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February 19, 1991

MEMORANDUM FOR CHRISS WINSTON
SPEECHWRITERS
RESEARCH ASSISTANTS

FROM: CAROL BLYMIRE

SUBJECT: HHS MEETING

Last Thursday, I attended the departmental meeting for the Department of Health and Human Services. The following is a run-down of the highlights discussed:

SECRETARY SULLIVAN

Secretary Sullivan has started a series of five speeches on health care. They are as follows --

October, why health care is so expensive
November, personal responsibility in health care
February, public health and public support for the poor
March, insurance and costs involved in health care
April, medical research

These speeches are designed to provide a framework to expand ideas to the community. They provide the facts on HHS terms, and set the bottom line by getting out the facts the way HHS wants them released. Also, all speeches are being delivered at universities. I have copies of some if you would like to see them.

On March 14, Secretary Sullivan will speak to the National Newspaper Association. He will address the lack of reporting of major health care issues, and the fact that these issues must be treated seriously, if they are to be taken seriously.

CALENDAR OF EVENTS

In February, there will be a report released on death by guns. Quick HHS fact -- in 1988, 1 out of 5 children (age 0-18 yrs.) died of gun-related incidents.

In a few weeks, hospital efficiency regulations will be released, and will receive high press attention. This will hurt some rural and urban hospitals; some may close, whereas others may just specialize to stay alive. We need to find better and more efficient ways to subsidize hospitals than using Medicaid or Medicare. This will also shed light on other hospital-related issues.

This spring, there will be a release about mandatory child support (i.e. locating the primary financial supporter and forcing them to pay their obligations).

Also, this spring, HHS will continue its Drug Free America campaign. They will focus on personal responsibility in fighting drug use, shared responsibility (how government can work with people to combat widespread drug use), and offer achievement awards for community groups and/or individuals who make outstanding efforts and accomplishments in fighting drug use and abuse.

INITIATIVES

A major focus over the next few months will be on **children and families.** Children are the connector between the health side and the human service side of HHS. In the next 90 days, there will be an intense concentration on children's issues.

In May, HHS will release a publication of proposed regulations for child care grants. This will implement the child care reforms that have already gone through.

As for health policy, there are no new initiatives to be announced at this time. HHS is working one-on-one with insurance agencies, health activists, Congressmen, etc. to start a common base for discussion and set the parameters for debate.

Policy on HIV-infected health care workers: HHS needs to get a specific statistical base to do this study. The Center for Disease Control has a focus group working on this, so that regulations can be proposed later in the spring.

Prescription Drug Report: This is a system by which states can enjoy the lowest price for prescription drugs that manufacturers offer the public. This will save approximately $2 billion ($1 billion for the federal government and $1 billion for the states). This got a lot of press attention last year.

Regulation for clinical laboratories: Another major initiative in the working.

HIV immigration: Expect laws to go into effect in June. Proposed regulations have already been issued.

------ There will be an additional meeting to bring an HHS focus to the three pillars of the State of the Union: encouraging economic growth, investing in the future, and providing opportunity for individuals and families. Stay tuned!

FOR RELEASE UPON DELIVERY
TUESDAY, OCTOBER 23, 1990

*REMARKS BY

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

FORUM ON HEALTH CARE COSTS

STANFORD UNIVERSITY

STANFORD, CALIFORNIA

*THIS TEXT IS THE BASIS OF SECRETARY SULLIVAN'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

Good afternoon. It is a pleasure for me to be here at Stanford, one of this country's finest academic institutions and biomedical research centers. The work of those associated with this institution is world-renowned. The fruits of the research conducted here have been a body of achievement that has invigorated the quest of distinguished researchers everywhere and has nourished the lives of so many.

I am here today due, in large part, to this exemplary tradition at Stanford of meeting tough intellectual challenge through objective, rigorous analysis to reach sound and reasonable solutions.

My presence today is part of a much larger exhortation to the entire nation. It has two sources. First, the President has asked me to examine issues of health care quality, access and cost containment. Second, events of the past month in Washington again have made clear that before the federal government undertakes important decisions in these areas, we in government need to talk at length with the public about the nature of the problem, and the choices it requires of us so that we as a nation can develop a sustainable consensus on what we want from our health care system.

For the past several months, I have been engaged in a public dialogue with the American people on this very problem and I will continue this important dialogue in order to achieve this national consensus. The issues we need to confront are costs, the effectiveness of our medical practices, the structure of public and private insurance, and the role of personal responsibility and societal obligations.

I want today to address the hardest of these issues -- the dramatic rate of increase in health care costs, and the causes and consequences of this phenomenon.

I can summarize briefly, and I hope, usefully, what I take to be the three key engines primarily driving that growth:

0 First, many consumers have been desensitized to the costs of their health care decisions -- the very richness of insurance that insulates many from the immediate effects of health care costs perversely is the source of the long term cost growth which so seriously threatens us.

0 Second, doctors, hospitals, and other providers of health care are focused on curing and caring -- as, indeed we should be -- but we have paid too little attention to the costs of our decisions. By our inattentiveness in the near-term, we may threaten the longer-term viability of our health care system.

There is an additional engine of cost which is of sufficient importance that I will speak separately to it at another time. It is important not primarily <u>because</u> of cost, but because of its effect on the nation's health. I am talking about the degree to which we take personal responsibility for our health. Too many of us view the health care system as though it were a general purpose "fix-it" shop. We choose behaviors and lifestyles that, while personally gratifying in the short run, are harmful to our health. And we expect the health care system to compensate for our bad health habits, repair the consequences of our indulgences, and assure that we will live long lives. This is both an extraordinarily high cost use of and an unreasonable demand upon medical care.

These engines of increased costs have already driven us to a fearful point. Within the memory of many of us, most people could and did afford with out-of-pocket payments the best of the medical care available at the time. Today, health insurance has become a necessity if we are to afford even modest levels of care. To our benefit, the scope and curative power of the care now available is vastly improved -- in very large part, thanks to academic medical centers like Stanford.

Yet, because too many in our citizenry are uninsured, they lack the financial capacity to pay for much of the care they need, compelling public and many non-profit hospitals to contrive complex webs of cross-subsidies in order to pay their operating costs.

As payors recoil from rising costs they are coming to view as unbearable, both insurance coverage for the broad population and that web of cross-subsidies for the uninsured threaten to break down. Two fundamental consequences follow from this:

0 Low-income, uninsured persons, now dependent on charity, will increasingly find themselves faced with greatly increased difficulty in securing much of the care they need; and,

- There is the risk that, with costs perceived as out of control, all of us, the insured and uninsured alike, will get less as de facto rationing grows.

Let me present now a synopsis of the most important facts surrounding cost, financing, and delivery which contribute to the sense of crisis in health care generally.

First, and most visible, is the enormous scale of the numbers associated with health care costs. Americans, as a society, will spend some $650 billion or 12 percent of gross national product on health care in 1990. This compares with 5.3 percent in 1960, a bit more than 7 percent in 1970, and a little over 9 percent in 1980.

Unlike some, I do not argue that 12 percent of GNP is empirically too high. And, unlike others, I do not argue that we must spend substantially more. But, with an aging society, there is a built-in tendency for care costs to rise if nothing else is changed. However, it seems to me that the $2,600 we will spend in 1990 on average for each and every man, woman and child in the country ought be enough. Even if government has no special insight to determine how much to spend overall, it nonetheless has a key role to play in assuring that individual health care decisions are indeed informed and that choices are made intelligently.

Further, I believe government has a responsibility to assure that the goals of society as a whole play a role in the calculus.

That brings me to my second point. I wonder whether we as a society fully understand and appreciate the subtext of the $650 billion we spend for health care? For example, how widely is it understood that total health care expenditures have risen 30 percent faster than GNP since 1970 while health care prices have risen 60 percent faster than general price inflation?

- Is it fully appreciated that, despite this growth in the total amount of services, the even faster rise in their costs, and the $2,600 per capita we are now spending, access to basic health care services remains severely restricted for much of the population?

- Because of the high cost of health care, many without health insurance are simply unable to afford the care they need. For the 33 million people who are uninsured throughout the year, and especially for those with low incomes, access to needed health care is often uncertain and sometimes unavailable. They under-use preventive care, and delay seeking care -- which results in higher costs when care is ultimately secured. They misuse emergency room and other acute care services -- which results in higher system cost. And they do without some care.

What is more troubling: without appropriate action the problem is likely to get worse in two basic ways.

- First, under pressures of sharply rising health costs, both private and governmental payors will seek to restrain their costs by eliminating their contributions to cross-subsidies.

- And, second, insurers will attempt to avoid insuring risky and unprofitable businesses and individuals. As a result, the provision of care for the uninsured will further break down and the problem of their access to care will be exacerbated.

Because those who have the financial capacity to fully access care receive much of the best health care in the world, one could simplistically conclude that the residual problem of access to quality health care could be solved if the society would only spend more. Indeed, such a superficial multiplication of dollars per head is fundamentally the basis of some of the simplistic proposals which have been put forward of late to "solve" the problem of American health care.

But the more pertinent question that research on appropriateness and quality of outcome forces us to ask is whether even those with virtually unlimited financial access are getting the care they need? With appropriate caveats, the unfortunate answer seems to be: Well, no; not really. The best we can say is that the number and cost of patient care activities (procedures and interventions) undertaken by physicians and other health care providers which are of unproven medical necessity and effectiveness are unknown but substantial. We are all too familiar with such sundry estimates as that 20 percent or more of hospital days may be unnecessary, or that 50 percent of antibiotic prescriptions are probably unneeded or misused, or that too many of the coronary artery bypass grafts performed lack clear medical justification, and so forth.

Why is this? As physicians, we derive information from many sources but our clinical practice virtually always represents a mix of new knowledge with prior experiences about our patients, our own abilities, the limits of our practice and past training, and the experience of our professional colleagues. This pattern reflects the physician's professional and personal commitment to provide his or her patients with care which, having withstood the test of time and community usage, we perceive to be of acceptable quality and faithful to the commandment to "do no harm."

The evidence is substantial, however, that this behavior often leads to the provision of care which, while <u>usually</u> not harmful to the patient in its ultimate outcome, often is ineffective. This perverse result, in turn, is the consequence of rather incomplete evidence regarding the effectiveness of many medical practice.

This problem was most tersely stated by a former Harvard Medical School dean in addressing the graduating medical class. He said:

> "Half of what we have taught you is wrong. Unfortunately, we do not know which half."

We are all familiar with the fulmination of complaints that the growth of health care expenditures has led to. I want here only to touch on the litany from employers, individuals, government, and providers.

Employers find the cost pressures of health care too great.

- The differential growth in American health care costs is one factor increasingly claimed to disadvantage the competitive position of United States products internationally. Our ability to export is reduced and foreign products become increasingly attractive economic buys.

- Corporate employers are troubled by the increased costs and frustrated at their inability to control them. As the costs of health care rise, more employers seek to opt out of providing, or to reduce their financial exposure for, health benefits. The importance of employer health insurance decisions is evidenced by the AFL-CIO estimate that three quarters of the days lost to strikes in 1989 resulted from health care disputes.

Cost pressures of health care are too great for individuals.

- Health care consumes an increasing part of effective wages for labor in those businesses and industries providing health insurance to their employees. Even with the substitution of health insurance for direct wage compensation, workers find their health insurance covering a declining share of costs.

- More workers find themselves and their families without employer-sponsored coverage and must seek it on their own, demand government entitlement, or go without.

- Many individuals without employer-sponsored health insurance are simply priced out of the insurance market and, to the extent they are able, must purchase their health care with after-tax, out-of-pocket dollars.

Cost pressures on <u>government</u> are too great.

- Health care costs are the fastest growing segment of state budgets today. Providers, employers and the uninsured all look to their states for solutions to the health insurance problem. The Medicaid program often serves as a safety valve. However, the growing demands of long-term care consume nearly half of Medicaid's dollars; spurred primarily by population changes, this forces difficult choices on the states. State legislators increasingly look to the federal government for assistance or wholesale take-over of their health care financing.

- One has only to have watched the recent budget negotiations about Medicare to appreciate the pressures health care costs are placing on the federal government.

And cost pressures faced by providers are too great.

- To the extent that medical needs of the uninsured are met but exceed their ability to pay, the difference is made up by providers through uncompensated care, charity care and bad debt. And to the extent that the varied public payment programs under-compensate, providers must either absorb the loss or seek to shift it. The costs of uncompensated care often are passed on to those who do pay. The consequence is heavy economic pressure on health care providers (especially the public system), and charges that the system is unfair and requires major changes.

Yet, even as the plaint about uncontrolled health care cost grows, we need to consider the various underlying incentives which are at work. There are deliberately designed, as well as simply evolutionary incentives in our system which, although benign in intent, also drive up costs. Let me touch on several of these: tax treatment of employer-provided health insurance, government oversight, and state mandates.

- First, employer contributions to employment-based health insurance enjoy a unique status. These substitutions for taxable wages are tax-free to the employee, even while they are deducted from taxable employer profit as a form of labor recompense.

Because insurance is bought with untaxed dollars, it is economically reasonable for those who benefit most from the tax exclusion to buy more of it than something for which payment must be made in after-tax dollars. So the tendency has been for employees to seek from employers more and more untaxed money put into more and more costly coverage. The logical result: costs rise more than they would otherwise.

What is the cost to the federal government (and, ultimately, to the tax payer) of the subsidy this tax exclusion represents? This year it is $58.6 billion, more than $550 per insured employee.

Is this subsidy equitable? Do we want to allocate our resources in a way which provides greater subsidy to the high-salaried employee than to those with low wages?

- Second, the health care system and all its participants pay a further cost: government oversight. What some call the "micro-management" that my Department performs results from its role as protector of the public purse for health financing through Medicare and Medicaid. We are responsible for assuring that cost inefficiencies and fraud, waste and abuse which public insurance programs can lead to are rooted out.

If you do not like PPS updates calculated at less than market basket; if you are appalled at Medicare capital payments 15 or 25 percent below costs; if PRO review is at best a nuisance; if Medicaid payment rates appear low; if balance billing limits are a worry; if Medicare and Medicaid documentation consumes large amounts of time -- these and other concerns about which you and thousands of your peers write me are among the negative incentives which flow inexorably from public insurance. -- But, they are also part of the price accompanying the tremendous growth in physician incomes.

0 Third, state mandates on insurance. I will not dwell on this, but I refer you to a fascinating article in the Winter, 1989 issue of Inquiry by Gabel and Jensen. The article, "The Price of State Mandated Benefits," sought to quantify the cost of mandated benefits and found them quite substantial. Two conclusions drawn are particularly pertinent.

-- As many as one in six small firms that do not offer health insurance to their employees, the authors argue, would do so in a largely mandate-free system.

-- The other conclusion: about half of the large firms converting to self-insurance do so to avoid the cost consequences of mandates.

Lastly, as a physician talking to other providers of care, I have to note that we, too, have played a not entirely benign role. We face economic incentives which may modify our behavior.

0 The September 3 issue of Medical Economics carried a lead story, "Earnings Make a Huge Breakthrough," with the sub-head, "1989 was a banner year for most M.D.s." In 1989, a year in which the inflation rate was 4.6 percent, the article reports that median net individual physician incomes rose by 12.5 percent -- nearly three times the general inflation rate. Only once in 61 years has there been a greater percentage gain in physicians' net income.

I would like to be able to say the 12.5 percent income gain simply reflected physicians doing more for more people. Unfortunately, the survey's findings do not well accommodate that explanation -- no significant increase in patient encounters was found from the prior year.

Permit me to share with you in closing my own reason for concern about all this. I believe that, if we as a nation are ever to guarantee adequate health care to all -- and I believe we should -- we must somehow find a way of joining the patient's, the administrator's, and the payor's concern for reasonable costs with the physician's dedication to the needs of individual patients. We have to reconcile the need to serve the patient with the responsibility to avoid unnecessary expense. Absent this, we are doomed to failure in achieving the morally appropriate goal of full access to needed medical care for every American.

In my head and in my heart, I believe that this reconciliation, and the possibility for adequate health care for all is our highest goal. I ask your help and support as we explore how to achieve it. I ask you as an institution, and each of you personally as health care professionals, to join in this dialogue and analysis of why health care costs so much; to undertake actions as a group and on your own to find ways to address the problem as it arises in areas of your own professional expertise; to be prepared to do your part in making the needed sacrifices that all in the health care system are going to have to make to achieve the improvements so badly needed.

In short, I challenge you to help forge the greatly needed national consensus on health care reform through active and informed participation in the debate and meaningful contribution to solutions. I ask this of you today as I will be asking it of all in the system: the insurance companies, the hospitals, the patients, the employers and, even, eventually, the Congress.

Thank you.

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FOR RELEASE UPON DELIVERY

MONDAY, JULY 23, 1990

REMARKS BY

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

ATLANTA BUSINESS ROUNDTABLE

ATLANTA, GEORGIA

*THIS TEXT IS THE BASIS OF SECRETARY SULLIVAN'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

I am delighted to be here this morning with this audience -- with participants having different perspectives on the American health care system. Because you all represent varied interests in health care, I would make an analogy with the Rorschach test -- those ink-blots psychiatrists use to analyze a person's personality. As each of us individually would see different images in the ink-blots, so, too, various persons in this room have different vantage points on health care problems -- such as high costs, the presence of 31 million uninsured, how to finance long-term care, unnecessary medical intervention, and the special needs of inner cities and rural areas.

- Health care providers, and particularly hospitals, see the problem of uncompensated care. They see overloaded, and inappropriately used emergency rooms, because most of the uninsured don't have a regular doctor, and don't seek regular medical care.

- Insurers see some businesses opting-out of providing health care benefits because they can no longer afford it. They see intensifying competition for low-risk policy holders. They also see cost-shifting by providers trying to recoup for uncompensated care.

- Employers look at the health care system and see medical costs ballooning, and they worry about how this will affect international competitiveness.

- Workers see out-of-pocket health care costs climbing.

- Self-employed persons -- or other workers not covered by an employer-sponsored plan -- see insurance premiums climbing beyond their ability to pay.

- Governments at all levels see health care programs consuming a percentage of spending never imagined when those programs were started.

- Physicians see both public and private reimbursement schedules and regulations as interfering with the doctor-patient relationship.

- As the Secretary of Health and Human Services, I look at the nation's health care system and see.....Rorschach test ink-blots.

No, I say that only in jest, because it is possible to solve these problems. But we're going to have to make tough trade-offs.

In his State of the Union Message last January, the President asked me to look at possibilities for improvement in our health care system. I had initiated this process at the end of last year when I asked Under Secretary Constance Horner to oversee a comprehensive review of our public and private health and long term care financing and delivery. Here in Atlanta, I am beginning what will become a conversation with the American people on what they want from our health care system and what we're willing to pay. Over the coming weeks and months, I'm going to continue my talks with people representing wide-ranging viewpoints on health care.

Since becoming Secretary, I have talked about health care with many groups -- practitioners, Governors, industry and association leaders, state legislative leaders, consumer organizations, and many others. I now hope to engage the American people in a discussion of key issues through a series of speeches. I'm going to address a number of important points:

- Why health care costs so much.

- Personal responsibility for health, and why this must be a part of any cost containment strategy.

- How we fund and administer government health programs for the poor.

- How private insurance operates.

- And better medical practices, and more effective use of procedures.

Today, I would like to touch on some general principles I'll be bringing to bear on options we will be reviewing for the President.

A good starting point is the fundamental notion that everyone should be able to obtain necessary health care. And it is my opinion that we should remove unnecessary barriers to health insurance, and that the present private/public health system should be the primary means by which we achieve this goal.

Let me add, however, that even under the best system, there are still going to be people who need extra help from government -- those for whom even the best designed health care system won't be enough.

But for most people, insurance is the best way to be able to obtain necessary care. This implies two things.

First: in order to have access to proper medical treatment, more Americans should be able to obtain health insurance -- to protect against unexpected economic hardship, or to be able to obtain any medical care. And second: this nation's health care must remain essentially a free market system, within a strong private-public partnership.

Unlike a generation-or-so ago, the vast majority of Americans now have health insurance -- either publicly or privately sponsored. This is unquestionably a welcome development. And yet, this progress sharpens our concern about the 31 million Americans who are now without insurance. In a way, this is a paradox. There has been a most welcome financial restructuring for delivering a basic human need; yet we rightly worry about the significant minority of citizens who are now outside an established economic and social arrangement.

Nevertheless, those who call for a radical revamping of our health care system -- suggesting nationalized medicine -- are mistaken. We need to build on our achievements by getting an even higher percentage of people covered by insurance, rather than replacing our system with something that Americans do not need and would not tolerate.

For example, at a time when most Americans are receiving the finest health care in the world, I find it remarkable to hear some people proposing that we scrap the system and make a radical reform to nationalized medicine -- they often point to Canada as a model. But the Canadian system has some very serious problems, including long waiting lists for critical medical procedures, and de facto rationing. This, I contend, would never suit Americans.

But let it be understood: our independence has a price. To keep it, we must adhere to another general principle of health care financing: as much as possible, individuals must assume responsibility for the cost of their health care. Governments must concentrate their resources on the poorest and neediest.

In an era of federal fiscal constraints, government dollars will never supplant private insurance. Nor should they, regardless of budget considerations.

An optimal health care financing and delivery system should embrace another general principle: the necessity of individual responsibility for health, and care giving and financial support by family members for each other.

In this respect, we need to acknowledge what access to health care and insurance cannot accomplish.

As fire insurance, in and of itself, will not prevent your house from burning down if you fall asleep smoking in bed; nor will health insurance, in and of itself, prevent lung cancer and emphysema if you insist on smoking at all. Health insurance will not reduce infant mortality for mothers who smoke, drink or abuse drugs during pregnancy. Health insurance will not prevent cirrhosis for those who abuse alcohol....the list could go on and on.

Along with better access to insurance must be the acceptance of more personal and family responsibility for physical well-being. Families must care for their members. They must seek inoculations, and regular check-ups, for their children.

If all we accomplish in health care reform is to facilitate better access to care and getting costs under control, we will not have been fully successful. Regardless of access and costs, families and individuals must still be our first line of defense in preventing illness. Indeed, any strategy for constraining costs must include a plan to reduce the need for medical intervention.

This is a part of the overall economic realities we must face. Another of my general principles is that we must fashion methods of health care delivery and financing that constrain growth in health care expenditures.

We want the market to offer an array of products that will meet individual needs. It is also important that the market force individuals, as well as health care providers, to be aware of the costs of health care.

It is my intention to look at options that facilitate diversity, encourage individual financial responsibility, and constrain the growth in health care expenditures through greater efficiency.

For efficiency is needed. General principles for the design of health care financing should include: not stifling economic growth and employment opportunities; and constraining costs through the wise promotion of innovation and quality.

As much as possible, we must permit the medical marketplace to work. A dynamic economy will find some solutions on its own. We do not want to rush in with unproven government remedies which may create more problems than they solve. And the most dangerous unintended consequence could be that by adding overly burdensome mandates on business, we could retard economic growth and constrict employment opportunities.

Without job creation -- or worse, with job destruction -- we could end up with more, rather than fewer, persons lacking health insurance. If one does not have a job, one does not have access to employer-sponsored health care.

We need to find solutions that leave us better off than we were when we started.

Our health care system evolved in a uniquely American way; likewise, solutions must be uniquely American. Most importantly, we don't want to undo what is right about our system. In the coming weeks and months, I'm going to be talking not only about our problems but also about the superior aspects of American health care . Most of our citizens are well served.

It is in this positive context -- finding ways to improve the system -- rather than a negative context -- emphasizing the problems -- that I want to focus our deliberations on options for reform.

So with this in mind, I would like to further those deliberations now by listening to what some of you have to say.

Thank you very much for inviting me.

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But for most people, insurance is the best way to be able to obtain necessary care. This implies two things.

First: in order to have access to proper medical treatment, more Americans should be able to obtain health insurance -- to protect against unexpected economic hardship, or to be able to obtain any medical care. And second: this nation's health care must remain essentially a free market system, within a strong private-public partnership.

Unlike a generation-or-so ago, the vast majority of Americans now have health insurance -- either publicly or privately sponsored. This is unquestionably a welcome development. And yet, this progress sharpens our concern about the 31 million Americans who are now without insurance. In a way, this is a paradox. There has been a most welcome financial restructuring for delivering a basic human need; yet we rightly worry about the significant minority of citizens who are now outside an established economic and social arrangement.

Nevertheless, those who call for a radical revamping of our health care system -- suggesting nationalized medicine -- are mistaken. We need to build on our achievements by getting an even higher percentage of people covered by insurance, rather than replacing our system with something that Americans do not need and would not tolerate.

For example, at a time when most Americans are receiving the finest health care in the world, I find it remarkable to hear some people proposing that we scrap the system and make a radical reform to nationalized medicine -- they often point to Canada as a model. But the Canadian system has some very serious problems, including long waiting lists for critical medical procedures, and de facto rationing. This, I contend, would never suit Americans.

But let it be understood: our independence has a price. To keep it, we must adhere to another general principle of health care financing: as much as possible, individuals must assume responsibility for the cost of their health care. Governments must concentrate their resources on the poorest and neediest.

In an era of federal fiscal constraints, government dollars will never supplant private insurance. Nor should they, regardless of budget considerations.

An optimal health care financing and delivery system should embrace another general principle: the necessity of individual responsibility for health, and care giving and financial support by family members for each other.

In this respect, we need to acknowledge what access to health care and insurance cannot accomplish.

As fire insurance, in and of itself, will not prevent your house from burning down if you fall asleep smoking in bed; nor will health insurance, in and of itself, prevent lung cancer and emphysema if you insist on smoking at all. Health insurance will not reduce infant mortality for mothers who smoke, drink or abuse drugs during pregnancy. Health insurance will not prevent cirrhosis for those who abuse alcohol....the list could go on and on.

Along with better access to insurance must be the acceptance of more personal and family responsibility for physical well-being. Families must care for their members. They must seek inoculations, and regular check-ups, for their children.

If all we accomplish in health care reform is to facilitate better access to care and getting costs under control, we will not have been fully successful. Regardless of access and costs, families and individuals must still be our first line of defense in preventing illness. Indeed, any strategy for constraining costs must include a plan to reduce the need for medical intervention.

This is a part of the overall economic realities we must face. Another of my general principles is that we must fashion methods of health care delivery and financing that constrain growth in health care expenditures.

We want the market to offer an array of products that will meet individual needs. It is also important that the market force individuals, as well as health care providers, to be aware of the costs of health care.

It is my intention to look at options that facilitate diversity, encourage individual financial responsibility, and constrain the growth in health care expenditures through greater efficiency.

For efficiency is needed. General principles for the design of health care financing should include: not stifling economic growth and employment opportunities; and constraining costs through the wise promotion of innovation and quality.

As much as possible, we must permit the medical marketplace to work. A dynamic economy will find some solutions on its own. We do not want to rush in with unproven government remedies which may create more problems than they solve. And the most dangerous unintended consequence could be that by adding overly burdensome mandates on business, we could retard economic growth and constrict employment opportunities.

Without job creation -- or worse, with job destruction -- we could end up with more, rather than fewer, persons lacking health insurance. If one does not have a job, one does not have access to employer-sponsored health care.

We need to find solutions that leave us better off than we were when we started.

Our health care system evolved in a uniquely American way; likewise, solutions must be uniquely American. Most importantly, we don't want to undo what is right about our system. In the coming weeks and months, I'm going to be talking not only about our problems but also about the superior aspects of American health care . Most of our citizens are well served.

It is in this positive context -- finding ways to improve the system -- rather than a negative context -- emphasizing the problems -- that I want to focus our deliberations on options for reform.

So with this in mind, I would like to further those deliberations now by listening to what some of you have to say.

Thank you very much for inviting me.

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FOR RELEASE UPON DELIVERY
WEDNESDAY, NOVEMBER 28, 1990

*REMARKS BY

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

TETELMAN LECTURE/YALE UNIVERSITY

NEW HAVEN, CONNECTICUT

*THIS TEXT IS THE BASIS OF SECRETARY SULLIVAN'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

Thanks very much, Dr. Lytton, and thank you all for that warm welcome. It's a great honor to have been invited by Jonathan Edwards College and Yale University to join you as a Tetelman Fellow, following in the footsteps of so many distinguished scientists and physicians upon whom you have previously bestowed this singular honor.

My lecture this morning will range far beyond what we normally consider science and medicine. Indeed, we will venture into some territory that this college's namesake, Jonathan Edwards, would have found familiar. For I propose to talk about the role of individual responsibility in health care today, and our need to cultivate a new "culture of character" within this nation.

But first, a word of context. My discussion today is part of a larger dialogue that I am conducting with the American people, about the problems afflicting our nation's health care system, and some possible solutions. Recent events in Washington have reminded us once again that, before we attempt to make significant change and reform in our health care system, we must first explore thoroughly with the American people the problems we face, and the difficult and painful choices we must make.

Upon the firm foundation of mutual understanding and trust, we can build the widespread and durable consensus that must undergird any proposed changes in our system of health care.

Last month, at Stanford, I discussed the factors that have driven the dramatic rate of increase in health care costs. In future presentations, I will talk about providing essential health care to those who are currently underserved; the structure of public and private insurance; and the effectiveness of our medical practices.

But today, I wish to discuss the critical role that a renewed sense of personal responsibility must play, as we seek to forge a more effective, less costly, and more humane system of health care. For the harsh truth is that a high percentage of the disease and disability afflicting the American people is a consequence of unwise choices of behavior and lifestyle.

Those poor choices result in lives that are blighted, stunted, and less fulfilling, and they cause an unnecessary, costly drain on the resources available for health care.

The decision to smoke, for instance, is responsible for one of every six deaths in America each year. The cumulative toll is 390,000 deaths per year, including 21% of heart disease deaths, 87% of lung cancer deaths, and 30% of all cancer deaths. In addition, smoking is responsible for 20 to 30% of low birth weight babies. Smoking costs our society over $52 billion annually.

Abuse of alcohol was responsible for one half of the 30,000 motor vehicle deaths in 1988, and 40% of the drownings. Drinking is a major cause of cirrhosis, the ninth leading cause of death in the United States; it has been linked to violence, homicide and suicide; and its costs to society amounted to some $70 billion in 1989.

Improper diet and inadequate exercise are other major contributors to poor health outcomes. Poor diet is related to five of the ten leading causes of death in the U.S., including coronary heart disease, some types of cancer, stroke, and diabetes. Together, unhealthy diet and sedentary habits contribute to 300,000 to 400,000 deaths each year.

For children and youth, injuries are the leading cause of death. The lifetime costs of injuries were estimated to be $158 billion in 1985.

Problems of behavior and lifestyle contribute to some of the leading health problems facing this nation, including infant mortality, heart disease, and cancer.

If we are to bring better lives to all Americans -- and if we are to cope with the dramatic increases in health care costs in America -- it will be necessary for us to address directly the problem of ill-advised choice of behavior and lifestyle. And taking on this challenge, carries us well into the difficult realms of ethics and culture.

Now, this is not a comfortable passage for physicians and health care professionals -- nor for Americans in general. By our actions, it would appear that we would rather avoid the issue of appropriate, healthy behavior altogether. But, clearly, our avoidance is ill-advised, both from the standpoints of healthy, fulfilling lives, and of financial costs.

Why do we approach health this way? In part, I believe, because we have seen such miraculous achievements in medical science that we believe that medical science can, indeed, fix virtually any ailment. Our faith in medicine grows ever stronger as we push out the frontiers of research, unveiling more of the secrets of life. Consequently, we have come to think of medicine as a safety net, strong and wide enough to catch all who fall from the high wire of an unhealthy lifestyle.

Even as our trust as a society in medical science grows, however, I am troubled by diminishing confidence in our willingness and ability as a society and individuals to make sound judgments about healthy human behavior and lifestyles. Linked to this declining faith in ethical and value judgment is an erosion of those institutions that have generated, shaped, and sustained our ethical and cultural standards -- family, neighborhood, church, school, and voluntary associations. As a consequence of this institutional decline, we have fewer sources of instruction in healthy, constructive behavior.

I leave it to the students and faculty of this splendid university to explore fully the profound issues of science, ethics, and philosophy into which we've ventured as a society. But from my practical standpoint -- as a physician, and as Secretary of Health and Human Services -- let me simply say this: every day, all about me, I see the toll of our ethical dilemma, the tragic price of our cultural indifference -- not only in the prevalence of preventable disease and injury, but also in the vast range of social problems afflicting the American people -- drug and alcohol addiction, escalating child abuse and neglect, children born to unwed teen mothers, families abandoned or never formed. So many of these problems have their roots in the alienation, isolation, and lack of direction that follow from the collapse of societal standards, and the institutions that generate them.

That is why I have travelled from one end of the country to the other over the past two years, calling for a renewed sense of personal responsibility on the part of every American citizen -- in short, a new "culture of character."

By "character," I mean the personal values and qualities encompassed by that sturdy, time-honored word -- values like self-discipline, integrity, taking responsibility for one's acts, respect for others, perseverance, moderation, and a commitment to serve others and the broader community.

By "culture," I mean these values that must be embraced as cornerstones of our society. I seek to remind Americans that we can best cultivate character in our citizens by reinvigorating and shoring up those institutions that teach and nurture values and principles of healthy behavior, especially the institutions of family and community.

I certainly came to appreciate, in my own experience, the critical value of strong families and communities, and the standards they nurture. The neighborhoods in Atlanta and Blakely, Georgia, where I grew up, were by no means wealthy, but they <u>were</u> genuine communities -- joined together in joy and sorrow, sharing our benefits and burdens, committed to common values and principles.

I was not just the child of my father and mother -- I was in fact a child of the entire neighborhood. When I was out of sight of the folks and thought I could get away with something, Mr. Jones or Mrs. Smith down the block was sure to step in and administer appropriate, corrective caring -- whether I liked it, or not.

Now, I have to admit, there were times when all this caring about my personal life was not particularly welcome. But I have since come to appreciate just how critical that attention and discipline are. Through it I learned certain values -- reinforced at every turn by my family, neighbors, church, and school -- values that carried me to medical school, and that carried you into your studies and professions -- values like self-esteem, self-discipline, the desire to learn, responsibility, and service.

In short, my neighborhood built around me a culture of character -- an ethic of personal responsibility. As my beloved mentor, the late Dr. Benjamin Elijah Mays, former president of Morehouse College, put it, I learned that "It is not your environment, it is you -- the quality of your mind, the integrity of your soul, the determination of your will -- that will decide your future and shape your life."

Translated into strategies that would mean healthier, longer lives for all citizens, a new culture of character calls upon Americans to end drug abuse; avoid the high risk behavior that spreads the AIDS virus; reduce consumption of alcohol; seek early prenatal care; improve eating habits; wear seat belts and take other necessary precautions; increase exercise; learn to resolve conflicts without resort to violence; seek the necessary medical examinations and vaccinations; and, yes, stop smoking.

Were we to follow these injunctions, studies have shown that we could eliminate 45% of deaths from cardiovascular disease, 23% of deaths from cancer, and more than 50% of the disabling complications of diabetes. Indeed, control of fewer than ten risk factors, including the above -- could prevent between 40 and 70% of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.

Just as important, a new culture of character in America, nurtured by strengthened families and communities, would do much to alleviate the alienation, isolation and despair that fuel teen pregnancy, violence, drug and alcohol abuse and other social problems afflicting us. The lives of Americans would be healthier in every sense of the word.

Now, I have heard it said that my call to a new culture of character is in fact nothing more than a way of diverting attention from a Federal government and a society that refuses to provide the resources necessary for better health care for all Americans.

To be sure, poverty is linked to ill health and social dysfunction. But let us never be guilty of suggesting to our citizens that first they must be wealthier, before they can be healthier. In fact, many impoverished families and neighborhoods have sustained the values and institutions necessary for healthy, productive lives -- lives that will eventually lead them out of poverty.

To suggest that our poor and minority citizens cannot improve their lives, by drawing on their own strong, traditional values and institutions, is not only inaccurate, it is patronizing and insulting. To counsel them to sit and wait patiently for massive new Federal (or other) programs is to counsel resignation, defeat, pessimism, and despair.

Ill-advised choices of behavior and lifestyle characterize all strata of American society. And so the call for a new culture of character applies with equal force to all Americans, regardless of income, race, sex, or other status.

Let me be clear about another aspect of the "culture of character." It by no means puts the onus for healthy behavior exclusively on the individual, nor does it rely simply on a heightened sense of personal responsibility. That's why our culture -- the broader realm of social, economic, and political institutions that shape our lives -- figures centrally in my message. We must mobilize all those institutions in the cause of healthier, more productive lives for our citizens.

The Federal government is playing a leadership role by marshalling all facets of society behind disease prevention and health promotion, as demonstrated most recently by our report of health goals for the nation, entitled Healthy People 2000 -- a careful, thorough enunciation of certain clearly defined health goals to be reached by the turn of the century. We are also working to elevate the status of preventive services in our approach to health care delivery and health policy reform.

More broadly, the Federal government today is working to revitalize institutions like the family and local community, which cultivate healthier, life-sustaining values. This approach carries us beyond the attitude of the 80s, when government retreated from active social policy.

We now know that Federal programs are most effective when they work through, and help to reinforce, active, indigenous community groups. And so today, we are providing resources and assistance to community coalitions that are striving to prevent the spread of AIDS; halt drug and alcohol abuse; provide early childhood development programs; counsel young minority males; reduce violence; bring expectant mothers into prenatal care programs; and a vast range of other activities.

Workplace America also has a role to play in building a new culture of character. Businesses must become far more attentive to the health and lifestyle of their employees, both by discouraging unhealthy behavior like smoking and drug and alcohol abuse, and by encouraging positive behavior, like exercise and proper diet.

Equally important, some corporations must be held accountable when they undertake actions that erode the culture of character. Heavily promoting alcohol and tobacco sales in low-income communities is one such reprehensible act.

The media and cultural leadership groups also have a vital role to play in shaping a new culture of character in America. If they can help us celebrate solid values and institutions, then Americans will be far more likely to adopt healthy lifestyles.

A step in the right direction is the dramatic turn-about in Hollywood's and Madison Avenue's treatment of drug use. Where once it was accepted, today it is the target of a highly effective, voluntary multi-million dollar prevention campaign. This is a good example of what can be accomplished, if our media leaders can be mobilized behind healthier lifestyles.

Finally, within my own profession of medicine, health promotion and disease prevention must play a much larger role. We must work to redress the imbalance in health care expenditures devoted to promoting health versus treating disease -- currently, only 4% of total expenditures go to prevention -- and we must make prevention a central part of the improved primary health care that we are striving to make available to all Americans. Above all, physicians must overcome their reluctance to venture into the personal, private behaviors of those to whom we minister, in order to give them thoughtful counsel about the effect their choices have on their health.

This brings me to one final comment about my vision for a new culture of character in America. It is a culture in which we not only are more careful about our own health behavior, but also more attentive to the behavior of those around us -- our family members, friends, neighbors, and coworkers.

We must have the courage to point out the dangers of unhealthy, self-destructive behaviors in those around us, as well as voice approval for their healthy behaviors. And when these judgments are rendered -- not out of smugness, or self-righteousness, or condemnation, but out of compassion, concern, and love -- when they come in the spirit of family and friendship -- then the message of a new culture of character will have discovered its most effective and profound voice.

My plea for a new culture of character, a new ethic of personal responsibility, is by no means intended to be a substitute for the changes that we must make in our broader system of health care. Government will have to be more active on behalf of those who are underserved by current health care arrangements -- especially our poor and minority citizens -- as I will discuss at another time.

But I believe that, as we struggle to overcome the barriers to healthier lives for all our citizens, we can learn much from the experience of the Black community in America. That experience teaches us that progress and reform are most likely to come when we pursue a two-fold strategy: first, strive to change the external circumstances that are unjust and hold us back; but second, strive to reinforce the strength of character necessary to survive and prosper in spite of adverse circumstances.

Neither strategy in isolation is sufficient; both strategies together cannot fail to bring significant progress and reform. Frederick Douglas, for example, worked not only to abolish the social circumstance of slavery; he also sought to build better individuals, by emphasizing the importance of character. "With character we can be powerful," he proclaimed. "Nothing can harm us so long as we have character."

In our time, the outstanding leaders of our community continue to pursue both strategies simultaneously. Dr. Martin Luther King, Jr. resolutely pursued changes in society's laws and institutions, so that one day his daughters would not be judged by the color of their skin. But at the same time, he worked to prepare people for the day when they would be judged by the "content of their character."

Similarly, Jesse Jackson's quest for social and economic change in the larger society is joined inseparably to a call for personal reform, for better character. As he put it, "When you drink liquor, and when you take drugs, and when you sell drugs, and when you shoot people and when you rob people . . . nobody can save you but you from yourself."

So today, as we search for ways to ensure that our expenditures for health care are wisely spent, and not squandered treating unnecessary and preventable disease -- more important, as we search for ways to bring healthier, safer, more fulfilling and productive lives to all our citizens -- let us pursue both strategies at once. Let us not only seek ways to change and improve our health care system -- let us search for ways to improve ourselves -- our behavior and lifestyles, our values, indeed, our very character.

A new culture of character is not the entire answer to the health care dilemmas we face. But it is an essential, crucial part of the answer. And it is a vital key to better lives for all Americans.

Thank you very much.

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THE WHITE HOUSE

Office of the Press Secretary

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UNTIL 10:10 AM, EST

January 21, 1992

MEETING THE NATIONAL EDUCATION GOALS: THE PRESIDENT'S HEAD START INITIATIVE

FACT SHEET

The President today announced he will propose the largest increase in Head Start funding in history -- $600 million -- in his Fiscal Year 1993 budget. If approved by Congress, this will mean funding for Head Start will have more than doubled -- a 127 percent increase -- since the President took office.

The President stated that this increase will "allow every eligible four year old whose parents want them to participate to have the Head Start experience before starting school." This will enable economically disadvantaged children and their parents to benefit from quality preschool education and preventive health services.

This unprecedented increase in funding will help move the nation toward achieving the first national education goal established by the President and the Governors that "By the year 2000, all children in America will start school ready to learn."

Background on Head Start

Head Start is a comprehensive child development program serving pre-school, low-income children, usually in the year just before they enter school. It provides educational, health, medical, nutritional, social, and parenting services to children and their parents.

Children enrolled in Head Start receive immunizations, medical care, dental care, speech and hearing screening, and social services. Every program also provides each enrollee with at least one meal per session. A typical Head Start program lasts for nine months with 3-4 hours of service each day and can be home-based, center-based, or a combination. The program emphasizes parental involvement in the program's direction.

Head Start is one of many efforts to ensure that children arrive at school ready to learn. In addition to Head Start, thirty eight states and the District of Columbia also fund pre-school programs.

The President's Head Start Initiative

The President's proposed increase represents a 27 percent increase over 1992 to a total of $2.8 billion. This would allow Head Start to serve 779,206 children -- 157,206 more than the number who will be served this year. In addition to this record expansion of children served, the President's budget will further Head Start's effectiveness through:

- Drug Prevention. The budget includes $13.2 million to help Head Start families who are at risk of or who face problems due to alcohol or drug abuse.

- Evaluation. The budget includes $12 million for studies of the long-term effectiveness of Head Start.

- Parental Involvement and Support. Parents have a central role in determining the goals of Head Start Centers as well as its day-to-day operation. The Administration will continue to support and expand Head Start's new Family Service Centers, which provide parents with literacy services, job training services, and child care workshops.

Transition to School: The Head Start Challenge

Evaluation studies suggest that, while Head Start participants are better off than comparable non-participants when they start school, in some cases the advantage may fade as they progress in school. To assure that Head Start incorporates programs that will have long term benefits, the Administration is working to evaluate Head Start's structure and to strengthen the transition between Head Start and the schools Head Start children will enter.

- A recent conference of Head Start program directors and urban school administrators concluded that a working relationship between Head Start programs and individual schools is imperative if Head Start is to ensure the success of young children.

- $20 million has been awarded to 32 communities to develop Head Start-to-school collaboration strategies.

- At the Federal level, the Head Start program and the Department of Education are working to ensure that the benefits of Head Start carry through to an elementary school system that will build on the Head Start base.

When children leave Head Start, ready to learn, they deserve to enter a revitalized, innovative, education system that will challenge, motivate, and provide them with the knowledge and skills they need for the 21st century.

# # #

A Head Start Does Not Last

A new study finds that poor kids need intensive help long after they leave nursery school

Head Start is virtually the only antipoverty program backed by liberals and conservatives, parents and early-childhood experts. Even in the midst of the recession the federal government doled out $2.2 billion this academic year for programs in all 50 states, guaranteeing up to two years of preschool for 600,000 3- to 5-year-olds. This week, President Bush is expected to announce that he is asking for a record increase in Head Start funding in the fiscal 1993 budget. Much of the support for Head Start is based on the belief that it levels the playing field for poor kids, giving them, as Bush put it in his 1988 campaign, "an equal place at the starting line." But now, a new long-term study suggests that underprivileged youngsters need a much bigger boost if they are going to finish the race.

J. S. Fuerst of Chicago's Loyola University School of Social Work studied the lives of 684 children who attended six special, publicly funded schools in Chicago between 1967 and 1977. Most had not only two years of preschool but also from two to seven additional years in an intensive elementary-school program that Fuerst describes as "Head Start to the fourth power." The six child-parent centers set up in the city's worst neighborhoods encouraged parents to help out at school and gave kids a heavy dose of academics, with an emphasis on language development.

All of the children were black, and a majority were raised in single-parent families. Sixty percent were on welfare. Classes had no more than 20 students and in many cases children had the same team of teachers and aides for a number of years. Students spent all of their school hours—half days for preschoolers, full days for primary pupils—at the centers. There were different instructional programs, but all were academically oriented. After they finished the program, most went on to regular public schools; others transferred to parochial schools.

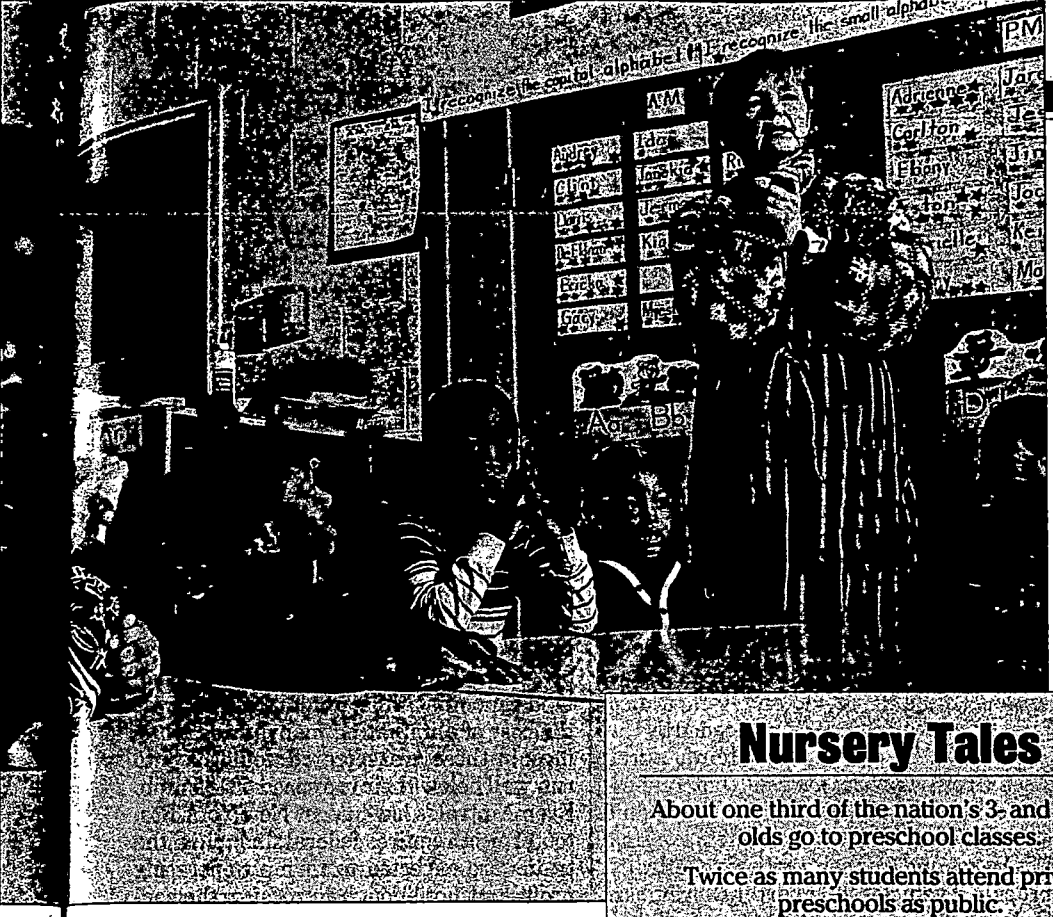
In 1974, when he first looked at reading- and math-test scores of center graduates,

First lessons: *A class at the Cole Child Parent Center in Chicago*

Fuerst found that they outranked their neighborhood peers and even exceeded national norms. Most of the kids he studied were then 13 or under. Their high scores were especially remarkable because Chicago had a rapidly deteriorating public-school system that former education secretary William Bennett later classified as America's worst. A decade later, when Fuerst and his wife, Dorothy, began gathering data for a much larger study tracking center kids through their high-school years, he found

PHOTOS BY STEVE LEONARD—BLACK STAR

Clear benefits: *Edwards, left, with daughter, Kiah, and Fuerst, above*



Nursery Tales

About one third of the nation's 3- and 4-year-olds go to preschool classes.

Twice as many students attend private preschools as public.

The odds against failing in school, researchers say, rest on a litany of factors. Poor children are the most at risk. Their chances get worse if they have a single parent who didn't finish school or has limited English skills.

In this academic year, Washington doled out $2.2 billion for Head Start programs in all 50 states, guaranteeing up to two years of preschool for 600,000 3- to 5-year-olds.

SOURCES: NATIONAL CENTER FOR EDUCATIONAL STATISTICS; HEAD START

that many of those early gains had been lost. Only 62 percent graduated from high school. That was better than the 49 percent graduation rate among a control group of 676 non-Center kids from the same backgrounds, but well under the national average of about 80 percent for 19-year-olds. Even more alarming, there were stark differences between boys and girls. A total of 74 percent of the girls finished school, but only 49 percent of the boys got diplomas. It was a dramatic reversal of his 1974 finding that boys' and girls' test scores were almost identical when they left the centers.

Some hope: At first glance, these seem like extremely discouraging results. But Fuerst says that when he studied the numbers more closely, he found some hope. At one of the six centers, children received an extraordinary amount of special instruction: seven to nine years. In that group the gains in high-school graduation were dramatic: 70 percent of the boys and 85 percent of the girls finished. Fuerst thinks his study shows that girls should get four to six years of extra help, while boys—who appear to be much more susceptible to peer pressures—need seven to nine years of intensive academics. "Nobody wants to knock the one ray of light warming a sea of darkness," says Fuerst. "But overestimating Head Start isn't fair to these kids."

Fuerst's study adds considerable weight to a growing sentiment among early-childhood educators that inner-city kids need much more than a year or two of preschool. "The best program in the world for a very short time at age 4 is not going to help children survive the onslaught" of neighborhoods devastated by crime and drugs, says Barbara Willer, public-affairs director of the National Association for the Education of Young Children. "If you view it as an inoculation, you're in for a surprise."

Head Start's long-term effectiveness was just a theory at its conception in 1965. Initially, Head Start's creators envisioned it as a six- to eight-week summer program. "We thought that very minimal intervention would give us very big payoffs," says Edward Zigler, a psychology professor at Yale who helped develop Head Start and was one of its first directors. Zigler says the founders soon realized that kids needed at least a year or two of Head Start. Early studies of Head Start and similar programs confirmed that this preparation did indeed help kids in their first years of grammar school.

In the public mind, however, Head Start's benefits got a tremendous boost in the past decade from a widely publicized study of the Perry Preschool Project in Ypsilanti, Mich. That research indicated that early intervention could lower delinquency, joblessness and teen-pregnancy rates. Some early-childhood experts say these results have been misinterpreted: the Ypsilanti project was not a Head Start program and was more rigorous than typical Head Start classes.

In the last few years, educators have been looking for effective ways to sustain Head Start's gains. The search has become more urgent, with so many children in single-parent homes. They are the most likely to grow up in poverty and have problems in school. Zigler says he favors a three-year "transition" project in the early elementary grades that would emphasize parental involvement. At Johns Hopkins University in Baltimore, Robert Slavin and his colleagues at the Center for Research on Effective Schooling for Disadvantaged Students have developed the "Success for All" program for preschool through third grade. It emphasizes extra help in reading, family support and teacher training. So far, the results are encouraging: most third graders are reading at grade level, and many are over.

Helping parents: Wade Horn, the federal Head Start administrator, says Washington is also looking for new approaches. Getting parents involved in school is generally recognized as a key ingredient, and Horn says that part of the Head Start budget is going toward what he calls a "two-generation model." By the end of this year, he says, there will be adult-literacy programs in every Head Start center, and there are ongoing efforts to include job-training and substance-abuse projects. Head Start has also given out $20 million in research grants to experimental transition-to-school programs.

The Chicago programs Fuerst studied have survived in greatly modified form. Now they're mostly for preschoolers; many of the auxiliary staffers, such as social workers and full-time nurses, have been laid off. But Claretta Edwards still has fond memories of the Cole Child Parent Center. In 1967 she was one of the first 4-year-olds in the program. "We were pushed to do our best," she says. After high school Edwards earned a bachelor's degree in nursing, and she now works in a hospital emergency room. Her 4-year-old daughter, Kiah, attends preschool at Cole, where some of the same teachers who inspired Edwards now help her daughter. Those teachers also get a lot of support on the home front. For Christmas, Edwards gave her daughter a gift with clear long-term benefits: 30 books.

BARBARA KANTROWITZ *with* JOHN MCCORMICK *in Chicago*

Wanted: Mary Poppins

For many middle-class families, the hand that rocks the cradle belongs to a nanny. Despite a few headline horror stories, the business is booming.

Stevie Lewis was behaving strangely, and her parents, Betty and John, were baffled. When the 2-year-old said her nanny's name, she slapped herself on the forehead. She threw herself on the floor and said, "I fall" and "ouch." One morning last September, after Betty had left for work and John was about to, Stevie screamed and clung to him. When her nanny appeared, says John, "Stevie shrieked as though Freddy Krueger just walked in the door. It wasn't a normal cry." John, suspicions aroused, discreetly set up a video camera in their Palmdale, Calif., house. He came home to a horror movie, and called the police. The tape showed nanny Martha Mendoza, 19, repeatedly hitting Stevie on the head with a spoon because she wouldn't finish her yogurt and throwing her to the floor, holding her arm to break the fall. Mendoza, who pleaded guilty to a misdemeanor, cruelty to children, is serving 120 days in jail. John says that Stevie "brings up the nanny's name every now and then. She says, 'She's bad'."

Bad nannies are the wicked stepmothers of the '90s. "The Hand That Rocks the Cradle," which features a psychopath who tries to murder her employer and run off with the children, is the top-grossing movie in the country. In a real-life tragedy last month, 3-month-old Kristie Fischer died in a fire in her Thornwood, N.Y., house. Police have charged Olivia Riner, 20, the Swiss woman Denise and William Fischer had hired, with murder and arson. Riner, who pleaded innocent, is awaiting trial. Fortunately, such a case is rare. As more families have two working parents, the demand for live-in child care is increasing. Nannies are now big business. The International Nanny Association, a nonprofit service organization based in Austin, Texas, estimates that there are 75,000 experienced nannies in the United States. For every family who hires one, there are several more waiting.

The term nanny is often used to describe any in-home child-care worker. In fact, a nanny is someone who may or may not have formal training, but usually has experience, often lives with the family and takes on almost all child-related tasks. A nanny often considers the job a career and

What to Ask

Hiring a nanny is easier if you follow some common-sense rules:

- Be very specific in describing your household and the nanny's responsibilities.
- Reinterview any candidate you're seriously considering.
- Have a prospective nanny spend time with your children and watch how they react to one another.
- Double-check all references and ask hometown police if the candidate has a record.
- Ask plenty of "What would you do if . . .?" questions.
- If you're hiring a professionally trained nanny, ask for a complete description of the training.

SOURCE: INTERNATIONAL NANNY ASSOCIATION

DAVID WALBERG

AP

JAMES D. WILSON—NEWSWEEK

Who's minding the kids? *Riner after her arrest (top), California Nanny College students learning infant CPR, Fanning with the Borre children*

may be paid commensurately. An au pair is usually a young woman, often from abroad, who lives in, helps with the kids, does some housework and gets a small salary. An au pair (Riner was one) may or may not be experienced, is supervised by the employer and usually stays for a limited period. A babysitter minds the children but is not expected to be trained, or to do housework, may work only part time and usually is not paid as well as a nanny.

Nannies, however, are no longer only for the rich. "This is becoming a real middle-class phenomenon," says Janet Shannon, executive director of the INA. For families who have room and are willing to sacrifice some privacy, nannies can be both convenient and economical. Larry and Barbara Cafero of Norwalk, Conn., pay $175 to $200 a week for a nanny to look after their two children and do some chores. Some of their friends pay $150 a week just for day care, Larry says, "and they have to bundle the kids up, drive them across town, drop them off at the center and bring them home at night. They have no quality time with their kids. I think I'm paying less money than they are." Urban families can draw on a pool of immigrants who may have no special training but need a place to live and will work for low wages.

Want ads: All parents worry about child care, but there are many things they can do to reduce the risk of hiring someone unsuitable. It's possible, and less expensive, to find a good person through the want ads. But, says a New Jersey father who has hired many nannies for his two daughters, "The worst ones were the ones we found on our own." Reputable employment agencies can help weed out the bad prospects; some hire private detectives to do background checks. (The INA supplies names of approved agencies.)

The burden is still on the employers (chart). They should double-check every reference, even if they're using an agency. Most important, they should make their needs very clear. "You have to be absolutely honest about what the job is, that they'll be emptying the trash as well as playing Candyland," says Charlotte Smith, a Neshanic, N.J., mother of four. "Sometimes nannies come back from meeting parents," says Sandra Costantino, who runs Neighborhood Nannies in Haddonfield, N.J., "and we say, 'Did they tell you about their German shepherd that has to be walked?' The nanny says, 'No.' Fido comes up to your waist and, oh yeah, the family just forgot to mention it." Poor communication is often the root of a nanny problem. Parents should take a few minutes every day to talk to the nanny about the day's events, and once a week hold a general discussion, including grievances on either side. "Above all," the INA recommends, "express your appreciation often."

When there's trouble, the nanny is not always to blame. Some employers demand too much, asking nannies to wash windows, clean the garage and mow the lawn. Others make more serious demands. Last month, a 23-year-old nanny in California told the wife in the household that the husband was sexually harassing her. The woman didn't believe her. When the nanny quit, the couple refused to pay. Elaine Santor, owner of Santor ABC Services in Ventura, Calif., the agency that had placed the nanny, convinced her to sue for back pay and report the sexual-harassment charges. Two weeks later the wife called the young woman to say that every nanny she had had made the same complaints. "She knew something was wrong," says Santor, "but what could she do? She loved her husband."

"Everybody wants Mary Poppins," says Carole Johnson, director of Malibu Mamas in Malibu, Calif. "But if she was around today, she would probably be making about $750 a week, have her own guest house, health insurance and a three-week vacation." With nannies, as with many things, you get what you pay for. A young, inexperienced person can work out well, but if you hire one, says Margaret Ann Campbell, 32, who works for NBC and lives with her husband and son in South Orange, N.J., "you're also somewhat a parent. You have to set rules." The INA urges nannies to get some training; the National Council of Nanny Schools in University Center, Mich., is in the process of accrediting various programs. Sacramento's California Nanny College graduates 200 people (some male) a year. Students get six months of intensive classes in everything from child development and nutrition to infant and toddler health and safety. All are CPR-certified and do a supervised internship while in college. Mary Jo Fanning, 28, couldn't make ends meet as a day-care worker. Now, after graduating from the nanny-training program at Oakton College in Des Plaines, Ill., she's a nanny for 13-month-old Alex and Kalen Borre, 2, in Chicago. "I love it," she says. "As far as jobs go, this is it. I feel like I've found my niche."

Maggie Weber, a single parent in Port Washington, N.Y., has three children, including disabled twins. "Nannies have been a lifeline," she says. She's learned that what's most important is to roll with the punches. "I don't care if we tap dance in banana pudding on the floor," she says, "as long as it's a good experience." The best nannies are remembered happily long after they have moved on. This spring, one of Charlotte Smith's daughters will be a flower girl in the wedding of her former nanny—proof positive that the hired hand that rocks the cradle can be loving indeed.

KATRINE AMES *with* LYDIA DENWORTH *in New York,* JEANNE GORDON *in Los Angeles,* BINNIE K. FISHER *in Dallas,* DIANA MARSZALEK *in Chicago and* DANIEL GLICK *in Washington*