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Creating Health And Abundance With Complementary Currencies

Victoria Temple
Regis University

Regis University
School for Professional Studies Graduate Programs
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USING COMPLEMENTARY CURRENCIES IN THE NONPROFIT SECTOR

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Victoria Temple

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Abstract

This paper examines the ways in which the use of complementary currencies can help solve the current crisis in American health care and create abundance in the lives of those people who have been marginalized by both the prevailing health care and economic systems. It explores the positive effects that the use of these social currencies can have on the programs and financial stability of nonprofit health care organizations, as well as on the communities in which they operate. This paper looks at several implementations of complementary currencies in health care organizations, particularly those based on the Time Dollars model. Finally, it draws conclusions for the continued use of social currencies to help solve health, social, and economic problems.

1. Introduction

This paper examines the use of complementary currencies in the nonprofit sector, with a particular focus on health care. The typical charitable nonprofit organization (NPO) faces constant, persistent, and many times insurmountable challenges around its finances and funding. While diversifying its income streams to decrease its dependence on any one funding source is a wise business decision, diversification among sources that generate from the same national currency does not entirely solve the problem. This paper proposes that true diversification and true financial stability involve the use of income streams not tied to, valued to, or based on the U.S. dollar, but rather on alternative, social currencies that complement and work in parallel with the national currency.

An examination of several complementary currency systems in place around the country and around the world reveals that these systems can be and are successful, profitable, sustainable, and thriving. They have resulted in stable, more profitable organizations; in stronger, more self-sufficient communities; and, in more self-reliant populations. Nowhere is this more obvious than in the health care field, which in the U.S. is largely inadequate, inefficient, and inaccessible to the people who need it most. This paper describes ways in which nonprofit and health organizations have begun to integrate complementary currencies into their operations.

The author of this paper is a student in the Master of Nonprofit Management program at Regis University in Denver, Colorado. This paper fulfills the professional project requirement for graduation from that program. It is the intent of the author that this paper become an integral part of the growing body of work that advocates for a holistic set of systemic changes to our social structures and our collective behavior that can help to solve the social, economic, and environmental issues facing the world today.

2. Methods

This paper reflects information and insights gained from interviews with seven people who have studied economic and health care systems or who have been involved in the design and

implementation of complementary currency systems. These unstructured interviews took place in May and June of 2005 and lasted from one to two hours. All interviews began with questions about how each person was involved with complementary currencies and proceeded with spontaneous discussion and additional questions based on his or her responses:

- Octavia Allis is the founder of a complementary currency system, SkillShare, in Boulder, Colorado. She provided information on the history and philosophy of Time Dollars systems, the kinds of services that can be exchanged, how to create and implement an automated system to track exchanges, and how to maintain and expand an exchange network.
- Thomas Cogswell has followed the development and uses of complementary currencies for many years. He provided access and introductions to other relevant resources.
- Donna Frost is a financial management professional and small business consultant, with a particular interest in affordable housing. She provided information on the bartering techniques that she has used and continues to use successfully, as well as details on the diverse exchanges she had made.
- Richard Lamm is a former governor of Colorado and a current director of the Center for Public Policy and Contemporary Issues at Denver University. He is also the author of the book, *The Brave New World of Health Care.* He provided information on the use of complementary currencies as an instrument to advance public policy.
- Bernard Lietaer has researched and written much of the seminal work on modern complementary currencies and their relevance to current economic and monetary systems. His books include *The Future of Money: Creating New Wealth, Work and a Wise World*; *Our Future Economy: Money and Sustainability—the Missing Link* (with Stefan Brunnhuber); and *Of Human Wealth: Beyond Greed and Scarcity* (with Stephen Belgin). He provided historical perspectives on the use of complementary currencies, information about how these currencies are working in implementations

throughout the world, and advice on how NPOs can create new or integrate into existing exchange systems.

- Michele Sumpter is a holistic health practitioner who accepts a complementary currency, Denver Dollars, in her practice. Her interview centered around her motivations for becoming involved in the Denver Dollars system, the impact of that involvement on her practice, and her ideas for strengthening and expanding the network as it moves forward.
- Alec Tsoucatos is a professor of economics at Regis University. He provided information about economic systems in general, the role of capitalism in the world economy, and the impact of globalism on local economies where complementary currencies have been used most successfully.

This paper also reflects research and anecdotal information documented in books, journals, magazines, and web-based articles. These books and articles describe various global, national, and local economic initiatives, as well as various health care systems. Their authors are people who have studied and/or successfully designed, implemented, and are using alternative currency systems to address health and other social problems in their communities.

3. The Nonprofit / Health Care / Money Problem

This paper addresses a three-fold problem: 1) the typical charitable NPO suffers from a perpetual lack of money; 2) the health care system in America is largely inadequate, inefficient, and inaccessible; and, 3) the economic system on which both of these industries are dependent is itself a cause of the very problems these NPOs and health care organizations try to address and is ultimately unsustainable.

The Problem in Nonprofits

From the moment a typical charitable NPO opens its doors to its community, it struggles with money. The NPO never has quite enough money to offer its services to all the people who need them or to compensate staff with fair, competitive salaries. Experts advise the NPO that the best way to counteract this constant, incessant, and potentially fatal financial pressure is to

diversify its income streams and obtain money from a varied number of reliable sources—from government agencies at the federal, state, and/or local levels, from private individual philanthropic sources, from foundations, from for-profit businesses, from fees charged for services rendered, for example—and not become too dependent on one source of income. This, they say, ensures financial stability.

While this is surely good advice and most NPOs recognize its value and attempt to follow it, it fails to recognize a fundamental fact. Virtually all of these income streams generate from the same flawed economic system—that is, the operation of the national currency in a market economy. As we have seen both historically and in recent times, national currencies are notoriously unstable and subject to wild fluctuation and even failure. (Lietaer, 2001; Dykema, 2003) Problems in one stream are usually a harbinger of problems to come in other streams.

Relying solely on diverse income streams that generate from one unstable source and that are subject to the same marketplace pressure does not guarantee that an NPO can design, build, and implement useful, scalable programs. It does not build self-supporting community. It does not take an NPO into a successful, sustainable future.

Virtually all NPOs must compete with each other—and in many cases, with other for-profit organizations—for limited resources in all revenue streams. If the revenue stream generates from the government, NPOs must also compete with critical public policy initiatives concerned with education, health care, infrastructure, and environment, to name just a few. (Lamm, 2003) Whenever there is a finite amount of money to be shared among diverse, equally deserving recipients, trade-offs must and will be made. Some worthy causes will go without money and services. They and their clients will suffer.

The Problem in Health Care

Richard Lamm, in his book, *The Brave New World of Health Care,* evaluates the American health care system according to three criteria: 1) the technology it can bring to bear to solve health problems; 2) how accessible it is to the general population; 3) and, what outcomes it produces in terms of improved health. Lamm acknowledges that in technology, the American

health care system is unsurpassed in the world. He defers to international health care expert, George Schieber, in evaluating the accessibility and outcomes of the system: “In comparison with other major industrial countries, health care in the United States costs more per person and per unit of service, is less accessible to a large portion of its citizens, is provided at a more intensive level and offers comparatively poor gross outcomes.” (Lamm, 2003, p. x)

Lamm presents a several-count indictment of the government’s public policy on national health care:

1. Ignoring the needs of the uninsured. The government provides excess funds to some people while leaving other people completely without access to the health care system. He sees a particular moral conflict in keeping terminally ill people alive at great public expense, while others die for lack of basic services.

2. Overfunding the health care costs of the elderly. The government taxes the working poor, many of whom cannot afford their own health care, to fund a program (Medicare) much of which subsidizes health care for those who can easily afford to pay for their own and who are often more wealthy than those being taxed.

3. Underfunding public health. It is the responsibility of a government to ensure and provide the most health coverage for the most people. The American health care system spends too much money on high technology and marginal medicine and not enough to provide basic health care, to prevent disability and disease, to encourage healthy life style choices and, to understand and act on the influence that the physical, social, and economic environments have on the health of a population.

4. Uncontrolled, unsustainable growth of the U.S. health care system. Health care costs in the U.S. are growing at twice the rate of inflation. The system controls and spends tremendous amounts of money and resources that are needed in other parts of the economy for other, equally critical social and environmental problems. In addition, Americans demand much more from their health care system than they as taxpayers have paid for and certainly much,

much more than future generations can pay for. Americans simply cannot afford their health care system nor can they sustain it. (Lamm, 2003)

The issue of insurance coverage is particularly thorny. There are approximately 43.6 million uninsured citizens in the U.S. today. Contrary to popular opinion, "8 out of 10 of these are in working families that cannot afford health insurance and not are eligible for public programs." (Boucher, 2005, p. 1) The uninsured are more likely not to seek preventative care and more likely to seek treatment only when their illnesses are severe enough to require emergency room treatment. Their illnesses are by this time advanced and require more expensive treatment. The uninsured are more likely to receive inadequate care when they finally do seek medical treatment and to die sooner. (Pugh, 2003)

Research conducted by the Kaiser Commission on Medicaid and the Uninsured provides confirming evidence. That research also shows that since the uninsured are "less likely to receive preventative care, they are also more likely to be hospitalized for avoidable health problems ... Having insurance improves health overall and could reduce mortality rates for the uninsured for 10 to 15%." (Kaiser Commission on Medicaid and the Uninsured, 2003, p. 1)

Having insurance coverage does not always guarantee care when it is needed. Patients are many times denied coverage and treatment and experience a corresponding decline in health. Patients also fear that their insurance carriers are motivated more by cost than by quality of care. (Healthcare In America: did you know?, n.d.) Arthur Warmoth (1998) would seem to agree. He sees the problem in health care as the industry's focus on generating profits, rather than in finding ways to meet "collectively defined social goals."

Again, whenever there is a finite amount of money to be divided among diverse, equally deserving recipients, trade-offs must and will be made. This is particularly true in the area of public policy during the appropriations process. Some programs and initiatives will get full funding, some will get less funding than they need and ask for, and some will get no funding at all. Resentment and competition will grow. All will suffer.

The Problem with Money

While this is not a paper on economics, a short discussion of the history and nature of money is helpful to understand how it contributes to the problems in NPOs and health care. The earliest "money" was a barter—an exchange of goods and services for mutual advantage. (NOVA Online, 2002) These early barters involved cattle and eventually agricultural products, including wheat. The shekel was the first coin of ancient Sumarians. "She" meant "wheat" and "kel" was a measurement. The value of a shekel was, therefore, a bushel of wheat. (Lietaer, 2001)

Gold coins were a common currency during the Middle Ages. Coin owners typically gave their coins to goldsmiths to place in strongboxes for safekeeping from thieves. In return, goldsmiths gave coin owners receipts for the coins placed in their care. When coin owners wanted to retrieve their coins to make purchases elsewhere, they presented their receipts in exchange for their coins. Eventually, rather than risk moving the actual gold coins whenever they wanted to make purchases, it became customary for coin owners to present their receipts, not the actual coins, to the vendors with whom they wanted to deal. The receipts, therefore, became promises to pay and were actually loans or credit agreements with the goldsmith. (Lietaer, 2001)

A similar kind of agreement exists today. Banks create modern money. In the case of the U.S., the banking system, under the supervision of the Federal Reserve, issues all U.S. money. All money comes into being as bank debt—that is, for money to come into existence, it must be borrowed into circulation. When we want to buy a house for which we do not have adequate cash, we must go into debt to a bank. When the U.S. government wants to finance a war for which it does not have adequate money, it must go into debt to the Federal Reserve. If there were no bank debt, there would be no money. (Greco, 2001)

When government spending spirals out of control, the result is inflation—that is, a general increase in prices. However, as economist Milton Friedman argues, "The increase in

prices is not due to goods and services being worth more but to the money being worth less." (Greco, 2001, p. 10)

Banks create the principal required for loans, but they do not create the interest that must accompany all principal payments. Obtaining money to pay interest comes only by incurring more debt. When I buy a house, I must provide collateral for the debt just incurred—that is, I must agree to forfeit something of equal value if I do not repay the loan (usually the house being purchased). Since the interest that I need to make my payments does not exist, I can obtain my interest only when you forfeit your collateral by defaulting on your loan, placing back into circulation the principal and interest you have paid.

We will always owe more money than exists and we must always compete with others for this critical, scarce resource. The Federal Reserve openly admits that it tries to maintain the scarcity of money and that "money derives its value from its scarcity in relation to its usefulness." (Greco, 2001, p. 9)

Bernard Lietaer (2001) sees at least three negative implications of interest on society as a whole: " … 1) interest indirectly encourages systematic competition among the participants in the system; 2) interest continually fuels the need for endless economic growth, even when actual standards of living remain stagnant; and 3) … [because the wealthiest people and companies own the most interest-bearing assets] … interest concentrates wealth by taxing the vast majority in favor of a small minority." (p. 50)

This system is ultimately self-destructive and unsustainable. People spend more time working to make more money to compete for more money in what will always be an uneven playing field. Wayne Muller (1999) says that, "When people are not using their time to get money, they are using their time to spend money." (p. 99) They contribute to the growth of the economy by incurring more debt; they improve their social and economic situation not at all. The working poor are presented with a particularly bleak future: in this highly competitive labor market, they will never be able to generate wages high enough to purchase the services they need. (Warmoth, 1998) The gap in access to resources will always exist because money does not

reach the people who need it the most. (Greco, 2001) As Wendall Berry (2005) points out, the free market is by nature inequitable. It is "freest to those who have the most money and is not free at all to those with little or no money." (p. 4)

4. A Solution: Complementary Currencies

We take money for granted. We admittedly worry about it a great deal as we try to obtain enough to meet out needs, but we do not "know" about it, how it works, or how it affects our lives. Economist Alec Tsoucatos says that we have become trapped within a particular way of thinking about money … so trapped that we simply cannot think about it in a different way. (A. Tsoucatos, personal communication, June 2, 2005)

Margaret Thatcher is responsible for a phrase—TINA (there is no alternative)—that has some applicability here. While she used TINA to refer to her policies of neoliberal globalism (Mittelman, 2004), it applies in a narrow sense to our beliefs about money. We forget that money is a human invention and that, as such, humans can change it when it stops meeting their needs. (Greco, 2001; Lietaer, 2001) We forget that there *are* alternatives.

Overcoming the problems described above starts with the realization that "we are working for the wrong reward … we are being paid in the wrong currency." (Muller, 1999, p. 101) Overcoming these problems starts with breaking the tradition of overvaluing money and of undervaluing the skills and talents that communities have available or can develop and offer, not in dollars, but rather, *in time*. Overcoming these problems starts with measuring wealth not by how much money or goods people can accumulate or consume, but rather by how much time they can give to their communities (Muller, 1999) and how much time they can invest in their own well-being. Overcoming these problems starts with the realization that there are other economic initiatives that can address the social problems that conventional currencies create, but are ill-equipped to solve.

Definitions

Some definitions help to understand the discussion that follows.

Complementary Currencies

A complementary currency is an agreement among people or organizations to accept a non-traditional currency as the basis for exchange. These currencies are not designed to replace conventional currencies, but rather to work in parallel with them, on a smaller scale, to "perform social functions that the official currency was not designed to fulfill." Lietaer (2001, p. 30) They have also been defined as a non-conventional exchange, used to link unmet needs with unused resources. They bear no interest and promote cooperation rather than competition among users. (Gerloff, 2004)

At their core, complementary currencies involve a person offering a service to someone who needs it and in return receiving a reciprocal service from someone who can offer it.

Abundance

Parker Palmer (2000) defines abundance as follows:

> Abundance is created when we have the sense to choose community, to come together to celebrate and share our common store. Whether the scarce resource is money or love or power or words, the true law of life is that we generate more of whatever seems scarce by trusting its supply and passing it around. Authentic abundance does not lie in secured stockpiles of food or cash or influence or affection but in belonging to a community where we can give those goods to others who need them—and receive them from others when we are in need. (p. 107-108)

Sustainability

Norwegian Prime-Minister Bro Harlem Brundtland provides the commonly accepted definition of sustainable development: "Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs." (World Commission on Environment and Development, p. 43)

Matching Needs to Resources

It is so often the case that people, communities, and NPOs have identified workable solutions to problems that confront them, only to be stopped in their tracks for lack of money.

They have identified the skills needed to solve the problem and the people who have those skills, but they have no money to offer in payment.

Social currencies create a new type of agreement that operates outside the exchange of traditional money. They do this by letting people use skills and provide services that the market may not value at the moment—that is, a skill or service that somebody needs, but for which nobody can pay them in traditional dollars. In return, they receive something they need—many times a similarly undervalued skill or service—from someone else. They match unused resources with unmet needs. (Dykema, 2003)

This represents a radical shift in thinking from the predominate situation today in which people either receive services for which they do not pay (welfare) or they receive health care paid for by third parties, either insurance or government. As Lamm (2003) says, "What we don't pay for directly we tend to undervalue." (p. 18)

Implementations

There are currently more than 7,000 implementations of complementary currencies throughout the world, being used to solve a myriad of social problems. (Dykema, 2003) This paper now examines several implementations that deal specifically with health care.

Fureai Kippu

Created by a group of 300 nonprofit organizations, Fureai Kippu (Caring Relationship Ticket) is a social currency used in Japan for the care of the elderly. It operates in conjunction with the national currency and has as its base unit an hour of service. Someone who provides a service for an elderly person—shopping, body care, meal service, or transportation, for example—earns credits in a health care time savings account. Different tasks have different time values. Care-givers can spend earned credits when they become sick and need similar services. They can also transfer the credits to friends or relatives who may need services. The elderly prefer the services of these caregivers to those of social workers paid for with yen, saying the service is more caring and of higher quality. (Lietaer & Belgin, 2004)

This system has resulted in a significant increase in the number of volunteers, even when the volunteers do not themselves open time savings accounts. Volunteers say that in this system, they "feel more acknowledged." (Lietaer, 2001, page 202)

Time Dollars

The Time Dollars model has been used as the basis of hundreds of complementary currency implementations in the U.S. and throughout the world. Like the Fureai Kippu, it allows service exchanges on an hour-to-hour basis. Unlike the Fureai Kippu, all hours are of equal value. One hour equals one hour, regardless of the service. While the exchange of service is important, connecting people and keeping them engaged is a primary Time Dollars goal. (Gerloff, 2004)

Time Dollars advocates four key values that would seem to be fundamental to all complementary currency implementations, regardless of the model being used: "… 1) everyone has strengths and assets; 2) raising children and building community is valuable work; 3) mutual support is more powerful and empowering than one-way helping; and, 4) trust is the basis for community." (Munnecke, 2001, p. 14-15)

The Time Dollars model defines a concept known as co-production. Co-production turns "clients, beneficiaries, takers, and dependents into co-producers and contributors by recognizing, validating, and rewarding their skills, their capacities, and their contributions." (Time Dollar USA, 2004) It is a mission of Time Dollars to allow marginalized, "problem" populations to participate and become partners in producing solutions.

As stated above, the Time Dollars model is being used by NPOs and health care organizations across the country and the world. A hospital in North Carolina is typical. It uses Time Dollars to operate a successful diabetes prevention and treatment program. Through their insurance carriers, patients use Time Dollars to pay for clinic visits, to attend workshops and exercise classes, and to receive training on how to prevent and/or manage this disease. The hospital spends its Time Dollars to hire people to telephone patients to remind them of their appointments and classes and to generally check up on them. The hospital reports that the health

of patients involved in this program improved significantly, they spend less time in the emergency room than previously, and costs decreased dramatically.

In another program between NPOs and a local government, the elderly perform gardening tasks in public areas in exchange for a discount on their property taxes. (O. Allis, personal communication, May 24, 2005)

Elderplan

Elderplan is a Time Dollars-based, health maintenance organization (HMO) for seniors in Brooklyn in which its members take care of each other. As in Time Dollars, each hour that members spend helping someone else is credited to their account, to be used when they themselves are in need. This program has resulted in significant reductions in health care costs by allowing seniors to stay at home during illnesses, rather than spend expensive time in a nursing home or hospital. Elderplan acknowledged this savings by eventually allowing members to use their service credits to pay for part of their HMO premiums. (Rowe, 1993)

Other statistics are equally impressive: participants remained healthy longer than average. This allowed Elderplan to offer a 25 percent discount on insurance premiums, in return for Time Dollars. Since 1998, when Elderplan became zero-premium, its participants have been able to spend their Time Dollars outside of the system on things like blood pressure monitors, theater tickets, and supermarket vouchers. Local businesses provide these items to the program at a discount. (Boyle, 2000) Since 1987, Eldercare has provided at least a half-million dollars worth of care that the HMO could not have afforded otherwise. (Rowe, 1997)

Edgar Cahn, founder of Time Dollars, reports that as of June 1999, 4,316 members have earned 97,623 Time Dollars through 41,985 exchanges. Elderplan was rated the number one HMO in New York in 1999. (Cahn, 2000)

Elderplan participants also report on the higher quality of care provided by members. An often reported problem in social services is that seniors do not want social workers or other professionals in their homes; elderly women do not want to talk to young men or women about the problems of aging. They are more open to care when someone of their own age and

experience works with them not as a paid professional, but as a friend. (Rowe, 1993) Mashi Blech, director of community services for Elderplan, says, “Often you can’t buy what you really need. You can’t hire a new best friend. You can’t buy somebody you can talk to over the phone when you’re worried about surgery.” (Boyle, 2000)

Elderplan participants adamantly declare that this is not charity. They understand that they are active players in this system. They understand that when they receive a service, they have an obligation to reciprocate. Elderplan participants say that earning Time Dollars is not their primary motivation for being involved in the program, but rather the opportunity they have to help others. They gain a sense of personal worth, value, and usefulness … something that American culture and society deny them. (Rowe, 1993)

It is hard to argue with the results that Elderplan has seen. Its costs have decreased because “members tend to stay more healthy because they are active and needed.” (Cahn & Rowe, 1992, p. 45)

True North

True North is a health center in Falmouth, Maine. It provides an environment centered on its patients and one in which patients actively participate in their own healing. True North is a member of the Maine Time Dollars Network. Patients can exchange their Time Dollars for appointments with a True North doctor. When they present their Time Dollars ID card, patients also receive a 10 percent discount on services, classes and workshops, and items in the health center store. (True North, n.d.) True North uses Time Dollars to hire people to make phone calls to remind patients of their appointments and to perform other needed services such as maintenance and computer consulting. (O. Allis, personal communication, May 24, 2005)

Veterans Health Administration

The Veterans Health Administration in Washington, DC is considering a VA Health Bucks system, based on Time Dollars. Veterans would earn Health Bucks by performing such services as volunteering at a hospital; serving as a health buddy; organizing a support group; participating in research; adopting a healthier life style by losing weight, stopping smoking or

drug use; or, donating blood. They would spend Health Bucks on such things as discounted or free food at the Canteen; discounted co-payments on prescriptions; or, transportation services. (Munnecke, 2001)

SkillShare Network

SkillShare Network is a Time Dollars organization in Boulder, Colorado. Its members include health care providers, insurance companies, supermarkets, schools, and various other community partners. Health care providers accept Time Dollars in payment for services rendered; insurance companies offer discounted insurance premiums to SkillShare members; and, community partners accept Time Dollars in payment of purchased goods and services, often at a discount. (SkillShare Network, n.d.)

Virginia HMO

In his book, *No More Throw-Away People*, Edgar Cahn describes a Time Dollars-based asthma management program operated by an HMO in Virginia. This program has seen "a 39 percent drop in emergency room visits, an 80 percent drop in in-patient days; a 74 percent drop in hospital admissions; and, $80,000 saved in Year 1 and $137,500 in Year 2." (Cahn, 2000, p. 15)

Centro San Vicente

Centro San Vicente is a health clinic run by the Daughters of Charity in the Lower Valley area of El Paso, Texas. Two of four residents in the Lower Valley live below the poverty line. There is no water, sewer service, or transportation. There is no access to medical care, schools, or jobs. There is no tax base to pay for services that the community needs. There are countless medical problems in the region—diabetes, anemia, malnutrition, hepatitis, and premature births. The residents do not have money to pay for the health care they need. (Cahn & Rowe, 1992)

By treating their patients as resources rather than burdens and by allowing their patients to pay with time instead of only money, the clinic has managed to overcome many of these problems, to expand its programs, and to build a community where none existed before. Patients earn Time Dollars by providing such things as transportation for other patients, counseling and

prenatal care for expectant mothers, babysitting services for the children of sick parents, and maintenance services for the cars used in the program. Patients spend their Time Dollars on their own health care services at the clinic, often times at a significant discount. It is true that Centro San Vicente receives less money when its patients pay with Time Dollars, but it also *needs* less money. Patients act as partners with the clinic by providing many of the services that the clinic would otherwise have to pay for with traditional money. (Cahn & Rowe, 1992)

Implications for Public Policy

State legislatures are beginning to examine alternative ways to address their budget deficits. Missouri and Michigan have successfully used complementary currencies to provide health care to the elderly and address other social problems. Both states have enacted Time Dollars legislation. (Cahn & Rowe, 1992)

While government use of complementary currencies has been successful in addressing and solving a myriad of social problems, there are many obstacles to their expanded use. A failed implementation in Florida proved that threats to a large, existing bureaucracy that served the elderly, a perceived potential loss of state jobs, and the self-interest of social service professionals were all barriers that an innovative complementary currency solution could not overcome. It is interesting to note that after state-sponsored efforts to implement a Time Dollars system failed, grass-roots organizations revived this program, which is thriving today. (Cahn & Rowe, 1992)

It is also interesting that Edgar Cahn, Jonathan Rowe, and Richard Lamm all see similarities between the economic and social conditions that exist today and those that existed in the 1930's. The environment in the 1930's forced social service agencies to rediscover time barter and self-reliance (Cahn & Rowe, 1992), much as they are today. Lamm sees an even more ominous connection: not considering new, perhaps radical ways to solve current deficit crises could "lock the nation into an economic crisis that could be as serious as the one of the 1930's." (R. Lamm, personal communication, June 14, 2005)

Lamm also acknowledges the significant barriers that exist to any large-scale, nation-wide attempt to redefine money and how consumers relate to it. He says that while these barriers reflect valid concerns, they are ultimately trumped by the fact that "public policy cannot live at variance with reality" and the reality is that our current market economy is simply not sustainable. (R. Lamm, personal communication, June 14, 2005)

5. Recommendations

The easiest, most important thing that those interested in using complementary currencies can do is simply to recognize how much barter is already a part of their lives and how extending that relationship is really not so difficult or threatening. It starts with a person washing dishes in exchange for a meal and extends to the owner of a stable offering free horseback riding lessons to the person who sets up the stable's accounting system. It extends to the artist who trades one of his original artworks for educational testing for his son. (D. Frost, personal communication, June 21, 2005) It extends to the owner of a flower shop who offers free delivery of a customer's flowers if that customer will deliver another order of flowers on her way home.

It is critical that economists, legislators, service professionals, and government, business, and NPO leaders continue to study and define the relationship between the market and the non-market economies. It is critical that they understand that the non-market economy is a real economy and has a real impact on organizations, communities, and people, as well as on the market economy. It is critical that they understand that we as a society cannot define progress, growth, and reality in terms of money transactions alone. (Cahn, 2000)

It is important that they continue to find ways to let the market and non-market economies interact successfully. A professional health care provider who accepts a complementary currency in payment for her professional fee or a merchant to gives discounts to the members of a complementary currency network promote this interaction. (M. Sumpter, personal communication, June 7, 2005) They provide "a market incentive for labor done in the non-market economy while expanding the market for their own goods and services." (Cahn,

2000, p. 45) Finding ways to promote these interactions increases understanding and prevents one economy from undervaluing or devaluing the other.

NPOs and health care organizations can positively affect public policy by uniting and organizing collaborative advocacy and lobbying efforts. They can help educate legislators on the need for a public policy on health care that includes solutions from both the market and non-market economies. They can help educate legislators to the fact that money does not solve all problems, and that money, in fact, creates many of the problems that it eventually tries to solve. (Cahn, 2000)

Many critics consider this shift in thinking too radical. The reality is that this shift has already produced real benefits in nonprofit and for-profit organizations, local communities, and governments at various levels. As we have seen, these benefits include the improved health of participants, a decrease in health care costs, an increase in reciprocal exchanges, a decrease in one-way giving (welfare), and the re-emergence of the social safety net that communities and families typically provide when the national economy falters. These outcomes should resonate with anyone who is concerned with the state of health care and the state of the economy, regardless of political party or professional affiliation.

Advocacy efforts can focus on the fact that less public policy money is required to fund social programs, or even on the need for fewer social programs, when those programs view their clients as co-creators of and participants in solutions to their problems. Advocates can prove these claims by pointing to the real solutions to difficult, long-standing social problems that organizations, communities, and governments are seeing through their use of alternative currencies.

NPOs have been most successful when they cooperate rather than compete with each other for scarce resources, whether those resources are equipment, people, or money. While these collaborations have had a positive impact on the economic bottom line of the organizations, their funders also notice, appreciate, and reward their willingness to compromise and collaborate for the common good.

The same logic holds true when NPOs try to implement a complementary currency. The network is stronger and chances for success are greater when NPOs, businesses, and governments work together, understand, and are committed to the belief that "more of the same" is not the solution; when they agree on the problems to be solved; and, when they recognize the untapped skills and productivity available from the clients they are trying to serve. NPOs interested in exploring the use of complementary currencies can examine the histories, stories, successes, and failures of organizations that provide similar services or operate in similar environments and seek advice from the people who led or were involved in those efforts. They can consult with local resources such as the Access Foundation, in Boulder, Colorado, which provides information on how to select a complementary currency and start a complementary currency network. The Foundation also advises on legal issues and best practices. (Access Foundation, 2005)

The concern about identifying what to trade or exchange always arises. While services like making telephone calls to remind patients of their doctor appointments, providing transportation to doctor appointments, providing housekeeping or child care services, discontinuing unhealthy habits like smoking or drugs, and embracing healthy habits like diet and exercise are common in health care networks, there is no master list from which to choose. The answer lies in determining what the organization needs, what its clients have to offer, and who else in the community can offer goods or services in response to need and skill availability. The answer lies in noticing what flows naturally through the community. (T. Osgood, personal communication, May 20, 2005)

6. Conclusions

This paper has examined only several of more than 7,000 implementations of complementary currencies in operation around the world. (Klassen, n.d.) By incorporating these currencies into their operations, NPOs and health care organizations have seen dramatic reductions in their costs and equally dramatic improvements in the health of their clients. They have created abundance—that is, they have a steady supply of many things they need. They

have also created sustainability. They can operate their programs with resources currently available to them, without borrowing against the resources of future generations.

One thing that these implementations have in common is that they take place in a second, non-market economy. This is an "invisible economy—the world of family and community where transactions take place that economists do not measure, where work takes place that the market does not value, and where vast assets exist for which the market has no use or that the private sector has already chosen to exploit, deplete or contaminate in pursuit of profit." (Cahn, 2000, p. ix-x)

Many NPOs and health organizations, both individually and collaboratively, have created smaller, alternative economies in their communities that allow them to use a method of exchange that encourages cooperation rather than competition and that values the skills and talents of their clients. They have created opportunities for the marginalized people in society to perform useful work, to engage in reciprocal exchanges rather than receive one-way welfare, and to connect in a meaningful way to their larger communities.

This kind of cooperation, together with a well-designed, reasoned use of complementary currencies in support of the national currency, allows us to honor and embrace what is unique to us as human beings, what Annie Dillard (1982) calls " … the unified field, our complex and inexplicable caring for each other." (p. 94-95)

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