LaRouche outlines a viable health-care policy for U.S.

On Jan. 22, Democratic Presidential pre-candidate Lyndon LaRouche's campaign sponsored a dialogue with several health-care professionals, and citizens. A panel of professionals in New York City was joined by an audience of about 80 people on the spot, and by LaRouche and groups of citizens in Boston, Connecticut, Buffalo, Rochester, and Ithaca on the telephone, for more than two hours of discussion on health issues.

Joining LaRouche on the panel were Dr. Abdul Alim Muhammad, director of the Abundant Life Clinic in Washington, D.C. and Minister of Health for the Nation of Islam; Dr. Kildare Clarke, assistant director of the Emergency Room at Kings County Hospital in Brooklyn; and Richard Freeman, of EIR*'s economics department. The discussion was moderated by Dennis Speed, the campaign representative in the New York-New Jersey area.*

We reproduce here a large portion of the slightly edited transcript of the dialogue.

Opening remarks

Lyndon LaRouche: I should just briefly summarize points I made earlier this month on the subject. There are three areas of control of health within the responsibility of government for promoting the general welfare for present and future generations.

One, of course, is public sanitation in the most general form, which includes infrastructure. It means clean environment, that sort of thing. That, of course, has been responsible for much of the great increase in life expectancy in European civilization over the past five centuries, when this occurred.

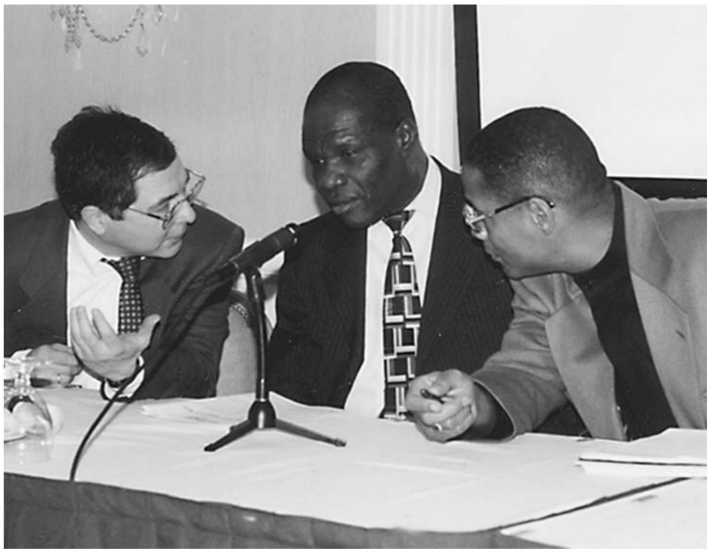
The second, of course, is in the general area of medicine and related biological practice and research.

What I've proposed that the central feature of U.S. government approach to health care should be, would be *institutional facilities,* the same kind of objective which was expressed by the Hill-Burton legislation enacted in the 1940s, which was continuing essentially in effect until about 1975, when the New York City Big MAC crisis began to bring down the whole medical structure and infrastructure of the New York City area, and upstate New York as well.

So, what we need to do today, is to resume an emphasis on building up the institutional facilities which are the central feature of medical practice: hospitals, clinics, and so forth. If we have the right number of facilities with the right categories, with the right number of beds and specialist capabilities; if we have these also as training centers, medical training centers for medical professionals, and technicians as well, then the medical profession generally, the private practitioner generally, will be able to function, in cooperation with these institutions, to effectively deliver health care as it's needed. First, the emergency or related health care, which has to be conducted in hospital facilities, whether emergency wards or otherwise. Or, as an ongoing, serious medical practice.

And thus the relationship of the patient, or the potential patient, to health care, lies largely with these institutions. Does each county in the United States, taken one at a time, have the available facilities to deliver care as an emergency condition, on time, to the citizen of that community or other person who needs it? Do we have the right beds? Do we have the right people, staff, there to do that job? Do we also have the ability to mobilize reserves for cases of epidemic disease or catastrophes, for example, where these may be needed?

And therefore, my first emphasis is there. I assume that if we have this kind of program, these kinds of facilities, in which the Federal government plays a key role, in cooperation with Federal, state, and local institutions, institutional facilities, and also with private facilities, that on the regional and local basis, groups representing these kinds of organizations will meet, and will try to work out a planning budget for the coming year and beyond, to provide, in that county, *an ability to make a timely delivery of medical care to those who need it,* especially in terms of institutions, and assuming that around



In a campaign webcast on Jan. 22, Lyndon H. LaRouche, Jr. (right) was joined by a panel of health-care professionals, to discuss how the U.S. health-care crisis can be solved. The central feature of Federal government policy, said LaRouche, should be to guarantee the necessary institutional facilities, as the Hill-Burton legislation of the 1940s did very effectively. Panelists shown here, from left: Richard Freeman, Dr. Kildare Clarke, Dr. Abdul Alim Muhammad.

that skeleton of the institutional capabilities, that we organize the medical profession in general, as it was done before.

There is nothing particularly novel in that. It's a matter of reviving it, and carrying it a step further, in light of present conditions.

That's where I think the emphasis ought to be. The government should be a partner, with some overall responsibility for ensuring that the result is achieved, but generally otherwise a partner, with state and local public facilities, public institutions and private institutions, in ensuring that every county in the United States has the available kind of care, in terms of institutions it needs, and building up the medical profession for the private practice around these institutions, to ensure that everybody has an adequate program.

At that point, then something like the old Blue Cross/Blue Shield and other programs that we knew from the 1950s and '60s, those kinds of programs, and public welfare assistance, can ensure that the job that needs to be done, will be done.

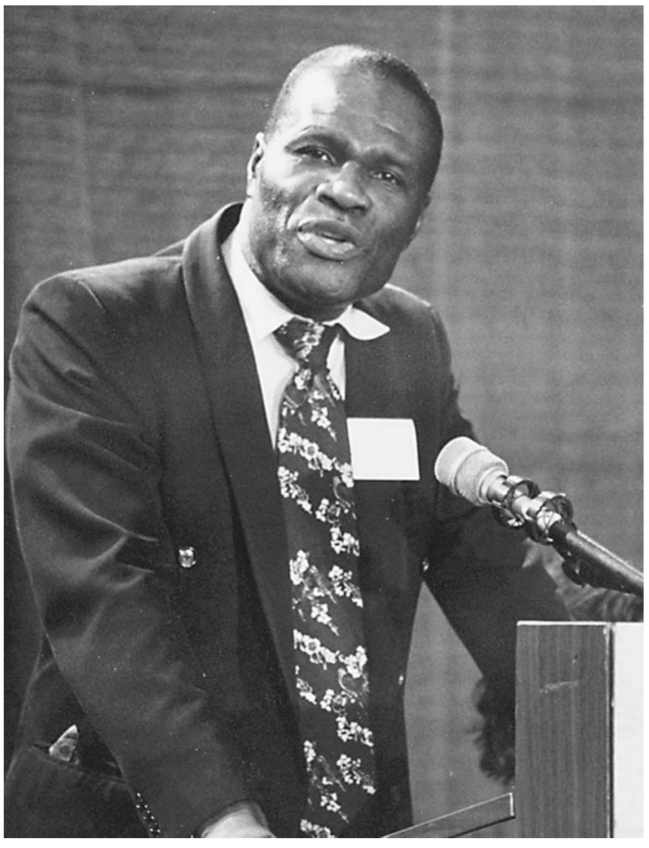
That's a general summary of what I think my policy is. And a lot more can be said about it, but I think that suffices for a present summary.

Dennis Speed: Thank you, Lyn. I want to state at this point something that I omitted from the introduction, which is that we've been privileged, over the course of the last several weeks, to have Mr. LaRouche make himself available for a series of citizens' dialogues of precisely this variety, in which so-called issues of the campaign, are gone into much more deeply, and in a much more respectful way for the citizenry, so that what we get, is the kind of discussion and dialogue which allows for the citizen who participates, to provide himself with a much more informed view of how his activity can change what are dire conditions in the country, whether it's in medical care, education, or any other issue.

We have a panel here with us in New York City. And I'm going to introduce the panel, and I'm going to then ask for the first representative of that panel to speak, in response to what Mr. LaRouche has just said.

We have with us Dr. Kildare Clarke, who I believe is now the assistant director of the Emergency Room at Kings County Hospital in Brooklyn. He's very well-known in New York. He's known as both a whistle-blower and an agitator, but mostly as an honest man, who tells you the way it is with respect to the issue of medical care, and why you're not getting it in the New York City area.

We have Dr. Abdul Alim Muhammad, who is the director of the Abundant Life Clinic in Washington, D.C. He is also the national health spokesman for the Nation of Islam, and, I



Dr. Kildare Clarke: "No country is wealthy, unless all of its inhabitants are healthy. Health care is the foundation of the economy of any country."

believe, the national spokesman of the Nation of Islam. . . . I'm going to ask first that Dr. Clarke might respond, if he has any remarks at this time, that he'd like to make.

Eliminating the right to health care

Dr. Kildare Clarke: First of all, let me thank Mr. LaRouche for tackling this problem head-on. It's been a major concern of mine over the years, that health care has been divided into four basic components: one for the rich, one for the poor, one for the black, and one for the white.

Now there's a fifth component: The elderly and the young are taken out and looked at as bad people. "We do not want to take care of you, you are too costly. So, let's take care of just the healthy, young individual, who doesn't cost us any money."

As far as health care has gone over the years, it's become a stock market commodity. You are no longer patients, you are just a commodity on the stock market, that is, which HMO [health maintenance organization] is going to make a substantial amount of money off of you, and if you are costly to them, you should be put in a grave six feet six inches under and be forgotten.

Well, let's say it's not going to happen as long as myself and the other panel members, and people like Mr. LaRouche and others, are around, because we are fighting. We are the champions, and we will stay that way.

Because those who make decisions about your health care, do not even have a medical degree. They have no knowledge of health care. But, they are bean-counters, and they will always make policy, and exclude out of that policy—for instance, if you take the Mayor of New York and the Governor of New York, you should ask them who takes care of their health. When they are sick, they go to Columbia, Mount Sinai, or New York Medical College—not the very hospital which they support, which is the City Hospital, which unfortunately the Mayor is no longer supporting, because he thinks you should drop dead, just like the Federal government said to New York City when the Big MAC crisis went on.

Well, we're not going to let that happen. And the reason we are not going to let that happen—even though we are doctors, we are basically just one paycheck away from using the public hospital system, or being in need of health care; and, if we do not have the money, we will be in the same position you are in today, where if you do not have insurance, there is no health care. That's one part of it.

Then, the second part of it, is that not all, but a large percentage of the doctors, do not think about you as a patient as long as you are not going to line their pocket with some money, which I think is a deliberate crime against humanity.

No country is wealthy, unless all of its inhabitants are healthy. *Health care is the foundation of the economy of any country.*

For instance, on a subject which the other members will talk about: If you look at the AIDS epidemic, each time someone gets to the full-blown AIDS, where they can not work, or for that matter, someone has pneumonia and can not go to work, the economy slows down, because that person is no longer productive. So therefore, it would make sense to me, as Mr. LaRouche said, that the Federal government should be the mainstay of making sure that every American citizen gets the maximum health-care benefits. *And it should not be a privilege, it should be a right. And you must demand that right.*

Thank you very much.

Human beings sacrificed to speculation

Dr. Abdul Alim Muhammad: Thank you very much. I'm very happy to be a part of this panel discussion. I want to thank Mr. LaRouche for his bringing this issue to the forefront of this Presidential campaign. It's shameful, the way the other candidates are skirting the issue and making it a laughing stock and a joke, when in fact, the health of a nation, as Dr. Clarke just finished telling us, is the wealth of a nation.

And so, I think that Mr. LaRouche, better than anyone else, is best suited to explore the ways in which the economic policies of this country over the last two or three decades, tie in directly to the destruction of the health-care system that once was the glory of the world.

Dr. Abdul Alim Muhammad. Citing Abraham Lincoln's statement that the nation can not be half-free and half-slave, Dr. Muhammad said that the AIDS epidemic emphasizes that principle in another way: "It is impossible for there to be a world of humanity, where part of that world is prosperous, relatively well-off, and the beneficiaries of a health-care system, and then, another huge portion of that humanity, that is deprived of that same thing."

What is actually happening, literally happening before our eyes, is that human beings, human lives are being sacrificed, to feed the bubble of speculation on Wall Street. I think if we look at the change that has occurred in the language that gets applied to health care and health-care policies recently, that would be very instructive.

When I was in medical school—I graduated in 1975—I was trained to take care of patients. Now, my patients have suddenly become "health-care consumers." Or they are "managed-care members," but no longer patients.

But not to worry, because I'm no longer a physician. I'm a "health-care provider." And I no longer practice a profession, I am "participating in the health-care industry or the health-care business." And hospitals and clinics in other parts of the health-care infrastructure, are no longer considered to be beneficial, because in fact, they are analyzed as "cost centers" that need to be reduced to the bare minimum.

And so, there has been a wholesale hoodwinking of the American public through the fraudulent policies of dishonest politicians, who are in league with the bandits of Wall Street, who looked out their windows of their investment houses, and realized some years ago, that health care was a huge cash cow that needed to be milked—that health care was approaching the level of $1 trillion of net economic activity per year, but all of that money was being wasted on people and their health-care needs.

The boys on Wall Street decided that they could do a better job, that doctors and others who were trained in the health profession didn't know how to manage money, and they needed "help" from the people on Wall Street. And in fact, we have received that "help." They have helped us out of everything that we once had.

The money that flows through the health-care system, is now seen as an added income stream, to further pump up and maintain the bubble of investment-speculation that Mr. LaRouche and others are so famous in analyzing. And literally, what is taking place, is the sacrifice of human lives, to support this speculative bubble.

I'm from Washington, D.C., and I've looked, over the last four years or so, at what has taken place there. And basically, what we're witnessing, is the wholesale destruction of the health-care infrastructure in the nation's capital. And I can only imagine what might be taking place in other parts of the country.

Let me give you a brief summary of some of what has been taking place. And the crime that's being perpetrated in Washington, D.C., as elsewhere, is fraud, is robbery, is murder.

About four years ago, the District government was budgeting nearly $1 billion per year for health care for the citizens of the District of Columbia. It was around this time, that managed care was brought in and proposed as a way to "improve the system."

And right away, the fraud begins, because once this was agreed to, then this $1 billion budget for health care in the District of Columbia was immediately reduced, to $800 million—a 20% reduction right off the bat, so that the dishonest politicians of Washington, D.C. could go to the Federal D.C. Control Board, and say, "See? We've already saved $200 million from health care, simply by switching from a fee-for-service system, to a fee-without-the-service system called managed care."

And then, of course, the 80% that is now in a managed-care system, this $800 million, now goes into the hands of the managed-care organizations, who bid on contracts to deliver services to the Medicaid population and other population groups in Washington, D.C. They, of course, as is their custom, take an immediate 15% of that amount off the top as their management fee, just because they have agreed to get involved in this business.

So, if you do the math, you see that a $1 billion health-care budget in the District of Columbia, has just summarily been reduced down to about $680 million. And the fraud is,

that [they say], "We can deliver the same quality and quantity of health care for only 68% of what we were spending just a few years ago."

And that simply isn't so. In order for this fraud to be perpetrated, it's necessary to have physicians who are willing to go along with being "providers." Dr. Clarke said most physicians are deathly afraid that they are just one or two paychecks away from bankruptcy, because they graduated from medical school in many cases having well over $100,000, $200,000 of debt from school loans, and so they're basically looking for a job with a steady paycheck to pay their way out of debt.

And, of course, they have to uphold the artificial standard of living that is traditionally associated with being a physician, so they've got to have the Big House, the Big Car, the Big Boat, and these other signs of conspicuous consumerism, which makes them vulnerable to the fraud that is being perpetrated by the HMOs.

In the District of Columbia, in order to deliver the same amount of health care on 68% of the money—it's not surprising, is it?—that we have had about 50% of the public health clinics in the District that were in operation three years ago—they're shut down now.

The public hospital, D.C. General Hospital, has been privatized. There goes that term again; where it's been handed over into the private sector, and now the board is composed of straight-up business types, who are only looking for the bottom line.

And guess what? They, in their wisdom, have learned that the only way to make D.C. General Hospital "profitable," is to shut it down; that we would all be better off, if it didn't exist. So, plans are afoot right now to "slowly phase out" D.C. General Hospital, and along the way, we almost lost the other hospital in Southeast Washington, D.C., Greater Southeast Community Hospital. It's still not clear what the fate of Greater Southeast Community Hospital is, but it also may be shut down.

There's been a wholesale reduction in the health-care staffing, professional staffing: nurses and other workers in health-care delivery and services to the District of Columbia.

Finally, the two HMOs that were touted as being the "workhorses" that would be able to pull the load, the managed-care load in the Medicaid population, Prime Health and Chartered Health Care, both of them have filed for bankruptcy, and will no longer be there to provide the services that they contracted with the City for.

And of course, the Health Department administrators who engineered and negotiated all of the above, just within the last month and a half, they've jumped ship, as rats do when they see the ship going down. They've jumped ship, and have gotten jobs in the private sector, leaving the D.C. health-care system to sink.

One final note: George Washington Hospital is on the auction block—they have a buyer . . . Columbia. The big hold-up in that deal right now, is that Columbia wants to purchase the professional staff of George Washington Hospital. They don't want to purchase the hospital. They don't want to purchase the buildings. They don't want to purchase the equipment.

They want to purchase the reputation, they want to purchase the expertise of the professional staff. Let somebody else pay the mortgage, let somebody else pay for the utilities, let somebody else take care of the ancillary staff. All they want is the professional reputations. This is an unheard-of kind of negotiation. It's obscene. It smacks even of servitude/slavery.

We are also experiencing, in the District of Columbia, "Y2K-related glitches," I think the accepted term is. These glitches mean that the electronic payment of claims under Medicaid and Medicare, is no longer happening. And I myself, as a director of a clinic in the District of Columbia, am waiting for HRSA, which is the arm of HHS [U.S. Department of Health and Human Services] that makes the payments, to pay us for contracted AIDS services going back to the month of October. For some reason, the computers are not working well enough to allow for my clinic, and other clinics throughout the District of Columbia, to be paid.

Meanwhile, we continue to deliver services on a daily basis.

And so, the fraud of D.C., I think, is emblematic of the fraud in health care that is occurring all over the country. It's time that we had the kind of visionary political leadership represented by Lyndon LaRouche and others, to stand up, to organize the providers, organize the consumers, organize the people to realize that they are being ripped off, and they in fact are the intended human sacrifices to the pagan gods of speculation.

And we need to bring a stop to this, we need to bring the perpetrators of these high crimes and misdemeanors to the bar of justice. We need to get things back on a footing where compassion, and not profit, is the motive for those who are involved in health care.

I thank you for these moments to make these comments. Thank you.

The dismantling of health care in New York City

Q: My name is Lillian Heard and I live in Queens, New York. I'd like to ask, as far as the city hospitals are concerned: I know Mr. Giuliani wants to privatize a lot of them, and what has happened in terms of the service generally provided, usually most of the poorer people in the city had access to health care, they could go to any public hospital and get whatever care they needed if they didn't have the funds. What happened? I know that it failed, that he couldn't privatize them, because the people fought against it. But in terms of service being cut, do you have an idea of just what was cut?

Dr. Clarke: Well, let me make this very clear: The death

According to Dr. Clarke, New York City "is no longer putting any money into the health-care system. They reduced their billion-dollar subsidy of the health-care system to zero." Shown here is a former hospital in the South Bronx.

rate in the City Hospital has gone up dramatically, although it's not being reported. And one of the reasons it's not being reported—we have the so-called Emergency Room doctors, not all of them who prefer to discharge patients and self-admitted patients, and subsequently the patients will come back to their demise.

The service has been cut dramatically. You know, the city is no longer putting any money into the health-care system. They reduced their billion-dollar subsidy of the health-care system to zero.

As far as privatizing, we went to the unions, and we were able to hit back [at] Mr. Giuliani—psychotic Giuliani—to challenge [his plan]. And he couldn't privatize the hospital.

What has happened, he has selected administrators who bow to him, and the operative motive, as Dr. Muhammad has said, is *to cut service*. So therefore, what is done—they have offered buyout packages. The nursing staff has gone to nothing. Senior doctors have gone. And some of the service has been summarily privatized, where the chairman of those departments sits in a private hospital, and they take the cream of the crop, those who have insurance, to those private hospitals.

And those who do not have insurance, might have to wait for months to get service. For instance, if you are a male with a prostatic problem, the first appointment you get to GU is seven months away. *That's a crime*. That's unconstitutional, and that's a crime. That's what it is.

If you are diabetic, with an ophthalmologic condition, unless it's an emergency, where we can convince the resident, not even the attending physician, that it's an emergency, you will not see an ophthalmologist for the next six months.

But it's not publicized. If I tried to publicize [such a situation], which I have done over the years, I am summarily called every name in the book. I am removed from a position where I could see the disaster of what is happening.

Again, I am blaming the citizen, because Giuliani told us before he got elected this is what he was going to do. And yet, we voted for him! Now we have to go back, and bury him, and take control of our hospital system back into the hands of the people who it is there to serve.

As Dr. Muhammad has said, HMOs have been brought in. There's a disincentive built into HMOs, where the doctors are not supposed to provide care for you, because if they provide true care for you, their income goes down.

Therefore, there will be this dismissive attitude, that you're not sick, you can come back at some other time. Nothing is being done. And again, I am blaming the citizen.

And that's why it is so important, what Mr. LaRouche is doing, to bring this to the public's attention, so that you know that the power is within your grasp, and you must throw out the bastards, and put in people who will do what is right, and just, for the community.

Richard Freeman: I want to provide just two things to

back up what Dr. Clarke just pointed out very well. First, is, we used to have 16 public hospitals in New York, and it's now down to 11. It's run by the Health and Hospital Corporation.

So we've eliminated five since the 1960s. We'll be talking about this a little bit later, but this is part of what Big MAC, or the Municipal Assistance Corporation, did to New York starting in 1975.

A second feature of this, is what has been going on with tuberculosis, which again, we'll talk about. But I think it's very important.

Back in 1988-89, in New York City, the number of TB clinics was reduced from 24 to 8. And the staff that treated tuberculosis, was reduced by two-thirds. What happened was, as a result, we had an epidemic. It was not covered adequately at all by the press, but it was very, very real.

The incidence rates went up 50%, which is extraordinarily high. In places like Central Harlem, it was 212 per 100,000 population—which is higher than in Bangladesh.

And the city ended up having to spend a billion dollars to do things which they could have prevented, had they kept the clinics open and done other things. And instead—it's hard to know what the amount is, but let's just say it's two times, four times what they would have had to spend. They had to go into Riker's Island, where TB was rampant, and you had multiple-drug-resistant tuberculosis, which is very, very dangerous. We're seeing it in Russian prisons, we saw it in American prisons, in New York prisons, ten years ago.

So, they had to do all sorts of things, because they had cut the clinics, and they had cut the budget.

This year, after getting out of the woods with a huge amount of expenditure, everyone's saying, "Well, it's all behind us," just like after a big financial crisis, the people with the flea-sized attention spans on Wall Street say, "Everything's behind us."

So, since they got the rates down, what did they do this year? They're cutting the TB budget by 30% in New York, 10% in Massachusetts.

So, these are the sorts of things that are being done by Giuliani and others, right at this very second.

Public health: the lessons of war

Q: Good afternoon, Doctor. As soon as you start speaking about tuberculosis, that was one of the topics I wanted to really talk about today.

Recently, there were presented papers that there is a strain of tuberculosis coming in from another part of the world that is very hard to treat. Now, we here in America, we have not been very good in treating tuberculosis patients, because the follow-up was very poor. As we said before, the clinics are closing; in the hospitals, they get poor care, they are being treated for three weeks, they are being sent home after one test is negative, which is not adequate. And then, what about the families? They go home, and in turn, they infect the families.

And this is what I wanted to ask you: What do we do about follow-up? When you have a mother being admitted into the hospital, who has a baby, and when you look through the chart, you see that the mother was a positive TB case. Do we refer that case to the Public Health Department? Do we refer that child to come back to the hospital, probably a month after? Do we check up on that patient? Do we continue to check that child, while the child is in school?

Maybe that child will end up having a positive TB test. Do we follow up that child? And these are some of the things that we really and truly have to address, because—I am an RN from way back. And what we used to do, is to have the kids being vaccinated against all the different childhood diseases. We do not wait until they are ready to go to school. So, what are we doing?

You find kids entering school [without immunization], and you see it, it's all over the papers. See to it that they're being immunized before they go to school, which they are not being. What are we doing about things like this? If you're closing half the clinics, the doctors and the nurses in the hospital, their hands are tied. Do we just sit back and decide, "Well, this is it"?

I don't think so, because since they're closing all these places, we the people now are going to suffer later on, because our children are the future of the country.

Dennis Speed: I'd like to exercise the prerogative of the chair, and give the first opportunity to respond to that to Mr. LaRouche, particularly because, in the Jan. 6 webcast, which people here, many of you here may not have heard, he focussed on what he always refers to as the Hill-Burton measures in health care. And then I'll open it up for others here.

LaRouche: Well, actually, Hill-Burton's passage in the 1940s, was a reflection of the military experience of the United States in World War II, following the military experience in World War I, following the military experience in the United States in the Civil War.

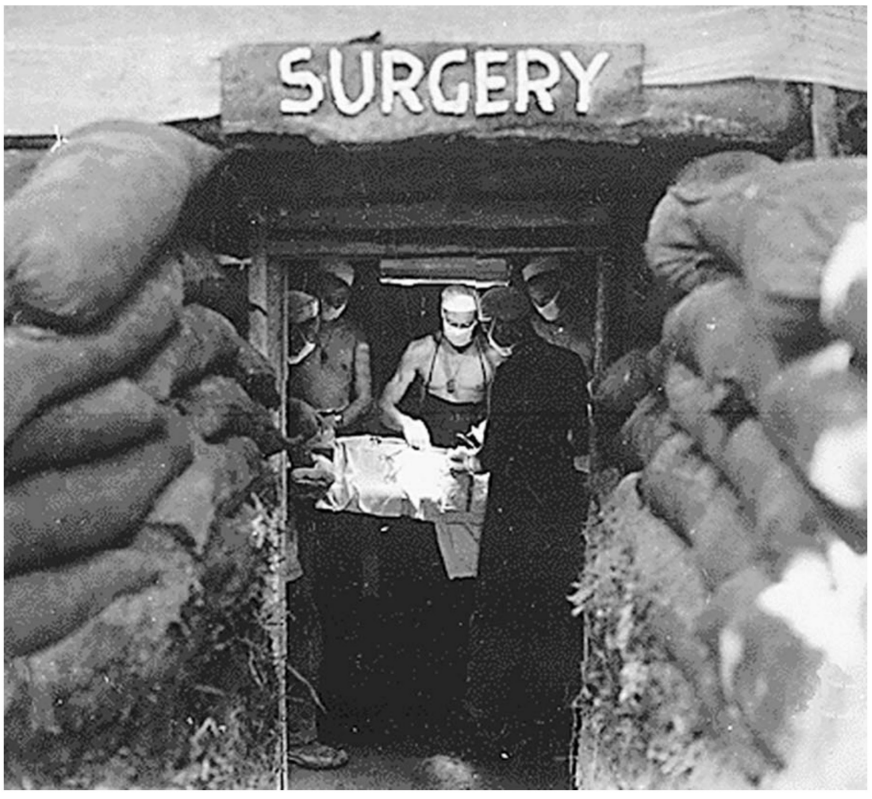
Now, the Civil War was a horrible war. And we began to realize, more and more, what a conflict, a war among people, meant to medicine. You could not look at medicine as being practiced on the patient.

It's like an idea. Every true principle of nature, is discovered by an individual mind, and is conveyed from an individual mind to other minds. But the effect of education, and the effect of discovery, is the benefit to the population as a whole, the nation as a whole.

The same thing is true in medicine, that from the state's standpoint, from the standpoint of governments and institutions, medical care is a responsibility to the whole population. It is not to one patient at a time. Even though the delivery of care may be, in the sense of a patient-doctor relationship, the actual effect is on the total population.

This tuberculosis issue of course brings that up. It's typical of the problem.

For example, you had the case in World War I in France,



During World War II, says LaRouche, we developed an understanding of how to avoid getting into a "triage" situation with respect to battlefield casualties. The lesson to be learned, is that "you look at the total population, look at the profile of what you expect you may have to deal with, and build up a capacity which can address all of these kinds of programs." Here, an underground operating room at Bougainville, during World War II.

where the French were sending much of their population as canned meat into this trench warfare. The British were doing the same thing with their troops, but they didn't care. And the French invented the term for how they would deal with the medical effects of these tremendous slaughters, of the maimed and bleeding, of the slaughters carrying back from the front in these charges out of the trenches. They called it "triage." That is, you made a schedule of who you could treat and who you couldn't, because you didn't have enough facilities to deal with the total population.

Now, as we entered World War II and during World War II, we did a lot more work in this direction in the military medical practice, to try to understand better how to avoid getting into this kind of triage situation, at least most of the time, in warfare.

Of course, a lot of our problems in the military area were not combat casualties. The great incidence of casualties, tended to be in the non-combat area—you know, a jeep turns over, somebody gets a sickness.

In the area I was serving in, for example, we had Tsutsugamushi, which at that time was virtually uncurable. It was something that had been carried into the bushes in Burma by Japanese troops who had picked it up elsewhere. It was carried by our local typhus, a local louse in that area. And you had these people coming in: seven days, they're dead.

So these kinds of problems were typical. We had, for example, an amoebic dysentery outbreak in the area at the same time, in the same period—the same thing.

So, you had, in the military situation, you had not only the combat casualties, you had the non-combat casualties, or what the military tradition calls "frictional losses." And the "frictional losses" are sometimes the biggest cost in warfare, except in the most horrendous kinds of battles.

So, the idea was: How do you design a military medical program? And you design it, not to meet the need of, "maybe we'll have this patient and give them this care"; no. You look at the total population, look at the profile of *what you expect you may have to deal with,* and build up a capacity which can address all of these kinds of programs, using the fact that there's some flexibility that physicians and so forth who are good at one thing, may be able to slip over, if they have freedom, to take up the slack on some other area of care, or to pick up the slack.

And that worked. And Hill-Burton of course was a reflection of that, the lessons of warfare. We had a system in the United States—that I referred to the last time we were doing a talk about this issue, about the public-health service, the Veterans Hospital system. That if we had a crisis in the United States, following World War II, through the public health system, through the Veterans Hospital system, and related things, we would have some slack in the economy, a problem which required that sort of mobilization.

What they've done today, in the name of "efficiency," is they have gone the other way. Each case is taken one at a time. Well, yes, the physician who is treating a patient has to take the case one at a time. *But the system, which is providing that physician, or providing the physician that facility in which to administer care, has to look at the population as a whole.*

And this mention of this resistant tuberculosis epidemic, or the HIV crisis in Africa, or even here, the same thing: This requires us to look at the total population.

How do we cure the sickness of the total population, which is not composed of any one disease, it's composed of a whole lot of problems, including occupational disability problems? For example, you have certain kinds of occupations, you have

disabilities, which may require treatment, prophylactic or other treatment. That's part of the system.

And so, the idea that you're going to treat one patient at a time by looking at their health-care card, or their credit card, and deciding whether you're going to treat them or not, which is what's now—is the dream of an insane accountant, of the lowest and most mean-spirited kind; a Scrooge accountant, who says, "This person gets care, this one doesn't."

The result is, when you don't treat some people, or don't treat the problems of part of the population, the diseases and problems spread throughout the population as a whole.

And that's what I thought we had learned, from the experience of military medical practice, in cases like the U.S. case, like the experience of the Civil War, of World War I and World War II, especially World War II. And that's what Hill-Burton represented, in my view: a reflection of the lessons we had learned from the medical profession as a whole and the administrators, of what you have to do in defining a medical policy.

You must not lose sight of the fact of treating the population as a whole, and then that system, which addresses treating the population as a whole, then will provide the mechanisms by which the physician, the nurse, and so forth, are delivered to the case which needs the specific attention.

Preventive medicine

Q: How would this possibly tie in, this kind of infrastructure—we see the decay going on, almost like they're planning, causing that, but also, part of an epidemic problem is often the susceptibility of the population to diseases that they might otherwise be resistant to. And I'm just wondering how that ties in, in this overall planning structure.

LaRouche: Absolutely. That's the same principle. Preventive medicine is a part of medicine, and public health, overlapping preventive care, is an essential part of the practice of medicine. If you know that a population has a propensity, or a certain population, or part of it, has a propensity for sickness, it's often much more economical, and certainly more effective, to treat the problem, address the problem beforehand.

For example, for companies that were enlightened, you would have people who were safety specialists, who would work on trying to prevent likely types of accidents, depending on the profile. People used to exchange this kind of information. Insurance and their specialists used to do that, would get into these studies of how do we deal with accidents and disease rates that come from dust, or other things, these kinds of problems.

So, preventive care and public health prevention, public health measures which prevent, and even just plain public education, which informs people. And today, I think the medical education program largely consists of panicking people about: You might gain weight by eating this, or not eating that, or not taking this. And the public is distracted from what ought to concern them, which is a general profile of what the problems are, what measures are being taken, by whom, to deal with these problems.

So, the preventive aspect is as much a matter of medical and public health administration as the actual care once the problem has developed.

Dr. Muhammad: I would just briefly like to remind everyone of something that they all already know: that some of the greatest preventatives are simple things like food, clothing, shelter, warmth, and that at a time when you have a society that is depriving more and more of its citizens of these basic necessities of life, you are certainly increasing the susceptibility of these deprived populations to all sorts of diseases.

So, I just don't want us to lose sight of the fact that perhaps the greatest advances in public health have not necessarily come from magic pills and potions and vaccines. It's just been simple things like providing people with an adequate, balanced diet, adequate housing, warmth, and education.

The cost of health care

Q: My name is Peter. I am from Connecticut. I have two questions for Lyndon LaRouche. The first question is: Don't you think that health care should be a Constitutional right? The second one is: How high do you estimate the costs of a national health-care system as you raised it?

LaRouche: Well, there are two things. First of all, health care is Constitutional in the general sense, in the sense of the General Welfare. I've laid this out in a number of locations, so I'll try to keep it foreshortened here. But essentially, the fundamental principle of republican form of government, as opposed to a government which is owned by some person or class of people, that the only legitimate authority of government to exist, is its authority and responsibility for promotion of the General Welfare of all living persons and their posterity.

So therefore, in that sense, the right to health care *is implicitly, under U.S. Constitutional law, a Constitutional right.*

Now, Franklin Roosevelt, for example, was the last President who made that very clear in his fight against the Supreme Court, and against Wall Street, where he said, the General Welfare is the fundamental law of the United States, the Constitutional law, and [he] adopted emergency measures intended to provide for the General Welfare.

So, in that sense, it is incumbent upon any honest American citizen or official to take such measures as may be necessary to ensure the right of everyone to what we can judge to be the kind of health-care facility and delivery of care implied.

Now, on the cost part. That when you take the approach of delivering health care through adequate institutions, institutions which have a proper relationship to the private physicians' practice, and to clinics which are ancillary to this, then it's cheaper to provide health care than if you have an HMO-administered, accounting-supervised, form-fill-out dense system. That is, if you're delivering bulk health care,

even though the health care is individual patient-nurse relationship to patient, that you're delivering bulk health care. You're having the right number of physicians, in training, interns, so forth, in a hospital institution, for example. That represents a capacity for treating a certain number of patients, certain number of incidents in the course of the year. You buy that.

Now, if you don't exceed the capacity that you've provided, that's what it's going to cost you to provide health care through that facility for that year. In the old days, people in hospitals, as under Hill-Burton, you'd have the Federal government, the state government, the city government, municipal institutions, and private hospitals, and so forth, would meet once a year, to make a budget. They would look at what they had in terms of money from the Federal government, from the state government, from the municipal government, and from private institutions. What they had as a kitty. What they were able to provide, in terms of beds and facilities, types of care, training, all these things.

Then they would say, we don't have enough money. So, they would do various things to raise the money, to provide that capacity. It might be a fundraising campaign, voluntary organizations may raise funds, to fill up the budgetary gap. You'd get the gap filled. You'd have the hospitals, clinics in place, the emergency wards. You would treat the patients. And you would treat the patients who could pay, or who had insurance who would pay. Then you'd get the patient who couldn't pay, and you'd take care of him anyway. Because your budget—you've built into the system the capacity to absorb treatment of the patient who can't afford to pay.

When you say: No, we're only going to treat patients by first determining the ability to pay, you increase greatly the cost of that system for that community. So, the first way to reduce cost is to eliminate, as Dr. Alim said, in terms of the takeover of the hospital in Washington, D.C., if you have somebody come in, and put a 15% management cost, fee, on top of the administration of an existing institution, *that's pure looting of the institution!*

So the thing to do, is to keep the overhead and the unnecessary administrative, non-medical paperwork down to a minimum, to keep those kinds of procedures down to a minimum, have a higher percentile of people who actually deliver care, as opposed to those who are supervising, and telling physicians and nurses when they can and can not provide care. It's the basic way to do it.

Now otherwise, this: When people talk about the increase of health care, you've got to do some work with a pencil. Since 1983 in particular, the Federal government, the Federal Reserve System, have faked all reports on inflation. I've seen figures as high as 30-40% of fakery in reports on inflation, by virtue of use of a trick called "quality adjustment index." What they would do, is you would get a product, and they'd say, "Well, this product smells better than the one before, therefore, this is 30% better, so therefore, we'll take 30% off the cost of this product, relative to the previous product, because it smells better." And it was called a quality adjustment index. Sometimes they'd just pull it out of a hat. They wouldn't even give a reason for it.

So therefore, when people talk about inflation, the cost of living, the cost of living has increased *far more*—we're talking probably 100% or more—over the past 15 years, than the government and other institutions have reported it.

Now, for example, if you go to the question about compensated health care, we had schedules of fees. Physicians now, relative to 10, 15 years ago, may get, in money terms, as little as half the fee for performing the same surgical procedure as 15 years ago. The same thing goes through the whole process. Through that, and through the so-called risk insurance, the so-called malpractice insurance, the medical profession itself has been ripped off, institutions as such, as well as physicians: ripped off. So therefore, the so-called increase of costs of medical care is not really an increase, in absolute terms. What has happened is the actual income of the population has collapsed much more than the inflation estimates will allow you to estimate.

So, the problem is, to get the funding for health care back to the same real content cost that it was 15, 20 years ago, say, in 1976, 1980, as a benchmark. If you look at the market-basket of what people consume as families, look at what they're getting in physical terms, compared with 25 years ago, or less, with today, suddenly the truth hits you. That you're not getting—there is not an improvement of the standard of living. There's a collapse in the standard of living. And it's because of that, that you can't afford what you could afford 25 years ago.

That's the general problem.

In addition to that, we have cut our productivity. We have cut our agriculture; we've destroyed private agriculture, that is, the farmer agriculture. We've destroyed industries; we're destroyed places of employment. We now say we can not afford today the same content of care in education or in health care or social security. It's in jeopardy. We can't afford it any more. Why? Did the cost increase? Not the real cost. The price did not increase. What's happened is, our income has collapsed. And the reason our income has collapsed is because somebody decided to go to a shareholder-value economy, a post-industrial economy; we shut down the growth of our industries. We've shut down the improvement of our basic economic infrastructure. We've shut down all kinds of things, and thus, we're much poorer.

The basic solution is, we're going to have to pay the bill. The question is, how do we generate the growth, in the real economy, which will enable us to pay this bill. We're going to have to do both. We're going to have to increase our expenditure in these categories, which means we're going to cancel the capital gains bonanza which Kemp-Roth and others gave to parasites. People who get financial capital gains from gambling on the markets are not going to get favorable treatment

any more. We're going to have to increase the revenue. And that's one place we're going to have to do it.

But the basic solution is, we're going to have to make the economy grow. And it's not been growing. All this talk about a bustling, growing economy is bunk. This thing is about to go, go into the garbage can. And if we look at it that way, and say, "We're going to raise the money. We're going to raise the money because we're determined to increase the actual net economic growth in physical terms of this economy"—and that's what we have to do.

The question of government support

Q: My name is Miriam Lopez, and I'm a volunteer for public service and public announcement for WNCY-990 in Southington, Connecticut. And I just met with your campaign at the grocery store petitioning for your ballot here in Connecticut. And I'm a grandparent, and I lost my job several years ago. I raised my family out of that income. And, now that I'm partly disabled, I would say, I'm raising my grandchildren, and I find myself struggling to help these children, because the government aid that is there for grandparents raising children is very minimum. I feel that the children that are raised by grandparents should have equal financial help, as well as any other children adopted by any other families.

Also, the help that these grandparents receive shouldn't be, in any way, decreased by any amount. If I'm trying to rehabilitate myself and go back to the work field, and to continue to raise these children, I'm saving the government hundreds of thousands of dollars a year, raising this child. In other words, avoiding the welfare, to completely support them. I feel that the grandparents should get better programs.

Also, I find myself, after an operation, that there was not even money to pay for the childcare for these children while I was hospitalized. That was something that was very bitter for me, because they were trying to remove the children from my home, and place them in another home, which was going to cost the government a lot more money. So, I feel that they should help the grandparents on that issue.

And also, another issue was the mandatory sentencing for Federal offenders: There's many parents who could be working for these children, and they ain't. Because the programs are failing, and I feel that the government, the Federal Bureau of Investigation, are using real criminals to solve cases, and releasing them back into the communities in exchange for information, and I think that's a disgrace for the nation—instead of helping rehabilitate offenders who are qualified, and help them go back to helping them raise their families and become more efficient.

LaRouche: Let's take the second question first, because it's a related question, but it's a different one. And that is, that the Federal government, the Federal Bureau of Prisons, to the best of my knowledge, still has abandoned the former policy of rehabilitation, and this is an adjunct to mandatory sentencing, in which the judges have no discretion—creates a real mess. We're going to have 1% of the adult population of the United States, or more, or a larger percent, in prison during this year. *One percent of the population!* We had less than 50,000 inmates in prisons in the United States at the beginning of the century. Now our population has grown considerably, but not that much, not from 50,000 to 2 million. So, you either have to say there's something wrong with the society—maybe we're becoming more criminal—but also, at the same time, maybe we're becoming silly. Or, maybe we're doing something immoral and wrong in our whole Federal, and also state policy. It's insane.

You see George W. Bush and Jeb Bush: George W. was described by one of my friends as the "Texas Chainsaw Governor"—and that kind of mentality is part of the problem.

On the question of the income, as such: Now, what we're doing is, we're cheating with the tax policy. The tax policy says, essentially, we wish to discourage births and family formation among poorer classes of people. The tax exemption, per-capita tax exemption, is much too low. It's not fair, and again, this quality adjustment index is part of a hokum which is used not to raise it.

Actually, as you probably know, and you're saying it, really, in your own terms, in this experience, that the Federal government, and the state governments, lose money by taxing people in lower income brackets, because they tax them into a poverty state where they need public assistance. So, there are two things that are needed: First of all, we've got to shift this tax policy, and shift this economic policy overall. We've got to increase the per-capita exemption, in terms of family income, and let the family define itself. I mean, a grandparent caring for some children—that's a *family,* and should be treated as a family in our tax policy.

The minimum—the tax exemption on income should match that, and should match the reality of the situation, so we're not taxing people into poverty, into welfare, the first objective.

Secondly, the General Welfare policy means that we're trying to develop everybody in the society to be able to make a contribution to the society, if possible. In the case of children, it takes 25 years to produce a fully cultivated mind from the birth of a child. The objective is, that at 25 years later, after the birth, to have an adult who's had an adequate education and maturity, development, who's now begun to raise a family, is working, supporting, contributing to the community, in terms of production or something, and to have that person.

So, we are really investing—in developing that first 25 years of life of every individual. We're really investing in producing the adult citizen, who's going to create the wealth in society for the next generation. And that's the way we have to look at it.

So, we have to have a public welfare policy, like an education policy, like a health-care policy, which looks at these

problems from the standpoint of the long term, a generation—it takes 25 years to bring a fully educated, professional person, or really an experienced technician, to maturity from birth. And during that period, we have to, in large degree, *subsidize* the development of that child, and the family that goes with it. Which means that we have to have welfare policies, and other public policies, and taxation policies, which meet that condition. And that's the only way to do it.

And, within that framework, rather than trying to get a single issue, or hit-or-miss addressed to a specific problem of the type you describe, what we need is a general policy which does that.

I'll give an example: the Hill-Burton policy. Hill-Burton does not specify what you do in every hospital. It doesn't give you a long, legalistic contract, do's and don'ts and so forth. We don't need that. What we need is a very clear *mission definition* of what any law and any policy must do. One such mission definition is: The family is the unit in which we take a child from birth to up to 25 years later to when they are a fully matured, trained adult, in these days. And we have to treat that family as something which is protected as the source of the adult individual who will then make the paying contribution to society.

With that policy, we can do everything.

A national health policy

Q: My name is Marisa Gordon, and I'm a graduate student at New York University in the Robert Wagner Graduate School of Public Service, and I'm studying health policy and management. And I'm 25 years old, so I hope my mind is sufficiently cultivated.

I just want to go back to the proposal for national health policy. It's my understanding that, historically, attempts to establish national health insurance programs in this country have been blocked by media propaganda campaigns, particularly targetted to the elderly, putting them in fear of socialized medicine, making those comparisons to communism, and trying to put fear in people's minds about what it would mean to have nationalized health care. So, assuming that we're all on the same page, and that we would want national health policy, what is the plan, according to the LaRouche idea? What is the plan to disseminate correct information, so that we can correct the fear, and make people understand what national health insurance would be, and how it wouldn't be lines and 25-month waiting periods?

LaRouche: I don't think we should go too far in terms of government-directed or government-controlled health policy. What I think—Hill-Burton expresses exactly which is the best approach.

We should structure our health polices and care policies in such a way that the combination of institutions, public and private, involved, are able to put together packages which ensure that everyone is going to be cared for, as needed. And that should be the approach.

As I said, we have Social Security programs, fine. You can have adjuncts to health-care policies and Social Security, but the idea of having a turnstyle economy, where you pay a fee, and for public health, for this or that, you buy this contract, and you get care doled out to you based on your contract: I'm against that kind of contract approach to public health. You have to have more flexibility.

My approach is: Define in advance what the requirement is for public health facilities, including the number of private physicians in practice, in every county, every state in the United States. And say that our objective is to ensure that everybody who needs health care, in their opinion, or the opinion of the medical profession, will get it.

Now, the way we do that, is we say, some people will pay this way, some people will have this insurance, some people will have that. Some people will have nothing. But everybody's going to be treated. Because this is a national concern. Cut down the amount of overhead, the calculation, the paperwork. Forget it. You know, just forget all this paper, this turnstyle-economy thinking. It doesn't work. What you do, is you take people into a hospital, and they have a program under which they're covered. All right. Use that. Someone else has a different program. Use that. Somebody pays by cash; they choose to. Use that. Somebody has nothing. Take care of them anyway.

And the way you do that is, you have enough money coming into the system to sustain all the institutions and all the physicians you require to meet that objective. And if you don't have quite enough to do that, you put a little more in. Because this is the General Welfare.

It's like fighting a war. You have to fight this like you fight a war. You do what you have to do. But the principle is, that those who are administering, either from the government's side, especially from the government side, must see to it that the job is done, and if they're not able to do the job with present laws, come back and we'll work on it. But that's the only way to go at it.

Yes, there are schemes, there are plans. But generally, what the best thing is, the best thing is estimates—the number of doctors, the investment in number of beds, the investment in the number of clinics, laboratories, research programs, research institutions, a public health system, the Veterans Hospital system—which should be expanded and used right now, because that will absorb a lot of people who need health care, who otherwise don't have the money or insurance for it. There are veterans. We're having a bunch of veterans coming out of the Vietnam War generation now; they're getting toward maturity. They're getting past 50, 55. They're going to need more health care, increased incidence, and requirement. So, we have to have back-up.

But, anyway, the point is: Build the system, have the capacity built into it, and the government's responsibility is to ensure, by oversight, that all bases are covered, by somebody in the network. And if it's not covered, get people together to

A blood-testing laboratory in New York City, prior to the shutdown of medical services that began in 1975. The lab carried out routine screening for a wide variety of communicable diseases.

find a way to meet the responsibility. It's the cheapest and best way to get the job done.

Dr. Muhammad: Yes, I'd just like to make one brief comment, just to get an accurate measure of where we are right now in terms of capacity of the current system. Recently, all of us have heard through the media a lot about the new flu epidemic, that has broken out all over the country. As a part of that reporting, we learned that in many regions of the country, hospitals are at over-capacity, that all of the beds are filled up with people suffering from the flu, and many hundreds, and even thousands, of people have been turned away from hospitals because, simply, there isn't any room for them. So, in all that we're talking about this afternoon, I think it is wise for us to bear in mind that this, degenerative process of the health-care infrastructure, has already gone a very, very long way, and we're already at a point of crisis. Suppose something more serious than the flu came along—what would we really do? And the person who would be at the door of the hospital, being turned away, may not be some nameless poor person. It may be you; it may be me.

Dr. Clarke: Let me make one comment, and I'd like to tell this famous story, because, it's so real to me, that, you've got to hear it. There was a hospital, which had an administrator in Brooklyn, which runs a private hospital, who puts out a policy that, if you do not have certain insurance coverage, you should be turned away from the emergency room. It so happened, that one night he was in a car accident. He was taken to his own hospital. They did not recognize him. He was turned away from there, and came to the public hospital system, which is Kings County. When he looked up and asked, "Where am I?" they told him, "Kings County." He died. Don't ask me why he died, but he died. This was his own policy.

Just to take that one step further. Kings County used to be a 3,000-bed hospital. It's down to 660 beds, now. The population is growing. It's not shrinking, it's growing. The health-care needs of the population are growing. Yet we do not have the service available to them. The next thing, I think everyone believes that socialized, or nationalizing health care, means that you're going to wait 20 years to get to an operation. No one is saying that. We're saying that the government's traditional responsibility is to make sure that every citizen is provided for with the best health care, regardless of his or her ability to pay. If you want liposuction, that's a different story. You can buy health insurance for that. No one is denying you that right. We are saying that, if you have a government, their basic function is to make sure that—health, education, your ability to have a decent place to live, and that you don't starve, should be their function. If not, there's no need for government.

Freeman: Let me add two things: On the count of hospitals—and this gets to some of what Hill-Burton was doing, and you can see now the retrogression from Hill-Burton. These are figures from the 1980s, but the process actually

begins in the 1970s, with the introduction of the post-industrial society. But, between 1985 and 1997, we have shut down, in the nation, 675 hospitals—that's 11.8% of the hospitals. In the same timeframe, we have eliminated 853,000 beds. That represents 14.7, let's call it 15%, of the beds. In some states, the figures are shocking. Massachusetts, in that same timeframe, 1985-97: 32.8% of the beds have been eliminated; Michigan, 25.7%, in George W. Bush's great state of Texas, 15%; and so on.

Now, this gets to the point that Mr. LaRouche was raising earlier. If you look at things simply in income terms (which has many, many problems, but leaving that aside), let's say that you had all the money in the world, but if you're sick, and you can not go to a hospital, what does that mean? If you start to look at these infrastructure questions—water mains: In New York City one out of every ten water mains breaks every year. They are filled with bacteria. This is a transmission vector. Instead of clean water, it's become a transmission vector, potentially, for disease. Look at the other elements of infrastructure: When you have electricity breakdown—no modern hospital can work without electricity. Therefore, if you look at the total society's infrastructure, you start to realize just how seriously health is decayed. You then look at the individual figures of what hospitals have been shut down.

Now, the interesting thing about Hill-Burton—and Mr. LaRouche is absolutely correct, that you must have a Civil War approach—but also, this comes directly out of Franklin Roosevelt. Around 1938-39, and then 1942, President Roosevelt convened conferences. And, you have to imagine what it was like in the South: There were no hospital systems for major cities, like New Orleans, and so forth. And the way they treated mental patients—in Alabama they used to literally have a cage, on the back of a truck, and go around and pick people up, and put people in the cage and take them somewhere.

So, what Roosevelt did, is he said, "Look, let us assess what the needs would be, how many hospitals would you need?" And, what's fascinating about the New Deal, is that the New Deal built over 600 hospitals, many of them in the South. One of the most fascinating things about the whole New Deal is, that it was the Reconstruction program of Thaddeus Stevens. If you look at it, most of these people who come out and say, "I don't understand why we have this state . . . "—you know, Phil Gramm, and others. The South would not exist, were it not for FDR. And what they did, is they said, "Let us do a survey, and let us build a number of hospitals, get a number of doctors." Lester Hill, who's the Hill in Hill-Burton, who is from Alabama—I don't know his whole story, but he carried forward the 1942 work, and formulated a law in 1946, which carried through the Roosevelt approach. And they said, we will have 4.5 to 5.5 hospital beds, for every 1,000 persons in a community. You have to imagine that, in the 1930s and 1940s, more than a third of the communities in the United States had no hospitals. So they did this, and they said, "If we meet these parameters, and we flesh out the other elements that go into this (water supply and so forth), we know that the health will be met at a certain level."

And I think, that's what Mr. LaRouche is addressing. If you meet the parameters, whether you're doing a fee-for-service basis, or whatever you do with it, then you're addressing the real question of: If you're sick, will you have a hospital?

Now, in Brooklyn, there's a place called East New York. It is a zone of 175,000 people. There's not a *single* hospital. North of 125th Street, in New York, many Dominicans, Haitians, poor blacks, poor whites, and so forth, a district that has more than 350,000 people—it used to have five hospitals—has two hospitals. This is the type of situation, therefore, that you're looking at. We have to address the physical requirements, along with the other things, of rebuilding our hospital system.

Dr. Clarke: If you take that same situation, with the population and the number of hospitals: Come back into the central core of Manhattan, and look at the number of hospital beds and the number of hospitals, per population, and you will see the disparity, and it's clear, it's a racial issue, which we can not avoid.

The financial crisis and health care

Q: The Pope has made this a Jubilee Year, whereby debts should be forgiven. Is the United States capable of doing this, for the countries that still owe us, the United States, so that their countries can provide better health care for their people, for the prevention of diseases, so that more doctors, nurses, alternative medicines, etc. would be available for their people? And would we still have enough money for us, in the United States?

LaRouche: Yes. We're going to have a situation, which is now in process, something which many people in the United States have been conditioned into believing can not occur, but it's going to occur soon: in which the present international financial system will go belly-up. It will go into bankruptcy, and possibly chaos. In the process, most of the international financial debt in the system, will never be paid.

What we shall have to do, otherwise we will get absolute chaos for two or three generations to come—like the Dark Ages of the post-Roman period, or the middle of the Fourteenth Century—what we shall have to do, is the governments will have to agree to freeze much of this debt. They'll take some off the top, like gambling debts, such as derivatives debts, and they'll cancel it, absolutely, off the top. That will take over $300 trillion out of the international financial system. The rest of the debt we'll have to slice through, and figure out what we're going to do about it. We obviously have to take things like savings accounts, which are debt, and other things, and we have to say: All right, we may have frozen

everything, but people have a right to draw against the assets represented by their savings accounts, because we can not have chaos in the society. We must keep the society functioning. We must keep businesses operating, and so forth and so on.

So we'll have to do that. But what that means, is this. You take the countries which are the poorer countries of the world, which is what His Holiness's program refers to, and these are countries in Africa, or we see the situation in Ecuador right now, where a country is actually in the process of disintegrating, as Venezuela's disintegrating, Colombia's disintegrating, that Argentina's on the verge of disintegration. Brazil is ready to blow up; Africa's disintegrating; Indonesia's disintegrating as a nation. In these cases, there is no point in saying there's a debt that has to be paid. The people who ran this financial system, especially for the past thirty years, twenty-five or thirty years in particular, made this mess. They had the power; they had the authority; they created this evil. Now we're never going to be able to pay all this debt, and so that debt will simply have to go.

What does it mean? It means that, instead of looking to past debt, instead of allowing the debt to grip the throats of the living, what we shall have to do, is say, we're going to start afresh. We're going to do the right thing this time, which we should have done at the end of the War. We should have taken all those areas which were victims of colonialism and imperialism—and we wanted to make them, or Roosevelt did, free, sovereign nations, and cooperate with them in providing them access to technology, so they could develop as we as a nation had developed. We're going to have to do that now. The result will be, once we clear the decks of bad debt, which could never be paid anyway, and free nations from the grip of that usurer, then we have the opportunity to really begin to grow in real terms. And sometimes, you have to do that; that's the idea of the Jubilee. In the old Jewish law, you had that prescription, that after a certain number of years, you clear up the unpayable debt, because it's just a clutter, which is sucking at the necks of the living.

So, that's what you should do. There's no problem in doing that. Do it; get going; don't worry about paper. The paper is already wasted, the bankruptcy is already implicitly there: What do you do with a bankrupt company? You reorganize it. You write off things that can not be paid. Just write them off—in order to concentrate on things that have to be paid, in order to get the world going again. But that approach, with a new monetary system to replace this junk-heap that's lumbering around our necks now. We can grow again. And we'll all be better; we'll be better morally, and our grandchildren and great-grandchildren will be happy, if we do it. And so that's the right thing to do.

The AIDS epidemic

Q: Mr. LaRouche, my name is Carl Husanna. The question I'm asking, is about the AIDS epidemic in the world situation. Dr. Clarke started to say something about it, but he didn't follow up on it, so I'm raising the awareness of the AIDS epidemic, especially in Africa, and South America. As far as we understand, the people in New York City receive a type of AIDS, but as far as I notice, when it came here to the United States, we realized this is a serious epidemic, because in Africa, it's one of the major epidemics. We don't talk much about it in South America—I'm from Guyana. In Washington, D.C., they have a program going on—we can't cure the AIDS, what we do, we put a number on it, so we are able to identify you, and where you go with it. They had a conference, I think a couple of weeks ago, on the AIDS epidemic, saying, okay, we can't cure it, but what we do, we'll identify people. So, I'd like you to say something about that, because, until it hit home here in America, then we would understand about the AIDS epidemic that is going on around the world.

LaRouche: Well, on that, Dr. Alim has some specific knowledge of this. But I'll take the general case. In 1976, there were samples, left over from tissue samples in San Francisco, and also in Kinshasa, in what was then called Zaire. And the incidence of HIV in the tissue samples in those two cases were comparable. Then, of course, as is inevitable, which is the point to be made, is that in Africa, the rate of spread of HIV was much more rapid than it was in the United States. Why? Because of cultural conditions in the United States, that is, economic culture primarily. Some attention to medical treatment of the victims.

But also, you had the problem of co-factors. In the poverty of Africa, generally, you have tropical disease belts which are particularly pernicious, where you have all these biting insects, and all these other co-factors running loose, and a generally deprived population, increasingly deprived, in which the spread of HIV-related problems is epidemic in a degree far exceeding that in the United States. So, in part, the problem is a marker—while it's a new type of general epidemic disease, it's a marker, the spread is a marker of the conditions of life we're providing for people.

So, you have two problems. One is to provide the care, the medication, pharmaceutical products and so forth, that are needed for the population, and making sure they get delivered to the people who need them. And the other thing is, simply, apart from providing the care, is to recognize that these physical environmental conditions of poverty, and the terrible things that are happening in Africa now, create a holocaust, and there are people in the area, like the followers of the late [Field] Marshal Montgomery—who probably increased the length of World War II by two or three years by his shenanigans as a commander of British forces—that this fellow was a real rabid racist, who said publicly, that he's a supporter of the Rhodes plan, which is to depopulate so-called black Africa, to get it down to the number of shoe-shine people and hod-carriers and weapons-bearers, who would amuse the Great White Father. And part of the problem in Africa, is that you have precisely that condition. You have people who are

stealing the mineral resources out from under the people, as George Bush is doing, for example, in Barrick Gold and things like that. And you have other people who are simply saying, "Let's kill them off."

And so, you have a deliberate policy of genocide targetting Africa, by people like the late Marshal Montgomery, who are doing that deliberately, and other people are standing by and letting it happen. So that the problem of HIV is a marker, in a sense. Yes, it is a new type of epidemic disease. But it's a marker of two things. It's a marker of the relative degree of public health conditions. It's also a marker of the attitude of powerful institutions and powerful forces, in dealing with these areas of the world. We could do something about Africa. We don't know that we've got the solution yet for the problem, but we know we could do a great deal more, if we could restore nation-states, if we could stop the bloodshed, if we could attack some of the conditions which are now being fostered by international institutions and so forth.

Dr. Muhammad: Yes, if I could address the question about AIDS. Abraham Lincoln put forth a principle in a political context, that it was impossible for there to be a nation that was half-free and half-slave. What I think, is that the epidemic of AIDS, which is global in its nature, emphasizes that underlying principle in another way. That it is impossible for there to be a world of humanity, where part of that world is prosperous, relatively well-off, and the beneficiaries of a health-care system, and then, another huge portion of that humanity, that is deprived of that same thing. What AIDS forces humanity to do, is to either accept, acquiesce, to extinction, or come together on the basis of the best principles of Christianity, Islam, Judaism, and other great faiths of the world, and say, in the spirit of compassion, "I am my brother's keeper."

And it is not an issue of money, it is not an issue of politics, it's an issue of spirituality; it's an issue of compassion. And that we, together, must pledge ourselves and devote ourselves to a solution—and it can not be a partial solution. For someone to think that there's a solution to the AIDS problem that only involves my family, or my household—that's preposterous. For someone to think, "Well, this is a New York problem." Or, "It's a Washington, D.C. problem." Or it's the problem of a particular state—that preposteous. Or to think, "This is a problem of the Third World, and we in the First World or Second World, we don't need to worry about it." That's preposterous. If we don't address it as the global issue that it is, then soon, and very soon, sooner than people think, it will engulf us all, and overwhelm us all. [For more from Dr. Muhammad on AIDS, see interview which follows.]

How do we get the personnel?

Q: The best health-care needs the best doctors. Do you think physicians should have a ceiling on their fees for service? We are beginning to lose our pool of best doctors, as our best doctors find it professionally friendlier to enter fields that are less adversarial than medicine. It seems we may have to lower our admissions standards for medical school, to attract less-qualified doctors.

LaRouche: I don't think that's necessary. I think the problem is, the destruction of the medical facilities began with two things. Number one, it started with the medical malpractice operation, which was a secondary phase. But the increase of medical malpractice insurance, is what was the biggest factor in destroying the medical profession, as such. Because doctors couldn't afford it; they went out of practice. The cost of doing business as a physician increased. The income of a physician, decreased. And then, the medical malpractice insurance on top of it, on institutions and so forth, all these kinds of things, produced hell.

Now, the other part of the thing is that the destruction came from government policy, and other policy, but it was government-featured policy, in the Carter administration, when, in deregulation, there was a policy of looting entitlements. What you had under Carter, and then, especially, in the early 1980s, a real wave, a mad rush, to loot entitlements, which meant Social Security; it meant health-care systems; it meant all these things—entitlements. Including public facilities, that is, the infrastructural facilities. As a part of this looting of entitlements—which included Social Security, pension systems in general, looting also the health system. So they said, here's the big-ticket item. Here's the area where coming in with financial piracy can skim off the biggest amount of profit, without actually producing anything; simply by reprocessing through this privatization process, Wall Street privatization, we can loot it.

So what we've done, is, we've looted the system into a state of crisis. The system is not, inherently because it's a medical system, a failure. It's not because of costs of physicians, or to physicians; that's not the problem. The problem is, we've created a total environment, which is totally wrong. And, we're going to have to get at this thing. Government is going to have to play a big role. We're going to have to intervene, on the state and Federal government level, and probably the local community, too, to reorganize. We're going to have to take a Hill-Burton approach, and say, "We've got to save the capacity to meet the medical needs of our population, under a General Welfare concept. We therefore have to keep the institutions that are necessary, alive, that is, the actual delivery institutions, alive, and we're going to have to find ways in which to manage the other kinds of costs which are incurred in delivering health care. We're going to put the thing under reorganization. We don't want it on the government; it's not a good idea to have a government-controlled system, but we want to get it back, in a transition period, to something like the system which existed, say, in the early 1970s. The public-private division at that time. Something like that, we've got to get to quickly.

But we're going to have to do it through very drastic intervention by government: the Federal, state, and local governments combined.

One of the responsibilities of the Federal government in health-care policy, is to foster basic medical research, in the interests of the General Welfare. Here, scientists examine a tissue specimen at the National Cancer Institute.

What's the starting point?

Q: My name is Nancy. I am a mediator between service providers from hospitals, and managed-care companies. I hear complaints from patients, clients, as well as the service providers on a day-to-day basis. And my question is, and I'm wondering, what can we do, or what should be the starting point for what we do, to change the position that we're in, in terms of being so limited in terms of what we can actually provide the patients?

LaRouche: Well I think, Nancy, the key thing is, we have to have a national health-care bill, modelled on the successful features of Hill-Burton, which addresses all these areas. In other words, we're going to have to say, we are prepared—the Federal government, primarily, together with state and local governments, and private institutions—we are prepared to work together, to take a system which is about to disintegrate, and keep the essential viable elements of that functioning and in place.

And so, it's going to be that kind of operation. It's going to be essentially a process of reorganization in bankruptcy, of what is now, essentially, a bankrupt health-care system. That is, if you take all the people that need health care, which the health-care system should be serving, we are not meeting that demand, and we can not meet the demand. The ability to meet that demand, by the existing health-care system, is being destroyed, both by general economic conditions, and also by the HMO managed-care system itself, because of the overload at the top, the skimming from the top, which is a very destructive process. Plus the fact that the economy, contrary to boola-boola rumors, is not growing in the United States now.

We're going to have to move in, as you would move in in bankruptcy, and say, we have something in the community health-care system, which we must keep alive, like the fire department, at all costs. And we're going to keep it alive. But we know it's now bankrupt, in the sense that it is in a spiral, a hopeless spiral of bankruptcy, until we can get it reorganized. So, we're going to step in, we'll have to. We're going to get together, the Federal government, the state goverment, local government, and private institutions involved in this. We're going to have to work together, and say, "This thing is bankrupt." We're going to have to work out in each locality, the specifics of how we rebuild the system.

Summary remarks

Dr. Clarke: I just wanted to thank Mr. LaRouche for having the tenacity and the guts, to stand up and to attack a problem which is the mainstay of the American public, and it is so critical to the existence of this great nation, and yet, our bungling politicians, somewhat, are either too crazy to understand, or not wise enough. But Mr. LaRouche has taken this by the horns, and decided, well, it's a major issue. It's not just a small issue. It is *the* issue. And as Dr. Muhammad has clearly pointed out before, the ancillary issues are very critical, which is not only health care, but education, to make sure the people really are well taken care of, to provide for their health care. Therefore, Mr. LaRouche has done a marvellous job, and I hope we make sure we are there, not only to

support him, but to support a leader who has the wisdom, the courage, and the guts, to stand up to a corrupt society. Thank you.

Dr. Muhammad: Just briefly, I would say that I certainly have appreciated the opportunity to be a part of this discussion, about the crime of managed care, and I think that this is the kind of issue that should be discussed more widely. It's the kind of issue that the people themselves have to decide. It's not going to be done by someone else. It's going to be done, if it is done, by we ourselves. This is a corrupt system. In case someone is feeling some sympathy for the managed care organizations, the HMOs, and thinks, perhaps, that we're being a bit unfair in our criticisms of them, then I would hold out this challenge to the HMOs: That, if you are not corrupt, if you are not thieves, if you are not robbers, if you are not involved in human sacrifice for the sake of your profits, then you can prove that, by entering into community partnership agreements with your managed-care membership, and plow the profits that you generate from maintenance of your heath maintenance organization, back into the communities from which those profits have been derived. And if you are unwilling or unable to form those kinds of community partnerships with those that you are exploiting, then you will just have to accept the harsh criticism that you are hearing and will continue to hear, and you will have to expect that one of these days, we the people of the United States will rise up and destroy you, and replace this ungodly system which you have erected, with one that is based upon compassion and other humane values, that revere the sanctity of human life, above all other values.

LaRouche: What you have, is you have going on in the nation now, a spectacle of two party leaderships competing for 35% of the people eligible to vote. Isn't that funny? Now, the 35% is dominated by people whose income brackets are in the upper 20% of the nation's income brackets. The upper income brackets represent 50% of the family income of the families of the nation as a whole. And at the top, of course, is the top 1 to 2%, who are a little smarter, but the 18%, the lower 18% of the top 20%, are generally suckers who are fascinated by their money-manager accounts, and similar kinds of things, their stock prices and whatnot. And they're so fascinated by that, they are living in a fantasy-land, out of reality.

So, the politicians, like the Gores, and to some degree the Bradleys, and certainly the Bushes and the people behind them, are appealing—imagine!—to try to get the majority of 35% of the Americans who might be potentially eligible to vote in this election. Whereas, the lower 80% of the total population, who are more and more disaffected from the politicians, and may turn out in some part to vote for them, but they're going to bet on the front-runner, or what they think the front-runner is, or a protest vote; they're not going to try to change the nation.

Now, our job is to convince the average American, that somebody cares about the average American. Because the conviction is, that this is a spectacle, that they're like the proletariat of the Roman Empire, going into the Colosseum to watch some gladiators kill each other, maybe on a television set or something, these days, rather than being part of the self-governing process of a nation. The health-care question comes directly to this point. Does leadership care about a frightened, desperate citizen, especially in the lower 80% of the family-income brackets of this nation?

Our problem in politics, is to show that citizen that somebody does care. Not in order to win their vote, that's not the issue—we need the vote, because we've got to take power, and it's their power, it's not ours. But we've got to mobilize them to take power back, away from the deluded people who now dominate national politics, and who are the object of lust by the principal candidates and parties.

And we won't do that, unless we can get you, and other citizens who are blocked into this lower 80% of family-income brackets, to realize, not only that somebody cares about you—and the health-care question defines that very clearly, especially if you're young, or you're a little bit over 55 years of age. But also, to make it obvious to you, that you don't have to put up with this nonsense. That there is a concept of the General Welfare. And that you should be optimistic about what we can do, if you will but get out, and take the power, which you, as representatives of the lower 80% of the family-income brackets of the nation, represent. If we can get African-Americans, Hispanic-Americans, Asian-Americans, people in labor, just concerned professionals, and senior citizens, to unite, around this question of General Welfare, and say the General Welfare comes first—because we're convinced that if we can win the point of the General Welfare, then winning that point will put us in a position to address the specific issues of different groupings within the population.

And I think health care and education are the two most unifying questions of concern, especially for the people who live in the lower 80% of family-income brackets. We should look at it this way: We know what we're talking about; we've had this discussion; we'll have more of it. But that's not the point. The question is, can our discussion lead to a solution. It can lead to a solution only politically. Only if we can inspire the people, especially the lower 80% of income brackets, who are now totally unrepresented by most candidates—the candidates don't care about them, as long as they keep them out of the way, keep the upper 35%, that actually turn out to vote, in their pocket, the majority of that, and they divide that up. They don't care about the rest of the citizens.

But the rest of the citizens, if they will realize that they care, if they have the optimism, we can win. And we can win around a central, unifying question, or a series of such questions, which express the General Welfare. And if we can inspire our fellow citizens to get out and march and vote, to take power back, then all these fools, of politicians who are tracing the shares, the crumbs, of the 35% of the citizens now expected to vote—we can just brush them aside, and go on and get this mess straightened out. And that's the way to look at the health-care problem.