that would have reinstated all of these heroes—all 8,000 of them—but my Democratic colleagues refused and rejected it. Now, these same Democrats are lecturing us about readiness and about their support for military families. I hear about it every day.

Meanwhile, the Democrats' efforts to inject leftwing politics into our military have only continued. I have spoken at length about their illegal use of the Pentagon budget for abortion for the last 7 months.

Since my hold went into effect, it has allowed me more time to look into the background of some of the Pentagon's nominees. These are nominees that my colleagues on the left are saying should not receive a vote. Democrats are saying we should just approve them without ever voting. Senator REED said it was ''disrespectful'' not to approve them by unanimous consent. I do not agree with that. Many of these nominees are worthy of confirmation. I will agree and I will vote for them. But some are not. The Senate ought to do our job under the Constitution and advise and consent to these nominations. Some we should confirm. Some we should reject.

A large number of these nominees have publicly expressed support for so-called diversity, equity, and inclusion initiatives. I am concerned—very concerned—that DEI distracts our military from its mission. The American military is not a social justice program. It is not a jobs program. The military is not an equal opportunity employer. It never has been and shouldn't be. The American military is the world's greatest killing machine. The military has one mission and one mission only: to win wars. Other considerations, no matter how reasonable or admirable they might be, have to be set aside. As General MacArthur famously said, ''there is no substitute for victory.''

Everything we have in this country depends on our military—everything. Our entire way of life is made possible by the fact that we have the best fighting force that has ever been assembled. Our enemies would love to take away our role as world leader. If we lose a strong military, then we will lose everything.

Therefore, it is my view that the Senate ought to vote on these nominations, especially those at the very top.

It is my view that, this month, the U.S. Senate ought to vote on the Chairman of the Joint Chiefs of Staff. The current Chairman, General Milley, received a floor vote in 2018. The nominee, General Brown, received a floor vote for his current position as Chief of Staff of the Air Force. There is nothing wrong with a floor vote on these nominations. Contrary to what Senator REED said, there is nothing disrespectful about a confirmation vote. If we do not vote on General Brown's nomination, then that is entirely the fault of the Democratic majority that runs this floor.

The Chairman of the Joint Chiefs of Staff has a budget of more than $1 billion—that is a ''b''—$1 billion and a staff of thousands. This job is too important not to receive consideration by the Senate or to simply be confirmed without a vote. Democrats can either stop complaining about having acting officials or they can confirm these nominees. You can't have it both ways.

If my colleagues on the left were actually worried about readiness and about military families, then we would be voting on these nominees today. If Democrats were really concerned about readiness for militarily families, then they would have reinstated the 8,000 heroes discharged under the vaccine mandate—8,000 people who lost their jobs and who had to go find something else to do to support their families. But my Democratic colleagues refuse to do that.

Despite what the Pentagon just said falsely last week, it would take just 2 hours to confirm one of these nominees—2 hours. The Democrats' excuses that votes take time is not good enough. The Senate has had more than 80 days off this year, not counting weekends. We just had a 5-week recess. We took Labor Day off. This is one of the least productive Senates in memory.

I had a 40-year career before I came here. I didn't need this job, but I wanted to help my country. I came here to the Senate to vote and to uphold the Constitution. That is what this group and floor is about. I came here to make laws, not to outsource my job to the executive branch.

I grew up in a military family. There is nothing in this world that I honor more than the U.S. military, except the Constitution, which they have sworn to defend and to follow.

We need to get politics out of the military. It has no place in the place that keeps this country and our allies safe.

The widespread perception that our military has gone woke under Joe Biden is driving away recruits. They are not signing up. Unfortunately, that perception is becoming more and more justified. Unlike my hold, recruiting is a real crisis, as we speak.

We need the best of the best in our military and, generally speaking, that is exactly who we have. We have the best of the best in our military. We do not need politically or ideologically motivated people in our military. We do not need political activists in the Pentagon. We need a military that is focused on its mission of fighting and winning wars, nothing else. That is their job. We depend on that.

I still believe that our military is the best fighting force this world has ever seen. I still believe that our military has been the greatest force for peace for the last 75 years. All the false attacks on me, including on the Senate floor, do nothing to change those facts. All the false attacks on me do nothing except to strengthen my resolve.

For my entire life, I have held the U.S. military as sacred—and the blood of the fallen heroes. If we allow our military to become political, then we will have done a disservice to every one of the people who have fought and died. If my Democratic colleagues and the Biden administration continue to inject politics into our military, then our children and our grandchildren will have to live in a much more dangerous world.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CARDIN). Without objection, it is so ordered.

The Senator from Iowa.

HEALTHCARE

Mr. GRASSLEY. Mr. President, I am committed to lowering healthcare costs, expanding access to high-quality care, and supporting research and innovation. The healthcare system in the United States needs more reform and accountability. However, we shouldn't ruin it by turning it into a government-run healthcare system, whether you want to call it government-run healthcare system, Medicare for All, or single payer, or even socialized medicine.

A government-run healthcare system is a one-size-fits-all approach. It results in longer wait times, delayed care, and do-it-yourself healthcare because you cannot access a doctor.

In February, the Wall Street Journal highlighted the failure of the United Kingdom's National Health Service, NHS for short.

They wrote:

> Now, the state-funded service is falling apart. People who suffer heart attacks or strokes wait more than 1½ hours on average for an ambulance. Hospitals are so full that they are turning patients away. A record 7.1 million people in England—more than one in 10—are stuck on waiting lists for non-emergency hospital treatment like hip replacements.

But I want to quote from the article of the Wall Street Journal, another one:

> Delays in treating people are causing the premature deaths of 300 to 500 people a week. One in five British people were waiting for a medical appointment or treatment by NHS in December.

If you didn't find that article about the United Kingdom alarming, in May, British Columbia announced that they are sending cancer patients to Bellingham, WA, in the United States, for treatment.

A Canadian news outlet wrote this:

> Health Minister Adrian Dix announced . . . that eligible breast and prostate cancer patients will be sent to one of two clinics in Bellingham for radiation treatment. . . . The unprecedented move to send thousands of [British Columbia] patients to the [United

States] over the next two years is an attempt to address the backlog in [British Columbia] which has one of the longest waits for radiation treatment in Canada.

Canada is taking this action because its cancer patients face unacceptable waiting times. Currently, only 82.9 percent of the British cancer patients who require radiation start treatment within 28 days. That means that 17 percent of cancer patients are waiting at least a month or longer to start cancer treatment.

Canada's single-payer healthcare problems aren't found in just one province. In January, the Wall Street Journal reported that Ontario is turning to private healthcare options to fix the growing problem with its single-payer-funded healthcare system. Canada's most populous province is allowing more patients to go to private treatment centers for cataracts and joint replacement surgeries and for services such as MRIs and CT scans.

The Wall Street Journal writes:

[T]he median wait time in Canada last year between referral and treatment was between 27.4 weeks, the longest on record, compared with 9.3 weeks in 1993. Ontario reported the shortest wait times of 20.3 weeks, while the eastern province of Prince Edward Island reported the longest at 64.7 weeks.

And, finally, back to Great Britain, a YouGov poll recently found that Britons are ''pulling their teeth out with pliers'' because they can't access the National Healthcare Service dentists. The poll found 10 percent of the respondents had attempted do-it-yourself dentistry.

I am committed to improving the healthcare system. I am working to lower the cost of prescription drugs, maintain access to rural healthcare, ensure our Nation's seniors can have high-quality, affordable hearing aids, address high maternal mortality rates, and, lastly, improve the healthcare delivery systems for kids with complex medical needs. And that is just to name a few.

However, a government-run healthcare system is not the answer. British and Canadian healthcare systems are plagued by longer and longer wait times and delayed care. These government-run healthcare systems are paying for patients to get care in the United States, not resorting to DIY healthcare. This body needs to be reminded how government-run healthcare systems are broken and do not work.

In closing, I ask unanimous consent that the articles I referred to in my remarks be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Senator Grassley Floor Remarks—More Examples of Socialized Health Systems Failing Patients

[From the Wall Street Journal, Feb. 6, 2023]

THE U.K.'S GOVERNMENT-RUN HEALTHCARE SERVICE IS IN CRISIS

(By David Luhnow and Max Colchester)

For more than a decade, the British government has run its National Health Service, the world's largest government-run healthcare system, on a tight budget. The NHS prided itself on being one of the leanest healthcare systems in the developed world, spending less per head on average than its large European neighbors—and far less than the U.S.

Now the state-funded service is falling apart. People who suffer heart attacks or strokes wait more than 1½ hours on average for an ambulance. Hospitals are so full they are turning patients away. A record 7.1 million people in England—more than one in 10 people—are stuck on waiting lists for non-emergency hospital treatment like hip replacements. The NHS on Monday faced the biggest strike in its history, with thousands of paramedics and nurses walking out over pay.

The NHS's woes are an extreme example of issues playing out across the developed world. Healthcare systems, hit hard by Covid, are under pressure as people live longer and have a wider range of treatment options. Aging populations mean costs will keep growing. The U.K.'s experience is a warning of what happens when supply in healthcare provision can't keep up with demand.

''The healthcare system in the U.K. is facing a crisis like no other I have seen in my career,'' said Nigel Edwards, the retiring chief executive of the Nuffield Trust, a healthcare think tank, and former chief executive for the NHS. ''The U.K. has mistaken cheapness for efficiency in its approach to health, and it's coming home to roost.''

The NHS has lost thousands of hospital beds in the past decade in its drive for efficiency. Covid delayed treatments for patients, resulting in a vast waiting list. Hospitals in England were already at 98% capacity in December when the brutal flu season began to take hold. The mass of sick patients gummed up the system to devastating effect.

Delays in treating people are causing the premature deaths of 300 to 500 people a week, according to estimates from the Royal College of Emergency Medicine, a professional association in London. One in five British people were waiting for a medical appointment or treatment by the NHS in December, according to the U.K. Office for National Statistics (ONS).

The NHS said those excess death figures are likely too high but acknowledged delays are costing lives. In late January, the U.K. government announced funding to provide more ambulances, call handlers and 1,000 extra hospital beds to relieve the strain on the health system.

Fixing the service will take time, said NHS chief executive Amanda. Pritchard. The NHS said that over the next year it aims to cut the average time a heart attack sufferer waits for an ambulance to 30 minutes.

''No one should be waiting longer than necessary for treatment,'' said Will Quince, a minister of state for health, adding that the government is spending up to $17 billion over the next two years to address issues facing the NHS and social care services.

Just before 5 p.m. on Nov. 18, the family of Martin Clark called 999, the U.K. equivalent of 911, after the 68-year-old father of five began having chest pains. After waiting half an hour, the family said, they called again and pleaded for an ambulance, saying Mr. Clark's condition was getting worse. In another call 15 minutes later, they told the dispatcher they were going to drive him to hospital themselves, according to the family, even though the dispatcher encouraged them to wait for the paramedics.

Twenty minutes after the family had left for the hospital, the dispatcher left a voice mail to say the service still didn't have an ambulance to send. Mr. Clark died shortly after arriving at the hospital.

About a week later, 5-year-old Yusuf Mahmud Nazir died from what began as a throat infection. His family said they had taken the boy, who was having trouble breathing, to the emergency room at their local hospital in Rotherham, which gave him some antibiotic pills after a six-hour wait and sent him home. The family said it pleaded with the hospital a few days later to let Yusuf be admitted and given further tests, but were told the hospital was full.

By the time the family got Yusuf by ambulance to another hospital, he had severe pneumonia. He died days later from organ failure and cardiac arrest.

''They killed Yusuf—it's as simple as that,'' said Yusufs uncle, Zaheer Ahmed, who accompanied the boy's family at the hospital. ''A 5-year-old boy has died of tonsillitis in a rich, industrialized country. It shows the entire system has serious issues.''

The Rotherham hospital said in a public statement it had met with the family, apologized and launched an independent investigation into what happened. It declined to comment further.

Almost every day, media reports allege new horror stories: An 83-year-old woman in Leicester with a suspected stroke waited more than 18 hours in a makeshift tent outside a hospital emergency room. A 90-year-old woman with suspected sepsis waited three days. A man in Wales with diabetes lost his toe after it turned blue and then black after he sat waiting for treatment for three days.

The NHS is Europe's biggest employer, with around 1.2 million staffers, and has a budget this year of about $188.6 billion, funded through taxes. It now has 2.9 doctors per 1,000 people, compared with a European average of 3.7. The U.S. has slightly less, at about 2.6 doctors per 1,000, according to the Organization for Economic Cooperation and Development.

Aging populations will add to the demand. The elderly consume between three and five times the amount of healthcare compared with younger people, according to an estimate by the OECD. The number of people in the U.K. aged 85 and above is expected to double to more than 3 million by 2041. The U.K.'s current population is around 67 million.

Until 2010, governments of all political stripes kept funding for the NHS growing faster than both population growth and inflation—with annual increases from 2% to nearly 6% per capita, adjusted for inflation. But from 2010 to 2020, per capita, inflation-adjusted funding declined very slightly.

The Conservative government has sharply increased funds to the NHS since 2020, but most of the money has gone toward the pandemic, including for vaccines. Inflation is now eating away at about half the additional yearly funding. Overall, the inflation-adjusted increase in funding amounts to a 2.9 yearly increase, still below the historic average of 3.4%, according to the Institute for Fiscal Studies think tank in London.

Healthcare expenditures, both public and private, amounted to around 11.9% of the U.K.'s gross domestic product in 2021, according to the ONS. That compares with 18.3% of GDP in the U.S. that year, according to government data.

For the first time since the Industrial Revolution, Britain's ill health is acting as a brake on economic growth, said Andy Haldane, a former chief economist at the Bank of England. The growing number of sick people is exacerbating a productivity crisis within the British economy, he said. The number of long-term ill people in the U.K. has shot up by half a million in the past two

years, to a record 2.5 million, something economists say is due in part to the NHS's inability to quickly treat sick people.

The NHS was created after World War II to offer free healthcare to a war-hit population. Every hospital was effectively nationalized and put under government direction. It was a more sweeping overhaul than in any European country. Some countries, such as Denmark, adopted a similar system, while others have varying degrees of private care and publicly funded insurance.

The NHS has long been a point of pride for many Britons, who have generally received quality care and can simply walk out of hospital, without paying a bill. Yet seven in 10 now describe the NHS service as bad, compared with 21% who describe it as good, according to a YouGov poll.

People can pay to access private healthcare in the U.K., and according to the ONS, one in eight adults in Britain said they paid for private healthcare in the past year because NHS waiting lists were too long. Several private healthcare providers have reported a jump in demand.

Still, the overwhelming majority continue to support the NHS's basic model of a government-run system. Just 3% said they wanted the system totally privatized, according to the YouGov poll.

The government started constraining the NHS's budget in 2010, at the same time it launched an effort to make the system more efficient, such as adding more internal competition between different parts of the NHS for government funds.

These changes proved a distraction for management, former and current officials say. As part of the drive for efficiency, NHS managers were pressured to keep bed vacancies low. Recruiting and training was given less priority, and salaries for doctors and nurses steadily fell behind inflation.

When the pandemic hit in early 2020, the NHS's centralized system helped it weather the crisis. The service delayed non-urgent treatments, and successfully rolled out a mass vaccination program.

The ripple effects are being felt now. By December, a total of 401,537 people in England were waiting more than a year for hospital treatment. The total was 1,613 just before the pandemic.

Struggles in the U.K.'s elderly care system, which has major staff shortages and is funded separately from the NHS, has also meant that many patients who would normally be looked after at home or in a retirement home instead languished in hospital wards.

In December, an average of 13,439 beds a day in England out of the roughly 100,000 available were taken up by elderly patients medically fit for discharge—up almost a third from the previous year, according to the NHS.

The lack of space at hospitals this winter, when the flu began to take hold, had a cascading effect. Ambulances began to form lines outside of hospitals, waiting to discharge patients because of a lack of free beds. That delayed the time it took for ambulances to attend to other people in need.

By this winter, half of all patients in an emergency ward waited four hours or more to be seen by a doctor, and a further four hours on average to get a bed, according to NHS data.

A study of more than 5 million patients published in early 2022 by the U.K.'s top medical journal, the BMJ, found that for every 82 people forced to wait beyond four hours for emergency care, one additional person died who otherwise would not have. The longer the wait, the worse the outcomes.

''Every day, I wake up thinking, how much harm is going to occur to patients that we are responsible for,'' said Simon Walsh, head of emergency-room services at a London hospital. ''It's not if harm is going to occur, it's how much.''

The stress of the pandemic and funding squeeze is exacerbating a staffing crisis in the U.K. As of September last year, there were 133,000 staff vacancies in the NHS, compared with 83,000 before the pandemic, according to government data.

The average fully qualified family doctor in England is now responsible for 2,300 patients on average, compared with 2,100 in 2018, according to government statistics. Average pay has fallen by more than a third since 2008, adjusted for inflation, according to the British Medical Association, a union for doctors. The number of doctors who are retiring early has tripled in the past 13 years.

While the overall numbers of nurses have remained stable, turnover has grown. From mid-2021 to mid-2022, more than 34,000 nurses left their role in the NHS, an increase of 25% from the previous year, according to the King's Fund, a healthcare think tank.

Demands for increases in spending are coming up against economic pressures. The Bank of England projects the U.K.'s economy will shrink this year, potentially lowering tax revenues. And as changes in demographics and medical technology continue to weigh on the NHS, everhigher funding risks crowding out state spending in other areas, such as education and infrastructure.

Money alone may not solve the problem, some in the industry warn. In Wales, the regional government has for most years since 2000 spent more money per capita than any region in the U.K. Yet nearly every indicator from waiting times to health outcomes are still worse. One explanation: Wales is both poorer and has the oldest population in the U.K.

Focus is turning to whether the system needs to be revamped. In Scotland, which runs its own NHS, officials have discussed ideas including further rationing of care or having wealthier residents pay for care in order to fund free care for the rest—an option that officials say was discarded.

One former U.K. health secretary recently said patients should pay to see a doctor. The idea was quickly dismissed by the government.

Just over a year ago, Akshay Patel, an IT professional in northern England, made five calls to 999 when his mother, Bina Patel, developed breathing problems. Initially the call handler told him an ambulance would be there soon, Mr. Patel said. His mother's health quickly worsened and she became too sick to be loaded into a car. He watched his distressed 56–year-old mother gradually go pale and die. The paramedics arrived after an hour and were unable to resuscitate her. The local hospital was a 2-minute drive away.

''We always believe that the NHS exists for us when we're in need,'' said Mr. Patel. ''But personally if I had to call an ambulance. I wouldn't. I don't trust them. I can't.''

[From the Wall Street Journal, Jan. 21, 2023]

CANADA PURSUES PRIVATE OPTIONS TO EASE HEALTHCARE BACKLOGS

(By Vipal Monga)

TORONTO.—Ontario is the latest Canadian province that is turning to private healthcare options in a bid to fix growing problems with the publicly funded healthcare system.

Canada's most-populous province this past week outlined a plan to allow more patients to go to private treatment centers for cataract and joint-replacement surgeries as well as for services such as MRIs or CT scans. The province will invest more than 18 million Canadian dollars, equivalent to $13.4 million, in the private facilities to increase their capacity.

Ontario Premier Doug Ford said the moves would reduce the backlog of 206,000 surgeries in the province and free up public hospitals to concentrate on more-complicated procedures. Patients wouldn't pay out of pocket, and the treatments would be covered by the provincial insurance plan, said Mr. Ford.

British Columbia, Alberta, Saskatchewan and Quebec have all in recent years increased the role of private clinics in their provinces.

Health authorities across Canada have been grappling with long wait times in emergency rooms, backlogs for surgeries and shortages of doctors and nurses.

According to the Fraser Institute, a public-policy think tank, the median wait time in Canada last year between referral and treatment was 27.4 weeks, the longest on record, compared with 9.3 weeks in 1993. Ontario reported the shortest wait time of 20.3 weeks, while the eastern province of Prince Edward Island reported the longest at 64.7 weeks.

Former government officials have been calling for a rethink of the way the Canadian system has been structured.

Bill Morneau, former finance minister under Prime Minister Justin Trudeau, said in a memoir published this past week that Canada needed to change a system that costs the country an amount equal to roughly 13% of gross domestic product.

Peter Nicholson, who advised then-Prime Minister Paul Martin in the early 2000s, said in a policy paper earlier this month that Canada should look to countries such as Australia, Germany and Norway, which have used private healthcare to improve their systems.

Canada's healthcare system is run separately by each province.

In Ontario, healthcare unions have said Mr. Ford's plan would enrich the private providers at the expense of the public hospitals and create a system in which wealthy residents get better services and treatment. Mr. Ford's government has said that residents wouldn't have to pay for procedures covered by the provincial insurance plan, but the private clinics would be able to sell patients more-expensive products not covered by the insurance.

Sharleen Stewart, president of SEIU Healthcare, which represents 60,000 Canadian healthcare workers, said the plan risks starving public hospitals of resources and siphoning doctors and nurses into private clinics, which could worsen outcomes for more-complex surgeries and deepen an already-acute healthcare labor shortage. ''It will be a two-tiered system,'' she said.

Job vacancies in healthcare and social services rose to a record high of about 150,100 in the third quarter of last year as demand for nurses surged, according to Statistics Canada. The Canadian healthcare system could be short 44,000 doctors by 2028, according to government projections.

Mr. Ford said his plan is meant to deal with the lingering impact of the Covid–19 pandemic, which caused delays for patients who needed treatment for nonpriority conditions or wanted to have tests done. Hospital wait times have surged since 2020. Patients in Ontario spent an average of 22.9 hours in an emergency department before being admitted to a hospital in October, the longest average wait time on record, according to provincial data.

There are roughly 900 private clinics in Ontario, most of which only do diagnostic testing; 10 private clinics are licensed to perform surgeries. More would open under the government's plan.

During his announcement, Mr. Ford dismissed the concerns about how treatments

are delivered. He said something must be done quickly to reduce the backlog of surgeries in the province. ''A lot of people out there, they want to have the endless debates about who should provide care,'' Mr. Ford said. ''All our government cares about is that you get the care you need quickly and safely.''

Other supporters said that the plan could provide patients with more options, give them greater access to timely care and relieve stress on a system that has begun to buckle.

''We need to be more effective at deploying resources we currently have,'' said Allan O'Dette, chief executive of the Ontario Medical Association, a group that represents 43,000 doctors and medical students and that supports Ontario's plan. ''Noncomplicated, low-acuity surgeries can easily be done outside a hospital setting.''

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[From the Vancouver Sun, May 16, 2023]

SENDING B.C. CANCER PATIENTS TO BELLINGHAM FOR TREATMENT 'A SAD STATE OF REALITY,' CRITICS SAY

(By Katie DeRosa)

Quote from the article: ''While the decision by the province to send breast cancer and prostate cancer patients to the U.S. for faster radiation treatment is being welcomed by some, critics say it's an indictment of a flagging health care system that has not kept up with demand. Health Minister Adrian Dix announced Monday that eligible breast and prostate cancer patients will be sent to one of two clinics in Bellingham for radiation treatment, starting May 29. The unprecedented move to send thousands of B.C. patients to the U.S. over the next two years is an attempt to address the backlog in B.C. which has one of the longest waits for radiation treatment in Canada.''

Quote from the article: ''Dix acknowledged cancer patients face unacceptable waiting times which is why the province opted to strike a deal with the clinics in Washington state. Currently, 82.9 per cent of B.C. cancer patients who require radiation start treatment within 28 days, Dix said. That's well below the national average of 97 per cent, according to figures compiled by the Canadian Institute for Health Information. ''We want to be at 95 to 100 per cent within 28 days,'' he said. The percentage of British Columbians receiving timely radiation has steadily declined, down from 93 per cent in 2019. Dix in February announced the government will spend $440 million over the next 10 years to reduce the waiting times for cancer treatment. Some of that money will boost wages for radiation technologists and oncologists as part of the recruitment drive, Dix said. The province is also trying to acquire more linear accelerators, a specialized piece of equipment which delivers external beam radiation therapy to target and shrink cancer cells. Radiation therapy is different from chemotherapy, which uses special drugs to kill the cancer cells. More than 30,000 people in B.C. were diagnosed with cancer in 2021 and B.C. Cancer projects that number could rise to 45,000 by 2034. About half of cancer patients need radiation treatment.''

The article continues at: https://vancouversun.com/ news/local-news/ critics-upset-that-b-c-has-to-send-cancer- patients-to-bellingham- for-treatment?mc _cid=4baf8999cb&mc _eid=3337eaf99e.

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[From Sky News, July 14, 2023]

BRITONS ARE 'PULLING THEIR OWN TEETH OUT WITH PLIERS' BECAUSE THEY CAN'T ACCESS NHS DENTISTS

Quote from the article: A YouGov poll which spoke to more than 2,000 people found more than 10% of people had attempted ''DIY dentistry''—with more than half of those having carried it out in the last year. People across the UK have had to pull their own teeth out because they can't access or afford an NHS dentist, a report suggests. Extractions have been performed with pliers in some cases, while others have been forced to make a five-hour round trip to see a professional. The Health and Social Care Committee says ''urgent and fundamental reform'' is needed—and there is evidence of pain and distress that is ''totally unacceptable in the 21st century''. Its report includes figures from a YouGov poll performed in March 2023 that found 10% of respondents had attempted ''DIY dentistry''—and of those, 20% did so because they couldn't find an NHS dentist.''

The article continues at: https://news.sky.com/story/britons-are-pulling-their-own-teeth-out-with-pliers-because-they-cant-access-nhs-dentists-12920715#:g807-:text=People%20across%20the%20UK%20have,trip%20to%20see%20a%20professional.

Mr. GRASSLEY. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

MILITARY PROMOTIONS

Mr. MURPHY. Mr. President, as you know, we are at an unprecedented moment in the history of the Senate. There are hundreds of brave, courageous leaders in our military who are being denied—promotions being denied—the rank that they deserve because of the actions of Senator TUBERVILLE and Senate Republicans.

And Senator TUBERVILLE was out on the floor just moments ago defending his actions. I think most Americans believe that his hold on all of these promotions is indefensible. But what probably won't get covered is an additional idea that he presented to the Senate in his remarks.

Senator TUBERVILLE said today that he thinks that our military leadership should be fired for failing to defeat the Taliban. That is pretty extraordinary. For those of us who have served in the Senate and in the House during the time that we have been in Afghanistan, we had the opportunity to see that mission on the ground. It was a difficult, hard mission. Some might say it was an impossible mission, badly underresourced, right from the beginning.

But the idea that our soldiers or our military leadership—captains, lieutenant colonels, generals—should be fired because they couldn't perform a mission that was likely impossible, that, frankly, will have an even bigger chilling effect than Senator TUBERVILLE's hold on military promotions.

There is no doubt that there should be consequences for gross negligence on the job in any profession, including the military, but for any of us who saw the work being done in Afghanistan, our military from the top down, they were doing the best they could under difficult circumstances.

Refusing military promotions apparently isn't cruel enough. Now, Republicans want military leaders fired when they can't complete impossible, underresourced missions.

This is a growing attack, a growing set of attacks on our military, and all in the service of a bunch of old men telling young women what healthcare they can get and what healthcare they can't get.

BACKGROUND CHECKS

Mr. President, in May of 2019, Leilah Hernandez had her quinceanera. She was in a bedazzled green gown. She looked absolutely magnificent. She was having a great sophomore year in high school. She was playing basketball, No. 23. She had a lot of friends.

One friend said that Leilah is just one of these people ''full of joy and happiness. She knew how to make somebody's bad day turn into a good day.''

In September of that year, 2019, Leilah went to a car dealership in the Midland-Odessa area of Texas. Her 18-year-old brother Nathan was buying a truck. This was a big deal for this family. I don't know if it was the whole family, but her mom was there, Nathan was there, she was there, and her 9-year-old brother was there.

And I believe that they were emerging from the dealership. They heard gunshots. Her mother took the younger brother—the 9-year-old—and they ducked underneath a car. Nathan, 18, all he could do was just wrap his hands around Leilah. But the shooting was relentless. Nathan was hit in the arm, but Leilah was hit closer to the neck. Leilah's last words in the embrace of her brother were ''Help me, help me.''

She was one of seven who died in the Midland-Odessa mass shooting. Thirty-two people were shot. A lot of them, like Nathan, survived, many with injuries that will impact them for the rest of their life. But Leilah Hernandez, just a few months from her quinceanera, died that day.

The young man who shot her was ineligible to own a weapon. He had serious mental illness—serious enough that he was on the list of individuals who was prohibited from buying a weapon. He had tried to buy a weapon, but he had been denied when he tried to do it at a licensed gun dealer. He is one of millions of Americans who have been stopped from buying a gun because they are a felon or they are seriously mentally ill. But this young man was still able, rather easily, to get a weapon.

Why is that? Well, it is because many of our weapons in this country are sold without background checks.

What happened in this case? How did this young man with a serious history of mental illness get his hands on a powerful weapon that allowed him to kill Leilah and six others?

Well, the story runs through a man named Marcus Braziel. Marcus Braziel was a gun dealer. No doubt, he was a gun dealer. He might not have had a brick-and-mortar store, but Mr. Braziel was regularly selling guns. In a 3-year period of time, he bought 90-some-odd guns and resold 70 of them.