DEMOCRATIC LEFT
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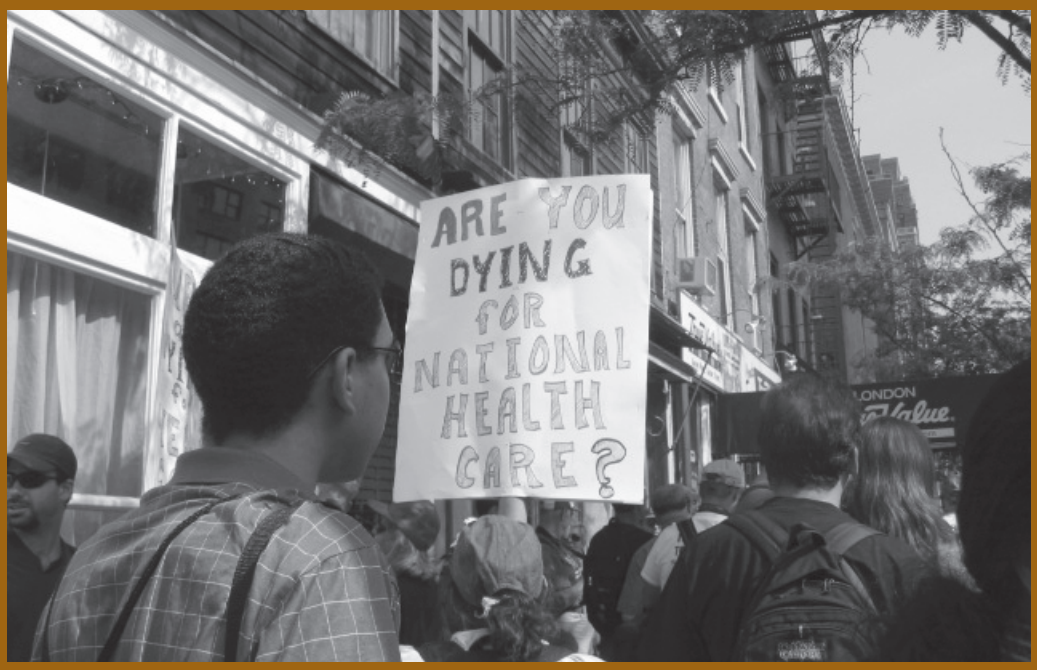

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DSA NPC Resolution on Israel's Occupation of the West Bank and Gaza

Democratic socialists are appalled by the escalating violence in the Middle East, as two competing nationalist movements ratchet up the use of military power as the prime tool for resolving differences. The damage to civilians in life and property is incalculable, and the deepening hostilities are rapidly becoming a permanent source of war and brutality in the Holy Land. The fratricide must stop and differences must be resolved if there are to be just and egalitarian societies in Israel and Palestine. Whatever one's view of the origins of the conflict, the first steps toward peace can only come today when the Israeli and Palestinian communities renounce armed struggle and commit to live within two economically and strategically viable states. We do not say this as pacifists deploring wars in general, but as socialists understanding that the rights and security of both Israelis and Palestinians cannot be won through armed struggle, but through arbitrating legitimate grievances.

Since its founding in 1983, Democratic Socialists of America has consistently held that peace would only come to the Middle East in a settlement that recognized both the Palestinian and Jewish peoples' right to self-determination. Thus we have consistently supported the Palestinian right to a sovereign state on the West Bank and Gaza Strip, as well as Israel's right to retain its character as a majority Jewish state, with full political and civil rights accorded to Palestinians and Jews, whether secular or religious, as well as to other national and religious minorities, without qualification. We reaffirm that commitment today.

DSA believes that the greatest barrier to peace is the Sharon government's efforts to *de facto* annex most of the occupied territories. The "wall" being built by the Israeli government is said to be a defense against terror attacks and protection for isolated, illegal and – in DSA's view – undesirable Israeli settlements, but its creation – whether purposeful or not – will divide Palestinian communities in a manner that precludes the creation of an independent Palestinian state. The occupation also contributes to a profound sense of humiliation and resentment as Palestinians continue to live under the most dire conditions. The Israeli government's policy of administering collective punishment, including road blocks, military incursions, the demolition of homes and the wholesale closure of the territories, is self–defeating. By contributing to mass unemployment, economic destitution and homelessness, the policy only increases the pool of extremist recruits and threatens the viability of Palestinian communities.

DSA has forthrightly condemned suicide bombings and calls on the Palestinian Authority to do all within its power to stop them. But as long as Palestinian desires for self-determination are violently denied by the Israeli occupation, terrorist acts of desperation will continue. This analysis is in no way a justification for attacks on Israeli civilians or a vindication of the wisdom of Palestinian leadership, including its often-invoked rejectionism. That leadership has been negligent – if not criminally implicated – in the failure to bring peace and justice to the region. It is to say that the Israeli government, an American ally that talks in the name of the Enlightenment and of democratic values, has pursued for 37 years a ruinous policy of occupation, and one that must end.

Peace will also not be possible until the United States government stops framing the Israeli-Palestinian conflict as part of the "war on terrorism," as its roots lie not in some nihilistic global conspiracy but in denying self-determination to the Palestinians. Nor should the legitimate cause of Palestinian self-rule be left in the hands of Islamist religious extremists who use the cause to whip up anti-Jewish hatred or allowed to be exploited by authoritarian Arab regimes to deflect their own people's attention away from their undemocratic domestic practices.

The Sharon government can pursue its destructive policies only because the Bush administration (and both parties in the U.S. Congress) grants the Israeli administration a

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(1928-1989)

Democratic Socialists of America share a vision of a humane international social order based on equitable distribution of resources, meaningful work, a healthy environment, sustainable growth, gender and racial equality, and non-oppressive relationships. Equality, solidarity, and democracy can only be achieved through international political and social cooperation aimed at ensuring that economic institutions benefit all people. We are dedicated to building truly international social movements – of unionists, environmentalists, feminists, and people of color – which together can elevate global justice over brutalizing global competition.

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"blank check." Despite the horrific Israeli occupation, no mainstream politicians have the courage or foresight to call for the end of U.S. military aid to Israel, a cessation that should last until Israel ends all illegal settlement activity and demonstrates a renewed willingness to trade land for peace.

The militarization of Israeli society is complemented by right-wing-backed free market "reforms," austerity measures and other blatant attacks on workers' living standards. These have made Israel less secure, vulnerable not just from physical assault by external enemies but from a self-induced crisis economy. The recent massive public workers strike, led by the Histadrut Labour Federation – the third nationwide strike in 18 months – is a direct outcome of the government's iron-wall intransigence, the accumulated financial burden of maintaining Israel as a garrison state, and efforts by the Likud-led government to ruthlessly privatize Israel's public sector. Similarly, the continued violence buttresses the role of the most regressive elements in Palestinian society, at the expense of the emergence of a secular, progressive leadership. As socialists, DSA supports workers on both sides of the Green Line, and not their reactionary political leaderships.

The pro-peace and labor forces in both Palestine and Israel are the segments of the region's societies with which we politically identify and from which we draw strength. They cannot succeed absent the aid of the international community. Only a U.S. government willing to take a forthright stand against Israel's occupation policies by threatening to cut off military aid can move Israeli policy in a pro-peace direction. At the same time, the U.S. and the European Union (the main provider of aid to the Palestinian Authority) should pressure the Palestinian Authority to do all in its power to cease attacks on Israeli civilians.

In addition, the United States, the European Union and the United Nations must station a permanent international armed peace-keeping force to separate the parties now. Such a force must be maintained during what will be, by its nature, an initially fragile peace. Only years of peaceful coexistence between a viable Palestinian state and a secure, but non-expansionist Israel can bring a durable, self-sustaining peace to the Middle East.

The outline of a just peace settlement has been visible since the nearly successful secret talks between Israel and the Palestinian Authority in 1995. In return for a just peace, there must be an abandonment of all Israeli settlements on the West Bank and Gaza Strip, except those that a peace treaty might exempt through a mutual exchange of territory. In addition, the capital of the Palestinian state must be sited in the Palestinian parts of Jerusalem, as the Palestine National Council argues. Finally, Israel must recognize its responsibility in the creation of the 1948 Palestinian refugees, as well as acknowledge that its majority Jewish character is predicated on the permanent displacement of hundreds of thousands of Palestinians and their descendants. That clear-eyed understanding should be balanced by Arab acknowledgement that nearly an equal number of Jews were forced out of Arab lands – states in which they had lived peacefully for thousands of years – during and after the creation of the state of Israel. A just settlement to the Palestinian refugee question will involve limited resettlement of refugees within pre-1967 Israel, but mostly massive economic compensation paid for by Israel and the Western Nations that refused to absorb the Jewish refugees from the Holocaust.

Whatever the precise nature of a just two-state solution to the Israeli-Palestinian conflict, peace will remain elusive absent a balanced U.S. regional foreign policy. As a U.S.-based organization that supports a just two-state solution to the Israeli-Palestinian conflict, DSA is committed to alter the ruinous bipartisan policy of successive Washington administrations that facilitates Israel's disastrous and self-defeating occupation of the Palestinian people.

—Adopted October 2004

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BACK COVER: DSA PAC Statement on the Kerry Campaign

SPECIAL CENTER SECTION

Affordable Health Care for All: Turning a Dream into a Reality

by
Ken Frisof, MD

In the lead up to next month's election, health care is barely on the radar screen. Bush's blithe ignorance of the problem is only partially addressed by the Kerry campaign's incremental efforts to beef up accessibility to prohibitive private insurance. After Nov 2, regardless of which party wins the White House, a fight for health care will have to be waged again. That is why we are publishing Dr. Ken Frisof's primer, both as a supplement to DL *and as a separate pamphlet.*

Beyond Kerry: DSAers Back Local Candidates

By Theresa Alt and Michael Hirsch

Electoral campaigns are just one arm of socialist activity, but in a presidential campaign year that's the arm that gets the workout. A survey of DSA leaders and locals around the country found members up to their elbows in voter registration and issue-oriented, get-out-the-vote efforts in strategically chosen Congressional, state legislative and municipal contests. Local races were targeted where control of state houses were up for grabs and where statewide electoral-vote outcomes hinged on successful local district turnouts.

Detroit's Aldo Vagnozzi

DSA comrades chose candidates for diverse and often divergent reasons. Some few candidates made the effort to offer an alternative to mainstream, corporate-dominated politics, promising to be a voice for labor and social movements once in office. Such candidacies were also easy vehicles in what is shaping up as a battleground state "pull operation" in which activists could help deliver progressive turnout for the presidential race. In many other cases, support was tactical, given to those professional politicians whose programs or quality of character were neither exceptional nor noteworthy but whose races challenged particularly odious right-wing incumbents while also ginning up the anti-Bush vote.

In at least one case—where an all-but-elected Democratic centrist is sleepwalking past token Republican opposition—DSA members are stumping for a lion of the socialist Left running as a Green Party candidate for U.S. Senate. The point? Paying down long accumulating debts to a worthy movement veteran while telling the state Democratic leadership: you better do better.

While many DSAers are individually supporting attractive local independents, too, the consensus is that involvement in purely symbolic or educational campaigns in the general election is a non-starter. In some cases it was the ostensibly radical and alternative candidate who was the one needing the education. As one sobered comrade joked, a case could be made that his district's long-despised Democratic centrist incumbent was "the 'lesser of two evils' when measured against the bizarro-world leftist competition."

SWING STATES

Michigan

Detroit DSAers isolated two state legislative races where they can make a difference in swing districts of this toss-up state. In the Detroit suburbs of Farmington/Farmington Hills (SD 37) labor-backed Democratic incumbent Aldo Vagnozzi holds his seat thanks to a 2002 upset. A supporter of gay marriage, a strong patients' bill of rights, and an opponent of the death penalty, Vagnozzi filed prescription drug bills before the legislature. In response, state Republicans are putting more than $250,000 into defeating him. In Port Huron/Lexington (SD 83) former migrant farm worker John Espinoza, who opposes school vouchers, is making living wage and health care features of his campaign. Thanks to Farm Workers leader Dolores Huerta for connecting DSA with the candidate, who is well-liked but is running a poorly financed operation. That may not matter, as his Republican opponent is caught in a scandal over use of nonprofit funds for campaign purposes. A fund raiser was hosted by Detroit DSA chair David Green, who urges friends to "...write two checks (made out to 'Aldo Vagnozzi for State Representative' and 'Committee to Elect John Espinoza' respectively). Write 'DSA Fundraiser' on the memo line."


Philadelphia's Tim Kearney

Pennsylvania

Greater Philadelphia DSA's PAC is stumping for Democrat and longtime progressive activist Tim Kearney in his run for state representative (172nd District) in Northeast Philadelphia. Battling on healthcare and education, Kearney would introduce a comprehensive single-payer health bill to the Harrisburg legislature, increase funding for public schools statewide, raise the state's share of local school funding, equalize funding between urban and better supported suburban schools, and freeze state university tuition for in-state students. Comrades are also supporting state Senator and health activist Allyson Schwartz in her effort to win the open 13th CD seat left by Joe Hoeffel, who is—also with DSA support—challenging Republican

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Affordable Health Care for All

Turning a Dream into a Reality

by

Ken Frisof, MD

Published by the Democratic Socialists of America

Health is an indicator of social class. When the Labor Government established Britain's long-needed National Health Service after World War II, the move had the unanticipated consequence of removing the most visible distinction separating working men and women from their upper class betters: bad teeth. As expected, NHS provision of ready access to virtually free care drastically increased workers' longevity by sparking a drop-off in deaths from opportunistic and easy-to-spot-and-treat illnesses. But the real physical distinctions between the classes – not just the elite myth of a working class "smell" that George Orwell isolated and satirized – were also eliminated by positive government intervention to end a social problem.

The class divide in health care is not much less visible in America today than it was in pre-war Britain. The public sector in general and all forms of social welfare policy are under the privatizing gun. 45 million Americas go without any health care coverage. Many of the elderly choose between medicine and food. Malnutrition is prevalent among new immigrants. The poor are undiagnosed and primary care doctors are still scarce in rural areas and inner city neighborhoods. Undetected lead poisoning harms children's ability to compete for a place even on the lower rungs of the social ladder. Poor health is still the mark of Cain.

Unlike Europe, where socialists succeeded in having health care judged as a human right, core elements of the U.S. public accept it as a purchasable commodity, and public discourse revolves around how to pay for it. And unlike in the Scandinavian countries, whose conservatives were frustrated in efforts to privatize the system, the U.S. takes private health care as a fact of life. Only in a few states such as New York are private for-profit hospitals even disallowed, though the non-profit university and other hospitals are frequently operated along market lines as cash cows for their parent institutions and private boards.

Nationwide, private chains such as Humana are growing and research aims at treating the ills of the rich and the needs of corporations. Only public education is still prized, and even there, voucher supporters and charter school advocates are making inroads and attempting to drain public dollars into private hands.

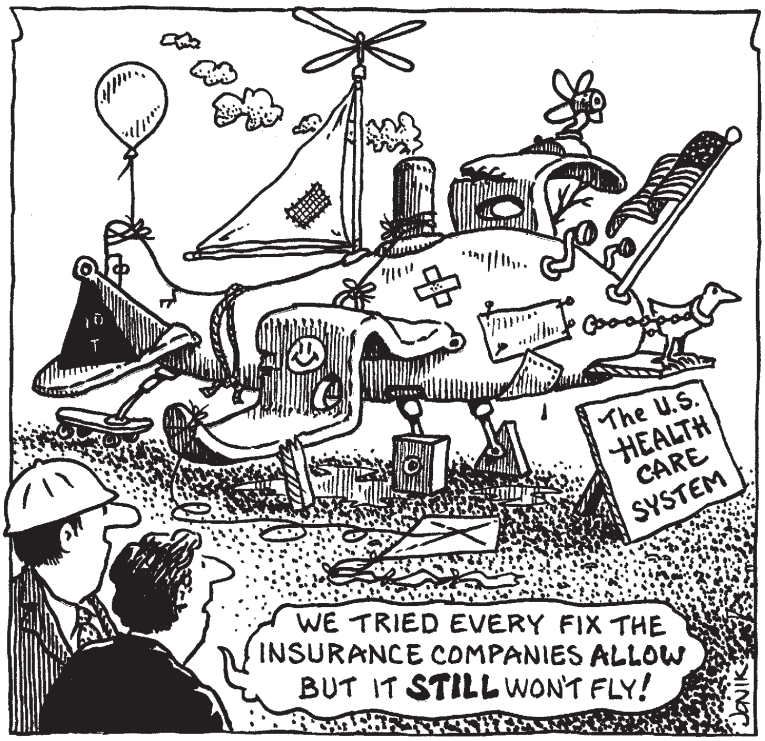
Instead of government subsidies to private insurers, DSA supports a single-payer system, similar to the Canadian model and to legislation introduced more than 10 years ago by the late Senator Paul Wellstone and Rep. James McDermott. Their initiative—needed more than ever—would offer continuous coverage funded through progressive tax levies. With far fewer administrators than are required by the myriad private plans, with less paperwork leading to cost containment and with corporate influence over diagnosis and treatment blunted, hospitals and doctors could focus on medical delivery. Doctors would still operate private practices, but lower rates would be set by the government as the sole purchaser.

Frisof helps demystify and unravel the complex issue of how health care developed in the United States and what the prospects are for universal health care today.

Introduction

Imagine the U.S. health care system as a big, complicated machine, full of nuts and bolts and cogs and wheels and motors. There are thousands of pieces – an intricate jumble of law, policy, tradition, technology, bureaucracy, and practice – transforming what we put into the machine (money, time, energy) into what comes out: health care. Our health-care producing machine was assembled slowly over the last 150 years, pieced together from a variety of laws and traditions that weren't designed or intended to work together. Our machine has been patched up a number of times as we've added new cogs or tightened some screws and filled in some gaps, and new and changing technologies have improved some of the machine's parts, but this machine has never received a complete overhaul.

This machine – the U.S. health care system – is breaking down. It still works – very well for some, so-so for most, and barely at all for far too many. The machine consumes one-seventh of the national economy, an input so great that it will never suffer a total breakdown. But it is certainly the least efficient machine of its class, consuming far more and producing considerably less than the health care systems constructed by other industrialized democracies.



This DSA pamphlet will:

- Describe the current problems in U.S. health care;
- Provide a brief history of the political economics of American health care;
- Explore the economic and political roots of the problems;
- Delineate how to make change happen.

The Current Problems in U.S. Health Care

The central dynamic causing the current crisis in U.S. health care, leading to the breakdown of our health care machine, is escalating cost. As costs rise, health care becomes less and less affordable for more and more people.

The access problems in American health care are a consequence of the cost problems. Health insurance premiums are rising, so fewer employers are offering health insurance. Fewer workers can afford to pay their share of the premium, so they elect not to carry health insurance. They gamble that no one in their family will get seriously ill. Others have insurance policies, but the policies have such high deductibles and copayments that families delay seeking care to avoid the expense until they feel absolutely compelled. They go for care and do not pick up all the prescriptions written for them, or they pick up prescriptions for medicines needed every day but take them every other day to save money.

There is regular public discussion about the problems of the uninsured. Their number has increased by 5 million over the past four years, to 45 million in 2003, more than one in six Americans under the age of 65 (virtually everyone over 65 has publicly financed insurance through Medicare). But this is not a stable group. As people lose jobs or get new ones, they go through episodes of health insecurity when they lose their insurance. Over the last two years, nearly one in three Americans under the age of 65 was without insurance for one or more months.

But uninsurance is only part of the problem. Underinsurance, insurance which leaves such big financial burdens on patients as to hinder their access to care, is harder to estimate exactly, but is at least as large a problem. Conservative estimates place the number of underinsured in the U.S. at 50-70 million. In fact, underinsurance (i.e., excessive financial strain as a consequence of costs associated with illness) is a major contributor to half of the personal bankruptcies in this country.

Not surprisingly, uninsurance and underinsurance are almost exclusively problems of low and middle income workers.

A Brief History of the Political Economy of Health Care in America

From 1776 through the early twentieth century, the vast majority of payment for health care came directly from the pockets of patients – sometimes in cash, sometimes in goods, sometimes immediately, sometimes later. Doctors made house calls. For the poor, local governments and reli-

gious institutions set up charity care in which providers volunteered their services.

In the early decades of the twentieth century, hospitals rose in importance and medicine was institutionalized. Advances in medical technology, hard times during the Great Depression, the growing influence of organized labor, and the political recognition of the importance of security issues led to the initiation of private insurance in America. Employment-based insurance was an unintentional side-effect of wage and price controls during World War II. Employers could compete for scarce labor through benefits to their workers (e.g., health insurance) but not through higher wages.

After Medicare and Medicaid were added to the Social Security Act in 1965, publicly financed health insurance has become the largest health care payer. Expanded and modified since their inception, these programs increased the role of federal and state governments in making health care accessible for specific populations. Also, they have contributed to portions of our health care system that facilitate everyone's care, such as medical education and research.

Cost containment became a hot issue within five years after the implementation of Medicare and Medicaid. The Johnson Administration, afraid of strong opposition from physicians, had devised reimbursement techniques that included no cost-containment measures. As a consequence, federal health care spending grew much more rapidly than anticipated.

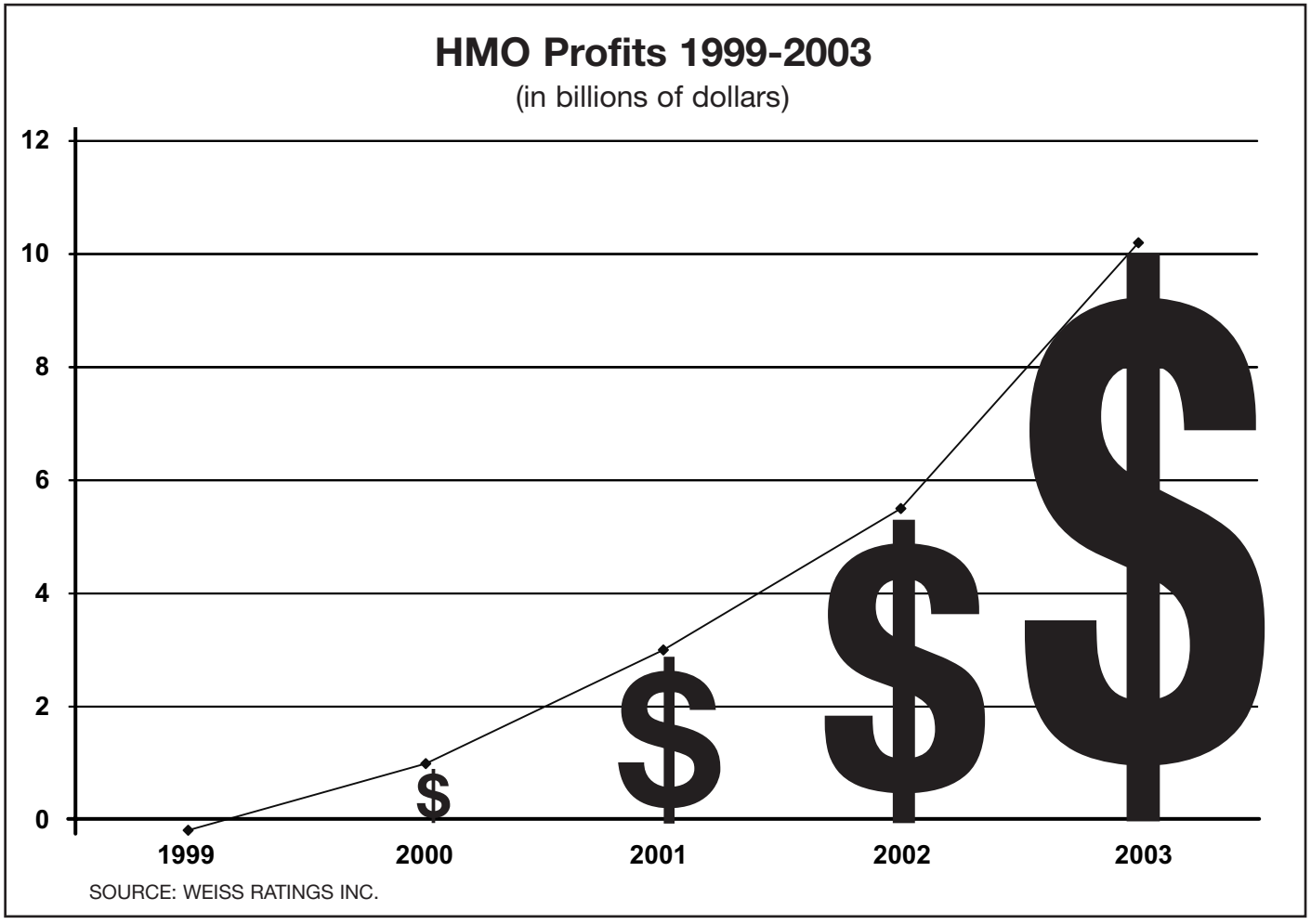
In the 1980s, the federal government introduced by administrative regulation two new methods to control costs.

Hospitals were reimbursed by a "prospective payment" system through which they receive a flat rate for patients with similar problems (Diagnosis Related Groups or DRGs).

Physician payment changed to a Resource Based Relative Value System (RBRVS) in which fees were set by calculations of complexity, time involved, and training needed.

Under these arrangements, hospitals finally had financial incentives to be efficient. There was a lever to reduce grossly excessive historical physician fees. The rate of health care inflation for the government fell sharply. But the health industry, always seeking "greener pastures," recouped its money by raising charges to private payers. This led to major private sector inflation of the late 1980s and early 1990s and the push for managed care.

What is now known as managed care started as "prepaid group practice," a progressive reform in the middle of the twentieth century that offered workers organized, integrated, comprehensive care with little to no copayments. Ideologically reluctant to support national health insurance



SOURCE: WEISS RATINGS INC.

during the cost crisis of the early 70s, the Nixon Administration enacted HMO legislation, primarily with an eye to controlling health care spending. But HMOs did not really take off until the late 80s, when U.S. corporations embraced them as a way of containing costs and forced workers into using them. Starting in the mid 90s, state governments forced Medicaid patients into managed care, while the federal government tried to entice seniors into Medicare HMOs.

In theory, managed care could save money by:

Managing costs: Lowering prices through strong negotiations with providers and threatening to take business elsewhere.

Improving care: Providing financial incentives and bureaucratic mechanisms that promote less wasteful practice patterns, reducing the quantities of services actually delivered.

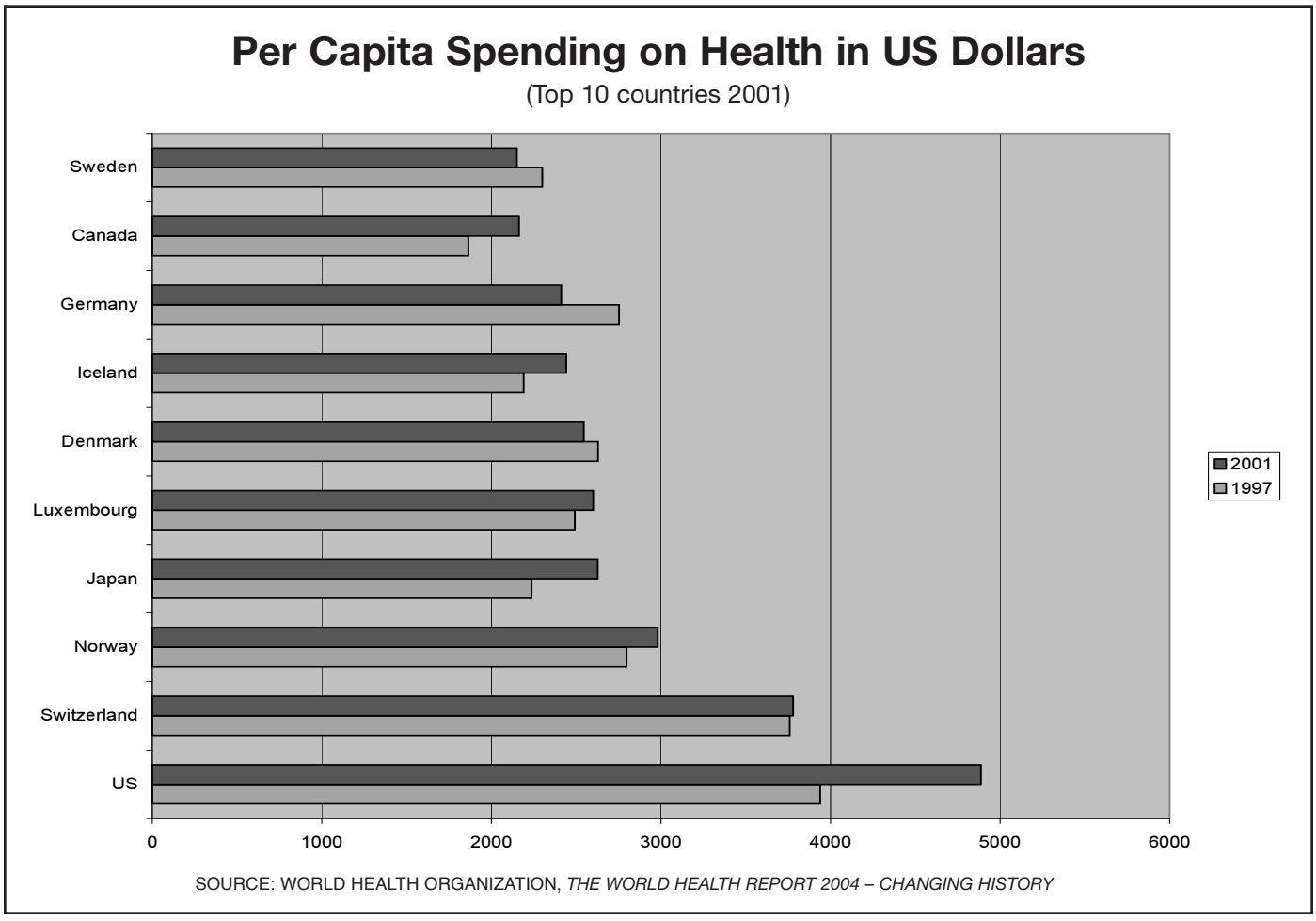
Most analysts agree that in the mid-90s, managed care reduced health spending, primarily through strong negotiations that lowered provider prices. But the attempt to reduce quantities of service led to a backlash that undermined its political legitimacy. Beginning with political opposition to particular medical procedures, i.e. state bans on "drive-through deliveries," the backlash expanded to patient "bills of rights." Moreover, because they preferentially recruit healthier patients, HMOs do not reduce overall spending. Finally, hospitals in many metropolitan areas have consolidated into for-profit "chains" or not for profit "systems," increasing their strength at the bargaining table.

Roots of the Problems in U.S. Health Care

The best way to understand the roots of the problems in American health care is through comparison with other long-standing democracies. The World Health Organization's *World Health Report 2000: Health Systems: Improving Performance* is the most widely quoted international comparative study.

It offered two main quantitative conclusions. First, the United States ranks first in health care spending. American health care costs twice the average of other industrialized nations, and is a third more expensive than the second nation, Switzerland.

Second, the U.S. ranks 37th in the world in the efficiency of our health care system. In other words, for the dollars we spend, we are obtaining much worse results than other nations. For example, the U.S. ranks 16th in the world in female life expectancy, 17th in the world in male life expectancy. We rate 21st in the world in infant mortality. We have the third lowest rate of childhood vaccination in the western hemisphere.



Why does the U.S. rank so poorly in health care outcomes and efficiency?

First and foremost, it is because we don't have a national commitment to health care for all.

The technical details of health system financing and delivery in the thirty-six nations that are more efficient than us vary widely, but all differ from ours in the fact that they have real systems that include everyone. Unlike the U.S., with its steadily growing population of the uninsured and underinsured, all persons in these nations have affordable access to comprehensive care.

The Market Fallacy in health care

Other nations understand that health care is a social good, a public good – a good that benefits all people, like fire departments, police departments, and clean water. The United States stands alone in continuing to treat health care primarily as a market commodity purchased by individuals for their "personal" use.

While the ideology of the market dominates American political and economic discussion today, it is particularly inappropriate in health care. Health care is not a "pure" market for several reasons:

In classical markets, if one cannot afford a commodity, he does not get it. In health care, even though we do not guarantee affordable access to comprehensive health care to all, we do not want people to die on the streets. There is a legally enforceable right to emergency room access and subsequent hospitalization if needed. So it is not that the uninsured get no health care. In the words of the Institute of Medicine, the care they get is "too little, too late" – and, consequently, less effective and more expensive.

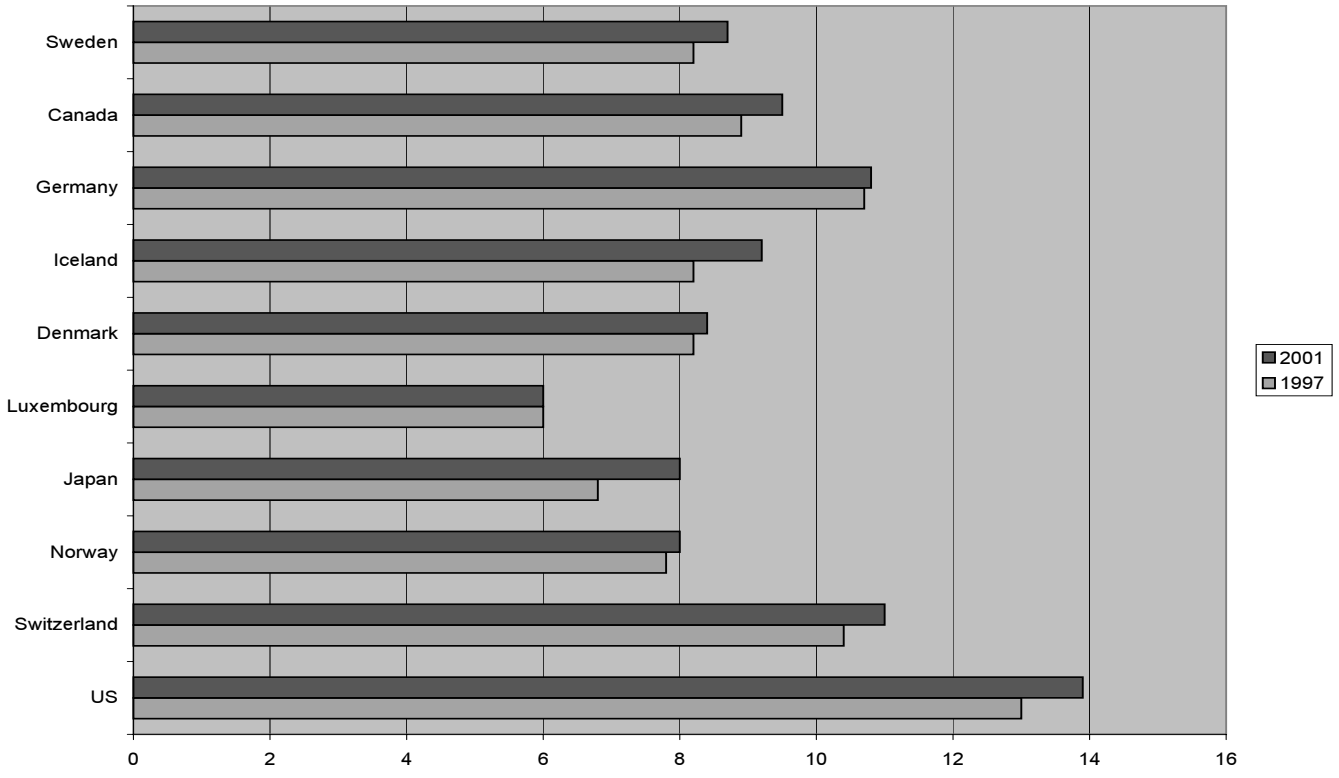
In classical markets, rational consumers make thoughtful decisions on purchases based on price and quality. In health care, patients are rarely totally rational; they are in pain, fearful about their symptoms, anxious. Prices are rarely known. Information on quality is hard to come by.

Entry into the medical field is restricted. No one can simply hang up a shingle and begin treating patients.

Physicians are not perfect substitutes for each other. The doctor-patient relationship requires time to cultivate.

In economics, when a particular market deviates from the characteristics of a "pure" market, attempts to make it perform according to pure market principles will have uncertain effects on overall economic efficiency – and may produce perverse outcomes. This market mentality is the root cause of the three components of the economic problems of American health care: high prices, waste, and excessive fragmentation. But since all economics is fundamentally political economics, the reason these problems persist is

Spending on Health as Percentage of Gross Domestic Product



SOURCE: WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 2004 – CHANGING HISTORY*

the power of vested interests to influence the debate on how to fix American health care.

Economic Problems in U.S. health care: High costs and waste

High costs and waste impede reform by making it seem as though expanding access is prohibitively expensive. Based on the misconception that overall costs can only be controlled by reducing use of health care services, this illusion has long hampered reform efforts.

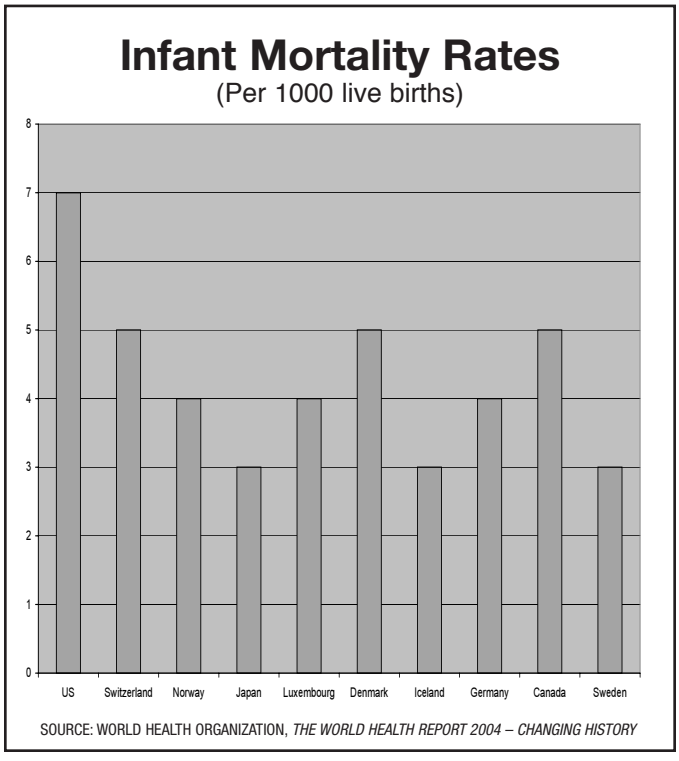
High costs are caused by more than merely high utilization. Some causes of high costs include:

- high prices for goods and services, demonstrated most vividly in drug prices;
- high administrative costs due to the enormous complexity of American health care financing (fragmentation) - huge numbers of insurance companies and insurance products, frequent gaps in coverage and changes in plans. (A 2000 study in Seattle already showed that 2277 people were covered by 755 different policies linked to 189 different health plans!)
- economic incentives and cultural expectations that promote clinical practice that excessively utilizes high cost treatments and inadequately reward prevention, chronic care, and information sharing.

Fragmentation of health care finance and delivery

Unlike health care systems in other western democracies – all of which more or less guarantee comprehensive health care to all residents – American health care lacks clear lines of authority and responsibility. It is less a "system" than an assortment of haphazard arrangements, with thousands of small players vying for a good spot in the game.

This contributes to the high cost of American health care by making administration, communication, and coordination more difficult and more expensive. Effective solutions will have to "defragment" American health care and simplify it.



SOURCE: WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 2004 – CHANGING HISTORY*

The role of vested interests

Many key players have a vested interest in seeing the fragmentation that characterizes the status quo continue indefinitely. In health care, because the services clinicians, hospitals, pharmaceutical manufacturers, and others provide are seen as so essential, the balance of power is widely skewed in their favor. Even seemingly monolithic government-sponsored insurance is in reality divided into a number of smaller groups.

This has direct consequences for the politics of policy change. Many of those comfortable with the status quo are able to spend a lot of money defending those interests. While the activities of lobbyists and campaign donors may not always determine how politicians vote, they certainly influence how legislation is framed.

Moving forward: making reform happen

In January 2004, the Institute of Medicine of the National Academy of Sciences issued a report entitled Insuring America's Health: Principles and Recommendations that contains five principles to guide and evaluate reform. The United States needs health insurance that is:

- Universal
- Continuous
- Affordable to individuals and families
- Affordable and sustainable for society
- Able to enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.(IOM: 8-9)

The IOM emphasizes high-quality care because it would be very easy and completely meaningless to expand insurance coverage by leaving patients with complex, expensive, and limited insurance. The ultimate goal of health care reform is to improve health. Expanding coverage is merely a means to that end.

However, providing everyone with access to comprehensive health care has to be undertaken at the same time as we tackle the political barrier of cost control.

A large number of policy solutions have been advanced in recent decades to reform health care. These are best understood as consisting of three broad categories:

Conservative solutions: seeing health care as an individual responsibility;

Liberal solutions: Expansions of group coverage through employers or public systems;

Hybrid models.

Health Care as an individual responsibility

In this model, individuals are responsible for purchasing their own health insurance. Called the individual mandate, it parallels state requirements for motorists to purchase auto insurance.

Tax credits. For those whose incomes are too low, tax credits can be made available. Tax credits can go either to individuals to help them buy private insurance or to companies with low-wage workers to help them purchase insurance. In some of the more sweeping versions of the individual mandate approach, the employer tax deduction for paying for health insurance is eliminated and the funds redistributed as tax credits.

Health Savings Accounts. Another approach for holding individuals responsible for making financial choices as consumers about how much care they can afford is the establishment of Health Savings accounts (formerly called Medical Savings Accounts). Individuals purchase a "high deductible" form of catastrophic health insurance. If they stay healthy and don't spend all their deductible, they can bank it for future use and/or spend it for non-health related purposes.

Expansions of group coverage: Employer-based

Since most people who are uninsured are workers, one approach is to increase the number of companies offering health insurance. This is known as the employer mandate. One widely used model is called pay or play. In this approach, a company may either purchase health insurance from a private company or pay a payroll tax on its employees to enroll them in a publicly designed and accountable insurance plan.

Expansion of public insurance

Two models of expanding public financing arise from the two major public programs in the U.S. – Medicare and Medicaid – while a third is based on Canada's system of public finance.

Medicare. Medicare is social insurance, covering all in certain categories of age and disability regardless of their ability to pay. Some proposals build on this social insurance model, putting everyone under Medicare because of the administrative efficiencies of this "single-payer model." Other proposals pick certain age ranges – children or pre-retirement adults – for Medicare program insurance expansions.

Medicaid. A second model of expansion of public financing is targeted to people with low incomes. Enacted in 1965, Medicaid is a means tested program that covers low-income individuals of all ages. The State Children's Health Insurance Program (S-CHIP), passed in 1997, is an addition that makes children at higher income levels eligible for publicly supported coverage. Some proposals focus on increasing the income eligibility for these programs. Public financing also can be targeted to assist community health centers to improve access in poor neighborhoods.

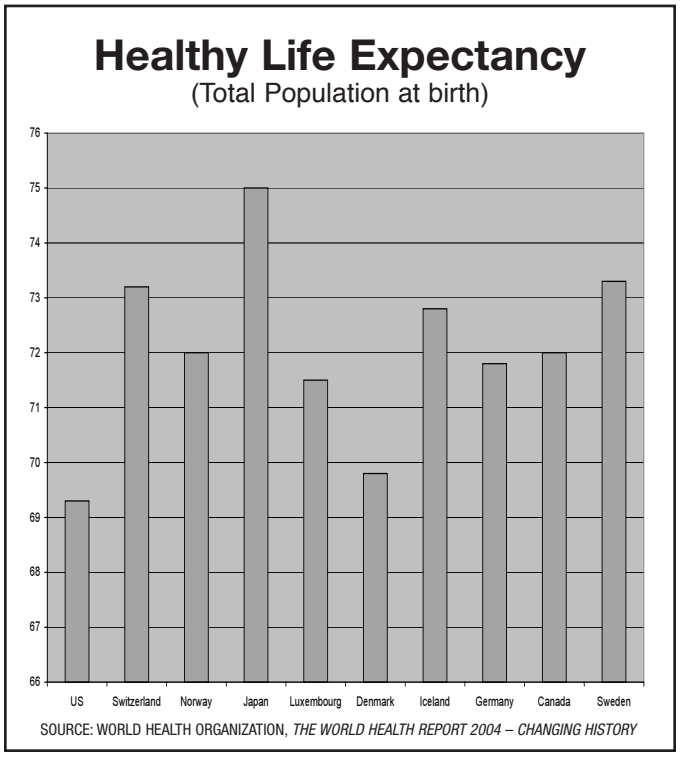
Single-payer. Single-payer or "Canadian style" health care means that the government becomes the exclusive insurer and financer of health care. All Canadians pay taxes – some of which are earmarked for health insurance – and all Canadians are automatically enrolled in the provincially run insurance programs. Costs in the Canadian system are lower because of much lower administrative costs, the ability to bargain for lower prices from providers and suppliers, organized planning and sharing of major capital expenditures, and an emphasis on preventive, chronic, and primary care.

Hybrid models

Recognizing the long-term political deadlock on comprehensive health reform, some proposals mix reform elements popular with different constituencies.

Public program expansions and tax credits. Commonly, hybrid proposals at the federal level include both public program expansions and tax credits. Medicare, Medicaid, and possibly S-CHIP would cover more categories of patients. Tax credits would be offered to businesses who insured their employees and private individuals who chose to purchase insurance.

Federalist Model. A second hybrid approach uses states as "laboratories of democracy." In the federalist model of comprehensive health care reform, national legislation offers federal financial support to states implementing universal health care plans that meet federally established standards of affordability, comprehensiveness, cost containment and public accountability. States could choose any



one of a variety of models consistent with their local political cultures and institutional structures.

Fixing American Health Care

Fixing American health care is not "rocket science," but "political science." We may or may not need more money for health care. We certainly need more health care for our money.

We offer three broad suggestions to make the health care justice movement more strategic and savvy.

Making change involves recognizing what needs to change and who needs to be involved. In the U.S., the first part of the prescription means honestly assessing and planning for cultural and institutional resistance to change. The activist should be equipped with arguments for universal, comprehensive health care that speak to everyone across the political spectrum. The second part of this prescription, recognizing who needs to be involved, means that activists should identify and target key players in the health care politics game. In particular, this entails appreciating the power of health care special interests and learning to work with them or to undermine them at key points.

Fixing health care isn't just a question of "may the best plan win." There are no plans that are best for everybody. Instead, there are plans that do a reasonable job of balancing competing interests, plans that better reflect the financial interests of interested parties, and plans that better reflect the health needs of individuals and commu-nities. There are plans that are focused on providing a bare minimum or changing as little as possible, plans that aim for truly comprehensive care, and plans that aim to change as much as possible. All plans involve some compromises between competing interests. For us, the best plans will be those that build effective coalitions that are compatible with the ideals of justice in health care – comprehensive care, fair financing, and accessible delivery.

There is a dialectic between the long-term goal of achieving universal health care and the short-term goal of improving access and affordability. Many health care justice activists believe that only a federally funded and regulated health care system will solve the problems of access, quality, and cost currently facing us. Others believe that the current health care system is such a mess that any legislation improving access or controlling costs is better than the status quo. The challenge for health care justice advocates is to strike a balance between working for long-term change and supporting short-term fixes, between holding fast to ideals of equality and justice and finding practical paths to improving access and quality. This task is daunting but not impossible. Equipped with a basic understanding of the health care system, a working map of the political system, and the conviction that health care justice is possible and worth striving for, we can make change happen.

We need to be loud, constant, and articulate advocates for including everyone, spreading costs fairly, and using limited resources in a way that best improves the health of the largest number of people. While working in broader coalitions to achieve modest but immediate improvements in the health care system, we must keep our eyes on the prize: universal health care. We must remind our fellow citizens that no nation ever achieved universal health care through pure market mechanisms. As the United Nations recognized in its Universal Declaration of Human Rights over 50 years ago, health care is a human right, not a commodity.

This pamphlet has been adapted from Seeking Justice in Health Care: A Guide for Advocates*, produced by UHCAN, the Universal Health Care Action Network. Individual or bulk copies of the Guide can be purchased from UHCAN by going to www.uhcan.org or by calling 216 241-8422.*

United For Peace and Justice:
A Work in Progress, but Progressing

By Jason Schulman

United for Peace and Justice is the premier national peace coalition, which emerged in opposition to the Bush administration's war on Iraq. Consisting of over 750 local and national organizations, including DSA, UFPJ has significant achievements under its belt, most prominently helping to coordinate and publicize more than 790 demonstrations worldwide on February 15, 2003. These included a rally at the United Nations headquarters that drew more than 500,000 participants. Two days after the bombing of Iraq began, on March 22, 2003, UFPJ mobilized more than 300,000 people for a protest march down Broadway. UFPJ has coordinated or helped coordinate a number of other marches and rallies since then, including those on the global day of protest of March 20, 2004, the one-year anniversary of the start of the bombing.

UFPJ continues to agitate against the occupation of Iraq and to demand that U.S. troops be brought home and that payment be made for the reconstruction of and reparations to Iraq, in accordance with international law. There had been significant debate within the coalition over whether or not to call for a UN-controlled peacekeeping force in Iraq, with some seeing it as unavoidable and others decrying it as an interference with Iraqi self-determination. Eventually the language was adopted that a role for the UN in Iraq was acceptable "if representative sectors of Iraqi society invite it…backed by other international bodies such as the Arab League and the Organization of the Islamic Conference."

Another point of focus for UFPJ is the Israeli occupation of Palestine – the West Bank, Gaza Strip, and East Jerusalem – and U.S. support for it. All in UFPJ agree that the occupation must end, though there are differences over what a just solution to the Israeli-Palestinian conflict would be – "two states for two peoples" or "a secular democratic state of all Palestine." UFPJ has not endorsed a particular solution, though member groups are free to advocate for their preferred solution. Recently, in New York City, there has been some demand for UFPJ to support the Palestinian Right of Return – which, if taken literally, means the collective migration into what is now Israel of two-thirds as many people as are already there – but UFPJ has yet to do so. Over the summer there was a rather heated meeting over the structure of NYC UFPJ, with some calling for the branch to become part of an "alliance of alliances" that would automatically support any demonstration by any anti-war grouping, including the ANSWER (Act Now to Stop War and End Racism) "coalition" – that is, front group – set up by the neo-Stalinist Workers World Party. Supposedly this would attract more people of color towards UFPJ. The proposal has been shelved, but at least for some it did emerge out of a sincere belief that a number of people had been turned off by UFPJ because they didn't feel that they were really part of the decision-making process. A different, interim structure was proposed for mobilizing against the Republican National Convention in NYC on August 29, and was unanimously approved.

UFPJ has yet to grow beyond its capacity to mobilize people as bodies in the street

While UFPJ won the right to march past Madison Square Garden – the site of the Convention – we were denied the right to rally at the Great Lawn in Central Park. As UFPJ national coordinator Leslie Cagan has noted, what emerged in this struggle is that the privately run and managed Central Park conservancy seems to be setting policy for the park: "These policies are not on the website of the parks department, they are not in the regulations. So you want to play by the rules, but we don't even know what the rules are." Still, the march against the Bush agenda was extremely successful, if judged by numbers alone: at least 500,000 people showed up, and the majority of people in NYC were known to have supported us. The frustrating thing, of course, is that none of these mass marches appear to have affected the Bush administration one iota, nor have they affected the stance of John Kerry towards the war and the occupation. And it is not clear how the election of Kerry – or the "reelection" of Bush – would affect the movement; the former, while clearly preferable, might demobilize it as activists take a "wait and see" approach regarding Kerry's foreign policy.

That said, despite its limitations, UFPJ has accomplished much. The ability to generate thousands upon thousands of demonstrators is nothing to sneer at. But UFPJ has yet to grow beyond its capacity to mobilize people as bodies in the street. It does not give its member groups things to do in their political clubs, in their unions, in the mass organizations to which they belong. Hopefully, in the near future, this will change.

Jason Schulman is on the editorial boards of Democratic Left *and* New Politics.

DSAers Back Candidates

continued from page 4

incumbent Senator Arlen Specter. Philly DSAers also like Democrat Lois Murphy, who is challenging Republican Party incumbent and Bush loyalist Jim Gerlach in the 6th CD, south and west of Philadelphia. Murphy has made national healthcare system one of her major issues. The Philly DSAers also call attention to Democrat Ginny Schrader, who is running for an open seat against a very conservative Republican in Bucks County, the 8th CD.

Wisconsin's Russ Feingold

Wisconsin

Two-term incumbent Senator Russ Feingold was alone among his 99 colleagues in voting against the Patriot Act. An opponent of the death penalty, Feingold supports statebased health insurance plans along the lines of the Canadian model, and has a strong environmental and pro-labor record. For that he is being challenged by right-wing multi-millionaire construction-industry mogul Tim Michels, who is stressing his Airborne Ranger credentials and his antichoice stance while slamming Feingold for supporting what he calls "a creative new name for nationalized, socialized health care." From his lips to G-d's ears, DSAers say. But, in a state that's come a long way since Robert LaFollette and where President Bush could call Kerry a deeply flawed, even dangerous alternative to him, Feingold's decent standing can help win the state for Kerry.

In the combination state capital/sprawling university town that is Madison, 2nd CD Democratic incumbent Tammy Baldwin vocally supports equal rights, gay rights, and expanded health insurance benefits, and her public posture as an out lesbian is symbolically important. Left critics widely view her leadership, however, as disappointing and ineffective. Like Feingold, she faces well-funded right wing opposition. DSAers also are backing what they call "old-fashioned democrat" Dave Obey in the northwestern part of the state, and are pulling for Bryan Kennedy to defeat the Paleolithic Jim Sensenbrenner in the suburban-rural 5th CD north and west of Milwaukee. Meanwhile, support is growing for 16th District state Senate candidate Mark Miller, battling a Republican for the open seat.

Virginia

DSAers in Charlottesville, home of the University of Virginia, are enthused about the candidacy of Al Weed in the state's 5th CD, known as "Southside Virginia." A conservationist and single-payer health care supporter, Weed faces incumbent Republican Virgil Goode, a tobacco-industry booster who was credited with the most conservative voting record in Congress while still a Democrat, before officially moving across the aisle to become a Republican in 2002.

Indiana's Julia Carson

Iowa

Iowa's 2nd CD incumbent Republican Jim Leach is facing a stiff challenge from Dave Franker, a public school and community college teacher and member of the Iowa City school board. The competitive race is one of the few toss-ups in the Midwest, and DSAers are enthused that Franker pledges to join the House Progressive Caucus when elected. In Iowa, Tom Fiegen—who says his politics are in the tradition of the radical lay Catholic Worker Movement,—is attempting a return to the Iowa state Senate (District 40).

Ohio

Progressive Dennis Kucinich is working hard to keep his West Cleveland 10th CD seat after his presidential primary campaign failed to catch fire, and DSAers are committed to returning the firebrand veteran politician and Progressive Caucus co-chair to Congress.

STATES LEANING TOWARD BUSH

Indiana

DSAers in central Indiana are supporting veteran civil rights worker Julia Carson in her re-election bid to the state's 7th CD, in Indianapolis. An opponent of the Iraq War from its inception, Carson is a member of the Congressional Black Caucus and the Progressive Caucus. Indiana's first female and first African-American representative in Congress, she is a strong supporter of national health care.

Idaho

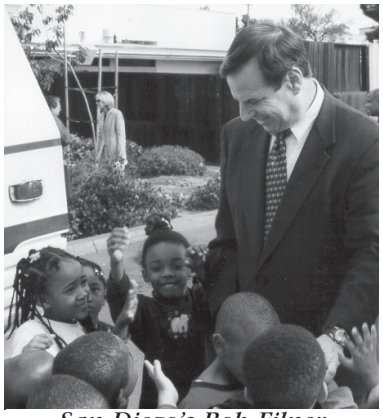
Longtime DSAer Hunter Gray calls Idaho labor activist and former state Senator Lin Whitworth "a vigorous and promising grassroots populist." His campaign for the 2nd CD seat, which includes the capital, Boise, and all of the eastern half of the state, stresses universal health insurance in his battle against incumbent Mike Simpson. While the House features worse conserva-

tives than Simpson, there are few progressives as good as Whitworth, who gives example after example in his publication, Working Man News, of how "the Republican Congress has caused irreparable harm to working families."

KERRY-SOLID STATES

California

In the state capital of Sacramento, DSAers are joining organized labor in promoting the "Yes on Prop. 72" campaign. The proposition would require large and medium sized companies to pay for health care insurance for their employees while also extending health insurance to the 1.1 million low-income Californians presently uninsured.



San Diego's Bob Filner

While far less than a single payer plan, the fight to implement the proposition allows DSAers the space to argue for a more far-reaching solution.

Meanwhile, San Diego DSAers are involved in progressive Democrat Bob Filner's 51st CD re-election race. Democratic centrist incumbent Susan Davis, representing much of San Diego in the 53rd CD is facing only token Republican opposition; San Diego DSA is supporting Green candidate Lawrence Rockwood in this race. They are also targeting a number of City Council and state Assembly races.

And in San Francisco, democratic socialists are taking advantage of the city's new instant runoff procedures, backing two candidates in one of the supervisor races—even though there is only one open seat. San Francisco DSA also endorsed an advisory proposition on the ballot urging the US to bring the troops home from Iraq.

New York State

In New York City, DSAers are backing long-time labor ally Frank Barbaro in his attempt to take the conservative 13th District in Brooklyn and Staten Island from Republican incumbent Vito Fossella, Bush's most loyal supporter in the state congressional delegation. The district is an anomaly. Boasting among the highest concentrations of union households in the nation, it is also socially conservative, and the former state Assembly labor committee chair—both pro-peace and pro-choice—has an uphill fight on his hands. In a companion two-borough state Senate race, social workers union leader Diane Savino is posed to win an open seat, potentially threatening Republican control of the legislative chamber. NYDSA activists are also backing David McReynolds in what the local views as a spirited and needed educational campaign for U.S. Senate against centrist incumbent Democrat Charles Schumer, who faces token Republican opposition. McReynolds, a DSA member, longtime peace activist, staff member with the War Resisters' League and a Socialist Party leader, is running on the Green Party ticket.

NY's Diane Savino

In Albany County, incumbent Democratic District Attorney Paul Clyne is a notorious champion of the punitive New York State Rockefeller drug laws unrevised. Enter former Assistant D.A. David Soares to challenge his old boss in a Sept. primary race that was widely seen as a referendum on the 32-year-old drug legislation. At the same time, he got on the ballot line of the Working Families Party, a statewide labor-backed fusion effort many DSAers support. Soares won the primary by nearly two to one, and now faces a well-financed Republican. On Long Island, the fusion strategy got complicated when Republicans tried and failed to run their judicial candidates against progressive Democrats on the WFP ballot line. Ithaca DSA produced videos for Community Access television highlighting longtime labor activist Dan Cleveland's race for an open state Senate seat on the Democratic and Working Families Party lines. The district is heavily Republican.

Massachusetts

The one-party liberal Congressional delegation faces no significant challenges this year, and Boston DSA comrades are focusing on state legislative races. The group is the anchor for the Commonwealth Coalition, a state-wide alliance of labor, environmental, women's and community organizations, and several issues of its DSA publication, *Yankee Radical*—mailed to some 1,500 union officials, area activists, elected officials, left groups, media pundits and statehouse hangers on—publicized their list of 32 endorsed candidates. *Yankee Radical* has grown to be a broad channel for Coalition outreach to the progressive political public. Boston DSAers prioritized two September primary races—both of which produced winners. Carl Sciortino won an upset victory over a longtime Somerville state representative, while Andrea Cabral clinched the Democratic nod for Suffolk County Sheriff. Once elected, she will be the first African-American and first woman to hold that post.

DSA PAC Statement on the Kerry Campaign

While the Democratic Socialists of America Political Action Committee appreciates Senator John Kerry's recent opposition to the way that the Bush administration has run the Iraq war – particularly the Senator's criticism of US unilateralism – we feel that the following steps would make his campaign much stronger and more meaningful for all Americans – and thus maximize both turnout and the chances of Democratic victory, as well as lay the groundwork for superior policies to those of the current Bush administration.

In issues related to war, Kerry should take a distinct stand against the very idea of unilateral US military strikes, promoting instead multi-lateral action in favor of human rights as the only justifiable form of action against unjust regimes. In addition, Kerry cannot win solely by arguing that he would be a superior commander-in-chief; he must also convince the public that as president he would increase social and economic justice at home and abroad. Thus, the Kerry campaign must frontally attack plutocratic Republicans and advance a coherent vision of economic justice.

The Kerry campaign can only win if it focuses "like a laser beam" on inspiring and mobilizing working-class people, people of color, and students and getting them to the polls. Likewise, Kerry needs to bring the majority of women back to the Democratic Party, in large part by highlighting the Republicans' anti-choice and anti-working women policies – including pointing out the dangers of a second Bush administration's inevitable Supreme Court appointments.

So far neither major party candidate has distanced himself from the grip of corporate and wealthy Americans on the campaign finance system. To truly attack the plutocratic political system, Kerry should announce a commitment to true public financing of campaigns. He should come out in favor of requiring TV stations to give free air-time for true debates and policy statements by candidates, thus eliminating paid-for TV advertising. Only by criticizing sound-bite advertising (which lies more than it informs) and coming out in favor of rational debate that informs the public can the Democratic campaign combat the understandable growing public alienation from politics.

Kerry must focus the last few weeks of his campaign on issues that would mobilize the majority of Americans who cannot make ends meet. He should promise to reverse tax cuts for the rich in favor of a truly progressive tax system; to guarantee the right to organize and form unions; and to overturn the wave of deregulation of corporate and financial governance that has given rise to Enron and the plundering of workers' pension funds. A majority of Americans would rally to a call to make work pay by increasing the earned-income tax credit and enacting a labor-rights and fair trade policy that would take on both the Walmartization of the US economy and the international global race to the bottom. Finally, the Democratic campaign should embrace human rights in this country by guaranteeing true, affordable national health care for all; increasing public funding of childcare and pre-school education; reforming public education funding; and reintroducing sound environmental protection policies and health and safety regulation.

While we have no illusions about how a Kerry administration would govern – absent mass pressure from below – and are not impressed with his delayed criticism of the war and his earlier commitments in favor of "free trade," we also realize that the Bush administration is as reactionary as Reagan's. A Kerry defeat would be taken not as a defeat of the US political center, which Kerry represents, but of the mainstream Left. As a result, it would embolden the Right and demoralize the Left (as well as trade unionists and people of color) as much as Reagan's 1984 defeat of Mondale did. On the other hand, a Kerry victory will let us press onward, with progressives aggressively pressuring an administration that owed its victory to democratic mobilization from below.

With a Kerry (and Congressional) win, the DSA PAC will fight to strengthen grassroots forces in and around the left of the Democratic Party so as to avoid Kerry opting for a Clintonian strategy of Republocrat centrism. In case of a Bush win, we will fight to stop his legislative initiatives through mass mobilization and pressuring the Democrats to be a real opposition. In either case, the greater a turnout for the election, the greater effect progressives will be able to have on our next government.

The DSA PAC recognizes that a Kerry victory would only be a small tactical step toward reversing nearly four decades of conservative dominance of American politics. But a victory of the Bush administration would only further consolidate that dominance. It will be the working class, women, and people of color – not only at home, but also abroad – who would suffer the most from a Bush re-election. That is why we urge people to vote for John Kerry for president.

—Adopted October 2004