PUBLIC HEARING
TAKEN BEFORE THE
ADEQUATE HEALTH CARE TASK FORCE

THE CHAMPAIGN COUNTY PUBLIC HEARING before the Adequate Health Care Task Force, taken before me, Jill A. Bleskey, CSR-RPR, License Number 084-004430, a Notary Public in and for the State of Illinois, at the Illinois Terminal, 45 East University Avenue, in the City of Champaign, County of Champaign, and State of Illinois on the 15th day of February, A.D., 2006 commencing at 4:00 p.m.

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Jill A. Bleskey, RPR
CSR #084-004430

APPEARANCES

Task Force Members:
Quentin Young, M.D., President of the Senate
James Duffett, Governor
Margaret A. Davis, President of the Senate
Robert Wagner
Kenneth L. Smithmier, Minority Leader of Senate
Timothy M. Carrigan, Governor
Ralph Schubert

Illinois Department of Public Health:
David Carvalho, Deputy Director
Ashley Walter, Policy Analyst

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NOTE: No Exhibits were marked.

MR. YOUNG: I'm Quentin Young, a member of the task force and I have a few minor tasks in telling you what's up here. And thank you all for coming, we greatly appreciate that. I've been instructed to tell you that until five o'clock you're on a pay parking arrangement. If you didn't notice it, I'm letting you know.

This is the work product of the Health Care Justice Act passed by the State legislature and signed by the Governor. It's been charged with coming up with recommendations to the legislature for achieving access for every person in Illinois. And the law also mandates what's happening here, that every congressional district have a hearing. And this is maybe our eighth or tenth and they've been remarkable in public expression and we welcome what you all have to say today. It informs this commission.

There will be -- just to acquaint you with the process -- consulting firm hired by the Department of Public Health, not the Commission, which will be charged with looking into different models to achieve the goal of the Act, achieving

access to every person to decent health care in the state. That will happen mid-year. And after that process, we are charged with making recommendations to the legislature which in its wisdom will do the right thing, we know legislatures always do the right thing.

And in that vein, I'll tell you the way we do things. We've got, I think, a very good system. You all signed up to give testimony. And that's another way of saying if you haven't signed up please do so and we'll hear everybody. We are scheduled to be between here between four and six and we won't leave before six. If people are waiting to talk at six we'll stay as long as you want to talk. That shows our devotion to you all and what we're trying to do here.

I will call the first five people and encourage you or instruct you to take the five seats here. And please approach the mic in the order that we call your name. And please, because we have a Court Reporter here recording all what's going on, give your name and spell it. I know I sound very bureaucratic, that's not me at all but

those are the deals.

And I'm only chairing because I was asked to, we rotate the chair. Our Chair, Wayne Lerner, attends most of these, he's not here today. So that said, I trust I -- oh, yeah. We have -- this is the gatekeeper here. You have three minutes. We would like to remind you when you have a minute left, to remind you further --

MR. SMITHMIER: We'll hold up signs just so you know.

MR. YOUNG: This is Ken Smithmier, a member of the commission, that has taken that task and then he'll tell you when your time is up. We're not crude if you run over a little bit. With respect to the large number of people who've asked to testify, try and stick to the time line. I'm going to invite the first five people to take these seats up here, if you will. David Bertauski, I hope I pronounced your name correctly, David Gill, Claudia Lennhoff, Sheldon Keyser, and Jerry Andrews. David.

DAVID BERTAUSKI: Bertauski.

MR. YOUNG: Thank you. David

Bertauski. Please testify.

DAVID BERTAUSKI: Good afternoon. My name is David Bertauski, B, as in boy, E-R-T-A-U-S-K-I, and I am the president and CEO of Provena Covenant and United Samaritan Medical Center in Danville. Not turning away a signal person who walks through our door is something we are very proud of and we do our best to continue. And that does fulfill our mission at Provena.

Regionally we provide over 49.7 million dollars in community benefits, 21.7 million dollars in uncompensated care of which 2.9 million in charity care and 18.6 million in bad debt, 28. million dollars in health services, government programs, research, and other types of assistance.

Like many hospitals across the state we are doing our best to serve our community's needs but there are still maladies that we need help to fix. One of the most serious issues we have experienced in central Illinois is a lack of access to primary care for the uninsured and underinsured. From a hospital's perspective, we see the outcomes of this problem in our emergency

department. Speaking on behalf of Covenant, we have seen a 28 percent increase in self-pay patients and 49 percent increase in Public Aid patients from 2003 to 2005 in our emergency room.

When people turn to us in a time of crisis we want to insure the best possible care for them at all times. This can be difficult when preventable injuries fill the emergency rooms and make it harder to attend to those urgently in need. Sometimes it's used as a primary care center.

We must also take into consideration the importance of responsibile regional planning when it comes to health care facilities and services. If legislation is not passed this session the Health Facilities Planning Board will sunset in July giving way to the likelihood of uneven distribution of facilities and services. This makes it even more difficult for those who need to have access to care.

These issues place a great financial strain on not just our hospitals but hospitals across the state. Illinois Hospital Association cites one-third of Illinois hospitals as having a

negative operating margin, Covenant included. As I mentioned before, we will not turn away any person in need despite ability care, insurance status, or citizenship status. In order for us and other Illinois hospitals to do the same changes need to be made.

I urge you, the task force, to carefully consider the many proposals that come before you to insure our doors stay open to serve our community and hospitals will stay the same. On behalf of Provena and our regional medical centers, we appreciate you giving us the time regarding our concerns and we thank you.

MR. YOUNG: Thank you very much. I left out the fact, those of you who have written testimony, if you prefer to submit it please give it to Ashley Walter, our staff person at the desk. Finally, I left out introducing your distinguished panel. Perhaps if you call your names rather than me call them for you. Bob Wagner, please.

MR. WAGNER: Bob Wagner with the Illinois Division of Insurance.

MS. DAVIS: Margaret Davis, the

Health Care Consortium of Illinois.

MR. DUFFETT: Jim Duffett, the Campaign for Better Health Care.

MR. SMITHMIER: Ken Smithmier, Decatur Memorial Hospital.

MR. CARRIGAN: Timothy Carrigan, University of Illinois Medical Center at Chicago.

MR. CARVALHO: David Carvalho from the Illinois Department of Public Health. And by the way, I heard your testimony as I came in and I just came from Springfield and the bill to extend the Health Facilities Planning Board came out of committee and is on the House floor today.

DAVID BERTAUSKI: Thank you, good news.

MR. YOUNG: Fast.

MR. SMITHMIER: Timely.

MR. YOUNG: Thank you very much.

DAVID BERTAUSKI: Thank you.

MR. YOUNG: Dr. Gill, David Gill.

DAVID GILL: My name's David Gill, G-I-L-L. I appreciate the opportunity to address the Adequate Health Care Task Force today. I'm an

emergency department physician from Clinton, Illinois, I'm also past president of the Board of Directors of Dr. John Warner Hospital in Clinton and thus I've witnessed the difficulties inherent in health care financing from more than one perspective.

As a 15 year member of Physicians for National Health Program I've long been convinced that America desperately needs a single payer national health care plan for the well being of both our citizens and our large and small businesses.

I am currently running, for the second time, for Illinois' 15th District seat in the U.S. House of Representatives. But until I can convince a majority of 15th District voters to send me to Washington where I intend to be a leader in bringing adequate health care to all Americans, I feel that Illinois' Health Care Justice Act is an appropriate and necessary step in the right direction.

For more than 20 years I've borne witness to the lunacy and injustice of health care

financing here in Illinois. I've watched as Illinois citizens, young, old, rich, poor, black, white, have suffered and died because of the failure of our elected leaders to implement a health care plan which provides access to needed care. These same citizens would be alive and well today had they lived in Japan, Germany, Canada, Switzerland, or any other industrialized country in the world.

Our Illinois businesses, large and small, now compete in a global economy but we force them to compete on a playing field which is far from level as companies from all those other countries have the benefit of universal health care plans. For this reason, American companies will eagerly flock to the first states that implement adequate health care for all.

Within the past month I watched a young man less than 40 years old die of a heart attack leaving behind a wife and two young children. He worked as a full-time househusband and father while his wife worked full-time outside their household. He experienced mild intermittent

chest pain for one week but because he was unable to afford health insurance he ignored his wife's pleas to have his chest pain evaluated and as so often happens over and over and over again he arrived at my emergency department too late. His children will now grow up without their father leaving them with broken hearts and putting them increased for a host of negative social consequences. As a society we fail such children each day that we stand by and fail to implement universal health care. Thank you very much.

MR. YOUNG: Thank you. Claudia Lennhoff.

CLAUDIA LENNHOFF: Good afternoon. My name is Claudia Lennhoff, L-E-N-N-H-O-F-F. I'm the executive director of the Champaign County Health Care Consumers, a local nonprofit consumer health advocacy organization founded in 1977. I am grateful for the opportunity to participate in this hearing and the state's process for developing a plan or plans to provide quality affordable health care to all Illinois residents.

Too many Champaign County residents

are locked out of our local health care system and lack timely and affordable access to health care. In particular, consumers who have Medicaid and consumers who are uninsured are experiencing a very real crisis in access to health care.

Although our community is blessed with a wealth of health care resources, plenty of doctors, dentists, medical facilities, and state of the art equipment, there are too many of our community members who have no access to these resources and are going without the care that they need.

The numbers David Bertauski talked about in the Provena Covenant Health Department are very, very real. We routinely refer people to the emergency department because they have no place else to go. I'm talking about consumers who need simple oral surgery to have a tooth removed and they end up trying to remove it themselves with pliers because they can't stand the pain anymore and they can't stand being on antibiotics for years on end trying to fight an infection. I have a client who developed a cardiac problem as a result

of an untreated oral infection because of a tooth that went untreated and so on.

So every day we get calls from desperate consumers. Some have to travel out of our communities to find doctors who will take uninsured patients or patients with Medicaid so we're producing medical refugees out of our community.

Based on the needs of our community, I would like to make the following recommendations to the State as you move forward in developing a plan or plans to provide quality affordable health care for all.

First, the health care must be accessible for all Illinois residents whether they have insurance through public programs or are uninsured. The State plan must insure the participation of the majority of health care providers. Health care must also be fully accessible for people with disabilities, people whose primary language is not English, must be comprehensive, include physical health, oral health, dentistry, mental, behavioral health,

substance abuse treatment, vision and hearing, durable medical equipment, prescriptions, reproductive health, in-home and community based health care, and long term care. And of course it must be affordable and timely. Thank you very much.

MR. YOUNG: There's a question.

MR. DUFFETT: Claudia, you mentioned about access. What would you say are the main reasons that -- is it just reimbursement rates or are there other issues that are related to people being able to get access to services here?

CLAUDIA LENNHOFF: Well, one of the dynamics is that over 90 percent of our physicians are concentrated into two large for-profit physician clinics. And those clinics have practices of limiting or refusing care to Medicaid and uninsured. The clinics had said that the Medicaid reimbursement is a problem and that that's one of the reasons that we were not, you know, allowing appointments for Medicaid folks.

However, my concern is that it's not just a matter of the level of reimbursement and the

speed of reimbursement because recently, as a result of a lawsuit settlement, the State of Illinois has prioritized pediatric Medicaid payments and greatly increased the rate of reimbursement for pediatric Medicaid services. And still our clinics were quoted in the newspaper as saying that they were still not going to -- that even with those higher and faster reimbursements they still were not going to be taking children with Medicaid. So I don't actually know, you know, what the problem is. And hopefully they can be, you know, part of the discussion and explain what it is.

Another thing that I wanted to just add is that a lot of times the assumption is that uninsured patients cannot pay when, in fact, many small business owners are uninsured and they would be able to pay to go see doctor to have their bronchitis treated, they just need to be able to make payments or have a fair price. Thank you.

MR. YOUNG: Thank you. Please.

SHELDON KEYSER: Good afternoon. I'm Sheldon Keyser, S-H-E-L-D-O-N, K-E-Y-S-E-R, I am

president of the Illinois Rural Health Association. Our mission is to insure that every rural resident in this state has access to quality health care. And I'm not going to tell you anything you haven't heard. Because when you look at access problems it's -- often you find it's not available.

Here recently we've been looking in depth at mental health, access to mental health, oral health, emergency services where they're available and provided on a voluntary basis or not, how they're financially supported, and a whole host of other things. Oral health, you know. I mean, shortage of dentists for Medicaid. All this stuff you've heard.

And what we've kind of discovered over time is there's a lot of problems. And when I went on the board -- I'm not employed in any way in the medical profession. One of my avocations is I'm a farmer from southern Illinois. And when I went on the board, you know, I'm a problem solver, I've been professional problem solver, military, my professional life. And I thought why can't these people define the problem and figure out how to

solve the darn thing and get on with their lives. And after I'd served on the board and got more immersed in some of these problems I've figured out they're too dog-gone complicated.

But I think the first step is obviously getting out and understanding where the problems are. The second step is really hard. How do you solve these? We can't just take problems and dump them on the legislature and say, hey, here's the problem, solve them. I think we have to really immerse ourselves in a problem solving process in identifying models at work, best practices, and, you know, really figure out how to serve rural.

You know, one point, you know, we've heard about finance, rural hospitals struggling to stay open, struggling financially. At the same time, you know, I was setting in the meeting at Springfield we talked about how a hospital on the gold coast is setting there with one billion dollars in cash, period, you know, and they serve the gold cost and really an upper scale population. Where our rural hospitals are serving poor people,

people on Public Aid, and people who can't pay.

And, you know, should everybody get the same health care, probably not. I mean, if you can afford it should you be able -- you probably should be able to buy better care. On the other hard, the disparities that are there now are too broad and we really need to look at ways of meeting those. Thank you for this opportunity, delighted to be here. Thank you.

MR. YOUNG: I'd like to invite any members of the government who are here, the legislature or otherwise, we'd be happy to identify you. Mr. Andrews.

JERRY ANDREWS: Hi, my name is Jerry Andrews, J-E-R-R-Y, A-N-D-R-E-W-S, and I'm the administrator of the Macon County Health Department in Decatur, Illinois. I'd like to take a few minutes to discuss the role of local health departments in Illinois in insuring quality health care for the citizens of Illinois.

First of all, what is health? The constitution of the Rural Health Organization states health is a state of complete physical,

mental, and social well being and not merely the absence of disease and infirmity. It further states, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction to race, religion, political beliefs, economic and social conditions. All of us in this room would agree with that statement.

The challenge for all of us is to determine how to get the help. I apologize, I get breathless once in a while so just bear me, if you don't mind.

MS. DAVIS: Take your time.

MR. YOUNG: That's fine.

JERRY ANDREWS: Public health departments are in a position to help citizens in Illinois enjoy the highest attainable standards of health by providing a wide variety of preventative services. Prevention is the most cost effective and the most humane and least burdensome way to keep people healthy.

What is the cost of prevention versus treatment? I've provided each of you a pamphlet

entitled Cost Efficiency Analysis. We were able to determine the cost of prevention versus treatment for a variety of services traditionally provided by health departments. You can see the cost of treating a single case of flu, including possible hospitalization, $6,154 versus the cost of administering a flu shot at $10.12. Not surprisingly, the cost is far less than the cost of treatment.

We need to look where to direct our resources. I've provided you two examples of health problem analysis worksheets. As we look at the worksheets you can see that heart disease is a health concern we want to prevent. But what we really need to look at are the indirect contributing factors on the far right of the page. If we can address these factors we can prevent heart disease in thousands of people living in Illinois.

We should be looking far beyond the traditional partners, that include state and local agencies and others, who address economic and other social conditions that influence an individual and

family lives.

Many of the indirect contributing factors represented on the worksheet are what are commonly referred to social determinants of health, which are the economic and social conditions that influence the health of individuals and communities and jurisdictions as a whole. They are the causes behind the causes of ill health.

The last challenge we as local health -- at the local level face is the categorical funding from the state for services we provide for our citizens. Sometimes state agencies work in narrowly focused groups only addressing a segment of the population they can provide funding to implement change. Where many of us at the local level look at the holistic care for the entire family as the most effective and efficient way in delivering services.

Clients we work with have multiple complex issues in their lives that cross the boundaries and services that each state agency will fund. It would be a refreshing change if state agencies could pool their resources to provide

holistic broadly defined health care for family and individuals living in Illinois.

In conclusion, I would like to applaud the efforts of this task force taking the time to go to the public and finding out how we think quality health care can be provided for all citizens in Illinois. I can assure that any health department administer in Illinois would be glad to help with the continuous deliberations the task force will face after these hearings are over. Thank you.

MR. YOUNG: Thank you.

MS. DAVIS: I've got a question.

MR. YOUNG: Yeah. Congratulations on your excellent teaching material. That's wonderful.

MS. DAVIS: I've got a question.

JERRY ANDREWS: Oh, I'm sorry.

MS. DAVIS: In the event that Illinois does insure all of its citizens, how do you feel the health departments, the public health facilities, the safety net providers will fare in this process?

JERRY ANDREWS: It depends on how that insurance takes place, whether it's through Medicaid or whatever it might be. For example, All Kids, which is going to take place in what, July 1, I think.

MS. DAVIS: Uh-huh.

JERRY ANDREWS: There are suggestions -- and I'm sure Ralph can address this -- that certain services provided by Public Health departments, such as immunizations and so on could still be provided at the local Health Department where they have been for years.

And the fact is you're right, we are the safety net. A physicians office could decide they don't want to treat a patient, that's their prerogative. In that case it would become the responsibility of the local health department to do that. And we are willing and able to do that with whatever resources we have.

MR. YOUNG: Good. I'm going to invite the next five people registered. Jacob Briskman, if you guys can come up front here, Charlene Stevens, Valerie McWilliams, Trisha

Crowley, and Rafael Gonzalez. And Jacob, if you could lead off.

JACOB BRISKMAN: Jacob Briskman, J-A-C-O-B, B-R-I-S-K-M-A-N. Okay. As I just said, my name is Jacob Briskman and I volunteer in Champaign as a Spanish interpreter. And what I can say is that this community is in desperate need of medical interpreter services to the many non-English speaking community members.

Working as an interpreter and with the Latino community as a DCFS caseworker in both Champaign and in Chicago for the past four years I have come to see how people who do not speak English are at an extreme disadvantage when they are receiving something as basic as a dental or medical checkup. People become very frustrated when they're not even able to express to the primary care provider what hurts them or what their symptoms are. This is simply not fair.

Quoting the relevant language from Title 6 of the Civil Rights Act of 1964, "No person in the United States shall, on the ground of race, color, or national origin, be denied the benefits

of any program or activity receiving federal financial assistance."

Now, I would also like to quote from a Brookings -- Princeton Brookings study, from one of their journals in the winter of 2004. "When language barriers result in denial, delay, or otherwise differential treatment of limited English proficiency speaking populations it represents a violation of Title 6 of the Civil Rights Act."

These violations have resulted in the adoption of different policies in other Illinois State governmental programs because of these practices being in conflict with Title 6. For example, the Burcos (phonetic) decree affecting the Illinois foster system. The consent decree mandates that all services and documents offered to Spanish speaking clients be available in Spanish and that the Department of Children and Family Services hires workers, enough workers to serve Latino clients in Illinois.

We now ask that the Illinois legislature extend this protection to the health care system. I would encourage the State of

Illinois to include requirements for medical interpreters in any plan that they develop and also some means of feedback to make sure they hold the state accountable for this requirement. It is very difficult for people to get the most out of their health care if their health care is not provided in their native language.

We would like to encourage the state to insure that medical interpreters are part of the health care system so that all Illinoians can get the health care that they are entitled to. Thank you.

MR. YOUNG: Thank you very much.

MS. DAVIS: Jacob. Is there any -- I know that there's a limited number of Spanish speaking human beings to do interpretation. But in this area, are they using any technology, any phone hookups or anything, to address this interpretation problem?

JACOB BRISKMAN: Well, I'd first like to make the qualification that I am by far nothing of an expert in any of this field whatsoever. I just -- I'm a student at the University and I

volunteer my time as a Spanish speaking interpreter. But in regards to your question, I do not know of any of this technology being used to help interpret services.

MS. DAVIS: Thank you.

JACOB BRISKMAN: You're welcome.

CHARLENE STEVENS: Good afternoon. My name is Charlene Stevens, C-H-A-R-L-E-N-E, Stevens with a V, and I work at a multi-cultural clinic at Orchard Downs at the University of Illinois and we do have those telephone systems where we can dialogue with people of foreign language and it works quite well.

Good afternoon, and good afternoon. I'm happy to be here and I appreciate the opportunity to speak.

MR. YOUNG: Face the mic.

CHARLENE STEVENS: Oh. I appreciate the opportunity to speak and to be heard. My name is Charlene Stevens and I grew up in Champaign. I've been a nurse in Champaign-Urbana for 28 years and for the last 12 years a Public Health nurse.

We have a unique community here in

Champaign-Urbana, we have world renowned center of learning research at the University of Illinois, a medical school, a nursing school, a center for supercomputing, and Noble prize winners are our neighbors.

Champaign-Urbana is a unique community. We are insulated from economic depression because of Parkland College, the University of Illinois, and we are surrounded by rich fertile farmland. Here in our community we are also rich in health care services and health care providers. In Champaign-Urbana 90 percent of all physicians practice their skills in two quality local medical clinics. This is a rare and unique scenario.

Another distinct fact is that it is estimated that some 30 to 40,000 uninsured, underinsured, and state insured citizens of Champaign County are barred from quality primary medical care. These two medical health clinics have a policy of not accepting appointments for new state insured clients in need of their health services. These clients however can get their ear

infections treated by our two local emergency rooms. Emergency rooms are where the cost of health care is the most expensive.

Frances Nelson Health Center, the only federal qualified health center in Champaign-Urbana, is relocating to a larger space and this is a good thing for our community. But will Frances Nelson be able to offer health services to these 30 and 40,000 county residents in their new building even with planned additional staff? No, the effort is insufficient to offer quality services.

As a Public Health nurse, at my screening clinics, I have no place to refer these residents with no medical insurance or state health insurance to receive proper diagnosis for hypertension or prescriptions for that. This is an illustration that the emergency room gets used over and over again like an office call.

Our community residents are working, walking, living with undiagnosed, untreated chronic illnesses with little opportunity for treatment. I am here today to increase your awareness that here

in the Midwest we boast of rich soil in our nation, we are one of the three supercomputing centers, we have Noble prize winners walking, and our insured are stumbling.

In Champaign-Urbana we have a unique community, a unique opportunity for team work and focus. All of our riches and health care providers, Carle Clinic, Christie Clinic, Frances Nelson, Champaign-Urbana Public Health District, Champaign County Christian Health Center, U of I McKinley Center can work together and we need to do it. So let's get going. Thank you.

MR. YOUNG: Charlene, I have a question. You use -- you refer to state insured, is that a synonym for Medicaid?

CHARLENE STEVENS: Yes.

MR. YOUNG: That wouldn't therefore cover State employees who have State --

CHARLENE STEVENS: Thank you for qualifying that, sir, you're correct. Thank you.

VALERIE McWILLIAMS: My name is Valerie McWilliams, V-A-L-E-R-I-E, M-C-W-I-L-L-I-A-M-S, and I have worked for Land of

Lincoln Legal Assistance for the last 22 years. Part of my specialization as an attorney working for Legal Aid has been in the area of Medicaid benefits. And I'd just like to address two points.

One is quite a few years ago, as a budget cut, the State eliminated a category of coverage, under the Medicaid program, for people who had pending applications for Social Security disability. The process of applying for benefits from Social Security can take people a long time, it can take several years. And a key element of a successful application is that you have to have medical documentation of the problem that you have.

It used to be that on a presumptive basis the State would provide a medical card to low income people so that they could have at least whatever access a medical card can get you to some continuity of care and they were able to establish the documentation needed to establish that they met the Social Security standards for disability and that they were able to get a certain amount of at least safety net income each month.

That has been eliminated by the State

of Illinois and we've really created this whole class of individuals that are just floundering around from social service agency to social service agency who are probably disabled but are unable to convince the Social Security Administration or the Department of Public Aid that they meet the disability standard because they can't get the documentation that they need.

And I'd like to advocate that the State needs to reinstate that class of coverage even though it's not a particularly politically popular group of people.

The other point I'd like to make is that medical debt is a huge problem for many people throughout this state. It affects their access to care prospectively and it also affects them in ways that not everybody might think. It affects their ability to get a car that they can afford, if affects their ability to get a house, it affects in many cases their ability to get a job, in some cases it affects their ability to get an apartment.

So, -- and in this community we've documented the large numbers of people that are

seeking bankruptcy at least in part due to the impact of medical debt. So it's more than just an accounting entry in the different providers, books, and it's -- it has a very real impact on the providers themselves but it also has a very negative, long lasting effect on the consumers and I hope that that's something that you consider as you come up with solutions to these problems. Thank you.

TRISHA CROWLEY: Trisha Crowley, T-R-I-S-H-A, C-R-O-W-L-E-Y. And I'm here today representing the League of Women Voters of Champaign County and we're happy to be here to support the efforts of concerned citizens and civic groups to improve the health care delivery system in Illinois.

While we don't have solutions to health care problems that the task force is investigating, the League of Women Voters of the United States has developed a set of goals which any just system must satisfy. And we subscribe to those goals and urge you to keep them in the forefront as you develop your recommendations.

It has long been the League's policy that a basic level of quality health care at an affordable cost should be available to all residents. It should be the goal of any changes which the task force recommends that there be an equitable distribution of medical services and that there be efficient and economic delivery of care.

A basic level of care must include preventative care and health education as these will ultimately contribute to lower cost and better health. Basic services must include primary and acute care but also must include long term care and access to mental health services.

If state funds are needed to provide a basic level of care the League of Women Voters supports providing those funds through general taxes. But a state supported system can only be accepted by tax payers if there is strong, efficient, and effective cost control strategies that are built into those systems.

Equitable distribution of basic health care is important and is lacking in the current system. Medical resources should be

allocated to underserved areas, both rural areas and to underserved populations. And a major hole in our current health care system is many employees are not offered affordable insurance by their employers and small businesses in particular find it difficult. And so you need to find and recommend some solutions to that.

What Illinois needs is a system that provides basic level of health care to all residents and if government funding is necessary to achieve such a system the funding should be by general taxes. And any system must include efficient and effective cost control in order to succeed in the long term. Thank you.

MR. YOUNG: Thank you very much.

RAFAEL GONZALEZ: Good afternoon, members of the task force. My name's Rafael Gonzalez, I'm a community organizer with the Health Care Consortium of Illinois. That's R-A-F-A-E-L, G-O-N-Z-A-L-E-Z. I am here to read a testimony. I had the honor and was asked to read a testimony of Julieta Gonzalez, that's J-U-L-I-E-T-A, Gonzalez, G-O-N-Z-A-L-E-Z. She sends her testimony and she

says, "Good afternoon. My name is Julieta Gonzalez, I am a senior nursing student at Chicago State University of Mexican descent. I would like to express the issue of the lack of insurance among the Hispanics and how it effects the members of my family.

Last year I was experiencing some problems with my health. I ended up in the emergency room. Later that day I was admitted but my family was reluctant to allow me to stay. We made -- we had a very important appointment with the immigration the next day. We finally agreed to stay with the condition that the doctor would discharge me early in the morning and all tests would be performed during the night. The doctor did not come to see me and I had no choice but to leave against medical advice. But my family's future depended on me.

Needless to say, we have been paying for the bill up to now and it seems to never end. At times my father has worked overtime to help cover the expenses so that I don't have to work and focus on my studies. I can also say my credit is

now bad as a result of the hospital visit.

Many Hispanics are faced with the lack of insurance due to their immigration status and don't seek medical attention due to fear. Fear of what, you say? Being deported back to their country and fear of paying the high price of health care. This affects -- that way they don't seek health care until it's too late or the disease has progressed. If it is the head of the household the family is in great strain financially. Now who will pay the rent or put food on the table? Not to mention the emotional stress an illness possesses.

When I graduate I will be in the ranks of the few bachelorette's prepared Hispanic nurses. I believe with the great need for Spanish speaking health providers this community should not only focus on health care access but you should focus on recruitment, retention, the graduation of students who will contribute to the diversity in the health work force which is reflective of the American society. Thank you for your time and your attention."

MR. YOUNG: Thank you. I presently

have four more testifiers and invite them up front. Ada Brown, Yvonne Hawkins-Massey, Antoinette, I hope I get this right, Atchitina, and Germaine Light.

ADA BROWN: Hello, my name is Ada Brown, that's A-D-A, B-R-O-W-N. I am a senior nursing student at Chicago State University. I'd like to thank the task force for allowing me to testify today. I'd like to address the nursing shortage.

As most Americans are aware, there's an acute nursing shortage. It's predicted that by the year 2010 there will be a shortage of 200,000 nurses and also 40 percent of RN's will be more than 50 years old. This is only four years away. Currently the average age of a working nurse is 46 years old. This shortage is expected to double by the year 2020 unless there is an immediate resolution.

Nurses are at the forefront of health care, they serve as advocates for patients. Without adequate nurses the end result would be adverse patient outcomes including high incidents

of medical errors and lack of time spent with patients because of increased patient workloads.

This nursing shortage stems from, one, nurses aging and retiring and this includes educators. Without them respective students are being turned away from programs, not being allowed to graduate into the field. Also, many students have a hard time receiving money to pay for school. Two, unsatisfactory working conditions because of working shorthanded and in high stress areas. Three, more paperwork, taking away from patient interaction times. And four, nurses leaving the bedside to seek other career opportunities.

I'm a 24-year-old -- I am 24 years of age, I completed my LPN in the Chicago Public Schools LPN program. After graduation, the first year I made $30,000. How many 19 year olds can say this? I feel the State of Illinois should adequately fund the Chicago Public Schools LPN program for students graduating with high GPA's, 100 percent enrollment in college, and 70 percent complete their RN degree. These graduates are young enough to contribute to the nursing working

force. I hope this information's helped you to understand what is needed to satisfy this shortage. Thank you.

MR. YOUNG: Thank you.

YVONNE HAWKINS-MASSEY: Good afternoon. My name is Yvonne Hawkins-Massey, H-A-W-K-I-N-S, hyphen, M-A-S-S-E-Y, I am a senior at Chicago State University College of Nursing. I would like to address my concerns regarding health insurance and the lack thereof it.

Prior to my enlistment into the military I was one of many who went to work daily and wasn't able to afford coverage. I entered the military in 2001. While in basic training I got injured, slipping my cervical disc at C6 and C7. My surgical procedure consisted of an anterior discectomy and fusion at C6 and C7. Now, because this was a service connected injury the military upheld full responsibility for my medical expenses.

As you know with any neurological procedures, the costs are astronomical. The military paid for my medical expenses and they are paying for me to go to school so that I can be

gainfully employed upon graduation. I would like to share you with the plight of many military individuals who return home and are not so lucky.

Yes, it's true that one can always visit any military facility for services. But what about those individuals who aren't fortunate enough to reside within proximity of a military installation or how about those individuals who reside in rural areas where there aren't any military facilities at all and as a result have to seek medical services from elsewhere.

Therefore, I feel Illinois should be at the vanguard of providing comprehensive health care for all of its citizens regardless of employment, military connections, income status, or immigration status. Thank you.

MR. YOUNG: Thank you.

ANTOINETTE ATCHITINA: Good afternoon. My name is Antoinette Atchitina, that's A-T-C-H-I-T-I-N-A. I am presently a BSN completion student at North Park University. I would like tell you a little story of my sister who was also a nurse. She was a foster mother of three small

children. She had recently quit her job in order to fight for care of the children and find adequate child care at the time. In the process of doing this, shortly after that, she noticed that she had a lump in her breast. Due to the fact that she, at this present time, did not have a job nor did she have any health insurance.

She visited John A. Shroger Hospital's emergency room and was given an appointment for a diagnostic procedure for mammogram for one year later. In the meantime, she had -- by the time she had gotten seen she had noticed that the cancer had spread both to the pancrease and kidney. My sister has recently died and we have three small children to care for in the family. My sister refused to have these children returned to DCFS.

One of the things that she wanted to work on was obtaining health care for foster parents and for parents that care for these children by the DCFS. I hope the committee will adopt a plan that will allow every one in Illinois to have health care insurance that is not

necessarily job related. Thank you.

GERMAINE LIGHT: Hello. I'm Germaine Light, I'm a teacher at Mahomet-Seymour High School and I'm also very active in my union which is the Illinois Education Association, one of the teachers unions. We also have another one around here called Illinois Federation of Teachers which is our sister union who we think very highly of. And I thought there was somebody here from that union as well. I noticed as I walked in today that there somebody with a jacket that said SEIU on it so I welcome my union bothers and sisters here today too and I bet they can vouch for a lot of the things that I'm going to say to you today.

Oh, my name is Germaine Light, and I forgot to spell it, G-E-R-M-A-I-N-E, and then Light like let there be light. I'm going to shed some light on the subject today. You've heard a lot of testimonies and a lot of information about why we should have health care available for people, health care that they can afford, good quality health care that people can afford, that every one can afford.

Probably you hadn't thought that it might affect our teaching and our schools and it does. I mean, the fact that health care is expensive has all kinds of fingers that go out into society and affects our society. For example, contract negotiation. One of our biggest stumbling blocks to date is health care insurance. When we go to negotiate a settlement in our Locals here in this area, and all over Illinois, the biggest problem we have is that we have to negotiate our health care too. I mean, we don't just negotiate our contract language and our salaries and everything, but it's also the health care and what we have to actually pay as opposed to what, you know, kind of a group insurance situation the District can offer us.

And when you get little tiny districts like Ludlow, Illinois, for example, which is part of our region here. And that -- you know, they're having health care -- because they have a small group, a small school, their health care goes up maybe 14 percent, 25 percent in one year. Well, my gosh, when you can barely afford to get a three

or four percent raise out of the district because of bad economic times right now just how does that stand out to a 14 or 25 percent raise in your health insurance. I mean, you're regressing. And I know people that work for companies that aren't lucky enough to have been organized into a union yet, okay, are finding similar situations.

So, you know, I definitely -- one minute remaining, okay. I definitely feel sorry for them but we're having problems with this.

So another thing I would like to say is that when you don't have a Union you have problems too because you have companies like Wal-Mart who cannot offer health insurance that is even affordable to people that take their wages and they openly encourage their employees to go to the government for aid in health care.

So people who say that a more socialized health care situation would cost them more tax dollars, I don't think so. Because you have all these people going to the government for aid because they can't afford it. You have people going to the hospitals, as I heard other people

testify today, when they should be going to office calls, going to hospitals on emergency calls when maybe with preventative maintenance and office calls we could have saved a whole lot of money and gotten better care and in the end it wouldn't have cost you as much.

All these things costs us a lot of money. Tax payers, we're already paying for this, we might as well make it official. And I'm out of time. Thank you very much.

MR. YOUNG: Thank you. I have two more people I'd like to invite up front. Dipesh Navsaria, Mueth Paul. I'm almost certain I'm misreading that. Christina Nelson, we'll soon get the right name. Come forward people, please. We have another one. This just in. Lisa Bell, please. And we can start.

DIPESH NAVSARIA: Hi. My name is Dipesh Navsaria. I'm sorry, that's spelled, D-I-P-E-S-H, N-A-V-S-A-R-I-A. I'm a recently graduated physician from the University of Illinois College of Medicine here in Champaign, I am also the founder and Executive Director of a student run

free clinic here in town named Hermes, H-E-R-M-E-S. We see a lot in this community who are uninsured and are in need of health care. The tales we here are remarkably compelling.

One thing that might strike you as interesting is that in the curriculum of our medical school the uninsured and the issue of how people can pay for health care is rarely brought up and I think that's something that the community should also look at in its deliberations. We spend a lot of time looking at some very unusual and rare illnesses but we spend very little time talking about the uninsured.

One thing that struck me, as I came to the college, last fall I was standing in this very room while this community came together and decided what to do about the flood of people we were expecting fleeing the ravaged gulf coast. I was proud to say that our health care providers, clinics, hospitals, et cetera, did come together and made sure that those folks had health care for when they arrived.

However, the irony was interesting.

We were willing to spend a lot of time and energy and effort helping people who are coming from elsewhere but yet in our own community people who are in need every single day when we have this quiet disaster happening around us, the clinics are often willing to say, well, we can see you if you bring cash, we can see you if you have some insurance that's not Medicaid, et cetera. That's something we need to address.

Illinois is a bad neighbor to its states. I recently was on the residency interview trail and went to some of our adjoining states and spoke with people and they admitted to me that they were seeing a lot of Illinoians. We are exporting our problems. Iowa City told me that they're actually having trouble caring for uninsured Iowans because of so many people from Illinois coming over.

I had a chance -- I was also a pediatric physician's assistant for several years in Danville. I had an easier time getting my Medicaid patients seen in Indianapolis than I did within the State of Illinois. Something's wrong

when that's the case.

As a free clinic with a decent web presence I sometimes receive E-mail messages from people who are out of state or so desperate they're searching the web at night trying to find someone who will help them. Give you a few brief quotes here. "I'm writing to you in the hope that you can help or advise me about my brother. He's 52 years old on disability, Public Aid, and has no private insurance. He has asthma, very bad lungs, and now has a bladder infection, UTI, and a blockage that prevents him from urinating. He had laser surgery to break up the blockage but it didn't work. He spent six hours in the ER. They should have admitted him but sent him home with three prescriptions that he can't get filled due to cost. He's even threatening suicide. What can I do?"

Another woman who just had a sit down with a physician and no exam, no ultrasound, et cetera, and said, "I have a cyst that may burst but the doctor can't tell me what it is. Ever since I heard the word tumor I haven't been able to sleep. Where can I go?"

They're e-mailing us from out of the blue from all across the state. Some are even willing to drive to Champaign-Urbana to see us, for heaven sakes, because they can't see the resources in their area.

I would be very happy if this process resulted in the State of Illinois indirectly putting my clinic out of business because they no longer needed us to provide a free clinic. Thank you.

MR. YOUNG: Thank you. Mueth.

PAUL MUETH: Thank you. That's close enough. Paul Mueth, it's M-U-E-T-H. After that, I don't know, that was quite moving. What I'd like to say is that just -- I'm unaffiliated, I'm with service employees, I'm represented through them, and I'm glad that they're on board backing this act and the effort to provide, I guess, hopefully eventually beyond adequate health care.

But I've been shopping for health care quite a bit lately and I would like to say, whatever you decide don't rely on people shopping for health care to solve things and make things

cheaper. I'll probably end on some kind of attack of this health care savings account business because I just find it so outrageous. This is the last thing -- it's not like getting cantaloupes, please, I don't know how that has any currency at all. It looks like a veiled way of getting tax relief -- and put quotes around tax relief, please -- to the people who are already well off. It's pernicious to the currently existing system of insurance it seems to me and I don't know. So eschew that, eschew any kind of market model.

In a longer term, I'd like to see a non-employer based system. But I think, looking at some of the Wal-Mart laws, as they're called, for major employers that are doing so little, as referred to, might be something to include as well.

But thanks for all the effort that went into all of this through the months.

MR. YOUNG: Christina Nelson.

CHRISTINA NELSON: Hi, my name is Christina, C-H-R-I-S-T-I-N-A, Nelson, N-E-L-S-O-N, and my family has lived in Champaign-Urbana, my father's family, for about 150 years which is one

reason I became so adamant. I don't have a prepared statement so I'm going to wing it. But sitting in the audience listening to some of the things that people said I decided that I had to say something.

First of all, as you're evaluating the various testimonies, I hope that you will look with a good deal of skepticism at some of the figures being purported by the not-for-profit hospitals. They are -- I have done a bit of research in this and I have noticed that they have probably hired very expensive lawyers to do this but there's a good deal of information that they can now hide, they don't have to report on their 1090's.

And when you talk about community benefits make them show you exactly what they have counted as a community benefit. How have they calculated the, you know, free care that they're giving out. Is it the discounted rate, are they using the discounted rate to calculate this, or are they using the rate that the uninsured would pay, for example. Because there are all kinds of ways

to inflate what they do.

The other reason that I'm here is that I am in the ICHIP program. I'm sure you all know what that is so I won't take time talking about it. But I moved back here to take care of my mother who is dying of cancer. I am a saint to her friends. But I am a cash account to the local -- the local clinics. One of them, Carle Clinic, 'in particular. They knowingly exploit ICHIP patients, I have brought this to their attention, and they make no apologies for it.

Both the insurance industry, with all due respect, and the -- and Carle Clinic -- and I'm sure there are other clinics around the state -- enrich themselves by impoverishing others. I have never paid more for my health insurance, never had worse care anywhere hands down, including the British National Health Service. I'm lucky that I can afford the ICHIP program because a lot of people can't. But it's the -- the clinics have figured a way to basically turn the uninsurable into cash cows whether they have insurance or whether they're on the ICHIP programs.

Civilized countries like England, France, Germany, Dr. Gill mentioned all of this, believe that a healthy population is to the public good, the national good and -- like education. But in this country we've been sucked into believing the moral hazard myth. And if you don't know what the moral hazard myth is I suggest that you read an article that appeared in the New Yorker about, oh, six months ago which explains it top to bottom and explodes the morale hazard myth which the insurance industry has talked Congress into believing, that basically explains why and how we got where we are and why the rest of the civilized world is in a completely different place. And that about does it if nobody has any questions.

MR. YOUNG: This is Mr. Carvalho.

MR. CARVALHO: Not a question but just to inform the task force members that the morale hazard myth article has been put in your package of materials and available at the web site for you to consider during the course.

CHRISTINA NELSON: Excellent, that's great. Thank you.

MR. YOUNG: Ms. Bell.

LISA BELL: Yes, I am. Good evening. My name is Lisa Bell, it's L-I-S-A, B-E-L-L. I'm going to talk a little bit about a different area of the body, a different area of my concern, dental health care. I'm the executive director of the Champaign County Child Dental Access Program. We are a community based, community sustained not-for-profit organization that provides free dental care to low income children residing in the rural areas of our county.

Oftentimes the mouth and dental health care is ignored. It is time for every one to recognize that without healthy mouths our bodies are not healthy as a whole. We know that as a dental community, dental professionals we're completely aware of that. Unfortunately that's not being completely followed through, particularly in this state.

I currently case manage about 3,500 children on a yearly basis, we touch an additional 6,000 children and their families on a yearly basis as well through oral health educational programs.

All of these children are Medicaid eligible, every single one of them.

Without adequate health care, without adequate resources, without adequate reimbursement of Medicaid for dental professionals in this state and in this county I can promise you we will never overcome the dilemma that our low income families face in trying to obtain quality dental health care for their families.

We have the Medicaid system and it's broken as far as we're concerned. The reimbursement rates are so low that we can't get private pay, private practioners, small business people who -- small business people dentists who are trying to keep their doors open yet understand the need and dilemma, they want to help, they want to provide.

I am very fortunate in this community that we have 27 dentists, over 27 at this point in time, that provide care to these families, to these children from within their own clinical dental offices. We are a success story. But not because of the State of Illinois and not because our

insurance has helped us become that. We are a success story in Champaign County because Champaign County has made us a success story, okay. They have supported my efforts, they have supported our work. And we're beginning to get national, state, and local recognition for that work.

The dilemma that I see every single day is in our adult patients. I can make care, I can create care for the children, I cannot create care for the adults that are searching. We cannot have healthy families -- if I can't get the parents on board to buy into really good oral health care because they're suffering with abscesses, they can't work, they can't obtain employment because of their mouths and their overall health, we can never expect to have an entirely healthy family in that situation, we can't do that in this county.

We are completely, completely blocked from providing care. We have a couple of providers that will do it one week and not the next, okay. That's irresponsible and it's dumping -- it dumps patients and they have nowhere to go.

And a brief aside , I often work with

a lot of our social service agencies to -- sorry, I'm out of time.

MR. YOUNG: Finish.

LISA BELL: A lot of our social service agencies here in town, we'll try to get children into the two clinics -- the two public clinics, Carle and Christie Clinic. DCFS wards, they're foster children, if their parents owe money to those facilities they are not seen. And I've tried numerous times to work around that system. It is the ills of the parents that are preventing care to the children, that has to stop as well. Thank you for your time and if you have any questions.

MR. YOUNG: Ms. Bell, this task force, which has some 30 -- 29 people on it, is subject to education courtesy of the staff. And we had a remarkably good, by my standards, presentation on just this problem by a state dental health person. So I want you to know that we're being educated beyond your excellent presentation.

LISA BELL: Thank you. We appreciate that. We need your help.

MR. YOUNG: Okay.

LISA BELL: Thank you.

MR. YOUNG: We have yet another presenter. And we remind the group that we're here to six regardless and if people get called to testify sign up with Ashley and we'll be happy to hear you. I'm calling Martha Rediehs.

MARTHA REDIEHS: Rediehs, Martha Rediehs, like release with a D.

MR. YOUNG: I've been taught that doctors have very bad handwriting. You're setting a new standard.

MARTHA REDIEHS: I should have been a doctor.

MR. YOUNG: Please.

MARTHA REDIEHS: My name is Martha Rediehs, R-E-D-I-E-H as in Henry, S as in Sam. I'm a retired nurse, certified nurse practitioner though I never practiced as such. And I'm a parish nurse, practicing parish nurse now. I couldn't help but listening to people think of some of the ideas that have run through my mind for many years.

As you get older you recognize that

not every one can work until they're 65. Today in order to work in this highly competitive society, you have to be fast, you have to be bright as well as committed and dependable. And sometimes older people just can't do that. And so in an employer based insurance system they're out of luck.

The lady who used to clean my house when I was teaching full-time now has lung cancer and she's not quite 65. And her husband retired and those extended benefits have run out. No one will insure her. That's the situation for a lot of people just under the age 65.

In the U.S. unfortunately, unless somebody can make money from it, it's probably not going to happen. And I think we need to be humble enough as a society to look at what's happening in other countries. And as you determine how to go ahead on this we need to look at what's worked elsewhere and we need to be aware that every other country -- and many of them end up with better health statistics than we do for less money -- but they have all ration, they all have to ration, they all have to make hard decisions.

We ration in one of the most unethical, in my mind, manners, we ration on the basis of who can pay. But we have to be able to make those hard decisions because we cannot give everything to everybody. The medical costs are going up higher, faster than the gross national product. If this goes on forever the entire gross national product will be spent on health care, we can't do that. So we have to be willing to make those hard choices. I wish you really well on your work.

MR. YOUNG: We have completed all the requests to testify. I'll make a final offer, 'cause we're here 'til six, for anybody who wants to speak would you just let Ashley know and we'll receive your remarks.

MARTHA REDIEHS: Could I say one more thing?

MR. YOUNG: Come on.

MARTHA REDIEHS: I only found out about this meeting -- I'm from Danville -- because I got a letter from the lady for better health care, I'm a member. How much publicity went in and

went out to the community? I mean, I don't read the paper page-for-page but we do get the News Gazette and we listen to WIL all the time. We never heard about this meeting and if I hadn't have gotten a mailing I wouldn't have known.

MR. YOUNG: David, you want to tell her.

MR. CARVALHO: Sure. If Ashley is paying attention she can correct me. The question was about the publicity for this meeting. What we have done for all of these hearings is we've distributed press releases to the press in the congressional district, we've put notices on our web site, we've done mailings to all of the legislators in the district, and we've done a mailing to the contact group of the Department of Public Health, which is to say all the entities that we deal with, like the local health departments and hospitals and nursing homes and other entities that we have contact with. And then we've in turn asked them to convey that to their constituencies, either their patients or customers or whatever constituency group they have. In fact,

I think there was something on the TV today as well, although I -- someone told me.

MARTHA REDIEHS: I'm glad. I just missed it.

MR. CARVALHO: Yeah. I mean, we haven't run advertisements on commercials or things like that but we have made those distributions for all of these areas.

MR. YOUNG: Thank you. We have another guest. Chris Dangles, sir, if you'll approach the mic and spell your name we'll hear from you. Mr. Dangles.

CHRIS DANGLES: It's Dr. Dangles, I was one of your interns in 1974 at the County Hospital. You've aged well. You know, I've heard a lot of talk about the access problems and the insurance and financial barriers to access to care in this community. But there's truly a shortage of physicians in the community.

Within my specialty, in orthopedic surgery, I've lost two partners in the last year due to retirement and they have not been replaced. And I know that the Provena Covenant organization,

which at one time had five orthopedic surgeons now has two. Right now, no matter how much money you have, if you want to get your total hip, and I'm one of two doctors in the county doing total hips, my next available total hip appointment is mid-June. So you have a true shortage of physicians in certain specialties in this community.

And part of that is due to the malpractice crisis that we have. My malpractice premium is $235,000 per year, my reimbursement from a total hip from Medicaid is $1,500. And, yes, I do other things but do the math, it takes a lot of total hips to pay my malpractice premium. And, yes, just like it's easier to get a Public Aid patient into Indianapolis it's easier to go to Morrisville or Indianapolis and get your total hip done if you don't have a personal, you know, liking to the doctors here in the county. So the access problem extends beyond finances.

Dental care's been brought up. It's a chronic problem. I learned a long time ago you don't do joint replacements in people with bad

dental care because you're looking for a problem. And I have at least five patients waiting out there on Medicare, have some type of insurance, that can't get their teeth pulled to get their joint replacement and it's a problem that has to be addressed. We see problems with people becoming septic because of their dental care on a monthly basis in the hospital and usually it's their joint replacement that gets infected.

It's an insulting joke but it's something that goes -- you know, that you hear all the time. What do you have when you have five Danvillians in your office, a full set of teeth. And if you haven't heard it before you've heard it now. Thank you.

MR. YOUNG: Thank you very much. I thought those long waits only occurred in Canada, what a revelation. I've never had this problem before. I appreciate we have a large turnout and number of excellent presenters. Anybody else at this moment?

MR. CARVALHO: May I?

MR. YOUNG: Yes, please.

MR. CARVALHO: What we've done at prior hearings in situations like this is taken a ten minute break and then come back and see if there's anyone that's come in in the meantime and then, if not, adjourn.

MR. YOUNG: Okay. That's a deal. And I want to thank everybody for the exceptionally good testimony here today.

(At this point in the proceedings a short recess was taken, after which the following proceedings were conducted;)

MR. YOUNG: I'd like Janet Anderson and Ms. Nelson to come up front and let's hear what you have to say. Janet, please tell them how to spell your name?

JANET ANDERSON: J-A-N-E-T, A-N-D-E-R-S-O-N. I've been away for about ten days and I didn't really have anything prepared. But I came down for a mental health board meeting at six o'clock. I am the liaison from the county board to the mental health board so my statement's really pretty general.

But I would urge you not to forget

mental health services in the whole mix of things. And I'm sure there were a couple of other people who indicated that too. But I know that in our county we do have tax to provide mental health services but it's limited. And if you're uninsured the mental health center does a great job but they can't serve everybody. And there are other things that could be done to help that we're limited in how much we can give for that sort of thing too. And I think there is a shortage of psychiatrists too in the community. And so I would just urge you to keep that in mind as you go about your work. Thank you.

MR. YOUNG: Thank you. Again.

CHRISTINA NELSON: Yes.

MR. YOUNG: Go ahead.

CHRISTINA NELSON: I'm back. Christina, C-H-R-I-S-T-I-N-A, Nelson, N-E-L-S-O-N. And I'd like -- I wanted to come back for a couple of minutes to refute something that Dr. Dangles said -- or to challenge it, not refute it because I can't refute it. He's talking about the shortage of doctors in this town.

And one reason there's a shortage of doctors is that both of the large clinics have non-complete clauses in their physician's contracts so when people leave -- if anybody wants to leave one of the clinics they have to move 50 miles away for two years. A couple of them, very courageously, have come back and just gotten in their face which is just fabulous.

But the reason they give is that, oh, it costs us -- at least Carle gives is that it costs us a million dollars a year to recruit physicians. But they have absolutely refused to -- or I shouldn't say refused. They have never produced a detailed list of how -- of the costs that go -- that they have used to calculate that. So if the hospital industry says, oh, well it costs us blah-blah-blah to recruit make them produce a list and challenge every single figure on it. That's all I have to say. Thanks.

MR. YOUNG: Please.

NANCY BROWN-SMITH: If I may be so bold. I just have one comment that I didn't hear addressed and that's the nursing home.

MR. YOUNG: So you'll sign in with me.

NANCY BROWN-SMITH: Nancy Brown-Smith. And I've lived in this area for eight years and I'm part of what's called the sandwich generation. We're not only taking care of and raising grandchildren but we're also trying to see to the needs of our parents and sometimes if our parents have divorced we may inherit four parents instead of two.

My parents were blue color workers on the south side of Chicago and raised us with a heavy emphasis on education so thank God I have that. But my parents scrimped and saved and my father had TB and we were bought up through the public health system and the TB clinics of Chicago. My parents saved every penny that came into that house and I worked work study.

I just witnessed my father and mother lose everything because mother had to be taken care of in a nursing home on the south side of Chicago. She's in South Holland, Illinois. I don't believe in outsourcing a family member to the nursing home

system but when you have to work and provide for yourself and you're raising children and grandchildren that comes to be the only way.

So everything was fair game. IRAs. They worked for the mills. That money was put into your own hands to invest in the bank so it wasn't like you had a monthly pension to put on the application. My mother had $27,000, my father had 54,000, and they had two small amounts of 25,000 each that was inherited from grandparents that when they died that was their home, and when they left this earth to go home that was all the money they had. It's all gone.

So now we're having to take on the bills of my father, who's 85 years old. I don't believe in dumping him into the system or whatever. But when I see people like that, good people, hard working people that have raised the rest of us to get our education and be responsible and then see, when all of that money is saved, and what people have done without, coats for not ten years, shoes, wear them and put cardboard on the inside, and then what little they thought they had to be able to pay

their monthly bills is gone and have to sell their home of 50 some years that my dad paid cash for. Sure, it was maybe $9,000 and it wasn't much more than a cottage shack but it was his that he thought no one could take away. Yes, I understand what the impoverished spouse law is that you can keep the exemption of your home and 95,000 but there are other catches in that, believe me.

And really, look out once you become a part of this sandwich generation because you're going to take on three generations of debt. Thank you.

MR. YOUNG: Thank you. Keep pouring in. I like it. It's making the commission, you know, toe the line and put our time in. I'm inviting Ms. Antoline -- struggling with the name. First we have Megan McClaire. I'm not illiterate, honest. And Grant Antoline I venture is a guy rather than a gal. Okay. Thank you, Megan.

MEGAN McCLAIRE: Good evening. My name is Megan McClaire, M-E-G-A-N, M-C-C-L-A-I-R-E. I volunteer as an advocate for Champaign County Health Care Consumers and I've seen first-hand how

many thousands of Champaign County residents are being barred from access to health care.

I was thinking, while everyone was speaking, of four people I know in particular, clients I have right now, who are being denied surgery. They're all four in pain and aren't being allowed to have surgery for multiple reasons. One has a cyst and went to Carle, is uninsured, and was told, even though she's in pain, and has called regularly to say that she didn't know what to do, that she's not to come back unless she has eight of ten symptoms in spite of the fact she's in pain and she doesn't know what's wrong.

We have another one that's in need of leg surgery and since they're not accepting new Medicare recipients -- you know, 90 percent of all physicians in the county aren't accepting Medicare or Medicaid -- they're not able to get surgery, the necessary surgery.

Another one is in need of a colostomy bag and they are not -- because of past due bills they're being denied access to their doctors. Actually, the doctor that just spoke has also been

a party that's been denying care to this patient.

And I just wanted to have those things taken into consideration as well as have all of the hospitals participate because, you know, even though we can implement things some of them are still failing to take part. That's pretty much all I have to say.

MR. YOUNG: Grant.

GRANT ANTOLINE: Hello. My name is Grant Antoline, A-N-T-O-L-I-N-E. I'm a board member with Champaign County Health Care Consumers as well as I work for a group called Campaign for Real Choice in Illinois. And this group, what their main focus is is to stop the unnecessary institutionalization of people with disabilities and seniors.

In Illinois we have a huge problem with that. Very able, very healthy, very mentally stable people are constantly being forced to go into institutions where their freedom is limited and they are disregarded. Their cares, their thoughts, how they feel, what they want to do during the day is neglected.

This group wants to have the money allocated to these institutions follow the person so that they can live in their community and receive community based support. I wanted to express the importance of that to you, this task force, and hope that we can develop a plan that allows these people to remain independent, be in their community, and be a part of the citizenry that we feel is very important in this democracy. So thank you very much.

MR. DUFFETT: Grant, I just wanted to -- maybe David, you can help me here too. I know Mike Elder from the Department of Aging spoke to us about two months ago. And Department of Aging has got also a task force that is looking at different options for long term care and homebound care.

And I would say -- I don't think Dave issued their report yet. Do you -- not to put you on the spot, David, do you have an idea of where they're at since Michael spoke to us? And I didn't know if you knew that this was happening, that there's a full-fledged assessment that's going on about how to deal with long term care services here

in Illinois.

GRANT ANTOLINE: I did not. Thank you.

MR. CARVALHO: Well, you only put me on the spot if I presume to know everything and I don't so I don't know the answer to that one. But I did hear testimony today, actually. There was a bill up that Michael Elder from the Department on Aging was testifying about relating to the subject and he reported that the task force meetings are ongoing. I just don't know the status of when they expect to formulate some conclusions.

GRANT ANTOLINE: Thank you, gentlemen.

MR. YOUNG: Last call. Well, I want to commend --

JERRY ANDREWS: Can I say one more thing?

MR. YOUNG: I love it. They're going to keep us here 'til six. You have every right.

JERRY ANDREWS: I'd like to just say a couple things about the senior population since that's been brought up by a couple of speakers. We

provide a number of senior services at our local Health Department through the Area Agency on Aging and the Illinois Department on Aging.

And some of the funding doesn't make sense to me, or lack of funding at the state level, Medicaid funding in particular. We do a program with some funding from the area agency called medication management where we have nurses that go out and provide medication management for seniors to allow them to stay in their homes.

One of the first reasons why seniors will go to long term care is because they can't manage their medications. So we do. But we can only take a total of 90 clients because that's all we can afford to do with local resources and some money from the Area on Aging. This is not a Medicaid reimbursable expense which makes no sense whatsoever to me because our cost of providing per client per month is about $140, the cost of Medicaid, nursing home care for that client is $2,700 a month.

So as you're looking at ways of providing better health for people that live in

Illinois look at what is common sense use of the Medicaid and Medicare and other dollars that are provided by the government and at the local level. We at the local Health Department invest probably $80,000 in that program at the local level and we're glad to do it but we can't do any more than that. So that's one issue.

And then the other issue that the gentleman just talked about are the seniors and people with disabilities being able to stay in the community. We are probably going to be one of the pilot programs for that for seniors which will allow seniors to make choices on how they would spend the money they would get normally based upon what they call a DON score. The seniors will be allowed to determine how many times they want someone to come a week to clean their house or how many times they want this or how many times they want that.

The stumbling block that we feel is, the way it's going now, each senior would have to become their own business and hire this individual as a business, have to do 1090's, have to do all

that kind of stuff. And, you know, when I'm 70 years of age -- you could do it, Doctor, I know you could because you're very intelligent.

MR. YOUNG: Cause I'm not 70, I'm 82.

JERRY ANDREWS: You don't look a day over 70 to me. But at any rate, that just is ridiculous to, I think, require a senior to become their own business. So I think that needs to be rethought by someone before this takes place.

And in Macon County over 20 percent of our population is seniors and will double in the next ten years so it's a huge issue.

MR. YOUNG: Thank you. That last statement is the name of the game. We have a rapidly expanding baby boomer and we must listen to the admonitions.

Am I safe in saying we may adjourn now? I want to once again congratulate the audience, they were very good.

CERTIFIED SHORTHAND REPORTER'S CERTIFICATION

I, JILL A. BLESKEY, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public of the State of Illinois, do hereby certify that the foregoing is a true, correct, and complete copy of all proceedings conducted before the Adequate Health Care Task Force, taken at the Illinois Terminal, 45 East University Avenue, Champaign, Illinois on February 15th, 2006, at 4:00 p.m.

Dated this 27th day of February, 2006.

Jill A. Bleskey, CSR-RPR

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