Box 10 of 12

Office of the First Lady
Domestic Policy Council
The Files of Jennifer Klein
File Inventory

File Type: Loose Files
File Size: Letter
File Contents: Health Issues

- Children's Health
- Children's Hospitals
- Disease Specific: Cancers, Parkinson's Disease, Cystic Fibrosis
- HRC Health Care Speeches, Articles, About Health Reform
- Tobacco
- Assisted Suicide

ENCLOSURES FILED OVERSIZE ATTACHMENTS 13532

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FIRST LADY HILLARY RODHAM CLINTON
HARVARD MEDICAL SCHOOL COMMENCEMENT
BOSTON, MASSACHUSETTS
JUNE 4, 1998

CEO of Beth Israel
CEO
Care Group
Retiring

Where is Dr. Rabkin? Was Dean?

20 Nobel Laureates? Only 18

Dr. Martin; Dr. Donoff; families; alumni; faculty; our co-moderators Alison Bryant and Samuel Somers, others distinguished guests, and most important, the class of 1998: Congratulations. You have done it!

I know you come here today with a whole range of emotions: Exhilaration. Sheer exhaustion. Gratitude for the teachers and loved ones who stood beside you for 4 or 5 or 6 or more years -- just as they stand beside you today.

And I hope -- tremendous pride. More than 70 percent of you took out loans to reach your dream. Some of you finished school while caring for a family. You may have been the first in your family to attend college. Maybe you only recently came to this country. More than 15 percent of you also managed to earn a Ph.D., masters or J.D. All of you have made great sacrifices to reach this day, to graduate from this extraordinary institution, and to enter the noblest of all professions.

Now, even as you celebrate, I know many of you are already thinking about the next chapter of life. The food may not be quite as good as the restaurants on Newbury Street. The sleeping accommodations won't exactly be 5 Star. You know it as -- internship or specialty training. The words bring with them excitement and expectation. Images of countless hours. Little sleep. And even a tinge of fear. You may want to know: "Am I prepared?"

I have come here with a direct answer: No group of new doctors and dentists have ever been better prepared to care for their patients. No group has ever been better prepared to usher in the next century, the next Millennium, of medicine.

From the clinic to the classroom to the community, you have received a first-rate education from one of the finest schools in the world. Your entering class was the first to have more women than men. Thirty years after your diversity program began, yours was the first class where ethic minorities are the majority.

Today, you stand on the shoulders of all Harvard graduates and faculty who dreamed about -- and then created -- a new future. You stand on the shoulders of Judah Folkman, as he unlocks the secrets behind cancer. You stand on the shoulders of Orah Platt, one of the top researchers in sickle-cell disease. You stand on the shoulders of David Ho, who is working to rid our world of AIDS. And, yes, you stand on the shoulders of Michael Crichton and Neal Baer who bring Dr. Ross, Nurse Hathaway and the entire team at ER to us every Thursday night.

Now, it is your turn to carry the future on your shoulders. Class of 1998, it is your time to lead. You have been given the chance to use your training during the most exciting time ever in medicine. Just 30 years ago, few would have thought we'd see revolutions in biology and technology, revolutions in the way we deliver and finance care, seismic shifts in demographics. All of these changes offer incredible opportunities, opportunities your predecessors could have only dreamed of, but they also present fundamental challenges..the most critical of which is this: In our revolutionary health care system, how can you stay true to the oath you will take today...to make "The health of my patients my first concern?"

I know many of you worry about this. About how you'll manage to keep the business of medicine from compromising the healing of medicine. How you'll keep sacred the bond between patient and doctor. I've read the extraordinary oath you've written. And I believe the future of health care in the 21st century will depend upon what we do as individuals and as a nation to ensure that you keep the promises of your oath, while reaping the promises of a new health care world.

Class of 1998: When you pledge today to promote health and prevent disease, you do so in a world where breakthroughs in research are putting the medical keys in your grasp. You have treatments for stroke and AIDS...and the potential to slow the progress of diseases like Alzheimer's. Computer technology is allowing you to instantly share life-saving information. The mapping of the Human Genome is revealing genes linked to breast cancer, colon cancer, and Parkinson's diseases.

These kinds of advances don't just happen by accident or overnight. They are the result of sustained investments in research, especially in basic science. Which is why the President wants to increase our research budget at NIH to historic levels -- by 50 percent over the next five years...and by almost two-thirds at the National Cancer Institute alone.

These continuing advancements also depend upon ~~our~~ ethics keeping pace with ~~our~~ science. We've all heard stories of people avoiding critical tests or refusing to use their insurance, out of fear they'll be discriminated against or have their privacy violated. You should be able to look your patients in the eye and say: information about your genes will be used to heal you, not deny you a job or affordable health insurance. The President has asked Congress to outlaw genetic discrimination.

And you should be able to guarantee your patients that the privacy we took for granted in the Marcus Welby era will still be around in the ER days. At a time when our most personal health information is electronically criss-crossing the country, moving among ~~our~~ health plans, insurance companies, and employers with fewer federal safeguards than ~~our~~ video records...It is time to pass a law safeguarding the medical records of every American.

Class of 1998: When you pledge to respect the dignity and autonomy of your patients in living and in dying, you make that promise in a world of rapidly changing demographics....where the baby boomers are graying and Americans are living far longer with less disability.

Like many nations, we must answer some tough questions about how we will provide and finance care for this expanding group of older Americans. Before Medicare was enacted, almost 50 percent of older Americans went without health insurance. People used to work their entire lives, only to enter their golden years making unthinkable choices between paying their heating bills and their doctors bills. We hear a lot of talk about what's wrong with government. But let's never forget what's right. Medicare forever changed what it means to grow old in this country. And we must make sure it is there for every generation.

But, Medicare, like every program, must adapt to a new world. We've worked in a bipartisan fashion to extend the life of the Trust Fund for a decade. To give your patients more choices and new prevention benefits like mammograms and flu shots. And there is consensus between Republicans and Democrats that we must address the long-term future of Medicare together.

[But it's not just care for the elderly that we must rethink. Whenever I've been privileged to travel throughout the world. It doesn't matter if it's the World Health Assembly in Geneva or a small women's clinic in Kazahkstan...I encounter nations and citizens who are facing up to difficult decisions about how we finance and deliver health care with growing populations, new diseases, and other cost pressures. Some countries are cutting back on necessary services just to make ends meet. Others are in danger of having their existing structures collapse under the weight of caseloads from HIV/AIDS or TB. Even some of those with universal systems are now unable to afford the facilities they have or the technology they need.]

Class of 1998: You will dedicate yourself to the profession of medicine at a time when revolutions in our own health care delivery system are blurring the lines between payers, providers, and insurers. There are more than 160 million people enrolled in managed care plans, an increase of 75 percent since 1990. More physicians are forming their own health plans. We have more opportunity than ever to share risks and control costs. But we have more responsibility to ensure that new forms of care don't mean substandard care...that the bottom line of profits never eclipses the bottom line of good medicine.

You know what can happen when new market forces squeeze our cherished Academic Health Centers -- and you have shown in Boston what can be accomplished when managed care plans join forces with our teaching hospitals. What the President has done is ensure that teaching facilities receive payments directly from Medicare -- not inadequately funneled back through managed care plans.

Now, we must look at whether there are other ways to help finance your mission. Because if we want to train the next generation, if we want to give birth to a new generation of great discoveries, if we want to care for our vulnerable...It is not enough to make sure our academic health centers survive year to year. We must ensure they thrive into the future.

We must also listen to the 60 percent of Americans who say they're worried that if they were sick their health plan would be more concerned with saving money than giving them the best treatment.

We must listen to the family of a 12 year-old boy, who had a cancerous tumor in his leg. His doctor wanted to try a procedure to save the boy's leg, but the health plan would only pay for amputation. His parents appealed once. And were turned down. Twice, they appealed. And were turned down again. Finally, the health plan changed its mind. By then, the cancer had spread. By then, it was too late. Amputation was the only choice left. It, of course, was covered.

We should work for the day when stories like this never happen. Whether Americans have managed care or traditional care, they should always feel confident that they will get quality care. What better place to make that promise. This is where Dr. Mitchell Rabkin introduced the first Patient's Bill of Rights. And this is where we must say for all to hear: Patients should never have to beg and plead to see a specialist they need. When an emergency arises, they should get care whenever and wherever they need it. They should a right to a fast and fair appeal when they disagree with decisions about their care. Congress must pass a Patient's Bill of Rights to protect every American.

Class of 1998, if you are going to fulfill your promise to care for all in need, our nation must promise to continue to reform our health care system. People often ask: Were we disappointed that we didn't pass comprehensive health care reform? Of course. We fought hard. And we are proud we tried. I know that pride is shared by many leaders from this institution and this State's Congressional delegation who worked to make the Health Security Act the law of the land.

Our disappointment comes because of the 41 million people still living without health insurance, living under the threat of being one illness away from bankruptcy. [We are the richest nation in the world...but the only industrialized country which does not provide all its citizens access to affordable health care.] No, the problem hasn't disappeared.

But, when the political environment makes it impossible to take large steps, you have two choices -- take small steps or sit on the sidelines and do nothing. We moved ahead believing that it is far better to help 10 million people, far better to help 100,000 people, far better to help 1,000 people, than to help no one at all.

Thanks to the continuing leadership of Senator Kennedy, we said you won't lose your health insurance just because you lose your job or have a pre-existing condition. Is this a cure-all? Absolutely not. There are still questions about whether the insurance is affordable. There are still issues we are addressing to stop insurance companies from rewarding those who deny coverage. But this law is making a difference for your all patients who wake up worried about whether a change in their life will mean an end to their health insurance.

It's the same with the new Children's Health Insurance Program. Just a few years ago, who would have believed that we would expand health insurance to millions of children who don't have it? But our job isn't done. Passing this legislation was a remarkable accomplishment. But the real test is implementing it well. The real test is whether all of us find these children when they come in for check-ups, when they walk into church, when they play in our communities and enroll them -- either through Medicaid or the new program.

Our job is not yet done when the number of people living without health insurance...the number of people shut out of the best health care system in the world has increased by 4 million since 1992. Who will take care of them as fewer and fewer employers are providing insurance? Who will pay as health care costs, once on the decline, and now leveling off, start to increase? Our job is not done when our citizen's access to care too often depends on the color of their skin, the neighborhood they live in, and the amount of money in their wallet. Let me be clear: Our job as a nation will not be done until every American has access to affordable quality health care.

While we must continue to work toward that day...continue to protect the sacred doctor-patient bond...it is you who must be the architects of this changing health care world. Not the bystanders. It is not enough to criticize from afar. You are entering a world where you will be judged -- not by your grades or boards, but by whether you fulfill your responsibility to live up to your oath and lead us into the next century.

Almost 100 years ago, one of your predecessors said, "We are very glad it is in the class of 1900, and not that of 1800, in which we are graduating; for, as great as the progress in the century just closing, we confidently believe that we all shall witness, some us perhaps share in, still greater triumphs in the century now dawning."

I hope you feel the same. A hundred years from now, when they look back at the class of 1998, I hope they'll say that, when given the opportunity, you went far beyond the instructions to do no harm at the patient's bedside...and instead worked in the service of humanity. Not just in your own backyard, but also in the service of citizens I've seen worldwide...whose lives have been saved because we helped a community eradicate polio. Or a woman get pre-natal care. Because we believed that when the health of one of us is threatened, all of us are threatened.

Just as we conquered bacteria in the 20th century, they will say we conquered viruses in the 21st. We tackled chronic illnesses and gave people the tools to live not only longer, but better. We made sure no child ever picks up a cigarette and throws away a future. We created a world where our grandchildren had to look to the history books to learn about cancer and AIDS.

A hundred years from now, I believe they will be inspired by how, through all this, you managed to still maintain your own well-being. How you sought balance between work and family. Between the responsibilities of medicine and citizenship. And that you had fun. Yes, fun. That you enjoyed your colleagues, your patients, and your incredible gift of healing.

And I believe that, during a time of great revolutions in health care...when there was uncertainly about which direction we would go...they will say that you were the ones who made sure your nation kept sacred the bond between doctor and patient. You were the ones who ensured that, "above all, the health of my patients will be my first concern."

Congratulations, good luck, and Godspeed.

HARVARD MEDICAL ALUMNI ASSOCIATION

25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115
(617) 432-1560
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OFFICE OF THE DIRECTOR

Please forward to Ms. Laura Schiller

Dear Ms. Schiller:

Here are the responses from our graduates who might be called upon by the First Lady:

Coming to hear the First Lady:

Dr. Maria Alexander Bridges
Dr. Kenneth Roland Bridges
Dr. Dewayne Pursley
Dr. Steven Weinberger
Dr. Frank Lepreau
Dr. Orah Platt
Dr. Martha Tracy
Dr. William Chin (most probably)
Dr. Marshall Wolf (most probably)
Dr. Alison May (most probably)

Definitely not coming:

Dr. Eric Chivian
Dr. Judah Folkman (will be in Helsinki and very much regrets he won't be there)
Dr. David Ho

Sincerely,

Nora N. Nercessian, Ph.D.
Executive Director of Alumni Relations

OATH OF THE CLASS OF 1998
HARVARD MEDICAL SCHOOL – HARVARD SCHOOL OF DENTAL MEDICINE

Prepared by the Oath Committee of the Class of 1998
Ratified by the Class on 14 May 1998
[1]*Please read Physician or Dentist as appropriate*

Dean:

Members of the Class of 1998, please rise.

I now invite you, as a class, to affirm your commitment to the profession of Medicine or Dentistry and to articulate the ideals and principles that will guide you in the years ahead.

Class:

Today, in the presence of family, friends, teachers, and colleagues,
I dedicate myself to the profession of Medicine.

I pledge myself to the service of humanity.
I will use my skills to care for all in need, without bias and with openness of spirit.
The health of my patients will be my first concern.

I vow to hold sacred the bond between doctor and patient.
I will hold in confidence all that my patients entrust to me.
I will strive to alleviate suffering.
I will respect the dignity and autonomy of my patients in living and in dying.

As a *Physician/Dentist*[1], I recognize my duty to society.
I will work to promote health and to prevent disease. I will advocate for the welfare of my community.
Even under duress, I will not use my knowledge or my skills against humanity.

I will acknowledge my limitations and my mistakes so that I may learn from them.
To uphold these responsibilities, I will maintain my own well-being and the well-being of those close to me.

I will promote the integrity of the practice of Medicine.
In the tradition of my profession, I honor all who teach me this Art.
Through honest and respectful collaboration with my colleagues, I will uphold the highest standards in the service of patients.
I will seek new knowledge, reexamine ideas and practices of the past, and teach what I have learned.

Above all, the health of my patients will be my first concern.

This Oath I take freely and upon my honor.

Nobel Laureates from the Harvard Medical School

George Minot, 1934, Medicine and Physiology
Research on liver treatment of the anemias (with Murphy)

William P. Murphy, 1934, Medicine and Physiology
Diabetes and diseases of the blood (with Minot)

Fritz A. Lipmann, 1953, Medicine and Physiology
Identified coenzyme A and discovered basic principles in understanding of proteins

John F. Enders, 1954, Medicine and Physiology
Application of tissue-culture methods in developing a polio virus, the ingredient of the polio vaccine (with Robbins and Weller)

Frederick C. Robbins,* 1954, Medicine and Physiology
Application of tissue-culture methods to the study of viral diseases (with Enders and Weller)

Thomas H. Weller, 1954, Medicine and Physiology
Application of tissue-culture methods to the study of viral diseases (with Enders and Robbins)

Georg von Bekesy, 1961, Medicine and Physiology
Discovered the traveling wave while researching how the ear responds to sound waves

James D. Watson, 1962, Medicine and Physiology
Described the structure of DNA

Konrad E. Bloch, 1964, Medicine and Physiology
Studied the pattern of reactions involved in the biosynthesis of cholesterol and fatty acids

George Wald, 1967, Medicine and Physiology
Research on the biochemistry of vision

Baruj Benacerraf, 1980, Medicine and Physiology
Discovered that disease-fighting ability is passed on genetically, although the immune-response gene varies from person to person

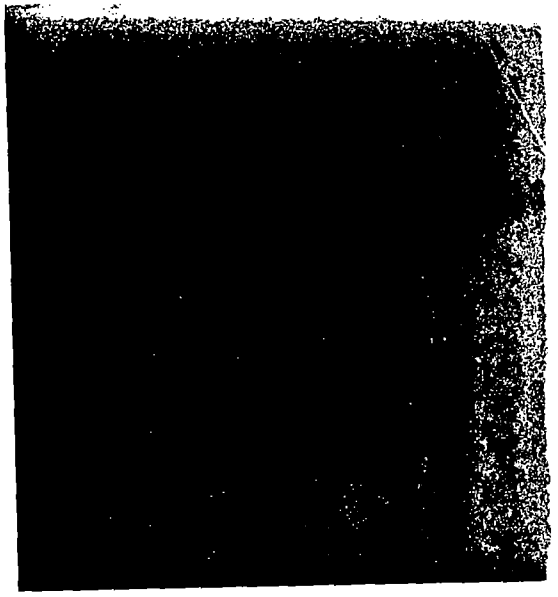
David Hubel, 1981, Medicine
Research on information-processing in the visual system (with Wiesel)

Torsten Wiesel, 1981, Medicine
Research on information-processing in the visual system (with Hubel)

Bernard Lown, Herbert Abrams, Eric Chivian, and James Muller, 1985, Peace
Cofounders, with Evgueni Chazov, Leonid Ilyin, and Mikhail Kuzin from the Soviet Union, of the International Physicians for the Prevention of Nuclear War

Joseph E. Murray, 1990, Medicine
Developed new procedures for organ transplant (with E. Donnall Thomas, formerly of the University of Washington)

Harvard Medical School, 1870-1920



by Kenneth M. Ludmerer

Prior to 1870 Harvard was a proprietary medical school, respected on the standards of the day but not much different than the dozens of other such schools of the time. By 1920, Harvard was a medical school of worldwide importance, offering up-to-date, scientific instruction of the highest quality. Though it has grown and changed in many ways since then, if any of us could visit Harvard Medical School of 1920, we would surely recognize it. It is Harvard's transformation from an inconspicuous nineteenth-century proprietary college into a modern medical school of international eminence that will be the focus of my remarks.

Like all American medical schools of the period, Harvard Medical School in 1870 stood desperately in need of reform. Admission was open to anyone who could pay the fees. Only twenty percent of the students held college degrees, and one faculty member estimated that over half the students could not write. The curriculum consisted of two, four-month terms of lectures, the second identical to the first. There was no gradation of studies, nor were there written examinations. To graduate, a student needed only to pass five of nine perfunctory, five-minute oral examinations at the end of the term. Instruction was almost wholly didactic, relying heavily on the lecture, textbook, and demonstration. In the scientific courses, except for anatomy, students did not engage in laboratory work; in the clinical subjects, students did not participate in patient care.

At this time only a nominal connection existed between the University and the Medical School, which operated on a separate calendar, managed its own financial affairs, and divided the profits among the faculty. For this reason the school strove for large student enrollments and large receipts. The recent book *Medicine at Harvard,* by Beecher and Altschule, has described the Medical School at this time as "a money-making institution, not much better than a diploma mill." Such were the conditions not only at Harvard, but at every American medical school of the period. Henry Jacob Bigelow, the professor of surgery, correctly stated in 1871 that "no successful [medical] school has thought proper to risk large existing classes and large receipts in attempting a more thorough education."

By 1870, however, advances in medical science had rendered obsolete the methods of the proprietary schools. Charles Eliot, President of Harvard University from 1869 to 1909, understood the need to teach medicine in a more rigorous, scientific fashion. Eliot, a chemist, was introduced to chemistry as a Harvard undergraduate working with

Henry J. Bigelow, courtesy The Harvard Medical Archives

Josiah Cooke, and learned the subject by working in the laboratory rather than by simply attending lectures and reading textbooks.

From 1863 to 1865 Eliot studied chemistry abroad, and took advantage of that opportunity to observe closely the French and German systems of medical education. Upon his return to the United States, he was convinced of the importance of science to medicine and of the need to teach scientific principles with laboratories as well as lectures. "The whole system of medical education in this country needs thorough reformation," he wrote in his inaugural report as Harvard president in 1870. He felt that "the ignorance and general incompetency of the average graduate of American Medical Schools, at the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate."

Why, Bigelow asked, should a new president wish to introduce so many changes into a program that had been successful for eighty years? The reason, Eliot answered, was quite simple: "There is a new President."

After assuming the presidency of Harvard, Eliot made reform of the Medical School one of his critically important goals. His plan encompassed three principal areas. First, a series of administrative changes was introduced. The Medical School, which previously had been an independent proprietary school—that is, owned by the faculty and only nominally connected to the University—now became an integral part of the University. The Medical School received the status of a full professional school of the University, began to adhere to the University calendar, and surrendered management of its finances to the University administration.

Second, major changes were made in the curriculum. Before Eliot's arrival, Harvard, like every other American medical school of the time, had offered only two identical sixteen-week courses of lectures. In 1871, the course of instruction was expanded to a three-year program with nine-month terms, and written examinations were introduced into each course. In addition, the subject matter for the first time was ordered in a logical, progressive, structured sequence—the basic sciences preceding pathology and therapeutics, and the scientific courses preceding the clinical work.

Third, and most important, the new curriculum emphasized the laboratory sciences. Previously the only scientific subject taught in a thorough way was anatomy. Now instruction in anatomy was expanded; and rigorous teaching was introduced in chemistry, physiology, microscopic anatomy, and pathology—all of which required significant laboratory work. With these changes, Harvard Medical School entered the modern era.

Eliot's proposals, so reasonable to those of us with the perspective of 1982, were revolutionary at the time and triggered a fierce debate within the medical faculty. The senior members of the faculty, led by the influential Henry Jacob Bigelow and Oliver Wendell Holmes, strenuously opposed the plan. The junior members of the staff, particularly James Clarke White, David Cheever, and Calvin Ellis, strongly supported Eliot's proposals.

With such divisions, the year was one of profound tension and strife. Numerous strained, bitter meetings of the medical faculty were held. Holmes and Bigelow were furious, and their outrage threatened to snuff out the career of the still unestablished Eliot, who had been elected University president by the barest of margins. Nevertheless, through tact, perseverance, conviction, and sheer determination to triumph, Eliot imposed his will. Why, Bigelow asked at one faculty meeting, should a new president wish to introduce so many changes into a program that had been successful for eighty years? The reason, Eliot answered in an immortalized reply, was quite simple: "There is a new President."

Why should the conservative faction of the faculty have opposed the reforms? A flip answer points to selfish motives, arguing that the senior members did not wish to relinquish receipts or control of the school. Such a reply ignores the important fact that Holmes and Bigelow were magnanimous, not petty, men who had worked long and selflessly for Harvard and for Boston.

An equally glib reply speaks of a "generation gap," asserting that Holmes and Bigelow were too old to appreciate the importance of change. Aside from the fact that this interpretation forgets how instrumental teachers usually are in forming the value system and ethos of their students, it overlooks the fact that Holmes, discoverer of the mode of transmission of puerperal fever, and Bigelow, a participant at the first public demonstration of anesthesia and one of the eminent surgeons of his generation, possessed two of the great minds in nineteenth-century American medicine.

A more satisfactory explanation relates to the way science was perceived by the members of the medical faculty. The senior professors, including Holmes and Bigelow, had taken post-graduate training in France and from their French mentors had learned the skills of astute clinical observation. Like their French teachers, however, they remained skeptical that experimental investigation played any role in medical progress. Medical discovery, they maintained, resulted from the keen observations of workers who could recognize the importance of phenomena they might stumble upon by chance, not from controlled, designed experiments aimed at wresting nature's secrets from her. (Recall that the two greatest scientific figures in nineteenth-century French medicine, Claude Bernard and Louis Pasteur, did not hold positions on a medical faculty.)

The younger members of the Harvard faculty, however, were part of that first wave of American migration to Germany and Austria for post-graduate medical training. This experience had convinced them that basic science was applicable to clinical medicine—that disease phenomena could ultimately be understood in physicochemical terms, and that the mysteries of disease and of therapeutics could be unraveled by experimental manipulation of nature, not just by fortuitous observation alone.

The faculty member most outspoken in this regard was James Clarke White, the strongest supporter of Eliot's proposals. In the 1860's he had already stirred the ire of his senior colleagues by publishing an editorial in the *Boston Medical and Surgical Journal* in which he praised the virtues of scientific medicine that had made Berlin and Vienna the world's "great schools of medicine." Parisian medicine, in contrast, by its neglect of the basic sciences, was in a state of "decadence," living "chiefly on the reputation of its past greatness." In these contrasting views of the relationship of experimental science to medical progress can the rift in the medical faculty over Eliot's proposals be best understood.

The primary consequence of the 1871 reforms was the establishment of much better instruction in the basic sciences. Previously, the only scientific subject taught effectively was anatomy. Now, instruction was added or greatly expanded in chemistry, physiology, and pathology. In addition, in 1871 Henry Pickering Bowditch received a full-time, salaried appointment in physiology. Bowditch, later Dean of the Medical School and the premiere American physiologist of his generation, was the first medical professor

in America to spend his entire time in teaching and research, freed from the necessity of private practice to earn a living. For the first time science was legitimized at Harvard Medical School.

Although science received increased attention in the new curriculum, a much more important change occurred in the *way* science was taught after 1871. The student's role in the learning process changed from passive observer to active participant. This was accomplished by the introduction of required laboratory instruction for every student in each of the science courses. Previously, the only required laboratory work had been in anatomy, and the school contained only sixteen chemistry desks for 300 students. In 1871, the number of chemistry desks was increased to 100; three large, new laboratories were built for physiologic and microscopic work; and laboratory instruction soon became mandatory in anatomy, physiology, chemistry, and pathological anatomy.

Scientific principles were now to be learned not from lectures or demonstrations alone, but from the student's own experimentation in the laboratory—as Eliot had learned chemistry and as the German medical schools were teaching the sciences to their students. Scientific principles, Eliot contended, were more readily grasped by those who actually experienced them than by those who merely heard about them. This emphasis upon "learning by doing" was by far the most important pedagogic innovation of the 1871 reforms. It constituted a qualitative change in teaching methods that dwarfed in significance the quantitative changes of a longer curriculum, new subjects, and more rigorous standards of admission and grading. Learning by doing was to become the hallmark of the educational changes that later swept American medical schools generally, including the Johns Hopkins Medical School in 1893.

To Eliot and his faculty supporters, there was a further purpose to making the laboratory the primary vehicle of scientific instruction. The empiricism of laboratory training fostered a distrust of traditional explanations and speculative theories—a distrust that was increasingly felt to be justified as the pace of medical discovery grew during the mid-nineteenth century. As Bowditch put it, the laboratory method is "to be regarded as a reaction against the too exclusive use of the so-called didactic method of instruction, as a result of which students, getting their knowledge wholly from lectures and textbooks. . .were thus insensibly led to depend upon authority instead of upon the direct observation of nature."

Nothing less than a new philosophy of education emerged out of the 1871 reforms. The primary purpose of medical education was now considered to be the cultivation of critical habits of thinking, not the mere memorization of facts, because, with knowledge so rapidly increasing and changing, today's truth might be tomorrow's fallacy. The purpose of medical training was now to foster the student's ability to think critically and rigorously, to solve problems, to acquire new information, to keep up with the changing times. This was best done in the laboratory rather than in the lecture hall. "Contact with the phenomena themselves and not with descriptions of them trains the mind of the student for power by teaching him to observe carefully and reason correctly," Bowditch wrote.

The reforms of 1871 were significant for another reason: the newly forged link between the Medical School and the University. The post-Civil War years witnessed the birth of the modern university in America, and Eliot's appointment as president of Harvard coincided closely with the appointments of several other prominent university presidents: Andrew Dickson White at Cornell in 1868; James Burrill Angell at Michigan in 1871; and Daniel Coit Gilman at Johns Hopkins in 1876. These university presidents considered themselves to be *educators,* and they argued that all activities of higher education belonged within the university's jurisprudence. To Eliot, medicine—and every other academic subject—belonged within the province of the new American university. "It is only necessary that every subject should be taught at the university on a higher plane than elsewhere," he wrote.

David W. Cheever, courtesy The Harvard Medical Archives

Although the thrust of the 1871 reforms at Harvard Medical School concerned the basic-science teaching, significant improvements in clinical teaching also occurred during the Eliot administration. However, these changes occurred later and in a more gradual, evolutionary way. In the late 1870's the obstetrics department began to offer increased clinical training on an optional basis; in 1883 the department made it mandatory that each student conduct at least two deliveries.

Similar changes designed to provide the student greater practical experience came in surgery in 1887 with the appointment of Charles B. Porter as professor, and in medicine in 1892 with the appointment of Reginald H. Fitz. Within individual departments, improvements in instruction also occurred gradually rather than precipitously. Fitz, for example, from the beginning offered much more practical instruction than his predecessor, but over the next decade he continued to expand the amount of clinical teaching in internal medicine wherever he had the opportunity to do so.

The emphasis upon "learning by doing" dwarfed in significance the quantitative changes of a longer curriculum, new subjects, and more rigorous standards of admission and grading.

Coincident with the expansion and improvement of the clinical instruction were other changes. In 1880 the school added an optional fourth year, largely to provide an opportunity for additional clinical instruction in small groups at the various hospitals. In 1892 the fourth year became mandatory. In 1895, in response to the increasing amount of medical knowledge, the faculty introduced the elective system to provide the students more latitude and choice in their studies. With the increasing rigor of both the scientific and clinical training, the faculty observed that the students' performance in medical school correlated with the quality of their preliminary training. Accordingly, in 1900 the faculty made the bachelor's degree a requirement for admission. That requirement had been preceded since 1877 by a rule that students without a degree pass an entrance examination, and by 1900 approximately half the entering students had taken the degree anyway.

The improvements in clinical teaching carried the same thrust as the earlier innovations in scientific instruction. The amount of instruction in the clinical subjects was greatly expanded, but more important, the students became increasingly involved in the learning process. In the late 1870's and 1880's, earlier didactic techniques—lectures, demonstration, ward walks in large groups—were reduced to a supplementary role in the clinical courses. In their place arose a system in which clinical subjects were taught to students in small groups or sections at the bedside, with personalized instruction and close supervision. Students would spend an hour or two a day, three to five days a week, examining patients in the hospital and following the progress of cases under their mentors' care.

The changes in clinical teaching that began in the 1870's and 1880's with the section method culminated in the early 1890's with an attempt to establish the clerkship as the standard method of clinical instruction for fourth-year students. The clerkship, in which students would continuously observe the course of very ill patients, not only allowed students to receive instruction in the hospital but also to become an active part of the hospital machinery.

As clerks, students took their patients' histories, performed physical examinations and laboratory tests, made suggestions regarding therapy, carried out procedures such as catheterization and dressing changes, and followed the daily progress of their patients until discharge. In the surgical courses, they assisted at operations; and in many courses, if their patients died, they helped perform the autopsy. The clerkship thus represented a fundamental advance over the section method of instruction. Whereas in the basic sciences the transition of the student from passive observer to active participant in the learning process came with the laboratory method of instruction, in the clinical subjects that transition came with the clerkship.

By the early 1890's the Harvard clinical faculty, led by Reginald Fitz in medicine and John Collins Warren in surgery, wished to implement the clerkship as the standard vehicle of clinical instruction for all fourth-year students. Nevertheless, for over twenty years they were unsuccessful. The clerkship, or "house pupil rotation" as it was called at the Massachusetts General Hospital, remained reserved for only a handful of students. For the rest, the section method of teaching and more intensive use of several out-patient dispensaries had to suffice. This is why the famous Flexner Report of 1910 criticized the clinical teaching at Harvard, and those criticisms were justified. It was ironic, as Flexner pointed out, to find in such close proximity to the Medical School so much clinical material that was so poorly utilized for teaching purposes.

The obstacle to implementing the clerkship at this time did not stem from any lack of faculty desire but from the attitude of the school's affiliated hospitals. As late as 1912 both the Boston City Hospital and the Massachusetts General Hospital adamantly refused to permit the routine use of the clerkship on their wards, notwithstanding the vigorous protests of the medical faculty. To understand why, we must remember that the American hospital of the nineteenth century was an entirely different institution from what it became in the twentieth. Throughout most of the 1800's the hospital was a domicile for the sick poor, not an institution for the delivery of effective scientific medical care. In this context, hospital trustees viewed teaching and research as, at most, peripheral functions of hospitals. Students were considered intruders, to be tolerated under rigidly controlled conditions but not to be welcomed.

Earlier in the history of Harvard Medical School, students had to pay additional fees just to be permitted to enter various hospitals for the ward talks, and as late as 1883 they had to pay extra fees to obtain patients for their obstetrics course. Some hospitals even refused to permit students to enter the buildings. A group of Harvard students in 1899 complained: "As students, we have sometimes had serious reason to doubt that the hospital authorities were in sympathy with the cause of medical education, and it has at least been suggested that they regard the students as interlopers, to be disposed of with all possible speed." Such attitudes characterized not just the Boston hospitals but all American hospitals of the period.

As Harvard earlier had solved its problems of science teaching, so too did the school solve its problems of clinical teaching. During the first decade of this century negotiations were being conducted between representatives of the school and of the Peter Bent Brigham Hospital. The result was a new arrangement, based on that between the Johns Hopkins Medical School and Hospital, in which the Brigham agreed to permit the medical school to appoint the hospital staff and to use the wards for teaching and research. Although the hospital opened in 1912, this arrangement with the Medical School had been agreed upon by 1909. (Had Abraham Flexner been cognizant of this, his report on Harvard Medical School might have read differently.)

The Brigham was one of the first hospitals in the United States to be a true teaching hospital, and, as such, it opened its wards to all fourth-year students so they could work as

hospital clerks. Within a few years, as a result of negotiations led by Harvard's new dean, David Edsall, the Massachusetts General Hospital and the Boston City Hospital followed course. Before World War I had ended, to quote John Collins Warren, "the Medical School of Harvard University actually extended into the great teaching hospitals of metropolitan Boston." The clerkship had at last arrived.

One last aspect of the school's development between 1870 and 1920 deserves attention: the enormous growth of its physical plant, and a corresponding growth of its endowment. In 1874, the value of Harvard Medical School's plant at its modest headquarters, then at North Grove Street, was approximately $100,000; and the school had no surplus funds for investment. By 1883, the school's assets had grown to approximately $420,000. In 1884 the school moved to a new location on Boylston Street, which in 1900 was conservatively appraised at $500,000; in 1900 the school's permanent endowment came close to $1,000,000.

By the end of the first decade of the present century, the school possessed assets that could be matched among American medical schools only by Johns Hopkins. Its new plant on Longwood Avenue, which was opened in 1906, was built at a cost of $3,000,000, and the school's operating budget for 1908 was $251,398. This enormous fiscal growth resulted not from student fees, which in the 1870's amounted to $200 per year, but from private gifts to the school.

Much of the school's financial growth occurred gradually. In the background was the accumulation of wealth in the country. Between 1869 and 1901, the gross national product doubled, and by 1892 over 4,000 Americans had reached the status of millionaire. Also important was an emerging tradition of philanthropy in America—toward "worthy" purposes in general, and toward education in particular. Between 1875 and 1902, higher education in America received $153,000,000 in endowment gifts. Harvard's drive toward economic security was aided by several wealthy members of the medical faculty who clearly understood the school's need for financial assistance. Upon his death in 1883, Calvin Ellis, who had served as dean for the previous ten years, left the school his estate of $400,000. In 1889 Henry F. Sears, a young faculty member and a recent Harvard Medical graduate, donated $35,000 to construct a much needed laboratory building.

The large part of the school's endowment, however, was raised in two critical fund-raising drives. The first, initiated in 1874, collected $200,000 to permit the erection of a modern complex for improved instruction in the laboratory sciences. The second, begun in 1901, raised $3,000,000 to enable construction of the school's present campus on Longwood Avenue. These fund-raising drives were essential to the emergence of Harvard as a modern medical school, making possible substantial improvements in both scientific and clinical teaching, as well as the support of research.

Both campaigns were initiated by the medical faculty itself. In 1874 and 1901, the school determined its needs and launched fund-raising drives to meet them. The leaders of both campaigns were Bowditch and Warren, who approached this task with missionary fervor. As entrepreneurs, they served Harvard as William Welch later served Johns Hopkins and the country's medical schools as a whole. Their persuasiveness, tact, and perseverance accounted for much of the school's success in raising money. Most donors to both campaigns, large and small, were passive, responding to the solicitations of the professors. The efforts of Bowditch and Warren in both drives greatly benefited from changes in the public's perception of the school's goals and directions. The 1874 campaign profited from the school's new image as a genuine educational institution rather than a business; and the 1901 campaign was facilitated by public recognition of the school's research role.

Nothing less than a new philosophy of education emerged out of the 1871 reforms. The primary purpose of medical education was now considered to be the cultivation of critical habits of thinking, not the mere memorization of facts.

Harvard's success in raising funds for its Medical School during the Eliot administration forces a revision of the standard interpretation of the development of medical philanthropy in America. It is customary to regard Johns Hopkins as an anomaly and to view World War I, with the growth of the foundations, as the beginning of the era of medical philanthropy in the United States. Clearly, however, as the case of Harvard demonstrates, a willingness to donate to medical schools existed a full generation earlier than usually supposed. The sum of $200,000 was no small amount in 1874, nor was $3,000,000 in 1901. It is true that Harvard Medical School was distinctly unusual in its ability to raise large sums at that time. Nevertheless, as Harvard demonstrated, donations to support medical education and research could be procured if the circumstances were right.

All of these events, it should be noted, were important not only to the development of Harvard Medical School but to American medical education generally. By the 1890's the intellectual revolution in American medical education had been completed. Dedicated faculties across the country understood the need to teach medicine in a more intensive, scientific way and attempted to do so. Virtually everywhere, however, progress was severely hindered because schools lacked the teaching hospitals and financial resources necessary to implement their ideals adequately. What was lacking in American medical schools at the time of the Flexner Report in 1910 was the way, not the will, to reform. Harvard between 1870 and 1920 showed its fellow medical schools how to find the way. □

Kenneth M. Ludmerer is Assistant Professor of Medicine and Assistant Professor of History at Washington University, St. Louis. He is also a Henry J. Kaiser Family Foundation Faculty Scholar in General Internal Medicine, and a Teaching and Research Scholar, American College of Physicians. His article "Reform at Harvard Medical School, 1869-1909," Bulletin of the History of Medicine, Fall 1981, *contains more details about HMS during the Eliot administration.*

THE WHITE HOUSE AT WORK

Tuesday, March 17, 1998

PRESIDENT CLINTON: HEALTH CARE FOR THE 21st CENTURY

It is time to fulfill our obligation to older Americans. It is time to expand the availability of health care to those who need it most. This time of prosperity should not be a time of delay -- it should be a time of action.

- President Bill Clinton
March 17, 1998

Today, President Clinton joins Democratic Members of Congress on Capitol Hill to unveil legislation that would provide greater health insurance options for an estimated 300,000 to 400,000 Americans ages 55 to 65.

Protecting America's Most Vulnerable Population. Adults ages 55 to 65 are part of one of the nation's most vulnerable and difficult to insure populations: *they have less access to employer-based health insurance; they are twice as likely to have health problems; and they are at greater risk of losing coverage.* Today, the President releases a state-by-state analysis that documents the difficulty that Americans in this age range have gaining access to health insurance. According to the report, twenty-two percent of Americans ages 55 to 65 -- a total of five million people -- are either uninsured or insured through the individual insurance market.

Giving Americans New Choices To Gain Access To Health Care Coverage. The legislation unveiled on the Hill today provides new health insurance options for Americans ages to 55 to 65. This legislation, supported by the President, would:

- **Enable Americans ages 62 to 65 to buy into Medicare**, by paying a premium.
- **Provide displaced workers over 55 access to Medicare** by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option.
- **Allow retirees, ages 55 and older, whose employers dropped their health coverage, access to their former employers' health plan** through "COBRA" coverage.

Protecting Medicare For The Future. The Congressional Budget Office recently released estimates showing that the Medicare buy-in proposal is a carefully targeted policy that will not burden the Medicare Trust Fund:

- **Paid for by premiums and anti-fraud and overpayment savings.** The costs associated with the proposal impose only temporary costs on the Medicare program, and are paid for -- dollar-for-dollar -- by a series of anti-fraud and anti-overpayment initiatives;
- **Separate Trust Fund.** While the buy-in takes advantage of Medicare's low administrative costs and choice of providers and plans, its financing is kept completely separate from the Medicare Trust Fund.

PRESIDENT CLINTON:
"WE MUST PASS A BIPARTISAN PATIENTS' BILL OF RIGHTS"

May 28, 1998

"This bill says, how can you let some person with the mentality of an accountant, who will only see the number of what it costs to have somebody do her surgery, who will only see the number at the bottom line of what the chemotherapy costs, make a decision. We're not that kind of people; we're not that kind of society."

President Bill Clinton
May 28, 1998

Today, President Clinton is joined by Vice President Gore, Secretary of Health and Human Services Donna Shalala, and Secretary of Labor Alexis Herman, in calling on Congress to pass a Patients' Bill of Rights, legislation which offers certain protections to all Americans when they become ill. The President will also release a report showing the impact of health care issues on women, and why a Patients' Bill of Rights is necessary to protect all Americans.

PATIENTS' BILL OF RIGHTS. The nation's health care system is undergoing significant change. Many Americans worry that these changes may reduce their health care options and lower the standards of care. The President has already signed an executive order requiring that all federal agencies substantially comply with the Patients' Bill of Rights. Now, these protections must be extended to all Americans. A Patients' Bill of Rights would give Americans much needed protections, including:

- **Access to health care specialists** to ensure patients receive the appropriate care they need;
- **Access to emergency services** when and where the need arises;
- **Access to easily understood information** to help patients make informed decisions;
- **Grievance and appeals processes** for consumers to resolve their differences with their health plans and health care providers.

A PATIENTS' BILL OF RIGHTS HELPS ENSURE WOMEN GET ACCESS TO THE SERVICES THEY NEED. Women are particularly affected by health care issues. A new study shows that:

- **Over 60 percent of physician visits are made by women, and women make three quarters of the health care decisions in American households.** Without adequate patient protections, women will be unable to effectively navigate through the nation's rapidly changing health care system.
- **Women in managed care plans are increasingly dissatisfied with the quality of care.** Nearly 70 percent of privately insured women ages 18 to 65 are in managed care plans. Almost two-fifths of these women worry that they will not be able to get speciality care when they need it. And 27 percent of these women worry that they will be denied a medical procedure they need.
- **Without a patients' bill of rights, women may not receive important preventive services.** The consumer protection that gives women direct access to an obstetrician/gynecologist is not only necessary to make sure that pregnant women get the care they need, but is also important to ensure that women get important preventive services. Studies show that gynecologists are almost two times as likely as internists to perform timely, needed women's preventive services.
- **Patients' Bill of Rights legislation must be passed.** The only way to assure that all women, and all Americans, have the patient protections they need is to pass and enact a Federally-enforceable Patients' Bill of Rights.

STATE LAWS CANNOT PROTECT ALL CITIZENS. The President congratulates the 44 states who have passed at least one element of the Patients' Bill of Rights. However, over 122 million Americans are enrolled in health care plans which are not fully governed by state law, and therefore do not enjoy the full protection that these laws are intended to give.

CHALLENGING CONGRESS TO PASS A FEDERALLY-ENFORCEABLE PATIENTS' BILL OF RIGHTS THIS YEAR. The President renews his call to Congress to pass a Patients' Bill of Rights this year. Without this legislation, the millions of Americans in private health plans will never be assured these basic protections.

To: Jen Klein
From: Michael O'Mary
Re: Harvard Med Commencement Issues

1) Chris Jennings would like you to call him following the speech if you feel HRC made any news.
2) Jean and Chris ok'd the bracketed line about the US being the only industrialized country not to provide health care for all of our citizens.
3) At the Harvard Commencement Ceremony that takes place during the morning, and includes students from all of the schools, one of the people getting an honorary degree is Gertrude Elion. The following bio appeared in the Harvard Crimson this morning:

> "A doctor whose drug research helped to save the lives of countless leukemia patients and earned her a Nobel Prize in Medicine and the National Medal of Science, Elion will be honored today with a Doctorate of Science.
>
> "One of only 10 women who have been awarded a Nobel Prize in science, Elion further distinguished herself by being one of only a handful to do so without a Ph.D.
>
> "Elion did much of her research at pharmaceutical giant Glaxo Wellcome, where she helped develop a drug that prevents the body from rejecting foreign tissue, aiding kidney transplants.
>
> "She was also a professor at Duke University."

Good luck!!

Call me if you need anything!

MARIA ALEXANDER BRIDGES (HMS Class of 1980) and Kenneth Roland Bridges (HMS class of 1976); both are African-Americans. Dr. Maria Alexander Bridges conducts basic laboratory research in reproduction and Diabetes; Dr. Kenneth Bridges is a researcher in the mechanisms underlying blood diseases.

WILLIAM W. CHIN is an Asian-American who graduated Harvard Medical School in 1972. He conducts research in how hormones work and works toward the development of clinical genetics in an adult population and "translate" advances in the genetic basis of disease to the bedside in the areas of diagnosis and treatment.

JUDAH FOLKMAN, a graduate of 1957, teaches pediatric surgery and cell biology; in research, he is credited with truly novel approaches to the treatment of cancer.

MARSHALL WOLF, who graduated HMS in 1963, is a physician and is recognized a teacher excellence. He is a teacher of young men and women in residency training.

ERIC CHIVIAN graduated HMS in 1968 is a psychiatrist who is the founder and director of the Center for Health and the Global Environment at Harvard Medical School. He was co-founder of the Society of International Physicians for the Prevention of Nuclear War. Received the Nobel Prize in 1985.

STEPHEN WEINBERGER graduated in 1973. He is involved in patient care, teaching and research. His research is in the area of critical care and pulmonary disease.

MARTHA TRACY graduated in 1973 is an oncologist who devotes 100% of her time to patient care. She is a private pilot who uses her flying peripherally for medicine--lifeline flights, flying doctors, etc.

ORAH PLATT graduated in 1973 and is the Master of one of the academic societies at Harvard Medical School. She is a leader in research of sickle cell disease.

ALLYSON G. MAY graduated in 1991. She is an African-American who has recently completed her residency training and has joined a practice that serves the underserved populations in the inner city in Boston, working through the Healthcare for the Homeless Program and the community health center.

DAVID HO is an Asian-American who graduated in 1978, and is a member of the Committee of 100, a Chinese-American leadership Organization. He is a leader in the research and science of AIDS. He was cited as Man of the Year in Time Magazine (1996).

DEWAYNE PURSLEY is an African American who graduate in 1982. He is a well-known neonatologist, a teacher, physician and researcher and widely known for his outstanding clinical care and dedicated teaching in neonatal health services research.

FRANK LEPREAU graduated in 1938. He has worked in Haiti, rural Appalachia, and currently, although retired, works with AIDS and Rehab patients in Providence, RI. He was, before retirement, Professor of Medicine at Brown University.

TO: The First Lady

FROM: Neera

RE: Issues for the Harvard Commencement Speech

You raised a few issues which indicate a conflict between the briefing and the speech. The following is what I was able to ascertain:

1. Women's enrollment: Women comprised more than 50% of the entering class of Class of 1998, but the majority of graduates of this class are men, for the reasons that you alluded to, such as varying lengths of academic careers. Laura is trying to make this distinction more clear.

2. Written examinations: President Eliot began implementing educational reforms, including written examinations and the requirement of a bachelor's degree, in 1871. However, these educational reforms were phased in over a period of two decades. We do not have the exact date of the introduction of written exams, but they may have been introduced as early as the 1870s. [Harvard Med: The Story Behind Harvard's Premier Medical School, 1995]

3. First vaccinations: The first vaccination, which was for smallpox, was introduced in America in 1799. While data as to the total extent of vaccination during the 19th century are sparse, it is clear that vaccinations were introduced into the general population before 1900, although it is not clear whether their use was widespread in the United States. These vaccinations for smallpox were limited in their effectiveness mostly because few countries had health structures capable of sustaining vaccinations on a regularized and long-term basis. [Public Health Reports, March 13, 1997]

4. Harvard Medical School Nobel Prize Winners: Later tonight, Michael will forward you the list of the 20 members of the Harvard Medical School faculty who have been awarded the Nobel Prize.

I will be in the office for some time in case you have any additional concerns.

DEMOCRATIC BILL

Areas Where Different Than Quality Commission

PRIMARY DIFFERENCES

- **ERISA Remedies.** Allows state cause of action to recover personal damages for personal injury or wrongful death. (Note: that does not hold employers liable when their only involvement was selecting the health plan).

- **Clinical Trials.** Requires plans to cover patient care costs associated with clinical trials at NIH and similar peer review process. Quality Commission did not include this provision. [$5 billion over five for Medicare and $4 billion over five for Medicaid].

- **Mastectomies.** Requires plans to allow women to stay in the hospital 48 hours following a mastectomy and 24 hours following lymph node removal.

- **Breast Reconstruction.** Health plan that cover breast cancer surgery, must provide coverage for breast cancer reconstruction following the mastectomy to reestablish symmetry -- including surgery on the non-diseased breast. (Rep Ecshoo main sponsor)

- **Mandatory Point-of-Service Option.** Mandates that plan provide a POS option w/ all of the same services as provided in other plans. Can have higher premiums and cost sharing.

- **Whistleblower Protections.** Quality Commission did not include this provision.

SECONDARY DIFFERENCES

- **Access to Women's Health Specialists.** Goes further than the Commission in that it allows women to choose OB-GYN as primary care provider in addition to allowing direct access to OB-GYNS as a specialist. Does not mention other types of women's health specialists as Quality Commission did.

- **Financial Incentives.** Quality Commission only requires disclosure of financial incentives to physicians. Dingell bill prohibits physicians from having any of these types of incentives.

- **Drug Formularies.** Requires plans to provide exceptions from non-formulary when recommended by health professionals, (check w/ HHS how extensive this is drafted).

- **Ombudsman.** Requires states to establish a health insurance ombudsmen to assist consumers in choosing health plans and to help provide counseling for consumers who are not satisfied. Requires Federal Government to step in when states not providing.

- **Provider Protections.** Requires notification and appeals process for providers who are rejected from the plan Quality Commission does not mention these provisions.

- **Internal Quality Assurance Programs.** Requires health plans to have a quality assurance program to review services, consistency, patient outcomes.

CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The "Consumer Bill of Rights" consists of the following rights and responsibilities:

(1) **Access to Accurate, Easily Understood Information** about consumers' health plans, facilities and professionals to assist them in making informed health care decisions.

(2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes:

Access to specialists: assuring consumers with complex or serious medical conditions access to to the specialists they need;
Access to specialists for women's health needs: giving women access to qualified providers to cover routine women's health services, and
Transitional care: providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition.

(3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a "prudent slayperson" could reasonably expect that the absence of care could place their health in serious jeopardy;

(4) **Participation in Treatment Decisions** including:

Requiring disclosure of financial incentives: requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and
Prohibiting "gag clauses": which restrict health care providers' ability to communicate with and advise patients about medically necessary options;

(5) **Assurance that Patients are Respected and Not Discriminated Against,** including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;

(6) **Medical Privacy** which assures that individually identifiable medical information is not disseminated and that also provides consumers the right to review, copy and request amendments to their own medical records;

(7) **Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and

(8) **Consumer Responsibilities** which asks consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, reporting fraud, among others.

NORWOOD BILL

Areas Where Differs From Quality Commission

- **Provider Protections.** The Quality Commission did not recommend any provider protections. However, the Norwood legislation contains extensive provider protections, including:

Rights for Providers Applying to a Health Plan

(1) Open Season for Providers Allows health professionals and providers in a service area to become a participating health provider at least one period in each calendar year.

(2) Objective Standards Health plans are required to select health professionals and providers based on an objective standards of quality, developed with the suggestion and advice of professional associations, health professionals, and providers and make these selection available to every health professional and provider.

(3) Information About Why Not Accepted Health plans must provide health professional or provider who are not chosen to participate in the health plan with information about why they were not accepted.

(4) Corrective Information Providers and health professionals not accepted into a health plan can submit a corrective information plan.

(5) Appeals Providers and health professionals who are not accepted have the right to an appeals process.

Rights for Providers Who Are Asked to Leave A Health Plan

(1) Notification Plan has to notify any health professional or provider of any information indicating why they failed to meet the standards of the issuer.

(2) Review Gives those who are turned down the opportunity to review and discuss all information on which the determination is based.

(3) Corrective Action Plan Allows the health professional or provider to submit supplemental information or a corrected action plan.

(4) Appeals Provides a due process appeal for all determinations that are adverse to the health professional or provider.

Anti-discrimination Provisions. Health professionals may not be discriminated against because of their lack of affiliation with hospital, age, gender, race, or based solely on licensing.

- **Access to Specialists.** The Norwood legislation does include a provision for access to specialists. However, HHS believes this provision is poorly drafted, and it is unclear what kind of authorization is necessary.

- **Access to Women's Health Providers.** The Norwood bill does not contain any special provisions with regard to accessing women's health services. The Quality Commission includes a provision that says that women should be able to choose a qualified provider offered by a plan for the provision of covered care to provide routine and preventative women's services.

- **Mandatory POS Option.** The Norwood legislation requires health plans to have a mandatory POS option, that has the same reimbursement rates and fair and reasonable premiums. The Quality Commission does not include this provision.

- **ERISA Remedies.** Allows states to determine whether or not ERISA health plans can be held liable for damages in a court of law. Does not specifically exempt employers from being sued. However, Norwood has introduced a bill, H.R. 2960, that would clarify that employers are not to be sued in these instances unless they exercised discretionary authority that lead to death or wrongful injury. The Quality Commission did not make recommendations for an enforcement mechanism.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release **April 29, 1998**

STATEMENT BY THE PRESIDENT
On New Bipartisan Support for the Patients' Bill of Rights

I am extremely pleased that today at least nine Republican Members of Congress joined as cosponsors to H.R. 3605, the Patients' Bill of Rights Act of 1998. In announcing their support for this legislation, they are sending a strong signal that it is unacceptable for this Congress to adjourn this year without passing a strong patients' rights bill.

I commend Representatives Ganske, Bass, Forbes, Fox, Gilchrest, Graham, Horn, LaTourette, and Leach for their leadership, and I look forward to working with them. We have learned again and again that when we reach across party lines we can pass important legislation that improves our nation's health care system. Making the Patients' Bill of Rights Act of 1998 bipartisan provides new momentum towards ensuring that a patients' bill of rights will become the law of the land.

The Patients' Bill of Rights Act of 1998, recently introduced by Representative Dingell, provides long overdue protections that Americans need to renew their confidence in the nation's rapidly changing health care system. It allows patients to see the specialists they need; to get emergency care wherever and whenever a medical emergency arises; to talk freely with doctors and nurses about all the medical options available -- not only the cheapest; and to appeal when they have grievances about their health care.

I urge Congress to send me legislation that gives Americans the health care protections they need and deserve. I look forward to working with Members of Congress on both sides of the aisle to ensure that we pass a strong patients' bill of rights this year.

-30-30-30-

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release **April 22, 1998**

STATEMENT BY THE PRESIDENT ON THE NEW KAISER FOUNDATION REPORT ON THE PATIENTS' BILL OF RIGHTS

Today, the Kaiser Family Foundation released a new report that confirms our longstanding belief that the cost of the Quality Commission's patients' bill of rights, which I have endorsed, is modest and well worth the protections it would provide. By affirming the Congressional Budget Office's (CBO) estimates, the Kaiser report convincingly rebuts the scare tactics that some have used to undermine bipartisan efforts in the Congress to pass a patients' bill of rights this year.

Many Americans today lack the protections necessary to ensure high quality health care. They may not be able to see the specialists they need, or to get emergency care wherever and whenever a medical emergency arises. They may not be able to talk freely with doctors and nurses about all the medical options available -- not only the cheapest. They may have no place to go to present grievances about their health care. The Quality Commission's patients' bill of rights guarantees Americans these and other common sense protections.

The Kaiser Report reaffirms recent estimates by the CBO that these protections would increase health insurance premiums less than one percent (less than $3 per family per month). The improvement in the quality of health care that will result from these protections is more than worth the very modest premium increases projected by both Kaiser and CBO.

This report again shows the utter groundlessness of claims that a patients' bill of rights will significantly increase health care costs. With this new information, there is no excuse left for inaction. I therefore call on Congress again to send me legislation that gives Americans the health care protections they need and deserve. I look forward to working with members on both sides of the aisle to ensure that we pass a strong patient's bill of rights this year.

-30-30-30-

PRESIDENT ENDORSES QUALITY COMMISSION'S FINAL REPORT AND ISSUES EXECUTIVE MEMORANDUM TO IMPROVE HEALTH CARE QUALITY
March 13, 1998

Today, the President accepted the final report from his Advisory Commission on Consumer Protection and Quality, which calls for a health quality council to develop unprecedented national quality improvement goals and a privately-administered forum to develop new tools to empower consumers and businesses to purchase quality health care. The President praised the Commission's work and endorsed its new recommendations for a national effort to improve quality throughout the health care system.

Hundreds of thousands of Americans each year are injured and even die from avoidable medical errors in the health care system, and millions more receive unnecessary services or substandard care that cause needless health complications and increase health care costs. Establishing uniform standards which allow consumers compare health plans to help ensure that health plans finally begin to compete on the basis of quality -- not just costs and benefits.

To implement these new recommendations, the President also issued an Executive Memorandum that directs five Federal agencies to establish immediately an interagency task force to ensure the Federal government takes the lead on improving health care quality. The President also asked the Vice President to hold a planning meeting this June to kick off the work of the health care forum recommended by the Quality Commission.

NUMEROUS INCONSISTENCIES AND AVOIDABLE ERRORS IN THE NATION'S HEALTH CARE SYSTEM COST LIVES AND UNDERMINE HEALTH. Too many Americans receive substandard health care, causing avoidable injuries and death, needless complications, and increased health care costs, including:

Underutilization of services: Millions of Americans do not receive necessary care and suffer needless complications that can add to health care costs. For example, far too many Americans do not get the preventive care they need.
Overuse of services: Others receive unnecessary health care that can increase costs and even endanger a patient's heath. For example, 80,000 women every year undergo unnecessary hysterectomies.
Wide variation in health care quality: There is tremendous variation in health care services including wide regional disparities and different hospitalization rates for similar conditions.

ENDORSED COMMISSION'S NEW RECOMMENDATIONS TO IMPROVE QUALITY HEALTH CARE. The President endorsed the Commission's recommendations which call for:

- **Creating an Advisory Council for Health Care Quality.** This public advisory panel would establish, for the first time, national goals to improve health care quality and develop strategies to achieve them. The Council would emphasize areas such as ensuring consumers have access to clear information to make decisions about health plans and professionals, identifying strategies to reduce avoidable medical errors, reducing variation in health care services, and promoting evidence-based medicine. Such a council, which would include representatives from both the public and private sector, would make an annual report to Congress on the nation's progress in improving health care quality.

- **Creating a Health Care Forum and Asking the Vice President to Hold the First Planning Meeting This June.** The absence of uniform quality standards means that consumers do not have the necessary information to choose health plans based on quality. The forum would bring together the public and private sectors to identify a core set of measures to be adopted by health plans across the country. This would ensure that, for the first time, consumers have a consistent set of standards so they can choose health plans based on quality -- not just on cost. The President asked the Vice President to hold a blue ribbon planning meeting this June to kick off the work of the health quality forum as recommended by the Commission.

ISSUED A PRESIDENTIAL MEMORANDUM DIRECTING AGENCIES TO DEVELOP A FEDERAL TASK FORCE TO COORDINATE AND IMPROVE HEALTH QUALITY. The President directed the Departments of Health and Human Services, Labor, Veterans Affairs, Defense, and the Office of Personnel Management to establish the "Quality Interagency Coordination" (QuIC) task force. He directed this task force to ensure better collaboration and coordination across the Federal government, through initiatives such as developing consistent goals, models, and timetables; sharing information about evidence-based medical research and quality outcomes, and coordinating Federal programs' quality reporting and compliance requirements.

RENEWED HIS CALL ON CONGRESS TO PASS A PATIENTS' BILL OF RIGHTS THIS YEAR. Following his speech earlier in the week to the American Medical Association, the President urged Congress to step up its efforts to pass a Patients' Bill of Rights this year. He also asked Congress to ensure that the Patients' Bill of Rights includes the health care quality council he endorsed today. With less than 70 working days in this legislative session, the President urged Congress not to adjourn without passing a Patients' Bill of Rights which includes important protections for patients such as: access to the specialists they need, access to emergency room services, and an external appeals process to address grievances with their health plans.

PRESIDENT CLINTON RELEASES STATE-BY-STATE REPORT THAT UNDERSCORES IMPORTANCE OF A FEDERALLY-ENFORCEABLE PATIENTS' BILL OF RIGHTS AND RENEWS CALL ON CONGRESS TO PASS LEGISLATION THIS YEAR

May 28, 1998

Today, the President is releasing a state-by-state report that underscores the need for a Federal patients' bill of rights by showing that even if every state enacted all the patient protections recommended by the President's Advisory Commission on Consumer Protection and Quality into law, 122 million Americans could still lack protections. The report also underscores the importance of the patients' bill of rights for women. In releasing this report, the President renewed his call on Congress to pass a federally enforceable patients' bill of rights before its adjourns this year.

Millions of Americans Do Not Have the Patient Protections Recommended by the Quality Commission. Although 44 states have enacted at least one of the protections recommended by the President's Quality Commission, millions of Americans lack many of these protections because of the extent to which the Employee Retirement Income Security Act of 1974 (ERISA) preempts state-enacted protections. Because of ERISA, state laws cannot require self-insured plans (plans directly underwritten by employers) to provide critical patient protections. Indeed, ERISA can even prevent state laws from having the full effect even in health plans directly regulated by states. In short, a patchwork of non-comprehensive state laws cannot provide Americans with all the protections they need because states do not have full authority over the 122 million Americans who are in health plans governed by ERISA.

A Patients' Bill of Rights is Particularly Important to Women. Approximately 60 million women are in ERISA health plans and therefore need Federal legislation to be assured of receiving the full range of protections recommended by the Quality Commission without Federal legislation. Women are particularly vulnerable without these protections because they are greater users of health care services, they make three-quarters of the health care decisions for their families, and they have specific health care needs that are directly addressed by a patients' bill of rights.

- **Over 60 percent of physician visits are made by women, and women make three quarters of the health care decisions in American households.** Without adequate patient protections, women will be unable to effectively navigate through the nation's rapidly changing health care system.

- **Women in managed care plans are increasingly dissatisfied with the quality of care.** Nearly 70 percent of privately insured women ages 18 to 65 are in managed care plans. Almost two-fifths of these women worry that they will not be able to get speciality care when they need it. And 27 percent of these women worry that they will be denied a medical procedure they need.

- **Without a patients' bill of rights, women may not receive important preventive services.** The consumer protection that gives women direct access to an obstetrician/gynecologist is not only necessary to make sure that pregnant women get the care they need, but is also important to ensure that women get important preventive services. Studies show that gynecologists are almost two times as likely as internists to perform timely, needed women's preventive services.

The President Renews Call on the Congress to Pass a Patients' Bill of Rights.
The President called on Congress to enact the Quality Commission's recommendations to assure high quality care for all patients. These recommendations include: providing patients with access to easily understood information; providing access to specialists, including specialists for women's health needs; ensuring continuity of care for those undergoing a course of treatment for a chronic or disabling condition; assuring access to emergency services when and where the need arises; disclosing financial incentives that could influence medical decisions; prohibiting "gag clauses"; providing anti-discrimination protections; and providing an internal and external appeals process to address grievances with health decisions. The President is pleased that there is growing bipartisan support in the Congress to pass these long overdue protections.

Q&As on Patients' Bill of Rights/Women's Event

Q: Has the President endorsed the Democratic Leadership bill to provide a patients' bill of rights? Would he sign this legislation?

A: The President believes this legislation represents a critically important step towards enacting a long overdue and eventually bipartisan "Patients' Bill of Rights." It builds on the Quality Commission's recommendations and the President hopes that it continues to make progress in the Congress.

Q: Are you explicitly endorsing this legislation?

A: If this legislation passed the Congress, the President would sign it. He recognizes, however, that it will likely undergo some changes as it attracts additional support from members on both sides of the aisle.

Q: Isn't this legislation going to cause premiums to rise and increase the number of uninsured Americans?

A: No. The Congressional Budget Office recently estimated that the consumer protections recommended by the President's Quality Commission would raise health insurance premiums by only one-third of one percent; as such it would have no significant impact on the number of uninsured. More importantly, the inexpensive patient protections would provide Americans with the quality health care they deserve, and give them renewed confidence in their health care system.

Q: But aren't there some protections in the Democratic bill, including a remedies provision, that could prove to be far more costly?

A: The President will evaluate any legislation eventually passed by Congress by looking at both the kind of patient protections it would provide and its potential to increase health care costs. While we do not believe the enforcement provisions in the Democratic Leadership bill will be too costly, we are still awaiting the final estimates from CBO.

Q: Do you support the remedies provision in the Democratic bill?

A: We have consistently said that there must be an appropriate enforcement mechanism to make any patient protections real. The Democratic bill certainly provides one viable enforcement approach. However, there may be other good options to enforce a patients' bill of rights, and we are open to considering them as well.

Q: The Democratic bill includes some "body part" mandates that are not included in the recommendations the President endorsed. Do you support those mandates?

A: Numerous concerns have been raised about the inadequacy of protections for women going through highly traumatic health procedures, such as mastectomies. The President and the First Lady have a longstanding record to improve women's health and their access to needed health care procedures. Although some policy analysts raise concerns about benefit and coverage requirements, there are times when reports of inappropriate care are so frequent--and so repugnant--that Federal legislation is needed.

Q: What is your reaction to reports that Gingrich is trying to head off legislation for new curbs on managed care plans?

A: We are extremely disappointed about reports that Speaker Gingrich is trying to stall or dilute the House Republican patient protections' bill. We certainly hope it is not true. Passing a bipartisan patients' bill of rights that assures Americans high quality care is one of the highest priorities for the President. We urge the Speaker and the rest of the Republican Leadership not to turn a deaf ear on the millions of Americans who have made it quite clear that they feel extremely vulnerable in the rapidly changing health care system.

Q: Do you have a position on the fact that the House Republicans in addition to the consumer protections are likely to include tax incentives and so-called "health care marts"?

A: We are always open to new approaches to improving the health care delivery system, but we have not yet seen any specific proposals, so it would premature to comment on them.

Q: You are taking the position that the patients' bill of rights is important for women but you are not taking a position on whether health plans should cover contraceptive coverage, which is extremely important to women. How do you reconcile this?

A: We believe that patient protections and benefit coverage are important but separable issues. The patient protections recommended by the Commission focused on process protections rather than explicit coverage mandates. We have made no decisions as to the feasibility or advisability of requiring coverage of contraception or any other medication. We do believe, however that both private and public health plans should make the decision to pay for all medically necessary prescription drugs.

PROVISION	QUALITY COMMISSION	NORWOOD	DINGELL
Information Disclosure	Yes. Health plans should be required to disclose information including: covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information. Also, health professional education and board (re)certification; years of practice; experience performing certain procedures; comparable measures of quality and consumer satisfaction; and for health facilities, procedures for resolving complaints; community benefits provided.	Yes Health plans should be required to disclose information including: covered and excluded benefits, enrolled financial obligations, list of health plan providers, description of PA/UR processes and requirements, outcomes of UR determinations and percentage reversed on appeal, quality indicators, grievance and appeals data, financial arrangements and incentives that may limit services or treatment options, percent of premium spent on patient care, ratio of enrollees to providers in professional category. The Secretaries of Labor and HHS shall issue regulations establishing the format of this information publication and the placement and positioning of the information in health plan marketing materials.	Yes. Disclosure to include: (at the time of initial coverage) explanation of covered and excluded benefits, enrollee financial obligations, list of health plan providers, description of appeals and grievances criteria, outcomes of grievance and appeals decisions, summary data on quality, plan loss ratios, and methods to assist non-English speaking. Provided upon request: description of prior authorization/UR process and requirements, provider selection standards, provider financial incentives and payment methods, confidentiality policies and procedures.
Access to Specialists	Yes. Consumers with complex or serious medical conditions who require frequent speciality care should have direct access to a qualified specialist of their choice. Authorizations, when required, should be for an adequate number of visits.	Yes. Patients will have direct access to specialists if that care is needed in the judgement of treating health professionals. (Poorly drafted and ambigious).	Yes. Individuals with condition or disease of sufficient seriousness to require specialist, shall make referral. Plans may restrict choice to participating specialists unless no appropriate specialist available. If ongoing specialist needs then specialist can coordinate as primary care provider and if appropriate gets ongoing referral.

Giving women access to qualified providers to cover routine women's health services	Yes Women should be able to choose a qualified provider offered by a plan for the provision of covered care to provide routine and preventative women's services.	No Provision	Yes Women should be able to designate OB-GYN as a primary care provider. If not, may not require direct authorization for routine OB-GYN services. *(Goes beyond the Commission b/c allows to choose as primary care provider.)*
Continuity of Care	Yes If the course of treatment for chronic or disabling condition at the time they involuntarily change health plans or when provider is terminated, the individual is able to receive care for up to 90 days or through pregnancy.	Yes In circumstances where changes in health professionals might disrupt care, providers for continuous coverage for a reasonable period of time. *(Unlike Commission it does not have specific time periods)*	Yes If provider terminated (for reasons other than quality) remain with provider under same rates for (1) 90 days (2) thru pregnancy; (3) terminal illness (life expectancy of 6 months.)
Access to Emergency Services	Yes. Emergency room services covered "prudent layperson standard"	Yes Requires access to emergency room services w/o prior authorization with "prudent layperson" standard. Similar to Commission.	Yes Similar to Commission. Requires access to emergency room services without prior authorization, regardless of treating physicians. Uses the prudent layperson standard.
Out of Network Referral When Network Inadequate	Yes. If plan has insufficient number or type of providers to provide a covered benefit, plan should ensure that the consumer can obtain the benefit outside the network at no greater cost than if obtained from participating providers. Also should maintain adequate reasonable proximity to providers.	Yes Requires health plans to have an adequate mix and range of health professionals to ensure access to the services provided by the plans.	Yes Must have sufficient number of health providers to ensure that all services are covered.
Anti-Gag/Conscience Clause	Yes. ensure that provider contracts do not contain any "gag clauses" or other contractual mechanisms to prevent communication.	Yes Can't prohibit or limit health professionals from engaging in medical communications.	Yes. Forbids anti-gag clauses.
Financial Incentives	Yes Does not forbid health plans from using financial incentives but does ensure that they are disclosed.	Yes Forbids any provisions -- either direct or indirect -- to reduce medically services.	Yes Forbids health plans from having any financial incentives.

Whistleblower	No Provision	No Provision	Includes compromise provision that builds on new provisions that the Joint Commission on Accreditation of Healthcare Organizations is already adopting.
Confidentiality	Yes Consistent with Secretary's recommendations for new Federal privacy protections (Commission had different approach on law enforcement).	Yes Requires health plans to establish procedures to comply w/ state and Federal privacy laws w/ respect individually identifyable information.	Yes Requires health plans to develop a written plan to follow Federal and state privacy laws.
Medical Necessity	No provision	No provision	Includes a provision that states that a health insurer may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which the particular services are delivered if the services are determined to be medically necessary.
Internal/External Appeals	Yes Includes internal and external appeals process along w/ expedited appeals when necessary.	Yes Includes internal and external appeals process along w/ expedited appeals when necessary.	Yes Includes an internal and external appeals process. (The external appeals process is funded by the health plans)
ERISA Remedies	Commission did not recommend an enforcement mechanism.	Yes. Allows states to determine whether or not ERISA health plans can be held liable for damages in a court of law. Does not specifically exempt employers from being sued. However, Norwood has introduced a bill, H.R. 2960, that would clarify that employers are not to be sued in these instances unless they exercised discretionary authority that lead to death or wrongful injury or financial injury.	Protects employers from liability when they were not involved in the decision. Includes provision that would allow states to determine whether or not ERISA health plans can be held liable for damages in a court of law. Only allows remedies for wrongful death and personal injury -- not financial injury -- which could be a provider protection for doctors who sue if they are kicked out of a health plan and suffer financial injury.

48 Hour Mastectomy Law	No provision	No Provision	Yes. Cannot limit hospitals stays to less than 48 hours following mastectomy.
Breast Reconstruction	No provision	No Provision.	Yes Health plans that cover breast cancer surgery, must provide coverage for breast cancer reconstruction following the mastectomy to reestablish symmetry -- including surgery on the non-diseased breast.
Clinical Trials	No provision	No Provision.	Yes Cannot deny coverage of or impose additional restrictions on covering patient care costs for those who participate in clinical trials. (NIH approved and those w/ similar peer review).
Drug Formularies	No provision	No provision	Yes Have to disclose the chosen formulary and provide exceptions from formulary when non-formulary is indicated.
Mandatory POS Option	No provision.	Yes Requires plans to offer a mandatory point of service option with same reimbursement rates and fair and reasonable premiums.	Yes Requires plans to offer a POS option w/ all the same services. Can have higher premiums, cost-sharing etc.
Non-Discrimination Provisions.	Health plans cannot discriminate against consistent w/ their policy on race, disability, genetic info, sexual orientation, etc.	Health plans cannot discriminate on the basis race, sex, etc. *(Does not appear to go quite as far as Commission or Dingell) more specific,*	Health plans cannot discriminate against consistent w/ their policy on race, disability, genetic info, sexual orientation, etc. *Similar to the Commission.*
Health Quality Advisory Board	Health Quality Council and Forum required	No provision	Yes Requires HHS to create a advisory board for quality to provide recommendations to continuously monitor and improve health care quality. Annual report to the Congress.

Ombudsman	No provision.	No provision	Yes States shall provide for the creation of an health insurance ombudsman to: assist consumers in choosing health options; provide counseling for those who are dissatisfied. Federal govt must do this in those areas where states do not.
Internal Quality Assurance Program		Yes Requires plans to have a quality improvement program that systemically assesses and improves patient outcomes, and supports and emphasizes preventive care.	Yes Requires plans to have internal quality assurance program to systematically review health services, consistency, patient outcomes. Must have procedures for reporting. Collect standardized data.
Provider Protections	No provision.	Yes. Requires an open enrollment process that health plans must notify providers about, must have an objective selection process and an opportunity for health plans who are not selected to submit corrective information and reapply. It also includes an extensive process for providers are asked to leave the plans -- providing them an opportunity to review information on why they were not accepted, submit a corrective action plan and appeal an unlimited number of times.	Yes. Health plans must provide reasonable notice to providers who are kicked out of a health plan and allow one appeals process and non-discrimination based on licensure.

THE WHITE HOUSE AT WORK

Wednesday, March 13, 1998

PRESIDENT CLINTON: IMPROVING THE QUALITY OF HEALTH CARE

Our nation has the best health care system in the world. We have the best doctors, the most advanced technology, and the most exciting research. But we can make the American health care system even better. And as we approach the 21st Century, with all its stunning medical advances, we must act now to spread these breakthroughs and improve the quality of health care for every American.

- President Bill Clinton
March 13, 1998

Today, President Clinton accepts the final report from his Advisory Commission on Consumer Protection and Quality. The report calls for a health quality council to develop unprecedented national quality improvement goals and a privately-administered forum to develop new tools to empower consumers and businesses to purchase quality health care.

Signing An Executive Memorandum. To implement the Commission's recommendations, the President issues an Executive Memorandum directing five Federal agencies to immediately establish an interagency task force to ensure the Federal government takes the lead on improving health care quality.

Directing Agencies To Coordinate And Improve Health Quality. The President is directing the Departments of Health and Human Services, Labor, Veterans Affairs, Defense, and the Office of Personnel Management to immediately establish the "Quality Interagency Coordination" (QuIC) task force. This task force will ensure better collaboration and coordination across the Federal government.

Improving Quality Health Care. Each year, hundreds of thousands of Americans are injured and even die from avoidable medical errors in the health care system. Millions more receive unnecessary services or substandard care that add needless health complications and increase health care costs. Establishing uniform standards will help ensure that health plans finally begin to compete on the basis of quality -- not just costs and benefits. The President's Commission's recommends:

- *Creating an Advisory Council for Health Care Quality*, to establish, for the first time, national goals to improve health care quality and develop strategies to achieve them. The Council would emphasize areas such as ensuring consumers have access to clear information to make decisions about health plans and professionals, identifying strategies to reduce avoidable medical errors, reducing variation in health care services, and promoting evidence-based medicine.
- *Creating a Health Care Forum*, to bring together the public and private sectors to identify a core set of measures to be adopted by health plans across the country. This would ensure that, for the first time, consumers have a consistent set of standards so they can choose health plans based

on quality -- not just on cost.

Calling For A Patients' Bill Of Rights. President Clinton is urging Congress to step up their efforts to pass a Patients' Bill of Rights this year. With fewer than 70 working days remaining in this legislative session, the President is calling on Congress not to adjourn without passing a Patients' Bill of Rights that includes important protections for patients such as: access to the specialists they need, access to emergency room services, and an external appeals process to address grievances with their health plans.

The White House Briefing Room
The White House at Work Archives

June 1, 1998

TO: Gene, Chris

FROM: Jeanne

RE: **NOTES ON TODAY'S MEDICARE COMMISSION MEETING**

As scheduled, the Medicare Commission ran from 1pm to 5pm today. All of the members were in attendance. The following is a list of the notable / controversial statements.

IMPORTANT QUOTES

Not just about insolvency: Stated at the top of the modeling task force paper; reinforced by Breaux and Thomas. After Ganske and (I think) Gramm said that it would be hard to add benefits to Medicare at this point, Rockefeller pushed about whether the only issue taken up by the Commission is Medicare's insolvency. Breaux said no; Ganske reminded him that at the first meeting he said he did not want this only to be a green eyeshade exercise; that quality is important as well.

Kasich budget: McDermott brought up the fact that the Republican House budget would cut $10 billion from Medicare over 5 years. Should the commission have any say about this? Breaux responded that in the same way that he recommended that Congress defer considering the Medicare buy-in, he thinks that Congress should wait to consider Medicare cuts [I think -- I am trying to get the transcript].

Surplus: Rockefeller said that maybe not all the surplus should go for Social Security. Why not split it so that half goes for Social Security, half goes for Medicare, maybe to pay for a prescription drug (note: Laura asked me about the same thing after the meeting)

High-income premium, 65 to 67: Rockefeller said that he was one of the two people who did not vote for it, because it was put out as a "symbolic solution for problems so much larger" than what they solved. If you voted for it, you were "heroic, strong, brave", on the other hand, if you voted against it, you were a "Neanderthal". Gramm agreed that there was not very much savings which suggests that you must do at least this, assume this, in order to solve Medicare's problems.

Importance of health insurance if 65 to 67: Altman opened up the discussion with the history of Medicare, how it was created because an experience rated insurance market did not want to cover the elderly; nothing has changed. Dingell agreed and said that the age of 65 was chosen more or less arbitrarily, because that was what the Social Security age was. Tyson said that if the goal of changing the eligibility age is to improve solvency, then you are risking the other goals of the commission (efficiency, equity and adequacy). Kerrey and Thomas argue that we should develop insurance options for all Americans, not just the near elderly, while Gramm said raise the age then figure out the coverage later.

Managed care: At one point, Watson got angry at some of the discussion of managed care. He said, "Mr. Dingell, your legislating managed care out of existence. Managed care never promised to be the answer to all of the health care promises. Government did, and we oppose it." Dingell responded by saying that not everyone has a choice about going into managed care; that to say that there are no errors flies in the face of reality; that it can interfere with the doctor patient relationship. Then Ganske said that some managed care plans have abused the system, put reputable firms at a competitive disadvantage. Watson said that no managed care plans ration, and then there was a fight.

Failure of cost containment: Altman opened the cost section with the fact that he has worked his whole life in health care and has been a failure. We have not succeeded in controlling costs, because the driver is technology which has generated increased quality and costs. This is not unique to health care; expenditures on computers, for example, has risen enormously but the unit price has dropped. The same is true in health care. Even though in capitated environment, should be constraints, faces quality issues, legal issues, patient demands. Managed care has had a thimble level imposition of control on technology. When faced with the tidal wave of the baby boom generation and rising health care inflation, we will have to face rationing or some restrictions on expenditures.

Note: Lott and Daschle were not there.

MAJOR DISCUSSION AREAS

Modeling Task Force Presentation: The attachment was presented by Laura and Debbie Steelman. There was a fair amount of debate over whether the two Medicare baselines presented were adequate. Bruce and Laura argued that it is difficult to project that far; Gramm, Thomas and Steelman all read from the Trustees' Report that says that the estimated Medicare spending may be higher than expected. There was general agreement that the financial picture of Medicare is only partial and that other dimensions are important and will be analyzed as well.

Benefits: Breaux opened the discussion with the fact that Medicare benefits are in the 10th percentile of benefits when compared with private benefits. Thomas countered with the fact that many Medicare beneficiaries make the decision to get extra benefits by reducing doctor choice by going into managed care. Vladeck raised the importance of long-term care, recognizing that it would have to be addressed carefully, and might be done in a public-private or private-only basis.

Altman, in response to the assertion that people can get more rational benefits in managed care, thanked Thomas for the additional managed care choices, but argued that managed care should not be the only option because (a) may not be available in all areas; and (b) many people may not want to go to managed care for other reasons. He said that we should consider Medigap reform. When Medicare was designed, 100 percent of the beneficiaries had access to the same benefits. Now, the somewhat less sick beneficiaries go into managed care, making adverse selection a problem for Medigap. Think of combining Medigap and drug plus limited long-term care, no

separate deductibles, something comparable to what people in the private sector have. This will make managed care a fair choice.

Breaux: Maybe Medicare should set benefits like FEHBP. Rather than having Congress set benefits, there would be more interaction with plans, competition.

Gordon: One problem that she hears is people on disability waiting the 30 months to get on Medicare (SSDI). Also people definitely complain about prescription drugs.

Thomas: Said that we need to ground ourselves. FEHB is not as useful since Medicare population is older than 65 while Federal employees are younger. Even setting aside these differences, let's look at what is spent on seniors' care: in addition to the $200 billion from Medicare, there is $50 billion from Medicaid, $7 billion from VA, $1.2 billion from DoD, 412 billion in Medigap, and $60 billion in out-of-pocket payments. This is enough money to make benefits "rational and ensure that we maximize payments for beneficiaries". There is a "significant ability to add benefits if we rationalize."

Cost issues: Vladeck: hard issue is the extent to which Congress lets the Administratrator save money. Congress is reluctant to overly delegate; we could cut hospitals or managed care payments by 3 or 4 percent, but political constraints. Medicare is the largest payer and can save money if we allow it to behave like a purchaser with 40 percent of the market.

Thomas: Why has the private sector turned to managed care? (1) ability to define costs, capitate payments; and (2) ability to manage care better. In the long run, this may not always work. So we don't want to lock into managed care. Nor do we want to define cost effectiveness as compared to a baseline or last year's spending. Through data, results, we can set prices on the basis of effectiveness. One advantage of fixed cost is constraint of technology; invert the incentives.

Tyson: Reluctant to lock in command and control system in Medicare with a cap on everything as an effort to control costs in an uncertain world. We need to focus on incentives and competition, reform Medigap, etc.

Eligibility: Vladeck: We need to carefully examine retirement trends.

Gramm: clear facts: population is aging but retiring early. Need to look at the big picture then figure out what to do with small problems like the potential to increase uninsured.

Kerrey: As the sponsor of 65 to 67, heard lots of complaints from businesses when proposed the age increase. Medicare is corporate welfare.

Rockefeller: Concerned about the 500,000 people who could lose coverage (Commonwealth study); unacceptable.

June 2, 1998

TO: Gene and Chris

FROM: Jeanne

RE: **SUMMARY OF MEDICARE COMMISSION: DAY 2**

There was about a 3 hour discussion of two topics today: management and administration and financing. Before the meeting began, a whole bunch of people from the National Council of Senior Citizens came with signs like "NO MEDICARE CUTS" and statements about more field hearings. Breaux made an opening statement, saying that he would like to have more than the 2 scheduled field hearings and that he would work on additional ways of communicating (e.g., teleconferences, C-SPAN weekly dialogues, etc.). Nancy Ann was present for the first session and answered lots of questions.

MANAGEMENT AND ADMINISTRATION

Dividing HCFA: Thomas argued that there should be two separate parts: billing and consumer education. Altman responded that he thought that HCFA should focus on billing, since a whole private sector full of consultants like himself will be hired to go on cruise ships to educate seniors about their choices.

Fraud and abuse: Rockefeller: it's an enormous issue. General agreement that it is not enough to save Medicare. Tyson conceded to Howard that it is hard to prevent in a price control system.

Congressional and DHHS oversight: General agreement that Congress micromanaged Medicare. Vladeck: Also a lot of HHS assistant Secretaries, internal HHS bureaucracy that limits HCFA..

HCFA efficiency: Gramm showed examples of how much more Medicare pays for medical equipment than VA. Nancy Ann: There is no question that Medicare can get a better price; embarrassed that I can walk into a drug store and get a better price. Need more authority to competitively bid. Gramm: what if we gave HCFA blanket demonstration authority so that Congress would have to act to block demos.

FEHB: Howard: looks better; Vladeck: HCFA actually does a lot of work for FEHB, licensing providers. There are also personnel in all agencies that assist OPM in running FEHB. Frist: OPM interacts differently, given authority, responds more rapidly, flexibly. HCFA's hands are tied, FEHB is out from under a tremendous rigidity. Why don't you adopt this? Nancy Ann: I don't want to engage without more information to let me know if there is a red flag. Watson: It's a mistake to confuse Medicare with FEHBP. Medicare is a unique Federal program for our elders. I serve 50,000 Federal employees and the FEHB is the most stingy benefit, no deductibles or copays. When Medicare contracts with me, my discounts are built into my rates.

We should not get carried away with comparing Medicare with everything else. Not other insurer matches its efficiency, breadth of coverage, sophisticated surveillance.

Local management: Steelman: Doesn't it work better when it is local versus national? Gramm: rate variation in Medicare is much larger than that in FEHBP.

FINANCING

Graduate Medical Education: Gramm: inequity of financing from payroll tax; why should teaching hospitals be entitled to train doctors. DSH: basically a subsidy, also be moved out. Altman: I support Senator Gramm on DME, not indirect. Ganske: Steady funding stream is necessary.

Tax increases: Vladeck: Real per capita income will increase 50 to 100 percent, will result in new revenue, in that context, tax increase may not be a problem. More affluent nationals spend more on health care. Will these income increases extend to the elderly? Probably not.

Tyson: Should not just consider Medicare as a percent of payroll tax: look at general tax burden. Don't just look at Medicare's increase as a percent of GDP; private health care. Health care is a positive good. Should not focus on spending as a percent of payroll, GDP. Should focus on: (1) is financing efficient (copays, deductibles); (2) fairness; (3) burdens on the economy; 6 to 8 percent of GDP spent on Medicare will not change the fate of the U.S. economy.

Thomas: Medicare spending is other people's money. Can't have it both ways.

Tyson: Warning: through 1994, Medicare outperformed private sector; cannot be unrealistic about what we can save. The notion that it will not grow as a percent of GDP is not right.

Altman: Concerned about a fixed amount of dollars that is inviolate and the claim that if Medicare continues to grow, it will gobble up the Federal budget. Problem not a new one. In the 1950s, a lot of toddlers showed up at school; education spending increased by 116 percent. Then it fell when they graduated. We survived.

Gramm: Medicare will grow as a payroll equivalent form 5 to 17 percent of GDP [includes Part B and premiums]

May 31, 1998

TO: Gene

FROM: Jeanne and Chris

RE: **MEDICARE COMMISSION UPDATE**

The Medicare Commission meeting on Monday and Tuesday is the third of 7 planned meetings (see attachment 1). As a reminder, the first meeting included allowed opening remarks and approval of bylaws, and the second meeting consisted of 5 panels of guest speakers on a range of topics from the effect of Medicare on the economy (Greenspan) to multigenerational perspectives (representatives from Third Millennium and AARP). The Commission also agreed at that second meeting to form three task forces (Modeling, Reforming and Restructuring) that meet in between full commission meetings (see attachment 2 for membership).

Modeling Task Force. The meeting on Monday and Tuesday will begin with an hour-long discussion of the work of the Modeling task force. This task force has met 4 times. The primary focus has been on what projected Medicare baseline to use. Some of the task force members are concerned with the Medicare Trustees' report assumption that, beginning in 2015 or so, the extra health care inflation attributable to unique health care factors (e.g., increases in volume and intensity) is assumed to go away. This is a convention that the actuaries have always used, primarily because "straight-lining" Medicare per capita cost growth at a rate higher than GDP will result in 50 to 75 years with Medicare taking over the economy. However, it is hard to argue that Medicare growth will revert to the rate of general growth. Thus, the task force has decided to use two baselines: one which is the Trustees' intermediate assumptions baseline and the second, the intermediate assumptions without the slow-down in health inflation. Even though this makes the Medicare problem look worse in the out-years, we feel good that one of the baselines is the "official" baseline of Medicare.

Although these two baselines are the only agreed-to products of the Modeling task force, it does have a larger agenda of analytic activities. At the Task Force's second meeting, Reischauer was invited and spoke about the problem being more than insolvency: it includes inadequacy of benefits, inefficiency, and inequity across regions (in managed care). The task force thus has a broader list of analytic activities that it plans to conduct.

General Discussion. After the Modeling task force report, the Commission agenda consists of 5 hours of discussions to "allow Commission members to understand each others' perspectives" and to help guide the other two task forces (Reforming and Restructuring Task Forces). We have heard that Lott and Daschle are coming to emphasize the importance of the Commission's work. Nancy Ann Min DeParle may be invited to the Management discussion on Tuesday, but it's not clear at this point.

At last Friday's call with our 4 appointees, we agreed on the following brief messages for each topic on the agenda:

- **Benefits**: Importance of rationalizing benefits and cost sharing, including coordinating copayments as well as adding benefits and reforming Medigap.

    - For example, there is a $764 deductible per inpatient visit, but only a $100 deductible per year for all Part B services; about 85 percent of beneficiaries have some type of supplemental coverage (e.g., Medigap or Medicaid) that covers this cost sharing. Medigap coverage is highly variable, duplicative, and its premiums have been growing rapidly in recent years. And, Medicare does not cover prescription drugs and most long-term care.

- **Costs**: Importance of benchmarking Medicare growth to private growth and avoiding arbitrary links. Since Medicare covers the most sick individual in society, its cost growth cannot be expected to be much below the private rate for those less than 65 years old.

- **Eligibility**: Need to examine how any change affects health insurance coverage and how much it reduces Medicare costs. Emphasize that any increase in the eligibility age must be accompanied by policies that ensure that the number of uninsured Americans does not increase.

- **Management and administration**: Emphasize Medicare's low administrative costs; successes at fraud and abuse control; and the need for adequate resources to fund HCFA. Also, highlight that implementing the BBA offers new choices and challenges in modernizing Medicare.

- **Financing**: Stress belief that there are still significant savings from program reform, that we should look to program savings first before we suggest new revenue sources. Note: three out of four of our people are fine with income-related premiums while Bruce Vladeck is both concerned about its implications for Medicare as a social insurance program.

We'll give you a report on the meeting's outcome.

Administration activities. In addition to tracking the work of the Commission, we have several projects underway. Some are small information papers written at Commission members' request (e.g., background on graduate medical education; effect of technology and aging on health costs). For two topics, we have set up policy development processes: long-term care and a prescription drug benefit. Our goal is to come up with a set of policy options (mid-summer) and decide strategically what to do with them.

Outcomes/Timeline

The following summary is a conceptual outline of the Commission's goals throughout the year. This guide is a tool, not a work plan or a final product, to help focus the Commission's decision-making and to measure its progress. We have incorporated suggestions received from individual Commission members. The outline is a "living document" and may change throughout the year as the Commission decides how it wants to proceed. The agenda is very ambitious, and additional meetings may be added if necessary. Also, the specific topics may be expanded or deleted depending on the Commission's interests.

March: Organizational Meeting

- ☐ introductory statements
- ☐ adoption of rules
- ☐ composition of task forces
- ☐ broad outline of future meetings

Part I: Define Problem

May: Medicare Overview/Commission's Goals (Modeling Task Force)

We would like to start building consensus on the Commission's goal and on the program's current role/outlook, for example:

- ☐ strengths and accomplishments of program (e.g., current income and health status of elderly)
- ☐ definition of problem which Commission should address - specific aspects of program (e.g., financing, benefits, administration, eligibility, health outcomes, cost, etc.)
- ☐ sensitivity of program outlook to external variables/key assumptions (e.g., disability trends, retirement patterns, technology, inflation assumptions, immigration policies, etc.)
- ☐ what success looks like - Commission's purpose, goals, and criteria/principles to evaluate policy recommendations
- ☐ other

Part II: Review Recommendations

July: Strengthen Current Program (Reform Task Force)

We would like to develop initial recommendations on incremental reforms to current program, for example:

- ☐ steps needed to improve health outcomes and preserve protection

for elderly and disabled
- ☐ adequacy of and modifications to benefits package
- ☐ policy recommendations to control growth in per capita costs (e.g., payment issues, technology, fraud and abuse, clinical protocols, etc.)
- ☐ eligibility thresholds
- ☐ appropriate coordination with Medicaid program and long-term care providers
- ☐ appropriate interactions with external constituents, e.g., non-government health programs and providers, vulnerable communities
- ☐ response to anticipated changes in technology, demographics, health trends, etc.
- ☐ other

September: Redesign Options (Fundamental Restructuring Task Force)

We would like to develop initial recommendations on what the Commission would design for future recipients:

- ☐ whether program needs to be redesigned
- ☐ if so, how the program should be redesigned
- ☐ other

November: Financing Issues

We would like to develop initial recommendations on how program should be paid for, for example:

- ☐ appropriate balance between general revenues and other sources of funding
- ☐ policy recommendations on solvency issues (e.g., means-testing, premiums, deductibles, trust funds, carve-outs, etc.)
- ☐ proper role of recipients in paying for program
- ☐ role of Medicare in financing medical education
- ☐ other

Part III: Achieve Consensus

January: Final Recommendations

We would like to achieve consensus on:

- ☐ overall Commission report based on earlier recommendations
- ☐ additions, deletions, modifications to earlier recommendations

February: Report Issued

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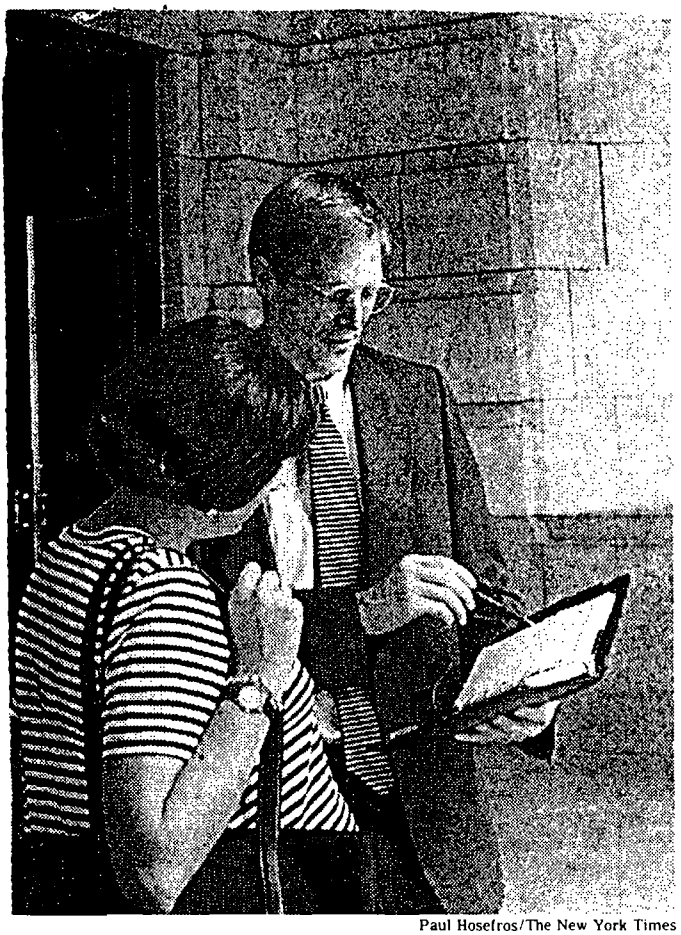

Paul Hosefros/The New York Times

yor and Wes Metheny in Washington yesterday represent- groups that oppose a bill to overhaul managed care.

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co-sponsored a bill by
ve Charlie Norwood, the
dentist from Georgia
ded the first overhaul
those members backed

A popular issue brings out the checkbooks.

off. When nine Republicans supported the Democratic proposal, they were snowed under with faxes, letters and telephone calls. Two of the lawmakers dropped their support within 24 hours.

Now it is the study-group members, many of whom are sympathetic to the views of insurance companies and small-business owners, along with a few moderate Republican senators, who are the focus of attention from both sides.

Proponents of an overhaul have run television advertisements as well, and at least one umbrella organization has said it will run radio advertisements if the bill appears to be foundering.

All agree that the lobbying and political tongue-lashings will only intensify, reaching fever pitch once a bill actually hits the floor

Panel Finds Medicare Costs Are Underestimated by U.S.

By ROBERT PEAR

WASHINGTON, June 2 — A bipartisan Federal advisory panel said today that the long-term costs of Medicare were likely to be higher than estimated by the Clinton Administration, because the program was likely to continue growing at a brisk pace.

That conclusion increases the pressure for major changes in the popular health program for the elderly.

The Administration had been assuming that the growth of Medicare spending per beneficiary would slow after 2010, just as the first baby boomers become eligible. But the National Bipartisan Commission on the Future of Medicare, at a two-day meeting that ended today, said it was just as plausible to assume that there would be no slowdown.

Medicare spending grows not only because the number of beneficiaries and their average age are increasing, but also because elderly people are receiving more health care and more costly services. The Administration assumed that the average annual growth in Medicare spending per beneficiary would gradually drop to about 4 percent, the commission said, but experience suggests that it could just as easily remain at around 6 percent.

Those differing assumptions lead to a difference of $760 billion a year in Medicare spending by 2030, the panel said.

The 17-member commission, created by Congress and headed by Senator John B. Breaux, Democrat of Louisiana, has decided to assess the effects of all its proposals on Medicare spending under both sets of assumptions.

The panel is considering fundamental changes in the structure of Medicare, but has not yet made specific recommendations. The higher estimates of Medicare spending, considered more realistic by many commission members, accentuate the need for changes in the program to keep it solvent for 76 million baby boomers, born from 1946 to 1964.

One panel member, Representative John D. Dingell, Democrat of Michigan, said the estimates of Medicare spending could have a profound effect on the commission's recommendations, which must be submitted to the President and Congress by March 1, 1999.

Another panel member, Bruce C. Vladeck, former administrator of the Medicare program, said any forecast of Medicare spending beyond 10 years was "an exercise in comparative fantasy."

But most commission members said it was necessary to make such estimates because otherwise the panel would not see the huge effects of the baby boom on Medicare.

Laura D'Andrea Tyson, a commission member and former economic adviser to President Clinton, said history suggested that the Administration's estimates of future Medicare spending were, in fact, optimistic.

The Administration assumes that the growth of Medicare will slow so that costs per beneficiary eventually grow at about the same rate as the nation's economy, measured by the total output of goods and services per person. But Mr. Breaux and other commission members said this assumption was at odds with the history of Medicare because costs have generally increased faster than the gross domestic product.

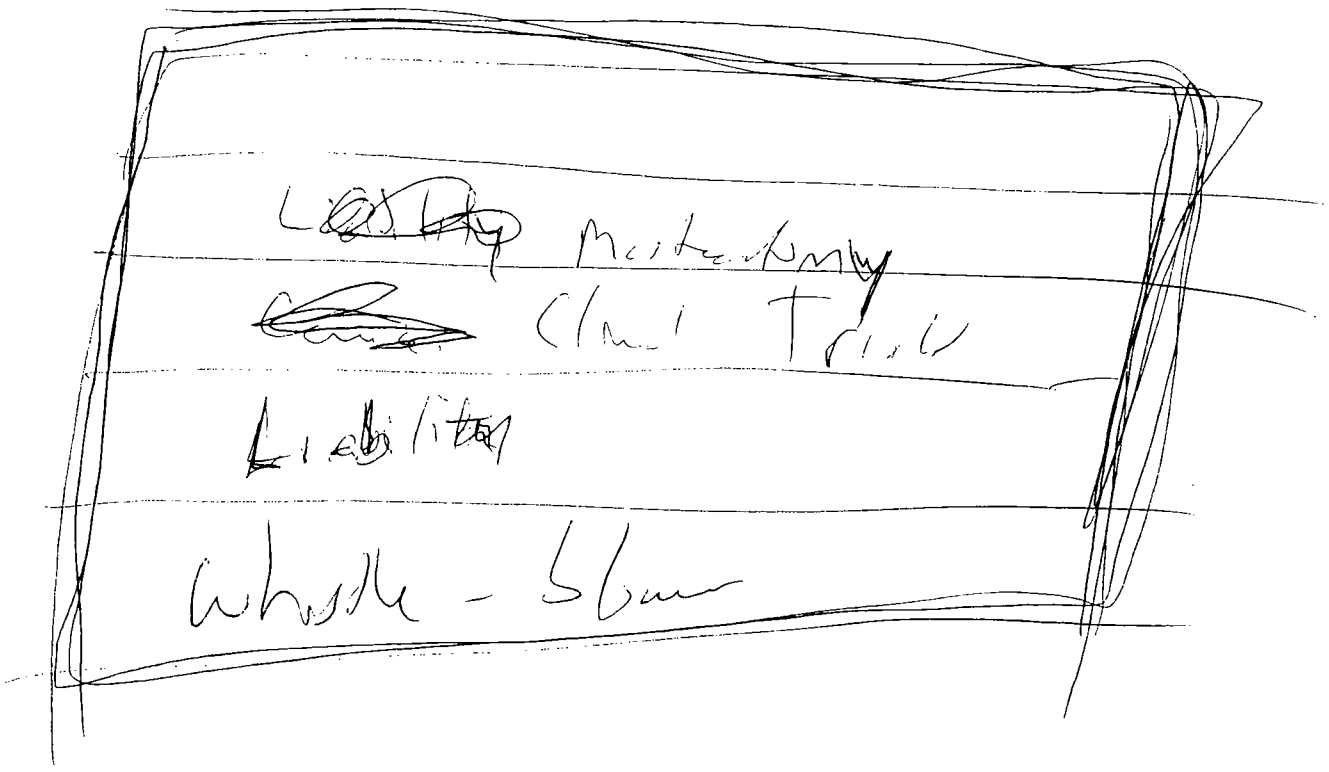
Stuart H. Altman, a Brandeis University professor appointed to the commission by Mr. Clinton, said, "We are going to see a resumption of health cost increases in this country." If that coincides with the "tidal wave" of baby boomers reaching retirement age, he said, there will be immense pressure to restrict spending or to ration health care.

The advisory panel got a vivid reminder of the politics of Medicare when it convened today at the Library of Congress. In the audience were dozens of members of the Gray Panthers, an advocacy group for the elderly. They held up signs that said, "No more Medicare cuts!" They also demanded that the commission hold public hearings.

In an interview, Mr. Breaux said the commission would hold hearings on July 10 and 13 and seek public comment in other ways.

Commissioners agreed that they must also assess the overall fairness of the Medicare program and the adequacy of its benefits.

Senator John D. Rockefeller 4th, Democrat of West Virginia, a member of the commission, said he hoped that the panel would not become entranced with cost projections. "If this commission is simply about solvency," he said, "I'd like to get that cleared up right now, because I'm not sure I belong on it."



MEDICARE Q & A, JUNE 3, 1998

Q. TODAY'S NEW YORK TIMES ARTICLE REPORTED THAT THE MEDICARE COMMISSION STATED THE ADMINISTRATION'S MEDICARE PROJECTIONS ARE OVERLY OPTIMISTIC AND MUCH TOO LOW. ISN'T THE CLINTON ADMINISTRATION TRYING TO HIDE HOW DIFFICULT THE MEDICARE PROBLEM IS?

A. Absolutely not. The Administration has always relied in independent, non-partisan Actuaries whose projections in recent years have actually been overly pessimistic.

The Medicare baseline referred to in the article is not the "Clinton Administration's"; it is from the independent, non-partisan Medicare Trustees. The Trustees' report has been the official source of Medicare projections for nearly 30 years. Because of the inherent uncertainty of health care cost projections, their annual report has always contained a high, intermediate, and low baseline. In fact, the high baseline in the 1998 Trustees' report is even higher than the "high" baseline recommended by the Commission.

Irrespective of which baseline is used, Medicare faces serious challenges in the 21st century. The President fully supports the Medicare Commission in its goal of identifying viable policy options to strengthen this program so it can meet these challenges.

Commencement Speech
First Lady Hillary Rodham Clinton
Harvard Medical School
June 4, 1998

Thank you. Thank you very much. Thank you, Dr. Martin, Dr. Federman, Dr. Donoff. I am delighted to be here. I want to thank the class for extending this invitation to me. I have, as you might expect, attended numerous commencement ceremonies in my lifetime and I must say I have never attended one where we've already heard so many good speeches. We could quit right now and feel that we had been in the presence of some extraordinary young people who imparted some rather significant words of advice, and even wisdom to us. I want to commend to co-moderators, Dr. Bryant and Dr. Somers, for this commencement ceremony (applause) and I want to thank the student speakers. I want to thank Dr. Cook for not only reminding us that it's done, Mom and Dad, but for showing extraordinary composure while speaking in the course of having a helicopter take off in the background. I want to thank Dr. Babagbemi for her eloquent description of On-Call, but even more for her understanding of what the requirements are for one who has been blessed with the kind of education and gifts that she has on behalf of humanity. And I want to thank Dr. Mitchell for reminding us that in life it is competence, and confidence, and compassion that separate us as human beings from mere technicians.

Each of these student speakers has already set the stage for the graduation of this extraordinary class. This class comes with, I'm sure, a range of emotions that we can only guess at--exhilaration and exhaustion among them. But also, as we've already heard, a lot of gratitude for the opportunities that they have been given. They also deserve gratitude from us for undertaking the rigorous education which they have, for pushing themselves to the limits and now for going into the world ready to use their talents and their education on behalf of the rest of us.

They have made many sacrifices. More than 70 percent of this class had to take out loans to complete the degrees that they receive today. They will be paying back those loans for a number of years, and I hope that we as a nation will continue to look for ways to provide financial support to students such as these so that they do not have to go into the debt that these young graduates have. (Applause) Some of these graduates, these new doctors and dentists, are the first in their families to attend college. Some have completed their educations while they were caring for their own families. Some are recent immigrants to our country. More than 15 percent managed to earn additional degrees, and all of them have worked extremely hard. They deserve this celebration by family and friends, and by alumni of these institutions who are gathered here to pay you credit. I hope that each of you feels the competence and the confidence that you've already heard described, because I can imagine that as you think about your new futures you've got some questions in your mind. You're thinking about the next chapters of your lives.

Now, I don't think the food wherever you're going will be as good as the restaurants on Newbury Street. The sleeping accommodations are not going to be exactly five-star ones. You know where you're going, it's called internship or specialty training. As we've already heard that means a lot of hard work and not very much sleep. And some of you in the dark of night when those beepers go off or those phone calls come may ask yourselves, 'My goodness, am I ready for all of this?'

Based on what I have learned about your class and your preparation, I think the answer is very clear -- you certainly are. You are more than prepared to enter the world of medicine and dentistry and serve your patients.

I was very impressed by the oath that the class has written, which you'll find at the end of your program. That oath describes very well what this class of extraordinary young men and women are committing themselves to doing. No group of new doctors and dentists has ever been better prepared to care for their patients. No group has ever been better prepared to help us usher in the next century, the next millennium of medicine. From the clinic to the classroom to the community you have received a first-rate education from one of the finest schools in the world.

We've already heard about the extraordinary diversity in your class. If you think back for a minute, a hundred or so years ago, to classes that also stood on the brink of a new century and new discoveries, you can see starkly the differences. The doors of medical education were virtually glued shut to women and people of color. Tuition here at Harvard was a couple of hundred dollars and you didn't even need a bachelors degree to get into Harvard Medical School. Until the 1870's, there were no written exams. And in fact, when President Elliott first suggested them, there was an objection because many of the students couldn't write. Yet like you, the students at the end of the last century had much to look forward to. When Oliver Wendell Holmes spoke at the 100th Anniversary of the Harvard Medical School, he referred to some things that never change, such as students sleeping in class. He noted that bleeding had almost become an unknown procedure, and he celebrated the exciting advances in surgical anesthesia, germ theory, and the microscope. He thought they would produce miracles that sounded as though they would come straight from some new Gulliver's Travels.

That day that he talked, future physicians such as yourselves were staring down challenges like cholera and typhoid. There were no antibiotics, no antiseptic surgery in America. The sanitation conditions were horrible. But those young doctors and dentists, like you, were armed with something very important called hope. The hope that they could write a new future for medicine in the 20th century, and they did. Today, all of you stand on the shoulders of those Harvard graduates and faculty who have come before you and pioneered many of the advances that we take for granted today. You stand on the shoulders of all the Nobel Laureates from Harvard who have unlocked the secrets behind some of the world's greatest medical mysteries. Even today, there are so many Harvard alumni here in the United States and around the world who are working to unlock the secrets of cancer and research into sickle cell disease, working to rid the world of AIDS and doing so much more. Now it is your turn to join them. It is your time to lead. You've been given the chance to use your education and training during the most exciting time ever in medicine.

Just think, who could have imagined even thirty years ago the revolutions in biology and technology, to see change in demographics, and the shifts in the way that we fund the health care system. All of these changes offer incredible opportunities and fundamental challenges. The real challenge for all of you, it seems to me, is how in the midst of these truly revolutionary changes, you can stay true to the oath you will take today to make, as you say, the health of my patients my first concern. I know that many of you worry about this. I imagine there have been many

conversations about what is happening in the health care system and how you will handle these new challenges, how you will manage the business of medicine from compromising the profession of medicine, how you will keep sacred the bond between patient, and doctor and patient and dentist.

In that extraordinary oath you've written, I think that there is a pathway to the future, a pathway that is not only one for you to follow, but for all physicians and dentists and lay people as well. When you pledge today to promote health and prevent disease, you do so at a time when there are extraordinary breakthroughs. You know all about them. Treatments for strokes and AIDS, the potential to slow diseases like Alzheimers, computer technology allowing you to share lifesaving information in real time, the mapping of the human genome that is revealing evolutionary secrets as we discover genes that are linked to breast cancer, colon cancer, and Parkinson's Disease.

And yet, with all of these breakthroughs come some questions that each of us, and particularly each of you, will have to address. For example, these kinds of advances don't just happen by accident or overnight. They are the result of sustained investments in research, especially in basic science. That is why we all have a stake in supporting the President's proposal for a 21st century research fund to increase our federal budget at NIH to historic levels. We should be increasing our budget at NIH as much as we can, at least by 50 percent over the next five years. That would give us the kind of investment that would enable you and your colleagues in the sciences to make these breakthroughs real in the lives of your patients. I hope that all of us (applause) will make clear that the United States must continue to be a leader in basic research and biomedical research, and that the United States government must, at this point in our history, make the kind of significant commitment that will enable us to move forward on the fronts that many of you will work on either in the research labs or apply in your practices.

Now, these continuing advancements in research and treatment also challenge us to ensure that our ethics keep pace with our science. We've all heard stories about people who are avoiding critical tests that their doctors recommend, or refusing to use their insurance out of fear that they will be discriminated against or have their privacy violated. It will do us little good if we discover genes that cause breast cancer or colon cancer, but people are afraid to be tested to find out if they have it because they worry that the information will cause them to lose their job or lose their insurance. You should be able to look your patients in the eye and say 'information about your genes will be used to heal you, not deny you a job or affordable health insurance.' The President has asked Congress to pass legislation prohibiting the use of genetic screening information to discriminate in health insurance and employment. The Congress should act to end genetic discrimination now (applause) and you should be able to guarantee your patients the privacy of their medical records.

At a time when personal health information is electronically criss-crossing the country, moving among health plans, insurance companies, and employers with fewer federal safeguards than the records of your video rentals, it is time to pass a law safeguarding the medical records and information of every American. (Applause) When you take your oath and you pledge to respect the dignity and autonomy of your patients in living and in dying, you make that promise in a world of rapidly changing demographics. The baby boomers like me are graying. Americans are

living longer with less disability. Now that is good news. It is what my husband likes to call a high-class problem.

But, as with any nation whose population is aging, we face tough questions about how we will provide and finance healthcare for this expanding group of older citizens. Think back. Before Medicare was enacted, almost fifty percent of older Americans went without health insurance. They found themselves often mired in poverty and chronic illness. People used to work their entire lives only to enter their later years facing unthinkable choices between paying their heating bills and their medical bills. We hear a lot of talk about what's wrong with government, but we shouldn't forget about what we have done right. Medicare forever changed what it means to grow old in this country and we have to make sure that it is there for generations to come. But Medicare, like any program in the public or the private sector, must adapt to a new world. The President worked in a bi-partisan fashion to extend the life of the trust fund as part of the Balanced Budget Act of 1997. And the changes in Medicare included not only an extension of its life, but more health plan choices and treatment options, and new prevention benefits like yearly mammogram, and colo-rectal screening, and diabetes self-management.

There is now a consensus between Republicans and Democrats that we have to address the long-term future of Medicare together. This should not be a partisan issue. Therefore, the President and Congress have appointed a National Bi-partisan Commission on the Future of Medicare that is scheduled to report in 1999. I hope that during the process of its deliberations and certainly in reaction to its report that all of you, and all of your colleagues will make sure your voices are heard, because we have to ensure that whatever changes are made are made in the best interest of patients.

You will dedicate yourselves to the profession of medicine and dentistry at a time when revolutions in our own health care delivery system are blurring the lines between payers, and providers, and insurers. There are more than 160 million people enrolled in managed care plans, an increase of 75 percent just since 1990. More physicians are forming their own health plans and working to find new ways to share risks and control costs. There is, however, another responsibility, that these new forms of care do not mean sub-standard care, that the bottom line of profits never eclipses the bottom line of good medicine. And you have to be on the front lines of ensuring that that occurs. Think about a recent statistic that came from a survey I read: 'Sixty percent of Americans say they are worried, that if they were sick their health plans would be more concerned about saving money than giving them the best treatment.' Physicians have been on the front lines arguing against these, standing up for patients who have been denied treatments that were recommended by their doctors. Physicians have spent countless hours on telephones arguing with insurers to try to make sure that a patient got the care that the physician thought necessary. We have to work to make it absolutely clear that it should be the medical professional who determines treatment options, not a checklist administered from some office thousands of miles away. (Applause)

Whatever kind of insurance plan any American has, that American should feel they will get quality care. What better place to make that pledge than here at this graduation. Dr. Mitchell Rabkin introduced the first Patients Bill of Rights here at Harvard hospital. Patients should never

have to beg and plead to see a specialist they need. When an emergency arises they should get the care whenever and wherever they need it. They should have a right to a fast and fair appeal when they or their physician disagree with decisions about their care. Congress should pass a Patients Bill of Rights to protect every American and pass it this year. (applause)

One of the most serious and unintended consequences of the changes in the financing and delivery of healthcare in America is its effect on academic health centers like this one. You have seen first-hand in your training what happens when new market forces squeeze academic health centers. Now you have also been part of putting some good models in place here in Boston, when managed care plans have joined forces with teaching hospitals. But the problem is one that is not just the concern of Harvard or Harvard's graduates, but should be the concern of every American. Because, just stop and think for a minute what our academic health centers have meant to each and every one of us.

Academic health centers have many missions. But three of them, in particular, have helped to make American health care the best in the world. The research mission of the academic health center has not been replicated anywhere else and could not be. We are all grateful for the extraordinary breakthroughs in research that have happened in the labs and clinics of academic health centers. The mission of training young doctors, and dentists, and nurses, and other health care professionals is also the province of the academic health center. And thirdly, the care for the most vulnerable, whether they are vulnerable because they are poor and disadvantaged, or they are vulnerable because they are sick and without hope, the academic health center has been there as a place of last refuge.

Now those three missions: research, education and training, and uncompensated care for the vulnerable, are not profitable missions. You rarely can make any money at all in the short-run, and even the medium-run, in research. You certainly cannot make money off training young physicians or dentists and you lose money when you open your doors to the most vulnerable. Yet, in this brave new world of HMOs and health care agencies that look to the bottom line, many academic health centers are being told, 'I'm sorry, we're not reimbursing you for these functions which are not directly related to the patient care activities that we have listed in our brochure. So you will not receive compensation for research, education, training. And you're just going to have to send those poor patients somewhere else.'

That attitude fails to recognize that the reason American health care is so good is because we've had the best research, education and training opportunities available of any country in the world. If we squeeze out those functions, if we force places like Harvard to have to cut back on what they do best, it is not only Harvard that will suffer, it is hospitals and patients throughout the world. It is time for us to recognize that paying for those academic health centers and their vital missions is in the best interest of us all. Historically, Medicare has borne a great deal of the cost, paying directly and indirectly for graduate medical education. We should do everything possible to continue Medicare and the federal government's commitment to academic health centers. But, I believe it is also fair and appropriate for every health plan and every insurance policy to pay something toward the maintenance of our academic health centers since we all benefit from the work which they do on our behalf. (Applause) This is not one of those abstract debates that

should only take place in Washington behind closed doors. It should be brought out in the light of day. Those of you on the front lines of delivering high quality medicine, doing cutting-edge research, and caring for the poorest and the sickest among us should make sure your voices are heard.

Now, all of these issues I've just mentioned were part of the overall plan that was presented a few years ago to reform our nation's health care system. Now clearly, that particular proposal was not successful, but it is critical that we do not give up on what must still be done. Many people ask me, 'Well, were you discouraged after the defeat of health care reform?' Well yes, I was discouraged we didn't have the kind of debate that we should have had in Congress, so that people in the country could have seen clearly what our true choices were. But, I also believe that the debate and the effort was very important for America. We did educate ourselves about many of the issues that you here at Harvard know so well. And we also learned that when the political environment makes it impossible to take large steps in a direction you believe you must go, then you have either the choice of taking smaller steps or sitting on the sidelines and doing nothing. I come from the school of smaller steps. It is far better to try to make changes that will help at least some people than to do nothing and help no one.

So, we've seen some progress since 1994. Thanks, for example, to the leadership of Senator Kennedy here in Massachusetts, the Congress passed a bill prohibiting the loss of health insurance just because of the loss of a job or a pre-existing condition. Now there are problems with the implementation of that provision, but it is still an important step, and it is a value that makes clear that we are moving toward ensuring that people are not wrongfully deprived of their access to health insurance. We've also seen major legislation, the most significant since 1965, in making it possible for uninsured children to have access to health insurance.

But, our job is far from done. We have 41 million people living without health insurance. You've treated many of them in the hospitals where you've done your rotation and waited to be on call. Who will take care of these people in the future? Who will ensure that they will be taken care of? How will we pay for their care? And how will we pay for the extra costs that come when someone is not treated for a chronic disease or turned away from the emergency room? The job of health care reform in America cannot be done when any of our citizens' access to care depends on the color of their skin, or the neighborhood they live in, or the amount of money in their wallet.

Let's be clear. As a nation, we have to continue to work toward universal, affordable, quality health care for every single American. (Applause) While all of us must continue to work toward that day and we will do our part, it is going to be up to each of you who graduates today to assume your place as one of the architects of this changing health care world. I'm afraid you can't just be bystanders or kibitzers because you have the information and the experience that all of us need. About 100 years ago, one of your predecessors said, "We are very glad to be in the class of 1900 and not 1800, because we confidently believe we shall all witness greater triumphs in the century now dawning." I hope each of you feels the same and I trust that in 100 years when your successors look back at the class of 1998, they will say that, given the opportunity, you went far beyond the instructions to do no harm at the patients' bedside. Instead, you worked in

the service of your patients and humanity. And you worked to improve the system in which you care for your patients.

I hope also that we'll be able to look back and see that just as medicine conquered bacteria in the 20th century that the 21st will see the defeat of viruses; that chronic illness will be cured or tamed; that so many of the problems we have seen in disease around the world will finally be put at bay; that our grandchildren will have to look in history books to learn about the devastation of cancer or AIDS. During a time of great change, there is always uncertainty about which direction each of us individually will go and which direction collectively we will choose. We are at such a point in your lives as you enter this system.

I am extraordinarily hopeful as I look out at these graduates, that the decisions will be made with their guidance and expertise, and that the oath that they take today will be fulfilled in full measure. Because after all, it is they who must ensure that above all, "the health of my patients will be my first concern." We need your competence and your confidence, as we've already heard. Even more, we may need your compassion--harnessed to that competence and confidence--and we will need your voices to ensure that what you know, what you see, what you experience cannot be ignored as our nation debates what direction we take. And I'm confident that if we follow your oath we will make the right decisions. Congratulations, good luck, and God speed.

End Oratory by First Lady, Hillary Clinton

MEMO

To: The First Lady

From: Jen Klein, Neera Tanden

Re: Meeting with Dr. Martin of Harvard Medical School

Date: June 3, 1998

In your meeting with Dr. Martin (who prefers to be addressed as Dr. Martin, rather than Dean Martin), he is likely to raise the following issues: the National Institutes of Health research budget; graduate medical education; and medical student debt. The purpose of this memo is to provide you with background information on each of these issues.

National Institute of Health Research

During the Clinton Administration, the budget for the National Institutes of Health (NIH) has increased 32%, from $10.33 billion in FY 1993 to $13.65 billion in FY 1998. This year, the President proposed a "21st Century Research Fund," which would provide new funding for investments in biomedical research, prevention research, and research to improve health outcomes.

The proposed increase for FY 99 would be $1.15 billion and over the next five years funding would increase by nearly 50%. This represents an increase in funding at all of the Institutes at NIH, including a 65% increase in cancer research funding. The President's budget initiative would fund most of this research increase from the proposed tobacco legislation.

In addition, the President has proposed an increase of $25 million in FY 99 for a new Prevention Research Program at Centers for Disease Control (CDC) to identify interventions that prevent diseases. Finally, total funding for the Agency of Health Care Policy and Research (AHCPR), the agency that translates scientific breakthroughs into medical practice, would increase by $25 million in FY 99 and $147 million from FY 1999 to 2003.

Medicare Support for Graduate Medical Education

Academic health centers have experienced increased costs for graduate medical education (GME) over the last few years. Medicare has financed much of GME, and in a world where managed care is reducing its support for such expenses, academic health centers are increasingly relying on Medicare as their main source of funding. Last year, the President assisted teaching hospitals by winning agreement during the Balanced Budget negotiations for a Medicare "carve out" for teaching hospitals so that rather than having their funding flow from Medicare, through managed care plans, to them, teaching hospitals would receive funding directly from Medicare. However, the Medicare Commission is currently considering a number of proposals to address the long-term

viability of Medicare's system of support for GME, including a proposal to withdraw this support entirely. Academic health centers are clearly opposed to such proposals, and are generally opposed to any fundamental changes in Medicare's system of support of GME.

Background

Care in teaching hospitals is generally recognized as costlier than similar care in non-teaching facilities. Medicare has recognized the additional costs associated with training and paid its share since its inception. In 1997, total GME costs were estimated to be $18.6 billion, according to research by Lewin for the Commonwealth Fund, of which a significant portion is explicit funding through Medicare.

Medicare and, to a much lesser extent, Medicaid have played a key role in financing GME. Direct graduate medical education (DGME) covers Medicare's share of costs directly associated with operating resident training programs (e.g., salaries, fringe benefits). Medicare's Part A DGME payments are estimated to be $2.56 billion in federal fiscal year (FY) 1998. The second component of Medicare's GME payments recognizes the indirect costs of graduate medical education (IME), including the more expensive practice pattern associated with teaching programs. The IME adjustment is a percentage add-on to the hospital's Medicare payment . Medicare IME payments are estimated to be $5.3 billion in FY 1998. Over five years (FY 1999-2003), the HCFA Actuary estimates that Medicare Part A spending on direct and indirect medical education will be about $42 billion. In addition to the Part A payment for DGME, a portion of Medicare's payments to hospitals for DGME is from Part B. DGME payments from Part B are estimated to be roughly $360 million for FY 1998, and roughly $2 billion over five years (FY 1999-2003). GME is projected to represent 3.8% of total Medicare benefits in FY 1998.

The Medicare Commission, as part of its mandate, is reviewing the advisability of maintaining or modifying Medicare's investment in GME. This question of restructuring was put before the Medicare Commission as an option to improve Medicare's financial solvency and could have the effect of reducing support of academic health centers. The two questions the Commission is focusing its attention on are how to finance GME over the long term, and at what level.

The Medicare Commission is examining a number of options on ways to finance GME over the long term. One option is to continue to use Medicare as a financing system, which has proven to be a reliable and predictable source of funding. Another option is to finance GME through general revenues as a discretionary program. While this option recognizes that everyone benefits from support of graduate medical education, it would require GME funding to compete annually with other spending priorities as part of the discretionary appropriations process. A third option is to transfer spending to Medicare Part B and continue GME "entitlement" status. Since 75 % of Part B funding comes from general revenue, this approach would spread part of the costs of graduate medical education through a more progressive tax structure than the payroll tax. This approach to GME funding under Part B would maintain its mandatory spending nature, which would not provide for an annual discussion of the "right" level of spending. Finally, some have proposed a self-funded trust fund or all-payer pool that recognizes that everyone, not just Medicare beneficiaries, benefits from support for GME. Such a trust fund would probably be

funded by dedicated revenue sources (e.g., through contributions from all payers and self-funded employer plans or mandatory general revenue contributions).

Beyond the issue of the source of financing is the question of the amount of resources that should be devoted to support for GME. Current Medicare payments for DGME and IME in FY 1998 are estimated to be nearly $7.9 billion. While additional funding could be directed towards graduate medical education that some consider under funded, cutting funding could help address the problem of too many physicians in general and too many specialists in particular because it may well lead hospitals to cut down on the number of residencies they provide.

Teaching Hospitals' Concerns

Teaching hospitals are particularly concerned about the long-term viability of our system of financing graduate medical education. Indeed, in the context of a changing health system, the financial support from Medicare for graduate medical education has provided stability for teaching hospitals. Managed care, for example, often does not compensate for the extra costs of teaching hospitals, so a significant reductions in Medicare support for GME would be very disruptive in the present system. The academic medical centers are likely to oppose proposals to remove DGME and IME from the Part A Trust Fund, particularly if there is a risk that funding may be reduced. In addition, the political opposition to the effects of any related redistributions might confound, for example, the prospects for establishing a new trust fund structure.

There is also the fundamental question of whether Medicare's support for GME is integral to Medicare's adequate payment for its beneficiaries or is simply a straight forward mechanism to support a "social good." Without doubt, a high-quality medical education system is important to this nation. Thus, in addressing the financial concerns of the program, the Medicare Commission will be assessing the broader "social goods" that have been achieved under Medicare's auspices.

Medical Student Debt

Dr. Martin would also like to discuss the financial burdens medical students face after graduation. The average debt load for the Harvard Medical School's class of 1997 was $73,000, with some students facing as much as $162,000 in debt. Roughly two-thirds of students received financial aid in each class. Dr. Martin would like to discuss financial aid and loan forgiveness options available to medical students.

The Clinton Administration has taken a series of steps to make both college and graduate education more affordable:

1. Direct Loan Program. The President proposed a new Direct Loan Program which streamlined the student aid delivery system, thereby eliminating confusion and complexity and resulting in better and faster service to borrowers. Most important, the Direct Loan Program charges much lower fees because students borrow directly from the federal government. More than 2.1 million student and parent borrowers have received direct loans since the program began. [You should know that there have been a series of articles written criticizing the quality of services the Direct Loan Program offers.]

2. 20% Tuition Tax Credit for Graduate Students and Others. The 20% credit will be applied to the first $5,000 of tuition and fees through 2002, and to the first $10,000 thereafter.

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The only loan forgiveness program that specifically benefits the medical profession is the National Health Service Corps Scholarship Program, which focuses on placing doctors in under served areas. The program costs roughly $120 million per year; however, over the past five years, the program has received level funding. The National Health Service Corps [NHSC] placed nearly 2,000 health professionals rural and urban areas in the past year. Nearly 50% of all NHSC placements have stayed in under served areas over the past four years. The program's members provided care to over 3 million patients, and made nearly 7 million patient visits to residents of undeserved urban and rural areas in the past year.

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Nobel Laureates from the Harvard Medical School

George Minot, 1934, Medicine and Physiology
Research on liver treatment of the anemias (with Murphy)

William P. Murphy, 1934, Medicine and Physiology
Diabetes and diseases of the blood (with Minot)

Fritz A. Lipmann, 1953, Medicine and Physiology
Identified coenzyme A and discovered basic principles in understanding of proteins

John F. Enders, 1954, Medicine and Physiology
Application of tissue-culture methods in developing a polio virus, the ingredient of the polio vaccine (with Robbins and Weller)

Frederick C. Robbins,* 1954, Medicine and Physiology
Application of tissue-culture methods to the study of viral diseases (with Enders and Weller)

Thomas H. Weller, 1954, Medicine and Physiology
Application of tissue-culture methods to the study of viral diseases (with Enders and Robbins)

Georg von Bekesy, 1961, Medicine and Physiology
Discovered the traveling wave while researching how the ear responds to sound waves

James D. Watson, 1962, Medicine and Physiology
Described the structure of DNA

Konrad E. Bloch, 1964, Medicine and Physiology
Studied the pattern of reactions involved in the biosynthesis of cholesterol and fatty acids

George Wald, 1967, Medicine and Physiology
Research on the biochemistry of vision

Baruj Benacerraf, 1980, Medicine and Physiology
Discovered that disease-fighting ability is passed on genetically, although the immune-response gene varies from person to person

David Hubel, 1981, Medicine
Research on information-processing in the visual system (with Wiesel)

Torsten Wiesel, 1981, Medicine
Research on information-processing in the visual system (with Hubel)

Bernard Lown, Herbert Abrams, Eric Chivian, and James Muller, 1985, Peace
Cofounders, with Evgueni Chazov, Leonid Ilyin, and Mikhail Kuzin from the Soviet Union, of the International Physicians for the Prevention of Nuclear War

Joseph E. Murray, 1990, Medicine
Developed new procedures for organ transplant (with E. Donnall Thomas, formerly of the University of Washington)