Opinion articles do not necessarily represent the views of the Portland Observer. We welcome reader essays, photos and story ideas. Submit to news@portlandobserver.com.

Opinion

Why Are We Eating in the Dark?

Shining a light on genetically engineered foods

BY JILL RICHARDSON

Have you ever eaten a genetically engineered food? If you're like most Americans, you have no idea. Genetic engineering is a controversial technology in which genes from one species (say, bacteria) are inserted into the DNA of a different species (for example, corn).

Here's a simple quiz you can take to figure out whether you've eaten any of this newfangled stuff: Have you eaten food in the United States in the last 20 years? If yes, then you've almost certainly eaten something that was genetically engineered.

How can I be so certain? Start by considering which crops are genetically engineered: corn, soybeans, canola, cotton, sugar beets, alfalfa, papaya, and a small amount of zucchini and squash. You probably aren't eating cotton, and maybe you don't like papaya, but avoiding corn and soybeans while eating in America is nearly impossible. And nearly all of the corn and soybeans grown here are genetically engineered.

Most of the corn and soy we eat comes to us in processed foods — cookies, cereal, crackers, chips, etc. Soybean oil, often labeled as "vegetable oil," is the most common fat consumed in America.

And yet, most Americans have no idea whether genetically engineered foods are in our supermarkets and pantries. That's no accident either, because the food industry has intentionally kept us in the dark.

It's not exactly a secret that 60 to 70 percent of all food U.S. consumers buy is genetically engineered. But none of those foods are labeled as such.

When you grab a box of corn flakes off the shelf, it looks like the exact same corn flakes you've eaten for decades. Without sending it to a lab for scientific testing, there's no way for you to discover whether the DNA inside the corn in that cereal box is different. So most of us just go about our lives, buying our favorite foods like we always have and assuming they haven't changed. That's what the industry wants.

"If you put a label on genetically engineered food you might as well put a skull and crossbones on it," Norman Braksick, an executive of a company that makes genetically engineered seeds, famously said back in 1994.

Let me get this straight. You're afraid we won't buy your product unless you slip it into our food secretly without a label?

And because of that belief, Big Food has made darn sure that the government didn't require companies to mention genetically engineered foods on their labels. Until now.

When surveyed, consumers overwhelmingly say they want genetically engineered foods to be labeled. In 2012, a ballot measure to label these foods narrowly lost in California after the food industry poured over $45 million into a misleading campaign to oppose it.

This year, the momentum to require labels continued on both coasts. Connecticut was the first state to pass a labeling bill. Maine followed soon thereafter, but the state's governor refused to sign it. Vermont, New Hampshire, and New York are considering labeling bills as well.

Out west, Washington State is gearing up for a ballot measure requiring labeling that they will vote on in November. As before in California, companies like biotech giant Monsanto are spending heavily to keep consumers in the dark.

It's outrageous that the manufacturer of any product fights so hard to avoid telling consumers what they're buying (and, in this case, eating). Big Food needs to come clean. If there is something wrong with genetically engineered foods, stop selling them. If not, label them so an educated public can decide whether we want to eat them. It's that simple.

OtherWords columnist Jill Richardson is the author of Recipe for America: Why Our Food System Is Broken and What We Can Do to Fix It.

When it comes to Health, Place Matters

All people should have equal opportunities

BY BRIAN SMEDLEY

The implementation of the Affordable Care Act is an achievement Americans can be proud of. Making sure that all our brothers and sisters, children and grandchildren, have proper health insurance makes us a stronger, more prosperous nation.

Amid this important change, however, we cannot ignore the work that remains to be done, especially in communities of color. Insurance cards are not enough.

To become a society with better health - not just better health coverage - we must also look at the role "place" plays in the lives of minority communities.

Where we live, work and play is surprisingly predictive of lifespan. Within the city of Boston, for instance, people in some census tracts live 33 years less than those in nearby tracts. In Bernalillo County, N.M., the difference is 22 years.

A new report presented at the Place Matters 2013 National Health Equity Conference in Washington, D.C. last week demonstrates that where you live is a powerful determinant for how long you'll live.

"Health equity" may sound like a jargon term, but it's really a simple and just concept: all people should have equal opportunities for good health.

Unfortunately, in conversations, people often reduce health issues to questions of access to health care or to behavior; in other words, if people only ate right, exercised, or saw a doctor regularly, health inequities could be eliminated.

Now, to be sure, access to high-quality health care is important, particularly for those who face health risks. And individuals should strive for active lifestyles and healthy diets.

But a large and growing body of research demonstrates that the spaces and places where people live, work, study and play powerfully shape the opportunities they have to achieve good health.

People of color - who are still subject to persistent social, if not legal, segregation - are disproportionately located in unhealthy spaces. This is a major factor that helps explain the poorer health of many minority groups.

Consider the numbers: One in four African Americans, one in six Hispanics, and one in eight American Indians in metropolitan America lives in a census tract in which 30 percent or more of the population is in poverty.

But only an estimated one in 25 non-Hispanic whites live in one of these tracts.

Neighborhood conditions can overwhelm even the most persistent and determined efforts of individuals to take steps to improve their health. Neighborhoods with high rates of poverty are subject to significant health risks, from the presence of polluting industries to the absence of a grocery offering fresh fruits and vegetables.

These same communities typically have poorer quality housing and transportation options, and are hit hardest by the home-mortgage lending crisis, which crushed wealth opportunities and disproportionately affected communities of color.

Many of these neighborhoods also experience high rates of crime and violence, which affect even those who are not directly victimized, as a result of stress and an inability to exercise or play outside. Even healthcare providers, hospitals, and clinics are harder to find in these neighborhoods.

It's no wonder life-spans vary so greatly among neighborhoods, even those close to each other.

Some policymakers are working to address these place-based disparities.

Federal programs that stimulate investment in the nation's hardest-hit communities are working to attract businesses, create jobs, and reduce the concentration of health risks.

The Healthy Food Financing Initiative creates financial incentives for grocery stores or farmers' markets to open in "food deserts." And the Obama Administration's "Promise Zones" initiative will streamline a host of federal "place-based" projects and offer technical assistance to jurisdictions that seek to stimulate economic activity and build ladders of opportunity.

Investments in vulnerable communities may be among the most cost-effective strategies to close the health gap and improve the overall health of the nation.

A study commissioned by the Joint Center for Political and Economic Studies found that the direct medical costs associated with health inequities -- in other words, additional costs of health care incurred because of the higher burden of disease and illness experienced by minorities -- was nearly $230 billion between 2003 and 2006.

Add the indirect costs, such as lost wages and productivity and lost tax revenue, and the total cost of health inequities for the nation was $1.24 trillion.

Our nation's poorest need health insurance. But we cannot afford to stop there.

Only by recognizing and then erasing the deep divides that create communities with fewer health opportunities can we create a nation of individuals given the chance to reach their full potential.

Dr. Brian D. Smedley is vice president and director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, D.C.

THE LAW OFFICES OF
Patrick John Sweeney, P.C.

Patrick John Sweeney
Attorney at Law

1549 SE Ladd
Portland, Oregon

Portland: (503) 244-2080
Hillsoboro: (503) 244-2081
Facsimile: (503) 244-2084
Email: Sweeney@PDXLawyer.com