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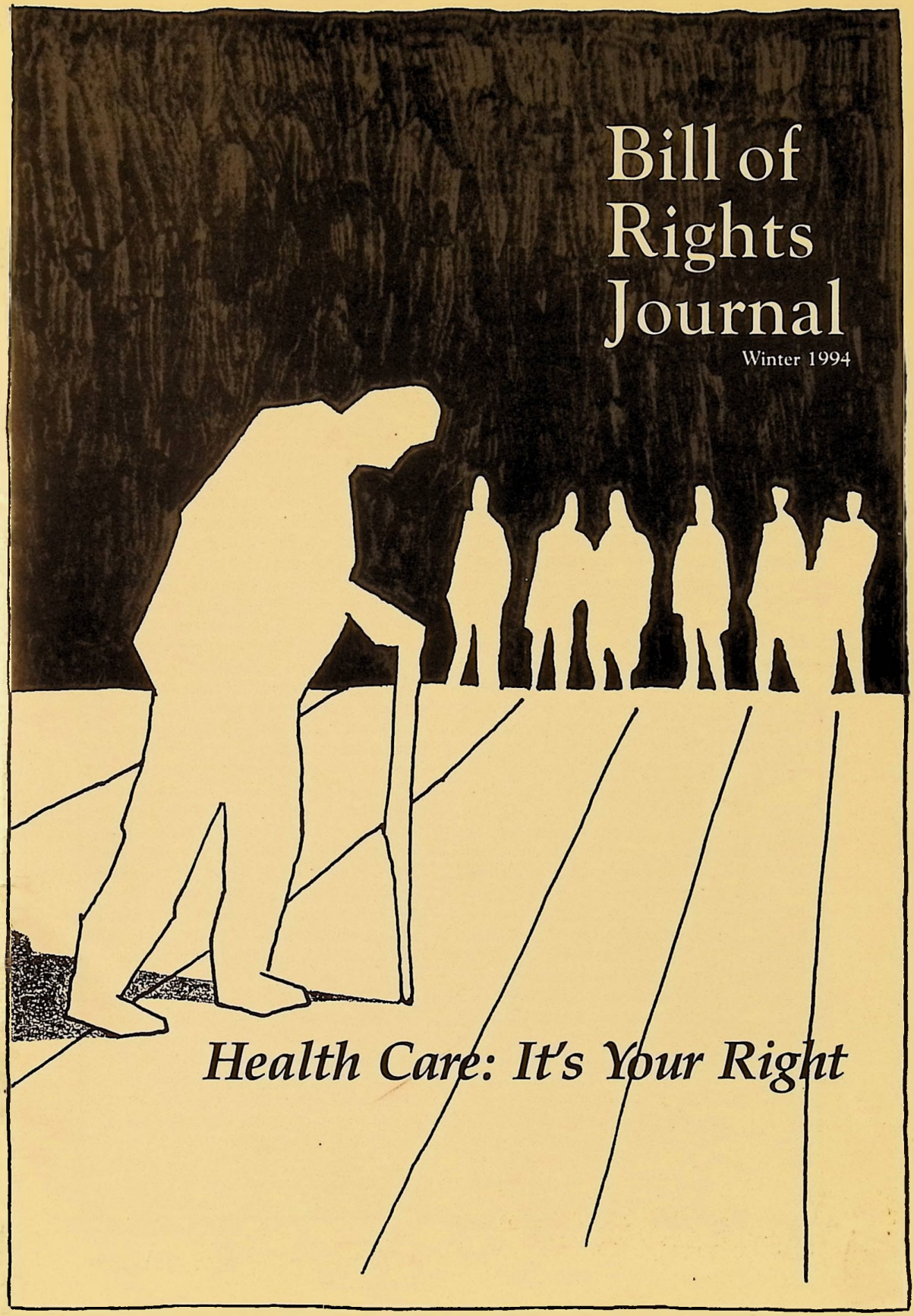

Health Care: It's Your Right

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PETER WEISS

The Right to Good Health

There has always been a tension between treating health as a right and treating it as a consumer product, available, like beer or dill pickles, according to what you find on the shelves and what you can afford to pay. To speak passionately of the need for universal health care, as Bill and Hillary once did, is not necessarily to recognize a right to health, anymore than Huey Long's call for a chicken in every pot implied the existence of a right to chickens. Yet there is evidence that just as Moliere's Bourgeois Gentilhomme spoke in prose without realizing what he was doing, people throughout the world believe there is a right to health, even though they might deny it.

Medical costs can ruin many a family. People die or get worse because thay cannot, or their insurance companies will not, pay for the right kind of treatment. Still, the notion of the state as health care provider of last resort is now a solid fixture of our political landscape.

There is an oft cited paradox that the poor are better off, in terms of health care, than the uninsured or underinsured middle class. That means that while our society remains farther than any other developed country from providing decent health care for all, it has accepted the principle that some form of health care must be provided for all. But the state's obligation to provide a service is merely the reverse side of the coin of the individual's entitlement. Hence, at least in embryonic form, the right to health already exists in the United States. It is certainly more so than the right to housing, given the number of homeless in our towns and cities.

It is also true, however, that we are far behind many other countries in dressing the right to health in constitutional or legislative garb. One of the penalties we pay for being the first country to have enacted a Bill of Rights is that we are stuck with a document woefully, nay totally, deficient in what much of the world, in the second half of this century, has come to know as economic and social rights. Yet one could argue that the Magna Carta of such rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted by the United Nations in 1966, and ratified, so far, by 124 countries, not including the United States, can trace its ancestry to the New Deal.

In 1943, The National Resources Planning Board proposed a "New Bill of Rights" which included the right to work, to fair pay, to education, to rest and to "adequate food, clothing, shelter and medical care." While Congress refused to enact the proposal into law – what else is new? – it became the basis for FDR's Economic Bill of Rights in his 1944 State of the Union message. "In our days," said FDR, "these economic truths have become self-evident. We have accepted so to speak a second Bill of Rights under which a new basis of security and prosperity can be established for all – regardless of station, rank or creed." Number 6 in FDR's Economic Bill of Rights was "the right to adequate medical care and the opportunity to achieve and enjoy good health."

It is no coincidence that perhaps the principal architect of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, was Eleanor Roosevelt. Article 25 of the Universal Declaration reads in part: "Everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food, clothing, housing and medical care." ICESCR then goes Article 25 of UDHR one better by stating, in Article 12, "the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

In fact, it was not ICESCR which raised the formulation of the right to health from "adequate" to "highest attainable." It was the Constitution of the World Health Organization (WHO), adopted in 1946, with the vote of the United States, which states, in its Preamble, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or so-

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cial conditions." Similar formulations are found in other international treaties and conventions, including the recent Convention on the Rights of the Child.

Do these high flown phrases have any relevance to the problems of a cancer patient or the parent of a premature baby, or are they merely the empty words product of cynical diplomats and naive academics. It's the former. Words, as Tom Stoppard once said, "deserve respect. If you get the right ones in the right order, you can nudge the world a little". Words about rights become tools for social justice by repetition, by exegesis, by creative use in the courts. Most of all, they can be used by people engaging in political action to lead their representatives into deceiving themselves that they are leading the people.

Some practical suggestions along these lines:

*Educate lawyers and judges, most of whom are illiterate on the subject, about the existence of international human rights. It will come as a surprise to them that "fundamental human rights" are considered by the international law community to be binding on all states as a matter of customary law, regardless of their adherence to particular covenants.

*Disabuse people of the notion that the First Amendment, for instance, is a "real" right, but the right to health is only an "inspirational" right, because health care costs money and free speech doesn't. Remind them that the preambles of both of the major Covenants say that there can be no political and civil rights without economic and social rights and vice versa. Use the mass of literature produced by advocates of the single payer plan to show that money is not the problem.

*Get the right to health written into state and federal legislation and into state constitutions, which are easier to amend than the federal one. Use the referendum process where available.

*It took the United States 26 years to ratify the International Covenant on Civil and Political Rights. Keep asking the State Department how long it will take to ratify the International Covenant on Economic, Social and Cultural Rights.

*Make sure that, when the Human Rights Committee of the United Nations holds hearings on US compliance with ICCPR in New York next spring, it gets plenty of testimony on economic and social conditions in this country, including health care. Such testimony falls within the Committee's guidelines, even for countries which have only ratified ICCPR.

*Make a million signs saying "Health is a Human Right." Parade them in front of the White House, Congress, your State houses and AMA headquarters.

*Support the Wofford bill to deprive members of Congress of their federal health insurance until they have enacted a universal health care bill.

Just about everyone knows that the right to health is an idea whose time has come. All we have to do now is get it across to those few whom it has escaped so far: Our gridlock Congress, our hidebound medical establishment, our greedy insurance companies and those whom, in the old days, we used to call the scions of privilege.ß

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A President's Plan

The following was a special message on the health care crisis, with specific proposals to rectify the situation, sent to Congress by the President of the United States. See if you can guess which President made these remarks. The sad truth is revealed at the end of the speech.

There were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen. One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of sickness."

Millions of our citizens do not have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our nation. These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives.

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation –especially during the last four years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future--unless Government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new economic bill of rights should mean health security for all, regardless of residence, station, or race -- everywhere in the United States. We should resolve now that the health of this nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the nation.

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

1. The first has to do with the number, and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel -- doctors, dentists, public health and hospital administrators, nurses and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason – closely allied with the first – is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States. The deficiencies are especially severe in rural and semi-rural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public health services and maternal and child care. The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and inoculation for the prevention of communicable diseases are accepted public health functions. So too are many kinds of personal services, such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

Research -- well directed and continuously supported -- can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability and premature death --diseases of the heart, kidneys and arteries, rheumatism, cancer, diseases of childbirth, infancy and childhood, respiratory diseases and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. We need more coordinated research on the cause, prevention and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses. A great many of those who suffer frim mental illnesses would be helped by proper care. We need more mental-disease hospitals, more outpatient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also, we must have many more trained and qualified doctors in this field.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

Individual families may be hit with sickness that creates expenses that exceed their annual

income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day there are about 7,000,000 persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about 3,250,000 are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for six months; many of them will continue to be disabled for years, and some for the remainder of their lives.

Every year four or five hundred million working days are lost from productive employment, because of illness and accident among those working or looking for work. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment and is therefore not covered by workmen's compensation laws.

These then are the five important problems which must be solved, if we hope to attain our objective of adequate medical care, good health, and protection from the economic fears of sickness and disability.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the nation, consisting of five major parts -- each of which contributes to all the others.

1. Construction of Hospitals and Related Facilities -- The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services -- for both prevention and cure--can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have.

In carrying out this program, there should be a clear division of responsibilities between the States and the Federal Government. The States, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation, and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving State plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases -- mental as well as physical -- and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

2. Expansion of Public Health, Maternal and Child Health Services -- Our programs for public health and related services should be enlarged and strengthened. The present Federal-State cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services and services for crippled children.

No area in the nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population, and must make adequate provision for the safe birth of every baby, and for the health protection of infants and children.

The Federal Government should cooperate by more generous grants to the States than are provided under present law for public health services and for maternal and child health care.

The program should continue to be partly financed by the States themselves, and should be administered by the States. Federal grants should be in proportion to State and local expenditures, and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education. should be recognized as a definite public responsibility.

In the conquest of many diseases, prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and widespread health and physical education and examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

3. Third: Medical Education and Research – The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to non-profit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and non-profit private agencies.

4. Prepayment of Medical Costs – Everyone should have ready access to all necessary medical, hospital and related services. I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people – sick and well -- were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all, and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care--as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund, instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Medical services are personal. Therefore the nationwide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain any pay for medical services outside of the health insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, though they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance sys-

tem -- full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county and State general hospitals in the same way must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine." I repeat -- what I am recommending is not socialized medicine. Socialized medicine means that all doctors work as employes of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now -- on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employes, Government employes and employes of non-profit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the States in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render.

5. Protection Against Loss of Wages From Sickness and Disability -- No matter what we do, sickness will of course come to many. Sickness brings with it loss of wages. Therefore, the workers of the nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long-term disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

I strongly urge that the Congress give careful consideration to this program of health legislation now. By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

-- Harry S. Truman
Nov. 19, 1945

DR. DAVID U. HIMMELSTEIN & EDITH TIGER

The Doctor's Prescription

Dr. David U. Himmelstein is the co-author of The National Health Program Book *and co-founder of Physicians for a National Health Program. He recently spoke with NECLC Director Edith Tiger about health reform. This issue went to press before the November election. Depending on the outcome, one might have to read the first few paragraphs in the past subjunctive.*

If the California proposition passes, what will that mean for the rest of the country?

It would mean an enormous step. First, it would create a good healthcare system in California. That would be a beneficial virus that would spread across the country very rapidly, as people would see a working single-payer system. In some ways, that's analogous to the way the system was implemented in Canada. There, Saskatchewan implemented a single-payer system. It worked so well that a conservative Supreme Court justice, who was the chair of the special commission impaneled to recommend a healthcare system in Canada, said what to do is to copy Saskatchewan.

Do you think it will come down to states doing this instead of the federal government?

I hope not. The states can start it, but I don't think they can finish it alone. If we leave it to each state one at a time to do it, many states will be without a good healthcare system for years to come.

How do we make the populace understand that everyone deserves healthcare, even though it means more taxes?

The biggest problem is that our media dominate most of the national discussion, and the media are largely owned and operated by powerful groups who don't want significant reforms in healthcare. That's been the major block to an effective national debate, the fact that the most powerful and well-monied interests in our society don't want there to be a useful reform.

So how do we overcome it?

Well, there is powerful community organizing going on as witnessed by the one million signatures they got in California in the space of six weeks. I am always surprised when I travel around this country that there is real knowledge about the single payer system.

Polls show clear support for a single payer system with the understanding that while it may require higher taxes, it means lower total costs for most people, because it would cut costs for premiums. It would in fact cut other taxes. For instance, a significant portion of our school taxes are spent for teachers' health insurance benefits. We pay taxes to cover police and fire departments' health insurance benefits, some 15 percent of the total costs of those department personnel.

There is a great deal of sentiment toward reform in the population, but that sentiment is kept from coalescing by a lack of leadership and a domination of our public life by monied interests. That's a profound problem in our society not just for the health care system.

How does the majority take over the reins from the monied people?

We take the reins by organizing where we live and work to say that money will not win out on this issue. Our politicians must answer to the majority of the people not to the small minority who wish to block a useful reform.

I think the opposition is better organized. We need to overcome that by improving our organization, in church groups, in professional organizations, in civic organizations. We must say to politicians, "We insist that we be heard, or you will not be re-elected." Ultimately, that's the only power we have, but it's great power.

I became ill when I was in Canada. I asked, "Where do we go?" I was sent to a supermarket, and within the confines of the supermarket was a clinic. I walked in. I told the doctor what was bothering me. No questions asked, they helped me. These clinics were all over. Why do people get the impression that the Canadian system doesn't work?

Because our insurance companies have spent tens of millions of dollars misrepresenting the Canadian healthcare system. That's because our insurance industry has $300 billion a year in revenues from our healthcare system that would be imperiled by a Canadian style reform. That flow of revenues gives

them enormous power to use the public media to hire huge staffs of people to misrepresent the situation in Canada.

The insurance companies are gathering into cartels and putting on a facade that they are really going to be healthcare providers. What is the impact of that?

It's disastrous that we are moving with great speed to giving utter control of our healthcare system over to a small, as you say cartel, whose only interest is their own profitability, and for whom health and healthcare are essentially irrelevant.

I think that means that any activity that is not profitable will be excluded from the healthcare system; that patients will be abused in exchange for financial gain; that those working in the healthcare system will be abused in exchange for financial gain, and that that will quickly become the norm. Then we will hear debate in Washington about how we will regulate the abuse, not how to structure a system that doesn't have abuse as its norm.

How do you account for these groups that say, "Give me your Medicare, and I will provide for your medical care for $10 a visit?

Through sophisticated marketing they attract the healthy, for whom they can provide care at very low cost, because they need little care. Under the Medicare system, those who signed up with the HMO's have been exactly the patients who would have cost very little to care for outside of the HMO's, and the HMO's participation has actually increased the cost of care not decreased it. There's very little trick to spending little money if you take care of healthy patients. That's what those HMO's have principally done.

How do we show the people of this country that they have to be concerned about the children, elderly, the poor, the people who can't help themselves?

First, we need to recognize that we only serve those groups well if they are in the same system with those who are empowered in the system already, that a separate system must be unequal. We have good evidence of that from the Medicaid program. Putting the poor and many children into that separate system has insured them inadequate care. In Canada, Mr. Eaton, the owner of Eaton's Department Stores in Canada, has the same coverage as the poorest person in the society, and that coverage is good coverage.

The extraordinary fact is that for medical care in the United States we now spend so much that were we to spend it rationally, we could provide everybody with top quality care. We have such irrationality in our system to a large extent because of the corporate dominance and profits and the irrationalities they have introduced. Just eliminating those allows us to upgrade the care for the middle class, the poor, the elderly without downgrading the care of anyone. We have the extraordinary opportunity to create winners without losers, and there are very few parts in our society where that is true.

Is it only the insurance companies? Isn't it also the medical profession?

It is not only the insurance companies, though they are the most important factor. The medical profession has a very undistinguished 70-year history of opposing national health insurance, but now it sees increasingly that it only has two alternatives. One is to answer to the public through a national health insurance program. The other is to answer to private corporations who will employ doctors, and at whose whim doctors will be governed if the system is not a public one.

There are some diehard opponents of national health insurance, but at least a third, and perhaps as many as a half of all doctors now would support a Canadian-style system. The president of the California Medical Association has announced that his organization cannot play a major role in the referendum campaign there because a third of the membership in his organization actively supports the single payer ballot initiative.

Still, there are other powerful forces that oppose progressive reform -- increasingly the hospital industry, which to a large extent now is a corporate-dominated industry. Medical equipment suppliers and drug firms are dead set against it because it would challenge their profits and marketing strategy, and to some extent some of the largest firms in our country are worried that if the health insurance companies' business can be taken away, their business might also be taken away some day.

The jeopardy of free enterprise.

For that reason, there are many within the corporate world who are concerned about national health insurance, though polls show that about 20-30 percent of the Fortune 500 leadership are now prepared to support national health insurance because their healthcare costs have become such a problem for them. They would prefer to have "socialized" medicine.ß

REP. JIM MCDERMOTT

Single-Payer Makes Cents

It is no exaggeration to say that we have been witnessing in recent weeks the meltdown of health care reform. When we started the reform process almost two years ago, we shared a vision -- of a health care system financed by everyone and covering everyone. We had a vision of a health care system that was fair, and ended the cost-shifting that business and the insured no longer can sustain. We envisioned providing our people with health care coverage so secure that they could devote themselves without distraction to their families and their jobs. We envisioned a health care system that would grow at a predictable rate so that the rest of our economy could flourish.

Well, I must tell you that none of the proposals now viewed as the framework for some kind of nominal health care reform will deliver even one element of that vision. In fact, they won't even bring us close. This is a pretty sorry state of affairs. I know it, you know it, and the public knows it.

I am not interested in fingerpointing or accusations. I want to talk about the fundamentals of health care and why our system is failing. Universality, affordability, security, and choice, these are our goals, because they are the hallmarks of a successful health care system. Chief among them is universality. Without it, we will never have a successful system. Why? What is so crucial about this simple concept? Universal health care coverage illustrates the underlying principle of *all* group insurance -- and one with which I am sure you all are familiar: the larger the pool of participants, the more widely risk is spread and thus, the lower the cost of coverage.

In health care, universal coverage means that we no longer have uninsured patients going to the emergency room for treatment, receiving care in its most expensive setting, and the cost of that care no longer is shifted onto the premium costs of insured patients. Without universal coverage there is no way to keep healthy people in the insurance system. If the only people in the system are those who need immediate care, there is no way to spread the risk and, thus, the cost of that care. So premium prices increase, fewer people can afford them, and more people lose coverage, shrinking the pool even further.

Only universal coverage makes insurance affordable. Without it, we will never be able to control cost-shifting -- the means by which the insured patient pays for the debt of the uninsured patient. And unless we stop cost shifting, cost containment throughout the entire system is a pipe dream.

Without universal coverage, someone is uninsured. And providing care to uninsured patients is terribly expensive because they are simply too sick by the time they seek care. The uninsured patient is like the leak in the dike. Either you fix the dike or you face the flood - and without universal coverage, the flood is uncontrollable health care costs. So universal coverage is the foundation of successful health care reform.

So what happened to the universal coverage in the health care reform struggle? It was overrun by two immense political pressures:

1) Keeping insurance companies in charge of the health care system, and

2) Making sure employers continue to administer health care benefits for their employees.

This relentless effort to retain a system of employer-based insurance led to endless complexity and confusion and delay that ultimately sank health care reform. It ultimately obliterated the goals of universality, affordability, security, and choice because there simply is no way to achieve universal coverage through private insurance companies without staggering complexity. And complexity is a poor tool with which to mobilize support.

So no matter how original or clever, the President's proposal, not to mention all the other plans based on insurance purchased from private companies, was never going to work because it was just too complicated.

So what to do instead? How could we attain the goals - universality, affordability, security, and choice - without drowning in complexity? I believe there is an alternative and a superior one at that. It is called single payer.

Rep. Jim McDermott is a Democrat who representsWashington state's Seventh District. This is an edited version of his speech before the Seattle Downtown Rotary on Sept. 7, 1994.

A single payer system works very simply: the government -- not the employer -- collects the health insurance premium of all Americans in the form of payroll or income taxes. That money is collected in a separate health security trust fund and then distributed through a budget to the states. The states negotiate fees with health care providers to prevent prices from rising too fast, and then they pay providers' charges from their budgeted allotments of the trust fund.

The health delivery system stays entirely in private hands. There are no government doctors, no government hospitals. The federal government merely provides the insurance -- the health care continues to be provided through the system of private doctors and hospitals that we have now.

Every American is guaranteed full coverage and unrestricted free choice of provider. This means that you can enroll in an HMO if you want to, but if you don't want to, you don't have to. You can see any doctor you wish.

Single payer does not require the government to subsidize lower-income people on an individual basis for their health insurance -- the subsidies occur automatically through the tax system and require no administration.

It does not require employers to select health insurance plans for their employees or calculate premiums based on family size or hours worked.

It does not require employers to resolve employee complaints about unsatisfactory medical care. It does not require employers to file forms, report claims, or register employees or their families. It does not require employers to spend time negotiating with insurance companies.

All of these tasks, which are the daily diet of American businesses that provide health insurance to their employees today, are unknown among our trading partners who contribute to their employees' health care coverage through single-payer systems. And I can assure you, none of our foreign business competitors is lobbying its government to replace those single payer systems with the American model of private health insurance companies driving a system marked by spiralling costs, runaway expenditures, rationed care, and millions of citizens with no coverage whatsoever.

And yet we persist in maintaining our disadvantage.

We have spent a year in the Congress struggling mightily to preserve a foundering health care system that is costing almost inconceivable amounts of money and delivering a miserably inadequate product. The obvious question is, why? Why try so hard to keep something so unsatisfactory?

The greatest obstacle to single-payer in this country has been the foregone conclusion -- totally untested and in fact contradictory to our experience with Medicare -- that somehow, single-payer is not "politically feasible". So we have wasted a year trying to accommodate and enlarge the private insurance market through mandates and the privatization of Medicaid and much of Medicare while we refused to acknowledge that no amount of private market adjustment could match the simplicity, the savings, and the security of single payer.

By ignoring single payer, nothing was gained toward achieving the goals we began with. Worse, substance was sacrificed to tactics, as committees and caucuses shadowboxed with plan after plan, none of which offered the clear advantages of single payer.

And the American people spent the last year replacing hope for real reform with anxiety about the whole mess. By dismissing single payer, we are walking away from universal coverage within a year, with unrestricted choice of provider, comprehensive benefits, including long-term care, lower costs for 75% of all Americans, annual savings in national health care expenditures of at least $175 billion per year, including up to $100 billion dollars in administrative savings, and substantial deficit reduction within five years.

It is no wonder that our international competitors are incredulous at our approach to health care. It defies logic and, perhaps even more important, it denies our own self-interest. The bottom line is that universal coverage is cheaper in a single-payer system. It is cheaper because it is simpler -- and it is simpler because it is less bureaucratic.

Financing health insurance for the uninsured through commercial insurance companies is the most expensive way to achieve universal coverage. Without a single-payer system, there are no off-setting savings; the money to finance the uninsured has to be provided over and above the costs of providing health care as we do today. Not only are the inherent administrative costs much higher; profit and marketing costs of the insurance companies also must be calculated into the price of covering the uninsured with private policies.

No other country in the world provides universal coverage and systematic cost contain-

ment through private insurance companies. And no other country in the world spends nearly as much as we do on health care and gets as little in return for the money. So if the advantages of Single-Payer are so persuasive, why did the political process fail so completely? What makes a practical, cost effective solution "politically unfeasible"? At least a part of the answer is the fact that the business community doesn't like it.

Despite the clear advantages single payer brings to our economy, American business interests remain wary of this approach to health care reform -- even though single payer would liberate American business from health benefits administration and all the headaches associated with it.

I am intrigued by the irony of business's apparent desire to cling to employment-based health insurance. On the production side of business, for virtually every product component, firms must evaluate whether it is more cost-effective to generate production components "in-house" or to purchase them from a supplier. If American firms applied this standard to health care benefits, they would realize that employee health insurance -- insurance, not care -- is one product that employers can obtain least expensively and most satisfactorily from the government.

The four percent to 8.4 percent payroll tax in the single-payer proposal to finance universal coverage and comprehensive benefits is significantly less than 9.9 percent -- 13.5 percent of payroll employers spend now to provide their own health plans -- plans with fewer benefits, less choice, and infuriating preauthorization requirements.

Business is striving to eliminate wasteful middle management that absorbs resources but does not necessarily enhance productivity. Yet, in health care, business clings to a model that mushrooms middle management costs needlessly. We know that commercial insurance companies spend up to 25 cents of every health dollar on administration, marketing, and profits. Some of the nation's largest managed care companies spend up to 30 percent on those categories.

Now consider Medicare, our national system to provide health care to the elderly. Medicare spends 2.1 percent of its budget on administration. It serves a segment of the population whose health care demands are high and whose satisfaction with the program is well-documented. Medicare is a single payer system.

The administrative savings alone in a single-payer system provide enough money to finance health care for all the currently uninsured. Sadly, the American business community's posture in health care reform appears to have been shaped by the tired refrain that "government cannot do anything right." Actually, single-payer is exactly the kind of thing that governments do best.

I've already mentioned Medicare's very efficient performance and high customer satisfaction. We need to note, too, that American biomedical research, the envy of the world, also, is a product of federal financing of private practitioners: The federal government funds privately conducted research that is coordinated by the National Institutes of Health (NIH). In fact, much of the research attributed to American pharmaceutical companies is initiated by NIH and then farmed out to those pharmaceutical companies for development in a classic public/private partnership.

Or consider the federal interstate highway system. It, too, is a single-payer government-financed, privately-delivered system, as was the GI Bill of Rights -- another one of those "terrible government programs" -- that sent a generation of American veterans to college and thereby transformed the caliber of the country's labor force.

It is time to retire the "government ruins everything" mantra. Patently false, it has lulled us into maintaining a health care system that is wasting billions of dollars while neglecting millions of Americans.

Single-Payer systems around the globe demonstrate unequivocally that the goals of a successful health care system -- universality, affordability, security and choice -- are attainable. And we can reach them quickly if we have the courage to adjust our oversized and wasteful health care system to serve all of our citizens.

This is not Mount Everest. We already have the delivery system. We already conduct the research. And we already spend the money. To say that we are the only nation in the industrialized world that cannot provide affordable universal health coverage is unworthy of the American people.

Winston Churchill observed that "you can always count on the Americans to do the right thing -- but only after they have tried everything else." When it comes to health care reform, we have tried everything else, and it now is time to do the right thing.ß

SUZANNE GORDON & JUDITH SHINDUL-ROTHSCHILD

The H.M.O. Scam

When Ruth Trotman talks about her daughter Robin's condition she can barely contain her despair. Her 19-year-old is suicidal because of a very rare and difficult to treat mental illness -- obsessive compulsive disorder (O.C.D.). Robin is terrified of germs and washes her hands until they are raw; she is often so fearful that her mother cannot even leave her side, and she is totally consumed by thoughts about God and His punishment.

Unfortunately, Robin also suffers from a new health care disorder -- managed care. She is insured by Bay State Health Care, one of Massachusetts' biggest managed care companies. When trying to lure subscribers, Bay State says that patients will have "thousands of physicians to choose from." Trotman says Bay State told her Robin could be treated out of its network of providers and hospitals if it was medically necessary. Although there seems to be no dispute about the fact that Trotman's daughter needs hospitalization, there is intense disagreement about where. Bay State refuses to allow her to be hospitalized at McLean's, a prestigious psychiatric facility that has the only O.C.D. in-patient unit in the state. Instead, Bay State insists Robin be hospitalized at Fuller Memorial Hospital--a small community hospital in Attleboro that lacks such a specialized program.

Fuller does have one distinct advantage -- to Bay State, that is. To attract a managed care contract in psychiatry it provides discounted services to Bay State. Despite Trotman's efforts, including a lengthy appeal through Bay State internal channels, contacts with an attorney and her political representatives, the insurance company has not budged.

"There are nights when I stay up cradling Robin in my arms because she can't stop crying," the anguished mother recounts. "She says she can't stand to go on living this way. What's so terrible is that there's help for her and Bay State won't let her get it. No one can cure her, but they can help her to live with O.C.D."

While Ruth Trotman was trying to save her daughter's life, another Massachusetts woman was trying to deal with a less critical but still troublesome health problem -- an immobilizing tendinitis in her right shoulder. She went to an orthopedic specialist, who recommended a course of anti-inflammatory drugs and physical therapy. The woman's insurance company required her to get prior authorization for physical therapy, so she called the number indicated and reached a nurse sitting behind a video display terminal in Washington, D.C. The nurse informed her that her insurer would not allow her to make a physical therapy appointment before she finished a two-week course of anti-inflammatories. When the woman reminded the nurse that she was only following her doctor's orders, the nurse responded, "This is company policy."

When the woman arrived in the physical therapist's office after the two-week drug course, the clinician was shocked at the state of her arm. "Why have you waited so long to come to me?" she said. "You should have come much sooner."

Then there's the case of the elderly California woman dying of multiple myeloma -- a cancer of the bone marrow. She had been seeing an oncologist before her health plan switched to managed care. Once that happened, she was told she had to pick a primary care physician from an approved list who would then refer her to an oncologist approved by the plan. Her new primary care physician agreed to allow her to continue with her oncologist, who was not part of the plan, but only on one condition: Before each oncology visit she had to appear at his office to be handed a signed permission slip to see the specialist. The primary care physician billed the health management organization $85 for each slip. This went on for three months, until the woman became eligible for Medicare."To have to deal with fighting for care while

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Suzanne Gordon is a freelance journalist who writes about health care. *Judith Shindul-Rothschild*, assistant professor at Boston College School of Nursing, is co-author of *Aging and Public Policy: Social Control or Social Justice* (Charles Thomas). This article is reprinted from *The Nation* with permission.

you're dying is cruel," she said.

Such experiences are becoming the norm in American health care. President Clinton's American Health Security Act may be in trouble in Congress, but its grounding philosophy -- managed competition and managed care -- is alive and well. Representative Jim Cooper's and all the Republican health care proposals endorse managed care's central tenets -- that the way to cut costs is to discipline patients and give insurance companies the responsibility for policing medical practice and patient behavior. Most important, managed care has become the darling of employers, who believe it will save them money. As *Barron's* recently put it, "employers are already switching en masse from traditional insurance plans to 'managed care'."

Americans traditionally equate access to health insurance with access to health care and reimbursement for their treatments and services. With managed care -- a byzantine system in which insurers and employers herd patients and families into health maintenance organizations (H.M.O.s) or networks of approved physicians and other providers and hospitals, all competing against one another to provide the cheapest services -- this equation can no longer be taken for granted.

Managed care does not guarantee access to health care. It merely assures access to what we call "the denial game." This is an elaborately choreographed dance of come-hither advertising designed to attract subscribers, followed by a series of rules and rejections that get in the way when a patient actually seeks services. The main goal of the denial game is to maintain the profitability of some of the most lucrative corporations in America today--for-profit H.M.O.s and managed care companies that earn profits of up to 20 percent annually. They achieve this goal by three primary mechanisms:

*The denial of free choice of doctor and hospital and the substitution of a select group of providers who are generally chosen by the criteria of cost and their willingness to follow a managed care plan's guidelines on which services are appropriate and when.

*The erection of rigid barriers to access, which are applied to all enrollees regardless of how much or how little they may, in fact, use the system.

*The bureaucratic micromanagement of care by a group of what we call "invisible diagnosticians" -- nurses and physicians who never examine patients but nonetheless decide the course of their treatment.

Consider the impact of the first principle -- the denial of choice. The requirement that patients may go only to members of a closed panel of primary care physicians or specialists, the bedrock of managed care, pits clinician against clinician to discount services.

Here's how it works: Every year physicians on the panel get a report card that grades them according to how much they saved or cost the managed care company in providing patient care. If your primary care physician or specialist is at the top of the list -- spending more money than his or her peers on patient care or advocating too aggressively for patients -- that doctor will be dropped from the panel and you'll have to switch to a more "cost-effective" or more tractable provider. Provider report cards are not based on quality indicators, like complications, re-admissions, suicide or mortality rates. Clinicians are judged solely by their contribution to the corporate bottom line.

In their effort to obtain cut-rate care, managed care plans also negotiate deep discounts with hospitals. Because managed care groups seek to negotiate the least costly services from year to year, subscribers may be forced to change physicians, nurses and hospitals frequently. Last fall in Massachusetts, Pilgrim Health Care decided to end its $10 million managed care contract with Tufts New England Medical Center and informed patients they would have to switch to another hospital. After eight years, Harvard Community Health Plan declined to renew its pediatrics contract with Massachusetts General Hospital and instead diverted its patients to Children's Hospital.

This kind of hospital and clinician hopping encourages discontinuities of care. "Competition addicts think that health care is a machine assembled with interchangeable parts. They're wrong," says Alan Sager of Boston University of Public Health's Access and Affordability Monitoring Project. "Health care is an ecology, in which different organisms often have symbiotic relationships with one another. The patient-clinician relationship is dangerous to uproot, and hard to re-establish. Market forces act like tornadoes, destructively tossing around hospitals, their patients and their staff."

These restrictive policies not only inhibit patients, they severely restrict providers. A prominent Boston physician explained that "if

a patient of mine needs a particularly tricky operation, I know there are three or four excellent surgeons in town to whom I can refer the patient. But many insurance companies now force me to refer the patient to surgeons that I know may botch the job."

Physicians and nurses who want to prescribe a particular drug or treatment may not be able to do so because their patient's managed care company will pay for drug A but not drug B. "I had a kid with recurrent ear infections, so I prescribed a stronger antibiotic at the bottom of the H.M.O.'s list, which happened to be the most expensive," one frustrated physician said. "The next thing I knew, the mother of the patient is calling me from home saying that some anonymous reviewer from the H.M.O. -- who had never laid eyes on the kid -- called and told her I should have prescribed cheaper antibiotic. She was told that if she wanted the one I prescribed, she would have to get the kid the medicine he needs. What an incredible waste of time. Just give me the list of the least expensive drugs and I'll prescribe them when appropriate. Don't second-guess my clinical judgment."

Limiting choice -- and thus real quality competition among providers -- is only the beginning of the denial game. Next comes restricting the availability of this narrowed range of providers.

One common technique is to decrease staffing levels and increase patient load. Large H.M.O.s tend to keep physician staffing to a minimum, employing one physician for every 800 enrollees (compared with a ratio of about 1:400 in traditional fee-for-service practices). The Kaiser Permanente Foundation Health Plan is one of the most respected H.M.O.s in the country. But following industry trends, it is dramatically increasing physicians' caseloads. For example, in the Sacramento region Kaiser is now adding patients to internists' and family practitioners' caseloads, in some instances increasing the ratio up to 2,700 patients per doctor.

"What is very worrisome in H.M.O.s and managed care plans are the very subtle barriers to even primary care," says Dr. Steffi Woolhandler, assistant professor of medicine at Harvard Medical School, and one of the founders of Physicians for a National Health Program. "There are often long waits before appointments, people can't get to see their own primary care physician and have to talk to someone else on the phone. Patients are forced into big practices, where the person they talk to on the phone today may not be the same person they explained their problem to yesterday. When they get to see a provider, they may have only a limited amount of time to outline their complaints."

Other features of most insurance plans today include requirement of prior notification before using emergency room services and the use of the primary care physician as a gatekeeper who will curb unnecessary use of specialist care. The first referral to a specialist may be only the beginning of an unnecessarily complex and costly process that ends up harassing patients, as the dying woman in California so rudely discovered. Often patients become so tired of going through managed care hoops that they forgo needed treatment or pay for specialist or other services out of pocket.

The roadblocks to care for the supposedly well insured are assiduously patrolled by a new cadre of health care personnel --the care police -- who often receive more money for denying needed care than nurses and doctors who are actually delivering care at the bedside. Insurance company executives insist that these "utilization reviewers," as they are euphemistically dubbed, are only making sure that providers follow accepted standards of care and that patients don't "overuse the system." In fact, they are diagnosing and treating patients without ever setting eyes on them.

Pam Calarese, an oncology nurse at Norwood Hospital in Norwood, Massachusetts, and the nurse manager of its out-patient oncology-hematology department, describes what is now becoming routine practice. She recently had a patient with head and neck cancer. Physicians ordered a standard protocol, which includes doses of a chemical, cisplatin. Cisplatin is highly toxic to the kidneys. If the dose is too high and/or if patients do not receive sufficient hydration, they can go into renal failure.

When the patient's oncologist called his insurance company to get an authorization for the treatment, the anonymous physician at the other end of the line informed him that they would approve payment only under one condition -- that the patient be given a dose of cisplatin five times stronger than that recommended in the protocol.

"To say that we were shocked is an understatement," said Calarese. "If we did that we would have killed the patient, which is just what the doctor and the nurses at the clinic

told the insurer. But they insisted. The doctor refused and they backed down."

In managed care plans, the physician or nurse harassing other doctors or nurses is not required to see the patient whose clinical needs this individual is assessing and whose future is being determined. Utilization review physicians and nurses sometimes have no specialty training in the field they are evaluating. Even more frightening, many utilization reviewers are not even health care professionals. Their names are not written into the patient chart. Most important, they cannot be sued or otherwise held accountable for their decisions.

"We have a structure for providing medical care in this country. What insurers have created is a shadow structure," says Woolhandler. "For every action a physician or nurse takes, there is a paper construction reflecting it and a person reviewing it. Everything is done twice–by me and by my shadow. These shadows follow computer protocols that are kept secret. They won't tell us why they are denying needed care, they just say the protocol says no. If I see a patient who I think has a retinal detachment that can lead to blindness, and I say she needs to see an ophthalmologist, and the shadow says no she doesn't, that shadow is not legally liable. But I am. These people are entirely out of the loop of accountability and quality."

The role of these new, invisible diagnosticians makes a mockery of managed care advocates' rhetorical pronouncements about quality care, consumer choice and the potential of consumer education -- all touted features of the Clinton plan. How can patients and families learn how to navigate a health care system in which the real decision-makers are completely insulated from public scrutiny and patient criticism? What good is consumer information about a hospital or physician or other provider, when neither that institution nor that individual provider is really the one pulling the most important health care levers? What good does it do to increase the number of primary care providers, if those providers are simply viewed as servants of managed care companies?

The final irony of managed care is that it raises, rather than lowers, health care costs, as studies by numerous government agencies and health care researchers have shown. Managed care groups have higher administrative overhead than did Medicare or traditional indemnity plans like Blue Cross ten or twenty years ago. Managed care companies spend huge sums on advertising and marketing, and on paying utilization reviewers to micromanage each case. In order to amass the profits necessary to pay executive salaries in the seven figures, enrich stockholders and offer bonuses to elite physician providers -- some of whom now receive year-end perks based on the amount of care and treatment they denied -- managed care companies must cut labor costs, increase provider productivity by enforcing assembly-line conditions and skimp on the care and treatment they make available to patients.

Over and over Washington politicians insist that Americans must be willing to make sacrifices and tough choices to solve the nation's health crisis. But it is politicians, not patients and their families, who need to make them. Our health care crisis will be solved only when government leaders are willing to set global budgets, negotiate fee scales for physicians, rein in drug company costs and fairly and democratically ration expensive medical technology, as is done in every other industrialized country. Not surprisingly, politicians, who would rather avoid the accountability for such tough decisions, are attracted to a free-market approach (not to mention free-market dollars). But substituting the invisible hand of the market for the visible courage of political leadership is the wrong prescription.

Study after study -- as well as the experience of governments in Europe and Canada -- has documented that a single-payer financial reimbursement mechanism is the only way to save money and increase access while maintaining quality and continuity of care. As patients are learning every day, managed care, on the other hand, does little but manage the care right out of our health system.ß

HENRY MORGAN

On Socialized Medicine

The problem of socialized medicine is a big one, and I'm glad you came to me, Dad. I happen to be an authority on medicine and also on socialization of stuff.

I became an expert on medicine through the kind offices of a great uncle once removed. Isn't it interesting how you can forget a brother you don't like but you can remember (or invent) a relationship to someone you do? He was a dermatologist and when I asked him why some disease or other I was sporting at the time hadn't cleared up, he said, "Son, there really isn't a lot that doctors know for sure, but the thing they know least about is the human skin."

Among doctors there is usually one to whom the others in the fee-splitting group refer as "a great diagnostician." This means that he's the quickest in the bunch to give a name to what the patient died of. I hear that many people are living longer these days owing to increased sanitation and the elimination of scurvy and yaws, but I've never heard anyone even attempt to prove that this is necessarily a good thing. I'm not even sure of what they live longer *than*.

If the Bible is only half kidding, people used to live a heck of a lot longer in the days when North Africa was a cultural hothouse and the Germans were still living in the trees. One of the apparent aims of "medicine" is to keep totterers tottering in vast enclosures built on Florida fill spattered with shuffleboard courts and morticians. The U.S. government says a guy is entitled to quit at 62. At that age they are ready to turn him over to the one-bedroom-jalousied-porch people and the poorer geriatricians.

South Sea Islanders paddle away into the sunset when they've had it. Eskimos wander off to freeze into their own monuments. Hindus set fire to their loved ones in huge ghats, sharing the cost of the charcoal with their friends and neighbors. These people do not have socialized medicine. They do not have special communities and housing developments with ramps for the wheelchairs. No trailer heavens filled with jolly companions in baseball caps and mouths full of fake choppers.

All that these ignorant native goofs have to look forward to is that ol' Mother Iceberg in the sky (Esquimaux), that Holy Cow in Buddha-land (Sikhs), or that 10 to the 23rd power billion cubic miles of galactic dust and thin helium (Captured German Scientists).

Well, we want more than that for *our* senior citizens. And, seriously, folks (since I intend to be one), there must be provision made for people who can't afford to take care of themselves. After spending all that dough on research to keep them alive, there's no sense in allowing them to rheumatize to death. It's too bad that we live in a time when people still talk of the *republic* when they mean they want the State to be Daddy...it's a rough dichotomy, doc, but it's *ours*.

It's also rough that medical treatment *should* be available to those who can't afford it, but that the worst thing that can happen to an American is God Forbid somebody should think he's *poor*.

It's too bad, too, that the moment you take a dime from Uncle you lose twenty cents' worth of Freedom, but nobody can even define Freedom anymore and I doubt that they'd care to. We live in a time when everybody has rights and nobody has any responsibilities. It's not my fault that sometimes Freedom means Freedom To Drop Dead because of lack of medical attention, such as it is.

The A.M.A. could have forestalled all this talk by being doctors. In the old days, a doctor took care of the rich and the poor and grumbled about his unpaid bills and managed to live about as long as his patients. That was the old days. Now there are no docs...just specialists and politicians. They've managed among them to make two new dirty words--Hippocratic (which was already an oath) and Socialist.

Henry Morgan (1915-1994) was one of America's great curmudgeons. This piece originally appeared in *The Realist* in 1961, and is reprinted with permission from *The Best of The Realist* with permission.

In solemn, soul-searching conventions, they have finally reasoned that medicine is for those who pay for it and the dirty socialists can drop dead. This dignified conclusion has been gravely presented to the American people as the medical profession's contribution to the war against godless Communism.

When I was a kid, our family doctor (are they still around?) took care of "his" poor folks for nothing. It didn't occur to him that they were the Red Menace. Today not one out of a hundred ever so much as pokes the emerald clasp of his alligator bag into a clinic.

Federal housing is socialist. Federal aid to schools is socialist. Federal any-damn-thing is socialist. The electric light and power companies scream their heads off at the Tennessee Valley Authority...well, why didn't *they* build the dam?

The whole sorry, miserable point is that we have a Federal Government to do what you can't or won't do for yourself. The doctors threw out the poor and the aged poor. All right. I hope the whole thing gets socialized up to hell and gone, and that we fight against becoming a socialist state by becoming a socialist state. That'll show' em.

If this seems a bit muddled, I would like to remind you that there was a time, very shortly in the past, when a man *did* have the right not to belong to a union, not to have two TV's and a barbecue pit, and the right to fall down in the street of starvation. It is not recorded that many did fall down...even in the Great Depression. I believe it was a better time and that many people knew who the hell they were, at least. It was called the good old days, and with plenty of reason.

Well, we've managed to improve everything now to the point where the average American family, given that the leader is thrown out of work for a month, is bankrupt. It's the richest country in the history of the world in which every family owns one-eighteenth of its own home, half a dishwasher and has a five-month equity in a car.

In my little old home town, the wives of ignorant Puerto Rican busboys buy frozen lobster tails fresh from the waters of South Africa. What the hell do *I* know?ß

Paul Sweezy and Harry Magdoff
are in the exhilarating tradition of Tom Paine,
nailing down a truth simply and, thus, eloquently.

Studs Terkel

STEFFI WOOLHANDLER, M.D. & DAVID U. HIMMELSTEIN, M.D.

Bottom-Line Health Care

The Washington health reform hoopla turns out to be a mere sideshow to the Clinton era's main event: the accelerating corporate takeover of health care. Patients' care and caregivers' working lives will be poorer in 1995 than in 1985, and this will be the case even if Congress manages to squeeze out a me-too variant of managed competition. The extinction of both professionalism and medical altruism, and the depersonalization of care, not the legislative details of a paltry reform, define the medical context for this decade.

When, early on, Bill Clinton signaled that health care investors were safe on his watch--that for-profit H.M.O.s, private insurers and other health care businesses wouldn't just linger but flourish--he unleashed an unprecedented torrent of mergers and acquisitions. Never has control of so vast an industry shifted so rapidly from a dispersed array of small- and medium-scale producers--in this case, doctors and local hospitals--to a few huge corporations whose leveraged financial clout is their only qualification for health care leadership.

Each week now, thousands of physicians are forced into a bizarre variant of musical chairs: Sell your practice on the terms offered, or be left out for good as your patients are herded into restrictive managed care plans. In Springfield, Missouri, St. John's Hospital gave doctors until August 1 to sell out and sign on as employees of a new plan. Once doctors committed, their contracts called for a $1,000-a-day penalty if they quit and practiced medicine within twenty-five miles of town.

The doctors' dilemma, in Springfield as elsewhere, is caused by the likely crash of medical practice outside the realm of managed care. H.M.O.s typically employ one physician for every 800 enrollees, but the United States has one doctor for every 400 people. Hence H.M.O. expansion absorbs many patients but relatively few physicians. When half the patients in a given region have signed on to managed care, only 250 patients per non-H.M.O. physician remain, too few even to pay practice overhead. Congressional guarantees of free choice in a fee-for-service option are meaningless; market forces insure that non-H.M.O. practice will shrivel, maintained only for an elite few able to afford astronomical fees. For most of us, the choice will be restricted to giant corporate H.M.O. "A" or giant corporate H.M.O. "B."

By 1993 ten firms controlled 70 percent of the H.M.O. market; two of them, Met Life and Travellers, have since merged. Bowing to marketplace necessities, Blue Cross is going for-profit, so it can sell stock to raise the billions it needs to buy hospitals and clinics for its own managed care networks. Pharmaceutical giants Merck, SmithKline and Eli Lilly paid $13 billion this year for firms that "manage" drug benefits, presaging the death of marketing through so-called drug detailing, whereby drug companies provide free trinkets and intensive miseducation to individual physicians. In its place: drug choices made directly by subsidiaries of the drug makers, with sales commissions (*aka* bribes) for pharmacists who lure patients to the desired brand.

The top ten for-profit hospital chains have been coupling like rabbits (though, unlike rabbits, each liaison leaves fewer firms, not more). In September of last year Columbia swallowed Galen; in February, H.C.A.; in July, it proposed the takeover of Medical Care America. Quorum acquired part of Charter last October, growing to 32,000 beds. American Healthcare Management and Ornda merged in April. Healthtrust bought Epic in May. And in most big cities, the non-chain hospitals are consolidating into a few giant groups. Under the guise of competition we've galloped toward oligopoly.

Meanwhile, as Congress debates coverage for the uninsured, the care of the insured is being transformed. The patient/doctor rela-

Steffie Woolhandler, M.D. and *David U. Himmelstein, M.D.* practice and teach medicine at the Cambridge Hospital/Harvard Medical School and are co-founders of Physicians for a National Health Program. Their latest book is *The National Health Program Book.* (Common Courage). This article is reprinted with permission from *The Nation.*

tionship is giving way to the employer/health plan contract. Managed care plans often force physicians and therapists to consult the plan's "utilization reviewers" (the insurers' representatives assigned to cut costs by limiting care) before discussing therapy with the patient, and then forbid disclosure of compromises on quality. G.E. employees in Boston are now forbidden to call their doctors for an appointment; instead, they must call a company reviewer, who filters requests. In California, Kaiser has told its primary care doctors that their patient caseloads have been increased to 2,000 (roughly double the typical number). The seven-minute doctor's visit becomes the norm, while health planners fret that there will soon be 165,000 unemployed doctors. Health plan administrators demand industrial "efficiency" at the level of each doctor/patient encounter, producing chaotic inefficiency for the health care system as a whole.

The new health care powers know finance, insurance, perhaps law--not medicine, or nursing, or cleaning bed pans, or patienthood. The new structure of care aims at profit, its new leaders are experts in that field. Why should doctors and nurses manage care; do chefs run McDonald's?

The Washington process that produced the Clintons' health plan is emblematic of the new structure. The policy experts and health management leaders have no medical or nursing knowledge, no clinical experience, no intimate encounter with illness. Hillary Rodham Clinton's task force of 500 included only a handful of people who had ever been to a hospital ward outside of visiting hours; most were too young and healthy even to have served as patients. It's no wonder they followed a script written by the Jackson Hole Group--a menage funded by insurers, convened by Nixon's health policy guru, Paul Ellwood, and guided by Alain Enthoven, Robert McNamara's Pentagon protege who went on to a senior position at the military-contracting Litton Industries before sinking his teeth into health policy. The result, as Ellwood forecast: conversion to larger units of production, substitution of capital for labor and "profitability as the mandatory condition of survival"--a nightmare vision of for-profit, corporate medicine, utterly indifferent to the human experience of care.

For its part, the American Medical Association, having long ago abandoned patients' interests, has been so distracted by its fear of government that it barely noticed insurance company shackles snapping shut on its profession. The surgeons, quick to clamp a bleeder, were the first in organized medicine to react. The 53,000-member College of Surgeons endorsed a single-payer system this past winter; it's the only way to preserve their autonomy, and even jobs, as managed care plans whittle their specialist rosters. The conservative surgeons are strange bedfellows for the progressive docs who've rallied 6,000 strong to Physicians for a National Health Program, the Chicago-based group that put single-payer on the American medical map in 1989.

Soon the legislative details of whatever emerges from the bowels of Congress will fade to insignificance. Tens of millions will remain uninsured as promised savings from competition and managed care evaporate, and as government subsidies fall prey to budget-cutting. In Massachusetts (which is a world leader in both H.M.O. membership and health costs) more people are uninsured today than when Governor Michael Dukakis's "pay-or-play" plan, with its employer mandates, became law in 1988. Like the Democrats' 1994 version, Massachusetts' universal health care bill coupled a rosy promise of future coverage with a green light to health care corporations. As costs soared, universality was indefinitely delayed.

As in Massachusetts, Congress's promises of full coverage are ephemeral, but the corporate advance toward a medical system dominated by a few giant, vertically integrated firms continues apace. Insurers will own hospitals, surgicenters and home care agencies; employ doctors and the rest of the medical work force; and perhaps merge with drug firms. For the insured, care will be defined by a deal struck between a corporate-care purchaser (i.e., your employer) and a corporate-care deliverer.

In such a context, whither real health care reform?

In many areas of the country small-scale, fee-for-service practice is already dead or dying, foreclosing a purely Canadian-style reform for America. Once most doctors have become H.M.O. and hospital employees, breaking up these institutional arrangements would severely disrupt care. Resurrecting the Atlantis of mid-twentieth-century medicine is impossible.

An anticorporate, antimarket focus for re-

form is ever more germane. Corporate competitive imperatives are the palpable force destroying care. The managers and financiers who increasingly dominate care are not bad people (if so, we'd need only replace them); they're just responding appropriately to a system that demands misbehavior: Put profits before patients or go under.

Mere opposition to corporate H.M.O.s is insufficient. We must devise their transformation. We need control by patients and caregivers, not stockholders, managers and employers. We need medical integration, so that health care in communities is not carved up among ostensibly competing organizations, each avoiding financially unrewarding tasks and patients, and shunning community-wide cooperation. We must scale care to a human size, so patients and providers can know one another and receive the care that is needed, not act as interchangeable corporate cogs. Unless H.M.O. physicians, workers and patients are centrally involved in planning this transformation, and in the movement for reform, it will surely fail. Recapturing the rational service orientation that characterized the original prepaid group practices (e.g., Group Health Cooperative of Puget Sound, a consumer-controlled cooperative, and even the early Kaiser, with its altruistic leadership and physician corps) can be revitalizing.

A public single-payer system *can* evolve from H.M.O.s and corporate care--if there's sufficient political pressure from a mass movement. Such a reform may share features with a national health service--salaried practice in integrated systems of care, with accountability to an electorate rather than to a corporate bureaucracy shaped by market forces.

The struggle over health care's future will continue. Immediately, attention will turn to the states, particularly California, where a binding single-payer referendum is on the ballot this November. And even D.C. won't be quiescent for long. The immiseration of care and caring touches a widening circle of patients, doctors and other health workers, including groups that have been quite powerful until recently. Top-class care will be reserved for an ever smaller aristocracy, with 98 percent of us relegated to factory-style medicine or worse. Even the local elites that have heretofore controlled local hospitals will be force-fed bitter pills, as national hospital chains and managed care plans take over. The constituency for opposition will necessarily broaden.

The strength of the single-payer movement has been, and must remain, a clear vision of health care that is kind to patients, satisfying for caregivers and fiscally conservative. In contrast, Clinton's plan, even before all the compromises, was a prescription for corporate takeover. Few could, or should, rally to this banner. Clinton didn't try and fail. He refused to try.ß

IN THE NAME OF FREEDOM

On this and the following pages are the names of persons in all endeavors who have contributed through the *Bill of Rights Journal* to the work of the National Emergency Civil Liberties Committee

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Remembering our friend,
John Scudder.
We spent many joyful years
with him.

Edith Tiger
Charles Roach

Steve Gardner

We Salute

Harry Magdoff
and
Paul Sweezy

For their lifelong commitment to principle.

Rabinowitz, Boudin, Standard, Krinsky & Lieberman, P.C.

Harry Magdoff and Paul Sweezy

are good Socialists and they do love.

Bess & Harry Starfield

We're happy to join in honoring
Two dear and lifelong friends,

Harry Magdoff & Paul Sweezy

We also salute NECLC for their continuing fight for our civil rights

In solidarity,
Fran and Bob Boehm

IN MEMORY OF

GEORGE WATT

Nov. 5, 1913 - July 7, 1994

Anti-Fascist Warrior

"Ever since I was six years old I remember my father telling me of his vision of a new world where there would be peace, where production would be for use instead of for profit, and everything would be for the benefit of mankind... This was our scripture."

Remembered and loved by

Family, Friends, Comrades and Colleagues

Donations to the GEORGE WATT MEMORIAL FUND, which will annually award a prize for the best student paper on the Abraham Lincoln Brigade and the Spanish Civil War, Abraham Lincoln Brigade Archives - c/o Morris Brier, 799 Broadway, N.Y., N.Y. 10003

For many years, Edith Tiger has been the courageous, innovative leader of the National Emergency Civil Liberties Committee.

She freely offers her vast experience, boundless energy and warm heart to young and old, blacks and whites, males and females with civil liberties problems.

She is truly an international person, fighting to preserve the Bill of Rights.

The Officers and Executive Committee
Of N.E.C.L.C.
Salute her.

IN MEMORIAM

GEORGE WATT
1913-1994

He fought the good fight against fascism
In Spain and in World War II
Student leader in the 30's
Long time fighter for civil rights and civil liberties
Author of "The Comet Connection"
Friend and comrade
Respected and admired by all who knew him

Erica & Jack Karan
May & Max Katz
Norma Starobin & Leon Nelson
Herb Freeman
Bernard & Natasha Brightman
Pearl & Joe Bucholt
Julie & Bertha Lowitt
Dave Rosenberg
Israel & Rebecca Friedman
Dorothy & Abe Shtob
Joe Dermer
Abe & Ruth Turkin

In Loving Memory of

Sam Chavkin
1913-1994

Activist for
Civil Rights
Civil Liberties
And
International Affairs

The Chavkin Family

In Memory of our Partner

HARRY WEINSTOCK

and our friend

LEONARD BOUDIN

SIPSER, WEINSTOCK, HARPER & DORN

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Belle Harper
Richard Dorn
Jerome Tauber
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"Those who expect to reap the blessings of freedom must undergo the fatigue of supporting it."

--Tom Paine (1777)

"It is all well and good to ask a person to lift himself by his bootstraps--but what if he has no boots?"

--Martin Luther King, Jr. (1968)

"We didn't come all this way for no <u>two</u> seats, and <u>all</u> of us is tired."

--Fannie Lou Hamer

Reportedly responding to the offer of only two seats for the Mississippi Freedom Democratic Party at the National Democratic Convention, 1964. (Quoted by Lani Guinier)

DONALD AND DORIS SHAFFER

We are the "Peaceful Warriors" living in Florida's Sarasota-Manatee area, who for decades have supported N.E.C.L.C., promoted peace among nations and brotherhood among mankind.

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MORRIS OSER

Congratulations to

Harry Magdoff & Paul Sweezy

Eve & Sam Osman

Martin Garbus, Esq.

Freedom Summer '94

Staff, Executive Committee and Youth Activists

salute

Edith Tiger, activist and friend

Carolyn Goodman
President, the Andrew Goodman Foundation

Joseph M.Steele 2nd

Joins the NECLC in honoring
Harry Magdoff
Paul Sweezy
&
Dr. Joan Y. Reede

Marion Knobler
9/11/1912 - 10/4/1994

Bernard N. Knobler

We honor their memory by carrying on their ideas and beliefs that were the mainstay of their lives.

the struggle goes on ....

Alfred Knobler for the Knobler Family

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We are proud to be counted among the supporters of NECLC and pleased to join in congratulating this year's honorees

We also salute Edith Tiger for her great leadership.

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In Loving Memory Of
WILLIAM H. NUCHOW
1928-1993

His dedication to justice and freedom
lives on in his family

Laura Nuchow Vural
Robert Nuchow
Leslie Nuchow
Joni Lane Nuchow
Sylvia Manheim
Samir Vural
Marisa Vural

We salute

Harry Magdoff and Paul Sweezy

dedicated seekers for
a better world

Miriam and Benedict Wolf

Congratulations to our beloved Harry Magdoff and to his staunch friend and colleague Paul Sweezy for their life long commitment to Socialism and Human Rights.

Sam & Laura Magdoff
JoAnn Magdoff
Steve Barnett
Elizabeth Rae Barnett

Greetings From

Marjorie and Daniel Krauss

We salute Harry Magdoff and Paul Sweezy, who have been outspoken in the struggle for freedom for underprivileged and working people.

Eisner, Goldfeder and Hubbard, P.C.

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Jerry H. Goldfeder
K. Dean Hubbard, Jr.

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In '76 Thomas Paine published COMMON SENSE, and in arguing for the necessity for a profound political change, wrote

"it must come to that some time or other"

Today Paul and Harry are the standard bearers of this simple but urgent truth.

Gladys & Percy Brazil

Leybl & Edith Drabkin
Boca Raton, FL.

Mr. and Mrs. Bernard Aisenberg

We honor two who have combined vigorous intellectual work with a dedication to humanity in the best of Marxist tradition.

Jonathan W. Lubell

In Memory of
Mort Stavis
Defender of Constitutional Rights

Friends and Colleagues at
Rutgers Law School, Newark:

Frank Askin
Al Blumrosen
Jon Hyman
Arthur Kinoy
Eric Neisser
Jim Pope
Annamay Sheppard
Nadine Taub
Penny Venetis

Congratulations and best wishes to the National Emergency Civil Liberties Committee for its dedication to, support and guidance of, the people in their fight for civil liberties, and a special salute to its 1994 Bill of Rights honorees.

Jeff L. Greenup, Esq.
Attorney at Law
205 West 137th Street
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IN MEMORY OF
MILDRED KLARE

Charles, Michael, Karl and Jane Klare

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We salute NECLC for its many years of dedication to the defense of civil liberties and congratulate the honorees, Paul Sweezy, Harry Magdoff and Dr. Joan Reede.

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HAROLD SILVERMAN

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salutes the

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in its efforts to defend the Bill of Rights and extend civil liberties

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We miss you here

Lily Engelhardt
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In Memory of Three Great Women:
Anne Brier
Mary Cohen
Ann Smith

Morris Brier

MICHAEL & ESTHER
WARSHAW

Greetings to NECLC

Steadfast in the Fight for Liberty

Bernice Crane

Charles R. Brainard, Esq.

IN MEMORY OF
WILLIAM ROSS

HE GAVE EVERYTHING.
THANKS,

Charlotte & Perry Bruskin

Warm Greetings

Jane Benedict
Peter K. Hawley

In Loving Memory
of
EUGENE REICH
1913-1972

Gertrude, Rachel & Alan

Happy Birthday
to
Carol,
Our wonderful daughter

Elsa and Resi

Keep Up
The Good Work!

Virginia and Fred Miles

The Clark Foreman Memorial Award

Clark Foreman was born in the South. He spent much of his adult life fighting for civil rights and civil liberties. He was the first director of the National Emergency Civil Liberties Committee.

This award, a candelabra, was created by Joan Klakow, Foreman's daughter. It symbolizes the eternal fight for these rights.

Best Wishes

from

Joe Sabbeth

The Fight Goes On

Peace, Love and Justice,
Johnny Randolph

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HARRY MAGDOFF AND
PAUL SWEEZY
When the history of our troubled time is written, their names will head a chapter telling of those few whose light never failed.
Dominic & Iris D'Eustachio
William L. Fisch
Alan Sbarsky
Muriel Shapiro
John Weber

Greetings from

FRANKLIN FOLSOM

author of

DAYS OF ANGER, DAYS OF HOPE: A Memoir of the League of American Writers, 1937-1942, University Press of Colorado

In Memory of
Morris J. Kaplan

Laura P. Kaplan

Hello, Goldie.

Congratulations to
PAUL and HARRY
And many thanks!

Ken Coplon and Bernie Mazel

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In Loving Memory of

NAT and ANNIE SCHWERNER

They touched our lives -- deeply.

Joe, Shelley and Lesley Miller

Michael A. Bleich

He Loved
Liberty

In Memory Of

Richard P. Morton
1917-1984

Ed & Ruth Meskin

In Loving Memory of

F. Palmer Weber, Ph.D.
A True Friend of
Civil Liberties

Alice and Paul Jarvis

In Loving Memory of
Theodor Rosebury

Amy L. Rosebury
Celia Rosebury Lighthill

In Honor of the Memory
of
DR. JOHN SOMERVILLE
Scholar/Activist
1905-1994

Author:
SOVIET PHILOSOPHY
THE PEACE REVOLUTION
THE COMMUNIST TRIALS AND THE AMERICAN TRADITION

Harry and Anna Rand

In loving memory of

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Nelda Scudder
Elizabeth and Mikel Osuch and family
Goldie and Ray Steele

Deborah Douglas Weisburd

Activist

1910-1994

Staunch suporter of civil rights and liberties

The Veterans of the Abraham Lincoln Brigade
Salute the

National Emergency Civil Liberties Committee

For its legal support of the right to travel to Cuba
and its continuing effort
to break the blockade of Cuba.

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DECEMBER, 1994

The purpose of NECLC

The Constitution of the United States, ratified in 1789, is the world's oldest charter of government. Two years later, the ten amendments which made up the Bill of Rights were put in effect.

The National Emergency Civil Liberties Committee was founded in 1951 with one objective: To reestablish the freedoms guaranteed by the Constitution and the Bill of Rights. For forty-three years, the NECLC has pursued this single-minded goal, through test cases involving freedom of speech, press, religion, and the right of people to assemble or to travel freely, to remain silent in the face of an inquisition, and to refuse to fight in an illegal and immoral war. Above all, it has defended the right to dissent. And it has expanded the meaning of freedom to include rights previously denied to women and minorities.

Toward this end it has raised and spent hundreds of thousands of dollars in cases which have become landmark decisions. It has informed hundreds of thousands of citizens through its publications and meetings. All its funds come from citizens of this country whose stake in the restoration of the Bill of Rights is paramount. If you are not already a member, we invite you to join. Individual membership is $35. The *Bill of Rights Journal*, the magazine *Rights* and other pertinent publications are sent free to all members during the year. Send your check or money order to:

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