even forty percent of GDP, with the burden falling appropriately on the rich through steeply progressive taxation rates.

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DSAction

Urgent

DSA Vice-Chair Congressman Ronald Dellums has initiated a lawsuit demanding that President Bush obtain Congressional approval for the use of military force in the current Gulf crisis. A recent ruling by a Federal District Court Judge reveals the necessity of a political campaign around this lawsuit: Judge Harold Green indicated that if a majority of congress had signed onto the suit as co-plaintiffs, then he would have considered granting a temporary restraining order preventing Bush from using troops. Congressman Dellums' office urges DSAers to contact their representatives immediately urging them to become coplaintiffs in this crucial challenge to Bush's war preparations. Urge Congress to oppose a war and any deal with the White house that would allow a war without open debate and exlicit approval by the House and Senate. Write House members at Wash., D.C. 20515 and Senate members at Wash., D.C. 20510, or call their local offices.

Events

Over ninety delegates and observers attended the DSA National Board in San Francisco, November 9-11th. Marked by a productive and pleasant atmosphere, the Board established the campaign for a National Health Care System as DSA's top domestic political project. An ambitious recruitment drive with the goal of increasing DSA's membership to 9000 by the end of 1991 received strong support from local activists. Responding to the crisis in the Gulf, the Board endorsed the National Campaign for Peace in the Middle East and urged locals and the youth section to get involved in local and national efforts to prevent a war. The Board also adopted the NPC Draft Resolution on the Gulf as the basis for the organization's political work within the anti-war movement.

The DSA Labor Commission reception brought local trade unionists and DSAers together on November 9th. The head of the California AFL-CIO State Federation of Labor, Jack Henning, and the President of the International Longshoremen's and Warehousemen's Union, James Herman, joined DSA on the spot. Guillermo Ungo of the Salvadoran Movimiento Nacional Revolucionario spoke at the outreach event later that evening along with DSA Vice-Chairs Bogdan Denitch and Frances Fox Piven. DSA Vice-Chair San Francisco Supervisor Harry Britt enlivened the meeting Saturday morning. Many delegates and observers participated in the Racial Politics in the '90s Conference on November 11th, which was followed by an Anti-Racism Commission meeting that elected new officers and decided on a program for the coming year.

Resolutions on Native Peoples and 1992, Democratic Party strategy, labor support, the Puerto Rican elections, establishing an Environmental Commission, and chartering the new Inland Counties DSA local also passed.

DSA National Director Michael Lighty joined health care activists from around the northeast and the south at the Families USA/ Citizen Action Conference, "Winning Affordable Heath Care For All," in Philadelphia, December 7-9th. The program included assessments of the current crisis with an emphasis on sharing strategies and resources for state and national campaigns aimed toward achieving a government administered health care system based on universal access, comprehensive coverage, and affordability. Participants heard presentations on talking health care to the media and the Canadian health care system. The new Families USA video, "Crisis" about the catastrophic state of U.S. health care premiered to an enthusiastic response. The conference also featured sessions on The Long Term Care Campaign which seeks to establish a government administered program to cover the expenses of providing daily care to the chronically ill. Philadelphia DSA staffer Ric Kolenda, and local senior activist Bernice Sassen joined NYC DSA Health Care Task Force Coordinator Steve Oliver represented their locals at the conference.

The DSA Youth Section Winter Conference takes place February 15-17, 1991 at Barnhard College in New York City. This year's conference will focus on the Persian Gulf crisis and the prospects for peace in a post-cold war world. Invited speakers include DSA Honorary Chairs Irving Howe, Barbara Ehrenreich, Dolores Huerta, and Cornel West. For more information contact Youth Organizer Dinah Leventhal at (212) 962-0390.

The DSA Labor Commission announces its 1991 meeting slated for Chicago's Congress Hotel, May 10-12th. This conference coincides with Chicago DSA's annual Debs-Thomas-Harrington dinner on the evening of May 11th. For more information about the Labor Commission meeting, contact commission coordinator Mike Schippani (313) 665-0175.

Resources

"Socialist Perspectives on Race," a new pamphlet featuring contributions from DSAers Jerry Watts and Cornel West, received at the National Board with much enthusiasm, is now available from the DSA National Office in bulk. To order contact Barbara Farrow at the DSA National Office, 15 Dutch Street, Suite 500, New York, NY 10038, (212) 962-0390.

The Digger is a new publication of the University of Chicago DSA edited by R.J. Hinde. It addresses itself to how democratic socialists can combine the best elements of new social movement theory with an emphasis on building a coalition for progressive social change in the U.S. and around the world. *The Digger* welcomes letters, articles, advertisements and subscriptions ($10/yr - 5 issues). Send them to "The Digger," c/o UCDSA, 1212 E. 59th Street, Chicago, IL 60637.

The DSA Labor Commission has published a new working paper, *International Labor Solidarity* by Paul Garver, currently Coordinator of Transnational Corporate Campaigns for the International Union of Food Workers in Geneva. Garver argues that international solidarity work is the best hope for meeting the challenges posed by transnational capital and for promoting democratic socialism. For individual copies ($1.00) and bulk orders, contact the DSA National Office.

ON THE LEFT

California
San Diego DSA hosted "Beer with Barbara" featuring a talk by DSA Honorary Chair Barbara Ehrenreich on December 11th. The press showed up and joined the sixty or so DSAers in a spirited evening . . . . Valley DSA co-sponsored the largest anti-war rally since Vietnam when over 500 people demonstrated for peace in the Middle East on December 8th. The event included sending postcards to Congress demanding a stop to war preparations.

Illinois
Chicago DSA has endorsed 29th Ward Alderman Danny Davis for Mayor in the 1991 city elections. They held a successful fund raising event for DSAer Ron Sable as his campaign for Alderman from the 44th Ward continues apace . . . DSA's Labor Commission will join the Chicago Local in planning the Midwest DSA Retreat May 10 - 12, 1991.

Kentucky
Central Kentucky DSA's anti-imperialism committee is organizing support for the Salvadoran Coffee Boycott initiated by Neighbor-to-Neighbor. So far, they have demonstrated at four stores, with over twenty people catching the attention of thousands of motorists and shoppers. The local TV news and the *Lexington Herald-Leader* have covered these actions. Proctor and Gamble, the maker of Folgers brand coffee which is the largest user of Salvadoran beans, did their own photographing of protesters during a recruiting trip to the University of Kentucky.

Maine
Maine DSA has initiated a public forum series in Portland with a very successful discussion on the Gulf Crisis featuring DSA Vice-Chair Bogdan Denitch on November 29th.

Massachusettes
Boston DSA put on a very successful forum on health care for all featuring Susan Sherry, states campaign coordinator of Families USA on November 4th, as part of their effort to increase the democratic socialist presence in the Massachusettes health care reform effort.

Missouri
St. Louis DSA has also made the Folger Boycott a major activity with help from UFCW International Affairs Director Stan Gacek.

New York
New York City DSA is doing strike support for workers at the *Daily News*. This support has included early morning leafletting around street hawkers and newsstands who sell the scab paper as well as participation in several demonstrations. The reinvigorated Education Committee has announced a schedule of classes including an introduction to democratic socialism beginning in February along with a film series . . . . SUNY-Geneseo DSA co-organized a 500 person demonstration for peace in the Middle East at the College Union the day before final exams began. NPC member and Sociology professor Nancy Kleniewski spoke to the crowd which included students from Geneseo High School. DSAer Alex Ott appeared on three local TV news programs promoting their anti-war message.

New Jersey
Seacucus, NJ is the site of "9 Broadcast Plaza," a talk/news program produced by WWOR-TV and cablecast around the country. On December 12th, the audience participation special on the Gulf Crisis included DSA Youth Organizer Dinah Leventhal and former Organizational Director Patrick Lacefield flashing their DSA buttons while expressing opposition to war and unilateral U.S. actions in the Middle East, and advocating for time to allow (non-food and medicine) sanctions to work.

Ohio
Cleveland DSA sponsored a forum on the Gulf Crisis and how socialists should respond on December 17th. Mobilizations are now in the works for local and national demonstrations in January.

Pennsylvania
Philadelphia DSA has embarked on a recruitment drive targeted first to subscribers of the *Philadelphia Socialist*, whose most recent issue featured articles on the U.S. health care crisis and a socialist response.

Washington
Seattle DSA brought Honorary Chair Barbara Ehrenreich to a packed auditorium of over 400 at the University of Washington on October 29 to give "irreverent notes on the worst years of our lives." A burgeoning DSA Youth Section has begun at the University. The Local was also involved in the successful campaign to prevent the repeal of the city domestic partners bill. Their recent forum on the Gulf Crisis attracted over twenty area activists.

Daily News Strike: Scabs vs. Solidarity

Facing the art deco News Building on East 42nd Street in New York City, Governor Mario Cuomo, Reverend Jesse Jackson, and Cardinal John O'Connor joined strikers and their supporters at a solidarity rally for Daily News workers on a brisk December 10th. The rally planted the unions firmly on the moral high ground. Throughout the evening, the 10,000+ crowd created a chorus of condemnation directed at News management. Mineworkers President Richard Trumka, Local 1199 President Dennis Rivera, and others led chants of "scabs go home!" Participants vowed to return again and again and again until the strikers get their jobs back with justice.

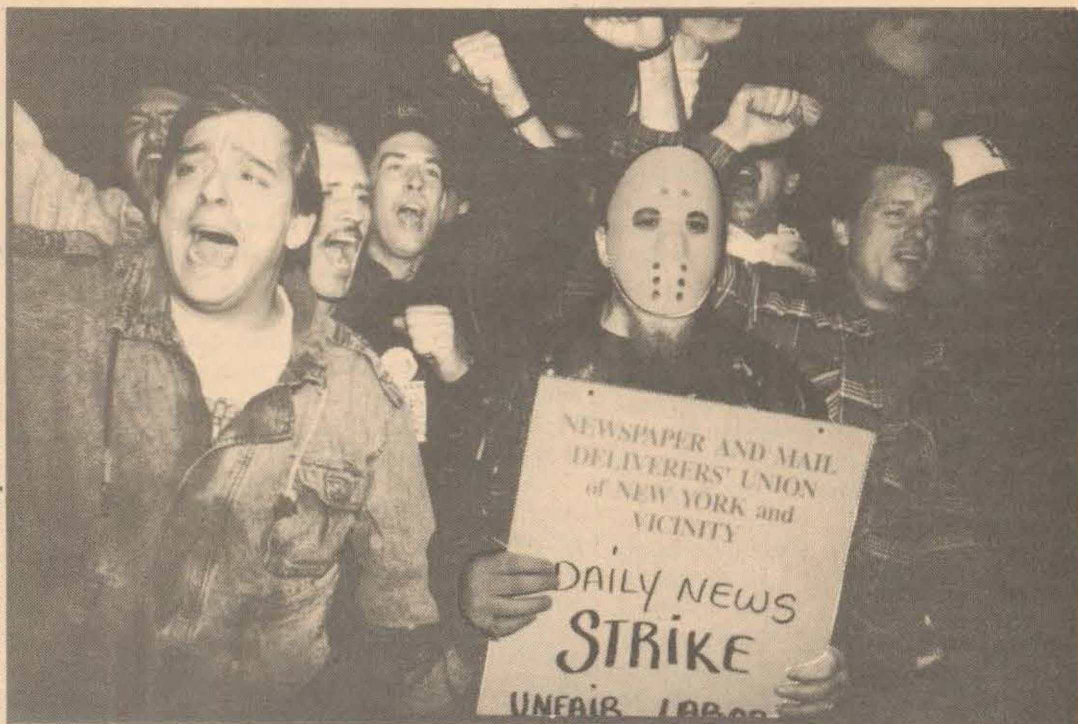
The following morning, Ohio Senator Howard Metzenbaum conducted a hearing on his bill that would ban the hiring of scabs, a.k.a. permanent replacements. The hearing sought to investigate the impact of the News' use of over 800 replacement workers. Congressman Major Owens, a DSA member, opened with a strong condemnation of this practice. Witnesses at the hearing stressed that without the legal opportunity to hire scabs, this provocation by management which became an unfair labor practice strike, would have been quickly resolved. At the conclusion of the hearing, Metzenbaum's staff received over 2000 signatures collected by DSA's American Solidarity Campaign supporting the anti-scab legislation. News publisher Jim Hoge declined to testify in person, sending instead a written statement and an anonymous "observer."

Michael Lighty

Breaking their Haughty Power:

Strike at the Daily News

By Dominic Chan



Tom McKitterick/Impact Visuals

"A turning point," a "watershed,"the "World Series of strikes", these are some of the hyperboles that are being used to describe the strike at the *Daily News*. There is little doubt that this strike, like PATCO in 1981 will set the standards for labor relations in the 1990s. On October 25, 1990, the *Daily News* management created an incident as a pretext to provoke, lock out and then fire delivery drivers at a Brooklyn printing plant. Within thirty minutes, management had brought in several busloads of "replacement" workers. Since they had put their energies into preventing a strike while working without a union contract for several months, the Allied Printing Trades Council was caught off guard. The Council and then the Newspaper Guild decided to declare an unfair labor practice strike and hit the streets. Having broken the unions at the Chicago Tribune and with the notorious firm of King and Ballow on his payroll, Publisher James Hoge was about to achieve the greatest union-busting victory under the Reagan/Bush era.

But something happened which few observers expected. Other unions in the city mobilized their forces to support the striking workers, initiating an effort among over twenty city unions to mobilize their membership and resources to do strike support work. Wavering strikers who contemplated crossing the picket line suddenly reaffirmed their solidarity and vowed to never go back to a scab paper. Some workers who crossed rejoined their sisters and brothers on strike.

A rally of 15 thousand supporters was followed by another rally of 5 thousand the next day. Subsequent rallies have numbered between 5 and 10 thousand. Nationally, the AFL-CIO made this strike its top priority; unions from across the country pledged $2 million toward the strike fund. New and innovative tactics are being used to bring the *Daily News* to the negotiating table. Unions initiated an adopt-a-newsstand campaign, urging vendors to stop selling the *Daily News*. Other supporters have gone door to door asking home subscribers to cancel their subscriptions. Another effort targeted advertisers with picketing and the "shop and drop" tactic. Reminiscent of the J.P. Stevens campaign, union members go shopping at stores that advertised in the *News*. Carrying to the cash register several dozen items, they asked if the store advertises in the *Daily News*. The "consumer" then expressed her/his shock and walked out of the store leaving the items on the counter.

The *Daily News* did not expect this kind of support for the unions. Major advertisers left at the beginning of the holiday shopping season. Most vendors have refused to carry the paper. Though some have refused out of fear of retribution, no strike-related violence has involved vendors (despite the mainstream press' reports to the contrary). Pointing out that hiring scabs is economic violence, the unions have condemned all violence, some of which has been targeted at scabs, particularly at drivers.

The *News* has resorted to using desperation tactics. Management has paid vendors to carry the News. They used New York's reserved army of the unemployed, the homeless, as street vendors. They have cut advertising rates as much as seventy percent to keep and attract new advertisers. A front page *News* story reported that a blind vendor had been threatened by union members who vowed to kill his seeing eye dog. The vendor came forward to say that no such threat existed and that he fully supported the unions. Demands for a retraction have so far been ignored.

Support for the striking unions has also come from unexpected sources. A wealthy contributor who resides in the Waldorf-Astoria Towers donated $10,000 to the strike fund. Owners of restaurants and nightclubs are providing free food and drinks to striking workers. Musicians Lou Reed, The Roaches, and Pete Seeger performed bene-

Chan

Continued from previous page

fit concerts for the *Daily News* strikers. Crossroads Magazine, a publication produced for and by homeless, is outraged at the use of the city's poorest to hawk the *Daily News*. They responded by hiring striking workers to sell their magazine. Striking workers even printed and distributed their own paper *"Real News."*

Several factors have motivated labor solidarity efforts. For public employee unions AFSCME DC37 and the Teamsters, the possible repercussions of a failed strike would be immediate as they are in the process of negotiating city contracts. For other unions, the *Daily News* is full of symbolic meaning. In the same way that Coca-Cola is a national symbol, the *Daily News* is a staple of New York. For every working-class person, the day was not complete unless you had read a copy of the *News*. For every paperboy, it was a prestigious status symbol to deliver the *News* (as opposed to the sensationalist *Post*, or the stuffy *Times*). In short, New Yorkers grew up with the *Daily News*.

The unions at the *Daily News* could have ended up like PATCO. Unable to prevent a lockout, lacking a fully developed strategy to deal with a strike that management had wanted all along, having discouraged meetings with the rank and file, the unions turned to use grass-roots activism in order to win this strike. New leaders emerged, particuarly Juan Gonzalez of the Newspaper Guild. Progressive unions which have developed sophisticated activist approaches became important for developing strategies because of their experience with rank and file activism.

The *Daily News* strike could well be on its way to victory for the striking members if community support keeps up. Union leaders argue that the paper must be sold to its employees or to an owner who will negotiate in good faith with the unions or it will go under. The Chicago Tribune Company in the tradition of Frank Lorenzo, seems more intent on busting their unions than in running their companies. Until the rights of unionized workers are recognized in the United States as they are in other industrialized countries, unions will have to keep fighting against a management that seeks to destroy even at the risk of having the company come crashing down. ●

The writer is a former Daily News *paperboy and is currently on DSA's national staff.*

Sidel

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Despite the obvious needs and the public demand, opposition to change persists. The American Medical Association and other physician groups fear loss of physician power. Insurance carriers fear los of income. Medical care institutions fear loss of control of resources. Medical schools fear changes of emphasis in physician education. Medical suppliers fear loss of profits. Lawyers fear loss of income from medical tort cases. Government officials resist any demand for higher taxes to provide services. Management (except for that in specific industries, such as the auto industry, which already through collective bargaining is paying high medical costs for its workers) fears higher medical care costs to their firms. Much of organized labor fears loss of their internal benefit and insurance programs, which provide them with income and power. Nonetheless, the public has displayed a decided desire for reform. Some proposed responses are listed below.

a. Public health" and "social medicine." Dealing effectively with the vast problems that require attention outside the conventionally-defined health care system is virtually impossible for doctors or other health workers, however well-informed and well-motivated they are, if they act alone. it is only through political action -- by health workers together and in conjunction with others -- that there is any hope of meeting these urgent needs. Rudolph Virchow, a famed Berlin pathologist, was asked by the Prussian Government in 1848 to investigate a raging epidemic in Upper Silesia. The causes of the medical problems, he reported, were government neglect and oppression, poverty, religious exploitation and illiteracy. Virchow taught that it was as much a part of the physician's role to work for social change in the name of health as to deal with the treatment of individual patients.

b. "Preventive medicine." In addition to the elements of "social medicine" and "public health" described above, which are community based, part of the treatment for patients must include "preventive medicine," such as immunization counselling to stop smoking or wear seat belts. There is little or no incentive under current insurance programs to provide such care. A special area of concern is the area of occupational and environmental health, which is almost universally neglected in U.S. medical education and medical practice. All physicians should be trained in counselling patients on such hazards, and on recognition and care for occupationally and environmentally related illness in their early stages. Furthermore larger numbers of physicians and other health workers should be trained in specialized work in this field and given greater incentives to work in it on behalf of workers, labor unions and consumers rather than on behalf of management.

Unfortunately, but all too understandably in a capitalist society, almost all the "viable" proposals that have been advanced for changing the medical care system merely attempt to fill in some of the gaps in insurance coverage. Many of these efforts are attempts within a single state to extend coverage to people who are totally uninsured and to "control costs" in that state (which usually means reducing the benefits to those covered by publicly-funded insurance).

The problem with state-based programs, of course, is that the states are severely limited in their tax-based resources and may feel they cannot raise taxes to rates higher than those of other state and there is little to prevent people in need of medical services who live in states with poor coverage from moving into states with better coverage.

The first few proposals listed in accompanying box (*page 15*) would do little or nothing to change the system in the direction of the CNHS principles (*see box, page 5*), not to speak of the socialist principles listed at the beginning of this article. Proposals near the end of the list would be more effective. The proposal of the Physicians for a National Health Program, for example, goes further in changing the reimbursement system -- by establishing a single payer system, doing away with insurance companies as intermediaries and establishing global budgeting for hospitals, as in Canada -- but fails to address many of the remaining problems. Nonetheless it has attracted the support of some unions, including the Oil, Chemical and Atomic Workers Union and of many of the progressive forces concerned with health care. The proposal that in many ways come closest to principles is the bill introduced into Congress by Ronald Dellums, but it is still incomplete and, in any case, has essentially no chance of enactment in its current form.

A fundamental problem in any medical service plan is placing limitations on the availability of specific services, which has been called "rationing." Limitations are necessary because no society can afford to pay for every medical procedure that physicians can provide or patients can demand. In

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Tax Reform and School Funding Overhaul in New Jersey

Too Radical? Or Not Radical Enough?

By Dorothy Gutenkauf

Jim Florio is "an outright socialist!" The ultimate insult was hurled at New Jersey's Democratic governor early in November by a conservative Republican legislator from one of the wealthiest counties in the nation. Although several newspapers condemned this as "McCarthyism," the remark won cheers and applause from the audience of local school board members from some of the state's wealthiest districts. Later that month, New Jersey Democrats were drubbed by the voters, who elected Republican freeholders in several counties and Republican council members in many municipalities, and almost denied Bill Bradley a third U.S. Senate term. The voter backlash was spearheaded by a coalition calling itself "Hands Across New Jersey," a peculiar alliance that included the ever-present United Taxpayers (who object to paying any taxes at all), the National Rifle Association, and the Republican Party.

Popular wisdom holds that the election was a referendum on "Jim Florio's tax program." The Democrats are scrambling to pick up the pieces before next year's state legislative elections, and the governor -- who just a year ago swamped his conservative Republican opponent -- has hit an all-time low in public support.

To understand what is happening in New Jersey politics, we must examine the events of the past year. In the 1989 gubernatorial campaign, the Republican ran on a "no new taxes" pledge while Florio, on the basis of then-current estimates, said he didn't see any need for tax increases.

But the estimates were flawed. To balance the state budget (mandated by the state constitution), outgoing Republican Governor Thomas Kean had used inflated revenue projections. When Florio took office, he found a deficit of about $600 million. Obviously, new taxes were going to be necessary.

And that wasn't the only problem. The State Supreme Court was about to rule on a challenge to the school funding law, in a case (Abbot v. Burke) brought in behalf of a number of children in urban school districts.

Essentially, the plaintiffs claimed that New Jersey's over-reliance on property taxes to fund public schools violated the state constitution by denying children in poorer districts the same "thorough and efficient" education provided by more affluent districts which spent much more per student.

The amount spent per student per year ranged from $4,000 in some districts to $14,000 in others. And it was clear that the court -- which had ruled on school funding in the past -- was going to call for a change in financing.

To deal with both problems simultaneously, Governor Florio proposed both a complete restructuring of school funding and a massive overhaul of the state's tax system. After intensive hearings and substantial amendments, his proposals were passed by the Democratic majorities in both houses of the State Legislature.

Some elements of the tax reform program were more progressive than others. The one percent increase in the sales tax, which was expanded to include such items as paper goods, was clearly regressive. But the changes in the state income tax were just as clearly progressive. In a state where local property taxes have been provided for a major portion of public services, the state will pick up the cost of such social service programs. New Jersey's income tax brackets (three, with a maximum of 3.5 percent on income over $50,000) were expanded to creat a graduated schedule of marginal increases beginning at four percent on individual income over $35,000 and family income over $70,000, and reaching a maximum of seven percent on income over $75,000 for individuals, $150,000 for families.

The governor's office estimates that eighty-three percent of New Jersey's citizens will pay no more income tax under the new formula than they had paid previously and that most of the $1.2 billion increase in revenue will come from those with yearly incomes of more than $100,000.

The revised school funding plan -- the Quality Education Act -- was equally radical. A "foundation" per-student expenditure figure was established and a complicated formula -- based on property ratables and per capita income -- developed to establish what districts could afford. State aid will make up the difference between what districts can afford and what they need to meet the foundation formula.

School districts that have suffered declining tax ratable -- that is, the state's poor and urban centers -- will get vastly increased funding, so that their property tax rates will no longer continue to skyrocket. In fact, most school districts will get additional state funding under the new "foundation" formula. But the most affluent districts, which have had the luxury of being able to provide well-funded schools while keeping their property tax rates low, will begin to pay their fair share for education.

A property tax cap and rebate schedule is designed to prevent excessive hardship for senior citizens and others living on fixed incomes. And the poorest school districts in the state will be eligible for additional state aid -- up to five percent -- if they develop improvement plans approved by the education commissioner.

It was this provision that upset the NJEA and -- in addition to the "foundation" formula -- that upset local school board members in affluent communities now facing the need to increase their low property tax rates.

It's true that affluent districts will feel a degree of strain as they begin to experience gradual withdrawal of the state funding that has allowed them to keep property taxes low. But -- like all other districts -- they will still receive state funds for special education, bilingual education, and pupil transportation.

In addition, all districts will receive special aid for "at-risk" students, calcu-

lated on the basis of the number eligible for the federal lunch program. Previously, the state provided special funding for "compensatory education," based on the number of students failing such standardized tests as the New Jersey High School Proficiency Test.

New Jersey is now widely viewed as a "test case" for school funding reform. Although national polls consistently report public willingness to pay more taxes in order to increase funding for education, the 1990 election results are not encouraging.

Unfortunately, the election results are viewed as a mandate from the voters, and the Governor has publicly proclaimed his "mea culpas." But while "Hands Across New Jersey" has called for repeal of the entire program, such action does not seem likely. Governor Florio and the Democratic legislative leadership are firmly committed to equality of educational opportunity, progressive tax reform and property tax relief.

Governor Florio's tax reform package and school funding program are steps in the right direction. Unfortunately, they are being used to sharpen the divisions between the "haves" and the "have-nots" in New Jersey -- the state which, last year, had the fifth highest property tax burden in the country. If these reforms are given a chance to work, they will probably become more attractive as public understanding grows and the positive impact on property taxes becomes visible.

And, of course, New Jersey's Governor isn't a "socialist." The program he is pursuing -- progressive taxation and equality of educational opportunity -- is solidly within the liberal-labor tradition. Indeed, if the principles of this program were radically extended, they would be a basis for a "kinder, gentler" America.

●

Dorothy Gutenkauf, a member of DSA, is a staff representative for New Jersey State Federation of Teachers (AFT).

Postscript

"Hands Across New Jersey" and its allies are now setting their sights on the 1991 state legislative elections, in which the Democrats risk losing their majorities in both houses--and the Republicans, the United Taxpayers, and the NRA are enthusiastic about the prospects.

Recently, when a group of nervous Democratic legislators announced their intention to "jump ship" relative to the teacher pension issue, the Republicans, hoping to capitalize on their uneasiness, introduced a proposal -- described by the media as "rich-friendly" and "suburban-oriented" -- for complete revision of the school funding plan. Their hopes were dashed when their proposal, which would have returned to the state responsibility for funding employer contributions to teacher pensions, was described even by the disaffected Democrats as "obscene" because it would have eliminated state aid to all districts for special education students.

The funding of employer contributions to the teacher pension fund is an issue with a $900 million price tag, and one which is intimately related to the disparity in education funding, As teacher salaries rise, the amount of money put into the pension fund rises proportionately -- and ultimately, so does teacher pensions. In affluent suburban districts, where salaries are high, more is contributed into the pension fund -- and, at retirement, teacher pensions are higher. Even the State Supreme Court pointed out the shaky constitutionality of these results.

Some Democratic legislators have now introduced a proposal to allocate a flat amount per student for employer contributions to the teacher pension fund. Such an approach could resolve the pension issue in a more equitable way.

The situation in New Jersey seems to change daily. It was amusing to note, shortly before Thanksgiving, statements by several school superintendents from some of New Jersey's most affluent districts, decrying the disparities between rich and poor districts in school funding, and making the astonishing suggestion that reliance on property taxes be *totally eliminated* in favor of a system based on a progressive income tax. Now *that* sounds more like socialism than anything in Governor Florio's program! *Dorothy Gutenkauf*

Sidel

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What is to be Done?

The only way, of course, to change the U.S. health care system so that it meets the goals we have set forth to any large degree is to change the socioeconomic principle on which U.S. society is based. Yet societies such as Sweden -- take an example that would not appear ridiculously unattainable in the United States at this time -- teach us that it is possible within a basically capitalist society to operate on socialist principles that bring health services and many other social programs closer to our model. Even lacking such principles in the general society, it is possible politically, I believe, to begin to restructure the U.S. health care sys-

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tem in ways that bring us closer to our desired principles and even bring the society closer to our goals.

Having the support of labor unions, which were instrumental in forcing the development of excellent health care programs in Europe and Canada, would be extremely important. Convincing organized labor that it will be in its interest and in the interests of its members to join in the effort for a significant change in the health care system will have to be large part of the process. There are also some large industries, such as the auto industry, that may be supportive because of their current large outlays for insurance -- outlays that would diminish if the medical care system were rationalized and financed from tax revenues. But the real support for change would have to come from the users of the systems, middle and working class as well as poor people, who would have to be convinced they will receive better care without significant added cost.

Are fundamental reorganization of the medical care system, substantial strengthening of the health care system, or major reduction in the societal threats to health likely at this time? Probably not. But the only way to be certain we will *not* get them is to fail to work for their achievement. ●

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Proposals for Change

More hope for a successful American health care system lies in federally-based proposals. Those that have been proposed range from plans to merely eliminate gaps in coverage on a regressive basis to those that would establish a genuine national health service in the United States. They include:

* A National Health System for America, proposed by the Heritage Foundation. Calls for consumers to purchase health insurance directly from insurance companies, rather than being provided it through their employers. Consumers would receive an across-the-board tax credit for insurance and out-of-pocket medical expenses. An expanded Medicaid Program would cover the long-term unemployed and the very poor.

* Comprehensive Heath For All Americans Act (HR4253), introduced by Representative Mary Rose Oakar. Requires all states to enroll their citizens in a qualified state health plan.

* Health Access America, proposed by the American Medical Association. Requires employers to provide health insurance for full-time employees and their dependents, combined with the expansion of Medicaid to cover all below the poverty line.

* Recommendations to Congress on Health Care by the US Bipartisan Commission on Comprehensive Health Care (Pepper Commission). Would broaden the current job-based/public coverage system. All employers would be required to either provide insurance for employees or contribute to a public plan. The program would also cover the unemployed and self-employed. In addition, it calls for government-sponsored long-term care, including home and community-based services.

* Basic Health Benefits for All Americans Act, introduced by Senator Edward Kennedy and Representative Henry Waxman. Employers would be required to provide basic health insurance coverage to employees and their families. The self-employed and unemployed would be covered by an expanded Medicaid program phased in by the year 2000. A basic set of benefits, including hospital and physician services, prenatal and well-baby care, and mental health services would be mandated.

* Universal New York Health Care Plan (UNY*CARE), proposed by the New York State Department of Health (Revised May 10, 1990). Recommends, for New York State, a single-payer system (but leaves the private insurance industry largely untouched) with employers responsible for purchasing medical insurance for their full-time and part-time workers and expansions in public programs for those not in the work force.

* Proposal by the Physicians for a National Health Program. Modeled on the single-payer health care system in Canada. Calls for the Federal government to finance health care for all and for the states to administer it, with global budgeting for capital and operating costs for hospitals and negotiated fee schedules for practitioners.

* Progressive Proposal for a National Medical Care System, proposed by the Council on Medical Care, National Association for Public Health Policy. recommends fundamental changes in the financing and structure of the medical care system and urges that six percent of all medical care expenditures be devoted to public health measures.

* U.S. Health Service Act (HR2500), introduced by Representative Ronald Dellums. Establishes a National Health Service with responsibility for all medical and health care for the entire population.

Victor W. Sidel

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Jimmy Higgins

"Thank you Sadaam Hussein" began Milwaukee investment banker Jim Roberts in a recent speech to defense contractors. They knew exactly what he meant and responded with laughter and applause.

But Roberts did not know that there was a peace activist in the room. When the activist told other local organizers about Roberts, they responded with protests and demonstrations. The marched outside the headquarters of Roberts' firm and draped long petitions from the buildings indoor balconies. Activists had scheduled a meeting with Roberts, but were greeted instead by a p.r. person who handed out press releases and then bid the crowd adieu. One protestor challenged Roberts to a debate, but has gotten no response. The incident was ignored by the local media, covered only by the Milwaukee Advocate, a publication of Jobs With Peace.

Roberts was traveling abroad and unavailable for comment. In the prepared statement he insisted that his words had been misinterpreted. "The point I was attempting to make was that it's still essential for the United States to maintain a military force sufficient to protect U.S. interests and citizens throughout the world."

"He's lying through his teeth," said Roger Quindel, Executive Director of Jobs With Peace in Milwaukee. Goes to show, those capitalists are certainly honest with each other.

If it walks and talks like a duck, it must be a recession. Or a "glitch," as Henry Kissinger said, or Alan Greenspan's temporary "unwinding" of economic activity. Presumably, the quote unwinding counts for more than the underreported long-term unemployment and depressed economic conditions of poor and working class communities. While one-half of all Americans believe a depression is around the corner, the free marketeers around the White House refuse to utter the "r-word." Consumer expectations have fallen to a ten year low. What some call "holiday jitters" over war and the economy have the Bush-men's knees a quaking. The reason: fear of capital flight. As oil prices rise, little money is left over. Since the deficit prevents the government from spending to stimulate the economy, foreign capital becomes ever more important. Yet, badly shaken "investor confidence" continues to erode. So euphemisms get used to try to cover-up declining employment/rising unemployment, halting housing starts and sales, disappointing retail activity, and layoffs among white collar service sector workers. Meanwhile, entry level jobs evaporate. It seems the devotees of the market (and the rest of us) are getting a refresher in Capitalism 101 -- boom and bust. Unfortunately, they seem to be studying rhetoric instead.

Now, you complain . . . As direct foreign investment in the United States falls to one-third of last year's pace, media resentment over foreign ownership of U.S. companies has reached epic proportions. The recent acquisition by Matshushita Electric of entertainment giant MCA/Universal provoked the LA Times to ask, "Have foreign buys gone too far?" Since movies exert a unique influence on national identity, the uproar should surprise no one. The media continues to report the nationality rather than the character of media ownership.

In a corporate self-description, former co-chief of Time/Warner J. Richard Munro opines that these media takeovers create "a global version of Times Square" (one thinks of homelessness, tourist towers, and a distinct lack of quality of life) which to Munro is a "raucous, noisy arena of competing messages, the good, the bad and the genuinely offensive all mixed in." That may be good enough for the backyard of the New York Times, but in contrast to this vision of a high-tech free marketplace of ideas stands the reality of expanding transnational corporate media control that reduces access and limits expression. Yet, the L.A. Times reports that the only threat to the plentiful audience choice provided by "modern multi-national conglomerates" is the "inevitable conflicts of national interests." These problems (and others) have nothing to do with ideology. Oh noooo.

At least the creator of USA Today, Al (capitalism is *natural*) Nueharth knows what's what: "whether it is the media or anything else, the economic fact is the global interests dominate over national." Perhaps it does matter what kind of entities serve *the* global interests.

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