The 14th Congressional District's
Santa Cruz County Student Advisory Board

Health Policy

2006 Annual Report

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TABLE OF CONTENTS

Introduction
Alok Pandey, Student Advisory Board Chair

No matter where you are on the political spectrum, left, right, or center, the one most important issue, above all others, is your health. In America, we are a society that celebrates life, and good health is a priority for all of us. Today you will hear a presentation from the 14th Congressional Student Advisory Board focusing on Health Care in the United States. Our presentation this afternoon aims to address a variety of topics ranging from Universal Healthcare to Immigrant Health Care to Diabetes and Obesity. In the last six months we have conducted much research and have had the opportunity to come together every other week to help each other formulate ideas on healthcare policy.

As students, we value education and knowledge and we will begin our journey to the real world very soon. The eminent British economist Arnold Toynbee once said "apathy can be overcome by enthusiasm, and enthusiasm can only be aroused by two things: first, an ideal, with takes the imagination by storm, and second, a definite intelligible plan for carrying that ideal into practice." Today you will see our enthusiasm and passion for solving the health problems of the world. Our ideas are well-thought out and reasonable, and we plan to take this experience with us to the next stages of our lives. We hope that what we have to tell you today will at least allow you to ponder some of the inequities of our world, and even make a difference in your outlook. Thank you Congresswoman Eshoo for being here with us today, and thank you for hearing what we have to say.

Obesity
Jillian Wagman

Our nation is getting fatter and fatter. The epidemic of obesity is not receiving the support and funding that it deserves compared to its overwhelming effect on our society. In the United States, 127 million adults are overweight, 60 million are obese, and 9 million are severely obese. Obesity has become the second leading cause of preventable death in the United States, just behind smoking. It is now close to surpassing smoking as the leading preventable cause of death. Smoking has received a lot of attention throughout the past four decades, and now it is time to increase the funding to fight obesity as well, so that we can eventually find a cure.

Obesity is measured by using the Body Mass Index, or BMI. It is based on height and weight, and gives an assessment of total body fat. If a person has a BMI between 18.5 and 24.9, they are at a healthy weight. If their BMI is from 25 to 29.9, they are overweight. A BMI between 30 and 39.9 is considered obesity, and a BMI over 40 denotes severe obesity.[1] It is important to note that people with different builds such as above average musculature may have a BMI that puts them in an unhealthy category, but each individual must determine his or her healthy weight with his or her doctor.

People are obese for a variety of reasons: the dramatic increase in portion sizes has people consuming more fat and calories. Excessive intake of soft drinks fueled by ready availability, low cost, and pervasive advertising, increases the risk of being overweight. Low activity levels also contribute to the high rate of obesity. Drug-induced weight gain is also becoming increasingly prevalent as Americans are using prescription drugs to treat previously incurable illnesses.

Childhood obesity is on the rise for a number of reasons. A key issue is the lack of physical activity; as kids spend more time in front of the television and computers, they play outside less and less. Exacerbating this problem, physical education programs and recess are disappearing from the nation's schools at a shocking rate as school funding decreases and curricular priorities increase. Children are overexposed to advertising for high-calorie, low nutrient foods that increase caloric intake to unhealthy levels.[2] Obesity is also more prevalent in children with obese parents, suggesting that genetics plays a role. Children that are overweight and have at least one overweight or obese parent have a 79% likelihood of being overweight through adulthood.[3]

Whereas in the past obesity was infrequent among children, this problem is growing in my generation. In the early 1970s, 4.3% of boys and 3.6% of girls aged six to eleven were obese. Now, 16% of boys and 14.5% of girls in the same age group are obese. In the early 1970s, 6.1% of boys and 6.2% of girls aged twelve to nineteen were obese. Now, 15.5% of both teenage boys and girls are obese.[4]

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[1] American Obesity Association. http://www.obesity.org.

[2] http://www.obesityinamerica.org.

[3] American Obesity Association. http://www.obesity.org.

[4] American Obesity Association. http://www.obesity.org.

On the whole, obesity increases the risk for more than 30 different serious medical conditions.[5] Obese people are 1.6 times more likely to be admitted to a hospital than their counterparts of a healthy weight.

Having more obese people admitted to hospitals has put a strain on hospital facilities. Traditional hospital equipment is not designed to accommodate obese people. Further, moving obese patients requires more staff and endangers them. Over 80% of hospitals in 2003 stated that they had to spend an estimated $3,500 to $500,000 more annually to care for obese people and purchase new equipment to handle their patients' greater weight.[6] For example, hospital beds that accommodate obese patients cost upwards of five times more than beds for healthy-weight patients.

These striking facts show that obesity research deserves significant funding. Right now it is under-funded. An estimated 60 million people suffer from obesity, but the National Institutes of Health (NIH) spends only about $440 million annually on obesity research. In contrast, AIDS, which affects about 566,000 people in the United States, receives $2.9 billion in funding each year.[7] This means that, per victim, obesity research gets about $7.33 annually, while AIDS research gets $5120. If you include the number of Americans that are overweight or severely obese in these calculations, the amount that we spend per person is only $2.24.

The economic cost of obesity in America far outweighs the research commitment. Compared to the $440 million spent on research, the cost of complications resulting from obesity amounts to an estimated $122.9 billion per year. Of this total annual cost, about $62.7 million is spent on medical visits, and $39.3 million comes from lost workdays and reduced productivity.[8] With so many people at risk for obesity-related illnesses, the NIH should markedly increase obesity funding.

Congress must now increase funding for research and development to find a cure for obesity. Government healthcare plans should also offer incentives for people to achieve and maintain a healthy weight. Many healthcare plans will cover all of the costs of surgery for the morbidly obese but will charge for patients to see a nutritionist. This sends the wrong message, as it is much less expensive to prevent obesity than it is to treat it after someone becomes obese. The United States needs to combat this epidemic that is sweeping our country before our average life expectancy and quality of life declines dramatically and healthcare costs go even higher due to obesity-related complications. Not only does obesity affect individuals, it costs society billions of dollars. Congress must encourage schools to emphasize physical education and healthy lifestyles. I urge Congress to substantially increase funding for obesity research to identify a cure before this problem gets any worse.

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[5] American Obesity Association. http://www.obesity.org.

[6] Pallarito, Karen. "Plumping Up Profits." http://www.usnews.com/usnews/biztech/articles/041220/ 20fat_3.htm.

[7] American Obesity Association. http://www.obesity.org.

[8] http://www.obesityinamerica.org.

Diabetes
Alok Pandey

Driven in part by overeating and inactivity, diabetes has already stricken an estimated one of every eight adult New Yorkers, a rate nearly one-third higher than in the nation as a whole[9]. It is finding new victims, and killing many of them, faster than any other major illness - even as diseases like heart disease or all cancers taken together have leveled off or fallen. If unchecked, it is expected to ensnare coming generations on an unheard-of scale: One in every three Americans born five years ago and one in two Latinos[10].

Diabetes allows sugar to build up in the blood, having many complications: kidney failure, strokes, decaying limbs. Type 2 diabetes, the most widespread variety, increasingly afflicts children, who rarely got it a generation ago[11]. It can often be controlled, or possibly prevented, but many of those at risk - and the medical system that could help them - seem hindered by the effort and cost. Doctors and hospitals reap financial rewards by performing diabetes-related amputations, but little money is available for preventive care and education. For example, patients have trouble securing a reimbursement for visiting a nutritionist costing 75 dollars a visit, but can easily receive 315 dollars for one session of dialysis, one of the disease's serious complications.[12] Diabetes costs the United States $98.2 billion each year. Medical costs for diabetes care -- including hospitalizations, medical care and treatment supplies -- total $44.1 billion. Indirect costs -- including disability payments, time lost from work and premature death -- total $54.1 billion[13].

In our country today, inactivity and lack of exercise is a major problem. Although our media is filled with diet ads, and we have no dearth of wonderful places such as 24 hour fitness and other exercise locations, the majority of Americans are overweight. One of the most probable causes of this situation is the ubiquity of fast food: McDonald's, Burger King, KFC, Taco Bell, and many other fast food chains that dominate our society. Another major problem is the harmful effect of soda to our society. In schools around the nation, soda is being sold to eager children who are not aware of the deleterious impact of drinking these sugar filled drinks. The average American drinks fifty-four gallons of soda a year and Americans over the age of two get an average of 132 calories a day from high-fructose corn syrup found in soda pop[14]. If children consume large amounts of soda when they are young and do not do much exercise that they are on a direct road to diabetes. I encourage Congresswoman Eshoo to support legislation currently sponsored by a bi-partisan group in Congress that would ban unhealthy foods like French fries and soft drinks from our nation's schools.

Congress must create legislation for education starting at the elementary school level for children to beware of the impacts of fast food, and lack of activity. We must also increase the emphasis on physical education throughout our nation. An active and self-confident population will stimulate our economy and give the people of the United States a much needed boost.

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[9] Kristof, Nicholas. *The New York Times*. January 26, 2006
[10] Ibid.
[11] www.diabetes.org
[12] Ibid.
[13] www.diabetes.org
[14] The American Diabetes Association

Under-funded Diseases
Hila Mehr

Forbes Magazine reported on June 13, 2005 that the United States "spends $29 billion each year on medical research" yet "some deadly diseases simply fall through the cracks[15]." Pancreatic cancer, for example, has a five-year survival rate of only 5%, yet only receives one-ninth of the funding from the government that prostate cancer receives, which kills the same number of people. While lung cancer is responsible for 28% of all cancer deaths in the country, it only receives 5% of the National Institute of Health (NIH) cancer research funding[16]. Cystic Fibrosis is a relatively unknown disease that too many children suffer and lose their lives from. This report will focus on the diseases mentioned above that deserve more attention and funding for research by Congress and the National Institute of Health.

Cystic Fibrosis

Cystic Fibrosis, a disease that causes breathing and lung problems because of a gene mutation, has no known cure with a life expectancy of little more than 35 years. Cystic Fibrosis (CF) is unfortunately a devastating disease that does not receive a lot of attention from the media, and therefore does not receive enough funding for research and treatment. In a May 9, 2005 Senate Resolution (S. RES. 115. IS) designation of May 2005 as "National Cystic Fibrosis Awareness Month," it was written that "1 of every 3,500 babies born in the United States is born with cystic fibrosis" and there are approximately 30,000 people in the U.S. with CF. Although there are few treatments for CF, one aspect of treatment is early screening in babies. The Senate Resolution states that "newborn screening for cystic fibrosis has been implemented by 12 States and facilitates early diagnosis and treatment which improves health and longevity" and that "the Centers for Disease Control and Prevention and the Cystic Fibrosis Foundation recommend that all States consider newborn screening for cystic fibrosis[17]." I would encourage Congresswoman Eshoo to persuade her fellow representatives to implement early cystic fibrosis screenings in their states.

Pancreatic Cancer

In House Resolution H. Res. 276, which passed October 6, 2005, it is stated that "over 31,860 people will be diagnosed with pancreatic cancer" in 2005 in the United States and that the mortality rate is the highest of any other cancer at 99 percent[18]. In fact, pancreatic cancer is the fourth leading cause of death in the United States[19]. Research into the causes and treatment of pancreatic cancer is vital because there are few treatment options and no method to detect the cancer early. It has been reported that approximately $1.5 billion is spent each year on treatment for this cancer. Because the

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[15] Langreth, Robert. "Underfunded Diseases." Forbes.com. 13 June 2005. 16 February 2006. http://www.forbes.com/technology/sciences/2005/06/13/drugs-healthcare-disease_cz_rl_0613underfunded.html
[16] Ibid.
[17] Senator Salazar, Ken. S.RES.115.IS "A resolution designating May 2005 as 'National Cystic Fibrosis Awareness Month.'" Introduced April 20, 2005. Passed/agreed to by Senate May 9, 2005. Retrieved from the World Wide Web: http://www.thomas.loc.gov.
[18] Representative Platts, Todd Russell. H. Res. 276 "Supporting the goals and ideals of Pancreatic Cancer Awareness Month." Introduced May 12, 2005. Passed/agreed to in House October 6, 2005. Retrieved from the World Wide Web: http://www.thomas.loc.gov.
[19] "A Snapshot of Pancreatic Cancer." National Cancer Institute. August 2005. 21 February 2006. http://planning.cancer.gov/disease/Pancreatic-Snapshot.pdf

National Cancer Institute's funding for pancreatic cancer research has increased by almost $33.7 million in fiscal year 2000 for a total of $53.7 million in fiscal year 2005, more research opportunities and initiatives have made good progress in research[20]. However, in order to lessen the financial burden and death rate that occurs with pancreatic cancer, more research and funding is necessary.

Lung Cancer

In H. CON. RES. 298, a resolution introduced in the House, it was reported that "lung cancer claims the lives of more people each year than breast, prostate, colon, liver, melanoma, and kidney cancers combined" and that "the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute estimates that 172,570 new lung cases will be diagnosed in 2005 and 163,510 individuals will die of lung cancer in 2005." As well, more and more cases of lung cancer are showing up in non-smokers, a sign that more research is necessary into other causes of the cancer. In fact, the recent death of non-smoker Dana Reeve, wife of famous Christopher Reeve, has brought more attention to the dangerous lung cancer. However, one problem with this cancer is that it is difficult if not impossible to detect early, increasing the risk of death for those diagnosed too late. Therefore, more research into diagnosing and treating lung cancer is imperative. Dealing with the issue of lung cancer also includes further education for the public on the health effects of smoking. The NIH Funding for Lung Cancer in 2005 was $300 million.

Overview

It has been reported that around "75% of the research grant proposals submitted to NIH do not receive funding, leaving many scientists to find support elsewhere. This situation has resulted in many young investigators leaving research for other careers[21]." The lack of researchers, and especially recent college graduates, willing to research less publicized diseases is also a factor in less progress in research for some devastating and deadly diseases. This also occurs because funding for under funded diseases is unpredictable. While the NIH has released its new "Pathway to Independence Program" for grants for young researchers to become "financially independent[22]," similar grant and encouragement programs can still be initiated by Congress. As well, because many of these diseases, like pancreatic cancer, cost Americans and U.S. hospitals millions of dollars in treatment each year, new discoveries and treatments could lessen the burden of costs for those hospitals and families already struggling financially.

I am suggesting to Congresswoman Eshoo that she encourages an increase in funding for Cystic Fibrosis, Pancreatic Cancer and Lung Cancer through the NIH or another reputable organization. To help screen for Cystic Fibrosis in children, screening for CF in newborns should occur in every state. More education about these diseases and the risks of smoking will also help bring awareness to the public about their health. One other disease to watch out for, yet not mentioned in this report is liver disease such as deadly Hepatitis C. Finally, I encourage the Congresswoman to vote for H. CON. RES. 298 for Lung Cancer and H. R. 1108, the Liver Research Enhancement Act of 2005, should they come through the House for a vote.

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[20] Ibid.

[21] Johnson, Judith A. CRS Report 97-917 STM "Disease Funding and NIH Priority Setting." Congressional Research Service. 10 September 1998.

[22] Weiss, Rick. "NIH's Research Grants Offer Seed Funding for Budding Scientists." Washington Post. 30 January 2006: A15.

The AIDS and HIV Global Epidemic
Vanessa Silverstein

At least 40.3 million people worldwide are currently infected and suffering from AIDS or HIV[23]. AIDS stands for Acquired Immune Deficiency Syndrome and is the final and most severe stage of HIV[24]. HIV or the Human Immunodeficiency Virus is a virus which attacks the immune system leaving the body vulnerable to a variety of life threatening infections and cancers. In 2005 4.9 million people became infected with HIV[25]. Of these almost 5 million new infections, 3.2 million occurred in Sub-Saharan Africa making up a vast majority of the infections [26]. Other countries although suffering with less infection must undergo aggressive prevention methods as well. As addressed on the 2005 Worldwide AIDS Day, many highly populated countries like China, India, Russia, Ethiopia and Nigeria who account for a total of 43 percent of the earth's population, are on the brinks of huge HIV outbursts. With the threat of millions more infections in the near future we must act by organizing the best way to treat and prevent AIDS worldwide.

The way that HIV prevention and treatment is treated in Sub-Saharan Africa and these other countries will shape the future of this global virus. In order to prevent HIV from spreading we must find out who is risk of contracting AIDS in certain countries and eliminate the conditions that make them vulnerable to the virus. By focusing on certain groups we ensure that our help will definitely make a noticeable difference and we can more efficiently track our programs, seeing which programs are helping whom. In many infected countries the group that we should be focusing on is women and girls.

Why We Need to Focus on Women Contracting AIDS

By 2005 women accounted for nearly half of all people living with AIDS worldwide. Women represent 77 percent of people infected in sub-Saharan Africa. The impact of women is also growing in Eastern Europe and Asia Globally, 62 percent of young people infected are female. Not only are women biologically more susceptible to contracting AIDS sexually than men, their social positions often leave them powerless to control the circumstances of who they have sex with and whether protection is used. Because 70 percent the world's poor are women, they have few economic options and if allowed to work they are usually limited to teaching and nursing. If a significant number of women died, the country would lose education and heath-care workers which are vital anywhere where there is a severe AIDS epidemic.

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[23] "Human rights, women and HIV/AIDS", June 2000, http://www.who.int/hiv/en

[24] "Women and girls need access to AIDS treatment and protection from violence", 30 Nov. 2004, http://www.who.int/hiv/epi-update2005-en.pdf

[25] Population Reference Bureau (PRB), 2005 World Population Data Sheet (Washington, D.C.: PRB, August 2005), http://prb.org/pdf05/05World Data Sheet-Eng.pdf

[26] Global Health Council, "HIV/AIDS", 3 March 2006, http://globalhealth.org/view-top.php3?id=227

How We Can Prevent Women and Girls from Contracting AIDS

To prevent women and girls from contracting AIDS we must focus on both "structural" and "operational" prevention[27]. "Structurally" we must focus on improving women's place in society so they are not at risk of HIV infection. "Operationally" we must focus on directly supporting programs and prevention interventions that will most effectively stop women from being infected with AIDS.

How to Most Effectively Stop Women from Contracting AIDS

A condom is the only birth control method that can prevent AIDS and without access to condoms hundreds of preventable HIV infections result daily. The value of condoms can be clearly seen in the case of AIDS prevention in Uganda. After Bush's Emergency Plan for AIDS relief in 2003 where 15 billion dollars was designated to AIDS relief in the countries worst hit by AIDS, Uganda received more than twice the money now reaching 169.9 million in 2006. Because now one third of the money goes to "abstinence-only" projects after years of decline Uganda's AIDS infections, infections are up to 130,000 from 70,000 in 2002[28]. In order for AIDS to be prevented we must continue to offer alternative options other than abstinence. The confusion brought by teaching only abstinence is deadly and people have stopped believing that condoms can prevent AIDS. We must be clear in teaching that condoms should be used at all times if you are not abstaining from sex.

In order to stop the spread of AIDS within the sexually active we must support programs that allow free access to condoms and programs that teach males to respect women's rights so that women are in a position to negotiate the use of these life-saving contraceptives. One situation which females are often unable to ever negotiate the use of condoms is prostitution. In addition to fighting sex-trafficking we must also acknowledge that in order to stop HIV from spreading we must help the victims of these activities by allowing access to condoms. Outside of prostitution, many women aren't allowed to initiate the use of condoms even within marriage.

We must acknowledge the cultural differences between the United States and the third-world countries suffering from AIDS. Although sex-education in US schools is based on the idea of abstinence until marriage, men in many other countries are allowed to have sexual relationships with multiple partners during marriage. Even if a women is abstinent until marriage it will not protect her from contracting AIDS from her husband who is having unprotect sex with other partners. In order to make access to condoms most effective we must teach males condoms can prevent AIDS and teach appropriate relationships to males and that allow women the right to use condoms. Male abuse towards women is also a huge factor in women contracting AIDS.

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[27] Kate, Jennifer and Philip Nieburg, "HIV Prevention in Complex Macro-Scale Societies", The Kaiser commission on Medicaid and the Uninsured

[28] "Public health and religion: Aids, America, abstinence…", 1 June 2006, http://new/independent.co.uk/world/africa/article622736.ece.

South Africa has one of the highest rates of sexual violence in the world and as a result also has the highest rate of HIV infections in the world, 77 percent of people infected being female. In some parts of Africa young women and children are raped by HIV+ men because of a belief that having sex with a virgin will cure HIV. AIDS is also being increasingly used in war as a tool of 'ethnic cleansing'. For example the reports of women in Uganda, Sudan and Zimbabwe being raped with the intentions of deliberately giving them HIV is growing. It is unrealistic to think that all males can be taught to stop abusing females in these countries so we must also offer access to free post-exposure medical techniques to rape victims to reduce the risk of infection.

Conclusion

Obviously the global AIDS/HIV epidemic is of great importance If in addition to the 40.3 million people already infected by AIDS, women in the regions of Sub-Saharan Africa, China, India, Russia, Ethiopia and Nigeria were to increasingly continue to contract the virus it would be nearly impossible to treat AIDS globally even if a cure were found. In order to stop the HIV epidemic we must fund programs which provide free access of condoms because unlike the United States abstinence until marriage will not prevent women from contracting AIDS in other counties because men are allowed multiple sexual partners within marriage. In order for females to be able to negotiate the use our donated condoms we must also eliminate the social factors that make women powerless in sexual relationships due to inhumane gender-roles. By empowering women with positions in society where they can negotiate the use of condoms and giving access to them we can stop AIDS from spreading.

Sigurd Illing an ambassador to Uganda said, "We need an end to this bedeviling of condoms by people who take a high moralistic stance and don't care about the impact that this has on reality." The reality is that we should not longer reserve one third of the AID relief fund for "abstinence-only" projects and instead give more money to fund programs which promote condoms as a positive prevention tool. The reality is that the countries with the highest rate of HIV infections are some of the poorest countries in the world where women are forced to prostitute themselves to survive and in the slums of Uganda girls tend to loose there virginity between ages nine and eleven. The reality is that women and girls have sex and the only way to prevent the sexually active from contracting AIDS is condoms. I ask that Congress continue to support programs that prevent AIDS through condom donations and stop allocating one third of the AIDS funding to "abstinence-only" projects as it is hindering the prevention of the epidemic.

Euthanasia/Physician-Assisted Suicide
Ashley Gilliam

In the past seven years, Oregon has had 208 people who have chosen to end their life with physician-assisted suicide. Out of the 208, 74 people only chose to end their life because they felt like they could be a burden to their family, not necessarily stating that they were terminally ill. 6 people stated that their only reasons for going through with such was because they were not financially stable, while only 45 out of the 208 people who chose to go through with their physician-assisted suicide actually had a substantial amount of pain, and were most likely terminally ill patients. This information is horrifying.

In more legal words, the way to distinguish the two terms "euthanasia" and "physician-assisted suicide", is to look at the last act. the act without which death would not occur. Euthanasia, which literally means "the good death", is the means of a third party performs the last act that intentionally causes a patient's death. For example, giving a patient a lethal injection or putting a plastic bag over their head to suffocate them would be considered euthanasia. On the other hand, if the person who dies performs the last act, assisted suicide has taken place. Thus it would be assisted suicide if a person swallows an overdose of drugs that has been provided by a doctor for the purpose of causing death. It would also be assisted suicide if a patient pushes a switch to trigger a fatal injection after the doctor has inserted an intravenous needle into the patient's vein.

Regardless of such, my goal today is to answer the question as to when, not if, euthanasia or physician assisted suicide should be used. Currently, the Netherlands, Belgium, and the state of Oregon are the only jurisdictions in the world where laws specifically permit euthanasia or assisted suicide. While in 1994, Oregon passed its Death with Dignity Act, becoming the first state in the country to legalize euthanasia, in June 1997, the Supreme Court ruled that physician assisted suicide is not a constitutional right but made each state free to determine its own euthanasia laws within its boundaries. However, when determining the rights of the patient, or the reasons for or against such acts, several questions must be considered:
1. Should people be forced to stay alive?
2. Does the government have the right to determine who gets to live, and who has to die? 3. Or is it the families will as to the destiny of their loved one?
4. Should such means of dying be only available to those who are terminally ill, or for all who wish to end their live peacefully?

According to Oregon's doctors, to qualify for assisted suicide a patient's must be of at least 18 years of age, in a terminal condition that must be verified by two physicians, and two witnesses must certify the decision is voluntary, and the patient must wait for 15 days before the request can be granted. Even then, the physician can only prescribe the lethal drugs – the patient must physically ingest the drugs without assistance. However, this is not always the case, seeing as only 45 out of 208 people who participated in assisted suicide in Oregon from 1998 to 2004, were classified as people with a significant amount of pain, or terminally ill. So, who draws the boundaries?

In 1977, California became the first to pass the death-with-dignity statute; a statement written by a mentally alert patient that can be used to express a wish to forgo artificial means to

sustain life during terminal illness. The absence of a written living will complicated the case of Terri Schiavo, a Florida woman who was in a persistent vegetative state from 1990 until 2005, when she died after having her feeding tube removed. In 2000 her husband, who was her legal guardian, won the right to remove it based upon what he stated were her orally expressed wishes, but legal challenges from her parents and Florida governor Jeb Bush and attempted government interventions through Florida and federal legislation delayed the tube's removal for five years.

My personal opinion aside as to whether euthanasia or assisted-suicide should be used, I believe that if our country must use such methods of ending life, there should be more restrictions to the procedure. There should not be any more cases like that of Terri Schiavo's, the late victim of euthanasia, which may or may not have been in her wishes. It is in my belief that in order to obtain assisted-suicide the patient must be in a state of terminal illness where the only humane choice would be to end their life, and, the patient must have a written statement, or a "living will", declaring that it was in their wish that such measures be taken upon them, in case they ever happen to go into a state where they can no longer make decisions for themselves.

Thus, I encourage Congress to be more aware of such a problem if they ever decide to pass a federal legislation with regards to Euthanasia. And if such an event occurs, that they create extra measures to keep the Euthanasia law strict, and encourage the "living will" document to be forced upon all patients who wish to undergo such a procedure.

Immigrant Health Care
Kelly Sanford

Approximately 11.5 percent of the population of the United States are immigrants, which is over 30 million people[1]. Most immigrants (with few exceptions) must now wait five years before they can access Medicare, Medicaid, and other federal programs under the Personal Responsibility and Work Opportunity Reconciliation Act, ["PRWORA" PL 104-193] which was passed in 1996. However, even before the five years are up immigrants are able to access emergency care. The share of legal permanent residents entering after August 1996 with incomes below poverty is 30 percent in Los Angeles and 40 percent in New York City. Before 1996 the level of incomes below poverty was 27 percent in Los Angeles and 29 percent in New York[2]. This shows that immigrants need help more than before due to the severe cuts in their eligibility for Medicaid and Medicare.

Half of the immigrants in the United States identify themselves as being Latino. While only 12 percent of natives lack health insurance, almost 30 percent of immigrants and their children have no health insurance[3]. Medicaid only covers emergency room visits, not regular check-ups. Because of the lack of availability in preventative care, there are more visits to the emergency room. This is a problem because it means that there is more traffic in the emergency room, and even more money must be paid to heal the person after the problem has manifested itself. Only 13 percent of low-income non-citizens received Medicaid, while 60 percent went uninsured[4].

Part of the problem is that there is confusion about Medicaid among immigrants. They are afraid that if they apply for it they will be in danger of becoming a public charge and being deported or unable to achieve full citizenship over time. The Citizenship and Immigration Service does not use these documents to punish immigrants, and this needs to be made very clear to them. It is difficult and confusing for many immigrants to understand the health care system and get proper care due to the language barrier that many of them face. The ability to communicate with a doctor is crucial for getting proper treatment. Patients must be able to understand what they need to do so that they can make themselves feel better, and stop whatever their disease might be from spreading and causing greater problems.

Although illegal immigrants are technically "illegal" the fact is that they have become a valuable part of our economy and some of them have been living here for years. They account for 27 percent of all immigrants. Shown by the recent protests and reactions to the Immigration bill, they are a population that we need to consider in upcoming legislation. 70 percent of low-income Latino Adults who don't speak English are uninsured and 74 percent of non-citizen Latino children are uninsured. These children are less than half as likely to see a doctor as Caucasian children[5]. Not only does this mean that they wouldn't be getting the general monitoring of their health as they grow, but they may not be getting the necessary immunizations, which becomes a problem for all of us. In order to aid these immigrants with their health problems I suggest that we establish health clinics that are designed specifically for them. These should provide basic health care like immunizations and antibiotics. In order to protect privacy and encourage immigrants to use these services, patients could be given an identification number under which their medical records could be stored. Their names would not be on file so that they would not be suspicious of being deported.

I alternatively suggest that we develop free and anonymous health counseling available to immigrants so that at least they clearly know what their options are, and they see the value of getting check ups and other preventative care. Many immigrants are not well educated, so without the help of an expert, they have difficulty understanding what type of health care they need. It would also be helpful to provide literature explaining federal laws and restrictions in several languages for immigrants. Ideally, a universal health care system could solve most of these problems by providing care for everyone. Here in Santa Cruz we have established programs like Healthy Families and Healthy Children that provide insurance for a very low price to low-income families and we need to establish similar programs across the United States. Until we can get a national health care system in place, not only do we need to show immigrants what their options are, we need to show Americans how important immigrants are. We need to join together to make all of our people healthy and happy by expanding Medicare and supporting our immigrant population.

Sources:

1. "Immigrants in the United States – 2002 A Snapshot of America's Foreign-Born Population" Center for Immigration Studies, November 2002, Available Online: http://www.cis.org/articles/2002/back1302
2. "How Are Immigrants Faring After Welfare Reform?" The Urban Institute, Available Online: http://aspe.hhs.gov/HSP/immigrants-faring02/
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5. "Disparities in Health Coverage, Access, and Quality: The Impact of Citizenship status and Language on Low-Income Immigrants" The Kaiser Commission on Medicaid and the Uninsured.
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Medicare Part D
Jessica Silverstein

Imagine being denied life saving medicines simply because of your new switch in health plans. This is what's happening to millions of people throughout the United States, due to their new change in medical coverage. This new program, known as Medicare Part D was developed intending to aid millions of elderly and disabled Americans in affording increasingly costly medications. But since the programs start on January first 2006, it has been crumbling under the pressure of over nine million people who have enrolled in their drug plans. These people were given many complicated rules to follow, in order to become correctly registered. All participants who currently have Medicare coverage have until the fifteenth of May 2006 to decide whether or not to sign up and choose a plan. But signing up is no small feat, these elderly and disabled persons will be responsible for signing up for one plan out of the given one hundred and twelve plans[29]. Although Medicare part D sounds good in theory, it is already suffering the effects of many severe road blocks. Due to all of these bumps in its path to a successful and smooth operation, the Medicare Part D plan needs to aid its participants more, providing them with the help they desperately need. The main problems with the current set-up of Medicare Part D are the reliance on faulty technology, the problems for Medicaid beneficiaries, and the problems with choosing a plan.

Technological problems are greatly hindering the success of Medicare Part D. Computers play a very big role in making Part D work. For example, the only easy way to compare costs and benefits of the separate plans is to use tools on Medicare's website. Computers were thought to provide help, but instead they're making things steadily disorganized and confusing. The vast networks of computers have not been able to handle the data on the millions of people who have joined. This results in people being lost in the system, people's financial aid packages disappearing, and many other frustrating mishaps. Per-Se, the data processing company that pharmacists access to pull up the files of Part D plan subscribers, had added more computer hardware to handle the flood of enrollment information. But even this doesn't seem to have solved the problem. There are still hundreds of people who have had their information lost or mislabeled in the system. This creates problems for seniors wanting to access their medicine. Without being entered correctly in a plan they have no coverage when they go to the pharmacy; thus they are forced to pay for their medicine out-of-pocket. Yet another problem with Medicare Part D's technology is that many seniors struggle with using the computer. If a senior doesn't have access to the Internet or doesn't know how to work a website's complex navigation system, they are at a severe loss. Another major problem with Part D's reliance on technology has to do with telephones. Beneficiaries, case workers, and pharmacists have tried for hours to get through to insurance hotlines and Medicare help lines, never getting a chance to talk to an employee. Technology has clearly caused many problems for Part D.

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[29] Bavley, Alan. "Medicare Part D's Shotcomings Force Many to Struggle with Loss of Coverage." 23 Jan. 2006. 24 Jan.-Feb. 2006 <http://www.kansascity.com/mld/kansascity/news/local/13688480>.

Another problem with the current way Medicare Part D is run is how it is affecting Medicaid beneficiaries. Low-income Medicare beneficiaries who were receiving drug coverage through state Medicaid programs are signed up automatically for random Medicare Part D plans. These people are now referred to as "dual-eligibles"[30]. A large number of these dual-eligibles are nursing-home residents or disabled persons. Many Medicaid beneficiaries are going to the drugstore to buy medicine, only to discover that their desired medicine is not covered by their randomly selected Part D plan. About two dozen states including Kansas and Missouri have started covering portions of the cost for some low-income patients who aren't receiving any drug discounts. In just one week, Kansas paid out more than a million dollars to low-income patients and dealt with calls for help from fourteen thousand people. Missouri estimates it may have to spend several million dollars per month[31]. Medicare officials estimate that about three hundred thousand Medicaid beneficiaries were left without coverage or discounts during the Part D's first month of implementation[32]. It will be a while yet for the five point six million dual-eligibles enrolled in Part D drug plans receive the assistance and plans they deserve.

Medicare Part D also creates huge problems for those who sign up for a plan. If a person signs up incorrectly, or isn't offered a plan that suits their needs, they may be denied critical, lifesaving medicine. Not only does this provide for a perilous problem for those with heart disease and diabetes, but it also greatly affects those with serious mental illness. Patients who were stable due to a continuous medicine intake are now at risk of hospitalization. Medicare Part D offers one hundred and twelve different medical plans[33]. At first this number may seem like a lot, but imagine the group of over nine million people already signed up for Medicare Part D. This group is diverse, and comprised of many different individuals all with very unique medical needs. Due to the limited number of plans offered, many people are bound to require drugs that are not all offered together on one plan. Beneficiaries also are forced to pay a higher fee if they enroll later than their initial enrollment period. These people will have their monthly premiums cost one percent more for each month that they waited to enroll[34]. For example if a beneficiary waits six months to sign up for a plan, their monthly premium will always cost six percent more than what others pay. With such a confusing system, and bad service, undoubtedly many confused people will be trapped with a higher monthly premium. Medicare Part D is at times an unclear program to follow. Many senior citizens will go through turmoil to receive their prescriptions.

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[30] Hatch, Stephen. "AMID PLAN D SUCCESSES, MANY STILL STRUGGLING." 12 Apr. 2006 <http://www.cnn.com/apps/pbcs.dll/article?AID=/20060129/NEWS/60129011290323>.

[31] "Medicare Part D Surveillance & Response." 18 Mar.-Apr. 2006. 7 Feb. 2006 <http://www.baltimorecitymedicare.org/>.

[32] "Medicare Prescription Dug Coverage." 18 Apr. 2206 <http://egyptianaaa.org/MedicareDrugBill.htm>.

[33] "Current Legislative Issues: Health." CRS. 19 Feb. 2006 <http://beta.crs.gov/cli/level_2.aspx?PRDS_CLI_ITEM_ID=13>.

[34] Rover, Julie. "Problems Plague Rollout of New Medicare Drug Plan." NPR. 5 Feb.-Mar. 2006. 17 Apr. 2006 <http://www.npr.org/templates/story/story.php?storyId=5148817>.

If Medicare Part D is to continue becoming a substantial part of out nation's healthcare, some changes should be made. The government needs to seriously look into its most troubling problems. These mistakes should be rectified sooner than later, as to help Medicare beneficiaries make as smooth of a transition as possible. The glitches in the computer programs that are causing so many deletions and mix-ups of patients should be fixed. Time and money should be spent fixing this critical technology. The government should also make sure that Medicare provides more employees working at their telephone help lines. This will make it easier for confused people to receive the help they need. Another problem that should be looked into is treatment toward dual eligibles. The government needs to provide more flexibility in the plans offered to dual eligibles. They should not be forced to be signed up for random plans, leaving them to use only the drugs offered by the plan they were assigned to without choice. The government also should reimburse the states and cities that are paying the costs for their low income citizens that have been facing problems with enrollment. These generous states have been doing their civic duty, all for a cause they weren't warned of. Lastly, the government needs to come up with more ways to help seniors enroll in plans. More publicity is needed, instructing seniors on what they need to do. Also, the harsh financial penalty should be softened for those who sign up late. This is not fair to those who simply are having difficulties maneuvering their way around such a complex and problem filled system. It might also be beneficial to offer more plans. The government should either allow waivers for people who do not fit into a plan, or create more plans to avoid this problem. Medicare Part D will have a large impact of millions of lives. These people deserve to be a part of a well-rounded, beneficial healthcare system. Until some rectifications have been made of the current Medicare Part D, people will continue to face important problems.

Visas for Physicians
Ariel Bowman

Many patients in third world countries are dying unnecessarily because the physicians there do not have the resources necessary for proper medicine and treatment. American doctors wish to provide the physicians from third world countries with adequate medicine and resources for research; however, the American government is not willing to spend money to provide other countries with the medical supplies they need. Since our doctors cannot send free medicine or provide medical research, the only way that foreign physicians have found to acquire adequate knowledge and equipment is to train in the United States. Many physicians from underdeveloped countries have earned their medical licenses in American medical institutions and universities. In this way, they achieve their license to practice legally in the United States, thus gaining access to advanced medicine and research equipment. After a few years in the United States, many foreign physicians return to their native country to practice with the extensive knowledge in their field as well as the adequate medical research that they have acquired. The only problem is that the United States government does not approve of providing funding for foreign doctors to come to America, train and take advantage of our research equipment, and then return home. As a country with a thriving economy, we must figure out a way to allow these physicians the resources they need in order to stop the unnecessary death rates in many countries.

Foreign doctors have found a creative way to attain the knowledge and resources they need. The only problem now is that the US government will not fund their training if it does not benefit the United States. Some method must be found for doctors to obtain the materials necessary to their career without burdening the United States.

Today, many immigrants come to the united States for a few years on a work visa in order to earn enough money to send back to their families. The reason so many people come to America to work is because, while there are limited resources in their countries, America is a prosperous country with plenty of resources. This situation is analogous to the physicians who come to this country in order to acquire knowledge to bring to their practices back home.

Several medical students at Stanford University demonstrated their desire to help physicians in underdeveloped countries during a tour in which they traveled to medical clinics around the world. The Stanford students traveled frequently to hospitals with inadequate equipment all over the globe in order to provide them with proper machinery for research and treatment. Medical students at Berkeley University have proposed training programs for physicians of third world countries. These programs would make it possible for foreign doctors to acquire the knowledge necessary to their field, and then return to practice in their home country. The problem with this proposal is that it would require our government to provide funding for the training of foreign persons with little or no benefit to the United States. American doctors, professors, and students have shown no hesitation to help foreign physicians gain a proper knowledge of the field; in fact, they have shown eagerness to support the education of such physicians. Considering the necessity for doctors from underdeveloped countries to have an increased knowledge of medicine as well as better resources for treatment and research, and the number of Americans willing to assist the education on foreign physicians, who are very

knowledgeable in the field, a program could easily be created to train these doctors and to allow them to return home to effectively treat desperate patients from their native countries.

It is the variety of work and visitor visas offered by the United States that allow foreigners to spend a limited number of years working in the United States and to earn more money for their families that they could in their home countries. Today, a professional visa must be requested by the immigrant's employer. This means that the person that wishes to come to America to earn money by working professionally must establish an agreement with an employer and find a secure spot at a company before applying for their work visa. The first problem with this system is that work visas are limited, so even if the person wishing to come to the United States does secure a relationship and employment with a company, they may or may not be able to work simply because our government may run out of work visas. The second problem is that immigrants wishing to come to America to work professionally from third world countries have a large number of disadvantages. If an immigrant is coming from a third world country, they will not have had the ability to pursue a higher education. Today, physicians of the third world come to the United States to train and become better educated before the begin their practices, at home or in the States. Furthermore, international communication from an underdeveloped country is considerably more difficult that from one of technological competence. For example, most of today's professional immigrants come from China. This is because the Chinese have access to an excellent education prior to their work in the United States, and it is no problem for them to contact American employers prior to their arrival.

Doctors from the third world are different from other immigrants; they need more than just employment in America, they need training and education. The introduction of a visa that would allow immigrants to come to America as students, train professionally in their field, then work for a minimum number of years would provide a perfect solution to this problem. This would allow them to get the training they need while benefiting our government with their professional services and taxes. In this way, without greatly burdening the American government, we could stop the millions of unnecessary deaths that occur every day in underdeveloped countries due to lack of education, or inadequate resources.

Medical Outsourcing and Foreign Participation in the U.S. Healthcare System
Rachel Spiegel

As costs to run hospitals continue to rise, administrators are looking to medical outsourcing as a way to lower production and service costs. The outsourcing of medical jobs and work, formally done by Americans, has led to an ethical argument as to whether outsourcing really does benefit our hospitals. Advocates for medical outsourcing mention that it increases availability of medical services and provides local physicians incentive to raise their quality of care.[35] Opponents of outsourcing say that it becomes increasingly easy for fraud, misinterpretation, and error to occur with transfer of medical data, that it is difficult to work with a foreign employee who speaks English as a second language, and that it threatens the quality and the protection of healthcare jobs in the US.[36] Due to these conflicts the debate of medical outsourcing is much at a standstill.

Gartner Dataquest, a research and analysis company for the IT industry, predicted that by 2007, 60% of Health Care Organizations (HCOs) will outsource more than half of their technology operations. Right now, these HCOs dedicate more than one third of their IT budget to consulting, outsourcing, and support services.[37] As laws such as the Balanced Budget Act of 1997, which requires hospitals and healthcare systems to reduce costs while maintaining quality patient care, are enacted, HCOs have begun outsourcing filing and patient records.[38] However, privacy and viewing rights of patients, under the Health Insurance Portability and Accountability Act, force outsourcing centers to strengthen their privacy systems.[39] The Phoenix Health System, a healthcare management organization, estimates that 32% of Data Security Systems still experience breaches.[40] Introducing stronger laws to stop the breaching of information and the transfer of information without consent overseas would stop this major outsourcing problem.

One incident occurring in the US is the arrival of foreign medical students and graduates looking to temporarily and permanently work in the United States. Leaving their mother countries is attractive because larger, richer countries assure financial stability, availability of new technology, and political stability.[41] However, both Foreign Medical Graduates and International Medical Graduates have more difficulty coming to America than ever seeing as it is difficult getting a visa after 9/11.[42] Many foreign doctors are discouraged by cutbacks in healthcare funds that cut doctors, with the foreign born often the first to go, and discrimination by ethnicity. These kinds of deterrents and safeguards come at a time when we are not

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[35] Seth Hayes, *Medical Outsourcing Debate Grows*, http://www.medtech1.com/new_tech/newtechnologyfeature.cfm/224/1 (March 2006).
[36] Douglas Irwin, *'Outsourcing' is Good for America*, http://www.dartmouth.edu/~dirwin/WSJ.html (January 2004).
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[38] The Daily Gazette, *Rochester Hospital to Cut Up to 50 Jobs,* http://www.amc.edu/UnionUpdate/SEIU/seiunews.cfm?action=industrynews (March 2002).
[39] ibid
[40] Phoenix Health System, *No Pain for Ignoring HIPAA Requirements – No Gain on HIPAA Compliance,* http://www.phoenixhealth.com/phx.cfm?subsec=2&sec=pressroom&title=surveypress8-05 (August 2005).
[41] BBC News, *Is the UK Damaging Africa's Healthcare?*, http://news.bbc.co.uk/1/hi/talking_point/4586405.stm (June 2005)
[42] Steve Raymer, *Indian Doctors Help Fill US Health Care Needs*, http://yaleglobal.yale.edu/display.article?id=3340 (February 2004).

encouraging growth of medical schools, yet we need more doctors to cope with a growing and aging population.[43] However, the lack of doctors in special fields increases the probability of a hospital's likelihood of hiring foreign doctors to do the job.[44] I would recommend that we should allow more foreign doctors to come to the United States so we can manage our growing population's healthcare.

Two bills regarding medical outsourcing and general outsourcing in the Senate and Assembly of California have previously been submitted. The Assembly Bill No. 2163 prohibits a health care institution from entering into a contract with any company that permits sending medical transcriptions outside of the US, while the Senate Bill No. 1453 requires companies that displace more than 20 workers through outsourcing to provide 60 days notification to the employee and the state.[45] Existing law already specifies that the sharing of an individual's medical information without consent is illegal.[46] These bills were vetoed by Governor Arnold Schwarzenegger, but they could effectively regulate outsourcing.[47] Along with these bills, other solutions to outsourcing have emerged.

One solution to medical outsourcing is that health care providers are spending a little more money to send an outsourced job to a small rural city. Moving jobs to another country requires extra executive hours needed to manage an offshore base, as well as travel and other startup costs.[48] This method provides higher paying jobs for people in lower-middle class areas and it keeps complete businesses in America. The medical-supplies distributor McKesson Corp. has moved its primary data center from San Francisco to Dubuque, Iowa.[49] Encouraging healthcare companies to move their jobs to simple areas will create more jobs for the American people while keeping costs low. Looking to alternatives like this instead of outsourcing keeps jobs in America and keeps the unemployment rate low.

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[43] Saad Safqat, *The Foreign Underclass in American Medicine*, http://www.chowk.com/show_article.cgi?aid=00000232&channel=university%20ave (May 1998).
[44] ibid
[45] Outsourcing Law, *Vetoeing the Legislation Against Outsourcing in California*, http://www.rppi.org/vetoing.shtml (September 2004).
[46] ibid
[47] ibid
[48] Paul McDougall, *Onshore Outsourcing: Made in America*, http://www.informationweek.com/story/showArticle.jhtml?articleID=162800086 (May 2005).
[49] ibid

Universal Health Care
Akash Pandey

America was founded on the principle that all men are created equal. As history shows us, we have clearly not held true to this principle. Now, I admit that in order for a society to exist and function, there has to be class divisions. American presidents have often tried to make life better for the lower class by passing such acts as the Social Security Act of 1935 and by creating departments such as the Health, Education, and Welfare department in 1953.

Beginning in the early 20th century, companies instituted "contract medicine"- which gave medical assistance to any employee if they paid a certain amount of money[1]. Some companies were more generous- building hospitals and medical facilities to accommodate their workers. Contract medicine flourished, however, independent doctors began to complain and riot that this sort of medicine was unethical. They argued that it both shattered the doctor-patient relationship by introducing a third party and also gave less money to practicing doctors. By the 1920's, contact medicine had vanished.

In the 1960's, the government took direct control of health care and decided that it should be paid for by the taxpayer's money. This system flourished and it did not intrude on the doctor-patient relationship. However, there was a huge problem. All patients- poor or rich- believed there were paying taxes to fund the best healthcare possible. The bottomless expectations of both the patients and physicians created a system that demanded more and more and more. It was destined for disaster.

Today, there are 45 million uninsured Americans[2]. Not only is most of the lower class uninsured, but the middle class is also being affected. The United States is the only industrialized nation that has no form of universal health care. The uninsured- people from the lower and middle classes- are more likely to get bad treatment for chronic diseases. They are more likely to be forced to delay needed medical attention. They are less likely to receive needed preventive care, among other things. According to amsa.org[3], the uninsured have an excess mortality rate of 25% or one in four. That rate makes eighteen thousand excess deaths a year to ages 25-64, which is comparable to the death rates of diabetes, HIV, and homicide. Concern of medical costs is proven to cause anxiety, stress, and even bankruptcy. A statistical study showed that of a sample of people who filed for bankruptcy in 2005, 46.2% cited medical reasons as the cause.

We Americans claim to have learned a lesson from not following the principle of all men being created equal. Slavery, injustice to women and segregation are supposed to be mistakes that we have left behind. If this is so, then how can we not help these suffering people? As persuasive as the moral part is, it is also important to examine the economic part.

Of the 100 billion dollars spent on healthcare in 2005, the uninsured paid 26 billion. The Institute of Medicine estimates that universal health care will cost about 35-69 billion dollars more. Much of the money spent on health care today is unwisely allocated, and a just distribution of money could cut down on the projected cost. The 35-69 billion dollars may seem like an extreme amount to consider, however, by not achieving health care for all we are shortening the

average life span and opening the door for various health problems and diseases. The Institute of Health estimates that the future costs of these problems could amount to 65-130 billion dollars a year. Also, by not allowing this sort of health care coverage, America is stunting development for children, cutting down on access to emergency rooms, weakening local economy, and the list goes on.

Recently, Congressmen Conyers and Kucinich introduced H.R. 676- a resolution moving to establish universal health care in the United States. In a speech supporting the resolution, Marcia Angell, a doctor, said "Americans have the most expensive health care system in the world. We spend about twice as much per person as other developed nations, and that gap is growing[4]." H.R. 676 will directly deal with the source of the problem, which as Angell says, is that "we treat health care like a market commodity instead of a social service[5]." This resolution can be incredibly effective and I urge Congresswoman Eshoo to support and argue for this resolution.

Overall, the benefits of universal healthcare far outweigh its costs. Great programs such as Medicaid are being cut down by many states. We must look at the long term effects of having 45 million uninsured Americans suffering from health problems that force them to quit work early. America cannot make the mistake of not caring for the lower class. We have to show that we have learned from history. As an expert on healthcare says "In a time when thousands of people lose their health insurance every day...and when any person is one pink slip away from becoming uninsured, it becomes clear that health care for all is not just important to achieve, but imperative[6]."

Sources:

1 www.amsa.org
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3 site of the American Medical Student Association
4 http://www.kucinich.us/issues/universalhealth.php
5 http://www.kucinich.us/issues/universalhealth.php
6 www.amsa.org

Conclusion
Hila Mehr, Student Advisory Board Vice Chair

The members of the 14th Congressional District Student Advisory Board strive to be involved in the community, understand current events and make a difference. As a group of high school students, where the majority of us are not of voting age, we have researched individually and discussed as a board issues surrounding health. Through our discoveries, we have come up with solutions which have shown up throughout this report. We have realized the importance of healthcare for all, carefully administered physician-assisted suicide and the dangers of obesity and diabetes. While we may not have eradicated AIDS or created a perfect universal health care system, we have accomplished more than many of our peers could say: we have become experts on dire issues we are passionate about solving. In a world where many teenagers have been named "apathetic," we have set out on a journey to prove those people wrong, to take a problem and find solutions, to show that we are driven to better the health of society. Peering into the world of a policymaker, we have discovered the roadblocks in the way of some great ideas and we have thought out-side the box for answers to issues as seemingly small as lack of early cystic fibrosis screening in every state to as monumental as immigrants in our healthcare system.

With our passion for solving the health problems of the world, we want to see our solutions taken into consideration and put into action. We want to see action taken no matter how small or "politically risky" it may be. Famous philosopher Goethe once said that "knowing is not enough; we must apply. Willing is not enough; we must do." Now, more than ever, is the time for Congress to set political issues aside to save lives not just in America, but in countries across the globe.

The Student Advisory Board has spoken of worthy solutions for bettering the health of the world. In the hands of the 109th United States Congress, local and state governments as well as non-governmental organizations, we hope it is only the beginning of new medical discoveries, programs and healthy lives for all.

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