THE WHITE HOUSE

Office of the Press Secretary

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REMARKS BY THE FIRST LADY
AT THE SYMPOSIUM ON HEALTH CARE REFORM

Johns Hopkins University
Baltimore, Maryland

11:30 A.M. EDT

MRS. CLINTON: Thank you very much. President Richardson and Dean Johns, thank you for those very warm words of welcome. And I am delighted, Dean Johns, that you have made it clear that my predecessor, Mrs. Harrison, was here before. and also I believe Mrs. Cleveland served on the committee that finally got the money together that enabled JohnS Hopkins to open its doors. And I'm also pleased that you reinforced the very strong admonition that both Mrs. Harrison and Mrs. Cleveland gave 100 years ago that women should be admitted to the Johns Hopkins School. I did not have time to go back and read the clippings, but I'm sure they were roundly criticized for being so aggressive and assertive in their views. (Laughter.)

I'm also very pleased to be here with Congressman Cardin and Mayor Schmoke, two leaders not just in the Congress and not just in Baltimore, but nationally on a number of issue that are very important to the well-being of our country. And I particularly enjoyed working with Congressman Cardin, whose expertise on health care and what has been accomplished in the state of Maryland with respect to the changes that have come about here and have really appreciated his counsel. And I'm always pleased to be with Mayor Schmoke in his city.

I also wish to extend my congratulations to all of you who are part of the Hopkins community -- to trustees, to the distinguished members of this faculty, to staff, to students, to friends of this institution. There really isn't any other quite like it. And I am honored to be part of its centennial anniversary.

One need not be a doctor, a nurse, a medical student or even involved with health care reform to appreciate the magnitude of Johns Hopkins' contributions to medicine and health care in the past

100 years. How many other institutions can boast of revolutionizing the standards for medical school admission or claim credit for being among the first to include women as students? How many have so ably served the poor and indigent in the inner city around them? And how many have spawned so many important discoveries in medical treatment?

Indeed, Johns Hopkins, as you know, is widely respected for excellence, progress, and vision in health care. And besides that, how many other schools of medicine are distinguished enough to be immortalized as a question on Jeopardy? (Laughter.) As we all know, when you make it in the popular culture you really make it. And so that ought to be one of the issues you discuss during this centennial conversation.

But given your history as trailblazers in medical education and research, your tradition of socially responsible medicine, your remarkable faculty and students, you have much to be proud of. And yet, there is also much to look forward to in the next 100 years. You will continue, I am sure, the tradition of research that brought you the Nobel Prizes of Doctors Daniel Nathen and Hamilton Smith, to the medical advancements and the treatment of blindness, to the innovative research that Hopkins doctors have produced on brain chemistry. And, although I cannot tell you what a P53 gene is, I do know that Dr. Vogelstein's recent revelation about genetic connections to colon cancer are a welcome breakthrough for those thousands of Americans who suffer from and die from that disease each year.

And yet I also know that no matter how distinguished your past and future in research is, and no matter how great your reputation as an academic medical center throughout the world is, you have also set and changed the agenda for medical education. Few medical schools were as quick to understand the importance of incorporating humanistic learning in the training of doctors. And few others have even yet today a curriculum that so emphasizes general practice and the role of the physician in society.

And you have done all of this while not neglecting to treat patients. You are a beacon in this region and in the nation when it comes to clinical and tertiary care, and most importantly, you are an anchor in East Baltimore, providing quality treatment for poor and needy citizens who might otherwise go without.

There are many things that I could say and that will be said during this day and in days to come about the achievements of this institution. But what I would like to do for a few minutes is look toward the future and share with you what I believe will be the impact of the President's reform effort on academic medical centers such as Hopkins. I believe you will be encouraged by our ideas and

the assumptions we are operating on. And yet, I think we also have to understand fully the context in which this reform effort is developing and moving forward.

You know better than most that although we do have much to be proud of in this country when it comes to the quality of our physicians, our nurses, our medical care, our technology, our research, we are facing a crisis. It is not a crisis that is evenly distributed throughout our population. There are many parts of our country that still wake up every day not really touched by what many of you see day in and day out here at this institution. They do not see the crowded emergency rooms. They do not see the hard choices that doctors now have to make, struggling with the competing demands of so-called managed care and their own consciences about what needs to be done.

And yet, we can't turn back the clock. We are not likely to go back to the time when health calls were made routinely, although there is some clinical work being done now which demonstrates that house calls and even telephone calls are very clinically efficacious. So it may be that a return to that would help us in other ways.

But what we now are confronting, what you confront is often a nightmarish vision of overcrowded emergency rooms, layers of paperwork, confusing insurance plans, and all too often, inadequate treatment at the end.

You have devoted your professional lives to improving the health and well-being of your fellow citizens. You're the ones who are on the front lines. And you're the ones with whom I have spent many, many hours, both personally and in my role on the health care reform task force, talking about what has happened to medicine; what has happened to the patient-doctor relationship; what has happened that has created a system that no one will take credit for, which has spun out of control, creating unintended consequences, whether it be in mountains of paperwork or in the kinds of cost-cutting practices that interfere with the quality of care. You're the ones faced with the ethical dilemmas about proper treatment for people with no health insurance. You see it all firsthand. And I have come through the last several months to see many of those same issues with you.

It is very difficult for me, and I can imagine, even more difficult for you to experience what I see happening to so many people -- doctors, nurses, other care-givers, patients, hospital administrators. When I go to a hospital, as I have in the last few months, and visit with the medical director, a man who had practiced for 30 years, who looks at me and says, "You know, there's that old

saying, 'if it ain't broke, don't fix it.' Well, this system is broke and I don't know who's going to fix it but somebody better." And then goes on to say, "And nobody speaks for me or my patients. Those folks up in Washington, they don't represent me. I don't know who speaks for a person in my position, who has to make the kinds of choices I make every day."

And I know many of you have been in situations where you sit and talk with a family or a patient who doesn't have insurance, doesn't qualify for Medicaid or any other kind of assistance, yet, faces a medical crisis. I will never forget sitting in a small business in New Orleans, talking to workers there who had worked, some of them for 30 years for the same company. They weren't well educated people, but they got up every day and went to work. They didn't have any medical insurance because they couldn't afford it on the salaries they made. And one woman who had been there about 15 years who was a bookkeeper, a single mother, raising a child, said she tried to take good care of herself. She got a physical exam every year. But this past year she'd gone to her doctor and he'd found a lump in her breast and he referred her to a surgeon. And the surgeon had said it looked suspicious and if she had insurance he would have biopsied it. But because she didn't he would just watch it.

And I sat there and I don't think you need to be a woman to feel as I felt, that why on earth was that choice for that surgeon made not on the basis of a professional decision but on the basis of whether the kind of decision that was the right one to make was going to be paid for.

There are a million stories like this all over the country. A level of frustration among those of you who work in institutions like this or who work in emergency rooms or in Indian health clinics and to patients who come in all sizes and shapes with all kinds of problems. And as President Richardson and Dean Johns said, we need the help of people like you who know firsthand what this country is up against. We need to start by being honest with one another. We need to recognize that, as that doctor in Philadelphia told me, the system is broke and it does need to be fixed. I have yet to find anyone who with a straight face who's actually in the business of delivering health care who will tell me that everything is fine.

And our principal goal in this effort has to be to find a way to provide quality affordable health care for all Americans. The two goals of access to quality health care for every American and controlling costs so that we can afford to have a system that provides quality health care for all Americans are in separable. We cannot do one without the other.

As you know so well in this hospital here associated with this institution, the more we try to cut around the edges, to jimmy people in the systems and make the people fit the systems instead of the other way around, the more problems we cause ourself. And the costs continue to go up. And this is not a problem any longer primarily for the uninsured or the poor. This is a problem now that threatens to undermine the security of every American. There is no one I know except the very richest in our country who can be sure, given what is happening in our economy, given the changes in companies as they make decisions about benefits or lay people off or go out of business, that even those among our citizens with the best insurance will have it next year or even, in some cases, next month.

Tens of thousands of Americans join the ranks of the uninsured each month. Workers and employers are grappling over who should pay the escalating price of health benefits. American corporations are often at a competitive disadvantage because their foreign competitors usually provide health care at a cheaper cost, not less health care but more effectively delivered health care. And doctors are burdened with more and more paperwork that doesn't necessarily have anything to do with quality and with the specter of lawsuits hanging over their decisions.

Hundreds of Americans have come together in this effort to find an answer. We have had the help of many people associated with Johns Hopkins and I could not name them all. But they have been there consulting with us, advising us, giving us guidance about what will be the best solutions. Those people who are members of the Johns Hopkins community have looked at an extraordinary range of issues, along with the other members of the task force. And it is clear that we cannot just attack one part of this problem.

That is part of why we are in the situation we are in today. If you try to control the rising costs in health care by controlling price, volume goes up. If you try to control the rising costs by regulations you have more micromanagement with checkers checking the checkers, which has very little to do with quality.

So what we have to do is to look comprehensively at all of the problems that impact on the overall issue that confronts us in the health care system today. Clearly, we believe that there are a number of principles that have to guide us if we expect the system we want to see created to be effective. First, it has to provide security for every American. Health care has to be available no matter who you work for, no matter what your health status. It has to be portable from job to job and across the state lines. That level of security is absolutely essential. It does have to control costs, but it needs to focus on eliminating the unnecessary costs in

the system first and be able to reallocate those resources to actually providing health care.

I do not know now, I have lost count of how many doctors have told me the huge percentage they are currently paying out of their income, those who are in private practice, to pay for the administrative side of their business; how many more people they have had to add; how many more hassles they have had to contend with. There are costs in this system that need to be eliminated. There is no excuse for the proliferation of forms that are of absolutely no use to the provider or the patient. There is no excuse for the kind of bureaucracy that has been built up in both the private insurance world and in the government in order to check people and double-check their decisions.

We also need to be committed to improving and retaining quality and by maintaining choice on behalf of patients. And we need to have a system that is simple enough for the average person to understand and feel good about.

We are looking for those kinds of solutions and believe that we are close to being able to present a proposal that will enable us to achieve a system that meets them. But there is a particular piece of this that I know is of great importance to the Johns Hopkins community, and that is the role of the Academic Medical Center. The kind of important role that has been played by Johns Hopkins and will continue to be played is one that we have spent a great deal of time working on, to be sure that we understand how best to put into place an overall reform system that will enable the Johns Hopkins of our country to continue and even enhance the important roles currently played.

There are a number of issues that come into consideration when we look at the Academic Medical Center. The first is the supply of physicians and the kinds of physicians in that supply. There is no way we can provide the kind of universal access that is required, and require a benefits package to be available to all Americans that emphasizes primary and preventative health care without a larger supply of primary physicians.

That is a simplistic statement, but one which will take a great deal of effort to meet. How do we move from our current imbalance of the number of specialists for primary care physicians and get to a point where we can promise there will be primary care physicians, not just in the suburbs, but in the inner city and in rural areas so there will be a true network of care that will fulfill the promise we are attempting to make to Americans.

As Dean Johns and others have suggested, the success of our health care reform effort depends in part on our ability to put doctors and health care resources where they are most needed, not simply where they are most profitable. But that will happen only if incentives that have traditionally gone into medical education to promote specialists now go into medical education to promote generalists.

The bold curricular changes undertaken at Hopkins reflect exactly the sort of creativity and vision we need across the board. Ultimately we have to recognize that there are values in our health care system that we need to promote and reassert and even to introduce. And this curricular change that will lead to the possibility of more primary care physicians is one of those values.

I commend Hopkins and I suggest to you that our national health care reform effort will in many ways have to follow the model that Hopkins has set. Through the government provision of resources for medical education we will have to alter the incentives that are currently there if we are to have an adequate supply of primary care physicians.

We will then have to look for ways of actually providing real loan repayment options and forgiveness of loans for students who are willing to go into those area that our country most dramatically needs in primary care. We will also have to be sure that we have the kind of linkages between primary care physicians and secondary and tertiary care practitioners and facilities that will enable the primary care physician to be part of a network of care.

Technology will help us in that regard. I'm sure many of you, as I have, have watched now the kind of technological linkage that exists in rural areas with academic medical centers in some parts of our country. Where we are getting to the point where a doctor in a rural area can hold an X-ray up and it can actually be read 400 or 500 miles away.

We need the kind of communication and cooperation between our academic medical centers and these primary care physicians once their supply is increased to ensure that we have the quality of care that they will expect to be able to delivery to their patients. We also will have to be sure that the academic medical centers do not in any way fall down on their responsibility to train specialists and subspecialists, but at least for the immediate future, the balance has to be altered.

I am particularly grateful to Dean Johns and to Dr. Jim Block for the time that they have spent with us talking through the problems of the academic medical centers, how to keep the missions of

these centers alive. And let me just run through some additional issues that we think will be particularly helpful to these centers.

In addition to your obligation to help us meet our supply problem, we anticipate being able to help centers such as this deal with their financial problems. You currently bear a disproportionate burden of treating patients who cannot afford to pay. Under a new health care system, however, all patients will be entitled to health care coverage and all providers will be fairly compensated for their services. This is particularly important for the uncompensated care that is delivered by a hospital such as the one here and many others like it around the country.

I have often explained, or tried to explain to audiences of citizens what that $20 bill for the Tylenol means on the hospital bill they receive in trying to explain to them how uncompensated care is paid for. Because one of the sad, and perhaps unfair, facts that we confront in the health care reform debate is that most American believe there is a very simple answer: Don't charge as much for what you do. That, to them, is the answer. All the rest of these issues that we have looked at and worried about over the last five months pale into insignificance against the overwhelming public perception that the real problem in health care is that doctors charge too much, hospitals charge too much, insurance companies charge too much, everybody charges too much so we just cut everybody's prices and everything will be fine.

You know that is not the case, and I know it. But it will be one of our challenges to educate the public and the more that you can talk about what it means for an institution like Hopkins Hospital to try to care for the people of East Baltimore, and to try to fund that care when so many patients are either uninsured or underinsured will enable us to have a much better educated audience when we come forward with health care reform.

So there will be great opportunities because there will be so little uncompensated care left when we are able to reform the system. There will also be incentives for hospitals, such as the one at Hopkins, to be part of networks that remove care away from the emergency and the tertiary care facility out into the community.

I have visited other hospitals, much as what you're trying to do here, where you begin to have a screening system so that when people walk in the door of the emergency it is not assumed that they will sit there and wait for several hours until their minor problem can be dealt with while you deal with emergencies, but instead they are immediately deflected off into a different system, maybe down the block, maybe across the street, maybe into a van where

they are taken to a family clinic where the problem that they have can be effectively and cost effectively dealt with.

We also will continue to do what we can to support the traditional research role of the academic medical center. We know how important that is. I ticked off earlier some of the many advances that have been and will continue to be made in medical research here at this institution.

We will look for ways to support that research. We believe that medical research is a cost effective investment, and we will be looking for ways to spread the burden more fairly and to increase the resources available to academic medical centers so that you can look forward to a steady stream of revenue, maybe even increasing in some areas a particular need so that we can continue the kind of breakthrough research that has been the hallmark of Hopkins and other academic medical centers.

We will also look for ways to be sure that that wonderful phrase that comes from one of your leaders, managed cooperation, is the reality. That is what we are really looking for. We are not looking for an environment in which the academic medical center competes with any other institution at the lowest common denominator. We are looking for ways to enhance the special roles of all kinds of institutions within our health care delivery system. That can only come about through cooperation.

And I had no idea before I got into this how difficult cooperation was. (Laughter.) You know how difficult it is. But it's going to require new attitudes on the part of lots of people. Specialists are going to have to cooperate with non-specialists; doctors are going to have to cooperate with nurses; hospitals are going to have to cooperate with clinics. All kinds of cooperative, collaborative arrangement should be seeded and nurtured in a reformed environment.

There will be so many opportunities for you as physicians or nurses or other staff members to have your roles enhanced and to be given back authority for making decisions again. But that will then put the burden on you of cooperating.

We have, inadvertently over the years, created a system in which cooperation was not necessarily valued. And it has not gotten us what we want. It has instead gotten us a system in which people are pitted against one another; in which reimbursement is based often on diagnosis or tests rather than quality and outcome; where teamwork is valued because it has to be there when you're actually on the floor doing what needs to be done; but is not valued within the larger system.

So we will look to you to help us create those new relationships of cooperation. And we will look to those who are not professionals to be more responsible for their own health care; to take that primary or preventive health care option that we will now require to be given to them; to be responsible for their own well-being; to give you a little help in your efforts to try to be the healers. But you will also have to perhaps go beyond the traditional medical school orientation, to talk more about things like nutrition, diet, exercise, stress reduction, the kinds of issues that until recently have not been considered part of the mainstream medical school curriculum but which many of us in this room practice ourselves, whether you talk to your patients about them or not.

And so we will have to look to you to give new leadership of a different kind, new meaning to the words health care. Because of President Richardson said, we often have a system that is a sickness system, not a health system. And we have to participate in changing the attitudes of ourselves and our fellow citizens if this reform is really to do what we hope it will do.

The kind of opportunities available for an Academic Medical Center are really only limited by the scope of imagination and vision. I anticipate that as we move forward in the next weeks we will engage in a vigorous and, I hope, constructive debate about what direction we need to go and how the President's policies will be received. That's what should take place as we embark on a great effort to reform this system to benefit everyone.

But I hope that it will not be a debate just about narrow issues and that each of us from whatever perspective we bring will be able to step outside our own view and our own experience to think as broadly as possible. There is no better place to get that kind of vision than a place like this one. We will need your continuing guidance as so many of you have already given to us. We will need your voices.

And for every question you ask, suggest a possible answer, because there isn't any doubt, I don't think, that we can do better. We can do better as a nation because when one stops and thinks a minute about what is a stake, it is not just about how we finance health care, although certainly it is that. It is not just about insuring that we rid ourselves of the unnecessary bureaucracy and paperwork, and how we deal with the threat of malpractice that hangs over your heads, It is not just about increasing and enhancing our research agenda so that we get better results more quickly delivered to the maximum number of people. It is not even just about how we cooperate with one another among professionals. It is not

even just about how much responsibility individuals finally are willing to take for themselves.

It is all of that, but it is more. It is about the quality of our community together. It is about what kind of people we are and intend to be. It is about how we treat one another, how we care for all of us, but particularly those who are least fortunate among us. This health care reform will certainly say a lot about Johns Hopkins, about hospitals, about medicine, but it will ultimately say a lot more about what kind of social contract we have with one another, what kind of country we are, and what kind of country we want to be. Thank you all very much. (Applause.)

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THE WHITE HOUSE

Office of the Press Secretary

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REMARKS BY THE FIRST LADY
AT HEALTH CARE BRIEFING

Lincoln, Nebraska

MRS. CLINTON: Thank you very much. It is a great delight for me to be here. I am especially pleased to be with your Senator, whom I have known for a number of years since he served as your governor when my husband was also a governor, and have admired and respected his commitment and concerns on issues; but, particularly, his concern and commitment to the issue of health care in this country.

I don't quite know how to take the Navy Seal analogy. (Laughter.) It is a little bit too apt, too close to home. But throughout this process, when I have been treading through very choppy and dangerous waters, Bob Kerrey has given good advice and good counsel and, I think, made my task much easier by the fact that he has been there before. And I am personally very grateful for his lifelong commitment to doing what he believes is right and, particularly, his willingness to put himself on the line in the last couple of years on behalf of better health care for all Americans.

It's a real tribute, Bob. (Applause.)

I'm also pleased to be here with Governor and Mrs. Nelson. They have become friends of my husband's and mine. I always enjoy being with them, and I always learn something. I learned just a few minutes ago about how the Governor is not only enormously popular in this state for a lot of very obvious and strong reasons, but how he handles the bane of all people in political life, and that is the unfair, unjust, inaccurate reporting that goes on from coast to coast, north to south, east to west. (Applause.) And he has given me some tips that I think I'll start putting into effect. I'm not going to share them with you right now. (Laughter.) But I'm very grateful to the Governor.

And I'm also pleased to be here with another governor whom you'll hear from in a few minutes: Governor Howard Dean from Vermont is a practicing physician as well as the governor of his

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state, and has been intimately involved with the work of the President's task force. And it's a remarkable combination to have someone who sees this complex issue from the ground up as a practicing physician whose wife is also a practicing physician, and from the policy perspective of a governor's office. And I know that you will find Governor Dean's remarks as useful and provocative, as I always do, and am delighted to be here with him.

Those of you who are here are obviously concerned about the subject of this conference and wanting to know more about it. I assume from the great size of this crowd there are people from all walks of life and from very differing perspectives -- people who deliver health care, people who receive it, people who study about it, people who are concerned as citizens, as parents, as members of the community that you live in.

That is a very good sign. Because part of what we have tried to accomplish in the last several months is exactly the sort of conversation that this conference represents and which your presence exemplifies. We have to be willing to strip away the years and years of papering over the problems in our health care system, of denying the reality that was all about us and impinging upon us and be honest with one another. That is where we have to start. We have to be willing to talk about our problems, put aside our own personal interests, our own prejudices, our own experiences insofar as that is humanly possible.

Physicians and nurses and patients and insurers, business people of all sizes, working people -- all of us must recognize we are all part of the problem and we will all have to be part of a solution if it is going to work for America.

Starting from that premise, let me share with you some of the facts that have made it impossible to ignore this problem any longer, and which prompted the President to commit himself as he has to trying to make our country provide quality, affordable health care to all Americans.

First of all, there is a lot that is right about our health care system. No one can deny that. We are always proud of the accomplishments and achievements within the various sectors of our health care community. We are secure in the knowledge that we have among the best health care in the entire world, and in many, many respects the very best. And we want to do all we can to make sure that our children and our grandchildren will be able to say that as well.

What is happening, however, is that beneath that statement of fact, there are many other facts that now are breaking

through the surface that we have to deal with as well. The security that many of us have come to take for granted -- that the doctor, the nurse, the hospital would be there for us in time of care and need -- the fact that so many of us have relied on the kind of care that we have grown accustomed to and that we feel comfortable with, as we look around our country today, that fundamental, personal security can no longer be taken for granted.

Instead, what we find is not only skyrocketing costs, but the effects of those costs. We find the growing numbers of people who work hard for a living who do not have access to health care. We find that more than 100,000 Americans move into the ranks of the uninsured each month. And more than half of the uninsured in 1990 were full-time workers and their families, and the rest were part-time workers, seasonal workers, people who worked.

Now, that's the kind of statement that, taken in a vacuum, sounds frightening. But if you're not in that group, you wonder to yourself: Well, that's not me and that's not those whom I know. But it could be. Because now more than ever, Americans worry about losing the insurance that they have, that they have taken for granted.

I wish all of you could have come with me on the visits I've been privileged to make around the country, talking to people about health care. It is very hard to explain, as I tried to explain to a group of working people in New Orleans a month ago why they, who had worked for the same employer, some of them for 20 years and 30 years, did not have insurance, could not afford it for them or their families, but lived down the block from people who were poor enough and not working that they were eligible for Medicaid.

It was very difficult for me to look at the woman who worked in the clerical office of that small steel company who could not afford insurance, her company could not afford, they believed, to offer any help to her in purchasing that insurance, but she tried to take care of herself. She was a single woman who had raised a child, and she went every year to have a physical exam. She tried to read what she needed to read, to eat the right things. She said to me she even tried to start exercising a few years ago and tried to walk every day.

But when she went for her physical exam, her doctor found a lump in her breast and referred her to a surgeon. And then when she kept that appointment with the surgeon, she reported to me that following the appointment the surgeon said, you know, if you had insurance, I would biopsy that. But since you don't, we will just watch it for a while.

It's very hard to look in the eyes of working Americans, people who are really at the backbone of this country and always have been, and to know that some, by the grace of their employer, have an insurance, and some do not. Some women can be referred to a surgeon for a biopsy and some will just have that lump watched.

Or to listen to a veteran in that same group who had worked in that same business for many years but who wasn't eligible for VA benefits because he didn't have a service-connected disability and he was working and wasn't poor enough to access the VA system. So, again, without insurance the emergency room was his physician. And he talked about how he hated to go to the emergency room because it was always so expensive. He tried not to go, but the times that he did have to go often he couldn't pay the bill he was presented. And he felt bad about that as well.

So, there is, beneath the security that many of us still feel, because we can afford insurance, we are lucky enough to work for someone who helps us pay for that insurance, there are millions and growing numbers reaching millions more of Americans who are not so lucky. I call that the "there-but-for-the-grace-of-God-go-I" group, because many of us are one job away, one layoff away from not being able to afford insurance ourselves.

And then there are so many others who are in the position of being self-employed. Many of the farmers and ranchers in this state are like the ones that I met in Iowa when I sat for over an hour and listened to four farm families talk to me about how they could not afford insurance. And these were people who put literally the food on our table. And what they did was despite the fact it made no sense by any accounting measure, they just squeezed every possible dollar out of everything else so that they paid for those very expensive single-family policies that they were able to access.

Or they even went through their local farm bureau; but because it wasn't a very big policy or they had a preexisting condition, they were still paying more and more every year with the cost continuing to escalate.

And I sat there in the living room of this farmhouse thinking to myself: Why on Earth would we want, literally, to drive out of business, which is what we are doing, farm families and ranch families who are still among the most productive workers in our entire country? Why would we want our government to look at their balance sheet when they come in for some kind of loan from some government-supported program and have the government representative say, you know, you're not really in a good position to borrow as much money as you want because your assets are obviously highly mortgaged. You can't really afford much but if you cut out your monthly health

insurance, we think we can make this work for you? Why are we doing that to ourselves, why are we doing that to the people who work for us?

We also know that in addition to the 37 to 40 million Americans who are uninsured, to the group of Americans who are paying for insurance at extremely high rates for a variety of reasons such as preexisting conditions, there are 22 million more Americans who do have insurance but whose insurance is the barest bones insurance that often when the catastrophe strikes, the accident occurs, the illness worsens, they find they are not covered for all that they expected.

I always wonder when people start playing with the numbers, when they say, well, this is really just a problem of the uninsured if they have not talked to same people I've talked to, if they haven't talked and looked into the faces of people who are uninsured, who are barely insured, who are insured at extraordinary costs that never seem to reach an endpoint. And then if they don't talk with the rest of us who worry that it could happen to us next.

If we do nothing, if we just say to ourselves: this is such a complicated problem, we really don't think we will ever come up with a comprehensive solution to solve all of the aspects of it, then here is what we can look forward to. Experts estimate that the annual cost of health care for an American family will more than double by the end of the decade to approximately $14,000 per family. Workers will lose about $655 in income each year if health care costs are allowed to continue to eat up wage increases.

So, if we just keep our focus on the individual and on the household and think about what is at stake, we can see how big an issue this is for most Americans. But it is not just an individual and family issue, it is also a business issue. And it is a business issue in a number of respects. Right now, two-thirds of small businesses do provide their employees with health insurance. Many small businesses do so at great cost and at sacrifice. And about the most poignant meetings that I think I have personally had in the last months have been with small business owners who have told me in great detail the struggle they have gone through to try to continue to insure their two or five or nine or 10 employees.

Some have been able to continue to meet those costs by doing all kinds of things. Certainly, by doing the obvious of increasing copays and deductibles and all. Some by taking members of their families off the health insurance and putting them on another health insurance that another member of a family had. There have been enormous efforts made by so many small businesses who do provide insurance to keep doing so.

For many others, they have not been able to. And I can recall, particularly, sitting in a small restaurant in a suburb of Boston talking to a group of small business people who told me in excruciating detail the struggles they had undertaken to try to provide and continue health insurance.

One man who owns a small family bowling alley has one employee. That one employee had a son with a serious illness and the illness was one that was difficult to continue to insure for and the costs continued to go up. And the owner looked at me with tears in his eyes and he said, look at the choice I'm asked to make. This man has worked with me like a member of my family. And now I'm either going to have to make a decision to just cut him and his family off of health insurance or to tell him to see if there's any other place he can go to work where he might get it, but I've checked for him and I don't think that's possible. Or to continue to try to pay the insurance when we don't make all that much money. What am I supposed to do?

The human side of the business story is one that is filled with tales like that. There's another side as well. And that is that small businesses because they are small pay premiums that are one-third higher on average than large employers and those premiums have continued to increase 50 percent faster than premiums for larger employers.

So, it's a never-ending cycle. It's not enough just to make it one year. Given the history we've had in the last several, it keeps getting worse. There's also a competitiveness issue here with business. Our large businesses very often have a tradition of insuring their workers; and not only workers but their retirees. As a result, they have paid out millions and by now billions of dollars in both premium and costs that they will never recover in terms of investing in more jobs and opportunities for Americans.

In 1990, for example, General Motors spent $3.2 billion in medical coverage for its 1.9 million employees and retirees -- $3.2 billion. This was more money than the company spent on steel to build new cars.

Health care costs add $1,100 to the price of every car made in America. How can we expect to revitalize the manufacturing sector of this country if we basically have told our large employers: Fight the global economic battles with two arms tied behind your back. So it is not just the human side when it comes to business, insurance, and health care costs, it is a question that every American needs to be aware of because it impacts on our quality of life and the economy of this country.

In addition though to business, we have government. But governmental costs for health care are the primary reason behind the increase in the government deficit. I want to stress this point because so many people when we hear about the enormous deficit that has swallowed up so much of the investment potential in this country, it is such a big number, it has grown so much in the last 10 years that it's almost hard even to grasp.

But right now we are currently spending 14 percent of every dollar that your country produces -- and that's referred to as the Gross Domestic Product -- 14 cents out of every dollar is spent on health care in this country and the government's share of that is growing faster than the private sector's share of it. If we continue at the same rate of growth, then we are likely to see that in seven years almost one dollar out of every five dollars earned by Americans will go to health care spending, and more than half of the increase in federal revenues that we hope to see in the next four years because of economic growth will be absorbed by health care cost increases.

If we do not deal with the costs of health care in the federal and the state and the local government budgets, we will bankrupt cities and counties and states. They may never go to a bankruptcy court because we don't have a system big enough even to comprehend that. But they will continue to do what they have done for the last years -- run enormous deficits which will never ever quite get closed and the federal government will be in a position, as it has been in the last years, of pretending that there is an answer to a budget deficit that grows by leaps and bounds because we will not face up to the role that health care costs play in keeping that growth accelerated.

When my husband made his announcements about what he wanted to do with the budget, and he spoke to the Joint Session of Congress, he made it very clear that what we were facing was a budget deficit that had to be addressed on several fronts at once -- had to be addressed by cutting spending, which is being done dramatically and honestly for the first time in a very long time. But it also had to be addressed by reining in health care costs in both the public and the private sector.

Now, these are the facts that, no matter how much we would like to deny them and wish they would go away, are really framing the debates about what we should do in health care. And you have heard in this conference, and will continue to hear, from people who have spent a lot of time thinking about the best answers.

What the President did when he established the Health Care Task Force was to say, look at everything everywhere that might

work. Make sure every issue that has an impact on health care, its cost, its quality, its availability, is pulled out to the light of day and evaluated.

To that end, hundreds and hundreds of Americans have been spending countless hours trying to make sure that the President's charge to them has been met. People from all over the country, all walks of life, more than a hundred medical practitioners, nurses, others who are on the front lines of health care, many people who have studied the issue from a different perspective, whether it be the VA's problems or the Indian Health Services problems; and countless others have given of their time and energy to be consulted with on an ongoing basis.

And one thing that is clear from having looked at the extraordinary range of issues is that any attempt to try to rein in our health care costs cannot just attack one part of the problem. To do that would be leaving opportunities for explosions of costs and continuing growth in other parts of the system. So the President has called for recommendations of a comprehensive approach to try to reform the health care system, put it on a sound financial footing for the future, retain the qualities of choice and opportunities that currently exist, and be sure that all Americans have access to health care.

And to that end, a number of different programs and potential models have been examined in an effort to come up with an American solution to an American problem, to make sure that what was proposed would provide flexibility to states like Nebraska or Vermont, because the people in different localities might need different approaches if they were to solve their own health care problems.

The costs associated with trying to provide a comprehensive solution are ones that we have to also be honest about. We believe that there is money in the system now that can be reallocated and used to meet a new system's more realistic requirements. We believe there is money to be saved in ridding the system of unnecessary paperwork and bureaucracy and red tape and micromanagement that has stood in the way of delivering health care. We believe that insurance companies like the great one that is headquartered here can help a great deal by coming up with uniform reporting forms and making it possible to move toward a computer-based information system that would save in the future billions of dollars.

We also believe that changes have to be made in our laws as they currently exist -- laws like antitrust laws that prohibit physicians or hospitals from cooperating instead of competing. There

are communities in this country that tried to bring their hospitals together so that they could work out sharing arrangements of expensive equipment like MRIs or CAT scans. And we're told that if all the hospital administrators met in the same room, they would violate the antitrust laws. So instead, they all went out and bought their own machines. And that's one of the reasons Tylenols cost $50 when you go to the hospital, because you have to amortize the costs of those machines. You have to make them pay for themselves, even though the volume demand may not warrant it.

So there are so many issues to be looked at, all of which are being considered, evaluated, and serving to make recommendations for the President.

But I want to say something very clearly about the principles that need to underlie whatever the President proposes. The first principle has to be that Americans will be secure in knowing they will have access to quality, affordable health care, no matter who they are, no matter where they live, and no matter what their health status is. They also have to be given the security that the costs that they pay for health insurance will not continue to skyrocket, but instead, will be controlled in some way by the marketplace so that they will understand that they can budget for that, businesses can budget for it, that will not be hit by surprises on a yearly basis, and not be able to deal with the costs.

We also have to recognize that there are values in our health care system that we need to promote and some we need to introduce. Individuals will have to be more responsible for their own health care. They will have to behave in ways that will promote health care. Now, how can we do that? We can't write a law that says go out and be responsible and take better care of your health, but we can put incentives into our system to try to promote certain kinds of behavior and discourage others.

We also need to value the full range of health care professionals. We have subsidized through the Medicare system the creation of many subspecialties in medicine. Those are important. But we have now 70 percent of our physicians who are specialists and only 30 percent who are generalists. You cannot run a system of health care that will tend to the primary and preventive health care needs of Americans when only 30 percent of the physicians currently in practice and only 15 percent of those attending medical school now will be there to provide primary and preventive health care. So the incentives that have traditionally gone into medical education to promote specialists now have to go into medical education to promote generalists.

We also need to expand the work force composition in health care. We need more nurse midwives, we need more nurse practitioners and other advanced practice nurses. We have to have a health care profession that reflects the broadbased needs of Americans.

So the kinds of values that we are struggling with, the kinds of issues that you live with, whether you're in a household or as an individual or in a business or part of the health care system, are all being looked at so that we can come up with answers to what we think will be the best American response.

Now, how will this program affect your life? We hope it will not change much about how you actually access and receive medical care. We do hope that you will have a card which is your passport, as Senator Kerrey has said, to health care in America. We hope that you will continue to have choice in the doctors and other health care professionals whom you choose to go to to receive care. And we hope that the states will be willing to take on a lot of the responsibility for making sure that the system actually fits the needs of the real people in a region.

Before coming out here, I was privileged to meet with representatives of the Lancaster County Medical Society and the local public health and social services offices and representatives from the state who have innovated a program here in this county to be able to care for Medicaid recipients by using private physicians through a referral system run by the public health system.

That is the kind of partnership and cooperation that we have to have if we're going to have a true comprehensive system that provides a continuum of care.

I like the word "cooperation" when I think about the health care system in the future. We have spent too much time in the past arguing and fighting over shrinking dollars that are creating barriers to access instead of expanding opportunities and removing those barriers.

When the President comes forward with his proposal, it will be based on extensive and lengthy and thoughtful suggestions from literally hundreds of thousands of Americans. But we will need you to take a hard look at it and to continue the process of consultation and suggestion through your senator, through your governor, because there is no magic bullet out there. There isn't any one simple model that can take care of Alliance and Broken Bow and Omaha and Lincoln, or Little Rock and Los Angeles. We need a national system with state and local opportunities to make sure that differences can be adequately met.

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE IRIS CANTOR CENTER HUMANITARIAN AWARD LUNCHEON
LOS ANGELES, CALIFORNIA
JULY 19, 1993

DRAFT

Good afternoon.

It is a privilege to be here with you today to accept the Iris Cantor Center Humanitarian Award. This award has special meaning for me because it represents a goal that we all share -- promoting better health care for all Americans, and particularly for a segment of the population whose health problems are too often ignored: women.

Let me also say that I am especially honored to receive an award that has Iris Cantor's name attached to it. I can scarcely think of anyone who has done more for her community, more for women, than Iris Cantor. In fact, I sometimes wonder if any worthy enterprise has escaped her reach!

As a champion of the arts, as a champion of education, as a champion of breast cancer research and treatment, Iris Cantor epitomizes a brand of selfless generosity and civic spirit that is much too rare today. Day in and day out, she reminds us of what it means to help others. Of what it means to give of oneself. Of what it means to be a good citizen.

Iris Cantor is certainly a model for me, and I hope for all Americans. And I assure you that in accepting this award, I am inspired to try to live up to her example, particularly as we revamp our nation's health care system in the months ahead.

Iris Cantor founded the Center for Breast Imaging at UCLA five years ago, and it has been exciting to learn more about the work being done there:

The evaluations and mammography screenings given to 700 women each month. The pioneering work of Dr. Bassett, Dr. [Nanette] DeBruhl, and Dr. [Marie] McCombs on the use of core biopsies, rather than surgical biopsies, to investigate abnormalities detected on mammograms. The research into silicone implant leakage. The education of physicians through books published by the center and through a special one-year fellowship. The outreach programs for underserved women throughout Los Angeles. And finally, the rigorous standards the center has set for quality mammography in the United States.

Truly, the Iris Cantor Center is a testament to the promise and rewards of new approaches to medical treatment, particularly

preventive care. And we all know that preventive care is crucial to improving the health and well-being of women in this country.

You, who support the center, should be applauded for your contributions. Your generosity has saved lives -- and opened up new options for women beset with one of the most pervasive and frightening diseases in our history.

But even with your efforts, the need to find the cause of and cure for breast cancer -- and other diseases that primarily endanger women -- remains great.

For too long, the conventional wisdom has been that women's health problems are no different from men's. After all, women live longer than men. So, they must be healthier, right?

Wrong.

American women in general suffer from disproportionately poorer health than American men. They may have a biological advantage when it comes to life expectancy, but they don't have a medical advantage when it comes to funding, research, and treatment of the illnesses that burden them most.

Just last week [July 14], one of the most comprehensive surveys ever completed on women's health was released. It showed that 40 percent of women experience "severe depression" during their lives. It showed that women are too often victims of sexual, physical and verbal abuse. It showed that women are generally poorer than men, and thus less likely to receive needed medical care.

What this study confirmed is that too often, those bonus years when women outlive men are not really bonus years. They are lonely days and nights clouded by needless infirmity and inadequate care.

Sadly, even in 1993, women grow older with few clues about the health problems they face. Breast cancer is but one example. We don't know what causes it. We don't know how to prevent it. We don't know how to cure it.

We have technology sophisticated enough to detect missiles thousands of miles away . . . but we don't have technology sophisticated enough to detect all of the smallest, fatal lumps in women's breasts.

Every three minutes a woman is diagnosed with breast cancer. Every 12 minutes a woman dies from it. And that means too many women are suffering and perishing from a disease that we should be able to beat!

Today, 2.6 million women have breast cancer, and the rate is going up. Just 30 years ago, a woman's chances of being diagnosed were 1 in 20. Today, the chances are 1 in 8. Of the 186,000 who will be diagnosed this year, only about 30 percent will come from a high-risk category.

Equally ominous, breast cancer mortality rates refuse to decline. Last year, 46,000 women died of breast cancer. And while African-American women are less likely to get the disease, their death rate is higher if they do. That is a very disturbing statistic, and one that our health care system must address.

We all know how indiscriminate breast cancer can be. So indiscriminate that being famous -- like former First Ladies Betty Ford and Nancy Reagan, actresses Julie Harris and Kate Jackson, journalists Gloria Steinem, Linda Ellerbee and Betty Rollin -- does not protect you from it. So indiscriminate that one's socio-economic station in life does not guard against it.

We all have friends or relatives who have been diagnosed with breast cancer, perhaps even died of it. My own mother-in-law was diagnosed in 1990.

At the White House, I receive letter after letter from women whose lives have been shaken by breast cancer. Women like Chris Carpenter of Alabama, an employee of the Social Security Administration, who has battled the disease vainly for three years. Now her friends are trying to raise $170,000 for a bone marrow transplant that is not covered by her insurance.

And I've heard from women like Dolores Engelhardt of San Antonio, who was diagnosed in 1989. In the intervening four years, she has undergone six months of chemotherapy, a mastectomy, more chemotherapy, 26 radiation treatments, and a variety of experimental drug therapies. Now her doctors are contemplating a bone marrow transplant.

For Chris Carpenter and Dolores Engelhardt, the issue is not just life or death, not just whether they will lose a breast, not just how they will care for their families and loved ones. But who will pay for their escalating medical bills.

For the past 30 years, the treatment for breast cancer did not appreciably change. And even with new approaches underway today, most women continue to rely on surgery, radiation, and chemotherapy for treatment. That costs about $6 billion a year in medical bills and lost productivity.

Until we learn more about breast cancer -- what causes it, how to treat it, and ultimately how to prevent it -- all of us will share in the emotional and financial costs borne by women like Chris Carpenter and Dolores Engelhardt.

Fortunately, times are beginning to change, thanks to the extraordinary efforts of women and men across this country. Women like Iris Cantor, and cancer survivors, and scientists, and physicians, and health care advocates, and members of Congress have helped awaken our nation to the urgency of this epidemic.

Fran Visco, a trial attorney who was diagnosed at age 39, helped call attention to the seriousness of breast cancer as a co-founder of the National Breast Cancer Coalition, a grass roots organization that convened research hearings in Washington, lobbied Congress and successfully pushed for better funding and coordination of breast cancer programs. I'm proud to say that my husband appointed Fran Visco to the president's cancer panel [ck whether still in existence].

So where do we stand with breast cancer research and treatment? what before 1990?

In 1990, the federal government spent $80 million on breast cancer programs. In the current appropriations bill, $449 million is earmarked for programs at the National Cancer Institute and the Department of the Army. That's an improvement.

Scientists are also exploring promising drug therapies, such as taxol and tamoxifen. They have uncovered potential uses of RU-486 in tumor treatments. And now, at the National Institutes of Health, scientists may be on the verge of identifying a gene marker in high-risk women.

As you may know, the president also has lifted the ban on importation of RU-486, which will pave the way for more aggressive research. And he has lifted the ban on fetal tissue research, which may prove useful in finding a cure for breast cancer. These are heartening signs of progress.

But the truth is we still know far too little about this and other diseases that primarily afflict women. For example, do environmental factors, such as toxins, pollutants, diet, and drugs contribute to the rise in breast cancer rates? We don't really know.

Why don't we know? Because it wasn't until a few years ago that an energetic group of women scientists and grass-roots advocates alerted us to the inequities that existed in research and funding of these diseases.

Groups such as the Society for the Advancement of Women's Health Research showed us the appalling degree to which women were routinely excluded from major clinical trials of most illnesses.

Even when women are victims of the same diseases as men -- such as coronary heart disease and strokes -- research has tended to focus on men.

Although hypertension is 2 to 3 times more common in women -- and most prevalent in African-American women -- drugs to treat hypertension have largely been tested on men.

A major study on the relationship between cholesterol and heart disease involved 15,000 men. And no women.

And one of the most significant clinical trials in the 1980s -- which studied the preventive effects of aspirin on heart disease -- failed to include a single woman among 22,000 patients screened. . . . Even though heart disease is the leading cause of death among women, followed by cancer and strokes.

The frightening research patterns must change.

The fact is that women have unique health problems, unique symptoms, and unique responses to treatments. And they play a unique role as caregivers in our society.

But even so, they have never enjoyed the security they deserve when it comes to health care.

Too many women -- about 16 million -- don't have any insurance at all. Too many women suffer from ailments that have been ignored for decades in the scientific community. Cervical and ovarian cancer. Osteoporosis. Immunological illnesses such as lupus and MS. Certain forms of mental illness. Eating disorders. Menopause. Endometriosis. And the list goes on and on.

Why should we focus more attention on women's health. Because to do so will greatly benefit our country as a whole. Women make up 51 percent of the population. Their lifespans on average are eight years longer than men's. And their well-being often dictates the well-being of family members around them.

In economic terms alone, continued ignorance about women's health matters will cost our nation far more than any investment we make now to prevent and control these diseases.

Osteoporosis, a painful ailment that often results in deformities and loss of mobility, offers compelling proof. Nearly 75 percent of women over 65 suffer from it. The disease causes 1.3 million bone fractures each year. And the annual medical bills associated with it total as much as $10 billion.

If we knew more about osteoporosis, if we developed ways to prevent its onset, we could simultaneously enrich life for elderly women, reduce hospital visits and stays in nursing homes,

and save billions of dollars a year. All from targeting that one disease.

Now I don't want to paint an entirely bleak picture, because we are making progress. Women's health is no longer thought of solely in terms of women's reproductive capacities. Medical students are no longer taught that women should only bear children between ages 18 and 25. Women are no longer lectured that they will contract endometriosis if they give birth after 30. Women do not automatically have their ovaries removed if they undergo a hysterectomy. And women do not automatically lose an entire breast if they are diagnosed with breast cancer.

Today, we have a more realistic view of women's health. And fortunately the federal government's interest in promoting women's health is greater than ever before.

The president recently signed the National Institutes of Health bill [ck title], which includes the newly created Office of Women's Health Research as part of statute. That office [ck] is currently funding a 14-year, $625 million effort called the Women's Health Initiative that will explore long-term patterns of heart disease, cancer and osteoporosis in women. And the Congressional Caucus on Women's Issues is working on a Women's Health Equity Act and has organized task forces to study three specific areas of women's health.

As we look to the challenges ahead, we can't let women's health be treated as "the flavor of the month" in health care -- a fad that is soon forgotten. Improving women's health care should be elemental to improving our nation's health care overall.

To that end, I'm very excited about the changes we envision as we outline our health care reform proposal.

The administration's health care plan will give us a fresh start in tackling many of the problems women face. First and foremost, it will encourage new approaches to prevention and primary care that should help all Americans, and particularly women and children.

We have no choice but to change our mindset in this country and to focus more energy on preventive and primary care. We must offer a system that keeps people healthy, not a system that only treats patients once they're sick.

Our plan will include a benefits package that will allow women to get regular tests and screenings -- like pap smears, pelvic exams, and mammograms.

We will make prenatal care, dental and eye exams, immunizations and regular medical check-ups part of a comprehensive health package. Our system will provide incentives for patients to get diagnostic tests that pinpoint problems early -- rather than wait until an illness becomes acute.

Perhaps most important, our plan will provide American women and their families with security.

The security of knowing that they will have health coverage even if they have a preexisting condition or if they switch jobs. The security of knowing that every American will be guaranteed core benefits regardless of income. The security of having a doctor-patient relationship that encourages personal interaction, not abbreviated office visits and batteries of unnecessary tests.

And we will build a system that cares more about the health of the whole person and cares less about filling out forms and leaving medical decisions to anonymous representatives of insurance companies sitting in offices thousands of miles away.

Ultimately, our reforms will harness runaway costs. We will stop rewarding doctors for performing more tests and procedures, and will restore common sense and sound clinical judgment to the practice of medicine.

We will reduce the mountainous paperwork that now confronts doctors and hospitals and undermines the delivery of care.

We will produce a more efficient, streamlined system that provides better access, better distribution of doctors and nurses and technicians, and better care for patients.

These are enormous goals. They come at a critical point in our history. And we will all need to work together to ensure that they are met. Simply put, we cannot afford to fail. We cannot afford to maintain the status quo. It costs too much. And for too many Americans, it doesn't work well enough.

That said, I would like to offer one parting thought. No matter what the government does, no matter how we reform the system, no matter what cures and treatments scientists discover in the coming years, we must all be more responsible for our own good health.

As women, particularly, we must take better care of ourselves. And that's not always easy when you're working hard and looking after your own children and tending to aging parents and trying to keep a household functioning.

But we can help ourselves by improving our diets, exercising regularly, quitting smoking, examining our breasts each month,

and getting regular medical check-ups. We can take advantage of the technology that does exist -- like mammography screening. We can change our behavior.

As Hippocrates wrote more than 2,000 years ago: "The patient must combat the disease along with the physician."

This is important because, to me, health care reform is not just about reducing bureaucratic hassles, not just about balancing out the number of specialists and primary care physicians, not just about curbing the number of unnecessary hysterectomies performed each year.

Health care reform is really about our own vision of what it means to be healthy. Healthy as individuals. And healthy as a society.

It's about creating a climate in which women are treated on par with men and all Americans end up with better -- and happier -- lives.

It's about fostering a culture that enables us to care for ourselves -- and for each other.

It's about restoring a community-wide spirit of caring and good health.

Thank you very much for all the work you have done to make our nation healthier and stronger. And thank you for whatever support you can lend in standing behind the reforms that we must make together to ensure a happier, healthier future for all Americans.

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

REMARKS BY THE FIRST LADY
TO THE AMERICAN MEDICAL ASSOCIATION
June 13, 1993
Chicago, Illinois

MRS. CLINTON: Thank you very much, Mr. Speaker; all of the members of the House of Delegates, the officers and trustees of the AMA, and all whom you represent. It is an honor for me to be with you at this meeting and to have the opportunity to participate with you in an ongoing conversation about our health care system and the kinds of constructive changes that we all wish to see brought to it.

I know that you have, through Health Access America, and through other activities and programs of the AMA been deeply involved in this conversation already, and all of us are grateful for your contribution. I'm also pleased that you invited students from the Nathan Davis Elementary School to join us here this afternoon. (Applause.) I know that the AMA has a special relationship with this school, named as it is for the founder of the AMA, and that the AMA participates in its corporate capacity in the Adopt a School program here in Chicago. You have made a real contribution to these young men and women. And not only have you provided free immunizations and physicals and lectures and help about health and related matters, but you have served as role models and mentors. It is very important that all of us as adults do what we can to give young people the skills they will need to become responsible and successful adults. And I congratulate you for your efforts and welcome the students here today.

All of us respond to children. We want to nurture them so they can dream the dreams that free and healthy children should have. This is our primary responsibility as adults. And it is our primary responsibility as a government. We should stand behind families, teachers and others who work with the young, so that we can enable them to meet their own needs by becoming self-sufficient and responsible so that they, in turn, will be able to meet their families and their own children's needs.

When I was growing up, not far from where we are today, this seemed an easier task. There seemed to be more strong families. There seemed to be safer neighborhoods. There seemed to be an outlook of caring and cooperation among adults that stood for and behind children. I remember so well my father saying to me that if

you get in trouble at school, you get in trouble at home -- no questions asked -- because there was this sense among the adult community that all of them, from my child's perspective, were involved in helping their own and others' children.

Much has changed since those days. We have lost some of the hope and optimism of that earlier time. Today, we too often meet our greatest challenges, whether it is the raising of children or reforming the health care system, with a sense that our problems have grown too large and unmanageable. And I don't need to tell you that kind of attitude begins to undermine one's sense of hope, optimism, and even competence.

We know now -- and you know better than I -- that over the last decade our health care system has been under extraordinary stress. It is one of the many institutions in our society that has experienced such stress. That stress has begun to break down many of the relationships that should stand at the core of the health care system. That breakdown has, in turn, undermined your profession in many ways, changing the nature of and the rewards of practicing medicine.

Most doctors and other health care professionals choose careers in health and medicine because they want to help people. But too often because our system isn't working and we haven't taken full responsibility for fixing it, that motive is clouded by perceptions that doctors aren't the same as they used to be. They're not really doing what they used to do. They don't really care like they once did.

You know and I know that we have to work harder to renew a trust in who doctors are and what doctors do. That is also not unique to the medical community. Just as our institutions across society are under attack and stress, all elements of those institutions are finding that they no longer can command the trust and respect, whether we talk of parents or government officials or other professionals -- police officers, teachers -- that should come with giving of themselves and doing a job well that needs to be done.

But focusing this afternoon on those concerns that are yours -- what has happened with medicine, what is likely to happen -- we need to start with a fundamental commitment to making the practice of medicine again a visible, honored link in our efforts to promote the common good. And the way to do that is to improve the entire system of which you are a part. We cannot create the atmosphere of trust and respect and professionalism that you deserve to have, and that many of you who are in this room remember from earlier years, without changing the incentives and the way the entire system operates. That has to be our primary commitment. If we do not put

medicine and those who operate within medicine in the forefront of the respect they deserve to have, no matter what we do to the system on the margins will not make the differences that it should. (Applause.)

As you know, the President is in the process of finalizing his proposal for health care reform, and I am grateful to speak with you about that process and where it is today and where it is going. I had originally hoped to join you at your meeting in March in Washington, D.C. And I, again, want to apologize for my absence. I very much appreciated Vice President Gore attending for me, and I also appreciated the kind words from your executive officials on behalf of the entire association because of my absence.

My father was ill and I spent several weeks with him in the hospital before he died. During his hospitalization at St. Vincent's Hospital in Little Rock, Arkansas, I witnessed firsthand the courage and commitment of health care professionals, both directly and indirectly. I will always appreciate the sensitivity and the skills they showed, not just in caring for my father, not just in caring for his family -- which, as you know, often needs as much care as the patient, but in caring for the many others whose names I will never know. I know that some of you worry about what the impact of health care reform will be on your profession and on your practice. Let me say from the start, if I read only what the newspapers have said about what we are doing in our plan, I'd probably be a little afraid myself, too, because it is very difficult to get out what is going on in such a complex process.

But the simple fact is this: The President has asked all of us, representatives of the AMA, of every other element of the health care system, as well as the administration, to work on making changes where they are needed, to keeping and improving those things that work, and to preserving and conserving the best parts of our system as we try to improve and change those that are not.

This system is not working as well as it did, or as well as it could -- for you, for the private sector, for the public or for the nation. The one area that is so important to be understood on a macronational level is how our failure to deal with the health care system and its financial demands is at the center of our problems financially in Washington. Because we cannot control health care costs and become further and further behind in our efforts to do so, we find our economy, and particularly the federal budget, under increasing pressure.

Just as it would be irresponsible, therefore, to change what is working in the health care system, it is equally irresponsible for us not to fix what we know is no longer working.

So let us start with some basic principles that are remarkably like the ones that you have adopted in your statements, and in particularly in Health Access America. We must guarantee all Americans access to a comprehensive package of benefits, no matter where they work, where they live, or whether they have ever been sick before. If we do not reach universal access, we cannot deal with our other problems.

And that is a point that you understand that you have to help the rest of the country understand -- that until we do provide security for every American when it comes to health care, we cannot fix what is wrong with the health care system. Secondly, we do have to control costs. How we do that is one of the great challenges in this system, but one thing we can all agree on is that we have to cut down on the paperwork and reduce the bureaucracy in both the public and private sectors. (Applause.)

We also have to be sure that when we look at costs, we look at it not just from a financial perspective, but also from a human perspective. I remember sitting in the family waiting area of St. Vincent's, talking to a number of my physician friends to stop by to see how we were doing. And one day, one of my friends told me that, every day, he discharges patients who need medication to stabilize a condition. And at least once a day, he knows there is a patient who will not be able to afford the prescription drugs he has prescribed, with the result that that patient may decide not to fill the prescription when the hospital supply runs out. Or that patient may decide that even though the doctor told him to take three pills a day, he'll just take one a day so it can be stretched further.

And even though St. Vincent's has created a fund to try to help support the needs of patients who cannot afford prescriptions, there's not enough to go around, and so every day there is someone who my friend knows and you know will be back in the hospital because of their inability either to afford the care that is required after they leave, or because they try to cut the corners on it, with the net result that then you and I will pay more for that person who is back in the hospital than we would have if we had taken a sensible approach toward what the real costs in the medical system are. That is why we will try, for example, to include prescription drugs in the comprehensive benefit package for all Americans, including those over 65, through Medicare. (Applause.)

We believe that if we help control costs up front, we will save costs on the back end. That is a principle that runs through our proposal and which each of you knows from firsthand experience is more likely to be efficient in both human and financial terms. We will also preserve what is best in the American health care system today.

We have looked at every other system in the world. We have tried to talk to every expert whom we can find to describe how any other country tries to provide health care. And we have concluded that what is needed is an American solution for an American problem by creating an American health care system that works for America. (Applause.) And two of the principles that underlie that American solution are quality and choice. (Applause.)

We want to ensure and enhance quality. And in order to do that, we're going to have to make some changes, and you know that. We cannot, for example, promise to really achieve universal access if we do not expand our supply of primary care physicians, and we must do that. (Applause.) And you will have to help us determine the best way to go about achieving that goal.

I've spoken with representatives of our medical schools, and we have talked about how the funding of graduate medical education will have to be changed to provide incentives for the training of more primary care physicians. (Applause.) I have talked with representatives of many of the associations, such as this one, about how continuing educational opportunities could help even mid-career physicians, once we have a real supply of primary care physicians who are adequately reimbursed and adequately supported, how they might even go back into primary care. (Applause.)

We have also very much put choice in the center of our system so that we will have not just choice for patients as to which plan they choose to join, but choice for physicians as to which plan they choose to practice with, including the option of being part of more than one plan at the same time. (Applause.)

Now, as we work out all of the details in the many proposals and its parts that must come together, I am not suggesting that you will agree with every recommendation the President makes. I don't expect any group to do that. In fact, I suppose that if everybody's not a little put out that means we probably haven't done it right. But I do hope and expect that this group, as with other groups representing physicians and nurses and other health care professionals will find in this plan much to be applauded and supported. And I also believe that given the complexities of the problem we face, it would be difficult to arrive at a solution that was universally accepted.

But the reason I have confidence that this house, the AMA, and others will be supportive of the President's proposal is because we have benefited so much from what you have already done and from the involvement of many of you and others around the country.

Again, contrary to what you may have heard scores of practicing physicians served on the working groups that were studying health care reform. I am deeply grateful on a personal level that members of the AMA's leadership spent invaluable time coming to meeting after meeting, day after day sharing their ideas, reacting to ideas at the White House. And, of course, in the course of that we learned we had many common goals and objectives.

We will not only stand for universal coverage, but in addition the following: community rating so that we can assure all Americans they will be taken care of -- (applause); eliminating restrictions based on preexisting conditions so that every American will be eligible -- (applause); a nationally guaranteed comprehensive benefits package that will emphasize primary and preventive health care as well as hospitalization and other care -- (applause); the kind of choice and quality assurances that we will need to have to make sure this new system not only operates well during the transition but gets a firm footing as it moves into the future and we will therefore be emphasizing more on practice parameters and outcomes research so that you, too, can know better what works.

One of the great interesting experiences I have had during the past months is as I've traveled around from state to state is having doctors coming up to me and telling me that they need more information; that all too often the information they receive doesn't come to them in forms that they believe are practical in their particular context. And what we want to do is by working with organizations like yours is be sure that the quality outcomes and the kind of research that will done will be readily available to every practicing physician in the country.

We also believe that it will be essential to continue medical research and to use the breakthroughs in medical research, again, not just to alleviate human suffering but to save money, because you know better than I that often times a breakthrough in research, a new drug, a new procedure is the quickest way to take care of the most people in a cost-effective manner. So we will continue to support medical research. (Applause.)

All of these principles arise from the same common assumption -- that the status quo is unacceptable. And it is not really even any longer a status quo because we do not stand still, we drift backwards. Every month people lose their insurance; every month you have more micromanagement and regulation to put up with; every month our health care system becomes more expensive to fix.

I know that many of you feel that as doctors you are under siege in the current system. And I think there is cause for

you to believe that, because we are witnessing a disturbing assault on the doctor/patient relationship. More and more employers are buying into managed care plans that force employees to choose from a specific pool of doctors. And too often, even when a doctor is willing to join a new plan to maintain his relationship with patients, he, or she I should say, is frozen out.

What we want to see is a system in which the employer does not make the choice as to what plan is available for the employee, the employee makes that choice for him or herself. (Applause.) But if we do not change and if the present pattern continues, as it will if we do not act quickly, the art of practicing medicine will be forever transformed. Gone will be the patients treasured privilege to choose his or her doctor. Gone will be the close trusting bonds built up between physicians and patients over the years. Gone will be the security of knowing you can switch jobs and still visit your longtime internist or pediatrician or OB/GYN.

We cannot afford to let that happen. But the erosion of the doctor/patient relationship is only one piece of the problem. Another piece is the role that insurance companies have come to play and the role that the government has come to play along with them in second-guessing medical decisions.

I can understand how many of you must feel. When instead of being trusted for your expertise, you're expected to call an 800 number and get approval for even basic medical procedures from a total stranger. (Applause.)

Frankly, despite my best efforts of the last month to understand every aspect of the health care system, it is and remains a mystery to me how a person sitting at a computer in some air-conditioned office thousands of miles away can make a judgment about what should or shouldn't happen at a patient's bedside in Illinois or Georgia or California. The result of this excessive oversight, this peering over all of your shoulder's is a system of backward incentives. It rewards providers for over prescribing, overtesting, and generally overdoing. And worse, it punishes doctors who show proper restraint and exercise their professional judgment in ways that those sitting at the computers disagree with. (Applause.)

Dr. Bob Barrinson, one of the practicing physicians who spent hours and hours working with us while also maintaining his practice, told us recently of an experience that he had as one of many. He admitted an emergency room patient named Jeff. Jeff suffered from cirrhosis of the liver and --. Dr. Barrinson put him in the hospital and within 24 hours received a call from Jeff's insurance company. The insurance company wanted to know exactly how many days Jeff would be in the hospital and why. Dr. Barrinson

replied that he couldn't predict the precise length of stay. A few days later the insurance company called back and questioned whether Jeff would need surgery. Again, Dr. Barrinson said he wasn't yet sure.

And what was Dr. Barrinson's reward for his honesty and his professionalism? He was placed on the insurance company's "special exceptions" list. You know, that's a list of troublesome doctors who make the insurance company wait a few days or a few weeks to determine the bottom line on a particular patient.

From that point on, the insurance company called Dr. Barrinson six times in two weeks. Each time he had to be summoned away from the patient to take the call. Each time he spoke to a different insurance company representative. Each time he repeated the same story. Each time his role as the physician was subverted. And each time the treatment of the patient was impeded.

Dr. Barrinson and you know that medicine, the art of healing, doesn't work like that. There is no master checklist that can be administered by some faceless bureaucrat that can tell you what you need to do on an hourly basis to take care of your patients; and, frankly, I wouldn't want to be one of your patients if there were. (Applause.)

Now, adding to these difficulties doctors and hospitals and nurses, particularly, are being buried under an avalanche of paperwork. There are mountains of forms, mountains of rules, mountains of hours spent on administrative minutiae instead of caring for the sick. Where, you might ask yourself, did all this bureaucracy come from? And the short answer is, basically, everywhere.

There are forms to ensure appropriate care for the sick and the dying; forms to guard against unnecessary tests and procedures. And from each insurance company and government agency there are forms to record the decisions of doctors and nurses. I remember going to Boston and having a physician bring into a hearing I held there the stack of forms his office is required to fill out. And he held up a Medicare form and next to it he held up an insurance company form. And he said that they are the same forms that ask the same questions, but the insurance company form will not be accepted by the government, and the government form will not be accepted by the insurance company. And the insurance company basically took the government form, changed the title to call it by its own name and requires them to have it filled out. That was the tip of the iceberg.

One nurse told me that she entered the profession because she wanted to care for people. She said that if she had wanted to be an accountant, she would have gone to work for an accounting company instead. (Laughter.) But she, like many other nurses, and as you know so well, many of the people in your offices now, are required to be bookkeepers and accountants, not clinicians, not caregivers. (Applause.)

The latest statistic I have seen is that for every doctor a hospital hires, four new administrative staff are hired. (Applause.) And that in the average doctor's office 80 hours a month is now spent on administration. That is not time spent with a patient recovering from bypass surgery or with a child or teenager who needs a checkup and maybe a little extra TLC time of listening and counseling, and certainly not spent with a patient who has to run in quickly for some kind of an emergency.

Blanketing an entire profession with rules aimed at catching those who are not living up to their professional standards does not improve quality. What we need is a new bargain. We need to remove from the vast majority of physicians these unnecessary, repetitive, often uneven read forms and instead substitute for what they were attempting to do -- more discipline, more peer review, more careful scrutiny of your colleagues. You are the ones who can tell better than I or better than some bureaucrat whether the quality of medicine that is being practiced in your clinic, in your hospital, is what you would want for yourself and your family. (Applause.)

Let us remove the kind of micromanagement and regulation that has not improved quality and has wasted billions of dollars, but then you have to help us substitute for it, a system that the patients of this country, the public of this country, the decision-makers of this country can have confidence in. Now, I know there are legal obstacles for your being able to do that, and we are looking very closely at how we can remove those so that you can be part -- (applause) -- of creating a new solution in which everyone, including yourself, can believe in.

In every private conversation I've had with a physician, whether it's someone I knew from St. Vincent's or someone I had just met, I have asked: Tell me, have you ever practiced with or around someone you did not think was living up to your standards? And, invariably, the answer is, well, yes, I remember in my training; well, yes, I remember this emergency room work I used to do; yes, I remember in the hospital when so-and-so had that problem. And I've said, do you believe enough was done by the profession to deal with that problem and to eliminate it? And, invariably, no matter who the doctor is, I've been told, no, I don't.

We want you to have the chance so that in the future you can say, yes, I do believe we've been dealing with our problems. It is not something we should leave for the government, and, certainly, we cannot leave it to the patient. That is the new kind of relationship I think that we need to have.

Finally, if we do not, as I said earlier, provide universal coverage, we cannot do any of what I have just been speaking about because we cannot fulfill our basic commitment you as physicians, us as a society, that we will care for one another. It should no longer be left to the individual doctor to decide to probe his conscience before determining whether to treat a needy patient. I cannot tell you what it is like for me to travel around to hear stories from doctors and patients that are right on point.

But the most poignant that I tell because it struck me so personally was of the woman with no insurance; working for a company in New Orleans; had worked there for a number of years; tried to take good care of herself; went for the annual physical every year; and I sat with her on a folding chair in the loading dock of her company along with others -- all of whom were uninsured; all of whom had worked numbers of years -- while she told me at her last physical her doctor had found a lump in her breast and referred her to a surgeon. And the surgeon told her that if she had insurance, he would have biopsied it but because she did not he would watch it.

I don't think you have to be a woman to feel what I felt when that woman told me that story. And I don't think you have to be a physician to feel what you felt when you heard that story. We need to create a system in which no one ever has to say that for good cause or bad, and no one has to hear it ever again. (Applause.)

If we move toward universal coverage, so therefore everyone has a payment stream behind them to be able to come into your office, to be able to come into the hospital, you will again be able to make decisions that should be made with clinical autonomy, with professional judgment. And we intend to try to give you the time and free you up from other conditions to be able to do that.

One specific issue I want to mention, because I feel strongly about it -- if my husband had not asked me to do this, I would have felt strongly about it because of the impact in my state of Arkansas -- we have to simplify and eliminate the burdensome regulations created under *CLEA -- (applause) -- a well-intentioned law with many unintended consequences that have affected not only those of you in private practice but public health departments like ours in Arkansas around the country.

But again we need that new bargain. You have to help us know what should be eliminated so that we then can just focus in on a very small part of this whole situation and eliminate the rest of the regulations that were thrown on top.

So those are the kinds of issues in which we think we can make it more possible for you to practice in a more efficient, humane, better manner. We also believe strongly that we have to emphasize preventive care. And we have to provide a basic policy of preventive care. And we have to be sure that all of you and those who come after you into medicine are trained well in medical school to appreciate the importance of preventive care. (Applause.)

Much of what is now considered outside the scope of mainstream medicine is crowding in. Many of us in this room I know exercise, try to watch our diets, do things to try to remain healthier. And yet often medical education and medicine as it's practiced does not include those new kind of common-sense approaches to health. We need to be a system that does not take care of the sick but instead promotes health wherever we can in whatever way we possibly can do it. (Applause.)

And finally, let me say that we will offer a serious proposal to curb malpractice problems for all of you. (Applause.) But let me add that it, too, must be part of this new contract. In order to do that and to do it in a way that engenders the confidence of the average American, we must have organized medicine standing ready to say we will do a better job of taking care of the problems within us. (Applause.)

I have read or tried to read everything I can find about all of this. And you know as well as I do there are studies all over the field. It depends upon who writes it and who it's written for and the like. But we know there's a problem. We know we're going to deal with it. But one of the stark statistics from these studies is that all too often the largest number of malpractice suits is brought against the same physicians on a repetitive basis.

Now, it may be that for some that is an unfair accusation, and we need to deal with that through reform. But for others, you need to weed them out of your profession if they cannot practice to the quality that you expect your fellow colleagues to practice to. So we will propose serious malpractice reform, and we will have to look to you to help us make sure that the problems that will still flow from people who should not be making decisions will be eliminated. That way we can give confidence back to you as a profession, that you will not be second-guessed or unfairly called into court. And we will give confidence to the public that they will

be protected insofar as humanly possible. So that is what we will have to look for when we come forward with that. (Applause.)

Now, reaching consensus on all that should be done and putting it into a piece of legislation and moving it through the Congress is not going to be easy. There will be many groups that will nibble at the edges of it, not like the whole idea of it, want to continue to the status quo. But if we do not have the courage to change now, if we do not move toward a system that once again gives you back your professionalism to practice prudent, practical, intelligent medicine again; if we do not move toward restoring the dignity again to the doctor-patient relationship, and that encourages young people to become physicians because they want to participate in that wonderful process of healing and caring, then the entire society, but most particularly medicine, will suffer.

The reason we are doing any of this is because of children like those who are here from Nathan Davis. Most of us in this room are at least halfway through. (Laughter.) And most of us in this room have sat in dozens and dozens of meetings just like this. We've sat and listened to people tell us what was wrong with health care or what medicine or with whatever, and we've talked about the problems at least seriously since the 1970s. And we've produced proposals like yours for Health Access America.

But while we have talked, our problems have gotten worse, and the frustration on the part of all of you and others has increased. Time and again, groups, individuals, and particularly the government, has walked up to trying to reform health care and then walked away.

There's enough blame to go around, every kind of political stripes can be included, but the point now is that we could have done something about health care reform 20 years ago and solved our problems for millions of dollars, and we walked away. Later we could have done something and solved our problems for hundreds of millions, and we walked away.

After 20 years with rate of medical inflation going up and with all of the problems you know so well, it is a harder and more difficult solution that confronts us. But I believe that if one looks at what is at stake, we are not talking just about reforming the way we finance health care, we are not talking just about the particulars of how we deliver health care, we are talking about creating a new sense of community and caring in this country in which we once again value your contribution, value the dignity of all people.

How many more meetings do we need? How many alerts? How many more plans? How many more brochures? The time has come for all of us, not just with respect to health care, but with respect to all of the difficulties our country faces to stop walking away and to start stepping up and taking responsibility. We are supposed to be the ones to lead for our children and our grandchildren. And the way we have behaved in the last years, we have run away and abdicated that responsibility. And at the core of the human experience is responsibility for children to leave them a better world than the one we found.

We can do that with health care. We can make a difference now that will be a legacy for all of you. We can once again give you the confidence to say to your grandsons and granddaughters, yes, do go into medicine; yes, it is the most rewarding profession there is.

So let's celebrate your profession by improving health care. Let's celebrate our children by reforming this system. Let's come together not as liberals or conservatives or Republicans or Democrats, but as Americans who want the best for their country and know we can no longer wait to get about the business of providing it.

Thank you all very much. (Applause.)

END

Melanne

THE WHITE HOUSE

Office of the Press Secretary

For Internal Use June 23, 1993

REMARKS BY THE FIRST LADY
IN SPEECH TO CSIS CONFERENCE

Capitol Hill

MRS. CLINTON: Senator Nunn and Senator Domenici and ladies and gentlemen, thank you for this opportunity. And, Senator, because I know you're committed to responsible deficit reduction -- you just go right back to that -- (laughter) -- you're going to try to move this agenda forward so that we can continue to get the country back on the right track that will lead to the strengthening of America, which is a commitment that all of us share and which Senator Nunn and all of you have been leading spokespeople for and for which I am very grateful.

I welcome this opportunity to visit with you about health care. And what I would like to do is to speak for a few minutes, but mostly to have time to answer any of your questions or, as Senator Domenici suggested, to take advantage of your suggestions about how we proceed with this extraordinarily important and very complex matter.

I don't think that I need to remind this group what is at stake in health care reform, because you have been looking at what needs to be done to reverse the kind of economic stagnation and undermining of our future that has gone on because of decisions that we have failed to make over the last several decades. But it is clear that, in the absence of serious health care reform that controls costs and puts, finally, some discipline into the health care market, we are unlikely to be able to deal with the federal budget, the deficit, the debt, and we are going to continue to be undermined in the private sector with respect to our competitiveness. So there could not be a more timely issue for this group to address.

There are a number of competing proposals that have been analyzed and worked on for several years as to how we best go about reforming our health care system to assure security to every American so that we reach universal coverage that will enable us to provide a comprehensive benefits package at affordable cost, and will control costs, therefore, within both the public and the private sectors.

MORE

There has been an enormous amount of good and thoughtful work that has gone on. And I was pleased to receive a draft copy of the "Vision and Principles" paper that CSIS is working on, and add that to the list of organizations that are taking a responsible approach to this complex issue.

In the work that we have been doing in conjunction with many groups in both the public and the private and the nonprofit arenas, we have attempted to analyze every single proposal from a variety of perspectives, and to how well it reaches the principles that we think are essential -- principles that you, too, have adopted in your approach in this draft paper.

It became quickly apparent that there were strengths and weaknesses to every one of these independent approaches that had to be taken into account, and that what we would have to do to come up with a system that we thought met the underlying principles in a timely and affordable manner, was to create an American solution to this American problem. There was no model anywhere that could be adopted wholesale. And that we needed to build on the strengths of our health care system while we tended to shoring up and eliminating where possible its weaknesses.

And what I would like quickly to do is to run through your "Visions" paper so that we can put the discussion into the terms that you have already been working on and point out the similarities and the approach we're taking and discuss areas where we need, perhaps, to continue consultations.

We believe, along with you, that we need a market-based approach to the financing and delivery of health care that will create sound and effective consumer decision-making. This is an area that individuals like in which information that is readily usable is rare. I wouldn't embarrass anyone, including myself -- if I wanted to, I could, though -- by asking each of you to tell me exactly what your insurance coverage is and all of the rest that goes into it, and how you shop to make your choices, and if you didn't, who made the choices for you and on what basis they did.

It would be a relatively short conversation, because I've done this in many groups with many well-educated people, and there's been embarrassed silence and then a scrambling to say something. If I'm contract, I would ask you why did you buy the car you most recently bought, we could have a very well informed conversation and a good debate back and forth, as Sam Nunn argued with Jim Cooper, who argued with somebody else about why they chose whatever car they bought and what kind of deal they got for it and how they negotiated the best price.

There is nothing like that in our current system. The kind of system we envision relies fundamentally on empowering and informing consumers to make those kinds of decisions. In order to do that, we need to create options among the choices that are available to consumers, and we agreed with your approach of providing what we call "accountable health plans," and you do as well, that will provide a basic benefit package that will be required by the federal government and the basic option available to every consumer.

Now, accountable health plans can deliver those benefits in a variety of ways -- through an HMO, a PPO, a fee-for-service network, some as yet undiscovered ways of delivering services the market will help to generate. And we will encourage that kind of competition and choice because we think there should be that availability of options within the delivery of health care.

In order for that system to work effectively, we will have to have adequate information, the use of report cards -- a term that you use in your draft is one that we have also used. We will go, in addition to reporting what is currently available in the market, we will have to create new sources of information better than what we have currently been able to produce. And we will have to start comparing apples to apples instead of apples to oranges. Because, as has been pointed out in many of the discussions I've had, the primitive use of information can be contrary to the outcome's quality measurements that we are looking for. So there will have to be some real thought given to creating an effectively functioning data collection system that can be easily accessed and reported to consumers and providers.

We certainly believe that there has to be the integration of providers in the delivery of services. It has been very interesting and encouraging to me to watch other organizations reach the same conclusions. Catholic Health Association, for example, studying health care reform for two years, issued its report before the President was inaugurated. It is very much along the same lines as what we are proposing, what is in the CSIS draft paper. Because if you look at our system, one of the clearest needs is for increased coordination and better integrated delivery systems, which we believe will be created by the kind of emphasis on incentive for cooperation through the creation of these accountable health plans.

Preventive health care will be a major part of the benefits package. This is a change in direction from where we have come from. And if one goes back and looks at the history of how we got into the rather anomalous situation of insuring against the disease or the chronic condition and not insuring against the preventive measure, the well child care, the other kind of diagnostic tests that lead to discovery of illness, it is a national outgrowth

of the early decisions to insure against catastrophic instances which, of course, all of us would agree with.

But the result of that, going back to the 1930s with the very first private health insurance plan is that we worked our way out of a market for primary preventive health care. We have to create that market, we have to mandate it as part of the benefits package. We strongly agree with you that we must look at ways of providing organized, coordinated care within a budget.

There are a number of laws at both the state and federal level that interfere with competition. But, more importantly, interfere with coordination. We have to think about the kind of arrangement of care we need and the best and highest use of providers within those arrangements. And so, looking at changing anticompetitive practices or laws is very important. Looking at the federal antitrust laws so that collaboration will be permitted instead of prohibited is key.

We also think, along with you, that once we establish a comprehensive benefits package -- and we are looking at a package that is approximately what one would expect from the good federally qualified HMO, the Blue Cross-Blue Shield package with the primary and preventive care in it -- then we have to be willing to remove tax deductibility for benefits above that level. So that we will continue tax deduction treatment for what is in the comprehensive benefits package. But after-tax dollars will then be used for any benefits or ancillary services beyond that package.

This is a key part of making it possible to extend such a benefits package to the underinsured and the uninsured and give those who are currently insured the security that even though they are currently insured, none of us can predict whether they will even be employed next year, let alone what their benefits level will be, and that they will always have the security that this level of benefits will be available to them. And that it will be affordable, it will remain with them whether they are employed or unemployed, because we think what we need to do is to enhance the existing employer-employee system by bringing Medicaid recipients into the same purchasing pools so that there will be both federal and private money, as well as whatever state contributions are required to cover the entire population.

We, too, agree that there need to be purchasing arrangements created to empower the consumer and to negotiate with the accountable health plan. We are referring to the entity that's health alliances, because they bring together in one entity consumers and providers, businesses, labor -- all will be available through

that alliance to negotiate for the best possible health plans which will then be open for enrollment by any citizen.

Even if one continues to finance health care through an employer-based system, consumers will be free to enroll in any accountable health plan -- not the only one that is selected by the employer.

Clearly, one of the hopes behind our reform is to reduce the costs and redundancy of health care administration, and there are a number of reforms that we believe will bring that about. Community rating is a key which will eliminate the expensive underwriting and experience rating procedures currently driving much of the costs.

If we are able to bring about these health care reforms in the administrative areas we will be able to stabilize the costs. -- it's a chicken and egg issue, how do we get to universal coverage with affordable benefits package while sweeping out the administrative costs so that those costs can be recycled through the economy and even through the health care system. We have to proceed, in our view, on both fronts at once.

We also believe we have to create a framework, as you have suggested, to eliminate excessive expenses associated with malpractice litigation and with defensive medicine that is driven by fears of such litigation. We are also concerned, as you are, about creating some kind of consensus about the appropriate treatment that is available in the last months and days of life. And Senator Domenici has already left, but he took a step toward this with the Patient Self-Determination Act, in the last Congress I believe, and we think it is appropriate to move as you do on encouraging consumers when they sign up for health plans to complete a living will, or at the very least, to have the kinds of issues that they may face in an emergency situation explained to them so we have better informed decisions being made.

An absolute red-line, bottom-line principle for us is that all Americans have to be secure. There should be no prohibition of health insurance or access to health care to anyone. And the kind of benefits package and the delivery of it will be key to that.

I could not say better than what is said in your paper that the perfect is the enemy of the good. There is no way we will create a system either that is perfect or that will satisfy everybody. I have thought for quite some time now, perhaps necessity being the mother of invention, that if everybody is a little bit put out we're probably doing the right thing. But we have to look for the best possible system in order to deliver that security which is the key to whether or not we will have a successful reform.

We agree that biomedical innovation and the appropriate use of technology and the continued role of medical research is essential, because, we think, it is one of the few ways open to us to actually improve productivity in the delivery of health care. And so the suggestions that you include in your paper about innovation and research are ones that we take very seriously and have had a number of conversations with medical research groups, academic medical centers and others who are at the forefront of assuring that the American health care system stays on the cutting edge of the development of treatments that will enable us to deliver care more efficiently.

It is also absolutely essential that we control the growth of federal spending for health care. But it is also essential that we control the growth of private spending for health care because one of the net effects of reducing federal spending, as many of you who are providers around this table know, is that it knows up in the bills that you and I pay because we carry insurance. And it particularly becomes an additional burden on the large employers, those who are providing the bulk of the private money that is funding our health insurance system. So, yes, we need to weigh in and budget the federal contribution, but we also need to be sure we have some discipline that is imposed through the market on the private sector.

And let me say a word about this because there has been a great deal of conversation about budget in this situation and how budgets do or do not correspond with competition. It is our view that we need to start with the idea of a budgeted system that is based on the average weighted premium cost that will be paid through comprehensive benefits package. That budget, we believe, should become redundant. It is a backstop, if the market works as we expect it to work. But in the absence of budget targets, of some kind of discipline as states and accountable health plans and providers adapt to this new system, we are afraid that the controlling of the costs in the federal system without some kind of discipline in the private system will further discourage the kind of steps toward more efficient delivery than we have seen in the last years and put more pressure in turn on the federal system.

Every time you cap a federal entitlement program in health care, in the absence of reforming the market in the private sector, you shift cost to the private sector, which has a result of eliminating people from coverage either because their employers no longer can provide it, or the co-pay and deductible become so high they no longer participate in it, or they get laid off, or something else happens to them. They then join the 100,000 people a month who lose their insurance. They then find their way on the public rolls

for some period of time, which then busts the cap on the public system.

This is a total system that feeds on each part of it. So from our perspective we have to define the costs within the federal system according to a formula that is paid to what we believe should be the budget for the entire system, and that we then have to do everything we can, as I said before, to make that budget with respect to the private sector largely redundant. It would only apply to the comprehensive benefits package premium costs. Anything that is bought with after tax dollars would obviously be available for any of us to do whatever we chose to do with. But with respect to how we try to get the whole system operating under some kind of discipline until we think these reforms can kick in this one of those areas that we have thought about very hard.

And one of the people working with us said, you know, the traditional way of trying to restrain health care costs has been to put a leash around every cow and try to keep it in one spot and not let them move. What we're trying to do is just put a fence around the whole system and let people decide within it how they can allocate the federally mandated part of the expenditures and the accountable health plans marketing of and delivering of the comprehensive benefits package.

Now, finally, I think it is absolutely essential that we do everything we can to come up with a system that is understandable and workable and in the eyes of the vast majority of Americans, a positive change from what they have now.

And what we hope to be able to do is to come up with such a plan that will be as inexpensive as our entire economy can manage to make it in terms of both new private sector contributions and any new revenue. We believe that an employer-based system, which is what we have now, that has a very wide range of contributions within it from zero, as you all know, to a high -- employer high of 25 percent of payroll for health benefits, but most start at the eight to 15 range with the costs going up at 10 or 11 percent a year and they're trying to keep cost increases down to eight percent.

Most of us are working off the premise that we are not going to replace our existing system, we are not going to look for public past monies to replace the existing kind of contribution to the health care system. So therefore, how do we create a system with the least amount of disruption and the least amount of new revenues required. And what we are attempting to do is to create a premium that is paid to this benefits package that will enable most employers who currently provide the comparable benefits to realize considerable savings over the next years and those employers who do not make any

contribution now or whose contribution is inadequate to fund that comprehensive benefits package --

(End Side 1)

(Begin Side 2, in progress)

-- in any way pay their fair share now, but who in many ways burden the system that the rest of us pay for.

So, finally, this system is not going to be changed by any wave of a magic wand or any silver bullet. It is, however, a system that we're convinced we need to take a comprehensive approach to initially even if we choose to phase in that approach; rather than taking an incremental step now and then hoping for an incremental step later. Because there are too many interactions among the systems not to try to lay out an approach that will affect the very pieces of it so that we can watch it being phased in, largely by the states, through a market-driven approach.

Q Let's open the floor to questions, so why don't we start around and whoever has a question --

Q Thank you so very much for being here today. The statement that we should not put anymore into the system than we absolutely have to that is already there, I think is what we really need to do. So how, when we consider the fact that 14 percent of our gross domestic product now goes to health care, more than any other industrialized nation, something that we -- (inaudible) -- how can we justify putting additional money in, which will make that percentage even greater?

MRS. CLINTON: Well, Congressman, this is one of those dilemmas that we are stuck with because of our current system. In order to control costs, you have to have everybody in the system. In order to get everybody in the system, everybody has to bear their fair share of the responsibility. At this moment in time, you have 40 million Americans who do get health care -- they show up at our emergency rooms, as you well know. They get taken care of, usually at the highest cost at the last possible moment.

We are unable, therefore, to control their access and usage of that system. In addition, we have a public system that goes up and down based on political decisions as opposed to being incorporated within the broader market system. And we see it going up and down depending upon decisions that are made that often impact adversely on the costs then in the private system. So we think it's a chicken-and-egg kind of a problem.

If we can get everybody into the system with a rather limited new amount of money that comes primarily from the private sector, which is the primary funder now, but which for the first time expects everyone to participate, then we will actually begin to see the kinds of costs savings that can come from administrative savings and from better utilization of the existing system.

It will be a great accomplishment for our economy if we in the first years freeze our GDP percentage at its current rate, because right now we are looking at moving to 19 percent by the end of this decade. So if we can freeze and then move down, that would be the most likely and least disruptive way of getting this situation under control.

Q I'm with an organization called Georgia Health -- (inaudible) -- in a community-based effort in understanding some of the problems in our state. One of my fears and one that we hear over and over again is the lack of infrastructure in much of the rural areas of our country. It's true in Georgia, and it's true across the nation. There's also a major infrastructure problem in some of our inner urban areas also. It would seem that even though I certainly understand that we all do the deed for fiscal restraint, there's going to need to be some infusion of capital from somewhere to provide the bricks, the mortar, the buildings to people to go out and deliver the care where it just simply isn't right now. I wonder if you have any comment on that.

MRS. CLINTON: Yes, sir. We absolutely agree with that -- that the underserved urban and rural areas have got to be given a health care infrastructure and personnel in order for universal coverage and cost containment to work. And we have several approaches to that. We do think that the federal government will have to raise some funds in order to beef up the public health infrastructure.

We also believe that the accountable health plans will have to utilize those existing structures in order to serve the population that they're going to be bidding on to serve. And they will an incentive to do that, which they don't currently have, which is a reimbursement stream, so that the level of uncompensated care that often burdens inner city and rural providers, will be dramatically lifted. I'm not going to say it will be eliminated, because we won't know how this all works until we get into it. But I do know it will be dramatically reduced; so that there will be for the first time in many years a much fairer return for those people who are actually willing to deliver the care in those underserved areas.

Additionally, we have to look for ways to make it attractive for physicians, nurses and other medical personnel to provide care in those areas. And our plans there range from everything from providing a much broader loan forgiveness and loan program for people who are willing to serve in those areas, to a higher reimbursement rate by encouraging plans to be able to provide services in those areas and looking at some of the models that have worked, to better use of technology, because it's not just a question of pay, it's also a question of professional isolation and the like.

And we are very encouraged by how these kinds of networks of cooperation in which rural and inner city practitioners would become a part would help to create a climate in which they were much better supported, could provide better care, in which reimbursements would flow to them. So we've thought very carefully about that and think we've got to wade through the system to fund it and to continue to provide it.

Q I appreciate very much the logic and care which you've laid out the problem and principles. I'd like to ask a question about process. And that is, by what process do you anticipating in determining the coverage contained in the comprehensive package, including deductibles, copayments and so forth, since I would assume and I believe that that will strongly influence the cost, even I hope the calculated budget premiums and so forth in such matters as deductibles, copayments, even if the federal government takes care of them or reduces them for poor people -- actually have been shown I think by tests to have a substantial effect on the cost of the program.

MRS. CLINTON: You're absolutely right about the benefits package and its cost being the key to all of this. And it has been probably the most complicated task we have faced among many. Just as an aside, which I told several of the senators -- Senator Lieberman and others here probably heard me say this before -- but one of the first tasks that we did was to get into one room all the federal government actuaries who dealt with the cost projected on health care programs that were run by or funded by the federal government. They had never been at a meeting before ever.

And if you wonder why we have problems in America and in our government, just think about how driving a factor health care costs have been in the last 10 years in every budget that has ever been put together; and the actuaries have never met before I got together in a room. And they've been meeting continually since then.

And they, along with an outside panel of actuaries whom we've convened, have worked very hard to cost out the benefits package. It will include copays, and it will include deductibles,

because most of the actuarial matters and as a matter of personal responsibilities, we think that the important part of the whole approach to reforming health care. We are trying to keep the costs as low as possible. So we are looking very hard at the benefits and in the costs of them.

But we have a problem, which I never knew was a problem until I came to Washington, and that's called something called scorability. And when one presents a budget to the federal government, we end up with these kinds of arcane or -- maybe they're not arcane, they're just rules of budgeting I've never encountered in my prior life before -- in which issues like competition and the savings from competition are not giving any weight whatsoever.

And so we have tried very hard to come up with a benefits package that is a reasonable package that most Americans who are insured will feel good about, and which is affordable on actuarial tables and which in a market-driven system will generate savings that are real that can be filed back, to go back to Dr. Roland's point, even if they can't be scored in the federal budget.

So that's the key to trying to keep -- this is the centerpiece of making all this happen, as Dr. Brown clearly put his finger on. And we think we're going to come up with a benefits package that is comparable to what a federally qualified HMO would offer, an average Blue Cross-Blue Shield policy, which we think is pretty good to be available to the entire country. It won't make everybody happy, because some people, as you know, have first dollar coverage and a lot more benefits. But we think as a national guarantee package is certainly one that should be supported.

Q You mentioned personal responsibility, and a lot of the health problems and a lot of -- (inaudible) -- responsibility. Is there some way of incorporating in this formulation a disincentive for -- (inaudible) -- or an incentive for living -- (inaudible.)

MRS. CLINTON: I joked the other day that if there were a way to do that, it would probably be a disadvantage, because the actuaries would then claim people would live longer and it would cost more. So, I mean, it's like -- this is like a never-ending set of issues. But we do want to discourage unhealthy behavior. And one of the reasons we are looking at funding the public health infrastructure through some of the research improvements that we're thinking of, through a combination of tobacco and liquor is because we do think that's sends a disincentive.

Now, I'm also hopeful that once we get this system up and running, we will begin to look at some of the other ways we could provide incentives for healthy kinds of behavior. It is not easy to

build those into the benefits package or to really monitor them carefully. But I'm hopeful that once we are running, the accountable health plan, we'll be able better to compete on the basis of what kinds of additional services they're able to afford because they get the costs of the benefits package down, which will keep those people who enroll in them cheaper, which will have the benefit that you're talking about. But we do think that cigarettes and alcohol are key to preventable health care, and that we need to take a look at those for sources of funds.

Q Just following up a question, I wonder if I could suggest -- (inaudible) --

MRS. CLINTON: What you ask -- and I had a meeting yesterday with 25 physicians and other health care providers from Houston with Congressman Andrews. And Red Duke, the TV doctor, was there, and he said that he believes that we could have a massive public education campaign on accident prevention and other community public health problems, it would be one of the quickest ways to cut our costs. And he has some proposal that we're going to try to implement through this kind of process of creating models and then distributing them to states through their alliances and their health plans so that we can actually do exactly what you're saying, because that is where there are huge savings available if we can change community activities as well as individual behavior.

Q Hillary, you haven't said anything about the drug industry yet. Do you envisage it being part of the basic package? And secondly, do you envisage interim price controls for that industry?

MRS. CLINTON: Well, we do envisage their being a prescription drug benefit that would be part of the basic package as well as part of Medicare. Again, it would have a cost attached to it, but we think a reasonable cost. That would provide a significant increase in the funding available for prescription drugs, if we're able to get this actuarially squared with what we think our affordable costs are.

On the issue of price controls, this is one of the more emotional and thorny issues that confront us, because there are many who, frankly, believe that in the absence of some kind of price restraint -- whether it be freezes, controls, rate settings -- that the competitive system alone is inadequate, at least in the short run, to deal with the kinds of costs that are built into the system.

And there others -- and you know the arguments very well -- that it distorts the market, it leaks, it doesn't work -- I mean,

there are arguments on both sides and I don't think it will ever be fully resolved to anybody's total satisfaction.

But I do think that it would be very helpful for us to try to create an environment in which voluntary action on the part of providers was part of our initial presentation of this package. That would include the drug manufacturers and everyone else. I've had conversations with some of the manufacturers, I've had conversations with other entities who represent major parts of the health care system who seem to be moving towards a willingness to talk about voluntary restraint, some kind of freeze, however it could be structured.

There might also, though, need to be in the legislation some kind of trigger for this transition period that would help enforce that in the event that we were unable to achieve the kinds of initial savings that we think will help fund the whole system. There's been no final decision on that. This is something we welcome everybody to weigh in on. It is highly emotional. It's hard to kind of cut through the emotion to get to what actually would or would not work. But in any event, we would only be looking at either a voluntary system or a system with a trigger for a very short transition period. We want to stabilize the system.

And one of the big problems we've got is the huge differential in practice patterns and costs around the country. I mean, if you can pick an average and try to say this is the average hospital cost, the is the average physician cost for this kind of procedure, you literally have a 100 percent variation on both sides of that average at work right now. And it is something that you cannot overnight change those practice patterns and eliminate the excess costs in those systems in many parts of this country. But without some discipline, it will take longer than we might have in order to get ahead of the curve. So those are the kinds of issues we're struggling with.

Q The question I have is to administrative costs. Currently, in some states, my hospitals will in a year undergo a Medicare inspection, joint -- (inaudible) -- inspection a Department of Health inspection, a Department of Mental Health inspection and a CHAMPUS inspection. And a lot of times, being inspected, we'll spend hundreds of thousands of dollars and hours dealing with those and when we should be delivering care. My question to you is what are the certification for provider empowerments you envision from the alliances and the health plans, or is this going to be another layer of life insurance certification that providers have to deal with and adds administration costs?

MRS. CLINTON: Well, the answer better be no. Otherwise, we won't have done our job. What we think is that much of what you now are subjected to in terms of monitoring and checkers checking checkers and utilization review and the like, derives from a regulatory model that attempted to micromanage the delivery of health care. With a capitated model -- with some kind of budget backup, so that people know when they're running up against the limits of what we as a country or Georgia as a state is willing to pay for health care, we think better decisions will be made and we also believe, frankly, quality will be enhanced. Because for every doctor that a hospital has been able to hire in the last two years, they've had to hire four administrators in order to do exactly what you just described. So cut the difference -- give us two doctors and another trained nurse and you'll get better care at less cost and less hassle probably.

So, yes, we think that this capitated, market approach will eliminate much of what you are now putting up with. You will still have to report -- (inaudible) -- compile the kind of report card mechanism that will enable the health plan and then the consumer to make good decisions. But that we think is a minor burden that will be much more easily borne compared to what you're having to do now.

Q I'm very intrigued with the proposals that are being made because tough competition reduces costs. And I also understand the necessity to allow the states to make individual decisions about their own health care programs. Having spent quite a bit of time in Canada, I'm very familiar with the single payor system. And I wonder about the compatibility of single payor system with the notion of competition amongst the kind of health plans. And I was just wondering if there's any way -- or if you've thought about that problem and what your views on it are.

MRS. CLINTON: I think that the single payor system can be viewed as either a single payor financing system or a single payor government-driven delivery system. And what a number of governors have said to us, particularly of smaller states with very rural populations, is they don't have any idea how they can generate the kind of competition among accountable health plans that I presume will be available in Atlanta or Chicago or most of the larger areas.

So they are asking for the option of being able to provide a system within this plan that is close to a delivery system that integrates all of their existing providers. So that, for example, Montana, with a Republican governor, has just passed a piece of legislation setting up a commission to determine whether my payor should be a multi-payor or a single payor system. They have 800,000 people in that huge land mass. Their primary medical center is

Billings. They believe that they create a system that creates collaboration in Billings among their tertiary and secondary care facilities, they will then be able to contract out, those facilities will, out into the areas that are very rural with lots of need.

I don't know that they would consider that a single payor system under the Canadian model, but I think they would consider it, given their circumstances, the best they could probably put together in one, maybe two, accountable health plans. But that's something we want to let them have a choice in making. It will not change the amount of money that goes into the system. They will still have to provide the same benefits package and consumers will still have some choice in determining what the outcome is. But we don't believe from the federal government we're in a position to say to Montana, you've got to do exactly what Chicago does, and if you don't have competition, get out there and create it somehow. We just don't think that will work.

So we're going to try to provide enough flexibility so that states can make some of those decisions on their own.

Q We promised to get Mrs. Clinton out at 3:00 p.m., and she's been very gracious with her time. Let me get two more questions. And then I think if you have more time, we will respect your schedule, and let that be the end of the questions.

Q The question I'd like to ask gets back to your speech before Johns Hopkins about a week or so -- two weeks ago, and after that -- (inaudible) -- also a major source of progress and -- (inaudible) -- In a world that is largely composed of accountable health plans with this competition, there's some question as to whether or not academic health centers can survive. As we now note, there's also some question as to whether they should survive -- (inaudible).

Are you contemplating -- is the task force contemplating a separate mechanism for financing academic health centers to some sort of a pooled fund or will they be subject to the prices as computed -- (inaudible.)

MRS. CLINTON: No. We believe that academic health centers and the comprehensive cancer centers and some of the other freestanding tertiary care facilities that are at the high end of the system should be supported by the entire population so that there will be a pooling of funds to be able to support those. Now, as you well know, academic health centers have a variety of missions. They have a research -- important research mission which will have to have continued help from the federal government, and I would argue, increasing our research capacity and commitment will be a very good

investment that will save us money in the long run if we're able to do that. So we want to have a funding strain that supports that.

Secondly, they have an obligation to train medical students, and we do have to make some changes there. The current imbalance between specialists and generalists cannot continue if we expect to have a health care system that puts an emphasis on primary and preventive health care. So we have to change some of the incentives that go into medical education.

And then, thirdly, most academic health centers take care of patients. They run emergency rooms often and they certainly take care of physician-referred patients as well as, in Johns Hopkins case, serving as the primary care giver for low income areas.

So in our conversations with them, they have taken their respective mission and looked at them as independents to some extent because it very well could be that you might have a Johns Hopkins accountable health plan, just as Mayo's is now doing in Minnesota. So that Johns Hopkins would be the tertiary care center and might even, through medical students and others, help to staff clinics, but also might contract with local physicians and even contract with some independent hospitals. I mean, that is an option that many other medical centers are looking at.

Or they might be part of an integrated network that somebody else runs, but they would be the referral place. So there are a number of available ways for the independent functions of the academic health centers to be funded and to be delivered. And I'm delighted at the result of the conversations we've been having with them because I think they're beginning to understand their opportunities and not just the changes that they're facing.

Q You mentioned the term -- (inaudible) -- and market-oriented health care on a number of occasions. Have you thought about what would happen -- (inaudible) -- but have Medicare, which is clearly not either capitated or market-oriented, going on for the over 65? I don't know whether you or members of the task force have given thought about what if anything to do with Medicare, how soon it would even need to be done, and finally, whether the types of changes you envision in the under 65 population would occur -- (inaudible) --

MRS. CLINTON: We've given lots of thought to that because it's one of the key phase-in issues. I personally favor the eventual phase-in of Medicare into the entire system. And I think that that will happen. But in the short-run, while we're trying to get the alliance -- (inaudible) -- running, while we're trying to deal with the problems of the insured and the uninsured, our

perspective has been we need to get this system running. Because as much as people complain about the Medicare system -- and I always get two reactions when I speak to groups of senior citizens. I ask if they think it could be done better, and of course, they all yell and clap and say it can. And then I ask if they want to give it up immediately and try something different, there's a reluctance there. Because they've got it and the rest of us don't, as we all know.

But I think that in the transition to an alliance-based system that delivers care to the under 65 -- and one thing we're considering is making the alliances available to Medicare recipients who could choose to go in and purchase an accountable health plan with some transfer of funds from Medicare into the alliance; and depending upon where the benefits package ends up, with perhaps a supplemental, it would go into the alliance in order to pay for any additional benefits that would be otherwise unavailable in Medicare -- we think we can prove over the course of several years that this system will work. And we strongly believe that Medicare ought to be a part of it.

We don't think we can bite that all off at once, which is why it's very important to continue to do all we can to control expenditures within the Medicare system and stop the cost shifting so that we can get to a phasing-in of Medicare eventually as well.

(Lunch break. End of tape.)

Pres. NFIB

economy in the last five months. That compares with only a net gain of a million over the previous four years -- all tied to bringing down the long-term interest rates.

There are people in this room today who are responsible for that, directly or indirectly -- people who have refinanced their home loans. Most of the real financial gains have come from people who have refinanced their home loans and then turned around and done something else with the money, and that's bumped the economy. But business loans are lower -- consumer loans, car loans, college loans, the whole nine yards. That is the strategy.

It is estimated that if we can pass this deficit reduction plan and keep the interest rates down for a year, that'll put another $110 billion back into this economy. And by the end of the year or next year, that will really begin to produce some job growth, and we'll also begin to produce some real earnings potential.

So that is why we have done what we have done. And I'll say again, as somebody who was a governor in a state with a very tough budgeting system, it was very painful for me to ask anybody to pay any money just to pay down the deficit. But unless we do something about this, we will never -- it's like a bone in our throat as a nation -- unless we deal with this, we can't get on to dealing with our other problems. We'll spend all our time in Washington working around the edges of these other problems because we have not faced the problem of the deficit.

Now, let me just make one or two other comments about that. No matter what plan you might embrace to reduce the deficit, and no matter what plan you've read or heard about, every one of them can have our annual deficit go down for five years, and then it starts to go up again. Why? Health care costs.

We cut $50 billion in the House version, $60 billion in the Senate version off of projected Medicare expenses from the previous year's budget. And it is still estimated that over five years, the Medicare budget alone will go up 45 percent. Now, that's better than most of you are doing, right? Most of you are paying more than 9 percent a year in increased premiums. Most of you are paying almost twice that.

But I say that to try to illustrate the next point. There's been a lot of controversy about the willingness of this administration to try to take on this health issue, and whether we're being too comprehensive and what we're going to do and all that. The point I want to make is this: We've got to do something to bring costs within inflation or it's going to break the country. (Applause.) That's the first thing.

You can talk to just about any conservative in Congress of either party -- you can talk to the most conservative Republican in either party -- in the Republican party, and most of them will tell you now we are not spending enough money on some of the things that will generate jobs in the future. If we don't spend enough money to keep our technology lead over other countries in areas critical to the future -- in super computing and electronics and aerospace and these other things -- and if we don't really educate and train our people, then our incomes will fall behind. But if we are strangled by rising health care costs, the future can have no lobby in the Congress.

So this budget plan that we presented is great on deficit reduction. It does invest some money in the future, but it doesn't invest anything like what you would want us to invest if we weren't strung up by our heels by the deficit. And there is no answer to it except to get health costs in line with inflation. There is no other answer, because that's the only thing that's eating

us alive now through Medicare and Medicaid. It is the same with you.

Now, what we see is people have learned a lot about controlling health care costs, and a lot of big businesses that can self-insure now have their costs in line with inflation. The California public employees system, which is a huge system with bulk purchasing power, this year has a contract which is below inflation. That's great for them. But what does that mean? Even more pressure on you to pay for the uncompensated care bills of people who don't have health insurance if you do. Which means every year more and more small businesses are either dropping coverage, about 100,000 Americans a month lose their health insurance, or they have more limited coverage that may or may not be adequate for the people whom they insure.

So, what I want to say about that is this: It seems to me clear, if you study the federal budget and you want the deficit down to zero and you want America to invest and grow again, if you look at the private budgets of businesses in this country, that we have to do something to give small businesses bulk purchasing power; relief from all these rules and regulations the federal government imposes; relief from the incredible paperwork imposed on health care providers by this country being the only country in the world having 1,500 different health insurance companies -- thousands of different policies -- a dime on the dollar more in paperwork costs than any other advanced country in the world -- a dime on the dollar. And the more big businesses self-insure and control their own costs, the more you're paying the difference. So, we have got to do some things to simplify and make more uniform this system.

Now, the big controversy obviously is over whether there should be a mandate for employers, employees, one or both, to cover people who have no health insurance. Here is the problem, and I invite you to the debate, but here is the problem: Seventy percent of all small businesses have some health insurance. And they're paying out the ears for it. I have to be delicate in my language. (Laughter.) Seventy percent do. Costs are going up like crazy. For the 30 percent who don't, those folks, if they get sick, will still get health care. Show up at the emergency room and they will get it. Everybody gets it. But who paid for the emergency room to be there? The rest of you. You built the infrastructure. You financed. You maintain the infrastructure.

The government should clearly insure the umemployed, uninsured. And my goal has been to do that by managing the system better so we don't have to raise taxes on you to do that, because people who are paying too much already shouldn't pay more to fix the system. But if you look at every system in the world, it is perfectly clear that unless you have some mechanism by which everybody is covered, you cannot control the costs and you cannot stop the cost-shifting.

Now, nobody wants to do this in a way that kills the only job-generator we've had in America over the last two years, which is you. But it's very important to remember that most small businesses do provide health insurance. This is the nub of the economic dilemma. If it were easy, somebody would have done it already. Right? I mean, if it were easy, it would already be done. It's not easy. (Applause.)

There is no perfect solution. But I assure you that we're all going to be better off if we enter into an honest debate and try to work through this, and we try to resolve it. The worst thing we can do is to leave it alone; and especially, the worst thing we can do for the small business sector, because bigger employers will figure out how to get managed care and they'll just go around this whole health insurance system we have today. Everybody else is going to be out there just strung up. So we must face it. And we've

got to provide some means of covering people, letting them change jobs, and having people have this without going bankrupt. And that is something that I am deeply dedicated to.

Let me mention one or two other issues that are very important and then we'll move on to questions. I believe the SBA can be a force for good in small businesses. (Applause.) And I promised myself if I got elected President, when I started, I would appoint somebody to run the SBA who had literally had real experience and was not just a political appointee. (Applause.)

Now I plead guilty. Erskine Bowles is a personal friend of mine. His wife went to college with my wife. That does not disqualify him. (Laughter and applause.) But his wife is a successful business person and he has spent his lifetime trying to help people like you start your businesses, expand your business, market your business overseas. He actually knows what he's doing. So it seems to me that would be nice to have an SBA director who could do that, who had been through that. (Applause.)

The second thing that I really thought about a lot early in the election because of the experiences I had seen, not only in my state but around the country, is that we had to do something to try to deal with the credit crunch. The access to credit is obviously going to have more to do with how a lot of your members do than a lot of other things this government does.

So, early in my administration we brought together all the appropriate banking regulatory agencies and, in what was then an act of unprecedented cooperation, we changed a lot of the restricted regulations that cause so much of the credit crunch. Banks are now clearly empowered to make more character loans based on the reputation of the borrower. Documentation requirements by the federal government have been relaxed dramatically as have regulations regarding appraisals of real estate to secure small business loans. And there will be more flexibility in classifying loans.

Now, that has been done at our level. It takes more time than I wish it did for all those changes here to actually be felt in every community bank in America. And one of the things that the NFIB needs to do with Erskine Bowles is to let us know in which communities this is working and in which communities there has been no change; because we made a vigorous clear effort to send this signal out all across America by changing the way we did business with the banks. But it has not changed in every community in America, and a lot of people are still really stung by what happened to them in the '80s. But the banks are in much better shape today than they were three years ago. And that's good, that's a good omen for our future.

But now that they're in better shape the time has come for them to loan money on good terms at low interest rates. (Applause.) So, we need your help on that.

Next I'd like to say a little something about regulatory reform. Every president talks about it and almost nothing ever happens. There's a division in our budget office that a lot of you probably have never heard of in the Office of Management and Budget called OIRA -- that would gag you -- (laughter) -- OIRA, the Office of Information and Regulatory Affairs. For years, the position of administrator of this office, believe it or not, was vacant. But this office actually has the capacity to rationally review all of these regulations. We have named, and Congress has confirmed, an administrator for OIRA, and we are going to do our best to see what we can do to reduce unnecessary regulations. (Applause.)

Perhaps more important, I have asked the Vice President as part of his job in reviewing the whole operations of the federal

government -- and, by the way, I predict you will be very pleased by the report that is issued by his group in September -- we are reviewing the operations of every last part of this government. Unlike your business, unlike all big businesses, the way we do business in the federal government and many of these agencies has been largely unexamined for decades.

So that when something new comes along that we have to do, it normally is just added on to what was being done already, instead of being substituted for it. And the whole quality revolution that has engulfed the American private sector and led to rapid increases in productivity has largely escaped government. And we're trying to change that, too. It escapes nearly every organization that has a mandate for customers and income, so we're trying to change that.

Our goal is pretty simple: We want to avoid regulations that are inconsistent with the goals of jobs and growth; we want to avoid regulations that overlap; we want to create a process that is open and fair where business has some input and not just large businesses, but also medium and small ones as well; and we want to change the whole way Washington works.

I think these are the kinds of things that you would want us to do, and these are certainly the things that we have to do. I don't plan or pretend that we're always going to agree on all these issues. And I wish that the world looked to me as President just the way it does to you or the way it even did to me as Governor. Like I said, it took a lot of mental gymnastics for me to finally face the hard reality that we had this huge deficit and unless we did something about it, we were never going to be able to do anything else. We'd spend all our time -- I spent all my time giving speeches about things we were going to do and no impact would be felt because we were out of control of our economic destiny.

So I hope that you will be supportive -- not supportive of me personally so much as supportive of our efforts -- common efforts to deal with our common problems.

The one thing I made up my mind to do when I won the election in November was at least try to level with the American people about the problems and try to face things that other people in public life had avoided. This is painful. I tell all the time -- you know, my daughter and the kids her age who get into all this interesting music has got this great phrase. She said, "Dad, denial is not just a river in Egypt." (Laughter.) And sometimes I think that -- (applause) -- sometimes -- that's probably a good phrase for us to remember in a lot of ways.

But my plain duty to you is at least to try to articulate what these issues are and face them. We tried it the other way. We tried ignoring the deficit. It didn't go away. We tried telling everybody what they wanted to hear -- that it could all be done by some slight of hand, and it didn't happen. And we tried a lot of things about health care in the federal government which, frankly, made your problems worse. I could control health care costs without doing anything on the health care system. And what would happen? All the providers when we just cut Medicare and Medicaid more, all the providers will send you the bill. That's what happens today.

So, I ask you to think about this. Let us face our problems, let us talk about our problems. The first big urgent thing is to pass a deficit-reduction plan that keeps as many of these growth incentives as we can possibly have. (Applause.) That was the good thing about the House bill. (Applause.) Then I look forward to engaging in the health debate; I look forward to engaging in the trade debate; I look forward to engaging in the job-creation debate.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 7, 1993

REMARKS OF THE FIRST LADY
AT LIZ CARPENTER'S LECTURESHIP SERIES

University of Texas
Austin, Texas

3:00 P.M. CDT

MRS. CLINTON: Thank you so much. I am reminded, in following Anne Richards, of that old story of the fellow who died in one of the early Arkansas floods and makes his way to heaven and is met at the gates. And St. Peter says, "Well, you're just in time for our monthly seminar. What do you want to talk about?" The man said, "I want to talk about the most important experience that I have ever encountered. I want to talk about what it is like to be in a flood. I feel like I can make a real contribution to that dialogue." St. Peter says, "Fine. You'll go on after Noah." (Laughter.) So, here we are after Noah. (Applause.)

You know, it is not a common experience for me to be in any Texas athletic facility and feel good about it -- (applause) -- but I must say that now that we're no longer in the same conferences, my state and yours, that I am honored to be -- (laughter) -- in the arena where the Lady Longhorns play. (Applause.) And I also have to say -- and I hope that you feel the same way I did -- I was mighty proud of Texas Tech, too. I thought that was a great victory. (Applause.)

You know, when Liz Carpenter asked me to come speak at her little seminar -- (laughter) -- it was one of those conversations that you have with Liz -- those of us who are lucky enough to know her and call her a friend -- where her enthusiasm just kind of takes over. She said, I'm going to have some of my friends in, we're going to do this lecture. You know, it will be fun. I'll get Anne to come over and Mrs. Johnson will come over, and we'll just have a good old time.

And I had this sort of mental image of being over in one of the small rooms at the LBJ School and sitting with a bunch of my friends, maybe with some students around a table. And then I just

put it out of my mind. And over the last two weeks, as Liz knows, it's been kind of touch-and-go for me whether I thought I could be here, and I told Liz that I would certainly try. And when it became clearer that I could, I renewed contact with the people who were helping her put this on and was then told that there were going to be thousands, maybe 14,000 people at this event.

And my first response was no, no, no, you must have read it wrong, there's an extra zero in there somewhere. But my second was why would I doubt Liz Carpenter on anything? If she's going to put on a lectureship that's like Anne says, it's going to be a big one and besides it's in Texas. So what do we expect? And I'm just pleased to be part of it. (Applause.)

I also want to say a special word of appreciation to Mrs. Johnson. You know, there is that wonderful old saying about how you never quite know what it's like until you've walked in another person's moccasins. Well, I don't know if you've ever worn moccasins, Mrs. Johnson, but I'm getting a sense of what it is like to try to walk in the footsteps of you and the other women who have been in the position that I now find myself in. And every day that goes by, I am more impressed by the kind of qualities that you and other women in this position have brought to taking care of your personal business on behalf of your family and your husband, and also trying to make your contribution to the country. And all of us in this arena are grateful for the grace and beauty by which you carried out both of those functions and as a wonderful example, not just for me, but for all of us. And I very much wanted to say that to you publicly. (Applause.)

You know, after you hear what I have to say, you'll think that Governor Richards and I not only coordinated outfits but coordinated comments. And I suppose the only thing left for me is to get a hair-do like that. (Laughter.) You know, I'm actually due for a new one and I figure that if we ever want to get Bosnia off the front page, all I have to do is either put on a headband or change my hair and we'll be occupied with something else. (Laughter and applause.)

But what Anne Richards talked about is what I want to expand on in my remarks leading into the panel discussion with all of these distinguished panelists and with questions from many of you that I understand were submitted. Because the problems that she alluded to are not just American problems, they are not just governmental problems. We are at a stage in history, I would suggest, in which remolding society certainly in the West is one of the great challenges facing all of us as individuals and as citizens.

And we have to begin realistically to take stock of where we are, stripping perhaps away the romanticism that Governor Richards referred to, to be able to understand where we are in history at this point and what our real challenges happen to be.

And I say that it is not just an American problem because if one looks around the Western world, if one looks at Europe, if one looks at the emerging democracies, at Asia, if one looks certainly here in North America, you can see the rumblings of discontent, almost regardless of political systems, as we come face to face with the problems that the modern age has dealt us.

And if we take a step back and ask ourselves, why is it in a country as economically wealthy as we are despite our economic problems, in a country that is the longest surviving democracy, there is this undercurrent of discontent -- this sense that somehow economic growth and prosperity, political democracy and freedom are not enough -- that we lack at some core level meaning in our individual lives and meaning collectively -- that sense that our lives are part of some greater effort, that we are connected to one another, that community means that we have a place where we belong no matter who we are. And it isn't very far below the surface because we can see popping through the surface the signs of alienation and despair and hopelessness that are all too common and cannot be ignored. They're in our living rooms at night on the news. They're on the front pages; they are in all of our neighborhoods.

On the plane coming down I read a phrase in an article in the newspaper this morning talking about how desperate conditions are in so many of our cities that are filled with hopeless girls with babies and angry boys with guns. And yet, it is not just the most violent and the most alienated that we can look to. The discontent of which I speak is broader than that, deeper than that. We are, I think, in a crisis of meaning. What do our governmental institutions mean? What do our lives in today's world mean? What does this economic global event that Governor Richards spoke of mean? What do all of our institutions mean? What does it mean to be educated? What does it mean to be a journalist? What does it mean in today's world to pursue not only vocations, to be part of institutions, but to be human?

And, certainly, coming off the last year when the ethos of selfishness and greed were given places of honor never before accorded, it is certainly timely to ask ourselves these questions. (Applause.)

One of the clearest and most poignant posings of this question that I have run across was the one provided by Lee Atwater as he lay dying. For those of you who may not know, Lee Atwater was

credited with being the architect of the Republican victories of the '70s and the '80s. The vaunted campaign manager of Reagan and Bush. The man who knew how to fight bare-knuckled in the political arena, who was willing to engage in any tactics so long as it worked and he wasn't caught at it.

And yet, when Lee Atwater was struck down with cancer, he said something which we reprinted in Life Magazine, which I cut out and carry with me in a little book I have of sayings and Scriptures that I find important and that replenish me from time to time that I want to share with you.

He said the following: "Long before I was struck with cancer, I felt something stirring in American society. It was a sense among the people of the country, Republicans and Democrats alike, that something was missing from their lives, something crucial. I was trying to position the Republican Party to take advantage of it. But I wasn't exactly sure what it was. My illness helped me to see that what was missing in society is what was missing in me. A little heart, a lot of brotherhood.

The '80s were about acquiring -- acquiring wealth, power prestige. I know. I acquired more wealth, power, and prestige than most. But you can acquire all you want and still feel empty. What power wouldn't I trade for a little more time with my family? What price wouldn't I pay for an evening with friends? It took a deadly illness to put me eye-to-eye with that true, but it is a truth that the country, caught up in its ruthless ambitions and moral decay, can learn on my dime.

I don't know who will lead us through the '90s, but they must be made to speak to this spiritual vacuum at the heart of American society, this tumor of the soul."

That to me will be Lee Atwater's real lasting legacy, not the elections that he helped to win. (Applause.)

But I think the answer to his question -- "who will lead us out of this spiritual vacuum" -- the answer is all of us. Because remolding society does not depend on just changing government, on just reinventing our institutions to be more in tune with present realities. It requires each of us to play our part in redefining what our lives are and what they should be.

We are caught between two great political forces. On the one hand we have our economy -- the market economy -- which knows the price of everything, but the value of nothing. That is not its job. And then the state or government which attempts to use its means of acquiring tax money, of making decisions to assist us in

becoming a better, more equitable society as it defines it. That is what all societies are currently caught between -- forces that are more complex and bigger than any of us can understand. And missing in that equation, as we have political and ideological struggles between those who think market economics are the answer to everything, those who think government programs are the answer to everything, is the recognition among all of us that neither of those is an adequate explanation for the challenges confronting us.

And what we each must do is to break through the old thinking that has for too long captured us politically and institutionally, so that we can begin to devise new ways of thinking about not only what it means to have governments that work again, not only what it means to have economies that don't discard people like they were excess baggage that we no longer need, but to define our institutional and personal responsibilities in ways that answer this lack of meaning.

We need a new politics of meaning. We need a new ethos of individual responsibility and caring. We need a new definition of civil society which answers the unanswerable questions posed by both the market forces and the governmental ones, as to how we can have a society that fills us up again and makes us feel that we are part of something bigger than ourselves.

Now, will it be easy to do that? Of course not. Because we are breaking new ground. This is a trend that has been developing over hundreds of years. It is not something that just happened to us in the last decade or two. And so it is not going to be easy to redefine who we are as human beings in this post-modern age. Nor will it be easy to figure out how to make our institutions more responsive to the kind of human beings we wish to be.

But part of the great challenge of living is defining yourself in your moment, of seizing the opportunities that you are given, and of making the very best choices you can. That is what this administration, this President, and those of us who are hoping for these changes are attempting to do.

I used to wonder during the election when my husband would attempt to explain how so many of the problems that we were confronting were not easy Democratic-Republican-liberal-conservative problems. They were problems that shared different characteristics, that we had to not only define clearly, but search for new ways of confronting.

Then someone would say, well, you know, he can't make up his mind, or he doesn't know what he wants to say about that. When instead what I was hearing and what we had been struggling with for

years is how does one define these new issues. How do we begin to inject some meaning? How do we take old values and apply them to these new -- for many of us -- undreamed of problems that we now confront? And that is what all of us must be engaged in in our own lives, at every level, in every institution with which we interact.

Let me just give you some examples. If we believe that the reconstruction of civil society with its institutions of family, friendship networks, communities, voluntary organizations, are really the glue of what holds us together; if we go back and read de Toqueville and notice how he talked over and over again about the unique characteristics that he found among Americans and rooted so many of those in that kind of intermediary institution of civil society that I just mentioned, then we know we have to better understand what we can do to strengthen those institutions, to understand how they have changed over time, and to try to find meaning in them as they currently are.

That's why the debate over family values over the last year, which was devised for political purposes, seemed so off-point. There is no -- or should be no debates that our family structure is in trouble. There should be no debate that children need the stability, the predictability of a family. But there should be debate over how we best make sure that children and families flourish. And once that debate is carried out on honest terms, then we have to recognize that either the old idea that only parental influence and parental values matters, or the nearly as old idea that only state programmatic intervention matters are both equally fallacious.

Instead we ought to recognize what should be a common-sense truth -- that children are the result of both the values of their parents and the values of the society in which they live. And that you can have an important -- (applause) --
(end of side one tape)

(in progress) -- how best to make sure parental values are the ones that will help children grow and be strengthened, and how social values equally must be recognized for the role they play in how children feel about themselves and act in the world. And then we can begin to have what should be a sensible conversation about how to strengthen both. That's the kind of approach that has to get beyond the dogma of right or left, conservative or liberal. Those views are inadequate to the problems we see.

Any of you who have ever been in an inner city, working with young people as I have over the years, will know as I do the heroic stories of parents and grandparents who, against overwhelming odds, fight to keep their children safe -- just physically safe; and

who hold high expectations for those children; whose values I would put up against any other person in the country, but who has no control over the day-to-day violence and influence that comes flooding in the doors of that housing project apartment; and who need a society that is more supportive of their value than the one they currently have. (Applause.)

Equally, all of us know the contrary story of families with enough economic means, affluent enough to live in neighborhoods that are as safe as they can be in our country today, so they have the social value structure of what we would hope that each child in America could have in terms of just basic kinds of fundamental safety and physical well-being, but whose parental values are not ones to promote a childhood that is a positive one, giving children the chance to grow up to achieve their own God-given potential. So that the presence of values of society are not enough, either.

There are so many examples of how we have to think differently and how we have to go beyond not only the traditions of the past, but unfortunately for many of us, well-held and cherished views of the past; and how we have to break out of the kind of gridlock mentality which exists not just in the Congress from time to time, but exists as well in all of us as we struggle to see the world differently and cope with the challenges it has given us.

Yet I am very hopeful about where we stand in this last decade of the 20th century, because for all of the problems that we see around us, both abroad and at home, there is a growing body of people who want to deal with them, who want to be part of this conversation about how we break through old views and deal with new problems. And we will need millions more of those conversations.

Those conversations need to take place in every family, every workplace, every political institution in our country. They need to take place in our schools, where we have to be honest about what we are and are not able to convey to our children; where we have to be honest about the conditions with which are confronting so many of our teachers and our students day in and day out; where we have to be honest that we do have to set high expectations for all children and we should not discard any because of who they are or where they come from. (Laughter.)

And where we need to hold accountable every member of the educational enterprise -- parents, teachers and students. Each should be held accountable for the opportunity they have been given to participate in one of the greatest efforts of humankind, passing on knowledge to children. And we have to expect more than we are currently getting. (Applause.)

We also need to take a hard look at other institutions. As Governor Richards said we are in the midst of an intensive effort of trying to determine how we can provide decent, affordable health care to every American. (Applause.) And in that process we have had to ask hard questions about every aspect of our health care system. Why do doctors do what they do? Why are nurses not permitted to do more than they do? Why are patients put in the position they're in? (Applause.)

And we have with us today Bill Moyers, who has helped to enlighten all of us about how what we currently have is a system for taking care of sickness. We do not have a system for enhancing and promoting health. (Applause.) And what we need to do is recognize how each of us, whether we are a care giver or a care receiver -- and that role may change from time to time as we go through life -- will have to think differently about health care. And we will have to come up with a system that promotes wellness, promotes health and provides care for us when we are sick that we can afford.

But to give you just one example about how this ties in with what I have said before about how these problems we are confronting now in many ways are the result of our progress as we have moved toward being modern men and women: Our ancestors did not have to think about many of the issues we are now confronted with. When does life start; when does life end? Who makes those decisions? How do we dare to impinge upon these areas of such delicate, difficult questions? And, yet, every day in hospitals and homes and hospices all over this country, people are struggling with those very profound issues.

These are not issues that we have guidebooks about. They are issues that we have to summon up what we believe is morally and ethically and spiritually correct and do the best we can with God's guidance. How do we create a system that gets rid of the micromanagement, the regulation and the bureaucracy, and substitutes instead human caring, concern and love? And that is our real challenge in redesigning a health care system. (Applause.)

I want to say a word about another institution and that is the media, because it is the filter through which we see ourselves and one another. And in many ways the challenge confronting it is just as difficult as those confronting any other institution we can imagine. How does one keep up with the extraordinary pace of information now available? How do we make sense of that information? How do we make values about it even if we think we have made sense? How do we rid ourselves of the lowest common denominator that is the easiest way of conveying information? How do we have a media that understands how difficult these issues are and looks at itself

honestly because the role it must play is so critical to our success in making decisions about how we will proceed as a society?

I remember in the beginning of the campaign being asked a question at an editorial meeting in South Carolina that my husband was at to meet a lot of the editors and reporters from a lot of the small-town papers. These were not folks who you'll see on a TV station anywhere; these are people who got up every day and did the best they could to put out the paper that covered their community or their region. And one of the men, after hearing my husband speak, said, "Now, you've talked about how we have to change. How we have to change government, how we have to change society. But as a journalist, how do I change to be able to understand and report on those changes?" My husband said, "You know, I can't answer that. That's something you have to answer. But I'm really glad you asked the question, because every institution in our life has to ask those hard questions about who we are, what contribution we make to dealing with our problems and to injecting meaning again in the lives of us all."

So every one of our institutions is under the same kind of mandate. Change will come whether we want it or not, and what we have to do is to try to make change our friend, not our enemy. But probably most profoundly and importantly, the changes that will count the most are the millions and millions of changes that take place on the individual level as people reject cynicism, as they are willing to be hopeful again, as they are willing to take risks to meet the challenges they see around them, as they truly begin to try to see other people as they wish to be seen and to treat them as they wish to be treated, to overcome all of the obstacles we have erected around ourselves that keep us apart from one another, fearful and afraid, not willing to build the bridges necessary, to fill that spiritual vacuum that Lee Atwater talked about.

You know, one of my other favorite quotes is from Albert Schweitzer. And he talks about how you know the disease in Central Africa called sleeping sickness; there also exists a sleeping sickness of the soul. The most dangerous aspect is that one is unaware of it's coming. That is why we have to be careful. As soon as you notice the slightest sign of indifference, the moment you become aware of a loss of character or a serious longing of enthusiasm, it is best, take it as a warning. You should realize that your soul suffers if you can't live superficially. Not just your soul, but your society. Being here on this great campus, with so many thousands of people who care about learning and are committed to making a difference. Let us be willing to remold society by redefining what it means to be a human being in the 20th century, moving into a new millennium. Let us be willing to help our institutions to change, to deal with the new challenges that confront

them. Let us try to restore the importance of civil society by committing ourselves to our children, our families, our friends; and to reaching out beyond the circle of those of whom we know, to the many others on whom we are dependent in this complex society; and understanding a little more about what their lives are like and doing what we can to help ease their burdens.

Our greatest opportunities lie ahead, because so many of the struggles of the Depression and the World War and the other challenges posed by the Cold War and communism are behind us. The new ones are equally threatening. But we should have learned a lot in the last few years that will prepare us to play our part in remolding a society that we are proud to be a part of.

Thank you all very much. (Applause.)

END

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 11, 1993

REMARKS BY THE FIRST LADY
DURING HEALTH CARE FORUM

Morgantown, West Virginia

6:30 P.M. EDT

MRS. CLINTON: Clap when you think it'll make the Senator and me feel better. How's that? (Laughter and applause.) We're trying to promote health care here. (Applause.)

SENATOR ROCKEFELLER: Now, when you read your tickets when you came in, at the very bottom lefthand side, it said that, by virtue of being here, you have to be flat-out for passing health care reform this year. Anybody who is for 1994, out. (Laughter.) Only 1993.

MRS. CLINTON: That is what he has been saying to me ever since the election, I think, before I ever even got this assignment. Your senator has been preaching and teaching and reaching out to everybody who will listen about how important this is. I think he deserves a big hand, because he's trying -- (applause.)

SENATOR ROCKEFELLER: Mrs. Clinton, I notice we have the Speaker of our House of Delegates and the President of our State Senate right here in the second row.

MRS. CLINTON: While we're still waiting and they're checking our mikes, there's somebody else here who I think deserves a hand, because I'm a great fan of hers and have known here for a long time when Jay was your Governor, and that's Sharon Rockefeller. (Applause.)

SENATOR ROCKEFELLER: Just a comment to all the staff here that have put in hours and have really made an effort, my thanks for all you've done. Thank you very much. (Applause.) And if you don't thank them before the show starts, then you may not see yourself on TV, or hear yourself. (Laughter.)

MODERATOR: The following special program is sponsored in part by West Virginia Bankers Association, West Virginia Hospital Association, Warner-Lambert Company, United Mine Workers of America, and West Virginia University.

From the Health Sciences Campus of West Virginia University in Morgantown, West Virginia Speaks: Our Hopes for Health Care Reform. A special program with First Lady Hillary Rodham Clinton and United States Senator Jay Rockefeller.

MR. D'ALESSANDRI: Good evening. I'm Robert D'Alessandri, Vice President for Health Sciences at West Virginia University. Welcome to our health care forum: West Virginia Speaks: Our Hopes for Health Care Reform.

Tonight we will have an opportunity to talk with the leading national policy makers about what we in West Virginia hope health care reform will accomplish.

I want to thank Hillary Rodham Clinton, Chair of the President's Task Force on Health Care Reform, for coming to West Virginia to listen to our thoughts on this important subject. All of America has been impressed with Mrs. Clinton's energy, sense of mission and willingness to listen to all sides on this important subject. I hope she will find more support here tonight for the changes that need to be made.

We in West Virginia are very fortunate to be represented in the Senate by Senator Jay Rockefeller. Senator Rockefeller arranged for tonight's forum. Even before health reform was at the top of the national agenda, Senator Rockefeller already was a major force for reform. Through is work leading the Pepper Commission and the National Commission for Children, he has tirelessly raised the issues of the need for affordable health care for all. He is absolutely committed to improving the health of West Virginians and the health of all Americans.

The plan that the Task Force is preparing is expected to be presented to Congress soon. This is an opportune moment to relay our desires on this important issue to the White House and Congress. Tonight we are going to hear from people in all areas of our state about the most pressing issues with health care reform. We will hear about the need for universal access to health care for some of the 350,000 West Virginians with no health care coverage. We will hear about the problems health care providers face in trying to care for the uninsured. We'll hear the concerns small businesses have about health care reform and how the costs of reform will affect them. And we will hear the special problems that rural areas face in attracting health care providers to care for a fragile population.

We will be going live to Raynell, New Martinsville, Martinsburg and Cabin Creek to hear from West Virginians who will talk about their health care. And we will hear from labor and business leaders here in Morgantown about the issues involved in health care reform.

The reforms the Clinton administration proposes will have an impact on each and every American. How and when health care will be available to every American and how much it will cost us to achieve that goal are still outstanding questions.

Health care reform presents us with many opportunities. This is an opportunity for West Virginia to let our national leaders know what our concerns are.

Thank you, Mrs. Clinton, and thank you, Senator Rockefeller, for giving us this opportunity.

SENATOR ROCKEFELLER: Bob, thank you very, very much. That was much too generous. I want to thank West Virginia University; I want to thank you, Bob D'Alessandri; Neal Buckler, the President of the University. I want to thank everybody who is going to be participating, particularly in the four counties that we'll be talking tonight.

I cannot tell you how happy I am that Mrs. Clinton is here tonight to share with us not just here, but all across the state on television and radio, what we in West Virginia are faced with in terms of health care problems. And when you think of it, Mrs. Clinton and the President put together a task force of 500 people that have been working now for months and months, and it is so important, I think, that they do what they have been doing so expertly, which is to go out into America and listen.

It's a terrible problem, health care; we all know that. I mean, last year, for example, 1,200,000 people lost their health insurance. And, of those, 1 million of them made between $25,000 and

$50,000 a year. This is a problem for working America, mainstream America. It is crushing our families, it's crushing our state government, it's crushing our federal government. It's a terrible problem for small business.

So what I am really grateful for is the concern of Mrs. Clinton, coming to West Virginia to listen precisely to what our problems are, because our problems, in many ways, might be like others, but maybe they're a little bit different. And we want to look at some of them in depth tonight.

And, Mrs. Clinton, I want to tell you that we in West Virginia are very grateful to you for coming.

MRS. CLINTON: Well, it is I who am grateful. This is a wonderful opportunity. I always like coming to West Virginia and didn't really have to think very long when Senator Rockefeller suggested this opportunity, which is a very unique one, to be able to hear from people all over one state, talking in-depth about the problems that are affecting not only West Virginians, but all Americans.

I'm very grateful for the kind of help and cooperation that I have received from Senator Rockefeller who has been in the forefront of talking about the need for reforming our health care system -- not just because it's the right thing to do, not just because we will help millions of Americans who are really on the edge right now -- those who are insured, but could be wiped out because their insurance doesn't cover everything, those millions who are uninsured, generally everyone who is feeling insecure about health care today.

But it's also the economically smart thing to do -- to reform our health care system now before it consumes $1 out of every $5 that Americans will make by the year 2000. So it's a great treat for me to be back in West Virginia to have an opportunity to listen and to learn and to take that back with me to the President as he moves forward toward announcing a comprehensive health care reform for our country.

MR. D'ALESSANDRI: Thank you, Mrs. Clinton. And let's move right to Raynell, West Virginia. Craig and Vicki McClung, can you see us and hear us?

MR. MCCLUNG: Yes, sir.

MR. D'ALESSANDRI: Okay, we're going to go to the tape first.

VIDEOTAPE SHOWN:

MODERATOR: The town of Raynell in Greenbrier County has deep roots in West Virginia tradition. Coal is still important here. So are lumber and farming. People value cooperation, self-sufficiency and family life. The work ethic is strong, but times are tough in this region and the unemployment rate in Raynell is now close to 15 percent.

Raynell stands outside the mainstream of urban America. And most people here like it that way. School sports are an important part of family life. Many believe that such activities cultivate family values and stability. Raynell Medical Center is the heart of the health care delivery system for this town of 1700 people, and the surrounding area.

It's estimated that between 250,000 and 300,000 West Virginians have no health insurance. That means usually they aren't getting the care they need. And when they do seek medical attention,

it's often not until a health problem has reached crisis proportions.

Craig McClung had a good job in the coal industry until a serious accident in 1988 ended his career. He's currently unemployed. And except for a son with spina bifida, who is eligible for Medicaid, his family of six has no health insurance.

MR. D'ALESSANDRI: Craig and Vicki, can you hear us? We're with Jay Rockefeller and Hillary Clinton.

MR. MCCLUNG: Yes, sir.

MR. D'ALESSANDRI: Oh, that's great. Craig, maybe you could just catch us up a little bit in terms of what losing health insurance and your accident and everything, what that's meant to you and to your family.

MR. MCCLUNG: Well, I had been employed in the coal industry for 12 years, and that I fell 65 feet on December 14th, 1988. But for the grace of God and from fine doctors at Plateau Medical Center, I was --

MR. D'ALESSANDRI: Yes, you go ahead and just take your time. When you went to that hospital, they fixed you up. But you still -- you went back to work, but you still couldn't stay with it, could you, because the pain was too bad.

MR. MCCLUNG: Yes, sir. That was what has happened.

MR. D'ALESSANDRI: And how has that affected your life? And, Vicki, you, too -- what's that meant for your family and for your children?

MS. MCLUNG: Well, when we had health insurance, health care wasn't a major concern. But when we lost our health insurance, it became a major worry. Last summer, I found out firsthand what it was like whenever you a problem arises and you have no insurance. I woke up one morning with severe pains, and since I have a brother who has had kidney stones, I knew the symptoms I was having, but in the back of my mind, I kept knowing the cost that would be involved. And so I put off going to the doctor until the last possible minute.

Luckily, I only had to spend one night in the hospital. But because of that one-night stay, we're having to pay out about $100 a month -- have be, and will be for the next year. So it's a big worry.

MRS. CLINTON: Vicki, this is Hillary Clinton. How are you?

MRS. MCCLUNG: I'm just fine.

MRS. CLINTON: I'm glad to meet you through satellite technology like this.

When Craig had his accident and was injured so badly, did the insurance initially -- the worker's comp and the insurance -- did that cover your expenses; but then when he couldn't go back to work, then you lost your insurance? Is that what happened?

MRS. MCCLUNG: That's right, ma'am.

MRS. CLINTON: And how long have you as a family been without insurance?

MRS. MCCLUNG: For about four years now.

MRS. CLINTON: And have you had any medical needs that you, in addition to the one you just described to us for yourself and for Craig and the children, have gone unmet because of no insurance?

MRS. MCCLUNG: Well, just maybe some routine health check-ups, like eye care and dentistry and preventive medicine more. Luckily, we've been pretty healthy.

MRS. CLINTON: That's a blessing, isn't it?

MRS. MCCLUNG: Right.

MRS. CLINTON: Now, in the introduction they mentioned that one of your sons had spina bifida. Is that right?

MRS. MCCLUNG: Yes, ma'am.

MRS. CLINTON: And how is his medical treatment covered?

MRS. MCCLUNG: Right now it's covered by a medical card. Up until Craig was hurt, we always had health insurance that covered all of his needs. But when he was hurt, luckily he qualified for a medical card, and it's taken care of his surgeries and necessities.

MRS. CLINTON: So you've got one of your children that's eligible through the state, but then your other three are not, for any of their care and treatment?

MRS. MCCLUNG: Right.

MRS. CLINTON: When you were talking about the kidney problems, you said that you postponed going as late as possible. If you had had insurance, would you have gone in earlier, and is there any reason to believe it might not have been as expensive or you might not have been hospitalized overnight?

MRS. MCCLUNG: My brother has had to be in the hospital several times with kidney stones. He's had surgery, plus he's had to have them blasted. And so I knew how expensive it could be. The major worry I have now is that his has reoccurred real often, and I just hope I'm fortunate in that I don't have that happen again.

SENATOR ROCKEFELLER: If you had to tell Mrs. Clinton the one thing that you'd like to really see happen in health care reform in this country, Vicki, what would it be?

MRS. MCCLUNG: Preventative health care. I would like to be able to take the kids for well check-ups and not wait until they're sick.

MRS. CLINTON: Is this a problem with your friends and neighbors in Raynell? I heard when they were introducing your family to us that unemployment's up to 15 percent. Are there a lot of people you know without health insurance right now?

MRS. MCCLUNG: Yes, ma'am. Several. The way it stands right now, the ones on welfare are the ones who get to go and have their kids checked for well care, and -- you know, they get more care.

MRS. CLINTON: Vicki, you have made a very important point, and it's something that I get upset about every time I think about it. Because what we have done is to tell people that if they work and try to make a decent living for themselves and their families, if they're unable to work but they keep trying and they keep going back trying to get something to support themselves, they're out of luck; if they don't have health insurance, that's their problem. If they just stop, if you all just stop and just kind

of gave up and went on welfare, you'd have preventive health care for your boys, wouldn't you?

MRS. MCCLUNG: That's right.

MRS. CLINTON: I mean, that is just absolutely backwards from what we ought to be doing in this country and, yet, we're doing it, we're sending the wrong signals and we're not doing a very good job taking care of people.

SENATOR ROCKEFELLER: Vicki, can I ask you -- Brandon has his health are through the Medicaid; on the other hand, your other children don't. What is it that you worry about? I mean, what is it like to be a mother with four children, and for three of them there's no health insurance whatsoever? I mean, don't you wake up at night sometimes just worrying about an accident, and what would you do? What would you do?

MRS. MCCLUNG: Well, my boys have always been involved in a lot of sports, and when we lost our health insurance I was constantly saying, no, you can't go skating, or, be careful when you're playing soccer for the fear something would happen to them. And then I realized it's not their fault that we have no health insurance, and we just have to pray that they won't have any problems.

SENATOR ROCKEFELLER: But you never really have -- you never go to sleep at night with a sense of peace of mind, do you -- either of you, Craig or Vicki?

MRS. MCCLUNG: No, sir.

SENATOR ROCKEFELLER: Well, we're awfully grateful to you. It's a hard thing, I guess, I would assume, to just open your lives up to so many people all across West Virginia. But by doing so, you're speaking for hundreds of thousands of our people, and that's incredibly important. And it's so important that the First Lady of our land get to hear what it is that you have to say.

MRS. CLINTON: Well, I think it's especially important. Because, you know, there are a lot of people who talk about the uninsured in America, and they say, "You know, the uninsured are people who don't want insurance. The uninsured are young people, and they don't mind taking risks. So, why do we have to worry about insuring the uninsured?" And I hope that your willingness as a family to come forward and say, "Look, here we are. We are the uninsured," will help some people see this problem in a more realistic way, and they will quit saying that people who are uninsured don't really need health care, because I don't know what they think they are, some kind of special super people when they're just people like us.

And, as Senator Rockefeller said, 1,200,000 Americans lose their health insurance every year, and most of those people are just like your family -- they're people who have worked hard, they're people who try to do their best and, through no fault of their own -- an accident, a layoff, a plant closing -- they find themselves without health insurance. So today, you're really speaking for millions of other Americans, and I really appreciate that.

SENATOR ROCKEFELLER: Vicki and Craig, could you introduce your four children to us so we can just see them and meet them?

MR. MCCLUNG: Off and to my left is my oldest son, Brandon, our youngest son, Brent, our next to oldest son, Brian, and our middle son, Brad.

MRS. CLINTON: Where did all those Bs come from, Craig and Vicki. (Laughter.)

MR. MCCLUNG: From their mother.

MRS. CLINTON: I like that. (Laughter.) Well, "B" is for "boy." That makes a lot of sense. I think that's great.

SENATOR ROCKEFELLER: We really thank both of you very much. You've shared yourself with, really, the whole country, and we're very, very grateful to you.

MR. MCCLUNG: Thank you.

SENATOR ROCKEFELLER: Thanks so much for letting us into your lives. And I know now that Linda Amon, who works at C & P and who represents the communication workers, I know that you have some comment that you'd like to make, Linda, and we look forward to hearing what that is.

MS. AMON: Okay, thank you. Thank you, Senator. And welcome, again, Mrs. Clinton to wild, wonderful West Virginia. With many companies downsizing, jobs relocating to Mexico or overseas, retirees facing health insurance cost-shifting, many West Virginians could very well find themselves in a similar situation, just as the McClung family. Even those who are fortunate to have health insurance are not adequately covered in the event of a catastrophic illness or accident.

I am very pleased to tell you that West Virginians have the highest per capita of homeownership in the United States. However, one serious illness or accident certainly could make any of us homeless.

Virtually, all the strikes over the past six to eight years in our industry have been over health care issues. Last year, our CWA members that are employed at Century Cable TV here in Morgantown, have seen their family insurance copayment almost triple, resulting in many members having no choice but to drop their health insurance, because, you see, they no longer could afford to keep it.

CWA is on record as supporting the single-pair concept for universal health care. We're hopeful that health care issues will be addressed to Congress, and it will be as fair as possible to all parties, particularly the working people and retirees. Thank you.

SENATOR ROCKEFELLER: Linda, thank you very much. That was a going point, and we're very grateful to you. And now we're going to go to New Martinsville in Wetzel County.

VIDEOTAPE IS SHOWN:

MODERATOR: New Martinsville in Wetzel County is an industrial town in a rural area. Along the Ohio River are chemical and manufacturing plants and service industries. The river itself is busy with commerce as heavily-laden barges sail north and south. The steep ridges that wind back from the river are home to livestock farms and dense woodlands. Many residents with a lack of transportation and long distances, can make access to health care difficult.

Wetzel County Hospital is the center of the county's health care network. The hospital and community physicians provide substantial amounts of charity care. Like many rural hospitals, it faces a continuing challenge to provide a high level of services in the face of severe financial difficulty.

Dan Dunmeyer has been administrator of Wetzel County Hospital since 1987 and has guided it through several financial crises.

SENATOR ROCKEFELLER: Dan Dunmeyer and Dr. James Kamersi, this is Jay Rockefeller and Hillary Clinton. Can you hear us all right?

MR. DUNMEYER: Yes, we can.

DR. KAMERSI: Yes, we can.

SENATOR ROCKEFELLER: All right, Dan. I don't know if you're sitting in the emergency room there, but what percentage of folks that come into your emergency room, Dan, are people that just don't have health insurance?

MR. DUNMEYER: Senator, we serve quite a few patients in our emergency room that do not have insurance or are uninsured or underinsured. The percentage seems to have been growing the last five to six years. Our volume has increased overall. But what we have experienced is fewer people being able to pay. So it's a dichotomy of things -- volume increases, but dollars have decreased.

SENATOR ROCKEFELLER: Dan, if you had to say what was wrong with our current health care system, what would you say to Mrs. Clinton and to the rest of us?

MR. DUNMEYER: Well, I think there's a number of issues. We can't fragment out approach. Coming from a small rural hospital approach in a small rural community, it is easy for me to say that the focus needs to be on primary care, therefore allowing access to care. There's a whole lifestyle issue as well, trying to educate our children to improve their nutritional aspects, their exercise aspects, and take more ownership and responsibility for their own lifestyle. So those two predominant issues -- primary care and wellness -- there's other issues, such as reimbursement or financing and being able to expand programs that reach out into the community. But I think the emphasis should be on primary care.

SENATOR ROCKEFELLER: Let me just ask Dr. Kamersi -- do you find that the folks in that area that don't have health insurance are, in fact, reluctant to seek care, that they kind of put things off? What is the effect in that area of just not having any health insurance? What happens in people's lives?

DR. KAMERSI: I think there are many people who are reluctant because they feel they can't pay for their health care, so they will put things off until they end up having to be in the hospital or go to an emergency room where they don't know someone so they don't feel bad about accepting free care. So it does lead to increased costs, especially for them.

MRS. CLINTON: Doctor, I'd like to ask you and Mr. Dunmeyer to expand, if you will, on what you think the best ways we could improve primary care in a community such as yours and other communities like yours around the country. What are some of the different approaches that you think would work? How do we increase the supply of primary care physicians and others, nurse-practitioners, nurses, physician's assistants and the like, so that we have better access in the rural areas?

DR. KAMERSI: I think one very important way is to look at what it costs me to provide care. So, some help in making it easier for me to provide care, and looking at that cost issue will help me provide care to more patients. I think that's the primary --

MRS. CLINTON: Could you explain that, Doctor? When you say what it costs you, could you describe a little bit more what you mean by that?

DR. KAMERSI: Well, within the last several years, the primary control has been to try and reduce reimbursement. But the other side of the equation, my expenses, have not been looked at, specifically. So, it continues to cost me more to provide care, plus insurance processing is a significant expense for my practice.

MRS. CLINTON: Are you primarily reimbursed as a primary care physician through Medicare and the other third party payers?

DR. KAMERSI: Yes.

MRS. CLINTON: So you, then, are in the same position as general internists and family physicians and pediatricians and others who are really at a disadvantage because you don't get reimbursed appropriately for your -- in the office kind of work, your clinical work, whereas, if you were doing procedures and tests and surgeries, you'd be reimbursed at a higher level? Is that your experience?

DR. KAMERSI: That has been the experience, and I think the expense in processing those claims is the same for a primary physician as it would be for someone either in a larger institution or a consultant.

SENATOR ROCKEFELLER: You know, both to Dan and to Jim, I hear so much about the hassle factor. I have a first cousin who practices family medicine up in Portland, Maine, and he actually had to sort of -- after 14 years or 15 years, he just kind of quit for a year just to get his burners going again. He was just so distressed about paperwork and filling out forms and the so-called "hassle factor." Can you tell us a little bit about that from both of your points of view?

MR. DUNMEYER: I'll start, Senator. I believe my numbers may be off, but there's close to 1500 different insurance companies. Every one requires different information on each of those pieces of paper. So, yes, I think one simple approach is to have that uniform billing to make it easier. There is no reason why a hospital our size should have to have as many people specializing in Medicare reimbursement and Medicaid reimbursement, and the other third party payers when it would be most, or more simple to just have one form to complete and go on our way.

MRS. CLINTON: That is one of our goals. We want to streamline reimbursement, eliminate all of these forms, have a single form which everybody is required to use, and I think it would be one of the greatest improvements we could make in the very short-term. Because you would find it so much easier to run your hospital, and most physicians would be freed from the responsibility they now face of hiring people to hassle with insurance companies, to respond to inquiries and to fill out those forms. That's the fastest-growing part of medical care is the paperwork part of it.

DR. KAMERSI: I think if you would talk to our clinical staff, our nurses and technicians are tremendously frustrated with removing themselves from patient care to do paperwork. So we could applaud that effort of streamlining our paperwork.

MRS. CLINTON: Great.

SENATOR ROCKEFELLER: If everybody in America had health insurance, and everybody in Wetzel County and all the counties throughout there that use your hospital, you wouldn't have so-called "charity care." Either you as a hospital administrator or Dr. Kamersi as a physician -- in other words, when people get health

insurance and they have health insurance, that means they can pay their bills. And that's not all bad, is it, for a doctor or a hospital?

DR. KAMERSI: Obviously not. I think, if I may, that a perfect segue for a point that I would like to make, this hospital, like most hospitals and physicians, do not turn patients away. We take it upon our mission to treat everyone who comes to our facility. So we've accepted that responsibility of uncompensated care; but universal access, that, too, would be a great help.

MRS. CLINTON: But, you know, one of the really sad parts about that is that your willingness to treat everyone and to, in a sense, do so at a cost to your hospital has meant that, for many hospitals, you've had to try to shift those costs because you couldn't run on empty for very long. And so, it's the private pay insurance, it's the Medicaid, it's the Medicare system that pick up the payment for individuals who cannot afford the entire cost or only a part of it. And I often have conversations with people who are so angry about their hospital bills -- and I'm sure you've had conversations like that -- where somebody points and says, $50.00 for two Tylenols, or $1,100 for a foam rubber mattress that I could go down to the wholesale store and buy myself for $80.00.

But the problem, of course, is that hospital administrators like you are put into an impossible position. I mean, once you do what we want you to do, which is to take care of sick people who can't pay for it, that money has to come from somewhere, so we're caught in a vicious circle that, as the Senator points out, if we had universal coverage, everybody would be paying their fair share again.

MR. DUNMEYER: That's right. When they live across the street from you, it is hard to turn people away.

MRS. CLINTON: That's right.

SENATOR ROCKEFELLER: Dan and Jim, we're incredibly grateful to both of you for sharing part of your frustrations and your evening with the First Lady and myself. And we really thank you.

And we have also here in our audience in Morgantown, Dr. Bernie Westfall, who is president of this whole West Virginia University hospital system.

Bernie, we welcome any comment you might have.

DR. WESTFALL: Thank you, Senator. Mrs. Clinton, it is a real pleasure to welcome you to the health sciences center here and to speak to you about the health care system as it relates to a university referral hospital. Obviously, you have a great deal of insight into cost-shifting, and that's one of the things that I've wanted to talk about.

As you might expect, here at the University Hospital we treat large numbers of very, very sick patients. And many of these patients come here from long distances, and many of them do not have insurance. And to give you a very direct example of the outcome of that is that, for a patient who has insurance that's admitted to West Virginia University Hospital, they will pay approximately $500 more per day on their bill in order for us to cover the cost of the free care that's provided at the Ruby Memorial Hospital here. And that, of course, means that hospitals that provide a lot of care to uninsured patients have to charge more. And that's the way the system is currently financed, and there's a lot of inequities in that.

We certainly are proponents of a universal coverage. We believe it's the only way to make a -- put all hospitals on even footing and to eliminate this business and this confusion about shifting these costs to the patients that can pay. There's nothing fair about that.

The one concern that we have is that getting to universal coverage for all of the people in this country that do not have insurance is going to be a very expensive proposition, and we know that. Our concern is that you may be forced, in looking at health care reform, to phase it, to begin with trying to fine-tune the payment systems and to get rid of the insurance bureaucracy, which we favor, but then we may have to delay or phase-in the coverage for everyone.

That would mean that, for a hospital like ours, we would be at a great competitive disadvantage during that phase-in period. And I'm sure that you're aware of this, but we want to restate it from West Virginia and from the Ruby Memorial Hospital here. It's very important.

SENATOR ROCKEFELLER: Bernie, I hate to interrupt you, but we've got a lot of people on the line and I really apologize to you, but we need to thank you very, very much and we need, now, to go to Martinsburg, West Virginia.

VIDEOTAPE IS SHOWN:

MODERATOR: West Virginia's historic eastern panhandle is one of the state's most affluent and rapidly-growing areas. Just an hour from Washington, D.C., it's becoming populated by people who commute to the capital for their jobs.

Martinsburg, in Berkeley County, is the area's largest town with a population of about 14,000. The region is the center of West Virginia's fruit growing industry, and the seasonal employees who work the orchards pose special health care issues.

Industry has found the panhandle's flat terrain, mild climate and accessibility to East Coast markets attractive. The large companies, which nearly always provide health insurance for their workers, health care reform may bring relatively minor changes. But small businesses worry that required coverage for their workers may be too expensive.

Berkeley Upholstery in Martinsburg is a manufacturer of custom furniture that currently has 18 employees. It's a family business now in its third generation.

SENATOR ROCKEFELLER: Mike Ellens and Jerry Keith -- Mike, we know that you're the business owner there. And, Jerry, you've been working and we also know that you're a Vietnam Vet. Mike, maybe you could talk to us a little bit as the owner of a small business what it means, the problems of health insurance, in trying to get -- or, the frustrations of it. If you could just talk to us as representing a typical small business in West Virginia.

MR. ELLENS: Good evening, Senator, and Mrs. Clinton. During the five-year period, from 1982 to 1987, we found our employee and employee dependent health care insurance coverage increase a total of about 32 percent. In the next five years, from 1987 to 1992, it increased in excess of 500 percent. We had one carrier fail, and the second carrier got hit with two major claims and became very recalcitrant to deal with, ending up forcing us to go to the West Virginia Insurance Commission on at least three occasions to settle claims.

Anticipating another 50 some-odd percent increase in premium, we shopped for other carriers but found because of the small group, and we have an old group -- average age is about 53 and our oldest employee is 81 and many have pre-existing conditions -- many carriers did not want to deal with a small group, and those that did were reluctant to do so because of the age and the pre-existing conditions or wanted to exclude employees.

This has basically been our problem with trying to provide our employees with insurance. And we have found that as the cost increased a family now is in excess -- was approaching $7,200 a year, we've had to reduce coverages and shift more of the cost over to our employees.

SENATOR ROCKEFELLER: Maybe I could just butt in there with Jerry, and if you could talk, Jerry, to Mrs. Clinton and myself and to West Virginia about what your health care insurance problems have been let's say over the last five or 10 years. What have been the frustrations for you?

MR. KEITH: Basically, my frustrations come out to be that the big industry is offered all kind of incentives and discounts. When it comes to the smaller industry, there's no incentives, no discounts and, quite often, no insurance offered whatsoever to us. Here at Berkeley, we've seen our costs keep rising and rising. Every time they've rose, we've had to lower our coverage and raise our deductible to be able to afford it. And, finally, in the past year or so the company has had to add a certain portion of this cost onto us individually right on the paycheck at the end of the week.

This is getting harder and harder on all the people here, and they've had to ask themselves an important question -- can I afford this insurance and, possibly more important, can I afford not to have health insurance? We talked about this earlier and they -- some of the people here asked me what I thought was a reasonable cost of health insurance. And I can't answer it in dollars and cents but I can tell you I don't think it should be the highest number in my monthly budget. I don't think it should be higher than my house payment. I don't think it should financially burden small industry out of existence, and I don't think it should financially burden me to the point that I can't enjoy my good health for the fear of a possibility of bad health.

MRS. CLINTON: Jerry, that's an eloquent, eloquent statement. (Applause.) You have said so well what I have heard all over America because more than two-thirds of our small businesses like Berkeley do insure and they have run into exactly the same problems that you both have described tonight. And it's just heartbreaking because it's clear from listening to both of you that this is a company where people talk to each other, where they stay employed for long periods of time, where your oldest worker is 81, where there's a real sense of community as well as a job. And yet what you have faced is what small business has faced in the last 10 years. There is no excuse for it.

And among the reforms that the President will propose are the following: There will no longer be the kind of disadvantage that small business has encountered. You will be part of great, big pools to buy insurance and you will get all the breaks and all the discounts that the big guys have been entitled to, and they won't be able to play you off against one another the way insurance companies have in the last few years; so that it got to be more like how few people could you insure for how much money instead of how many people you could insure for a reasonable return.

Secondly, people will not be denied insurance coverage because of their age or a preexisting condition. They will be

eligible for reasonably priced insurance because they are Americans. And that is something that is very important to us, particularly when it comes to people who have been working hard and have been disadvantaged, as you have described.

So one of the things that I feel very comfortable telling you both tonight is that for companies like yours that have suffered and struggled to try to maintain insurance and found it more and more difficult and more and more expensive, I think that the kind of reforms the President will propose will make it not only possible to insure everybody, but will do it at an affordable cost that will be bearable to both the company and the employee. And that is our primary goal in trying to make sure that companies like yours and individuals are no longer disadvantaged the way you have been.

SENATOR ROCKEFELLER: Jerry, just not having health insurance -- I mean, you know a lot of folks like that. I mean, let's get down to it. There's a sense of self-esteem, isn't it? A sense of helplessness when people don't have health insurance?

MR. KEITH: Oh, it's definitely helpless. I think basically they've lost a lot of faith in the system. You know, some of these people have paid into something for -- a pool supposedly that we've had for 20 years and they've been paying in monthly. And now that they're getting a little bit older, it seems like the system has copped out on them. You know, it's left them standing after paying for it for all this time.

SENATOR ROCKEFELLER: Mike and Jerry, I hate to say this, but we're going to have to go to another part of the state. Mrs. Clinton is incredibly grateful that you've just been -- both of you -- so straight with us and you shared your experience with all of West Virginians, and I think people can identify with what you're saying. We're awfully proud of you, and we thank you very, very much.

And I know now that Steve Roberts, who is President of the West Virginia Chamber of Commerce, has a very short comment that he wants to make. (Laughter.)

MR. ROBERTS: Mrs. Clinton, thank you very much for coming to West Virginia and listening to our ideas and listening to our problems. We invite you to return soon. And Senator Rockefeller, thank you for your outstanding and extraordinary leadership in this important issue.

The West Virginia Chamber of Commerce hears from companies like Berkeley Upholstery often, and the story is very much the same. We believe in universal access, but we believe that in order to have universal access, that costs must be controlled first. We believe in cost control measures that include preventive medicine, education. We certainly love the idea of uniformity of claims and form administration. And we're particularly intrigued with the idea of employer buying groups. Pool buying groups make so much sense. And yet, in a state like West Virginia, which is rural in nature, there are some problems in figuring out just how to do it. So we'll be eager to work with you and to hear what comes from Washington so that perhaps we can put together employer buying groups in West Virginia and participate in those kinds of savings as well.

SPEAKER: Steve, thank you very, very much. And Mrs. Clinton, we're going to go on now to Cabin Creek, West Virginia.

VIDEOTAPE IS SHOWN:

MODERATOR: Cabin Creek runs through a long, narrow gap between two mountain ridges in southern West Virginia. The settlement, which spread out for miles along the creek, are mostly

former coal mine company towns. Most of the mines closed years ago, and the economy has never recovered. Several thousand West Virginians live along Cabin Creek. Many are elderly, others work at small businesses, or commute long distances in their jobs. A large number are unemployed. The community has worked long and hard to keep health care available. A health care center was begun was union and community activists in the 1970s, but it was difficult to attract and keep physicians. And the clinic struggled financially.

In 1991, the Cabin Creek Medical Center closed for several months, leaving the area with no primary care. West Virginia Governor Gaston Caperton worked with the state's three medical schools to reopen the clinic. It's now a training site for medical students and provides care to some 6,000 people from three counties.

SENATOR ROCKEFELLER: Jane Hughes, can you hear us all right?

Q Yes, I sure can.

SPEAKER: Okay. And Daisy Austin, can you hear us, too? And Holly Hartman? All right. Good. We're very glad that you're with us. Jane, I'm just wondering if you could tell us what it was like when, in fact, the Cabin Creek Clinic just flat out closed. There was a period of time there where it was just closed. What happened? What happened in the community?

MS. HUGHES: Well, you know, so many people depended on Cabin Creek Clinic tremendously. Up here transportation is a problem. You can't always get a ride to a doctor somewhere else. The bus only runs up here once in the morning and once in the evening. It's not like other places. And myself personally, I have transportation. But at one point, I had a very sick baby and I had a newborn at home. My son awakened with over 105 temperature. And the clinic was closed and I had to have someone to drive me about 30 minutes. I was just so scared. And then I had to have somebody to keep my newborn. So if the clinic had been here that would have never happened because I would just have come right up here.

SENATOR ROCKEFELLER: Holly Hartman, let me just ask you a question. You want to be a primary care physician, and here you are in the heart of rural West Virginia. And the odds say that you can't do it, in other words, that you just can't make enough money or that there's just -- you owe too much when you get out of medical school and yet you want to do primary care. What can Mrs. Clinton and the President of the United States and others do to help people like you practice primary care?

MS. HARTMAN: I think a lot of the issues that have been discussed already in the program about reimbursement, decreasing the cost of paperwork and insurance are all things that would greatly encourage students go into practice in rural care. Rural care is interesting in that it has an aspect of human care that no other specialty does -- you can follow a family for three generations, you can perhaps deliver a child, follow that child through it's childhood years, but there's also so many drawbacks to rural care as far as the reimbursement, quality of life issues in a rural area.

I think what the Clinton's need to do -- is the bottom line is patient care. So they need to change things and make it more attractive for physicians.

MRS. CLINTON: Now, Holly, that's a good way of putting it. I mean, all of the issues we've talked about are very important: reimbursement, forms, cost containment, all of those are very important. But those are a means to an end, and the end is quality patient care. I mean, the end is how do we provide better care for Americans so that they can be healthier, which then will have the

impact of making our health care system more efficient as it moves through time. And what you've said is so significant because I hope we measure everything we're going to propose in terms of what is the impact on patient care. And I believe that if we look at our problems honestly and ask that question we will come back to the points that you made. We will support rural clinics because they make sense and they'll be tied into delivery networks so that they're not out there all by themselves as some kind of little outpost, but they're part of an extended system of care that, you know, stretches from Morgantown to Cabin Creek, and where physicians are going to be supported to do the kind of quality patient care you're talking about.

SENATOR ROCKEFELLER: Daisy, if I could just get you there on screen for a moment. You've been a teacher for 41 years, Daisy Austin, you're a member of the board there. And you're a senior citizen and I've known you for a long time and I love you dearly. Now what is it, as a senior citizen, that you'd like to say to President and Mrs. Clinton about what we ought to be concerned about in our health care reform?

MS. AUSTIN: Hello Senator Rockefeller and Mrs. Clinton. I'm so happy to be able to speak for the senior citizens. As you know I am -- I have been here almost eight decades. So I've gone through a lot. My greatest desire is that the senior citizens be taken care of in the manner that they like to live in.

For example, I've lived at my home for about 43 years. I built the home and raised many, many children there. I would like to stay in my home when I become disabled and perhaps have some system in place that I could have a para-professional or someone to come in and help me to maintain my home and live happily. I would like to live there until the Hallmark Hall of Fame would recognize me for my 100th birthday. (Laughter.) So please help me. (Applause.)

MRS. CLINTON: Well, I have some kind of a feeling that may very well happen. (Laughter.) You know, one of the -- one of the issues that Senator Rockefeller and I have talked about a lot together in this issue of long-term care, because you're absolutely right, if we provided more support for older Americans to stay in their own homes. to be helped at home, maybe when that were no longer possible to move in with people and be helped in a small setting, we would be doing a great service to our older Americans. And we also would be saving money. Right now what we do is to say, you're either on your own or you're in a nursing home. Nothing in between -- we're not going to help you with any of these other needs. So I think what you're saying makes a whole lot of sense. Probably the Senator and I are going to have to call you to come down to talk to some folks in Washington about how much sense that makes.

MS. AUSTIN: I'll be glad to.

MRS. CLINTON: Good, good. (Laughter.)

SENATOR ROCKEFELLER: Cabin Creek has been losing population over the years, Daisy, and any of the rest of you that want to comment on this. Is Cabin Creek -- is the clinic there meeting the needs of the health care folks or is it not? What do we need to do for Cabin Creek in the southern West Virginia area to help on health care?

MS. AUSTIN: This facility is first-rate and it has been recently renovated and painted and it could be a hallmark for preventive care, in particular, because a great work had been going on here for a couple of years in order to work in that place. And then, two, you know, we serve parts of -- County and Boone County, all of the lower Chesapeake and across the river --. We have a great outreach here, so this clinic has a great need for this vicinity.

SENATOR ROCKEFELLER: Jane Hughes, and Holly Hartman, and Daisy Austin, God bless all of you. Mrs. Clinton and I are so grateful, we didn't have -- there's more we wanted to talk about, but we just don't have the time to do it. Air time is going to run out on us, but we really thank you for sharing with us, for being so honest with us, and we wish you all the very best. And we'll be seeing you very soon.

Here in our audience, Dr. Donald Westin, who is West Virginia State Director of Health, has a comment, I expect, good doctor, and we welcome him.

DR. WESTIN: Senator Rockefeller, Mrs. Clinton, it's a privilege to describe, very briefly, some initiatives on training health manpower. In 1991, Governor Caperton and the legislature put through a rural health initiative. We've got a Kellogg Grant to really turn the university system, our three medical schools, our nursing -- school to the rural areas.

We now have over 110 rural health care facilities, clinics, rural hospitals, networked into 12 networks for rural health education of where all of our health science students -- 1,200 -- will spend a minimum of three months training in these rural health sites. We believe this is an amazing direction. A lot of commitment has come from the state legislature. But also it's a big partnership with the communities, because the communities are equal partners in this. The oversight responsibility at both the local level and the state level is with the university system and the communities.

Just one last thing about keeping health professionals and that's economic development for these areas, the quality of life is the key issue. Thank you.

SENATOR ROCKEFELLER: Thank you very much, Don. Mrs. Clinton, I hate to say it but we've come just about to the end of our time. And I want to thank so much each of the people that talked with us from the four different sites in West Virginia. It's technologically a very difficult thing to do, you know, all of a sudden you have the camera staring you in the face and you've got to talk to the First Lady of the United States. That's not easy, but people have done it and, of course, we in West Virginia are very forceful in our thinking and in our views.

I really want to thank you and I know that Mrs. Clinton does also. I want to thank very much the TV and radio stations that have carried this live. It's a remarkable thing. It's never happened before in the history of West Virginia that we have so many people tuned in and listening to a serious discussion on health care. I want to thank West Virginia University. I want to thank our audience here in Morgantown, the Speaker of the House and the President of the Senate and all the many good people.

And let me just make a quick closing statement, Mrs. Clinton. This is just desperately serious stuff. It makes me very angry sometimes to hear people talking and trying to figure out what it is the task force is doing in Washington, D.C. Well, let me tell you what they're doing. Mrs. Clinton has brought together -- first of all the President takes the First Lady for the first time in American history and says I want you to take charge of this, the most important problem that we have other than our economy itself. And this White House Task Force has been working now for months, 500 people, 60 physicians, all over the country. And they're in a position right now, in fact, where we're beginning -- they're beginning to come down to their basic decision making.

Mrs. Clinton views this, as I do and as I know our people in West Virginia do, as really a matter of life and death for

our country. It can be said fairly and it can be said accurately, there is no way that we can reduce the budget deficit in this country unless we get the cost of health care under control. There is no way we can call ourselves good West Virginians or Good Americans unless we know that every single West Virginian and every single American has health insurance.

And the hard part is that we're going to do all of that and we're going to do it this year. This is a real national calling, and I'm just calling on West Virginians to support what it is that the Clinton administration comes out with in the way of health care reform. Will it be complicated? Yes. Will it be important? You better belief it. Will it be worth fighting for? Absolutely.

Most of all, Mrs. Clinton, obviously I really thank you, I mean, the whole country wants to see you and you've come here to West Virginia. And we're incredibly grateful and maybe you should just -- we've got about three minutes left. (Laughter.)

MRS. CLINTON: You know, I like coming to West Virginia. We have pretty good results when we come to West Virginia. (Laughter.) It always makes me feel good. I may come back permanently. (Applause.) Everything that Senator Rockefeller has just said and that we've heard from people here talking about their own experiences really points to the need for change.

And one thing we haven't said is what the cost of staying where we are is, the cost of doing nothing, of throwing our hands up and saying, you know, we've heard all these problems and they're all so difficult and, gosh, I just don't think we should tackle something that complex. Well, while we sit here for the next minutes and hours and days, our health care costs will continue to go up; more and more people will lose insurance; more and more people will worry at night about what will happen to them; and our country will spend over a $100 billion more next year that will not give one more ounce of care to anybody who doesn't have it already. So there's not really a choice if we're going to really pull together as a nation.

And what I have so appreciated is how interested Americans are. I laughed the other day and said we have 250 million Americans and I think we have 250 million experts because everybody takes this so seriously. And what we need, as Senator Rockefeller has said on so many occasions, is for all of us as Americans to say to ourselves, what kind of country do we want to live in? What kind of people do we want to be? What kind of future do we want to have for ourselves and our children? Do we want to be a country that takes care of each other again, that permits doctors and nurses to take care of people instead of fill out forms? Do we want to see our children be healthier, instead of declining in health as they're currently are? Do we want to see older Americans live with more security in their own homes wherever possible? I think most of us answer those questions, yes. And the way to get there is by doing what we're doing tonight: listening and talking honestly to each other and then acting together.

I really appreciate all that I've heard, and I'm looking forward to working with your Senator and your other elected officials to make health care a reality in West Virginia and America this year, Senator.

SENATOR ROCKEFELLER: Absolutely. (Applause.) Thank you, everybody. Thank you very much and good night. (Applause.)

END 7:45 P.M. EDT

HEALTH CARE
THAT'S ALWAYS THERE

A FIFTEEN MINUTE VIDEO PRESENTATION
OF THE CLINTON HEALTH SECURITY PLAN

PURPOSE

This program is designed as a primer on the Clinton Health Security Plan for Members of Congress, Democratic Party activists, community groups, and anyone else who needs to understand it or to explain it to others. Although it will be of broadcast quality, it is not intended to be a stand alone TV program for the general public.

OVERVIEW

I imagine this piece as a fifteen minute, inspirational, educational piece. It needs to communicate the urgency and humanity of the health care issue and at the same time clearly and calmly explain how the Clinton Health Security Plan will address the problem of a system out of control.

As such, I feel the tone of the piece should be human and emotional rather than newsy. I see us relying on real people to communicate the dimensions of the problem and on the President to explain the solutions.

In order to identify people to talk to in the program, we might look to the thousands of letters the White House has received or the many people Hillary Clinton has met around the country who have shared their fears and concerns about the state of our health care system.

STRUCTURE

As I understand it, we have several distinct elements to communicate in our program.

1. The problem: The system is out of control, costs are skyrocketing and meanwhile, people live in fear of losing access to health care.

2. **The vision:** This plan reflects a commitment on the part of the President to take on the special interests who have kept us from reforming the health care system to give Americans real security that they will always have health care.

3. **The solution:** A. The Clinton Health Security Plan will bring the system under control
B. It will provide security to every American that their health care will always be there no matter what.
C. We will pay for the plan through controlling costs, and through asking every American -- employers, consumers, everyonem -- to take responsibility for his/her health care.

I have chosen to divide the plan into three sections to reflect what I see as distinct themes:

* How we will fix the system
* How the system will *work for you*
* How we will pay for health care

Section 1: Introduction: A System Out of Control

What we say: The introduction must carry the message that, as it stands, our health care system no longer makes sense. Health care costs are out of control, having quadrupled since 1980. And they are rising at a rate that will have the cost of care to American families doubling by the end of the decade.

Meanwhile, everyone lives in fear of losing their coverage, and every month, 2 million people do. *If we do nothing, one in four Americans will lose their health insurance in the next two years.*

In short, everything that is wrong with our health care system is threatening everything that is right about American health care. We must fix the system -- preserving the things people care about: the right to choose their own doctor and the ability to get high-quality, affordable care.

What we see: Here we need to communicate the seriousness and immediacy of problem in an evocative way. I imagine a montage of "health care" images: doctors in hospital rooms, people in clinic waiting rooms, nurses filling out reams of forms, a crowded urban emergency room, probably all slowed down and in black and white. Not scary, but urgent. Over these, we will hear the voices of Americans telling us of their fears and concerns about the health care system:

Man's voice: "I've been stuck in my job for 10 years because I'm afraid that if I leave, I'll lose my health insurance."

Woman's voice: "I work for a small company and they don't cover me and my little girl. If we get sick, I don't know what I'll do."

Man's voice: "I've run a diner for fifteen years and I'd love to get insurance for the folks who work for me, but I just can't afford it."

Woman's voice: "I became a doctor to help people. Now I spend half my time just filling out forms."

You get the idea. These people *must be real*, they must be expressing*their* concerns, and we must be able to relate to them. I would intersperse the visual images we're seeing with factoids (graphically represented on the screen) about the general state of the health care system so as to broaden these individual experiences to illustrate the big picture.

This section might even want music. I see it lasting about 3 minutes.

Section 2: The Vision behind the plan

What we say: Here the President needs to tell us where this plan is coming from. Something like, "For decades, we have watched our health care system become bloated and inefficient -- costing more and more, yet leaving Americans without the security of knowing that when they need health care, it will be available to them. And for decades special interests have protected their profits and blocked efforts to meaningfully reform the system. But no more."

He should then elucidate the principals on which this plan is based:

***Security:** A plan that let's people know that they can never lose their health care coverage.

***Savings:** A plan that will control the skyrocketing costs.

***Simplicity:** A plan that will close the loopholes and reduce the bureaucracy that are bringing the system to its knees.

***Responsibility:** A plan that asks every American to take responsibility for reforming the system so that once again, it will work for us instead of against us.

What we see: This should be the President speaking directly to us, probably in a setting somewhat less formal than behind his desk in the Oval Office.

Section 3: Getting the system under control

What we say: In today's health care system costs are out of control, and we are awash in a sea of bureaucracy, red tape, waste, inefficiency and fraud.

The Clinton plan will get the system under control by:

* **slashing the red tape** that forces doctors and patients to spend their time filling out forms and fighting bureaucrats,

* **cracking down on fraud** by imposing and enforcing stiff penalties on anyone who takes kickbacks, files fraudulent claims, or in any way abuses the system for profit.

* **reforming malpractice** to eliminate "defensive medicine" (doctors ordering extra tests or procedures just to protect themselves from malpractice suits) that hurts the quality of care while driving up the cost.

* **controlling costs** by stopping overcharging by doctors and hospitals, and limiting drug prices that are three times higher here than they are overseas.

What we see: I see this section starting with a montage, not unlike the introduction, but with people on the screen, not just in voice over. Again, these should be real people (lay people, health care professionals, maybe lawyers) in interview settings, telling personal stories that specifically relate to the things that are wrong with the *system.*

We will hear a patient describing the ordeal of trying to get reimbursed for an operation only to be told, after filling out mountains of paperwork and countless phone calls, that the insurance company was not going to pay. Or a doctor talking about ordering a whole battery of expensive tests on a patient *not* because she felt they were necessary for the health of the patient, but because she feared a lawsuit if she didn't.

As in the introduction, I see this montage as visually stylized, interspersed with images that relate to the stories we are hearing, and possibly graphic "facts" relating the individual story to the larger problems with the health care system. This segment lasts about one and a half minutes.

Then the President will respond by describing the way in which the stories we've just heard relate to the larger issues at stake and how the Health Security Plan will address them.

The President's explanations should, I think, be helped out with graphics. Not Perot-type charts, but highly produced, animated graphics to which we would cut away during his explanations. This section should run about 5 minutes.

Section 4: Protecting the best and providing security

What we say: The Clinton plan protects and expands access to high-quality health care for all Americans. Without reform, one out of four people will lose their coverage in the next two years. This plan will give every American the security of knowing that they can never lose their health care coverage, no matter what. How does this work? Well, under the Clinton plan:

* **Everyone gets a health security card** which nobody can ever take away. It guarantees them access to a comprehensive benefits package that is at least as good as most Fortune 500 companies currently offer their employees. And that goes for everyone, whether they are employed or not, whether they work for a huge company or a small business. *Everyone!*

* **People stay healthier** because, unlike most current insurance plans, the Clinton plan emphasizes preventive care by providing coverage for a wide range of preventive services.

* **People have increased options for long-term care.** The Clinton plan makes it possible for more elderly and disabled Americans to stay in their homes while receiving care rather than being forced into nursing homes.

* **Insurers won't be able to hurt small businesses and consumers** the way they can now because under the Clinton plan, it will be illegal for them to drop people *for any reason.* The plan will close the loopholes that permit insurers to deny coverage because of preexisting conditions. They won't be able to cancel your insurance if you lose your job. And they won't be able to charge small businesses and individuals double what they charge big business.

* **The consumer will be in the driver's seat** when it comes to dealing with insurance companies. Having small businesses and consumers band together in health alliances will level the playing field and give them the same bargaining power as big businesses.

What we see: As in section 3, I see this section starting with a montage of stories and images, this time relating specifically to issues of security. A man who has been without health insurance for three years and is scared death of ever getting really sick. A woman who couldn't afford to go to the doctor for routine checkups because her insurance didn't cover them, and only finally went when she developed a serious illness that required hospitalization which *was* covered by her insurance. Or a small business owner whose insurance premiums were tripled because one of her employees got sick and racked up some high medical bills.

Again, the President will respond to these stories by describing, with the help of graphics on the screen, how the Health Security Plan will give us the security that these people, and so many of the rest of us, crave, but have never had.

This section should take about 5 minutes.

Section 5: How we're going to pay for this

It seems to me that there is only one way to tell this story and that's for Bill Clinton to tell it, directly to camera, probably aided by graphics. This section should be no more than 3 minutes long and should consist of "nothing but the facts." Here's how we're going to finance the system, and here's what *you* will be responsible for.

We'll get costs under control through:

A. reductions in administrative costs,

B. savings in Medicare and Medicaid, and

C. possibly a cigarette tax to fund
long-term care for the elderly and disabled.

And *every* American will be responsible for participating in the system:

* If you are a self-employed individual, it will cost you this much.

* If you are employed by a company that currently provides insurance, here's what they'll pay, here's what you'll pay.

* If you have a small-business that hasn't been able to afford to provide health insurance for your employees, here's how you'll be able to and here's what it'll cost. Etc., etc.

Obviously we will need real numbers to make this section work.

We will, I believe, also want to let people know that their costs are likely to be the same or lower than they are now, and that their coverage is likely to be the same or better than it is now.

Conclusion

Here, the President should make some brief concluding remarks. He should restate the purpose of the plan, rally the viewers to the difficult fight we have before us, warn people that the opponents of change will try to thwart this effort but that we cannot, under any circumstances let them prevail, and that people must speak out and let their views be known in order for this plan to succeed.

Following this, I think it would most effective for us to hear how some people feel about the plan. I'm thinking of very brief testimonial quotes from a doctor, a health care economist, a small business owner, etc. This section should, I think, be run with music and last no more than 2 minutes.