

FRIDAY EVENING – 2ND SESSION
(KATHLEEN & GERALD HILL)

SKIP: ... The couple, the Hills, who are going to speak with you, are very special experts in this and they're delights besides. So without further ado I give you the Hills and here we go.

KATHLEEN HILL: Well, thank you, Skip for putting all of this together again and for including us, and thank all of you for staying after the break. You probably wonder why we are here. We have been teaching the last five years at least one semester a year. We have been teaching American Politics at the University of British Columbia and at the University of Victoria in Canada. We have become quite knowledgeable about their health care system as well as ours, hopefully not as intimately as most of you, but we also teach here. We teach The Politics of Health Care and a course called Campaigns and Elections, which is how to get all of that done. And just a little plug – we will be doing a 2-day workshop with Skip on the politics of health care and other things on May 8 and 9, and then this summer we will be teaching through Extended Education here an undergraduate course called The Politics of Health Care, which will be cross-listed in Nursing, Psychology and Political Science. So anybody in any field is welcome.

Most recently, Jerry and I coordinated Howard Dean's campaign in California, primarily from Bakersfield to the Oregon border, which left Los Angeles and San Diego basically to other people. Out of that effort, among other things, came fatigue, and something called Doctors for Dean, which was a group of youngish progressive doctors not affiliated with any existing organization, who wanted to do something to change things. Out of Doctors for Dean, after Dr. Governor Howard Dean withdrew from the race, out of Doctors for Dean has come a new group of progressive doctors who have somehow now motivated the San Francisco Medical Society to have us do a workshop on the politics of health care and on campaigning and getting the right people elected. And the leader of all of that is an ophthalmologist in San Francisco named Andy Kalman, who practices mostly in Spanish, which is not his native language, in the Mission District in San Francisco. And three weeks ago he invited us to a dinner honoring public health heroes put on by the School of Public Health at Berkeley. And he filled a table with people he thought would be good to talk together about the future of health care. I was seated next to Representative Nancy Pelosi's District Director, who is herself a nurse. And I said to her and the people within earshot, "I am now committing myself to changing our health care system." And she and her friend to her left said almost as a chorus: "Not in our lifetimes." And I said, "You want to bet?" What I was saying was that the public wants a change, all we need is to organize a campaign. I mean I know from the professional perspective that seems oversimplifying it, but as you know in your lives, your professional lives and your personal lives, people are getting desperate. And if the people are motivated properly, they're going to lose the fear of speaking out that the Bush administration has given us, and begin to demand health care changes. As you know, we have 46 million people now in this country without health care coverage of any kind. We have the semantic games being played with single payer, universal and national health care. We have some politicians telling us that we're better off the way we are. We have others telling us it's God's will. And then we also have some people being told that they're radicals and unpatriotic for wanting to upset the apple cart. We've all heard that on various issues. Among the candidates remaining, of course, we have the presumptive Democratic nominee, John Kerry, Senator from Massachusetts, whom the Republicans are trying to label as radical left-wing

liberal à la Ted Kennedy. I mean, what could be worse? Kerry, of course, has votes – one thing they say about Kerry in some of the Republican commercials that is unfortunately close to the truth is that he has taken many positions on some issues. But he does favor what he calls affordable health care for every American. And I noticed there was an excellent handout – I don't know if you did it, Skip, somebody did it out there on the positions of Kerry and Bush on health care. Terrific. It has just about everything you could have found recently on their Web sites, I believe. But what Kerry is now saying is something that others have said and Howard Dean said, and that was that Kerry wants coverage for all Americans that the president and the members of Congress have. Now I would be happy to accept that, and in deference – I'm sorry to say this in your presence, but our dear friend Lynn Woolsey, to whom we give support every year – once I said to her about four years ago that I'd just like to have the coverage you have. And she said, "Well, you know, it isn't really that good." And I said, "That's okay, I'll take it." So I'm delighted that Kerry is now apparently firmly for that. But then we get into the semantics of what is affordable health care for every American? Does that mean that we subsidize the insurance companies so that we can afford or subsidize us with dedicated funds so that we can pay the insurance companies? Or should we change the system entirely? President Bush is relatively silent on the subject. Of course, the Medicare prescription drug bill, which all of you I'm sure know inside and out, doesn't do what they purport it does and really puts a lot of people in worse shape than they are now but they don't know it yet because they won't be experiencing it till 2006. And then we had Senator John McCain in the last day or two, when asked about whether we need to send a few thousand more troops to Iraq and how we were going to finance this and the possibility that the administration was going to come back to Congress for more funds, another figure nobody yet can pinpoint, John McCain said, "Americans have hard choices ahead." What does that mean? That means choosing to spend for defense and cutting social programs, which some people suggest was their plan all along. They of course think that's not it, the free market system will take care of everything, and we're not quite sure what happens to those who lose their coverage.

Now speaking of graphs, we have a graph just like that that one of our learners in the Osher Lifelong Learning Institute class here that we teach in the Politics of Health Care, he did a graph like that, an almost identical curve. He was an engineer for Lockheed, contributed to some of what's going on – he knows that. Based on Lockheed's cuts in his retirement health care coverage, his chart with that curve shows that if he lives to be 90, he will be paying more for his health care coverage through Lockheed than he is getting in his retirement pension. So we have this terrible situation where we have the Bush tax cuts, we have the war with unknown costs in terms of money, we have the worst deficit ever and the worst trade deficit ever. The new Medicare Reform Bill will give people supposedly choices of coverage, three different ways to pay. Actually two different ways to pay and then the third way for the people who can't afford to pay. And here we'll get gradations of service and coverage through that. And we also have the situation where veterans' health care has been cut as well. They are not getting any longer what they were promised. They are very upset about that which is true. And then we have the situation where we have the pharmaceutical companies and certain parts of the, if I may call it, medical-industrial complex, giving enormous contributions to members of Congress and the President and the President's father's presidential library, and the inaugural committees and buying influence all over Capitol Hill and Washington DC. So my question is: Who's fighting for us? We have to do it. Now Jerry is going to talk a little bit about some realities here that you may not know in comparison with Canada, and then I'm going to cover Canada and France and he's

going to do Sweden and Denmark, and then if we still have time I'll do two more countries. We also have coming out – we do know a little bit about this – coming out in June we have a book which will really keep Danielle Steele up late at night worrying about and it's called "The Encyclopedia of Federal Agencies and Commissions." Your turn.

JERRY HILL: Thank you. You didn't have to give that plug for the book, I mean everybody will be rushing down to get it. We doubt it. Well, we're talking about politics and we do not sugarcoat the issues, because just not telling you what's really going on or what the fights are really about doesn't do much good. And quite clearly, we have a couple of measures on the state ballot coming up including Senator Kuehl's bill, which is they're not calling these bills single payer any more. It didn't sell, people don't know what it means. But they are talking about universal health care, which has a sort of broader and more generalized aspect to it and it's probably more easy to swallow. One thing I want to make clear, and that is that proposals for universal health care historically have not been some purview of radicals. The first proposal in Congress was in 1935 was introduced by a Republican senator from Kansas. The first governor who worked hard and staked a good deal of his efforts for a state program was Governor Earl Warren of California. And it's interesting, Dr. Phil Lee, who was formerly the UCSF CEO, recently has come out for a single payer type of health care. And the irony of it is that his father was the first person, or first medical person, to propose health insurance. Before the mid 1930s there was not health insurance and it was considered very radical at the time and of course it led to Blue Shield and Blue Cross. And it is only as the costs went up of hospitalization and medical care that it became obvious that this was not going to do the job in all cases and was going to leave, as Kathleen has pointed out, some 43-44 million people uncovered. Now there have been efforts made in one way or another to try and take care of those people but they have not been successful, obviously, when you have a fifth of your nation not covered by health care. So we are going to have this fight in California and I think several other states. If you can't do it nationally, then you better devise a state program. And the arguments made against it are, well, Hillary Clinton proposed something like this and it was a disaster. And what she proposed was sort of an amalgam which even she didn't understand too well, and it was also – we have an interesting story because they approached us to help in trying to get California congressmen to support the measure, and the only thing they had was something 300 and some pages long. And my wife Kathleen said, well, can you get that down to one page? Or do you? And they said no. And she said, well, I'd be glad to try. And she never heard from them again.

KATHLEEN: Well, they said they wanted me to do it and then they gave up.

JERRY: They gave up. And they also say that it was defeated in California, it's been defeated in a couple of other states, and that's true. One thing that we were going to get into, I just want to briefly point out some of the sort of hard financial aspects as you'll learn or hear if you don't already know. In those countries that have some kind of universal health plan, they have national taxes on the low end of 40% of your income ranging up to 50%. And you'll say. Oh my God. But the truth is that we're already paying a great deal of taxes that do go to health care. We have the bond issues, we have payroll taxes, we have parcel taxes, we have money that goes through the Department of Veterans Affairs, and we have Medicare, Medi-Cal and payroll deductions. In a sense we penalize the employers by forcing them to pay a certain amount for these programs and therefore the only way they get it back is to raise their prices. If you had some kind of program where the funding of it came on some centralized basis or a consistent basis, either

statewide or nationally, there would be some savings, considerable savings. In the first place, you know, doctors' offices if you look at them today, there are more people in there processing insurance forms and billing than there are providing medical assistance. If the government or an agency – it doesn't necessarily have to be "the government" – were processing the allocation of health care, it could be in a position to negotiate on a more equal basis with the pharmaceutical companies, and they could insist on the use of generics where it was appropriate. If you had some overall control, you could cut down on redundancy so that you didn't have two and three hospitals in the same area having the same very expensive equipment, which wasn't being used that much. Or you could increase the use of specialized hospitals, all of which would be some savings. As far as malpractice for potential negligence – and it is a big cost – it isn't the only thing, it isn't just a thing to make lawyers rich, it probably needs some improvement but, and in California we've already got tort reform. But you could have self-insurance through that program and therefore cut down that burden on doctors and therefore theoretically on patients. You could help reduce some of the confusion and the difficulties connected with making Workers Compensation claims. And of course, sadly for one industry, it could greatly reduce the profit for insurance companies, which you are paying for. And I know the insurance companies say, well, sometimes these other programs they allocate or they delay the treatment and so forth. Well, insurance companies are doing that here.

I had some notes on some of the things that are going to go on in the upcoming campaigns, and one thing that bothered me in the past was there a congressman up in Montana or a congressional candidate in Montana who was running on a national health care program, and immediately a committee – not a political committee supposedly, but a committee for fair treatment or something like that – started running ads showing busloads of people coming from Canada down to the United States to get health care because the Canadian system was so bad. And so while I was sitting here, I picked up a piece by the National Association of Health Underwriters, and I don't mean to pick a fight, except they have a paragraph in here that I want to read to you. And it's out there on the table. "We only have to look to Canada to see that government run health care doesn't work." For health care itself, of course, we're talking about the funding and the delivery and the costs of it and the processing of that. It says, "Single payer plans inevitably control costs by rationing health care." Not necessarily. "Canadians often wait months to see his doctor or specialist or to receive much needed medical treatment. 90% of Canadians live within 100 miles of the United States and Canadians cross those borders by the thousands to receive private medical care because private practice in Canada is limited to dentistry and veterinarians." The only thing that's true in that paragraph is that 90% of Canadians live within 50 miles of the border. The rest of it is all untrue. In the first place, there are some people from Canada who come down to the United States, particularly the Oncology Center in Seattle. What they don't tell you is that the province of British Columbia pays their freight because it's such a good hospital. The truth is that private practice is not limited to dentistry and veterinarians. You can walk in – we have ourselves, and we don't have their coverage and we pay their way – so there is private practice there. It upsets me, not because somebody opposes it – that's fine, but at least tell the truth about it. And you're going to hear all kinds of propaganda and I think we ought to – I don't know if the Kuehl bill, I haven't read it, I don't know how good it is, but I do know that this is a political campaign that's coming forward. I just hope that people look at it carefully and see if this is what they want and rely on what are the facts and not propaganda that's repeated so often that people start to believe it.

I might point out one other thing. Back when Medicare was first proposed, the AMA spent millions of dollars opposing it. And once it was passed, they've made millions of dollars and legitimately so, because it helped pay the financing of medical care for older people. I'll just give you one example, by the way, in regard to the kind of saving and a test. A few years ago there was a study made of two hospitals, one of them in Port Angeles, Washington – it's right across the strait from Canada, and a hospital in Victoria, British Columbia. Approximately the same size, same number of beds, same type of care. And the test was to check how many people on payroll were involved in processing paper and the finances. Well, don't laugh yet. Okay. The Port Angeles hospital – 24 people on staff who did nothing but processing paper and applications for insurance payments. And the number in the Canadian hospital, right across the water – 1. One. Took all the bills up, sent in one bill for it and got one back from the government. Now Kathleen's going to talk a little bit about Canada and some other countries and I'll be back with Sweden and Denmark.

KATHLEEN: One thing in Canada is that there is coverage for all, one way or another. In British Columbia Jerry's children pay \$70 a person or \$140 per family per month, it doesn't matter how many children you have. I have goose bumps just saying that. The federal government provides subsidies to the provinces and of course in an election year, which this is going to be up there one way or another, the subsidies flow a little more freely to the provinces to make people happy, and health care is in fact one of the campaign debate issues up there at this point. And I'll get to that but let me run through quickly the history of health care in Canada. Canada didn't always have the kind of health care it does now, the single payer form. In 1947 the province of Saskatchewan introduced a public insurance plan for hospital services only. In 1956 the federal government offered cost sharing for hospital and diagnostic services to encourage provinces to develop hospital insurance for everyone. And in fact, eventually all of the provinces, all of the people of all of the provinces, voted strongly for this sort of health plan. In 1961, all provinces and what were then the two territories, signed agreements for federal cost sharing for at least inpatient hospital care. And in 1968 the federal government began cost sharing of physician services to all the doctors in all the provinces. In 1972, all provincial and territorial plans extended to include physician services and the big thing that made the biggest change was in 1984 with passage of the universal health care system called the Canada Health Act. Now I have to tell you that there is a little different premise in Canada about caring for each other than there is here. Canadians do care for each other. They worry about each other. When you are looking at real estate, the real estate agent the first thing they talk about, other than the building is strong, is the sense of community in the neighborhood. And by sense of community they mean caring for each other. What a concept. So I was telling someone earlier today how the new Premier, when he came in, acted as if he was taking a class from George Bush, and the first thing he did on his first day in office was to cut senior bus passes. Two days later the demonstration on the lawn of the Parliament in Victoria was incredible, and it wasn't just people with gray hair, it was everybody – because everybody was outraged that anyone would do that to seniors. They care about seniors. They care about each other. And actually, I wondered how this happened after five years and ten years of commuting there and all of this. We went out for a beer with some of our students last spring, and it was about the third time we'd done this with this particular group, and finally I said, "How did you guys get this way? Where did you get this sense of community? I mean you don't just say – okay, community time, we think that way." Well, it turns out that in primary school, fourth graders mentor first graders. And they're responsible for making sure that first grader does well in every way, all the way through school. And then when that first grader

becomes a fourth grader, they take a first grader. And the families become associated and they worry about the welfare of the families they're mentoring. And it's an incredible process that is a truly community-building one. So we have this Canada Health Act where everyone is covered. It includes a minimum standard of health care, I mean a definition of that; mandates federal cost sharing and oversight; describes responsibilities of federal and provincial governments; establishes penalties and means of arbitration between federal and provincial governments when the standards are not met; and it allows for the government to bargain with suppliers and pharmaceutical companies on behalf of the people. Remember, in our new Medicare prescription drug bill, it is specified by the Bush administration that the government may not negotiate with pharmaceutical companies. You begin to wonder how that can be in the people's best interest.

The health insurance plans of the provinces and territories must insure all health services now. Insured health services include medically necessary hospital, physician and dental surgical – that is dental surgery, dental work performed in a hospital and oral surgery services. All of the insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. This requires that everyone who meets eligibility requirements – and eligibility is defined as “a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province.” Now that means if Jerry and I were to go there and live permanently, we'd be covered. As part-time employees of the University of British Columbia, there is a requirement that you have to live there three months, in some provinces it's now six months, before you can qualify. And as a foreigner, you have to be earning money and contributing to the tax system in order to qualify. And they've actually kicked out some Americans or been big scenes where Americans would go with their Social Security and did things a little too flamboyantly and got caught, and were either told that they would be taxed or have their health insurance removed.

Residents moving from one province or territory to another or temporarily traveling within Canada or abroad must be continually covered. And in that case, if they're moving within Canada, their home province covers their expenses if they're treated in an emergency situation in the province they're visiting. The reason that Victoria is such a popular place is that if Canadians go abroad, especially to the United States, they have to buy extra health care insurance to be in the United States to be served, because Canada can only pay, except in these reciprocal cases with the Oncology Center in Seattle and others across our country where they have official relationships. Individuals traveling from Canada to here in the past have bought supplemental insurance which is only available through American insurance companies, and it's now been put out of almost any Canadian's reach as far as cost in the last two or three years. And those costs were increased when Canada refused to send troops to Iraq. Only a coincidence. But Canadians can travel within the British Commonwealth and have full coverage. Once they get to England, if they go to Spain and break a hip it's fixed. It's fixed. So we don't enjoy that reciprocal agreement with the European Union or basically anybody else I guess. So Canadians have full care within Canada basically. The costs for health insurance do vary from province to province but it's never above \$150 or \$160 per month per family.

That's basically the Canadian picture and it is very different from ours. As Jerry said, there are people coming to the United States for some care, especially cancer operations, but the government of Canada generally pays for those. People with a lot of money can use a second tier

– and this is a very big political discussion not only in Canada but France, Sweden, Denmark and all the countries we'll cover quickly – more quickly anyway – and that is the consideration of a second or third tier level of medical care. Now politically the more conservative parties in Canada have united into what is now called the Conservative party, and this just happened very recently. But the most conservative candidate or member of Parliament in Canada would never dream of suggesting they do away with their national health care – never dream of it. It would be suicide. It's just against their principles.

So I'm going to move on to France. Many of you may know that in the year 2000 the World Health Organization rated France's health care system the best in the world. I think people living in France would not say that now necessarily. The recession and the economic downturn has been universal and every government, the problems that we have are perhaps greater than those in other countries because we start at a lower place. We're, as you all know, the only industrialized nation in the world without health care for all of its citizens, or even residents. When I was talking about Canada, you don't have to be a citizen. You don't even have to be a citizen to vote. If you're there, they care about you.

In 1996 France had a tremendous economic tax, welfare and health care crisis which when they thought their whole health care system was going to fall apart, and instead of putting Band-Aids on it, they got together, the Ministry of Health with health care practitioners, specialists and patients – imagine consulting patients – and came up with new legislation to develop a new health plan. By 1998 they had upgraded practicing guidelines by and for doctors, wiping out vague old rules and attempting to establish moral and ethical approaches to providing sound medicine to all. I keep stressing that. In 1999, they passed the *Couverture Maladie Universelle*, or CMU, which provides health care for all French citizens. Now that's a little less generous than Canada, you notice – not just anyone there but citizens. This system means anyone in France is covered in slightly varying degrees, and if you're working especially you're covered because you pay taxes. France, of course, has a huge migratory population right now and has for the last 10 years. People from North Africa and Eastern Europe have flocked to France, especially North Africa from French-speaking countries, so they have about a 10% Muslim population from Algeria and other Northern African countries. So the new system combines private medical services with the government paying for 96% of all medical care including checkups, doctor visits, immunizations, alternative medicine and hospital care. And I forgot to mention alternative medicine, most of it is covered in Canada as well. Specialists, transplants, surgery and long-term private care by physicians and in hospitals and clinics are covered. Prenatal care, child and infant care, people with disabilities, mental health, elderly assistance including devices such as wheelchairs and scooters, drugs, health care education in middle schools is covered by the government, safe sex and contraception education, access to abortions, chiropractors, and some dental care. People of all incomes have equal access. I forgot to mention abortions in Canada as well, where our students were always shocked about two things. They'd never heard of a pre-existing condition, they didn't know what it was, and they were just gasping over somebody trying to stop somebody from having an abortion. The Canadian attitude generally is, it's a person's own decision. Period. There are, though, religious groups trying to influence things in another direction. I won't say it's all of one mind. 90% of the hospitals, private clinics and not-for-profit medical offices in France are paid by the government, which is all funded by the Social Security Sickness Insurance – that's the English translation – SSSI.

Today things are a little different in France than when the World Health Organization rated it first in the world. Last summer, 15,000 people died in a heat wave due to a lack of fresh air, air conditioning, and health care. Local clinics couldn't handle what happened and that became an extremely volatile, huge, mega political problem for the incumbents. So you'll notice if you read the newspapers in the last few weeks, in provincial elections Chirac's government has taken some real hits. It's in response primarily to health care provision.

A couple of weeks ago, thousands of health care workers protested in front of the Health Ministry in Paris, protesting staff shortages and creeping privatization of health care. So this is going on everywhere. They don't call it a second tier, they call it creeping privatization. They claim that regulation hasn't worked, economics, lower incomes, more people unemployed does the same thing it does here, it lowers the revenue coming into the government to be spent on health care. Now of course, in our case we're spending more on war and an attempt to spend less on health care. France also has an aging population and an even higher rate than ours, and they're actually thinking of higher taxes and co-payments. Co-payments. Do you want to do Sweden and Denmark now or should I keep going? I'll go quicker.

In Germany there is an incredible web of *crankencossen*, which are 600 sickness funds, which are sort of like private insurance but it's a network that provides a combination of socialized and private health care for all residents, not just citizens. One has to join a fund and you get the same results that you would if you were paying a health insurance company. The funds pay health care providers for the services. Anyone employed has to join. People with higher incomes may join at a higher cost, for which they would get better benefits, or take out private insurance to supplement their sickness fund. Many self-employed people may do that as well. The government pays the *crankencossen* memberships for the unemployed and welfare recipients. So this is in a way the government subsidizing a kind of insurer. There's no separation of medical and hospitalization benefits, which are uniform for everyone with some slight variations among plans. You may choose your doctor and dentist, while some doctors only accept private patients. Now this is sounding a little more like ours. Germans present a card to the doctor, the doctor bills the Sickness Fund directly, quarterly for consultations, exams, surgery, therapy and both mental and physical, convalescence and home nursing. Co-payments are required for drugs, acute hospital care and dental care. There are special rates for students and no contribution is required for the unemployed, people on welfare, the disabled, pensioners or other Social Security recipients. Chancellor Gerhard Schröder's 2003 agenda, 2010, aimed to reform the welfare and health care systems and the tax code. And what he really wanted to do was to increase the taxes and reduce the benefits. We've heard that before, right? He's having a hard time politically, as you all know. His results as he forecast would limit unemployment benefits and make it easier for small companies to fire workers. Now we just heard today in the Press Democrat that employers are now going to be allowed to reduce benefits of retirees. And hospital stays the charge will be increased to 10 Euros a day. That's about what now - \$12 or \$13 - a day to the patient, up to 28 days. And keep in mind that Germany spends more on health care than any other country except the United States and Switzerland.

France- French people use more pharmaceuticals than anyone else in Europe, and that's another thing that they're trying to do is to reduce - also because they have television commercials advertising them, people are asking for them more, and because it's connected to the government they're trying to stop that from happening. Of course here we have the opposite going on where

we have free speech and you can spend your money however you want, so you can try to convince people to ask their doctors to prescribe the blue pill.

JERRY: By the way, just so you don't think I'm unfairly picking on anybody, there was a lot of good stuff in the National Association of Health Underwriters paper – dangers of obesity and the problems that have occurred by the federal government cutting back on the Veterans Affairs and their hospitals and other dangers from the way people treat themselves and so forth. What I object to is carrying water for the insurance propaganda and not telling the real truth. There's an item in here about Goebel, Hitler's propaganda minister, saying if you tell a big lie often enough people will believe it. And that's kind of the way it is about what people have been saying about some of the things about Canada.

Anyway, Sweden – Marcus Childs wrote a book in the late 1930s called “Sweden, the Middle Way” and that's really what it is. It's sort of a modest form of gentle noncommunist socialism and the amazing thing is that government health care was first a consideration of the Swedish government in the 1700s. And at that time they required that each municipality provide some medical care for indigent people. Anyway, finally in the '60s it reformulated all this and their system, which is somewhat similar to what they do in Denmark, is a sort of 3-tier system. There's a national health system that sets policies and oversees what goes on, but the basic work that is done in medical care, hospitals and so forth are handled by what are in effect counties and by county councils, and there are 26 of these and they're elected for 4-year terms. And then outpatient work and public health and so forth, much of it is in the hands of municipalities. And there are some 288 of those. They do require, they passed a rule called the 7 Crown Law, which required a co-payment of 7 crowns and I think that's about a dollar, but I'm not quite sure what the latest rate is. And the reason for that, not only in Sweden but the British system, at first when it came in and when the Atlee government put in a national health system in the late 1940s, you could just walk in and get medical treatment and that all sounded all well and good. But they decided to put in at least a minimal co-pay, and I think it was about a shilling. And the reason was that they found that there were a lot of people, it was like people going down and enjoying trying on shoes at the shoe store – they just loved to go see their doctor. And the hypochondriacs had a hay-day. So at least make that cost them a little something and cut that down, they required some co-pay. And that's what the 7 crown law does in Sweden. It's not just that it helps fund the program but also it's a method of keeping down the people who don't really need the help. It's a country of course much smaller. Physically it's about the same size as California but it only has 9 million people. And so it's somewhat easier to keep track of things and to run, but they have a very low mortality rate in early childhood, they have long life expectancies and generally it's considered a very satisfactory system by the people of Sweden. In fact, Sweden is so good to its people, it gets boring, which may account for the fact that it has one of the highest suicide rates in the world. But this 3-tier system seems to work pretty well and the kind of care they get seems to be pretty good. And the taxes are not overwhelming but they can run as high as 50%, but in the lower ranges they're about 27%, which is not too different from what the US was except for the fact that up until about 15 years ago. And the reason, but the difference is that we've always had a lot of exemptions and deductions that we can take. But the local municipalities cover a lot of things besides hospitalization, which is handled by these councils. They have social welfare service, child care, care of the elderly, care of the disabled, long-term psychiatric patients are under their care, care of environmental hygiene and school health services, and public nursing homes and home care are all directly handled by the municipalities.

In Denmark, the system is even maybe a little more generous and it also has approximately the same type of 3-tier system: a general overall national board looks at what is called the Ministry of Health, and then they have operational responsibilities in the counties, and municipal medical authorities cover outpatient care and so forth. The tax rate is about 50%, but they have a smaller population, they have a population of 5 million people. They are really sort of laissez-faire on things. Prostitution, for instance, is not a crime in Denmark and only recently have they begun monitoring it because of the great health dangers of this business. There are three main medical schools in Denmark and the quality of the education is good. The cost, as I say, is a little higher, that is the cost to the government and therefore to the people is a little higher as far as the taxation is concerned in Sweden, but basically it's similar. It covers a little more, has less co-pay. People can get private care but there is really not a regular system set up for it. The pharmacies and the payment for coverage for prescriptions and drugs is operated by a separate board coming out of the Ministry of Health, and so they have some control of that and it means the cost to the average person or even the non-average person who needs pharmaceuticals is very, very low. The people seem happy with these and the results are pretty good. Of course you would see some unhappiness about the tax rate but as I showed earlier, we are already paying substantial taxes and we're paying other costs that the average person in the street does not have to bear in these two countries. Of course these countries are smaller and they're probably easier to monitor and to handle, but they seem quite satisfied.

KATHLEEN: I can see that we're beyond I think our time that we were allotted but there are some commonalities through these countries. We have lived in Sonoma for 30 years and have suffered through the ups and downs of Sonoma Valley Hospital, one of the health care districts now. Jerry served as treasurer of the board of that hospital and I have just been recently, about a month ago, appointed to a new committee to figure out what to do with the hospital. It hasn't met yet, interestingly enough. We in this county have a crisis and we have a national crisis, and all of the countries we've talked about have similar problems and it all in some ways has to do with money. In our case in this country, it also has to do with national attitudes, which I think if we want to change the system we need to change public attitudes. And there are clinics closing in Canada, Sweden, France, England, Germany, because of lack of money. But what national health care systems offer is what Jerry suggested earlier, is a consolidation of resources. And this doesn't necessarily mean rationing of health care any more than we have it now, rationalized by the insurance companies. It just means – I mean here we are into semantics again – is rationing health care what you call giving everybody a chance at health care, distributing the resources somewhat equally? Some people will call that socialized. I don't really care what it's called but we need to change our system to make sure that we all, locally and nationally, have an equal opportunity at health care. Thank you.