Thou Shalt Not Stand Idly By: Health Care is a Human Right

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THOU SHALT NOT STAND IDLY BY: HEALTH CARE IS A HUMAN RIGHT

Elaine Fox

Thou shalt not stand idly by when a human life is in danger
—Leviticus 19:16

In late 1938 my father was 19 years old and had already spent a week of unknown trauma under Nazi arrest. He was able to get out of Vienna, increasing his own personal peril by secretly carrying a small silver Torah with him as a favor to its owner. He spent two years working in London, with the organization that had saved him, helping to get other Jews out of Nazi-occupied Europe. Then he was arrested again, this time by the British, as an alien from an enemy state. After spending months in various internment camps in England, he was deported to Canada on a ship filled not only with other Jews like himself but with Nazis as well. Two years after his release from the Canadian internment camps where he labored as a lumberjack, he went to school. While under internment my father had developed diabetes.

Recently my sister discovered among my father's papers a report he had written in English in 1946 entitled "The Need for Social Insurance." In it he supported the Austrian national health system that had kept him healthy in pre-annexation Vienna, despite his family's poverty. His paper detailed the comprehensiveness and universality of that program. In contrast, he wrote, in Canada in 1946

most hospitals and medical centers were either run privately or sustained by charitable donations and the condition of those institutions was clearly dependent on their financial status. He noted difficulties in accessing care, highlighted increasing costs, and identified the humiliation associated with seeking care for the very poor. He also noted that poverty meant that financial hardships would be accompanied by untreated physical ailments. Lastly, he wrote that it was unwise to entrust medical research only to private or charitable funding, as was the case in Canada then. Years later, when Canada adopted its national health insurance program, I doubt my father remembered his old report. However, I do think his ideas were steeped in the Jewish ethics instilled in him as a youth in pre-war Europe. And, as his daughter, I am sure that I inherited a Jewish dedication to social justice that shaped both my career as a physician and my more recently developed health care activism.

Through my years of practicing medicine I have become sensitized to the institutionalized race and class biases that affect our health care system. Certainly racism and anti-Semitism had been a fact of life for me—both my parents escaped the bulk of the Holocaust in Europe with their lives, but they were never the same—and my sister and I were deeply affected by our parents' experience. My father's side of the family was wiped out, and I never knew the great-uncle and aunt I would have had on my mother's side. But, I always say that as a child I was ostracized for three reasons: I was poor, fat, and smart. Most of the Jewish kids whom my parents would have preferred be my friends lived on the "right" side of the tracks, and we didn't. My father (his memory is a blessing) was a synagogue administrator who worked with a membership of incredibly wealthy people, and my mother worked as a secretary in the high school guidance office when my sister and I were old enough for her to do so. My parents, I think, looked at education as essential, not for education's sake, but as a means to being able to take care of ourselves.

I started college very altruistically with the idea of becoming a social worker. When I was accepted as a sophomore at Yale the first year they took women, I felt empowered enough to think that I might do more for people as a physician. And, surely, I would always be able to find a job….

It was a twist of fate that when I moved back to New York City to marry my husband, who is an abstract artist, we could not afford to stay there to start a family. When a job in a medical group became available in Southampton on Long Island, it seemed like a reasonable compromise—it was close enough to NYC for it to be a day trip, and it had an art history all its own. Though it is the center of "the Hamptons," resort to the rich and famous, the hospital is a community hospital that serves the regular year-round residents as well and is the biggest employer in the town. It is the closest hospital for points as far as 30 miles east. The population at least triples during the summer months, and the disparity between rich and poor is striking. The hospital is not a teaching hospital and only recently hired a hospitalist. This meant that, if a patient of mine—or one for whom I was covering—was acutely ill at 3 a.m., I had to go to the hospital to take care of him or her.

February 1987

As the only female partner in a small multispecialty medical group with 12 male partners, I saved up all my vacation and CME

(continuing medical education) time and took no vacation at all the year I became pregnant—that way I would be able to use those precious days as my maternity leave. My baby was born via C-section, and all went pretty well until my first day back at work a short eight weeks later. Immediately, I was thrown into full-time primary care medicine and a heavy on-call schedule, and I came home my first night as a working mother to a snowstorm. While I was watching the 11:00 news on TV, sitting in the den with my husband and new baby, the phone rang.

I tensed up a little as I always did when on call, worried that I would be responsible for a very sick patient. But this time, the doctor on the other end of the line was calling from Florida, telling me that hours earlier my parents had been in a motor vehicle accident. He said that my mother was in critical condition with multiple trauma, and my father had been killed. I was totally devastated. My sister flew to Florida from Oregon and I flew there from New York. We visited my mother while we made funeral arrangements for my father. The funeral was in New York, and my sister and I had to leave our mother in the Intensive Care Unit to attend the funeral. Of course, while I was gone one of my partners had to take my weekend call. When I returned to work one week later, I was expected to "take call" the following weekend, as if there had been a run of the mill weekend switch.

Emotionally overwhelmed, it did not occur to me to protest. It wasn't until years later that I would realize that the group—my all male partners—were not interested in meeting my needs in the least. *Only in retrospect did it become clear to me that sexism had permeated the group. My inability to recognize it as such at the time surely added to my stress*.

FEBRUARY 1988

Exactly one year later, our two beautiful dogs, a mother and son, got out of our fenced back yard at night, as they had done previously. Unlike other times, they did not return the next morning. For two weeks, my husband and I spent every spare minute we had searching for them. Each added day they were missing brought us more despair. Finally, after someone gave him a "tip" as to their whereabouts, my husband found them near the railroad tracks. He called me immediately—I was at work. It was worse than our worst nightmares; the dogs were not killed by a train. They were killed by people who had purposefully and methodically mutilated them, leaving their dismembered bodies by the tracks.

FEBRUARY 1989

The loss of my father, the near death of my mother, the care of a new baby, the gruesome murder of our dogs, and the care of others at work took their toll. Though I was able to continue working, I had to seek psychiatric support for depression and stress. In a way, that added more stress because, unable to easily keep things private in my small town with a small town hospital, I was always afraid of being "found out." Although mental health is a part of physical health, the stigma attached to mental health problems in our country is as blatant as a scarlet letter. I felt I would have been talked about and demeaned or labeled if others knew.

SEPTEMBER 1991

About two years later, after making several unsuccessful attempts to get my group to accommodate my needs, I finally left the

group. I started my own solo private medical practice. As we were no longer part of the group health insurance plan, my family had to apply for our own coverage. We got a policy that had a low premium but a huge deductible, much like those being touted now to accompany health savings accounts (HSAs). Luckily, we were healthy. I say luckily, because this is really the only scenario in which these policies work. If you are seriously or chronically ill, they can financially decimate you. In order to get this policy, I had to sign a waiver stating that I would not be covered for any claims relating to either a C-section or psychotherapy. It seemed to me, as both a physician and a patient (especially when I decided to have another child a couple of years later), that disallowing coverage for a C-section bordered on the unethical. (I later realized that so too does the exclusion of mental health services, clearly a large enough topic for another essay. Parity between physical health coverage and mental health coverage is extremely rare.)

Shortly after I left the group practice and went out on my own, I learned of an organization called Physicians for a National Health Program (PNHP), a national single-issue organization advocating a universal, comprehensive single-payer national health program. At the time I was trying to make a living as a solo practitioner while remaining true to myself as a physician, and for me that meant always putting the patient first. I felt acutely the ways in which I was being pushed to be a businesswoman first and a physician only second. Health insurance for people under 65 without Medicare was often a problem, and its seemingly arbitrary rules intruded into my relationship with my patients, sometimes becoming an unwelcome variable in medical decision-making. It seemed wrong. As I learned more about PNHP, I was increasingly impressed by their idealism and professionalism. A single-payer plan made sense to me because, if there were single payer national health insurance, I wouldn't have to agonize over ordering appropriate tests for which the patient was not covered. I wouldn't have to balance helping them medically with harming them financially. I wouldn't have to jump through hoops to make things "fair" for patients.

Although no health care policy can be perfect, I still feel today that this plan makes the most sense. In retrospect, although I didn't recognize it then, my sense of professional isolation in my own community was profound. None of my colleagues seemed to see things from the same perspective, although they may simply have had no time to look, working as hard as they were to survive and given our town's high cost of living. At times, it seemed like the physicians of PNHP—dispersed across the country—were my only real colleagues, the only ones who lived in the real world.

If one possesses medicines and [ones] neighbor falls sick, [one] is forbidden to advance the price thereof unreasonably
—Shulchan Aruch,
Code of Jewish Law CXCII:10

Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible.
—Milton Friedman, in
Capitalism & Freedom, 1962.

As managed care spread, the insurance companies became more and more aggressive. While my colleagues were all scrambling

ABOUT PNHP

FOUNDED IN 1987 BY A SMALL GROUP OF PHYSICIANS convinced that the nation's health care system needed reform, PNHP today is a member-based organization with over 12,000 members, representing every specialty and every state. It has played a key role in focusing the health care policy debate on the need for non-profit national health insurance and specifically advocates for single-payer national health insurance. PNHP physician activists organize meetings and debates, coordinate speakers and forum discussions, and contribute Op-Eds, Letters to the Editor, and articles to newspapers, medical journals and magazines.

PNHP MISSION STATEMENT

Physicians for a National Health Program (PNHP) believes that access to high-quality health care is a right of all people and should be provided equitably as a public service rather than bought and sold as a commodity.

The mission of PNHP is therefore to educate physicians, other health workers, and the general public on the need for a comprehensive, high-quality, publicly-funded health care program, equitably-accessible to all residents of the United States.

Equitable accessibility requires, in the view of PNHP, removal of the barriers to adequate health care currently faced by the uninsured, the poor, minority populations and immigrants, both documented and undocumented.

PNHP views this campaign as part of the campaign for social justice in the United States. PNHP opposes for-profit control, and especially corporate control, of the health system and favors democratic control, public administration, and single-payer financing.

PNHP believes this program should be financed by truly progressive taxation. PNHP actively opposes current changes in the health care system that are designed to maximize the profits of investors and the incomes of high-level executives rather than to serve patients.

PNHP's goal is the restoration of what it views as the primary mission of physicians, acting as professional advocates for our patients.

PNHP is an independent, non-partisan, voluntary organization. PNHP's work is supported by our members' dues and contributions, and by grants from progressive foundations; it accepts no funding from pharmaceutical companies or other for-profit entities. PNHP organizes physicians, medical students, other health workers, and the public in support of this program and promotes discussion of health policy in the U.S. through conferences, lectures, articles, and other methods.

to be accepted on provider panels for these managed care plans, I held out on principle, refusing to participate—even, I said then, if it put me out of business. I was the breadwinner for the family, but that did not mean I had to stay in solo practice. If necessary, I was prepared to find a salaried position with the

While my colleagues were all scrambling to be accepted on provider panels for these managed care plans, I held out on principle, refusing to participate—even, I said then, if it put me out of business.

county or elsewhere. While my income had not gone up since leaving my group, I had not left because of money.

Many of my patients who were in the managed care plans were loyal to me and continued to see me "out of network," which meant that they had to pay more, or all, of my fees. My income remained generally stable for that reason. As time went on, more and more patients were covered by these employer-sponsored plans and had no alternative. I became uncomfortable, as many of them had to pay extra to see me.

I found myself in a Catch-22. Even if I had decided, in order to accommodate more of my patients, to cave in and start participating in some of the plans (if the plans would still have accepted me at that late date), I would have had to hire another staff person to do all the extra paperwork that was necessary. I could not afford to do that. Ironically, it would have been the participation in the programs that would have put me out of business, rather than the non-participation I had chosen on principle.

"If all the doctors become businessmen, who can we go to when we get sick?" asks a main character in the HBO version of the story of the discovery of the AIDS virus *And The Band Played On.* It has become fashionable for physicians to get masters degrees in business administration, not just to "get rich," but to help them make a living by practicing medicine. I didn't think I had blinders on, but if I had wanted to go to business school, I would have done that and not become a doctor.

The business of medicine, I found, did not offer equal treatment to everyone. Poor people are disproportionately people of color, and over and over again, I saw examples of patients whose care I could advance only so much because of the way our system works to disadvantage poor people, especially those of color. For instance, an African-American/Native-American woman worked as a housekeeper for an extremely wealthy artist and got no benefits with her job. As her heart disease evolved and progressed, I suggested she apply for disability benefits. Still, she had to wait two years to become eligible for Medicare. Another African-American patient of mine was dependent on Medicaid to get proper medication for her diabetes; if the complicated paperwork did not go through for each period, she was out of luck. Despite the fact that doctors and pharmacists counsel against this, she was sometimes forced to borrow some of her brother's medication. Later, she had to undergo some lower extremity amputations. Now, she also has some difficulty with her hands, but she can function independently with a limited amount of assistance each day. However, she was placed in a for-profit nursing home after her last hospital discharge, and, now that she is more solidly on the Medicaid rosters, the nursing home will not help her return to independent living

so that she can be a mother to her 14-year-old daughter. The nursing home stands to lose $7,000/month in Medicaid reimbursement if the patient leaves. Our current health care system and our taxes support these nursing home payments, despite the fact that it would only cost $1500/month to cover an apartment, prescriptions, and a home health aide a few hours a day on weekdays. This would allow her daughter to live with her.

There are similar stories all over the country. And all over the country, there are doctors who want to give their disadvantaged patients a voice. What PNHP tries to do is highlight the fact that these stories are becoming less unusual—and more the norm. Those full-time Wal-Mart employees who have health care themselves may be told to get their children on Medicaid. Many Wal-Mart employees are kept from working enough hours to qualify for Wal-Mart's health care coverage at all, yet they make too much to qualify for Medicaid. Manufacturing corporations like Delphi, and airlines like Northwest declare bankruptcy in part to force workers to assume a tremendous share of their health insurance costs. These working people are not on the public rolls and may technically have private insurance. They are swelling the ranks of the *under*insured as the employment-based health care system in our country fails at an accelerated rate.

Health insurance is no longer affordable to employers. In order to remain in business, they have to shift costs to their workers, who *certainly* can't afford it. Many organizations are now supporting universal health care plans, where every person in the country would have health care coverage. These plans take a variety of forms, and some of them are a complicated patchwork of public and private coverage. PNHP believes that our American companies are losing competitive advantage in the world because we do not have a "single-payer" system of *national* health insurance. Every other developed nation has a national health program that covers its people.

When I first joined PNHP, it was a national organization and there was little local activity, even in New York City. For five years, I paid dues but did little else. In 1997 The Ad Hoc Committee to Defend Health Care, started in Boston by those who founded PNHP ten years earlier as well as others, provided a strategy, "A Call to Action," that I was able to embrace locally. This document addressed the evils of the corporatization of medicine and articulated my feelings very well. Though perhaps written in a bit of a melodramatic style, the "Call to Action" expressed ideas that are reflected as well in ancient Jewish texts. For example, "Mounting shadows darken our calling and threaten to transform healing from a covenant into a business contract." Was there ever a more Biblical concept than a covenant?

I felt then, and I feel now, that the idea that everyone deserves health care is an inherently Jewish concept. When I was accepted as a member of the second class of the Hadassah Leadership Academy, which was designed to train qualified women to become (Hadassah) leaders, I hoped to combine my interest in Judaism and women's issues with my interest in medicine and health care. During my time in that program, I made an effort to get national Hadassah to issue a policy statement supporting a national health plan. I was unsuccessful (although I did have an article in the January 2004 issue of Hadassah magazine about the issue). Perhaps the timing was not right for Hadassah, although I feel now—more than ever—that Hillel's question: "If not now, when?" is urgent.

The language of the "Call To Action" made it amenable to use as a petition, and my activism really began in that moment. I circu-

lated it around our small hospital and got close to 50 signatures of doctors and nurses who endorsed it. One local paper printed "A Call to Action" in its entirety, along with the signatures, and a second paper reported on it.

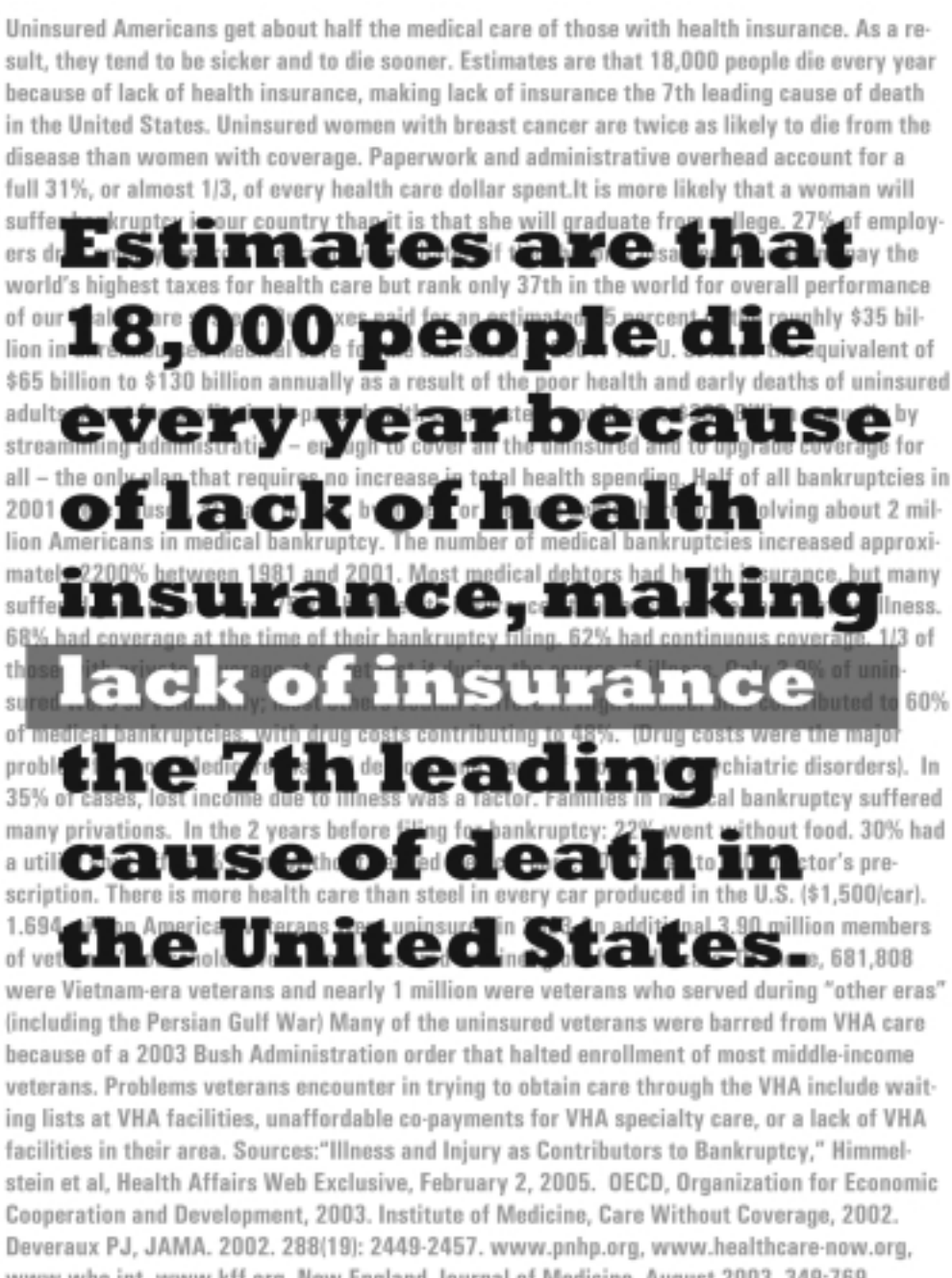
On December 2, 1997, I presented my first program on the subject, the day that many other national activities pertinent to the "Call to Action" were occurring, most notably a Boston Tea Party in which boxes of HMO paperwork were symbolically dumped into Boston Harbor (and promptly retrieved for environmental reasons). My talk was poorly attended, but it was a start.

one of my patients, after a long hospital stay, found that she no longer existed in the Medicare system. She, or someone in her family, had unwittingly signed over her Medicare benefits to a United Healthcare HMO that took over during her long stay.

I formed a local branch of the Ad Hoc Committee to Defend Health Care. However, the Ad Hoc Committee was aimed at reopening the debate about health care reform; while it presented the problems quite clearly, it did not call for any particular solution other than a moratorium on the transformation of public and voluntary hospitals to for-profit ventures. I believe that even though it provided a good platform (for me) from which to begin addressing the problems of the health care system, it did not evolve further into a committee of active members—because there was no goal around which people could rally. Our funds were ultimately used for further educational materials.

Meanwhile, my practice kept providing me with sad examples of our troubled health care system, which was becoming increasingly market-driven and full of confusing paperwork. Disparities in care were blatant. For instance, one of my patients, after a long hospital stay, found that she no longer existed in the Medicare system. She, or someone in her family, had unwittingly signed over her Medicare benefits to a United Healthcare HMO that took over during her long stay. Clearly, this patient was a victim of aggressive marketing that did not provide informed consent as is required for medical procedures; she and her family had no idea that signing up with United Healthcare meant that she forfeited her Medicare rights to a profit-driven corporation whose primary responsibility was to its shareholders. Her premium, in this case, her Medicare benefits (for which we all pay taxes), was being used to fuel stockholder profits rather than to provide for her health. Indeed, the new Medicare prescription "benefit" for seniors is another good example of the ways in which our current health care system requires complicated paperwork and tremendous bureaucracies, limits benefits to consumers, and, at the same time, funnels our tax dollars to the profit-driven insurance and drug companies.

Since health care in this country is a business, PNHP also examines who is profiting from health care. For example, they reported that United Healthcare (the HMO in the example just cited) had previously been under the aegis of MetLife, an insurance company that itself owned millions of dollars in stock in Phillip Morris and RJ Reynolds (tobacco companies). So, not only does "big tobacco" cause suffering, profiting from that directly, but it also profits from the suffering of others indirectly, via



Uninsured Americans get about half the medical care of those with health insurance. As a result, they tend to be sicker and to die sooner. Estimates are that 18,000 people die every year because of lack of health insurance, making lack of insurance the 7th leading cause of death in the United States. Uninsured women with breast cancer are twice as likely to die from the disease than women with coverage. Paperwork and administrative overhead account for a full 31%, or almost 1/3, of every health care dollar spent.It is more likely that a woman will suffer bankruptcy in our country than it is that she will graduate from college. 27% of employers dr say the world's highest taxes for health care but rank only 37th in the world for overall performance of our h taxes paid for an estimated 5 percent of roughly $35 billion in equivalent of $65 billion to $130 billion annually as a result of the poor health and early deaths of uninsured adults by streamlining administrati – enough to cover all the uninsured and to upgrade coverage for all – the only plan that requires no increase in total health spending. Half of all bankruptcies in 2001 involving about 2 million Americans in medical bankruptcy. The number of medical bankruptcies increased approximately 2200% between 1981 and 2001. Most medical debtors had health insurance, but many suffered illness. 68% had coverage at the time of their bankruptcy filing. 62% had continuous coverage. 1/3 of those of uninsured; contributed to 60% of medical bankruptcies. With drug costs contributing to 48%. (Drug costs were the major problem psychiatric disorders). In 35% of cases, lost income due to illness was a factor. Families in medical bankruptcy suffered many privations. In the 2 years before filing for bankruptcy: 22% went without food. 30% had a utility doctor's prescription. There is more health care than steel in every car produced in the U.S. ($1,500/car). 1.694 Million American Veterans are uninsured. In addition, 3.90 million members of veterans' households are uninsured. Of the uninsured veterans, 681,808 were Vietnam-era veterans and nearly 1 million were veterans who served during "other eras" (including the Persian Gulf War) Many of the uninsured veterans were barred from VHA care because of a 2003 Bush Administration order that halted enrollment of most middle-income veterans. Problems veterans encounter in trying to obtain care through the VHA include waiting lists at VHA facilities, unaffordable co-payments for VHA specialty care, or a lack of VHA facilities in their area. Sources:"Illness and Injury as Contributors to Bankruptcy," Himmelstein et al, Health Affairs Web Exclusive, February 2, 2005. OECD, Organization for Economic Cooperation and Development, 2003. Institute of Medicine, Care Without Coverage, 2002. Deveraux PJ, JAMA. 2002. 288(19): 2449-2457. www.pnhp.org, www.healthcare-now.org, www.who.int, www.kff.org. New England Journal of Medicine, August 2003. 349:769.

investments from health care and insurance companies. Coming full circle, the HMOs pay hospitals slowly so as to accrue the most interest possible on their own investments.

Later in the spring of 1998, despite my mother's newly failing health, I put together a great forum of eight people from the hospital and the community. The Question & Answer period after my talk helped me to crystallize some ideas, specifically that health care is a human right, not a commodity. My own experiences have taught me that, as a physician, sworn to "first do no harm," it is my responsibility to raise the issues of health care reform by "speaking truth to power." Interestingly, there was a recent study in the *Archives of Internal Medicine* (2004) that showed that 67% of doctors in Massachusetts favored a single payer national health insurance system, but only 42% knew that so many of their colleagues favored it. Thus, it appears that there is a silent majority of physicians who support a single-payer plan. They may not want to stick their necks out in part because they do not realize they are a majority.

In 2000 I had some medical problems of my own. These, added to the cumulative stresses of a solo practice, a hospital with no house staff, and the issues with paperwork and the "business" of medicine, led me to decide to stop my clinical practice in the fall of that year. I felt sad that the changing health care system, in part, cost me many long-term doctor-patient relationships (I had cared for some of my patients for 17 years—a tremendous loss). It also saddened me greatly to know that, as a female physician, I had been excluded from the local old boys' network both professionally and socially.

In early 2003, Congressman John Conyers of Detroit introduced HR 676, The National Health Insurance Act, or the Expanded and Improved Medicare for All Act. Finally, we had something around which to rally! This bill, all 24 pages of it, looks a lot like the proposal presented in an 1989 issue of *New England Journal of Medicine*. In fact, another Physicians' Proposal for National Health Insurance was published in August 2003 in the *Journal of the American Medical Association* (*JAMA*), this time endorsed by 7,000 doctors, including two former Surgeons General, the former editor of the *NEJM*, and many deans of medical schools. (The number of signatures is now up to 12,000+.) This newer proposal, 14 years later, was written by the Physicians' Working Group for Single-Payer National Health Insurance which includes the co-founders of PNHP, David Himmelstein and Steffie Woolhandler, authors of the 1989 proposal. HR 676 is based on the Physicians' Proposal; as of November 2005, the bill had 55 co-sponsors.

In addition to the Physicians' Proposal in *JAMA*, two major studies by Himmelstein and Woolhandler were published in the *NEJM* in August 2003. The first, "The Cost of Health Care Administration in the U.S. and Canada," found that heath care bureaucracy cost U.S. residents $294.3 billion in 1999. Administrative costs accounted for at least 31% of total U.S. health spending that year, compared to 16.7% in Canada. The second study, co-authored with Dr. Sidney Wolfe, director of Public Citizen's Health Research Group, showed that National Health Insurance could save the U.S. about $286 billion in administrative costs in 2003, enough to cover all the uninsured and seniors' drug costs, as well as to improve coverage for the underinsured by adding coverage for mental health, dental, eye, and long term care—all without increasing total U.S. health care spending. Taken to-

gether, these two studies frame our current warped health care system, which actually allows 18,000 people to die each year for lack of health insurance.

Just as medicine needs to be evidence-based, so too does health care policy—it must be based on evidence and not on ideology. I was not surprised to learn that for-profit hospitals have worse outcomes than non-profit hospitals, or that 50% of personal bankruptcies are due to medical debt.

These financial issues translate into real-life pain, as was made starkly clear in a panel discussion in which I participated in early 2005. The fourth member of the panel, a woman who was the founder and chief of the local volunteer ambulance, had been diagnosed with a brain tumor at a time when she had given up her health insurance because it was no longer affordable. She had managed to continue her 14-year-old daughter's insurance, but the two of them lost their own home and had to move in with her parents, where she sleeps on the sofa every night. There had been a generous fundraiser organized for her benefit that raised thousands of dollars, but this money just disappeared into the black hole of medical bills. Fundraisers like these take place in communities all over our country, but they cannot and do not substitute for an adequate health care system that would obviate the need for them altogether

I am now in a new graduate program in Public Health at SUNY Stony Brook, in part to gain some skills to better advocate for national health care. I feel lucky that I was able to graduate from college and not be one of the many women who have had to declare bankruptcy. Education, certainly a Jewish priority, is key—but not just formal education. People don't know about HR 676 or other efforts toward health care reform. Educating the public is essential if we are to become the kind of country that we want to be.

I am passionate about seeing a national health plan implemented because I believe it would save lives and make countless lives better. It would channel our taxes into actual health care and not into administrative waste or the pockets of drug and insurance company stockholders and CEO's. It would save money, both for individuals and businesses. Our current system is biased and broken; we don't have the best health care system in the world, or even the 20th-best. Our life expectancy is shorter than that in Germany, the UK, France, Italy, Canada, and Sweden, and babies die here more often than in Cuba or Beijing. And, the truth is that we already ration health care here—by the ability to pay. I am passionate about seeing a national health plan implemented because of who I am—a Jew, a physician, a mother, a wife. No woman should have to worry about bills and bankruptcy while struggling to deliver a healthy baby. No parents should have to choose between the health of their children and the roof over their heads. No one, depressed and despondent, should be drawn closer to suicide because they have no access to a mental health care provider. No one else should be allowed to die because of lack of insurance. To me, changing our health care system is a moral mandate and a monumental task. But, as Rabbi Tarfon said, "It is not up to you to complete the task, but neither are you free to desist from it."