

**Physicians for a National Health Program (PNHP)
“Nation’s Top Physicians to Endorse Nation Health Insurance
Bill With Representative John Conyers”
Tuesday, February 4, 2003**

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DR. CLINTON YOUNG: -on the Volunteer National Convener of the Physicians National Health Program and yes this year, it's 50 years of practice for me so if nothing else I have time engraved and I want to share the happy news given the sea of unpleasant news we as a nation and the world has been subjected to that we're presenting to the Congress a bill which will guarantee every person in the country access to decent healthcare on a national healthcare on a single payer basis introduced by Congressman Conyers and at this point some 20 other of his colleagues and some few are here today to join in this presentation. I want to share the genesis of this briefly. In May of 2001 Congressman Conyers challenged me to come through with a representation that I made to him that mainstream doctors, leaders of American medicine are thinking anew of the issue of national health insurance and felt I could put together a very distinguished crew of leaders of medicine who would present through his colleagues in this room actually a vision of a universal national health insurance with a system that has everybody in, nobody out, that is financed on a tax basis, a progressive tax basis, that has a comprehensive coverage that takes the matter of choice off the table, that is to say people have total choice, it does away with co-pays, deductibles and caps, sounds a little utopian but it turns out the huge amount of money much of which we're squandering at

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least half of which we're squandering in America today can be captured through this bill to serve the American people and many things that have festered and have gone bad like long-term care, the absence of drug coverage, the issue of mental health parody, all these things can be answered. That's the very good news. The resources are there. We're speaking to a social problem of the first magnitude where all of the resources in terms of money spent, tremendous health workforce, some 10 million of our people are dedicated to delivering healthcare in the course comprised of the most outstanding scientists, doctors, technicians and basic health workers and compared to any nation and in terms of the plan it's all there. Where high tech grabs to the excess. So this is the vision that we're putting forward today and we will be presenting the argument and the case for the kind of system that we're proposing. A simple way to look at it, a little bit too simple, but a good way is to think of Medicare, which is an entitlement for all of our people over 65 and those who are or have disability. Medicare is of course a remarkable achievement, needs improvement, but it's a really - in terms of health legislation - a spectacular achievement and extremely popular with the people it serves. We think of Medicare for all but without the co-pays, without the deductibles and the caps and all the other deficits in Medicare but I want to of course introduce the man who brought us together and sponsored legislation doctor -

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doctor - there you go -

[LAUGHTER]

DR. CLINTON YOUNG: Representative John Conyers.

[AUDIENCE APPRECIATION]

JOHN CONYERS: Thank you very much everybody. I'm very happy to be here and I want to tell you - I was going to say it was the most important bill I've ever introduced, except that I'm the original sponsor of the Martin Luther King Holiday bill and so-

[AUDIENCE APPRECIATION]

JOHN CONYERS: -and so because it was the philosophy of Martin Luther King that even before I came to Congress the [unintelligible] of my philosophy and point of view. It is only appropriate that I mentioned that bill because it only [unintelligible]. The second reason I mentioned that bill is that it took 15 years to pass and I will now tell you and as in reality TV exactly what happened to me [unintelligible]. I was in the Congressional clinic which is headed by Admiral John Eisel [Misspelled?]. It serves only members of Congress, members of the Senate and members of the United States Supreme Court. We've got our national healthcare legislation already. It's already working for us and in - into the office of getting my annual check up came a dear colleague of mine and I said why don't you come to the news conference at 11:30 - at 11:00 I'm introducing the single payer national healthcare bill and he

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was smiling - we're always sad a lot around here -

[LAUGHTER]

JOHN CONYERS: He was smiling and he said - I said wait a minute I said you can't have any problems with that. I said our doctors are now moving to it, everybody's moving to it, people that don't like it are moving to it, there's nothing else left. Don't you know in Joel Siegel's file cabinet we've got copies of every single bill that anybody in the Congress has introduced about healthcare? And almost all of them have not been passed. And you know he said but John you know the reality of the situation and you know what we're up against, you know and I said yes I know but we've got to start somewhere we can't wait until we're out of here and then somebody does what we should be doing and - and the rest of the nation literally the majority of the nation will say thank God somebody did something and so I am so pleased to have people like you here especially the ones that are up here. This doctor from Chicago is incredible.

[AUDIENCE APPRECIATION]

JOHN CONYERS: He's got enough energy for a hundred members of Congress some of whom are running on low batteries but we - we're picking them up. We're embracing them. Marsha Angel of the New England Journal of Medicine goodness sakes she led the way here and when I get to my good friend from Washington state, Congressman McDermott, Jim McDermott.

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[AUDIENCE APPRECIATION]

JOHN CONYERS: Who's been doing this all of his life not just a Congressman but a doctor and not just a doctor but a psychiatriatrist which we need more of in the Congress!

[LAUGHTER]

JOHN CONYERS: I mean here - here's a man that has led - this is his second or third national healthcare single payer bill. This is not a new subject it was drawn into and all of you here deserve our thanks. Dr. Himmelstein [Misspelled?] has written, preached, met he and his partner Steffie [Misspelled?] Woolhandler [Misspelled?] they've been working on this - when I met them they were working on this. As a matter of fact he talked me into it come to think about it. I almost got him up here for a year - and leave. We're talking about key dedicated human beings, members of Congress, medical people who know what they're talking about. We have no illusions. This not pie in the sky or this is the ideal thing and we know you're not - no this is what is - and I made this last point and I remember now. I said I'm not inventing something. Do you know how many countries already have this? We didn't invent a national healthcare system that would insure you with a simple card the size of your business card. That enrolls you from the moment you're born into a system, into a nation and into a democracy that assures that you will live your lifetime as an American citizen and not be denied healthcare that you need. Is that

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radical or is that democratic?

[AUDIENCE APPRECIATION]

JOHN CONYERS: So my moderator, I told him not to bring a hook and he's so - such a sweet guy, Clinton but I have one person that I want to give to just for a moment but he works with me on everything and you know you have great staffers and I've been blessed and everybody knows that but you have some people that work on everything. I mean whenever you're planning something you can count on him for a good idea and I want you now to just welcome Burt Wides [Misspelled?], attorney Burt Wides [Misspelled?].

[AUDIENCE APPRECIATION]

BURT WIDES: Thank you. Well everything I know about healthcare I've learned from Joel Siegel and the Congressman and I don't think he knows it. I have sat in on meetings on the healthcare insurance industry but the Congressmen believe in redemption and salvation so now he has me working on the right side. I just want to make two points, one, even employees I think and unions who now are indicating more support for the Congressmen's bills who have focused before on the existing employer system are now supporting it because employer's faced with the skyrocketing costs are cutting back on the benefits or increasing co-pays and there was to my knowledge the first strike - work stoppage it was sort of a strike in history over healthcare benefits and what was being done to them by the

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employer is the result of what GE was doing in a substantial part of its workforce only a few weeks ago. The other thing I think is critical based on 35 years of working on many issues in Washington particularly critical that you explain to the population what this bill is and what it isn't. You all remember Harry and Louise. I think that even though there's a Niagara of horror stories of someone not getting the healthcare they need because the HMO denies it or because they can't afford it despite that the health industry, the for profit part of the industry, HMO's and insurance companies will prey on the human fear of the unknown. The devil I know was better than something new and different and I think it needs to be emphasized the degree to which this is still the private healthcare system, still the basic private healthcare infrastructure of doctors and hospitals that we have now and the one difference is because the government will be paying for it with the revenue laid out in the analysis you will be taking out the huge cost of advertising. The extremely large salaries and dividends of the very profitable companies like the one that provided Majority Leader Frist's family with billions of dollars.

[LAUGHTER]

BURT WIDES: And the other thing you'll be taking out which is perhaps most critical is the incentive of companies to withhold needed healthcare so they can make more profits. I'll

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just say that this is another example of where as - as William Butler Yeats said around this Capitol Hill often the best are full and weak and lack all conviction while the worst are full of passion and intensity. Luckily you have several members who do have passionate intensity and they'll need your matching intensity to get this passed.

JOHN CONYERS: Thank you very much. Now Ken Frizah [Misspelled?] please come to the podium. Give him a round of applause because he heads [unintelligible]

[AUDIENCE APPREICATION]

KEN FRIZAH: Thank you I didn't expect to go before the distinguished panel so I'll be very brief. This is a long struggle and the struggle is a century old. The organizations that all the people on the - at the podium are old but the organizations are young and they're youthful positions for national healthcare programs. Our organization is Universal Healthcare Action Network. Our goal is to build powerful coalitions to make this happen. The United States as we all know is the only advanced nation, the only democracy that does not have a system of healthcare for all and what we seek to do is to work at the state level. We have worked with Congress and Conyers, we've worked with Congressman Christensen and a variety of people both at the federal level and at the state level pushing all possible ways to make this happen. Congressman Conyers is also to be congratulated not only for

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his leadership on this bill, the national health insurance bill but also in the healthcare access resolution in each [unintelligible] 1999 in the last Congress and soon to be re-introduced in this Congress which we see as a unifying vehicle to bring advocates whatever their policy solution is to the fight for healthcare for all. Thank you Congressman.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Thank you Ken and I can't resist saying that I'm a founding member of you, Ken with Ken and I've made - probably made the motion at the very first meeting that the organization would be called the single payer national organization and that was a fine thing that they did that. Let me, Congressman pointed out to the perks that the people have David and Steffie [Misspelled?] Woolhandler [Misspelled?] have done this since this data. There are only two occupations that have 100% coverage, you mentioned one, all the legislators in America and all the judges. The rest of us in varying degrees are not covered. Doctors about 30% uncovered, health workers, just over 60%, so we have our work cut out and this bill attends to those very things. Next person that I'd like to introduce - I have introduced but I want to embellish it because the Congressman has many virtues but not least is that he trained in Illinois and then went on to become the popular representative of this city of Seattle and we honor Jim McDermott for his sponsorship and leadership in single payer

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bills along the way of what do they call it the house

resolution. 1200 was his handiwork with Congressman Conyers and he's in the front line of sponsoring this bill. Jim please come up and favor us.

[AUDIENCE APPRECIATION]

JIM MCDERMOTT: Some good things come out of Illinois. Clinton and I both went to the University of Illinois. I really appreciate the opportunity to talk to you today about this need for a national health plan. I think John's to be - John is to be commended for putting this together and for getting all the people here today organized to talk about this because it's time that we started talking about it again. The people of the United States deserve and they need a national healthcare plan. It is a right in my view. It's not some thing that you might have in a society. It's like police and fire protection. It ought to be on the same level as those things that are in our society today and the providers of healthcare, the doctors and nurses and hospitals and nursing homes deserve a government guaranteed revenue system. That revenue stream is what's missing in this whole process. It is a process right now where it's kind of like what kind of plastic do you have in your pocket? And it really is a lottery and this ought to be something as a guaranteed revenue stream so that no one could ever be bankrupted or put in any kind of difficulty because of an illness or an injury. I've been doing this for as long as

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John and a lot of other people have and you might remember my speech as a young Democrat in 1972 when I was in the state legislature and I think it's safe to say that we abandoned reform in the early '90's because certain people thought that managed care and the markets would save our healthcare system. I come from the Northwest where we have lots of managed care and we've had it for a long time back to the '40's people looked out there and saw it and said gee that's a good idea. Only one thing, they added the for profit motive to it and that killed it and that's really what you're living with today and we do not have a system that works. We have 42 million people without insurance, 40 million who are under insured and another 40 million in Medicaid. If the President has his way we'll have less and less and less healthcare and at the same time health insurance premiums - we hear about people talking about getting tax credits that will let people go out and buy their own insurance. Well the premiums have been going up 10, 15 or 20 percent each year and the employers you've heard have already begun - and for a long time have been shifting costs onto their employees. I mean that's Boeing - and in my city always has that as a strike - always a central issue and it's one across the country. Now you and I as Americans spend - people say we can't afford it, we can't afford a national health program. That's the first thing - I mean on this stump millions of times I know what the first question from the audience will be. How

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are we going to afford it/ We spent in this country \$1.4 trillion dollars in 2001, now that's up from \$1.2 trillion in 1989 and 1995 when we were working on this issue we were about \$950 billion. So we've been climbing every couple of years some more. So let's put this whole question in perspective as to whether we can afford it or not, we spend \$4,350 dollars per person for everybody in the United States on healthcare, \$4,350 dollars. The average of the next 29 industrialized countries in the world, Japan, Sweden, France, Germany all of them is \$1,760 dollars, \$1,760 dollars is the average expenditure, now Switzerland - now you say some of those countries don't have that good of health insurance - well okay let's take the next one down from us, Switzerland, remember we spend \$4,350, the Swiss spend \$2,850 that's the second country below us in expenditure. Now every single one of those countries has a national health program and there is not one uninsured person in any of those countries. My - I've had people from Seattle who've gone to Germany to work in opera, singing in the Munich opera, they get a contract in the opera company they're in the German system immediately. That's true all over the place and in this country we have 1 out of 7 people walking around without health insurance. Now we also and this is a figure that you should have drilled into your head. We spend \$720 billion out of that \$1.4 billion - or out of the \$1.2 billion nearly 60% comes from the government. The government already spends

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\$720 billion dollars, 60% of every dime spent in this country is paid for by the government today, now that's \$213 billion in Medicare, \$186 billion in Medicaid, \$65 billion in public employees' benefits programs and \$110 billion dollars in tax subsidies that we give away to employers that provide healthcare. So we are already spending a huge amount. That comes out to \$2,600 dollars per person in the United States today. We're spending \$1,000 dollars per person more than the average in every other industrialized world in the government - in the government programs in this country. Now the question you have to ask yourself is why don't we have universal coverage? Well I think you'll hear others talk about this but my view is that we have gotten the for profit motive in it and we have simply corrupted the system to the point where it is now a money maker and we must deal with that. We have to give Americans, every one of them the right to health insurance that is guaranteed, that can never be taken away, that has a government guaranteed revenue stream in it, that doesn't go away. That doesn't mean you have to change, this is always the second question. Oh now you're going to have government doctors and you're going to have - you're going to take away my healthcare system. That's not true either. You can have a system with a government guaranteed money system and have private doctors developing and running the system just as we do today in this country. You don't have to change the delivery

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system of private, you don't have to make everybody a public employee to make this work. Now the President said in his State of the Union and kind of went out of his way to talk about us here today. These problems will not be solved with a nationalized healthcare system that dictates coverage and rations care. I think it was a great stroke of political genius in the White House to get Mr. Frist to be the leader in the Senate because the President can always say well Mr. Frist is taking care of our healthcare and he's going to wash his hands of it but I don't agree with the President's assertion in the - the - his argument is disingenuous. Every single healthcare insurer in the United States dictates coverage and rations care. That's how they do business. I mean that's what it's about. So anybody to say that this new system we're talking about some hugging a change that's going on now, simply is not correct. Just isn't true. If you want to take a look at rationed care, look at what the 42 million people in this country don't have insurance how does their care rationed out? They go to the emergency room when they're in extremis then they get healthcare, they don't get any preventive care. So they are rationed and my belief is that system is comprehensive because everybody in this country does get healthcare of one sort or another, but not good healthcare because it is always brought to the last - when everybody's sick or you could always get healthcare down at the county hospital, as long as the

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county hospital's around and you've got plenty of cities around this country where that is a real problem. It's true in Seattle, it's true in Los Angeles, it's true everywhere and my belief is that in general doctors, hospitals, nursing homes and other providers will not change, in fact the chance to choose your own doctor will be guaranteed by this. Will be guaranteed by it and my belief is that that more than anything else is the essence of what happens. What Dr. Young and I were taught in our medical school was you know that doctor/patient relationship. Not decided by some insurance company or some quality assurance report. I remember standing in a ward in Seattle arguing over the phone with somebody in Omaha Nebraska about whether I could keep a patient in the hospital an extra two days. Now what kind of healthcare is that? And that's what is going on under the present system, that's the rationing. We don't have to ration. We have enough money in the system now and this bill is a good organizing tool to get the country beginning to think again about why isn't it a right?

[Unintelligible]. Thank you.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Thank you very much Jim. Thank you in particular for being the key diagnostician and putting your finger on something we recognize in this bill. That the turning to the marketplace before the for profit system is very much at the center of our problem and that no solution, including ours

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will work with the for profit system and the law provides for phasing out part of our healthcare system in a large charge but it's our estimate that you can't do it any other way. One of the joys of being on this side of the podium is that you get to meet really remarkable people and I think it's wonderful to point out that two of a handful of doctors in the Congress are supporters of our bill and indeed the one I'm introducing is the very first woman doctor and who I've - in this process I've gotten to know and admire tremendously. It's Donna Christensen, Dr. Christensen is the delegate from the Virgin Islands and also leader of the Congressional Black Caucus [unintelligible] will you say something to us.

[AUDIENCE APPRECIATION]

DR. DONNA CHRISTENSEN: Thank you Dr. Young. Good morning everyone. It's a pleasure to bring a report of welcome and to be here with our leader John Conyers, my colleague Jim McDermott and Ken who spoke before me, Dr. Young. Our distinguished panel has added some new partners and has continued to press for universal healthcare for this country. Shamefully as you've heard and as you all know is the last industrialized nation in the world that yet fails to ensure healthcare, to provide that right for all of its residents. I've been proud to co-chair the universal healthcare taskforce with John and to have been an original co-sponsor on all his bills leading up to this one the United States National

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Healthcare Insurance Act on which you will be applauding John on. I also want to applaud John, Dr. McDermott and other colleagues who've long worked to achieve this important goal sometimes alone and being the lone voice out there. I want to thank the physician's groups working on single payer working group for their commitment to universal coverage and for putting on this [unintelligible]. I want to thank also Kaiser for their - for the work they have done on this issue by web casting they've been providing. This bill will be the premier bill. It's going to be the bill against which all others will be judged. It provides equity of access, everyone will have the same card regardless of income level or any other socio-economic factor. There are no requirements that one or the other of us might not be able to meet, one doesn't have to be employed, there are no income requirements, no geographical or political exclusions. To be eligible one just has to be a resident of the United States. It's comprehensive, providing mental health and substance abuse parity as well as the coverage of The Territories which is my district, The Virgin Islands. We're often left out. It's beautiful in its simplicity, means of implementation, the ease of infrastructure already in place, although John I would have to differ and I'm sure the other doctors in here will differ as to the efficiency of Medicare as implemented by HICFA [Misspelled?] now CMS but that's something that we can work on and we will stop the

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skyrocketing costs of healthcare so we can devote those dollars to other important issues. I'm also glad to be here to applaud this bill because we in the Congressional Black Caucus have made universal coverage centerpiece of our healthcare agenda for the 108th Congress. As chair of the Health Brain Trust of the CDC, thank you.

[AUDIENCE APPRECIATION]

DR. DONNA CHRISTENSEN: I work with my colleagues in our partnering organization to eliminate disparities in healthcare for African-Americans and other people of color but we know that it's of utmost importance that we in the health disparities community focus on the larger picture of health access and quality instead of just disease ideology. Without universal access to the basic quality of comprehensive healthcare anything else that we do [unintelligible]. Our country leads all others in healthcare spending yet over 80 million people are either un or under insured. Lack of insurance is decided as the 7th leading cause of death resulting in over 80,000 deaths annually, many of whom are people of color. Almost 1/3 of all Hispanics and 1/5 of all blacks in the United States have no health insurance compared with about 22% of whites. In addition blacks are the most likely to be covered by public insurance and Hispanics are under represented [unintelligible]. About 30% of Hispanic and 20% of black Americans lack a usual source of healthcare

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compared with less than 16% of whites. Hispanic children are nearly three times as likely as non-Hispanic white children have no usual source of healthcare. African-Americans and Hispanic-Americans are far more likely to rely on emergency rooms as their sources of healthcare. There'll be many bills reflecting a variety of approaches to this critical issue but we're looking forward to working with John and our other colleagues, other caucuses, our community, regional and national organizations and hopefully all of you to build on what we begin here today to achieve universal health coverage for all Americans and I'd like to invite you to follow our progress and to join us when we have a healthcare rally on Capitol Hill. It was originally scheduled to be on the 15th of April but the changing Congressional schedule has caused us to change the date and we're now scheduling it for April 29th, it's a Tuesday, we're going to have some flyers outside to let you know how you can follow the development of this rally and we really invite you all and I look forward to having you join us on April 29th here on the Hill to bring a loud message to this Congress and to the leadership of this country that we must have universal coverage. Thank you.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Thank you very much Dr. Christensen. We in the Physicians National Health Program, while we're eager to push our ideas recognize that it will happen only when the

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people of America demand it and we think that's happening but it - I want to share with you the facts that America's doctors are increasingly responsive to this idea. PNHP has been polling doctors one by one, we've circulated the polls to 100,000 of the 675,000 doctors and the first return is well over 4,000 doctors individually have done this, they've signed an endorsement of this single payer proposal that is what we're presenting here. If you have any connection to the medical profession I think you'll recognize that's a remarkable fact and achievement for this conservative group and among the signers are two former Surgeons General, David Satcher [Misspelled?] and Jules Richmond [Misspelled?], a Nobel Laureate and we continue the poll, we're going - we didn't have the resources to do all 700,000 in one swoop but we're going to get it done in six months and we expect to be able to show at least twenty to thirty thousand doctors in America say yes to this proposal with many others not ready to sign but in polls showing a partiality. We now get to at long last to the presentation of this bill and we have three people taking different parts of the issues to give to you and it's my pleasure to introduce the first of those and I want to make one other comment before I do and note that we have already of the increasing readiness of the labor movement to join this crusade and this is a fact. We mentioned that all the other industrialized countries in the world have the equivalent of

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single payer universal healthcare and in every instance no exception it's always been the labor movement to the parties or the actual trade unions that led the way no exceptions and it will be so in this country. So it's very good news that I can tell you without going further that there are a number of major unions that are looking seriously at this legislation and we hope very much they'll express their support in the near future. Now it's my special pleasure to introduce Dr. Marsha Angel who I presume is known to all of you by reputation if not by otherwise. She's a very distinguished former editor of the New England Journal of Medicine and one of the wiser choices that our group made was to designate her as our spokesperson at the presentation here in May. It was spectacular and I anticipate it will be equally so. She's worked very hard in shaping this achievement is her good work. Marsha.

[AUDIENCE APPRECIATION]

DR. MARSHA ANGEL: Thank you Clinton. It's really a great pleasure to be here this morning. We're here today with Representative Conyers to explain the National Health Insurance Bill that he's introducing in Congress. This bill would create a single payer healthcare system. That is a system in which the funding is coordinated through a single public body. Such a program is no longer optional. It's necessary and I'd like to tell you why. As most of you know, Americans have the most expensive healthcare system in the world. We spend over twice

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as much per person as other developed nations and that gap is growing. That's not because we're sicker or more demanding, Canadians for example see their doctors more often than we do and they are allowed to spend more time in the hospitals and it's not because we get better results. By the usual measures of health and I think one of the charts shows life expectancy, infant mortality, immunization rates, we do worse than most other developed nations. Furthermore we're the only developed nation that does not provide comprehensive healthcare to all its citizens. Some 42 million Americans are uninsured. Disproportionately the sick, poor and the minorities and most of the rest of them, almost all of the rest of those are under insured in that we are not covered for all medical needs. In short our healthcare system is outrageously expensive yet woefully inadequate. Why is that? The only plausible explanation is that there's something about our system, about the way we finance and deliver healthcare that's enormously inefficient. In my view and that of many other critics of our system the underlying problem is that we treat healthcare like a market commodity to be distributed according to the ability to pay and not as a social service to be distributed according to medical need. Now markets are good for many things but they're not a good way to distribute healthcare. Let's look for a minute at how this particular market works. Most Americans receive tax free health benefits from their employers,

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employers pay private insurers a portion of the premiums but not all employers offer health benefits and when they do the benefits may not be comprehensive. It's entirely voluntary, this whole system is entirely voluntary and when employers are competing for workers as they were in the last part of the 1990's they offer pretty good, fairly good health benefits at least for their high salaried employees but when unemployment rises as it is now they drop them. The insurers with whom the employers do business are mostly investor owned for profit managed care businesses. They try to keep premiums up or premiums down rather to get business from employers, they try to keep premiums down and profits up by stinting on the medical services. That's why people hate managed care. In fact the best way for insurers to compete is by not insuring high risk patients at all, limiting the coverage of those they do have to insure. For example by excluding certain expenses and services like heart transplantation or excluding treatment for pre-existing conditions and by costs - and by increasingly passing costs back to patients by denying claims or in the form of higher deductibles and co-payments. We're the only nation in the world with a healthcare system based on dodging sick people. Think about that. These practices of dodging the sick people add greatly to overhead costs because they require a mountain of paperwork. They also require creative marketing to attract the affluent and healthy and to dump the poor and sick

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on some other payer. Not surprisingly, the U.S. has by far the highest overhead costs in the world. In fact the hallmark of our system is the extent to which health funds are diverted to overhead and profits. It's instructive to follow the healthcare dollar as it wends its way from employers toward the doctors and nurses and hospitals that actually provide the medical care. First private insurers regularly skim off the top a substantial fraction of the premiums, anywhere from 10%-25% for their administrative costs, marketing and profits. The remainder is then passed along a veritable gauntlet of satellite businesses that feed on the healthcare industry, including brokers to cut deals, disease management utilization review companies, drug management companies, legal services, marketing consultants, billing agencies, information management firms and so on and so on. The function of all these satellite businesses is often to limit services. They too make a cut including enough for their own administrative costs, marketing and profit. It's often said that the excess overhead in our system amounts to about 10% but that's looking only at the primary private insurers. It is not taking account of all of these downstream satellite businesses. Most of which would not exist under the single payer system. I would estimate that no more than \$.50 cents of the healthcare dollar actually reaches the providers who offer the services, who themselves face very high overhead costs in insurers [unintelligible]. The failures

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of this system work partly amassed during the economic boom of the 1990's but now they stand starkly exposed. There's no question that with the continuing recession and rising unemployment and in the words of John Brogue of all people, "The system is collapsing around us". Private health insurance premiums are now rising at an unsustainable rate of about 13% per year and as much as 25% in some parts of the country. Coverage is shrinking as more employers decide to cap their contributions to health insurance and workers find that they can't pay their growing share of the premiums and finally with the sharp rise in unemployment more people are losing what limited coverage they had. Now tempering at the edges for this system won't help. Incrementalism [Misspelled?] won't help. It needs a real fundamental overhaul. The system we're introducing today is the very soul of simplicity and efficiency compared to the current system because better healthcare would be coordinated to eliminate both gaps and overlap. In many ways it would be tantamount to extending Medicare to the entire population. Medicare is after all a government financed single payer system embedded in our private market driven system. It's by far the most efficient part of our healthcare system with overhead costs of less than 3% and it covers virtually everyone over 65 not just some of them. Now Medicare is not perfect but it's the most popular part of the U.S. healthcare system and in my opinion it's problems would be relatively easy to fix but

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that's another subject. Now what are the usual objections to this sort of national program that we're calling for today? They're mostly based on a number of myths and in the President's State of the Union address he showed that he subscribes to every one of these myths. Myth number one is that we can't afford a national healthcare system. My answer is that we can't afford not to have a national health insurance system. A single payer-

[AUDIENCE APPRECIATION]

DR. MARSHA ANGEL: A single payer system would be far more efficient since it would eliminate excess administrative costs, profits, cost shifting and unnecessary duplication. Furthermore it would permit the establishment of an overall budget, a global budget and the fair and rational distribution of resources within that budget. We should remember, we should always remember that we now pay for healthcare in multiple ways. It's not free, we pay for it, through our paychecks, the prices of goods and services, taxes at all levels of government and increasingly out of pocket. It all adds up to at least as much as a national system would cost. It makes more - and the costs are far harder to control - it makes more sense to pay just once especially if it costs less and the healthcare is better.

[AUDIENCE APPRECIATION]

DR. MARSHA ANGEL: According to myth number two,

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innovative technologies would be scarce under a single payer system. We would have long waiting lists for operations and procedures and there might even be rationing in the President's terminology. This misconception is based on the fact that there are indeed waits for elected procedures in some countries with national health systems such as the U.K. and Canada but that's because they spend far less on healthcare than we do. The U.K. for example spends about 1/3 of what we do per person. If they were to put the same amount of money as we do into their systems there would be no waits and all their citizens would have immediate access to all care they need or could possibly want. For them the problem is not the system it's money. For us it's not the money it's the system. The money is already there its just going for the wrong things. Myth number three is that a single payer system amounts to socialized medicine which would subject doctors and other providers to onerous bureaucratic regulations but in fact although a national program would be publicly funded providers would not work for the government, that's currently the case with Medicare which is publicly funded but privately delivered. As for onerous regulations nothing could be more onerous both to patients and providers than the multiple, intrusive regulations imposed on them by the private insurance industry now. Indeed many doctors who once opposed a single payer system are now coming to see it as a [unintelligible] option. Myth number four is that the

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government can't do anything right. Some Americans like to say that without thinking of all the ways in which the government functions very well indeed and without considering the alternatives. I'd not want to see for example the NIH or the National Parks Service privatized. We should remember that the government is elected by the public and we're responsible for it and investor owned insurance companies in contrast reports to its owners not to the public. Many people say that the single payer system is a good idea but politically unrealistic but that's a self fulfilling prophecy. In my opinion the medical profession and the public would be enthusiastic about a single payer system if the facts were known and these myths expelled and in fact some surveys have shown already that the majority of the public now favor a single payer system. Yes there would be powerful special interest opposing it and don't underestimate them but with courageous leadership such as Representative Conyers is providing and the support of the medical profession and the public I believe there's nothing unrealistic about a national health insurance program. I want to mention one final and very important reason for enacting a national health insurance program. We live in a country that tolerates enormous disparities, in income, material possessions and social privileges, that may be an inevitable consequence of a free market economy but those disparities should not extend to denying some of our citizens certain essential services

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because of their income or social status. One of those services is healthcare, others are education, clean water and air, equal justice and protection from crime, all of which we already acknowledge are public responsibilities. We need to acknowledge the same thing for health. Providing these essential services to all Americans regardless of who they are helps insure the humane, a decent, cohesive, optimistic country. It says that when it comes to vital need we are one community not 280 million individuals competing with one another. In seeking to ensure adequate healthcare for all our citizens we have an opportunity to reassert that we really do stand united.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Okay. Thank you very much. We're going to introduce another member of our working group who's produced prodigiously over the years. Before I do I just want to take one moment to acknowledge the excellence of Representative Conyers' staff by working most closely with Joel Siegel. He's indefatigable and he drives you hard but it's a pleasure to work with him. I wanted to-

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: I want to introduce Dr. David Himmelstein [Misspelled?] who if you read any medical journal more than once you will have read some of his works. There's no question that Steffie [Misspelled?] Woolhandler [Misspelled?] - they've been the main collectors of hard data that make the

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case of our proposal. David.

[AUDIENCE APPRECIATION]

DR. DAVID HIMMELSTEIN: Thank you Clinton. I - the first thing they taught me when I went to Harvard is an expert is anyone who comes from out of town and brings along slides but Clinton told me I couldn't bring slides to this. So I have a handout back there with my slides on it that I'll refer to but you needn't. Let me first of all say that there are many colleagues in the audience who ought to be up here speaking but for reasons of time or random occurrence are not in front but are in back there and I will leave out many names but certainly Oliver Fine who is the Associate Dean at Cornell's Medical School has-

[AUDIENCE APPRECIATION]

DR. DAVID HIMMELSTEIN: One of my teachers in this and Lynn Rodberg [Misspelled?] who was one of the principal drafters of the Ron Dellum's [Misspelled?] Bill back in the 1970's and has been in this fight for many years-

[AUDIENCE APPRECIATION]

DR. DAVID HIMMELSTEIN: Walter Slopersue [Misspelled?] who's the former Health Commissioner of the city of Philadelphia and-

[AUDIENCE APPRECIATION]

DR. DAVID HIMMELSTEIN: And Mark Dougsig [Misspelled?] if you - earlier, Mark who has said if we're going to have a

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chance to improve our healthcare system we rely for our main force on our leadership on the labor movement and Mark is now the National Organizer of the Labor Party and will surely play a critical role in moving this forward.

[AUDIENCE APPRECIATION]

DR. DAVID HIMMELSTEIN: I come to advocacy for national health insurance from clinical experience. Never having intended to becoming active in health policy. Twenty five years ago I was standing in an emergency room in Oakland California when a young woman was brought to our emergency room having been hit by a truck while walking next to a road and she'd been taken to a fully equipped hospital where she had only one procedure done. A wallet biopsy which was negative and was then shoved into an ambulance and transferred 30 miles across the county where we received her and discovered a ruptured aorta, fractured pelvis and 6 other long bone fractures. We were unable to stabilize her at our hospital because the open heart surgical program had been closed because it was too profitable to leave to a public hospital, county hospital and had to then transfer urgently to a third hospital where we paid the bill from the county hospital. She miraculously survived but that actually led me to say should we just receive patients in extremis brought to us by the deficiencies of our healthcare system or should we try and do something about it? Some colleagues and I started back then in 1978 to collect cases of

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patients abused by our healthcare system and emergency rooms and that work in part led to the passage to the ban on the emergency room dumping in our society. A ban which has been almost totally ineffective. They - 20% of American hospitals have now been cited for violating that ban or 10% have been cited for violating that ban on more than one occasion and 300,000 Americans are denied emergency care each year despite it being illegal to deny people in extremis. When I saw that woman, there were 21,000,000 uninsured in our nation and we thought the healthcare system could scarcely get worse. We were paying \$1,000 per capita at that time and we thought that those costs could scarcely get higher and of course both of those figures are now dwarfed. We have twice as many uninsured and 4 times - 5 times the healthcare costs and rising rapidly on both accounts. We have not just people who are healthy as some would have us believe and choose not to have coverage but we have 700,000 people with diagnosed diabetes who have no health insurance coverage, some 10,000,000 people with high blood pressure unable to access basic care because of lack of coverage. The Institute of Medicine tells us that 80,000 American adults die each year for lack of health insurance coverage. That's a minimum estimate based on the absolutely secure data. The real numbers are almost certainly higher. When one works in a hospital you see even among the insured the extreme stresses of the financial side of our industry. A study

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that was done at hospital ICU's and among mostly uninsured patients back in 1999 that interviewed the patients or families of those patients of 988 extremely ill patients and 39% of them had suffered extreme financial duress due to that illness usually because they stopped their coverage. In 12% of cases the families were forced to sell an asset or go into or take a second job at the time of the illness to support the medical care and we are now the leading or second leading cause of bankruptcy in the United States and our healthcare system bankrupts nearly 1,000,000 people a year in this country. An American woman is now as likely to be bankrupted by medical care in the course of her lifetime as to graduate from college. We know that millions can't afford prescriptions including many seniors but including many with private insurance with Medicaid and of course many of the uninsured about 29% of all uninsured people say they failed to fill a prescription within the last year because they couldn't afford it and even many in the middle class with coverage saying that they have problems paying medical bills, they avoid going to see the doctor often because of high co-payment and deductibles and they don't get the care that they need and 12% of middle class families say that they've been called by a collection agency within the last year about a healthcare bill. Many with insurance, we've heard the President talk about the specter of limiting choice and of a monolithic government run healthcare system but many with

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insurance today lack any meaningful choice of healthcare. 42% of all of those with private coverage are only a single choice of coverage. It's a myth that we have a system of choice today and Medicare beneficiaries are in fact happier with their coverage than those with the private insurance that the President and many others would have us move to. Surveys repeatedly show that for all of its quirks and faults and there are many, Medicare is the most popular healthcare system in our nation today and while the President would have us shift millions of seniors to private coverage in the name of efficiency and choice not only would there not be choice but the efficiency is clearly not there. If you look over the last 30 years Medicare costs have risen by 1500% and that's an astounding figure but private insurance costs for a comparable benefit package have risen by 2200% far faster than Medicare. By any measure Medicare is a more efficient program both in its administration and in its cost containment than the private programs that the President would have us shift to and of course the experience of Medicare patients and HMO's to date has been disastrous. Many have been pushed out of those programs as they've been found unprofitable for the HMO's and the evidence is that the HMO's have actually increased Medicare costs up to date. We have considerable evidence that the participation of for profit firms substantially worsens the quality of care in virtually every healthcare setting. We now

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have solid data that for profit HMO's deliver worse quality care than not for profit HMO's for every quality measure that has been looked at. We have now a series of disturbing studies about the quality of care in for profit hospitals. Roughly 7% higher death rates in for profit hospitals than comparable patients in not for profit hospitals and of course here we're largely talking about the family of our Senate Majority Leader. They have gotten rich by killing people. We know that for profit dialysis facilities have higher death rates than not for profit dialysis facilities. That they're less likely to administer [unintelligible] dialysis to children the preferred method because it's not as profitable and yet they've been profitable firms these many years. We know that for profit nursing homes deliver lower quality care than the not for profit nursing homes and the list goes on and of course we've had a long list of multi-million dollar frauds from the same variety of bad actors. It takes, as been said here a good deal of work to keep sick patients out of empty hospitals and idle doctors offices. There's been a good deal of discussion in health policy literature of whether we have too many doctors but relatively little of the outside of this room of the growing surplus of administrative personnel - I guess I first became aware of that issue when I was again a resident at what had been a 600 bed hospital that in 1960 had been administered by one administer working with one secretary as support

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personnel and by 1978 was a 275 bed hospital with 250

administrative personnel and has since grown larger and that seemed only natural to me at the time but when I moved from California to Boston I stopped off in Toronto to visit a friend hospitalized at was then called Toronto General Hospital a large 900 bed tertiary referral center with a full range of specialty services and he asked us to set up his bill down in the billing office. Now he was an American and it turned out the billing office at the Toronto General at that time consisted of three people and a PC whose main job was to send bills to Americans who wandered across the border and when we completed our move east we went by the billing office of Massachusetts General Hospital a 900 bed tertiary care referral center with roughly comparable range and quality of care and at that time the billing departments at Mass General had 352 full time equivalent billing personnel and some \$3,000,000 dollars worth of billing computer equipment not because they were inefficient but that's because that's what one needed to do to stay open as a hospital in this country and my group practice has had as much trouble with it as any others. We pay 10% of our gross receipts to a billing service to try and collect our daily bread. The upshot of that has been said is that the good news now is that we now spend enough to deliver care to every American of superb quality. If we were to divert the resources from these hangers on it's actually delivering the care that

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Americans need. It's a message that's at least passively received positively by a very large portion of our society and our task in the coming months and I suspect years is to get this message out more broadly and actively. If one surveys now even small business owners who have been the core of opposition to national health insurance for generations, 40% say that they favor single payer national health insurance with the government paying the bills for everyone out of taxes, 9% are unsure and 50% oppose it. We break even basically in the small business. Clinton referred to support in the physician community. When we started Physicians for National Health Program a reporter once said to us that sounds like furriers for animal rights and -

[LAUGHTER]

DR. DAVID HIMMELSTEIN: Yet a survey of academic physicians at medical schools across the country showed 56% or 57% of medical school faculty now support single payer national health insurance including the majority of medical school deans in this country. Our survey of a random sample of physicians in Massachusetts, some thousand physicians was that 62% favor single payer as the best option for healthcare reform. We are a majority and yet our voices have been muted by the tremendous financial power that's arrayed against us. We are again in the midst of a growing healthcare crisis for which we are being told is the same kind of old wine that we've tasted before. The

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President asks for more market medicine, for more HMO's, for more of the same kind of competitive forces that have been pushed on us for the last 20 years and yes I end with a New England flavor coming from the land of the moose at least post [unintelligible] Maine, the story of the three moose hunters up in northern Maine who ask a pilot to fly them into a remote lake where they're going to be hunting and he drops them off and says I'll pick you up in a week but only one moose we can't take more than one out of here and he comes back and they've got three and he says you know I told you guys no more than one and they say you said the same thing last year and last year we got two. We paid you double last year and you agreed to take them both, this year we'll pay you triple and he thinks about it and says okay. So they go to take off and crash in the woods not a very gory story though, no one's killed, one guy is knocked out and as he comes to he looks up at his buddies and he says where am I? And one of his friends says I'm not really sure but I think we're about 50 yards from where we crashed last year.

[GENERAL LAUGHTER]

DR. DAVID HIMMELSTEIN: The President's health policy is [unintelligible] of those moose hunters. Thank you very much.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: We have one more presenter and we're very proud to present and want to pay tribute to him. Dean

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Baker's with the Center of Economic and Policy Research and crunching the numbers as they say is what he helped us do and he will be our last formal presenter. Dean.

DEAN BAKER: [Off mic] We've heard endlessly about the Social Security crisis and if you just have a simple number to keep in mind for the Social Security crisis. Social Security Trustees Report comes out every year of what's our Social Security crisis? Well they make projections for 75 years, you look at the books right now and it's not balanced. What would it take to balance it? Well according to the latest Social Security Trustees Report if we raise the payroll tax by a total of 1.86% points or 0.93% on both employer and employee you would have the program balanced for 75 years. Crisis goes away. A total of 1.86% points well think of this in the context of healthcare. Healthcare premiums have been going up about 13% a year. What that means for someone who's getting healthcare through their workplace, their costs, their healthcare costs, every two years is going up more than the Social Security crisis amount. In other words the additional funds of the healthcare premium of 2003 compared to 2001 for a typical worker is larger than the tax increase that it would take to balance Social Security for 75 years. Okay now to me that sort of seems like straightforward economics if that's a crisis but personally I don't think Social Security is a crisis but I won't argue with our wise members of Congress over here. If

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that's a crisis then what does that mean if you're facing that every two years? So you know I think that this and I think we all should if we're paying more for healthcare and not getting anything for it as I'll make my point in a second think of it as a tax and it's a very, very high tax and it's rising very rapidly. Okay so just to go through some of the numbers and I'll be quick because there's been reference on this already. The first point what I have here is the United States compared to other nations, nations that have single payer type healthcare what we've shown here is what has been the increase in costs for healthcare measured to share GDP over the period of 1970 to 2000. A little different periods for some of these nations but we tried to make it equal for all nations. What I'm trying to show is that in the United States is that we have much higher increase over this period 10.6% points GDP compared to Norway's the next worse case of a little over 3%, then we go down the list. Denmark's actually reducing the healthcare expense [unintelligible]. My wife's Danish and I get stories from her every now and then about problems with their healthcare system but you know I go well maybe [unintelligible]

[GENERAL LAUGHTER]

DEAN BAKER: You know so yeah she's - we could all get stories and I'm sure you've all heard stories about you know waiting lists in Canada or Denmark or wherever but you know given how much less they're spending on healthcare than the

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United States that shouldn't be altogether surprising. Okay so the important point here and I'll come back to this is that unlike the United States every nation that has the single payer type health insurance has been largely successful in controlling health care costs not completely successful but I'm sure they've got a thing, as you get richer maybe you want to spend more on healthcare and that's not obviously a bad thing but none of the nations have had sort of the runaway expenditures that the United States has. A second point we begin with a reference and he has nothing to show for it. If we had a better healthcare system we're all healthier, living longer, you know we knew our kids weren't dying at birth than fair enough we could at least say we were getting something for our spending but the numbers simply don't show this. They're always [unintelligible] numbers here you know, they're sort of the benchmark in the field and what we see is that the U.S. has the lowest mark compared to all the nations that have single payer healthcare and the highest in mortality rates. So I mean you could look for other measures but you'll find the same sort of thing. We just picked these because everyone's familiar with them. You could go through just about any list of outcome measures that you want and you find that the United States does worse than nations with single payer healthcare. So we're spending more than anyone else and we don't have anything to show for it. Okay so the next thing is you know what

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[unintelligible] single payer [off mic] Share one of my stories here from one of my colleagues because I'm using - taking estimates that were made by the Luna Group a consulting firm out here that's not been known to be friendly to single payer but they made estimates of a single payer type plan in California and they guesstimated what sort of savings you would see if you adopted the single payer type plan in California and now we've just applied that to the national model and it goes to 2005 same as if we got this into effect by 2005. Okay the first source of savings is administrative savings using projections for 2005 we looked to again using the Luna Group's numbers which I think are very, very conservative numbers, almost \$180 billion a year in savings and again this is the sort of story we're talking about you know where you have all these people involved in billing, you have the insurance companies allowing very clever people in the insurance companies are sitting there right now figuring out how to make sure that they don't insure people that get sick because obviously that's how you make money or alternatively how they can make sure that they don't have to pay for some particular type of procedure and that's how you make money you know and that's what they're there for. You get fired if you don't do that. Okay so one of the ways in which you have savings, \$180 billion a year taking an estimate it is by eliminating all this duplication in billing in insurance companies roll in - in

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trying to find ways to deny people care. The other way and this is probably very, very conservative estimate both buying the most obvious thing in here is the prescription drugs but also a lot of medical equipment. Again hardly a secret around this town or anywhere else for that matter, we pay way more for prescription drugs than anyone else in the world. In fact a number of studies show probably we pay two or three times more than nations like Canada, Australia, other nations, other industrialized nations. So again if you could get to a single payer system where you've got a [unintelligible] negotiating with the pharmaceutical companies with the manufactured and the medical [unintelligible] get down those [unintelligible] quite a great deal. This is destined to amass about \$50 billion a year and I'd say that's a very, very conservative estimate because we're spending about \$130 billion a year on prescription drugs now like by the year 2005 it'll be up to \$180 billion. It wouldn't be shocking to me if you would say half of that [unintelligible]. This is a very conservative estimate and it's pointing out that it's very recent and much, much better. Okay so getting this out what will be the cost with the current system projections and the current system - by the way the projections for the current system come from the Center for Medicaid/Medicare Services and what's their projection? Well for the single payer plan, the single payer plan there will be additional costs because more people will be

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getting care. Okay we're assuming somewhat higher utilization but we still end up saving about \$60 billion a year in the first year in 2005. Okay so again this is very conservative estimates of what the savings would be. We're assuming that people get more care and that's the point. We're assuming higher utilization rates but we still wind up paying \$60 billion a year less. Okay how will we pay for it? I won't go through this in great detail but I'll - I'll just sort of give you the finals of it. First off we're starting with government - current government spending and we assume we keep that in place reallocating it to the single payer system and we're assuming that we have the Medicare/Medicaid expenditures and various state and federal insurance programs and we keep those in place because that's our starting point. That's about 45% [unintelligible] second [unintelligible] addition because it would tax employers, a payroll tax to employers 3.3% and that's in addition here and then we decided [unintelligible] small items, gift shops things like that [unintelligible]. We will have some limited out of pocket [unintelligible] out of pocket and the other things we have in here are the [unintelligible] Bush 2001 tax cut and also this coming tax [unintelligible]. He wants to run up the deficit for his tax cut then okay we can have the deficit [unintelligible] Healthcare - close corporate tax loopholes essentially with these loose calculations suppose we raised corporate tax rates back to where it was in the 60's

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and the economy did very well back in the 60's by the way.

Suppose we had corporations pay tax at roughly the same rate about 44 or 45 percent of corporate profits like they did back in the 60's currently it's now 30 and not back where it was and we have a [unintelligible] tax on about 5% of taxpayers. These are the people with incomes over \$150,000 what we proposed is for the 2nd through 5th percent okay the not extremely rich but the fairly wealthy we'll give them a 5% point surcharge on income above \$150,000 and for the very rich those who are earning over \$250,000 give them a 10% point surcharge and that would raise their tax rate but it would still be less than 50% which some of us are old enough to remember the pre-Regan years where it was over 70% prior to 1980 so it'd still be facing a much, much lower tax rate than they did through the 50's, 60's and 70's. The last part of the story is that you'd have a small tax on stock transfers, 0.25% point and that would raise an awful lot of money and there were a lot of people that looked back and said it worked and you know day trading, people buy at 2:00 and sell at 3:00. It doesn't do much for the economy but you might enjoy doing it. I think it's very similar to gambling it's sort of gambling I don't mind taxing so you know we do it but in Maryland I guess they - you know that's how they're going to solve their budget problems so [unintelligible] Okay so that gets you about \$144 billion but this is I mean these are rough outlines just to show how you could do it you know

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obviously you know when we get there we'll be doing it somewhat different than what we're laying out here but this just is showing how you can make the numbers stand out. Okay so what does that mean? We're going to put more on employers. Okay well if you have a firm that's currently providing coverage and currently they're paying about \$2,600 per year on average okay for their workers. Okay and if we switch to the system where they have this 3.3% payroll tax they're saving about \$1,600 a year on their workers okay so they're currently paying about \$2,600, they'll be paying a little over \$1,000 about \$100 dollars a month, a little over \$100 dollars a month but they'll [unintelligible]. Okay in contrast [off mic] small business there will be [off mic] some buy insurance and some don't. Those that don't they're going to have a - they're going to have higher costs no doubt about it. But for a bit over \$1,000 dollars they'll be getting their workers [off mic]. The last slide and this is from an economic standpoint and I think the more important point we get on a slow growth path and so when you talk about savings in year one, we could talk about savings in year 2005 yet we implement it by eliminating a lot of the administrative fees, the duplication well fine we could talk about savings year one but more importantly we could [unintelligible] what we're looking at currently what the current system is non-sustainable. Keep going more and more payers are going to lose insurance, those who are able to

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maintain it, if you have a good union let's say you might be able to maintain you're union with the insurance but that's going to come out of your wages. It's not going to come out of air. So what's really important about this in my mind is not so much the administrative savings, the one time savings but the [off mic] across the nation. So the long and short it is possible to have a national single health payer and insure everyone but [off mic] current path isn't sustainable. [Off mic]

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Dean thanks. And you can tell there are many more avenues that we've explored but the time is gone and it's my pleasure as the final presenter to welcome Maya Roccamore [Misspelled?] from the Urban League. She's their director for healthcare policy and I'm very pleased with the message she brings to us.

[AUDIENCE APPRECIATION]

MAYA ROCCAMORE: Really not going to keep you long but what we've been talking about to here today is a national disgrace. The healthcare system and the status of our healthcare system is a national disgrace. In fact it's such a disgrace that we question the use of the word system. System implies coordination, organization, efficiency and our current state of affairs has none of those things. We already heard that 42 million - the latest Census Bureau figures show that 42

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million of the nation's uninsured are Americans. That's 15% of the United States population, but how many of you know that over half of that number are either African-American, Hispanic or Asian-American? African-Americans, Hispanics and Asian-Americans are 30% of the population when taken in total yet they are 52.2% of that 42 million uninsured - of the nations uninsured now we Dr. Angel talked about the myths that we engage in and I would like to propose that there's another myth that we need to be very aware of as an advocacy coalition focused on universal healthcare. We often talk about disparities in healthcare in terms of racial disparities, African-Americans/Hispanics being more likely to have all kinds of chronic diseases that effect their health and create early morbidity and mortality. However we often engage in the notion that that's a separate debate from the universal healthcare debate and that's simply a myth. It's the same thing. Research shows that inadequate access to healthcare particularly early and continuous healthcare may help explain why minorities and low income Americans have a higher prevalence of chronic diseases that result in disability and early mortality and why they are more likely to self report as being in poor health. Low income and minority Americans are caught in a [unintelligible] storm when it comes to healthcare in America. Research shows that populations who are low income and minority are less likely to receive employer based health coverage as a

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result of labor market segmentation and labor market discrimination. They're less likely to afford health insurance premiums if the coverage is offered. They're more likely to work in industries that offer fewer benefits or any benefits at all and more likely to have frequent spells of unemployment. Unfortunately instead of enacting policies to close these gaps for this population, federal and state policy makers are going in the opposite direction. Proposed cuts in Medicaid and Medicare brought on by the recession, the state fiscal crisis and yes exacerbated by the ill advised tax cuts that are draining the federal coffers will only serve to increase the number of the nations uninsured. Ironically society does not have to - does not escape paying for health outcomes for those with chronic conditions. Indeed I'm engaging in a study right now. I requested from the Social Security Administration some figures and facts about the disability insurance program and the supplemental insurance program. Just curious to see what the unintended consequences of not having a preventive system of comprehensive care in place would be in terms of disability coverage and not surprisingly health disparities showing up dramatically in all areas of preventive care and when I say preventive - those chronic - I looked at those chronic diseases that were responsive to primary and secondary preventive care measures and what happens to over 20 - to \$10 billion dollars paid out per year through SSI and DI and \$38 billion in

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inpatient hospital costs paid for by Medicare and Medicaid. The costs of preventable chronic diseases to social insurance and safety net programs are indeed substantial. So we've already heard tonight the cost of the direct medical care programs but there are also costs to things that we don't traditionally think about in terms of the consequences of not having healthcare. So with health costs spiraling out of control and no discernible decrease in the number of inpatient discharges due to the chronic conditions analyzed it's likely that the economic and human toll will continue unabated unless policy measures are enacted to encourage the delivery of preventative medicine focused on effective public health efforts in a coordinated system of early [unintelligible] and quality treatment and consistent care. The time is now for our nation to stop wasting our resources on an antiquated adhoc inefficient system of care. The time is now to pass the U.S. National Health Insurance Act. I commend Congressman Conyers for his great leadership on this issue and it's time to act. Thanks.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: Thank you very much. I think we all agree that the such an expression from such an important mainstream organization is a harbinger of good tidings for our efforts are now going to Q&A you've been a very patient audience and the press and all of them are invited to ask their

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questions but gosh you've been so good I'm going to tell you my joke, my single payer joke. This is a story about an emergency room where at least the front end of the event worked that is to say this poor guy was brought in with crushing pain in the chest to an ER not unlike David and everybody was on the ball they took a tracing and demonstrated an acute event, they rushed him up to the CATH lab and showed the obstruction, an hour or two later the OR was prepared, they scheduled the heart surgeon William David and the operation went very well and indeed he was let to go home and this is the part of my story that's incredible, at that point the financial people came in and they approached him and they asked him how he was and he says I'm fine I'm really grateful for the wonderful care and he said that's nice because we have a substantial bill here, very high and we'd like to have your insurance and he says I don't have any insurance. Well are you - do you have any other assets? He says no it's terrible I lost my job, I lost my insurance, I have literally nothing. That's very serious, but do you have any relatives who might help? Well it turns out this is incredible I know but I have only one relative and she just joined a nunnery she's taken a vow of chastity and charity, she's married to God. Can your brother-in-law help?

[GENERAL LAUGHTER]

DR. CLINTON YOUNG: All right we're ready for questions. I feel everything was answered but I've got a feeling there may

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be a question or two that you'd like to ask our very expert group. So I'm ready to recognize anybody. If I'm right, oh there we go. Okay just come right up here.

MALE VOICE 1: I'm going to throw you a softball but you didn't say in your presentation what percentage of Americans would pay less in economics if there were [unintelligible]?

JOHN CONYERS: That is a real softball. Basically anyone who's not in the richest 5%, so basically 95% of Americans would be paying less and the vast, vast majority of people end up paying less.

DR. CLINTON YOUNG: Anybody else? C'mon.

MALE VOICE 2: I have two questions for Mr. Baker. In the pie chart you showed was the total dollar amount you're trying to keep the same number as today? Is that the -?

DEAN BAKER: No the number is shooting for our estimate of the cost of single payer as of 2005 you know based on you know I was deriving the numbers largely from the Luna Group's estimates of the cost of the program in California.

MALE VOICE 2: And the second one's kind of a strange question but from a lot of the discussion sort of how the dollar starts at the top of the healthcare trickle down tree and makes it to the providers and gets siphoned off by lots of these external groups, has there been any examination of the economic fallout of what will happen to - you know if we do manage to cut out those groups - what happens to those

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businesses or are there proposals that handle any of those people?

JOHN CONYERS: So in effect like the insurance companies they are the intermediaries. There would be fallout I mean there's no two ways about it but you know it's - you know it's a case of they're kind of services would no longer be needed because it would be comparable in some ways to when you had seems like ancient history the Cold War downsizing of the military but there would be some fallout and I think it would be reasonable to talk about you know if you could do something for workers in some of those cases I mean I'm not going to worry about the topics of [unintelligible] HMO but or Mr. Frist's family but you may want to have programs to protect some of those workers. That's a reasonable concern.

DR. DAVID HIMMELSTEIN: Dr. Woolhandler [Misspelled?] and I have done some fairly detailed analysis that turns out that there's about 1.1 million administrative workers who would be thrown out of work through this process and I think we really would need a transition program implemented and in some of the discussion of this we in concert with the Labor Party laid out a transition which would devote much of the savings in the early years of the program to transition these people so the CEO's who were making three, four or even ten million dollars, we can't replace their jobs with anything comparable and we probably don't want to but the folks that were making

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\$30,000 dollars actually what we need to do is find useful work for them to do and there's a lot of useful work for them to do in the healthcare system that's not currently being done. We're not screening for high blood pressure in our communities and we have hundreds of thousands of strokes per year as a result of that and that's a simple community health work that's not being done. We're not actually providing anything to support for nurses in hospitals that would alleviate the nursing shortage, so the nurses are doing a number of non-nursing tasks in order to quote save the hospital and if we just transferred on the wards I work on the clerical personnel doing clinical support test if that's what they would want to do as an alternative job. We could relieve the nursing shortage in my hospital personally over night so we need as part of the detailed planning of this a transition program that actually takes the skills and resources and does something useful with it.

DR. CLINTON YOUNG: Next before the next speaker I want to announce a couple of doctors, not that we're pointing out doctors but these are members of PNHP who've come to join us. Dr. Pinishell [Misspelled?] will be asking some questions, Ludie [Misspelled?] Miller who's the author of a very useful book on this topic is in the audience. Please go ahead.

MALE VOICE 3: Yes I read Dr. Himmelstein's [Misspelled?] excellent book 'Leading the Patient' and it talks about the problem which crops up all the time that forces

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against this are so strong in our democracy seems so week I mean it seems to me that hopefully there's going along with this there's people looking into campaign finance reform because I feel that without campaign finance reform it's going to be very difficult and the same point I don't think it's that far off the subject but when I told some of the people that I'm involved with back in my home state of New Jersey they sent best wishes to Congressman Conyers and asked me to please ask him to consider another health issue that he's very involved with, very sick patients that get benefits for medical marijuana, again Congressman Conyers is doing God's work with being a co-sponsor of Marti Frank's bill and the people from New Jersey that I'm involved with appeal to you to think about pushing it forward a little bit instead of waiting until April.

MALE VOICE 4: I have two questions that are directed kind of to whoever wants to answer them. The first is what's your reaction to Senator Brogue's proposal to cover the uninsured which might be seen as kind of the competing bill and also as far as comparing healthcare costs in the U.S. to other countries has there been any studies to what physician rates are in the other countries compared to in the United States or anything like that?

DR. MARSHA ANGEL: [Off mic] - I don't know [unintelligible] he's proposing [unintelligible] because that's been around for some time in the Bush campaign on the notion of

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tax credits. Even the most generous proposal for tax credits would be about a half of what a policy would cost. It still leaves the poor with the problem of making up the other half. Most of them can't do that by definition. That's why you have to [unintelligible] them. So the help is very minor and inadequate. It also leaves them loose in a very treacherous and private health insurance where there would be plenty of people there to promise them lots but if you looked at the package it would be a very, very narrow package of benefits. So it would be a bonanza for the private insurance industry. It would probably lead to more inflation and the premiums going up. In a sense it's really giving them a voucher but that's not inflation and it still leaves them out there trying to buy insurance in a very, very difficult market. It's a form of incrementalism [Misspelled?] and that can't work because if something is sticking out here [unintelligible] non-system and you try to deal with that and something pops up. You have to deal with the whole fundamental -

JOHN CONYERS: If I could just add a word to that. I mean we've had a lot of experiments in this area certainly with Medicare and to my mind it's not an issue of do you believe in the market, you believe in the government. You believe market - I believe in the market if it does and again the insurance company makes its money by not insuring people who are going to get sick and that's not saying bad things about them that's

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what they're there for. They're to make money and you don't make money by insuring someone who's going to get sick and when you raise this with the people on the other side they say oh we're going to regulate them. So you're oh the government regulators are going to be better than the insurance company at managing its business? It never believed that otherwise. I don't believe that. You know so it's - if you don't address that basic problem in the system it seems to me that you can't ever get costs under control, you can't provide universal care effectively.

DR. DAVID HIMMELSTEIN: But the other thing to say is we've had in the 25 years I've been active on this issue a variety of promises that we were going to solve it with these kinds of incremental steps. My state back in 1987 actually we passed a universal health insurance bill along the line of some of the proposals for incremental changes that are currently before the Congress. That was never implemented because the only way it could get additional coverage was to dump still more money into a system which was already out of control financially. So that the proposal that we needn't change the system all we need is some extra money for tax credits or for purchase or expansion of Medicaid or other incremental steps and we don't need a fundamental change has actually been proven wrong time after time and folks tell us why do you want a home run swing when a bunt would do? And I guess my response is that

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we've seen so many strike outs from the folks who claim to be bunting that we wonder how many more times they're going to try that same failed strategy over again. You asked also about physicians' incomes. U.S. physicians' income are relatively high by international standards but not outstandingly so - so primary care doctors in the U.S. are paid roughly what Canadian primary care doctors are paid in their take home income. An American specialist makes somewhat more 20-25% more in most specialties, but not outlandishly more. What is very different is the gross receipts of U.S. physicians are higher because the average American doctor pays 56% of their gross income for overhead largely going for their clerical and administrative staff. So we could substantially cut doctors incomes in their gross receipts without very substantially cutting their take home pay. Now the other thing to say is that when doctors have been surveyed about this as they have on at least two occasions, the majority of American doctors say that they would accept a 10% cut of their income in exchange for a very substantial cut in the paperwork they have to do. Our profession is ready for this.

JOEL SIEGEL: Just one really quick comment. Hi I'm Joel Siegel Legislative Assistant for Congressman John Conyers.

[AUDIENCE APPRECIATION]

JOEL SIEGEL: That's a nice welcome. In the words of Congressman Conyers our extended family, that's you are welcome

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to a strategy session with the Congressman and this is going to

- to get this bill passed we have to have a social movement.

Yeah. Yeah. We have to have a massive grassroots movement

because we're right. This meeting will be on February 12th.

Mark this on your calendars. Next Wednesday 2416 Rayburn at

10:30am to 12:00pm and you may want to bring a sandwich or

drink or whatever and we'll also offer some food there and we

look forward to seeing you and we're really going to sit down

and talk about what do we really need to do to get this bill

passed? Because we're going to get the bill passed. We're going

to get it passed. We have to get it passed. Okay thank you and

please continue.

MALE VOICE 5: Oh well I-

JOEL SIEGEL: Oh was there a question? I'm sorry. Oh it's February the 12th, next Wednesday, 10:30 to 12:00 and you're all more than welcome. Yes. Rayburn building Congressman Conyers' lovely office, okay, thank you.

JOHN GREEN: I'm John Green from the National Association of Health Underwriters and I represent the other side but I'm not related to Frist-

[GENERAL LAUGHTER]

JOHN GREEN: Thank you. A couple of observations on regard to the charts, you know the United States is a very diverse country many of these other European countries are very homogeneous and so I'm not surprised that you get such

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different results where we have a growing population, they have negative birth rates, a declining population, so I would have some caution there. If we didn't legislate by body part in this country and this community issue of ratings that destroy markets that would help the cost of insurance and as far as administrative costs are concerned you're not comparing apples and apples but apples and oranges between what the public care administrative costs are and what the administration costs in the private sector is. They don't count enrollment costs in the public care, Social Security, and a lot of other costs that should be factored in so I think they're actually more comparable around 18%.

DR. DAVID HIMMELSTEIN: I can answer at least some of those things. Canada is actually a very good comparison. Canada in many respects is a more diverse nation than ours. They have a larger proportion of immigrants than we do by far, more languages are spoken in the Toronto school system than even in the Boston school system and other diverse systems. ⁷⁷ languages my colleagues told me is the estimate as of last year. The first language in Toronto and they've been more open directly to English and it's also worth saying that the lowest income group in Canada has a lower infant mortality group than the average mortality in the United States. We're not talking about comparing extremes in the U.S. to extremes in Canada, we're talking about Canada does better for its poor population

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or its minority population than we do on average in the United States on most health issues. Not to say they don't have problems but it's to say that they do rather well. We've seen a number of initiatives for guaranteed issues, the Kennedy/Castlebaum [Misspelled?] Initiative which had essentially had no impact on the health insurance market and part of the point of the Senate where we're comparing apples to oranges is you're exactly right. Medicare doesn't need to enroll people because they're enrolled automatically when they reach age 65 and the health insurance system is part of enrolling in Social Security. So there is no extra administrative costs for enrolling them. We have a parallel bureaucracy who implement our health insurance systems which is useless. We have no need to see whether someone is employed at Harvard or at Yale or wherever else they might happen to go in their academic career and we enroll them at each stop along the way or at each employer or when they become unemployed and yet we maintain the whole private healthcare system to do that and part of the point of this is that we actually need to abolish that orange that it contrasts with the Medicaid apple that says that you can cut administrative costs even in our inefficient government bureaucracy from 13% its average in the private sector to 3% in Medicare. I might say that Canada and some suggested that we ought to contract with the Canadian government to administer our program. Canada does it for 0.9%

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overhead. There are fewer people employed by the Canadian national health insurance system than are employed by the cross program in my state of Massachusetts. There are ten times as many people covered by that Canadian system than by Blue Cross.

JOHN CONYERS: Actually if I could just get in a quick thing about the older population because this is a very good point. In all those countries the population's considerably older than the United States which should mean they have higher insurance costs in fact of course we know they have very, very much lower costs and it's a very good point.

DR. MARSHA ANGEL: And I'd like to add one more thing. The implication was that if you could regulate the private system in some ways like have community ratings and risk ratings that you could make it a better system but the whole point is whenever you try to regulate the entirely voluntary system by having things like patients' rights bills or a community legislating a community rating the first thing that will happen is that the premiums will go up and the employers will drop it all together. So you can't regulate them.

MALE VOICE 6: I just want to make an announcement. As has been said we're going to have to make a movement in order for - to get this program passed and I want to announce that we're creating a coalition for a national healthcare program to bring together all those people in this country who want this kind of program. In the modern style of doing these things

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we've created a web site and it's an American bill and the web address is www.cnhp.us, www.cnhp.us. It's open although not quite for business. The purpose of the web site will be to both provide information, fact sheets, copies of the bill and so on but also to allow people to sign up as supporters of the bill and to sign up their organizations when they're organizations around the country pass resolutions for the bill. We want them to put the names of their organizations on that list. It's called the Coalition for a National Health Program.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: We love the name. Just a moment before I saluted Joel Siegel with Conyers' staff I want to salute a member of our staff Kimberly Sonnan [Misspelled?] who worked very hard as well to make this happen so would you -?

[AUDIENCE APPRECIATION]

DONNA MEG: Oh hello my name's Donna Meg I'm a student at Hopkins University School of Medicine and I obviously I'm surrounded by people who do all sorts of great research everyday and I've talked to people about this students and faculty alike and one of the concerns that I haven't been able to address although you all have talked about it and so I have been able to figure it out how to try to solve those but a concern that people have around me is that there's all this great research that goes on and a lot of it and I don't have the figures on it but a lot of it seems to be actually funded

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by pharmaceutical companies that - is there something in this bill that will address the fact that the high end of the medical industry in this country are great and they're great and they're doing really good things and how can I address that to the people back in Hackensack?

DR. MARSHA ANGEL: Well the lion's share of certain research is shared by the NIH which is a government agency. The pharmaceutical industry does sponsor a certain amount of research most of it is better considered marketing than research. If it's to study one [unintelligible] to drug as to another [unintelligible] drug or to get FDA approval for a ME2 [Misspelled?] drug the pharmaceutical industry would remain private though according to this bill although the health authorities would negotiate with them for volume discounts, believe me they would have plenty of profits leftover and plenty of money for their R&D. Excuse me?

FEMALE VOICE 1: [Off mic] medicine going to be generic?

DR. MARSHA ANGEL: No there would be a formulary and there would be a list of drugs that would be a part of what's offered under the national health insurance program that would exclude drugs that were of no proven benefit and were more expensive than those already on the market and there are plenty of formularies around. Large HMO's have them, Medicaid has them, so that if a doctor wanted to use a drug not on the formulary then there might be some co-payment or they might

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have to pay out of pocket but it would be a formulary which would be updated constantly to make sure that every important drug was there. Generics preferably but if they weren't generic then it would be the best brand name out there.

FEMALE VOICE 2: [Off mic]

DR. MARSHA ANGEL: Well you have to look at the motivation and what the HMO is trying to do is to save money and keep their profits up and that's a different sort of a thing in which the - every drug that the physician needed would be there but not the ones that they don't need or the ones that are exactly like another drug already on the market or maybe even worse [unintelligible].

JOHN CONYERS: Without implicating my colleagues on the panel this is something that I've looked a little bit at more from the economic standpoint again being a big fan of markets. If you imagined that you had public support for the other half of prescription drugs or most prescription drugs or most important [unintelligible] is actually already financed by the government through NIH and also is funded by non-profits and other entities other than the pharmaceutical industry. Imagine picking up the tab for the other half and then you made all the findings in the public domain and let anyone be - you know produce as generics do. The savings as of 2013 looking at the CPO productions for drug use management would be on the order of \$200 billion a year even assuming we've - after we contained

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the costs of the additional research of the government. So there's potential savings there that are enormous but there's a lot of reasons there and again I'm thinking of the market. When you have a distortion like a patent you see a lot of bad incentives [unintelligible] drugs and you lie about your research findings, you keep them secret, you promote drugs that might not be good for people or better than existing drugs but you try to convince them that it is. So you know there are alternatives there. So you know I don't want to influence my colleagues on this - this is just some area - some research I've done you know I think there's certainly a lot of ways that we can get drug costs down and you know.

DR. CLINTON YOUNG: Let me add one quick note there -you spoke of corruption in the profession and some of the doctors - some of them very prominent researchers are in the pay of the drug companies and you have to worry about that.

DR. DAVID HIMMELSTEIN: And I too have two brief things to add. One is to the colleague from Hopkins who was concerned about the impact of compromising drug companies funding of medical school research. The fact that the drug companies are now discovering that advertising and marketing agencies are more economical and reliable partners in research than medical school faculty by and large and much of the research budget is now being sifted from traditional academic research to research run by the marketing department of drug companies and

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essentially the academic mission is now in danger and by that and increasingly so in the years ahead. The second is the difference between a formulary for an HMO and formulary from a national health insurance system and in addition to what Dr. Angel said, one of my problems with the formularies that I work with from the HMO's is not so much as what's on the formulary but it's that I work with seven different formularies. So as a physician I carry around in my usual white coat a book with the formularies - with formularies from each of the insurance plans that I work with which each has a different drug in a particular class of medication and that means that I can't actually get to know any one of those well. Beta Blocker's one group of drugs very commonly used. I'm required by Harvard Pilgrim to do one [unintelligible] or to use a third by failing health plans [unintelligible] and therefore when I prescribe a drug instead of knowing and the dose I have to look up the side effects and of course in a busy practice you're always tempted to [unintelligible] but the actual looking up and getting those things as well as the price.

FEMALE VOICE 3: I have one question. I would have thought it illegal in [unintelligible]?

DR. CLINTON YOUNG: This is for residents of the nation. There's not prescription [unintelligible] in that case [unintelligible].

FEMALE VOICE 4: Hi I'm also a medical student at Johns

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Hopkins. Mental Health has certainly been destigmatized over the last 20 years and I don't think many people would argue about its being part of this but what about more controversial services such as abortion, emergency contraception, any kind of contraception, how does the plan address and incorporate those? I think many people who support this bill probably wonder about this as well.

JOHN CONYERS: Recovery services as well-

DR. MARSHA ANGEL: That's right. Whatever legal service you can get now you can get under this bill and whatever medically necessary service.

DR. CLINTON YOUNG: Having heard from so many medical students I take the moment to celebrate the fact that we've had superb collaboration from the American medical student [unintelligible].

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: And as a member of our board was here I don't see her but I want to note that that's a huge source of things. They are the future doctors.

FEMALE VOICE 5: [Off mic]

DR. CLINTON YOUNG: Yes. That's right and well-

FEMALE VOICE 5: [Off mic]

DR. CLINTON YOUNG: They're very much part of the mix and they've come to our convention [cross talk] very close [cross talk] happy to say yes. NMA two members, two Presidents

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of NMA were on the working group, Rodney Hood and

[unintelligible] [cross talk] yeah thank you for trying but I'm
happy to be able to report they [off mic]

MALE VOICE 3: -ability in health but I understand that
there are a lot of administrative wastes in the system that
you've identified particularly in the claims processing area
and in the enrollment and risk avoidance area but it seems to
me that there are also some real economic advantage
deficiencies that could occur under this national system that
you are talking about that do not exist right now because at
the community level where you have different health insurance
companies, not only are they advertising separately, but
they're not coordinating their resources efficiently. So in the
example you gave of a woman who's hit by a car, she's first
brought to one hospital, for profit hospital and then after the
biopsy of the wallet she gets transferred to another, all of
those inefficiencies would be avoided in this new system, I'm
just wondering since I've heard you say many times that
administrative costs are - need to cut through just wondering
what heights of administrative costs that we don't do right now
we would really need to expand in the new system to make it
more efficient? Since we don't coordinate providers efficiently
at the community level.

DR. DAVID HIMMELSTEIN: Well I think several categories.
We clearly don't have the health planning that we need in many

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respects and we know that that would not only in many cases reduce cost but also improve quality. There's substantial evidence that high volume providers of tertiary care services [unintelligible] than low volume places that do a few operations of the complex types. The regionalizing in those things would clearly be worth while. We know that they have an excess investment in facilities that often do no good. While many women don't get mammograms that are recommended. We have more mammogram facilities that are needed to do all of the tests that are recommended for everybody in this country and they often lie idle because we can't get people with the actual clinical practice they need to maintain a high level of confidence so that's an area and the second is a lot of community based prevention. We have an epidemic of obesity, we have an epidemic on a variety of things in our country that we don't intervene at because it doesn't fall within the [unintelligible] of any of the providers and there isn't any profit to be made off of it. Those off the top of my head are two areas.

DR. MARSHA ANGEL: And you're talking about something that's a little bit more than inefficiency what you're talking about is what for profit businesses are designed to do which is to expand. So you'll have several hospitals and one town advertising that you should come and get such and such service you're MRI in my hospital and then you'll end up with an MRI

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which as David says is not reasonably being used but they're marketing for paying customers and the whole impulse for a for profit business is to expand and yet what we're talking about is a system we want to contract now how much sense does that make? So this is more than an inefficiency.

DR. CLINTON YOUNG: Before we hear from this young lady I wanted to announce Congressman [unintelligible] offices and he'll give us something to eat. So in addition [cross talk] well I meant Larry and I want you to know it's no ordinary faire.

DACIE HANNAH: Can I speak now?

DR. CLINTON YOUNG: You're next. I just wanted to say because we'll probably disperse very quickly how much I appreciate the people that took the time to come and some of you from long distances and it's a harbinger of good work.

[AUDIENCE APPRECIATION]

DR. CLINTON YOUNG: And would you please take your turn?

DACIE HANNAH: Hi I'm Dacie [Misspelled?] Hannah and I've worked on the Hill and I think this is a very important bill and one of the things that I'm concerned with is how we get out and I'm interested in working with it but it's about organizing and getting grassroots African-American people and yes we have minorities but African-Americans have been here a long, long time so that's an area that I'm interested in working with in terms of you all have looked at and in terms of

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the [unintelligible] and the organization that's putting it together and creating this bill you know in terms of looking at strategies to get the grassroots African-Americans involved on a lot of different levels because we're dying disproportionately in terms of preventable diseases as you said and it could be in terms of infant mortality it's - we're on it disproportionately dying in terms of our children, old age. So that's an area that I'm very excited about and I've worked with Mr. Conyers and other Congressmen here and I'm interested and along with the other illegal immigrants and et cetera.

[TAPE SILENCE?]

DR. CLINTON YOUNG: -the parallel important organization, Julian Bond told me they support it and we were told that his Washington assistant Hilary Shelton would express her support [unintelligible] and we've heard that labor is beginning to open its eyes and that's a bad way to put it [cross talk] yes? Exactly. Well let me make a compact answer to grassroots we have significant members and we're growing in about 40 different cities and I pledge to you that we will do all we could to unite our membership which includes many African-Americans including leaders of our group to join with your groups and labor if they would and those are the elements of a winning coalition. Is there any other unreadiness [Misspelled?]? I'm about you to adjourn you to the wonderful faire the Congressman has [unintelligible] and thank you all.

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