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.

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.

HARVARD MEDICAL ALUMNI ASSOCIATION

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BOSTON, MASSACHUSETTS 02115
(617) 432-1560
FAX (617) 432-3366

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.

Insert 1

And that means continuing to reform our health care system. The United States has the best medcial research, the best medical education, the best prepared doctors and nurses in the world. Yet our system of paying for health care leaves us with an inadequate health care system. We are the richest nation in the world, yet we are the only developed country which does not provide all of its citizens access to affordable health care. We spend almost 14% of our economy on health care compared to between 7 % and 10% in other developed countries and they insure everyone while we have tens of millions of uninsured and underinsured people. And our health outcomes are no better than in many other developed nations. (We spend over 20 (25) cents of every health care dollar on administration while other nations spend far less.)

In 1993, President Clinton tried to reform the health care system to provide affordable health care to all Americans. Like six other Presidents before him, Roosvelt, Truman, Kennedy, Johnson, Nixon and Carter, he failed. Vested interests with a stake in the current system succeeded in scaring the American people about our intentions and plans and killed our attempts at comprehensive reform. (I am glad to say that many at Harvard Medical School, the Massachusetts medical community and in the Massachusetts Congressional delegation supported our efforts.)

People often ask: Were we disappointed about failing to pass comprehensive health care reform in 1994? Of course we were. Among Washington pundits, it is considered one of our greatest political failures. But our disappointment doesn't come because we suffered a political defeat. My family, like the families of all elected Federal officials who decided this matter, have health insurance. We are protected.

Our disappointment comes because of the over forty one million uninsured Americans including almost ten million of our children, who were depending on us and who are still receiving inadequate care and are left with the threat of being only one illness away from bankruptcy because we did not pass comprehensive health reform. Our disappointment comes from the over twenty five million additional Americans who are underinsured, with small lifetime limits on their insurance policies so that when they need health insurance the most it runs out on them. They are the source of our disappointment.

After the defeat of health reform, the political environment stopped us from taking large steps to address these problems and gave us two choices --

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.

3. Education and Retirement Savings Accounts. Allows penalty-free IRA withdrawals for undergraduate, post-secondary vocational, and graduate education expenses. Additionally, taxpayers are given the opportunity to deposit $500 into an education IRA. Earnings accumulate tax-free and no taxes are due upon withdrawal for an approved purpose.

4. Student Loan Interest Deduction. Included in last year's budget agreement was an initiative to allow a deduction of up to $2,500 per year of interest on education loans for expenses of students enrolled at an institution of higher education. This deduction will be available even if the taxpayer does not itemize deductions.

5. Community Service Loan Forgiveness. In most circumstances, a loan that is forgiven is considered income and is therefore taxable. To encourage programs that offer loan forgiveness to borrowers who take lower-paying, community-service jobs, this program excludes from taxable income both loan amounts forgiven through programs run by nonprofit tax-exempt charitable and educational institutions.

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.

TO: Laura Schiller
FROM: Jen
6-5709

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

Dr. Martin; Dean 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 mix 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.

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 speciality training. The words bring with them excitement and expectation. Images of countless hours. Little sleep. And even a tinge of fear: "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. This medical school class was the first to enroll more women than men. Thirty years after your diversity program began, yours is the first class to boast an enrollment that is majority minority.

Think back a minute to your predecessors around the turn of the last century. The doors of medical education were virtually glued shut to women and people of color. You didn't need a bachelor's degree to get into Harvard Medical School. Tuition was a couple hundred dollars. After President Eliot suggested that written exams supplement the oral ones, there was an outcry because most of the students couldn't write.

Yet, like you, the students of that day had much to be thankful for. When Oliver Wendell Holmes spoke at the 100 year anniversary of Harvard Medical School in 1883, he referred to some things that never change, such as students sleeping in class. He noted that bleeding ~~was now~~ had become an almost unknown ~~operation~~ procedure. And he celebrated the exciting advances in surgical anesthesia, germ theory, and the microscope, which produced miracles he thought sounded as if they came from some new Gulliver's Travels.

That day, he talked to future physicians who were staring down challenges like smallpox. Cholera. Typhoid. Without no modern vaccinations. No antibiotics. With horrible sanitation conditions. But, they were armed with the hope that they could write a new future for medicine in the 20th century. And they did.

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, ~~who~~ few would have thought we'd see incredible 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 patient my first concern?"

I know that you have thought a lot about this. I know you worry about how you'll manage to always place the healing of medicine before the business 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 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. 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 for the National Cancer Institute alone.

These continuing advancements also depend upon our ethics keeping pace with our science. Too many people are avoiding care, refusing to use their insurance, because they think they'll be discriminated against or have their privacy violated. You should be able to look your patients in the eye and say: 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 greying 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. It wasn't too long ago, when we'd hear about people working 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 (choices give your patients 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.

end of sentence . . .

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 nations 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.

New ¶

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. With more than 85 percent of people enrolled in managed care plans...With more physicians 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 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 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 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 boys 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 ever happen. Whether Americans choose 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 drafted the first Patient's Bill of Rights. And this is where we must say for all to hear: No patients should 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. 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. And I know that disappointment was shared by many leaders from this institution and this State's Congressional delegation who worked hard to make the Health Security Act the law of the land.

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 1 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 provide health insurance for millions of children who don't have it. But our job isn't done. Passing legislation is difficult. 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.

remarkable accomplishment

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 swelled to 41 million. 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 our nation must continue to work toward that day...continue to make changes that safeguard 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 MCATs or boards, but by whether you fulfill your responsibility to live up to your oath and lead us into the next century.

As Robert Kennedy, who graduated from Harvard 50 years ago...and passed away 30 years ago...once said: "You live in the most privileged nation on earth. You are the most privileged citizens of that privileged nation; for you have been given the opportunity to study and learn . You can use your enormous privilege and opportunity to seek purely private pleasure and gain. But history will judge you, and, as the years pass, you will ultimately judge yourself, on the extent to which you have used your gifts to lighten and enrich the lives of your fellow man. In your hands, not with presidents or leaders, is the future of your world and the fulfillment to the best qualities of your own spirit."

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.

PRESIDENT CLINTON'S PROPOSALS: HEALTH CARE THAT STRENGTHENS AMERICA'S FAMILIES

Protecting Patients Through a Consumer Bill of Rights. The President has called on Congress to pass federally enforceable consumer health care protections before it adjourns this fall. This patients' bill of rights should contain a range of protections, including guaranteed access to needed health care specialists, access to emergency room services when and where the need arises, an assurance that medical records are confidential, and access to a meaningful internal and external appeals process for consumers to resolve their differences with their health plans and health care providers. The nation's health care system has changed dramatically, with 160 million Americans now in managed care plans. This legislation will ensure that whether Americans have traditional health insurance or managed care, they are assured quality care.

Providing New Options for Americans Ages 55 to 65 to Obtain Health Insurance, Including Buying Into Medicare. Americans ages 55 to 65, particularly those with disabilities or preexisting conditions, are one of the most difficult-to-insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems as the population generally. The President's proposal gives this vulnerable population three new ways to gain access to health insurance by: (1) allowing Americans ages 62 to 65 to buy into Medicare, through a premium that ensures that this policy is self-financed; (2) assisting vulnerable displaced workers 55 and over by offering those who have involuntarily lost their jobs and health care coverage a similar Medicare buy-in option; and (3) giving Americans 55 and over who have lost their retiree benefits access to their former employers' health insurance.

Reducing Teen Smoking and Changing the Way Tobacco Companies Do Business. Every day 3,000 young people start smoking and 1,000 of them will die prematurely from a tobacco-related disease. The President called on Congress to pass comprehensive national bipartisan legislation that includes five key principles: (1) it must mandate the development of a comprehensive plan to reduce teen smoking, including raising the cost of cigarettes by $1.50 per pack over the next 10 years as necessary to meet youth smoking targets; (2) it must affirm the FDA's full authority to regulate tobacco products; (3) it must include measures to hold tobacco companies accountable, especially for marketing products to children; (4) it must include concrete measures to improve public health, from investing in research to reducing second-hand smoke to expanding smoking cessation; and (5) it must protect the financial well-being of tobacco farmers and their communities from the loss of income caused by our efforts to reduce smoking.

Proposing New Incentives To States To Enroll Uninsured Children. The President's FY 1999 budget includes $900 million over 5 years for children's health outreach

policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law. This budget proposal builds on the nationwide public/private initiative that the President and the First Lady have initiated to help enroll uninsured children, including working with foundations, schools, churches, voluntary organizations, pharmacies, and groceries stores to help reach out to families with uninsured children.

Supporting Legislation to End Genetic Discrimination. Studies show that a leading reason women do not get new genetic testing for susceptibility to breast cancer is because they worry about this kind of discrimination. According to another study, 63 percent of Americans would not take a genetic test if their health insurers or employers could get access to the results. To ensure that new advances in genetics are used to improve health rather than to discriminate against individuals, the President has called for legislation prohibiting the use of genetic screening to discriminate in health insurance and employment.

Creating a Historic "21st Century Research Fund" With Unprecedented Increases in Biomedical Research at the National Institutes of Health (NIH). Scientists are on the cusp of important new breakthroughs in biomedical research, which could revolutionize the way medical experts understand, treat, and prevent some of our most devastating diseases. To promote this progress, the President's budget contains a historic upfront investment in biomedical research -- a $1.15 billion increase in FY 1999 -- and proposes an increase in NIH funding of about 50 percent over the next five years as well as an historic 65 percent increase in cancer research. Under the President's proposal, the NIH will devote over $20 billion to biomedical research in 2003. Funding at the National Institutes of Health has increased 32 percent, since the President took office (from $10.33 billion in FY 1993 to $13.65 billion in FY1998).

Covering Cancer Clinical Trials for Medicare Beneficiaries. Americans over age 65 make up half of all cancer patients. However, Medicare only covers treatments that are established as standard therapies. In January, the Vice President unveiled the Administration's proposal for a three-year, $750 million demonstration to cover Medicare beneficiaries' patient care costs associated with certain Federally-sponsored cancer clinical trials. The recent promising cancer therapies all have to go through clinical trials. Scientists have said that expanding access to these trials will increase their participation rates, which is critical to ensuring that these promising new therapies go from the experimental phase to the market where

they can potentially help millions of Americans.

Proposing Over $400 Million to Develop New Approaches and to Build on Existing Successes to Address Racial and Ethnic Health Disparities. The President's budget proposes a total of $150 million over five years for grants to up to 30 communities to devise innovative new strategies to improve minority health status. Successful approaches learned in these communities will be applied to all health programs across the Department of Health and Human Services. The President has also proposed a $250 million investment over five years that would strengthen public health programs that have a proven record of effectively targeting these problems. These proposals include new investments in prostate cancer screening education, diabetes outreach and education, breast and cervical cancer screening for Native Americans, heart disease awareness programs, and HIV prevention.

PRESIDENT CLINTON'S HEALTH CARE ACHIEVEMENTS

✔ **Signed into law the most comprehensive Medicare reforms in the program's history.** The Balanced Budget Act of 1997 (BBA), which the President enacted last year, contained major new Medicare reforms including:

-- **Payment and structural reforms that extend the life of the Medicare Trust Fund for a decade.** This builds on the President's 1993 economic package which included policy and structural changes that extended the life of the Medicare Trust Fund by three years.

-- **New structural reforms to modernize the program.** The President's budget contains a series of structural reforms which modernize the program, bringing it in line with the private sector and preparing it for the baby boom generation. These reforms: increased the number of health plan options; improved Medicare managed care payment methodology and informed beneficiary choice; implemented a prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments; and adopted private-sector oriented purchasing.

-- **New preventive benefits.** The BBA also: waived cost-sharing for mammography services and provided annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer; established a diabetes self-management benefit; ensured Medicare coverage of colorectal screening (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure); ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

-- **Medicare Commission to address long-term financing challenges.** The BBA also created a Commission to examine the challenges facing the program as the baby boomers retire. The number of elderly will increase by 45 percent in the next 20 years and by 2030, one in five Americans will be elderly. The Commission is scheduled to make its final report in 1999.

✔ **Enacted single largest investment in children's health care since 1965.** The Balanced Budget included $24 billion for the Children's Health Insurance Program -- the single largest investment in health care for children since the

passage of Medicaid in 1965. This new program will provide meaningful health care coverage for up to five million currently uninsured children -- including prescription drugs, vision, hearing, and mental health services.

✔ **Enacted the Kennedy-Kassebaum health insurance reforms that will benefit millions of Americans.** This law helps individuals keep health insurance when they change jobs. Many of the provisions in this law were included in the President's balanced budget proposal and the Health Security Act. This law also includes several other key provisions that:

-- Guarantee renewability of coverage
-- Guarantee access to health insurance for small businesses
-- Eliminate the discriminatory tax treatment of the self- employed
-- Establish penalty-free withdrawals from IRA's for qualified medical expenses
-- Strengthen efforts to combat health care fraud, waste, and abuse
-- Provide consumer protections and tax incentives for private long-term care insurance
-- Simplify the health care system and reduce paperwork

There have been recent reports that some insurers are trying to find ways around this new law by giving insurance agents incentives to delay or deny coverage to those individuals now eligible for coverage. This spring, the President took action to stop these practices by directing the Department of Health and Human Services to send a letter to all state insurance agencies stating that these practices are inconsistent with the law and must be stopped.

✔ **Fought fraud and waste in Medicare.** Since 1993, the Clinton Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240% saving more than $20 billion in health care claims. The Balanced Budget Act gave an array of new weapons in our fight to keep scam artists and fly-by-night health care out of Medicare and Medicaid. Most recently the President proposed legislation to stop the Medicare program from overpaying for the drugs it covers, and imposed an unprecedented moratorium to prevent bad apple providers out of the home health industry.

✔ **Protected the Medicaid guarantee for children, elderly, pregnant women, and**

people with disabilities. The President vetoed the Republican's proposal to block grant the Medicaid program, guaranteeing health care coverage or benefits to 37 million beneficiaries.

✔ **Established protections for mothers and their newborns.** Some health plans have refused to pay for anything more than a 24-hour hospital stay, and some have recommended releasing mothers as few as 8 hours after delivery. The President signed into law common sense legislation that requires health plans to allow new mothers to remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Caesarean section.

✔ **Signed into law mental health parity provisions.** The President signed into law legislation to prohibit health plans from establishing separate lifetime and annual limits for mental health coverage.

✔ **Increased childhood immunizations to an historic high.** Concerned that too few children were receiving much-needed vaccinations, in 1993 the President launched a major childhood immunization effort to increase the number of children who were being immunized. As a result, over 90 percent of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1993.

✔ **Ensured that prescription drugs will be adequately tested for children.** President Clinton announced an important Food and Drug Administration regulation requiring manufacturers to do studies on pediatric populations for new prescription drugs -- and those currently on the market -- to ensure that prescription drugs have been adequately tested for the unique needs of children.

✔ **Signed an Executive Memorandum to bring the Federal Health Programs in compliance with the Quality Commission's Consumer Bill of Rights.** In February, the President released an Executive Memorandum directing all Federal health plans, which serve over 85 million Americans, to come into substantial compliance with the President's Quality Commission's Consumer Bill of Rights. The Executive Memorandum follows a report that the Vice President forwarded to the President on the current status of compliance with the Consumer Bill of Rights and what steps the Federal government could take to come further into compliance.

✔ **Expedited the FDA review and approval of new drug products.** Under the President's watch, U.S. drug approvals are now as fast or faster than any other industrialized nation. Average drug approval times have dropped since

the beginning of the Administration from almost three years to just over one year. In 1997, virtually all breakthrough drugs will be approved within six months without compromising safety standards.

✔ **Increased funding for AIDS research, prevention, housing, and treatment.** In the President's first term, he presided over a 56 percent increase in spending on programs for people living with AIDS including: the Ryan White Care Act, research, State AIDS drug assistance programs that help patients buy new protease inhibitor drugs, and Housing Opportunities for Persons with AIDS that provides housing assistance for over 65,000 people.

✔ **Helped Vietnam veterans whose children were born with spina bifida.** The President signed legislation to provide health care and rehabilitative training for children of Vietnam veterans who are born with spina bifida. The legislation will help thousands of children whose birth defects may be a result of their fathers' or mothers' service to our country.

✔ **Enacted laws to prevent and punish handgun violence.** The Administration fought for the Brady Bill, which has already prevented more than 60,000 fugitives, felons, and criminals from buying handguns. The President expanded this bill to prevent individuals who commit acts of domestic violence from buying guns. Banned 19 of the deadliest assault weapons and stopped efforts to repeal the assault weapons ban. Every year at least 39,000 people die and 100,000 are treated in emergency rooms from gun violence.

HEALTH RESEARCH IN THE 21ST CENTURY RESEARCH FUND FOR AMERICA

Historic increases
1993 → present

BACKGROUND

Recent progress in biomedical research has ensured that many of the diseases Americans faced a generation ago can now be prevented or treated. Smallpox has been eradicated from the entire world and polio is gone from the Western Hemisphere. There are new therapies for some of the most devastating diseases, such as AIDS. These successes would not have occurred without a strong sustained support of biomedical research. Even more breakthroughs are in sight. For example, new knowledge about both genetics and the structure of tumors may enable scientists to pinpoint more effective treatments for prostate, breast, and ovarian cancer. There are also new opportunities to learn more about preventing diseases. Finally, there are new possibilities to determine how to translate cutting edge discoveries into practical, improved care.

POLICY DESCRIPTION

To build on this progress and new possibilities, the "21st Century Research Fund" contains an unprecedented, multi-year commitment to improve health care research. It contains new funding for investments in biomedical research, prevention research, and research to improve health outcomes. In 1999 alone, this Fund contains:

- **An Historic $1.15 Billion Investment in Biomedical Research.** To build on the progress in biomedical research, the Fund contains a historic up-front investment in biomedical research — a $1.15 billion increase in FY 1999 — and proposes an increase in National Institutes of Health (NIH) funding of nearly 50 percent over the next five years. Under the President's proposal, the NIH will devote over $20 billion to biomedical research in 2003. This increases funding at all of the Institutes at NIH, including a 65 percent increase in cancer research funding.

- **$25 Million Increase in New Prevention Research.** The Fund also includes a new Prevention Research Program at CDC to identify interventions that

prevent diseases.

- **$25 Million Increase In Quality and Health Outcomes Research.** Research at the Agency of Health Care Policy and Research (AHCPR) bridges the gap between what scientists know and the health care Americans receive. In FY1999, total funding for AHCPR would increase by $25 million to a total of $171 million. Funding for health care quality improvement, which will address the scientific research recommendations of the President's Quality Commission, would double from $15 million to $30 million.

- **$28 Million Increase In Veterans' Research.** The Budget provides a $28 million increase to VA's research program to conduct basic clinical, epidemiological, and behavioral studies across the entire spectrum of scientific disciplines. FY 1999 research will focus on aging, chronic diseases, mental illness, substance abuse, sensory loss, trauma, health systems, special populations (including Persian Gulf veterans), and military occupation and environmental exposures.

BUDGET EFFECTS

Most of the research increase would be funded from tobacco legislation.

	FY 1999 to 2003 ($ millions)
National Institutes of Health Increase	**17,036**
Centers for Disease Control and Prevention (CDC) Prevention Research Increase	**138**
Agency for Health Care Research and Policy Increase	**147**
Veterans' Administration Research Increase	**28**

To DO
- Review Speech Imeet
- Finish briefings for Thursday
- Review McGovern event w/ Neera
- ~~Check in on House Dems~~
- Check in on After-School Event w/ Neera
- Review possible At Risk panelists

DRAFT 4/10/98

ISSUES RELATING TO MEDICARE SUPPORT FOR GRADUATE MEDICAL EDUCATION

The Medicare Commission, as part of its mandate, will review the advisability of maintaining or modifying Medicare's investment in support of graduate medical education (GME). GME restructuring was included as an option to improve Medicare's financial solvency because its funding represents a significant burden on the Medicare Trust fund and relying only on traditional Medicare savings may be insufficient. This memo provides background on Medicare funding of GME and describes and discusses major issues and options for GME restructuring.

- Do more re dsh?

BACKGROUND

Care in teaching hospitals is generally recognized as costlier1 than similar care in non-teaching facilities. Medicare has recognized the additional costs associated with training and paid its share since its inception. As noted in the 1965 Ways and Means Committee report on the original Medicare legislation:

> "Many hospitals engage in substantial educational activities. . .Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program."

Use but shorten

Prior to the prospective payment system (PPS), expenses related to training programs were part of Medicare's allowable costs. When Medicare moved to PPS, the program continued to recognize its share of the direct and indirect costs of graduate medical education (GME). In 1997, total GME costs were estimated to be $18.6 billion, according to research by Lewin for the Commonwealth Fund -- a significant portion of which 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 (FY1999-2003). GME is projected to represent 3.8% of total Medicare benefits in FY1998.

OVERVIEW OF ISSUES

Medicare's medical education payments have both sustained a high-quality medical education system and assisted the hospitals that have trained providers. Medicare bears the primary cost of **explicit** financing of direct and indirect medical education. While it is recognized that private payers also support GME, this is not done explicitly. Thus, it is difficult to accurately ascertain the relative share that various payers bear.

An argument can be made that medical education is a social benefit -- society at-large benefits from medical training -- and that these explicit payments should not be made by Medicare alone. The equity issue becomes even more compelling in light of the concern about the future status of the Medicare Hospital Insurance Trust Fund, which is the major source of GME payments. There is also concern that the current structure of funding through Medicare hospital payments may not be responsive to policy objectives in terms of training the right numbers and mix of specialties and providing support for academic health centers.

Because of similarities in the issues involved, the consideration of how to handle support for graduate medical education is likely to engender a discussion as well around Medicare disproportionate share hospital (DSH) payments. The issue of Medicare DSH payments is significant and merits separate attention.

SOURCE OF FINANCING

A major question that has been raised is should payments for GME (direct and indirect) be removed from Medicare?

Options:

1. **Continue to use Medicare as a financing stream.** Support of graduate medical education through Medicare provides a reliable and predictable source of funding. Given that graduate medical education training requires institutional commitments over long periods of time, reliability of a financing stream is an important consideration. In addition, the Medicare payment

system has avoided the Federal government being in the business of micro-managing the Nation's medical education programs. At the same time, there has been recognition, reflected in part in the changes included in the Balanced Budget Act (see later discussion), that Medicare GME financing can be improved to more closely align incentives in Medicare payment policy to help achieve certain goals.

2. **Finance GME through general revenues as a discretionary program.** This option recognizes that everyone benefits from support of graduate medical education. Under this approach, GME funding would compete annually with other spending priorities as part of the discretionary appropriations process. This approach has the advantage that it would make it easier to adjust GME support in response to current needs. However, this approach would make the GME revenue stream more uncertain compared to the current situation, making it harder for institutions to plan. In addition, as discretionary funds they would be subject to the discretionary caps. If no adjustment were made to the caps, other programs would need to be reduced to fund GME.

3. **Transfer spending to Medicare Part B and continue GME "entitlement" status.** Since 75 percent 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. The transfer to Part B, however, would increase the premiums paid by Medicare beneficiaries, raising the equity issue in a new way. In addition, this approach is inconsistent with the traditional role of Part A paying for costs associated with hospitals (which bear most of the cost of medical education).

4. **All-Payer Pool / Self-funded Trust Fund.** As with general revenue, funding a trust fund would recognize that everyone, not just Medicare beneficiaries, benefits from support for GME. A graduate medical education 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). For purposes of the Federal contribution on behalf of Medicare, a decision would be made as to whether the public share should come from general revenue appropriations or as a special payment from the Medicare trust fund(s). A combined approach could also be used where, in addition to a payment from Medicare, general funds could be appropriated to the trust fund (as proposed in the 1995 balanced budget bill).

LEVEL OF FINANCING

Summarize

Beyond the issue of the source of financing is the question of the amount of resources that should be devoted to support for GME.

Options:

1. **Current Level of Financing.** Medicare payments for DGME and IME in FY 1998 are estimated to be nearly $7.9 billion. If the current structure is modified, Medicare's contribution could be set equal to the current projected expenditures for GME, assuming that this amount is sufficient to finance today's system.

2. **Additional Financing.** Increases in funding could be directed towards graduate medical education that some consider underfunded. Possible uses of additional funding include: a set-aside for payments to new programs in non-traditional sites; greater funding for programs with providers with very low Medicare utilization such as children's hospitals; demonstration projects; or incentives for the type of training that will be needed to create the best medical workforce in the future. Alternatively, consideration could be given to maintaining the current, overall level of financing but supporting training of fewer physicians, allowing the remaining balance to be used for these purposes. However, reallocation in a budget-neutral manner would have a negative financial impact on institutions used to current reimbursement practices.

3. **Reducing Medicare Payment Level.** There is broad consensus that there are too many physicians in general and too many specialists in particular (Commonwealth Fund, Council on Graduate Medical Education, PPRC). Medicare's support for GME was, until enactment of the Balanced Budget Act, open-ended. The Balanced Budget Act includes caps on the number of FTE residents used to calculate direct GME and IME payments, incentives to downsize residency training programs and reductions in Medicare IME payments. The Act also expands the types of entities eligible (e.g., rural health clinics, community health centers) to receive Medicare support in an attempt to redirect some funds to support training in non-hospital settings. HCFA's Actuary estimates that the Balanced Budget Act will produce a 3 percent decrease in the number of residents.

   Some argue that the projected reduction in the number of residency training positions due to the Balanced Budget Act is modest compared to suggestions that there is a need to curb slots by one-quarter to one-third. (Commonwealth Fund, October 1997) Another point made is that since PPS was implemented, teaching hospitals' PPS margins (i.e., the difference between PPS payments and costs) have exceeded those of other hospitals. (MEDPAC, 1998) Others note that the reduction in GME financing may provide incentives to training programs to develop more efficient practice patterns.

   The BBA reduces the level of IME adjustment from 7.7% to 5.5% for every 10% increase in the hospitals intern to bed ratio by FY 2001. Analysis of

hospital cost functions documents that teaching hospitals have higher costs. While there was general agreement that an adjustment of 7.7% overcompensated hospitals for their indirect costs, a 5.5% adjustment may still be too high particularly since hospitals may count residents for IME when they are not providing services in inpatient settings. In the context of dealing with the federal support for graduate medical education, further reductions in Medicare expenditures for GME may need to be considered.

METHOD OF ALLOCATION

Some of the goals that have been proposed for GME funding are:

- The nation's health workforce should be more equitably distributed in order to provide reasonable access to care for all Americans.

- The nation's health workforce should be as diverse as the nation's population in order to help meet the service needs of vulnerable and diverse populations.

- Certain components of the health workforce should be augmented while other components should be reduced in order to provide balanced access to care for certain Americans.

- The settings for health workforce education and training should be reflective of the settings in which services are delivered to assure that the health workforce is competent. The content of training should be reflective of the care needs of the populations served today and in the future.

The options of continuing to distribute GME funding based on current policy or using alternative approaches need to be considered against the goals.

Options:

1. **Maintain Current Medicare Policies**. There are separate policies for IME and DGME. The IME is an add-on to hospitals' operating payments with the amount determined based on several factors including the number of residents per bed, Medicare volume, Medicare case mix, and wage index and cost-of-living adjustment levels. An adjustment is also made to PPS capital payments. Payment for DGME is made as a separate amount from PPS payments. DGME payments are based on a formula related to the number and specialty of trainees, hospital-specific historical costs, and Medicare volume.

Although, it is asserted that Medicare payment policies have not adequately fostered these goals, Medicare policies may be somewhat better aligned with achieving these goals as a result of changes made under the Balanced Budget Act (BBA). For example, caps established under the BBA on the number of residents paid for by Medicare for IME and DGME may limit the future rate of increase in physician supply in areas of the country which have an over-supply of doctors. The BBA also enables the hospital to count resident training time in non-hospital sites for DGME and IME if the hospital incurs the cost of the training, and for some clinics and managed care plans to receive DGME from Medicare. These provisions may encourage training in more diverse settings and training of a specialty mix that matches service needs. However, several shortcomings remain in current Medicare policies:

- There are large variations in the per resident amounts which are used as the basis for DGME payments. These variations, which ultimately derive from large variations in the historic costs of these programs, are difficult to justify on the basis of the goals for GME payment.

- Since Medicare finances the majority of GME, GME support is related to Medicare services, depriving facilities with low Medicare utilization, such as children's hospitals, of any significant GME support.

- There are no direct policies to make programs accountable for promoting a better geographical distribution and a more appropriate mix of specialties in the physician workforce.

2. **Use an Alternative Payment Method.** There are a number of ways of distributing DGME and IME funds. For instance, separate average prospective payment per resident rates based on the current IME and DGME payment levels could be developed and paid either to the site of training, the sponsor of the program (which could be a medical school), or even the residents themselves. Payments could also be provided under a block grant system related to each institution's percentage of historical Medicare graduate medical education payments. (Such a proposal was part of the balanced budget legislation proposed in 1995. HCFA had major concerns about how to adjust payments to all hospitals when other hospitals which newly participate in training become entitled to payments). Whatever alternative payment mechanism is developed, it is important to recognize:

   - The alternative formulae would inevitably produce redistributions of graduate medical education payments.

   - There is no broad consensus supporting specific alternatives. Proposals to allocate funds based on historical Medicare payments do

not hold teaching hospitals accountable for meeting policy goals and build-in current payment inequities. Other proposals continue to link payment to resident counts and provide incentives for increasing the size of residency programs (within the limits established by the BBA caps).

- Depending upon the nature of the allocation system developed, it potentially could involve dealing with such micro-level issues as the number of trainees and specialties for which particular sites would receive support.

- Any significant funding redistributions would likely require a transition period to mitigate the impact.

DISCUSSION

The issues of support for graduate medical education and the impact of the changing health system on academic health centers have received attention on a number of occasions, and have lead to modest changes and improvements in Medicare's financing of GME. Attention will again turn to this area in the context of the Medicare Commission because of Medicare's financial status and its significant role in support of GME. Consideration in the context of Medicare's financial status will need to balance a number of factors.

For example, in the context of a changing health system, the financial support from Medicare for graduate medical education has provided some 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 could be disruptive. The academic medical centers are not likely to support the removal of 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. Changes from the current system can be expected to pose difficult issues around allocation decisions and government micro-management, something that has been avoided in the Medicare GME financial support structure. However, concerns might be mitigated depending on the structure of future payments. If a self-funded trust fund included funding from other payers plus a dedicated revenue stream (e.g., the 1995 proposed balanced budget bill closed several tax loopholes and used the resulting savings to fund the trust fund), the teaching hospitals may be less likely to object because they would gain access to a larger funding source.

There is also the fundamental question of how much of Medicare's support for GME is solely related to paying on behalf of Medicare beneficiaries the fair share of

the costs for patients treated in teaching hospitals versus using public funding (in this case from payroll taxes) to support a "social good" and relying on the public insurance program simply as a relatively straight forward revenue delivery mechanism. In addressing the financial concerns of the program there needs to be recognition of the broader "social goods" that have been achieved under Medicare's auspices. Consideration of alternatives needs to carefully weigh the advantages and disadvantages of any a change.

Critical days/ ~~years~~ on CC - Tobacco and child care

6-5709

Other academics/ profs - e.g. Brazelton?

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

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

I hope you will find time today to step back and take tremendous pride in all you've accomplished. Some of you finished school while caring for a family. Many of you took out loans to reach your dream. You may have been the first in your family to attend college. Maybe you only recently came to this country. You might have graduated in 4 years...or 5..or 6...or 7...or more. Some of you also managed to earn a Ph.D. 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.

Even as you celebrate, I know most of you are already thinking about a new phase of life. The food will probably not be as good as the restaurants on Newbury Street. The sleeping accommodations won't be quite as comfortable as Vanderbilt Hall. You know it as -- internship. The word brings with it excitement and expectation. Images of countless hours in the intensive care unit. And even lingering questions like: "Will I be ready?" I have come here today with a very direct answer: No group of young 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.

In the clinic, the classroom, and the community, you have received a

first-rate education from one of the finest, most diverse, schools in the world. Your class was the first to enroll more women than men. Thirty years after your diversity program began, this is the first class to be majority minority.

Think back a minute to what your predecessors encountered at the turn of the last century. Back then, the doors of medical education were virtually glued shut to women and people of color. You didn't need a bachelor's degree to get into Harvard Medical School. Tuition was about $200 for all two or three years of school. After Dean Eliot suggested that written exams supplement the oral ones, there was an outcry because most of the students couldn't write. And, in a 1898 edition of JAMA, a doctor who is mistaken for a night watch man, simply answers "No, friend...they can go to sleep on their beat and they draw their wages regularly."

Yet, like you, the students of that day had much to celebrate, much to look forward to. When Oliver Wendell Holmes spoke at the 100 year anniversary of Harvard in the late 19th century, he talked about the exciting advances in the microscope, the thermometer, surgical anesthesia, and germ theory. And he talked to future physicians who were staring down challenges like smallpox. Cholera. Typhoid. With little information about vaccinations. With no antibiotics. With horrible sanitation conditions. But, they were armed with the hope that they could write a new future for medicine in the 20th century. And they did.

Today, you stand on their shoulders...and the shoulders of all Harvard

graduates who dreamed of -- and then set about creating -- a new future. Many of these alumni are here today. You stand on the shoulders of Judah Folkman, who has captivated this nation as he works to unlock 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, Time Magazine's Man of the Year in 1996...who is working day and night to rid our world of AIDS. And, yes, you stand on the shoulders of graduates like Michael Creighten and Noah Beir, 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 put your training to use during the most exciting time ever in medicine. A time of revolutions in biology and technology, revolutions in demographics, revolutions in the way we deliver and finance care. All of these revolutions offer incredible opportunities, but they also present a fundamental challenge. In this changing health care system, how can you stay true to your oath? "The health of my patient will always be my first concern."

Challenges

Competition is not direct

I know this is something you worry about. Whether in your class show or your patient/doctor course, you have voiced fears about making sure the healing of medicine is never overshadowed by the business of medicine. But what has impressed me most about your class is not just your concerns, but your commitment to address them. I've read the extraordinary oath you've written. And I believe that 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.

When you pledge to promote health and prevent disease, you do that in a world where daily breakthroughs in research are putting the medical keys in your grasp. Where we've uncovered drugs to prevent cancer and treatments for stroke and AIDS. Where technology is bringing us life-saving information in seconds and giving us more insight into Alzheimer's and other degenerative diseases. And where the mapping of the Human Genome is revealing genes linked to breast cancer, colon cancer, and Parkinson's diseases.

These advances didn't just happen by accident. And they certainly didn't happen overnight. They were the result of steady and sustained investments in research...many of them made by people who didn't know if they'd see the fruits of their labor in their lifetimes. We must look ahead again. The President has proposed increasing our research budget at the NIH by more than 50 percent over the next five years.

But we must also make sure that our ethics keep pace with our science. We will not reap the benefits of genetic research. We will not be able to convince Americans that genetic testing can help heal them unless we outlaw genetic discrimination. Our citizens genetic make-up must be used to save them, not stigmatize them and deny them jobs or affordable health insurance.

When you vow 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. A world where the baby boomers are greying and all Americans are living far longer with less disability. In Holmes' speech at Harvard, he talked about two people's lives together filling a century. Now, a child born today may well live into the 22nd

century.

We, like many other nations, must answer some tough questions about how we will provide and finance care for this growing group of older Americans. There was a time when older Americans had to choose between paying their heating bills and their doctors bills. Medicare forever changed what it means to grow old in this country. And we must make sure it is there for every generation of Americans.

That's not a defense of the status quo. Which is why we slowed Medicare's growth and extended the life of the Trust Fund for a decade. We modernized it by including new prevention benefits like mammograms and flu shots. We expanded choices of health plans. As we look to the retirement of the baby boomers, there is consensus between Republicans and Democrats that we must address the long-term future of Medicare together. And there is a bipartisan commission which has been charged with examining structural changes so we can do just that.

[But what about older Americans between 55 and 65...citizens who have worked their whole lives, and are now at greater risk of losing their private health insurance? The President has a proposal that would allow them to pay a premium and receive Medicare.]

And all of us must address new end of life issues that arise when Americans live longer and longer. We must look at how health is affected around the world by not only the aging of our citizens, but also larger populations, environmental degradation, and resistance to antibiotics. With the same energy that we've battled infectious diseases, we must battle chronic diseases. Just think about how many lives we could save if we passed comprehensive tobacco legislation...if we made

sure that no child ever picks up a cigarette and throws away a future.

As I have been privileged to travel around the world. It doesn't matter whether I'm at the World Health Assembly in Geneva or a small women's clinic in Kazahkstan. Nations and citizens are facing up to the difficult decisions about how we finance and deliver health care amidst growing populations and other cost pressures. Some 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. Still others with universal systems are now unable to afford the facilities they have or the technology they need.

How fix?

more explicit transition to structure

In this country, you will dedicate yourself to the profession of medicine at a time when the lines between payers, providers, and insurers are blurring. When more employers are self-insuring. More physicians are forming their own health plans. And more than 85 [check] percent of people with private insurance are enrolled in managed care plans. The era of the struggling young doctor hanging up his shingle is gone. We have more opportunity than ever to share risks and control costs...but we have more responsibility than ever to make sure that the bottom line of profits never eclipses the bottom line of good medicine.

Structure

Chris

More direct criticism of managed care.

Many of our most important goods will simply not survive in the marketplace. You have seen first hand what happens when new market forces squeeze our cherished Academic Health Centers. We're ensuring that teaching facilities receive payments directly from Medicare -- not inadequately funneled through managed are plans. Because if we want to train the next generation of doctors and dentists, if we want to give birth to the next century's greatest discoveries, if we want to care for the most vulnerable among us...It is not enough

Chris

What about issues if it shld just be mm Medicare

Now we must look at

new, CME

to make sure our teaching hospitals survive year to year. We must ensure they thrive into the future.

When you vow today to hold in confidence all that your patients entrust to you, you can no longer do that just by keeping your mouths closed and your office doors locked at night. Our most personal health information is criss-crossing the country, electronically bouncing back and forth among our health plans, our insurance companies, our employers and other third parties with fewer federal safeguards than our video store records. We've all heard about patients who don't get care, who refuse to use their insurance, who don't get genetic tests because they think their privacy will be violated and they'll be discriminated against. It is time to pass a law to protect our patient's medical records.

And if you are going to fulfill your promise to use your skills to care for all in need, we must make a promise to continue to reform our health care system. People often ask: Were we disappointed that we didn't pass comprehensive health care reform in 1994? Of course. But, it seems to me that when the political environment stops you from taking large steps, you have two choices -- take small steps or sit on the sidelines and do nothing. We moved ahead...believing strongly that it is far better to help 1 million people, 100,000 people, 100 people, than to help no one at all.

Thanks to the continuing leadership of Senator Kennedy, we said you can't deny people health insurance just because they change jobs, lose jobs or have a pre-existing condition. Is this a cure-all? Absolutely not. There are still questions about whether that insurance is affordable. There are still issues we are addressing to stop insurance companies from rewarding those who deny coverage. But this

law will make a difference to [#] people who wake up tomorrow worried about whether a change in their life or health will mean the end of their health insurance.

It's the same with the Children's Health Insurance Program, the largest expansion of health care in our nation's history. It will mean health insurance for millions of children from working families who don't now have it. But, it doesn't mean our job is done. It will not be done until all of us work to find these uninsured children...to identify them when they come in to get their teeth cleaned or their immunizations updated...and sign them up, either through Medicaid or the new program.

Our job is not 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 swelled to 41 million. Who will take care of them if fewer and fewer employers are providing insurance? Who will pay if health care costs, once on the decline, and now leveling off, start to increase? Who will decide who gets access cutting-edge technology and treatments? Our job is not done when our citizens' access to health 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.

We must 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. And, frankly, more often than not, they're worried about their HMOs. I know you share your patients concerns. I know you worry about health care decisions in your office being second guessed by a

business person thousands of miles away. I know you worry about how you will fulfill your vow to hold sacred the bond between doctor and patient.

All of us have heard horror stories about patients who desperately needed treatment...but had to climb over mountains of red tape as they get sicker and sicker. Many of us heard stories of doctors suing HMOs over gag clauses and other invasions of the doctor-patient relationship. That should never be necessary.

Whether people choose 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 Ernest Codman gave birth to Results-Oriented Medicine. It's where Dr. Rabkin drafted the first Patient's Bill of Rights. And this is where we must say it for all to hear: No longer should patients have to beg and plead to see a specialist they need. They should have emergency care whenever and wherever they need it. They should have information to make good decisions. Congress must pass a Patient's Bill of Rights to protect every American.

While our nation must continue to make these changes...must continue to invest in you...you must be the architects of this changing health care world. 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. Because when your successors stand at the edge of the 22nd century, I know they will look at the class of 1998 and say, that when given the chance and the opportunity, you lived up to the oath you will swear to today. That you went far beyond the instructions to do no harm at the patient's bedside...and instead advocated for the welfare of the entire community

men

They will marvel at what you did in the service of humanity...not just in your own backyard...not just in your own country...but in the service of the ~~women and~~ children I have seen around the world...whose lives have been transformed because we helped their community eradicate polio. Because we helped their children get oral rehydration therapy. Because we helped women get pre natal care that saved their lives. and men children's lives

Just as we conquered bacteria in the 20th century, they will talk about how we conquered viruses in the 21st. How we taught spinal cord neurons to regenerate. How we gave people the tools they needed to prevent illness and death...to not only live longer, but better. And how we made sure that our grandchildren had to look to the history books to learn about menaces like cancer, AIDS, and TB.

also

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 and the well-being of those close to you. How you sought balance in your lives. Balance between work and family. Between work and leisure. Between the responsibilities of medicine and citizenship.

I hope they remark that you had fun. Yes, fun. That you laughed with your colleagues and patients. That you enjoyed the incredible gift of healing that you will give throughout your lives.

And, more than anything, I believe they will say that you took the opportunities you were given...the opportunities of an excellent education...the opportunities of great revolutions in health care...and that you used them each and every day to live up to your oath...to above all, ensure that the health of your patient is always your first concern. [need stronger ending].

Congratulations, good luck, and Godspeed.

OUTLINE #1
FIRST LADY HILLARY RODHAM CLINTON
HARVARD MEDICAL SCHOOL COMMENCMENT
JUNE 4, 1998

INTRODUCTION -- Acknowledgments, Congratulations, Jokes

INCREDIBLE TIME TO GRADUATE FROM MEDICAL SCHOOL

A. Think back to the graduates who sat here 100 years ago (we're getting copy of 1898 Commecement address from Harvard). The challenges they faced -- world peace, democracy, health, especially infectious diseases -- and the American Century in medicine that they helped create. [possible funny anecdotes -- parents advising their kids not to be doctors and doctors arguing about the dangers of giving patients any information at all.]

B. Major changes since then...in large part because of what those graduates...and others who have sat where you sit today have done [name a few outstanding harvard grads]

C. Now it is your turn. The country and world is looking to you for the next step. What we say about health and life in the 21st century will depend in large part with what you do with the opportunities you have been given. You have received an extraordinary education -- at one of the most diverse institutions in the world. You are graduating at a time of unprecedented change. Daily breakthroughs in research are putting the medical keys in our graps -- drugs with the potential to prevent cancer, rapidly mapping the human genome, new progress in understanding aging, new imaging technologies used to visualize brain activity and unlock the mysteries behind Alzheimers and other diseases).

CHALLENGES -- We have the keys...how will we use them? How will we make sure that our policies and ethics keep pace with science? That you can always stay true to the oath you take today -- "The Health of my patient will always be my first consideration"

A. To make sure that these advances -- that the best health care in the world -- reaches all Americans...we must continue to reform our health care sytem. Delivery system is dramatically changing...increases in number of people enrolled in managed care. Whether they have Medicare or private insurance, HMO or traditional care, all citizens must have access to quality care.

1. Access -- 41 million uninsured, an increase of 4 million since we debated health care reform alone. Pockets of major disparities based on race and income. Were we disappointed that we didn't pass comprehensive health reform in 1994? Of course. But, when it comes to improving the health of our nation, none of us can ever let setbacks or obstacles be used as excuses of doing nothing.

a. Children's Health Insurance -- more than 10 million children
b. Medicare reform
c. Kennedy-Kassebaum

2. Not only care, but quality care. "Results-oriented Medicine" born at Harvard with Ernest Codman, nurtured today by leaders like David Blumenthal, Heather Palmer, Arnold Epstein.

a. Quality...measured by results.

b. Consumer bill of rights...protecting the rights of the patient to appropriate and effective care and the sanctity of the doctor-patient relationship. Patients not tabula rasas -- importance of empowering them with information (mention Harvard Health Letter).

B. We must make sure that our quest for efficiency doesn't eclipse the public goods that led to the advances we celebrate today -- especially those borne in our extraordianry academic health centers -- research, training of the next generation, care for the most vulnerable among us.

1. Example of how HMO and teaching hosptial teaming up at Harvard.

Future ?

2. President's Research Fund.

C. Make sure ethics keep pace with science [genetic discrimination, privacy]

D. Because of the advances in the last century, antibiotics and immunizations have dramatically decreased infectious diseases. Americans are living far longer. What will we be able to do to ensure that they live better? How do we battle chronic diseases? Especially those that could be prevented -- like cancers and heart diseases caused by tobacco. New killers like AIDS and old foes like Malaria and TB?

THESE ARE NOT JUST CHALLENGES FOR POLICY MAKERS -- YOUR CHALLENGES. A hundred years, ago there was the image of the struggling young doctor, hanging up his (it was almost always a him) sign on the door. Far less insecurity about getting a job, more about what that job will be like. Not just dependent on what you've learned up until now, but on what you do from here on out.

Take a stand on the issues that affect your profession and patients.
Make sure business of medicine never overshadows the healing of medicine.
Etc...

REMARKS BY: DONNA E .SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES
PLACE: University of Wisconsin-Madison, Madison, Wisconsin
DATE: May 16, 1997

Medical School Recognition Ceremony

Dean Farrell, distinguished faculty, staff, families and most important, the 1997 graduates of the University of Wisconsin Medical School: My congratulations to all of you. Congratulations for working hard, for making your families proud, and for managing to always stay one year ahead of the "new curriculum."

I know that all of you have thanked your families for their love, support and endless patience that got you to this day. I hope you will also thank the hard working people of Wisconsin -- citizens you will never meet -- who pay taxes to maintain this great academic health center.

Somebody once defined home as "not where you live, but where they understand you." Let me just say, it's great to be home. Not that, in my heart, I've ever left this great university or this remarkable state. I'm probably the only Cabinet Member to ever stop in the middle of a big speech to Washington journalists -- so I could put on my cheese head.

I'll never forget the day I graduated. In the air, you could feel the sense of accomplishment, excitement, and the most chilling feeling of all -- absolute fear that the speaker would never end. They say Salvador Dali gave the shortest speech ever. He said, "I will be so brief I have already finished." Then he sat down.

We have come together at a moment where the past and future meet. You are graduating on one of the most important days in the history of medicine and public health, a day when we formally close one door on the past and open another to the future.

Because, in less than five hours, at a White House ceremony, President Clinton will formally apologize to the survivors and families of the Public Health Service's study on the black men of Tuskegee.

And when the President speaks, he will help our nation heal from one of the ugliest chapters in public health history. A chapter tinged with racism, with ignorance, and with good intentions gone awry. And a chapter that could never have been written if those physicians involved in the study had remained true to the most important part of the oath you will take today: "The health of my patient will always be my first consideration."

Because when the practice of medicine becomes unhinged from the moral purpose of medicine, when the progress of science becomes unhinged from the ethics of science, anything can happen. And in Tuskegee, it did.

Let me set the scene. The year was 1932 and the United States Public Health Service began an experiment in Alabama on 399 African American men with untreated syphilis. They called it the "Tuskegee Study of Untreated Syphilis in the Negro Male." And their goal was to examine the course of the disease for about a year.

Forty years later, despite the discovery of a cure, these men were still untreated. Many died. Some even passed it on to their children and wives. And all were scarred. Indeed our entire nation was scarred.

That was one message of the report issued by the Tuskegee Syphilis Study Legacy Committee, which is chaired by Professor Vanessa Gamble of Wisconsin. As her report made clear, we still see the scars in the deep distrust many African Americans have towards medicine and research. Distrust that has led some Americans to avoid care or clinical trials, to refuse to donate organs or accept advice from doctors. And to even believe rumors of genocide. And distrust that keeps us from closing the health care gaps that still exist for minorities.

To end that distrust and heal old wounds, the Legacy Committee called for the President to apologize on behalf of the U.S. government. Today, he will. The President will formally tell the victims and our nation: This will never happen again.

But, as Dr. Gamble made clear, we must make amends not just with words, but also with deeds. Armed with tough standards for human research and additional steps the President will announce today, we must be eternally vigilant. We must ensure that our ethics are always as sophisticated as our science. And we must always remember the past and use these lessons to build a better future.

Which is the message I want to leave you with today.

Because, for me personally, this ceremony is also a moment where the past and the future meet. I have come back to a place of old friends and wonderful memories. And I have proudly come to see you -- a new generation of doctors that is better trained, and more skilled, than any previous generation.

Medicine, perhaps more than any other profession, is about holding on to the sacred, while embracing the revolutionary. About tradition and change.

Yet, when I talk to young doctors and med students today, they often tell me that they're scared the profession they've trained for is not the same profession they dreamed about growing up; that the wonder years of Marcus Welby and Rex Morgan have been replaced by the frenetic years of ER and Chicago Hope; that the art of healing is losing its humanity.

These fears are very real, and perhaps many of you share them. Indeed, they have are part of a great tradition of medical graduates -- where each generation looks back at the way it "used to be."

I'll never forget a story I read about a young man who dreamt of becoming a doctor. So, he sits down to talk it over with his uncle, who is already a doctor. And how does the uncle react?

Let me quote the young man's own words. "Uncle Henri strongly advised against going into medicine. It wasn't what it had been in his day. Patients had become demanding. They pestered you for a yes or a no. You had to kill yourself just to make a living. In short, it had become a dog's trade."

Sound familiar? That conversation took place in the 1930s. The young man was Francois Jacob. And as it turns out, he didn't take his uncle's advice. Thank God. Instead he, like you, went to medical school, and in 1965 shared the Nobel Prize in Medicine for his work in genetics. And he, like you, was able to harness the health care revolutions of his day to improve the practice of medicine and the health of citizens all over the globe.

As the great Russian author and doctor Boris Pasternak once wrote: "The stake where we will stand will be the border of two different eras of history, and we are glad to be chosen."

Standing at a border between the old and new, you too are chosen -- chosen to uphold the tradition of

putting patients first, while at the same time facing real revolutions in health care. Revolutions that bring both great responsibility -- and great opportunity -- for you.

Revolutions that mean an explosion of information, technology, and new delivery systems -- but also an interconnected world of medicine where you'll be wired to computers, data bases, research centers and the best medical minds in the world. Revolutions that mean more integrated care -- but also more collaboration, more shared risk, and more shared accomplishments.

Revolutions in biomedical research that yield not only new treatment options, but also new ethical dilemmas. Revolutions that have led to greater consumer demand for quality -- but also greater personal responsibility from citizens to take care of their own health.

Our responsibility is to invest in you, to make sure that our health care training remains the best in the world; and that you can spend the maximum amount of time improving health, and the minimum amount of time filling out forms.

While our job is to invest in you, your job is to be the leaders, the architects, and the conscience of America's changing health care system.

Because these revolutions in medicine are like a big ocean wave. You can ride it or wipe out. The choice is yours.

So, in the spirit of Boris Pasternak, I challenge you to stand at the border of history and choose to take the greatest ride of your life.

I challenge you to always live up to the words you will recite today: "The health of my patient will be my first consideration."

Put your patients first by making your medical education a lifelong commitment. By never letting paper work be more important -- or even seem more important -- than healing the people under your care. Because the calling of medicine must always be higher than the business of medicine.

Put your patients first by always being their advocates; and by making sure that decisions about what is medically necessary are made by you, your patients and their families.

Put your patients first by continuing to heal them both as individuals and members of a community; by making sure that women's health is never treated as a second class citizen; and, by exerting your leadership in medicine, public health, and the critical interplay between them.

That's the same commitment you showed in your MEDIC organizations --offering primary care to uninsured working poor in South Madison. And it's the same commitment I know you will show throughout your careers.

Because remember, you are now entering a world where you will be judged not by your MCATs or your grades, but by your character. By whether you live by the oath you will take today. And by whether you make a stand and choose as Boris Pasternak chose; and conquer, like Dr. Jacob conquered, a revolutionary medical world.

Whatever path you take from here, I hope you will take real pride in all you have accomplished at the University of Wisconsin. Enjoy the people you serve, the profession you perfect, and the wonderful

careers you're about to start.

Congratulations and God speed.

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FAX MESSAGE

TO: Mr. Chris Jennings, the White House
FAX No.: 202-456-5557
From: May C. Reinhardt, 270 Brooks Bend, Princeton, N. J. 08540
Tel. 609-924-7625 or 609-924-5394
Fax 609-924-6083
Date: May 17, 1998
Pages (cover included): 20

Dear Chris:

As you suggested, attached is a 10-page narrative Uwe wrote today before he left this afternoon--his vision of a possible commencement address to those Harvard Medical School graduates many of whom will be future leaders in American health care. Everything he says in it has been documented, as I am sure you are familiar with, and their sources are available "upon request". Also, Uwe will be glad to elaborate and/or clarify any of the points if needed.

Also attached are two short pieces Uwe wrote from which he drew for the narrative. You and Mrs. Clinton might find them interesting reading. The Commentary piece "Wanted: A Clearly Articulated Social Ethic for American Health Care" especially found wide echoes from all corners of the land.

Uwe will be back tomorrow evening and will be in Princeton most of next week except for Wednesday afternoon when he will be in NYC to receive a special award at Columbia School of Nursing's commencement. He leaves for Hong Kong early morning Friday, May 22. From May 23-26 we may be reached at the Hong Kong Grand Hyatt. Please do not hesitate to call if you or Mrs. Clinton need to.

Have fun with the project. Please give Uwe's and my warmest regards to Mrs. Clinton. I am certain this is one assignment she will really enjoy.

All the best,

MR

IDEAS FOR ADDRESS ON HEALTH

Uwe E. Reinhardt
Princeton University
May 17, 1998

After a more general survey of the current health-care delivery system, of the current insurance status of Americans and of recent initiatives in federal health policy, one might focus more narrowly on major issues that confront the graduates themselves, in a very personal way. If I were the speaker, I would make it a bit provocative, so that they would remember my speech. Thus, it might continue

. . . .

As you embark upon your career in medicine, you will have to grapple with two major issues whose resolution will directly affect your daily work:

First, who will "manage" the treatment of your patients? Take it for granted that it won't any longer be you alone--the lone-ranger physician--as it has been for American physicians for so many decades. But will it be you and other members of your health-care team who will jointly manage the treatment of your patients, along with your patients themselves, or will it be done, as it now so often is, by strangers who monitor what you do and micro-manage you via an 800 number?

If you regain whatever control over clinical decisions your predecessors have lost in recent years, will you be able to exercise that control in a manner that rebuilds the trust American policy makers and the public once had in the medical profession? Think about it! What must you do to regain that trust?

Second, do you care what broader social ethic governs the distribution of health care in America, or should that question be left strictly to business executives and to politicians whose wishes in this regard you will faithfully execute? Remarkably, the bulk of your predecessors have remained aloof of this important decision, leaving it in the hands of politicians and executives. To make it very concrete, consider the following simple question [*****I had posed it recently in an op-ed piece in *The Journal of the American medical Association*--see the attached copy and, especially, the nasty letters thereto and my reply*****]

> *To the extent that a health system can make it possible, should the child of, say, a low-income gas-station attendant or restaurant worker have the same chance of staying healthy and the same chance of being cured from a given illness as the child of a corporate executive?*

Do you have a view on this question? Should your view carry political clout, as you have to live with the social ethic we impose on our health system? Your place in the history of

American medicine will be determined largely by how you will cope with these two challenges describe above. Because my remarks on them have been a bit provocative, let me examine both challenges in some more depth, looking at "managed care" first and "social ethics" thereafter.

A. WHO WILL "MANAGE" HEALTH CARE IN AMERICA?

In your conversations with older physicians, you will undoubtedly have discerned the deep disillusionment that has befallen many of them. Many of them would counsel their children against entering a profession that seems to have lost its professional freedom, its solid economic base and even its dignity. Older physicians may talk to you about the golden age of American medicine, when the individual physician was free to be the best for his or her patients and, in the process, made American medicine what they consider "the best in the world."

Surely you must have asked yourself: How was this golden age lost, and who stole it?

The answer, I'm afraid, is that the golden age was lost alright, but it was not stolen away. It simply was lost by a profession that took it too much for granted. American society was no longer able and willing to underwrite the rapidly rising cost of the clinical and economic freedom it had accorded its physicians. You had better get used to it: that golden age will never come back!

Only days after the election victory of then President-elect Clinton in the fall of 1992, American corporate executives jetted to Little Rock there to plead for help in addressing the seemingly intractable problem of rising health care costs. These costs, argued the executives, made it hard for them to compete in the global economy. Mayors, governors and the members of the United States Congress came to Arkansas, too, besieging the President-elect for help in addressing the deep inroads that health care was making into their budgets. In retrospect, it is truly remarkable that the leaders of academic medicine and of organized medicine paid these anguished voices so little heed. Was not the hand-writing of some form of "managed care" clearly on the wall?

What American medicine took for granted was the perpetuation of two rather naive **beliefs** among policy makers and the general public, to wit:

First, that the practice of modern medicine rested on solidly well tested scientific research--that it was solidly "evidence-based," as we now put it.

Second, that the providers of health care would not use more resources than were necessary to manage the health system.

On these two credos, for example, rested the methods by which physicians were compensated until the early 1990s. Private employers, who provide close to two thirds of Americans with private health insurance and account for about one third of all health spending in this country[1], basically told American physicians:

> *"When our employees come to you for advice or treatment, do for them what you, the individual doctor, thinks best and then send us a bill at your usual fees. We promise promptly to pay your bill, as long as it is at all reasonable."*

Formally this method of compensation was known as the "UCR" method, which stands for "usual, customary and reasonable." In practice, unless a physician's fee for a procedure exceeded the 90th percentile of fees for that procedure charged by physicians in the region, that physician was paid the fee. Furthermore, few if any private insurance companies then ever dared question the physician's clinical judgement.

Many of you may know that, at its inception, Medicare adapted itself to this UCR method as well. It did so until the mid 1970s, when the inflationary force of such a system became apparent and the Congress started to put a ceiling on that was considered "reasonable" fees. In the end, that effort resulted in a common fee schedule for Medicare to which, ironically, many private insurance companies now adapt themselves. But although both Medicare and Medicaid did in the end put ceilings on the fees they would pay, neither program did much if anything to interfere in the individual physician's clinical freedom. Managed care as we know it did not exist.

The ultimate result of this open-ended social contract Americans had with their health system was that their health system became too expensive and, moreover, that there seemed to be little observable correlation between what was spent on health care in various regions of the United States and the outcomes that were achieved with these expenditures. Both factors served to undermine the erstwhile blind trust Americans had in their health-care professionals, and both naturally led to the era of "managed care," which is best defined as

> *the external proctoring and, if necessary, micro-managing of the medical treatments otherwise managed by doctors and their patients.*

Let me first say a few words about costs and then about the relationship between costs and outcome.

Intolerable Cost Increases:

During the late 1980s, when GDP per capita (in current dollars) was rising in the neighborhood of 5.5 percent per year, the premiums private employers paid for health insurance rose by an average of between 15% to 20% per year. What individual firms paid fluctuated widely around these averages. Unable to pass on these costs to consumers in our increasingly competitive global economy, employers simply cut the premiums out of their workers' take-home pay. Health care was literally taking ever deeper bites out of the average American employee's paycheck.

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[1] Although covering close to **two thirds** of Americans, private employer-paid health insurance account for only **one third** spending because they cover mainly low-cost, young people while the public sector covers the old, the very poor, and the disabled.

By 1992, total national health spending in the United States had climbed to about 13.5 percent of the GDP, far ahead of health spending in other industrialized nations with much older populations, all of whom spent less than 10 percent of their GDP on health care, with no visible, deleterious effect on the population's health status.

More alarming still, the Congressional Budget office at that time produced forecasts according to which the United States would be spending about 19% of the GDP on health care by the year 2000--almost every fifth dollar of the GDP. You may recall when, as part of the Presidents health-reform plan it was proposed to constrain that figure to about 17%, there was a huge outcry in the press that such a policy would require a degree of rationing unheard of in the United States!

[****** I attach two copies of Xmas cards I then made, spoofing this entire scene******]

It should have been obvious to anyone that the spending trends begotten by our trusting, open-ended social contract with American medicine could not be sustained any longer. Someone had to break these trends, be it private payers, the government, or both in tandem. As already noted, neither the leaders of academic medicine nor those of organized medicine seem to have been alert to that prospect. On the contrary, year after year there were laments that Medicare (whose outlays then grew at an annual rate of over 10%) was being brutally "cut" and that "cost containment had gone too far."

Is it any wonder, then, that both the private sector and government looked to people outside the medical profession--that is the managed-care industry--to gain better control over health spending.

Lack of Evidence Based Clinical Practice

But the intolerable spending trends were not the only force that eroded society's trust in its medical profession. Just as disturbing was the mounting evidence coming from the health-services research community that much of medical practice in this country (and, for that matter, elsewhere in the world!) lacked a solid scientific base. Because that is so brazen a proposition for a lay-person to offer--especially at this hallowed center of medical research--let me seek cover here behind the words of Dr. Kenneth Shine, the President of the prestigious Institute of Medicine of the National Academy of Sciences:

> *"If we ask the question whether physicians have based their practice on scientific principles, it is clear that the profession has been sorely lacking."*
>
> *[***** I shot a slide of this statement, but don't have the exact source at hand. it can be gotten, however. In any event, I have the slide off a printed text.]*

Two strands of research from the health-services research community support this troublesome proposition.

First, as the pioneering research of epidemiologist and physician John Wennberg and his associates at Dartmouth University shows, even after adjustment for geographic difference in the age, gender and health status of the population, there remain huge, inexplicable variations in the per-capita use of health services and total health spending. To illustrate, the President has to budget over twice as much per elderly residing in Florida or New York than for similar elderly in

Minnesota, Oregon or the State of Washington. Why should that be so? Similarly, as Dr. Wennberg had shown in earlier work, why is the per-capita use of health care in Boston so much higher than it is in New Haven, even after adjustments for the demographic mix of the populations? In the late 1980s, Dr. Wennberg estimated that if all Americans were treated as Bostonians then were, the U.S. would be spending then close to 17% of the GDP on health care. On the other hand, if all Americans were treated like New Havenites, then only 9% of the GPD would have been spent on health care in the United States. That is a huge difference by any standard.

If you doubt my words, look at Dr. Wennberg's recently published *Dartmouth Atlas of Health Care*, which is accessible also on a website. You will be stunned by the hitherto inexplicable geographic practice variations in health spending and health-care use that are exhibited in that volume.

A second quite distrubing strand of research bearing during the 1980s had focused on the clinical appropriateness of health care that was actually delivered to patients. Using clinical protocols carefully composed by panels of clinical experts, researchers at the Rand Corporation and elsewhere raked through large samples of actual patient-files and discovered that a disturbingly high percentage--often in excess of 20%--of the procedures such as pacemaker implants, coronary bypass surgery, expensive imaging tests and so on that were actually applied to American patients would have been judged unnecessary by these expert panels.

Both strands of research subsequently have led to a new field of research generally known as "outcomes research" or "evidence-based medicine." That research seeks to shore up the practice of medicine with a more solid scientific basis. Dr. Barbara McNeil and Dr. David Blumenthal of this university are but two of many researchers engaged nationwide in this research. Many of you will devote a good part of your life to this research as well. And you have the President's full support for that important research which, incidentally, is now a worldwide campaign.

Society's Response: Managed Care:

But my point here is not so much to plug outcomes research as it is to explain why, sometime in the late 1980s, American society lost its erstwhile blind trust in its medical profession, in spite of the leadership American physicians had assumed in world medical affairs.

The unvarnished truth is that the profession did seem to need outside help in managing the nation's health resources productively, even if the profession itself seemed unaware of the need for that help. Unable to find support for better clinical and economic control of health care among physicians themselves, private and public payers naturally looked to others for that assistance.That "someone else" was the managed-care industry, which one may view as **private health-care regulators** ready to take the place of government regulators. As you may recall, "managed care" was to be the central control device also on the President's healht-reform plan. [***** In some of my writing, I have even called them "bounty hunters"--see the attached title page of a paper.******]

At the turn of the current decade, the managed-care industry faced a uniquely propitious constellation of three economic circumstances that helped it jump into the breach.

First, throughout the 1980s American industry was busily restructuring its workforce, which had put in jeopardy many jobs that seemed hitherto secure.

Second, staring with the stock-market crash of 1987, the American economy slid into a recession that lasted until about 1992 and amplified the job insecurity among American workers.

Both factors allowed employers to destroy one of the sacred pillars of American health care: the completely free choice of doctors and hospitals Americans traditionally had at time of illness. Henceforth, employers said, that choice would be restricted to physicians and hospitals in a closed health care network run by an insurance company--be it a Health Maintenance Organization or a preferred provider network.

The sacrifice of free choice of providers by employees made it possible for the insurance industry to engage a third propitious factor, namely, its decade old experimentation with closed-ended health panels and rather novel managed-care techniques. The willingness of employees to accept limited choice allowed insurers to engage in selective contracting with doctors and hospitals. **Selective contracting** became the legal foundation for a massive shift of market power from doctors and hospitals to the insurance industry. It is the *sine qua non* of the idea of "managed competition" (which forces health plans to compete fairly for enrolleees) and "managed care" (which allows health plans better to control doctors and hospitals).

Selective contracting is the central pillar of "managed care," because it allows a health plan to extract steep price discounts from doctors and other providers of care, as a condition for inclusion in the health plan's network. The economic power inherent in selective contracting also allows the health plan to impose upon freedom-loving physicians the straightjacket of extemally imposed clinical practice guidelines, often read to the physician by a non-physician, over an 800 telephone line.

That such a regime was anathema to physicians is understandable. That in the crisis mood of the late 1980s and early 1990s it was unavoidable should be understood by physicians as well. Managed care was not a conspiracy visited by some evil force upon an angelic profession and its clients, the patients. Rather, it was at the time the only feasible response of payers whose budgets could no longer absorb the rapid annual increases imposed on them by the health sector.

Seen in this light, one must give the managed care industry credit for breaking the frightening cost trends of the last decade, even though there is now some question about the future of the industry's ability to constrain costs. If the managed-care industry has trouble of its own now, it is for other reasons.

The Future of Managed Care

For one, since about 1992, we have enjoyed sustained economic growth, driving the unemployment rate to 4.3 percent, a low level it had not attained in 30 years. In such a tight labor market, employees once again sit in the drivers seat and it is difficult to force them into limited-choice health care. Point of service contracts, direct access of specialists and very wide physician networks have been the answer of the managed care industry. But in widening their networks, the managed-care companies lost much of the economic clout inherent in selective contracting. Consequently, physicians and hospitals are regaining much of the economic power they thought they had lost in the early 1990s.

The moral of the story is that economic boom times are good for physicians, and you should thank those who you believe helped us get these economic boom times. As you can imagine, I have my own theory on that, but I will spare you the details.

Furthermore, however, the managed care industry also made a few tactical mistakes that earned it the wrath of the public and amplified the difficulties it would have encountered by virtue of the economic boom. Kicking people out of the hospitals earlier and earlier may be clinically safe; but the point is: is it what patients as consumers want? If this is to be a so-called "consumer driven" health sector, then should the managed-care industry not have heeded these consumers? Should patients or their physicians not have more say in how long they stay in the hospital? Should consumers not have been given information about the health plans--the private health-care regulators--they are forced to choose? Should there not be grievance procedures through which a denial of care can be quickly and easily appealed?

It appears that the American people believe there should be those consumers rights, and they now have turned to politicians, prominently among them the President, to address their concerns.

Frankly, after the painful defeat of the President's health reform plan, it is nothing short of ironical that some of the most regulatory legislation to be imposed on the managed-care industry comes not from Liberal Democrats, but from staunchly conservative Republicans, such as Republican Governor Whitman of New Jersey, or Congressman Harwood and Senator D'Amato at the federal level. After the demise of the President's health-reform proposal in 1994, there arose the mantra that the American people wanted the "government off its back." A new religion had taken hold, namely, that market forces in the private sector would be able to regulate health care properly, and better than government ever could. Perhaps even Republicans have now learned an important truth about health care:

> *By their very nature, market forces in health care can work to society's advantage only of they are guided and strictly constrained by careful government regulation. In the end, properly functioning "managed competition" in health care will always become "regulated competition."*

During World War II, as Americans were hesitant to enter the fray, Winston Churchill is reported to have remarked:

> *In the long run, Americans will always do the right thing, after exploring all other alternatives.*

This is so in health care as it is in war. Perhaps Americans first had to see first hand what a relatively unfettered health care market would mean to them, where the proverbial rubber hits the road: in their own medical treatments. Perhaps the public, policy makers and the providers of health care have learned in the meantime and will appreciate better that the proper management of a health system will always have to be a close, cooperative enterprise of government and the private sector. Perhaps, when the health-reform train comes around the next time, we shall all be wiser.

The next time the train comes around may be sooner than you think. It could come from the private sector in the seemingly unlikely event of a major recession. Should private employers find a severe decline in its profits, they would undoubtedly look to their outlays on health care as a source of relief.

But more probably the train will leave the station of Medicare, whose outlays must be better controlled in the face of the retiring Baby Boomers. Whatever particulars the now working Bipartisan Commission on Medicare will recommend, among them is likely the idea to have more

of the program regulated by private health-care regulators. These regulators may continue to be the insurance industry. But it could also be you--network of doctors and hospitals ready to take capitation payments directly from medicare (and eventually from private employers) and ready to assume full financial risk for the illness of large enrolled population. Under its Health Partners umbrella, the Massachussets General Hospital already takes such full risk for some 250,000 insured lives. If you are ready for it, that form of managed care could be the wave of the future.

How well that might work would depend in large part not on your brains but on your souls. The problem is this: under the fee for service system patients know that physicians might profit from extra procedures, but there is the abiding belief that more health care is better than less. Patients have always accepted that economic conflict of interest with relative equanimity. Under capitation, however, providers earn more, the more of the capitation they keep--the less testing and other services they put into the treatment of an illness. That conflict of interest is more problematic in the eyes of patients. There might come a day when the media spread the story that physicians in the mammoth Hippocrates Clinic, PLC enjoyed banner profits, but there might also be anecdotes of patients who feel they were shortchanged on health care by that clinic. In other words,

> *one of the most serious challenges you will face as physicians in practices that assume full risk for patients will be to gain and to retain the trust of your patients.*

Are you ready for this challenge? Do you have concrete ideas on how to build this needed trust, and on how to nourish it as you go along? If so, good luck. You will face exciting and professionally rewarding times. If not, better let the insurance industry be the flak catcher and work under their tutelage, acting as the patient's trusted friend. Think about it!

B. THE GUIDING SOCIAL ETHIC FOR AMERICAN HEALTH CARE

So much for the question of who will "manage" health care in the 21st century--you, or the insurance industry. Let me now come to the second major challenge that I mentioned at the beginning--the choice of a social ethic that should drive American health care in the next century.

The puzzling truth is this: uniquely in the industrialized world, Americans have never been able to agree on the distributive ethic that should govern American health care. The Canadians actually have written down that ethic and have only recently reaffirmed it. The statement says that being sick is trouble enough, and that the cost of the calamity should be shared by all members of society. Europeans have a similar explicit code of ethics in what they call the contract of social solidarity. Only Americans have shied away from ever making an explicit statement on this issue. Indeed, we seem too shy ever to discuss it openly, as we should.

Let me repeat the question posed earlier in this connection, namely:

> *To the extent that a health system can make it possible, should the child of, say, a low-income gas-station attendant or restaurant worker have the same chance of staying healthy and the same chance of being cured from a given illness as the child of a corporate executive?*

If you think Americans are of one mind of this question, think again! [***** Without being presumptuous, perhaps this would be the spot to cite my JAMA piece and the stunning letters on that piece--especially the letter by law professor Epstein! You may also enjoy my reply to his letter.**********]

There are two polar views on this issue in our land, and many more nuanced views in between. The polar extremes are these:

A. *Health care is a social good to which all Americans should have access on roughly equal terms, regardless of their own ability to pay for that access. The United States should never ration the health care a family receives by the family's income and wealth.*

Z. *While health care may be a basic necessity--like food and clothing--it is inherently no different from these other basic consumer goods. While people should have access to a basic minimum of care, it is quite alright to ration a family's access to health care by its income and wealth.*

If you had read or listened carefully to the debate on the President's health reform plan in 1993-94, you would have noticed that much of that debate actually was not over actuarial or economic technicalities at all, but over the fundamental question which of these two social ethics should drive the American health system. In his State of the Union address of 1991, President Bush had left matters a bit ambiguous when he said "Good health care is every American's right." What did he mean by "good health care"?

Even so, his statement seems a far shade to the left of the prevailing sentiment in Congress, which would not now approve a sense-of-the Congress resolution that "good health care is every American's right."

In my view, the "health-care-is-just-like-food" ethic (Z) carried the day in 1994, at least for the duration. Whether the average American actually appreciates the full implications of that outcome remains a mystery. In any event, we now face a growing number of uninsured. The count is 41 to 44 million now; it was 35-37 million in 1992. The rolls of the uninsured keep rising in spite of the booming economy. Gone is the myth that economic growth will solve the problem.

It is no secret that I lean heavily towards view (A)--have all of my life and probably always will. But my purpose is not to proselytize on this occasion. Instead, I simply invite you to ask yourself: In which world would you rather practice medicine, in a world driven by ethic (A), even if not perfectly, or in a world driven by ethic (Z)? Of which world would you be prouder as an American citizen? In which world would you feel more comfortable as a prospective patient. What do you think the typical American would want--especially if they stood behind Harvard Professor John Rawls' famous "veil of ignorance" and did not know whether one day they will be rich or poor, chronically healthy or chronically ill.

World (Z), which declares health care to be basically a private consumption good, probably would be more profitable for you as physicians. World (A) might be less profitable, because only government intervention can actually drive a health system toward a reasonably egalitarian distribution of health care. But which world would you find more professionally rewarding?

Although to their credit *The Journal of the American Medical Association* and *The New England Journal of Medicine* have consistently kept the matter of social ethics before their readers' mind, it can fairly be said that most practicing American physicians and even organized labor as it lobbies the legislators have remained remarkably aloof of this important dimension of a health system. I urge you to be more engaged in the issue. We the people look to you not only as industrious folks who mastered a body a science and a bag full of clinical tricks. We know you are bright and have been trained beyond the strict confines of clinical medicine. We also know

that you know the drama of bedside health care not only in its clinical facet, but also its social and economic facets.

The Hippocratic oath, helpful as it is, deals in the main only with the professional ethic that physicians ought to observe at the bedside of those patients who have come to the physician (As an aside, in its classical version, the Oath also binds physicians to keep medical education strictly within the male progeny!)

"Primum non nocere!" says the Hippocratic Oath. "First do no harm!" A good admonition it is. But I plead with you, the future leaders of our health system, to think beyond the bedside, to see medicine as part of a larger society. I urge you to ask also the question: How can I help to avoid the harm that comes to my fellow human beings who, for want of ability to pay, do not even come to the site at which the Hippocratic Oath takes over.

Never forget that studied silence on that issue does harm, too!

Turning Our Gaze From Bread And Circus Games

by Uwe E. Reinhardt

Daniel Yankelovich argues that this nation's recent attempt at health care reform failed largely because the American public failed to "deliberate" properly on the issue. By "deliberation" Yankelovich means "mulling over" the costs and benefits of alternative choices and making tough choices, all in a serious "give-and-take" with the nation's "leadership class." Yankelovich places blame for the public's failure to deliberate squarely on the shoulders of the leadership class, which, according to him, deliberated only within its own ranks.

Embedded in Yankelovich's grand thesis are three hypotheses that warrant closer scrutiny: (1) The leadership class itself properly "deliberated" on health care reform but failed to communicate the product of that "deliberation" to the public; (2) there exist channels of communication through which the leadership class could, if it wished, engage in a "give-and-take" with the public; and (3) the public is intellectually and temperamentally predisposed to "deliberate" sincerely on complex issues of public policy and to make the tough choices in a lengthy conversation with leaders.

The validity of these hypotheses can be questioned. Indeed, they strike me as utopian, as does Yankelovich's strategy for fixing the "disconnect" between leaders and the public.

Deliberation In The Leadership Class

When America's leadership class sets out to debate health policy, its members invariably preface their deliberations with the mantra: "We all want the same things in health care. We are merely arguing over the means to that end." This is utter nonsense. The great health care reform debate of 1993–1994 was not just a technical dispute over alternative means of reaching a widely shared goal. It was a fiercely fought ideological battle over the goal itself. The nation's leadership class was and remains deeply divided over the ethical precepts that should govern the distribution of health care.

At one end of the ideological spectrum are the pure egalitarians who would like to see health care treated as a social good to be made available to all members of society, on equal terms, regardless of a person's ability to pay for it. This school of thought would like to see health care financed collectively, through mandatory contributions that vary strictly by households' ability to pay and certainly not by the health status of a household's members.

At the other end of the ideological spectrum is what one may dub the "food people." They are puzzled why anyone would make a distinction between health care and other basic, private consumption goods, such as food and housing. As Rep. Richard K. Armey (R-TX), a newly elected leader in the House of Representatives, put it to *The Wall Street Journal* in his inimitably blunt style: "Health care is just a commodity, just like bread, and just like housing and everything else."[1] The "food people" regard the procurement and financing of health care as chiefly the responsibility of the individual, whose own behavior is thought to be a major determinant of his or her health status. To be sure, the members of this school of thought do admit that the etiology of illness can be external, and they are prepared to guarantee the poor and near-poor at least a basic ration of critically needed health care. At the same time, however, they see nothing wrong with a health system in which the quantity, timeliness, and quality of the health care received by American families varies systematically and positively with household income. If one believes, as this school of thought tends to believe, that the American economy is the closest approximation worldwide to a true meritocracy, then an income-based

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health care system is much more defensible on ethical grounds than a purely egalitarian one would be.

The "food people" won the great health care reform battle of 1993–1994 squarely, although perhaps not fairly. One may question the fairness of the battle, because it was never fought openly, in the blunt language favored by Congressman Armey. Instead, much of the action was camouflaged behind soothing code words such as "empowerment," "personal responsibility," the "freedom to choose whether or not to be insured," and so on—code words all adding up to the proposition that well-to-do Americans should be empowered to allocate their income to health care and other commodities as they see fit, and that poor and low-income households should be empowered to do likewise with their much more meager budgets.

Three-tier system. In practical terms, the victory of the "food people" represents the official sanction, by the U.S. Congress, of an income-based health care system with the following three tiers.

For uninsured Americans who are poor or near-poor—chiefly, families of persons who work full time at low wages and salaries—we shall reserve and perhaps expand our current patchwork of public hospitals and clinics. These publicly financed institutions will be sorely underfunded, as they always have been, thus forcing severe limits on their physical capacity. Such limits, in turn, will beget the long queues that have always been the classic instrument of rationing. Lack of funding also will limit the medical technology available to physicians working in these public institutions. The uninsured will increasingly be driven to these public facilities, as government programs and private managed care systems eat ever more deeply into the profit margins of private hospitals, thereby limiting these institutions' financial ability to act as insurers of last resort.

The employed broad middle class will increasingly be enrolled in capitated health plans, such as health maintenance organizations (HMOs). These plans will be budgeted prospectively, on a per capita basis, through competitively bid premiums. To control their outlays, the plans necessarily must limit patients' choice of doctor and hospital at time of illness. Furthermore, they inevitably will come to withhold some care that patients and their physicians might judge desirable, but that the HMO's management (and the clinical experts advising them) may find too expensive relative to the expected medical benefits.

Finally, for well-to-do Americans there will continue to be the open-ended, free-choice, fee-for-service health care system without rationing of any form, even in instances in which additional care is of dubious clinical or economic merit. Well-to-do Americans will demand no less, and they will always have it. Furthermore, they will continue to have it on a fully tax-deductible basis, a tax preference to the rich that no economist would ever defend, but that no politician would dare to remove.

While the official sanction of this three-tier system by Congress is now a *fait accompli*, it cannot be said to be based upon a broad consensus among the leadership class. In Yankelovich's sense of the term, that class did not deliberate properly on the matter either. But even if there had been a forthright deliberation and there had been a consensus on the merit of a three-tier health care system, it would have been an extremely delicate task to explore that idea in an open give-and-take with the general public, large segments of which would find themselves at the short end of this arrangement. Furthermore, what channels actually exist for such a conversation?

Media As Communication Channel

Yankelovich takes the by now almost obligatory swipe at the media with his assertion that journalists were more interested in the political ramifications of the Clinton plan than in its contents. Although there is something to that proposition, his is much too broad an indictment. At the very least, a distinction should be made between the television media and the print media.

Television may, in the future, become a medium through which policymakers could communicate with the general public in an

informative "give-and-take." So far, however, that medium has not been structured to facilitate such an exchange. Both C-Span and the public television stations allow the public to observe experts in the act of "deliberation," but that is not a conversation with the public. The remainder of the television industry has not been able to facilitate even a coherent one-way, top-down communication with the general public, aside from a bewildering scatter of sound bites.

The producers of television programs devoted to public policy invariably feel compelled to pack these programs with a variety of opposing views. By the time this dictum of "fairness" and the imperative of commercials have been accommodated, any one person's role on the program is limited to a few minutes of air time. The thought of using a simple graph or even a simple table to amplify a point in such discussions is quickly discouraged by the producers as too intellectually taxing for the general public.

The print media offer a better potential in this respect. Indeed, the staff reporters of the major newspapers deserve high marks for their ceaseless efforts at digging out the relevant facts on the Clinton plan and other health care reform plans. They also deserve high marks for their skill in presenting these facts to the public. Unfortunately, this channel is best suited for the one-way, top-down communication Yankelovich decries. Furthermore, it is not clear that the general public even had the patience to digest the lengthier, excellent articles on health care reform in the major dailies.

To the extent that the print media did improperly politicize the recent health care reform debate, as Yankelovich suggests, one must blame the leaders of the industry, not the rank and file. A concrete case can serve to illustrate this assertion.

In a commentary dramatically entitled "The Clintons' Lethal Paternalism," published in the widely read weekly *Newsweek*, syndicated columnist George F. Will flatly asserted that under the Clinton plan "there would be 15-year jail terms for people driven to bribery for care they feel they need but the government does not deem 'necessary'."[2] To the best of my knowledge, this is a falsehood, for at the very beginning of the Health Security Act, it is stated that "Nothing in this Act shall be construed as prohibiting the following: (1) An individual from purchasing any health services. (2) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care not included within the comprehensive benefit package."[3]

Because it would be truly astounding to see an American president advocate fifteen-year jail terms for anyone seeking to purchase a health service that the government deems unnecessary (and therefore excludes from the mandated benefit package), I requested that Will pinpoint the paragraph in the Health Security Act that calls for the alleged penalty. So far, in my view, he has not been able to do that, and I doubt that he ever will.[4] One must wonder whether any senior editor of *Newsweek* at the time ever challenged him likewise on this point, as he ought to have been challenged.

It is entirely proper for a syndicated columnist to refract particular policy recommendations through the prism of his or her own ideology and to judge them on that basis. It is another matter entirely, however, when syndicated columnists use the extraordinary privilege granted them by the media to proffer their own ideology in the guise of synthetic "facts" that are likely to be accepted by the general public as reliable. Editors who passively accept that particular form of "spin doctoring" shortchange not only their own conscientious staff reporters, but the general public as well. They allow a potentially useful channel of communication to be polluted with static and thereby make it all the more difficult for conscientious leaders to communicate with the public. The recent debacle of health care reform offers media leaders an opportunity for some soul searching on this point.

Deliberation By The Public

But suppose that America's leadership class had deliberated properly on health care reform, and suppose the leaders of the print media had acted responsibly, carefully

checking the veracity of whatever was presented as fact in their publications. Would this happy circumstance then have led to a productive give-and-take between the leadership class and the general public, and would it have triggered the proper deliberation within the general public?

One wishes it were so. Alas, Yankelovich's own paper is anything but reassuring on this question. He deplores the American public's habit of "blam[ing] the system rather than itself," its failure to "come to grips with reality," its "persistence of wishful thinking and . . . failure to wrestle with hard choices," and its "continuing belief that [the public] can have it all—quality *and* convenience *and* high-tech medicine *and* lower costs." "Polling data on health care," he writes, "are replete with evidence that people neither understand nor accept the consequences of implementing their wish list of expanded health care benefits."

If one had to distill Yankelovich's description of American public opinion on health care reform into one adjective, it would be "adolescent." This eternal adolescence of the plebs is by no means confined only to health policy, nor is it a uniquely American trait. Of the Roman plebs, for example, that era's great poet Juvenal wrote, in the first century A.D.: "*Duas tantum res anxius optat, panem et circenses.* (Its anxious longing is confined to but two things—bread and circus games.)"

Yankelovich's paper suggests that not much has changed in the course of civilization. Although, unlike their peers in other nations, America's leadership class seems unduly eager to pay homage to the legendary perspicacity of the grass roots, Yankelovich's survey of public opinion leads one to wonder whether, even in the minds of politicians, their habitual praise of the grass roots really is more than an expedient courtesy.

Indeed, Yankelovich's paper leads one to wonder whether the American public is either intellectually or temperamentally inclined ever to engage in the protracted, sincere, public deliberation of complex public policies called for by the optimistic author. If successful health care reform must await the day when the public musters the patience to deliberate carefully on the hard choices before us, at the price of abandoning the endless "circus games" that engage its mind, then we may have to wait a long time.

As someone neither born nor schooled in this country, I certainly do not mean to be disrespectful of a basically admirable people. Nor am I persuaded, however, that the American public somehow stands out among its counterparts elsewhere in the world in its willingness and ability to deliberate seriously on serious issues of public policy. My observation of this nation during the past thirty years persuades me that, in almost all cases, successful major initiatives in public policy occurred when the leadership class had reached a broad consensus on the matter and then simply told the rest of the nation what was good for it. President Reagan's "supply-side economics" was enacted on that basis, and so was the quite revolutionary tax act of 1986. In either case, the general public had only the dimmest idea of what these policies entailed; it simply took the leadership's assurances on faith.

Given the general public's age-old preoccupation with *panem* and *circenses*, it will generally go along passively with its leadership, unless that leadership makes evidently egregious mistakes or is evidently divided. Thus we start wars, thus we bomb whomever our leadership has decided to bomb, thus we end wars, thus we pass tax laws and civil rights laws, thus we allow the leadership (along with leaders of sundry special interests) to regulate and sometimes to deregulate the conduct of the plebs, and thus, perhaps one day, we shall undertake a major reform of our health insurance system. Perhaps.

NOTES

1. *The Wall Street Journal*, 23 November 1993, A4.
2. G.F. Will, "The Clintons' Lethal Paternalism." *Newsweek* (7 February 1994): 64.
3. Title I, Section 1003, page 15 of the Health Security Act as presented to Congress 27 October 1993. Reprinted by the Commerce Clearing House, Inc., Chicago, Illinois, 1993.
4. Because I apprised Will in my first letter that I would like to share the correspondence with others, I feel at liberty to offer copies of that correspondence to anyone interested in obtaining it.

Commentary

Wanted: A Clearly Articulated Social Ethic for American Health Care

Throughout the past 3 decades, Americans have been locked in a tenacious ideological debate whose essence can be distilled into the following pointed question: As a matter of national policy, and to the extent that a nation's health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?

The "yeas" in all other industrialized nations had won that debate hands down decades ago, and these nations have worked hard to put in place health insurance and health care systems to match that predominant sentiment. In the United States, on the other hand, the "nays" so far have carried the day. As a matter of conscious national policy, the United States always has and still does openly countenance the practice of rationing health care for millions of American children by their parents' ability to procure health insurance for the family or, if the family is uninsured, by their parents' willingness and ability to pay for health care out of their own pocket or, if the family is unable to pay, by the parents' willingness and ability to procure charity care in their role as health care beggars.

At any moment, over 40 million Americans find themselves without health insurance coverage, among them some 10 million children younger than 18 years. All available evidence suggests that this number will grow.[1] America's policymaking elite has remained unfazed by these statistics, reciting the soothing mantra that "to be uninsured in these United States does not means to be without care." There is, to be sure, some truth to the mantra. Critically ill, uninsured Americans of all ages usually receive adequate if untimely care under an informal, albeit unreliable, catastrophic health insurance program operated by hospitals and many physicians, largely on a voluntary basis. Under that status is poor or only fair.[3] Studies have shown that uninsured Americans relying on the emergency departments of heavily crowded public hospitals experience very long waits before being seen by a physician, sometimes so long that they leave because they are too sick to wait any longer.[4-6] Studies have found that after careful statistical control for a host of socioeconomic and medical factors, uninsured Americans tend to die in hospitals from the same illness at up to triple the rate that is observed for equally situated insured Americans[7] and that, over the long run, uninsured Americans tend to die at an earlier age than do similarly situated insured Americans.[8] Indeed, before the managed care industry cut the fees paid physicians sufficiently to make fees paid by Medicaid look relatively attractive to physicians and hospitals, even patients insured by that program found it difficult to find access to timely care. In one study, in which research assistants approached private medical practices pretending to be Medicaid patients in need of care, 63% of them were denied access because the fees paid by Medicaid were then still paltry relative to the much higher fees from commercial insurers.[9]

If the champions of the uninsured believe that the assembly and dissemination of these statistics can move the nation's policymaking elite to embrace universal coverage, they may be in for a disappointment. The working majority of that elite not only are unperturbed by these statistics, but they believe that rationing by price and ability to pay actually serves a greater national purpose. In that belief they find ample support in the writing of distinguished American academics. Commenting critically on the State Childrens' Health Insurance Program enacted by Congress in August 1997 as part of its overall budget bill, for example, Richard Epstein, author of the recently published *Mortal Peril: Our Inalienable Right to Health Care?*,[10] warns darkly

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But these straits have never been smooth for the uninsured, notwithstanding the soothing mantra cited earlier. Empirical research must have convinced policymakers long ago that our nation rations health care, health status, and life-years by ability to pay. It is known that other socioeconomic factors (such as income, family status, location, and so on) being equal, uninsured Americans receive, on average, only about 60% of the health services received by equally situated insured Americans.[2] This appears to be true even for the subgroup of adults whose health status is poor or only fair.[3] Studies have shown that uninsured Americans relying on the emergency departments of heavily crowded public hospitals experience very long waits before being seen by a physician, sometimes so long that they leave because they are too sick to wait any longer.[4-6] Studies have found that after careful statistical control for a host of socioeconomic and medical factors, uninsured Americans tend to die in hospitals from the same illness at up to triple the rate that is observed for equally situated insured Americans[7] and that, over the long run, uninsured Americans tend to die at an earlier age than do similarly situated insured Americans.[8] Indeed, before the managed care industry cut the fees paid physicians sufficiently to make fees paid by Medicaid look relatively attractive to physicians and hospitals, even patients insured by that program found it difficult to find access to timely care. In one study, in which research assistants approached private medical practices pretending to be Medicaid patients in need of care, 63% of them were denied access because the fees paid by Medicaid were then still paltry relative to the much higher fees from commercial insurers.[9]

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Clearly, the scarcity Epstein would like to matter in health care would impinge much more heavily on the poor than it would on members of his own economic class, as Epstein surely is aware. In his view, by the way, Epstein finds distinguished company in former University of Chicago colleague Milton Friedman, the widely celebrated Nobel laureate in economics, who had proposed in 1991 that for the sake of economic efficiency, Medicare and Medicaid be abolished altogether and every American family have merely a catastrophic health insurance policy with a deductible of $20 000 per year or 30% of the previous 2 years' income, whichever is lower.[12] Certainly, Epstein and Friedman would be content to let price and family income ration the health care of American children. They rank prominently among the "nays."

In his book, Epstein frames the debate over the right to health care as a choice between the "maximization of social wealth" as a national objective and the "maximization of utility," by which he means human happiness. "Under wealth maximization," he writes, "individual preferences count only if

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they are backed by dollars. Preferences, however genuine, that are unmediated by wealth just do not count."[10(p132)] One implication of resource allocation with the objective of wealth maximization is that a physician visit to the healthy infant of a rich family is viewed as a more valuable activity than is a physician visit to the sick child of a poor family.[13] If one does not accept that relative valuation, then one does not favor wealth maximization as the binding social objective.

Although conceding that wealth maximization does imply a harsh algorithm for the allocation of scarce resources, Epstein nevertheless appears to embrace it, even for health care. Establishing positive legal rights to health care regardless of ability to pay, he argues, could well be counterproductive in the long run, because it detracts from the accumulation of wealth. "Allowing wealth to matter [in the allocation of health] is likely to do far better in the long run than any policy that insists on allocating health care without regard to ability to pay. To repeat, any effort to redistribute from rich to poor in the present generation necessarily entails the redistribution from the future to the present generation."[13] Applying his proposition to the question posed at the outset of this commentary, the argument seems to be that poor children in one generation can properly be left to suffer, so that all children of future generations may be made better off than they otherwise would have been.

One need not share Epstein's social ethic to agree with him that, over the long run, a nation that allocates resources generously to the unproductive frail, whether rich or poor, is likely to register a relatively slower growth of material wealth than does a nation that is more parsimonious vis-à-vis the frail.[10(p114)] Nor does one need to share his social ethic to admire him for his courage to expose his conviction so boldly for open debate. Deep down, many members of this nation's policymaking elite, including many pundits who inspire that elite, and certainly a working majority of the Congress, share Epstein's view, although only rarely do they have the temerity to reveal their social ethic to public scrutiny. Although this school of thought may not hold a numerical majority in American society, they appear to hold powerful sway over the political process as it operates in this country.[14] In any event, they have for decades been able to preserve a status quo that keeps millions of American families uninsured, among them about 10 million children.

At the risk of violating the American taboo against class warfare, it is legitimate to observe that virtually everyone who shares Epstein's and Friedman's distributive ethic tends to be rather comfortably ensconced in the upper tiers of the nation's income distribution. Their prescriptions do not emanate from behind a Rawlsian[15] veil of ignorance concerning their own families' station in life. Furthermore, most well-to-do Americans who strongly oppose government-subsidized health insurance for low-income families and who see the need for rationing health care by price and ability to pay enjoy the full protection of government-subsidized, employer-provided, private health insurance that affords their families comprehensive coverage with out-of-pocket payments that are trivial relative to their own incomes and therefore spare their own families the pain of rationing altogether. The government subsidy in these policies flows from the regressive tax preference traditionally accorded employment-based health insurance in this country, whose premiums are paid out of pretax income.[16] This subsidy was estimated to have amounted to about $70 billion in 1991, of which 26% accrued to high-income households with annual incomes over $75 000.[17] The subsidy probably is closer to $100 billion now—much more than it would cost for every uninsured American to afford the type of coverage enjoyed by insured Americans. In fairness it must be stated that at least some critics of government-financed health insurance—Epstein among them—argue against this tax preference as well.[10(p182)] But that untoward tax preference has widespread supporters among members of Congress of all political stripes, and also in the executive suites of corporate America.

This regressive tax preference would only be enlarged further under the medical savings accounts (MSAs) now favored by organized American medicine. Under that concept, families would purchase catastrophic health insurance policies with annual deductibles of $3000 to $5000 per family, and they would finance their deductible out of MSAs into which they could deposit $3000 to $5000 per year out of the family's pretax income. In terms of absolute, after-tax dollars, this construct effectively would make the out-of-pocket cost of a medical procedure much lower for high-income families (in high marginal tax brackets) than it would for low-income families. It is surely remarkable to see such steadfast support in the Congress for this subsidy for the well-to-do, in a nation that claims to lack the resources to afford every mother and child the peace of mind and the health benefits that come with universal health insurance, a privilege mothers and children in other countries have long taken for granted. Unwittingly, perhaps, by favoring this regressive scheme to finance health care, physicians take a distinct stand on the preferred distributive ethic for American health care. After all, can it be doubted that the MSA construct would lead to rationing childrens' health care by income class?

Typically, the opponents of universal health insurance cloak their sentiments in actuarial technicalities or in the mellifluous language of the standard economic theory of markets,[18] thereby avoiding a debate on ideology that truly might engage the public. It is time, after so many decades, that the rival factions in America's policymaking elite debate openly their distinct visions of a distributive ethic for health care in this country, so that the general public can decide by which of the rival elites it wishes to be ruled. A good start in that debate could be made by answering forthrightly the pointed question posed at the outset.

Uwe E. Reinhardt, PhD

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Letters

Articulating a Social Ethic for Health Care

To the Editor.—Dr Reinhardt's[1] recent attack on my book *Mortal Peril*[2] presents this challenge: "to the extent a nation's health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does a child of a rich American family?" The correct answer is no.

The health of youngsters is intimately tied to their parental care and attention; nutrition, location, and even the family car determine in part who will become injured or ill. Reinhardt tolerates these inequalities because they lie outside the health care system. But a consistent egalitarian should redress all sources of inequality, including child care, education, and crime prevention. Yet, Reinhardt neither justifies his priorities nor explains how to fund a full-scale initiative without destroying the social wealth it needs for support. Self-interest is not a universal and omnipresent human impulse, but it is a powerful one. To open the doors to forced redistribution induces the rich to spend more defending their wealth, and the poor to spend more to take it away. Both sides cannot win, and a smaller pie leads to worse health for the very persons Reinhardt cares most about.

Even within health care, his proposal for equal medical treatment perversely requires more care to children of poor parents than to children of rich ones, precisely because the rich families can more easily avoid injury and illness and can better pick up any slack in health care delivery. Worse, programmatic success depends not just on offering carrots but on wielding sticks by overriding parental judgments on children's food, lifestyle, and education. Yet, Reinhardt never explains how any ambitious program can curb political excesses, control administrative costs, prevent overutilization of resources, or ensure that equality in treatment comes from raising care for the poor instead of lowering it for the rich. Political interventions to date have created a 2-tier system that funds enormous Medicare subsidies in part by payroll taxes on the poor. Why expect the next generation of social programs to do better?

There is an alternative strategy. Do not increase taxes by ramping up subsidies and regulation. Reverse field and increase access by lowering costs, dismantling entry barriers, cutting subsidies, and increasing disposable income. Then, repair our tattered tradition of charitable service now crowded out by state-run programs. We can improve the situation for people at the bottom without lurching to Reinhardt's egalitarian ideal, which promises the same disastrous consequences in health care at home as it has wreaked in the world at large. How sad that at this late date Reinhardt has to search for a clearly articulated social ethic having none of his own to offer. After 30 years of trying, he should recognize that his conceptual cabinet is empty.

Richard A. Epstein, LLB
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1. Reinhardt U. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278:1446-1447.
2. Epstein RA. *Mortal Peril: Our Inalienable Right to Health Care?* New York, NY: Addison Wesley; 1997.

Edited by Margaret A. Winker, MD, Senior Editor, and Phil B. Fontanarosa, MD, Senior Editor.

To the Editor.—I admire the zeal of Dr Reinhardt.[1] Not a physician, he has missed the intimate view of medical science, medical practice, yes, even of poverty, which is part of every physician's training.

Reinhardt views medical care in the ideological abstract. Couple his zealotry with his lack of actual medical care experience and his Commentary, it seems, becomes socialist propaganda. His "pointed question" becomes a loaded question complete with the ancient propagandistic use of children. Asserting the superiority of access to care in other nations ignores the quality of that care once accessed. Who is the patient's advocate? Who actually delivers quality scientific medical care? At a pragmatic patient level, who gets cured, helped, and comforted, or who becomes a unit to process as quickly and inexpensively as possible? Even though fomenting class distinctions is now fashionable, a large middle class is much less inclined to zealously do so. Many Americans value equality of opportunity rather than financial homogeneity. Reinhardt failed to mention the large middle class when discussing the rich and the plight of the poor. There is a curious implication in such positions. There are the rich, the poor, and those with power to protect the poor. The manipulation of dependence is left unsaid. Hidden is the quest for power and control.

Medical care insurance is not insurance. Claims control is impossible. Health care insurance is the problem, not the solution. Catastrophic care insurance is insurance and makes sense when patients and their physicians have free choice among competitive alternatives. Medical savings accounts make eminently good sense for the majority of Americans. Neither fits with the socialist need for power and control, under which patients are vulnerable and physicians are nearly powerless. More and more third-party interests are interposed between patients and physicians. Who now is the patient's personal advocate?

A social ethic holds that patient and physician each must have free choice among competitive alternatives. The vital special role of physicians and the vulnerability of patients must be valued and protected from subjugation or abuse. Physicians must be held to the highest technical and ethical standards. Each physician must cherish and practice the sacred

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duty to care for all patients with dignity and compassion irrespective of ability to pay, and they must teach those who can follow this highly demanding calling.

Donald G. Lindsay, MD
Ventura, Calif

1. Reinhardt U. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278:1446-1447.

To the Editor.—Dr Reinhardt[1] paints a bleak portrait of America as a Dickensian society that woefully and consciously neglects its young. Few would admit to being a member of that society and few can argue with him since he has adroitly positioned himself so securely on the moral high ground that the rest of us, particularly those who may carp with some of his arguments, wallow in the swamps of social callousness and indifference. While other Western nations have said "yea" to his model for a nation's health care system, Reinhardt likely sees the United States as a primitive, socially backward society on the road to moral bankruptcy.

Why the contrast in attitudes about health care systems and social programs among these nations? Is it a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos? Is it because Americans have said "nay" not to a system that denies care but "yea" to the historical right of a democratic society to make its choices unintimidated by the steely hand of pernicious governmental influence and free of the specter of social systems that are bleeding the economies of Western Europe?

Reinhardt's bogeymen are the nation's "policymaking elite." He portrays them as a covert enemy, a cabal, ready to formulate policy that would deny social justice to the downtrodden and the dispossessed. Who are the members of this all-powerful elite? Where do they meet? Do they have an Internet address? I'm sure he realizes that it is not physicians who control the political process and the focus of health care. In Reinhardt's home state of New Jersey, physicians have become so politically impotent that they are attempting the unthinkable for professionals—joining a labor union. Reinhardt does tell us that a majority of the members of Congress are part of the nation's policymaking elite. If so, his argument is with the American people as their leaders and representatives mirror the ideas and sentiments of their constituency. If this elite that controls the direction of the nation's health care is special interest and lobbying groups, then Reinhardt's distress is with the current American political process. Reinhardt may be uncomfortable with this, but as we approach the fin de siècle, it is this same American political process that has triumphed in this century.

It has been said that "nearly every great domestic policy debate has revolved around the poles of elitism and egalitarianism."[2] In keeping with that theme and with all the guile of a polished politician, Reinhardt could not resist the temptation to frame his thesis in terms of class struggle and a redistribution of wealth. Reinhardt has much to contribute to the national debate about health care system reform; unfortunately, he dilutes his fine rhetorical skills by resorting to the effete ploy of class warfare.

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1. Reinhardt UE. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278:1446-1447.
2. Henry WE. *In Defense of Elitism*. New York, NY: Doubleday; 1994.

In Reply.—Only Mr Epstein answers my pointed question forthrightly; Dr Lindsay and Dr Lally beg the question with sermons.

Epstein considers it perverse to give more health care to poor children than to rich children whose parents can help them avoid illness or injury. To call giving disenfranchised children the health care that their parents cannot or neglect to give them a "deviation from what is considered right and good" (the meaning of "perverse") reflects his distinct social ethic and *de gustibus non est disputandum*. I wonder how many other Americans share that ethic? As to his query as to why redistributing wealth through health care is preferable to a full-scale but destructive redistribution of wealth, one answer is this: targeting subsidies narrowly on health care to avoid acute human suffering or stave off early death requires much less redistribution.

While impugning the quality of care that physicians in other countries give children, Lindsay sidesteps my question with the dictum that "each physician must cherish and practice the sacred duty to care for all patients with dignity and compassion irrespective of ability to pay." His is a romantic egalitarianism for which cost presumably is to be borne by the individual physician rather than by society as a whole. How could this work in practice? In the end, his approach would ration health care by ability to pay simply through the local choices of physicians.

Lally writes of "a fierce sense of rugged individualism, independence, and self-reliance that have been and still are the hallmarks of the American ethos." Where are these rugged individualists? Are they among the rugged farmers, who cannot make it through the day without huge government subsidies? Are they among any of the Americans who plead for federal funds and for the Federal Emergency Management Agency whenever disaster strikes, or, perchance, among the investment bankers whose investments in Hampton Beach properties are protected by the US Army Corps of Engineers and by federal flood insurance? Would I find them in the medical profession, whose members rely so heavily on public subsidies for their education and the science they apply, who now seek a federal tax preference for medical savings accounts, who plead with government to punish managed care organizations that are late in paying bills, to impose on managed care organizations any-willing-provider laws, and to regulate managed care organizations with countless other strictures, and who have never balked at using archaic licensure laws to protect their own economic turf? Are there really any rugged individualists at all in this society of imagined victims who run to the courts for succor at their slightest discomfiture?

As all of these self-styled, rugged individualists enlist their government's coercive power to protect their own fiscal health, they might more gracefully countenance the use of that power to also protect the physical health of poor children and, indeed, of all poor people. After all, serious illness is a natural disaster too.

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Antihypertensive Therapy: Recommendations and Realities

To the Editor.—Experienced physicians may be unenthusiastic about the Fifth Joint National Committee on the Detection, Evaluation, and Treatment of High Blood Pressure (JNC V) recommendations for treatment of hypertension for reasons not addressed by Drs Siegel and Lopez.[1] β-Blockers significantly impair quality of life for many patients. For instance, if a husband neglects to mention his drug-related impotence to a physician, his wife might do so. Lethargy, constipation, and bronchospasm are common enough adverse effects to engender reluctance among physicians to burden patients with β-