Only Dr. Lyons Sermon

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release October 2, 1994

REMARKS BY THE FIRST LADY
AT BETHEL METROPOLITAN BAPTIST CHURCH
ST. PETERSBURG, FLORIDA

MRS. CLINTON: Thank you so much. I am delighted and I am honored to have this chance to share Sunday worship with you and to be part of this congregation that I understand celebrated its 91st anniversary.

There are not many institutions that have served the Lord for 91 years, and this church has made a very special contribution over those many years, but certainly having its pastor become the president of the largest religious organization in our country, the National Baptist Convention. is a singular contribution.

My husband extends his greetings to the entire congregation and particularly to Dr. and Mrs. Lyons. We had the pleasure of meeting when we attended the national (inaudible).

But for any of you who have ever doubted that a single vote doesn't count, every person's vote counts, and it's wonderful that the votes at the National Baptist Convention counted and (inaudible) Dr. Lyons to be president, because his leadership will focus on (~~inaudible~~ saving) reform and spiritual rejuvenation and will provide opportunities for people all over our country, not only to know the Lord but to ~~tell~~ know how they can participate in the Lord's work here on earth. And that is surely our goal. It is that (inaudible).

I am delighted to be here with your Congresswoman. Congresswoman Brown, I would have traveled anywhere to see you so dressed up and looking beautiful because

Usually when I'm (inaudible) on the Hill she's running hard to get something done, and I'm running to (inaudible). She has papers in her arms. She's talking to an aide. She's absolutely committed, trying to get the job done. It's just wonderful to be here with you in this house of worship and to have a chance to say to your constituents how grateful we are for your leadership on so many important issues, issues that may have once again (inaudible).

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The mayor thanked the Clinton administration for (inaudible) the city. And, Mr. Mayor, I am grateful for that appreciation, because this President believes that our cities have been neglected, and that the work of mayors and members of city councils is very difficult, and there should be a partnership between the federal government and local governments to uplift the cities.

But (inaudible) the President has done for the city in the last 20 months was not done with much help from the outside. And if it had not been for Corinne Brown on many occasions casting her vote in favor of economic progress, in favor of helping our cities, there wouldn't be programs for this city and others (inaudible).

If it had not been for your Congresswoman, the crime bill, which will make a difference in the lives of people, might not be the law of the land. So there are many reasons why votes are important.

And certainly we need to look at Doug Jamerson. And you know what kind of work he has done to further education and, again, to work in partnership with this President, who truly believes every child in America should be given an skill, an opportunity to live up to that child's God-given potential. And that partnership is so important to continue. And this man cares about educating all the Lord's children. He cares about the kind of issues that many people just talk about and then walk away from.

He wants to work with his President and this administration to make our schools safe, and to make our schools productive, and to help our teachers and our principals so that they can do the job they want to do. But he can't do any of that if he doesn't get the votes in the election. Everybody has been telling him what a fine job he is doing. But if they don't vote, all that kind flattery doesn't give the kind of support that he needs to do the job that he is trying to do for the people.

And certainly the same is true for Governor Chiles. Florida under Governor Chiles has been a pioneer. It has taken on tough issues, health care reform, jobs creation, all of the hard issues that really make a difference in people's lives, and, again, in partnership.

Governor Chiles works with his administration to

make sure Washington knows what Florida needs, to make sure that Washington and this President help Florida. He has done a superb job. He will continue to do so. But, again, without the votes he cannot be here for the people of Florida.

And as Dr. Lyons said, Florida has a great United States Senator in Bob Graham, who has been a friend of the President's ever since they served as governors together. And Senator Graham has been there supporting the President's agenda, has been there helping him, giving him advice and counsel. But every time he votes, his vote is canceled out by Florida's other Senator.

And I want to ask you to consider voting for my brother.

He brings to his candidacy for the United States Senate a genuine commitment to the welfare of people for 14 years. He helped set up, in fact, the trade bill for Janet Reno and the drug courts in Dade County that revolutionized the way drug offenders were treated, disciplined, punished, and helped. And through that work he saw every social problem you can imagine. He is not an armchair critic. He is a person who rolls up his sleeves and gets to work, and as you can tell, he is my little brother only in years.

When he rolls up his sleeves, there's a lot to work with.

I love coming to Florida, and I am so grateful for the opportunity to be back here in St. Petersburg and in this part of the state, because there is a lot of energy and there's a lot of hopefulness. You are right. Your mayor (inaudible) immediately, showed me around the city, and started telling me what is going on. Congresswoman Brown grabbed me and began to talk to me about the things she wanted to help to make sure happened to the people of her district. Doug Jamerson talks about education.

There is a lot of positive energy. But we know that we're living in a time of change and uncertainty. And often times when change is upon us it's a frightening experience, isn't it? Even in our own lives, even good change -- having a baby, getting married, changing jobs, moving somewhere -- even though they might be good changes, they cause uncertainty as well.

And in the world in which we are now living and in our country there is so much change. I believe that our great country will work its way through these changes and emerge the stronger for it, just as I think that individuals who tackle the problems that they have with God's help emerge stronger from those challenges. But in the meantime it is often a difficult journey.

And as we look at our country, we know we are going through a period of transition. The end of the cold war has meant that much of what we took for granted about the way the world worked is no longer the reality.

Thank goodness we no longer are facing the evil empire of communism and the former Soviet Union. Thank goodness our soldiers are not on the other side of walls and barbed wire fences. Thank goodness those missiles are no longer pointed at us. Those are all great things for which we can be thankful. But in the face of those changes as the world has changed, it is still a place of great peril and promise, as it has always been.

One only has to read the Scriptures to know that every generation, every era holds promise and peril, and what made the difference was how people responded. There will always be dangers. There will always be evils. We know that from the Scriptures. But what the challenge is is for each of us to make the choices that will give us a responsible, positive life.

Now, every Sunday in churches across our country people come together to worship, to make individual decisions based on their own faith. Every time in our public life there is an election people gather together to make decisions based on what they believe is right for themselves and their families. But in a time of uncertainty they can be easily pushed back and forth. Their emotions can be created to be so passionate and inflamed. They can be mislead. And it is so important in a democracy that people be well-informed so they can make the best decisions.

What this President decided he wanted to do when he became President was to move our country forward economically and bring it together. We've made a lot of progress economically. Because of votes like those that your Congresswoman cast, the deficit is coming down three times in a row. That has not happened since Harry Truman was

President.

We have seen jobs being created. We know there are not enough of them and they are not often in the places they need to be, but 4.3 million new jobs have been created since the President took office. And there have been a lot of other positive changes. But we're not selling products (inaudible). Finally we have a President who got the Japanese to open up their markets for American products to bring Americans jobs.

(Inaudible) going on economically, and it is connected with improving education, which often determines what kind of job someone can get. It is connected with training workers so that they can advance. All of that is positive.

But the President would be the first to say that we have to work harder together. We have to make sure we are not afraid of those who would preach negativism and cynicism. We must be those who carry the message of hope and optimism. We must be those who say over and over again we can make progress. We don't need to turn our backs on each other. We don't need to become isolated from one another. We need to reach across the lines that too often divide us and hold hands and work together on behalf of our communities and our country. And if we do that, then we create all of this positive energy for change and progress.

Every day, every one of us has a choice when we wake up in the morning how will we thank God for the day of life (inaudible)? How will we help ourselves and our families and others? That is how my husband wakes up every day, determined to do what he can do to make it possible for more and more Americans to share in the opportunities that we have here in our country.

He cannot do it if he doesn't have partners. That is why he needs partners like your mayor, your Congresswoman, Doug Jamerson, my brother, people who believe in the possibility of us being better together, who will not give in to the cynicism of the times.

There is so much to be thankful for in America. There is so much to be grateful for as we worship in this church this morning. And I want to on behalf of the President thank you for the trust and honor you have given us

as we attempt to do what we can to fulfill the promise of America for our entire country. Thank you.

(End of speech.)

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songs
sermon - Dr. Lyons
song

short speeches
Corinne Brown
Hugh Rodham
special guest FLOTUS HRC

FIRST LADY HILLARY RODHAM CLINTON
COMMUNICATIONS WORKERS OF AMERICA LEGISLATIVE CONFERENCE
WASHINGTON, DC
APRIL 20, 1994

[Acknowledgments: Morty Bahr, President (who was with the President in Milwaukee on Monday; Barbara Easterling, secretary treasurer; Loretta Bowen, political director; Louise Novotny (Naa-vaht-nee), a member of the task force]

INTRODUCTION

I'd like to thank you for your incredible work on behalf of health care reform -- and for recognizing over the decades how important this issue is for working Americans.

Your union was born more than a half century ago -- along with one of the cutting edge industries of that era: the telephone. And in the decades since, your hard work has helped America usher in technological advances that have enabled us to outpace our competition -- not just in the telecommunications industry, but in many other industries as well.

But that competitive edge is jeopardized now because of rising health care costs.

I know I'm preaching to the choir here when I say we have a health care crisis. You have fought over the years for good health care coverage for your members, and you understand how crucial that coverage really is.

Let me put in simple terms: Today, we take the telephone for granted. We take telecommunications for granted. We take our utilities for granted -- at home and at work. And that's in large measure because of the commitment and dedication of your members.

These are basic services, services that are fundamental to our society functioning productively. Well, health care is also essential to our productivity. But none of us -- even those of us who have good coverage -- can take health care for granted today.

[Note: The rest is basically the same as the Building and Construction Trades speech]

But today we have an historic opportunity to change that -- to achieve meaningful health care reform. Thanks to the energy of organizations like this one, which has fought so hard for reform, the President has proposed legislation which Congress now has before it -- reform that will help us retain our competitive edge and give every citizen the health security they need.

Already we've made considerable strides in meeting the challenges that face us, particularly when it comes to working Americans. In 15 months, the President has won passage of the Family and Medical Leave Act that allows working parents to be good parents during family emergencies. He expanded the Earned Income Tax Credit that rewards parents for choosing work over welfare. He has introduced the Re-Employment Act of 1994 that will provide meaningful assistance to displaced workers and help them find good jobs with good incomes. And he is working toward real welfare reform that will help parents find jobs and regain their dignity.

These are first steps. But the biggest step of all -- the one that will determine the success of everything else we do -- is health care reform.

Without health care reform we will face not one crisis, but two: a national economic crisis, as well as a health care crisis in which more and more workers are denied insurance because employers refuse to pay for escalating premiums.

That is why, above all, we must provide guaranteed private insurance to everyone . . . even Harry and Louise!

THE MAIN ELEMENTS OF REFORM

* Guaranteed private insurance -- benefits than can never be taken away

* Choice -- the President's reform expands your choices

* Outlaw unfair insurance practices

* Protect and strengthen Medicare

* Health benefits guaranteed at work

OTHER KEY FEATURES OF THE PRESIDENT'S REFORM THAT ARE IMPORTANT TO WORKING AMERICANS

* It will NOT tax benefits

* It will protect early retirees.

* It will help restore wages to workers who have been denied increases they deserve.

Today, high health care costs are eroding our competitiveness overseas and eating away at the wages of workers. If we don't fix our health care system now, by the end of the decade it will cost the average working family about $600 in lost

wages each year.

That's not good for business, for workers, or for the nation as a whole.

CONCLUSION

As we press for reform now -- on the eve of the 21st century -- we have to remember the larger context of this debate.

Health care reform is not an isolated legislative goal. It's part of a broader agenda for progress and change that speaks to our very essence as Americans.

It's about restoring our collective sense of responsibility so that children, families, and workers across this country can flourish in a vastly more complicated world than we have ever known.

It's about something you do every day, every month, every year: Helping make society function productively and smoothly. It's about helping make our society one in which every American participates, and every American is secure. It's aboput helping make our economy sound so that our nation can compete in a new century. It's about helping create a sense of ourselves in which we show our concern and compassion for others.

By participating in the discussion of reform that has taken place across this country over the last 15 months, you have helped shape the reform that Congress has before it. Now we are counting on you to help us take the final step of achieving real health care reform in the months ahead.

Thank you very much.

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FIRST LADY HILLARY RODHAM CLINTON
NATIONAL INFANT IMMUNIZATION WEEK KICK-OFF
THE WHITE HOUSE
APRIL 20, 1994

TALKING POINTS

[Note: Dr. Johnson, Secretary Shalala, the Vice President, and the President will speak after you. Your remarks must be brief and should simply outline the scope of the problem, followed by an introduction of Dr. Johnson]

THE SCOPE OF THE PROBLEM

Last week the Carnegie Corporation issued a comprehensive report about American children aged zero to three. The report was stunning not only in its breadth and depth, but also in the urgency of its message: We are not doing enough to give our very youngest children a healthy start in life.

What could be more important to the future for our nation than ensuring that small children have the opportunity to grow into healthy, responsible adults?

It's so obvious that children -- particularly children from infancy until age two -- should be a top priority when it comes health care. And yet, we have failed our children time and time again.

* Today, only 64 percent of American children are fully immunized by the time they are two.

* The rate is worse for children in poorer, underserved communities, where as many as 50 percent do not receive their immunizations before they are two.

* Many parents aren't even aware that 80 percent of immunizations are needed by age 2.

* We have no standardized system for monitoring vaccinations or notifying parents when vaccinations are due. And often health care professionals do not track their own patients to make sure that vaccinations are up-to-date.

* There are not enough clinics to serve children who need vaccines.

* Our failure to immunize children is not only wrong, it's expensive.

-- We save more than $21 for every $1 spent on the measles, mumps, rubella vaccine.

-- We save more than $30 for every $1 spent on DPT--diphtheria, pertussis, and tetanus.

-- We save more than $6 for every $1 spent on polio vaccines.

* [Any stories about children you or the President have met who developed illnesses because they didn't get a basic vaccination when they were little]

INTRODUCTION OF DR. ROBERT JOHNSON

Nobody knows better than those on the front lines of the health care system the human cost of denying our children the health care they need. Dr. Robert Johnson is a pediatrician from Newark, New Jersey who witnesses daily the unfortunate effects of children not receiving adequate immunizations early in life.

Dr. Johnson sees children of all ages at the Children's Hospital of New Jersey. He also attends to children on a regular basis at the Adolescent Health Center -- called The DOOR -- in New York City, which he co-founded.

In addition to his clinical work, Dr. Johnson is a Professor of Clinical Pediatrics and Director of Adolescent and Young Adult Medicine at the University of Medicine of New Jersey. In 1976 he founded that institution's Division of Adolescent Medicine.

We are extremely pleased to have Dr. Johnson with us today to help educate all Americans about the moral and economic imperative we share in ensuring that all infants, toddlers, and young children receive the immunizations they need.

[Introduce Dr. Johnson]

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FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO AMERICORPS HUMAN NEEDS FORUM
THE WHITE HOUSE
APRIL 20, 1994

[Acknowledgments]

We're all here because we believe in the importance of service. Whether we are young or not-so-young, service is a way of reaching beyond ourselves and finding meaning in our own lives.

We're all interdependent and interconnected. As society becomes more complex, more fast-paced, more global, those connections with each other and reliances on each other will become that much more important.

Americans have a long and rich legacy of service, one that we are extremely proud of. Now that tradition will be expanded through AmeriCorps.

In September, when AmeriCorps is launched, we will see 20,000 members spread across the country helping their communities. Some will teach literacy to children. Some will provide after-school learning opportunities. Some will provide substance abuse counseling. Some will help renovate low-income housing. Some will provide assistance to people with disabilities or illnesses that keep them at home. Some will help maintain parks and gardens, or work on recycling projects.

But we don't plan to stop with 20,000 members. By the third year of this program, we hope that AmeriCorps will have 100,000 members doing good works in hundreds of communities and in every region of the country.

And judging from the number of calls that already have been logged on Eli's 800-number -- I gather that about 60,000 people have called to express an interest in AmeriCorps -- I don't think we'll fall short of our goal.

Today we are fortunate to have with us an intergenerational group of citizens whose service really defines what being an American is all about. Their efforts not only represent selfless dedication to helping others, but also demonstrate the affirmation we feel as individuals when we contribute our time and energy to fellow citizens in need.

Each of the presenters today represent a wonderful nexus

between service to others and the delivery of needed health care. One of the most important aspects of health care reform is finding ways to enable the chronically ill and disabled to stay at home, in comforting, familiar surroundings.

Providing opportunities for independent living is just one form of service. Of course, there are many. But I want to thank all of you for coming here today to see what an incredible difference we all can make if we take the time to think about community, responsibility, and opportunity -- and how we can enrich ourselves and our nation through serving others.

Thank you.

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E X E C U T I V E O F F I C E O F T H E P R E S I D E

30-Jun-1994 05:08pm

TO: Jennifer L. Klein

FROM: Karen E. Finney
Office of the First Lady

SUBJECT: Speech you requested

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 14, 1994

REMARKS BY THE FIRST LADY
TO NORTH CAROLINA CONGRESSIONAL DELEGATION
WASHINGTON ISSUES SEMINAR

Thank you very much. It is a great treat for me to be here and to have a chance to join the Members of Congress who have sponsored this event, every one of whom I know that you are very proud of, but they are also Members of Congress who the President and this Administration have particularly enjoyed working with because they have the unusual combination of common sense and guts on many important issues that we are very appreciative of.

So I personally would like to thank Congressman Hefner for that introduction but also Congressmen Neil and Valentine and Lancaster and Rhodes for the many good ideas and support that they have given.

And I want to take just a few minutes to talk about health care, but I want to start by talking about one of the prior votes that these members made and why it is so important to understand the relation between health care and the future prosperity of businesses and individuals in our

MORE

country -- and that is the vote on budget.

I know that several speakers have appeared before me. I hope I don't repeat anything that they said. It's very important that you understand that, from the President's perspective, getting our fiscal house in order means not only moving on the deficit and beginning to have the economic recovery that is really taking hold but it also means doing something about our health care system. They are inextricably combined.

So now, for the first time, because of the President's budget program and because of the votes of the members which (inaudible) and which drew a lot of criticism from people who didn't understand what was at stake, the deficit will be cut in half and it is now coming down for three years in a row.

That is the first time that our federal government deficit has gone down three years in a row since Harry Truman was President, so I think it's very significant that the budget proposal is working in one of the areas it was targeted to affect -- namely, deficit reduction -- and we now project that the United States will have the lowest deficit as a percentage of national income of any major world economy by 1995.

I want to stress again how important this is because, from 1980 to 1992, we ballooned our deficit. Our deficit, as a percentage of our national income, was much greater than most of the countries with whom we competed. We saw an outflow of all kinds of jobs and capital. We could not sustain the kind of economic growth that we needed in the private sector because of the huge demand on capital that the public sector was taking out of the economy because of the absolutely out of control deficit.

Because of a responsible President and some very courageous Members of Congress, we are now finally on the right track when it comes to deficit reduction. That's important, for many reasons.

One, those of you in business know that with credible deficit reduction we have seen not only interest rates drop but also we have seen the creation of now more than 3 million private sector jobs in 16 months. That is seven times the rate that private sector jobs had been created previously.

So, for the first time in 1993, we could see new business start up dramatically, new business investments higher than it had been for 20 years. It was the best year for business incorporation since Dunn and Bradstreet started keeping records back in 1946.

I think these underlined economic and budgetary points are important because it is against that backdrop that we need to consider health care reform because, although we have made progress with deficit reduction, it is clear that even under the budget that was passed, the deficit (inaudible) begin to go back up in a couple of years, and it does so for one reason only, and that is that Medicare and Medicaid are projected to grow by more than 10 percent each year for 10 years.

I just want to paint this picture for you. This Administration, with the help of Members of Congress like the ones here, has eliminated more than several hundred programs completely, has gotten the federal work force on a trend where it will be the lowest it has been in many decades when the work that the President and the Vice President, with reinventing government, has finally played out and the (inaudible) federal work force has shrunk.

Discretionary spending has been held even. It has been under the toughest caps -- budget caps -- that have ever been imposed, so even this defense spending, which fuels the huge deficit reduction, is being downsized in the safest way we can think of.

What is left is certainly payment on the debt -- we built it up; we are going to have to pay it off -- and the increase in entitlements. But when the word "entitlements" is used, it usually is shorthand for Medicare and Medicaid, because that is the part of the budget that is continuing to grow and will continue to put budget pressures on the federal government which will lead to an increase in the deficit.

Why does that have anything to do with health care? Well, let me just focus for a minute on North Carolina.

North Carolina businesses, according to the University of North Carolina, pay on average 30 to 40 percent above the cost of health care. You pay, for those of you who insure yourselves and/or your workers or are insured yourselves, you pay much higher than average costs. Why?

Well, because the other large payers in the health care system in North Carolina and (inaudible) around the rest of the country are the big (inaudible) programs of Medicaid and Medicare. The average hospital in North Carolina gets about 90 percent of its costs paid for by Medicaid or Medicare. It makes up the costs it doesn't get by charging businesses and individuals more, which is why your average costs are 30 to 40 percent higher.

Now, if you will, think about what will happen in the next several years. Think of the political rhetoric that will fill the airwaves in places like North Carolina. We've got the deficit going down. We've got jobs being created at the fastest pace anyone has seen in a very long time. Although the recovery hasn't touched everybody, it's

beginning to make an impact (inaudible).

And then, all of a sudden, we see the deficit start to go up again with all the resulting consequences, with capital getting tight again, with interest rates going up again, with jobs beginning to shrink again, and we'll all sit around and we'll say (inaudible) and people will turn to blame the President or they'll turn to blame a Member of Congress when, in fact, it is because of Medicaid and Medicare, which has continued to grow.

So what will the likely political consequences be? There will be calls in the Congress. Some of you will be in groups that will pass resolutions which will say: "Lower entitlements. Get them down. Get the deficit back under control."

The only way to do that, in whatever package of ideas anyone puts together, is to include dramatic cuts in Medicaid and Medicare. You cannot continue to reduce the deficit unless you're willing to make the hard political decision to do that.

Assuming there is a political will to further slow down the increase in Medicare or Medicaid, to try to really cut to the bone as much as possible on what we reimburse hospitals and physicians and everybody else, what will be the impact?

Well, we will certainly see an increase in the shifting of costs from the public sector to the private sector -- namely, to you and to anyone who is privately insured. That is the only way, in a system that has no comprehensive plan for containing costs, that is the only way Congress, with its blunt instruments of Medicare and Medicaid, can try to deal with the deficit.

So the impact will be, in places like North Carolina, hospitals will close, more and more doctors will refuse to take Medicare and Medicaid patients or at least refuse to take the payment available, because it cannot cover the costs they have, which are continuing to escalate in the absence of any systemic reform. The costs will be shifted onto the backs of businesses already paying.

Many businesses that are already paying -- and I have a chart from the University of North Carolina which

shows that the vast majority of workers in both public and private sector North Carolina are insured, no matter how small the employment but, under increasing cost pressures, because of this downward pressure from Medicaid and Medicare cutbacks, businesses will have to begin cutting back in insurance, eliminating insurance, which will throw more and more people into the ranks of the uninsured, which will put increasing pressures on hospitals in this community as more and more workers show up at the last possible moment at the emergency room to get health care because they are no longer insured and, those who remain insured, if they are not among the biggest possible employers, will not have access to the kinds of discounts that big government and other government, along with big employers, have been able to bargain for, and they will incur an increasing amount of the cost of the entire health care system.

Private insurance today amounts to a (inaudible) tax, in many respects, on those of our businesses and individuals who pay it, because you basically are covering everybody else who works for a competitor or works for a neighbor down the street who is not making any contribution and you are picking up the difference between what the public programs believe they can afford to pay and what the direct cost of the (inaudible) is that the hospital and the doctor then tries to make up by coming to you.

Now, this is what we're looking at, and I think there are very few people who will honestly look at the situation and argue that these are the likely consequences. What is it we need to do to try to get ahead of this curve?

We need to understand that comprehensive health care reform has several features that work together. First of all, unless everyone is covered, you cannot stop cost shifting. If you leave loopholes, if you leave people uncovered, then you will be holding onto a balloon at one end and it will be popping up and, even if you try to move up to get the top smaller and smaller, it will still distort the entire system.

So universal coverage, as it's called, guaranteed health insurance, is not only the right thing to do, the humane thing to do; it is the economically smart approach to take. If you look at other countries, even with their heavy government bureaucracies, even with their inefficiencies --which many of those other countries in Europe and Canada and

Japan -- have in their health care systems, they will manage to spend less money per capita than we do because they've got everybody in the system.

The closest analogy we have in the United States is the state of Hawaii which started in 1974 by mandating employer contributions for worker insurance. Twenty years later, Hawaii pays less of its gross domestic product, if you will, for health care than any other state.

Its citizens actually pay more visits to doctors than citizens in North Carolina do because they go for preventive health care, which is paid for, and they therefore are treated less expensively than what often happens in North Carolina where the uninsured or the grossly underinsured postpone going to the hospital until their problem is real serious and very expensive.

And that very expensive is what happens to you because when you, then, go to the hospital and you find that $25 charge for Tylenol, you are paying for the uninsured or the underinsured who have been taken care of but at the most expensive cost.

So if we look at universal coverage, which is what the President has been stressing over and over again, it is important to stop cost shifting, number one. Number two, it is important to begin to get some effective cost containment because until the public system and the private system are insuring people in a comprehensive health care system, you cannot begin to get costs under control and you cannot change the incentives that exist in the system.

That brings me to the second point. Comprehensive health care reform needs to preserve what works -- mainly, our doctors, our nurses, our hospitals -- but fix what does not -- namely, the financing system.

I have been very surprised at how many people have been willing to accept a financing system for health care that they would not tolerate for one minute in their own businesses. Imagine, if you will, that every cost you paid out in your own business carried with it a 20 to 26 percent administrative charge. That's what the private insurance market charges for health insurance in our country -- 20 to 26 percent.

Compare that with the cost of administering Medicare, which can obviously be improved -- it's not perfect by a very long shot -- but the cost of administering Medicare with government workers is less than 3 percent. Compare that with the 20 to 26 percent administrative cost which goes right into your (inaudible).

I've also been amazed at how the incentives in medicine drive the financing and most businesspeople, again, would never put up with this. In medicine, you don't get paid by the outcome or the efficiency of your delivery; you get paid by how many procedures or tests you've run.

Dr. Koop just said that there are probably $200 million of unnecessary tests and procedures run every year in our health care system. Now, that has become -- that is how we have structured our financing of health care, and so you have many, many examples every day in North Carolina where decisions are made driven by financing -- by an insurance company that makes a decision about what appropriate care is, by a physician who has to be thinking about the finances in order to deliver the care, by a hospital that decides whether or not to admit somebody without insurance.

So if we look at health care from what I view as a business-oriented perspective, you could make the following points very clearly:

American business is getting a very poor financial deal for what it currently spends for health care right now.

Secondly, every company that pays anything for insurance is giving a competitive advantage and basically paying a hidden tax that subsidizes every company that pays nothing for health insurance.

Number three, the number of the uninsured working Americans is increasing. When we started this work, it was 37.5 million; it is now approaching 40 million. That number will undermine the financial stability of everyone's private insurance.

And, number four, in the absence of comprehensive health care reform, the desire to keep the deficit going down will be to cutting entitlements, which everybody says they are for, but the two major entitlements -- Medicaid and Medicare -- as they are cut, either we will see decreasing

medical quality, very large numbers of facilities closing, or the costs will have to be made up by increasing costs to the private sector.

So from the perspective of this Administration, and the reason that my husband became so adamant about health care, is that he was a governor for 12 years. He watched manufacturers disappear. He watched costs going up so that we were no longer competitive. He saw companies unable to keep businesses in our state and not even be able to keep them in the United States during the 1980s. And he saw the role that out-of-control health care spending played in our business lives.

And he made a vow, then, that there were two things he was going to get done:

Number one, have honest budgeting with honest numbers that would give the American public an honest accounting of what our fiscal situation was and bring down the deficit and bring about comprehensive health care reform because, in the absence of it, we cannot stabilize our economic base for the long term.

If we do it right, however, we can begin to take back some of those dollars we now spend on health care and invest them here at home in new jobs, new kinds of expansion, and a bright future. And that's how the budget deficit and health care work together and that's why they're so intent on getting health care reform passed this year.

Thank you very much. (Applause.)

Q (Inaudible) answer some questions on what we would like to do (inaudible) every district will have a chance to have somebody from that district ask some questions. So we're going to take a few minutes here and have Mrs. Clinton perhaps answer a couple of questions. The lady here.

Q Yes. Mrs. Clinton, thank you very much for an (inaudible) description of our health care situation. We who live in rural areas particularly appreciate that.

I'm the president of (inaudible) Congress in Mount Olive (phonetic), North Carolina, and we're a rural area of about 5,000 people. We also are the home of the North

Carolina Pickle Festival and we've brought you and your family a tee-shirt just in case you'd like to remember that.

But my questions relate to (inaudible) very serious (inaudible) health care (inaudible).

In our town, we have four physicians. Two are in their 40s and two are of retirement age -- one is 60 and one is 70. They would like very much to retire but they can't, because their job is just so significant.

(Inaudible) attract other physicians to come in to practice with them and, as a result of that, our Chamber of Commerce has founded and put together a foundation in which (inaudible) recruit physicians to our community.

We've had some success with (inaudible). However, we have more money than we can give away, and we would like to know if there are any initiatives in your plan for improving the health care system that take into consideration particularly recruiting doctors, family physicians, to rural areas.

MRS. CLINTON: Yes, and that's a very important part of health care reform. It will not do us any good at all to say that we have universal coverage and not have physicians and other professionals available to take care of people.

There are several things that we think should be done.

The first is, I want to repeat that part of the problem in rural America, as in underserved urban America, is the financial base for maintaining doctors has been shrinking. The number of uninsured, the number of people on Medicare in rural areas, is often much higher than in other parts of the state, and that is true in North Carolina, so that you don't have the same financial rewards for practicing in a rural area and, as I pointed out, if Medicare keeps being cut, with the number of elderly people who live in rural areas, you will have even more difficulty keeping physicians.

Secondly, if you can stabilize the financial base by having universal coverage -- which means everybody comes with a payment stream attached to them -- you will take a big

step towards eliminating some of the problems that exist --the financial problems -- but you have to do some other things.

We want to designate certain hospitals in rural areas as essential community providers. They need to be there and they need to be given some extra funds in order to keep in business so they can serve as the center for health care.

We need to help medical students and other health care professionals pay off their loans and be able to afford to live in a rural area, and we have loan repayment programs and other financial incentives for locating in areas that are underserved.

We need, in both private and public health insurance programs, to change the way doctors are paid, which goes to a point I briefly made before. If you are paid on the basis of tests or procedures, that very much advantages physicians whose practice includes that primarily, whereas a family physician or an internist is really judged on his or her clinical diagnostic skills.

Sometimes the most important thing to do for a patient, particularly an elderly person in a rural area, is to spend time with them in trying to figure out how to take care of that person. Under many of our health insurance plans, in both the private and the public sector, you don't get reimbursed very much for doing what is the job of a family physican.

So we have designated five types of physicians as primary care physicians -- family physicians, internists, pediatricians, OB/GYNs, and general practitioners -- and we're changing the way we reimburse those particular physicians, so it won't be such a losing proposition to be one of a very few doctors.

And then, finally, we really think that investing in technology will be a big advantage for rural physicians because, if we can solve the financing problem, if we can solve the facility and reimbursement problem, there is still the problem that many physicians today don't want to be isolated from their colleagues in larger areas and so if, by technology -- (inaudible) medicine for example -- we can connect physicians in Mount Olive with physicians at

(inaudible), that eliminates the kind of professional isolation that also prevents many physicians from feeling confident and comfortable practicing in a rural area.

So all of those things are in the President's bill and there would be a very big difference in the number and quality of rural health care physicians if we were able to get that passed.

Q Thank you for your support, and my friend has a tee-shirt for you. (Laughter.)

Q The gentleman here (inaudible).

Q My name is Floyd Oliver (phonetic) and I (inaudible) North Carolina (inaudible) the home of Hillcrest (inaudible) the world's best (inaudible) product. I didn't bring any great gifts, but (inaudible). (Laughter.)

(Inaudible). Yesterday the (inaudible) a story that indicated it was a compromise (inaudible) for health care legislation. The article stated that President Clinton would not insist on having health care insurance for every American if Congress agrees to phase in, in the next -- the program, in the next several years.

Is there a compromise in the works to get the legislation passed and, if so, how will it affect the legislation?

MRS. CLINTON: Well, let me just clarify what the newspaper said. And this is not to knock the newspaper, but I spend a lot of time clarifying what newspapers say.

And what the President has indicated all along is that a phasing in of universal coverage is acceptable but it has to be done by a date certain and it has to be done, in his view, sooner instead of later.

If that is part of the bill that is passed, then that is in line with what the President has always (inaudible). There may be some steps that have to be taken or goals that have to be met or approaches that can be tried and it all has to be within the legislation that is passed.

And the bottom line is, still, whatever legislation is passed has to achieve universal coverage, but there are

many ways of getting there. And we have tried, during this entire debate, to be as open and forthcoming as we could about what we thought would work but also saying that, if others have better ideas to reach universal coverage, that was something that this Administration would consider.

So there's really not that much difference in what is being said now and what we have said for more than a year.

Q (Inaudible) this gentleman here. Where are you from, sir?

Q (Inaudible).

Q Okay.

Q (Inaudible). I'm (inaudible) from (inaudible), North Carolina. (Inaudible) and share your concern concerning health care. My question is the concern for Medicare and Medicaid participants and why Medicare participants were not part of the President's health care program.

MRS. CLINTON: Because we already have a universal system for Medicare. Everyone is eligible after a certain age. And, from the perspective of the Administration, it seems more prudent to create a system for the under-65 before we try to in any way dramatically change the Medicare system.

There should be some changes in Medicare, which are part of the Administration's proposal, but the Medicare system itself, we thought, was performing a very important function for our elderly citizens and we wanted to work on the under-65 first.

So there will be some changes and there will be some new incentives for Medicare recipients, we hope, that will help keep costs down in the Medicare program, and we think eventually there should be a merger of the systems. But we can't merge Medicare into nothing. We have to have a system first before we can look at how that merger might work.

Q (Inaudible). Is that not done in (inaudible)? It doesn't consider all (inaudible) Medicare does it?

MRS. CLINTON: It is a fairly comprehensive

percentage. I can't list out you everything that is in it right now but it is a fairly comprehensive listing of the administrative costs that are directly attributable to Medicare so that (inaudible) the (inaudible), the claims, the utilization reviews, and the like.

Q (Inaudible) help (inaudible) fund these programs that the federal calls for 26 percent compared to 5 (inaudible) health care (inaudible) 15 percent.

MRS. CLINTON: I've never seen that. I'd be glad to look at it. But that is certainly not the results of the research and analysis we have looked at.

Q (Inaudible).

MRS. CLINTON: I'd be happy to look at it. We have a wonderful North Carolina economist here who knows everything there is to know about the costs of these systems and I'd be happy to have you talk with him afterwards.

Q (Inaudible).

MRS. CLINTON: One of the points that I always like to make about Medicare is that, in audiences I've been in --I won't exclude this audience from any of the others I've been in -- often, when I ask people if they know how Medicare is paid for, there are a surprising number who don't know.

How many in this audience know how Medicare is paid for?

(A show of hands.)

MRS. CLINTON: That's -- I think that the Members of Congress will find that very interesting, because Medicare is a single-payer, government-financed, tax-paid health care system. It is, if you want to think about it, a Canadian single-payer system for people over 65.

And I haven't heard very many complaints about having it. I hear lots of complaints, about -- arguments about it. You know, "They didn't pay for this; they didn't pay for that." But much of the debate in the last year has been against the government running health care; and Medicare is paid for by a payroll tax. It comes out of your check every week or every two weeks. Your employer contributes and you contribute and you, therefore, pay for the health care of

your mother or father or aunt or uncle or grandparents.

It is important to know that, because there has been so much misinformed and downright inaccurate propaganda put out about health care and what the President's proposal is, because the President did not propose a single-payer system or a government system for health care. He proposed it build on the public-private system that we currently have for those of us who are under 65 and which is available for Medicare recipients by coverage over and above what Medicare pays for.

But I think it's very significant that very few of the most well-informed people in North Carolina, just like every audience I've been in -- and I've been in an auditorium of 3,000 doctors, and I've had a doctor stand up and say to me, "I can't afford these government-funded health care systems for anybody; you're trying to (inaudible) the life out of me."

And I said, "Well, do you take Medicare patients?" He says, "Well, I sure do; what does that have to do with anything?"

I said, "Well, do you know how Medicare is paid for?" "Well, no, but what does that have to do with anything?" (Laughter.)

So then I said, "Well, how many doctors know how how Medicare is paid for?" And I got about as many hands as I got here -- about 10 as I could best count them here.

And then I said: "Well, it's paid for by a payroll tax. The employer pays, the employee pays. It's a single-payer, tax-financed system that those of us who are working pay for to take care of people who are older."

So I think it's important to know our facts if we engage in these debates and not let people, you know, get into a rhetorical battle that may or may not have anything to do with the real issues in front of us.

Q Yes (inaudible) general commerce and I'm also the chief operating officer of our (inaudible) hospital in (inaudible) North Carolina, which is a 275-bed hospital (inaudible) provider.

We certainly see the patients coming into our emergency department who are uninsured and (inaudible) and we applaud the Administration for bringing (inaudible) so that universal coverage will eventually (inaudible).

One thing that you mentioned about Medicare is certainly we've operated our hospitals at 90 percent of cost as, I think, you indicated and I think our hospital (inaudible) the health care system in the country would not be as it is today. And, of course, you cannot operate a system losing money every day.

My major question to you is, in all the debate (inaudible) do not hear much about rationing of health care, and (inaudible) looked at the (inaudible) system and talked about that until we get to that point in this country. And, as you know, in all other major countries with a single-payer system, that's what they're doing, is rationing health care by not providing certain things.

What is the Administration's view on rationing of health care and how are you going to approach that in your plan?

MRS. CLINTON: Let me say a couple of things about that. We ration health care now but we ration it on your capacity to pay for it.

One of the most astonishing statistics that Dr. Koop uses whenever we speak together is that an uninsured person has three times more likely the chance to die from the same illness as an insured person. The first time he said that, I couldn't believe it, but I have learned never to question Dr. Koop. He knows, and he gave me all of the research and the backup. But I was stunned by it.

So we ration already. I think that if we're going to be honest, we should admit that. And we ration, not by any rational means, but by who gets paid and who doesn't get paid and who can afford what.

It's very difficult, in a system where people are left out, to talk about rationing. That is why our position has been, we need to achieve universal coverage so everybody is covered.

If any of you were to lose your job, if any of you

were to all of a sudden have a (inaudible) devastating accident and you used up the lifetime limits on your insurance policy within six months to a year, and you found yourself among the uninsured, you would understand very clearly what it is like to be on the other side of that line.

So, from our perspective, until everybody is covered, we cannot fairly talk about rationing service. We do, at some point, need to become more efficient and we absolutely think efficiency in our health care system is a much better goal than having to invoke some kind of rationing.

Let me just give you a few quick examples:

If we had an efficient system for delivering prenatal care to pregnant women in our country, we would save a lot of money.

If we had an efficient system for analyzing the relative cost and outcomes of various procedures, we would end up saving money. The state of Pennsylvania has done this. They have taken every coronary bypass that is performed in Pennsylvania, they have seen how much it costs, what the complications were, whether the patients died, and they have (inaudible) every hospital.

And guess what? The cost runs from about $20,000 in some hospitals to $80,000 in other hospitals, for the same operation on the same kind of patient. There is no difference in outcome. In fact, there is some argument that those on the slightly medium end of the scale are actually more efficient.

We could perform more bypass surgery if more people were performing closer to the 20s than closer to 80, but there's no incentive in our system for a hospital to be able to get that done.

So, from our perspective, we don't need to talk about rationing, other than to recognize we already do it for financial reasons, but we do need to get everybody covered and then begin to squeeze the system so that it becomes more efficient.

Whenever we talk about that somebody always says, "Well, that means, then, we won't get the quality of care

that we deserve to have." And again, I would just urge you to look at what is actually paid for the same kind of services in different parts of the country.

For example, there is no rational reason in the world why the same surgery costs three times more in Miami, Florida than it does in Minneapolis, Minnesota or why a hospital stay in New Haven, Connecticut is one-half the cost as the same hospital stay for the same illness in Boston, Massachusetts.

There are system problem that can be solved, and that's what we want. We want to start getting the health care we deserve to have but at a more cost-effective rate than what we're currently paying for, and we don't think that will diminish quality but, in fact, will spread the benefits of health care much more broadly and save us money because more people will get preventive care early.

Q I'm Lewis Carroll (phonetic) from (inaudible) Chamber of Commerce (inaudible) foothills of (inaudible) and it's a rural area. Our people are basically farmers or tobacco farmers.

We are all very excited about what you and President Clinton are doing (inaudible) this country (inaudible) financial base and what's being done with health care. We have great concern that tobacco has been the only sin that's been identified so far is helping pay for this.

Now, we want to help pay our share but my question is do you think there will be some other sins identified to share some of this burden? (Laughter.)

MRS. CLINTON: It would be great if we could tax all of them. (Laughter.)

We are very sensitive to the, not only economic, but, really, cultural concerns surrounding tobacco in a state like North Carolina, and there are Members of Congress who are here, I can assure you, who are very vigilant in trying to make very clear the economic impact that singling out tobacco would have. There is a lot of discussion going on, particularly in the Hour of Representatives, led by Members who are present here, to try to make sure that tobacco is treated fairly.

I don't think the Administration really would rule out taxing anything else that people thought was appropriate that could be taxed if there was the kind of support for it and relationship to health care reform that seems to be targeted now only on tobacco. I believe that is what the House Ways and Means Committee and others are struggling with right now.

So I know that many of you have a deep interest in this and we want to be very sensitive to what your legitimate concerns are. We have obviously health care concerns about tobacco that we think fairly suggest that tobacco is a target for some revenue but how that all plays out is something that we're really watching now as it's worked out in Congress.

But we have no problem with whatever the outcome or the remedies might be that the Congress (inaudible).

Q (Inaudible). (Applause.)

I think that that (inaudible) has to be at another meeting and we want to thank you for (inaudible), and I think people are obviously impressed with (inaudible) questions (inaudible) warn you about asking questions because they would be (inaudible). (Laughter.)

I want to thank you for coming and being with us and (inaudible). (Applause.)

(End of tape.)

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2/18/94	Northern Great Plains Health Summit	Lennox, SD	Overview of the President's plan. Elements of the plan that will help rural areas.	HC 3
2/18/94	Lennox High School	Lennox, SD	Brief remarks. Q & A from the audience.	HC 3
3/3/94	Children's Defense Fund Conference	The White House Via Satellite	The importance of health care reform and security, with emphasis on the health care needs of children. Q and A from the audience moderated by Marion Wright Edelman.	HC 3
3/4/94	National Farmers Union Convention	The White House Via Satellite	Brief remarks. Overview of the President's plan, the importance of health care reform.	HC 3
3/15/94	Address to Washington University Students	St. Louis, MO	Overview of health care reform. Emphasis of five features of the President's plan: guaranteed basic benefits for every American, the elimination of discriminatory practices by insurance companies, elimination of discriminatory practices towards the elderly, preservation of medicare and the guarantee of health insurance through employer.	HC 3

The President and I have now been in Washington for just over a year, and I cannot help but think about how far we have all come. During this past year, we have worked to move our economy in the right direction, restore our sense of security and renew America's spirit.

And thanks to the dedication of millions of Americans, we have made real progress.

Passing the Family and Medical Leave Act so good workers can be good parents. Expanding the earned income tax credit to reward work over welfare. Launching a new national service initiative that helps more young people go to college. Reducing the deficit. Expanding trade with NAFTA.

These measures -- which the President submitted and Congress approved during the past year -- all reflect a fundamental change that has taken place in our nation. The days of drift and gridlock are over. We have all taken responsibility for the future of this country. We have shown that when the American people set their minds and their hearts to doing something, <u>it gets done</u>.

And I know that our resolve will grow stronger still as we move forward in this new year -- a year that holds the hope and promise of achieving the most important legislation of a generation: health security for every American.

A year ago, as I began working on this problem, I met a doctor at St. Agnes Hospital in Philadelphia, who summed up the

problem rather simply. "You know," he said, "there's an old saying: If it ain't broke, don't fix it. Well, Mrs Clinton, our health care system is 'broke' and I'm begging you to make sure that it gets fixed.'"

In the past year, I have learned a great deal about what is right in our health care system. We have the best health care professionals and research institutions in the world. I have seen committed doctors and nurses in inner city emergency rooms battling to save lives hour after hour, day after day, sometimes under the most adverse of circumstances. I have seen talented young physicians donate their services to people in rural areas who cannot afford to pay for them.

But in speaking to and reading letters from people all across America -- farm families, small business owners, older Americans, and, yes, medical professionals-- the same message comes out loud and clear: our health care system is broken and it needs to be fixed.

Some in Washington would have us think there is no crisis. To them, the fact that 58 million Americans are without insurance at some point in a year appears to be no crisis. To them, the fact that small businesses pay as much as 30% more for coverage of their employees is no crisis. To them, the fact that millions of Americans can't change jobs for fear of losing their insurance is no crisis. To them, the fact that every year over 100,000 middle class families declare backrupcy because of a serious illness or injury, is no crisis. And to them, the fact

that federal and state government health costs are stifling are economy and preventing investments in other worthy purposes is no crisis.

Perhaps we need to remind them: behind every one of these statistics is an American business, an American family or an American child.

Tell them it's not a crisis. Tell it to the single mother who wants to work but has to stay on welfare to get health benefits for her child. Try telling it to Carol Weil of Rockport, Maine whose family is uninsured and ineligible for aid. Try telling her how she and her husband should pay for their son's enormous hospital bills, and what they should do with their four children now that their home has been foreclosed on. Tell it to the older American who has to choose each month between food and medicine. Tell it to the family that hit the 'lifetime limit' on their insurance coverage and was forced into bankruptcy. Tell it to the small business owner facing a 25% increase in insurance premiums. Tell it to the nurse who is forced to spend more time on paperwork than patient care.

Tell them there's no crisis. Because I won't -- and neither will the President.

Where we come from, facts like these, and real life stories like these, are indeed, a crisis. But the truth is, it doesn't matter what we call our health care situation-- it matters that we fix it. And that we fix it now.

We can begin with a simple promise: all Americans must be

guaranteed health care security that can never be taken away. They shouldn't lose it when they get sick, or when they change jobs, or when they lose a job. And it should include a comprehensive benefits package and the recognition that an emphasis on curing must not obscure the values of prevention. Immunizations, well-baby care, and check ups for children must be covered, and without co-payments or deductibles. Let us have, at last, a new health care system that focuses attention on those who are well, as well as those who are sick. Let us hear no more stories of infants who spent months in intensive care units because their mothers had no access to basic preventive care.

And let us extend a new sense of security to our older Americans. Both the President and I feel very strongly about this. We must preserve and strengthen Medicare by adding coverage of prescription drugs. And we must make a sizable start towards enabling those with severe disabilities to stay in their homes and communities, by enacting a new home and community based long term care program.

Health care reform must also mean putting the American family back in the health care driver's seat by offering the fullest range of health care choices to all American families. Today, those choices are diminishing. Increasing numbers of employees are finding that they no longer have access to plans offering full choice of physician, and at least 50% of employers offer their employees a choice of no more than 2 health plans.

Under the President's approach, all Americans will have a

full range of health care options, and they will have more information with which to make those choices. And let me emphasize this as strongly as possible --for some would have you believe otherwise; under the President's plan American families --not bureaucrats or government-- will decide how and from whom they will get their care.

Above all, the President's proposal envisions a new American health care system, and an American health care system will not and must not be run by the government. The President's plan acknowledges, as do all reform plans before the public today, that government must intervene to change some of the rules of today's insurance marketplace. As all of these proposals recognize, government may have to level the insurance playing field.

But government, itself, must not take the field. A new American health care system will be one in which the delivery of care, and the development of new and improved systems of care-giving are left to private health care plans, to physicians, and to the desires and needs of their patients --and not to the government. It must be one of increased efficiency, innovation and flexibility. And in the best American tradition, the new system must be one in which those private health care plans truly compete -- not over which insurer can do the best job of screening out higher cost families-- but over which can deliver the highest quality health care at the best possible price.

I know that many of you here want to be a part of that new

American health care system. And I am sure that in that context, some of you are concerned about images the public has of managed care in general, and health maintenance organizations in particular. In some cases your organizations have developed reputations for excessive reliance on gatekeepers, for heavy-handed utilization review techniques, and for restricting patient's opportunities for seeing physicians outside the HMO system.

But I am also well aware that critics of managed care often fail to recognize the many positive trends in your industry. We know, for example, that the fastest growing managed care systems are those that are giving patients more choice, and more opportunity to see physicians outside of the HMO network. We are also hearing about an increasing emphasis on teamwork --improved cooperation and communication between nurses, primary care physicians, specialists and hospitals. Today such programs are recognizing that cost control requires a parallel commitment to better health outcomes and ongoing quality improvement.

In the best of managed care worlds the fabled gatekeeper -- if one exists-- is there not to close doors, but to open them, and the pre-existing condition is something to be treated first, rather than something that won't be treated at all.

Above all, many of you have been trailblazers in the effort to improve preventive care. Your policies include these services at no additional cost, and increasingly, managed care programs are beginning to define wellness and prevention not just in terms

of the individual patient, but in terms of the health and well-being of a larger community. More than 90% of your enrollees are covered for well-baby care, and over 90% are covered for routine physicial examinations. And you are now working with the public health service on a new progam aimed at immunizing 90% of 2 year olds with every major vaccine by 1996.

These are all very positive trends. I commend you for them, and I urge you to continue moving forward in these directions.

Fifty years ago, when President Harry Truman called for health coverage for all, he may have been ahead of his time. But surely today, we are far behind our time.

A new American health care system such as I have outlined today, may sound far away. You and I know better. We can keep what is right, and right what is wrong. But we must first recognize that a crisis exists, and that we will have no more of it. If we do that today, health security for all can be ours tomorrow.

Others, of course, are taking different reform approaches. Their alternatives have merit, and we welcome them in this debate. But let us always remember that the goal must be health security for all. Let us be wary of those alternatives that promise an undefined set of benefits, delivered at an undefined price, to an undefined number of Americans, at some undefined point in time. That, my friends, is not the definition of health security that the President, and most Americans have in mind.

So let then all resolve to come together and to beat this

crisis. Let us form a partnership of those who give care and those who receive it; a partnership of public and private sectors, of the states and of the federal government; a partnership that is above partisanship.

And let us, as the President so often says, have the courage to change. Let us look upon that change as challenge. And let us remember that when challenged, America is at its very best. Thank you.

E X E C U T I V E O F F I C E O F T H E P R E S I D E

24-Jan-1994 10:38am

TO: Pamela Barnett

FROM: Karen E. Finney
Office of the First Lady

SUBJECT: Per Your Request

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release October 19, 1993

REMARKS BY THE FIRST LADY
INSTITUTE OF MEDICINE ANNUAL MEETING
WASHINGTON, D.C.

DR. KOOP: Good morning. Before I introduce Hillary Rodham Clinton to you, I want to express my personal admiration and my gratitude to her for her leadership of the President's health care reform effort.

She has brought to this assignment exemplary energy, unfailing diligence, breath of vision, attention to detail, care, and compassion. I'm sure that these words are not new to her at all. Ever since the Clinton Health Care Plan became public, and especially since her highly lauded testimony before congressional committees, accolades have come her way.

And although the compliments for her accomplishment in producing a comprehensive reform plan are well deserved, I must say that the tenor of much of the praise bothered me.

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There was too much oohing and aahing about how no first lady had never done such a thing before. I think these folks missed the point. They indeed missed the person.

It is my understanding that Hillary Rodham Clinton has presented this health care reform plan to the nation not as the First Lady, but as the American citizen whom the President decided he could best entrust with that task that he placed on top of his domestic agenda. Now, I'm not saying that being a friend of Bill hurt her chances at all. (Laughter)

After all, Presidents have always turned to trusted

friends to fill important positions. But I imagine in this case that Mrs. Clinton received the assignment as much in spite of her being First Lady as because of it.

A highly educated woman, an accomplished attorney, a proven manager, a thoughtful analyst, a champion of children and the disenfranchised in our society -- Hillary Clinton did not surprise anyone who knew her by producing a reform plan of such breadth and such depth. The kind of accomplishment was simply to be expected from her.

I also admire her, and the President, for their repeated statements that the plan they have offered is open to debate and amendment, that they welcome suggestions to improve upon it. And although the plan is complex, even complicated, I especially admire its breadth, and I thank you, Mrs. Clinton, for raising all of the issues, so that no matter what finally emerges from the national debate and the legislative process, you have forced us to deal with all of these issues: medical, financial, legal, public and private, as well as those of our personal responsibility for our own health.

No matter what any of us here today thinks about some of the plan's particular points, we all owe our gratitude and our admiration for placing the issues and the ethical imperative for health care reform so clearly before us. Hillary Rodham Clinton. (Applause)

MRS. CLINTON: Thank you. Thank you very much. Thank you very much, Dr. Koop. And thank you for your advice throughout this process, starting last spring, and your willingness to serve in this role as a facilitator of discussions moving forward, particularly with the medical and scientific communities.

And thank you, too, Dr. Shine, for your personal involvement and commitment to health care reform, and to all of you in the Institute of Medicine and associated with the National Academy that have been great supporters, but also excellent critics, as we have moved forward in this process. And I hope for both roles to continue in the months ahead.

When Dr. Koop and I first talked about what we hoped we could achieve, and what he is now referring to as our road show here, it was with the idea that I would do much less talking than listening and trying to answer questions

that were on your minds, because I assume that, with an audience such as this, not only have many of you been personally involved in some way with the reform process, but most of you have avidly read what has been written, and have questions about the nature of the reform and particular issues that are of concern to you.

I would like, therefore, just to make a few minutes of opening remarks. I have looked at the program that you will have for the rest of the day, and I am very pleased to see the time you will spend looking at particular issues.

I am delighted that many of the people who have helped in this process, particularly Dr. Phil Lee, will be addressing you, and you will have further opportunities to ask questions during today, and, I hope, into the future.

I am very excited by what lies ahead of us. And I am excited because, as Dr. Koop has said, we have tried very hard to lay out the full range of issues that have to be addressed. These issues are ones that overlap, and certainly one cannot easily rank them in any importance because so many of them bear one on the other.

But what is exciting to me is the willingness of so many in the medical profession and the scientific community to begin to talk more often in public, with colleagues and with citizens, about the interrelationships of the pieces of health care reform.

It is a complex undertaking that we are about to begin in our country. I know no way to attempt what we are doing: to achieve universal coverage; to guarantee a comprehensive benefits package; to begin to simplify a system that has become much too cumbersome, bureaucratic, and overregulated; to attempt to begin to achieve savings and eliminate inefficiencies; but at the same time, to enhance quality through better outcomes research and reporting of those outcomes; to guarantee choice -- in fact, to enhance choice -- for both the citizen/consumer and the provider/ practitioner; and to inject more responsibility into the system at every level.

And one of the questions that I'm often asked is how one expects to be able to do all of this in the face of complexity. And I always ask the one who questions me to

please describe to me the way our current system works -- to take a few minutes, describe how people get into the system, whether or not they carry with them financial reimbursement, what are the conditions that either eliminate them from coverage or in some way limit their coverage, who provides health care, who holds it accountable, who pays for it, and on down the line.

I think it would be extraordinarily difficult to design a more complex system than the one we currently have. So what I hope we will do as we move forward is not only to question where we are going, but to have a very clear idea of where we are now and what the options are available to us and the costs of staying with our current system -- or non-system, as some are more appropriately calling it -- or making only marginal changes that will, inevitably, have just as many unintended consequences as any attempt at comprehensive reform.

There are a few issues that I wanted to highlight in these opening comments, because of your concerns and the concerns of many in the professions.

First, the problems that physicians and patients face in the current system are such that we know care is being rationed every single day. We know that choice is being limited every single day -- two issues that are often discussed in the context of reform that we know are having a bad effect in many settings already in the current systems.

Contrary to the way the system currently operates, we have made some fundamental changes. Although we have built on the employer/employee system, individuals will choose their health plans -- not employers, and not the government. This is a sea-change.

What is currently happening in our current system is that employers, in their effort to control costs, are pushing more and more of their employees into limited choice options. That goes along with the trend that many of you have observed, in which providers -- whether they be physicians or others in hospitals and the like -- are being also forced into situations where their practice is being limited.

What we are trying to do is to take back that power

from insurers and from the federal government. Right now insurers have the ability to grant and deny coverage. They do it with a vengeance, because it has become the way in which they make money.

We believe that taking that power away from insurers is fundamental to any kind of health care reform. And so, from our perspective, putting the authority back in the hands of physicians and their patients will be absolutely essential to what we achieve.

Now, how will that work? Individuals will have choices among plans and providers. We will require that in every region there will have to be a fee-for-service network. It is absolutely not true that every physician will be forced into HMOs. That is not part of the plan. It is not going to occur, because we will guarantee a fee-for-service network.

We will also require that HMOs offer a point-of-service option. This is a very important feature, in part because we want to maximize choice as a principle, but also because we want academic health centers and other centers of medical excellence to be available for referral, even to patients within HMOs.

We also want physicians to have an option as to being able to join more than one plan. The fact that you might be in a closed-panel HMO would not prohibit you from also being in the fee-for-service network. The fee-for-service network will be open to all willing providers.

We think it is important to change the balance of power that currently makes too many of the decisions in the health care field. That's why having insurance reform is an absolute precondition of everything else we are attempting to achieve.

We intend not only to achieve universal coverage, but to eliminate preexisting conditions, to eliminate lifetime limits -- two of the issues that have been the most difficult for individuals, and for their physicians confronted with some of the hard choices that individuals with preexisting conditions or exhausted lifetime limits pose when care has not been completed.

I heard Dr. Shine speak about the work that you did

yesterday with respect to genetics research. And it reminded me of an extraordinary comment made to me at the Mary Lasker Awards by Dr. Nancy Wexler, one of the recipients, whose pioneering work on Huntington's Disease is, I'm sure, well known to many of you.

She came up to me and said that, as a researcher in the area of Huntington's Disease and as a member of the Human Gene Project, she wanted me to be aware that, probably within 10 years, the state of our knowledge would demonstrate unequivocally that we all have a preexisting condition of some sort or another.

So we'd better hurry up and get reform or we're all going to be out in the cold. (Laughter)

Secondly, we intend to change the balance of power by moving forward with antitrust reforms. We believe that we need to level the playing field and provide more freedom to doctors and hospitals to work together to determine what is the best and most efficient way to deliver high quality services.

Doctors and other health providers will be able, under these antitrust reforms, to band together to form their own community-based health networks in which doctors will be able to negotiate to reduce interference with their practice.

They will also be able to negotiate collectively to insure that they have a role in setting any fee-for-service reimbursement rates, so long as they represent 20 percent or fewer of the physicians in an area and share in the financial risk.

Now, this is a request that had come to us from a number of groups representing physicians. We think it is a very important feature of what we are attempting to do, because part of what we hope will occur is a real flowering of networks of doctors and hospitals throughout the country -- allied often, or maybe even begun, through academic health centers as the center of excellence within a community.

But it was clear, in looking at the antitrust laws, there were too many obstacles to being able to achieve that realistically without the changes we are proposing.

We also believe that, if we reduce the bureaucracy and the overregulation in the system, we will begin to free physicians from the kind of sapping of resources -- time, energy, financial -- that has occurred up until the present time. And I want to say something specifically about this, because it is not just rhetoric. It is a very important commitment to what we are trying to achieve.

We have tried -- and I think it has been a very good-faith effort in the past 20 years or so -- to perfect a micromanaged approach toward the paying for health care. We have done it in both the private and the public sector. We have laid out innumerable lists of what certain procedures should cost. We have gone to great lengths to check and double-check how procedures are described and coded and billed for.

But again, going back to my original question about describing our existing system -- if you take the time to actually list what the procedures are for a bill being paid by an insurance company or by Medicare or Medicaid, and you put everything in there -- you put in the billing and the coding departments, you put in the PROs and the fiscal intermediaries and all of the other acronyms that are out there -- you would be astonished to see where all of this money that you know is being spent is actually going and the kind of time that it is taking away from your practice.

The Children's Medical Center here in Washington conducted such a study recently, which they reported to the President. They actually went through and looked at every form unrelated to patient care or quality reporting -- mostly having to do with financing of the care -- and they determined that if every physician on the staff of that medical center, all 200 of them, were relieved of filling out the forms that were irrelevant, in their professional judgment, each physician would be able to see between one and two more patients a day.

That added up to 10,000 more children who could be seen by physicians in one hospital in one year, if we did away with the kinds of forms that they had identified. So this is a big issue. It's an issue not only for the financial implications, but also for patient care as well.

I also want to emphasize our commitment to quality. We believe very strongly, and have set aside in this plan, funding for academic health centers and funding in outcomes research and effectiveness research.

We believe, as strongly as I can express to you, that expanded investments in health research and greater support of academic health centers are critical not only to insuring quality, but in controlling costs over the long run and promoting a philosophy of prevention and wellness.

With reform, new funding will be available for prevention research, outcomes research, and health services research. We also want to continue the work that Dr. Koop and Dr. Weinberg and others have been doing at Dartmouth, that will focus on the kind of shared decision-making between patients and doctors, exemplified by the prostate study that has had so much notice in the last year.

Now, when we lay out these and the many other features of the reform plan, people often say, "Well, how can we afford this?" And, of course, my initial response is not only how can we afford not to, but look at what we are currently spending.

There is no way to justify our current expenditure level, especially when we don't provide universal coverage, and, especially when, even for millions who have some kind of insurance coverage, their coverage does not cover preventive services and the kind of intermediary services that are often required and cost-effective.

So, certainly, we will in the next months have a great debate about how we will finance this. There is no real secret to our financing. We're going to require every employer and employee to make a contribution. That will amount to approximately $50 billion. That's a lot of money -- new money going into the system.

With the new investments in health care, we will be driving up our GDP percentage, from the approximate 14 percent that it is now to about 17 percent by the end of the decade -- 2 percentage points below the projections if we do nothing, but still twice as much, at least, of any other industrialized country that is doing the job that needs to be done.

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So anyone who says we will be rationing the system or in any way constricting the system has not looked at the amount of money going into the system that will be new.

In the meantime, though, we recognize that there will be certain features of our existing system -- such as academic health centers, such as public health facilities in underserved urban and rural areas -- that will continue to need additional resources, which we have provided.

Now, finally, let me say that our commitment to basic research, our commitment to academic health centers, cannot be successful if we do not have an ongoing, consultative process with institutions, such as the institute with the group of academic health centers that Dr. Shine referred to, and that that kind of consultation be built into the reform process.

As a layperson, one of the surprising discoveries that I have made in the last month is that, here we are in a country that has by far the best basic research and best applied research in the medical sciences as any country -- or all of them put together in comparison, yet, too often, what you know in your academic health centers -- what this institute proves on the basis of the kind of rigorous peer review that it engages in -- does not penetrate into the larger medical and health care community.

There are still too many decisions being made which are being paid for -- not only made, but paid for -- that are neither related to quality nor cost-effectiveness. And if one looks at the pattern of expenditures and practice styles throughout this country, it is shocking.

Some of you may have seen Uwe Reinhardt's piece in -- I think it was the Times, over the last couple of days --where he pointed out something that is obvious to a political economist like himself, but which has not become clear to the American public and even to many practitioners.

And that is that without sacrificing quality --holding quality constant -- we have some areas of our country that charge three times or two times more than other areas for taking care of the very same kind of patients with the very same kind of problems.

We have not put to good use the kind of research

that we know about what should make good decision making in medicine. And we have not had any accountability system to be able to compare that and to determine what should be reimbursed.

Our efforts up until now, although we have made progress in the Medicare system, have not influenced the entire health care system.

So these are the issues that we're going to have to face with your help. We will need your constant constructive criticism and advice. But I would close by just saying that Dr. Shine is absolutely right. This institute is committed to not only research, but health care. Most of you know, very clearly better than I, the shortcomings of what we are attempting to do now. Changing this system, no matter how flawed, will be extremely difficult.

And I would argue that the people who are most likely to have credible voices are people like those of you in this room, that when the dust settles, the highly financed advertising campaigns on behalf of special interests -- like the one that the Independent Insurance Agents are running now -- which goes to your expertise, which says, "You know, we're going to ration care. We're going to take away choice."

When really, if they were held to any standard of truth in advertising, it would be, "We won't be needed anymore, because we won't be underwriting risks and eliminating people from health care coverage." And that is something that we're concerned about. (Applause)

So what we need are voices of experience and expertise to join with us and to continue to improve what we have struggled to put together, until finally -- before this Congress adjourns next year -- we have passed fundamental health care reform that guarantees every American a comprehensive benefits package and fulfills the other principles that the President talked about in his speech.

Thank you very much. (Applause)

DR. KOOP: Several weeks ago, on the 20th of September, when all of these things began to become much more publicly known, I spoke at the White House on behalf of this plan. And the First Lady was about to go over to talk to a

number of people from both Houses of Congress on what they called the university of health care reform."

And she suggested to me that I wait in the White House while she went across town, and I could work the crowd. (Laughter) And, whether you know it or not, yesterday I was working this crowd. (Laughter) And, some of the things that are of concern to you I have written down as questions that I would like to pose to the First Lady, and I would like to suggest the way that we would do it.

I would pose a question. Mrs. Clinton will answer it. If one of you out there has a question pertinent to what we're talking about at that moment, raise your hand and come forward to the microphone, and we'll take one such question. After I've done a few of these, then we will open the rest of the day to questions from you at the microphone.

I remind you that you were given some housekeeping rules yesterday by our President, (laughter) and be sure that you don't violate that. I think you've only violated half of them so far. (Laughter)

Mrs. Clinton, there was a very remarkable symposium here yesterday on genetics. And toward the end of the afternoon, a number of questions were raised. And I will just phrase those all as one. And that is, how will the plan deal with this exploding field of genetics? And just where will genetic screening come into it?

MRS. CLINTON: Genetic screening is part of the basic benefits package. And genetic screening and developments in genetics will be evaluated as we currently evaluate any new medical procedure or scientific breakthrough.

There will, obviously, continue to be clinical trials and research protocols. And the health plans will abide by those. But I think both with respect to inclusion of genetics testing, but also with an emphasis on increased investments in genetics research, I think this should be a step forward from where we are today.

DR. KOOP: Genetics question, near the microphones. Yes, sir.

DR. RIMOIN: I'm David Rimoin from Los Angeles. With genetic diseases, many of them are extremely rare, and there are only one or two places within the country that currently have the expertise to deal with them. How will the allied health plans be able to be forced to send their patients for such expert help?

MRS. CLINTON: Well, I think just as many insurance policies now provide for referral to specialists outside of area or outside of plan, we're not leaving that to chance. We are putting in a point-of-service option referral.

And, just as now, there probably will be some disputes over specific referrals, but we will establish the general principle that merely because one is an enrollee in a health plan does not mean that one cannot be referred to the highest and best treatment center that is available for whatever the particular disease is. And that is something that we intend to insist on, even with closed-panel HMOs.

DR. RIMOIN: Thank you.

DR. KOOP: I think the point-of-service option that the First Lady referred to in her prepared remarks should settle a lot of the questions that you people asked me yesterday that are based on that exact same principle.

The next question that I would like to ask is, you have said, Mrs. Clinton, that a person can follow his or her doctor into an HMO, for example. But, by the age of 50, many of us have several specialists. We may have accumulated a cardiologist, a surgeon. We have physicians that we think are our own. So how can these professional relationships be continued?

MRS. CLINTON: Well, I think that, with respect to the multitude of specialists that some patients have, there will always be the fee-for-service network. That's another one of the failsafe guarantees that we are putting into the plan.

There will also, we believe, be an explosion of the networks of physicians, again, which will not be able to discriminate against physicians who wish to join them plus something else.

Now, I cannot guarantee that you will be able to follow every single one of your specialists, if you have a multitude of them, if you do not go into the fee-for-service network. But that's one of the reasons we're having the fallback position on the fee-for-service network, so that that will be able to be continued.

And for Medicare patients over 65, who certainly have a tendency to have more specialists, that current system will remain a fee-for-service network for most recipients.

DR. KOOP: Will physicians be permitted to join an HMO or a PPO, for example, and maintain as well, a fee-for-service practice?

MRS. CLINTON: Yes. Yes.

DR. KOOP: That should answer a great many questions that I heard here yesterday. (Laughter)

MRS. CLINTON: Now, you know, clearly the HMO will be able -- if it's a closed-panel HMO -- to limit which doctors it will have on the panel. But that is not going to be a reciprocal limitation. The doctors will be free to join, if they choose. This is not required. It is if they choose to be, as well, in the fee-for-service network.

DR. KOOP: A question pertinent to this? Yes, sir.

A PARTICIPANT: Yesterday's Wall Street Journal said that a provider -- under the plan proposed, the provider may not charge or collect a fee in excess of the fee adopted by an alliance. Is that a true statement as regards the network?

MRS. CLINTON: Yes, but there will be fee reimbursement negotiations done within the health plans within an alliance, not the alliance so much as at the health plan level. But the alliance will be setting some kind of budget targets.

And under those targets the physicians in the various forms of health plans will be negotiating their own reimbursement rates, so that, for example, a fee-for-service, as I referred earlier, the physicians will be able to participate in negotiating what their reimbursement level is.

The alliance won't be doing that. The alliance will be setting out the big picture. You know, here is what we intend to spend on health care in this region. And then the individual health plans will be setting their own rates, but within that budget target.

DR. KOOP: I think the concern brought forward was that the fee-for-service network couldn't survive with that condition.

MRS. CLINTON: You know, I don't believe that, based on what we have looked at. We've looked at a number of -- if you take, for example, those communities that I referred to earlier, where you have a 3:2 or a 3:1 or 2:1 ratio of what it costs in Medicare compared to what it costs in some other community, there are many communities where the fee-for-service network, or the fee-for-service rates, are very close to what you would find at an HMO or a PPO.

There will be some communities for whom this will be a major change. I don't want to mislead you. I mean, if you practice traditional fee-for-service medicine in some of our regions -- and I'll just name names.

If you practice in Miami, where you charge, on average, three times more than San Francisco, a city of comparable cost, your fee-for-service charges may not be able to be as high as they are now in competition with HMOs or PPOs that will see a terrific market in that community.

So it's going to depend very much on what the level of cost is now, what the practice style is now. And that's one of the reasons we're trying to get out and talk about this, so that physicians and others can begin to evaluate where they stand right at this time.

DR. KOOP: I asked a question a moment ago from the patient's point of view. I'd like to turn it around through the physician's concern. If, as we expect, the adoption of the Clinton Plan leads to an increase in the number of HMOs, PPOs, and so on, and if a large number of doctors in the community move into such organizations, what will happen to those physicians who are unable to find a slot in such an organization?

MRS. CLINTON: They will be in the fee-for-service network, or, I think, there is a -- unless we're dealing with -- let's put aside people who, for professional reasons, nobody wants. (Laughter) One of the things that we're going to be asking all of you is to perhaps take a little stronger stand against some of your colleagues that you have basically let go by for years, because you weren't involved with them.

As everyone in this room knows, the stories that I have heard over the last months about, you know, you don't think the fill-in-the-X physician is doing what should be done, but there's no real way, or no real incentive, to do anything about inappropriate or unnecessary care -- or fill in the blank.

So certainly there will be some who, for professional reasons, people don't want. I don't think that's all bad. There will, however, be protections against discrimination that is not related to professional competence, but is related to gender or race or minority status of some kind.

But that does not guarantee that every physician will have a place in every organized delivery network that is going to be available. Again, that physician, though, will have to be considered as a member of the fee-for-service network. So there's going to be a sorting out.

But one of the things that I have been pleased by in recent conversations is that a number of these ideas about organizing delivery networks are certainly not new with the President's proposal.

For example, the Catholic Hospital Association had adopted its reform proposal during the two years before my husband was elected. It relies on networks. It relies on willing physicians working with hospitals, working with other providers to create organized networks of care.

Now, it may be that what is often said about lawyers is true about doctors -- that trying to organize them is like herding cats -- and I appreciate that. (Laughter) But I think there is such an opportunity here to get ahead of what is happening, and to not just wait to be purchased or to be moved into some kind of large delivery system, but to take the initiative.

And again, just sort of speaking out of school, I think there is an incredible opportunity for academic health centers, because you are the most respected institution in most communities. You carry with you the validation and credibility that would be impossible to buy by most others who are going to be organizing networks. So I think there's a real opportunity there.

DR. KOOP: Would it not also be possible for a group of physicians who felt that they had not gotten into an HMO in time, to themselves form?

MRS. CLINTON: Absolutely. And because individuals are going to be making the decisions, individuals are going to be looking at criteria that are not all related to bottom line.

I mean, it's going to be choices based on cost, certainly, but quality, familiarity, and -- I just, again, would stress that individual physicians, individual clinics, individual hospitals, have such an opportunity now to join together to figure out how best to do this, and that I would urge that some thought be given to that.

DR. KOOP: Dr. Relman has a question on this issue.

DR. RELMAN: Mrs. Clinton, I'm delighted to hear that you are concerned about making it possible for physicians to form organizations of their own -- perhaps with a community hospital -- to form a health plan.

Are you going to encourage not-for-profit plans? Because, if you want to, it seems to me that you're going to have to deal with the problem of start-up capital.

MRS. CLINTON: Yes.

DR. RELMAN: As you know very well, the investor-owned insurance companies and many other businesses are now actively shopping for group practices and HMOs and individual practices that they're buying up all over the country. It's a great wave of acquisitions of physicians' practices.

And if the administration wants, as I know it does, to encourage independent physician organizations that will be not-for-profit, you're going to have to think about some way

of giving them start-up capital that won't require such terrible risks that not-for-profit, community-based organizations are not able to assume. And I've suggested the possibility of grants -- maybe reimbursable grants. I hope you will consider that issue.

MRS. CLINTON: In fact, we have. And I appreciate that recommendation. We are putting into the plan a revolving loan fund and grants to do just exactly what you're talking about, because we know there are capital barriers to formation.

But don't sell yourselves and not-for-profits short. There is a tremendous capacity for entrepreneurial adjustments within the not-for-profit and the mission-driven provider world that -- you know, again, as an outside observer -- I think is not being fully appreciated.

One of my big fears is that too many physicians and hospitals -- particularly community and not-for-profit --will not realize their own potential and will sell out, basically, to the investor-owned and the for-profit.

And so we're trying to provide incentives -- not only financial, but also legal, with the anti-trust changes and the like -- that would enable you to form your own networks. But we have to hope that some discussions and planning on that will begin immediately, and that those of you in academic health centers affiliated with community and not-for-profit hospitals in clinics will appreciate what you have. I mean, you are big prizes as well as extraordinary resources.

And there is a lot that you could get in terms of technical assistance, and limited capital infusion from for-profit and investor that would not amount to giving up control or turning over your entire operation. So these are some things that I hope the medical profession will be thinking about.

DR. KOOP: You alluded to the failure of this profession to police itself adequately, and I think there's no question about that. But the track record of people who have tried to do that altruistic task is not a good one.

They frequently have lost out in courts, and have ended up not only without a job, without the policing effect taking place, but also without money. Is there any plan to provide some kind of protection -- some good samaritan principle -- for such people?

MRS. CLINTON: That's an interesting idea. The way we have approached it is along these lines. Part of the reason that the policing or the accountability -- whatever one calls it -- may not have been successful to date is because of our system of reimbursing almost on a piecework basis the work that you do, and treating all of you as individual entities.

And that has not created any incentives for you to hold each other accountable. And, in fact, there has been a tradition of basically keeping separate your business from others. And what I have hoped is that because -- if we form these networks, each of you will have a stake in both the quality and financial outcome, because every year citizens will choose.

The decision they make one year may not be the decision they make another year, which is another reason why I hope that doctor/provider groups and others form these networks, because I predict there will be evolving decision making and that it will, over time, trend toward the more not-for-profit community-based systems, if they are there to be taken advantage of.

If you, however, have this kind of joint responsibility, then all of a sudden decisions that were no matter to you become of consequence. And I'll just give you one example that I have used before, because I was so struck by it.

The hospital administrator of a large hospital in Ohio told me that many of the people on his staff were concerned about a particular surgeon admitting patients for care which they didn't think was appropriate. But nobody felt it was in their interest -- either professionally or financially or any other way -- to say much about it.

And when confronted, the surgeon just basically said, "I'm going to do what I want to do." And the net result was the hospital administrator and a number of his

medical staff were feeling very frustrated because they had no tools with which to carry on the conversation with this particular surgeon.

In our system, there will be some kind of accountability and sharing of responsibility that will enable all of you to have more of a say in what your colleagues do or don't do. So those are the kinds of approaches -- the good samaritan idea is one that we will look at, Dr. Koop. I'm not aware that we have included that.

(End of side 1)

DR. SHERDER (phonetic): -- Joe Sherder, family physician in San Diego. As you talk about physician networks and some doctors being left out, our problem is not incompetence, but an oversupply of specialists. We find that we have as many as twice as many specialists in a given area as we need for our population. The overspecialization has been described as the invisible driver of health care costs."

How do you propose to reform medical education in that area in terms of reimbursement for medical education to correct the problem?

MRS. CLINTON: Well, we are as concerned about that as you are. And what we have proposed is that we begin to fund at a higher level medical education for primary and preventive care physicians -- including internists, pediatricians, family practice physicians, and others -- and that we de-link some of the reimbursement patterns that have funded medical education over the last 20 years from providing only funding for subspecialists.

We have gotten the system we paid for. Every time somebody tells me that we're going to impinge upon the right of young medical students to go into subspecialty X, my response is, "Why do you think, over these years, this young medical student chooses to do that?"

Medicare, for years, has been funding that subspecialist. You all have been able to hire terrific people, exciting new ideas, more money coming into that area -- which is very attractive to these young medical students.

We have turned our back on primary and preventive health care. We've done it not only in medical education, but in the reimbursement system and Medicare. We have said to internists, or to pediatricians, "You're not going to get paid what you should get paid for clinical time with patients, which we know is important for your diagnostic needs. Unless you can figure out something to bill for, it's lost time."

I mean, we have just done this backwards. So it is absolutely clear, we have got to begin to bring more primary care physicians into our system, both through changing the incentives in medical education, changing the reimbursement patterns, and trying to provide incentives like loan repayment and the like.

And for those who will say that's unfair to specialists, please take a look at the overall system. It is not unfair to specialists to try to right a balance that is undermining our capacity to deliver quality health care so that specialists are not providing both primary care and specialty care, which too often is the case.

DR. KOOP: I have many more questions that you asked me yesterday. But, in fairness, we wanted to spend half the time taking questions from the floor. I would like to do that now, and would turn to Dr. Jonathan Rhodes (phonetic).

DR. RHODES: Mrs. Clinton, I find broad support for your program, but lingering doubts as to the financial viability of it. Those of us who are older remember, in the '60s, projections of the costs of Medicare and of Medicaid, which were shown later to be far too low.

In the event that the projections of this program should not be as favorable as they have been predicted to be, would the funds which will be raised under the deficit reduction legislation be available to bridge the gap?

MRS. CLINTON: Well, Doctor, let me just say a few words about the financing, because you raise a very important question, and it will be at the key -- it will be at the center, and one of the keys of what we do.

We know that there are going to be some evolving

assessments of what any of this will cost, no matter what plan we were to choose, no matter how we were to design it. We know that. And we've watched other countries with different kinds of plans, whose costs have gone up faster than anticipated in some respects, as well.

But what we believe is that there is sufficient funding in the plan to do what we are talking about, but that, clearly, one can always go back to the Congress, in the event of shortages or needs that aren't being met, and increase whatever the amount of money needed would be.

We do not want to extend that invitation without some very careful planning, because part of the reason we are in the situation we are today is, as you rightly point out, starting in the 1960s we created a program in the Medicare and Medicaid public sector that far exceeded any cost projections. And at the same time, we had an explosion of costs in the private sector.

Our attempt to bring down the rate of growth in both of those, we believe, will succeed. But in the event they do not, yes, there is deficit reduction projections in this plan that certainly could be altered in the event of the need for more money.

DR. KOOP: Over here now, please.

A PARTICIPANT: Madam Chairman, I commend your wisdom and commitment. I'm concerned about the possibility under managed care, managed competition plans -- both notable oxymorons -- for exclusion of special populations -- special populations in terms of their historical, social, and health care burdens.

I'm speaking about the persons in the inner city whose physicians traditionally have not been associated with medical associations, or on medical staffs. I'm talking about the community clinics. What will happen there?

And I'm particularly concerned about what I hear --that this plan will not embrace people in correctional institutions, which should be a matter of some concern, as they are imminent incubators of tuberculosis, which may be resurgent.