obsolete institution known as the electoral college.

It is no accident that this bill is being introduced today, the day that the electoral ballots are opened and counted in the presence of the House and Senate. I hope that the timing of this bill's introduction will only underscore the fact that the time has come to put an end to this archaic practice that we must endure every 4 years.

Only the President and the Vice President of the United States are currently elected indirectly by the electoral college—and not by the voting citizens of this country. All other elected officials, from the local officeholder up to U.S. Senator, are elected directly by the people.

Our bill will replace the complicated electoral college system with the simple method of using the popular vote to decide the winner of a Presidential election. By switching to a direct voting system, we can avoid the result of electing a President who failed to win the popular vote. This out come has, in fact, occurred three times in our history and resulted in the elections of John Quincy Adams, 1824, Rutherford B. Hayes, 1876, and Benjamin Harrison, 1888.

In addition to the problem of electing a President who failed to receive the popular vote, the electoral college system also allows for the peculiar possibility of having Congress decide the outcome should a Presidential ticket fail to receive a majority of the electoral college votes. Should this happen, the 12th amendment requires the House of Representatives to elect a President and the Senate to elect a Vice President. Such an occurrence would clearly not be in the best interest of the people, for they would be denied the ability to directly elect those who serve in our highest offices.

This bill will put to rest the electoral college and its potential for creating contrary and singular election results. And, it is introduced not without historical precedent. In 1969, the House of Representatives overwhelmingly passed a bill calling for the abolition of the electoral college and putting a system of direct election in its place. Despite passing the House by a vote of 338 to 70, the bill got bogged down in the Senate where a filibuster blocked its progress.

So, it is in the spirit of this previous action that we introduce legislation to end the electoral college. I am hopeful that our fellow members on both sides of the aisle will stand with us by cosponsoring this important piece of legislation.

THE FREEDOM OF CHOICE FOR WOMEN IN THE UNIFORMED SERVICES ACT

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, January 9, 1997

Ms. HARMAN. Mr. Speaker, among the more extreme laws put in place by the last Congress is the policy banning privately funded abortions performed at overseas military hospitals. This policy means that women serving overseas in our Nation's Armed Forces cannot exercise the same constitutional rights afforded women living in the continental United States. These servicewomen and their dependents could be forced to seek illegal and unsafe procedures or could be forced to delay the procedure until they can return to the United States.

This is an issue of fundamental fairness. Servicewomen and military dependents stationed abroad do not expect special treatment, only the right to receive the same constitutionally protected medical services that women in the United States receive.

That's why today, as the senior Democratic woman on the House National Security Committee, I am introducing the ''Freedom of Choice for Women in the Uniformed Services Act.'' This bill simply repeals the statutory prohibition on abortions in overseas military hospitals and restores the law to what it was during most of the Reagan administration. If enacted, women would be permitted to use their own funds to obtain abortion services. No Federal funds would be used and health care professionals who are opposed to performing abortions as a matter of conscience or moral principle would not be required to do so.

I would like to thank my colleagues CONNIE MORELLA, ROSA DELAURO, SUE KELLY, RON DELLUMS, JOHN BALDACCI, EVA CLAYTON, JOHN CONYERS, SAM FARR, BARNEY FRANK, MARTIN FROST, LYNN RIVERS, LUCILLE ROYBAL-ALLARD, and LOUISE SLAUGHTER for joining me as original cosponsors.

I urge the House to take up and pass this important legislation restoring the right of freedom of choice to women serving overseas in our Nation's Armed Forces.

THE PURSUIT OF PROFIT: NONPROFIT HOSPITALS BECOME THE BIG PUBLIC GIVEAWAY OF THE NINETIES

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, January 9, 1997

Mr. STARK. Mr. Speaker, today along with Mr. LEWIS of Georgia, Mr. MCDERMOTT, Mr. WAXMAN, Mr. FILNER, Mr. KENNEDY of Rhode Island, and Mr. BROWN of Ohio, I am pleased to introduce the Medicare Non-profit Hospital Protection Act of 1997 in response to the fast-growing number of hospital conversions. Conversion refers to the process by which a nonprofit entity opts to change its nonprofit status and forgo its tax exemption. In a conversion, investor-owned, for-profit companies buy community, nonprofit hospitals in deals that usually are secret, with costs and details not disclosed. Proceeds of the sales are suppose to establish charitable foundations.

HEALTH CARE IS A SERVICE, IT IS NOT A COMMODITY TO BE BOUGHT AND SOLD

Some how we've reached the point where our society thinks of the medical system not in terms of keeping patients well or helping them get better but instead as a fiercely competitive business in which survivors concentrate on making tremendous amounts of money.

The late Cardinal Bernadin, Archbishop of Chicago, had it right in his speech to The Harvard Business School Club of Chicago, He said:

> Health care . . . is special. It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is . . . one of those goods which by their nature are not and cannot be mere commodities. Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, not to earn a profit or a return on capital for shareholders.

The goal isn't health care anymore—the goal has become the care of the stockholder interest.

THE PROBLEM

Historically, the nonprofit hospital has, in general, assured that necessary services are available, that all populations are cared for, and that there is always a place to go for care. The goal of a for-profit hospital is just that—profit. The for-profits allegiance is to their shareholder, not the community—and certainly not the uninsured or poor. The for-profit hospital chains have the minds of piranha fish and the hearts of Doberman pinschers.

Whereas for-profit hospitals are accountable to their shareholders, nonprofit hospitals have another kind of accountability—to patients, to providers of care, to payers and to the communities in which they operate. Instead of producing a return on investments to shareholders, nonprofit hospitals have the inherent motivation and deep obligation to produce a different kind of return—that of quality care to their patients and overall good for the community.

The need to show a profit focuses the for-profit hospital on cost structure rather than on the structure of care. Their decisionmaking cannot help but he skewed toward shareholders rather than patients. Whereas nonprofit hospitals manage care because doing so improves health outcomes, for-profit hospitals manage the cost of care because it is the cheapest, most profitable thing to do. Their primary legal and fiduciary duty—to return a profit to the shareholders—puts patients and public welfare in second place.

In 1993, there were 18 conversions of nonprofit hospitals and health care plans. In 1995, there were 347. In the past 18 months, for example, Columbia HCA, the largest of the for-profit hospital chains, has completed, has pending, or is in the process of negotiating more that 100 acquisitions or joint ventures with nonprofit hospitals.

I have many concerns about the sale of nonprofit hospitals to for-profit corporations: too often the terms of the sale are secret; there are often conflicts of interest among the parties; the mission of the nonprofit foundation that results from the conversion may not be consistent with the original mission of the hospital—the funds in the resulting foundation are sometimes used for things like sports training facilities, flying lessons, or foreign language programs in schools; and the valuation price is often much less than it should be. Perhaps most important, quality and access to health care in the community is often significantly diminished.

COLUMBIA HCA—THE PAC-MAN OF THE INDUSTRY

Columbia HCA, the largest of the for-profit hospital chains, is characterized as the PAC-MAN of the industry—gobbling up nonprofit hospitals as it expands its market share in communities across the United States. Nationwide, Columbia HCA is riding high from dozens of acquisitions of hospitals that have made it not only the biggest—with 355 hospitals—but also one of the wealthiest for-profit chains with $18 billion in annual revenue.