SECURING UNIVERSAL HEALTH CARE, PART TWO:

Dialogue on recent grassroots
campaigns for universal health care
produced by Project EINO

Project EINO is based at **www.EverybodyInNobodyOut.org** and is dedicated to the autonomous state organizations which have taken on enormous task of grassroots organizing for Universal Health Care. We believe that these organizations and the activists within them constitute the critical leadership of the movement for Universal Health Care in the U.S.A.

Project EINO is in dire need of funding, being funded for several years by two state activists of only moderate income. As of this first edition of the Dialogue on State UHC Campaigns (November 2002) the project has received no more than a few hundred dollars over the 5 years of operation towards expenses. The project is actively seeking serious foundation support to support staff and expansion of services. In the meantime we are also greatly appreciative of any individual donations (large or small) to help us continue our work until some initial funding is found.

We hope to continue publishing updated editions of this dialogue - depending on the interest and the rate at which we receive contributions to the dialogue. Please email all contributions to **director@ProjectEINO.org** or to **webmaster@EverybodyInNobodyOut.org** Contributions can either be pasted into the email or sent as text of MS-word attachments (doc or txt file types). Send contributions to director@ProjectEINO.org and in the subject field enter "OR discussion". All contributions are subject to editing, but authors have final say in approving editorial work. DO NOT mail contributions through U.S. Post, but you can contact us at:

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Remember to include a two-sentence biography mentioning current affiliations and involvement with health policy and/or community organizing.

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What we tried to accomplish in this booklet.

In this booklet Part Two of a discussion about the Oregon initiative for universal health care, we have attempted to produce a cohesive representation of the discussion during the 8 weeks following the vote on Measure 23. Initial reactions at the end of the campaign and immediately following the defeat of M23 are still available in Part One[1], which also presents a sampling of the coverage of the measure in the media.

We hope to provide some useful tools for further discussion and, perhaps, some insight into how resources could better be utilized (in Oregon, or any state mounting a similar campaign) to get us much closer to our ultimate success of having everyone covered for medically appropriate and high quality care. Our project does not claim originality for very much of what is communicate here, indeed we tried to represent the discussion that followed the vote and to which we were just observers. That discussion itself was rich in insight. What we do present of our own ideas are distilled from discussions not just among our editors and board, but with many friends and UHC activists throughout the U.S. It is our hope, of course, that some of our comments and especially the concluding discussion will find resonance among many M23 supporters and prove somehow useful. We do suggest some new avenues for discussion in the conclusion. We include these not because we can claim to be "the authoritative voice", but rather because: (1) we believed these could be useful as tools for continuing analysis and discussion in Oregon and elsewhere and (2) because most of these suggestions seemed to follow logically from what a good number of Oregon activists themselves seemed to recommend. We certainly do not assume our Project will provide better answers than those involved in Oregon UHC will ultimately find for themselves.

What we have included and excluded.

There has been significant discussion during this two month period about details of a proposed future Oregon UHC plan, referred to in later discussion OHUP. In the proposal and discussions details have discussed of prescription plans, taxing structures (eg. income vs. VAT), copay and deductible schedules, how to set up panels to decide on what procedures to include and even specific plans for care to be excluded. <u>This booklet is less concerned with such details</u>, though, than we are in discussing the idea of cost-containment, the concept of rationing health care and the concept of completeness and high quality of health care (including of course mental health, prescriptions etc.). In agreement with some of the best advice voiced by M23-supporters during these last several weeks, we believe that state UHC activists need to agree on these general principles first before expending enormous energy on arguing specific details[2].

Detailed recommendations for websites, email lists and brochures are all important subjects which will have to be discussed for developing the successful grassroots campaign, but these are not within the scope of this more fundamental discussion. Apparently from the discussion of proposals in other states (notably Maryland) there is some interest among Oregon activists to understand other state approaches. Project EINO hopes to be able to assist state organizations in the future by providing at our website an area where the various state UHC campaigns (17 now, by the way)[3] could share downloadable materials and discuss their use of specific tactics (fund-raising, alliance building, brochures, TV and radio presence). Alas these dreams of ours are pending some resolution of our own funding crisis[4].

There were a great many wise and insightful comments in the discussion of the last couple of months. Only a few of these could be published in this booklet, as we tried to remain concise and on topic. The editors were moved by many of the contributions which we did not include and would encourage anyone interested to browse through the entire unedited dialogue which remains in the simplest essentially unformated, pasted together format.. It can be downloaded as a *.txt filetype and read by any word processor (it is about many times longer than this booklet) CLICK HERE.

About format and references

Although we did solicit them in Part One of this dialogue, we actually received very few comments or contributions directly. We have compiled Part Two based largely on the discussion that has followed in the Yahoo discussion group[5] on the Oregon measure. Our discussion roughly paralells the chronological order of the discussion these past several weeks, however several contributions have been moved out of the chronological order so that it there would be a thematic progression that would be easier to digest by any reader. All entries of #nnn-x refer to the number of the discussion group mailing and the message number within that mailing. These make the references easy to find in the *.txt unedited version.

Comments and paragraphs not attributed to anyone in particular are paraphrasings based on several contributions, or often remarks contributed by the editors at Project EINO.

Where Part One of this discussion left off

Part One presented a survey of opinions both from the press at-large about M23 and of initial reactions from some of the leadership and supporters of M23. Several of the initial comments from HCAO leadership were congratulatory about the accomplishments of the campaign and rather dismissive about shortcomings arguing that the referendum's failure to pass was largely a consequence of the slick and well-funded campaign of our opponents. Project EINO argued against the view (lack of analysis) in Part One, trying to emphasize the importance of a deep review and analysis of the campaign. The discussion indeed changed a great deal following that first edition (not necessarily because of anything our project wrote or published). It is possible to organize the recent discussion around these themes, which also roughly correspond to the questions Project EINO formulated at the end of Part One:

1. Overcoming 20:1 (or greater ratio) spending by the insurance indursty.
2. Structure of new state organization, local control, geographical coverage.
3. Improving ethnic and multi-racial support, as well as labor, working class support.
4. Major changes in emphasis, major principles of organizing.
   a. Cost-containment, copays, deductibles.
   b. Residency, eligibility, citizenship requirements.
   c. Revising tax scheme, improved clarity on costs.
   d. Commissioned panels, rationing care, deciding what's covered.
   e. Multi-tiered systems of health care.
5. Improved organizing and fund raising without major change to principles.

More on spending in campaign

This topic was sufficiently covered and commented upon in Part One. Grassroots work invariably begins with all volunteer work and little funding (Yahoo #356). Usually after painstaking organization building is there any chance of funding staff positions. Thankfully, there is a lot of work that should be prepared in the mean time, while building the organization and getting some core support and organizational alliances together. What we mean by getting the core support together is not only structural development taking into account geography and demographics, but also the basic educational work, so that the principles of what we are trying to achieve are consistent and are well-known and agreed upon by everyone working with and supporting the organization.

In fact, however, many of the contributers during the last two months of discussion have continued to focus on the "reason" for defeat of M23 being that the insurance industry created propaganda and the promulgated false ideas outspending the proponents 20 or 50 to 1 (eg. #346-1). Therefore, we would like to restate our position that the basic fact of being opposed and outspent by the insurance industry is certainly true but also unimportant. The whole reason that this struggle must be carried on by grassroots education and mobilization of the general public (and more effectively by statewide UHC organizations rather than national campaigns) is that our opponents will use lies, slick brochures, TV time and huge financial resources trying to defeat us. This should be viewed as an "initial concept" for what we are doing, not a reason to excuse any outcome of our work. To invoke the opposition as a main problem is like going downhill skiing and complaining about the combination of gravity and trees which make the skiing difficult.

Main Discussion

Meeting Notes, from November 9 by L. Porter.

The notes from the 11/9 meeting contain many short comments and perspectives which seemed to indicate that many activists did feel initially disappointed and that it was not the general feeling of those who worked on the campaign that the effort was geared towards merely getting the issue before the public, rather than having a good chance at getting the measure passed. So, if some of the leadership had this plan, it was apparently not shared widely with the public or even the activists.

All of the themes listed above were touched upon in these notes from the HCAO meeting. A few attendees mentioned that African-Americans were not involved in the campaign and should have been included from the early planning stages. Others expressed that the disempowered and disadvantaged were generally not reached and mobilized. Many activists seemed to think that there was not a clear enough position about the key economic issues, the tax side of things, additional initial expenses and the sources of savings in the medium and long-term. Young and low-wage workers who are other "natural allies" were also not mobilized to get involved, nor even to vote. A stronger state organization needed to be built, with improved coordination with allied organizations.

Also at the meeting of Nov 9, several attendees expressed doubt about some of the fundamental ideas, like the ability to provide all medically necessary procedures and treatments. UHC called by

some "pie in the sky", when need is to limit the treatments for which people will be covered (cost containment). Initial responses from some doctors (who see themselves, at least, as supporters of the idea of every one having access to health care) also indicated they did not believe all medically necessary treatments could be covered without a lot of additional taxation.

Overall financial basics.

M. Shapiro(Nov 13, #332-3) addressed several of the financial concerns. Marc correctly pointed out that there are "natural enemies" for any UHC plan, since certain industries will face greater regulation or even being shut out of profitable sectors entirely. [These are precisely the sort of straightforward facts that the public needs to become thoroughly acquainted with prior to a successful initiative. They should expect these opponents to fight against UHC "tooth and nail".] Marc wrote:

> Insurance companies, both profit and non profit consume a large part of the health care dollars. In Oregon, the Medical Insurance sales agents have a $350 million payroll that makes no contribution to health care. In 1990, it required 1.7 clerical workers to support each doctor. In 2002, that number has grown to 4.2 paper-pushers per doctor. All the money spent on those clerical workers and the space and equipment they require makes no contribution to health care. Insurance companies, hospitals and health care practitioners spend vast amounts of money on advertising that would not be necessary under a universal single payer health care delivery system. The money saved could be used to provide health care.
>
> Hospitals have a paper work overhead of about 30%. That probably could be cut in half by a single payer plan that did not involve insurance companies. The money saved could be spent on health care. There are over 500 companies in Oregon that self-insure saving vast amounts of money over what the same coverage would cost them. That savings is small compared to what they would save under a single payer system. Companies would not be put at a competitive disadvantage by providing health care under the charges of a reasonable system which does not include the waste caused by insurance companies. Competitors would be in the same situation. Companies operating under a plan such as what we had proposed would finally be able to compete internationally, where universal health care is the rule, not the exception.
>
> There was a viable plan on the table. The insurance companies scared the voters away. Had it passed, it could have been adjusted to make it work. That opportunity is no longer there. There is nothing else on the table. There will be nothing else on the table, because there is no mechanism available to get it there. The insurance companies have no incentive to put themselves out of business or even correct the way they do business. The legislators will not take any action that does not support the insurance companies, because so many are well paid by the insurance companies to keep the money flowing as it is.
>
> It will be two years before another initiative can be placed on the ballot. No matter what it is, it will meet the same opposition, because it can only work if it eliminates the middle man. In this case the middle man has unlimited funds to defeat what ever the measure is. Only when a large enough part of the society is really suffering, which will be in the

> near, not distant future, will it force people to look beyond the lies in negative advertising and take a chance on what works everywhere except in the US
>
> No matter what plan you devise, someone must pay. That someone is always the consumer. It doesn't matter how you mask it, the consumer always pays the bill. However, at this time, 2/3 of all health care is paid for by tax dollars. In spite of that fact, 470,000+ Oregonians are without coverage, 420,000 are on the OHP, and 25,000 apply each month, most of which are turned down because there are insufficient funds to provide the coverage. Countless people are trapped in poverty by the rules of the OHP which cut paraticpants off if they earn $1 too much.

EINO has omitted Marc's incorrect assertion that UHC exists in Hawaii, we have several articles at our website about the uninsured in Hawaii[6]. The Hawaii plan has no mandate at all for small businesses and most Americans work for small businesses. It is a common misconception even among many of the core activists in state UHC organizations.

Cost-containment

M. Beilstein forwarded comments from physicians (Nov. 22 #339-1). These doctors see themselves as supporters of UHC, but they believe that there has to be cost-containment, disincentives for "excessive care".

A few good answers to the "copay" issue have been contributed (eg. #340):

> First, the kind of people who would abuse health care coverage in the manner described must be a very small percentage of the population. The doctor. was describing hypochondriacs-- most of us do not suffer from that mental illness. More importantly, that is a DOCTOR PROBLEM. It is NOT AN INSURANCE PROBLEM. It is the responsibility of the doctor to not prescribe unneeded drugs/treatment to patients, not the insurance company's job to try to put up roadblocks that will affect everyone, but are only needed in a few cases. Finally, most of us will go to the doctor only when necessary. Measure 23 will not turn us into a state of hypochondriacs.

In a rationally-designed health care system the doctor would be encouraged or given incentive to be treating his patients appropriately - not necessarily scrimping on treatments. Over-prescribing doctors would be noticeable as statistical outliers in their prescriptions and medical panels could review the details of such outliers (many times there would be a logically clear reason why a particular physician tends to serve a certain patient population). This would be a very rational way to approach the problem. A more serious problem is providing incentives for people to use medical care - since most people are actually <u>excessively reluctant</u> to go to a doctor. Underuse actually costs the health care system a great deal, since health problems not addressed frequently become much more difficult and expensive to resolve[7]. The few people who are hypochondriacs need to be identified by the physician, their problem recorded and they need appropriate mental health treatment. In general an improved and efficient health care system will need close coordination and ease of referral between primary care and mental health professionals.

As put so well by M.A. Holser (#357)

> The assumption that people abuse health care by too many doctor visits is not supported by research, only anecdotal reports. If medical visits are prompted by psychological or other non-medical needs, patients should be referred to counseling or alternative resources. Utilization is already controlled by ability to pay rather than need. Estimates of average U.S. doctor visits per year vary from 5 to 8. In countries with universal coverage the range is 10 to 13 visits, but these countries rank higher than the U.S. on all indicators of health status. This proves the value of increased access to health care. Our low ranking in general health is the result of utilization control by ability to pay. In the end, those who neglect (rather than abuse) health services due to financial barriers end up costing us more in acute care and worsened general health status.

An important question for state activists to think about is why so many of "their supporters" seem uninformed on so many of these fine points, like copays, overuse of health care, savings acruing from UHC, invasions of the state by the sick and the logic of state level work. Why wasn't better use made of educational forums, the HCAO website, or even discussion of these points which is already written up at in EINO[8]. All of the evidence points the opposite way from what the insurance industry propaganda tells us and what even some "UHC supporters" in the state believe but they remain completely unaware of the evidence to the contrary. Physicians are supposed to be scientists, ask them what evidence they have to support their feelings about overuse of care. Also we might wonder how they draw this conclusion when any polling of neighbors, family or friend seems to turn up many individuals and their family members who resist going to the physician when medical problems first emerge. In other words what they claim is against the everyday experience of most of us.

Other "supporters of UHC" argue (#339) that "getting something for free" is "bad politics" in the USA. However, we haven't been charging for use of public libraries, nor for primary education - why should we encourage people to have lots of children and send them all to our free primary/secondary schools (sarcasm here). Are some UHC supporters really so convinced of this fact of "bad politics" that they are willing to spend more on health care (through our taxes) just to guard against it (not to save any money, but to willingly spend more)? Or are some of us just arguing that the public is so stupid and impossible and to educate that we can't make inroads against such prejudice? In the latter case it doesn't sound like these individuals have the background or character to be at all helpful with grassroots organizing of any kind.

Rationing Care

Other "UHC supporters" wrote in about rationing care (Nov 17 #339) - a subject closely related to that of copays (both are aspects of cost containment). This seems like it may be an unfortunate legacy of the Oregon Health Plan which early on became wedded to the concept that of rationed care. Project EINO states categorically that rationing care cannot be part of any genuine UHC system. You can't cover some people in a state for just some of their medical needs and still call the system you are promoting "universal", not honestly. Aren't we trying to convince people that all medically appropriate, necessary care can be provided in a UHC system and that this can be done without incurring additional cost to society over what we are now paying for some of us to be insured (temporarily, at our present employment)? And aren't we insisting that others, who are often the most at-risk or needy either fail to get the treatment or plunge extended families into poverty, just because of medical misforturne (that we are all running this risk in fact)?

Currently our health care is rationed by insurance companies who would cut us off from needed procedures to whatever extent they can get away with, in order to broaden their profit margins. Of course, we cannot tolerate unproven, untested or absurdly priced drugs and procedures to be charged to the public account on the whim of industry marketing crews. Efficacy, quality of life, extension of expected life and alternative treatments always will need to be reviewed and considered by medical professionals and guidelines developed for advanced procedures. But we need to have our most dedicated health professionals deciding these issues on the basis of overall patient welfare and without personal conflicts of interest. Will health care be budgeted? In some sense of course it will. For the first time ever in this country, it will be budgeted responsibly, looking at the overall costs and savings. A state enacting UHC will be able to globally plan how services will be provided, but can do so with an ample budget, inasmuch as we now pay about twice per capita what any other industrialized country does (and don't get care for everyone as all other industrialized nations do). Having a rational, just global budget for health expenditures is not the same as rationing care. We would argue its just the opposite.

Note that some of the arguments about rationing care and copays came from experts "supportive of UHC", even who teach courses in health policy. At Project EINO we have indeed read the books by some of these. They are unconvincing and usually begin with the concept of rationed care at the very onset. They also consistently fail to distinguish between rationing care and designing a system with a global budget - an ample one. It is unethical to assume a need for rationing health care while such tremendous profiteering remains in health care industries, not to mention wasteful redundant administration. If we fail to make the wasted health care dollars our focus and we accept the discussion of rationing as legitimate, we are discussing a rationing of human life and well-being so that profits of select industries can stay high and protected along with absurd CEO salaries[9]. Fact is, we would have had more funds available to provide health care with M23, so why bring in the rationing problem with M23? We must remain clear throughout any campaign that we are the ones targeting rationing as an evil, the rationing imposed by insurance administrators who have no interest in our health.

Speaking generally it is worth pointing out there is an appearance of racism when we suddenly become concerned with rationing, now that we are discussing a health care system that will take care of those who have disproportionately been left out of our health care system, African-Americans, Latinos, other ethnic minorities. We can't expect to get support from many African American organizations of integrity if we show concern at this time about how to ration care, now that we propose to include these communities for the first time. Why not first institute a system taking care of everyone's medical needs (at the level say afforded presently to federal employees) and then talk about the overall health budget when we can also take into account our savings, both direct and indirect from having everyone covered.

Residency requirements

Another theme that was brought up more than once was the "residency" requirement and the imagination of all sick people in the country flocking across the borders of the first state to offer UHC. Why stop there though? Maybe people who would rather work where they themselves their children, their employees and even their neighbors were covered for future medical problems, would want to live in the first UHC state? And maybe they would do so whether or not they

themselves currently had any ailments? It certainly would seem to be a good deal for small businesses which are suffering terribly throughout the country[10] unable to cover either the owners or their employees and also at a serious disadvantage for attracting the best employees (out-competing large employers with health plans). Hey wouldn't that be a benefit for the first state, being the first pick as the home state for any business looking to get started?

Maybe silicon valley would never have gotten started in California if Oregon had been able to attract businesses by virtue of efficient health care expenditures? This idea is supported by the preference of companies for setting up in Canada rather than the U.S. largely because of the savings to them in health care of the workers(a part of every manufactured product)[11]. Of course, many small businesses in the U.S. are now "getting away with murder" (depending on the state and their disposition). These are existing in a climate where health care is supposedly paid by employers and yet themselves not contributing a dime to employee's (nor their families') health coverage. These are getting unfair advantage now and no new system will be as "rewarding" to those businesses as is the current system which puts their workers at great risk.

Maybe this "imagination" of an invasion of Oregon is also a good reason not to have a good tuition break for residents at the universities and colleges and not to have to good state programs for the mentally ill or for drug addiction and not to have lenient welfare programs either? And how about a "head start" or "daycare" program in your state or city won't this just bring in a whole lot more single parents who are having a hard time making ends meet? In fact there are differences between states in all these programs but the attractiveness of the state is not often viewed as a detriment.

Zz pasted in, needed? As some have pointed out though (eg. #343-3) non-citizens pay taxes and generally use less state services (therefore they pay more net tax). Definitely they should not be excluded from UHC in the state. While it may require some extra educational effort around the state to make people aware of this and to educate people about the risk to Public Health by not having everyone in the system, it most definitely is part of the educational work that needs to be done by the committed organization.

State action vs. federal

Some UHC supporters in Oregon (Yahoo #339, 340) seem not to understand that some changes are more fundamental, too challenging to the status quo and powerful industries at a basic level. In these cases the federal government is unlikely to ever start moving on these without an example being set already in several states. Public primary and secondary education (and the idea of children having a "Right to Education") is probably the most analogous change for our country to the current struggle for UHC and the idea of people having a "Right to Health Care"[12]. The federal government got involved in universal education only after six out of every ten states already had legislated some style of mandated education. Sometimes you have to educate and mobilize the populace, which is best done state-by-state. Only then will you have the leverage to pass federal legislation while being outspent 20 or 50 to 1 by the most powerful industry in the country.

Probably most people who have worked on M23 were aware and convinced of the logic of work at the state level, since they chose to put their energy into that rather than existing federal campaign work on the issue. Still future work at the state level seems to need to clearly formulate and discuss

the logic, strategy and historical precedent for such work. Recent statements by some like the Oregon AFL-CIO President on Dec 19 (in #364) show that certainly some supporters understand the need for working at the state level. A good starting place would be the discussions of these issues which exist at www.EverybodyInNobodyOut.org within the FAQ section on strategic considerations.

Individual detailed issues

Much of the conversation during the first six weeks after the vote on M23 was devoted to a great many details of a future health care system. Schemes for organizing everyone into "HMO risk groups", how to raise taxes for initial costs, how to restructure the tax system for ongoing payment into the health care system, details about disallowing participation of for-profit insurance, copay and premium rate structures, reforming the education of physicians and specialists (special concern for numbers practicing) and the role of tobacco/alcohol taxes or settlements (see #341-2) can be found in the unedited text. See concluding remarks for more discussion about basic principles of agreement, rather than fine details.

Physicians' concerns Malpractice, medicare reimbursement

Physicians have several reasonable and specific concerns such as medicare reimbursement rates and malpractice insurance costs, which have been raised in the recent dialogue. These need to be taken into account, since any new state health care system will still have to address these concerns and hopefully resolve the issues. However why should solutions to these be tied to the passage of UHC? Do the physicians who raise these problems believe that establishing single-payer or any variety of genuine UHC in the state would make these problems more difficult to resolve? Won't it be easier to resolve these issues once commissions and panels are formed to globally plan and oversee the state's health care system for the first time? Right now these problems result from the infighting between industrial powers, insurers vs. hospitals vs. pharmaceuticals. What if the state (and public commissions) had more power to deal with these industries in ways to assure that everyone would have access to facilities and treatments? Wouldn't there be much greater opportunity to address these problems? What is the logic for holding up UHC until these individual problems are fixed (as some physicians Yahoo #340-1 have argued, or to resolve that only federal legislation is feasible).

Certainly other physicians, public health experts and citizens involved with M23 have demonstrated that they understand these issues very clearly (#340-2,3). The top priority is often clearly focused on reforming our health care system, so that it is designed according to the public's health need.. We should not think because M23 organizing was not as thorough and well-coordinated as possible, that we need to rethink the basic issue of everyone having a right to health care. Rather, we should wonder how organizing (educating and mobilizing) can be improved so that all those on the fringes (but who describe themselves as supporters of UHC in concept) will at least come up to the level where they understand what is based on data rather than the imaginations of our opponent industries and their hired PR firms. Certainly success in a statewide referendum, or in influencing a state assembly vote will not occur as long as our "supporters" among physicians remain confused about the logic and sense of organizing this on a state level.

Those interested in additional comments on the proper role for physicians and health policy experts in campaigns for UHC, their value and the criteria for their influence should refer to Project EINO's e-booklet on UHC organizing[13]. Not all physicians and physicians' organizations are natural allies in the movement to UHC. A few organizations are tied to industry interests and others are narrowly focused on preserving or extending priveleges of the best-paid and most powerful of physicians. Other organizations (and individual physicians often) are truly dedicated to the well-being of their patients beyond all else, and are real advocates for the general welfare.

Tax costs, details of taxing

Many supporters wrote in about a different clearer presentation of the cost and tax issue. One suggestion was to generate a table for employers of various size (employee number) and show what they are paying now and would be paying later under the new tax structure that is being recommended. Having this clear and making it fully accessible would short-circuit a lot of the lies, it was felt, that were generated about how the M23 plan would be an enormous tax burden. The great number of supporters who wrote in about making this clearer convinces us that a much improved presentation would be possible and very helpful for future organizing work. There are however some inevitable difficulties in detailing the costs and these should also become public knowledge.

There are many sources of indirect savings, especially in a single payer system, but some in any genuinely UHC system. It is known that these savings will certainly ensue and yet exact amounts of savings are difficult to predict and accrue to different parts of the public treasury than that into which the funding for UHC is first collected. Ignoring these many sources of savings though is certainly not fair in evaluating "the cost to the public" of UHC (they all make the cost of UHC much cheaper). For example, the enormous cost of crime, crime control efforts, neighborhood deterioration and lost productivity that result from drug addiction in this society. It is known that UHC with full mental health services and programs for addiction rehabilitation would save society immense sums. This is so even though no one claims that addictions would be eradicated or evolve to zero costs. Similarly, the costs in public health problems from having some of the state residents, including children without proper vaccination and regular checkups costs everyone both in terms of our own family's health and in larger expenses to treat ensuing problems later down the road. Having every resident fully covered for mental health problems would also result in a great many indirect savings in productivity, less domestic crime and improved neighborhood function and development. There are many other examples.

The indirect savings which accrue from UHC also underline another problem with just adding an additional tier to current systems of health care (see section on multi-tier system). The work of UHC activists devolves at this point into work which is more typical for those organizations and individuals fighting against roll-backs and for program expansions (incremental health reform activists). These good people are involved in similar struggles every year, nor do they envision an endpoint of having all health care needs met. They get trapped into arguing line by line about allowances in the state budget for needed programs, but never get to argue about what MUST BE INCLUDED for the public's health care needs in all future budgets. This makes their work very different than ours. UHC activists have the opportunity of arguing for wholly reformed health care system with global budgeting for health care based on what the public's needs are, not based on

which sectors were most attractive to the major high-profit industries involved - and what possibilities still remain after those profits are sucked out. But we forfeit this difference once we start arguing that we should approach universal coverage by adding a new public program (or two) to the existing system.

Expanding Current OHP, Tiered Care

Expanded OHP

A new plan was proposed by L. Porter (Yahoo #342-1) for expanding the present Oregon Health Plan to include all residents who are currently ineligible for both medicare and the current OHP. The plan is included at the end of the booklet as Appendix One. Basically, it was proposed as a possible way around the majority of criticisms that seemed to be effective against M23. Quite a few people followed up on this proposal with further suggestions and criticisms. Even M23 supporters extremely critical of the proposal can be appreciative of L. Porter taking the time to develop and articulate it, as it provided a very useful context for further discussion.

The concept was that such a plan would avoid many of the arguments with which proponents were beat up in pushing M23, a tighter definition for residency, avoiding dependence on getting the new system recognized as equivalent for federal funds directed towards medicare (by leaving medicare in tact). Cost-containment in the expanded program would basically correspond to the more generous part of existing OHP (including vision and dental), excluding alternative health care and giving the legislature explicit power to exclude massage therapy, marriage counseling, cosmetic surgery and other non-essential procedures. The entire text of the reasoning behind this plan can be found as #342-1 in the uneditied text version available for free download.

Multi-tiered systems

One problem brought up (eg. Yahoo #346-2) is that the current OHP is tied to the current system of administrative wastefulness and excessive profits of the insurance industry. Covering everyone in a state by expanding existing programs, makes it extremely costly, so that: **1)** it becomes unlikely that such a change would ever be enacted due to fiscal arguments, or **2)** that after all the work of getting the system initiated it would not be funded sufficiently to have it work to anyone's satisfaction, or **3)** that the current system remains intact for the middle and upper middle class while a low quality expanded system (rationed care, poor facilities, partial coverages) becomes the standard for the lower middle class and the poorest working families in the state.

Any situation where a new program or expansion is envisioned for resolving the problem of the low-income, chronically-ill, uninsured and poorly insured, the probabilities are great that the new coverage will not be up to appropriate medical standards. The majority of the middle class (and higher brackets) won't be concerned if their own care and their families are separate and unequal. They will not pressure state legislators for further improvements. The case is very similar to having segregated primary/secondary schools, except that here the separation is not strictly on racial lines. Tiered care is a favorite of the insurance industry. Introducing a fourth tier in Oregon insurers (all of the wealthier classes themselves) would want to still be involved in administering coverage and "containing costs" while they would be guaranteed public funds to keep their profit margin for the lowest tier on par with their profits for the upper tiers of care. This is precisely what

the many insurance industry-backed coalitions and websites promote as the realistic road to "universal health care" for which they are the champions[14]. Yeah, right!

Readers may want to read about the recent introduction of a bill by Sens. Hatch and Wyden which is a promotion of a system for rationing health care[15]. By encouraging a multi-tiered system with a separate program (or division) for the low-incomed and chronically ill, one next moves to the step of discussing rationing of the care and what the lowest acceptable standards of care are, since those standards are now being discussed only for "the others" for whom we are providing some publicly-backed charity. How very different it is to create a single risk pool for UHC and provide quality care for all, quality say as provided to our senators now for their publicly financed health care.

Detailed strategic considerations

Detailed strategic considerations for future organizing (mentioned by many of the respondents) include such things as: better fund-raising, media contact development, clear comparisons on costs, union support, principles to be spelled out on "cost-containment", including professionals (physicians and others) as spokespeople more effectively, position on the need and ability to get federal waivers for medicare and medicaid programs, better mobilization of key constituencies (uninsured and poorly insured). Overall better grassroots work.

Indeed many of these issues have been discussed in a short, free, downloadable e-booklet which was published by our Project in the fall of 2002[16]. As with all our publications we realize it could be improved (expanded) in the future and are happy to receive any comments and criticisms. However, we do believe that there would definitely be some improvement in the way UHC organizing is proceeding in several states if activists were aware and discussed (by all means improved upon) the core ideas presented in that volume.

Polling in grassroots strategy

Discussion was initiated (#347-1) on the role of polling in a grassroots campaign. Polling is indeed a necessary part of a successful campaign and we include these thoughts from J. Binninger:

> To find out how the people will vote on any of the ideas put forth, it is critical to do a poll designed by a professional who understands how to poll on political issues. Making good guesses simply doesn't work. I think we saw that this time. People are still guessing that "this idea" might change minds or "this twist" will be accepted. You don't know until you have a professionally designed poll interpreted by the professional pollster.
>
> During the campaign other issues or ways of looking at the idea often come up. Then it is time to poll voters again. They are the only ones who know how this ides or that will affect their vote. You also explore any variables around a particular issue to see what is acceptable. When the opposition brings in distortions, it is time to poll again. Polls cost a lot of money if they are done professionally by someone with political experience in polling.

Polling usually is and rightfully should be a part of any grassroots campaign. It can provide the basis for arguing with state legislators that the state taking responsibility to see that every resident has access to health care is a view supported by the overwhelming majority of voters in the state and (more importantly) in their particular voting districts. Sometimes a statistically valid poll (or a

few questions inserted into another poll) on attitudes toward health care and who should be responsible can be arranged working with a university in one's state (student work, public issues, check economics or business departments). In getting some good questions that will be most meaningful later on, check with some state UHC organizations (ask Project EINO for references) where such polls have been conducted.

Role of Democrats, politicians generally

Excerpt from comments by Bill Clinton on Salon.com pertinent to our discussion (sent in as Yahoo #354-2)

> The fundamental thing I tried to deal with is this: we spent over 14 percent of our GDP on healthcare. You can't provide the quality health care we provide with all the technology if you don't spend about 11 percent. Even the Canadians spend ten and they've got backups. So, we have to spend that much. The problem is we spent over 3 percent of that 14 percent of our GDP on administrative costs. It's a huge amount of money. Administrative costs of Medicare by comparison are 1 percent. Two percent of our gross domestic product is a huge amount of money.

Like the insurance industry which supports them, most politicians (federal and state levels), and even the more liberal Democrats who come out in support of UHC (Bill Bradley, just recently Al Gore) are usually talking about UHC as an additional tier of coverage to the current system. This means, no global budgeting, no fundamental restructuring of the system according to public's needs, no administrative savings, no increased restrictions on insurance industry profiteering or drug industry price gouging. Often in fact, they suggest a system whereby more public monies will be turned over to subsidize the insurers to cover the less-profitable people they left out of the system originally (so that their high profits are maintained even with these sicker and more at-risk individuals). It is a larger problem for UHC supporters that some of the support and leadership coming out of M23 campaign, seems to be in favor of a more multi-tiered style of UHC.

We have to give Clinton some credit here (not too much since he has now abdicated all public influence) for pointing out the core issue of administrative savings. This is why its several hundred dollars cheaper for Ford Motor Corp to build the identical car in Windsor than across the border in Detroit[17]. Its not a benefit to anyone, excepting the profiteers and the few people who could be better employed trained to provide real health services rather than counting our health care "beans" four times over.

Politically, to get state legislation passed in most state activists are trying to recruit not only sympathetic Democrats, but Republicans too (they can't get anything passed otherwise). There are lots of rational arguments for why business and Republicans should support UHC (like the cheaper cars produced in Windsor, Canada). For any politician (outside of those few who are already progressive), however, we may have to force them into discussing the issue and further pressure them into voting for UHC by demonstrating overwhelming popular support within their voting districts (i.e. they cannot get re-elected without supporting this). This is where polls and thorough grassroots organizing ultimately will work together for our success.

A new structure for organizing

A new structure is being considered for future organizing (Yahoo #341-1) in which there is a coming together of local organizations as equals, having only a facilitator, and possibly running on consensus. Grassroots organizing does need to be broken down to a community or county level eventually in order to provide complete geographical coverage of the state and lead to successful pressure on state legislators. Of course, the necessity will remain for statewide coordination to plan some actions, and the statewide campaign as a whole, to shore up the weak links and check on how the movement is progressing towards having influence over a majority of legislators. It might be optimal to have the committed parties in each county or community design their own best local campaign and for those who are doing such local work to be given appropriate influence in directing the statewide campaign.

Internal Democracry

Discussion arose over internal democracy in the grassroots organization HCAO or its successor (eg. Yahoo #343-1). It was hoped that the organization ought not again be in the position of "a few key people making unilateral decisions that are affecting the direction of the movement". This will hopefully become a top priority in future grassroots UHC organizing in Oregon. It is almost inconceivable that a grassroots organizing effort would be successful mobilizing through the communities of a state, both on a geographical and demographical (ethnic, racial) dimension without dealing fully with this aspect of organizational development. It merits not only quite a bit of thought initially, in getting the organization set up, but also an ongoing effort with some method provided for supporters to level complaints and make suggestions regarding the democratic operation. Getting new people motivated and involved is difficult if they are not involved in the whole process (they won't long stay enthused about taking on work, if their suggestions are not forthrightly considered).

D. Cohen wrote:

> I think the only job of the state group now, and the only democratic approach, would be to: 1. solicit and propose to every person associated with Health Care for All in the state options for how to structurally continue statewide and to steward the entry of whatever structure emerges as desirable, with no pre-determined roles for anyone on the current steering committee in the ensuing structure.
>
> The current hierarchical structure based on individuals who make what at times have seemed to be unilateral decisions that affect all groups in the state. This seems to have been the source of many problems. A preferable structure is more a "federation" of HCAO around the state that would participate based on what they see as the best approach for their organizations. Each group would be an autonomous organization; those strategies upon which all agree would be taken on statewide. Agreement for state actions would be made using a consensus model.
>
> As you see, I have spoken of a model for a structure for a statewide group. I have not discussed what specific approaches to health care reform should be undertaken. This is because without an adequate structure no valid decisions about strategies can be made.

In this last paragraph, D. Cohen makes a very good point about the highest priority being put on a democratic structure, and only thereafter discussions made about details in a future plan. We will be returning to the concept of who are the legitimate representatives to develop the principles, and the working details for a future UHC plan, see conclusion to Part II.

Conclusions on restructuring UHC campaign

There seems to be a strong, widespread committment to the objective of UHC and continuing interest in building a stronger more democratic movement (eg. Yahoo #344-2). Specific interest in analyzing past weaknesses and future improved organizing strategies for the state were expressed by several contributors and notably by the PDX Community Leadership Team. Definitely there is a willingness to reconsider and develop the best possible structure for the future state UHC organization.

The call for a restructuring of the UHC campaign and for greater internal democracy should not be taken as being critical of the individuals who got something started for the state Oregon to cover all its residents. After all the few who started HCAO were surely among the most concerned and dedicated to the cause at that time and all future work will be built upon what they began and were able to demonstrate. M.A. Holser's **brief history** of UHC in Oregon is required reading for anyone interested in seeing recent developments in context.

Conclusion and Recommendations

Closing remarks from several respondents

M. Shapiro (Yahoo #346-2) responded to the discussion for an expanded OHP and to the many comments about shifting positions on residency, "cost-containment":

> Only by obtaining the necessary resources to mount an enormous person to person campaign would an initiative have any chance of passing. The voters need to understand, from personal contact, that the negative advertising is/will be a distortion of the facts and should be ignored. Without a plan to achieve such a goal, an initiative campaign is an exercise in futility. Conversely, with such a plan in place, it would be possible to win. I believe it would be foolish to pursue anything other than a comprehensive, single payer, UHC system.
>
> I believe we need to create a coalition of forces backing single payer, comprehensive, UHC. It must be so inclusive and diverse that it will cause the politicians to believe, in spite of their political views and the paid influence of the insurance industry, that their failure to enact the legislation that we propose will lead to their losing their elected positions.

D. Cohen's idea about WHO is the legitimate broker of public's welfare and rights.

Also T. Miller (Yahoo #349-1) suggested organizing for a referendum which would set up a commission for the transition to UHC by 2008. The referendum would set up the commission which would then be responsible for working out many of the details. Commission would be charged with developing a plan to provide coverage for every US citizen and legal US immigrant in Oregon.

> The Commission will handle the details of the OHUP, how extensive coverage is, how much taxes will be increased, who pays, what happens to the undocumented and out of staters who may move to Oregon, to what extent alternative health treatments are covered, etc. All we ask is the people take a stand, much easier to defend and pass.

Message 2, 08 Dec #356, comments from "B. Michtom"

If we were to get a referendum passed and a commission installed, this would not likely be under our control and the people who have control (our opponents with all the money) will make sure that the devil is in the details.

Project EINO wraps it up with a few suggestions

It seems obvious that the activists coming out of the M23 campaign have learned a great deal and have already made numerous very helpful recommendations about proceeding on from this point. Hopefully, we can assist a little by trying to pull together some of the important threads of the last two months of suggestions. We will be happy to include other interpretations and criticisms in the next edition.

Fundamental principles, clearly stated

Probably everyone reading through this discussion will come to the same conclusion regarding the need for greater clarity of BASIC PRINCIPLES. Clarity in statement of them and clarity in the rationale for them. These basic principles should be developed with the intention of formulating and including the positions which are considered essential, to be agreed upon by all of your allies and supporters. Much too frequently in the above discussion did we hear from "supporters of measure 23" who were opposed to many of the essential features of the plan. Your plan may still be criticized by such individuals in the future, but they will be clearly marked as not being supporters. Think clearly about what is absolutely essential and who you must have as your activist, supporter and ally[18].

Internal Democracy, Empowerment

It is very encouraging that several of the respondents brought up issues of democratizing and restructuring the organization. We hope that these ideas are taken to heart and that the challenging work of developing a new organization is undertaken (democracy is always very time-consuming). We think that the movement in Oregon is at a very good stage to undertake that work now. Think about other state grassroots organizations in your state that you find impressive in this respect and invite some of their board, or past board members to make some comparisons and comments. This part of organizing doesn't cost you anything but time and lays a strong foundation for success.

A related topic is the greater involvement in the organizing work of the most at-risk and excluded (from health coverage) individuals in your state. As is evident from the self-criticism of several discussants, a critical weakness of the M23 organizing was the failure to involve the African-American community and ethnic minorities in the campaign - and especially to do so at an early point in organizing (deciding on the key issues). The strongest advocates that UHC organizing has are the people who are currently outside the system and most at risk. The fact that voting turnouts might be low among these groups, is all the more reason to involve them and make the campaign into an empowering movement for these communities which are so frequently left out of so many social benefits. They will organize their own communities, once you can get through to the key organizations and activists on other related issues of these same communities. Furthermore, many of the weak positions suggested such as on rationed care and multi-tiered systems are mistakes that an involved minority leadership will quickly challenge. Democratizing and employing a more sophisticated method of organization-building will indeed address several weaknesses.

Avoiding the proverbial foot shot

A great deal of resistance within the HCAO was rooted in failure to clearly distinguish details in the plan from basic principles related to the health plan. Several respondents wisely suggested working out "structural", "leadership" and "democracy" issues before undertaking any detailed plan development. Project EINO was impressed with the idea of getting a commission set up to work out some of the fine details of the plan, rather than arguing the many details of implementation and operation publicly for the next several decades (agreement on all these aspects will never be reached easily, much less so by consensus). We could indeed avoid the shooting of ourselves in the foot and weakly limping towards the finish line next time around.

But why not get the Oregon legislature committed to BASIC PRINCIPLES first before setting up such a commission? A future referendum, for example, might involve an iron-clad commitment by

the legislature to the principle that every resident of the state shall have access to quality health care to meet all their health care needs (eg. same quality as state executive officers). Or even get a committment to the "Right to Health Care" for all residents. Such an ironclad commitment would for example result from an amendment to the state constitution. The same law might stipulate a time-frame for the commission, some guidelines for the personnel make-up of the commission (so that the major citizens' organizations could not be excluded), and a time-frame within which the access of all Oregonians to health care would be assured (plan fully implemented).

In this case while the campaign would argue that a system like single-payer is feasible and affordable, but would not have argue for a specific change in tax law. The campaign would argue that rationing is what we now have, but not necessary in the new system, given the current waste and excessive profits. The campaign could argue about residency requirements and cost-containment based on existing data and the valid existing comparisons, but would not have to defend any specific wording. In short, the campaign could argue forcefully based on your own agreed upon BASIC PRINCIPLES and not have your support divided and your opponents reinforced by arguments over details. We support the several discussants who questioned whether there would ever be a successful campaign which lays itself open to every conceivable disagreement over health care details (many of which have little to do with UHC or single-payer, Example).

Appendices

Appendix One

OREGON HEALTHCARE EXPANSION PLAN

ELIGIBILITY 1. Oregon residents who: * Are U.S. citizens * Have established permanent residency in Oregon, through home ownership or rental * Are not eligible for the Oregon Health Plan or Medicare 2. Their domestic partners who are not eligible for the Oregon Health Plan or Medicare. 3. Their dependants who are not eligible for the Oregon Health Plan or Medicare.

COVERAGE 1. Medical, mental health, dental or vision care provided by a licensed: * Medical doctor (MD) * Mental health care provider * Dental care provider * Vision care provider 2. Doctor's office visits, outpatient treatment, hospitalization, prescriptions, tests. 3. With such exclusions as may be specified by the state legislature.

FINANCING 1. A tax on employers of $_XX_ per month per employee eligible under this Plan. 2. A monthly tax on employees, eligible under this Plan, according to their gross yearly income range. 3. These rates could be changed by the state legislature if necessary.

GOVERNANCE Put it under the same state department that now runs OHP, FHIAP and other healthcare finance programs, some of which it would replace.

COST CONTAINMENT 1. Medical treatment and prescription copays equivalent to those required under OHP. Not required for those with gross incomes equal to or less than 150 percent of the federal poverty level. 2. Yearly deductible of $100. Not required for those with gross incomes equal to or less than 150 percent of the federal poverty level. 3. The same voluntary drug formulary (recommended list) now used by OHP. Research a similar list for treatment procedures. 4. Bulk purchase of prescription drugs by the state for those covered under this Plan. 5. Administrative costs would be capped at the same percentage as OHP.

HEALTH CARE PROVIDERS REIMBURSEMENT For patients served under this Plan, health care providers would be reimbursed by the state for their services at a rate equal to their costs plus ___ percent.

Appendix Two

HISTORY OF OREGON HEALTH CARE REFORMS by Mary Ann Holser (Yahoo #357)

To put our efforts in perspective it might be useful to look at the history of efforts to achieve universal health care in Oregon. In the spring of 1998, I received a call from Betty Johnson of Mid Willamette Valley Health Associates asking me to gather some Lane County people concerned about access to health care in Oregon. Groups in Salem had been holding educational meetings and gathering support for access to health care. Portland also had an ongoing group, Single Payer Action Reform Committee (SPARC). In the early 1980's, 10 state legislators, including current state Senator, Bill Morrisette and current State Democratic Chair Jim Edmunson, had sponsored a single payer bill. Oregon Fair Share, a chapter of a national consumer action group, had done door-to-door canvass indicating that lack of health insurance was a major issue with respondents. Dr Michael Garland, at OHSU, and others had set-up statewide focus groups to explore health care needs. Interest in accessing Oregonians to health care was high.

The Oregon Health Plan Then Senate President, Dr John Kitzhaber, had his own plan for expanded coverage, which attempted to cover more people than traditional Medicaid through a prioritized list of effective treatments and a mandated employer insurance plan. The legislation also included insurance reforms to encourage small business as to provide health insurance. Kitzhaber's Oregon Health Plan prevailed, and passed after much controversy and opposition from conservatives. Some moderate Republican leaders eventually supported the plan. The employer mandate was blocked by the federal "Employee Retirement Income Security Act (ERISA), and small businesses did not respond by buying the "basic" health insurance package offered in the reform. However, a strong administrative organization to run the program was included in the legislation. Under the strong leadership of Oregon Health Plan director, Vicki Gates, insurance companies and provider organizations were brought into the planning. In the better economic conditions of the 1990's, the plan brought health care to many previously uncovered Oregonians.

It should be noted, that conservatives, from its inception, have continued to oppose the plan, always wanting co-payments, larger deductibles, and lower asset requirements to limit eligibility for the plan. They believed that low-income people should not receive benefits equal to those offered in the private sector. Even in good times, general fund support was not budgeted to meet the growing need. As the economy slowed and businesses cut back, it only got worse. When citizens voted to impose a cigarette tax to go to the plan, the legislature reduced the state funding in the amount the tax raised, thus defeating the citizen attempt to expand the plan! Insurance companies, hospitals and health systems, though originally supporting the plan, were unhappy with cost controls.

Current Situation of the Oregon Health Plan With the last two Republican controlled sessions, the giveback of the earlier budget surpluses and the slowed economy, the state experienced a budget shortfall. The health plan's response is to add co-pays and deductibles in a two-tier plan called OHP basic and OHP plus, supported by doctors as the "Cadillac and Chevrolet plans". Is there such a thing? Is "Cadillac" a room with a view or a liver transplant; tests for the cause of symptoms or use of the newest advertised prescription drugs? Is mental health treatment "Cadillac?" It is not in the OHP "basic" plan! Will defining such a distinction be made, by need, by providers or by

administrators? As incremental reforms continue the OHP is restricted; Measure 23 has failed at the polls, and 400,000 Oregonians remain without health insurance and/or very limited access to charity care.

HEALTH CARE FOR ALL-OREGON FORMED In the spring of 1998 when Betty Johnson called, I had been following the OHP for a book I was writing and was concerned about the fact that, despite the efforts of Governor Kitzhaber, we still had 400,000 uninsured and were struggling to adequately cover those fortunate enough to be eligible. In Eugene, about six of us organized a countywide meeting in September 1998. State Representative Bill Morrisette and then County Democratic Chair, Jim Edmunson, both supporters of universal health care, spoke to a well-attended interested audience. From this small beginning we eventually organized a Lane County leadership team and joined with other groups to form a statewide organization, "Health Care for All-Oregon." Representatives from local groups around the State formed a State Steering Committee. Groups in Ashland, Corvallis, Lane County, Portland, Roseburg as well as the state Green Party joined us. We were health professionals, citizen activists, political activists, retired folks, working folks, religious leaders, consumers and Oregonians who care about each other. Eventually we became a political action group in order to write a statewide initiative and you know the rest!

Plan, Language, Stakeholders and Commitment We struggled for 4 years to come up with the outlines of a plan. We formed a language committee to work out a specific universal health care initiative, consulting with sympathetic legislators, State officials, political leaders, and health professionals. We obtained the best advice we could, as a volunteer lightly funded grass roots group without major power brokers. We attempted to enjoin statewide organizations concerned with health and welfare in an active coalition. We were met with some support, but with a general reluctance to openly and actively participate. We had to do it ourselves and we came up with a plausible, unique, and attainable plan. Consulting health economists did the best to estimate financing. Far from vague, our initiative legislation had more detail than many other initiatives seen on State ballots. It is true that outside groups were not involved in the writing, but many appeared not interested in active involvement at the time. We worked with labor directly and did change language responding to their concerns, but their opposition was not related to language, rather to their own perceived interests at the time. We might have worked harder on this, but the pressure of deadlines for the initiative and the continuing worsening of the health access situation loomed large for our small volunteer group.

Although our endorsements indicated general support from many important statewide organizations, it was not backed up with adequate funding, person power or organizational efforts from these groups. As others have said, we will need to line up these groups with strong active commitments behind their verbal support before we proceed with our next move forward. Good news is that some organizations now want to talk with us. The failure of the initiative may actually wake up stakeholders to more actively support their stake in Oregon's health.

Endnotes

[1] Part One of Oregon Discussion still available and free from Project EINO CLICK HERE
[2] See Comments from D. Cohen #343-1 in yahoo group "Disc2.txt"
[2] See www.EverybodyInNobodyOut.org#Regnl for listing of state UHC organizations
[4] The Project has been running on a shoestring budget for 4+ years now, without ever receiving even a small start up grant. More details available at "Support EINO" on blue menu at www.EverybodyInNobodyOut.org or CLICK HERE
[5] The discussion group is at healthcareoregon@yahoogroups.com
[6] See #2 FAQ on page about Existing Models at EINO FAQ or CLICK HERE, or see news story about the 200,000 uninsured in Hawaii on this page CLICK HERE
[7] See document summary #5 on July-Dec 2001 at EINO (including link) CLICK HERE
[8] See discussion at the EINO website Q#6 in FAQ section on Financing UHC or CLICK HERE
[9] We're talking 50 million + annual compensation! see EverybodyInNobodyOut.org/FAQ/datCEOs.htm or CLICK HERE
[10] Search EverybodyInNobodyOut.org from blue menu for "small business" find many recent articles.
[11] See website of Canadian public employees www.nupge.ca , page on Kraft Corp (lifesavers) CLICK HERE
[12] Find much historical comparison to the struggle for "Right to Education" at www.EverybodyInNobodyOut.org in the FAQ section "Right to Health Care" or CLICK HERE
[13] Download "Grassroots Organizing for UHC", select Downloading from main blue menu OR CLICK HERE
[14] See www.coveringtheuninsured.org for worst example of insurance industry championing "UHC", actually promoting an understanding of UHC that will further boost their own profits. Unfortunately, several national citizens' organizations promote this "new" concept of UHC also and lend it legitimacy note partnership of, for example, Families USA with the insurance industry in this "Strange Bedfellows" coalition.
[15] See news archives at www.EverybodyInNobodyOut.org, or "Search EINO" from blue menu with keyword Wyden to read story.
[16] Download "Grassroots Organizing for UHC", select Downloading from main blue menu OR CLICK HERE
[17] See website of Canadian public employees www.nupge.ca , page on Kraft Corp (lifesavers) CLICK HERE
[18] Download "Grassroots Organizing for UHC", see page on "Natural Allies of UHC" CLICK HERE