UNIVERSAL HEALTH CARE BRIEFING

PROGRESSIVE CAUCUS

MAY 1, 2001

WASHINGTON, DC

REPRESENTATIVE DENNIS KUCINICH (D-OH): Thank you very much for being here this morning. Good morning to all of you, and it's a pleasure to have all of you here for this important discussion on Progressive Caucus' Universal Health Care Briefing. I'm honored to be here with all of you and I welcome my colleagues from the Progressive Caucus, the Black Caucus and the Hispanic Caucus, who will be joining us throughout this session this morning, and who are together in this coalition to work towards universal health care.

I welcome the Physicians Working Group who will present their proposal for today. These doctors are distinguished within the fields of medicine and public health. They've given extraordinary service in bringing better health to Americans and I welcome them today. I also thank the doctors, nurses, practitioners, and other witnesses on our third panel. Every day these individuals are intimately involved in the health care system working with patients. I applaud their effort and I thank them for their testimony.

In American, a decade of economic growth and record profits has not brought health care, or improved health care, to the American people. Who's uninsured in America today? Uninsured Americans are working Americans. 75 percent of uninsured people live in families where at least one person is working full time, and 20 percent of the uninsured are in families where two people work full time. So much for work hard and get ahead.

Most uninsured adults say the main reason they don't have insurance is because they cannot afford the premium. Today, in American, health care is rationed according to one's ability to pay for it. The market system for health care has failed the American people. For too long, we have allowed the health care business to spin out of control, gleaning more and more taxpayer funds to support Medicare or Medicaid HMOs, profiting on the loopholes and limits to care, while covering fewer people and providing fewer benefits.

Our health care system is like an old blanket, worn thin and patched too many times over. New patches make little difference. What we need is a fundamental change.

As Chair of the Progressive Caucus, I'm here to say that we have a moral obligation to restore health to our health care system. What do we need instead? Health care must be universal. The system must be efficient. Where Medicare HMOs operate with up to a 25 percent overhead and still shrink their benefits and their population served, that obviously is not efficient.

A health care system must give good benefits and not discriminate against the disabled, those who need mental health services, or those with pre-existing conditions. Our health system must not discriminate against those of different races or income levels, and must give the same quality of care no matter where you live or what your race or ethnicity is. We must have a better health care system for the people. A system not for the pharmaceutical and insurance industries.

Today, we are here at what I hope is a turning point. In this room, we have some of the nation's foremost experts, health care activists and change makers. We share a knowledge that our country has utterly failed in the provision of consistent quality care to our citizens, and that something must be done.

It is my goal, it is our goal, for this group that, by the end of this briefing, we will leave more educated about what universal health care means. We will be able to educate others on the true goals of universal health care and destroy the outdated myths. It is our goal that, when we leave here today, we will be more energized and mobilized to start a movement to bring health care to all.

Thank you again for being here and, at this time, I would like to introduce one of the senior members—okay, he was deferring at the moment. I would like to introduce Congresswoman Donna Christensen, who is going to make a few remarks and she is Chair of the Health Care Brain Trust.

REPRESENTATIVE DONNA CHRISTENSEN (D-VI): Thank you. Thanks. It’s my pleasure also to join my colleagues here this morning in hosting this important briefing, solutions to the American health care crisis.

In the world's richest nation, one that spends more than any other on health care, it's unbelievable that today, at the beginning of this third millennium, 43 million or more people in this country are without health care coverage, and hundreds of people today, primarily people of color, will die from preventable causes. Those two facts are causally linked and today we are going to look at how we can change the sad state of our country's health care system, or the lack of that system.

It is the mission of the Congressional Black Caucus' Health Brain Trust to eliminate gaps in health care and health status for African Americans, but

also for other people of color, and those who live in the more rural parts of our country.

To truly address health disparities among people of color, we must address the issue of universal health care in our nation. African Americans and our Latino, Latina, Native American, Asian, Pacific Island and rural brothers and sisters continue to comprise disproportionate numbers of those affected by heart disease, cancer, diabetes, HIV/AIDS and mental illness, just to name a few. And unarguably, not only the richest, but the most informed nation in the world, it continues to astound me that we cannot reach a consensus on the issue of universal health coverage, while the most vulnerable of our nation remain at risk.

It is my hope that our efforts today will bring us one step closer to acknowledging an undeniable fact that we must all face if we are to prevent the needless death of thousands of American citizens every year. We need not only to provide coverage to everyone, but to completely reform our health care system.

The theme of our spring Health Brain Trust this year was Health Care Justice Now, With Disparities for None and Access for All. Hundreds of people, some of you at the table, Dr. Hood from NMA, our Student American Medical Association President, and the Black Nurses Association, and Sickle Cell Group here joined us, and joined hundreds of people representing communities around this country with my colleagues to discuss barriers to achieving this goal and how to craft solutions.

Universal coverage is lynch pinned. We are united in our conviction and our commitment that wellness must become a reality for the people of color in this country. To this end, we will make the health care of minorities and, indeed, all Americans, the Civil Rights issue of the 21st Century.

The beginning of this effort is HR-1142, the Working American Families Access to Care Act of 2001. This Bill would amend Title 19 of the Social Security Act, permitting uninsured individuals and families with incomes at or below 400 percent of the poverty level to obtain coverage under the Medicaid program. It would also, for the first time, make full Medicaid coverage and access to health care services available to Americans living in our territories. It would be administered by the states and territories, with the federal government paying for additional costs.

The MediAccess Program would provide access to health care for nearly 40 million uninsured Americans, Americans who go to work every day, pay their taxes, and still cannot afford the health care they need. And despite the claims made by those who are not supportive of a universal health care, the MediAccess Plan is affordable, costing maybe about $40 billion every year.

Ladies and gentlemen, we are at the tide. This country has the resources to make universal coverage a reality today. This is a just movement that we are embarking on for, as in the words of Dr. Martin Luther King, "Of all the forms of inequity, injustice in health care is the most shocking and inhumane".

As people of color, we are sick and tired of being sick and tired, and so I thank all of our panelists for being here today and for their hard work and their dedication to this important cause. It's only with your help that we will meet the challenge that is the health and wellness of this nation. Thank you, Mr. Chairman. That ends my opening statement.

REP. KUCINICH: I want to thank the Congresswoman for her participation and also for her work on the Health Care Brain Trust. It's essential work, and we also have a member of Congress represented here who is active in the Hispanic Caucus and is Chair of the Hispanic Caucus' Health Care Task Force, it's Congressman Ciro Rodriguez from the state of Texas and, at this time, I would ask Congressman Rodriguez to make some remarks.

REPRESENTATIVE CIRO D. RODRIGUEZ (D-TX): Thank you very much. Let me, first of all, thank you for allowing us this opportunity to be here with you to talk about this critical issue. Let me just say that--and mention a couple of things. We have all talked about the fact that we have the largest number of uninsured in the country ever before, and things are not getting better, they're getting worse. This, proportionately, Hispanics get hit.

If you work—if you're working out there and you're working for a small company, if you're not working for government or for a major corporation, you don't have access to health care. And so there's a real need for us to reach out and see how we can provide that access. And so, if you're not poor enough to qualify for Medicaid, not old enough to qualify for Medicare, then you find yourself in limbo in between and not having access, yet paying all the taxes that everyone does, and so that's very unfortunate.

In addition to that, I think that we see the new data that's coming out. A few years ago, about a decade ago, we would have said that the issue of tuberculosis was a foregone conclusion, that we had beaten that disease. The reality is that that's only getting worse for us. We have a new strains that we need to be very cautious.

There's over 15 million Americans that suffer from Tuberculosis. One-third of them are along the Texas border and in that area, and there's a real need for us, when it comes to contagious diseases, that we look at it internationally. It's not an issue of just Americans. We've got to look at worldwide, 'cause it can have an impact on us and it's something that's extremely serious.

When we look at the issue of AIDS, we know that in the area of AIDS we've made some inroads. Yet right now, 20 percent of the new cases are Hispanic and we only represent 13 percent of the population. So those poor communities out there are getting hit disproportionately. So there's a real serious need for us to refocus our efforts in the area of health care like we've never done before and that opportunity is now.

When we look at issues of Medicaid and how we've complicated the issue, and I'm going to mention Texas cause the President comes from Texas, USA, Family USA, came up with a report that more than 100,000 families were knocked off the rolls of Medicaid in Texas alone, not to mention that states such as Texas choose not to fully participate in all the programs that Medicaid has to offer, such as prescription coverage. They limit prescription coverage to just three prescriptions, and so that, if you suffer from diabetes, like Hispanics have a tendency to do disproportionately, then you're in a bind because you don't have access, and you're an indigent, and you don't have access to that prescription coverage. And so, as Americans, we've got to make sure that we provide access to prescription coverage to all Americans.

When it was initially implemented, we recognized that it was not part of the total process of providing access to health care. Now we recognize differently. We know that access to prescription coverage is part of providing that access to health, and so it's important for us to look at those and I'm real pleased to be here with you. Looking forward to hearing from your testimony, and I'm looking forward to making something happen in this area. We're one of the worst industrialized countries when it comes to the access to health care, and we've got to change that around. We've got to make something happen.

And if I could add one little caveat. In the 1960s, we made some real inroads in the area of mental health with Kennedy and the push for the community of mental health centers. We've gone back in years in mental health. We have more people out in the streets. One third of the homeless out there are people suffering from mental illness. We have over 500,000 at any one time--veterans that are homeless out there, a large number are due to mental illness. And so there's a--when it comes to mental health, we're not doing enough and there's a real need for us to look at that seriously.

I was just recently provided with some data on young people that are committing suicide, and especially Hispanic young ladies, and when I was first told that, my first reaction was, "No, that's not true. You've got to provide me with the data". And they did, and it's extraordinary. A lot of our young people that are attempting suicide, and so I would ask that we really need to kind of look at that and see where we can make some inroads. Thank you for allowing me to be here.

REP. KUCINICH: Thank you very much, Congressman Ciro Rodriguez from Texas. Next, we will hear from Congresswoman Hilda Solis of California. Congresswoman Solis has distinguished herself as being a passionate and dedicated defender of the rights of working people and the poor. She came to Congress on the wings of the Kennedy Award, which she was recognized as someone who fought for people and challenged, in a very powerful way, some corporate interests. Her presence in the Progressive Caucus is much appreciated, and her presence here today, we're very grateful for. Congresswoman Hilda Solis, thank you.

REPRESENTATIVE HILDA SOLIS (D-CA): Thank you, Mr. Chairman and Members. It's a pleasure to be here. I know we have a wealth of information that's going to be presented to us today, so I'm looking forward to hearing all of your great ideas so that we can begin a process here, to really hopefully talk about how we can provide access to everyone. And some of you may know, in the State Legislature in California, I carried a Bill to start looking at providing universal health care alternatives. That's a small, small increment of where we need to go. Hopefully, we can get those ideas moving here in the country, in the capital, and we can really begin to provide access for all those working families that I represent in my district that have no other alternative, or any kind of health care at all.

So, I would just say thank you. My hat goes off to the Chairman of the Progressive Caucus, the Black Caucus, as well as the Hispanic Caucus, and all the health care providers and advocates who are there. Our voices have to be heard. We keep hearing about trying to provide incentives for better health care coverage, but I don't see anything in this upcoming budget, so I really want to hear more about what innovative ideas there are so that we can begin to do that. Thank you so much.

REP. KUCINICH: Thank you very much, Congresswoman Hilda Solis of California. Next, we'll hear from Congresswoman Tammy Baldwin of Wisconsin. Congresswoman Baldwin is known as a very courageous person who has brought to the congress her concerns for minorities, her concerns for health care, and her concerns for the rights of workers. So we want to welcome her here this morning. Thank you.

REPRESENTATIVE TAMMY BALDWIN (D-WI): Thank you. I'll be brief because I have the privilege of being able to testify on the second panel, and I'll save my substantive remarks for that time. But I do want to recognize the importance of this session today. This is what I believe should be the top center issue, centerpiece issue, that the Congress is debating and discussing right now. And I am delighted that Chairman Kucinich, which sounds awfully nice, has worked with others to bring this opportunity for all of us to listen to new ideas, to embrace ideas that have stood the test of time, and to figure out how we can, together, move to

the day that this country joins so many others in making a commitment to the health care of every one of its citizens.

REP. KUCINICH: Thank you very much, Congresswoman Tammy Baldwin from Wisconsin. For those who just entered the room, and I would encourage you, we do have some space. This is nice to see standing room. There's some space over here if you want to—if you feel you might be here for a while, you want a little bit more—a better standing position. You can come over here on this side, it's okay. Just feel free to.

For those of you who've just come in, we--I gave an opening statement, followed by Congresswoman Donna Christensen, who's Chair of the Brain Trust for Health Care. Then Congressman Ciro Rodriguez spoke, Congresswoman Hilda Solis, Congresswoman Tammy Baldwin, and next we will hear from the Vice Chair of the Progressive Caucus, a woman who is very dynamic and has shared with me the considerable amount of work in generating our efforts for the Progressive Caucus, and who has brought an energy and a vision to our work. And I want to introduce and thank the Vice Chair, Congresswoman Barbara Lee of the state of California. Congresswoman Lee.

REPRESENTATIVE BARBARA LEE (D-CA): Thank you very much and I do want to thank you, Mr. Chairman, for your leadership on so many issues, but especially on this issue with regard to universal health care, and for really pulling us all together for today's meeting. You know, health care should be a right in America for all Americans, and it's not. It should be--it's a human right, and until—until we recognize that and until we recognize that it is a mega-billion dollar industry, and that profits need to be made in this industry, until we really establish that fact realistically, I don't think there's a chance for universal health care reform to be real in this country.

So, I want to thank you for this meeting. I will reserve my comments for my testimony. I think I'm on the second panel. But I want to also acknowledge Congresswoman Hilda Solis, who I work with very closely in the California Legislature on single parent initiatives, actually, and universal health care for children, our Healthy Families Program in California, and also Congresswoman Christensen, who Chairs our Health Brain Trust with the Congressional Black Caucus. And so I think, here on the Hill, with all of our panelists here, we have some real energy and some very creative ideas in how we can move forward to establish this universal human rights for all, and that's health care for all. Thank you Mr. Chairman and I welcome everybody here.

REP. KUCINICH: Thank you very much. Congresswoman Barbara Lee is our Vice Chair of the Progressive Caucus. Congressman Danny Davis represents Chicago in the Congress of the United States and, as someone who has worked very closely with people who are struggling in inner cities

to try to maintain some kind of health care, he is a powerful spokesperson for the people, and I want to welcome Congressman Danny Davis of Illinois, and if you'd like to make a few comments we would certainly welcome them.

REPRESENTATIVE DANNY DAVIS (D-IL): Thank you very much, Mr. Chairman. I really don't need to speak, but I would like to take this moment to acknowledge the tremendous leadership that you have provided to the Progressive Caucus and to acknowledge the leadership of my colleague from the Virgin Islands, who has Chaired the Congressional Black Caucus' Brain Trust, and certainly all of the distinguished members of the group here who've done outstanding work in different areas, but I really just wanted to acknowledge the presence of my mentor and a person that I've been running with for more than 30 years on these particular issues, and I see that he's running just as hard today as he was 35 years ago when we first started working together, Dr. Quentin Young. So, it's a pleasure to be here with you and all of the members of the panel and I look forward to the discussion.

REP. KUCINICH: I thank the Congressman from Illinois, and if the gentleman would do us the privilege, at the appropriate time, perhaps you could introduce Dr. Young to all those that are here, and that will be shortly.

We have just been joined by another gentleman from the state of Illinois, my brother in all of these issues, someone who is a rising star of the Democratic party, a passionate defender of human rights and the rights of people everywhere, and I'd like to ask Jesse Jackson, Jr. for his—for greetings and for some words of encouragement.

REPRESENTATIVE JESSE JACKSON, JR. (D-IL): Let me thank Congressman Kucinich for being kind enough, and for the Progressive Caucus, African American, Hispanic and the Progressive Caucus for holding today's hearings. It's my understanding, Mr. Chairman, that we can have two minutes maybe to bring some brief remarks if it's okay.

REP. KUCINICH: I know that you're on the second panel, so if you wanted to--.

REP. J. JACKSON, JR.: I was just trying to find out what the regular order was to let us make statements.

REP. KUCINICH: We welcome your statement now. Those who are on the second panel are waiting until their panel comes up to make their formal presentation, so whatever you--.

REP. J. JACKSON, JR.: I will--Mr. Chairman, I will wait until my panel comes up. Thank you, Mr. Chairman.

REP. KUCINICH: Okay. Thank you very much, Jesse Jackson, Jr. from Illinois. My presence—my presence in this Congress was facilitated through the next gentleman I'm going to introduce. He's a person who has served long and well and has worked the vineyards of the Democratic Party, working to make the fine line, which someday we hope results in universal health care. Congressman John Conyers is an inspiration to all of us, and his representation in the Detroit area and for the state of Michigan has established him as one of the leaders of our Congress. He's our leading Democrat on Judiciary, and he's our leading Democrat in so many areas close to our heart. So I'd like to, without further ado, introduce our esteemed colleague and Dean, Congressman John Conyers.

REPRESENTATIVE JOHN CONYERS (D-MI): Thank you very much, Dennis. This is going to be an exercise in restraint. We have the best panel that has ever been assembled in America before us waiting to get on up. Dr. Mohammed, please just come on up here and sit down. You deserve a seat after what happened last night, the closing of the only public hospital in Washington, D.C.

Now, I gave up--I was supposed to be in front of the Supreme Court on May Day complaining about the fact that we haven't started voter reform yet, and I was going to have the opportunity to—and with the background of the United States Supreme Court, explain that this was the--November 7th was the first coup d'etat in American history with the Supreme Court, the five conservatives joining in, and I gave up that rare opportunity, which I will revisit very soon, don't worry, to be here with you and to get this thing started on time.

And I don't want to start praising all of my colleagues, but, you know, let me just say that we meet here the night after the only public hospital in Washington, D.C. was closed at a surreptitious meeting, removed from the citizens of the capital of Washington, D.C. Think I'm happy about that? Okay.

Now, there's a very interesting comment I want to make. It comes out of this really great book. The facts are plain. Most people's health is bad. The cause is plain. Health costs money and people don't have the money to pay for health. What to do in the wealthiest society in recorded history, spending more money on health care than anybody else in the world, and we've come together to try to determine how we move out of this mess that we're in.

Now, behind the fact that they don't--we don't, a lot of people don't have money, is the fact of racism and poverty, class and race that draws those to the bottom who can't, and will never, under this system of thousands of insurance companies, HMOs and everybody else squeezing themselves in in this very profitable business of delivering health.

And so I close on this quote from Richard Wilkinson: "The health effects of inequality have shown us how deeply are affected by the structural futures of our society. But even more important than the few extra years, which great equity would add to the average life, is the improvement in the social quality of life which it would give all of us. Not only is the cost of inequality a cost we incur for no economic benefit, but all the indications are that it imposes a substantial economic burden, which reduces the competitiveness of the whole society." So, let these hearings begin, and if anybody thinks that this is a two-hour hearing, this is the most important hearing on health we'll probably have this year.

REP. KUCINICH: Thank you, John Conyers, for the keynote remarks, because you have really described why we're here. I also want to welcome the gentleman who has—who fought the good fight to save the D.C. hospital. As a person who has worked on trying to save public institutions, I can tell you that I appreciate your struggle, and I also want to thank Mr. Conyers for welcoming the gentleman up to this dais because, in a sense, that symbolic gesture communicates that there is protection for all, and a place for all, within the plan that we're offering. And so there is then a sense of peace which comes about this, and so I say (inaudible) and welcome you in that spirit and ask you to please stay as long as you'd like.

And now we move to our panelists, which is the reason so many of you are here, to hear from this distinguished panel which, with the work of our various staffs, we've been able to assemble and I want to thank our staff members of all the congressional staffs here, who have come together, particularly those on my staff who've worked on this, Alison and others, and Jared, for all of your work because bringing all of these people together would be impossible unless staff made it happen.

You often hear the canard that, to a person who needs no introduction. Our first speaker is someone who doesn't need an introduction, but I want to say that this country was, for a few years, graced with the presence of a Secretary of Labor who became known as a fearless defender of workers' rights, a champion of work place safety, someone to whom collective bargaining meant a great deal, someone to whom the right to join a union was a cardinal principal in a Democratic compact, someone to whom the right of collective bargaining was something to fight for and to hold up as an essential part of a Democratic society, someone who worked to make sure that, if a work place was unsafe, that workers would have recourse.

In every category of workers' rights, Robert Reich has been there. In every category that relates to making an economy more humane, an economy which would be more responsive to all the people, Robert Reich has been there. In every area of endeavor in a Democracy where we need someone to speak out on behalf of all people, but in recognizing that the rights of

workers should not be subsumed to the rights of corporations, Robert Reich has been there. And Robert Reich is here today, too, to be our leading voice, one of our leading voices, in furthering the cause of universal health care.

It is an honor for me, it's humbling for me, to have the opportunity to have Secretary Reich be present and lead our panel, and I want to thank him for his presence here and all--I know I speak on behalf of all members of the Progressive Caucus, the Hispanic Caucus, and Black Caucus who are present here, in saying that we welcome your presence and we look forward to working with you as we move ahead with implementing this dream of universal health care. So, I ask all of you to join with me in giving a very strong welcome to Secretary Robert Reich.

SECRETARY ROBERT REICH: Well, thank you very much, Mr. Chairman, and I do like the sound of that, Mr. Chairman. "Mr. Chairman." Let me first of all salute the Progressive Caucus and the Black Caucus and the Hispanic Caucus for the work you continue to do on behalf of poor and working Americans and average, even middle class Americans, all Americans, in providing a voice in a city that very often, too often, in fact, there is not as articulate, as powerful, as strong a voice on behalf of average working people and the poor as there should be. You are that voice and just more power to you. That's all I can say.

Today, this is a terribly important hearing. I want to make sure, though, that we all have a context, that maybe my one comparative advantage here might be to provide a little bit of a context for this. I want to very strongly endorse the work that Congressman Conyers has done, the Working American Access to Health care Act, which I think is terribly important and salute you, Congressman, for your years and years and years of service to this country, and to poor people and to middle-class and working people. We're not excluding anybody here. This is not a matter of class discussion. You are there for Americans, and all of you have continued to be.

This is not, and should not be, viewed I don't think today as simply one part of the choir preaching to another part of the choir. You must understand, and I think many of you already do understand, and everybody in this room understands, that this is a ground swell in America. There is a ground swell of support for universal health care. This is not something that just progressives, just blacks, just Hispanics, just poor, just working class people want. More and more Americans—if polls are to be believed—and I, by the way, I'm as skeptical of polls as anybody, but the polls are showing a ground swell of support.

Now, I want to talk about what's happened in America a little bit over the last 10 years, and also talk a little bit about the last time the Administration, the Administration of which I was proud to serve in,

produced a Health care Bill and what happened there because, again, we need to understand context. We need to understand the past. I don't want to dwell on it, but I want to make sure that it's right there in front of us, and then I want to summarize what I consider to be the challenge before us.

First of all, where we've been. The dirty little secrets of the 1990's is that, despite an extraordinarily strong economy, the best economy of the 20th Century, and an expansion that, low and behold, we find out from the Commerce Department last—a day—a couple of days ago continues, continues even now, even though the economy has slowed. Despite that wonderful economic performance, medium wages, indeed the wages of the bottom half, either did not grow or actually continued to drop.

Now a very tight labor market, that is very low unemployment, was wonderful. We have almost a 30 year—continue to have almost a 30 year low in terms of unemployment. That's been terrific for working class people, for poor people, that's very, very important, but it has not been a magic bullet. It has not done the trick of lifting median wages more than about 2 percent, and a lot of people below the median never really got a raise. I emphasize this because I think it's important to understand that rising health care costs have occurred in the context of really no major increase in the wages of working people, and certainly not in the wages of poor people in this country.

We are facing two trends. One trend is widening inequality of wages and wealth and opportunity in this country. I wish it were not true. I wish I could say the 1990's were a time in which all boats were lifted. I cannot say that. We are seeing that trend and, simultaneously, we're seeing a trend of wider—of rising health care costs and more and more people losing health care coverage.

When we came to Washington, the Clinton Administration in 1993, 37 million Americans did not have health insurance. Now, in 2001, we're almost up to 44 million, and even people who do have health insurance are finding that they are paying more for their co-payments and deductibles and premiums than ever before. Survey after survey, and you're going to hear from this panel, survey after survey shows that Americans with health insurance are—can barely afford it. They are doing without because the co-payments are going up, the deductibles are going up and the premium's are going up.

And let me also, not wanting to be a Cassandra about this, but I want to issue a very clear warning. If this economy continues to slow, if a lot of people lose their jobs and that health insurance is connected to their job, that 44 million Americans without any health insurance is going to increase and it's going to increase faster than it's increased between 1993 and today. In other words, widening inequality, most Americans not really

getting very much out of the 90's boom, combined with increasing health care costs, is creating a major, major problem for this country and for working Americans, for poor Americans, for middle-class Americans.

What to do about it? In 1993, as you all remember, most of the people in this room were involved directly or indirectly, the Clinton Administration produced a health care plan. I am not the first to say it was too complicated. It was difficult to explain. I was out in the hustings. I would getting a lot of questions about it. People asked me to explain this or that detail. I had, frankly, a difficult time. It should have been a simpler plan. There was no reason it had to be that complicated. And the problem, politically, is that complexity made it fertile ground for demagogues on the right, who wanted to attack that plan and wanted to scare people; scare them into thinking that they would lose their doctor, their choices, whatever they had, they would lose it.

So rather than it being an opportunity for people, rather than that plan being an alleviation of anxiety for some Americans, because of the demagogues, and I want to emphasize this, I don't pull my punches and I want to be very clear about this. This was an orchestrated campaign. It was not just Harry and Louise Ads, it was a lot of companies, a lot of corporations, a lot of Republicans, a lot of lobbyists, who decided that no health care, no universal health care, was better than universal health care.

They were with us up to a certain point and Americans were with us. Most of those polls showed that most Americans wanted universal health care. And let me emphasize this. This is not something that has changed. Even though that health care plan went down to defeat, it was not a huge defeat. It went down, but if you remember, it did not go down nearly as dramatically as some of our contemporary historians want to suggest. It went down by some votes, but polls continued to show that most Americans wanted and needed universal health care.

And again, although I caution everyone in this room about polls, there was most recently an ABC poll showing that more Americans wanted universal health care than wanted a tax cut. That was a poll taken between April 4th and 6th, a random poll of Americans. Do you want universal health care? Do you want health insurance for the people who lack it? Or do you want a big tax cut? More people wanted universal health care.

Now here is something else that's happened between 1993 and 2001. We tried HMOs. We also tried fee-for-service. That's the way we had it. We tried fee-for-service; it didn't work. We tried HMOs and there is widespread public dissatisfaction. So what else are we going to try? How are we going to deal with what is rapidly becoming a crisis in America? That word "crisis" is used for everything. In fact, the Administration talks about the energy crisis. Well, the health care crisis is bigger by far than

the energy crisis, and we must recognize that our solutions are not working because they are not solutions.

One final point. Given the needs of working families, for poor families, for middle-class families; given their needs for affordable health care, for universal health care, using the surplus, the budget surplus, for a tax cut tax of over a trillion dollars, is not only bad policy. Given what has happened to the incomes of working families relative to the incomes of people at the top in America, a cut that mostly benefits a tax cut that mostly benefits the people who enjoyed most of the gains of the last decade, instead of universal health care, instead of the things that middle-class and working class and poor families need, that kind of a tax cut is morally repugnant.

Let me not mince words. It is very important that Americans hear loudly and clearly that their representatives in Washington stand for universal health care, stand for universal childcare, and better schools. And if there is going to be a tax cut, a tax cut for working people and the poor, not a trillion dollar plus tax cut using the surplus for awarding the same people who did extraordinarily well in the 1990's.

Every time I say anything like this, I am accused of class warfare. This is not class warfare. This is simply a matter of understanding what working families and poor families in this country desperately need. It's a matter of understanding that we live in the same society, that we have some social and moral obligations to one another. This is not a politics of resentments, this is a politics of inclusion.

Again, I want to salute the Progressive Caucus, the Black Caucus, the Hispanic Caucus. Congressman Conyers, Mr. Chairman, keep up the work and keep the flame alive. Thank you.

REP. KUCINICH: Thank you, Secretary--for, Mr. Secretary, for your presence, for your words of wisdom and encouragement, and I agree with you that this really isn't a class issue. I represent city and suburb and there are many people who live in the suburbs who are really afraid of losing their whole economic position because of the rising health care costs. So this is an issue that we can unite people on.

Now, Representative Danny Davis has a long-standing relationship to the next speaker and I'm going to defer to Representative Davis of Illinois for the purposes of an introduction.

REP. DAVIS: Thank you very much, Mr. Chairman, and I appreciate your deference. Certainly a pleasure for me to present one whose contributions to the struggle for access to quality health care for all has been well documented and well written. Therefore, he really needs no introduction.

He is a practicing physician who has been around a long time, you can tell by looking at his hair, but he organized the Medical Committee for Human Rights, Physicians for Social Responsibility, served as Medical Director for Cook County Hospital, is one of the main reasons that, instead of closing our Public Hospital in Cook County, Illinois, we are opening a brand new Cook County Hospital, and had it not been for the years of diligence on the part of Quentin Young to help save that institution, I am afraid that it would have gone the way of the D.C. Public Hospital. He has also served and is the past President of the American Public Health Association. While doing all of that, if you really want some good medical services, go to Quentin Young, he'll take care of you.

Dr. Young, it's a pleasure to have you.

DR. QUENTIN YOUNG: For the first time in my life, I'm at a loss for words. Thank you very much, Danny, for that generous introduction and I'll quickly get to the point.

I want to briefly describe the genesis of this panel. It grew out of early conversations, no more than two months ago, with Congressman Conyers, where I represented to him that leaders of medicine are no longer to be tainted with one stripe of conservative, even the actionary obstacles to universal health care, but that leadership is taking quite a different—quite a different tag, and he accepted my comments and challenged me to produce that group.

Well, the rest is what we see here today and I want to start out by saying I'm convinced that--I'm confident that when we get universal national health insurance, which will come a lot sooner than many of us in the room expect, this very hearing will be considered one of the launching pads of the beginning of that process in a fresh way.

I called 18 friends; some I knew well, some I only had telephone acquaintanceship, and I'm pleased to report, Congressman, that all 18 said yes. These are people who are in situations that are sensitive in their institutions and their colleges and so on. I can expect to bet 100 percent everybody said yes. I'm gonna very quickly introduce them. More than half of them are here today to add to the hearings.

But the other thing I want to say before I do that is to pay tribute, Mr. Conyers and Mr. Kucinich, to your spectacular staffs. I didn't know there could be that much efficiency in the Congress.

REP. KUCINICH: I'd like to ask all of you to join with the Doctor in applauding staff! And, Doctor, one of the things you might be interested in is that, in our Progressive Caucus, where we have our meetings, staff actually sits at the table and participates fully. We understand what helps keep us in Congress.

DR. YOUNG: That shows extraordinary good judgment on your part.

Very quickly, I want you to know who is before you and I'll start with those who couldn't make it; some for reasons of health, others are abroad, and the first one to start with is my favorite and you'll soon see why. Dr. Merlin K. Duval (?) was Assistant Secretary for Health under Mr. Nixon, President Nixon. So this is not a singular political stripe. Dr. Duval would describe himself, does describe himself, as a conservative who has come to believe that the only solution to this problem is the one we're presenting you today.

And I might say that the paper that you have, which I think will be very much the advising intellectual piece that are gonna guide the political struggles for advance in health insurance, was written by 18 people in a collective way. The leading authors were Stephie Walhandler (?), who's here, and David Hemelstein (?), who's not, and our presenter, who I'll talk about later, helped in the editing of the final piece. And then, believe it or not, all of the participants had their licks and, if you've ever tried to herd cats and try and get 18 doctors to agree on a paper, but we have and that adds to its virtue.

With us today is Joel Alfred. Dr. Alfred is Immediate Past President of the American Academy of Pediatrics. We have also Olveen Carrasquillo who is with the National Hispanic Medical Association, Dr. Eleanor Christensen is the President-Elect of the American Medical Women's Association. We have to my right, Dr. Rodney Hood, the distinguished leader, President of the National Medical Association, Edith Rasell is MD, Ph.D., doctor, doctor. She's both a physician and an economist who helped us a great deal in putting together the numbers. Sindhu Srinivas is the President of the American Medical Student Association, herself already a doctor, and a leader of a very dynamic, vital part of any effort to change the health system here.

Not with us is three leaders in public health: Dr. Walter Tsou, the Commission of Health in Philadelphia, Dr. Peter Beilenson, I might note a son of a Congressman from California, who is the Commissioner of Health in Baltimore, and the leader in Dallas of their health system, Ron Anderson. I think I've—no, Dr. Gary Dennis, a Past President of MMA, I don't believe has been able to join us.

UNIDENTIFIED FEMALE: He's here.

DR. YOUNG: I'm very sorry, Dr. Dennis, greetings. Okay, that's the group, and a very dynamic group it is, and it's all doctors. Now you can be assured every one of us doctors have no naïve notions about doctor elitism. We decided to do it as doctors because the panel had to hear,

the public, the nation had to hear that America's doctors increasingly are for universal health care, not to block it.

On the other hand, we, at the earliest moment after this hearing, plan to extend long term relations with other health workers, most importantly nurses, and literally the representatives of the millions of health workers that are the (inaudible) of our health system. And beyond that, we hope to talk to leaders of labor. It turns out, as others have noted, no country has had a national universal system that wasn't led by labor movement by the unions or their parties, and it has to happen in this country that way, too. That said, I will now turn to our presentation.

We chose our spokesperson. The very best—not in our group, but in the nation, if not the world. Dr. Marcia Angell is Immediate Past Editor of what is recognized as the most prestigious medical journal around, The New England Journal of Medicine. Thousands of doctors have been instructed by her, both in her editorship and her editorials which, for over a decade, have called for single payer national health insurance. We've asked her to present the essence of our proposal, it's in your packet, and some remarks of her own. Please.

REP. KUCINICH: Welcome.

DR. MARCIA ANGELL: Thank you very much, Dr. Young. First, I want to thank you for giving us the opportunity to address you this morning. I'll begin, I think, by reading the summary of the proposal of the physician's working group on single payer national health insurance. Copies, I believe, of the full proposed—proposal have been distributed. And then after I read the summary, I'll make a few additional comments of my own, if I may.

This is the summary. The United States spends more than twice as much on health care as the average of other developed nations, all of which boast universal coverage. Yet, over 42 million Americans have no health insurance whatsoever and most others are underinsured in the sense that they lack adequate coverage for all contingencies; for example, long-term care or prescription drug benefits. Why is the United States so different? The short answer is that we alone treat health care as a commodity, distributed according to the ability to pay, rather than as a social service to be distributed according to medical need.

In our market-driven system, investor owned firms compete, not so much by increasing quality or lowering costs, but by avoiding unprofitable patients and shifting costs back to patients or to other payers. This creates the paradox of a health care system based on avoiding the sick. It generates huge administrative costs which, along with profits, divert resources from clinical care to the demands of business.

In addition, burgeoning satellite businesses, such as consulting firms and marketing companies, consume an increasing fraction of the health care dollar. We endorse a fundamental change in America's health care. The creation of a comprehensive national health insurance program, or NHI. Such a program which, in essence, would be an expanded and improved version of Medicare, would cover every American for all necessary medical care. Most hospitals and clinics would remain privately owned and operated, receiving a budget from the NHI to cover all operating costs. Investor owned facilities would be converted to not-for-profit status and their former owners compensated for past investments. Physicians could continue to practice on a fee-for-service basis or receive salaries from group practices, hospitals or clinics.

A national health insurance program would save at least $150 billion annually by eliminating the high overhead and profits of the private investor owned insurance industry, and reducing spending for marketing and other satellite services. Doctors and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules, often rules designed to avoid payment.

During the transition to an NHI, the savings on administration and profits would fully offset the costs of expanded and improved coverage. NHI would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run.

A national health insurance program is the only affordable option for universal, comprehensive coverage. Under the current system, expanding access to health care inevitably means increasing costs, and reducing costs inevitably means limiting access. But an NHI could both expand access and reduce costs. It would squeeze out bureaucratic waste and eliminate the perverse incentives that threaten the quality of care and the ethical foundations of medicine.

Now I'd like to take a few minutes to expand on some of the points in the summary I just read and, in particular, to respond to some of the arguments often made against a national health insurance program.

As stated in the summary, Americans have the most expensive health care system in the world. We spend on average twice 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 spend more time in the hospital. And it's not because we get better results. By the usual measures of health, life expectancy, infant mortality, immunization rates, we do worse than most other developed countries.

Furthermore, we're the only developed nation that does not provide comprehensive health care to all its citizens. Over 42 million Americans are uninsured disproportionately, the sick, the poor and minorities. And most of the rest of us are underinsured, even while we sometimes receive far more of certain kinds of health care than we need.

In sum, our health care system is outrageously expensive, yet inadequate and inequitable. Why? The only plausible explanation is that there's something about our system, about the way we finance and deliver health care, that's enormously inefficient. We simply don't get our moneys worth.

In my view, and that of many other critics of our system, the underlying problem is that we treat health care like a market commodity instead of a social service.

UNIDENTIFIED MAN: There you go.

DR. ANGELL: Health care is targeted, not to medical need, but to the ability to pay. Now markets are good for many things, but they're not a good way to distribute health care. Let's look for a moment at how the health care market really works.

Most Americans receive tax free health benefits from the employers who pay insurers a portion of the premiums, but not all employers offer benefits. It's strictly voluntary. And when they do, the benefits may not be comprehensive. Higher salaried workers are more likely to be covered and the coverage is better. About one in five workers, mainly those with low salaries, turn down health benefits because they can't afford to pay their share of the premiums.

The insurance companies with whom employers do business are mostly investor-owned, for profit businesses, that first appeared on the scene 10 to 20 years ago when the managed care market opened up. They tried to keep premiums down and profits up by stinting on medical services. 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 insure, for example, by excluding expensive services such as heart transplantation, and by passing costs back to patients by denying their claims, or its deductibles and co-payments.

We are the only nation in the world with a health care system based on dodging sick people. These practices are collectively called cost shifting and they add enormously to overhead costs because they require a great deal of paperwork. They also require creative marketing to attract the affluent and healthy, and avoid the poor and sick. Not surprisingly, the United States has by far the highest overhead costs in the developed world. It's instructive to follow the health care dollar as it wends its way

from employers toward the doctors and nurses and hospitals that actually provide the medical services.

First, private insurers regularly skim off the top a substantial fraction of the premiums, anywhere from 10 to 30 percent, for their administrative costs, marketing and profits. The remainder of the health care dollar is then passed along a veritable gauntlet of satellite businesses that have sprung up around the health care industry. These include brokers to cut deals, disease management and utilization review companies, drug management companies, legal services, marketing consultants, billing agencies, information management firms, and so on and so on. They, too, skim off a portion of what they get for administrative costs, marketing and profits.

It's been estimated, no one knows for use, but it's been estimated that no more than 50 cents of the health care dollar actually reaches the providers, who themselves have high overhead costs to deal with the requirements of multiple insurers, often bent on avoiding payment.

One final comment on the inappropriateness of the market for delivering health care and controlling costs. Markets are meant to expand, not to contract. When the seller of a consumer good, like VCRs, lowers prices, it's only with the intention of increasing volume. And yet, we say we want the health care market to contract. That's simply not what successful markets do.

Now compare all that with the national program we're advocating today. This program is the very sole of simplicity and efficiency compared with our private health care system. In many ways, it would be tantamount to extending Medicare to the entire population. Medicare is the most efficient part of our health care system. Many people don't know that, but it's the most efficient part of our health care system, with overhead costs of less than 3 percent. It covers virtually everyone over the age of 65, not just some of them. Medicare is not perfect, but it's by far the most popular part of the U.S. health care system, as evidenced by the resistance of Medicare beneficiaries to any changes.

Not what are the usual objections to the sort of program we're calling for today? They are mostly based on a number of myths, which I'll review briefly. Myth number one is that we can't afford a national health care system. My answer is that we can't afford not to have one. Our costs are exorbitant, premiums are once again rising at double digit rates, and the number of uninsured will undoubtedly swell with the softening of the economy. We're headed for a crisis in health care. Professor Norris (?) is correct on that.

A single payer system would be far more cost effective, since it would eliminate excess administrative costs, profits, cost shifting and

unnecessary duplication. Furthermore, it would be permit the establishment of an overall budget and the fair and rational distribution of resources. We should remember also that we now pay for health care in multiple ways: through our paychecks, the prices of goods and services, taxes at all levels of government, and out-of-pocket. It makes more sense to pay just once. The most progressive way is to an earmarked health care tax on income.

According to myth number two, innovative technologies would be scarce under a single payer system. We would have long waiting lists and maybe rationing. This misconception is based on the fact that there are indeed waits for elective procedures in some countries with national health systems, such as the UK and Canada. But that's because they spend far less than we do on health care. The UK, for example, spends about a third 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 the care they need. For them, the problem is not the system, it's the money. For us, it's not the money, it's the system. There's plenty of money already there.

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, the micro-management imposed on them by the private insurance agencies—companies. Indeed, many doctors, and you see many of us here, who once opposed a single payer system are now coming to see it as a far preferable option.

Myth number four says that the government can't do anything right. Some Americans like to believe that, or say it, without thinking of all the ways in which government functions very well indeed, and without considering the alternatives. I had a very conservative uncle who once asked me, rhetorically, to name three things the government does well. I said the NIH, the National Park Service and the IRS, at least in that era. I might also have added Medicare which, as I've said, is far better at funding health care than the private sector.

We should remember too, that the government is elected by the public and is accountable to the public. An investor owned insurance company, in contrast, reports to its owners, not to the public.

A fifth and final myth is that a single payer system is a good idea, but politically unrealistic. Now that is a self-fulfilling prophesy. In my opinion, the medical profession and the public would be enthusiastic about

a single payer system if the facts were known and the myths dispelled. Yes, there would be powerful special interests opposing it, and I don't underestimate them, but with courageous leadership and the support of the medical profession and the public, I believe there's nothing unrealistic about a national health insurance program.

There's no question in my mind that a national program is the only way to provide universal, comprehensive care, while providing a mechanism to control costs. If we were to put the money we now spend into such a system, Americans would have the very best health care in the world.

I want to mention one final and very important reason for enacting a national health program. We live in a country that tolerates enormous disparities in income, material possessions, and social privilege. 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 because of their income or social status.

One of those services is health care. 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 care.

Providing these essential services to all Americans, regardless of who they are, helps insure that we remain a decent, cohesive and optimistic country. It says that when it comes to vital needs we are one community, not 280 million individuals competing with one another. And seeking to ensure adequate health care for all our citizens, we have an opportunity today to reassert that we are indeed a single nation. Thank you.

REP. KUCINICH: Congressman Conyers just said that's the best summary that he's ever heard in his life and I think that many of us would agree. Thank you, thank you, thank you. I would ask that the Gentlelady, and all of those who have testified, provide this panel with copies of your remarks. One of the things we can do is to make sure that it's inserted in the Congressional Record and we will do that.

I have polled the members of Congress who are here, and we've been joined by Congressmen John Tierney of the state of Massachusetts, and they have all agreed that we should immediately go into the second panel. After the second panel, we'll have time for questions and, in the interest of trying to keep on schedule, and I'm quite confident that, if our witnesses who are there are the table please, if you're able to stay with us, please remain seated, the members of Congress who are part of the second panel will be delivering their statements from this dais and also from that one, so we don't have to engage in a game of musical chairs here. I would--and we're also, we're expecting other members who have--

who will wish to testify as well and, when they join us, they'll join Mr. Tierney on the dais there.

So, why don't we move right now into panel number two and, before we do that, I want to ask all in the room if you would join me again to thank all the members of our first panel.

We're going to go to panel number two. Now, I've been given an order of presentation here by staff--is that--(inaudible) stay where we are--yeah, please. We're going to go to Representative Tierney first and Representative Tierney and I share Committee assignments. We've worked together on a number of issues that relate to openness in government and common sense approaches to government and, coming from New England, he brings that heritage to the Congress of the United States.

He's progressive in every way and we are grateful to have Congressman John Tierney here to make a presentation before our Progressive Caucus Health Care Briefing, which is also cosponsored by the Hispanic Caucus and the Black Caucus. Congressmen Tierney.

REPRESENTATIVE JOHN TIERNEY (D-MA): Thank you, Mr. Kucinich, and thank all of our presenters earlier. I'm sorry that I wasn't able to be here, but I've read your works and heard you before and I think that it's nice to have so many people so articulate on this issue.

I also want to begin by thanking the Progressive Caucus in conjunction with the Universal Health Care Task Force, which I'm pleased to be one of the Co-Chairman, and the Congressional Black Caucus and the Congressional Hispanic Caucus for coming together to present this particular program today, which I think is a step in the right direction and I'm really pleased to be able to sit on the panel and be able to proceed what I know there are going to be other esteemed members and colleagues.

I want to thank Dr. Angell and Dr. Young, and Mr. Reich for all of their great work, and other people that have been responsible for doing the white paper on this subject, which I hope is going to be widely disseminated and educate a lot of people on what we're doing and what we're addressing here today, and from this point onward hopefully. I applaud all of their dedication to the cause, as well as the members that sit behind me here today.

While we recognize that national reform is needed, I'm sorry to say, and I think you'll agree, that no consensus exists at the present time as to just how we're going to get there, and I don't think in the meantime we can sit around and wait. So, we tried to find out ways to move this prospect along that might gather some support, and one of those is the HR-1033

Bill, States Right to Innovative Health Care Act of 2001, which my office has put together and I'm sponsoring.

With this we've create a competitive grant process. It would offer selective states technical assistance and funding to assist those states with the costs of planning a new state program that would provide health care for everyone in that state, and offer generous benefits and protections that are equal or superior to the level that state residents currently receive.

It allows for quality, comprehensive, and affordable care at the discretion of states with a defined benchmark. Specifically, the Bill would allow each state to pool any federal health care funding that it would otherwise receive. It would waive federal laws and regulations that otherwise prevent states from proceeding, but it would maintain at a minimum all protections and benefits that currently are enjoyed under federal programs in which the state participates. It would give states the one time grant to cover start up costs, such as transitioning to the new programs.

The Bill is not a total solution to our problem and I don't present it as such. It was crafted with the idea in mind of generating models that will provide a solution eventually. Hopefully, we'll see different models because I really believe that our rural areas may have a different plan than urban areas, and there might be other differences, but if we have some of these plans put in place and these models work, then others will be able to adopt the model that applies to them. And I think you'll agree that we can ill afford to wait any longer before we start moving forward.

The mission today is a rather clear one. I agree with my colleagues who have signed onto the Universal Health Care Task Force Resolution, that Congress must pass legislation to ensure that every American has health care coverage. I hope you agree with me and with Dr. King, who said, "That of all the falls of inequity, injustice in health care is the most shocking and inhumane."

The message we articulate is also a rather clear one. Comprehensive, affordable, quality health care for every American is not our option in as much as it is our obligation. Together we can make this happen. Our presence here today is not about politics. Our presence here today is about real people with real problems. Real people with real, but often unnecessary problems, and it would be unnecessary if everyone had quality, comprehensive, and affordable health care.

I want to thank you for the opportunity to speak to you today. I hope those who haven't already endorsed and co-sponsored my Bill will do that. I urge us all to continue on the fight against this grave injustice and I believe that this Bill at least ought to be attractive to some of our members on the other side of the aisle, after all, it has the words "states

rights" in it and they all feel so very strongly about that, that we might just lure them into focusing on this problem and understanding that, together, we can craft answers that don't have to get partisan and don't have to be political, but deal with the real problems of real people. Thank you all very, very much.

REP. KUCINICH: Thank you, Congressman John Tierney of Massachusetts. Our next presenter is Congresswoman Tammy Baldwin of Wisconsin. Congresswoman Baldwin.

REP. BALDWIN: Thank you. Now I feel more strongly than ever. In my introductory comments, I was saying what an incredible opportunity this hearing was about to be and I've been--just delighted to hear the testimony so far. It is an extraordinary opportunity to shine the spotlight on an issue that has been too long ignored.

As elected representatives, we have a duty not only to think about the policies that will lead to universal health care in this nation, but also the politics that will lead to universal care in this nation, and I think this hearing is a great example of both. It is good policy combined with good politics. I was very pleased for the setting of some context as we move forward on what will not be an easy struggle.

At the risk of restating some of the obvious, I wanted to just also present some context on the politics of this. In just a short period of time, if you look at it historically in this nation, we've created the public will to put astronauts on the moon, to create a global village united by computer technology, we've perfected travel from one earth--or one end of the earth to another in just a matter of hours, and yet, 43 million of us cannot afford or cannot get health insurance, and most of these people have jobs, but increasingly they work in sectors of the economy like small business, or family farms, or service sector jobs that don't offer health insurance coverage to employees, or require them to pay so much for health insurance that workers simply cannot afford it.

And, as we've heard today, there are millions more probably, and close to 40 million—actually, we could probably argue all of us who are underinsured, who have health insurance, but would be at risk of having to spend significant percentages of our income on health care bills in the event of a catastrophic illness or injury, with gaps in dental care, with high deductibles, seniors on Medicare who yet lack prescription drug coverage, or are struggling to pay for long term care. And there are tens of millions more of Americans who have simply lost faith in the system; lost faith that comprehensive quality care will be available to them without a struggle when they need it, where they need it, and from whom they want it.

It is clearly time to put universal health care at the top of our national agenda. So many have called for it and so many more believe that it

should happen, but universal health care will never happen until we create the national will, the public will to make it so. But one lesson that I've learned over and over again is that, with these numbers that we're talking about, the silver lining to that tragic story of lack of insurance and under-insurance, is that we have the numbers to create the political clout to get something done. If 43 million Americans spoke with one voice tomorrow, this would happen with great rapidity in this country. And so it is up to us to help them find their voices, to help them speak as one.

Now, just a quick word about policies. I am actually a cosponsor, proudly so, of a number of universal health care initiatives that have been developed by my colleagues, by outside groups, presented to members of Congress and that has been a delight because, not only are a number of these very sound and very helpful, they are organizing tools to help uninsured and under-insured Americans who have lost faith in the health care system develop their voice on the absolute need for universal health care.

I have been proud to work with a small coalition of individuals on a Bill that we will be introducing shortly. Been working with the Service Employees' International Unions with Senator Wellstone and with Congressmen Dave Obey to develop legislation that we call the Health Security for All Americans Act. It is a work product that I feel very proud of. I, too, encourage colleagues to join with me, but I think we have to be working on all fronts and it is a great delight to be among you today as we set a course for renewing our--and re-igniting our battle for universal health care. Thank you.

REP. KUCINICH: Thank you very much, Congresswoman Tammy Baldwin from the state of Wisconsin. We've been joined by a gentleman from California, Congressman Pete Stark, who is the Ranking Democrat on the Health Subcommittee of the Ways and Means Committee. In that capacity, Congressman Pete Stark has been an advocate for Americans everywhere for the quality of health care, an advocate for the protection of the system which we have now in Medicare and Medicaid, someone who has helped to point out the deficiencies in the system and has worked to correct them, someone who understands currently the challenges that have been brought to us by the previous panel on this market-based approach to health care, how it's utterly failed, and someone who is joining us today as a partner in our endeavors. I want to thank Congressmen Pete Stark for his presence and we look forward to your remarks.

REPRESENTATIVE FOURTNEY PETE STARK (D-CA): Thank you, Dennis, very much. Can you hear me? There we go. I'm just pleased, I mean, to be in this room with some of my heroes. I mean, I wish I could--I'm at the left end of this spectrum, but I see very few of us have the chance to have a kind of a personal advisor for a pediatrician, like Joel Albert, who sits down there and has saved my young son, Fortney, from

the indignities of a managed care system. And my own personal John Wayne, Robert Reich, who was my--and it--was my candidate for the next President of the United States. And then of course, my colleagues on the dais who have tried in every way, I think we all know how, and perhaps in ways that we'll be dreaming up as we go along, to provide health care to all residents of the United States.

If I may just digress for a minute and be as modest as I can. There's a wonderful statement of health care that I refer to as the "Stark Trilogy." I use the word trilogy now that we're into all of this space base nonsense, but I gotta have something, so why shouldn't we--and I could do this test with the audience, I might even do it with our distinguished panel, but the first leg of my trilogy is that, as a matter of right, every resident in the United States should have quality health care. Now--if I ask you if the Constitution required that all--that our citizens or residents have health care, you'd probably say no, and I'd test my colleagues. There's one small group of Americans who do have the right under the constitution for health care. Who can tell me?

Prisoners! Not Congressmen, you're right, prisoners, you're right. So what I've always said is what's good enough for Haldeman and Erlichman is good enough for me.

The second, the second leg of my trilogy is that every provider of these services, Dr. Albert, and the hospitals, and the pharmaceutical manufactures, as a matter of right, should expect reasonable, not necessarily desired, but reasonable compensation for the services or products they provide. And the third leg of this stool or triangle, is that we all should pay for that according to our ability to pay.

Now, if we could all get together behind that kind of an outline, we'd have the problem solved. But obviously we can't and we are where we are today with probably 40 to 45 million people without insurance, which means without adequate health care, of which 12 million are children, which is tragic. And we have gone up the hill and down the hill in trying to provide legislative solution, lead really, as soon as we got rid of Ira Magaziner, led by the White House into a program that did follow the--follow the employment based system, and did not increase the budget, and was available to everybody and paid for on a progressive basis, and we got it out of the Ways and Means Committee, but actually couldn't even probably pass it on the--in the Democratic Caucus, and we were--we were knocked out of the box by Harry and Louise. I always love to see good, dirty campaigning, but I don't like conspiracies to which I'm not a party and I--.

So--I think we—I think that was the high water level of the idea that we would have a universal health care program that we could sell to the American public and the politicians, and we have to back track and I'm

perfectly willing to do this piece at a time. If that scares the Republicans into thinking that I'll be here as long as Strom Thurman, I'm willing to stay and do it for the time, so that, along that we've offered a lot of suggestions, whether we brought people into Medicare starting at age 55, and our opponents will tell us, gee, you're just putting the nose of the camel under the tent--that's right. We'll do what we can to expand the coverage that exists as best we're able, and that gets me, I guess, to the point where I'd like to suggest today.

I guess this Congress, we're going to start at least the efforts--my staff and myself and some of my colleagues with children. If we can't somehow make the stand that morally and ethically and financially, it's obscene to allow small children to go without protection, we're in real trouble. So, using Medicare and understanding the CHIP, like QMB and SLMB and Supplemental Security Income and a whole host of projects don't work because the outreach doesn't work. For whatever reason, these programs seem designed to scare people away. And my county in California, next to--which I share with Barbara Lee, we've got 15,000 kids we think who would qualify for the CHIP Program and I don't think we've signed up 2,000. That's awful.

So, what we're suggesting, and what I'm going to call Medi-Kids, kids are in the plan when they're born, okay? You're in. You're tagged, just like you get a social security number. If you, as a child, are taken as a dependent on a tax return, the person filing that return may have to pay something. MediGap—Medi-Kids would cost, I'm going to guess, 400 bucks a year, not outrageous amount, to give a minimal level of care for children, including well baby care and inoculation.

So, you're in the club when you're born. And if you're parents are paying taxes or your guardian is paying taxes, if somebody deducts you, they pay the 400 bucks, if they can afford it. And we graduate that down and if you're poor, you don't, and if your parent or guardian or whoever's on that birth certificate doesn't file a return, it's free. And that gets the kids taken care of and it sets a program and the provider knows that they'll get paid within 30 days. It's better than Medicaid, it isn't 50 different states.

If the parent has an employment-based or other type of insurance, they clip the receipt to the tax form, as long as the kids are included in that insurance, and they don't have to pay the $400.00. It's administratively simple, it's national, it's quick, and it's inexpensive.

We can't get scored by our budget’s process by what we prospectively save when we are not required to spend that money, if you will in the first place. Now, everybody in this room knows that for every dollar that we spend in the first year of life of a child will save $50 or $5 in the next ten years of their life. We can't get budget scoring for that. So we're gonna have to spend some money, there's no question about that. But if we can

spend $50 billion a year to make my children richer than they already have any right to be, and deny other children health care, there's something wrong with our priorities.

Or, we've just passed a Pension Bill out of the Ways and Means Committee last week. It was editorialized yesterday in The Washington Post, and that--or maybe it was Sunday, but at any rate, that's only five billion a year for the very richest people in this country who already has generous pension plans.

Where are we going—when--we have to identify--the money's there, we just have to get the American public redirected and I'm thrilled to be here. Dennis, thank you for your leadership in this, and thank the panel for participating, and I think that we'll just keep pushing and, at some point, the public will become so outraged by our collective failure to take care of these children that all we legislators will have to do is steer that horse back to the barn. I want to be around to help that day. Thank you.

REP. KUCINICH: Thank you very much. Thank you very much, Congressman Pete Stark from California. Next is Congressman Jesse Jackson, Jr. from Illinois. Congressman Jesse Jackson, Jr.

REPRESENTATIVE JESSEE JACKSON, JR.: Thank you Mr. Chairman. I want to make two observations before I make my single point. The first observation is that, during the Civil War, it was said that one of the differences between Abraham Lincoln and Jefferson Davis was that Davis seemed determined to win arguments and debates, even if he lost the war, while Lincoln was content to lose some debates, but he was determined to win the War.

Many progressives are like Jefferson Davis; content just to win public policy debates, but then lose the war and then blame the troops who would not vote for our public policy prescription. We are right on the issues. We are right on health care. I believe in a universal and comprehensive single payer program. We proclaim that. But 100 million Americans did not vote for our position in the last election. 50 million voted for George Bush, 51 million voted for Al Gore, 100 million Americans voted for neither Democrat or Republican, in part because they don't believe them.

Lincoln had a General named McClelland who trained his troops very well, but he was reluctant to fight. Lincoln much preferred Grant and Sherman because they were prepared to fight, because they fought. Lincoln once said, "Grant has the bear by the hind leg, while Sherman takes off his hide. Orders from our troops and to our troops from Grant and Sherman are quite different than orders from McClelland." We have a credibility problem.

Second observation. During the Civil War, Lincoln wanted to issue the Emancipation Proclamation, but the North had lost a series of important battles. The Cabinet Secretary, his Secretary of State, William Seaward, advised him that the timing of such an action had to be right, preferably after a Union victory. The northern victory at Antietam provided Lincoln with such an opportunity. But in finally issuing the Emancipation Proclamation on January 1, 1863, he transformed a somewhat demoralized army into an army of liberation.

I believe those of us who support universal and comprehensive coverage need such a moment; however, I believe our goal must be nothing short of health care liberation for every single American.

Charlton Heston and the NRA tells us everyday that the basis of their right to have as many guns as they want in their home is protected—and to protect their family, is protected in the Constitution. Whether you agree or disagree with that interpretation of the Second Amendment, and I happen to disagree with it, they use the constitutional argument in an attempt to establish a fundamental right. If their interpretation were actually true, it would be the most powerful argument they could use, and even now, it influences many Americans. If you don't believe me, just ask Democratic leader Dick Gephardt and those Democrats who either lost or were unable to win a seat because voters believed they had a constitutional right to a gun, and somehow, voting for Democrats, they were going to lose that fundamental right. Winning those seats would have meant Democratic control of the House.

Now, I support providing good, quality health care for every single American, and I support a single payer approach to achieving that goal. Additionally, while I support all incremental legislation that moves us in the progressive direction of comprehensive and universal health care, more fundamentally, I believe health care is a human right that should be transformed into an American right.

Thus, more strategic than a health care program is a health care right. Therefore, I believe our ultimate goal must be to secure the fundamental constitutional right to health care, regardless of who the Democrat is, the Republican is, the Liberal or the Conservative, it should be a right that is not subject to free market forces; it should be a right that should not be subject to whether or not one president wants to spend more money on military spending and therefore chip away at Title I or Title II, or Title III, or whatever comprehensive program we ultimately end up passing. It must be protected and secured as a fundamental right. That is what we ought to be organizing, mobilizing and educating our people around, even as we support incremental legislation.

That's why I introduced HJ Resolution 29 in the 107th Congress. It is an affirmative health care constitutional amendment. Section one says, "All

citizens of the United States shall enjoy the right to health care of equal high quality." And section two says, "The Congress shall have the power to implement this Article by appropriate legislation," which might be a national health insurance plan. It might be single payer comprehensive coverage. In other words, the American people must give the Congress of the United States, both Democrats and Republicans, Liberals and Conservatives, a specific instruction on closing a gap that we want closed as Americans.

Every politician says their goal is to provide good health care for every American. Most would be hard pressed to say that every American does not have a right to it. I say anyone who doesn't believe that health care is a human right for all should be given the opportunity to explain why some Americans should have it and others don't. So if providing health care for all Americans is truly our goal, we should be willing to codify it in the form of a new constitutional amendment.

Apparently, there's not a minimal chinbar, not to mention a high and equal gauge which Congress must continuously address with regard to health care. Only a constitutional amendment provides an eternal high (inaudible) for Congress to meet. Nothing in politics or the law is guaranteed, but a constitutional amendment is the best way to permanently codify the goal of high quality health care for all Americans. Having the right and entitlement is the only way every American is empowered to legally redress their health care grievances if the legislative and executive branches of government fail to provide such a system at any given moment in American history.

Therefore, today I urge everyone within the sound of my voice to contact their House member and get them to sign on as a cosponsor of HJ Res.29.

Two more observations, Mr. Chairman, and I'll yield back my time.

We've been organizing people around a potential program, universal coverage, national health insurance, and not a potential right. Trying to explain universal coverage and single payer programs on 47th and King Drive in the city of Chicago, just outside my Congressional district, has been nothing short of an amazing feat for me. I know it's right. I'm with the program. But when I ask people on 47th and King Drive, do they believe they have the right to health care, their answer overwhelmingly is yes.

I asked them, do they believe if they have the perceived right to a gun. Some of them say yes, some of them understand the Second Amendment as not granting such a fundamental right. But when asked forthrightly the fundamental question, they answer it affirmatively. They believe that it is their right and they're talking about a fundamental right.

Now, Mr. Chairman, 40 years of Democrats in Congress, no single payer, or NHI. Eight years of Clinton, 34 million Americans, no coverage. Eight years later, 45 million Americans, no coverage, no single payer, no NHI. A 100 days of George Bush, well you know, hasn't even mentioned the word health care. So why should 100 million Americans, who did not vote for Democrat or Republican, believe that either party is capable of advancing such a fundamental right? They have no faith that you're capable of closing the gap. Therefore, any program that ultimately passes, ultimately will be politically determined, but it ought to be politically determined in the context of such a fundamental right.

An African American expressed—the African American perspective, Mr. Chairman, is also instructive here. We must not only overcome the codification of health care, we must also overcome state centered federalist approach, just as the 13th Amendment overcame the state centered federalist approach on the question of slavery.

My community does not believe that health care block grants are going to help them either. Our problem is with the locals. Our problem is the 50 different systems in the 50 different states that never see the south side of Chicago, that never see Harlem, that never see the Barrios, that never see rural America, that never see the ghettos, that never see Appalachia. Our problem is the locals.

So just as—just as the 13th Amendment overcame a big local problem, slavery, we must overcome a big local and free market health care problem with such a fundamental right. And therefore, no matter who the next President of the United States is or isn't, Democrat of Republican, Liberal or Conservative, a poor mother, a working mother, a poor father, a working father, they should have, as a fundamental right, something that is not subject to the free market system, something that is not subject to an approach that denies them such a basic fundamental right, the constitutional right to health care.

And I will close on this. They say, Jesse, Jr., amending the Constitution of the United States is impossible. It's not true, it's been done 27 times. 27 times. One amendment took 202 years to pass. Another amendment took 10 months to pass. So passing constitutional amendments, our only function of how much fire is burning in the heart of every single American on that question at any given moment in American history. It's only a function of how much fire is burning.

So we're willing to take the case, that the parties have failed, that liberalism and conservatism has failed, that the states have failed, and that the free market has no interest in providing high quality coverage for every American, and that we need a fundamental right to secure it for every American. I'm more convinced than ever that we can close the gap and we'll earn the respect of those 100 million people who didn't vote,

because they'll be the beneficiaries of such a fundamental right. Thank you, Mr. Chairman.

REP. KUCINICH: Thank you, Jesse Jackson, Jr. Thank you for your dedication and your commitment. The Vice-Chair of the Progressive Caucus, Congresswoman Barbara Lee, will wrap up our presentation here of the second panel and then, with the permission of the members, we'll go right to the third panel and, if we have time left, we can have a discussion after that with some questions. So, Congresswoman Barbara Lee, our Vice-Chair.

REP. LEE: Thank you, Mr. Chairman, and let me once again just say how extremely proud I am today, especially today, to be Vice-Chair of our Progressive Caucus, also as a member of the Congressional Black Caucus and a member of the Universal Health Care Task Force.

What we've heard today from my colleagues and from the panel, I believe, really is setting the course for the future in terms of our children, families in America, and making sure that Congressman Jackson's constitutional amendment does pass. It is really embarrassing that in this, the richest nation in the world, that almost a fifth of all Americans, over 42 million, lack this basic human right, health care for all. And I am convinced that the profit motive and the fact that health care is a business is really morally wrong and is the major obstacle to universal health care. And so I want to thank Dr. Angell and Dr. Reich for stating that so eloquently and with clarity.

Today, I want to briefly talk about legislation that I will again introduce to provide health care to every American, regardless of income, employment, age, disability, race, gender, or any other factor, and that's HR-3000, the U.S. Universal Health Services Act. I also want to mention how racial disparities in health care affect minority populations, which Congresswoman Christensen has led the charge on in this Congress. She's done an unbelievable job with Dr. Satcher in terms of raising the level of awareness in the entire country with regard to the health disparities and I'm convinced, once again, that universal accessible health care is the only way we're gonna begin to close these racial disparities.

HR-3000, the U.S. Universal Health Services Act, establishes a United States Health Service, a health service, to provide high quality, comprehensive health care for all Americans, regardless of ability to pay, through a decentralized system, owned and controlled by the public. This Bill is a revised version of a Bill carried by Congressman Ron Dellums, my predecessor, who, for many years, beat the drum for universal and accessible health care for all.

This Bill reverses the trend of market driven, industry based medicine, which results in, of course, a growing percent of uninsured, routine denial

of necessary care by faceless bureaucracies, lack of accountability for quality and access. The Bill would implement elections for boards at the local, regional and national level to administer the health care system. Elected boards would represent health care users and workers, with no financial conflict of interest, which is very important in health care reform, and would plan, fund, distribute and (inaudible) health care services.

It would also make high quality acute and long term care available to all, regardless of demographics, employment status, or previous health status. It would allocate health services to all communities in proportion to their population, with additional funding and support for communities experiencing inequalities in health status and access to services and for special needs, such as epidemics. It would research—provide for research and report on and address health disparities.

HR-3000 would also encourage the active and informed participation of health care users in health care, free choice of provider, and full grievance and appeal mechanisms would further encourage quality. Services provided in my legislation would be funded through progressive taxation, including a combination of current public and private sources of funding.

Let me now just briefly touch on some facts about why universal health care is particularly important to people of color. The gaps between life expectancy for blacks, other minorities and whites has widened. Although infant mortality in African Americans has decreased somewhat, the disparity, actually, has increased. The same pattern is seen in Native Americans and Alaskan Natives.

The presence of heart disease is higher among African Americans than their white counterparts. In fact, black women are nearly two times more likely to hear heart disease, or to die from it, than white women. And despite significant advances in the detection and treatment of some cancers, communities of color continue to suffer disproportionately in terms of prevalence and death from this terrible disease.

African American men have the highest rates of prostrate cancer and are more likely than white men to die from it. The mortality rate for breast cancer, the most common form of cancer among women, is highest among African American females, with a similar picture for cervical cancer. And let me just mention a friend of mine, an African American male, has hypertension and, just last week, he tried to get medical insurance. He has a moderate level of hypertension so he needs medication and treatment. He's been trying to get medical insurance and has consistently, over the last six months, been denied health care coverage. What does he do? There's no way he can be treated for his hypertension unless he is wealth or has enormous sums of resources. He does not have that, so he's at the mercy of the whatever, the public health system that

there is, that he can avail himself of. So his hypertension, of course, is getting worse.

With regard to HIV and AIDS, African Americans comprise 12 percent of the U.S. population, but comprise 37 percent of those diagnosed with AIDS. In 1998, the rate of reported numbers of new AIDS cases—the reported number was eight times higher among African American men than white.

Finally, in terms of access to mental health services, the poor, of which African Americans and people of color are disproportionately concentrated, are more likely to be living with mental illness without treatment. People from the lowest socioeconomic class are 2.5 times more likely than those in the highest socioeconomic class to have mental illness, and African American families are more than three times more likely than whites to have incomes below the federal poverty level.

So it is really, for me and for most of us today, I think we can truly say that it is a crime, it is a crime, in this rich nation to have these kinds of disparities, to have babies born with AIDS and people dying of cancers that are treatable if caught early. Or seniors going without life saving protections—or life saving prescription drugs solely due to the cost of our medical services and the availability of our medical service today.

So health care, yes, it is a basic human right. And it should not be, it should not be a mega-billion dollar industry driven by the profit motive. And until, once again, we recognize, accept that, and understand that as a principal driving health care reform, we won't move forward. But, Mr. Chairman, I think today we've heard that. Over and over and over again and I'm very hopeful that the Progressive Caucus, the Congressional Hispanic Caucus and the Progressive Caucus and all of you here today will leave out of here with new energy and a new reason really for existence in terms of health care reform and I appreciate the opportunity to participate today and thank you, again, for everything and thank you all for everything that you've--.

REP. KUCINICH: Thank you very much, Congresswoman Barbara Lee of California. I want to thank all the members of Congress for participating in the panel, our second panel. We're gonna move immediately to the third panel. There are a number of individuals who have travel arrangements to catch and I want to make sure that we respect that.

Here's gonna be the order we'll start the panel with. I'm gonna ask the individuals to come up here. I'm gonna ask Dr. Lopez if he would come up, followed by Karyn Gill, followed by Dr. Henry Tomes (?). If—and for the panelists who are at the table right now, do not leave. You don't have to leave just yet, unless you have other commitments. Also if we could be joined on the dais here by Deborah Wilks and also Gloria Bates.

Okay, and we're going to—and if—and then we're going to ask the next individuals to come up here and join us on the upper dais. We're going to ask Ellen Schaffer, John and Christina Brehm. We have Dr. Mohammed, you're going to testify, you can just remain--. If we have another seat available, I'd like Ben Peck to join us up here. Sandy Ellis. And if we have—we have a seat available here for Linda McMann. You could sit next to Dr. Mohammed here. And if you're up here and you still don't have a seat, we'll find one for you as soon as we create some room for those who are testifying.

Okay. I want to thank all of you for your thoughtful attention and, again, I want to thank the members of Congress for their presence here. Again, for those of you who just joined us, the members of Congress who remain here, going into what is now—going into our third hour, we have Congresswoman Hilda Solis of California, Congresswoman Donna Christensen of the Virgin Islands, Congressman John Conyers of Michigan, our Vice-Chair, Congresswoman Barbara Lee of California, and Congressman Jesse Jackson of Illinois. We've also been joined by Congressman Bob Filner of the state of California. Again, would you join me in thanking these member of Congress for their participation.

And again, Mr. Secretary Reich, we want to thank you again for leading off what, I would agree, is going to be a very important new beginning in our efforts for universal health care. Please join me once again in thanking Secretary Reich.

We—and, if any of the people from the first panel have to go, we totally understand it, but we're going to move in and, hopefully, we'll have some opportunity to continue a dialogue after the third panel. I'd like to begin the third panel now and begin with testimony from Dr. Javier Lopez. As Mr.—as Congressman Davis took the privilege of introducing Dr. Quentin Young, I would like to ask for your thoughtful attention to this introduction of Dr. Javier Lopez.

Dr. Lopez has been in the practice of medicine for 37 years. He practices in the district I represent in the city of Cleveland. He is someone who is known for his singular dedication to his patients. And all doctors who are present here are singularly dedicated to their patients.

Dr. Lopez has brought a level of concern to his practice that I can speak to personally, because he administered, over those 37 years, to our—to my mother and father, as well as their seven children, my brothers and sisters. And with many people in our community, Dr. Lopez represented and represents universal health care because he takes care of people whether they have money or not. He does house calls in a country where that seems, I'm sure, an oddity to people. He tries to make the practice of medicine become a matter of, not just a science, but of a personal virtue.

For me to have the opportunity to have him testify at a panel which I'm Chairing, is one of the high points of my career and I want to thank him and to also indicate that, this past week, Dr. Lopez was honored and received special honors by the Cleveland Academy of Medicine for his efforts in saving a community hospital that was literally closed, that was basically ordered closed in a market manipulation. And Dr. Lopez worked with community leaders in helping to organize thousands of people to rescue St. Michael's Hospital in the City of Cleveland. He was honored by his own peers in the medical profession in Cleveland for his work as a doctor, as a community activist, and a humanitarian.

Dr. Lopez, it is my honor to introduce you and to welcome you to this important panel. Thank you.

DR. JAVIER LOPEZ: Thank you, Congressman Kucinich, and I--.

REP. KUCINICH: Let's get that mic up and, if it's not working, I'm gonna ask--.

DR. LOPEZ: Can you hear me now?

REP. KUCINICH: Yes.

DR. LOPEZ: Thank you, Congressman Kucinich, we couldn't have done--we could not have saved the hospital without your help. He is the one who organized the community, the politicians, and it was a difficult fight for three months, but the hospital is running very well.

As you say, my name is Javier Lopez. I am a physician in the private practice of medicine. I have practiced for over 37 years in the south side of Cleveland, Ohio, and deeply grateful for the opportunity to speak to you today on behalf of my patients and my profession.

Many of my colleagues and myself share serious concerns about the future of medicine and health care in our country. To quote the late Cardinal Joseph Bernard, (inaudible) January, 1995, "Our health care delivery system is rapidly commercializing itself and, in the process, is abandoning core value that should always be at the heart for health care delivery."

In the last four decades where we participate in astonishing advances in knowledge and medical technology, simultaneously, the facilitation of financial resources became excessive and uncontrolled. Despite warnings by many medical authorities, our profession remains passive, failing to monitor these trends. As a result of this, individuals and corporations with limited medical knowledge created MCOs and HMOs. Initially, they had the sincere hope of providing quality health care and control of spending.

The initial goals have never been achieved as solvencies became more and more elusive.

Health care in America in general is undergoing dramatic transitions, coupled with modern ethical dilemmas. If the numbers are to be believed, health costs have run two to three times their early inflation rate, pushing the U.S. expenditures to the highest levels in the world.

Health care costs have also resulted in an impressive and providence of courage. Americans without health insurance number over 40 million, and an equal number lack adequate insurance. Contrary to popular belief, two-thirds of the uninsured are workers and their dependents. And most disturbing of all, some 11 millions are children. At home, in Cuyahoga County, recently you show a decline in the uninsured between `98 to 2001. However, the figures are no less dramatic and shameful. Over 42,000 children and 123,000 adults lack health insurance in the county.

My practice is a micro-cross of our county, composed of the elderly, the working poor, African-Americans and Latinos, all of whom are frustrated by our lack of direction. Continuous changes in insurance coverage, almost on a yearly basis by the employers, as they too struggle to survive, have curtailed access to their long-time physicians and other health care providers.

The hospital where I completed my post graduate training and have since practiced out of, St. Michael's, which was formally closing St. Alexis, was built on the meager resources of the immigrant community; generations of doctors, nurses and other health care workers sharing the mission of the nuns who operated the hospital. Through them, we were educated and inspired to reach out and help the neediest persons in our society and to provide compassionate care to each individual entrusted to our care.

However, the landscape of health care delivery has become vastly different. Most of the health care that we physicians provide is mediated by contracting foes of (inaudible) by several multi-million insurance companies. These companies dictates to us the amount that can be reimbursed, what care will be allowed, where and by whom it will be performed, what drugs may be prescribed, and what bureaucratic procedures must be followed before any of this can occur.

This is not a culture of yesterday. Cut backs in public funding and aggressive cost containment have resulted in a smaller and a smaller operating margins and have reduced the cost subsidies by which care providers covered uncompensated care.

Today, hospitals are locked in intense competition for market share and survival. Oppression over regulations by the government and management

companies dictate how doctors should care for their patients. We have spent more time in the bureaucracy of health care than in its delivery.

We certainly have enough figures today to tell us what it costs to provide care to a patient. With how much we do know about the administrative costs of health care it seems to me that we have enough people managing health care, and there aren't enough people delivering.

By allowing profit-seeking corporations to shape the direction of health care without the values of social justice, equal access and individual attention and care, we have, and will continue to witness, a depersonalization of the most sacred of human services, and the destruction of our more fundamental freedom of choice. Thank you.

REP. KUCINICH: Thank you, Dr. Javier Lopez of St. Michael's Hospital in Cleveland, Ohio. Next we have Karyn Gill, who is with the Coalition for Quality Health Care. I want to welcome Karyn Gill and thank her for her work with the coalition.

REPRESENTATIVE BOB FILNER (D-CA): Can I just add a few words, Mr. Chairman?

CHAIRMAN KUCINICH: Excuse me, I'm a--I misspoke. I'm, Congressman Filner wants to--.

REPRESENTATIVE FILNER: Just briefly.

REP. KUCINICH: Be recognized and, as a member of the Progressive Caucus, it's tremendous to have you here, Congressman Filner.

REPRESENTATIVE FILNER: But I--thank you and thank you for leadership and for this symposium. I could tell you that the force of this issue is illustrated by the fact that San Diego, California, as illustrated by our next panelist, Karyn Gill, is in the forefront of demands for universal health care. And if San Diego has a grassroots movement, you know it's gonna sweep the country.

So, Karyn Gill is the President of the League of Women Voters of San Diego County. She is a member of the San Diego Coalition for Quality Health care, and she is involved in doing analyst--analysis and work that was mandated under California state law to look at universal health care and we--Karyn, we thank you for your grassroots efforts and your leadership in the community of San Diego.

REP. KUCINICH: Thank you very much, Congressman Filner, for that very important introduction, and again, I want to welcome the witness.

MS. KARYN GILL: Thank you. Can you hear me?

REP. KUCINICH: Yes.

MS. GILL: I'm Karyn Gill, President of the League of Women Voters of San Diego County and member of the San Diego Coalition for Quality Health Care, a local chapter of Health Care for All California.

I want to thank Congressman Bob Filner for his support of universal health care and for inviting me here today to tell you what grassroots organizations like mine are doing to address the critical lack of access to quality health care services for residents in San Diego County and in the State of California.

For the past 26 years I have worked on health care policy at the federal, state and local levels with the Health Care Financing Administration, Yale University, and the League of Women Voters. In 1997, the Board of Supervisors in San Diego County appointed me to a regional Health Care Advisory Counsel to examine ways that might be used to improve access to health care services for the county's 650,000 uninsured residents. That's one in four of our residents. One of the highest rates of uninsurance in the country.

The counsel, comprised of 22 local health care providers and consumers, found that our residents lacked health insurance for two reasons: Welfare Reform, which severed the connection between Welfare and Medicaid eligibility; and a high proportion of small business employers who do not offer health benefits to their employees.

The serious lack of health care coverage has had a very significant ripple effect throughout our community, not only for the uninsured, but even for those with good insurance. Examples of this ripple effect include the closure of three hospitals, the bankruptcy of a large managed care plan that's threatened the solvency of hundreds of San Diego physicians, and critically over crowded emergency rooms, which must, by law, provide access for potentially life-threatening conditions.

Local and state political leaders are currently cooperating on an incremental legislative reform strategy to fund a County Business Health Care Resource Center, designed to coordinate health care coverage for small business owners and their employees. Given California's current power deregulation crisis, I believe there is little hope that this innovative health care proposal will receive state support.

Consumer health care groups, such as the League of Women Voters and Health Care for All California, have worked since 1994 on statewide initiatives and legislative proposals to improve access to health care services for all state residents. Seven million California residents have no health insurance. With the support of over 300 consumer and provider

groups, state legislators, like Congresswomen Hilda Solis, passed, and Governor Gray Davis signed, in October of 1999, Senate Bill 480, which calls for a study of universal health care financing options in the state.

Just last month, the Federal Health Resources and Services Administration awarded California $1.2 million to partially fund this study. A request for proposal was released two weeks ago by the California Department of Health and Human Services to solicit white papers that would model various financing methods to achieve universal health care in our state. We firmly believe that this study, which will compare costs of the single payer plan, an incremental plan, and a market-based or voucher plan, will give our state legislators the important information they need to comprehensively address the health care crisis in California.

Based on my experience with these various local and state proposals to address the health care insurance crisis, I'd like to suggest three things. That you start by bringing together all sides of this issue to understand and commit to the importance of universal health care coverage as a policy goal. Without this initial consensus, I believe that any progress on the steps to achieve universal health care will be stymied.

Next, you need to define the term "universal health care." At our local level, this resulted in incremental steps based on current federal and state programs to achieve increased coverage of the uninsured. At the state level, this definition will be based on a mathematical study, comparing various options to pay for health care services for all state residents. You could use this later approach, a comprehensive study, perhaps conducted by the Institute of Medicine, to provide members of Congress with dependable, non-partisan data about the costs of various reform proposals, which they can use to construct a comprehensive national health care system.

Finally, I want to tell you that it's taken our Consumer Coalition seven years to get any political movement on an issue that voters in California have consistently ranked as either their number one, or their number two concern in numerous polls. The amount of money that health care providers, insurers and medical manufacturers have used to block true health care reform is just astounding.

If there is only one message that you remember from my remarks today, let it be this: If you want to see universal health care in this country, you must pass campaign finance reform legislation now. Thank you.

REP. KUCINICH: That's a great place to end and to begin, I suppose. Thank you, thank you very much, Karyn Gill, and we, again, appreciate your work with the Coalition for Quality Health Care. And I will say that, if there's any member of the panel having testified, needs to move on to complete their travel arrangements, I think all of us here will understand.

Our next presenter will be Dr. Henry Tomes (?). I hope I'm--am I pronouncing that correctly?

DR. HENRY TOMES: Tomes, yes.

REP. KUCINICH: Okay. Who is a psychologist and a Director of Public Policy for the American Psychological Association. We want to thank Dr. Tomes for his presence here today and we look forward to your testimony.

DR. TOMES: Thank you, Mr. Chairman. I'm Henry Tomes, Executive Director for Public Interest, the American Psychological Association. I thank you on the behalf of the Association for including us in this important briefing.

With 155,000 clinicians, researchers, educators, consultants and students engaged in the practice, research and teaching of psychology, we are dedicated to advancing psychology as a science, as a profession, and as a means of promoting human welfare.

We in the mental health community, and indeed, all Americans, have an especial debt of gratitude to Dr. David Satcher, the U.S. Surgeon General, for his landmark report "Mental Health: A Report of the Surgeon General," published in December, 1999. That was an enormous undertaking and one that helps tremendously in making the case to policy makers and citizens that mental health disorders are real, and just as treatable as medical disorders.

In our nation's health care system, about 20 percent of Americans experience a mental disorder each year. But nearly two-thirds of all people with a diagnosable mental disorder do not seek treatment. One--only one in seven individuals with a mental or addictive disorder actually receives treatment from trained mental health professionals. The situation is worse, in fact, much worse for communities of color. Untreated, serious, mental and emotional disorders of children and adults constitute one of America's major public health problems. The Surgeon General's Report cited research that mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes, slightly more than the burden associated with all forms of cancer.

It's estimated that the combined indirect and related costs of severe mental illness, including lost productivity, lost earnings and societal cost, such as increased criminal justice and family care giving, total $79 billion in 1990. The Surgeon General's Report goes on to state that, "Society can longer afford to view mental health as separate and unequal to general health."

Congress took the first step, a major step, last October in responding to the Surgeon General's Report when it passed the Children's Health Act 2000. Sections of that law create critically needed programs for persons with mental illness, including a mental health court demonstration to divert mentally ill persons from jails to community-based services. Youth suicide grants were included, along with the emergency mental health center grant and training grants to assist school personnel to recognize symptoms of childhood mental disorders.

There is much left to do, including research and training opportunities for minorities, and we expect to be working on another mental health Bill for introduction in this Congress, and we hope that you will be supportive of it.

APA is committed to efforts to eliminate health disparities among communities of color. Reduced access to quality, affordable and culturally competent health care services, delayed diagnosis of disorder disease, and socioeconomic status are critical factors that affect the health of racial and ethnic communities across the nation.

APA is also dedicated to working to provide coverage to the uninsured. It's easy to forget the uninsured if you're not one of them. The problem of devising legislation to extend coverage to the 44 million uninsured Americans can seem daunting and easy to put off to another day. But if not now, when?

We're in a time of low employment, economic prosperity; surely the Congress can muster the political will to tackle this issue.

There are a number of legislative proposals under consideration regarding the uninsured. I'd like to mention two. But first I'd like to express gratitude to Congressman Conyers and Congresswoman Christian Christensen and other members of the Caucus, the Congressional Hispanic Caucus and the Congressional Progressive--I'm sorry, the Congressional Progressive Caucus for their leadership and commitment on this issue, with a special thank you to their staff, Joel Seigel and Leonard Bates, for working with us on this.

We laud the Working American Families Access to Health Care Act of 2001, HR 1142, because it provides coverage for mental health and substance abuse treatment services without durational restrictions, as well as a number of other benefits that are critically important to the uninsured, such as assistive technology, diagnosis and treatment for sexually transmitted diseases, and reproductive health care services.

In addition, an enhanced match would be provided for Medicaid expenditures for the U.S. territories, and the legislation would require the Secretary of Health and Human Services to collect data on enrollment,

receipt of services and health outcomes, broken down by race and ethnicity of the Medicaid recipients, which is a critical component in the fight to eliminate racial and ethnic health disparities.

Another proposal is that of Families USA and the Health Insurance Association of American, strange bedfellows in deed. These ideologically polar organizations came together, along with six other consumer, provider and business groups, to propose expanding public programs like Medicaid and State Children's Health Insurance Program, as well as offering tax credits to businesses that pay a larger share of the premiums for low-wage workers than for other employees. This plan builds on the current employer-based system, where 9 of 10 privately insured Americans receive health coverage. It continues modest success in the public program covered--coverage, requiring states to provide Medicaid coverage for all individuals up to 133 percent of poverty, with an option to go even higher.

Psychologists are working this year to improve access to clinically necessary services through advocacy of a strong Patient Bill of Rights. Our top priority is inclusion of a strong section requiring Health Plan Legal Accountability. This was contained in the Norwood/Dingell Bill of 1999, and also in the Ganske/Dingell Bill, HR 526, this year. A strong Bill would not exclude mental injury, as did some alternatives, and would not cap non-economic damages, which would seriously disadvantage children and stay at home mothers, who typically have low economic damages.

On these issues, the psychologists of our nation, on the behalf of themselves and their patients, welcome your support. Thank you.

REP. KUCINICH: I want to thank Dr. Tomes for presenting the mental health perspective on this important issue. We're—next, we're going to have the perspective of a registered nurse. Deborah Wilks is a Registered Nurse at the Prince Georges County Hospital in Maryland. We want to thank her for enabling us to get a practical view of the urgency of this issue. Thank you.

MS. DEBORAH WILKS: Representative Kucinich, Representative--.

REP. KUCINICH: Would you--I'm gonna ask you if you'd--make sure that mic is close because, sometimes, it won't pick up the sound from--.

MS. WILKS: Is that better? Representative Kucinich, Representative Conyers and other members of the Progressive Caucus, thank you so much for the opportunity to participate in this health briefing on universal health care.

My name is Deborah Wilks and I am here on behalf of the 1.4 million members of the Service Employees International Union. SEIU is the largest health care union in the AFLCIO. We represent 710,000 health

care workers, including registered nurses, nursing home workers, home care workers and doctors. SEIU has long advocated for universal health care. We were very active during the health care reform debate in the early 1990's, and continue to advocate for comprehensive, affordable, quality health care for everyone.

Last year we worked with Senator Wellstone and Representatives Baldwin and Obey in developing the Health Security For All Americans Bill. Although much has been said today about the uninsured and the various approaches to providing universal health coverage, I'm here to speak on behalf of America's working families and those who devote their lives to providing quality health care to all of us.

I'm a registered nurse in a newborn intensive care unit in a not-for-profit hospital in the state of Maryland. I've worked in this unit for 25 years. Every day I see parents whose anxiety about the health of their newborn is made worse by concerns over how the bill will be paid. Some have health insurance, but not good comprehensive coverage. Some lost their insurance when they changed jobs, others simply worry that they might lose their insurance. I also see first hand what happens when people don't have insurance.

I care for the sickest, tiniest members of our society, who end up paying a lifelong price because their mothers were denied prenatal care. Recently I cared for a very sick pre-term infant. He had reached a point in his care where he could be discharged, but required a home monitor to alert anyone caring for him if he stopped breathing or if his heart rate dropped to an unsafe range. But Medicaid would--said they would not pay for it.

As a daycare worker on minimum wage, the mother certainly could not pay out-of-pocket for this monitor. We faced a dilemma; either send the baby home with no monitor and gamble that nothing would happen to this high-risk infant, or keep him in the hospital and face a good possibility that Medicaid would not pay for the extended care. Fortunately for this infant, we found another way to pay for the monitor. Will the next baby be so lucky?

Worrying about the baby's health and the mother's recovery is enough for one family to deal with. But the hospital I work in is filled with families that don't have the health security they need so they can stop worrying about who will pay the bill, and start rejoicing in the new addition to their family.

We support the Health Security for All Americans Bill as a principled and practical approach. It is just one approach. We believe that incremental changes such as vouchers, tax credits, CHIP or Medicaid expansions, while they may expand coverage for some of the uninsured, will not solve the

long-term problems American families face with escalating health costs and the lack of coverage, quality and security.

It is time again to put universal health coverage back on the national agenda. What SEIU and working families want is a health plan that guarantees comprehensive benefits, including preventative care and prescription drug coverage, that is, benefits at least as good as what members of Congress have, choice of plans and doctors, coverage that is secure no matter what and affordable, that employers pay their fair share, the elimination of waste and excessive profits, and high quality care and adequate staffing levels.

As a nurse, I feel compelled to raise the issue of the current staffing crisis in our nation's hospitals. Since the mid-90's, the cost cutting measures of hospitals have drastically reduced nursing staff, caused salaries to stagnate, and moved hospitals into using mandatory overtime as a system of staffing. This has resulted in hundreds of thousands of nurses leaving the profession, and in a dramatic reduction in nursing school admissions. But it's the patients who suffer the most when they do not get the care they deserve.

Even if we have universal coverage, there has to be adequate numbers of trained nurses in our health facilities who ensure that when you, your parents and children go to the hospital, they will get the best care possible. What we need are staffing standards that will--that will require, as a condition of Medicare, that hospitals develop staffing plans that take into consideration the volume, intensity and acuity of the patients.

As a nurse, I'm excited about the Health Security for All Americans Bill that would extend quality, affordable health coverage to all. It's a plan that would give good health care to all pregnant mothers. This will decrease the number of low birth weight babies born, give all the babies that I send home good follow up health care, regardless of the level of income of the family, and create a work environment where nurses can do what we were trained to do: provide quality care to those in need. Thank you.

REP. KUCINICH: Thank you very much, Deborah Wilks, of the Prince Georges County Hospital in Maryland.

MS. BATES: And that he would bless him indeed, and that the hand would be with him. And that he would keep him from evil and that he may not cause pain and the scripture says, "and God granted him his request."

Now, we've talked about the reality of having healthcare as a universal coverage but unless we allow God to expand our territory, and unless we pray for larger borders and ask God for a miracle, it's that simple. A miracle is an intervention by God to make something happen that wouldn't normally happen and nothing less (inaudible) had to transcend his name

and transform his circumstances.   So I believe in miracles and I believe that just like JayBezz (?) was honored in his prayer by God, I believe that if we together ask God to expand our territory to institute in--to strengthen our boarders, I think that universal healthcare can be a reality. And I think that God will keep us from evil and that we will not continue to be a nation that caused pain to anyone. Thank you.

REP. KUCINICH: Is there any--I want to make sure that we're not losing any of our witnesses here to due to time constraints. So if there's anyone who has travel arrangements that will cause you to need to testify immediately, make sure you make that known to myself or the staff and if anyone needs to move ahead with their schedule.   Doctor, I want to thank you.

Thanks--let's thank the witnesses who have participated so far. And to Gloria Bates of the North Alabama Sickle Cell Foundation. Ms. Bates, the last note that you sounded that talked about a miracle. We, in Congress understand that we're subject to a higher power as well, believe it or not. And when I was working with Dr. Lopez to save the community hospital in Cleveland, I actually have this badge here and we actually invoked St. Michael which in the Christian religion has a special place of being an arc angel and we asked him to defend us in battle to save our hospital. This is actually a button from the Community Grassroots Campaign, so I understand the spirit that animates your involvement.   Thank you very much.

Thank you very much. OK, we're now gonna hear from Ellen Schaffer, PhD, Director of Research and Policy for the San Mateo County Health Department's Health Works Project. Thank you very much for your presence here and I look forward to your testimony.

REP. LEE: Mr. Chairman, may I just--.

REP. KUCINICH: Of course.

REP. LEE: --Mention one thing about Ellen and that is Ellen Schaffer has really been the driving force behind the Bill which I discussed earlier HR 3000, which actually previously--previous to my coming to Congress, Congressman Dellums had carried. But, Ellen has stayed the course and she's never deterred her mission in life and that is to make sure that universal and accessible healthcare be established for all.

So I just want to welcome her here to Washington, D.C. And thank you for all of you work, not only in California, but your leadership on this issue nationwide. Welcome Ellen.

MS. ELLEN SCHAFFER: Thank you very much, Congresswoman Lee.

REP. KUCINICH: Thank you and if you'd draw near to that mic. Thank you.

MS. ELLEN SCHAFFER: Thank you very much. I'd like to thank you in turn for your exemplary leadership and many of the delegates from California. I was very pleased that Mr. Stark and Mr. Weiss were able to join us and also to note that, of course, I do this work with the support of the American Public Health Association and I'm also proud to note that we have so many co-members, Dr. Young and our Executive Director who are here today, who really feel that publicly accountable, publicly financed healthcare is a critical--a critical issue and the only way that we can move forward. I also appreciate acknowledgement that since I worked on the Hill, I've attained a high degree of further education and now that I have a PhD, I'd like to conduct a poll, a very scientifically constructed poll of the audience, the members, who--anyone who would like to participate. And I would like to ask you by a show of hands, or you can clap or speak out, who would like to continue our market driven, inequitable, unaffordable healthcare system in the form that it currently exists?

And, who would prefer a publicly financed, publicly administered, equitable system of high quality healthcare that's universally available to all residents?

Well now that we have settled that question, I've been asked to talk today based on my work in San Mateo County and my research on healthcare issues. To discuss what's at stake, if we don't take up the challenge to provide universal coverage and also to marshal our remarkable medical resources to provide coordinated, high quality care to everyone. And I think the answer is that America's workers are stake, our children are at stake, our very future as a society is at stake.

Our system denies insurance everyday to hardworking people who need it and deserve it. But it also fails to hold our healthcare system publicly accountable for coordinating high quality care to patients who depend upon it to save their lives.

Lack of insurance, lack of access and poor quality, these are "business as usual" in the healthcare system in the United States today. But to immigrant workers, to women with breast cancer, to parents of desperately ill babies, these are personal tragedies and the tragedies, as we've heard from others here today, are all too real.

I want to start off by talking about lack of insurance and what it means to workers in California and workers in San Mateo County. Representative Bill Thomas, whose another one who talked about this issue, he said it in 1999, the voluntary employment-based system of health insurance is fatally flawed. Professor Donald Light (?) notes that 43 percent of all businesses currently do not even offer health insurance and many that do

are providing Swiss cheese health insurance, full of holes, wherein reality there is no coverage.

The Health Works Project in San Mateo County in California sat down with a group of janitors, we wanted to--who only speak Spanish. We wanted to know how come so many unionized healthcare workers--I'm sorry, hotel and restaurant workers and janitors and service workers, who are supposed to have coverage in our very wealthy county. Most of these workers, by the way, are Latino, Filipino and Chinese. Why so many of them are, in fact, uninsured. And I want to tell you specifically and illustrate the answers that we got.

Out of these 12 workers that we polled together, everyone one of them had to work for a full year before they were eligible for health insurance for 12 full months. All of these people, in fact, had worked for longer than a year but none of them had succeeded in enrolling for insurance.   To get coverage they had to depend on their employer, who is often a small business contractor, subcontractor, to inform the employee that he or she was eligible, to correctly fill out the enrollment forms, and, this was the hard part, pay the insurance company every month. This had never occurred for any of these workers. Every one of them--

(tape change)

--Cancer. Breast cancer is a condition that cuts across the line of class and race. We know a lot about high quality treatment for breast cancer. And although women of color fair the worst in many respects, even wealth, insurance and education do not guarantee acceptable odds of receiving treatment that is based on the medical evidence and responsive to the patient's particular symptoms and personal preferences.

Rarely is care coordinated among the multiplicity of specialists and of--inevitably involved in treating breast cancer, including oncologists, surgeons, radiologists and numerous facilities nor is care coordinated across even the most rudimentary continuum of services. Accurate and timely diagnosis, lab tests properly evaluated and communicated, medications appropriately scheduled and delivered and a meaningful measure of psychosocial support.

This is business as usual in the U.S. healthcare system. But what it means to individual women with breast cancer is that everyday women who are stunned and confused by the news that they have a life-threatening disease are left on their own by a trillion dollar industry that ought to be helping.

OK, I want to give you one final example and it's a public--and it's about publicly--public accountability for delivering the highest quality of care to our high-risk newborns at the newborn ICUs that we heard about from

Deborah Wilks.

We know that regional systems of care can save babies' lives and in some parts of the country regional systems still target the highest technology to the sickest newborns, but we've allowed these systems to deteriorate. High-risk babies who could survive in the proper setting are dieing because we do not have a publicly accountable, dependable system of care of regionalized prenatal care that functions in every state.

National standards call for 90 percent, 90 percent of high-risk births to occur in high-level specialty centers but half of states don't even achieve 75 percent. That means that in many states, 40 and 50 percent of our high-risk babies are not getting to the care that's available and that we know that we need--that they need and that we know that works. We can assure that a high-risk baby in the suburbs or the inner cities of California or New Mexico have the same chance of getting high-risk care as a baby in Rhode Island or Louisiana.

This is business as usual in the U.S. healthcare system that every day parents with the highest hopes for their newborns, who believe that they are choosing the very best care for their precious newborn infant become grieving parents instead. They may not even know why but we do and we need to act.

A system built on markets cannot organize equitable, high quality universal care. A publicly accountable system is a necessity for bringing the interest of patients front and center the decisions about healthcare services.

A colleague of mine in the Public Health Association, Claudia Marici (?), provides some technical oversight to an NGO in Bangladesh. And she wrote to me recently, she said I'm often stumped when my Bangladeshi colleague question me about the corporatized, short thrift, medical care system in the U.S. It's nearly incomprehensible to folks in the developing world that nearly 45 million U.S. citizens are without guaranteed healthcare in a country that is wealthy beyond imagination.

Honorable members, we've heard here today that universal, high quality healthcare is attainable and is affordable. We know how to do it and we should do it. The issues of insurance coverage, access to services and quality of care are closely woven. It will take a renewed commitment to a publicly accountable system to provide the care that all of us need. Immigrant workers, women with breast cancer, distressed newborns, in fact, the friends, neighbors and families who give meaning to our society.

We know that it takes courage, vision and leadership to raise this difficult issue in the public arena and in the present political climate. And we know that the members of the Progressive Caucus and the Universal

Healthcare Task Force and the Hispanic Caucus, have that courage and have that vision. Again, I want to thank in particular, Representative Lee, who has been such a visionary leader from the State of California and I must also mention and thank her staff person, Daniel LaClare (?) and Allison Fredrick (?), who has helped to coordinate the hearing here today.

To Representative Lee, to Mr. Kucinich, to Ms. Christian Christensen, and to your colleagues, we thank you for showing us today what leadership means. We know that there are not enough of you and we know that it's our job to make sure that your numbers increase. So, thank you.

REP. KUCINICH: Thank you very much--.

MS. SCHAFFER: Mr. Conyers was hiding there and I certainly mean to acknowledge and thank you as well.

REP. KUCINICH: Thank you very much, Ellen Schaffer of the San Mateo County Health Department's Health Works Project. And it--I think it would be appropriate to point out that while we're--we have much work to do in gathering support in the Congress, the House goes into session at 6:00 tonight and yet you had 12 members of Congress show up here today and that, let me tell you, as someone who has been at many, many meetings and hearings, it is almost unprecedented to have this many members of Congress come on a matter that is not a regularly scheduled Committee meeting. This is really--when the cherry blossoms come out in Washington; we know that spring has arrived. When 12 members of Congress come out on a day that the House is in session late in the day, they're here early in the day, it means that our time for national health insurance is close at hand.

So we're gonna move to a practical discussion of the impact of lack of health insurance by hearing from two members of a family, which has had to face the realities of life without insurance coverage. We're going to hear from John Brehm and Jennifer Brehm, and I'd like, without further introduction, I'd like them to tell us their story. And, you know, whichever one of you wants to go first, it's up to you. John, do you want to start?

MR. JOHN BREHM: Age before beauty, I guess. Thank you, Congressman--.

REP. KUCINICH: And please, please come close to the mic so we can hear you.

MR. BREHM: Is that close enough?

REP. KUCINICH: Yeah, as long as we can all hear.

MR. BREHM: Thank you so much for this opportunity, it's a privilege, it's

humbling and it's an honor to be here among such angst people. I'm more sure than ever that we are beginning to see the end of healthcare as we've come to know it in this country. The end of corporate greed, the end of patients not having the confidence they'll get the healthcare they need, the end of dictatorial HMOs and the profiteering drug companies that we've learned to hate.

My name is John Brehm. I live in Silver Springs, Maryland. I am a Canadian citizen and a citizen of the United States. Both my wife and I are cancer survivors, she, breast cancer, and I, prostate. We have had "full coverage" health insurance since we've been together. We are survivors, yes. But we are survivors in spite of, not because of, our so-called full coverage health insurance.

Radiation kept my cancer in check for a while and then my PSA which is a prostate cancer indicator, began to rise. My urologist prescribed hormone therapy. At the pharmacy, claim denied. After many, many hours, we convinced our insurer that we were not interested in a sex change for me, we just wanted to keep me from dieing. We won that one.

And then my PSA started to rise again. Oncology this time prescribed high dosage Pediconozole (?), a proven therapy for recurrent prostate cancer. Denied. Again, after hours and hours spent talking to people far, far removed from me and my doctor, they approved the therapy. Three months after I was diagnosed, my wife was diagnosed with breast cancer. That's a whole other story.

Our medical bills mounted and mounted. Yes, we had that full coverage. But our insurer paid whatever percentage of whatever they decided the costs should be. The rest was up to us. We had laundry baskets, I mean, laundry baskets full of bills. They, in Atlanta, or wherever they were, told us not to worry, just to focus on our health but to be assertive and to fight and appeal the insurance company's decision. Both of us had cancer, we were fighting for our lives. The co-pays and the usual and customary and the not medically necessaries of the rapidly mounting medical bills absolutely terrified us. And so we resorted to credit cards. We were too sick and too scared to do anything else. Nearly $50,000 later, we went bankrupt.

I'm part of this effort because I am so angry, so scared and so disappointed with healthcare in this country that I vowed at one point, Joel, that I would chain myself to the Whitehouse fence until something sensible and humane is done to institute a single payer healthcare plan like or similar to the one I so appreciated in Canada.

For what it's worth, the offer still stands. But when I talk to people, and I do, about Canada and healthcare I hear "sounds like socialized medicine" or "oh, well, I know in Canada you don't get to choose your doctor." Or,

"I've heard that you have to wait forever to get vital procedures." Well, I am not sure where people are getting this information, I have a hunch but I don't care what you call it. When no one, no one from border to border, coat to coast, sea to sea has to worry about treatment for a hang nail or quadruple bypass surgery, no one has to make those endless phone calls to people who are paid by a company that cares only about its net profit, the bottom line. No one is denied a job, as was I, because they might be a liability to that corporate health plan. I don't care what you call it. I call it good.

So I'm glad to be in this fight and it is going to be a fight. I just hope to heaven that we all pull together, join to help the United States join forward-thinking nations of the world that provide one of the most basic of human rights, that of adequate and available healthcare for everyone. Thanks a lot.

It's now my distinguished pleasure to introduce my daughter, Jennifer.

MS. JENNIFER BREHM: Thank you. Is that close enough? Can you hear me? OK.

Thank you for this opportunity. I am Jennifer Brehm. I am an independent business owner, one voice among the 43 million uninsured Americans. I could not afford the premium and I had chosen to pay cash for my medical care until December of 2000. At that time I was diagnosed with Hepatitis C and I now have a preexisting condition. I would like the opportunity to treat my disease before it worsens.

My first visit to a gastroenterologist was disheartening. He would not prescribe the test to find out more about the disease because he thought they were too expensive for me. The doctor suggested that I begin a drug trial program.

I have been rejected for the ones that I have researched but I am hopeful to be accepted by NIH for one this summer. He also urged me not to read anything off the Internet about my disease and to ignore alternative methods. I feel discouraged by rejection. But I do not want to die of liver cancer or cirrhosis. I don't want to go through the cancer stuff my father's gone through, that's for sure.

I would like an opportunity to treat this disease before I need a liver transplant, that's much more costly than Interferon and Ribaverin. In the meantime, I am considering alternative methods, although I am afraid of treating myself for a chronic disease.

As a child in Canada, I never worried about medical care. If I still lived there, I would be receiving treatment now, even after the diagnosis. There is a better chance of cure with early treatment.

Healthcare is a right for all citizens. It should not be a choice for the wealthy or an opportunity for HMOs and the pharmaceutical industry to make money. A single payer plan similar to the one I enjoyed in Canada, will provide solutions for many Americans like myself. Thank you.

REP. KUCINICH: Dr. Mohammed, thank you for your efforts to try to save public health in the District of Columbia and we certainly appreciate your presence here.

DR. MOHAMMED: Thank you, Mr. Chairman. Can I be heard? I certainly feel honored to have the opportunity to participate in this much-needed hearing. But I cannot escape the sense of irony that the front page of "The Washington Post" today says D.C. General transferred from city to private firm, which, of course, flies in the face of all of the things that we're discussing here today.

I want to thank Mr. Conyers of--for his pending legislation the Working Americans Access to Healthcare. I think Mr. Conyers, you have me in a certain sense in a state of grace, grace being undeserved good and I can only accept such an honor as a part of the Citizens' Coalition to save D.C. General Hospital.

The thousands of men and women from the District of Columbia, who for reasons that we all know about, are deprived of the blessings of democracy, who made their will very clear in the matter of D.C. General Hospital that they wanted a full service, fully funded public hospital that was in the budget of the City and this will of the people was, in fact, voted unanimously by the 13 members of the City Council. And so this decision to privatize the public's hospital and turn it over into the hands of a privateer corporation from Arizona tramples democracy into the dirt.

And even though with all due respect to your little informal survey, where all of us unanimously agree that what we need is a single payer national health plan. The forces of privatization, the forces of corporate medicine don't give two cents for our unanimous consent for the principles that we are all about in terms of public health.

These forces operate in a way that disregards the welfare of the people and it challenges all of us to do something about that. I really appreciate it and find myself immediately inspired by the principles enunciated by Congressman Jesse Jackson, Jr., because he took the issue above the mundane, as important as those mundane issues might be, into the realm of high principle. I actually had written some notes. I was going to make a reference to President Abraham Lincoln as well that he enunciated a principle that said that the nation could not be half free and half slave--.

UNIDENTIFIED MAN: Right.

DR. MOHAMMED: --That the higher principle was freedom, so therefore, we had to fight for the freedom of everyone.

Well, we cannot have a nation that is half healthy and then the other half is sick. We can't have a nation that is partly insured and then the other part uninsured. It just doesn't work that way. If there are pockets of infectious diseases anywhere in our communities, then this represents a threat to the general welfare everywhere and money and power and position is not something that is respected by tuberculosis or AIDS or Hepatitis C viruses or any of these natural pathogens and so we must fight.

And I was consoling myself last night saying that sometimes you don't win every fight. But what's important is that you fight for what is right. But rethinking that this morning, I mean those principles are true, but there are some fights that are so important that they can--they must not be lost. They must be won. Because the very lives of all of us are at stake and at issue and the very principles that we hold dear as citizens of this country are literally at stake.

Representative Jackson also talked about the fire that must be in our hearts. Well, I think that there are many of us that have--in the words of the old Negro spirit, we have fire shut up in our bones on these issues and we are willing to go the full distance that is required. If we look at the civil rights struggle of a few decades back, it was very unlikely in those early days that we would see the wholesale changes in the society that overturns segregation, that overturned inequalities of all sorts in transportation, in housing, in employment opportunities, so on and so forth, it seemed, well, not impossible, that those institutions, those structures of inequality that seemed part and parcel of the American system could ever be overturned.

But now we're at another phase I believe of the same struggle. We're at another phase of the struggle that Lincoln led. We're at another phase of the struggle that was led by King. We're at a phase of the struggle where we are being asked the question, will we permit there to exist these extreme disparities in healthcare opportunity, healthcare access and healthcare outcomes? And just as ultimately we had to struggle for our higher--for the higher principle during the American Civil War and the higher principle in the Civil Rights struggle, so too today, must we struggle for that higher principle that all life is sacred and it is not something that money can buy. It is something that is the gift of God and it must be protected by the society at all costs. Because ultimately healthcare cannot be measured in terms of dollars and cents that are won or lost or profited by but healthcare is measured in terms of the basic nature of the society, in the basic security of the society that ultimately we cannot secure our country if we have a huge percentage of people outside the

healthcare system and existing in a state of ill health.

There's another dilemma in this control board decision. And I realize that perhaps some treading here on a mine field, a political mine field.

REP. KUCINICH: Go for it.

DR. MOHAMMED: Well, after all--.

UNIDENTIFIED SPEAKERS: (Cross talking).

DR. MOHAMMED: But a majority of the Congress voted some years ago to create the control board. And so now this raises a very, very difficult situation.

As I've already mentioned, the duly elected representatives of the people of the City of Washington, DC, voted unanimously. They have never been unanimous on any other issue in their history. But unanimously they voted in support of keeping the public hospital in our community. And so the Congress now, perhaps is facing the unintended consequences of the creation of the control board as an unelected, undemocratic power.

UNIDENTIFIED WOMAN: Exactly right.

DR. MOHAMMED: And so now the question must be asked:, will Congress recognize the duly elected representatives of the people of the Washington community or will they defer to the unelected, undemocratic financial control board? Because if you deny the legitimate right of the residence of the District of Columbia to be represented by those whom they elect to decide such weighty matters, then how can you yourselves, protect your own legitimacy as elected representatives of your constituents if this principle can be trampled underfoot in the District of Columbia, then it's not safe anywhere.

UNIDENTIFIED WOMAN: Right.

DR. MOHAMMED: And by extension, if public health cannot be maintained and protected in the nation's capital, then how can it be safe anywhere? There is no such thing as a bankrupt public hospital or when you have such a thing it's only due to under funding. And so there must be a full commitment to the funding of public health of--in this city that represents the entire nation. This is the principle that Representative Conyers understood instantly when I bumped into him a few weeks back in the halls of this building and I told him what was happening with D.C. General Hospital. He instantly understood that this not a local issue, this is a national issue. This is a symbolic issue that is important for every American and it even has international dimensions as well. How can we say to the entire world that we are a democratic society concerned with

the general welfare, when we see the general welfare being torn into tatters here in the nation's capital? And so, we must stand up for these principles.

What is the meaning of universal health coverage? What is the meaning of some kind of national insurance plan that has its own card if the very infrastructure of healthcare has been dismantled by the privateers?

So I would urge this Progressive Caucus and other members of Congress to look squarely at these issues of principle. The City Council approved an appropriation of $21 million to continue D.C. General Hospital until the control board expires at the end of September. But what they need is a congressional sponsor of their appropriation and it will require the political skill, all the political skill that can be mustered to shepard that appropriation through the proper channels here at Congress. I don't presume to tell you all how to do your work. But that is a very important fight that someone needs to take up. And in addition to that, it wouldn't hurt if Congress would just overrule the control board or abolish it three or four months earlier than they're expected to expire. That wouldn't hurt.

And so in conclusion, I wanted to express once again, you know, how deeply honored I feel personally to have this opportunity to speak not for myself, but for the thousands and thousands of members, of people from this community, members of the Citizens Coalition to Save D.C. General Hospital or the employees of that hospital who've showed their dedication.

I mean the story in "The Washington Post" recently that employees were calling in sick, using up their sick time. When we looked into that we had so many employees who had accumulated 800 to 1,000 hours of sick time. Well, what kind of employees accumulate 800 hours or 1,000 hours of sick time? These are very dedicated professionals who did not call in sick in the past even when they were sick but they showed up on the job in order to take care of their patients.

And so I would just like to say that we need to close the credibility gap, not only around the issues of healthcare, but as Representative Jackson indicated, there's a credibility gap in the framework and fabric of democracy itself that 100 million citizens of this Republic did not bother to get involved in the political process. We can help to close that gap by getting active on this issue. And if I could be so bold as to suggest, that the first step in closing that credibility gap is for Congress to do something about the travesty of the closing of D.C. General Hospital. Thank you.

REP. KUCINICH: Thank you very much for that very powerful presentation. Congressman Conyers and I were conferring here and afterwards we'd like to have a few moments with you to talk about a course of action that we might be able to consider--.

DR. MOHAMMED: Thank you.

REP. KUCINICH: --Which would respect the current moment. Thank you for your continuing attention here. We're moving along and for purposes of introduction of the next person to testify I want to recognize my colleague, Congresswoman Donna Christensen.

REP. CHRISTENSEN: Thank you and I just--before I introduce Dr. Richards, I want to say that the Health Brain Trust is also going to rise to the challenge that you've placed on us today.

It's a pleasure to introduce Dr. Richards. We have the pleasure of hosting the National Black Nurses' Association every February on the Hill when they bring their concerns to the members of Congress and policy makers in Washington. Dr. Richards retired in 1999 from the position of Chancellor of Indiana University Northwest after serving six years there. And she served previously as Provost at Indiana University--Indian University of Pennsylvania and as Dean of College of Health and Human Services at Ohio University in Athens. She, as I said, assumed the Presidency of the National Black Nurses' Association in August of 1999. Well I think to lead the nation's only African American Association for Professional Nurses. It's a pleasure to welcome you, again, Dr. Richards.

DR. RICHARDS: Thank you. I'm very pleased to be here. Can you hear me? I'm the last, so you could--should be happy. I have been asked--and thank you, Mr. Chairman and Dr. Christensen. I am pleased to be here to represent really 105,000 African American Nurses and 150,000 persons of color who work within the health profession.

The--I'm here to really, you know, I have been a nurse for 45 years. And prior to my being--becoming a nurse, I was in high school and I was the person who debated the Harry Truman's position on what was then called socialized medicine, universal healthcare. So this debate is an old debate. And it really--I hope we will be able to get to the fantasy and I'll talk about fantasy later, that we will really be able to have that for our people.

I'm here to talk about the fact that--oh, you're not gonna have anyone to implement all this. When we pass it and we will pass it, there's not gonna be anyone to implement it. There is an urgent, urgent need for us to look at the healthcare delivery system and the persons who are the providers. Yes, doctors are essential but nurses, professionally--I'm so--I want to say thank you Dr. Young because you see, I happen to live in Chicago and I listen to you every week. You're, right--yes, all right.

The--we are so in need right now of professionally trained, culturally competent, professional nurses to care for the persons you are talking about. In fact, you're basically talking about people who are not in this room. Most of you are the baby benners--baby boomers and you're very

fortunate right now. You have relatively good health, you are exercising daily, eating healthy diets, taking a vacation, playing golf or tennis or sailing. You have a reasonable healthcare plan even though it doesn't always do what it's suppose to do. And so that you have good access to healthcare and you have major coverage for extraordinary services. But within a few years, maybe 10 or so years, some of you will be retiring and you will only be joining all those other persons who you are trying to get care for.   At the--because as the workforce ages and as all of us join that retired group, we will see fewer nurses in the workforce. There are 2.7 million nurses right now, many of whom do not work in nursing and one-third of those currently in the workforce will retire within the next 10 years.

Imagine, therefore, if you have to look for care after that time, no matter how trivial your need is or you want some surgery and you are--you go to the hospital and they say we can't do it today because we do not have any beds and the reason we don't have any beds is we closed some services because there are not enough nurses to care for you.

So this is a vicious circle. Yes, we wanted to--somebody wanted to control the costs of healthcare, so they pushed it down and down. They are--they in relationship to what the--what money there was available and, of course, they hit those who were the most vulnerable which are the nurses who are really supposed to be there to care for you.

Now, right now, employers are requiring double time and evidently that's legal that you can require a nurse to work 16 hours versus 6 hours. But many employers are trying, of course, triple time, 24 hours. That there are some nurses' groups in this country who are working with legislators to try to get the national policy through that says they cannot force nurses to work triple time. Can you imagine?

We talk about the fact that we want people who are rested, who are there are at your bedside, who are available after you have your open heart surgery and your triple and quadruple bypass, who really can care for you and you get a professional nurse who is just finishing her 23rd hour of work.

Additionally, the fact that you even see a registered nurse might be questioned because many you'll see other persons who are the nursing extended persons but not necessarily the nurses.

Legislation--you know, many legislators are now out there saying that we should--that they should pass mandatory staffing ratios for registered nurses in acute care facilities.   This is not the solution. Rather public policy decisions must be based on data and no innuendoes or conclusions drawn from antidote records or news articles that profile the alarming incidence of death and error that occur within our healthcare delivery system.

I know I'm talking about nursing here but you know your doctors, your interns, are also working the 24 hours. So put us together, you know, shoulder to shoulder, working 24 hours in relationship to taking care of your mother or you with the open heart surgery. That--we're really in a very, very bad situation now, so we don't have to wait for you to retire.

There are a few solutions and some have been presented in relationship to trying to fix something. And I'm going to present just a few solutions, possible solutions. You may--since you want to fix something, since that's true for legislators, often--offer legislation to expand the funding levels for nursing education targeted to an increase the number of RNs and more specifically, the number of ethnic nurse--minority nurses prepared at the baccalaureate level. If the Congress is serious about eliminating healthcare disparity, then the Congress can legislate funding for the education and training of more healthcare professionals. And we really need this.

Now by the way, because of the work situations, one out of every four nurses plan to leave nursing within the next three years. So we are really--and they are talking about the work situation as well as the economic situation for them because there are other things that they can do and be respected as human beings at better income and maybe--so that they're there but we need to think about it.

If Congress wants to fix something, then expand funds for the faculty development and recruitment. The average black nursing receive--receiving a doctorate today is 55 years old. The people doctorately prepared are the ones that do the teaching. By the way, the average age of a nurse out there is 30--I'm sorry is 42.5. The average age of a black nurse is 45 years old. This is an aging profession. The average age of all faculty, by the way, is 53. According to the HRSA National Sample Survey of Registered Nurses, one-third of the current workforce will be retiring in the next 10 to 14 years.

We need to train more nurses and more nurse sciences as faculty, researchers and in health policy. We need to have more faculty members training the students in the classroom and at the clinical sites. If you want to fix something then provide the funding to determine the factors that contribute to errors and the creation of a safe delivery system, the available research data on nursing, staffing and patient care outcome is insufficient to determine the minimal nurse ratios required for good care.

If you want to fix something then expand the funding to establish contrary of nursing surgeries, who can address the ratio and ethnic healthcare disparities that disproportionately affect African Americans, and we know all about them, we've been hearing about them.

I hope that none of us have--here ever finds ourselves in need of health services all--only to find that no hospital bed is available due to inadequate staffing and unlicensed personnel are taking care of you--of us. Or no nurses are around for the critical time because of our caseload.

I want to speak a little bit about the--about maybe the kinds of things that Dr. Mohammed is speaking about. But this is happening across our country in relationship to care in inner city areas and in rural communities where facilities are closing left and right or being privatized, going to people who are really proprietary people and this is a major concern. People say to me well, what about the nurses? They're getting dislocated and it's true, maybe they will lose their seniority. But because of this quasi-forced shortage and because of greater demand, we can find employment. I'm 65 years old and a man offered me a job day before yesterday, I couldn't believe it, I said no, no more full-time employment.

All right. The--we can find employment and we can find respectable employment. But who is going to take care of our people? That's the issue. Who's going to take care of our people? I have major concerns. I have lived long enough to see progress and lack of progress. I want to be with you when we really do implement the fantasy that I have. And I'm going to give you a definition of a fantasy.

When a whole group of people believe in a fantasy, it's called a culture. When a few people believe in a fantasy, it's called a cult. When two people believe in a fantasy, it's called love and when one person believes in a fantasy, it's called psychosis.

Now being an old psych nurse I can appreciate it and I had--I feel like I've been in every level and I hope I am with you as we create a true culture in this country where all people are valued and all people have available healthcare. Thank you.

REP. KUCINICH: Doctor, we members of the Progressive Culture love you.

We're going to move to our next person, who's a registered nurse from St. Vincent Hospital, Sandy Ellis. So thank you for being here Sandy and we look forward to your remarks.

MS. SANDY ELLIS: Thank you, thank you so much. Thank you Representative Kucinich, Representative Conyers. It's indeed an honor to be here today and to be in the presence of these esteemed panelists.

My name is Sandy Ellis. I have been a nurse for 15 years primarily in the area of psychiatry. I have worked at St. Vincent Hospital, now the Worcester Medical Center in Worcester, Massachusetts, for nearly eight years. I'm also a member of the Massachusetts Nurses' Association.

I come before you not as financial expert who can describe the impact on the healthcare marketplace and not as an academic who can cite research studies, but as a front line nurse who has experienced the negative impact on patient care caused by the last decade of flawed healthcare reform initiative. This includes the devastation reaped by the widespread adoption of managed care and the overall inhumanity that had been the result of the hospital industry's rush to embrace a corporate model of healthcare delivery.

I come before you as a nurse who has watched her respected non-profit hospital be turned upside down and inside out by a for-profit conglomerate, Tenant Healthcare. I am here representing more than 500 of my colleagues at St. Vincent Hospital, who last year endured a heroic 49-day strike over our desire to negotiate a union contract that would improve the deplorable and dangerous staffing conditions at our facility and to prevent the unsafe practice of mandatory overtime. And by the way, my state is one of those states working with Congress right now to prohibit the use of mandatory overtime in this country.

We won our battle against mandatory overtime through that strike but for our nurses and for front line nurses across the country, the war for our patients and the integrity of our nursing practice rages on.

I'm here to tell you that nurses have seen what all the changes in healthcare have accomplished over the last decade and none of it, nothing about our current healthcare system is good. In fact, for nurses, and more importantly for our patients, the healthcare system has become patently dangerous.

In the early 1990s, we watched as managed care took hold, forcing hospitals to compete for access to patients by slashing their nursing budget. At our hospital we saw consultants brought in who immediately cut our nursing staff and replaced them with unlicensed aids with a high school education and just a few weeks of training. The result was chaos, poor patient care and the demoralization of the nursing workforce.

As corporate pressures continue to escalate in our community and throughout our state, we saw massive consolidation of the healthcare industry as hospitals merged, closed and in our case, purchased by for-profit providers hungry to gain a foothold in the Massachusetts' marketplace. Enter Tenant Healthcare which purchased our facility in 1997. The purchase of our facility by a for-profit provider has had a devastating impact on our nurses, patient care and the community. St. Vincent's Hospital is gone. Tenant has destroyed the institution that was once renowned for its close ties to the community and its service to the people of Worcester, Massachusetts, from cradle to grave.

Our community hospital was once focused on providing excellent patient care. It is now known as a money saving and making machine, whose only focus is on return investment for stockholders and generates great fear among those who must access its services.

My focusing on Tenant today should not be construed as an attack on this corporation. It should be viewed as a warning of what is to become of our healthcare system if the current trends continue. Tenant Corporation is simply the prototype of the healthcare provider of the future if we continue on the current path of healthcare corporatization. It is important to note that I have been speaking to my colleagues in the non-profit hospital sector in our state, one of whom is with me today, and they echo my--the sentiments I have presented.

Nurses want the public and our policy makers to know what we know. The system is in crisis and it is a crisis by design. People are dieing everyday. People are suffering everyday because of how our healthcare system is organized and financed.

For nurses, particularly nurses who belong to the Massachusetts's Nurses' Association, the solution does not lie in half measures and any incremental tinkering with the system. The nurses of the Massachusetts Nurses' Association support and endorse a single payer healthcare system with guaranteed access to care for all, real accountability for the delivery of quality healthcare and a system that views healthcare as a basic human right. Thank you.

REP. KUCINICH: OK, Linda McMann is the person who's gonna conclude the work of the third panel and she is an RN at Brockton hospital. I want to thank Ms. McMann--.

MS. LINDA MCMANN: Thank you for having me here.

REP. KUCINICH: --For being here and thank you for your testimony.

MS. MCMANN: Thank you. My name is Linda McMann, I'm a registered nurse and I have been one for 19 years. I work at the Brockton Hospital in Brockton, Massachusetts, and I specialize in emergency medicine.

Unlike Sandy, our facility remains a non-profit community hospital. But like Sandy, I can attest to the fact that our hospital has experienced many, if not all of the changes her facility has undergone. Our classification may be not-for-profit, but the way our CEO behaves, the way we function is very much in the corporate mode. In fact, if there's one thing I can tell you for certain about the last 10 years is that the bottom line has always come before the patient.

While Sandy and her colleagues endured a 49-day strike last year over

staffing and mandatory overtime issues, as I sit here today, myself and 450 of my colleagues are preparing to go out on strike over the very same issues.

Two weeks ago, our nurses voted to authorize a strike if something isn't done to address our concerns about the safety of our patients and our working conditions. Since January, more than 80 nurses at our facility have been forced to work mandatory overtime, forced to work double shifts with no notice, no matter how fatigued they have been at the time. Over the past four years, we have watched our staffing levels drop, our patient assignments and patient acuity level climb and the care our patients received deteriorate.

You'll hear much these days about preventable medication errors in hospitals which reportably kills almost 100,000 a year but little is said of the impact that poor staffing conditions have on this problem. I can tell you that last year I almost gave the wrong dose of the medication to a patient while working exhausted on a mandatory overtime shift. It was the low point of my career. And although nothing bad happened that night, I became painfully aware of the stakes of the game the healthcare industry was playing with me and my patients against our will.

I too have watched my hospital fight for survival in this free market healthcare system. I've watched hospitals close in our community and heard my CEO brag of his efforts to take patients away from the hospital down the street, boasting his desire to destroy the competition. This came after he wooed the community's largest physician practice away from that hospital, thereby stealing all the patients. The result: our nurses are bombarded with too many patients, our patients wait hours for care in the emergency department while a hospital down the road lies empty, struggling for survival.

Our CEO is considered a hero by our Board of Trustees because we are making money. The nurses are literally killing themselves to prevent the worse from occurring and our patients suffer poor care and wait longer for access to care. I have watched patients leave our hospital way to soon to be discharged into a system that fails to provide adequate homecare or long-term care. As an emergency room nurse, I see those patients come right back through our doors and into our hospital. Understand, they are back in our hospital simply because we are failing to provide the most basic level of patient care. And I'll tell you something else, it is costing the system millions of dollars. My CEO makes money, my hospital makes money, but the system, the taxpayers, we are losing money and losing big.

This is not healthcare. This is a crime. It's a crime committed everyday by those who endorse a system that knowingly places patients' lives in jeopardy and refuse to do anything about it. As nurses we have seen too

much and watch too much suffering. Like canaries in the mineshaft, we are the firsthand witness of the degradation of our system and we were among the first to cry foul.

The nurses at our hospital are preparing to put everything we own on the line to do something about it. Do we want to go out on strike? Absolutely not but we will. Somebody somewhere has to make a stand and say no to compromising policies that are killing those we are charged with protecting.

I am delighted to represent the nurses in my hospital and the nurses of America at today's briefing. I encourage you who have a progressive agenda to work with the nurses of America to make the changes that are necessary to solve this crisis we find ourselves in. As a member of the Massachusetts Nurses' Association, I support a move to a single payer healthcare system. I support a federal ban on the practice of mandatory overtime. I support caring for our nurses. I support healthcare for all as a right of every American. Thank you.

REP. KUCINICH: Thank you and good luck in your--.

MS. MCMANN: Thank you.

REP. KUCINICH: --Efforts. Thank you. I--we actually have one more person who I had--who is a substitute for Ben Peck. Frank Clamentay is the Director of Public Citizen's Congress Watch and after Mr. Clamentay is--has concluded, we have just a few more remarks and we will bring this healthcare briefing to a conclusion, so I want to thank you for being here. Mr. Clamentay?

REP. CONYERS: Mr. Chairman, could I merely interject that Frank Clamentay worked with me on my first National Universal Healthcare Bill with single payer. He did more work than probably anybody--any staffer in the Congress and I--we've never forgotten it. It's still a good base and even though he's gone on, we know he's still with us because he's here.

REP. KUCINICH: Thank you very much, Congressman Conyers.

MR. FRANK CLAMENTAY: Thank you, Congressman. We--that was the hay-day of our single payer movement. We got--Ellen was over on the Senate side and I was with the Congressman and we had close to a 100 co-sponsors in `93 and `94. And if Bill Clinton had done what we all thought he should of done and adopted the single payer model, I don't think he would have had--Congress would have gone Republican in `95 and we might be looking at universal healthcare coverage for all Americans right now. Unfortunately, he didn't take your advice.

Our public system is a national consumer organization, 150,000 members

and in various ways, we've worked on the healthcare issue for the last 30 years. So much of what we've heard today are people talking about the enormous failures of our system which is largely based on the private insurance model. And it's ironic because that is exactly what is being proposed now for "reforms to the Medicare system."

Folks have asked me to talk a little bit about what's called the Breaux-Frist proposal over in the Senate. I was in Germany a couple years ago and they had this frozen food called Breaux-Frist) and I keep thinking of Breaux-Frist Breaux-Frist. You ought to freeze that Breaux-Frist model in time because it's a terrible model. Basically they want to bring--they want to dismantle what is our only single payer system right now, the Medicare program and they want to make it a private insurance program. They want to let--give seniors subsidies, money, and let--put them out on the open market and let them make their educated choices and choose between this private insurance plan over here or this HMO plan over there or choose the traditional Medicare Program.

Now everybody loves the traditional Medicare Program, fewer than 10 percent of people who are on Medicare right now have gone into HMOs, that's because they love the traditional Medicare program because they can choose their own doctor. And they want to privatize the Medicare Program to force people to go to the lower cost plan, which is going to be the HMOs, which is where your coverage gets denied, which is where you don't see your doctor. And let us not forget that HMOs are already corrupting the Medicare Program now. They've dropped 1.6 million seniors from their programs over the last three years and yet respected Senators want us to adopt this program whole hog.

I don't think seniors are ready to give up their universal coverage which is what they would do under the Breaux-Frist proposal because the benefits would range--vary from one plan to the next depending on what that plan would cost. I don't think seniors are ready to give up their very efficient and effective containing cost Medicare Program. Let's face it, the private sector is doing worse and they're not ready to give up their choice of doctors.

The biggest failure of Medicare right now is the failure to provide a drug--comprehensive drug program and that can be easily fixed. We've got the money. If you didn't give it to the top 1 percent in the Bush tax cut, you've got the money to give that drug benefit to all the seniors and all the physically challenged people who are in the Medicare program right now.

There's two Breaux-Frist programs. I think it's important for folks to think about because, look it, if we can't hold on to what we've got, if we can't hold on to the Medicare program as it exists now, that's a giant step backwards. Forget comprehensive universal coverage in the future, our

fight right now is holding on just to what we have.

They want to--it's two models. One is what's called Breaux-Frist One. The model there is the Federal Health Employees Benefits Program which you members of Congress enjoy. The problem with that is you're a different group of folks because it's not just you members of Congress but it's all the staff and it's all the people who work throughout this federal government. It's a much healthier population, much less sick, much less costly. And they want to convert the Medicare Program to that option where the senior gets their money and try to choose. The problem is most seniors who are sicker, who are more costly, are going to be adversely selected into what is called the traditional Medicare Program where you've got doctor choice. But guess what? Price of the premiums in that program are going to be 25, 35, 45 percent higher than they are going to be if you join the HMO where you are denied coverage and you don't have the same quality care.

So we are looking at a collapse, a potential collapse of the social insurance model under Breaux-Frist One and that's a prescription for disaster, as I know all of us know here.

It may be worth moving somewhat in that direction if it saved money at least by some people's rationale, certainly not by mine but at least by some people's rationale who advocate that model. It might--you could see where there's some intelligence about it. But the fact is that since 1970, the Medicare Program has done a much better job at cutting costs of healthcare than the private insurance market. And it has done that while it has insured a much riskier population, a population that consumes much greater amounts of healthcare because it's older and sicker and that is for the 30 years and it's also for the most recent years. And why is it more efficient? Well we all know it's because administrative costs are so much lower, 2 percent in the Medicare Program. And yet they want us to have seniors all opting for private insurance, HMOs where we're gonna be wasting 15 or more percent of our healthcare dollar on administrative costs. I just--the logic escapes me. And the HMOs, the only way they save money is by denying care and by selecting the healthiest population groups. Therefore, their exposure is minimized. This is--there's no free lunch here, there are no magic efficiencies from private plans.

Under Breaux-Frist Two, the focus of that proposal is largely the drug--prescription drug benefit. You basically want seniors to be able to get drug coverage through privatization. Give you money in order to buy drug coverage, much like the Bill that was passed last Congress. Ten Democrats supported it, all the Republicans supported it, maybe three Republicans opposed it. But it was a Bill that the House Leadership put forward that was the drug company--the drug industry it was their Bill, the Bill they wanted which would of provided drug coverage through private insurance. The fact of the matter was the private insurance industry didn't

even want that program. And why didn't they want that program? Because they can't make a buck from it. They know the people who are going buy that insurance are the folks who are gonna have the highest drug costs. And what's that mean? It means the premiums for those plans are going to be through the roof.

(Cut in audio)

35--$1 out of three bucks is not going to deliver a drug benefit to people. And the biggest crime about doing this proposal is that you're completely segmenting the market which is what the drug companies want. The drug companies don't want drugs being purchased as a Part D Medicare drug benefit where a logic would be the Medicare program would negotiate the prices with drug--with the drug companies. Just like the insurance companies, they get to negotiate for drug prices, and the HMOs they get to negotiate for drug prices. But they don't want the Medicare Program on behalf of 40 million seniors and disabled negotiating drug prices. And that's what they're trying to avoid.

So the solution, let's keep our social insurance. Let's add drug coverage and let's make it affordable through Medicare negotiated drug prices, just like Medicare does currently for hospitals and it does for physician care.

This--we've got to keep what we've got, we can't let it get rolled back and Breaux-Frist, that is the danger of it and I'm floored members of Congress here on the House side start a campaign, opposed privatization of Medicare, it is in all of our interests.

REP. CONYERS: Thank you, Frank.

Frank Clamentay started off with me on this, but there were two people that were guiding us, you may remember, from the Boston Area, David Himmelstein and Steffie Woolhandler, and one of them is here today and she's been waiting so patiently. Her latest book is here that we will be going through with great care. But they guided us when we were first putting together our house version with Congressman McDermott and we're delighted that you're here now and we'd like to receive your remarks. Let's welcome Dr. Steffie Woolhandler.

DR. STEFFIE WOOLHANDLER: Thanks. I'll probably keep this brief because of the late hour. I--the thing that I think is important to remember is healthcare is an incredible bridge issue. For many of us, we're used to being involved in issues like housing or education where the issues of poor people are very much separated from more affluent Americans. But on healthcare the dissatisfaction is extremely widespread, ranging from very low income people to very high income people, very middle class people like the Brehm family, who were bankrupted by illness. And in fact, nearly half a million Americans every year are bankrupted by

illness and people who go bankrupt are not generally the poorest of the poor, those tend to be middle class people across section of America when you look at their level of education, their race and other demographic features. So even very middle class people who get a serious illness find that they're having a lot of trouble with the healthcare system.

This is a bridge issue. It's also a bridge issue because of the position of healthcare workers and healthcare professionals. I tend to work with organizing doctors, not exactly a low-income group. Nonetheless, we believe that a majority of U.S. physicians support national health insurance and at least in some states and in some parts of the medical profession a majority of the medical profession supports single payer.

For instance, in academic medicine among medical students, residents, medical school faculty, medical school Deans, a survey did find that 56 percent of all academic physicians support single payer. Similarly, our group physicians for a national health program now has over 9,000 physician members, that's about 1-1/2 percent of the medical profession in the United States. We've done some work in the State of Massachusetts around universal healthcare where we were able to recruit about 10 percent of the physicians in that state to sign on to a statement supporting universal healthcare. We're about to repeat an effort to sign on physicians in the United States to the idea of universal healthcare and we believe at this point that it's realistic to expect 50,000/100,000 signatures nationwide. This is tremendous physician support, tremendous middle class support for this issue and it makes it a very opportune time to move forward toward universal healthcare. Thanks.

REP. CONYERS: Thank you so much for being with us.

REP. LEE: Thank you very much.

Now, I'd like to ask Anita Estell to come forward and make her presentation. Anita is representing the Sickle Cell Disease Association of America. We all know her here on the Hill for her very effective work on behalf of education in healthcare, all those issues which are important and impact people throughout our country. Welcome, Anita, and thank you very much for being here.

MS. ANITA ESTELL: Thank you, Congresswoman. I appreciate the introduction. I've been asked--I'm Anita Estell and I'm the Washington Representative for the Sickle Cell Disease Association of America. Because of a family emergency, I've been asked to deliver remarks today on behalf of Linda Anderson, the President and COO of CDAA and Rose Peterson our Chair of the Program Department. Because of time and because of the courage and just passionate remarks of Gloria Bates earlier today, there's a lot in our testimony that I will not repeat. I have to applaud our member organization, Ms. Bates from Alabama for her

testimony.

I'm here really for the national organization. We represent over 90 member organizations, including several in the State of Alabama, cutting across 32 states in the nation and some of the territories. We are here really, Mr. Conyers and Congresswoman Lee and other members of the panel, to thank you for your leadership in this effort. We've worked with Joel Segal and other staff and we appreciate what you're trying to do for universal healthcare. And we want you to know that all of our organizations across the country will be supporting you in this effort.

Congresswoman Lee, you'll be pleased to know that within two days, just a couple of weeks ago, our California State organization which represents about 10 percent of the persons who have sickle cell disease in this country, gathered 4,000 signatures to bring--in two days, to bring greater attention to health disparities with a focus on sickle cell anemia.

What I'd like to do is share our detailed testimony, if I may, with your staff for the publication and the record. And if I may, because of just the profound and moving testimony of Gloria Bates, just highlight quickly four points that the organ--the national organization has put together.

The first would be development of a medical home concept that would provide designated primary care physicians for sickle cell disease patients. The other would be to provide expanded access to care and services. Right now, even though many children are covered by CHIP up to the age of 21, they receive basic services, there's a need for referrals or specialty services and what have you. There are also limitations on hospital stays. Again, referrals to specialists and other services that sickle cell disease patients may need.

And a third area where we need to look at is dental coverage. Many sickle cell disease patients also suffer from infections and gum diseases and particularly children, oftentimes a lot of the SCD children have (inaudible) and a lot of dentists, based on our--the input from our members advisors have indicated that dentists don't want to deal with children who are retarded or have certain types of disabilities and oftentimes they're referred outside of their healthcare plans. And also the other psychosocial issues related to mental health issues need to be addressed.

A third area has to do with cultural diversity. We're very much alarmed about the over representation of African Americans who are falling through the cracks of the system in terms of being uninsured. In the State of Alabama, for instance, only 80 percent of those people with SCD, based on our estimations, have access to health insurance and only--they're on Medicaid mostly, only 1 percent on a private plan. So we've got about 20 percent of SCD patients in the State of Alabama who are suffering on a regular and chronic basis with a very painful disease who have no access

to health insurance and I'm sure there are other patients who suffer from other ailments who are suffering also.

And the fourth and significant area that the association would like to bring to the Committee's attention is the need to train providers who are allied health professionals, who are cult--who come from the community and who have been trained in the area of sickle cell disease. Many times primary health physicians are not familiar with how to treat SCD patients and oftentimes these patients have to be referred elsewhere and we do believe that there's a need to train more people of color in the medical and allied health professions.

On behalf of the national organization, I would say thank you to all of the members of the panel, the physicians, the nurses, the allied health and public health providers who are on the front lines every day taking care of so many patients, including those who have sickle cell disease.

As I've sat and listened as a Washington representative, I was reminded of Claude McKay, when he said then--in his poem, when he said, "if we must die, let it not be like hogs hunted (inaudible) and in a glorious spot. If we must die, you know, while wild and hungry dogs make a mock of our cursed lives, if we must die, oh, let us nobly die." And I think we're all in consensus here that if we must die, let us die with some form of dignity and access to healthcare and we want you to know from the national office of the Sickle Cell Disease Association of America that we will work with you in any way to fight for access to care for all. Thank you very much.

REP. CONYERS: Thank you very much.

We're going to let Dr. Quentin Young, who brought us together this morning many hours ago, to make a few closing remarks.

DR. QUENTIN YOUNG: Well, as you guys say, I will yield my time. We have with us two leaders of American Medical Students and American Medical Women, I'd rather let them have the closing words. At least--.

REP. CONYERS: Fine.

DR. SINDHU SRINIVAS: Good afternoon, my name is Dr. Sindhu Srinivas and I'm President of the American Medical Student Association and I wanted to thank you, Representative Conyers and Representative Lee, for bringing us together here today.

I've heard a lot of moving testimony and I don't want to repeat what some said. But I do think that the one interesting kind of vantage point that I bring to the table here is that I represent over 30,000 physicians in training in this country. And one of the things that people have asked is, "well organized medicine has been opposed to socialized medicine for a

long time. Why are medical students and why is your organization, the American Medical Student Association, in particular, so dedicated for advocating for a single payer national healthcare program in this country?" And our Association has been around for over 50 years. And for over 30 years, we've been dedicated and have advocated for a single payer universal healthcare system in this country.

And what I would just like to say is that we kind of show our commitment by being here with you today we wanted to again reaffirm and state again, that we're willing to work with you in anyway to make sure that this country does see a universal healthcare system in the near future because we as medical students are tired of working in a system of for-profits and not for patients.

I just graduated from medical school myself last year and I'm tired of about hearing about how doctors are frustrated about how, you know, you should get out of medicine right now because it's not the way it used to be and that's true. It isn't the way it used to be but that doesn't mean that we all need to face the horrible reality that we see today.

What we need to realize is that the future of medicine and the future of the practice of medicine is in all of our hands here and in the hands of our country and we can do with it whatever we want to do with it. And that is the sort of slogan or the kind of powerful phrase that we keep in the back of our minds within the association where we don't want to be stripped of our idealism as we go through medical school. We keep that to heart and we keep to heart that we have the power to help shape the system. And we look forward to working with all the other stalwarts of the universal healthcare movement here as well as the Progressive Caucus, the Congressional Black Caucus and we thank you again for allowing us to speak here today. Thank you.

REP. CONYERS: Very good, thank you so much.

DR. ELEANOR CHRISTENSEN: I'm Dr. Eleanor Christensen, a physician from Denver, Colorado and a member of the Physicians for a National Health Plan. I'm also President-Elect of the American Medical Women's Association. And my passion is working toward universal access to healthcare.

I'm a possibility thinker. And I'm also an optimist and an idealist, but I'm a pragmatist as well and I know from my own personal experiences that universal healthcare is possible and affordable.

I started out doing private practice as a family physician after my training in the 50s and then had 20 years of experience as a college health physician and it was a private university where we had a mandatory health fee and a mandatory insurance plan, which we designed to cover all the

needs of our students.

In this setting, the last nine years of the 20 years, I was the Medical Director and we were able to provide quality care at a very reasonable cost to everyone that was enrolled in that University. So I know it's doable and the students selected the health service for the outstanding service award by the student government. I think that's the ultimate compliment that you can derive quality care.

The students served on an advisory board with me and having your constituents, your patients in an advisory capacity, deciding how funds will be allocated and used does assure quality care.

My experience after my first retirement later in my career was in underserved rural communities West of Denver, where only 10 percent of our patients were eligible for Medicaid or Medicare, 20 percent had some sort of health insurance, 70 percent were uninsured. It was a nightmare. We were so frustrated daily trying to arrange consultations, diagnostic procedures, hospitalization, nobody would take them, we couldn't even get appointments for them, even the University Hospital said if they had no insurance there'd be at least 11 weeks delay before they could possibly work them in. These are working people, consciences, responsible, they won't go to the emergency room when they can't afford to pay the ER bill. They don't want to bankrupt themselves.

On a more personal level closer to home, I have a daughter-in-law whose 40-year old brother has--is being forced into bankruptcy and selling his home, losing his home I should say, because of medical bills. He was between jobs and uninsured. This is so unfair. We should not tolerate the system any longer. We should work diligently and with great veal towards establishing a universal health plan and a single payer plan. Thank you.

REP. CONYERS: I just wanted to say that this is the best healthcare hearing that's ever been held in the United States' House of Representatives and you should all be proud of yourselves.

REP. KUCINICH: Thank you, Congressman Conyers, Congresswoman Barbara Lee, for your patience and your willingness to join with us for four and a half hours, now of 25 witnesses, coming from all across the United States. Particularly want to thank Quentin, Dr. Young, for your efforts in helping to put this together and to Dr. Angell is it? Dr. Angell for her brilliant statement and to all of you for the participation that you have brought to this day and to those in the audience who have stayed with us for the entire time. This does have a feel of something that is of the moment and momentous. There's so much work to do. We recognize the challenge and we're here to state that we believe that healthcare is a fundamental right in a democratic society, in any society that's worthy of

the name democracy has to sense that we are at a pivotal moment where if we move forward with our dream, with our vision, that we can change the social and economic structure of this country with a single movement for national health insurance. Congresswoman Lee?

REP. LEE: Yes, if the Congresswoman could finish, let me just first thank you very much for your vision and for your leadership and really providing the forum today for all of us to come together and I think you've seen a magnificent coalition of conscientious today.

And I wanted to mention a couple of things. You saw today here representatives from the Congressional Hispanic Caucus, the Congressional Black Caucus, the Congressional Progressive Caucus. In total, that's over 120 members of Congress, that's over a third of the United States Congress. That's--you know that means something, that means something.

Congressman Conyers and I were talking about the power of today as it relates to our grassroots organizing. And let me just say today that once we leave here, recognizing the fact that it is the power of the people that's really gonna change this around. I think it's upon us to take everything that we've heard today and really develop our grassroots organizing in a way that we have not seen heretofore. This is what will ensure that all of the issues which we discussed in terms of healthcare being a basic human right and the fact that universal expectable healthcare should be provided for all, that's how it's gonna become real. So that's our duty and our responsibility. And we've got to go out of here now and organize around this country and make sure that within this Congress these Bills get a hearing, will be presented to the rest of the country as options and hopefully, one of these Bills gets to the President's desk because I think that's what it's about. And thank you very much Congressman Kucinich for your--.

REP. KUCINICH: Thank you, thank you Congresswoman Barbara Lee, your point is well taken.

We really need to hold town hall meetings all across this country on this issue and wake the town, tell the people, we already know that people are ready to support it. There is an underlying unity across this country on this and many other issues. But we need to go back to the idea of government of the people, by the people and for the people. That's how this whole idea started for this particular forum.

I again want to thank the staff of--my staff and each and every other member's staff for their tremendous work in pulling this together. Thanks again to all of you. And thanks to the Kaiser Foundation for its willingness to tape these proceedings for a Web broadcast and for providing us with links to it where millions of Americans will have the opportunity to see the

proceedings. We're gonna--some of us will remain around here for a few minutes afterwards. At this point we're going to call this a day and call it a new beginning. Thank you very much.

END

© 2001 - Federal Network, Inc.

www.FedNet.net

202-393-7300